Department of Health Care Policy and Financing
Assumptions and Calculations
FY 05-06

Budget Request

NOVEMBER 1, 2004

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ORGANIZATION

This document is presented in Long Bill line item order. However, it begins with a discussion of the temporary increase in the Federal Medical Assistance Percentage since several line items were affected in FY 02-03 and FY 03-04. Line items that do not exist in the current Long Bill have been represented in their approximate historic location. This document is in order of the Schedule 3 spreadsheets.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) ENHANCEMENT

On May 28, 2003, President Bush signed into law the Jobs and Growth Tax Relief Reconciliation Act of 2003. Subsection 401(a) provided for a temporary 2.95% increase in the Federal Medical Assistance Percentage (FMAP) for medical services for all states. This additional 2.95% increased the federal match to 52.95% for Colorado. The enhanced FMAP was available for a period of five calendar quarters that began on April 1, 2003 and ended on June 30, 2004.

These additional federal funds did not change how the Department's budget was appropriated. Fund splits within each appropriation were maintained at the 50% federal Medicaid funds and 50% State or non-federal funds. Instead, the (M) provision as stated in the Long Bill was utilized. The key segments of this provision, as applicable to the Department's situation are as follows: "Where general fund . . . is required as a condition for the acceptance of federal funds and the state matching requirements are reduced, the combined general fund . . . amount noted as "(M)" shall be reduced proportionately."

The additional federal funds were appropriation neutral to the total funds available. The funds shifted within the total amount of the appropriation. As one fund source increased, the need for the second fund source was reduced by the same amount.

Based on the (M) provision, the additional FMAP was dealt with through an accounting mechanism for all Medicaid services that were eligible for the enhanced federal match. In the State's Colorado Financial Reporting System (COFRS), the Department's Controller restricted the amount of General Fund equal the projected additional 2.95% federal funds, in effect reducing the amount of General Fund available to be spent for each affected line. The Spending Authority equaled the original appropriated amount. The example below demonstrates how the funds were appropriated, and how in actuality the funds were loaded into COFRS. The Schedule 3s show how the funds were appropriated in the Long Bill, and the revised fund splits (with increased federal funds) in the "expenditures" and "overexpenditures / reversions" for each affected line item.

Example of Provision (M) Application

	Total Funds	**General Fund**	**Federal Funds**	**Restricted General Fund**
As Appropriated	$200,000	$100,000	$100,000	$0
Expenditures - (M) provision applied	$200,000	$97,050	$102,950	$2,950

(1) EXECUTIVE DIRECTOR'S OFFICE

PERSONAL SERVICES

Prior to FY 03-04, the FTE and funding for the Department's Personal Services were in five separate line items:

- Executive Director's Office, Personal Services;
- Executive Director's Office, Colorado Benefits Management System;
- Medical Programs Administration, Personal Services;
- Medical Programs Administration, Health Insurance Portability and Accountability Act (HIPAA) Staffing Costs; and,
- Indigent Care, Program Administration.

During that time, some of the Department's Personal Services appropriations (Colorado Benefits Management System, Indigent Care Program Administration and HIPAA Staffing Costs) had their Operating Expenses and Personal Services combined under one appropriation. At the Department's request, during FY 03-04 Figure Setting, the Joint Budget Committee recommended that all Personal Services within the Department be combined into one line item and that all operating expenses be separated into one appropriation (see page 163 of the FY 03-04 Figure Setting document dated March 11, 2003). By combining all Personal Services under the Executive Director's Office line item group, the Department gained flexibility in the utilization of funding and FTE. However, due to the consolidation of line items and reorganization, comparisons between the FY 03-04 actuals and previous years are difficult. It is important to note that the FY 02-03 Actuals column for Executive Director's Office in the Schedule 3, will only show expenditures for the old Executive Director's Office Personal Services line before the consolidation. For the FY 03-04 Actuals, the FY 04-05 Appropriation and Estimate, and FY 05-06 Request columns, the consolidated line is shown. Additionally, the Schedule 3 Position Detail now summarizes by position as directed by the Office of State Planning and Budgeting's Budget Instructions, page 8-5, dated June 1, 2004.

The Schedule 3 delineates the Personal Services appropriation, request of FTE, and request of Personal Services funding. The "FY 04-05 Estimate" and "FY 05-06 Request" columns consist of estimated expenditures of the FY 04-05 Personal Services appropriation, all related out-year legislative impacts, and any other Common Policy adjustments such as the 0.2% base reduction.

The Schedule 3 is presented with two calculations of Personal Services costs (the Position Detail Calculation and the Personal Services Request) and then details the difference between them in the Reconciliation.

I. Position Detail Calculation

The first calculation method used is the Position Detail, labeled "I" in the Schedule 3. The Position Detail is a summary of State employee wages and FTE by position title (totaled at "I.A."), with "Other Personal Services" separately stated (totaled in "I.B.").

"Other Personal Services" are costs not included in the base salaries calculation that typically include PERA, Medicare, State temporary employees' salaries, contractual services, termination and retirement payouts, and unemployment insurance. Then, central POTS (totaled in "I.D.") are added: Salary Survey, Performance-based Pay, Senior Executive Service, Health/Life/Dental, and Short-term Disability that were expended or are estimated for this line item for the Actual and Estimate years. Salary Survey/Senior Executive Service and Performance-based Pay expenditures are "non-add" items because the salaries listed by position should already reflect these costs.

The Position Detail method assumes continuation of the existing staffing pattern in the Request year including any annualizations of FTE; calculations start with actual salaries and then other anticipated costs are added. The Position Detail method ends with a "Difference" row (I.F.) that presents the difference between the Personal Services Reconciliation Total (III) and the Base Personal Services Subtotal (I.E.). The difference is shown for the Estimate and Request year columns.

The first method summarizes actual expenditures for FY 02-03 and FY 03-04. Then, the FY 04-05 Estimate and the FY 05-06 Request are broken out in the same manner. This is not the Department's Personal Services Request. The following is a description for the Position Detail (I) FTE and total funds described by column.

The FY 02-03 Actual column reflects actual expenditures for the year after the close of period 13 in the Colorado Financial Reporting System. Expenditures consist of the following:

- The Department's Executive Director's Office by position salary cost of $1,647,010 (I.A.); plus,
- Other Personal Services (I.B.) totaling $246,526 for items such as PERA, Medicare, Temporary Services, and Contractual Services, plus,
- POTS expenditures (I.D.) of $46,725 that consisted of Health/Life/Dental and Short Term Disability Insurance. Expenditures for Salary Survey, Anniversary Increases, and Senior Executive Services are non-add items as they are included in the salary costs in I.A. above.

The FY 03-04 Actual column reflects actual expenditures after the close of period 13 in the Colorado Financial Reporting System as summarized below:

- The Department's Executive Director's Office by position salary cost of $10,277,443 (I.A.);
- Other Personal Services (I.B.) totaling $2,121,442 for items such as PERA, Medicare, Temporary Services, and Contractual Services; plus,
- POTS expenditures of $365,245 (I.D.) that consisted of Health/Life/Dental and Short Term Disability Insurance. Expenditures for Salary Survey, Performance-based Pay, and Senior Executive Services are non-add items as they are included in the salary costs in I.A. above. However, these costs were zero for FY 03-04.

- Shift Differential is not applicable to Health Care Policy and Financing.

The FY 04-05 Appropriation column shows no detail for this piece of the calculation, but is the amount appropriated for base salaries plus other personal services (I.C.). POTS are not included.

The FY 04-05 Estimate column shows the current positions' salary costs (I.A.). Calculations for this section start with the current positions' salary costs including Salary Survey and Performance-based Pay Awards (July 1, 2004 salary * 12), yielding $11,372,999 with 195.5 FTE. The next step was to add Other Personal Services, of $1,976,937. This amount includes:

- PERA of $1,154,359 calculated using 10.15% of the $11,372,999 above;
- Medicare of $164,909 calculated using 1.45% of the $11,372,999 above;
- State Temporary Services of $37,568 incorporating existing Personnel Action Requests and estimates provided by program managers;
- Other Temporary Services estimated at $131,373 considering current Department contracts and estimates provided by program managers;
- Contractual Services estimated at $337,348 considering current Department contracts and estimates provided by program managers;
- Excess Short-term Disability estimated at zero because past actuals have been zero, except for FY 01-02 at $49;
- Termination/Retirement Payouts estimated at $117,952 for unused vacation/sick time accumulated during employment – estimated to be a percentage of the FY 04-05 salary base (the percentage is equal to the ratio of FY 03-04 actual payout expenditures to FY 03-04 salaries);
- Unemployment Insurance of $31,928 based on FY 03-04 actual expenditure ratios applied against the FY 04-05 salary base; and
- Employee incentives of $1,500 estimated according to actuals from FY 03-04.

POTS expenditures of $431,597, consisting of appropriated amounts for Health/Life/Dental Insurance and Short-term Disability Insurance, are then added to bring the Base Personal Services total (I.E.) to $13,781,533 for the 195.5 FTE. Appropriated amounts for Salary Survey of $243,786 and Performance-based Pay Awards of $133,314 are listed, but not added, as they have been included in the salaries delineated in the Position Detail. Even though there is a separate appropriation for Salary Survey and Performance-based Pay awards, actual wages for State employees are tracked and paid out of the Personal Services line, therefore these amounts are included in each position's salary amount for the estimate year.

Not all positions are filled all twelve months of the year. To account for this in the FY 04-05 Estimate column, currently vacant positions that do not have immediate fills pending are reduced by an incremental FTE count and dollar adjustment in order to ensure that the appropriated FTE (195.5) is not exceeded. Since these positions will not be the same positions vacant throughout the year, this is considered a budgeting adjustment only. The adjustment included 10 vacant positions and each was reduced from 1.0 FTE to 0.72 FTE. This does not mean that these 10 positions will be exactly 0.72 FTE, or that all filled positions will be 1.0 FTE, but the

adjustment allows the Department to accurately balance to the total appropriated FTE. The corresponding dollars are reduced accordingly through the same methodology (I.A.).

The Difference row (I.F.) in the Position Detail Section, calculates the difference between the Base Personal Services Total (I.E.) and the Reconciliation Personal Services Total (III). The difference is caused by comparing the calculation using actual salaries to the calculation using appropriation authority with Common Policy adjustments. The two are not expected to match, as over time salaries are changed with every hire and separation. The difference balances the Position Detail build to the appropriation.

The FY 05-06 Request column shows the positions' salary costs as reflected in the FY 04-05 Estimate column, including the FY 04-05 Salary Survey and Performance-based Pay Awards increases. In addition, the following bills impact the Position Detail by $84,559 ($75,770 salaries for 1.1 General Professional IV and $8,789 PERA and Medicare amounts):

- SB 04-177 Concerning Home and Community Based Services Under the State's Medicaid Program for Children with Autism for $81,874 and 1.0 FTE (General Professional IV); and
- The annualization of HB 04-1219, Concerning the Home and Community Based Services Community Transitions for $2,685 (0.1 FTE, General Professional IV).

Other Personal Services amounts (I.B.) are identical to the ones used in the FY 04-05 Estimate column with the following exceptions, bringing the total to $1,933,868:

- PERA increase of $37,988 for Salary Survey, Range Adjustments, and Performance-based Pay increases in FY 05-06;
- Medicare increase of $5,426 for the same factors;
- Temporary Services decrease to exclude one-time funding only applicable for FY 04-05: $43,482 for SB 04-028 Substance Abuse Treatment for Native Americans to write a federal waiver, and $44,000 for SB 04-206 Hospice Care for Persons who are Eligible under the "Colorado Medical Assistance Act;" and
- Termination/Retirement Payouts and Unemployment Insurance differ slightly due to the change in applying the FY 03-04 Payout-to-Salary Base ratio to the new FY 05-06 Salary Base figure.

POTS Expenditures are not part of the calculation component in this calculation, since they are requested in their distinct line items.

The Difference row (I.F.) in the Position Detail Section, calculates the difference between the Base Personal Services Total (I.E.) and the Reconciliation Personal Services Total (III). The difference is related to calculating the request via actual salaries times the appropriated number of FTE and calculating the request using appropriation authority with Common Policy adjustments. The two are not expected to match, as over time salaries are changed with every hire and separation.

II. Personal Services Request

The second method calculates the official FY 05-06 Personal Services Request (labeled as "II" in the Schedule 3) based on aggregate adjustments to the previous year's Long Bill appropriation. This is the Department's FY 05-06 Budget Request for this line, calculated as outlined in the Budget Request Instructions issued June 1, 2004 (page 8-8). These adjustments include special bills, Supplemental appropriations, Salary Survey, Range Adjustments, a Medicare Differential, PERA, Performance-based Pay, Amortization Equalization Disbursement, and the Office of State Planning and Budgeting 0.2% base adjustment. These are the numbers that feed into the Schedule 2A. A Change Request has been submitted that affects this line item.

A. The FY 05-06 Request before POTS is derived in the table below by applying the legislative and Common Policy adjustments to the FY 04-05 Long Bill (HB 04-1422). To calculate Section II.A., special bill adjustments are made, including annualizations for some bills.

B. The FY 04-05 Salary Survey (II.B.) is included. The Salary Survey amount is the FY 04-05 appropriated amount of $248,845 less the FY 04-05 amount of $5,059 identified for individuals in the Medicaid Mental Health Community Programs. Both exempt (the Executive Director) and classified employees are included in Salary Survey.

C. Range Adjustments are calculated by starting with the June 2005 estimated salaries for currently filled or approved to fill positions. There are 24 FTE identified below the pay range minimum after the computation of FY 05-06 salary survey. Any positions that do not meet the minimum pay requirement per the FY 05-06 Total Compensation Recommendation and Estimated Cost issued by the Department of Personnel and Administration on July 30, 2004, are increased to equal the minimum salary requirement.

D. The Amortization Equalization Disbursement (AED) (II.D.) is a new line in the Schedule 3 for the FY 05-06 Request. Beginning on January 1, 2006, the AED will start at a rate of 0.5% of total payroll for all divisions for five months in FY 05-06 (due to the impact of the Pay Date Shift legislation) and will increase to 3% of payroll over the next three years. It was calculated on all personal services items including Base Salary (Classified and Exempt), Salary Survey, Range Adjustment, and Performance-based Pay.

E. The FY 04-05 Performance-based Pay is then added. This amount equals the FY 04-05 appropriated amount of $136,130 less $2,816, the Mental Health portion of Pay for Performance. Performance-based Pay is not allocated to exempt employees.

F. Medicare and PERA rates are calculated on Base Salary, Salary Survey, and Range Adjustments. The Medicare Differential of $9,836 is comprised of the following:

- The difference of the Medicare amount between the FY 05-06 Request and the FY 04-05 Estimate in the Position Detail (I.B.), $170,335 - $164,909 = $5,426); less
- The portion of the Medicare calculation pertaining to employees exempt from the Medicare reduction due to a date of hire prior to April 1, 1986 (per Common Policy Instructions for the FY 05-06 Budget Submission, issued July 15, 2004, page 5). Currently there are 14 employees within the Department whose salaries should not be included in the Medicare calculation. Therefore, in FY 05-06, $15,262 is backed out from the total Medicare calculation. This amount is based on base salaries, Salary Survey, and Performance-based Pay for these 14 individuals.

G. The Cash Funds Exempt Adjustment for Classified FTE does not reflect a change in total funds. Rather, it is a change in funding split of $71,116 (from General Fund to Cash Funds Exempt) for employees in the Children's Basic Health Plan program and the Breast and Cervical Cancer program as it pertains to the FY 05-06 Request.

	Total Cash Funds Exempt
FY 04-05 Children's Basic Health Plan and Breast and Cervical Cancer Program Salaries per June 2005 Salary Base	$225,880
FY 04-05 Cash Funds Exempt Appropriation (HB 04-1422)	$154,764
Cash Funds Exempt Adjustment	**$71,116**

The Cash Funds Exempt calculation in the FY 05-06 Request is an allocation of the Classified FTE Salary Base according to the salaries for those employees who work directly with the Children's Basic Health Plan and the Breast and Cervical Cancer Program. Their salaries are funded by Cash Funds Exempt at 35% and 25% respectively. The Cash Funds Exempt funding of these employee's base salaries in June 2005 are comprised of 1.8% of the total classified FTE salary base, or $225,880. Of this amount, 93.9% of the total Cash Funds Exempt applies to employees funded by the Children's Basic Health Plan Trust Fund, and 6.1% applies to employees funded by the Breast and Cervical Cancer Prevention and Treatment Fund. These percentages are based upon the portion of all salaries funded by Cash Funds Exempt for each program.

H. After a FY 05-06 subtotal has been calculated on components A – G, a 0.2% reduction is taken on the subtotal as the Office of State Planning and Budgeting requires.

I. Lastly, the incremental Statewide Indirect Cost allocation is applied. The "Statewide Indirect" adjustment is a departmental allocation developed by the State Controller's Office, and distributed to the State Departments with the Common Policies (August 9, 2004). This allocation offsets statewide General Fund costs with proportionate amounts from federal funds, Cash Funds, or Cash Funds Exempt. The purpose is to allocate the unbilled costs of central service agencies to individual programs. The incremental difference between the FY 04-05 allocation and the FY 05-06 allocation is shown, including fund splits. The

incremental difference between the two years' General Fund is a decrease of $69,093. The difference between the current and Request year funding splits distribution is shown below:

Statewide Indirect Cost Allocation	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 04-05 Allocation from State Controller's Office	$0	($584,430)	$10,786	$573,644
FY 05-06 Allocation from State Controller's Office	$0	($653,523)	$17,517	$636,006
Incremental Difference between the 2 years	$0	($69,093)	$6,731	$62,362

It is important to know the sources of Cash Funds Exempt requested in the line item. The following table shows how the Cash Funds Exempt is allocated. In FY 05-06, SB 04-177 (Home and Community Based Services for Children with Autism) annualizes to $40,937 in Cash Funds Exempt funding. The remainder of $234,879 ($275,816 – $40,937) is allocated between the Children's Basic Health Plan and the Breast and Cervical Cancer programs according to the above ratios of 93.9% and 6.1%. Below is the FY 05-06 Request allocated by program:

FY 05-06 Request Cash Funds Exempt Allocation			
SB 04-177 Home and Community Based Services	Children's Basic Health Plan	Breast and Cervical Cancer Program	Total Cash Funds Exempt Requested
$40,937	$220,551	$14,328	$275,816

The following table delineates the sum of all adjustments:

Personal Services Activity from FY 04-05 to FY 05-06 Request

	Total Funds	General Fund	Cash Funds Exempt	Federal Funds	FTE
FY 04-05 Long Bill HB 04-1422	**$12,624,138**	**$5,683,628**	**$154,764**	**$6,785,746**	**196.1**
HB 04-1219 (Community Transition Services for HCBS for the Elderly, Blind, and Disabled)	$19,444	$9,722	$0	$9,722	0.4
SB 04-138 (Repeal of the Authority of the DHCPF to Charge a Monthly Fee to Families Whose Children are Enrolled in HCBS Waiver Program)	($38,797)	($19,399)	$0	($19,398)	(1.0)
SB 04-028 (Substance Abuse Treatment for Native Americans)	$43,482	$0	$21,741	$21,741	0.0
SB 04-206 (Hospice Care for Persons Who are Eligible Under the "Colorado Medical Assistance Act")	$44,000	$0	$22,000	$22,000	0.0
FY 04-05 Appropriation	**$12,692,267**	**$5,673,951**	**$198,505**	**$6,819,811**	**195.5**
Remove One-time Funding for SB 04-028 (Concerning Substance Abuse Treatment for Native Americans)	($43,482)	$0	($21,741)	($21,741)	0.0
Annualize SB 04-177 (Concerning HCBS under the State's Medicaid Program for Children with Autism)	$81,874	$0	$40,937	$40,937	1.0
Remove One-time Funding for SB 04-206 (Concerning Hospice Care)	($44,000)	$0	($22,000)	($22,000)	0.0
Annualize HB 04-1219 (Concerning the HCBS Community Transitions)	$2,685	$1,343	$0	$1,342	0.1
FY 05-06 Request Before Common Policy Adjustments	**$12,689,344**	**$5,675,294**	**$195,701**	**$6,818,349**	**196.6**
B. FY 04-05 Salary Survey	$243,786	$110,050	$1,393	$132,343	0.0
C. Range Adjustment	$5,410	$2,425	$0	$2,985	0.0
D. Amortization Equalization Disbursement Incremental Adjustment	$24,526	$11,079	$436	$13,011	0.0
E. FY 04-05 Performance Based Pay	$133,314	$60,010	$795	$72,509	0.0
F. Medicare Differential	($9,836)	($5,179)	$97	($4,754)	0.0
G. Cash Fund Exempt Adjustment for Classified FTE	$0	($71,116)	$71,116	$0	0.0
Subtotal Base Before OSPB 0.2% Reduction	**$13,086,544**	**$5,782,563**	**$269,538**	**$7,034,443**	**196.6**
H. Less OSPB Base Adjustment of 0.2%	($26,182)	($11,569)	($539)	($14,074)	0.0
I. Incremental Indirect Cost Allocation	$0	($69,093)	$6,731	$62,362	0.0
Total FY 05-06 Base Request	**$13,065,203**	**$5,704,086**	**$275,816***	**$7,085,301**	**196.6**

*Of this amount, $220,471 is from the Children's Basic Health Plan Trust, $14,322 is from the Breast and Cervical Cancer Prevention Treatment Fund, and $40,937 is from the Autism Treatment Fund.

III. Personal Services Reconciliation

The last section of the Schedule 3 delineates the spending authority for all years except the Request year, by bill. POTS are then included for Actual and Estimate years to obtain a final Personal Services Total. Overexpenditures and reversions are shown for the two years of Actuals.

The Reconciliation Difference (IV) subtracts the Personal Services Detail (or Position Detail in I) Total from the Reconciliation Personal Services Total (III).[1] The Reconciliation Difference (IV) is used to balance the two calculations. The difference, which is zero, is shown in the two Actual and Estimate year columns.

FY 02-03 Actual (III.A.) is as follows:

- The FY 02-03 Long Bill appropriation for the old Executive Director's Office Personal Services consisted of $2,074,161 total funds with 31.6 FTE; plus,
- SB 03-203 Supplemental resulted in a total funds reduction of $73,328, a decrease of $28,971 in federal funds, and a decrease of $44,357 in General Fund; and,
- SB 03-197 regarding Pay Day Shift reduced total funds by $176,816; $120,942 was federal funds, $3,466 Cash Funds Exempt, and $52,408 General Fund.

The reversion (III.B.) of total funds, General Fund, Cash Funds Exempt, and the overexpenditure of federal funds is the difference between appropriated and actual amounts.

The Allocated POTS (III.C.), consisting of Salary Survey, Senior Executive Service, Health/Life/Dental and Short Term Disability, was added to the spending authority plus overexpenditure/reversions. This resulted in the Reconciliation Personal Services Total (III).

For FY 03-04 Actual, the calculation is as follows:

The FY 03-04 Long Bill appropriation (SB 03-258) for the Executive Director's Office Personal Services consisted of $12,710,083 total funds and 196.6 FTE (III.A.); plus,

- HB 04-1320, the Supplemental Bill, added $36,029 for Temporary Services as one-time funding for an approved 1331 Emergency Supplemental authorizing 3 temporary staff to process applications for the Children's Basic Health Plan; plus,

[1]The Reconciliation Personal Services Total for the Request year (III) matches the Department Request or "Personal Services Request Total" (II).

- HB 04-1320, the Supplemental Bill, added $50,000 (JBC Staff recommendation within Department of Human Services, Mental Health and Alcohol Drug Abuse Division Programs Supplemental, January 14, 2004, page 1 footnote), 50% federal funds and 50% State match; plus,
- HB 04-1422, Long Bill add-on, decreased total funds by $85,468 due to SB 03-266 not being approved; plus,
- HB 04-1422, Long Bill add-on, corrected funding splits for SB 03-259 of $19,399 from Cash Funds to General Fund. This is because the State did not receive a waiver to collect fees from parents and children in the Model 200 waiver. Plus,
- SB 03-011, Prescription Drugs Under Medicaid, appropriated 0.8 FTE and $56,531 total funds at 75% federal financial participation; plus,
- SB 03-259, Fee for Children's Home Community Based Services, appropriated 1.0 FTE and $38,797 total funds with 50% federal funds and 50% State match from the Children's Home and Community Based Services Cash Fund; plus,
- SB 03-266 Nursing Facility Fees appropriated 2.0 FTE and $85,468 total funds with 75% Cash Funds from the Nursing Facility Cash Fund and 25% in federal funds. There were two positions funded from the legislation. One position, to work on the Nursing Facility Quality of Care Grant Program was funded with 50% from provider fees and 50% federal funding ($42,774), the other ($42,694) was for the State Nursing Facility Service Program and was 100% from provider fees. The net federal financial participation on the bills ended up as 25% federal funds; plus,
- HB 04-1265, Medicaid Mental Health Services, added $259,274 and 2.3 FTE to transfer the majority of the administrative appropriation from the Department of Human Services Medicaid Mental Health programs to the Department; plus,
- SB 04-138, Repeal of the Authority of the Department of Health Care Policy and Finance to Charge Monthly Fee, decreased funding changes made by the HB 04-1422 Long Bill add-on by $9,700 and 0.3 FTE.

A roll forward in FY 03-04 for $242,930 was approved for the following contracts: $142,930 for Mental Health Behavioral Health Organizations (formerly known as Mental Health Assessment and Services Agencies), $50,000 for Non-Emergency Transportation Audit, and $50,000 for Non-Emergency Transportation Dispatch.

At III.B., the reversion of total funds, General Fund, Cash Funds Exempt, and the overexpenditure of federal funds is shown as an adjustment after the total spending authority is calculated.

The Allocated POTS (III.C.) consisting of Salary Survey, Senior Executive Service, Health/Life/Dental and Short Term Disability, was added to the spending authority plus overexpenditure/reversions. This resulted in the Reconciliation Personal Services Total (III).

The spending authority calculation (III.A.) for the FY 04-05 Appropriation Column is as follows:

- The FY 04-05 Long Bill (HB 04-1422) for the new Executive Director's Office Personal Services consists of $12,624,138 total funds with 196.1 FTE (III.A.). It includes the annualization of SB 03-011 (Prescription Drugs under Medicaid), the removal of HB 04-1320 FY 03-04 one-time funding (per page 19 of March 9, 2004 Figure Setting document), Statewide Indirect Costs,

Common Policy Adjustments of 0.2%, Colorado Benefits Management System Reductions, the removal of impact related to HB 04-1265 (Medicaid Mental Health Services), and the reinstatement of the impact related to SB 04-138 since it was not considered to be removed in FY 03-04 until after the FY 04-05 Long Bill was signed into law; plus,

- HB 04-1219 (Community Transition Services for Home and Community Based Services for the Elderly, Blind, and Disabled) increased total funds by $19,444 and 0.4 FTE; plus,
- SB 04-028 (Substance Abuse for Treatment for Native Americans) increased total funds by $43,482; plus,
- SB 04-138, that repealed authority to charge a monthly fee to families of Home and Community Based Services waiver children, decreased funds by $38,797 and 1.0 FTE; plus,
- SB 04-206 (Hospice Care for Persons who are Eligible Under the "Colorado Medical Assistance Act"), that increased total funds by $44,000.

The total appropriation for FY 04-05 is $12,692,267 with 195.5 FTE. No POTS are added in the Appropriation column.

For the FY 04-05 Estimate, the spending authority calculation (III.A.) is calculated the same way as the FY 04-05 Appropriation column. However, in the Estimate Column, the rollforward of $242,930 is included. Also, the Executive Director's Office portion of POTS (III.C.) is added, totaling $808,697 ($243,786 Salary Survey, $133,314 Performance Based Pay Awards, and $413,392 Health/Life/Dental, and $18,205 Short-term Disability). POTS plus the Spending Authority Authorization (III.A.) equals the "III. Reconciliation Personal Services Total."

The Request FY 05-06 Column (III.A.) repeats the Department's Request from "II. Personal Services Request Total."

COLORADO BENEFITS MANAGEMENT SYSTEM

This line item was formerly the funding for 6.0 FTE to work on the Colorado Benefits Management System, and their associated operating expenses. Although the FTE have since annualized to 3.0 FTE, beginning in FY 03-04, Personal Services and Operating Expenses associated with this line item have been consolidated into the Personal Services and Operating Expenses line items in the Executive Director's Office where funding is now requested. FY 02-03 Actuals are presented in the Schedule 3.

HEALTH, LIFE, AND DENTAL

This insurance benefit is part of the POTS component paid jointly by the State and the State employees on a predetermined rate based on the type of package that each employee selected (e.g., employee, employee plus one, family, etc.).

In FY 03-04, the Long Bill appropriation (SB 03-258) for this line item was $363,665 total funds. The FY 03-04 Long Bill was adjusted by HB 03-1316 State Employee Total Compensation Modifications, which reduced total funds by $1,369. The final FY 03-04 appropriation was $362,296 total funds (see table below for fund splits).

The FY 04-05 Long Bill (HB 04-1422) appropriated $429,879 total funds, after a Common Policy Adjustment reflecting rate increases, and an increase in funding for the transfer of 9.0 FTEs from Mental Health Services to the Department. See table below for fund splits.

The FY 05-06 Request utilizes different rates for each plan as provided in the Common Policies Supplement issued by the Office of State Planning and Budgeting on August 3, 2004. The calculation for the Health, Life, and Dental request is based on employees with coverage as of June 2004, and includes two different calculations; one for July to December 2005, and the other for January to June 2006. Each calculation uses different plan designations (Employee, Employee + 1, Employee + Spouse, etc) and rates. The plans are then summarized by type and fund. The funding is in accordance to each employee's salary fund splits. In the FY 05-06 Request of $483,549, the rates for each plan are lower than those used to calculate the FY 04-05 Appropriation. However, the number of participants is higher.

Line Item: Health, Life, and Dental	**Total Funds**	**General Fund**	**Cash Fund Exempt**	**Federal Funds**
FY 05-06 Request	**$483,549**	**$217,009**	**$10,241***	**$256,299**
FY 04-05 Long Bill HB 04-1422	$429,879	$196,262	$2,247	$231,370
POTS for Mental Health Administration (9.0 FTE)	$16,487	$8,243	$0	$8,244
Common Policy Adjustment	$51,096	$26,797	$303	$23,996
FY 03-04 Appropriation	**$362,296**	**$161,222**	**$1,944**	**199,130**

***Of this amount, $10,172 is from the Children's Basic Health Plan Trust, and $69 is from the Breast and Cervical Cancer Prevention and Treatment Fund.

SHORT-TERM DISABILITY

This is one of the POTS expenditure components which provides partial payment of an employee's salary in the event that individual becomes disabled and cannot perform his or her work duties. It is calculated on a calendar year basis per the Common Policy instructions, page 7, issued July 15, 2004. The appropriated amount is reflected in the Estimate Column of the Personal Services calculation and the estimated rate from year-to-year is set by the Department of Personnel and Administration. If the actual rate for the fiscal year differs substantially from the estimated rate, the Department of Personnel and Administration will submit a statewide Supplemental Request to adjust the appropriation.

The Budget Request for this line is computed per the Office of State Planning and Budgeting's Budget Instructions. A given rate by the Department of Personnel and Administration is used against the sum of Base Salaries, Salary Survey, Range Adjustments, and Performance-based Pay. Prior to FY 02-03, the Short-term Disability request was calculated using the same rate for the entire fiscal year. Because the fund balance was reduced in FY 02-03 to better address statewide budget shortages, the Short-term Disability rates are currently calculated on a calendar year basis. Therefore, a split rate is necessary to account for any mid-year changes. The Short-term Disability rate of 0.15% was provided in July by the Department of Personnel and Administration for the first six months of the

fiscal year (calendar year 2004), and the rate of 0.16% was used for the last six months of FY 04-05 (calendar year 2005). Currently, 0.16% is the estimated rate reflected in the Department's FY 05-06 Request.

As reflected in the table below, the final FY 02-03 appropriation, after incorporating adjustments from special legislation and the Supplemental Bill, was $11,697 total funds. In FY 03-04, the Long Bill appropriated $16,770 for this line item. The FY 04-05 Long Bill appropriated $18,843 after a Common Policy adjustment of $1,435 (an increase in the Personal Services line item results in a change to the Short-term Disability line, per a March 13, 2004 Figure Setting Memorandum on Technical Changes, page 3), an increase of $638 to account for the 9.0 Mental Health FTEs transferred to the Department. Incorporating the current Common Policy rate of 0.16%, the FY 05-06 Request amount is $19,650. This amount includes calculations for personnel currently under the Medicaid Mental Health Community Programs, Program Administration line.

Short Term Disability	Appropriation/Request	General Fund	Cash Fund Exempt	Federal Funds
FY 05-06 Request	**$19,650**	**$8,914**	**$335***	**$10,401**
FY 04-05 Long Bill HB 04-1422	$18,843	$8,494	$193	$10,156
FY 03-04 Long Bill SB 03-258	$16,770	$7,338	$191	$9,241
FY 02-03 Final Appropriation	$11,697	$5,440	$30	$6,227
FY 02-03 Long Bill HB 02-1420	$14,061	$6,471	$47	$7,543

* Of this amount, $315 is from the Children's Basic Health Plan Trust, and $20 is from the Breast and Cervical Cancer Prevention and Treatment Fund.

SALARY SURVEY AND SENIOR EXECUTIVE SERVICE

The Salary Survey and Senior Executive Service appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the job and wage classification survey performed annually by the Department of Personnel and Administration. This line is a POTS item in that last year's appropriation becomes part of the base in the Personal Services line. Requested funds are for new increases starting July 1, 2005.

The Total Compensation Survey was appropriated in SB 03-258 for FY 03-04, and then removed in SB 03-273, resulting in a final appropriation of $0. The FY 04-05 amount was $235,928, per the Common Policy adopted on February 24, 2004. Subsequently, an increase of $12,917 was made to the base for FY 04-05 pay increases for the Mental Health FTE transferred from the Department of Human Services, resulting in a final appropriation of $248,845.

The FY 05-06 Request is computed according to the Office of State Planning and Budgeting's Budget Instructions and incorporates results of the 2005-06 Total Compensation recommendation which reflects percentage adjustments by occupational group. Each employee title or class is matched to an occupational group for a percentage increase. This percentage is then multiplied by the employee's estimated salary as of June 2005 to come up with the salary survey amount. In the Department, most of the employees fall

into the following occupational groups: Financial Services, Administrative Support and Related, or Professional Services. There are a few FTE that were identified below the pay range minimum after the computation of salary survey. Those FTEs were adjusted to reflect the minimum compensation according to the Proposed Compensation Plan Pay Structure for FY 05-06. However, this minimum range adjustment for FY 05-06 is not reflected in salary survey, but shown separately within the Personal Services line. The applicable PERA and Medicare were added into the Salary Survey calculations. The table below illustrates the request for FY 05-06:

Salary Survey Line Item	Appropriation/Request	General Fund	Cash Funds Exempt	Federal Funds
FY 05-06 Request	**$292,588**	**$132,723**	**$5,129***	**$154,736**
FY 04-05 Appropriation (HB 04-1422)	**$248,845**	**$112,580**	**$1,393**	**$134,872**
POTS for Mental Health Administration (9.0 FTE)	$12,917	$6,458	$0	$6,459
Common Policy	$235,928	$106,122	$1,393	$128,413
FY 03-04 Total Appropriation	**$0**	**$0**	**$0**	**$0**
SB 03-273 (State Employees' Salary Increase)	($378,592)	($170,286)	($3,656)	($204,650)
FY 03-04 Long Bill (SB 03-258)	**$378,592**	**$170,286**	**$3,656**	**$204,650**

*Of this amount, $4,827 is from the Children's Basic Health Plan Trust and $302 is from the Breast and Cervical Cancer Prevention and Treatment Fund.

PERFORMANCE-BASED PAY

This line item replaced the Anniversary Increases budget line item in FY 02-03. Performance-based Pay represents the annual amount appropriated for periodic salary increases for State employees based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work. According to the Department of Personnel and Administration, initial steps toward Performance-based Pay were taken as early as 1980 as published in Stateline Volume 21, Number 5, May, 2001. In 1996, HB 96-1262 was adopted that mandated a performance-based pay system be implemented by July 1, 2000. Subsequently, the Colorado Peak Performance System was developed in response to this legislation. Before Colorado Peak Performance could be implemented, SB 00-211 repealed HB 96-1262, the law that created it. This legislation not only repealed the mandate, but it also directed that a new plan be developed by September 1, 2000. The new plan was published and modified based upon feedback from State employees. The final plan was given to the Joint Budget Committee on August 31, 2000, as required by law. The new legislation mandated that performance management be effective July 2001. The law required the State Personnel Director to submit a plan to the Joint Budget Committee by September 1, 2000. The report submitted to the Joint Budget Committee in accordance with the law stated that payouts would occur on July 1, 2001. The Personnel Director subsequently delayed the payout date to July 1, 2002, due to the State's fiscal situation. However, the performance management component of the new system began on July 1, 2001.

In FY 03-04, no funding was appropriated due to statewide budget constraints. However, Performance-based Pay of $130,514 for FY 04-05 were calculated per the Department of Personnel and Administration Common Policy adjustment. A fund increase of $5,616

also occurred to transfer funds to the Department for the Mental Health 9.0 FTE, resulting in a total FY 04-05 appropriation of $136,130.

The FY 05-06 Request incorporates the Department of Personnel and Administration's FY 05-06 Department Allocations issued August 9, 2004. The total Request amount is $136,209 for Performance-based Pay, which includes PERA and Medicare related increases.

Line Item: Performance Based Pay	Appropriation/Request	General Fund	Cash Fund Exempt	Federal Funds
FY 05-06 Request	**$136,209**	**$61,712**	**$2,349***	**$72,148**
Common Policy Adjustment	$79	$293	$1,554	($1,768)
FY 04-05 Long Bill HB 04-1422	**$136,130**	**$61,418**	**$795**	**$73,917**
POTS for Mental Health Administration (9.0 FTE)	$5,616	2,808	$0	$2,808
Common Policy	$130,514	$58,610	$795	$71,109
FY 03-04 Long Bill Appropriation	**$0**	**$0**	**$0**	**$0**

*Of this amount, $2,206 is from the Children's Basic Health Plan Trust, and $143 from the Breast and Cervical Cancer Prevention and Treatment Fund.

WORKERS' COMPENSATION

Worker's Compensation is a statewide allocation to each Department based upon historic usage. This line item provides funding for payments made to the Department of Personnel and Administration to support the State's self-insured program. The cost basis is developed relative to estimated claim payouts, purchased professional services (actuarial and broker costs), and common policy adjustments. The Department of Personnel and Administration's actuaries determine departmental allocations. In FY 03-04, the Long Bill appropriation allocated the Department $36,186 at 50% federal funds. FY 04-05 was increased by $7,069 due to the Common Policy allocation issued August 8, 2003 by the Department of Personnel and Administration, which resulted in a total appropriation of $43,255. The FY 05-06 Request below reflects the Common Policy allocated dollar amount of $31,587 distributed by the Department of Personnel and Administration on August 9, 2004.

Line Item: Workers' Compensation	Appropriation/Request	General Fund	Cash Funds Exempt	Federal Funds
FY 05-06 Funding Request	**$31,587**	**$15,794**	**$0**	**$15,793**
HB 04-1422, FY 04-05 Long Bill	$43,255	$21,628	$0	$21,627
SB 03-258, FY 03-04 Long Bill	$36,186	$18,093	$0	$18,093

OPERATING EXPENSES

In FY 03-04, the Joint Budget Committee merged all operating budgets within the Department into one appropriation, at the request of the Department. This action placed five separate operating budgets into one titled Operating Expenses under the Executive Director's Office Long Bill group. SB 03-258 appropriated $954,308 for FY 03-04.

The final FY 03-04 and FY 04-05 appropriations resulted in a total of $965,755, and $929,648 respectively. Various Supplemental and Special Bills affected the amounts. See detail in the table below. The FY 05-06 Request of $933,438 includes an annualization of $4,739 from SB 04-177, Home and Community Based Services under the State's Medicaid Program for Children with Autism, and a decrease of $949 to remove one time funding for HB 04-1219 Community Transition Services. A Change Request has been submitted with this November 1, 2004 Budget Request that affects this line item.

Line Item: Operating Expenses	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 05-06 Base Request	**$933,438**	**$458,800**	**$0**	**$3,202**[2]	**$471,436**
Removal of one time funding for HB 04-1219 Concerning Community Transition Services	($949)	($474)	$0	$0	($475)
Annualization of SB 04-177 Concerning Home-and Community Based Services under the State's Medicaid Program for Children with Autism	$4,739	$0	$0	$2,370	$2,369
FY 04-05 Appropriation	**$929,648**	**$459,274**	**$0**	**$832**	**$469,542**
SB 04-138 (Repeal of the Authority to charge Monthly Fee to Families Whose Children are Enrolled in Home-and Community Based Services)	($7,555)	($3,778)	$0	$0	($3,777)
HB 04-1219 Community Transition Services for HCBS	$2,256	$1,128	$0	$0	$1,128
FY 04-05 Long Bill HB 04-1422	**$934,947**	**$461,924**	$0	**$832**	**$472,191**
Reinstate impact related to the FY 03-04 reduction from SB 04-138	$1,889	$945	$0	$0	$944
Removal of annualized of one-time expenses (***see next table***)	***($30,023)***	($13,917)	$0	$0	($16,106)
BAS-2 (Web Portal Maintenance, January 23, 2004 revised through Figure Setting March 9, 2004, pp. 26-27)	($2,000)	($1,000)	$0	$0	($1,000)
NP-2 (Truth in Rates), January 23, 2004	($674)	($337)	$0	$0	($337)
FY 03-04 Final Appropriation	**$965,755**	**$476,233**	$0	**$832**	**$488,690**
SB 04-138 (Repeal of the Authority to charge Monthly Fee to Families Whose Children are Enrolled in Home-and Community Based Services)	($1,889)	($945)	$0	$0	($944)

[2]Of this amount, $582 is from the Children's Basic Health Plan Trust, $250 is from the Breast and Cervical Cancer Prevention and Treatment Fund, and $2,370 is from the Autism Treatment Fund.

Line Item: Operating Expenses	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
Add-On to HB 04-1422 to correct funding splits for SB 03-259, Sliding Fee Scale for Home-and Community- Based Services	$0	$3,778	($3,778)	$0	$0
Add-On to HB 04-1422 due to SB 03-266 (Nursing Facility Provider Fee not being approved)	($2,532)	$0	($1,899)	$0	($633)
HB 04-1320 for 1331 Emergency Supplemental for Children's Basic Health Plan, dated August 5, 2003	$1,727	$0	$0	$0	$1,727
SB 03-011 Prescription Drugs under Medicaid	$4,054	$1,013	$0	$0	$3,041
SB 03-259 Sliding Fee Scale for Children's Home-and Community Based Services and Children's Extensive Support Families	$7,555	$0	$3,778	$0	$3,777
SB 03-266 Nursing Facility Provider Fees	$2,532	$0	$1,899	$0	$633
FY 03-04 Long Bill SB 03-258	**$954,308**	**$472,387**	**$0**	**$832***	**$481,089**

Removal of Annualized One Time Expenses of $30,023 from Table Above	**Total Funds**
Colorado Benefits Management System- Annualization FY 03-04 DI # 4	($2,610)
Early and Periodic Screening, Diagnosis and Treatment- 2nd year FTE operating annualization	($16,400)
Hearing and Orthodontia- 2nd year FTE operating annualization	($3,280)
SB 03-011 Prescription Medications under " The Colorado Medical Assistance Act" 2nd year FTE operating annualization	($3,184)
SB 03-259 Sliding Fee Scale 2nd year FTE operating annualization	($3,280)
SB 03-266 Nursing Facility Provider Fees 2nd year FTE operating annualization	($653)
1331 Emergency Supplemental for Children's Basic Health Plan out-year adjustment	($1,727)
SB 03-266 Nursing Facilities Provider Fees & Program not approved	$2,532
Figure Setting change on March 15, 2004 Memo, page 5	($1,421)
Total Adjustment	**($30,023)**

LEGAL SERVICES AND THIRD PARTY RECOVERY LEGAL SERVICES

Each department is billed for legal services provided by the Department of Law. For FY 02-03, $801,499, consisting of 13,403 hours at the $59.80 allowable blended attorney/paralegal hourly rate, was appropriated to the Department. The appropriation was fully expended.

The FY 03-04 appropriation was $814,768, a continuance of 13,403 legal services hours at the blended hourly rate of $60.79 per hour (per FY 03-04 Figure Setting, March 2003, page 44). A continuation base of 13,403 hours at the $60.79 allowable blended attorney/paralegal hourly rate was requested for FY 04-05. During the 2004 Figure Setting process, final legal service rates for FY 04-05 were established at $61.57 per hour for 12,684 legal hours, resulting in a total appropriated amount of $780,953.

The FY 05-06 Request uses a blended attorney/paralegal rate of $61.57 per hour established by the Common Policy Instructions on page 9, issued July 15, 2004. The FY 05-06 Request remains at 12,684 hours. The total funding results in $780,953, $316,901 of which is General Fund, $65,849 Cash Funds, $5,409 Cash Funds Exempt, and $392,794 federal funds.

The fund splits as provided in the March 15, 2004 Figure Setting memorandum are at 42% General Fund, 8.4% Cash Funds, 0.6% Cash Funds Exempt, and 50% federal funds. Cash Funds of $65,849 are from Estate Recoveries (2,139 hours * $61.57 hourly rate * 50%). Cash Funds Exempt of $5,409 (251 hours *$61.57 hourly rate * 35%) are from the Children's Basic Health Plan Trust Fund.

DEFENSE OF HMO LITIGATION COSTS

The Department contracts with health maintenance organizations to provide medical services to Colorado Medicaid clients. The contracts between the Department and the health maintenance organizations had terms of payment based on a capitated rate. These rates became the subject of litigation.

To effectively defend against the cases, an emergency supplemental appropriation of $385,000 was appropriated in FY 01-02 in the new line item "Defense of HMO Litigation Costs." This was a one-time appropriation. Funding was based on the estimated costs of retaining actuarial experts, database development, and litigation related expenses. In FY 01-02, $142,500 was spent and the balance was rolled forward to FY 02-03 to continue the defense of these cases. The rolled forward funds of $242,500 were fully expended in by the end of December 2002. This line item has been eliminated, and there is no FY 05-06 Request.

HMO LAWSUIT EXPENSES

In FY 02-03, issues over the health maintenance organizations capitated rates continued. Three separate lawsuits were expected to go to trial during the year, so an emergency Supplemental, #S-1, dated December 10, 2002 was requested to support the Department's defense in these lawsuits concerning the rates paid to health maintenance organizations. The Joint Budget Committee granted the emergency Supplemental Request, and with the passage of SB 03-203, established a new line titled "HMO Lawsuit Expenses." One-time funding of $1,198,870 was appropriated. Based on the three trials anticipated to occur during the fiscal year, the funding included estimates to retain actuarial experts ($943,215), rates and plaintiff experts ($112,500), establish a database required for both discovery and trial purposes ($104,400), and to cover litigation related expenses including travel, copying, postage, mailing, deposition transcripts and exhibits ($130,755). The Joint Budget Committee reduced the Department's request by $92,000 for trial expenses anticipated to occur in FY 03-04. In FY 02-03, $783,184 was spent. The balance of $415,686 was rolled forward into FY

03-04 to continue the defense of the pending litigation. In FY 03-04, $259,346 of the rollforward was spent on the remaining trial; the balance of $156,340 was reverted. This line has been eliminated and there is no request for FY 05-06.

ROCKY MOUNTAIN HMO LAWSUIT JUDGMENT PAYMENT

This line item consisted of one-time funding to pay for a lawsuit judgment in FY 02-03. The lawsuit was a result of a dispute over the health maintenance organization's capitated rates. Initially requested by the Department to be funded in the Medical Services Premiums, the Joint Budget Committee wanted this payment appropriated as a separate line item. This line item received a supplemental appropriation of $21,220,164 via SB 03-203, funded with 50% General Fund and 50% federal funds. This line item has been eliminated and there is no request for FY 05-06.

HEALTH MAINTENANCE ORGANIZATION LITIGATION SETTLEMENT PAYMENTS

This line item was created in FY 03-04 via Supplemental Bill HB 04-1320 to fund litigation settlements to Kaiser Foundation Health Plan of Colorado and Community Health Plan of the Rockies health maintenance organizations. These two health maintenance organizations that contracted with the Department disputed the administrative and rate setting process used by the Department to set the capitation payment rates paid to them. The disputes resulted in several lawsuits against the Department. Settlement agreements were reached to end the litigation.

The appropriation for this line item was $27,000,000. Although appropriated at 50% federal match, the Department received enhanced federal financial participation of 52.95% due to the Jobs and Growth Tax Relief Reconciliation Act of 2003, subsection 401(a). These adjustments are shown on the Schedule 3.

There is no request for funding in FY 05-06.

ADMINISTRATIVE LAW JUDGE SERVICES

This line item includes funding for services typically provided by administrative law judges and paralegals from the Division of Administrative Hearings. It is a Common Policy item. Beginning in FY 01-02, the methodology for calculating departmental appropriations changed from billing actual hours to one based upon a historical utilization; adjustments to the appropriation are made based on mid-year reviews by the Department of Personnel and Administration, referred to as a "mid-year true-up." The prior year's billing hours are applied to the estimated billable cost for the Department of Administrative Hearings for the request year, for the initial Request. A statewide supplemental is submitted that adjusts departmental appropriations according to the most recent year's actual usage; that information is not available when the Request is made.

The FY 02-03 Long Bill appropriation was $352,606, equivalent to 3,143 hours of Administrative Law Judge Services. A statewide supplemental, #S-5 in FY 02-03 increased the Department's appropriation by $184,380, to a total of $536,986 for the fiscal year in SB 03-203.

Based on the new methodology for each State department's allocation, the Department of Personnel and Administration used the Department's actual billable hours in FY 01-02 of 4,606.4 hours, which represented 14.46% of the total Administrative Law Judge Services, to calculate FY 03-04. This percentage was then applied to the total "FY 03-04 Billable Costs for Administrative Hearings" to determine the Department's share of these costs (total costs of $3,728,415, per Common Policy Figure Setting, March 12, 2003, page 3); the result was an initial appropriation of $539,129 for FY 03-04. As directed by the Department of Personnel and Administration for the Supplemental Request (NP-S1, January 2, 2004), the Department requested an increase of $231,203. The Joint Budget Committee staff chose instead to apply an over/under collection methodology used previously in FY 02-03, and the Department was appropriated an additional $121,462, for a final appropriation amount of $660,591, per Supplemental Bill HB 04-1320.

For FY 04-05, the Department requested $665,864, based on FY 02-03 actual usage of 17.94%, applied to total estimated costs of $3,712,346, per FY 04-05 Common Policies distributed August 8, 2003. During Common Policy Figure Setting (page 2, March 11, 2004), it was determined the annual total costs for the Administrative Law Judge Services were higher than the Department of Personnel and Administration had requested. As a result, the Department's allocation was increased in the FY 04-05 Long Bill for a final appropriation of $676,943 in HB 04-1422.

The FY 05-06 request amount of $673,933 is the FY 05-06 Department's Administrative Law Judge Services allocation released on August 9, 2004 by the Department of Personnel and Administration. It is based on FY 03-04 actual utilization, which equaled 17.48% percent of the total usage of Administrative Law Judge Services (the Department's FY 03-04 usage divided by total FY 03-04 usage). Below is a summary of the last three year's appropriations and the FY 05-06 request by fund split.

Line Item: Administrative Law Judge Services	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Appropriation/Request	$536,986	$660,591	$676,943	$673,933
General Fund	$268,493	$330,296	$338,471	$336,966
Federal Funds	$268,493	$330,295	$338,472	$336,967

PURCHASES OF SERVICES FROM COMPUTER CENTER

Prior to FY 04-05, this Purchases of Services from Computer Center line item was named Computer Systems Costs. The appropriation represented funding for the Department of Health Care Policy and Financing and the Department of Human Services, Information Resource Management Section. The Department of Personnel and Administration operates the computer center as a service to other departments in State government. This computer center, known as the General Government Computer Center, has costs including the Medicaid Management Information System for Medical Services computer and printing costs, Long Term Care computer and printing costs, and Client Oriented Information Network for Medical Services computer and printing costs.

A portion of General Government Computer Center costs is billed directly to the Department of Health Care Policy and Financing. The balance is paid on behalf of Health Care Policy and Financing by the Department of Human Services. An Interagency Agreement between the departments identifies the type and costs of services provided, and covers expenditures paid by the Department of Human Services. A description of services, computations, and justification related to Department of Human Services Systems Costs are contained in the Budget Request for that department. The Cash Funds Exempt portion of the funding is from the Old Age Pension Fund (not to be confused with Old Age Pension Health and Medical Fund).

The Long Bill appropriation for FY 01-02 was $409,077. The amount was reduced by $10,082 in Supplemental Bill HB 02-1370, resulting in a new amount of $398,995. The Breast and Cervical Cancer Fund bill, SB 01 S2-012, added $24,000 for systems costs, which brought the total amount to $422,995. The $24,000 was one-time funding.
The FY 02-03 total Long Bill appropriation was $356,622, including both the portion for Health Care Policy and Financing and the portion for the Department of Human Services. The Supplemental Bill, SB 03-203, added $3,572 resulting in a new amount of $360,194. However, $129,870 total funds were reverted.

The FY 03-04 Long Bill appropriated $228,468. This lower amount from previous years reflected both declining usage by Health Care Policy and Financing, and efforts by the Department of Personnel and Administration to match the charges to the departments actually using the services. The Supplemental Bill HB 04-1320 added $30,874, for a new total of $259,342. The Supplemental Bill also realigned the funding splits among General Fund, Cash Funds Exempt, and federal funds to reflect the accurate methodology for determining funding splits.

For FY 04-05, the Long Bill (HB 04-1422) appropriated $296,415 to the Department, based on Common Policies developed by the Department of Personnel and Administration. This Long Bill also renamed the line item to "Purchases of Services from Computer Center." FY 04-05 continued to include an amount for the Department of Health Care Policy and Financing to pay for the Client Oriented Information Network since the exact implementation date for the Colorado Benefits Management System was unknown when the FY 04-05 budget was prepared. Therefore, the Client Oriented Information Network funding still remains in the base for Purchases of Services from Computer Center line item and will continue to remain through FY 05-06 to permit the General Government Computer Center to recover prior year's costs since the cost recovery is done in arrears.

The requested amount of $169,148 total funding for FY 05-06 was submitted to the Department on August 9, 2004, as the share of the Computer Center costs for the Department of Health Care Policy and Financing to pay based on Common Policies calculated by the Department of Personnel and Administration.

Please see the following table for a specific reconciliation.

Purchases of Services from Computer Center
Total Health Care Policy and Financing with Human Services Share

Description	FY 04-05 to Health Care Policy and Financing	FY 04-05 Share to Human Services	FY 05-06 to Health Care Policy and Financing	FY 05-06 Share to Human Services
General Government Computer Center - Medicaid Management Information System	$113,630	$0	$155,058	$2,619
General Government Computer Center - Long Term Care	$78,889	$0	$474	$0
General Government Computer Center - Client Oriented Information Network System Medical Services	$37,638	$37,638	$0	$0
Subtotal	**$230,157**	**$37,638**	**$155,532**	**$2,619**
Personal Services for System Changes	$30,144	$30,144	$0	$0
County Equipment	$5,460	$5,460	$0	$0
Subtotal	**$35,604**	**$35,604**	**$0**	**$0**
Old Age Pension for Personal Services for Client Oriented Information Network System Old Age Pension Eligibility	$16,235	$16,235	$13,616	$13,616
Adult Category General Government Computer Center/Client Oriented Information Network System Costs	$11,532	$11,532	$0	$0
Operating	$2,887	$2,887	$0	$0
Subtotal	**$30,654**	**$30,654**	**$13,616**	**$13,616**
TOTAL APPROPRIATION BASE / REQUEST	**$296,415**	**$103,896**	**$169,148**	**$16,235**
General Fund	$131,973	$35,713	$68,339	$0
Cash Funds Exempt (Old Age Pension)	$16,235	$16,235	$16,235	$16,235
Federal Funds	$148,207	$51,948	$84,574	$0

Eligibility for Medicaid will be determined on an ongoing basis by the recently implemented Colorado Benefits Management System. A separate line item exists for the Department's contribution to operating the Colorado Benefits Management System, which is funded through the Department of Human Services Medicaid-Funded Programs Long Bill group.

Both the Department of Personnel and Administration and the Office of State Planning and Budgeting continue to develop a new cost methodology and new cost allocations to fund the General Government Computer Center. The total Cash Funds needed to fund the

General Government Computer Center is multiplied by a usage ratio for each State department. The Department of Personnel and Administration and the Office of State Planning and Budgeting calculate this number for each department.

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS

Payment to Risk Management and Property Funds is an allocation appropriated to each department based on a shared statewide risk formula of two programs, the Liability Program and the Property Program. The FY 01-02 Long Bill appropriation, SB 01-212, appropriated $53,874 to the Department. Supplemental Bill, HB 02-1370, decreased the total funds by $34,154. The FY 02-03 appropriation was $75,733, while the FY 03-04 Long Bill, SB 03-258, appropriated $78,312 to the Department. HB 04-1422, the FY 04-05 Long Bill, appropriated $67,493. The request for FY 05-06, based on the Common Policies issued by the Department of Personnel and Administration, dated August 8, 2004, is $52,144.

Line Item: Payment to Risk Management and Property Funds	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Appropriation/ Request: Total Funds	$19,720	$75,733	$78,312	$67,493	$52,144
General Fund	$9,860	$37,866	$39,156	$33,747	$26,072
Federal Funds	$9,860	$37,867	$39,156	$33,746	$26,072

CAPITOL COMPLEX LEASED SPACE

Capitol Complex Leased Space is appropriated based on usable square footage utilized by each State department. Currently, for the Department of Health Care Policy and Financing, this includes space of 27,661 square feet at 1570 Grant Street.

In FY 02-03, the Department was appropriated $325,992 total funds for 30,741 usable square feet at 1575 Sherman Street and an additional 2,308 usable square feet at 1570 Grant Street. In SB 03-203, the Department received Operating Expenses supplemental funding (Change Request #S-7, submitted January 2, 2003) to move all staff and operations to 1570 Grant Street. The prorated savings in leased space from this move was $1,976 for 4 months of FY 02-03.

The FY 03-04 Long Bill appropriation was $308,468 total funds, including the building at 1570 Grant Street (except for the State Employee Wellness Center housed in the basement), and 717 square feet of space at 1575 Sherman Street. The 717 square feet of space at 1575 Sherman Street was no longer needed, and the Department notified the Department of Personnel and Administration. This decrease in space, in addition to a revised methodology for measuring square footage, was reflected by Supplemental # NP-S3 Capitol Complex Lease Space Technical Adjustments, submitted on January 2, 2004, reducing the appropriation by $50,816. This amount plus a $12,850 Statewide Supplemental for Utilities resulted in the Supplemental Bill (HB 04-1320) reduction of ($37,966), resulting in a final appropriation of $270,502.

In FY 04-05, there was a Common Policy adjustment increase of $14,677, which resulted in a total appropriation of $285,179 at $10.31 per square foot.

The FY 05-06 Request is based off of the FY 05-06 Recommendations for Capitol Complex Leased Space by Agencies released by the Department of Personnel and Administration on August 9, 2004. The new request totals $276,498 based on 27,661 square feet. Due to rounding in the Department of Personnel and Administration's calculations, there is a $112 difference between the Department's Request and the actual calculation of 27,661 square feet times $10 per square foot.

Line Item: Capitol Complex Leased Space	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Square footage 1575 Sherman / 1570 Grant (beginning FY 03-04)	30,741	31,335	27,661	27,661
Rate	$9.86389	$9.8442	$10.31	$10.00
Total Appropriation/Request	**$303,226**	**$308,468**	**$285,179**	**$276,498**
Supplemental Adjustment HB 02-1370	$0	$0	$0	$0
Budget Amendment #2A, Request for Leased Space to Alleviate Overcrowding and Address Safety and Compliance Issues at 1575 Sherman (approved in Long Bill HB 02-1420)	$22,766	$0	$0	$0
SB 03-203 #S7 – Move to Grant Street	($1,976)	$0	$0	$0
HB 04-1320 Supplemental Adjustment	$0	($37,966)	$0	$0
TOTAL	$324,016	$270,502	$285,179	**$276,498**

COMMERCIAL LEASED SPACE

This line item was established in FY 03-04, as part of the transfer of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) and staff from the Department of Public Health and Environment via the Long Bill, SB 03-258. At the Joint Budget Committee's request, the Department submitted a memo on March 3, 2003, identifying the fiscal needs for the Department to administer the EPSDT administration program instead of the Department of Health and Environment. One of the identified needs was commercial leased space. The appropriation provided for 600 square feet at $22 per square foot in downtown commercial leased space.

In late FY 02-03, after other funding had been appropriated, the Department moved into new space at 1570 Grant Street. Once the Department moved into the new building, workspace was found for the new program staff within the appropriated Capitol Complex Leased Space, at no additional cost. Therefore, the Department never pursued the rental of commercial leased space. Supplemental Request # S-8 was submitted on January 2, 2004 to return the appropriation, and approved by the Joint Budget Committee. Funding in FY 03-04 was reduced to $0 via Supplemental Bill HB 04-1320 and the line item has been eliminated. There is no FY 05-06 Request.

TRANSFER TO THE DEPARTMENT OF HUMAN SERVICES FOR RELATED ADMINISTRATION

The Department of Health Care Policy and Financing has a Shared Services Agreement with the Department of Human Services to support 1.0 FTE to staff the Information Technology Help Desk for the Baby Care/Kids Care Program. In FY 02-03, Decision Item #11 was approved to transfer 3.0 FTE from the Department of Human Services to the Department of Health Care Policy and Financing. This request was cost neutral and was in response to the State Auditor's Office audit in June 2001 that recommended improvements in the management of Medicaid long term care community clients involved in the Single Point Entry system. Effective July 1, 2002, 1.0 FTE remains at the Department of Human Services, staffing the Information Technology Help Desk for the Baby Care/Kids Care Program. The FY 03-04 Long Bill, SB 03-258, appropriated $58,303 for this line item. The FY 04-05 request (November 3, 2003) was initially $58,303. However, in March 2004, the Department of Human Services unofficially requested an additional $16,261 to accommodate salary and POTS increases. The FY 04-05 Long Bill, HB 04-1422, appropriated $74,564 for this line item.

The Department of Human Services has stated that continuation funding of $74,564 is requested for FY 05-06. The table below shows the history of appropriations for the line.

Line Item: Transfer to the Department of Human Services for Related Administration	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Appropriation/Request: Total Funds	$275,220	$58,303	$58,303	$74,564	$74,564
General Fund	$137,611	$29,152	$29,152	$37,282	$37,282
Federal Funds	$137,609	$29,151	$29,151	$37,282	$37,282

Inquiries related to the FY 05-06 base request for this FTE should be directed to the Department of Human Services. The corresponding appropriation in the Department of Human Services budget can be found under Office of Information Technology Services, Personal Services.

MEDICAL PROGRAMS ADMINISTRATION PERSONAL SERVICES

This Long Bill line item existed prior to FY 03-04 and the implementation of SB-258, the FY 03-04 Long Bill. During the 2003 Legislative Session, the Joint Budget Committee and the General Assembly acted to consolidate all Department Personal Services into a single line item, Executive Director's Office Personal Services. Future years are included in the Executive Director's Office Personal Services line item. This line item has been eliminated, and remains in the Schedule 3 for the purpose of delineating the FY 02-03 actual expenditures.

MEDICAL PROGRAMS ADMINISTRATION OPERATING EXPENSES

This Long Bill line item was eliminated beginning in FY 03-04, after the Joint Budget Committee consolidated all operating budgets within the Department into one appropriation, at the request of the Department. The consolidated line item is in the Executive

Director's Office Long Bill group, titled Operating Expenses. This line item exists in the Schedule 3 to delineate the FY 02-03 actual expenditures.

SB 01-78 NURSING HOME QUALITY OF CARE CONTRACT COSTS

During FY 02-03 Figure Setting, the Joint Budget Committee recommended that the Quality of Care contract, part of the anticipated costs for SB 01-78, be separated from general Operating Expenses, and be monitored by the Department as a new line item. The contractor was to work with the Department to develop nursing facility data collection techniques for measuring financial stability, direct care staff turnover, staff expertise, provisions of supportive equipment, complaint resolution, and success in screening for de-institutionalization. In addition, the contract was to provide assistance in both analysis and interpretation of data, and establish processes for the ongoing collection of data from the nursing facilities.

The contract was to be based on the number of hours to be worked by the contractor each year at $32.63 per hour. The allocation for the line item was 50% General Fund and 50% federal funds. In FY 01-02, while the contract was to be for 2,900 hours, the Department formulated a way to accomplish its objectives while narrowing the scope of work. The Department achieved the objectives of SB 01-78 by meeting with two provider organizations rather than meeting with individual nursing home providers statewide. The Department also utilized the existing Resident Centered Quality Improvement Program advisory committee instead of creating a new committee. The tasks that were to be accomplished were absorbed by the FTE associated with the legislation. In FY 02-03 and FY 03-04, the line item was eliminated as part of budget reductions. There is no FY 05-06 Request.

ALTERNATIVE CARE FACILITY COST REPORTING SYSTEM CONSULTING SERVICES

This is no longer a requested line item. In FY 02-03, the line item was eliminated as part of the 4% Budget Balancing Plan. The following is the history of the line item.

This was a new Long Bill line item for FY 01-02, as a result of FY 01-02 Stand-Alone Budget Amendment 6a, submitted January 24, 2001. The funding was intended to research and develop a cost reporting system for Alternative Care Facilities over a three-year time frame. The "Footnote 50a Task Force" (HB 00-1451), found that their analysis required better cost information than was available and deemed this essential. The purpose of the cost reporting system was to assess funding for community long term care providers for various components of the program. By breaking down the cost components, rate increases could be passed through to the corresponding segment of the program's cost. A total of $55,000 was earmarked for the three years of the project, $5,000 for design of the cost reporting form in FY 01-02 and $50,000 equally divided over three years to develop and analyze cost reporting systems. $21,667 was appropriated in FY 01-02. The accounting firm Myers and Stauffer was hired to consult with the Department on cost reporting systems and data collection. No money was expended in FY 01-02. The appropriation in FY 02-03 was $16,667.

Forms were developed to collect cost information from alternative care facilities and home care providers. Blank forms were posted on the Department's web site to encourage providers to file the required data electronically. A full year of baseline information (FY

00-01) and quarterly reports for the first three quarters of FY 01-02 were sent to the Department. The Department had an 87.9% response rate by January 15, 2002. Unresponsive providers had their rates reverted to FY 00-01 rates effective February 1, 2002.

The Myers and Stauffer's final report, assessing provider cost reporting, found that the data collected is of limited use at the current level of resources. The report states, "The basic information already received must be further refined in order to provide the cost data necessary for the development of a permanent cost reporting system for the alternative care facility industry." Consistency of data between providers and verifiability of the self-reported data submissions are areas of particular concern. While direct health care staff wage costs can be accurately measured and verified through quarterly income tax withholding filed by the providers through the Internal Revenue Service, capital costs and administrative costs are far more difficult to measure and verify. This item had a 50% federal match. There is no FY 05-06 Request.

MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT

The Medicaid Management Information System is a nationally recognized, automated claims and capitation processing and reporting system. In Colorado, the Medicaid Management Information System processes or adjudicates claims and capitations, based on edits that determine payment or denial. Warrants are produced by the State based on the information electronically transmitted from the Medicaid Management Information System. The Department competitively bids this function and has contracted with Affiliated Computer Services, formerly Consultec, Inc., to perform as the State's "fiscal agent" for the operations of the Medicaid Management Information System. Affiliated Computer Services began operations effective December 1, 1998 under a three-year contract with the possibility of five optional years. The Department has negotiated for all of the option years, so the contract continues through November 30, 2006.

The Medicaid Management Information System Contract line item covers costs for running claims through the processing system and for certain administrative functions contracted to the fiscal agent. The dollars paid to providers of health services are appropriated separately in the Medical Services Premiums Long Bill group. Monies for the claims processing include: General Fund for regular Medicaid claims; Cash Funds Exempt for Old Age Pension State Medical Program claims; Cash Funds Exempt for Breast and Cervical Cancer Program claims with funds from the Tobacco Litigation Settlement Fund; Nurse Home Visitor Program claims (as Cash Funds Exempt transferred from the Department of Public Health and Environment); and, federal funds. The Old Age Pension State Medical Program claims processing expenditures are funded 100% from State sources, while the Breast and Cervical Cancer Program and the Nurse Home Visitor Program receive a federal match. Claims processing expenditures for School Health claims are funded with 100% federal funds that were drawn from certified public expenditures. Postage and Bulletin Board Service expenditures reflect 50% General Fund and 50% federal funds. The other types of claims processing expenditures are typically funded with 25% General Fund and 75% federal funds. Programming changes, called "Development Costs," are at 75% federal financial participation, or 90% if approved by the federal Centers for Medicare and Medicaid Services. Pharmacy prior authorization reviews were added in FY 03-04 and are approved for 50% federal financial participation.

In 2004, a major change occurred in the contract. For work beginning March 1, 2004, the contract was converted to a fixed price contract. Previously, each work activity in the contract had been billed for separately. For one fixed price amount, the contract covers all claims processing, most prior authorization reviews, provider enrollment and notification, and most system changes. Postage costs are actual costs not contained in the fixed price amount.

Please see the following table for an extensive reconciliation of past appropriations.

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Fiscal Year 01-02	
Long Bill SB 01-212	$17,076,162
Supplemental Bill (For One Year Only) HB 02-1370 for one year only for Claims Overage as requested in Supplemental Request #1 submitted January 2, 2002	$90,329
Claims processing for School Health Services, originally appropriated by SB 97-101, had been reduced to $0 during Figure Setting for FY 01-02 on March 15, 2001, page 85, but the appropriation was added back by HB 01-1199 in the amount of $282,801	$282,801
Dental Loan Repayment SB 01-164 for claims processing	$1,744
Dental Hygiene HB 01-1282 for claims processing	$27,383
Enrollment in Medicaid Managed Care HB 01-1343 for forms preparation and processing	$24,800
Breast and Cervical Cancer Prevention and Treatment Program Development Costs in SB 01S2-012 to make system changes	$89,280
Total Fiscal Year 01-02	**$17,592,499**
Fiscal Year 02-03	
Before Adjustments	$17,592,499
Remove HB 02-1370 Supplemental from Previous Year	($90,329)
Remove First-Year Impact of Dental Loan Repayment SB 01-164	($1,744)
Remove First-Year Impact of Dental Hygiene HB 01-1282	($27,383)
Remove One-Year Impact of Enrollment in Medicaid Managed Care HB 01-1343	($24,800)
Remove Breast and Cervical Cancer Prevention and Treatment One-Time Development Costs SB 01S2-012	($89,280)
Annualize Dental Loan Repayment SB 01-164	$1,648
Annualize Dental Hygiene HB 01-1282	$10,941
Annualize Breast and Cervical Cancer Prevention and Treatment Program SB 01S2-012	$1,295
FY 02-03 Base With Annualizations of FY 01-02 Legislation Included	**$17,372,847**

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

HB 02-1420 approved Budget Amendments 1 titled "Medicaid Management Information System Contract Adjustments" submitted January 2, 2002 for FY 02-03 in the amount of $951,612 (column 6 + column 8). These were costs for additional claims processing	$951,612
Total FY 02-03 Long Bill Appropriation HB 02-1420	**$18,324,459**
FY 02-03 funding was increased for development costs for Consumer Directed Care for the Elderly through Special Bill HB 02-1039	$73,408
4% Budget Balancing Reductions Reflected in SB 03-203 as approved by SB 03-203, by implementing administrative efficiencies	($881,417)
Increase to achieve Budget Balancing savings in the Medical Services Premiums line item: Prior Authorization Reviews for High Risk Classes of Drugs (Ongoing Costs) Supplemental Bill SB 03-203	$24,300
Increase to achieve Budget Balancing savings in the Medical Services Premiums line item: Prior Authorization Reviews for High Risk Classes of Drugs (Development Costs) Supplemental Bill SB 03-203	$20,000
Increase to achieve Budget Balancing savings in the Medical Services Premiums line item: 8-Drug Limit Therapeutic Consultation Prior Authorization Reviews (Ongoing Costs) SB 03-203	$654,200
Increase to achieve Budget Balancing savings in the Medical Services Premiums line item: 8-Drug Limit Therapeutic Consultation one-time system changes via SB 03-203[3]	$25,000
The Federal Mandate for Medicaid Managed Care Programs for $109,978 was added per SB 03-203, as requested by Supplemental Request #S-11 titled "Conform to Federal Mandate for Medicaid Managed Care Program" and submitted January 2, 2003	$109,978
A Supplemental Request, #NP-S6 was submitted January 2, 2003, for Nurse Home Visitor funds from the Department of Public Health and Environment as development costs added $124,000 per SB 03-258	$124,000
FY 02-03 Final Appropriated Amount	**$18,473,928**
FY 03-04	
Before Adjustments	$18,473,928
Remove One-Time Costs of Nurse Home Visitor Program SB 03-258 (#NP-S6, January 2, 2003)	($124,000)
Remove One-Time Costs of High Risk Classes of Drugs SB 03-203	($20,000)
Remove One-Time Costs of 8-Drug Limit Therapeutic Counseling Program SB 03-203	($25,000)
Annualize 8-Drug Limit Therapeutic Consultation (in addition to $654,201 in base) SB 03-203	$1,962,599
Add Claims Processing Ongoing Costs for Nurse Home Visitor Program SB 03-258 per the Department of Public Health and Environment's Figure Setting, March 6, 2003, page 95	$9,388

[3]This program was later terminated and the funding removed.

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Add development costs for changing the copayment amounts of Medicaid clients to save on Medical Services Premiums of $85,000 per the Department's Figure Setting, March 13, 2003, page 55; SB 03-203	$85,000
Annualize Consumer Directed Care for the Elderly for additional Development Costs per HB 02-1039 fiscal note	$36,704
Resulting Long Bill for FY 03-04	**$20,398,619**
Add Generic Drugs Mandate Prior Authorization Review (Ongoing Costs) as specified in the fiscal note for SB 03-011	$521,222
Add One-Time Development Costs for Mail Order Prescriptions – SB 03-011	$12,500
Add Claims Processing Savings Impact for Mail Order Prescriptions 3 Month Refills (refilled less frequently than when filled locally, resulting in fewer pharmacy claims processed) SB 03-011	($16,206)
Add Development Costs to Update Prescription Drug Edits for Prior Authorization Reviews – SB 03-294	$20,000
Add Ongoing Costs for Prior Authorization Review of Prescription Drugs – SB 03-294	$18,225
FY 03-04 Long Bill Plus Special Legislation	**$20,954,360**
Supplemental Request S-5, submitted January 2, 2004 "Technical Corrections for Funding of the Medicaid Management Information System" to Move Orthodontia Prior Authorization Reviews Funding from Medical Services Premium Line Item to Medicaid Management Information Systems Contract Line Item via HB 04-1320	$96,220
Supplemental Request S-5, submitted January 2, 2004 "Technical Corrections for Funding of the Medicaid Management Information System" to Add Additional Breast and Cervical Cancer Claims Funding via HB 04-1320	$839
Supplemental Request S-5, submitted January 2, 2004 "Technical Corrections for Funding of the Medicaid Management Information System" to Add Back Part of 4% Budget Balancing from FY 02-03 as agreed with Affiliated Computer Services via HB 04-1320	$48,000
Remove Unused Portion of Funding for Therapeutic Counseling (8-Drug Limit) Program HB 04-1320	($2,138,099)
Resulting FY 03-04 Funding After Supplemental Bill HB 04-1320	**$18,961,320**
FY 04-05	
Before Adjustments (both additions and subtractions)	$18,961,320
Remove Development Costs for Change Client Copays SB 03-258	($85,000)
Remove Development Costs for Mail Order Prescriptions SB 03-011	($12,500)
Remove Development Costs for Consumer Directed Care for the Elderly (HB 02-1039)	($110,112)
Annualization of Generic Drug Prior Authorization Review – SB 03-011	$521,223
Annualization of Drug Prior Authorization Review – SB 03-294	$6,075
Annualization of Federal Mandate for Managed Care – Supplemental Request # 13 submitted January 29, 2002	$10,022
Remove Balance of funding for Therapeutic Counseling Program	($478,700)

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Remove Funding to Support Separate Line Item called Health Insurance Portability and Accountability Act Web Portal Implementation – JBC Recommendation	($160,000)
Budget Amendment BAS-1, submitted January 23, 2004, titled "Maintenance Funding for the Health Insurance Portability and Accountability Act of 1996 Compliance in the Fiscal Agent Base Contract" sought remediation to the Medicaid Management Information System (page BAS.1-6)	$1,414,344
Budget Amendment BAS-1, submitted January 23, 2004, titled "Maintenance Funding for the Health Insurance Portability and Accountability Act of 1996 Compliance in the Fiscal Agent Base Contract" added maintenance for Decision Support System of Business Objects America in the Medicaid Management Information System (page BAS.1-6)	$196,326
FY 04-05 Appropriation in Long Bill HB 04-1422	**$20,262,998**
HB 04-1219, added claims processing for Community Transition for Elderly, Blind, and Disabled Clients in the amount of $225	$224
Resulting FY 04-05 After Special Bill HB 04-1219	**$20,263,222**
FY 05-06	
Before Adjustments (Both Additions and Subtractions)	$20,263,222
The FY 04-05 development costs for updates to drug prior authorization reviews, appropriated in SB 03-294 were removed	($20,000)
Annualization of SB 04-177 (Children with Autism) added $127,818. Of this amount, $122,500 is one-time funding for Development Charges that will not continue into FY 06-07.	$122,500
Annualization of SB 04-177 (Children with Autism) for Prior Authorization Reviews	$2,220
Annualization of SB 04-177 (Children with Autism) for Increased Claims Processing	$3,098
Add Development Charges for Community Transition Services for Elderly, Blind, Disabled – HB 04-1219, Community Transition Services for Elderly, Blind, and Disabled	$75,000
Add Additional Claims Processing for HB 04-1219, Community Transition Services for Elderly, Blind, Disabled	$76
Annualization of BAS-1, Submitted January 23, 2004 for Additional Maintenance Costs per Health Insurance Portability and Accountability Act Compliant Decision Support System in the Medicaid Management Information System	$17,941
FY 05-06 Base Request	**$20,464,057**
General Fund	$4,939,899
Cash Funds Exempt	$182,258
Federal Funds	$15,341,900

Rollforwards totaling $225,478 were approved for FY 03-04. This amount was comprised of $101,478 from the Federal Mandate for Managed Care and $124,000 from the development costs for Nurse Home Visitor. Work on both initiatives had been only partially completed by the end of FY 02-03.

Since the contract with the current fiscal agent ends on November 30, 2006, the Department will also be working to achieve reprocurement of a fiscal agent for operations beginning December 1, 2006 and forward. On May 21, 2004, an Emergency Supplemental for the Medicaid Management Information System reprocurement was submitted. The request was reviewed by the Joint Budget Committee on June 21, 2004; no additional funding was approved at that time. However, the Joint Budget Committee did authorize the Department to contract with a consulting firm to assist with rebidding the Medicaid Management Information System fiscal agent contract and authorized the expenditures for this consulting contract to be paid from the existing FY 04-05 appropriation for the Medicaid Management Information System.

Change Requests have been submitted that affect this line item.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) IMPLEMENTATION STAFFING COSTS

A new line item in FY 02-03, it was the result of FY 02-03 Budget Amendment #3B (HIPAA Implementation), January 24, 2002. The intent was to fund the implementation of HIPAA once the feasibility study for the Privacy and Transaction and Code Sets rules was completed. The line supported 5.0 FTE, including personal services and operating expenses.

In FY 03-04, all personal services within the Department were consolidated into one line item in the Executive Director's Office. Likewise, the operating expenses previously attributed to this line item are now consolidated with all other operating appropriations in the Operating Expenses line item in the Executive Director's Office. This line has been eliminated. The Schedule 3 shows the Actuals for FY 02-03.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) IMPLEMENTATION CONTRACT COSTS

A new line item in FY 02-03, it was the result of FY 02-03 Budget Amendment #3B (HIPAA Implementation), January 24, 2002. The intent was to fund the implementation of the HIPAA Privacy and Transaction and Code Sets rules once the feasibility study was completed. The FY 02-03 Long Bill appropriation was $11,530,545. The Privacy Rule was implemented on April 14, 2003. The FY 02-03 appropriation was revised via SB 03-203 with a supplemental reduction of $3,250,330 total funds, via Joint Budget Committee action on January 22, 2003 and FY 03-04 Figure Setting (page 57, March 13, 2003), related to contract costs associated with implementation of the HIPAA Transaction and Code Set rules. These expenditures were delayed from FY 02-03 to FY 03-04 based upon Joint Budget Committee recommendation, since the federally required effective date was October 16, 2003, during FY 03-04. Another adjustment in SB 03-203 was from Supplemental #S-9/BA-5, submitted January 2, 2003 for FY 02-03 to capture revised

funding splits based upon a federally approved Advanced Planning Document was approved. The result was a reduction of $1,492,248 General Fund, $2,973 Cash Funds Exempt, and an increase of $1,495,221 federal funds.

The FY 03-04 Long Bill Appropriation was $4,835,784. Also for FY 03-04, $3,339,021 total funds, of which $323,885 was General Fund Exempt, $35,060 Cash Funds Exempt, and $2,980,076 federal funds, were rolled forward from FY 02-03. This rollforward was associated with the HIPAA Transaction and Code Set Rule for the Medicaid Management Information System remediation contract. On September 4, 2003, the Department also submitted a 1331 Emergency Supplemental Request for those FY 02-03 unencumbered contractual funds. The Joint Budget Committee approved an increase with the passage of Supplemental Bill HB 04-1320 for FY 03-04 of $1,832,300 total funds to fund the Web Portal implementation, Decision Support System licenses, and the operation of a dual operating system for providers for the first six months. This funding was necessary in order to ensure timely completion of the Transaction and Code Set federal mandated rule by October 16, 2003.

A rollforward from FY 03-04 to FY 04-05 in the total amount of $616,662 was approved. The Children's Basic Health Plan Trust Fund contributes 3% of these funds in the amount of $18,500 total funds ($6,475 as Cash Funds Exempt and the rest as federal funds from Title XIX). The remaining 97% is Medicaid administrative funding at $598,162. Part of the Medicaid funding is at 75% federal match and part is at 90% federal match. The purpose of the rollforward was to allow completion of the Web Portal development, and, therefore, the rollforward funding was included in the FY 04-05 estimate for the Web Portal Implementation line item.

Ongoing maintenance funding for the Web Portal with HIPAA compliant functionality became a separate line item in FY 04-05, as did Security Rule Implementation, another HIPAA requirement. See separate discussions of these two line items.

No new funding for FY 04-05 under the title of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Implementation Contract Costs was requested, and no new funding is requested for FY 05-06. Refer to the chart below for fiscal activities associated with this line item. The Cash Funds Exempt amounts are related to the Children's Basic Health Plan.

Line Item: HIPAA Implementation Contract Costs	FY 02-03	FY 03-04	FY 04-05
Total Funds – Long Bill	**$11,530,545**	**$1,585,454***	**$0**
General Fund	$2,753,374	$372,661	$0
Cash Funds Exempt	$180,967	$33,184	$0
Federal Funds	$8,596,204	$1,179,609	$0
SB 03-203 – Reduction FY 02-03, restored FY 03-04	**($3,250,330)**	**$3,250,330**	**$0**
General Fund	($315,282)	$315,282	$0
Cash Funds Exempt	($34,129)	$34,129	$0
Federal Funds	($2,900,919)	$2,900,919	$0
SB 03-203 Fund Split Adjustment from S #9, BA #5	**$0**	**$0**	**$0**
General Fund	($1,492,248)	$45,352	$0
Cash Funds Exempt	($2,973)	($15,095)	$0
Federal Funds	$1,495,221	($30,257)	$0
Revised Appropriation (subtotal)	**$8,280,215**	**$4,835,784**	**$0**
General Fund (subtotal)	$945,844	$733,295	$0
Cash Funds Exempt (subtotal)	$143,865	$52,218	$0
Federal Funds (subtotal)	$7,190,506	$4,050,271	$0
Rollforward from FY 02-03 to FY 03-04	**($3,339,021)**	**$3,339,021**	**$0**
General Fund	($323,885)	$0	$0
General Fund Exempt	$0	$323,885	$0
Cash Funds Exempt	($35,060)	$35,060	$0
Federal Funds	($2,980,076)	$2,980,076	$0
1331 Emergency Supplemental – Approved by HB 04-1320	**$0**	**$1,832,300**	**$0**
General Fund	$0	$212,478	$0
Cash Funds Exempt	$0	$31,717	$0
Federal Funds	$0	$1,588,105	$0

*The $1,585,454 listed for FY 03-04 was the original FY 03-04 Base Request, and the Revised Appropriation of $4,835,784 total funds reflects the FY 03-04 Long Bill appropriation, with the restoration of $3,250,330 that was reduced in FY 02-03.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) IMPLEMENTATION CENTRAL STATE APPROPRIATIONS

A new line item in FY 02-03, it was the result of FY 02-03 Budget Amendment #3B, HIPAA Implementation, submitted January 24, 2002. For FY 02-03, the total Long Bill appropriation was $2,214,057. The FY 02-03 appropriation included one-time estimated expenditures for the Privacy and Transaction and Code Sets rules: $752,000 for Independent Validation and Verification Contracting;

$1,245,500 for Quality Assurance Contractor, transferred to the Office of Innovation and Technology; $117,500 for Privacy Standards Contractor; $74,057 for the Privacy Officer/Project Manager; and, $25,000 for a Privacy Training Coordinator, transferred to the Office of State Planning and Budgeting. For FY 02-03, the weighted average funding split was apportioned at 97% Medicaid with a 50% federal match rate, and 3% from the Children's Basic Health Plan with a 65% federal match rate.

Further, in FY 02-03, a supplemental adjustment (Supplemental #S-9 submitted January 2, 2003) was reflected in SB 03-203 to transfer the Privacy Officer to the HIPAA Implementation Staffing Costs line item, and to adjust the funding splits based upon a federally approved Advanced Planning Document. The final FY 02-03 appropriation was $2,182,257 total funds.

For FY 03-04, this line item reflected $662,500 total funds for the Security Rule Feasibility Study per Figure Setting of March 13, 2003, page 59, and as appropriated in the Long Bill (SB 03-258). Of the $662,500 total funds, $450,000 was for Health Care Policy and Financing, and $212,500 for other departments. The $450,000 was apportioned at 97% Medicaid and 3% Children's Health Plan Plus. The 97% Medicaid portion had a 75% federal match rate, and the 3% apportioned to the Children's Health Plan Plus had a 65% federal match rate. In addition, for FY 03-04, $731,041 total funds were rolled forward from FY 02-03 associated with the HIPAA Transaction and Code Set Rule for the Governor's Office of Innovation and Technology, HIPAA Independent Validation and Verification contractor, and the Quality Assurance contractor.

The Governor's Office of Innovation and Technology, which oversaw the Independent Validation and Verification contract for the Transaction and Code Set Rule implementation, submitted a 1331 Emergency Supplemental Request for FY 03-04 on August 8, 2003 titled "FY 04 Emergency Supplemental, Office of Innovation and Technology (OIT), HIPAA IV&V." The Request was for administrative expenditures of professional services, rent, printers, legal support, and unforeseen contract contingencies. These costs had been initially funded in FY 02-03 but were reverted. The Joint Budget Committee approved the request and the result was to increase this line item through HB 04-1320, the Supplemental Bill, by $115,991 total funds.

On September 4, 2003, the Department submitted a 1331 Emergency Supplemental Request for $230,500 total funds for User Acceptance Testing of the Transaction and Code Set Rule in FY 03-04. The same amount of funds had been reverted in FY 02-03 as they were unencumbered by the end of the fiscal year. These requests were necessary in order to ensure timely completion of the Transaction and Code Set federally mandated rule by October 16, 2003. The Joint Budget Committee recommended this request, and the General Assembly appropriated it via HB 04-1320.

The funding for this line item in FY 03-04 was reduced to $967,789 by a late supplemental request, #NP-S22, February 13, 2004 "Finalize Fund Splits for HIPAA Feasibility Study – Central State Appropriation" that was approved in the Add-On section of the FY 04-05 Long Bill, HB 04-1422. No FY 04-05 funding was requested, and there is no request for FY 05-06. The chart below summarizes the funding for this line item. The Cash Funds Exempt amounts are related to the Children's Basic Health Plan.

Line Item: HIPAA Implementation Central State Appropriations	FY 02-03	FY 03-04
Long Bill (Base Request)	**$2,214,057**	**$662,500**
General Fund	$520,407	$321,625
Cash Funds Exempt	$46,351	$4,725
Federal Funds	$1,647,299	$336,150
#S-9 (Revised HIPAA Funding Splits) January 2, 2003 through SB 03-203	**$0**	**$0**
General Fund	($140,816)	$0
Cash Funds Exempt	($23,103)	$0
Federal Funds	$163,919	$0
#S-9 (Transfer of Privacy Officer to Department) January 2, 2003 through SB 03-203	**($31,800)**	**$0**
General Fund	($14,949)	$0
Cash Funds Exempt	($666)	$0
Federal Funds	($16,185)	$0
1331 Emergency Supplemental Request- OIT IV&V Contract –Approved by HB 04-1320	**$0**	**$115,991**
General Fund	$0	$28,128
Cash Funds Exempt	$0	$1,218
Federal Funds	$0	$86,645
1331 Emergency Supplemental Request – QA Contract – Approved by HB 04-1320	**$0**	**$230,500**
General Fund	$0	$22,359
Cash Funds Exempt	$0	$2,420
Federal Funds	$0	$205,721
Late Supplemental – Approved by Add-On to HB 04-1422	**$0**	**($41,202)**
General Fund	$0	$0
Cash Funds Exempt	$0	($575)
Federal Funds	$0	($40,627)
Total Appropriations	**$2,182,257**	**$967,789**
General Fund	$364,642	$372,112
Cash Funds Exempt	$22,582	$7,788
Federal Funds (includes rollforward if applicable)	$1,795,033	$587,889

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) WEB PORTAL MAINTENANCE

This line item was established for FY 04-05 with an appropriation of $312,900. Previously, the web portal development and implementation was contracted to an outside vendor, CGI Information Systems and Management Consultants, Inc., during FY 03-04. Related expenditures were paid through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Implementation Contract Costs line item. The hardware and software infrastructure serves the Department's Internet and Intranet web sites, as well as

provides an application for claims to be submitted to the Medicaid Management Information System. Users with appropriate security clearance can also link to the Colorado Benefits Management System web page from the Department's general web site. Reports and files, such as claim responses for medical providers are also transmitted from Affiliated Computer Services, Inc., the Department's fiscal agent. However, the contract with CGI for the web portal is completely independent of, and has no legal or financial connection with, Affiliated Computer Services, Inc.

The initial funding for the Web Portal as a separate line item was requested by Budget Amendment #BAS-2, submitted January 23, 2004, for the amount of $312,900. The request was approved and funding appeared in Long Bill HB 04-1422.

A rollforward from FY 03-04 into FY 04-05, taken from the Health Insurance Portability and Accountability Act of 1996 Implementation Contract Costs line item of $616,662, was related to completion of the Web Portal, so $616,662 additional funding was included in the FY 04-05 Estimate Column in the Schedule 3 for the HIPAA Web Portal Maintenance line item totaling $929,562 for FY 04-05.

Since maintaining the web portal is an ongoing requirement, funding will be needed each fiscal year. The FY 05-06 request is for continuation funding at the FY 04-05 Long Bill appropriation level of $312,900. Expenditures for this line receive a 75% federal match.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) SECURITY RULE IMPLEMENTATION

This line item was requested by a late Change Request #NP-S19, submitted January 22, 2004. The request was for $196,350 in FY 03-04. During Figure Setting on March 9, 2004 (page 44), the amount was reduced to $125,600, and funded in FY 04-05. Funding for disaster recovery planning and policy planning and procedures writing were not approved with the recommendation that those work activities be handled by departmental staff rather than outside contractors. First-time funding in the amount of $125,600 was established in the FY 04-05 Long Bill, HB 04-1422, and included a series of administrative, technical, and physical security procedures for HIPAA-covered entities to use in order to assure confidentiality of electronic protected health information. The federally required date for complying with the HIPAA Security Rule is April 21, 2005.

During FY 04-05, several computer and security services will be purchased. These items have higher costs for initial purchases, followed by lower costs for ongoing licensing fees for software and security services needed for new employees. The annual license fees include maintenance patches when needed.

Cost Components	FY 04-05 Implementation Costs	FY 05-06 Base Request
Background Security Checks for Employees	(For all existing employees) $5,000	(For new employees) $1,000
Building Video Camera and Key Cards for Employees	(For all existing employees) $10,000	(For new employees) $240
System Level Security Software	(Purchase) $79,600	(Annual License Fee) $7,750
Network Intrusion Detection Software	(Purchase) $20,000	(Annual License Fee) $1,500
PC-FAX Security Software	(Purchase) $11,000	(Annual License Fee) $800
Total Funds	**$125,600 Total Appropriation**	**$11,290 Total Base Request**
General Fund	$60,916	$5,476
Cash Funds Exempt	$1,319	$119
Federal Funds	$63,365	$5,695

Since implementation will be completed in FY 04-05, the Department will enter into maintenance mode in FY 05-06 because the HIPAA rules require permanent continuation of the security measures. The Base Request for FY 05-06 is for ongoing costs and was established in FY 04-05 Figure Setting, page 43, March 9, 2004, related to Change Request #NP-S19, submitted January 22, 2004.

The Cash Funds Exempt portion of the funding is from the Children's Basic Health Plan Fund.

MEDICAID IDENTIFICATION CARDS

Prior to September 2003, each Medicaid recipient or family was mailed a monthly Medicaid Authorization Card to reflect eligibility for Medicaid. The client would present this identification card to medical providers when services were sought. Historically, Medicaid eligibility tied automatically to cash assistance to families provided through the Department of Human Services. With the implementation of Electronic Benefits Transfer service by the Department of Human Services, pursuant to HB 95-1144, cash assistance eligibility and Medicaid eligibility were separated. At that time, production and mailing of Medicaid cards became the responsibility of Health Care Policy and Financing.

The old monthly Medicaid Authorization Card guaranteed the client's eligibility to receive Medicaid benefits for the month. When clients sought medical care, the client's Medicaid card was presented as proof of eligibility to the provider. Providers relied on Medicaid clients having this card with them when requesting services. Providers sometimes refused to provide services if the client could not present the card at the time services were rendered. Change Request #BRI-2 was submitted November 1, 2002 for FY 03-04 for a new process and methodology to produce the card. The new process, a plastic card issued once to all eligible clients, and reissued only when replacements are needed or new clients become eligible, was implemented for FY 03-04 as authorized in the FY 03-04 Long Bill, SB 03-258. Medical providers are now required to verify eligibility electronically after viewing the client's card and the Department's liability has been reduced from a one-month guarantee to the exact periods of eligibility only. The new card also allows clients to move on and off covered programs without receiving a new card each time.

In the past, Medicaid cards were produced on a per household basis for clients. Households are defined by the federal rules on eligibility determination. Families could have up to four clients printed on a card, but most had just a single client on a card. For example, a mother and two children would have appeared on the same card. Disabled clients have received their own cards, even if they live with others who are also Medicaid eligible. The result of the "one card per household" was that not every client received a card for himself or herself. In FY 99-00, the ratio of the number of cards to the number of clients was 69%. By FY 00-01, it had increased to nearly 77%, and was projected to be 74% in FY 01-02. This statistic was referred to as the "household ratio." The percentage of 74% was carried forward for future years' calculations.

Starting in FY 03-04, the Department used plastic cards considered to be more durable. The new cards for Medical Identification were produced initially for every Medicaid and Old Age Pension State Medical Program client. The plastic cards are to be permanent for each client, and to be used whenever the client is eligible for Medicaid or the Old Age Pension State Medical Program. Only cards for new clients and replacement cards for clients who have lost their previous cards are now produced. Each client receives his or her own card. By reducing the need for continual reprinting of the cards, fewer total cards are produced. The lower frequency results in overall cost savings for the cards.

Old Age Pension State Medical Program clients have always received Medicaid Authorization Cards. However, in past years, no specific funds were provided to pay for the production of these cards. Beginning in FY 03-04, Cash Funds Exempt for the Old Age Pension State Medical Program's clients were reflected in the appropriation. The amount of Cash Funds Exempt needed is recalculated each year based on the projected caseload for Old Age Pension State Medical clients. Because these clients are not Medicaid eligible, no federal match is available on these funds.

Decision Item #9, submitted November 1, 2000, titled "Medical Authorization Card (MAC) Adjustment" requested $185,991 additional funding. Budget Amendment #2, submitted January 2, 2001, titled "Delinking Medicaid and Temporary Assistance for Needy Families (TANF) Eligibility Requirements" requested $18,868 additional funding for the card, along with additional funding for other line items as well. Common Policy Figure Setting, March 7, 2001, added $34,028 for the General Government Computer Center. The total request for FY 01-02 was $1,122,300 (Figure Setting, March 15, 2001, page 99), and that amount was appropriated in Long Bill, SB 01-212, for FY 01-02. Supplemental Request #5, submitted January 2, 2002, and titled "Inflation Increase for Medicaid Authorization Card Production" requested $71,416 additional funding. However, $65,842 was approved for FY 01-02 in Supplemental Bill HB 02-1370, resulting in a final FY 01-02 appropriation of $1,188,142.

For FY 02-03, the $65,842 supplemental amount was not carried forward from the prior year, reducing the beginning amount to $1,122,300. Per Figure Setting, March 11, 2002, page 80, $6,442 additional was requested for work done by the General Government Computer Center for card production and included in the Base Request of $1,128,742. Decision Item #2, submitted November 1, 2001, and titled "Inflation Increase for Medicaid Authorization Card Production" requested $204,027 additional funding for FY 02-03. The total increase for General Government Computer Center and the card stock and postage would have resulted in $1,332,769 as the

new appropriation (see page 80 in Figure Setting March 11, 2002). However, after a reduction of $9,669 to the requested increase by the Joint Budget Committee when Figure Setting was final, the appropriation for FY 02-03 was $1,323,100 as reflected in Long Bill HB 02-1420. Supplemental Request, #S-8, submitted January 2, 2003, and titled "Increase for Medicaid Authorization Card Production" requested $27,501 to be added for FY 02-03 and that amount was approved by Supplemental Bill SB 03-203. The total appropriation for FY 02-03 was $1,350,601.

The supplemental amount of $27,501 from FY 02-03 was not carried forward to FY 03-04, reducing the beginning amount to $1,323,100. Per Figure Setting, March 11, 2002, page 81, an increase of $10,312 for the General Government Computer Center was requested and included in the Base Request of $1,333,412. Base Reduction Item, #BRI-2, submitted November 1, 2002, and titled "New Medical Identification Card Process," requested a total reduction of $487,371 with plans to convert to a durable card. The resulting Long Bill appropriation was $846,041 for FY 03-04 per SB 03-258. In FY 03-04, funding of $10,656, Cash Funds Exempt, was appropriated for the production and mailing of cards for the Old Age Pension State Medical Program clients. SB 03-022 transferred administration of the Old Age Pension Health and Medical Care Fund to the Department, and the funding for the cards was converted to Cash Funds, since Cash Funds Exempt are typically for funds transferred between agencies. No supplemental request was made for FY 03-04.

In FY 03-04, the old paper cards were produced for July and August. The new plastic cards were put into use beginning in September 2003. Since the plastic cards will be used for the full fiscal year 04-05, funding needs decreased for FY 04-05. For FY 04-05, Base Reduction Item, #BRI-1, submitted November 3, 2003, and titled "Revision of Medical Identification Cards" requested a reduction of $615,814. However, that amount was modified to a reduction of $490,440 to allow for a higher caseload and more replacement cards (see page 49 in Figure Setting March 9, 2004). The result was $355,601 approved in the FY 04-05 Long Bill, HB 04-1422.

The FY 04-05 appropriation of $355,601 is the Base Request for FY 05-06. To assess FY 05-06, a cash flow analysis was completed with eleven months of actual expenditures and one month of estimated expenditures based on the monthly average for the first eleven months. The twelve month total of production costs and postage costs were added to an estimate for the Data Center Services. This calculation indicated that the current appropriation should be sufficient for FY 05-06 card volume.

See the chart below for the appropriations history of the Medicaid Authorization Cards and Identification Cards. The line is funded with 50% General Fund and 50% matching federal funds, with the exception of the cards for the Old Age Pension State Medical Program clients. These cards are cash funded and there is no federal match.

Medicaid Identification Cards (formerly known as Medicaid Authorization Cards)						
Fiscal Year	**Bill**	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 01-02	Continuing Base from FY 00-01	$883,414	$441,707	$0	$0	$441,707
	DI-9 Submitted November 1, 2000	$185,990	$92,995	$0	$0	$92,995
	Budget Amendment DI-2, Tatum Lawsuit	$18,868	9,424	$0	$0	9,424
	SB 01-212 Long Bill	$1,122,300	$561,150	$0	$0	$561,150
	HB 02-1370 Supplemental Bill	$65,842	$32,921	$0	$0	$32,921
	Total for FY 01-02	**$1,188,142**	**$594,071**	$0	$0	**$594,071**
FY 02-03	Supplemental Not Carried Forward	($65,842)	($32,921)	$0	$0	($32,921)
	Begin FY 02-03	$1,122,300	$561,150	$0	$0	$561,150
	Increase for General Government Computer Center (GGCC) Costs for Cards	$6,442	$3,221	$0	$0	$3,221
	Base Request for FY 02-03 (matches Schedule 3 submitted November 1, 2001)	$1,128,742	$564,371	$0	$0	$564,371
	DI-2 Submitted November 1, 2001	$204,027	$102,013	$0	$0	$102,014
	Total Funding Requested FY 02-03 (including GGCC and DI-2) per Figure Setting	$1,332,769	$666,384	$0	$0	$666,385
	Total Reduction to Requested Increase by Joint Budget Committee after Figure Setting	($9,669)	($4,834)	$0	$0	($4,835)
	HB 02-1420 Long Bill	$1,323,100	$661,550	$0	$0	$661,550
	SB 03-203 Supplemental Bill	$27,501	$13,751	$0	$0	$13,750
	Total for FY 02-03	**$1,350,601**	**$675,301**	$0	$0	**$675,300**
FY 03-04	Supplemental Not Carried Forward	($27,501)	($13,751)	$0	$0	($13,750)
	Begin FY 03-04	$1,323,100	$661,550	$0	$0	$661,550
	Increase for General Government Computer Center (GGCC) Costs for Cards	$10,312	$5,156	$0	$0	$5,156
	Base Request for FY 03-04 (matches Schedule 3 Submitted November 1, 2002	$1,333,412	$666,706	$0	$0	$666,706
	BRI-2 Submitted November 1, 2002	($487,371)	($249,013)	$0	$10,656	($249,014)
	SB 03-258 Long Bill	$846,041	$417,693	$0	$10,656	$417,692
	SB 03-022, Transfer Old Age Pension Health and Medical Care Fund	$0	$0	$10,656	($10,656)	$0
	Total for FY 03-04	**$846,041**	**$417,693**	**$10,656**	**$0**	**$417,692**
FY 04-05	Base Request for FY 04-05	$846,041	$417,693	$10,656	$0	$417,692
	BRI-1 Submitted November 3, 2003 but revised during Figure Setting	($490,440)	($240,651)	($9,139)	$0	($240,650)
	HB 04-1422 Long Bill	$355,601	$177,042	$1,517	$0	$177,042
	Total for FY 04-05	**$355,601**	**$177,042**	**$1,517**	**$0**	**$177,042**
FY 05-06	**Base Request for FY 05-06**	**$355,601**	**$177,042**	**$1,517**	**$0**	**$177,042**

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT FACILITY SURVEY AND CERTIFICATION

This line item funds the survey and certification of nursing facilities, hospices, home health agencies, and Home and Community Based Services agencies, and pays the Medicaid share to maintain and operate the Minimum Data Set system used for nursing facility case mix reimbursement methodology. Through an Interagency Agreement, the Department contracts with the Department of Public Health and Environment to perform these functions. The federal financial participation rate is 75%.

The FY 02-03 Long Bill (HB 02-1420) appropriation was $4,081,464. The Request was adjusted by an increase of $106,793 during Figure Setting, page 126, March 11 2002, from a Joint Budget Committee staff recommendation for personal services, operating expenses, and indirect costs. For FY 02-03, HB 02-1457 reduced estimated funding for the Quality of Care Incentive Payment Program and the Resident-Centered Quality Improvement Program by eliminating $89,506 total funds, which supported FTE in the Department of Public Health and Environment. The net effect of HB 02-1457 was a reduction in General Fund of $22,376. SB 03-203, the FY 02-03 Supplemental Bill, restored the earlier reduction to the Quality of Care Incentive Payment programs and Resident-Centered Quality Improvement with an increase of $89,506 total funds. This Supplemental Bill also included a budget reduction of $42,555 from the Department of Public Health and Environment's 4% Budget Balancing Reduction (NP-S24 and NP-S25 for FY 02-03, submitted January 2, 2003). SB 03-175, Nursing Home Penalty Cash Fund, replaced $558,514 General Fund with Cash Funds (one time activity), and SB 03-197, Pay Date Shift, resulted in a reduction of $229,734 total funds of which $57,434 was General Fund, and $172,300 was federal funds. These bills resulted in a final FY 02-03 appropriation of $3,809,175.

The FY 03-04 Long Bill appropriation was $3,698,759, including a decrease from the prior year of $110,416 in personal services, operating expenses, and indirect costs, as recommended by the Joint Budget Committee during Figure Setting, page 111, March 6, 2003. The FY 04-05 Long Bill appropriation (HB 04-1422) was $4,000,636. The change for FY 04-05 was due to an increase of $301,877 in indirect costs associated with POTS.

For FY 05-06, the Department of Public Health and Environment has requested $4,084,055 in Medicaid funding. This change is due to an increase in POTS and Common Policy funding based on information received from the Department of Public Health and Environment.

The table below explains the appropriation history of this line.

Line Item: DPHE Facility Survey and Certification	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Base	**$3,974,671**	**$3,809,175**	**$3,698,759**	**$4,000,636**
General Fund	$1,072,732	$500,401	$927,349	$1,000,288
Cash Funds	$0	$558,514	$0	$0
Federal Funds	$2,901,939	$2,750,260	$2,771,410	$3,000,348
POTS, Personal Services, and Indirect Adjustment			**$301,877**	**$83,419**
General Fund			$72,939	$20,726
Federal Funds			$228,938	$62,693
JBC Staff Recommendation at Figure Setting - Personal Services, Operating Expenses and Indirect Costs	**$106,793**	**($110,416)**	**$0**	**$0**
General Fund	$52,128	$426,948	$0	$0
Cash Funds	$0	($558,514)	$0	$0
Federal Funds	$54,665	$21,150	$0	$0
Total Funds – Long Bill	**$4,081,464**	**$3,698,759**	**$4,000,636**	**$0**
General Fund	$1,124,860	$927,349	$1,000,288	$0
Federal Funds	$2,956,604	$2,771,410	$3,000,348	$0
Total Funds - HB 02-1457 Reduction	**($89,506)**	**$0**	**$0**	**$0**
General Fund	($22,376)	$0	$0	$0
Federal Funds	($67,130)	$0	$0	$0
Total Funds - SB 03-175 (Nursing Home Penalty Cash Fund)	**$0**	**$0**	**$0**	**$0**
General Fund	($558,514)	$0	$0	$0
Cash Funds	$558,514	$0	$0	$0
Total Funds - SB 03-197 (Pay Date Shift)	**($229,734)**	**$0**	**$0**	**$0**
General Fund	($57,434)	$0	$0	$0
Federal Funds	($172,300)	$0	$0	$0
Total Funds – SB 03-203 (Supplemental - Budget Reductions)	**($42,555)**	**$0**	**$0**	**$0**
General Fund	($8,511)	$0	$0	$0
Federal Funds	($34,044)	$0	$0	$0
Total Funds – SB 03-203 (Technical Correction) - Related to HCPF Budget Amendment, #NP-23 January 24, 2003	**$89,506**	**$0**	**$0**	**$0**
General Fund	$22,376	$0	$0	$0
Federal Funds	$67,130	$0	$0	$0
Total Funds – Appropriation/Request	**$3,809,175**	**$3,698,759**	**$4,000,636**	**$4,084,055**
General Fund	$500,401	$927,349	$1,000,288	$1,021,014
Cash Funds	$558,514	$0	$0	$0
Federal Funds	$2,750,260	$2,771,410	$3,000,348	$3,063,041

OTHER CASE-MIX ADMINISTRATIVE COSTS

This is no longer a requested line item. The Colorado Medicaid case-mix system adjusts reimbursement rates for Class I and Class V Medicaid nursing facilities to reflect the acuity of Medicaid nursing home residents and their utilization of nursing services. The goal is a more appropriate distribution of resources by analyzing the consumption of services based on such factors as age, health status, resource utilization, and diagnoses of the facility's Medicaid residents. For example, a bed-ridden severely ill client in need of a number of therapies may receive a significantly higher reimbursement for the facility than would an ambulatory patient with post-operative monitoring needs only. The Department of Public Health and Environment collects functional assessment data reported by the nursing facilities for all residents. The Department of Health Care Policy and Financing then utilizes the collected data to adjust nursing home reimbursement rates for Medicaid clients accordingly. The effectiveness of the case-mix reimbursement system depends on the accuracy of the collected data. The funding in this line item allowed for both maintenance and operation of the case-mix database and the implementation of a data validation contract, which identified errors and discrepancies in the collection and reporting of resident acuity data to ensure the overall integrity of the Medicaid case mix program.

This was a new line item in FY 99-00 when Decision Item #22, submitted on October 30, 1998, was recommended to address the administrative costs associated with the new system. There were three parts to the Decision Item: acquisition of patient Minimum Data Set information ($126,068), system maintenance ($6,000), and Minimum Data Set validation audits ($36,000). The data sets are acquired by the Department of Public Health and Environment each year and Health Care Policy and Financing is responsible for system maintenance and validation audits. Because of the delay in implementing the case-mix reimbursement system until July 2000, there were no expenditures against this line in FY 99-00 and the funds were reverted at the end of the fiscal year. Some funds were required for system maintenance during FY 00-01 but the Department reverted the bulk of the funds, $38,452 of the $42,000 appropriation, because it did not have a full year's worth of data to audit.

In FY 01-02, contracting for the auditing and system maintenance was not initiated. The Department identified this line item as an opportunity where work could be postponed, reduced, or eliminated without affecting Colorado citizens. Postponement of the validation audit contracts in the last two years was possible while the Department became familiar with the case-mix reimbursement data sets. Because the auditing had been postponed for two years, eliminating the funding in FY 02-03 was recommended in budget reductions. In FY 02-03, the case mix validation and administration contract was permanently reduced in the Supplemental Bill, SB 03-203 and for FY 03-04 in the Long Bill SB 03-258.

NURSING HOME CORRECTIVE ACTION

This is no longer a requested line item. In FY 01-02, five nursing facilities operated by the same owner consistently failed State health inspections. The facilities were in jeopardy of being closed and the clients displaced. However, to avoid displacement, the Department negotiated to bring in a different management company. The new management company was required by the Department to make substantial improvements in both the physical environment and the manner of care for the clients to upgrade the health care and safety of the clients. The improvements were very expensive, and the new management found itself in financial difficulty. The

goal of the Department was to avoid closing the facilities because many of the clients had severe conditions that would cause them to be difficult, if not impossible, to be placed in other facilities. An Emergency Supplemental Request for $354,486 total funds was submitted by the Department on March 21, 2003 and was reflected as an FY 02-03 supplemental add-on to the FY 03-04 Long Bill, SB 03-258, as a one-time appropriation. The expenditures were recorded in the fourth quarter of FY 02-03 and qualified for the Federal Medical Assistance Percentage increase of 2.95% approved by the federal Jobs and Growth Tax Relief Reconciliation Act of 2003. This accounting adjustment is shown on the Schedule 3. The actual expenditures were $166,772 Cash Funds Exempt and $187,686 federal funds.

Utilization Review Overview

Three utilization review line items, Contractual Utilization Review, Phone Triage/Advice and Primary Care Physician Credentialing, were included in the Department's budget until FY 03-04. Those three line items were eliminated and their combined appropriations were allocated into four new line items. The new lines, added in the FY 03-04 Long Bill through November 1, 2002 Change Request #BRI-3, restructured utilization review and quality assurance activities. The reorganization of the appropriation has allowed the Department to better track information about different types of utilization reviews for better control and reporting. Described first is Contractual Utilization Review, followed by the four new lines Acute Care Utilization Review, Long Term Care Utilization Review, External Quality Review and Drug Utilization Review. Because the Assumptions and Calculations are in Long Bill order, Phone Triage/Advice and Primary Care Physician Credentialing are described later in this document.

CONTRACTUAL UTILIZATION REVIEW

This line item comprised the Utilization Review, External Quality Review, and Drug Utilization Review contracts in order to comply with various utilization review and control functions required by federal regulations. Effective July 1, 2003, this line item was reorganized and replaced.

For FY 02-03, a Change Request was submitted to fund 100% review of applicants to long-term care programs. Specifically, Budget Amendment #4A, submitted January 2, 2002, sought $217,471 total funds; including $73,664 General Fund and $143,807 federal funds to fully fund the long term care review process. This request followed the Joint Budget Committee's letter to the Department dated December 20, 2001, indicating its intent to fully fund this area. Subsequently, the General Assembly funded 100% review of long-term care clients by appropriating increased funding to the budget line item in FY 01-02 and FY 02-03. Additionally, FY 02-03 Decision Item #9, submitted January 2, 2002, requested a 1% cost of business increase for these contractors. This Decision Item sought $44,525 in total funds, including $11,403 General Fund and $33,122 federal funds, and provided the 1% cost of business increase to fund: Contractual Utilization Review, Phone Triage/Advice and Primary Care Physician Credentialing. The impact upon the Contractual Utilization Review line item was $40,224, including $10,056 General Fund and $30,168 federal funds. This amount, adjusted by the Joint Budget Committee due to Budget Request Amendment #4A, appropriated the 1% cost of business increase of $42,400 in total funds of which $10,600 was General Fund and $31,800 was federal funds.

For FY 02-03, this line was subject to budget balancing for a total reduction of $191,113 total funds. The Department's Supplemental Bill, SB 03-203, included the suspension of the approved 1% cost of business increase for $42,400 total funds, reduction of the External Quality Review contract for $83,807 total funds, the Acute Care contract for $63,488, and reductions of the utilization review contracts with the Single Entry Point agencies and the Peer Review Organization for $11,445 total funds and $152,473 total funds, respectively. These reductions were offset with increased funding of $100,000 total funds for the Home Oxygen Program, and $62,500 total funds for the Care Management Program. The distribution for the various contracts within the line item is reflected in the following table.

Year/Activity	TOTAL	Long Term Care Utilization Review Contract	Acute Care Utilization Review Contract	External Quality Review Contract	Drug Utilization Review Contract
FY 01-02					
FY 01-02 Long Bill	$4,342,938	$2,429,199	$900,414	$780,300	$233,025
HB 02-1370 (FY 01-02 Supplemental; 100% Review)	$108,736	$108,736	$0	$0	$0
Total FY 01-02 Appropriation	**$4,451,674**	**$2,537,935**	**$900,414**	**$780,300**	**$233,025**
FY 02-03					
FY 01-02 Base	$4,342,938	$2,429,199	$900,414	$780,300	$233,025
FY 01-02 DI #17 (Uniform Long Term Care Form) – one-time funding removed	($50,000)	($50,000)	$0	$0	$0
S.B. 01S2-12 (Cancer Prior Authorization Reviews)	$4,370	$0	$4,370	$0	$0
DI #9 (1.0% Cost of Business Increase)	$42,400	$25,592	$9,004	$7,804	$0
BA #4A (100% Prior Authorization Review)	$217,471	$217,471	$0	$0	$0
HB 02-1420 FY 02-03 Long Bill	$4,557,179	N/A	N/A	N/A	N/A
SB 03-203 (FY 02-03 Budget Balancing)	($191,113)	($189,510)	$90,007	($91,610)	$0
Total FY 02-03 Revised Appropriation	**$4,366,066**	**$2,432,752**	**$1,003,795**	**$696,494**	**$233,025**

For FY 03-04, Change Request # BRI-3, November 1, 2002, which restructured the Long Bill line items relating to Contractual Utilization Review, Phone Triage/Advice, and Primary Care Physician Credentialing for utilization review and quality assurance activities was approved. Implemented via the FY 03-04 Long Bill, this line item was restructured into the following budget line items: Acute Care Utilization Review; Long-Term Care Utilization Review; External Quality Review; and, Drug Utilization Review. The

intent of the restructuring was to ensure the utilization review and quality assurance activity were consistent with operational functions, reduce errors, and create efficiencies in administration. Please see these new budget line items for additional detail.

ACUTE CARE UTILIZATION REVIEW

The utilization review scope of work includes performing prior authorization and post payment reviews for certain services to determine medical necessity and appropriateness for these services. These reviews result in cost avoidance and recoveries of payments to providers. The Phone Triage Project ("Triage – First Help") stemmed from the Colorado Medicaid Reform (SB 93-122) study that recommended a telephone triage service for Medicaid clients. The Colorado Medicaid First Help phone triage/advice line became operational in June 1996. The budget components and contracts associated with the Contractual Utilization Review budget line were segregated to align the operational structure and contractual arrangements to be better matched and more consistent with the way the Department operates its business in these areas and restructured beginning in FY 03-04.

The Acute Care Utilization Review budget line for FY 04-05 consists of the previous Acute Care Utilization Review component of the Contractual Utilization Review budget line, which is $1,011,017 total funds, and the former Phone Triage/Advice budget line item of $298,809 total funds for a total of $1,309,826 with 73.6% federal financial participation. The 75% federal financial participation is adjusted for the $2,899 Cash Funds Exempt associated with the Breast and Cervical Cancer Treatment Program. Please see the FY 03-04 November 1, 2002, Change Request # BRI – 3 for details.

For FY 02-03, the Acute Care Utilization Review and Phone Triage/Advice line items were subject to budget reduction activity that eliminated the $9,004 total funds associated with the 1% Cost of Business increase, decreased the utilization review contracts by $63,489 total funds, increased $100,000 total funds for the Home Oxygen Program and increased $62,500 total funds to the Care Management Program per the Department's FY 02-03 Supplemental Bill, SB 03-203. For the Phone Triage/Advice budget line, the decreases were reflected by a $3,213 total funds reduction associated with elimination of the 1% Cost of Business increase and the reduction of $22,491 total funds to the contractor per the Department's FY 02-03 Supplemental Bill, SB 03-203. For the Acute Care Utilization Review budget line, this was an increase of $90,007 total funds, and the Phone Triage/Advice budget line a decrease of $25,704 total funds. The FY 02-03 revised appropriation for the Acute Care Utilization Review budget line was $1,003,795 total funds ($913,788 + $90,007), and for the Phone Triage/Advice budget line $298,809 total funds ($324,513 - $25,704).

For FY 03-04, the new Acute Care Utilization Review budget line received an increase of $7,222 of which $1,806 was Cash Funds Exempt and $5,416 was federal funds associated with the Breast and Cervical Cancer Prevention and Treatment Program per annualization of SB 01S2-12 pertaining to Cancer Prior Authorization Reviews. With this appropriation increase, the FY 03-04 Long Bill (SB 03-258) Acute Care Utilization Review line item totaled $1,309,826 total funds. There was no change for FY 04-05, and the Base Request for FY 05-06 is for the continuation amount.

Line Item: Acute Care Utilization Review	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Appropriation - Acute Care Utilization Review (previously included in Contractual Utilization Review Budget line)	$913,788	$0	$0	$0
General Fund	$246,652	$0	$0	$0
Cash Funds Exempt	$1,093	$0	$0	$0
Federal Funds	$666,043	$0	$0	$0
Prior Year Appropriation	$0	$1,302,604	$1,309,826	$1,309,826
General Fund	$0	$342,529	$342,529	$342,529
Cash Funds Exempt	$0	$1,093	$2,899	$2,899
Federal Funds	$0	$958,982	$964,398	$964,398
FY 02-03 Budget Balancing (SB 03-203)	$90,007	$0	$0	$0
General Fund	$21,176	$0	$0	$0
Federal Funds	$68,831	$0	$0	$0
Annualization of S.B. 01S2-12 (Prior Authorization Reviews)	$0	$7,222	$0	$0
Cash Funds Exempt	$0	$1,806	$0	$0
Federal Funds	$0	$5,416	$0	$0
Phone Triage/Advice Budget Line	$324,513	$0	$0	$0
General Fund	$81,128	$0	$0	$0
Federal Funds	$243,385	$0	$0	$0
FY 02-03 Budget Balancing (SB 03-203)	($25,704)	$0	$0	$0
General Fund	($6,427)	$0	$0	$0
Federal Funds	($19,277)	$0	$0	$0
Final Appropriation / Request	$1,302,604	$1,309,826	$1,309,826	$1,309,826
General Fund	$342,529	$342,529	$342,529	$342,529
Cash Funds Exempt	$1,093	$2,899	$2,899	$2,899
Federal Funds	$958,982	$964,398	$964,398	$964,398

LONG-TERM CARE UTILIZATION REVIEW

The utilization review scope of work includes performing prior authorization for certain services to determine medical necessity and appropriateness for these services. These reviews result in cost avoidance of payments to providers. In addition, the utilization review contractor performs pre-admission screening for Medicaid clients seeking admittance to nursing facilities and home and community based long-term care programs, as well as periodic continued stay reviews of these clients. Some of the reviews for long-term care programs are required by federal regulations.

The historical line item "Contractual Utilization Review" was reorganized due to FY 03-04 November 1, 2002, Change Request #BRI-3. This request was for a total appropriation of $2,557,752 (pg. H.12-2). The Department submitted a letter to Joint Budget Committee staff on February 20, 2003 to change the allocations. The letter requested a total appropriation for this line item of $2,395,252, due to the transfer of two programs to another line item. The letter also requested a change in funding splits because of a contractor transition, and this action reduced the total funds (at 100% federal funds) by $727,144. These changes were made during Figure Setting and are documented in a memo from Joint Budget Committee staff to the Committee dated March 18, 2003. These changes made the final appropriation in the Long Bill (SB 03-258) for the new Long-Term Care Utilization Review line item $1,668,108 total funds.

The Single Entry Point agencies and other contractors perform the following functions with funding from this line item:

- Uniform Long Term Care 100 Form (ULTC 100) screens;
- Pre-Admission Screening and Annual Resident Reviews;
- Hospital back-up program approvals;
- Children's Extensive Support Waiver expedited reviews;
- Ability to return home (versus remaining in a nursing home) screens;
- Private Duty Nursing approvals;
- Data management; and,
- Training of case managers.

The appropriation for FY 04-05 was the same as for FY 03-04, and the FY 05-06 Base Request and fund splits remain the same as FY 04-05, for a total of $1,668,108.

Line Item: Long-Term Care Utilization Review	**FY 03-04**	**FY 04-05**	**FY 05–06 Request**
Original Request from November 1, 2002, Change Request #BRI-3	$2,557,752	$0	$0
Revised Request after two programs moved to another line item (letter to Joint Budget Committee staff dated February 20, 2003, pg. 5)	$2,395,252	$0	$0
General Fund	*$598,813*	*$0*	*$0*
Federal Funds	*$1,796,439*	*$0*	*$0*
Funding Split Change (letter to Joint Budget Committee staff dated February 20, 2003, pg. 5)	($727,144)	$0	$0
Federal Funds	*($727,144)*	*$0*	*$0*
Final Appropriation/ Request	**$1,668,108**	**$1,668,108**	**$1,668,108**
General Fund	*$598,813*	*$598,813*	*$598,813*
Federal Funds	*$1,069,295*	*$1,069,295*	*$1,069,295*

EXTERNAL QUALITY REVIEW

With the restructure of the Contractual Utilization Review budget line item, the External Quality Review budget line consists of the previous external quality review component of the Contractual Utilization Review line item at $696,494 total funds (see table pg. M-52), and the Primary Care Physician Credentialing budget line item of $115,700 total funds. The FY 03-04 appropriation became $812,193, with 75% federal financial participation, due to FY 03-04 November 1, 2002, Change Request # BRI-3 (pg. H.12-8).

The Department, through the external quality review contract, began requiring both existing and new physicians to have their credentials verified and updated every three years, with approximately one third of all physicians credentialed annually through this ongoing process. The credentialing process can also reveal potential problems requiring investigation. An internal physician monitoring process has been implemented, including whether licenses have been revoked or suspended, or sanctions enacted. If actions from physician regulatory boards have been recommended, the Department staff would suggest further actions, which might even include termination of participation in Medicaid. The quality review contractor would research information in this process.

The FY 05-06 request seeks continuation funding at the current FY 04-05 level.

Line Item: External Quality Review	FY 03-04	FY 04-05	FY 05-06 Request
Total Funds – Long Bill	$812,193	$812,193	$812,193
General Fund at 25%	$203,048	$203,048	$203,048
Federal Funds at 75%	$609,145	$609,145	$609,145

DRUG UTILIZATION REVIEW

With the restructure of the Contractual Utilization Review budget line item, the new Drug Utilization Review line consists partially of the previous Drug Utilization Review component of the Contractual Utilization Review budget line item, $233,025 total funds with 75% federal financial participation. See FY 03-04 November 1, 2002, Change Request # BRI – 3 for details.

42 CFR Section 456.703 of the Code of Federal Regulations requires a drug utilization review function. The purpose of the drug utilization review program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary, and not likely to result in adverse medical effects. Programs must consist of prospective and retrospective drug use reviews, the application of explicit predetermined standards, and an educational program.

During the 2003 legislative session, two bills increased funding for the Drug Utilization Review line item. For FY 03-04, SB 03-011 – Prescription Drugs under Medicaid, increased the line item base appropriation by $300,000 total funds, of which $75,000 was General Fund and $225,000 was federal funds. In addition, SB 03-294, Drug Rebates, Discounts and Management, increased the line item appropriation for FY 03-04 by $80,000 total funds, of which $20,000 was General Fund and $60,000 was federal funds. This

funding is designated to contract for a professional, medical evaluation and analysis of the most effective drug classes for implementation of the drug utilization review mechanisms.

The FY 04-05 appropriation continued these amounts. The allocation for SB 03-294 did not change, but in FY 04-05, the appropriation for SB 03-011 annualized to $600,000 total funds with an incremental increase of $300,000 total funds. Continuation funding of $913,025 is requested for FY 05-06.

Line Item: Drug Utilization Review	FY 03-04	FY 04-05	FY 05-06 Request
Starting Base	$233,025	$613,025	$913,025
General Fund at 25%	$58,256	$153,256	$228,256
Federal Funds at 75%	$174,769	$459,769	$684,769
SB 03-011 – Prescription Drugs Under Medicaid	$300,000	$300,000	$0
General Fund at 25%	$75,000	$75,000	$0
Federal Funds at 75%	$225,000	$225,000	$0
SB 03-294 Drug Rebates, Discounts and Management	$80,000	$0	$0
General Fund at 25%	$20,000	$0	$0
Federal Funds at 75%	$60,000	$0	$0
Appropriation/Request	$613,025	$913,025	$913,025
General Fund at 25%	$153,256	$228,256	$228,256
Federal Funds at 75%	$459,769	$684,769	$684,769

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

The Department is required to ensure the continued provision of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative services of outreach and case management in a manner that is consistent with federal regulations as specified in 42 CFR 441.50-441.61.

The EPSDT administrative outreach and case management services are aimed at the promotion of health, the prevention of disease and improved access to health care services and include, but may not be limited to:

1) Contacting eligible clients to provide in-depth explanation of the Program and its importance;
2) Offering assistance and information to the eligible client, helping to overcome barriers which might impede access to services;
3) Clarifying the role of primary care providers, dentists and the managed care/prepaid health plans, including health maintenance organizations;
4) Emphasizing the client's obligation to maintain the linkage between the child/youth and the primary care physician;

5) Maintaining periodic contact, as needed and feasible, with the client to encourage the utilization of services needed or promoted by referrals and assisting with referrals as needed;
6) Contacting clients not currently receiving assistance under the "Colorado Works Act" to inform them of the possibility of continued eligibility for Medicaid;
7) Initiating collaborative activities with other child-related health and social services agencies and resources within each county and referring Early and Periodic Screening, Diagnosis, and Treatment clients as needed to those agencies and resources; and,
8) In selected counties, services provided by the outreach and case managers shall include assistance with the Program and managed care information process, including referral to the Enrollment Broker at the time of application for Medicaid in local social service agencies and presumptive eligibility sites.

In FY 02-03, $3,058,718 was appropriated in the Long Bill (HB 02-1420) for this line to transfer to the Department of Public Health and Environment. In that year, the Department of Public Health and Environment proposed budget reductions in the EPSDT program in the amount of $313,328, and these were appropriated through SB 03-203. Additionally, SB 03-197 reduced the appropriation by $23,632 for the pay date shift between fiscal years. The final appropriation for FY 02-03 was $2,721,758.

Prior to FY 03-04, administration of the EPSDT program was housed at the Department of Public Health and Environment. Action by the Joint Budget Committee during the 2003 Legislative Session returned program management to the Department of Health Care Policy and Financing. Funding for 5 positions was appropriated to Health Care Policy and Financing to manage the program (these positions are located in the Executive Director's Office, Personal Services and Operating Expenses Long Bill lines). The funding for medical services provided under the EPSDT program remains in the Medical Services Premiums line.

EPSDT administrative and outreach services are now funded by this line item and no funds are transferred to the Department of Public Health and Environment. These services are provided by contracted staff at the county level, primarily with the county health department staff, but occasionally includes other local outreach providers (such as the Northwest Visiting Nurses Association). $2,624,222 was appropriated in the FY 03-04 Long Bill (SB 03-258) solely for the contracted work in this line item, identified in the table below.

A Supplemental Request (#NP-S21) was submitted on February 4, 2004 to reduce the appropriation, so that the funding met the identified needs of the Department. The final appropriation for FY 03-04, adjusted by HB 04-1422, was $2,468,383. This appropriation continued into FY 04-05 through the Long Bill, HB 04-1422.

The request for FY 05-06 is a continuation of the final FY 04-05 appropriation level which is split at 50% federal Title XIX funds, 50% General Fund.

The following table details the appropriation history and departmental responsibility of this line.

Line Item: Early and Periodic Screening, Diagnosis, and Treatment Program	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06 Request**
Department Responsible for Administration	DPHE	DPHE	HCPF	HCPF	HCPF
Joint Budget Committee Action During Figure Setting	$0	($20,100)	$0	$0	$0
Savings from program transfer back to the Department of Health Care Policy and Financing	$0	$0	($97,536)	$0	$0
Long Bill	**$3,084,350**	**$3,058,718**	**$2,624,222**	**$2,468,383**	$0
HB 02-1370 Supplemental	($5,532)	$0	$0	$0	$0
SB 03-197 Pay Date Shift	$0	($23,632)	$0	$0	$0
SB 03-203 Budget Balancing	$0	($313,328)	$0	$0	$0
HB 04-1422 Long Bill Add-On (Supplemental #NP-S21)	$0	$0	($155,839)	$0	$0
Final Appropriation/Request	**$3,078,818**	**$2,721,758**	**$2,468,383**	**$2,468,383**	**$2,468,383**

NURSING FACILITY AUDITS

The Department contracts with an independent accounting firm to conduct audits of nursing facility cost reports. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care for Medicaid clients, in accordance with State and federal statutes. The audit services contract is competitively bid every five years. The Department issued a Request for Proposals in FY 98-99 based on the following historical information:

Area	**Number of Audits**	**Historical Costs per Audit FY 94-95 – FY 98-99**	**Total**
Field Audits	172	$4,210	$724,067
Desk Audits	21	$3,010	$63,207
Rate calculations	13	$958	$12,450
Special Projects	N/A	N/A	$19,110
Totals	206	N/A	$818,834

Source for historical costs per audit are from Figure Setting FY 99-00, page 65. Audits * Cost ≠ Total due to rounding in Figure Setting.

The contract bid price for FY 99-00 was $45,316 higher than the appropriation of $818,834, the final contract amount in FY 98-99 and the base request for FY 99-00. The number of audits in the contract bid had increased to 220. This increase in workload reflected changes in ownership, new facilities entering the program, and mergers, which were occurring. A FY 99-00 Supplemental Request (January 3, 2000, #8, "Increased General Fund for Contract Workload to Maintain Audit Integrity," page 113) of $45,316 ($22,658 General Fund and $22,658 federal funds) was submitted and approved adjusting the FY 99-00 appropriation to reflect the awarded

bid. The FY 00-01 appropriation maintained continuation funding of $864,150. The contract was extended for five years for $864,150 each year.

In FY 01-02, a Supplemental Request of $16,500 ($8,250 General Fund and $8,250 federal funds) was approved to allow the contract auditor to accurately estimate the difference between Colorado Medicaid reimbursement and the maximum reimbursement allowable under Medicare principles (Upper Payment Limit). This 2-year project enabled the Department to accurately certify public expenditures from nursing facilities and achieve General Fund savings. The FY 02-03 Medical Services Premiums supplemental refinancing was adjusted based on the findings of the contract auditor.

In FY 02-03, a supplemental reduction to achieve the 4% Budget Balancing Plan was approved through SB 03-203. The contract amount of $880,650 was reduced by $1,120 for calculating the Nursing Facility Refinancing Upper Payment Limit.

The FY 03-04 Long Bill (SB 03-258) appropriation was $864,150. Funding for the calculation of the Nursing Facility Refinancing Upper Payment Limit ($16,500) was not requested for FY 03-04 because the method for doing the calculation by the contractor was a one-time request spanning two years.

Under the FY 99-00 to FY 03-04 contract, the auditor was required to maintain a distribution of desk audits, rate calculations and field audits, determined using risk assessment criteria. In addition, the contractor was required to assist the Department on special projects where the audit information was needed for analysis. Field audits are the most complex type of audit, requiring intensive review of materials and often travel to the provider's accounting offices. Field audits are targeted to providers where the impact of the audits will be the greatest. In this way, the auditor can assist the Department in maintaining anticipated savings by only accepting allowed costs as part of the rate setting methodology for providers of nursing home services. Desk audits review the accounting information of providers without examining the supporting documentation a field audit affords. Rate calculations are provided when the level of risk associated with a provider cost report is sufficiently low to merit the minimum level of review only.

During FY 03-04, the Department solicited bids for a new five-year contract to begin in FY 04-05. The FY 04-05 appropriation and the FY 05-06 request are based on the FY 99-00 five-year contract amount of $864,150. Fund splits are 50% General Fund and 50% federal funds for this line. A Change Request has been submitted that affects this line item.

Line Item: Nursing Facility Audits	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Adjustment to the base for one-time funding for two year project ($1,120 +$15,380=$16,500)	$0	$0	$0	($15,380)	$0	$0
Base	$864,150	$864,150	$880,650	$864,150	$864,150	$864,150
January 2, 2002 FY 01-02 Supplemental #7 (pg. CR-92) and November 1, 2001 FY 02-03 Change Request #BRI-1 (pg. CR-144) "Nursing Facility Financing Opportunity"	$0	$16,500	$0	$0	$0	$0
Supplemental (4% Budget Balancing SB 03-203)	$0	$0	($1,120)	$0	$0	$0
Final Appropriation / Request	$864,150	$880,650	$879,530	$864,150	$864,150	$864,150

HOSPITAL AND FEDERALLY QUALIFIED HEALTH CLINIC AUDITS

The Department contracts with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers, and rural health centers that participate in Medicaid and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. The majority of the hospital audits are completed from the Medicare cost report audit and tailored to the Medicaid requirements. The accounting firm provides the following services: contract review and reimbursement, final settlements, rebasing calculations, consultation and assistance on cost report interpretation, and meetings with providers to resolve problems. The annual rates of reimbursement for hospitals, federally qualified health centers, and rural health centers are computed from and based on the results of these audits. Annual rates are set to cover the reasonable and necessary costs of an efficiently run facility per federal and State law.

Audits have produced savings in the Medical Services Premiums that are over $5 million in each of the past years with the continuing base appropriation of $250,000. Funding of $250,000, at 50% federal financial participation, is requested for FY 05-06 to continue these required efforts. Fund splits for this line are 50% General Fund and 50% federal funds. A Change Request has been submitted that affects this line.

Line Item: Hospital and Federally Qualified Health Clinic Audits	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Base Appropriation	$117,978	$250,000	$250,000	$250,000	$250,000
Supplemental Request #13, January 2, 2002, pg. CR-163	$132,022	$0	$0	$0	$0
Total	$250,000	$250,000	$250,000	$250,000	$250,000

NURSING HOME PREADMISSION AND RESIDENT ASSESSMENTS

This line item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing home placements for those with major mental illnesses or developmental disabilities. The federal financial participation rate for this activity is 75%. All nursing facility admissions to facilities that have Medicaid certified beds, and all residents of those nursing facilities are subject to the preadmission screening and annual review. The purpose of the reviews is to ensure that residents receive appropriate care and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility, a federal requirement to receive Medicaid funds.

There are two levels of Preadmission Resident Reviews. A Level I pre-screening is a series of questions asked concerning the diagnosis of a developmental disability or mental illness, or use of psychotropic medicine in the absence of a justifiable neurological disorder or diagnosis completed in the actual text of the ULTC-100.2. The ULTC 100.2 is a form completed by the Single Entry Point agency to determine the level of care (see Long Term Care - Utilization Review). If the Level I screen identifies a diagnosis of a mental illness and the client needs specialized services, a referral is made to the community mental health center for a Level II evaluation. An individual with a known diagnosis of depression may also be screened and diverted from the Level II if he/she does not have a major depression. These Depression Diversion screens and Level II evaluations are funded in the Preadmission Screening and Annual Resident Review line item. If the individual has a developmental disability diagnosis, the Level II evaluation client is referred to the Department of Human Services and the community center boards. Each Level II client is sent to the state mental health or mental retardation authority to determine appropriate placement. The Level II evaluation also provides recommendations to assist the nursing facility in developing an appropriate care plan for the delivery of mental health services while the individuals reside in the nursing facility, and is coordinated by the nursing facility with mental health providers.

A reassessment is completed at the time of significant changes in the individual's mental health or developmental disability status. A telephone review is completed if a change of status has occurred. These are categorized as partial evaluations.

The table below explains the funding history of this line.

Line Item: Nursing Home Preadmission and Resident Assessments	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Prior Year Final Appropriation	**$1,042,612**	**$1,162,705**	**$918,120**	**$1,010,040**	**$1,010,040**
Adjustment to the base for prior year one-time expenditures	$0	($120,093)	$0	$0	$0
FY 02-03 Budget Amendment 9A Utilization Increase for Nursing Home Pre-Admission and Resident Assessments, January 2, 2002 page CR-151	$0	$82,294	$0	$0	$0
FY 02-03 Decision Item #10 Pre-Admission Screening and Annual Resident Review Utilization Increase, November 1, 2001 page CR-122	$0	$115,628	$0	$0	$0
4% Budget Balancing SB 03-258	$0	$0	$91,920	$0	$0
Long Bill	**$1,042,612**	**$1,240,534**	**$1,010,040**	**$1,010,040**	**N/A**
Supplemental #12 Utilization Increase for Nursing Home Pre-Admission and Resident Assessments, January 2, 2002, page CR-151. JBC Recommendation January 24, 2002 slight change to amount, implemented in Supplemental Bill HB 02-1370	$120,093	$0	$0	$0	$0
4% Budget Balancing SB 03-203	$0	($322,414)	$0	$0	$0
Total Appropriation/Request	**$1,162,705**	**$918,120**	**$1,010,040**	**$1,010,040**	**$1,010,040**
General Fund at 25%	$290,676	$229,530	$252,510	$252,510	$252,510
Federal Funds at 75%	$872,029	$688,590	$757,530	$757,530	$757,530

Until FY 01-02, the Department of Human Services set the rates for the Preadmission Screening and Annual Resident Reviews. In FY 00-01, the actual expenditures were over $1,350,000. The Department of Health Care Policy and Financing became responsible for managing the screenings at the previous years' appropriation levels. Rates were reviewed across the State with the objective that they would be more consistent. A FY 01-02 supplemental increase was approved to cover FY 00-01 expenses that were paid from the FY 01-02 appropriation and to establish new rates to ensure that FY 01-02 expenditures would be within that new appropriation. The General Assembly approved an increase of $120,093 total funds via HB 02-1370 ($30,023 General Fund and $90,070 federal funds), bringing the appropriation to approximately the same level as appropriations in the prior years. The Department established new rates to ensure that FY 01-02 would be within the appropriation.

For FY 02-03, the General Assembly approved an additional $197,922 ($82,294 + $115,628), $49,481 of which was General Fund. This addressed both caseload and the new rates established in FY 01-02, which had overall, reduced expenditures from FY 00-01. In the same year, the Department revised utilization based on a more complete re-forecasting of caseload for each level of review. New

controls were added to the program. The combination of more Department oversight, new program controls and the revised forecast of caseload reallocations (a decline in some categories and increases in others) resulted in revised expenditure forecasts. Usage of the reviews/screens had shifted and a new projection was developed and submitted for the 4% Budget Balancing Plan for FY 02-03 (and FY 03-04). The estimated reduction in FY 02-03 was $322,414 total funds ($1,240,534 less $918,120 equals $322,414), 75% of which were federal funds.

The 4% Budget Balancing Plan for FY 02-03 also projected the number of reviews and resulting expenditures to grow in FY 03-04 by $91,920. The increase was appropriated in the Long Bill, SB 03-258 for FY 03-04. Growth was projected in Level I, Level II, and other types of partial evaluations.

Calculation Assumptions for FY 03-04 Long Bill (SB 03-258) Appropriation			
	Cost of Review	**Approximate Number of Clients**	**Projected Costs**
Level I Depression Diversion	$40.00	2,297	$91,880
Level II Pre-Admission Screen	$400.00	2,207	$882,800
Other Partial Evaluations	$160.00	221	$35,360
Total		**4,725**	**$1,010,040**

Each year the Department studies the adequacy of rates and efficiencies in the program through workgroups with the provider community. A forecast of utilization is developed in June and September each year to assess the trend in utilization and adjust the budget. For FY 04-05 and for FY 05-06, the forecast has indicated a slight shift in the categories of reviews, but the total budget amount is estimated to be adequate. Continuation funding of $1,010,040 for FY 05-06 is requested.

NURSE AIDE CERTIFICATION

Federal regulations require certification of nurse aides working in any medical facility with Medicaid or Medicare patients. The Department of Regulatory Agencies administers the program under an Interagency Agreement with the Department of Health Care Policy and Financing and the Department of Public Health and Environment. The program is funded from the Medicaid and Medicare programs. Included in this line is $12,844 in funding from HB 95-1266, which requires criminal background checks on nurse aides. The Department of Regulatory Agencies assesses and collects funds from nursing homes and other providers for the certification of their nurse aides to cover the costs of the criminal background checks.

The $12,844 appropriated on this line for the Department of Regulatory Agencies, Division of Registrations is initially transferred to the Department of Health Care Policy and Financing, where it is combined with General Fund in the Nurse Aide Certification line to earn the matching federal dollars. The federal financial participation rate for this line item is 50%. The entire sum is then sent back as

a Cash Funds Exempt transfer to the Department of Regulatory agencies for apportionment between the Division of Registrations and the Executive Director's office.

For FY 02-03 and FY 03-04, the base appropriation remained constant at $310,330. For FY 04-05, this amount was reduced by $12,561 due to a technical adjustment brought about by the Department of Health Care Policy and Financing's Budget Amendment #BAS-5, submitted January 23, 2004. This correction reconciled the Department of Health Care Policy and Financing's request with that of the Department of Regulatory Agencies' FY 04-05 base request. The Long Bill appropriation for FY 04-05 is $297,769. For FY 05-06, the request is for $319,098, which includes adjustments from the FY 04-05 Long Bill appropriation for POTS increases totaling $21,329. This amount includes individual adjustments of:

- An increase of $29,260 for POTS transfers;
- An increase of $404 for internal reallocations for Information Technology Asset Maintenance;
- An increase of $5,818 for the Department of Regulatory Agencies' internal reallocation for Legal Services;
- An increase of $6,596 for Leased Space; and
- A decrease of $20,749 for Indirect Costs.

Line Item: Nurse Aide Certification	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Base Request	**$310,330**	**$310,330**	**$310,330**	**$297,769**
DORA Adjustment to Nurse Aide Certification - Budget Amendment, #BAS-5, January 23, 2004	$0	$0	($12,561)	$0
Base Adjustments	$0	$0	$0	$21,329
Total Funds – Long Bill Appropriation / Request	**$310,330**	**$310,330**	**$297,769**	**$319,098**
General Fund	$142,321	$142,321	$136,041	$146,705
Cash Funds Exempt	$12,844	$12,844	$12,844	$12,844
Federal Funds	$155,165	$155,165	$148,884	$159,549

NURSING HOME QUALITY ASSESSMENTS

This function was mandated by the Omnibus Budget Reconciliation Act of 1990 and provides funding for quality assessment reviews of nursing homes. This program is administered by the Department of Public Health and Environment for enforcement of federal quality assessment regulations. Pursuant to SB 89-5, 83% of this line is for the Department's enforcement of federal quality assessment regulations, including the Department's legal expenses with payment to the Department of Law, and 17% is for other reimbursable expenses. The line item supports legal costs related to the Facility Survey and Certification line item. This appropriation also covers any litigation that might result from findings of facility survey reports. HB 02-1370 reduced the FY 01-02

appropriation by $272 as part of the Department of Public Health and Environment's 1.0% reduction. The federal financial participation is 75%.

There were no Medicaid expenditures at all for this line during FY 03-04, though $26,955 was appropriated. This was the second consecutive year in which there were no actual expenditures. The FY 04-05 Long Bill appropriated $26,954. The Department of Public Health and Environment has requested a continuation budget for FY 05-06 in the amount of $26,954.

Line Item: Nursing Home Quality Assessments	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06 Request**
Total Funds – Long Bill	$27,227	$26,955	$26,954	$26,954	$26,954
General Fund	$6,807	$6,739	$6,738	$6,738	$6,738
Federal Funds	$20,420	$20,216	$20,216	$20,216	$20,216
Total Funds – HB 02-1370 Supplemental	($272)	$0	$0	$0	$0
General Fund	($68)	$0	$0	$0	$0
Federal Funds	($204)	$0	$0	$0	$0
Total Funds - Appropriation	$26,955	$26,955	$26,954	$26,954	$26,954
General Fund	$6,739	$6,739	$6,738	$6,738	$6,738
Federal Funds	$20,216	$20,216	$20,216	$20,216	$20,216

NURSING FACILITY APPRAISALS

Nursing facility appraisals occur once every four years. The Department contracts with an independent firm to conduct the appraisals. The underlying result of the contracted appraisal is the determination of "fair rental value." The fair rental (property) value determination is used in the process of rate setting, which is governed by statute at 26-4-503, C.R.S. (2004). The FY 01-02 appropriation for this line item was $272,992, 50% General Fund and 50% federal funds. A rollforward request was approved for the nursing facility appraisal contract to extend into FY 02-03. There is no continuation request submitted, as this process is appropriated only once every four fiscal years after facilities are appraised. The next request will occur for FY 06-07.

ESTATE RECOVERY

Authorized by 26-4-403.3, C.R.S. (2004) and established by HB 91S2-1030, this program recovers Medicaid expenditures from the estates of Medicaid recipients of long term care and for Medicaid benefits paid after age 55. The Department contracts with a private sector entity that pursues the recoveries on a contingency fee basis. The recoveries are an offset to the Medical Services Premiums line, and therefore, fund the cost of this administrative contract.

Since its inception, the Estate Recovery program has grown each year. Over the years, the appropriation for this line item has been adjusted to fit the estimated recoveries by the contractor. In 1997, a supplemental appropriation, as well as Change Request (#11, November 1, 1996), was approved to accommodate an increasing amount of recoveries. The approved Decision Item brought the maximum contingency fee amount for FY 97-98 to $500,000. For FY 00-01, the appropriation was reduced $78,125 as a direct response to a decrease in the contingency fee from 16% to 13.5% in 1999 (Joint Budget Committee Figure Setting document, March 6, 2000, page 61). The largest recovery in the history of the program ($4,904,163) was in FY 00-01 and required a supplemental appropriation in 2001 that brought the maximum contingency fee amount to $700,000. The contractor is only paid the amount of the appropriation equal to the recoveries times the contracted fee. If the appropriation is set too low, then the contractor must stop recoveries until it is adjusted by the General Assembly. Therefore, the maximum contingency fee total has been held at $700,000 in order to accommodate above-average levels of recoveries. The current contingency fee allows for maximum recoveries of $6,422,018.

Data show that since implementation, the Estate Recovery Program has recovered a net amount of $26,846,997 for the Medicaid program.

Year	Amount Recovered	Number of Cases	Fees Paid
FY 92-93	$5,575	3	$273,883
FY 93-94	$418,224	41	$308,708
FY 94-95	$883,217	63	$251,560
FY 95-96	$1,989,421	141	$360,000
FY 96-97	$2,559,513	167	$409,522
FY 97-98	$2,727,744	152	$436,439
FY 98-99	$2,596,736	132	$350,559
FY 99-00	$3,376,330	175	$455,805
FY 00-01	$4,904,163	149	$662,062
FY 01-02	$3,845,730	195	$521,992
FY 02-03	$3,878,211	172	$530,164
FY 03-04	$4,750,954	201	$528,127
Total	$31,935,818	1,591	$5,088,821

Note: FY 92-93 through FY 95-96 was on a contractual fee basis. FY 96-97 and FY 97-98 were based upon a 16.0% fee basis.
FY 98-99 and forward are based upon a fee of 13.5%. The contract for FY 03-04 paid a fee based on 10.9% of the fees recovered. Under certain circumstances, the contingency fee can be higher than the contracted percentage in a month.

Since 2001, the appropriation for Estate Recovery has been $700,000, with a split of 50% Cash Funds, 50% federal funds. The Department requests continuation of the $700,000 appropriation level for FY 05-06.

SINGLE ENTRY POINT ADMINISTRATION

This line funds the Department's internal administrative costs of training, resource materials, data and financial reporting, and staff travel to provide technical assistance and monitoring of Single Entry Point agencies.

From FY 01-02 to FY 03-04, the funding remained static at $65,900. In FY 03-04, the Joint Budget Committee recommended a 10% reduction in the appropriation, reflected in Figure Setting, March 13, 2003, page 73, which was approved in the Long Bill SB 03-258, reducing the appropriation to $59,310 for administrative budget balancing. The federal match rate for Single Entry Point Administration is 50%. The budget request for FY 05-06 is a continuation of the FY 04-05 level of funding, and continues the 10% administrative reduction implemented in FY 03-04.

Line Item: Single Entry Point Administration	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Prior Year Appropriation	$65,900	$65,900	$65,900	$59,310	$59,310
FY 03-04 Joint Budget Committee Recommended 10% Reduction	$0	$0	($6,590)	$0	$0
Appropriation / Request	$65,900	$65,900	$59,310	$59,310	$59,310

SINGLE ENTRY POINT AUDITS

This line item funds annual audits of Single Entry Point agencies. In the past, the Department of Human Services' Field Audit staff, through an Interagency Agreement, performed these audits. During FY 02-03 and FY 03-04, the Department of Human Services agreed to continue performing the audits with an appropriation of $35,339 and $35,340 respectively. In FY 04-05, the Department of Human Services' entire Field Audit staff was reduced by 4.0 FTE. Because of this lower appropriation, the Department of Human Services made a decision to no longer conduct the Mental Health Assessment and Services Agency and Single Entry Point audits. Therefore, the Department is currently retaining an outside contractor to perform approximately 28 audits. The FY 05-06 request is for continuation funding of $35,340, the FY 04-05 appropriation, which includes 50% federal financial participation and will not be transferred to the Department of Human Services.

Line Item: Single Entry Point Audits	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Request
Total Funds	$35,339	$35,340	$35,340	$35,340
General Fund	$17,669	$17,670	$17,670	$17,670
Federal Funds	$17,670	$17,670	$17,670	$17,670

PHONE TRIAGE/ADVICE

For FY 03-04, as implemented via the FY 03-04 Long Bill, this line item was merged into the new Acute Care Utilization Review line item. This line item no longer exists but is reflected here to show FY 02-03 Actuals in the Schedule 3. As a background, this line item was created from a recommendation made from SB 93-122 to authorize the Phone Triage Project study. The study recommended a telephone triage service for Medicaid clients, and a 24 hours-a-day, seven day a week triage and medical advise line was appropriated with its own budget line item.

For FY 02-03, this line was subject to budget balancing. Through the Department's Supplemental Bill, SB 03-203, the budget line was reduced by the amount of the appropriated 1% cost of business increase for $3,213 total funds. The 4% Budget Balancing Plan also reduced the contract by $22,491 total funds. These funding changes had an overall decrease of $25,704 total funds. See FY 03-04 November 1, 2002, Decision Item # BRI–3 for details. There is no request for this line item.

Line Item: Phone Triage/Advice	FY 01-02	FY 02-03
Total Funds – Base from Prior Year	$321,300	$321,300
General Fund	$80,325	$80,325
Federal Funds	$240,975	$240,975
Total Funds – DI #9 (1.0% Cost of Business Increase) November 1, 2001, page CR-107	$0	$3,213
General Fund	$0	$803
Federal Funds	$0	$2,410
Long Bill FY 02-03 Appropriation	$0	$324,513
General Fund	$0	$81,128
Federal Funds	$0	$243,385
Total Funds – SB 03-203, DI #4 (Budget Balancing) Supplemental Appropriation	$0	$(25,704)
General Fund	$0	$(6,426)
Federal Funds	$0	$(19,278)
Total Funds – Appropriation	$321,300	$298,809
General Fund	$80,325	$74,702
Federal Funds	$240,975	$224,107

SB 97-05 ENROLLMENT BROKER

Funding for a Medicaid Managed Care Enrollment Broker was appropriated to the Department through SB 97-05. SB 97-05 compelled the State to have 75% of its Medicaid client population enrolled in managed care by July 1, 2000. The Enrollment Broker provides information on basic Medicaid benefits offered through all health plans.

The initial contract for Colorado's facilitator was awarded to Maximus, Inc. In Colorado, the services marketed by Maximus are referred to as HealthColorado, the name for Medicaid's managed care initiative. Due to a failed bid, funding in FY 97-98 for start-up costs was rolled forward to be spent in FY 98-99. Medicaid Managed Care enrollment and disenrollment services began on May 18, 1998. The contract for the Broker was increased in FY 99-00 by $51,482 to follow the Joint Budget Committee's funding methodology based on estimates of enrollment, disenrollment, and re-enrollment. Decision Item #6, submitted November 1, 1999, for five additional enrollment counselors at an additional cost of $171,605 was approved for FY 00-01, increasing the volume of calls handled. This brought the total appropriation to $1,073,258, 50% federal funds. In FY 00-01, with the settlement of the Tatum lawsuit, the Enrollment Broker was charged with contacting 47,533 clients affected by that settlement to inform them of their coverage. A total of $289,186 was added to the budget ($28,919 General Fund and $260,267 federal funds) in one-time funding. The Department continued the additional work into FY 01-02, rolling forward $62,560 to the next year.

In the FY 02-03 legislative session, HB 02-1292 was passed, which made changes to the State's managed care system, including the mailing of notices to clients that is a responsibility of the Enrollment Broker, operated by Maximus, Inc. HB 02-1292 eliminated the requirement that the Department send two notices informing Medicaid clients of their choices for managed care (either health maintenance organization or the Primary Care Physician Program) and reduced the period for Medicaid clients to notify the Department through the Enrollment Broker of that choice, from 65 days to 30 days. The decrease for postage and printing is reflected in the calculation of funding available starting in FY 02-03, and is ongoing into the future in the same amount, $61,797.

Budget Balancing also affected this line item. For FY 02-03, the Department submitted base reductions in Supplemental Request #4 to the Enrollment Broker as part of the 4% Budget Balancing to the Joint Budget Committee on November 15, 2002, that would reduce administrative costs for the Enrollment Broker by 6.5%. The estimated impact to this line was $69,260 total funds, with 50% federal funds. Also included in the Supplemental Bill SB 03-203 was the impact for a Change Request submitted January 2, 2003 (S-11, BA-6) to fund the implementation of new federal managed care rules. A client handbook and mailings for the Primary Care Physician Program were required under the new rules. In FY 02-03, this was an increase of $15,440 for design costs, open enrollment, and Enrollment Broker system changes. The net impact for these two supplementals was $53,820 total funds. In the 2003 legislative session, SB 03-187 resulted in a FY 02-03 contract reduction of $254,860. Staffing and overhead have been reduced for FY 03-04 and are included in the base budget for future years.

In FY 03-04, one-time funding of $460,089 was appropriated via SB 03-258, the Long Bill, for: printing and mailing of client information and notification; production and mailing of the Primary Care Physician Program Client Handbook; additional system changes; and, monthly mailing to new voluntary clients. That appropriation had two parts. The first was for on-going monthly mailings and the second piece of the appropriation was for one-time projects only in FY 03-04.

For FY 04-05, the Long Bill appropriation of $875,756 included continuation funding of $188,415 for annualization of monthly mailing for January 2, 2003 Change Request S-11/ BA-6. The table below shows the incremental adjustments from year to year. The

Enrollment Broker line is funded at 50% General Fund, 50% federal funds. The Base Request for FY 05-06 is $875,756, the appropriation from FY 04-05.

Line Item: SB 97-05 Enrollment Broker	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06 Request**
Previous year	$871,299	$953,135	$1,362,444	$1,073,258	$702,781	$1,162,870	$875,756
Adjustment for new methodology per JBC Figure Setting page 73, March 9, 1999	$30,354	$0	$0	$0	$0	$0	$0
Decision Item #6, November 1, 1999 , page 670	$0	$171,605	$0	$0	$0	$0	$0
January 3, 2000 FY 99-00 Supplemental Request #9 (one-time funding reversed)		($51,482)					
Supplemental SB 01-183 (one-time)	$0	$0	($289,186)	$0	$0	$0	$0
FY 03-04 and FY 04-05 impact of Managed Care Supplemental #11/ Budget Amendment Request #6; Approved in FY 02-03 (see below)					$460,089	($287,114)	
Long Bill / Request FY 05-06	**$901,653**	**$1,073,258**	**$1,073,258**	**$1,073,258**	**$1,162,870**	**$875,756**	**$875,756**
Supplemental SB 01-183 (one-time)	$0	$289,186		$0	$0	$0	$0
January 3, 2000 FY 99-00 Supplemental Request #9 "Increase to Facilitate Enrollments in Managed Care," page 122 (one-time funding)	$51,482	$0	$0	$0	$0	$0	$0
HB 02-1292 - Requirements for Medicaid Enrollment (reduction)	$0	$0	$0	($61,797)	$0	$0	$0
Supplemental Request # S-4 4% Budget Balancing Plan and Suspended Provider Increases (implemented SB 03-203) reduction submitted November 15, 2002 to the Joint Budget Committee	$0	$0	$0	($69,260)	$0	$0	$0
SB 03-187 Medicaid Managed Care	$0	$0	$0	($254,860)	$0	$0	$0
Managed Care Supplemental #11/ Budget Amendment Request #6, Conform to Federal Mandate for Medicaid Managed Care Programs, January 2, 2003, page S.11-1, approved SB 03-203 and SB 03-258	$0	$0	$0	$15,440			$0
Final Appropriation/ Request FY 05-06	**$953,135**	**$1,362,444**	**$1,073,258**	**$702,781**	**$1,162,870**	**$875,756**	**$875,756**

DENTAL INCENTIVE

The General Assembly appropriated $2,000,000 in FY 01-02 for dental incentive "clinic start up" money. This money was from the Children's Basic Health Plan Trust Fund to award grants for community dental projects to serve low-income children. The need for the grants was underscored by a FY 00-01 study that indicated that 25 counties in Colorado did not have a Medicaid dental provider. The dental incentive grants, which supported capital construction, equipment costs for dental facilities, or other costs, are assisting dentists in serving additional clients in under represented counties.

The Request for Proposals to distribute the funds was published on August 1, 2001. The Department received thirty applications for funding including eleven from dentists, four from public hospitals, one from school-based health center and fourteen from community based organizations totaling $6,339,592 in requests. The interest generated by the dental community far exceeded the $2 million available to expand the dental network and service delivery for Colorado. The process to award the grants and issue contracts was somewhat delayed due to 1) mail delivery after September 11, 2001; 2) additional time needed for evaluation due to more awardees than anticipated; 3) contract award protests that had to be resolved before contract negotiations began; and 4) unanticipated training of awardees on government procedures. The final awards were completed by April 4, 2002. A rollforward of FY 01-02 funding was approved to complete the grant process in FY 02-03.

The program continued in FY 02-03 with a rollforward of $1,041,815. All but $20,167 was spent on the grants in FY 02-03 and that amount reverted to the Children's Basic Health Plan Trust Fund. The grants were a one-time appropriation and no budget has been requested.

PRIMARY CARE PHYSICIAN CREDENTIALING

For FY 03-04, as implemented via the FY 03-04 Long Bill, this line item was merged into the new External Quality Review line item. This line item no longer exists.

As a background, this line item was established in FY 00-01 to create a credentialing process within the Primary Care Physician Program. Under this program, existing and new physicians enrolled to serve Medicaid clients were required to have their credentials verified and updated every three years. Part of the program's process was to determine if there were any potential problems requiring further investigation, or to identify questionable practice patterns.

Change Request #9 requested a 1% cost of business increase for this contractor. The increase was reflected in the Long Bill with $1,008 total funds, including $544 General Fund and $544 federal funds. In FY 02-03, Supplemental Bill SB 03-203 eliminated this appropriated increase as part of Budget Balancing. Additionally, via SB 03-203, Change Request #BRI –3 changed the federal financial participation from 50% to 75% with $0 total funds, a reduction of $28,925 General Fund and an increase of $28,925 federal funds.

Please refer to the External Quality Review line item for funding of the credentialing activities and the FY 05-06 Request. There is no request for this line item.

Line Item: Primary Care Physician Credentialing	FY 01-02	FY 02-03
Total Funds – Base Request	$115,700	$115,700
General Funds	$57,850	$57,850
Federal Funds	$57,850	$57,850
Total Funds - DI #9 (1.0% Cost of Business Increase) November 1, 2001, page CR-107	$0	$1,088
General Funds	$0	$544
Federal Funds	$0	$544
Total Funds Long Bill Appropriation (SB 01- 212, HB 02-1420)	**$115,700**	**$116,788**
General Funds	$57,850	$58,394
Federal Funds	$57,850	$58,394
Total Funds – SB 03-203, DI #4 (Budget Balancing), submitted January 2, 2003	$0	($1,088)
General Funds	$0	($544)
Federal Funds	$0	($544)
Total Funds – SB 03-203, BRI #3 (Funding Split Revision from 50% to 75%), submitted November 1, 2002, pg. H.12-1	$0	$0
General Funds	$0	$(28,925)
Federal Funds	$0	$28,925
Total Funds – Appropriated	**$115,700**	**$115,700**
General Funds	$57,850	$28,925
Federal Funds	$57,850	$86,775

HB 01-1271 MEDICAID BUY-IN

This line item was established by legislation, but has been revised since its original appropriation. The line is explained in the sections below for clarity.

The Legislation:

HB 01-1271 authorized a Medicaid Buy-in Program for disabled individuals not otherwise eligible for Medicaid due to their level of employment earnings. This Colorado program was intended to tie in with the federal "Ticket to Work and Work Incentives Improvement Act of 1999." The Department was directed to study the feasibility of this plan and to seek federal approval. Grants, gifts, and donations were to be deposited in the Medicaid Buy-In Cash Fund created by the legislation to fund the program and all program expenditures were to be classified as Cash Funds Exempt. Premiums, set in accordance with an actuarial analysis of the

population, were to be structured to offset program costs in order to assure budget neutrality. HB 01-1271 allocated $209,400 total funding including $80,000 Cash Funds Exempt and $129,400 federal funds in FY 01-02.

As instructed by the legislation, the Department applied to the Secretary of the federal Department of Health and Human Services for a Medicaid infrastructure grant to develop and implement the program.

	FY 01-02	**FY 02-03 per Fiscal Note**
HB 01-1271 Appropriation	$209,400	$109,554

The Original Grant:
In January 2002, the Department received a federal grant of $500,000 that was to be spread across 3 years. This award enabled the Department to design a more comprehensive program than envisioned when the fiscal note was prepared for HB 01-1271. Through research and projections, the Department was to determine if it was cost effective to purchase or pay premiums from an individual's employer rather than pay for the health costs via Medicaid. Individuals eligible for Medicare Part A and B were also included; Medicaid would pay for those premiums if they were cost effective to the Department.

The Department's original $500,000 grant proposal estimated expenditures of $92,100 in federal funds during FY 01-02 and $370,381 in federal funds during FY 02-03 with the remaining balance of $37,519 available for FY 03-04.

Original Grant Proposal	**FY 01-02**	**FY 02-03**	**FY 03-04**	**Total**
100% Federal Funds	$92,100	$370,381	$37,519	$500,000

To implement the legislation, a Request for Proposals for the feasibility study was issued in FY 01-02. A contract, in the amount of $100,000 for the actuarial feasibility study, was executed in December 2002 that required an actuarial report to be completed in April 2003.

For FY 02-03, HB 02-1420, the Long Bill, appropriated total funds of $327,427 (100% federal funds), in anticipation of the grant award and the actuarial study. When the actuarial analysis was completed, it was apparent that budget neutrality could not be assured. The Department reported these findings to both the General Assembly and to the Centers for Medicare and Medicaid Services. The Department did not proceed any further to implement the program as originally planned. The actual expenditures were $82,000 in FY 02-03.

The Revised Grant:
Because the Department did not proceed with the program originally designed for the grant, due to the program not being budget neutral, the Centers for Medicare and Medicaid Services requested the Department submit a new proposal to redesign the grant

program that would fulfill goals similar to the original grant. On July 31, 2003, the Department submitted an amendment to the original grant and requested a no-cost extension. The new proposal was approved for continued funding of the original grant amount.

The new grant proposal identified three main strategies for improving Medicaid services and supports:

- Investigate the redesign and "rationalization" of personal care services;
- Educate workers with disabilities about key Medicaid support services and programs, including but not restricted to Personal Assistance Services and Supports; and,
- Create a centralized mechanism to access individualized information on the Department's new Personal Assistance Services and Supports options.

To meet the goals of these strategies, the Department proposed establishing a policy task force that would study options for implementing personal care services as a Medicaid state plan benefit. The proposal also earmarked $226,500 to develop written and electronic consumer-friendly materials about Medicaid benefits and programs for adults with disabilities. These grant funds were also used to contract with an experienced project manager and several other consultants with backgrounds in health education/literacy issues, Medicaid services, outreach and marketing, graphic design and production, and disability issues. The grant funds would be used to hire a Technical Personal Assistance Services and Supports Navigator to provide accurate information to individuals about program eligibility, provider qualifications, and scope of services. In addition, grant funds would be used to contract with a community organization to train and support a number of community members to be consultants, as Community-Based Personal Assistance Services and Supports Navigators, and develop a tool that consumers would use to help assess the most appropriate form of personal assistance services. To implement the redesigned grant, the Department estimated expenditures of $215,500 for FY 03-04 and $199,335 for FY 04-05, 100% federal funds.

The grant extension to December 31, 2004 will see all aspects of the grant completed. The report on options for implementing personal care as a Medicaid state plan benefit is complete. The grant staff is completing the written and electronic consumer friendly materials about Medicaid benefits and programs for adults with disabilities. The Technical Personal Assistance Services and Supports Navigator is hired, and the grant staff is completing development of the Community-Based Personal Assistance Services and Supports Navigators project and self-assessment tool.

The Appropriations:
HB 01-1271 appropriated $209,400 total funding including $80,000 Cash Funds Exempt and $129,400 federal funds in FY 01-02. HB 02-1420 appropriated total funds of $327,427 (100% federal funds) for FY 02-03. FY 03-04 was appropriated $37,519 (100% federal funds) through SB 03-258, and FY 04-05, the final appropriation, was $65,081 of all federal funds. There is no request for FY 05-06.

MEDICAID CASH ACCOUNTING IMPLEMENTATION

This was a new line item in FY 02-03. SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums line item. This resulted in $140 million in one-time savings in FY 02-03. SB 03-196 also appropriated $500,000 total funds, of which 50% was General Fund and 50% was federal funds, for the Department's administrative costs associated with the transition to cash-based accounting. The appropriation had explicit rollforward authority, authorized because the project was expected to cross fiscal years, but not require additional funding. From FY 02-03, $483,124 rolled forward into FY 03-04.

In FY 03-04, spending was $60,520; the remaining $422,604 was reverted. Total costs to implement cash accounting were $77,395. The Department had initially included outside contracting to recalibrate the Medicaid databases and reforecast expenditures in the appropriation estimates. By investing in new hardware that could handle the large amount of data, upgrading software, hiring temporary personnel to facilitate data entry, and training existing personnel on the new systems, the Department was better able to control costs. Medicaid Cost Accounting Implementation was one time funding. There is no request for FY 05-06.

NON-EMERGENCY TRANSPORTATION SERVICES

HB 04-1220 changed non-emergency transportation from an optional medical service in the Medical Services Premiums line item to an administrative service in a new line item. Federal regulations require that states offer Medicaid clients necessary non-emergent transportation to access their medical needs. States can choose to offer these services as either an administrative or a medical service. Prior to the passage of HB 04-1220, Colorado had offered non-emergency transportation services as an optional medical service. $7.6 million was reduced from non-emergency transportation in the Medical Services Premiums line item in the FY 03-04 Long Bill (SB 03-258). HB 04-1220 did not include an appropriation clause, but funding was defended in a Legislative Council footnote, on February 2, 2004, page 2. The reduction in Medical Services Premiums of $4,400,778 and the appropriation to this line item of $4,400,778 (50% General Fund and 50% federal funds) was funded via the Long Bill, HB 04-1422. During FY 03-04, there was a billing problem with Arapahoe County transportation contractors and thus, these actuals do not include all of the claims for services provided during FY 03-04.

The Department of Health Care Policy and Financing and the Department of Human Services submitted a HB 98-1331 emergency supplemental to the Joint Budget Committee on September 3, 2004 to transfer funds from the Department of Human Services to the Department of Health Care Policy and Financing from the Developmental Disability Services Waiver. The transfer is necessary to fund State Plan services to waiver clients that were previously being paid out of the waiver. This is a condition of renewal with the Centers for Medicare and Medicaid Services for the Comprehensive Services waiver for individuals with developmental disabilities. The Joint Budget Committee approved the emergency supplemental on September 21, 2004. The supplemental includes a transfer of funds for non-emergency transportation. The approved total amount, $20,706, is for nine months of service in FY 04-05. The total request for FY 04-05 is $4,421,484. [FY 04-05 Appropriation $4,400,778 + 1331 Supplemental $20,706 = $4,421,484] The

annualized amount, three months, for FY 05-06 is $6,902. Therefore, the request for FY 05-06 is $4,428,386. [FY 04-05 Request $4,421,484 + 1331 Supplemental annualized amount $6,902 = $4,428,386]

Funding Source	FY 01-02 Cash-Based Actuals*	FY 02-03 Cash-Based Actuals*	FY 03-04 Cash-Based Actuals*	FY 04-05 Appropriation	FY 04-05 Estimate	FY 05-06 Request
Total Funds	$8,862,235	$5,640,392	$2,616,352	$4,400,778	$4,421,484	$4,428,386
General Fund	$4,431,564	$2,786,536	$1,230,890	$2,200,389	$2,210,742	$2,214,193
Federal Funds	$4,430,671	$2,853,855	$1,385,462	$2,200,389	$2,210,742	$2,214,193

*Actuals are part of the Long Bill group (2) Medical Services Premiums.

DISABILITY DETERMINATION SERVICES

For FY 04-05, a June 7, 2004 Emergency Change Request was approved by the Joint Budget Committee that stopped the portion of funding for disability determinations for Medicaid eligible persons from being transferred from the Department of Health Care Policy and Financing to the Department of Human Services and created a new line item in the Department of Health Care Policy and Financing budget. Specifically, funding for Medicaid disability determinations is now included in the Department of Health Care Policy and Financing's, Executive Director's Office Long Bill group. This Emergency Change Request also included continuation funding for FY 05-06 in the same amount. Federal law mandates disability determinations for clients who are eligible for Medicaid due to a disability. Starting on July 1, 2004, client applications received by the counties are forwarded to the Department of Health Care Policy and Financing then sent to a contractor for processing. Previously, all applications were processed by the Department of Human Services.

For FY 04-05, the Joint Budget Committee authorized the change to the State Controller in a letter dated June 21, 2004, until a Supplemental Bill can be passed. This Change Request assumes a new line item, in the amount of $1,163,662 in total funds, of which $581,831 is General Fund and $581,831 are federal funds for contracting for disability determination services.

For FY 05-06, the Department is requesting $1,173,662 in total funds, of which $581,831 is General Fund, $5,000 is Cash Funds Exempt, and $586,831 is federal funds for contracting for disability determination services. The additional $10,000 in total funds and the change in funding splits from FY 04-05 to FY 05-06 is due to the implementation of SB 04-177, which authorizes the Children with Autism Waiver program. The Children with Autism Treatment Fund is required to transfer $5,000 in Cash Funds Exempt (originating from the Tobacco Cash Settlement Fund) to this line item for disability determinations of clients.

(2) MEDICAL SERVICES PREMIUMS (Exhibits A through X)

I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, disabled, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year.

Several major change-producing forces cause this program to be complicated to project. Those change-producing forces are summarized as follows:

- The Colorado Benefit Management System was implemented on September 1, 2004. Although the Department has no experience at this time, it is expected that there will be variations in eligibility processes, including the elimination of presumptive eligibility for Medicaid pregnant women, and possible budget changes due to these variations. Moving from a human-based decision process where eligibility calculation results are recorded, to a rules-driven decision making information system, one can only expect services and clients to be affected. However, the Department can make no budget revisions based on this system implementation, and does not know if the net impact will be negative, positive, or cost-neutral. During a time of potentially unstable caseload reporting, expenditure-based global reasonableness tests become even more valuable to ensure that per capita based projections are on track. See the global reasonableness test at Exhibit W for more information.

- S.B. 03-176 eliminated services for legal immigrants and originally cut $11 million from the budget. After a year of litigation, it is budgeted to be implemented on January 1, 2005. The reduction is included in the caseload forecast. A total of 924 clients are removed from the FY 04-05 caseload forecast, for an estimated savings of $5.1 million. The savings are only accounted for in the caseload forecast to ensure they are not double-counted.

- Due to implementation of S.B. 03-176, the state-only prenatal program will also end January 1, 2005. This estimate is part of Exhibit D.

- Non-emergent transportation was moved from the Medical Services Premiums line item to an administrative line item within the Executive Director's Long Bill grouping. This was authorized in H.B. 04-1220 and funded in H.B. 04-1422.

- The FY 04-05 request includes lifting the FY 03-04 overexpenditure restriction of $14 million.

- The Department is currently contracting with one managed care plan as a health maintenance organization and is contracting with three health plans to provide services to clients as an Administrative Service Organization, or ASO. An ASO receives a monthly administrative fee per client and bills the Department for only the services provided to each client, at negotiated rates. This differs from a traditional health maintenance organization, in that HMOs receive a monthly capitation to cover almost all services to clients, regardless if the client utilizes the HMO. These changes will cause a change in expenditure patterns; however, the Department has no data available to support a change in the current budget forecasting in this budget request.

- FY 98-99 is excluded from expenditure trends because of the unstable nature of the data during the transition from the Blue Cross/Blue Shield claims processing system to the current Medicaid Management Information System in December 1998.

II. MEDICAID CASELOAD

INTRODUCTION

Biannually, the Department of Health Care Policy and Financing submits its estimated funding need for the Medical Services Premiums line item. The first step in generating the November and February submissions is to project the Medicaid caseload. The Medicaid caseload does not represent the number of uninsured individuals in Colorado, nor does it represent the number of Colorado residents living in poverty. Caseload figures only represent individuals that the Department expects will enroll in Medicaid because they meet specific eligibility requirements in one of three groups: 1) Families, Pregnant Women, and Children; 2) Aged and Disabled; or 3) Other.

Federal Medicaid statute defines over 50 groups of individuals that may qualify for Medicaid. Some groups are mandatory, while others are optional and each state decides which of the optional groups it will cover. From the inception of Medicaid in 1965 (Public Law 89-97) to the 1980s, the program was targeted at low-income families, elderly, and the disabled. During the 1980s, Medicaid expanded to include pregnant women and children with greater income levels, as well as some optional elderly and disabled groups. In 2000, Medicaid coverage was extended to women with breast and cervical cancer. From the 1990s to the present, other Medicaid categories have been added through State initiated demonstration waivers. All eligibility categories have specific income and resource limits, and some have additional criteria such as age or disability status. For budgetary purposes, the Department groups clients with similar characteristics and costs together. For example, clients grouped in the Eligible Children category have similar characteristics and costs, but might have gained Medicaid eligibility through different programs. Since each category of eligibility is affected by unique factors, the Department projects each category separately. Projecting an aggregate caseload would be easier, but could be less precise.

Historic caseload data are used in conjunction with economic data to project caseload in each category. To make a projection, the Department uses several different statistical techniques (as described in the Methodology section below), and chooses the projection

that best fits the data. After projections are chosen for each category, the Department presents its recommendations to the Office of State Planning and Budgeting. Independently, the Office of State Planning and Budgeting develops its own categorical caseload projections. The Department then meets with the Office of State Planning and Budgeting, and the two agencies agree on an Executive caseload proposal. It is important to note that the methodology the Department used to generate it's projections is not wholly reflected by the Executive caseload proposal presented in this document since those figures are often the result of compromises with the Office of State Planning and Budgeting. In addition, the Department is not privy to the methodologies used by the Office of State Planning and Budgeting, so information in this document refers only to methods used by the Department.

In 2003, the process of projecting the Medicaid caseload was drastically affected by SB 03-196, which mandated that the Department transition from accrual to cash based accounting. From that point forward, caseload numbers no longer incorporated retroactivity. Retroactivity caused historical adjustments to caseload to account for clients who were found to be eligible for Medicaid for past months, thus increasing the count of persons eligible for Medicaid. Since most clients are eligible back to the date of their application, retroactivity adjustments assured that all months were accounted for. However, this caused variability in the caseload reports, as monthly caseload was adjusted for months, even years, after the month had ended. It also required special manually run reports to make these adjustments. Under the cash accounting system, a monthly caseload report is created from the Medicaid Management Information System and that caseload is considered final.

If the Department had only applied the accounting conversion to the FY 03-04 caseload projection, this would have produced a synthetic drop in caseload relative to the prior year when retroactivity was still applicable. To control for this manufactured decrease in caseload, and to develop a more accurate portrayal of history, the Department recreated ten years of Medicaid caseload history sans retroactivity. By rebuilding the caseload without retroactivity, the Department was able to put the FY 03-04 projection in perspective, and test the historical data for accuracy. For a complete explanation of how the historical data was rebuilt and tested, refer to the November 3, 2003 Legislative Budget Request, pages K-98 and K-99.

Starting in 2003, the Department has reported caseload figures and projections without retroactivity. ***In continuing this practice, none of the figures in this document incorporate retroactivity.*** Again, the Department notes that the impact of Colorado Benefits Management System on caseload reporting cannot be known at this time. There will be a period of instability in the data. Only then can the full impact be evaluated.

Recent Caseload History

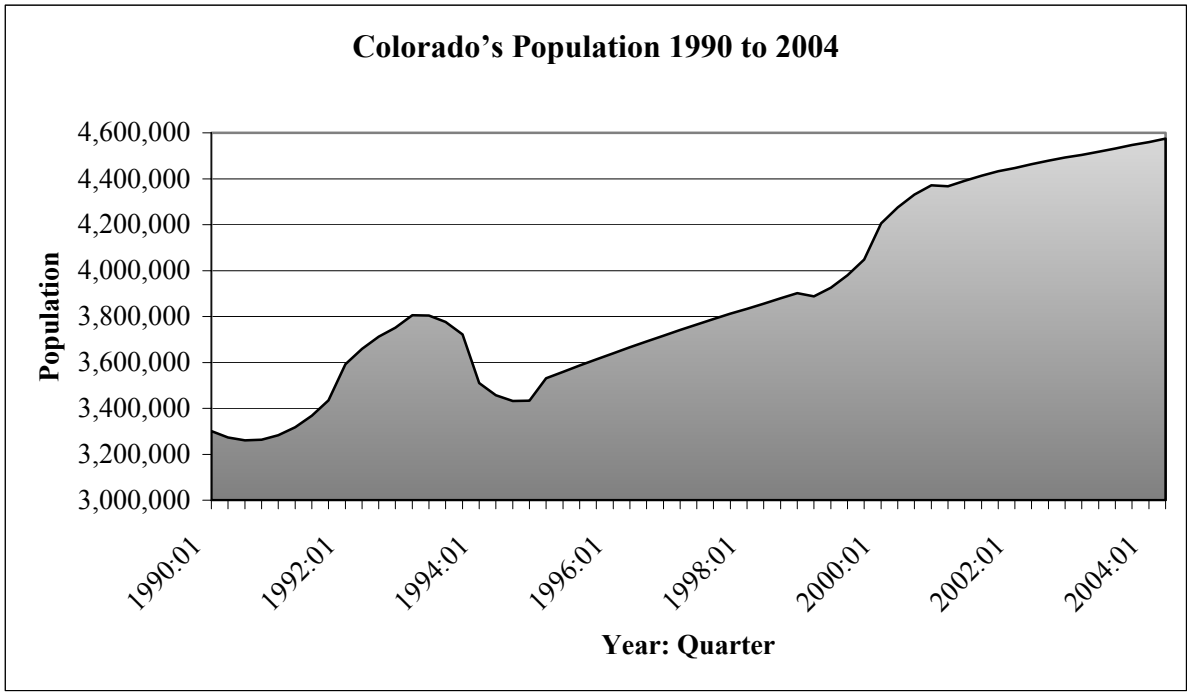
Exhibit A tabulates actual caseload figures and growth rates by eligibility category from FY 95-96 to FY 03-04. Projections for FY 04-05 and FY 05-06 are also presented in the table and will be discussed in the Categorical Projections section of this document. A graphic representation of aggregate Medicaid caseload history for the same period can be found in Exhibit X, page EX-1. This graph shows that from FY 93-94 to FY 02-03 overall Medicaid caseload grew 26%. Aggregate growth from FY 93-94 to FY 99-00 was stable, and in some years even declined. From FY 99-00 to FY 03-04 the State sustained positive and significant growth in caseload

ranging from 6.6% to 10.8%. Even more notable is the fact that Medicaid in Colorado had double-digit growth rates in FY 02-03 and FY 03-04 of 10.8% and 10.7%, respectively. Reasons for these recent growth rates will be discussed below, but having a reference for this unprecedented growth is important. Over the past five fiscal years, growth rates have not shown any signs of abatement.

The charts found in Exhibit X, page EX-2 show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 93-94 and FY 03-04. As a percentage of the entire Medicaid caseload, Eligible Children have increased 5%, the largest gain when compared with all other categories. In the more expensive categories of Supplemental Security Income 65+ and Supplemental Security Income for Disabled Individuals, the percentages of the overall caseload have fallen by 3% and 2% respectively. This is encouraging because the change in case mix implies that increases in a less expensive category (Eligible Children) have been coupled with decreases in more expensive categories (Supplemental Security Income 65+ and Supplemental Security Income for Disabled Individuals) over the last ten years.

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 confounded 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. Therefore, projections represent the *net effect* of what the Department expects will happen. Each factor and its expected impact on the Medicaid caseload are discussed below.

Population- Colorado's total population increased 38.6% from 1993 to 2003. The graph below shows an unusual pattern from 1990 to 1994. Starting in 1994 until 2003, the State's population has grown at a positive, albeit varying rate. As the overall population has grown, so too has the Medicaid caseload. This positive correlation implies that if population is projected to grow in the future, then it should also be expected that the Medicaid caseload would increase. The Department of Local Affairs forecasts that Colorado's population will increase 3% from the second quarter of 2004 to the second quarter of 2006.



Source: Department of Local Affairs, Demography Division

When using population data to project caseload, the Department marries population subgroups to their appropriate Medicaid category. For example, when projecting caseload for Eligible Children, the Department uses population statistics for Colorado residents aged 0 to 18. By using subgroups instead of total population figures, the Department is able to capture subgroup specific trends.

In-State Migration- Like population, in-State migration is positively correlated to Medicaid caseload. As more individuals move to Colorado from other states, Medicaid caseloads will increase. During economic downturns, people usually move from states with worse economic conditions to states with better conditions in search of jobs. Although most experts agree that Colorado experienced some of the worst economic conditions in the United States during the recent recession, net migration in 2003 was 16,500.[4] An increase of 16,500 persons in a population of over 4 million may not be significant, but a positive migration rate means more people who could conceivably be eligible for Medicaid. Conversely, as the economy recovers, in-state migration is expected to increase.

[4] Source: Dwyer, Kelly. "New Residents, Jobs on the Rise in Colorado." The Denver Post. 11 July 2004.

Age- The age of the population can provide some insight as to why Medicaid caseloads have been increasing. As the population ages, so too does the demand for medical care. Generally, as individuals age their health becomes more fragile and the more likely they are to seek health care. From 1993 to 2003, Colorado's population aged 1.6 years.[5] This may be the result of retirees moving to the State, increased longevity, or fewer births. Regardless of the reason, an aging population has a direct effect on the demand for medical services, but not necessarily Medicaid. A July 2004 study at Georgetown University estimated the future impact of an aging population for each state. The study focused on the number of working aged adults per elderly person within a state. Next, the study gathered population estimates from the U.S. Census Bureau for those same two groups. The percent change in the ratio of elderly to working aged adults was calculated from 2001 to 2025. Colorado ranked first in the study having the highest percent change.[6] This infers that Colorado will have more working adults per one elderly adult in 2025 than any other state. As of 2003, Colorado has not yet felt the impacts of aging in the Medicaid caseload, particularly in the categories that include Long Term Care. The Department suspects that this lagged impact of aging on the caseload is a result of several Home- and Community- Based waiver programs.

Length of Stay- The severity and length of the recent economic downturn has prolonged the average amount of time clients remain on the Medicaid caseload. An increased length of stay results in higher caseload numbers for longer periods. The table below shows that the average number of months of eligibility for adults and children on Medicaid has increased 16.78% and 12.14% respectively from FY 99-00 to FY 03-04. The Department does not expect the average length of stay to decrease until economic conditions are more robust.

Fiscal Year	Categorically Low Income Adults Average Number of Months on Medicaid	Eligible Children Average Number of Months on Medicaid
FY 99-00	7.27	8.56
FY 00-01	7.26	8.66
FY 01-02	7.57	8.87
FY 02-03	8.16	9.08
FY 03-04	8.47	9.60

Economic Conditions- Economic indicators help partially explain why some Medicaid caseload trends occur. Since Medicaid is a needs-based program where clients must meet income and resource limits, it follows that caseload for families and children should be countercyclical to economic conditions. For example, as the state experiences recessionary conditions, the Medicaid caseload will increase. After the recession that ended in the early 1990s, Colorado enjoyed almost ten years of economic expansion. The terror attacks on the United States in 2001 brought that expansion to an abrupt halt, and for the first time in a decade, Colorado lost a significant number of jobs coupled with falling wages. In 2003, the economy showed sporadic signs of recovery. It is now evident

[5] Source: Department of Local Affairs, Demography Division
[6] Source: "Medicaid an Aging Population." Georgetown University Long Term Care Financing Project. July 2004. <http://www.ltc.georgetown.edu>

that Colorado's economy is recovering from the recent recession, but at a sluggish pace. Colorado is one of eighteen states whose index of economic momentum is below the national average.[7] This index is measure by the growth in jobs and personal income as compared to the national average.

The table that follows shows historical and projected unemployment rates, non-agricultural employment, and job growth statistics.[8] The forecast predicts that by 2004, wage and salary income will exceed 2001 levels. Non-agricultural employment will not exceed 2001 levels until 2006. However, the unemployment rate is not expected to return to 2001 levels by 2006.

Year	Wage and Salary Income (billions)	Non-Agricultural Employment (thousands)	Unemployment Rate
2001	$88,308	2,225	3.7%
2002	$86,889	2,176	5.7%
2003	$88,091	2,145	6.0%
2004	$91,133	2,171	5.4%
2005	$95,669	2,219	4.8%
2006	$101,811	2,281	4.7%

While this is promising for the State as a whole, it is less encouraging for Medicaid for several reasons. First, the timing of an economic cycle is important in estimating the impact on the Medicaid caseload. As the economy recovers from a downturn, workers need to find jobs in order to withdraw from the Medicaid rolls. Jobs that primarily affect family and children Medicaid populations[9] are hourly and concentrated in the service industry. These employment types are often the last to benefit from improving economic conditions. Therefore, any economic impact on the Medicaid caseload will have a lagged affect. Second, as workers find jobs they do not instantaneously lose their Medicaid eligibility. Since 1990, states have been federally required to provide Transitional Medicaid benefits up to one year to families who lost eligibility because of increased income due to employment. This policy was directed at clients who potentially might turn down employment for fear of losing their Medicaid benefits. To be eligible for Transitional Medicaid, a client must have been eligible in at least three of the preceding six months. Clients may receive Transitional Medicaid as long as their income is below 185% of the federal poverty level. Although this program was set to expire in March 2004, it was extended until March 31, 2005, as it has been several times. Another small group of clients are eligible for Transitional Medicaid services that would otherwise lose their Medicaid benefits due to child or spousal support payments. Families in this group receive a four-month extension. As illustrated in the following table, the average number of adults and children on Transitional Medicaid has

[7] Source: Governing Magazine, Sourcebook 2004, page 6.
[8] Source: Office of State Planning and Budgeting, June 2004 *Colorado Economic Perspective*
[9] Projecting elderly and disabled client populations does not prioritize economic variables.

increased 28% and 19% respectively from FY 01-02 to FY 03-04. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 04-05 and FY 05-06.

Fiscal Year	Average Number of Adults on Transitional Medicaid	Average Number of Eligible Children on Transitional Medicaid
FY 01-02	3,823	6,598
FY 02-03	4,637	7,615
FY 03-04	4,900	7,864

Policy Changes- Finally, State and federal policy decisions can alter the Medicaid caseload. The following list briefly describes major federal policy changes that have affected Medicaid eligibility, and therefore caseload. This list is not meant to be comprehensive in nature, but a summary of major changes affecting eligibility since 1996.

- Personal Responsibility and Work Opportunity Act of 1996, Public Law 104-193: This act de-linked eligibility between welfare (formerly called Aid to Families with Dependent Children) and Medicaid. States were permitted to adjust their income and resource standards for Medicaid at that time, but they could not fall below the standard applied on May 1, 1988.
- Balanced Budget Act of 1997, Public Law 105-33: This act restored Medicaid eligibility to legal immigrants who entered the country before August 22, 1996 and later became disabled. Children who lost their Supplemental Security Income eligibility due to the Personal Responsibility and Work Opportunity Act continued to receive Medicaid. Coverage for refugees and asylees was extended from five to seven years.
- Foster Care Independence Act of 1999, Public Law 106-169: This Act allowed states to provide Medicaid benefits to children in foster care up to age 21 who were previously eligible under Title IV-E before turning 18.
- Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354: Establishes a new group of eligibility for women under 65 who have been screened under the Centers for Disease Control and Prevention Board and need treatment for either diagnosis.

In addition to adopting these federal policy changes, the State has applied and received approval for the following waiver programs that have affected the Medicaid caseload:

- Children's Home and Community Based Waiver, 26-4-509, C.R.S. (2004): Formerly known as the Katie Beckett waiver, this program serves disabled children in the home who are at risk of nursing facility or hospital placement.
- Brain Injury Waiver, 26-4-601 to 612, C.R.S. (2004): Serves persons with brain injury within a specific diagnosis code. Clients must be in the process of discharging from a hospital, rehabilitation hospital, or rehabilitation facility.
- Persons Living with AIDS, 26-4-641-648, C.R.S. (2004): Serves persons diagnosed with HIV/AIDS.
- Elderly, Blind and Disabled Waiver 26-4-601-612, C.R.S. (2004): Serves persons who have a functional impairment, are blind, or are physically disabled.

During the 2004 legislative session, SB 04-177 authorized the Children with Autism waiver and SB 04-028 authorized the Substance Abuse Treatment for Native Americans waiver. These bills direct the Department to submit a waiver application to the Centers for Medicare and Medicaid Services for approval. Until the Centers for Medicare and Medicaid Services approve or deny these waivers, the impact on caseload is indeterminate; therefore, no adjustments were made for the FY 04-05 and FY 05-06 caseload projections. However, a bottom-line adjustment has been made in the Premiums projection for SB 04-177.

The combination of the aforementioned factors has led to significant growth in the Medicaid caseload since FY 99-00. The Department is projecting an FY 04-05 caseload of 388,257 and an FY 05-06 caseload of 406,616. From the actual FY 03-04 caseload figures, this translates into a 7.1% growth rate in FY 04-05. In the February 16, 2004, Final Request for Medical Services Premiums, page MSP-5, the Department predicted an 8.8% growth in the FY 03-04 Medicaid caseload. Actual figures show that caseload grew 10.7% in FY 03-04, relatively steady from the prior year's growth of 10.8%. The Department expects that growth in the Medicaid caseload will slow as economic conditions improve, but that an overall decrease in caseload will not occur in either FY 04-05 or FY 05-06. National and state forecasts continue to be revised downward as expected job growth has not materialized and inflation and interest rates climb. Furthermore, jobs that have returned to the State have been concentrated in construction, trade, and business services.[10] In order for Medicaid caseloads to be affected, jobs in the service industry need to return.

In summary, Colorado's economy is recovering, but an impact on Medicaid clients will take more time to actualize. Accounting for these economic conditions, and the fact that population, age, and in-State migration continue to increase, the Department has revised its FY 04-05 projection from the February 16, 2004 submission upwards. The following table shows actual and projected aggregate Medicaid caseload from FY 02-03 to FY 05-06.

Fiscal Year	Medicaid Caseload	Level Growth	Growth Rate
FY 02-03 actual	327,395	31,984	10.8%
FY 03-04 actual[11]	362,531	35,136	10.7%
FY 04-05 projection	388,257	25,727	7.1%
FY 05-06 projection	406,616	18,359	4.7%

Colorado Benefits Management System Uncertainties - Colorado is the first state in the nation to develop and implement a fully integrated eligibility system for cash assistance and benefits. The Colorado Benefits Management System was designed so that clients could simultaneously apply for more than one benefit. Beyond streamlining benefits, the Colorado Benefits Management System was designed to remove the human element associated with eligibility decisions. The eligibility rules of each program are imbedded in the system. Eligibility decisions will become objective and uniform under the new system. However, with the implementation of any

[10] Source: Colorado Legislative Council Staff June 2004 *Economic and Revenue Forecast*.

[11] Aggregate average fiscal year caseload does not equal the Department's monthly Medicaid caseload report for June 2004 due to rounding. However, all fiscal year averages by category for FY 03-04 discussed in this document match the June 2004 report.

massive and complex system, the Department expects changes to caseload reporting. The Department estimates that these changes will affect the Medical Services Premiums line item. It is estimated that caseload and expenditures data could be unstable for a period of time following implementation. Certain phenomena will change data results or caseload reporting:

- Clients who have erroneously been made eligible or ineligible in the past will be corrected;
- There is a backlog of applications;
- There will be delayed determinations and redeterminations of eligibility;
- There is a learning curve and cultural change for county workers and Medical Assistance Site workers;
- An expected increase in Medicaid enrollment due to the Medicare Modernization Act; and,
- The 6 month Benefit Freeze Flag.

At the same time, unrelated to Colorado Benefits Management System, presumptive eligibility for Medicaid pregnant women was abolished, which will also affect caseload reporting.

Even if the Department could predict the direction that each scenario will have on caseload, predicting the magnitude of that effect is not possible. There will be a 6 month benefit freeze flag in place; therefore the attrition rate, or the rate of Medicaid ineligibles that naturally fall off the caseload each month, will not be realized. This means that the Medicaid caseload could be higher than it normally would be in the absence of a freeze. This scenario might indicate that the Department should incorporate a Colorado Benefits Management System "enrollment factor" into its caseload projections, but other scenarios indicate the caseload could be lower. Each scenario listed above will have its own compounding factors. As a result of these complexities, the Department must analyze data as it is available, and, in the meantime, rely more heavily on expenditure reporting trends. An update on these issues will be provided in the February 2005 Medical Service Premiums Final Request.

METHODOLOGY

The Department's caseload projections utilize statistical forecasting methodologies to predict the Medicaid caseload by eligibility category. Historical monthly caseload data from July 1993 to May 2004 and historical and forecasted economic and demographic data that were revised in June 2004 were used. Two forecasting methodologies were used: trend and regression. The software used by the Department for developing trend and regression forecasts is *Forecast Pro XE.*

Trend Models

Trend models have been very successful in forecasting Medicaid caseloads. There are two types of trend models used to forecast caseload: Box Jenkins and Exponential Smoothing. Each model employs a different mathematical algorithm that uses only the trend history of the variable itself to predict future values. The choice of algorithm varies depending on the statistical properties of the time-series. For example, if a time-series exhibits seasonal patterns, the algorithm adjusts for those variations. *Forecast Pro XE* is programmed to recommend logarithmic and other exponential transformations to the data series, when deemed appropriate, and will even recommend whether an Exponential Smoothing technique or the Box-Jenkins methodology is best for the particular series in question. Generally, both trend techniques are used to forecast caseload for each eligibility category. This allows for a greater choice of projections for the Department to consider.

Exponential Smoothing

For over thirty years, Exponential Smoothing models have been used to forecast data within a variety of applications. Considered simplistic, Exponential Smoothing models extract trend and seasonal patterns from a time-series to predict a future stream of values. One advantage of this model is that it produces robust results with limited data sets. This becomes invaluable for Medicaid eligibility categories that have not been in existence for very long, such as the Breast and Cervical Cancer Program category. Another advantage of the Exponential Smoothing model is that two types exist that address seasonality and trending: Holt and Winters. The Holt Exponential Smoothing model adjusts for trended data, while the Winters Exponential Smoothing model adjusts for both trended and seasonal data. Both Holt and Winters use recursive equations to determine the estimated parameters of the model.

Box Jenkins

As compared to Exponential Smoothing models, Box Jenkins models are more complex, but often produce results that are more accurate when the time-series are longer and stable. Box Jenkins models employ an Auto Regressive Integrated Moving Average procedure to extrapolate future values. This procedure fits the autocorrelation function of a stationary time-series with the minimum number of parameters. Since the forecaster individually specifies each parameter, Box Jenkins models can become much more complex than their Exponential Smoothing counterparts. A minimum of 36 observations is required to perform a Box-Jenkins forecast. Therefore, a Box Jenkins model cannot be used to forecast caseload for the Breast and Cervical Cancer Program category.

Regression Models

Regression analysis, unlike trend analysis, incorporates independent variables when making projections. For example, a regression equation may include the unemployment rate if the forecaster expects that it has an affect on the caseload for Categorically Eligible Low-Income Adults. Statistically, the forecaster can test whether or not there is a relationship between independent variables and the caseload by constructing a correlation matrix. Variables that are highly correlated with the caseload are more likely to be related. Regression equations are useful in that they provide some insight into why the trend projection is increasing, decreasing, or static. Although regression equations help explain why trends occur, their value depends on the quality of the independent variables used. In

order to project caseload, historical and forecasted values of the independent variables must be used. Therefore, the accuracy of the caseload forecast depends on the accuracy of the forecasted independent variables.

In June 2004, the Office of State Planning and Budgeting and the Colorado Department of Local Affairs' Demography Division supplied actual and forecasted values of the following independent variables, which were used in the regression models:

- Employment - level of employment, this variable is measured in thousands;
- Unemployment Rate - the number of unemployed divided by the number in the labor force, this variable is measured as a percent;
- Population by Age Group - level of population broken into specific age groupings, this variable is measured in thousands;
- Total Wages - level of total wages, this variable is measured in billions;
- Births - number of births per thousand women;
- Employment in the Service Industry - level of employment in the service industry, this variable is measured in thousands;
- Wages in the Service Industry - level of wages in the service industry, this variable is measured in billions; and
- Migration - net increases or decreases in the State population adjusted for births and deaths.

Trend vs. Regression Models

After several different forecasts are produced, the Department must choose one for each category. In most eligibility categories, trend and regression projections are considered. As previously mentioned, Exponential Smoothing models are best suited for short-term forecasts and since the Breast and Cervical Cancer category was created in FY 02-03, it can only be forecasted using that model.

To determine which model is the best, the Department evaluates each model's forecast on two criteria: goodness of fit and expected growth patterns. *Forecast Pro XE* performs several statistical tests that evaluate the goodness of fit. These tests include: serial correlation of first and multiple orders, heteroskedacticity, robustness of error terms, and collinearity. Each model is judged on its statistical soundness, and models that perform poorly are eliminated. Elimination is purely subjective, and directly related to the model's statistical performance. Finally, the Department is left with a reduced menu of forecasts to consider. Historical patterns, along with economic and policy expectations are considered, and one model is chosen to be the best.

SB 03-176

Oftentimes, a forecast cannot instantaneously incorporate policy changes even with the use of dummy or indicator variables. When this occurs, adjustments are made to the forecast off-line. Off-line adjustments were made to the FY 04-05 forecast to account for the implementation of SB 03-176.

Senate Bill 03-176 eliminated services for certain legal immigrants with a subsequent reduction in the Medical Services Premiums line item. Since the February 16, 2004, Final Request for Medical Services Premiums, the status of SB 03-176 has been finalized. After the Tenth Circuit court denied the plaintiff's petition for rehearing and the plaintiff informed the Department they would not petition for certiorari, the Department developed an implementation plan for SB 03-176. Starting January 1, 2005, the Department plans to

begin the process of removing the affected clients from Medicaid. According to the fiscal note, the Department estimated that in FY 04-05 3,549 clients would be removed. Using historical data, the distribution across categories was determined to be:

- 821 Supplemental Security Income Adults 65+,
- 117 Supplemental Income Adults 60 to 64,
- 707 Supplemental Security Income Disabled Individuals,
- 683 Categorically Eligible Low-Income Adults,
- 263 Baby Care Adults,
- 865 Eligible Children, and
- 93 Foster Care.

SB 03-176 will not affect Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries or Breast and Cervical Cancer Program clients.

Next, the Department had to determine which methodology was best to remove these clients from the FY 04-05 caseload projection. Although this may seem straightforward, it is not. Two methodologies were considered, and the pros and cons of each are listed below.

- *Methodology 1*- Reduce the FY 04-05 categorical fiscal year averages by the above amounts. For example, reduce the FY 04-05 projected fiscal year average for Foster Care by 93. Although this is the easiest way to reduce caseload, it reduces funding for twelve months when the Department will actually need funding from July 2004 to December 2004.
- *Methodology 2*- Reduce the FY 04-05 categories incrementally over six months. For example, from January 2005 to June 2005 the Foster Care projection would be reduced by 15.5 clients (93/6=15.5) per month. Although this results in a more conservative reduction of the *fiscal year average* for the Foster Care caseload, it allows for the needed six months of funding from July 2004 to December 2004. In addition, this methodology gives the Department ample time to identify and remove those clients from Medicaid.

The choice in methodology was influenced by the status of the Colorado Benefits Management System and the workload associated with verifying the immigration status of each affected client. In May 2004, the Department estimated that over 23,000 immigrants were receiving Medicaid services across all categories.[12] This figure includes both mandatory and optional immigrants. As directed in SB 03-176, only optional immigrants will be identified and subsequently removed from the caseload (see the Categorical Projections, Non-Citizens section for a discussion of mandatory versus optional immigrant status). At the time, the Client Oriented Information Network system, which determined eligibility for Medicaid clients, coded all immigrants (mandatory or optional) the same. Therefore, under the Client Oriented Information Network system, the Department was unable to quantify the true number of

[12] Source: Client Oriented Information Network report May 2004.

optional immigrants. To do so, the Department would need to manually review all 23,000 files to clarify each client's immigration status.

As outlined on page L-30 of the FY 05-06 Strategic Plan, the Colorado Benefits Management System will replace the Client Oriented Information Network system. A caseworker will have to review and physically "touch" or "activate" a case to determine the client's Medicaid eligibility. Furthermore, immigration status is volatile due to changes in immigrant status, veteran or active duty status, whether or not the client is a victim of trafficking, and citizenship. Either of these factors could alter a client's immigration status, which must be carefully verified before a client is removed from Medicaid. This implies that even though the Colorado Benefits Management System is online January 1, 2005, the removal of SB 03-176 clients will not be instantaneous and will increase the workloads of county eligibility technicians.

Considering all these factors, the Department chose to remove the SB 03-176 clients using Methodology 2. An initial projection was made for FY 04-05, and then monthly caseload was reduced by 1/6 of the appropriate amount for that category from January 2005 to June 2005. Next, the *adjusted* FY 04-05 forecast was used to make the FY 05-06 projections.

Finally, the Department adjusted the Non-Citizens caseload for the impact of SB 03-176. As detailed in the fiscal note, when clients are removed from Medicaid due to SB 03-176, federal law mandates that those clients be eligible for emergency services. Although, the fiscal note predicted that 3,194 of the affected clients would require emergency services, the Department felt that percentage was unrealistic. After further discussion, the Department estimated that 2,535 clients would need to be added to the Non-Citizens category. For consistency, the number of non-citizens was added over the same six-month period resulting in a monthly increase of 423 clients (2,535/6). The Department expects that non-citizens will receive emergency care as needed, and the probability of all 2,535 clients showing up in one month is unrealistic. ***Overall, the Department estimates that the effect of SB 03-176 will result in a reduction of 3,459 clients across all the affected Medicaid categories offset by an increase of 2,535 clients in the Non-Citizens category. Therefore, the net decrease of aggregate Medicaid caseload from January 2005 to June 2005 will be 924 clients.***

During the January 21, 2003 deliberations for FY 03-04 Supplemental Appropriations, page 8, the Joint Budget Committee did not allow for any changes in the Non-Citizens caseload category when implementing SB 03-176. Without an increase in the Non-Citizens caseload for emergency services, which federal law mandates, the Department will likely have insufficient funding for this group.

CATEGORICAL PROJECTIONS

This section details the caseload projections by eligibility category. For each category, the following are presented: a discussion of the category, rationale for the forecast, caseload history in tabular form, and statutory authority. For a Graphical representation of caseload history by category, see Exhibit X, pages EX-3 to EX-12.

Supplemental Security Income 65 +

Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. With a few exceptions, recipients must be United States citizens. The Supplemental Security Income for adults aged 65 and older is included in this category. Also included are individuals aged 65 and older who meet the Medicaid resource and income requirements, but are not receiving Supplemental Security Income. In addition, states may extend coverage to individuals with incomes above the Supplemental Security Income limit, and who are receiving long term care in an institution. Referred to as 300 Percenters, these clients have incomes no more than 3 times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home. 300 Percenters constitute greater than half of the enrollees in the Home and Community Based Services, Elderly, Blind, and Disabled waiver program.

The graph on Exhibit X, page EX-3, shows that growth in this category has been relatively stable. The Department speculates that the large spike in caseload in early 2003 may be correlated with false implementation of SB 03-176. As counties began to implement SB 03-176, they may have shifted clients from other categories into the Supplemental Security Income 65+ category. Once the court ordered injunction was in place, this shifting may have subsided. The Department projects a negative growth rate in FY 04-05 due to the implementation of SB 03-176, followed by a slightly positive rate in FY 05-06.

Supplemental Security Income 65+ Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	34,485	569	1.68%
FY 03-04	34,149	(336)	-0.97%
FY 04-05 projection	33,600	(549)	-1.61%
FY 05-06 projection	33,700	100	0.30%

26-4-201, C.R.S. (2004)
(j) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions.

26-4-301, C.R.S. (2004)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement.
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.

Supplemental Security Income 60 to 64

Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. With a few exceptions, recipients must be United States citizens. Disabled adults aged 60 to 64 who are eligible for Supplemental Security Income are included in this category. Quality control checks occur frequently to look for eligibility coding errors that commonly result in clients being misclassified between this Medicaid category and the Old Age Pension State Only Medical Program (non-Medicaid) category. Historical miscoding can make it difficult to forecast this Medicaid category as groups of individuals identified through this process may be abruptly moved in and out of this category.

Growth in FY 01-02 was unusually low, partially due to the movement of 400 clients out of this category into the Old Age Pension State Medical Program and due to the elimination of the "Med-9" disability determination process for those under age 65 (see the Supplemental Security Income for Disabled Individuals section for a complete description of the Med-9).

The graph on Exhibit X, page EX-4, shows that caseload trends in this category have been positive and relatively stable. Caseload is correlated with the population of adults aged 60-64. For FY 04-05, the Department expects a negative growth rate due to SB 03-176 and a positive growth rate in FY 05-06.

Supplemental Security Income 60 to 64 Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	5,456	273	5.25%
FY 03-04	5,528	72	1.32%
FY 04-05 projection	5,512	(16)	-0.29%
FY 05-06 projection	5,655	143	2.59%

26-4-201, C.R.S. (2004)
(j) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions.

26-4-301, C.R.S. (2004)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement.

Supplemental Security Income for Disabled Individuals

Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. With a few exceptions, recipients must be United States citizens. The Supplemental Security Income for Disabled Individuals category includes the disabled portion of this group. These individuals: are blind, have a physical or mental impairment that keeps them from performing substantial work expected to last 12 months or result in death, or are children who have a marked and severe functional limitation expected to last 12 months or until death. Children were added to the Title XVI Act in 1972. In addition, states may extend coverage to individuals with incomes too high for Supplemental Security Income, and who are receiving long term care in an institution. Referred to as 300 Percenters, these clients have incomes no more than 3 times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home. Often, 300 Percenters are enrolled in a Home and Community Based waiver program.

From 1990 to 1996, this eligibility category exhibited unprecedented growth rates. Factors contributing to this surge were: intensified outreach efforts to those with substance abuse; a backlog of disability determination applications; and the outcome of the *Zebley v. Sullivan* lawsuit. The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults were. Zebley required that children's disability be measured using child appropriate activities. As a result, the number of children determined to be disabled significantly increased until 1996. Welfare reform in 1996 tightened the disability criteria for children. An Individual Evaluation Plan from the public school system was no longer sufficient to verify disability, and children were required to have a physician document their level of functional impairment. However, any child receiving Supplemental Security Income before 1996 who lost their Supplemental Security Income benefits due to the new rules is still eligible for Medicaid. This category also includes disabled adult children age 18 and older who lost their Supplemental Security Income eligibility due to their parents receiving Social Security Administration benefits and disabled widows and widowers aged 50 to 64 who lost Supplemental Security Income due to the receipt of Social Security Administration benefits.

Growth rates in this category have been extremely low in recent years, less than 1% in most years. The graph in Exhibit X, page EX-5, shows that caseload dramatically increased from 1993 to 1997. During 1997 to 2003, caseload has remained relatively constant. The Department suspects that the implementation of several home- and community- based waivers have caused the caseload in this category to level off. Caseload trends are correlated with the population of residents aged 0 to 59 years. Finally, the elimination of the Med-9 disability determination reduced caseload somewhat. In July 2001, the Med-9 disability determination application process was disbanded due to federal requirements. This process let individuals under 65 who were seeking Medicaid coverage because of a disability experience an expeditious application process as compared to other applicants. By discontinuing the Med-9, caseload fell slightly.

Economic indicators should not have a significant impact on the caseload for this category. For FY 04-05, the Department projects a negative growth rate due to the implementation of SB 03-176, with a slight growth rate in FY 05-06.

Supplemental Security Income Disabled Individuals Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	46,378	29	0.06%
FY 03-04	46,565	187	0.40%
FY 04-05 projection	46,200	(365)	-0.78%
FY 05-06 projection	46,337	137	0.30%

26-4-201, C.R.S. (2004)
(i) Individuals receiving supplemental security income;
(l) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under Public Law 92-336
(m) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April, 1977;
(m.5) Disabled widows or widowers fifty through sixty years of age who have become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c.

26-4-301, C.R.S. (2004)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.

Categorically Eligible Low-Income Adults

One of the primary ways that adults qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to Families with Dependent Children program was discontinued. Aid to Families with Dependent Children was replaced by the Temporary Assistance for Needy Families program (referred to as Colorado Works) on July 16, 1996. Clients enrolled in the Temporary Assistance for Needy Families program are no longer automatically eligible for Medicaid. Therefore, the Categorically Eligible Low- Income Adults category includes adults who receive Medicaid under Section 1931 and those families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid. Also included in this category are adults receiving Transitional Medicaid. Transitional Medicaid is available to adults in families who have received

1931 Medicaid three of the past six months and become ineligible due to an increase in earned income. Adults may receive Transitional Medicaid benefits for up to one year. As of June 2003, there were 4,631 adults on Transitional Medicaid. On October 1, 2003, authorization for Transitional Medicaid Benefits was extended to March 31, 2004, and has since been authorized through March 31, 2005. The Department's forecast assumes that the Transitional Medicaid program will continues in FY 04-05 and FY 05-06.

Growth rates in this category have been unprecedented since FY 00-01. The graph in Exhibit X, page EX-6, shows that before 1999, caseload in this category fell. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash assistance for welfare and Medicaid was broken. When the Department implemented this change into the Client Oriented Information Network eligibility data system, it was estimated that 46,006[13] clients had their cases closed in error. In reaction, the Tatum lawsuit was brought against the State. Starting in May 2001, the Department began to reinstate clients who inadvertently lost their Medicaid eligibility. This may help to explain why from 1997 to 1999 caseload fell, and may have contributed to a spike in caseload in FY 01-02 (this spike can clearly be seen on the graph). For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Legislative Budget Request, pages A-37 to A-38.

From 1999 to 2003, caseload has grown by an average of 15% per year, as seen on the graph. Caseload trends in this category are highly affected by economic conditions, and correlated to the population of adults aged 18 to 59. From 1990 to 2000, the number of families in Colorado increased 21.3%, the average household size increased 0.9%, and the average Colorado family size increased 0.7%.[14] As compared to all other categories, this caseload is more sensitive to job growth, unemployment, and wages than any other, with the exception of Eligible Children. For FY 04-05 and FY 05-06, the Department projects high, but decreasing growth rates due a direct correlation with economic expectations.

Categorically Eligible Low-Income Adults Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	40,021	6,674	20.01%
FY 03-04	46,754	6,733	16.82%
FY 04-05 projection	51,032	4,278	9.15%
FY 05-06 projection	54,094	3,062	6.00%

[13] Source: November 1, 2001 Legislative Budget Request, page A-37
[14] Source: U.S. Census Bureau

26-4-201, C.R.S. (2004)
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;
(f) Qualified pregnant women . . . who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

26-4-301, C.R.S (2004)
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
(o) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706.

Breast and Cervical Cancer Program

The Breast and Cervical Cancer Treatment program was authorized under SB 01S2-012 and began enrolling eligible women in July 2002. Women under this optional coverage group were screened using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer. These women are under the age of 65, uninsured, and otherwise not eligible for Medicaid. The Colorado Medical Services Board establishes the income and resource eligibility requirements for this program. As of 2002, Colorado was one of 42 states that chose to cover women under this program.

The Department relies on Exponential Smoothing models to project the caseload, as Box Jenkins models are not useful with limited data series. It should be noted again that SB 03-176 does not affect this category. In FY 04-05 and FY 05-06, the Department expects significant growth rates in this category.

Breast and Cervical Cancer Program Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	46	-	-
FY 03-04	103	57	123.91%
FY 04-05 projection	162	59	57.28%
FY 05-06 projection	222	60	37.04%

26-4-301, C.R.S. (2004)
(q) The breast and cervical cancer prevention program pursuant to section 26-4-532.

Eligible Children

One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to Families with Dependent Children program was discontinued. Aid to Families with Dependent Children was replaced by the Temporary Assistance for Needy Families welfare program (referred to as Colorado Works) on July 16, 1996, and clients under the Temporary Assistance for Needy Families program were no longer automatically eligible for Medicaid.

Children who are born to women enrolled in the Baby Care/ Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby Care/ Kid Care in Colorado, this program was authorized through the Medicare Catastrophic Coverage Act of 1988. The program enrolls Baby Care women (see the Baby Care Adults section of this document for information on women) and Kid Care children. Kid Care children are born to women with incomes up to 133% of the federal poverty level. Children are covered up to age six. The Baby Care/ Kid Care Program serves a much higher income level than the 1931 Families program, and pregnant mothers are not subject to resource/asset limitations to qualify for the program. Moreover, the Baby Care Program has never had a cash-assistance component and was unaffected by welfare reform in 1996.

In previous years, this caseload was adjusted to include Ribicoff children. Ribicoff children were children aged six to 19, with incomes up to 100% of the federal poverty level with resources limited to $1,000 who were born after September 30, 1983. Beginning with age six, a new age cohort was phased-in each year. Caseload was adjusted upwards to include these children. However, the final cohort of children was phased-in during FY 02-03, so no further caseload adjustments are needed.

Therefore, the Eligible Children category includes: children in families who receive Medicaid under Section 1931, children in families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid, children who are eligible for Kid Care, Ribicoff children, and children who receive Transitional Medicaid. Transitional Medicaid is available to children in families who have received 1931 Medicaid three of the past six months and become ineligible due to an increase in earned income. Children may receive Transitional Medicaid benefits for up to one year. As of June 2003, there were 7,581 children on Transitional Medicaid. On October 1, 2003, authorization for Transitional Medicaid Benefits was extended to March 31, 2004, and later through March 31, 2005. The Department's forecast assumes that Transitional Medicaid continue in FY 04-05 and FY 05-06.

The graph in Exhibit X, page EX-8, shows that from 1993 to 1999 caseload in this category fell. This can be attributed to economic expansion, enactment of the Children's Basic Health Plan program, and effects from the Tatum lawsuit (see Categorically Eligible Low-Income Adults section for more information on the lawsuit). When the Children's Basic Health Plan program was enacted in 1998, it required that children be screened for Medicaid at the same time. The Children's Basic Health Plan program was heavily

marketed in its first few years of existence. As more children applied, many were found to be Medicaid eligible and were enrolled in Medicaid.

Since FY 00-01, growth rates in this category have been unprecedented, ranging from 12.21% to 15.73%. Caseload trends in this category are highly affected by economic conditions and correlated to population of children aged 0 to 18. Population of children aged 0 to 18 years has increased 23.3% from 1993 to 2003.[15] As compared to all other categories, this caseload is more sensitive to job growth, unemployment, and wages than any other (with the exception of Categorically Eligible Low-Income Adults). For FY 04-05 and FY 05-06, the Department projects high, but decreasing growth rates due a direct correlation with economic expectations.

Eligible Children Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	166,537	22,628	15.72%
FY 03-04	192,048	25,511	15.32%
FY 04-05 projection	211,252	19,204	10.00%
FY 05-06 projection	223,927	12,675	6.00%

26-4-201, C.R.S. (2004)
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;
(f) Qualified pregnant women, and children under the age of seven, who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(g) A newborn child born of a woman who is categorically needy. Such child is deemed Medicaid-eligible on the date of birth and remains eligible for one year so long as the woman remains categorically needy and the child is a member of her household.
(o) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government.

26-4-301, C.R.S. (2004)
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings,
(o) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706.

[15] Source: Department of Local Affairs, Demography Division

Foster Care

Federal law mandates that states provide Medicaid to individuals under Title IV-E of the Social Security Act (42 U.S.C. 470-479A) for adoption assistance and foster care. Title IV-E is a subpart of Title IV, Child Welfare, of the federal Social Security Act. Title IV-E provides federal reimbursement to states for the room and board costs of children placed in foster homes and other out-of-home placements. This is an entitlement program for children who are eligible and for whom the state can seek reimbursement. Eligibility is determined on family circumstances at the time when the child was removed from the home. Once eligible, the state determines if it can claim reimbursement for maintenance costs for the child. Adoption assistance is available for children with special health care needs who meet the same requirements. States have the option to extend Medicaid to former foster care children aged 18 to 20 years who were eligible for Title IV-E prior to their 18th birthday. In Colorado, all children in foster care aged 0 to 20 years are automatically Medicaid eligible.

Caseload in this category is also affected by programmatic changes initiated by the Department of Human Services who oversee the Child Welfare system. For example, in 1994 the State negotiated the Child Welfare Settlement Agreement with the Colorado Lawyers Committee on behalf of children in the foster care system. The Child Welfare Settlement Agreement mandated more statewide standards in the services that each county was to make available. Counties still had the flexibility to provide some services directly through a contract with other private or public providers. This legal agreement may have contributed to double-digit growth rates in FY 93-94. In January 2001, the Department of Human Services converted to a new data reporting system for children in foster care called Trails. The conversion may be partially responsible for the unusual slowness experienced in this category FY 00-01 and FY 01-02.

The graph in Exhibit X, page EX-9, shows that growth rates in this category since FY 02-03 have been positive and steady. Caseload trends are correlated with population of children aged 0 to 18, and somewhat correlated with economic indicators. For FY 04-05 and FY 05-06, the Department expects growth rates to decrease slightly, but remain positive.

Foster Care Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	13,843	722	5.50%
FY 03-04	14,790	947	6.84%
FY 04-05 projection	15,566	776	5.25%
FY 05-06 projection	16,301	735	4.72%

26-4-201, C.R.S. 2004
(h) Children for whom adoption assistance or foster care maintenance payments are made.

Baby Care Adults

Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby Care/ Kid Care in Colorado, the program was authorized though the Medicare Catastrophic Coverage Act of 1988. The program enrolls Baby Care women and Kid Care children (see the Eligible Children section of this document for information on children). Baby Care Adults are women with incomes up to 133% of the federal poverty level. Coverage includes prenatal care and delivery services, plus 60 days of postpartum care. The Baby Care/ Kid Care Program serves a much higher income level than the 1931 families program, and pregnant mothers are not subject to resource/asset limitations to qualify for the program. Moreover, the Baby Care Program has never had a cash-assistance component and was unaffected by welfare reform.

Caseload trends for this category shown in Exhibit X, page EX-10, are an enigma. From 1993 to 1998, overall caseload decreased, but was mired by numerous spikes. This overall decrease may have been due to economic expansion, but the presence of caseload spikes complicates that theory. Growth in this category has ranged between 6.28% and 8.23% since FY 00-01. Again, the graph shows an overall increase since 1999, but jagged peaks in the caseload are distributed across this period. To get an idea of why the caseload pattern is so odd, the Department investigated the trends of several contributing variables. From 1990 to 2000, the number of female- headed households increased 14.7% and the number of births per thousand Colorado women has increased 24.3%.[16] However, from 1991 to 2002 teen pregnancy rates in Colorado fell 19%.[17] Economic indicators may also affect caseload trends in this category.

In addition to other impacts due to the implementation of the Colorado Benefits Management System, future projections for this category will be affected by the discontinuance of presumptive eligibility for pregnant women. Presumptive eligibility allowed pregnant women who had applied for Medicaid to receive services until the status of their application had been determined. The State paid for all Medicaid costs during that time regardless of whether or not the woman was eventually found to be Medicaid eligible or not. As of September 1, 2004, the Department discontinued this procedure. Clients will not be eligible for Medicaid services until their application process is completed. At this time, no adjustment to caseload was made for this rule change due to possible offsets from the Colorado Benefits Management System implementation. For FY 04-05 and FY 05-06, the Department has projected positive, but reduced caseload growth.

[16] Source: Female headed households - U.S. Census Bureau, Number of Colorado births - Department of Local Affairs, Demography Division.
[17] Source: National Vital Statistics

Baby Care Adults Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	7,579	448	6.28%
FY 03-04	8,203	624	8.23%
FY 04-05 projection	8,490	287	3.50%
FY 05-06 projection	8,745	255	3.00%

26-4-201, C.R.S. (2004)
(f) Qualified pregnant women, and children under the age of seven, who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
o) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government.

Non-Citizens

Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived in the United States after August 22, 1996. Coverage of individuals beyond the five year ban is optional. As outlined in the SB 03-176 section above, Colorado no longer covers this optional group of clients after the five year ban.[18] However, per federal regulations, states must provide mandatory coverage for:

- Refugees for the first seven years after entry into the United States;
- Asylees for the first seven years after asylum is granted;
- Individuals whose deportation is being withheld for the first seven years after the initial withhold;
- Victims of trafficking;
- Lawful permanent residents who have 40 qualifying hours of Social Security coverage;
- Cuban or Haitian entrants; and,
- Immigrants who are honorably discharged veterans of the United States military.

Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. Citizenship.

[18] Colorado and Utah are the only two states that do not cover optional immigrants.

In April 2001, an eligibility policy change was implemented such that clients are now only counted as eligible in the months they receive emergency medical care. Prior to this policy change, eligibility for this group continued as it would for any other category, although only for emergency medical services. For example, a Non-Citizen with an emergency visit on April 2000 could be eligible in that month, and continue to be eligible for as many months as he/she met other eligibility criteria. The same client would only be eligible for one month, had the emergency service occurred in April 2001. Thus, caseloads presented from April 2001 and forward are much lower than in previous years. This explains the large decline in FY 01-02, as seen on the graph in Exhibit X, page EX-11.

The graph also illustrates that growth rates in this category have been positive since FY 01-02. Caseload trends should be correlated with economic conditions and migration trends. As the economy recovers, more immigrants are expected to migrate to the State. In addition, research shows that immigrants are living longer than natives of the United States are.[19] With gradual improvement in the economy, increased longevity, and the implementation of SB 03-176, the Department projects that the caseload in this category will significantly rise.

Non-Citizens Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	4,101	73	1.81%
FY 03-04	4,604	503	12.27%
FY 04-05 projection	5,895	1,291	28.04%
FY 05-06 projection	6,455	560	9.50%

26-4-201, C.R.S. (2004)
(2) (a) A qualified alien who entered the United States before August 22, 1996, who meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," Public Law 104-193, as amended, shall receive benefits under this article.
(b) A qualified alien who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article, except as provided in section 26-4-230 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Act of 1996", Public Law 104-193, as amended.

Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries

Medicare eligible beneficiaries who have incomes at a certain federal poverty level and limited resources may qualify to have Medicaid cover some of their out-of-pocket expenses, such as their Medicare Part B premiums and other coinsurance and deductibles. The two groups of clients qualify for this cost-sharing program: Qualified Medicare Beneficiaries, and Special Low Income Medicare

[19] Source: Pritchard, Justin. "Study: Immigrant Outlive U.S. Citizens." The Denver Post. 27 May 2004.

Beneficiaries. Qualified Medicare Beneficiaries have incomes at or below 100% of the federal poverty level, and resources twice the standard allowed under the federal Supplemental Security Income program. These clients receive hospital insurance and supplementary medical insurance premium coverage along with Medicare coinsurance and deductibles. Special Low Income Medicare Beneficiaries have incomes greater than 100% of the federal poverty level, but less than 120%. For Special Low Income Medicare Beneficiaries, Medicaid only pays the supplementary medical insurance premiums.

The graph in Exhibit X, page EX-12, illustrates that growth rates in this category have been positive and steady since FY 99-00, ranging from 3.32% to 9.36%. Caseload trends are somewhat correlated with economic indicators. For FY 04-05 and FY 05-06, the Department estimates positive but diminishing growth rates. It should be noted that SB 03-176 does not affect this category.

Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	8,949	521	6.18%
FY 03-04	9,787	838	9.36%
FY 04-05 projection	10,548	761	7.78%
FY 05-06 projection	11,180	632	5.99%

26-4-201, C.R.S. (2004)
(n) Individuals with income and resources at a level which qualifies them as medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act"

SUMMARY

The Department estimates that the Medicaid caseload will reach 388,257 in FY 04-05 and 406,616 in FY 05-06, without retroactivity. The increases in overall caseload projections are primarily due to slower than anticipated job growth. Projections will be updated in February 2005 to include the most recent economic conditions and the progress of the SB 03-176 implementation. See Exhibit A for complete information.

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

After the caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs are the embodiment of both price and utilization. Inherent in both aspects of per capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, preexisting condition, etc.), generally healthy clients are less costly to serve (lower "*risk"*) than clients with severe acute or chronic medical needs requiring medical intervention (higher "*risk"*). For example, on average, a Categorically Eligible Low Income-Children child is substantially less costly to serve than is an Aid to Needy Disabled person each year. Because the Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is therefore essential to determine the anticipated cost per capita of each of the kinds of clients who will be served.

The method used to compute the "premiums" or per capita cost for Medicaid eligibles for FY 04-05 is similar to that which has been used to compute the premiums in previous budget requests. While the Department seeks to instill continuity in the methods used in calculating the premium budget, the work towards more refinement in the approach to forecasting is ongoing. In very broad terms and for most services, the rate of change that was experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums that will be needed for FY 04-05 (current year) and the request year, FY 05-06. To that base, policy items or environmental changes (e.g., Change Requests and new legislation) are added or subtracted.

Following is the detailed discussion of how the projections were prepared for this budget request.

Analysis of the Rate of Change in the Services:

In regards to the annual rates of change in each individual service within the Medical Services Premiums Long Bill Group, an interesting observation relates to the issue of eligibility mix. Note that in the years when caseload overall was rising (i.e., FY 99-00 through FY 03-04), the per capita cost decreased or rose only nominally overall. This illustrates the impact of eligibility mix in that the majority of growth in these years was in the least costly populations. As such, it is not possible to review in isolation the per capita cost change over time to check for the reasonableness of the budget. One must look further into the per capita cost change by eligibility category (Exhibit U-1). See the following history of premium rates of growth.

Calculation of Rate of Change in Expenditures for Medical Services to Clients		
Fiscal Year	**Premium Expenditures**	**Annual Change**
FY 95-96	$1,088,703,178	N/A
FY 96-97	$1,129,080,316	3.71%
FY 97-98	$1,201,870,992	6.45%
FY 98-99	$1,291,929,280	7.49%
FY 99-00	$1,347,021,165	4.26%
FY 00-01	$1,442,921,955	7.12%
FY 01-02	$1,536,804,691	6.51%
FY 02-03	$1,651,868,402	7.47%
FY 03-04	$1,841,738,922	11.51%
FY 04-05 Projection	$1,959,301,734	6.38%
FY 05-06 Projection	$2,124,619,464	8.44%

$55 million of expenditures for the final week of FY 02-03 are included in FY 03-04; the FY 04-05 projection includes $14 million of the FY 03-04 overexpenditure restriction. The Upper Payment Limit financing in FY 01-02 through FY 05-06 is excluded from this table.

Rough Five Year Projection:

The following tables represent a ROUGH five-year projection of caseload and per capita costs. This is only a rough projection based on a basic trend from FY 99-00 to the projected FY 05-06. The projections are computed in a straight-line fashion from historic actual caseload growth and expenditure growth. This does not represent a sophisticated view of where the program will be in five years, as it does not include program policy changes, Decision Items or Base Reduction items, economic changes, and/or impacts on enrollment and eligibility. The projection is intended to give an overview of where Medicaid expenditures might be if the past is a predictor of the future. These projections exclude administrative expenditures and the programs that are operated by the Department of Human Services. Moreover, these projections do not represent the official Budget Request for Medical Services Premiums.

First the caseload is projected using past history and trends.

ROUGH Five Year Non-retroactive Caseload Projection											
	SSI 65+ (OAP-A)	**SSI 60-64 (OAP-B)**	**SSI Disabled (AND/AB)**	**CELI-A (AFDCA)**	**BCCP**	**Children**	**FC**	**BCA**	**Non-Citizen**	**QMB/ SLIMB**	**TOTAL**
FY 06-07	34,084	5,852	47,015	59,756	282	225,173	17,177	9,326	7,068	11,781	417,514
FY 07-08	34,493	6,016	47,062	62,445	305	238,683	17,864	12,497	7,598	12,488	439,451
FY 08-09	34,872	6,184	47,109	64,943	329	250,618	18,579	12,997	8,130	13,112	456,873
FY 09-10	35,256	6,357	47,156	67,541	352	263,148	19,322	13,517	8,699	13,768	475,116
FY 10-11	35,644	6,535	47,203	70,242	377	276,306	20,095	14,057	9,308	14,456	494,223

Secondly, the per capita costs from FY 95-96 through FY 05-06 projections are trended forward.

ROUGH Five Year Cost Per Capita Projection											
	SSI 65+ (OAP-A)	**SSI 60-64 (OAP-B)**	**SSI Disabled (AND/AB)**	**CELI-A (AFDCA)**	**BCCP**	**Children**	**FC**	**BCA**	**Non-Citizen**	**QMB/SLIMB**	**TOTAL**
FY 06-07	19,673.37	14,523.02	13,241.07	4,132.13	28,343.30	1,397.80	3,016.59	6,518.17	11,367.43	1,055.41	5,421.72
FY 07-08	20,298.63	15,043.76	13,829.14	4,236.43	27,893.25	1,386.97	3,077.63	6,502.26	11,628.74	1,067.09	5,479.88
FY 08-09	20,923.88	15,564.51	14,417.21	4,340.73	27,443.21	1,376.14	3,138.66	6,486.34	11,890.04	1,078.78	5,538.04
FY 09-10	21,549.14	16,085.25	15,005.28	4,445.04	26,993.16	1,365.31	3,199.70	6,470.43	12,151.34	1,090.46	5,596.20
FY 10-11	22,174.39	16,605.99	15,593.35	4,549.34	26,543.12	1,354.48	3,260.74	6,454.51	16,074.46	1,102.15	5,654.36

Next, the projected caseload is multiplied by the projected per capita.

ROUGH Five Year Projection of Expenditures by Eligibility Category										
	SSI 65+ (OAP-A)	**SSI 60-64 (OAP-B)**	**SSI Disabled (AND/AB)**	**CELI-A (AFDCA)**	**BCCP**	**Children**	**FC**	**BCA**	**Non-Citizen**	**QMB/ SLIMB**
FY 06-07	670,547,193	84,988,735	622,528,778	246,919,419	7,992,811	314,747,802	51,815,982	60,788,450	80,345,024	12,433,768
FY 07-08	700,160,688	90,501,123	650,827,044	264,544,030	8,495,169	331,047,360	54,978,980	81,257,648	88,356,299	13,325,715
FY 08-09	729,666,620	96,255,574	679,181,285	281,899,558	9,026,752	344,885,153	58,312,112	84,301,125	96,665,617	14,145,218
FY 09-10	759,736,964	102,261,321	707,591,583	300,220,257	9,500,231	359,279,106	61,823,928	87,458,067	105,705,293	15,013,356
FY 10-11	790,380,566	108,527,925	736,058,023	319,555,573	9,995,766	374,250,242	65,523,390	90,732,682	149,621,053	15,932,945

Finally, the estimated totals for each aid category are summed.

ROUGH Projection of Future Medicaid Expenditures		
Fiscal Year	**Projected**	**Annual Change**
FY 06-07	$2,246,114,279	5.72%
FY 07-08	$2,385,144,185	6.19%
FY 08-09	$2,524,174,092	5.83%
FY 09-10	$2,663,203,998	5.51%
FY 10-11	$2,802,233,904	5.22%

*Does not include Upper Payment Limit

IV. RATIONALE FOR GROUPING SERVICES FOR PROJECTION PURPOSES

The calculations that are described below are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is at the most detailed level and these groupings in no way compromise the ability to review and analyze data at the service level detail. For purposes of preparing projections only, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to cluster services that have like characteristics (e.g., community based long term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physicians services, etc.). If each service category was computed individually and the impact of the inter-relationships among services was disregarded, the resultant forecasts would be unrealistically volatile. Overall, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

Following are the service groupings used in computing the projections or summarizing individual service calculations in this Budget Request.

Acute Care Services:
- Physicians Services and Early and Periodic Screening, Diagnosis, and Treatment Program
- Emergency Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospital
- Lab and X-ray

- Durable Medical Equipment
- Outpatient Hospital
- Pharmacy Services
- Pharmacy Rebates
- Rural Clinics
- Federally Qualified Health Centers
- Title XVIII (Medicare Coinsurance and Deductible)
- Home Health
- Breast and Cervical Cancer Program (authorized by S.B. 01S2-012, services to clients began July 1, 2002).

***Community Based Long Term Care Services*:**
- Home and Community Based Services-Elderly, Blind and Disabled Client Services (will include In-Home Support Services in the near future)
- Home and Community Based Services-Elderly, Blind and Disabled Mentally Ill
- Children's Home and Community Based Services, or Model 200 Program [formerly called Katie Beckett Waiver] (will include In-Home Support Services in the near future)
- Home and Community Based Services-Persons Living With AIDS
- Consumer Directed Attendant Support Waiver
- Consumer Directed Care for the Elderly Waiver (projected to start by January 2005)
- Private Duty Nursing (often seen together with home health for budget purposes prior to FY 02-03)
- Hospice
- Home and Community Based Services for Persons with Brain Injuries

Long Term Care Services (<u>not a grouped calculation</u>; rather a summary of the totals of individual service calculations):
- Class I Nursing Facilities (independent calculation)
- Class II/IV Nursing Facilities (independent calculation)
- Program for the All-inclusive Care for the Elderly (independent calculation)
- Single Entry Point Services (independent calculation)

Insurance Services (<u>not a grouped calculation</u>; rather a summary of the totals of individual service calculations):
- Supplemental Medicare Insurance Benefit – included Health Insurance Buy-In in FY 92-93 (independent calculation)
- Health Insurance Buy-In (independent calculation)

Because these services are individually computed, there is virtually no impact to the projected costs as a result of this further breakout in the presentation of projected costs.

CASELOAD PROJECTION AND REQUEST WITHOUT RETROACTIVITY (Exhibit A)
This exhibit is described in the Caseload Narrative.

ACUTE CARE CALCULATIONS (Exhibit B)
Acute Care Services are calculated in a series of steps. First, the rate of growth or trend was computed. In order to do this one-time adjustments or programmatic changes were accounted for. The period of time that was selected for computing the trend or annual rate of change was FY 97-98 through FY 03-04, excluding FY 98-99. This period was selected for two reasons: first, it is a recent period and second, because mental health capitation expenditures were known and removed from the data.

Antipsychotic Drugs: Antipsychotic drugs were moved from the Department's premium line to the Department of Human Services for FY 01-02. For FY 03-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug line. Exhibit C is the rough projection of Antipsychotic Drug expenditures for FY 04-05 and FY 05-06. These dollars are shown again in the Long Bill under the Medicaid Mental Health Community Programs group for informational purposes only.

Trend Calculation: The annual rates of change from FY 99-00 through FY 01-02, FY 00-01 to FY 01-02, FY 00-01 to FY 02-03, FY 01-02 through FY 03-04, FY 99-00 through FY 03-04, and FY 00-01 through FY 03-04 are computed for each eligibility category on a per capita cost basis. FY 98-99 is excluded due to the change in fiscal agents. In December 1998, the fiscal agent contract moved from Blue Cross/Blue Shield to Affiliated Computer Systems. The transition year resulted in expenditure pattern instability, as had been expected.

Four rates of change are calculated to account for any policy changes or one-time costs that may skew just one trend year. From these rates of change a blended rate of change is calculated for each eligibility category, being mindful of changes that occurred in one category and not in others. Because the aid categories differ in eligibility requirements, demographics, and utilization, different trends are used for each aid category. The history of expenditures and policy changes are taken into account for each specific aid category when the trends are decided. The trends utilized, with the rationale, are as follows:

- SSI-65+ (OAP-A) – 4-year average (FY 00-01 through FY 03-04); 4.79%. This trend seemed most indicative to predict the future due to the policy changes affecting acute care services.
- SSI-60-64 (OAP-B) – 4-year average (FY 00-01 through FY 03-04); 4.17%. This trend seemed most indicative to predict the future due to the policy changes affecting acute care services.
- SSI Disabled (AND/AB) – average of FY 01-02 and 03-04; 3.75%. This trend seemed most indicative to predict the future due to the policy changes affecting acute care services.
- Categorically Eligible Low Income Adults (formerly called AFDC-A) – 5-year average (FY 99-00 through FY 03-04); 5.78%. This was the most stable growth for this population.

- Breast and Cervical Cancer Program – average of AND/AB and CELI-A (AFDC-A) Percent Utilized; 4.76%. There are only two years of prior history for this category. The trends for AND/AB and CELI-A (AFDC-A) were averaged because they are most similar in population and service needs.
- Children – 3-year average (FY 99-00 through FY 01-02); 3.87%. This was the most stable growth for this population.
- Foster Care – average of FY 01-02 through FY 03-04; 4.31%. This trend seemed most indicative to predict the future due to the policy changes affecting acute care services.
- Baby Care Adults – 5-year average (FY 99-00 through FY 03-04); 4.99%. This was the most stable growth for this population.
- Non-Citizens – average of FY 02-03 and FY 03-04; 4.45%. This was the most stable growth for this population.
- Qualified Medicare Beneficiary/Special Low-Income Medicare Beneficiary – SSI-65+; 4.79%. This trend was utilized because they are similar populations.

Calculation of the Base: Once the rate of change calculation is completed, it is applied to the final FY 03-04 per capita costs to generate the estimated FY 04-05 base per capita cost. Decision Items and policy adjustments are applied at this stage and then the trend is again applied to the adjusted base estimate for FY 04-05 to compute the FY 05-06 request.

Change Requests and Other Adjustments:
Adjustments to FY 04-05 include the following:

- Transfer of non-emergency medical transportation to an administrative line item within the Executive Director's Long Bill line item group was authorized in H.B. 04-1220 and funded in H.B. 04-1422. This is a reduction to Acute Care of $4.4 million.
- Several Joint Budget Committee actions occurred in the Long Bill, H.B. 04-1422:
  - Rate increase for Federally Qualified Health Centers - $3 million increase
  - Rate decrease for inpatient hospitals - $3 million decrease
  - Rate decrease in durable medical equipment - $747,360 decrease
  - Increase in physician rates due to a transfer of funds from the Primary Care Physician Market Rate Reimbursement Long Bill line item.
- 2003 Legislative impact in FY 04-05 for S.B. 03-011 for pharmacy savings. This is a reduction of $913,787. The fiscal note savings have been reduced by $598,840 due to non-implementation of a mail service pharmacy.
- 2003 Legislative impact in FY 04-05 for S.B. 03-294 for drug utilization review. This is a reduction of $357,636.

There are no policy or legislative adjustments to FY 05-06.

CALCULATION OF ANTIPSYCHOTIC DRUGS (Exhibit C)

In response to approved Change Request #DI-7 in the November 1, 2002 Budget Request, management of antipsychotic drug expenditures was returned to the Department of Health Care Policy and Financing. These expenditures are included in the pharmaceutical drug line within Acute Care Services. This line was moved to the Department of Human Services in FY 01-02 and

returned to the Department of Health Care Policy and Financing in FY 03-04. The most important observation in this area is that the growth in antipsychotics continues to grow well beyond other service categories in Medicaid. Future projections continue to show the growth. This Exhibit includes a breakout of actual and estimated expenditures for this line. The FY 04-05 and FY 05-06 projections are trended based on 48 months of history (FY 00-01 through FY 03-04) using exponential smoothing.

CALCULATION OF 100% GENERAL FUND PRENATAL CARE COSTS FOR NON-CITIZENS (Exhibit D)

Pursuant to 26-4-203(3)(a), C.R.S. (2002), Colorado had opted to provide prenatal care at its sole expense for Non-Citizens. However, S.B. 03-176 eliminated this service for legal immigrants. The implementation of this bill is planned for January 1, 2005. Therefore, there are no state-only prenatal services after implementation.

CALCULATION OF ENHANCED FAMILY PLANNING MATCH RATE (Exhibit E)

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. Beginning in late FY 01-02, the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State is now receiving the enhanced match on all family planning services provided to Medicaid clients.

COMMUNITY-BASED LONG TERM CARE DETAIL (Exhibit F)

This section used to include the entire home and community based services programs, home health, and hospice; however, home health services were moved to acute care services in FY 02-03 to reflect they were part of the health maintenance organization rate, hence, have interaction. Note that 90% of home health services are long term care in nature and that they were removed from the health maintenance organization rate effective in the September 2002 rates. Therefore, in the future home health services may fit better in Community Based Long Term Care as a future refinement. Like the other groupings, similarities in the type of service suggested the grouping.

The increased emphasis on utilizing these services has served to keep the census in Class I nursing facilities relatively flat. In FY 81-82, with the implementation of the first of the home and community based service waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients and that is where the census has generally remained despite nearly 2.5% per year increases in the elderly population of the State. However, despite the flat to declining census in nursing facilities, questions had arisen out of the steep rates of growth in this area of whether it is the expenditures in this area that are resulting in savings elsewhere or if utilization has moved to inappropriately high levels. The General Assembly and the Department undertook a series of strategies to better understand this area in an attempt to discern what is driving expenditures, whether or not the expenditure levels are appropriate and what must be done to manage the program area as carefully as possible. Rules were passed by the State Board of Medical Services to afford further management tools for this and similar program areas, which resulted in a sharp reduction of per capita spending.

In FY 02-03, the Department proposed a number of controls and management approaches to control expenditures in the community based programs by reducing inappropriate utilization of the programs. The Department raised the requirements necessary to meet the level of care screen required to qualify for nursing facility care and Home and Community Based Services. A requirement was added that, in order to be eligible for Long Term Home Health, a client 18 and over had to meet the level of care screen. High cost clients in the community were reviewed by Single Entry Points and were either transitioned, where possible, to less expensive alternatives or their care plan and services were evaluated in order to assure that all services being provided were, in fact, required. The Department also considered putting a cap on the Home and Community Based Services—Elderly, Blind and Disabled waiver as authorized by federal law. The Department worked with stakeholders and developed other interventions to control long term care services provided both at nursing facilities and in the community. The assessment tool which was the basis of the functional assessment to determine whether a client meets the long term care level of care was redone with the help of providers, Single Entry Point and clients. Responsibilities were shifted to insure that Single Entry Points are the entities through which clients access long term care and to insure that they had the tools and authority to act as gatekeepers to long term care benefits. Federal requirements that a client receive a Home and Community Based Services waiver service in order to retain eligibility for the waiver was implemented.

Calculation of Rate of Change: Despite the positive consequence that the availability of these services has had in providing an alternative to institutional care, the rate of growth that had been exhibited until FY 00-01 had substantially exceeded projections. Unlike prior years' budget request calculations, this portion of the budget request has been computed differently with respect to anticipating the rate of change. Due to the unstable and unpredictable trends in this service group, the Department is relying on prior experience and knowledge to determine effective trends.

Because the aid categories differ in eligibility requirements, demographics, and utilization, different trends are used for each aid category. The history of expenditures and policy changes are taken into account for each specific aid category when the trends are decided. The percent utilized for all aid categories for FY 04-05 and FY 05-06 projections is the caseload growth from FY 03-04 to FY 04-05: 7.10%. This percent was chosen as a more stable trend until the February 15, 2004 budget request is submitted. At that time, the Department will have six months of expenditure history for FY 04-05. Adjustments to FY 04-05 include the following:

- Restriction in Private Duty Nursing hours authorized by a Joint Budget Committee action in the Long Bill, H.B. 04-1422 - $991,188 decrease
- Community Transition Services for HCBS-EBD authorized in H.B. 04-1219 - $124,398 increase

Adjustments to FY 05-06 include the following:

- 2004 Legislative impact for H.B. 04-1219, Community Transition Services for HCBS-EBD - $165,864 increase
- 2004 Legislative impact for S.B. 04-177, HCBS-Children with Autism - $626,750 increase

LONG TERM CARE AND INSURANCE SERVICES (Exhibits G through N)

This section is for a series of services that, for a variety of reasons, are individually computed and then allocated to the eligibility categories based on experience. Those services are:

- Class I Nursing Facilities
- Class II Nursing Facilities (only one Class II facility remains in this category)
- Supplemental Medicare Insurance Benefits
- Single Entry Point Agencies
- Program for All-inclusive Care for the Elderly
- Health Insurance Buy In

Summary of Long Term Care Request (Exhibit G) This summarizes the total requests from the worksheets in exhibits H and J through N.

Class I Nursing Facilities (Exhibit H) Class I nursing facility costs are essentially a function of the application and interpretation of rate reimbursement methodology specified in detail in State statutes, the utilization of the services by Medicaid clients and the impact of the effect of cost offsets such as estate and income trust recoveries. The strategy for estimating the cost of these services is to predict the costs driven by the reimbursement methodology (weighted average per diem rates, average patient payment, quality incentive payments), expected utilization by clients (patient days), expected cost offsets from refunds and recoveries, and expected adjustments to be charged to the current year appropriations. The Department's request for Class I is Exhibit H. An alternate methodology, the trend of expenditures for Class I, is on page EI–1 (Exhibit I), and is provided to check the reasonableness of the request.

The methodology for the Class I request in Exhibit H is as follows:

- Claims data showing the average daily amount paid (by month) are extracted from the Medicaid Management Information System. Then the net impact of the patient payment offset (e.g., Supplemental Security Income, Social Security Disability Insurance, retirement income) to facility reimbursement is calculated to establish the difference between the per diem rate and actual payment made by the Department. This is trended with an incurred but not reported (IBNR) adjustment. Despite cash accounting, this adjustment is necessary to capture adjustments that occur throughout the years. This adjustment is the same methodology as used by the contractor who audits the cost reports. The estimated per diem rate also includes an adjustment for reinstatement of the 8% health care cap.

- A five-year moving trend of utilization (patient days) is then applied to claims–based data from the period July 1999 – June 2004 (FY 99-00, FY 00-01, FY 01-02, FY 02-03, and FY 03-04). Trended days are in a slight downward trend, however, it is unclear if this is going to continue.

- The product of the per diem payment trend and utilization trend is calculated to determine gross budget year and out year expenditures. This includes the reinstatement of the Nursing Facility Incentive from S.B. 03-173.

- A completion factor of 92.5% is applied to the calculated per diem service expenditures to estimate the claims payment rate for FY 04-05, which then becomes the Estimated Claim Payments for Prior Year Dates of Service in FY 05-06. This completion factor is based on the prior two years' actual experience, from FY 02-03 and FY 03-04. The same completion factor is used in FY 05-06.

- Other, non-rate factors are then added or subtracted from the gross budget estimate. These include the hospital back up program, savings from S.B. 03-176 Legal Immigrants bill, savings from H.B. 04-1219 (Home and Community Based Services—Elderly, Blind and Disabled Community Transition), estimated non-claims based financial transactions (e.g., audit adjustments and reconciliations), estimated estate and other recoveries, estimated prior year expenditures booked to the current year (i.e., payments for prior year liabilities made after the annual payable is closed), and other adjustments (e.g., due to claims processing or other operational issues). These adjustments are held constant into FY 05-06.

- Once the "non-rate" factors are estimated and applied, the net budget estimate is completed.

The following is a timeline of changes to Class I Nursing Facility policy:

FY 97-98	8% Health Care Cap and 6% Administrative Cap Implemented
FY 98-99	No change
FY 99-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 00-01	No change
FY 01-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
FY 02-03	Administrative Incentive Allowance removed for three months then reinstated
FY 04-05	8% Health Care Cap reinstated

Class I Nursing Facility (Exhibit I) This exhibit does not represent the Department's request for Class I nursing facilities. This page displays the trend of expenditures in Class I nursing facilities since FY 95-96. The calculation was computed by applying recent actual rates of growth to FY 03-04 to estimate FY 04-05 and then to FY 04-05 to estimate FY 05-06, and is provided to check for the reasonableness of the request.

The trends utilized and their rationale are as follows:

- SSI-65+ (OAP-A) – 2-year average of FY 01-02 and FY 03-04; 7.47%. This trend seemed most indicative to predict the future due to the policy changes affecting Class I Nursing Facilities.

- SSI-60-64 (OAP-B) – 2-year average of FY 02-03 through FY 03-04; 8.80%. This trend seemed most indicative to predict the future due to the policy changes affecting Class I Nursing Facilities.
- SSI Disabled (AND/AB) – 3-year average (FY 99-00 through FY 01-02); 13.50%. This trend seemed most indicative to predict the future due to the policy changes affecting Class I Nursing Facilities.
- Categorically Eligible Low Income Adults (AFDC-A) – 4-year average (FY 00-01 through FY 03-04); 4.31%. This trend seemed most indicative to predict the future due to the policy changes affecting Class I Nursing Facilities.
- Breast and Cervical Cancer Program – 0%; as this service group is not used by this population.
- Children – 0%; as this service group is not used by this population.
- Foster Care – 0%; as this population does not use this service group.
- Baby Care Adults – 0%; as this population does not use this service group.
- Non-Citizens – 0%; as this service group is not used by this population.
- Qualified Medicare Beneficiary/Special Low-Income Medicare Beneficiary – SSI-65+; 7.47%. This trend seemed most indicative to predict the future due to the policy changes affecting Class I Nursing Facilities.

Adjustments to FY 04-05 include the following:
- Nursing home audit recoveries - $838,722 decrease
- Community Transition Services for HCBS-EBD authorized in H.B. 04-1219 - $204,047 decrease

Adjustments to FY 05-06 include the following:
- 2004 Legislative impact for H.B. 04-1219, Community Transition Services for Home and Community Based Services—Elderly, Blind and Disabled - $1,182,604 decrease

This spreadsheet is included for historical purposes and offers an alternate calculation to the one presented in Exhibit H.

Class II Nursing Facility (Exhibit J) This service category is for private nursing facility care for developmentally disabled clients who have been directly affected by Department of Human Services initiatives to deinstitutionalize clients from such facilities to more appropriate care settings in that department's developmental disabilities system. The deinstitutionalization strategy was completed in April of FY 97-98. As of the start of FY 98-99, the service category was limited to one facility, Good Shepherd Lutheran providing services to 16 total clients. There are no current plans to downsize or eliminate this facility as it essentially functions more like a group home than an institutional facility. This service category was trended with the percent change from FY 02-03 to FY 03-04 (7.06%), based on prior experience. HB 03-1292 Intermediate Care Facility for the Mentally Retarded Fee affects this line and is described in detail at the end of this narrative.

Single Entry Point Services (Exhibit K) Single Entry Point services, also known as Options for Long Term Care services, were authorized by HB 91-1287. The services are intended to provide improved access and cohesive case management for long term care clients throughout the State. Statewide implementation was achieved July 1, 1995. The Single Entry Point budget was projected forward based on the average annual rate of change in recent years.

Some of the principles of payment of Single Entry Point expenditures are that case management services are classified as an administrative cost matchable at 50% federal financial participation by the federal government. However, as a portion of the case management is for non-Medicaid eligible clients, the federal share is calculated at 50% of 96% of the total.

Because the aid categories differ in eligibility requirements, demographics, and utilization, different trends are used for each aid category. The history of expenditures and policy changes are taken into account for each specific aid category when the trends are decided. The trends utilized are as follows:

- SSI-65+ (OAP-A) – FY 02-03 change in expenditures: 3.31%
- SSI-60-64 (OAP-B) – two year average of FY 01-02 and FY 03-04: 13.50%
- SSI Disabled (AND/AB) – two-year average (FY 00-01 and FY 01-02): 8.43%
- Categorically Eligible Low Income Adults (AFDC-A) – two-year average (FY 00-01 and FY 01-02): 2.49%
- Breast and Cervical Cancer Program – 0% because this service is not utilized by this aid category
- Children – 4 year average (FY 00-01 through FY 03-04): 12.49%
- Foster Care – same as Children category because they are similar populations: 12.49%
- Baby Care Adults – same as CELI-A/AFDC-A because they are similar populations: 2.49%
- Non-Citizens – same as CELI-A/AFDC-A because they are similar populations: 2.49%
- Qualified Medicare Beneficiary/Special Low-Income Medicare Beneficiary – same as OAP-A because they are similar populations: 3.31%.

PACE (Program for the All-inclusive Care for the Elderly) (Exhibit L) The FY 04-05 and FY 05-06 projections for the Program for the All-inclusive Care for the Elderly were computed by applying the average growth from FY 02-03 to FY 03-04 for the SSI 65+ aid category, 23.69%, to FY 03-04 actuals for the populations served by this program.

Supplemental Medicare Insurance Benefit (Exhibit M) The Supplemental Medicare Insurance Benefit consists of two parts: Medicare Part A, the insurance premium for hospital care and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. The Part A premium payments are made only for the Qualified Medicare Beneficiary eligibility group. The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all client types including Qualified Medicare Beneficiary clients and Part A payments for Qualified Medicare Beneficiary clients only. Premiums for Medicare are not federally matchable for clients who are 300%ers (i.e., long term care clients who would be categorically eligible but for their having income that is three times the Supplemental Security Income level). Important to report is

that it was understood previously that institutional long term clients were ineligible for the federal match on their Supplemental Medicare Insurance Benefit; while the budgetary impact of the current information is approximately equivalent, there are some differences. Currently, approximately 80.04% of the Supplemental Medicare Insurance Benefit total is eligible for federal match.

The law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to sunset on September 30, 2003; eligibility has been extended to September 30, 2004. This population was referred to as Medicare Qualified Individual 1. Legislation for the second group, referred to as Medicare Qualified Individual 2, was comprised of individuals whose income was between 135% and 175% of the federal poverty level, sunset on April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. These two eligible groups were 100% federally funded, subject to an annual cap, through 2002. To continue serving this population would require a State match (currently 100% federal funds), and therefore, the budgetary impact of these two groups would need to be addressed and a General Fund match would likely be required. The Department is not currently requesting General Fund to continue serving this population.

To calculate FY 04-05 and FY 05-06, the average increase from FY 02-03 to FY 03-04 of 11.25% is applied to the FY 03-04 actuals. This projection will be updated when the Centers for Medicare and Medicaid Services publishes the new Part A and Part B premium costs in October 2004.

Health Insurance Buy-In [26-4-518.5, C.R.S. (2004)] ***(Exhibit N)*** The Medicaid program purchases health insurance for individuals eligible for Medicaid if it is cost effective. Health Insurance Buy-In was trended forward by applying the five-year average of the growth from FY 99-00 to FY 03-04, to the FY 03-04 final expenditures for the populations served by this program.

SUMMARY OF PREMIUM REQUEST (Exhibit O)

This spreadsheet is a summary of the requests by service grouping (Acute Care, Long Term Care, Community Based Long Term Care) and by eligibility category for estimated FY 04-05, and the projected FY 05-06.

FEDERAL MATCH CALCULATIONS (Exhibit P)

This reflects the match information provided from the federal Centers for Medicare and Medicaid Services, as reported through the Federal Register. See the next section for detailed match information. The federal financial participation rate for Medicaid is recomputed by the Federal Funds Information Service each year, based on a statewide per capita earnings formula that is set in federal policy. Colorado's federal match rate history follows.

FEDERAL FINANCIAL PARTICIPATION RATE (FFP) MATCHING RATES

FEDERAL FISCAL YEAR	FEDERAL SHARE	STATE SHARE	STATE FISCAL YEAR	FEDERAL SHARE	STATE SHARE
October 1988	0.5000	0.5000	FY 87-88	0.5000	0.5000
October 1989	0.5211	0.4789	FY 88-89	0.5000	0.5000
October 1990	0.5359	0.4641	FY 89-90	0.5176	0.4824
October 1991	0.5479	0.4521	FY 90-91	0.5334	0.4666
October 1992	0.5442	0.4558	FY 91-92	0.5459	0.4541
October 1993	0.5430	0.4570	FY 92-93	0.5448	0.4552
October 1994	0.5310	0.4690	FY 93-94	0.5432	0.4568
October 1995	0.5244	0.4756	FY 94-95	0.5330	0.4670
October 1996	0.5232	0.4768	FY 95-96	0.5255	0.4745
October 1997	0.5197	0.4803	FY 96-97	0.5234	0.4766
October 1998	0.5059	0.4941	FY 97-98	0.5203	0.4797
October 1999	0.5000	0.5000	FFS FY 98-99	0.5082	0.4918
NA	NA	NA	CAP FY 98-99	0.5093	0.4907
NA	NA	NA	FFS FY 99-00	0.5010	0.4990
NA	NA	NA	CAP FY 99-00	0.5015	0.4985
NA	NA	NA	FY 00-01	0.5000	0.5000
October 2000	0.5000	0.5000	FY 01-02	0.5000	0.5000
October 2001	0.5000	0.5000	FY 02-03 (Q1-3)	0.5000	0.5000
October 2002	0.5000 (0.5295 as of April 2003)	0.5000 (0.4705 as of April 2003)	FY 02-03 (Q4)	0. 5295	0. 4705
October 2003	0.5295 (0.5000 as of July 2004)	0.4705 (0.5000 as of July 2004)	FY 03-04	0.5295	0. 4705
October 2004	0.5000	0.5000	FY 04-05	0.5000	0.5000
October 2005 est.	0.5000	0.5000	FY 05-06	0.5000	0.5000

"*FFS*" stands for Fee-for-Service; "*CAP*" stands for capitated programs for which care is prepaid and, therefore, exhibits a different cash flow pattern (i.e., capitated assumes three months of care is purchased in the first quarter of the fiscal year and fee-for-service assumes two months in the first quarter).

Bottom line adjustments are made for financing items and new legislation that mandates fees for H.B. 03-1292 (ICF-MR Fee) and the Upper Payment Limit financing. These items are all discussed further in this narrative. They are taken as bottom line adjustments because

they need to be held out of the trend of expenditures. Only expenditures for medical services to clients are included in the trend of expenditures.

The total request for FY 04-05 is compared to the FY 04-05 Long Bill plus Special Bills appropriation. The total request for FY 05-06 is compared to the total request and the appropriation for FY 04-05.

Finally, a checklist of items that have other than the standard calculation of program match rates is provided in the following:

- Family Planning: There is 90% federal financial participation available for all *documented* family planning expenditures. This also includes those services that are rendered through the health maintenance organizations. Please see Exhibit E.

- Prenatal Costs: There is a portion of this line that is for prenatal care for Non-Citizens. This is a state program and therefore must be funded through 100% General Fund. This is estimated only through December 31, 2004, as implementation of S.B. 03-176, Legal Immigrants, is expected to occur on January 1, 2005 and these prenatal services will no longer be provided. Please see Exhibit D.

- Breast and Cervical Cancer Program: The federal match for this program is 65% federal and 35% Cash Funds Exempt, from interest earnings from the Tobacco Litigation Settlement Cash Fund. H.B. 04-1416 (Funding Split for Breast and Cervical Cancer Program) continued this funding through FY 04-05. Beginning in FY 05-06, the funding split will be 65% federal, 17.5% Cash Funds Exempt from interest earnings from the Tobacco Litigation Settlement Cash Fund, and 17.5% General Fund.

- Indian Health Services: The federal match for this program is 100%. This is a rough estimate only, based on the prior four federal fiscal quarters of data reported on the CMS 67. It is included in the budget for information only.

- Single Entry Point: There is a portion of this line that is for private pay clients (4%) and is not matchable with Medicaid federal financial participation; instead, must be funded through 100% General Fund.

- Supplemental Medicare Insurance Benefit: The premiums for Medicare are not federally matchable for clients who are 300%ers (long term care clients whose income is 3 times the Supplemental Security Income payment level). Currently 80.04% is matchable.

- The Upper Payment Limit financing offset to General Fund is a bottom line adjustment to total expenditures. The Upper Payment Limit financing methodology accomplishes the following:

a. Increases the Medicare upper payment limit up to the federally allowable percentage for all non-state public government owned or operated hospitals, outpatient hospitals, and nursing facilities.
b. Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures for those hospitals that are public non-state government-owned hospitals, outpatient hospitals, and nursing facilities.
c. Reduces the existing General Fund cost by leveraging the federal funds that are available and uses certification of public expenditures for a portion of the State's share of the expenditures.

The FY 05-06 Projection over the FY 04-05 Appropriation plus Special Bills request row on page E.P-2 does not equal Column 6 of the Schedule 6 because of annualizations of specials bills from the 2004 Legislative Session. The reason for this difference is because the annualizations are accounted for in the Medical Services Premiums forecast in the service group exhibits (Exhibit B, F, and H through N). If the annualizations were added to Exhibit P, this would be "double-counting" them. A reconciliation of the FY 05-06 Base Request is as follows:

	Total Funds	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 04-05 Appropriation + Special Bills	$1,934,644,559	$936,641,159	$72,180	$30,181,738	$967,749,482
FY 05-06 Annualization of S.B. 04-177 (HCBS-Autism Waiver)	$626,750	$0	$0	$313,375	$313,375
FY 05-06 Annualization of H.B. 04-1219 (Community Transition Services for HCBS-EBD)	($937,091)	($468,545)	$0	$0	($468,546)
FY 05-06 Base Request (Matches Column 5 of Schedule 6)	$1,934,334,218	$936,172,614	$72,180	$30,495,113	$967,594,311

UPPER PAYMENT LIMIT CALCULATIONS (Exhibit Q)

Because of a struggling economy, government agencies at all levels have been laboring to continue to provide quality services and support, while program funding has become increasingly difficult to attain. Due to changes in the Medicare policy for medical services by the federal government, Medicare reimbursement to providers has decreased significantly in recent years. This decrease in reimbursement, which lessened the gap between Medicare and Medicaid rates, lowered the Upper Payment Limit funding available for medical services providers.

The basic calculation for Upper Payment Limit financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are

incorporated into the current year calculation. Growth rates available from the most recent November 1 Budget Request are used to increase these calculation drivers, to reflect actual experience when possible, and provide the Department with reliable estimates for the current fiscal year.

Typically, funds received through the Upper Payment Limit for outpatient hospital services are used to offset General Fund expenditures to minimize the need for direct Medicaid rate decreases. Similar methodologies are used for home health, and nursing home premiums. While outpatient hospital services and nursing facilities account for a large portion of Upper Payment Limit funding, home health has premiums that are relatively small by comparison, and will experience little impact relating to these changes in reimbursement rates.

Projections for all provider types are provided at Exhibit Q. FY 05-06 estimates have been inflated by 7.1% over the FY 04-05 Upper Payment Limit estimates, based on the estimated growth in caseload in the most recent caseload forecast.

FY 03-04 FINAL ACTUAL EXPENDITURES THROUGH JUNE 30, 2004 - Cash-based (Exhibit R)
This exhibit displays the FY 03-04 final actual total expenditures.

ACTUAL FINAL EXPENDITURES FY 95-96 THROUGH FY 03-04 (Exhibit S)
Actual final expenditure data for the past nine years are included for historical purpose and comparison. This history is now built around cash-based accounting; a 12 month period for each fiscal year, based on paid date. This exhibit displays the distribution of final service category expenditures from the estimated final expenditures to the eligibility categories. This is a necessary step because expenditures in the Colorado Financial Reporting System are not allocated to eligibility categories. The basis for this allocation is the Medicaid Management Information System, Management and Administrative Reporting Subsystem report named the "464600." This report provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, and Long Term Care and Insurance.

While trying to recreate the past history of expenditures in a cash-based environment, some documents and spreadsheets with the history of adjustments are no longer available. Also of note, there is a greater opportunity for manual adjustments in the Colorado Financial Reporting System that do not get recorded in the Medicaid Management Information System during the accounts payable period. This can skew the reconciliation between COLD (the Computer Output to Laser Disk storage of Medicaid Management Information System reports) and the Colorado Financial Reporting System. Therefore, some of the cash-based actuals need to continue to be refined.

ANNUAL RATES OF CHANGE IN MEDICAL SERVICES PREMIUMS (Exhibit T)
Annual rates of change in medical services by service group from FY 95-96 through FY 03-04 final actual expenditures are included in this budget request for historical purpose and comparison.

HISTORY of COSTS – Per Capita, Total Expenditures, and Caseload (Exhibit U)
Medical Services Premiums per capita costs, expenditure and caseload history (through FY 03-04) and projections are included for historical purpose and comparison.

COMPARISON OF APPROPRIATION TO BUDGET REQUEST (Exhibit V)
This exhibit displays the comparison of the February 16, 2004, Budget Request and the appropriation to the revised FY 04-05 projection in this Budget Request. The totals in this exhibit exclude the Upper Payment Limit financing estimates.

GLOBAL REASONABLENESS TEST (Exhibit W)
This exhibit displays a global reasonableness test as a comparison to the projection in this budget request. The totals in this exhibit exclude the Upper Payment Limit financing estimates.

CASELOAD GRAPHS (Exhibit X)
This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during the 2004 legislative session that have importance to the Department of Health Care Policy and Financing as relates to the construction of the Medical Services Premiums:

H.B. 04-1219 authorizes community transition services for elderly, blind, and disabled persons who are receiving home and community-based services. The transition services are not to exceed $2,000 per eligible person and are to be administered by a transition coordination service agency.

Line Item	Total Funds	General Fund	Federal Funds
FY 04-05			
Executive Director's Office – Personal Services - 0.4 FTE and a contract for Accounting Support	$19,444	$9,722	$9,722
Executive Director's Office – Operating Expenses	$2,256	$1,128	$1,128
Executive Director's Office – Medicaid Management Information System Contract (Claims Processing)	$224	$112	$112
Medical Services Premiums	($79,649)	($39,825)	($39,824)
Total FY 04-05	**($57,725)**	**($28,863)**	**($28,862)**
FY 05-06			
Executive Director's Office – Personal Services - 0.5 FTE and a contract for Accounting Support	$22,129	$11,065	$11,064
Executive Director's Office – Operating Expenses	$1,307	$654	$653
Executive Director's Office – Medicaid Management Information System Contract (Claims Processing)	$300	$150	$150
Executive Director's Office – Medicaid Management Information System Contract (Changes to system)	$75,000	$18,750	$56,250
Medical Services Premiums	($1,016,740)	($508,370)	($508,370)
Total **FY 05-06**	($918,004)	($447,751)	($440,253)

The Nursing Facility Transition grant expired on September 30, 2004. The Department reached the goal of moving 130 people out of nursing facilities by August 1, 2004, and informed over 900 people of their right to choose community based placement. A "best practices" manual was developed to assist case managers and other stakeholders in assisting with transitions. The Elderly, Blind and Disabled waiver amendment was submitted to the Centers for Medicare and Medicaid Services on June 18, 2004. The Department responded to questions from the Centers for Medicare and Medicaid Services on September 3, 2004 and approval is anticipated by December 1, 2004. Rules were passed on August 13, 2004 and the Department is in the process of training the Single Entry Point agencies on the new service.

H.B. 04-1220 changes Medicaid non-emergent medical transportation from an optional medical benefit to an administrative service. Structuring the benefit as an administrative service provides greater flexibility and ability to control costs.

Line Item	Appropriation	Legislative Council Fiscal Note
FY 04-05		
Net	$0	$0
Medical Services Premiums – Total Funds	$0	($4,400,778)
Medical Services Premiums – General Fund	$0	($2,200,389)
Medical Services Premiums – Federal Funds	$0	($2,200,389)
Executive Director's Office, Non-Emergency Transportation Services – Total Funds	$0	$4,400,778
Executive Director's Office, Non-Emergency Transportation Services– General Fund	$0	$2,200,389
Executive Director's Office, Non-Emergency Transportation Services– Federal Funds	$0	$2,200,389

Because the appropriation clause was not included in the final bill, decreasing the Medical Services Premium line and establishing a new line item in the Executive Director's Office, Non-Emergency Transportation Services, the Long Bill (H.B. 04-1422) was amended to include this technical correction. The correction is identical to the Legislative Council Fiscal Note calculation.

H.B. 04-1416 is a Joint Budget Committee Bill that changed statute [26-4-532 (7.5) (a), C.R.S. (2004)] to eliminate the requirement to use General Fund for 50% of the state-share of the Breast and Cervical Cancer Treatment Program for FY 04-05. Instead, Cash Funds Exempt from the Breast and Cervical Cancer Prevention and Treatment Fund in FY 04-05 is used to fund the program.

Funding in FY 05-06 remains at 17.5% General Fund, 17.5% from the Breast and Cervical Cancer Prevention and Treatment Fund, which are currently funded from the interest on the Tobacco Litigation Settlement, and 65% federal funds.

Line Item	Appropriation
FY 04-05	
Medical Services Premiums – Total Funds	$0
Medical Services Premiums – General Fund	($1,015,048)
Medical Services Premiums – Cash Funds Exempt	$1,015,048

S.B. 04-177 establishes the "Home and Community based Services for Children with Autism Act." The program is for Medicaid children birth to six years of age with a diagnosis of autism, at-risk of institutionalization in an ICF-MR,[20] a hospital, or a nursing

[20]Intensive Care Facility for the Mentally Retarded, federal definition

facility and not receiving services from any of the alternatives to long-term care waiver programs. The Department is to seek a federal waiver that meets budget neutrality requirements. Services under this waiver are outlined and limited to $25,000 annually per participant, starting January 2006. Community Centered Boards for persons with Developmental Disabilities are to be the Single Entry Point Agencies for services. Administrative costs for the Community Centered Boards are capped at 15%.

A fund is created for paying for the services and up to $1,000,000 is to be transferred from the Tobacco Litigation Settlement Cash Fund to the Colorado Autism Treatment Fund. At the end of each fiscal year, beginning in FY 04-05 (for the following year's expenses), the amount needed for the state share of the program is to be transferred from the Tobacco Fund, Tobacco Education, Prevention and Cessation Grant Program, which is 15% of the Tobacco Settlement Fund. The Act is to take effect January 1, 2005.

The fiscal note assumes that a 1915c waiver would be written with existing resources and submitted to Centers for Medicare and Medicaid Services in January 2005, with approval slated for July 1, 2005 (FY 05-06) when costs for the program, including system changes would begin and take approximately 6 months to complete. Costs for the waiver development in FY 04-05 are to be absorbed by the Department. The program is estimated to begin January 1, 2006.

Line Item	Total Funds	General Fund	Federal Funds
FY 05-06			
(1) Executive Director's Office – Personal Services – 1.0 FTE.	$51,974	$25,987	$25,987
(1) Executive Director's Office – Operating Expenses	$4,739	$2,370	$2,369
(1) Executive Director's Office – Medicaid Management Information System Contract (Utilization Review – PARs)	$2,220	$1,110	$1,110
(1) Executive Director's Office – Medicaid Management Information System Contract (Claims Processing)	$3,098	$775	$2,323
(1) Executive Director's Office – Medicaid Management Information System Contract (Changes to system)	$122,500	$30,625	$91,875
(1) Executive Director's Office – Personal Services (for changes to Colorado Benefits Management System)	$29,900	$14,950	$14,950
(1) Executive Director's Office - Disability Determination Services (for disability determinations at $400 each for 25 children)	$10,000	$5,000	$5,000
(2) Medical Services Premiums	$545,000	$272,500	$272,500
(2) Medical Services Premiums – Single Entry Point contract with Community Centered Boards (15%)	$81,750	$40,875	$40,875
Total	**$851,181**	**$394,192**	**$456,989**

S.B. 04-138

The bill repeals SB 03-259, which allowed the Department to charge a monthly fee for children enrolled in the Children's Home-and Community-based services or the Children's Extensive Support waiver programs. The fee was intended to build up a cash fund from which direct and indirect costs would be paid for at Health Care Policy and Financing and the Department of Human Services for their Children's Extensive Support waiver program, along with a staff person at the Department of Personnel and Administration for collections services. One FTE and associated operating expenses were appropriated to the Department through this SB 03-259.

In FY 03-04, SB 04-138 prorated and reduced the personal services and operating expenses by 25% for April, May, and June 2004, and the premiums funding splits were reversed to fully credit the cash funding, and re-established the General Fund/federal funds splits for these services. The Department of Human Services' Services to People with Disabilities, Services for Families and Children line item is treated in the same manner. The appropriation to the Department of Personnel and Administration is reversed in total. Essentially, SB 04-138 eliminated the cash funds for services that were established by SB 03-259 and replaced these funds with General Fund and federal funds.

Appropriations:
FY 03-04 - (Net changes to each line)

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Federal Funds
Executive Director's Office, Personal Services	($9,700)	($4,850)	$0	($4,850)
Executive Director's Office, Operating Expenses	($1,889)	($945)	$0	($944)
Medical Services Premiums (Cash Funds are from Home and Community Based Services Cash Fund)	$0	$92,612	($185,224)	$92,612
Department of Human Services, Medicaid Funded Programs, Services to People with Disabilities, Services for Families and Children-Medicaid Funding	$0	$9,540	($19,080)	$9,540
Department of Personnel and Administration, Finance and Procurement, Collection Services, Personal Services	($25,499)	$0	($25,499)	$0

In FY 04-05 and later years, SB 04-138 eliminates the full 1.0 FTE, personal services, and operating expenses originally appropriated, and reverses the premiums funding splits to fully credit the cash funds, and re-establishes the General Fund/federal funds splits for these services. The Department of Human Services' Services to People with Disabilities, Services for Families and Children line item is treated in the same manner. The appropriation to Department of Personnel and Administration is reversed in total. SB 04-138 eliminates the cash funding of the two programs and replaces that funding with General Fund and federal funds.

The fiscal impact of the Bill in FY 04-05 and future years is as follows:

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Federal Funds
Executive Director's Office, Personal Services	($38,797)	($19,399)	$0	($19,398)
Executive Director's Office, Operating Expenses	($7,555)	($3,778)	$0	($3,777)
Medical Services Premiums (Cash Funds are from Home and Community Based Services Cash Fund)	$0	$370,448	($740,896)	$370,448
Department of Human Services, Medicaid Funded Programs, Services to People with Disabilities, Services for Families and Children-Medicaid Funding	$0	$38,160	($76,320)	$38,160
Department of Personnel and Administration, Finance and Procurement, Collection Services, Personal Services	($25,499)	$0	($25,499)	$0

(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

(A) PROGRAM ADMINISTRATION

In April 2004, HB 04-1265 transferred administration of the Medicaid Mental Health Community Program to the Department of Health Care Policy and Financing from the Department of Human Services. A new budget grouping was created within the Department's portion of the Long Bill.

For FY 03-04, HB 04-1265 appropriated total funds in the amount of $259,274, $112,415 General Fund and $146,859 federal funds, to the Department of Health Care Policy and Financing Executive Director's Office, Personal Services line item to support salary and benefits for 2.3 FTE. The funds and FTE amounts were reduced from the Department of Human Services portion of the FY 03-04 Long Bill. For FY 04-05, HB 04-1422 appropriated total funds of $1,037,096, $430,346 General Fund and $606,750 federal funds, and 9.0 FTE to the Department of Health Care Policy and Financing for personal services, operating expenses, and the External Quality Review Organization contract. Amounts for FY 03-04 and FY 04-05 were calculated using the Department of Human Services historical appropriation information, minus ongoing funding for the Department of Human Services.

The Personal Services calculation for the FY 05-06 request is described below. A discussion on operating expenses is included. Personal Services and operating expenses receive a 50% federal match. The External Quality Review Organization contract reviews the quality of care provided by the Behavioral Health Organizations, formerly known as Mental Health Assessment and Services Agencies (MHASAs). This contract is federally mandated and receives 75% federal match.

Personal Services Calculation

The Schedule 3 delineates the Personal Services appropriation and base request of FTE and Personal Services funding. There were no expenditures for FY 02-03 or FY 03-04 since the line item did not exist in this part of the Department of Health Care Policy and Financing budget for these fiscal years. The "FY 04-05 Estimate" and "FY 05-06 Request" columns include estimates for Personal Services, out-year legislative impacts, and Common Policy adjustments such as the 0.2% base reduction.

The Schedule 3 is presented in three sections: Position Detail, Personal Services Request, and Personal Services Reconciliation. Each section is described in detail below.

I. Position Detail Calculation

The first calculation method is the Position Detail, labeled "I" in the Schedule 3. The Position Detail is a summary of state employee wages and FTE by position title (totaled at "I.A."), "Other Personal Services" (totaled in "I.B."), and POTS (totaled in "I.D."). "Other

Personal Services" are costs not included in the base salary calculation and typically include PERA, Medicare, State temporary employee salaries, contractual services, termination and retirement payouts, and unemployment insurance. "POTS" are costs related to Salary Survey, Performance-based Pay Awards, Health/Life/Dental, and Short-term Disability. Amounts expended, or estimated in this line item are presented for the Actual and Estimate years. Salary Survey, and Performance-based Pay Awards expenditures are "non-add" items, and are included for informational purposes only. The salaries listed by position should already reflect these costs.

The Position Detail method assumes continuation of the appropriated staffing pattern. Since specific classifications were not appropriated, the Department based the estimate on 1) classification of transferred persons, 2) classifications of existing mental health staff, and 3) two General Professional IVs, a common program position in the Department. In the Request year, the calculation begins with actual salaries and then other anticipated costs are added. The Position Detail method ends with a "Difference" row (I.F.) that represents the difference between the Personal Services Reconciliation Total (III) and the Base Personal Services Subtotal (I.E.). If applicable, differences are shown for the Estimate and Request year columns.

The following is a description for the Position Detail (I) FTE and amounts described by column. This is not the Department's Personal Services Request.

The FY 04-05 Estimate column shows the current positions' salary costs (I.A.). Base Request assumptions for this section are listed below:

- The current positions' salary costs equal $503,796, with 9.0 FTE; plus,
- The Other Personal Services equal the PERA and Medicare calculations based on the Position Detail salaries, ($503,796 * 0.1015 = $51,135 for PERA and $503,796 * 0.0145 = $7,305 for Medicare), Operating of $7,830 ($500 * 9 FTE = $4,500 for Office Supplies and $370 * 9 FTE = $3,330 for Communication/Telephones), Miscellaneous amount of $114,223, and Contractual Services of $352,807 for the External Quality Review Organization contract; plus,
- POTS Expenditures of $17,125, which consist of Health/Life/Dental and Short Term Disability.

The Base Personal Services total (I.E.) equals $1,054,221, with 9.0 FTE.

Salary Survey of $5,059 is calculated by the sum of salaries for four filled positions, $21,080, times 2.0%, annualized. Performance-based Pay Awards of $2,816 is calculated using the sum of salaries for four filled positions, plus Salary Survey, times a Performance-based Pay amount ranging from 0.00% to 3.02193%, depending on individual performance. Each of these items is also shown under the POTS Expenditures (I.D.), but are non-add items. This is because they are included in the Position Detail figures in section I.A. above.

The Difference row (I.F.) in the Position Detail Section, calculates the difference between the Base Personal Services Total (I.E.) and the Reconciliation Personal Services Total (III). The FY 04-05 Estimate column difference equals $7,875.

The FY 05-06 Request for the Position Detail column is equal to the FY 04-05 Estimate column since there were no special bills passed, and remains at $503,796 since this is the base salary amount for FY 05-06 (excludes Salary Survey, Range Adjustment and Performance-based Pay Awards for FY 05-06). Other Personal Services includes continuation funding for Operating and External Quality Review Organization and an increase in funding for PERA and Medicare related to the FY 05-06 Salary Survey, Range Adjustment and Performance-based Pay Awards amounts requested, plus Miscellaneous. The FY 05-06 PERA and Medicare amounts are based on the base salary of $503,796, plus Salary Survey, Range Adjustment, and Performance-based Pay Awards in the amounts of $9,672, $1,512, and $5,134, respectively, which totals $520,114. The new PERA and Medicare amounts equal $52,791 ($520,114 * 0.1015), and $7,541 ($520,114 * 0.0145), respectively. POTS Expenditures are not part of the calculation component, since they are requested in their distinct line items under the Executive Director's Office Long Bill group.

The Difference row (I.F.) in the Position Detail Section, calculates the difference between the Base Personal Services Total (I.E.) and the Reconciliation Personal Services Total (III). The FY 05-06 difference equals $7,831. The estimate via method "I," or the Position Detail method, is lower than the "II." method to calculate the request because of the way the appropriation was developed. During the appropriation cycle, the amount for Health Care Policy and Financing was calculated by taking the historical Department of Human Services appropriation, less ongoing Department of Human Services costs (the piece that remains as transfer dollars). The November 1, 2004 Change Request #BRI-1 "Balance Mental Health FTE to Department Need" addresses these issues.

II. Personal Services Request

The second method calculates the FY 05-06 Personal Services Request (labeled "II" in the Schedule 3) based on aggregate adjustments to the previous year's Long Bill appropriation. This is the Department's FY 05-06 Base Request for this line, calculated as outlined in the Budget Request Instructions issued June 1, 2004 (page 8-8). These adjustments include prior year Salary Survey, current year Range Adjustments, a Medicare Differential, prior year Performance-based Pay Awards, Amortization Equalization Disbursement (AED) Adjustment, and the OSPB 0.2% base adjustment. For a more detailed description of Range Adjustments, Medicare Differential, and AED, refer to the Department's Executive Director's Office, Personal Services line item in this document.

To further explain the Department's FY 05-06 Request, the table below starts with the FY 04-05 Long Bill (HB 04-1422) amount of $1,037,096. The FY 05-06 Request is then derived by applying the legislative and Common Policy adjustments to the FY 04-05 Long Bill (HB 04-1422). The total Base Request for FY 05-06 is $1,046,603.

FY 05-06 Mental Health Administration Funding:

Medicaid Mental Health, Administration	Total Funds	General Fund	Federal Funds	FTE
FY 04-05 Long Bill Appropriation	$1,037,096	$430,346	$606,750	9.0
FY 05-06 Annualization of Special Bills	$0	$0	$0	0.0
FY 05-06 Base Appropriation before POTS	**$1,037,096**	**$430,346**	**$606,750**	**9.0**
Salary Survey	$5,059	$2,530	$2,529	N/A
Performance Based Pay – Classified Employees	$2,816	$1,408	$1,408	N/A
Range Adjustment	$1,687	$844	$843	N/A
Amortization Equalization Disbursement (AED) Incremental Adjustment	$1,084	$542	$542	N/A
Medicare Differential	$236	$118	$118	N/A
Less Operating*	($7,830)	($3,915)	($3,915)	N/A
Less External Quality Review Organization Contract*	($352,807)	($88,202)	($264,605)	N/A
Subtotal Base before Office of State Planning and Budgeting 0.2% Reduction	**$687,341**	**$343,671**	**$343,670**	**N/A**
Less Office of State Planning and Budgeting Base Adjustment (0.2%)	($1,375)	($688)	($687)	N/A
Operating	$7,830	$3,915	$3,915	N/A
External Quality Review Organization Contract	$352,807	$88,202	$264,605	N/A
FY 05-06 Base Request	**$1,046,603**	**$435,100**	**$611,503**	**9.0**

*Operating Expenses and External Quality Review Organization Contract are excluded from the Office of State Planning and Budgeting 0.2% reduction calculation since this reduction only applies to base salary costs to account for turnover, vacancy savings, and reversions.

III. Personal Services Reconciliation

The last section of the Schedule 3 delineates the spending authority for all years except the Request year, by bill. POTS are then included to obtain a final Personal Services Total.

The Reconciliation Difference (IV) subtracts the Personal Services Detail (or Position Detail in I) Total from the Reconciliation Personal Services Total (III).[21] The Reconciliation Difference (IV) is used to balance the two calculations. The difference is shown in the two Actual and Estimate year columns. There are no Reconciliation differences for FY 02-03 or FY 03-04 since there were no expenditures.

[21]The Reconciliation Personal Services Total for the Request year (III) matches the Department Request or "Personal Services Request Total" (II).

For the FY 04-05 Estimate, the spending authority calculation (III.A.) equals the FY 04-05 Appropriation column. The Allocated POTS total funding of $25,000 ($5,059 Salary Survey, $2,816 Performance Based Pay Awards, and $16,487 Health/Life/Dental, and $638 Short-Term Disability) are added to the Spending Authority Authorization (III.A.) to get to the "III. Reconciliation Personal Services Total." (See Department of Health Care Policy and Financing Executive Director's Office Personal Services Assumptions and Calculations for a more descriptive explanation of these line items.)

(B) MENTAL HEALTH PROGRAMS (Exhibits AA-II)

History and Background Information

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the federal Centers for Medicare and Medicaid Services granted the State waivers that allowed the State to implement a managed mental health program. In 1992, HB 92-1306 authorized the Departments of Health Care Policy and Financing and Human Services to develop a pilot program to provide comprehensive mental health services to eligible Medicaid clients through a capitated managed care system. In 1995, SB 95-078 revised the reporting and termination dates of the pilot program and directed the Departments to implement a statewide mental health managed care program. In 1997, SB 97-005 authorized statewide implementation of a Medicaid Mental Health Capitation and Managed Care Program.

In 1995, implementation of the Colorado Medicaid Mental Health Capitation and Managed Care Program in fifty-one counties in the State was completed, with the remaining twelve counties added in 1998. Through a competitive bid process, six mental health assessment and services agencies (MHASAs) were awarded contracts to be a service provider in the program. The Department now calls these Behavioral Health Organizations. The six Behavioral Health Organizations serve eight regions. Each Behavioral Health Organization is responsible for providing or arranging any medically necessary mental health services to Medicaid eligible elderly, disabled, adults and children enrolled with a Behavioral Health Organization. A brief list of the capitation program services the Behavioral Health Organization provides includes, but is not limited to: inpatient hospitalization; rehabilitation and outpatient care; clinic services of case management, medication management and physician care; and, non-hospital residential care as it pertains to mental health. The Department is required to make prepaid capitation payments to contracted Behavioral Health Organizations for these services for each eligible Medicaid recipient enrolled in a Behavioral Health Organization. Payments may vary across each Behavioral Health Organization, as well as each eligibility category. The capitation program also includes alternatives to institutionalization.

Since the inception of the Medicaid Mental Health Community Services Program, the Department, as the Single State Agency authorized by federal Centers for Medicare and Medicaid Services, and as authorized in State statute, has been responsible for the oversight of the program and contracting with the managed care organizations. The budget projections, day-to-day operations, and administration of the program were the responsibility of the Colorado Department of Human Services. However, in April 2004, HB

04-1265 transferred the administration and programmatic duties from the Colorado Department of Human Services to the Department, with the exception of the Goebel lawsuit. The transfer also resulted in a new Long Bill group for the Department in the FY 04-05 Long Bill appropriation (HB 04-1422).

Per HB 04-1265, the Department shall administer all Medicaid Community Mental Health Services for Medicaid clients, including mental health capitation, Single Entry Points systems for mental health, fee-for-service mental health, and alternatives to institutionalization. The Department is also responsible for program approval, program monitoring, data collections and budget projections.

Additional major changes to the Mental Health Community Program are summarized as follows:

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medicaid-funded services in the Department of Human Services' budget. This resulted in one-time savings of approximately $7 million in FY 02-03. By moving to cash-based accounting, the Department no longer has a six-month accounts payable period for each fiscal year for these services. Previously, with accrual-based accounting, the State fiscal year closed on June 30 each year, however, the Mental Health Capitation and Mental Health Fee-for-Service line item appropriations remained "open" until December 31 of each year to account for any expenditure with a date of service in the prior fiscal year. With cash-based accounting, all expenditures are based on date-of-payment, regardless of when the date of service occurred; thus, eliminating the six-month accounts payable period. This complicates the budget process in that all prior expenditure history should be "rebuilt" on a cash-basis, in both the Colorado Financial Reporting System and the Medicaid Management Information System. The projection methodology of the entire capitation budget is currently in the process of being reviewed by the Department, and no prior year information has been rebuilt at this time.

- SB 03-282 gave the Department and Department of Human Services Medicaid-funded programs a one-time award of $1,000,000 in FY 03-04, of which $500,000 was derived from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. (2004) and the remaining $500,000 was from federal funds.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 02-03 and all of FY 03-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The enhanced match rate was discussed at length in the Department's Assumptions and Calculations section of the November 3, 2003 Budget Request. The federal financial participation match rate has returned to 50% for FY 04-05.

- In FY 02-03, budget reductions were implemented and Medicaid capitation payments were reduced significantly for FY 02-03 through FY 03-04. This led to a reduction of services provided by the Behavioral Health Organizations. The increase in Medicaid

caseload and funding for alternative programs to inpatient hospitalization has tempered the effect the reductions have had on the capitation budget.

- HB 04-1322 and HB 04-1320, Supplemental bills for the Department of Human Services and the Department, respectively, reorganized the Mental Health Community Program Long Bill appropriation line items by client eligibility, similar to the presentation of other medical programs within the Department. Under the Medicaid Mental Health Program appropriation, two sections were created:
  1. Mental Health Capitation - which includes Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization programs at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan, and an Alternative to the Fort Logan Aftercare Program; and
  2. Other Medicaid Mental Health Payments - which includes Medicaid Mental Health Fee-For-Service Payments, Child Placement Agency, and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals are listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively.

(1) MEDICAID MENTAL HEALTH CAPITATION PROGRAM

Calculations

The Department is reviewing methodology alternatives for forecasting the Mental Health Programs budget. For this request, the methodology used in prior years was utilized and is described in the paragraphs hereafter.

The Medicaid Mental Health Capitation line items are appropriations that fund Medicaid mental health services throughout Colorado through managed care providers contracted with the State. Contracts are awarded to Behavioral Health Organizations through a competitive bid process. The responsibility of the Behavioral Health Organization is to administer services to Medicaid eligible clients within a specified geographic location for a determined capitation rate. Capitation rates are paid based on the client's Medicaid eligibility category. The Medicaid populations that are eligible for mental health services covered by capitation are combined into five categories for which capitation rates are paid (Qualified Medicare Beneficiaries, Special Low-Income Medicare Beneficiaries and Non-citizens are excluded):

Supplemental Security Income Adults 65 and Older (SSI 65+)
Supplemental Security Income Adults 60 to 64 Years of Age (SSI 60-64) and Supplemental Security Income Disabled Individuals (SSI Disabled)
Category Eligible Low-Income Adults (AFDC-A) and Baby Care Program – Adults
Eligible Children (AFDC-C/BC)
Foster Children

Rates are calculated and paid based on the Medicaid client's eligibility category. The rate is paid by the State to the Behavioral Health Organization for each Medicaid eligible client for each month of eligibility. Amounts are prorated for partial months of service and retroactivity is covered. There are currently six Behavioral Health Organizations contracted in eight regions in the Mental Health Capitation Program. However, a Request for Proposal, to revise the number of Behavioral Health Organizations serving the State, along with updating capitation rates and services, has been published. New contracts will be awarded, and will go into effect January 1, 2005. The February 14, 2005 Mental Health Programs projection will incorporate the results of the bids.

The first step in the budget projection process is to forecast member months utilizing prior year expenditures and prior year capitation rates paid to each Behavioral Health Organization. The Medicaid Management Information System provides a dissection of expenditures by Behavioral Health Organization and eligibility category. However, a few financial adjustments and corrections do not get entered in the system to true up total actual expenditures. The only source that includes all actual expenditure activity is the Colorado Financial Reporting System. As such, this source should be the one utilized to calculate actual FY 03-04 member months. The drawback is this system only provides total expenditures by Behavioral Health Organization, and not by eligibility category. An allocation must be calculated to determine the amount of the expenditures across the eligibility categories.

Analysis of the Expenditure Allocation across Eligibility Categories and Forecasting Member Months:

The Medicaid Management Information System is where the Behavioral Health Organization capitation rates are entered at the beginning of a fiscal year and monthly payments are reported based on eligibility categories. Since the Medicaid Management Information System does not include all financial transactions or corrections, like the Colorado Financial Reporting System does, the total expenditures from the Colorado Financial Reporting System is analyzed to calculate member months. The disadvantage of using Colorado Financial Reporting System is that expenditures are only available by Behavioral Health Organization, and not by eligibility category. To allocate the FY 03-04 total expenditures for each Behavioral Health Organization from the Colorado Financial Reporting System by eligibility category, expenditures from the Medicaid Management Information System for FY 03-04 are analyzed (Exhibit DD–Table 1). Medicaid Management Information Systems expenditures are attainable by Behavioral Health Organization and by eligibility category. The expenditures obtained for FY 03-04 from the Medicaid Management Information System were $144,264,114. A one-time funding amount of $3,660,985 for Institutional Rate Relief was carved out of the funding for

Behavioral Health Organizations by eligibility category, since it was not rate related, for a more accurate calculation of member months. (See Exhibit EE-Table 1 and Institutional Rate Relief description below for more details.)

A ratio is then calculated for each Behavioral Health Organization by dividing the Behavioral Health Organization's Medicaid Management Information System expenditures by eligibility category expenditures by the total Medicaid Management Information System expenditures for each of the respective Behavioral Health Organizations (Exhibit DD-Table 2). This ratio is then multiplied by the total expenditures obtained from the Colorado Financial Reporting System (Exhibit DD-Table 2). This calculation estimates actual Colorado Financial Reporting System expenditures across each Behavioral Health Organization and eligibility category. This calculation does not include non-rate related one-time adjustments for Institute Rate Refinance, FY 01-02 Recoupment and FY 02-03 Overexpenditure, in the amounts of $2,952,045, ($3,775,623), and $3,011,685, respectively.

Once the Colorado Financial Reporting System expenditures were allocated across their respective eligibility categories, the Institutional Rate Relief amount was also carved out of the Colorado Financial Reporting System data (Exhibit EE-Table 1 and 2). To determine actual member months (Exhibit FF–Table 2), the total adjusted Colorado Financial Reporting System expenditures (Exhibit EE–Table 2) are divided by the capitation rates paid during FY 03-04 (Exhibit FF–Table 1). Once the Department's Medicaid caseload is approved, the member months are forecasted for FY 04-05 and FY 05-06 using the percentage increases from Exhibit A under the Medical Services Premium Exhibits (Exhibit GG).

Calculating Capitation Base Payments:

Each Behavioral Health Organization has contractual, actuary-certified capitation rates for Capitation Base, Alternative, and Aftercare Programs, based on the Medicaid eligibility categories specified above. These rates are multiplied by projected member months. Exhibit II shows FY 02-03 and FY 03-04 Colorado Financial Reporting System actuals, FY 04-05 estimates, and the FY 05-06 projection. Since SB 03-282 affected the capitation base rate for the FY 03-04 period, and the Alternative rates are added to the Capitation Base rates when entered into the Medicaid Management Information System, the rate for each item is broken out separately to show each specific amount. Since SB 03-282 is not effective for FY 04-05 or FY 05-06, member months for these periods are multiplied only by the Capitation Base rate and Alternative rates. Based on actual FY 03-04 member months and a new projected caseload growth amount, FY 04-05 has been re-estimated. The Department estimates an increase of $3,703,423 to the Capitation Base for FY 04-05. This increase comprised of $2,798,193 for caseload growth and $905,230 to cover the FY 03-04 overexpenditure.

Breast and Cervical Cancer Patients (Exhibit II, Pages 1-8):

The Mental Health Services for Breast and Cervical Cancer Patients appropriation was created through SB 01S2-012, adopted during the second special session in 2001. Originally, caseload was projected for seventy-one women at a cost of $1,002.46 per client for mental health services.[22] Thirty-five percent of the funding for this program is from the Breast and Cervical Cancer Prevention and

[22]FY 04-05 Figure Setting for Department of Human Services, Mental Health and Alcohol and Drug Abuse Division, page 43.

Treatment Fund created in section 26-4-532 (7), C.R.S. (2004). Based on this information, the program has had a continued level of funding of $71,175 for FY 02-03, FY 03-04, and FY 04-05. However, this program is managed through the capitation contracts with the Behavioral Health Organizations, therefore, the Department believes the budget should be projected based on Medicaid Breast and Cervical Cancer Patient caseload. The Organizations receive the same capitation amount for Breast and Cervical Cancer Patients as their Category Eligible Low-Income Adults and Baby Care Program – Adults amount.

Member months for FY 03-04 were calculated utilizing the methodology explained in the Analysis of the Expenditure Allocation across Eligibility Categories and Forecasting member months section above. Based on FY 03-04 expenditures, a capitation payment was paid for 1,124 Member months, or 94 clients (1,165 divided by 12). The monthly capitation rate for Breast and Cervical Cancer Patients eligibility category range from $6.32 to $23.47, and the adjusted expenditures were $8,344. The Department estimates a change for FY 04-05 if this methodology is approved.

The Department expects this funding will be incorporated into the capitation base during the Request for Proposal process for new contracts, effective January 1, 2005. For the FY 05-06 projection, the dollars are included, in capitation, but not separated out into a Breast and Cervical Cancer Patients line. However, the source for Cash Funds Exempt would continue to be the Breast and Cervical Cancer Prevention and Treatment Fund.

The FY 05-06 request for 2,423 member months is $17,842, an increase of 37.04% over the estimate for FY 04-05. Pursuant to HB 04-1416, the funding for the Mental Health Breast and Cervical Cancer Patients for FY 05-06 will be 17.5% General Fund, 17.5% Cash Funds Exempt, and 65% federal funds.

Mental Health Institute Rate Refinance Adjustment (Exhibit EE-Table 1):
This amount is part of the capitation line item, but not part of the capitation rate. The Behavioral Health Organizations purchase beds from mental health institutes, using funding from their capitation appropriations. It was discovered in 2001, that the Behavioral Health Organization payment was not covering the total cost of the institutes' bed cost. These funds are appropriated to refinance (backfill) the Behavioral Health Organizations for the total institute cost of beds they purchase that is not covered by the base capitation rate. The amounts are paid directly by the State to the Mental Health Institutes on behalf of the Behavioral Health Organizations. The Department expects this funding will be incorporated into the capitation base during the Request for Proposal process for new contracts, effective January 1, 2005. For the FY 05-06 projection, the dollars are included, in capitation, but not separated out into a refinance adjustment.

Alternatives to Inpatient Hospitalization and Aftercare Programs:
There are three alternative programs in the Mental Health Community Services Program: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute of Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs is the result of changes in institutional care that resulted in

closure of units (beds) or discontinued institutional services including, but not limited to, physical therapy, behavioral programs, medication administration education, and occupational therapy. This left the clients who required these units or services in need of alternative placement. The Community Mental Health Centers offered to provide the services through managed care at a much lower cost. By contracting with the Behavioral Health Organizations, Community Mental Health Centers provided Medicaid clients the medical attention they needed, provided services no longer subject to the Institutes of Mental Disease exclusion, and saved General Fund by receiving more federal funds. The Department expects this funding will be incorporated into the capitation base during the Request for Proposal process with contracts effective January 1, 2005. For the FY 05-06 projection, the dollars are included in capitation, but separate line items are not requested.

Appropriations

Capitation Appropriation for FY 04-05:

During FY 03-04, SB 03-282 (Tobacco Litigation Settlement Cash Fund) provided one-time funding of $1,000,000. Per the Joint Budget Committee's FY 03-04 Supplemental: Department of Human Services Mental Health and Alcohol and Drug Abuse Division Programs document, dated January 14, 2004 (page 15), $3,695,817 was provided for temporary rate relief for the Behavioral Health Organizations and $3,011,685 for the FY 02-03 overexpenditure restriction. The capitation program has overexpenditure authority and the amount was restricted for use during FY 03-04. Long Bill add-ons within HB 04-1422 approved an incremental increase to the Rate Refinance portion in the amount of $269,619,[23] and an incremental adjustment for the caseload projection for $8,464,603. Each of the aforementioned amounts increased the capitation amount for FY 03-04. The Breast and Cervical Cancer Patients appropriation, for $71,175, was moved to the capitation section through HB 04-1422. Decreases to the capitation base include the subtraction of the FY 01-02 recoupment of $3,775,623[24] and the Forensics Carve-Out of $141,751.[25] The Goebel Lawsuit was also transferred out of the capitation line appropriation to its own line item. The amount of the transfer was $11,655,584.[26] Unlike the Capitation Program appropriations, the lawsuit appropriation was not transferred to the Department through HB 04-1265, and remains the responsibility of the Department of Human Services.

The one-time funding from SB 03-282 of $1,000,000, the FY 03-04 Rate Relief for the Behavioral Health Organizations of $3,695,817, the FY 02-03 over expenditure of $3,011,685, and a FY 04-05 increase in the Forensics Carve Out of $928 were subtracted from the FY 03-04 appropriation to arrive at the FY 04-05 appropriation. Additionally, increases for caseload of $3,857,550, reversal of the FY 01-02 Recoupment and incremental adjustment of $373,742 to the alternatives to hospitalization

[23] Joint Budget Committee's FY 04-05 Figure Setting: Department of Human Services, Mental Health and Alcohol and Drug Abuse Division, page 45.
[24] Joint Budget Committee's FY 04-05 Figure Setting: Department of Human Services, Mental Health and Alcohol and Drug Abuse Division, page 35.
[25] Joint Budget Committee's FY 04-05 Figure Setting: Department of Human Services, Mental Health and Alcohol and Drug Abuse Division, page 35.
[26] Joint Budget Committee's FY 04-05 Figure Setting: Department of Human Services, Mental Health and Alcohol and Drug Abuse Division, page 67.

programs, all added to the FY 04-05 capitation appropriation for a total of $145,739,678. See page 60 of the FY 04-05 Long Bill (HB 04-1422).

Capitation Base Calculation for FY 05-06:

The Budget Request for FY 05-06 is calculated utilizing the estimated FY 05-06 member months multiplied by the sum of the Capitation Base and the Alternative and Aftercare Program rates (Exhibit II, pages 1-8). This methodology is used for each Behavioral Health Organization and summarized in Exhibit HH. Exhibit HH also summarizes FY 02-03 and FY 03-04 actual expenditures, estimated FY 04-05 member months, and estimated expenditures. A reconciliation of FY 03-04, FY 04-05, and FY 05-06 are detailed in Exhibit CC.

Although the Schedule 6 shows the incremental adjustment for the November 1, 2004 Budget Request, the Base Request as shown on the Schedule 3 incorporates changes due to caseload and budgetary annualizations. The true Decision Item request is for the elimination of the two informational line items, a discussion of which follows.

Please see the following tables that reconcile to the FY 05-06 request.

Medicaid Mental Health Capitation Long Bill Section

Legislation	Description	FY 03-04 Appropriation	FY 04-05 Appropriation	FY 04-05 Estimate	FY 05-06 Request
	Base	$144,501,252	$145,441,193	$145,739,678	$149,443,101
SB 03-282 (Tobacco Litigation Settlement Cash Fund – Creation)	Tobacco Settlement (one-time funding)	$1,000,000	($1,000,000)	$0	$0
HB 04-1320 Supplemental	Rate Relief for Behavioral Health Organizations (one-time funding)	$3,695,817	($3,695,817)	$0	$0
HB 04-1320 Supplemental	FY 02-03 Overexpenditure (one-time funding)	$3,011,685	($3,011,685)	$0	$0
HB 04-1320 Supplemental	FY 01-02 Recoupment of Over Payments (one-time funding)	($3,775,623)	$3,775,623	$0	$0
HB 04-1320 Supplemental	**Goebel Lawsuit Separated into Own Appropriation**	($11,655,584)	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Transfer of Breast and Cervical Cancer Patients Line Item	$71,175	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Forensics Carve-Out Adjustments	($141,751)	($928)	$0	$0
FY 04-05 Long Bill HB 04-1422	Adjustment for Institute Rate Refinance	$269,619	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Adjustment for Caseload Projection	$8,464,603	$3,857,550	$0	$0
FY 04-05 Long Bill HB 04-1422	Incremental Increase for Fort Logan Alternative to Hospitalization Program	$0	$355,511	$0	$0
FY 04-05 Long Bill HB 04-1422	Incremental Increase for Pueblo Alternative to Hospitalization Program	$0	$13,272	$0	$0
FY 04-05 Long Bill HB 04-1422	Incremental Increase for Aftercare Alternative to Hospitalization Program	$0	$4,959	$0	$0
	Adjustment for Caseload Projection	$0	$0	$2,856,348	$5,315,940
	Revised Breast and Cervical Cancer Patients Amount	$0	$0	($58,155)	$4,822
	FY 03-04 Overexpenditure	$0	$0	$905,230	($905,230)
	Final Appropriation/Request	$145,441,193[27]	$145,739,678	$149,443,101	$153,858,633

[27]The FY 04-05 Appropriation column, $145,739,678, equals Capitation Base Payments for 376,174 Estimated Medicaid Eligible Clients ($140,624,800), Mental Health Services for Breast and Cervical Cancer Patients ($71,175), Mental Health Institute Rate Refinance Adjustment ($3,097,499), Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo ($852,311), Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan ($783,191), and Alternatives to the Fort Logan Aftercare Program ($310,702). However, the Request incorporates funding of each of these lines into the Capitation Base Payment line item.

Appropriation Funding Splits

	Bill	Total Funds	General Fund	Cash Funds	Federal Funds
FY 03-04	SB 03-258 Long Bill	$144,501,252	$72,250,626	$0	$72,250,626
	SB 03-282 (Tobacco Litigation Settlement Cash Fund – Creation)	$1,000,000	$0	$500,000	$500,000
	HB 04-1320 Supplemental	($8,723,705)	($4,361,852)	$0	($4,361,853)
	Long Bill Add On HB 04-1422	$8,663,646	$4,296,235	$24,911	$4,342,500
FY 03-04	**Final Appropriation**	**$145,441,193**	**$72,185,009**	**$524,911**	**$72,731,273**
	Caseload Adjustment	$3,857,550	$1,928,775	$0	$1,928,775
	Incremental Adjustment for Fort Logan Alternative Program	$355,511	$177,756	$0	$177,755
	Incremental Adjustment for Pueblo Alternative Program	$13,272	$6,636	$0	$6,636
	Incremental Adjustment for Aftercare Program	$4,959	$2,480	$0	$2,479
	Incremental Adjustment for Forensics Carve Out	($928)	($464)	$0	($464)
	Rate Relief Removal	($3,695,817)	($1,847,909)	$0	($1,847,908)
	FY 02-03 Overexpenditure Removal	($3,011,685)	($1,505,843)	$0	($1,505,842)
	FY 01-02 Recoupment Removal	$3,775,623	$1,887,812	$0	$1,887,811
	Removal of SB 03-282 (Tobacco Litigation Cash Transfer)	($1,000,000)	$0	($500,000)	($500,000)
	Reconcile to Long Bill	$0	($1)	$0	$1
FY 04-05	**Final Appropriation (combined lines)**	**$145,739,678**	**$72,834,251**	**$24,911**	**$72,880,516**
	Caseload Adjustment	$2,856,348	$1,428,174	$0	$1,428,174
	Breast and Cervical Cancer Patients Change to Capitated Rate	($58,155)	$0	($20,354)	($37,801)
	FY 03-04 Overexpenditure	$905,230	$452,615	$0	$452,615
FY 04-05	**Estimate**	**$149,443,101**	**$74,715,040**	**$4,557**	**$74,723,504**
	Caseload Adjustment	$5,315,940	$2,657,970	$0	$2,657,970
	Breast and Cervical Cancer Patients Increase Caseload	$4,822	$844	$844	$3,134
	Breast and Cervical Cancer Patients Fund Split Adjustment	$0	$2,278	($2,278)	$0
	FY 03-04 Overexpenditure	($905,230)	($452,615)	$0	($452,615)
FY 05-06	**Request**	**$153,858,633**	**$76,923,517**	**$3,123**	**$76,931,993**

(2) OTHER MEDICAID MENTAL HEALTH PAYMENTS

Mental Health Fee for Service (Exhibit JJ):

The Mental Health Fee for Service Payments appropriation allows Medicaid clients not enrolled in the capitation program to receive mental health services from providers. Providers must be a qualified Medicaid-enrolled provider, including but not limited to, hospitals, psychiatrists, psychologists, and Mental Health Centers. The State will also reimburse the providers through a fee-for-service if either the diagnosis or the procedure is not in the capitation program.

The Mental Health Fee for Service Payments appropriation also includes contracts with community mental health centers to provide case management services to the Home and Community Based Services for the Mentally Ill clients. Since July 1, 2003, the Department has been utilizing contracted Single Entry Point agencies for these services instead of the mental health centers. It was expressed to the Joint Budget Committee on March 9, 2004, via letter, that although the funding for the Single Entry Point agencies is typically in the Medical Services Premiums, the Department was going to continue to pay the agencies from this line item FY 03-04. The Department has prepared a FY 05-06 Change Request that addresses this issue.

During the FY 04-05 Joint Budget Committee Figure Setting for the Department of Human Services Mental Health and Alcohol and Drug Abuse Division, it was determined an FY 03-04 Supplemental would be approved in the amount of $862,784. This amount contained two components: an FY 02-03 overexpenditure of $352,494, and $510,290 associated with an increase in utilization for FY 03-04. Both of these items were treated as one-time adjustments and not included in the base when calculating FY 04-05.[28]

On September 21, 2004, the Joint Budget Committee approved a 1331 Emergency Supplemental for FY 04-05, submitted September 3, 2004. The 1331 Supplemental transfers mental health funding from Department of Human Services' Home and Community Based Services waiver for clients with developmental disabilities to this Department of Health Care Policy and Financing line item. This ensures that State Plan services are funded in a manner approved by the federal Centers of Medicare and Medicaid Services. The funding will no longer be appropriated to the Department of Human Services, but will be appropriated to the Department of Health Care Policy and Financing's Medicaid Mental Health Fee for Service Payments. The Estimate includes three-quarters of FY 04-05, in the amount of $122,496. The Request was annualized to project the FY 05-06 amount of $163,328 ($122,496 ÷ 9 * 3).

With the addition of the 1331 Supplemental discussed above, and a new projected caseload growth amount for FY 04-05 from Exhibit A, under the Medical Services Premium Exhibits, FY 04-05 has been re-estimated. Based on this new information, the Department anticipates an increase of $484,916. This increase is comprised of $12,128 for increased utilization for Mental Health Fee For Service and Community Mental Health Centers ($11,000 and $1,128 respectively, Exhibit JJ, page 2), a Home and Community Based Services for Mental Illness reduction of $82,627 (at Exhibit JJ, page 2), a 1331 Supplemental for FY 04-05 of $122,496 (Exhibit JJ,

[28] Joint Budget Committee's FY 04-05 Figure Setting: Department of Human Services, Mental Health and Alcohol and Drug Abuse Division, pages 52-53.

page 1), and $432,919 to cover FY 03-04 overexpenditure (Exhibit JJ, page 1). The utilization increase is due to the new 7.10% growth rate applied to the mental health fee-for-service and mental health clients not covered in capitation components of the Mental Health Fee for Service Payments line. The adjustment to Home Based Services for Mental Illness Case Management is to adjust to the contracted need of the program.

Medicaid Mental Health Fee for Service Payments History and Request

Legislation	Description	FY 03-04 Appropriation	FY 04-05 Appropriation	FY 04-05 Estimate	FY 05-06 Request
	Base	$2,724,423	$3,587,207	$2,827,380	$3,312,296
FY 04-05 Long Bill, HB 04-1422	Revised FY 03-04, FY 02-03 Overexpenditure (one-time adjustment)	$352,494	($352,494)	$0	$0
FY 04-05 Long Bill, HB 04-1422	Adjustment for Increased Utilization for FY 03-04 (one-time adjustment)	$510,290	($510,290)	$0	$0
FY 04-05 Long Bill, HB 04-1422	Adjustment for Increased Utilization	$0	$102,957	$0	$0
Exhibit JJ	Adjustment for Increased Utilization	$0	$0	$12,128	$0
Joint Budget Committee Hearing, September 21, 2004	1331 Supplemental for FY 04-05 "Transfer of Funds from Department of Human Services for Developmental Disabled Waiver State Plan Services"	$0	$0	$122,496	$40,832
Exhibit JJ	Home and Community Based Services For Mental Illness Adjustment	$0	$0	($82,627)	$0
Exhibit JJ	**FY 03-04 Overexpenditure**	$0	$0	$432,919	($432,919)
Exhibit JJ	Increase Utilization for FY 05-06 Request	$0	$0	$0	$46,192
	Final Appropriation	**$3,587,207[29]**	**$2,827,380**	**$3,312,296**	**$2,966,401**

[29]In the Department of Human Services Medicaid-Funded Programs Long Bill group

Medicaid Mental Health Fee for Service Payments Funding Splits

	Bill	Total Funds	General Fund	Federal Funds
FY 03-04	SB 03-258 Long Bill	$2,724,423	$1,362,212	$1,362,211
	FY 04-05 Long Bill HB 04-1422 (add-on)	$352,494	$176,247	$176,247
	FY 04-05 Long Bill HB 04-1422 (add-on)	$510,290	$255,145	$255,145
FY 03-04	**Final Appropriation**	**$3,587,207**	**$1,793,604**	**$1,793,603**
	Reversal of FY 04-05 Long Bill HB 04-1422 (add-on)	($352,494)	($176,247)	($176,247)
	Reversal of FY 04-05 Long Bill HB 04-1422 (add-on)	($510,290)	($255,145)	($255,145)
	FY 04-05 Long Bill HB 04-1422	$102,957	$51,478	$51,479
FY 04-05	**Final Appropriation**	**$2,827,380**	**$1,413,690**	**$1,413,690**
	Adjustment for Increased Utilization	$12,128	$6,064	$6,064
	1331 Supplemental for FY 04-05 "Transfer of Funds from Department of Human Services for Developmental Disabled Waiver State Plan Services"	$122,496	$61,248	$61,248
	Home and Community Based Services For Mental Illness Adjustment	($82,627)	($41,313)	($41,314)
	FY 03-04 Overexpenditure	$432,919	$216,459	$216,460
FY 04-05	**New Estimate**	**$3,312,296**	**$1,656,148**	**$1,656,148**
	1331 Supplemental for FY 04-05 "Transfer of Funds from Department of Human Services for Developmental Disabled Waiver State Plan Services"	$40,832	$20,416	$20,416
	Adjustment for Increased Utilization	$46,192	$23,096	$23,096
	FY 03-04 Overexpenditure Reversal	($432,919)	($216,459)	($216,460)
FY 05-06	**Estimate**	**$2,966,401**	**$1,483,201**	**$1,483,200**

The FY 05-06 projected amount is based on the FY 04-05 estimated amount (Exhibit JJ), increased by Medicaid Caseload; growth factor of 4.73%. Only the fee-for-service and clients not covered in capitation components are inflated. The Home and Community Based Services for Mental Illness, Case Management is planned to be contracted for $1,780,300. The requested amount for FY 05-06 is $2,966,401 and includes overexpenditure authority for FY 04-05 as well as the anticipated need for FY 05-06 in order to stop the cycle of overexpenditure and requests to compensate for prior-year expenditures paid from the current appropriation.

Mental Health Child Placement Agency:

This line is included in the Other Medicaid Mental Health Payments appropriation section within the Long Bill and is for informational purposes only. The amount reflects collaborations between some counties and Medicaid mental health providers to provide mental health services for children placed through Child Placement Agencies. Based on county and Behavioral Health Organization agreements, some General Fund block grant monies are used to draw down federal Medicaid funding. Participating Behavioral Health Organizations used these monies to provide mental health services to children placed through child placement agencies.

The request for FY 05-06 is provided by the Department of Human Services. Please see that Department's Budget Request in the Child Welfare Services Long Bill line item under the Division of Child Welfare for more information.

The Department requests elimination of this informational line item. The Department believes that the same information could be provided in a footnote or a report. Removing it would eliminate some double-counting of funds in the Long Bill. These funds are not needed in this line in order to complete any administrative activity.

Mental Health Anti-Psychotic Drugs:

This line is included in the Other Medicaid Mental Health Payments appropriation section with the Long Bill and is for informational purposes only. The original funding is in the Medical Services Premiums appropriation of the Department's budget. For calculations of the requested amount, see Calculation of Anti-psychotic Drugs under the Medicaid Services Premiums section (Exhibit C).

The Department requests elimination of this informational line item. The Department believes that the same information could be provided in a footnote or a report. Removing it would eliminate some double-counting of funds in the Long Bill. These funds are not needed in this line in order to complete any administrative activity.

(4) INDIGENT CARE PROGRAM

The Indigent Care Program Long Bill group consists of: the Colorado Indigent Care Program, the Children's Basic Health Plan, and the Comprehensive Primary and Preventive Care Program. These programs are designed to serve Colorado's underinsured and uninsured population. A description of each program, along with budget history and the FY 05-06 funding request amounts, are presented separately in this document, following the same order as in the current Long Bill (HB 04-1422).

Colorado Indigent Care Program Description: The Colorado Indigent Care Program provides direct or indirect funding to hospitals and clinics that have uncompensated costs from treating underinsured or uninsured Coloradoans. It is not an insurance program, nor is it an entitlement program. As of FY 03-04, the program consists of two line items: Safety-Net Provider Payments and The Children's Hospital Clinic Based Indigent Care. Both line items allow providers to receive partial compensation for uncompensated costs associated with services rendered to uninsured or underinsured low-income residents who are not eligible for Medicaid or the Children's Basic Health Plan. Clients can have third party insurance, but this resource must be exhausted before any uncompensated costs can be reimbursed.

Established by the "Reform Act for the Provision of Health Care for the Medically Indigent" in 1983, this program was created as a partial solution to the health care needs of Colorado's indigent citizens. To the extent of available appropriations, the providers serve Colorado residents with income and assets at or below 185% of the federal poverty level ($32,873 for a family of four in 2004). The program directly contracts with hospitals and community health clinics. Providers are statutorily required to prioritize care in the following order: 1) emergency care for the entire year; 2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and 3) any other medical care. Providers are required to provide on-site eligibility and copayment determination. To determine eligibility, providers assign a ranking to clients based on their income and assets. Almost all clients are required to pay a minimal copayment, which varies according to services received and client ranking. Presently, copayments may not exceed 10% of the family's income for any ranking.

The majority of the program is funded with two types of federal funds: Disproportionate Share Hospital funds and Medicare Upper Payment Limit funds. Disproportionate Share Hospital funds are paid to qualifying hospitals that are eligible for federal matching funds at the same Medicaid rate paid for services to Medicaid clients. Upper Payment Limit funds are calculated by estimating the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services. The State uses both General Fund and Cash Funds Exempt to draw down these federal funds. Publicly-owned entities use Cash Funds Exempt to draw down the federal funds. This is accomplished by the certification of public expenditures, which are designated as Cash Funds Exempt. Therefore, public entities receive cash payments from the State consisting entirely of federal funds. Private entities may not certify expenditures, so the State must appropriate General Fund dollars to draw down the federal funds. Any provider who participates in the program is qualified to receive funding from the Disproportionate Share Hospital Allotment and the Medicare Upper Payment Limit. See the line item "Safety-Net Provider Payments" for more detail about funding mechanisms.

However, with the introduction of the federal Balanced Budget Act of 1997, which established declining limits of the amount on federal funds available to states for Disproportionate Share Hospital payments, funding methods required attention. Although these limits were established for each state starting in federal fiscal year (FFY) 1998 based on their previous levels of payments, their impact was not truly felt until FFY 2003. Under this Act, federal fund limits for Colorado were set at the following: FFY 1998: $93 million, FFY 1999: $85 million, FFY 2000: $79 million, and FFY 2001 and beyond: $74 million, with limits adjusted upward by a cost of living factor each year after FFY 2002. However, federal legislation enacted in December 2000 maintained the FFY 2000 allotment of $79 million for FFYs 2001 and 2002 plus increases tied to the Consumer Price Index for all Urban Consumers for those years. The new allotments for FFY 2001 and FFY 2002 were $81,765,000 and $83,890,890, respectively. But beginning in FFY 2003, the Disproportionate Share Hospital Payment limit reverted back to the Balanced Budget Act of 1997 legislation that indicated that Colorado's allotment would regress back to $74 million, plus an inflationary increase. This increase, determined to be 1.5% for FFY 2003, resulted in a final Disproportionate Share Payment Cap of $75,110,000 for that FFY, and if continued, would project the FFY 2004 cap at $76,236,650.

In late 2003, the Medicare Prescription Drug, Improvement, and Modernization Act was passed. Embedded in this legislation was further fiscal relief for disproportionate share hospitals beginning in FFY 2004. From FFY 04-05 to FFY 08-09, the State Disproportionate Share Hospital annual limit is estimated to be $87,127,600 (or 16% growth over the FFY 2003 Disproportionate Share Payment Cap).

As required by HB 04-1438, the Department must make available in the Executive Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. For FY 03-04, this data can be found in Exhibit Q, Page EQ-8 of this document.

PROGRAM ADMINISTRATION

Beginning in FY 03-04, personal services and operating associated with administration for the Colorado Indigent Care Program were transferred to the Personal Services and Operating Expenses line items in the Executive Director's Office. Since this line item is no longer applicable, there is no associated funding request for FY 05-06. Actuals are provided in the Schedule 3 for FY 02-03.

SAFETY-NET PROVIDER PAYMENTS

With primary goals of creating a more simplified system for Department staff and providers to comprehend, and maximizing the amount of federal funds while minimizing General Fund dollars, the Safety-Net Provider Payments line item was added to the Indigent Care Program Long Bill group in SB 03-258, starting in FY 03-04.

Decision Item #6 from the November 1, 2002 Budget Request consolidated the following line items into the new Safety-Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. Under this new

single line item, future Supplemental and Budget Request Amendments relating to the Colorado Indigent Care Program are expected to lessen, since greater amounts of information necessary for rate setting will be available for use before November 1 budget submissions. With this additional efficiency, it is expected that a more simplified payment system will be reached, while coverage for low-income recipients remains unchanged.

Additionally, Decision Item #6 incorporated a new financing methodology into the Safety-Net Provider Payments line item. The Safety-Net Provider Payments line item is composed of three types of payments: Low-Income, High-Volume, and Low-Income Shortfall. A summary of the new financial model is provided in the following matrix.

Payment Type	Public Hospitals	Private Hospitals
Low-Income Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Disproportionate Share Hospital federal funds limit imposed by the federal Centers for Medicare and Medicaid Services. For FY 05-06 this cap is expected to equal $87,127,600. The federal limit is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003.	The State share of payments to public hospitals is Cash Funds Exempt from the certification of uncompensated costs incurred from providing medical services to low income, uninsured, and under-insured Colorado residents. The federal share of payments is from Disproportionate Share Hospital federal funds. Additionally, Bad Debt payments are distributed for hospitals' costs associated with services provided for indigent patients. These funds are contingent upon remaining Disproportionate Share Hospital federal funds available under the limit, and can only be distributed to Denver Health and University hospitals. State funding is from Cash Funds Exempt, with the federal share of payments from Disproportionate Share Hospital federal funds.	The State share of payments to private hospitals is General Fund. The federal share is Disproportionate Share Hospital federal funds subject to the annual limit.
High-Volume Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit remaining for certification of public expenditure.	The State share of payment is Cash Funds Exempt, obtained through certification of public expenditure. Payment calculations for State owned and locally owned public hospitals are performed separately since these provider groups have unique pools of money. However, all State funds receive a federal match.	The State share of payment is General Fund, since privately owned facilities cannot utilize certification of public expenditures. The federal share is from the current federal matching rate for Colorado.
Low-Income Shortfall Payment: Payable to medical facilities that provide payments to a large number of low income, underinsured patients, but they do not participate in the Colorado Indigent Care Program. All funds are subject to Disproportionate Share Hospital annual limit.	The State share of payment is General Fund, and it receives a federal match.	The State share of payment is General Fund, and it receives a federal match.

Under the new financial model, the three separate payment calculations (Low-Income payments, High-Volume payments, and Low-Income Shortfall payments) will be used to determine funding available for reimbursement of costs associated with the treatment of the indigent population. Per federally funded program requirements, monies provided by federal match must be allocated as either Disproportionate Share Hospital funds or Upper Payment Limit funds. Both of these allocation types have limits that restrict the amount of federal match available, and therefore directly affect the amount of General Fund necessary to maintain the program.

Under the Disproportionate Share Hospital payments, the total federal amount available for FY 04-05 and FY 05-06 for the State to utilize is $87,127,600. Payments of this type include Low-Income and Low-Income Shortfall payments, with any additional federal funds available at fiscal year end to be obtained and distributed as Bad Debt reimbursement for providers who treat indigent clients.

The Upper Payment Limit, however, is determined on a hospital-by-hospital basis. Thus, the amount of funds available by federal match for these types of payments is limited to different amounts between providers and is not determined by a set figure for the entire program. Under the new financial model, this includes High-Volume payments.

In May of 2003, the federal government increased the federal share of Medicaid (the Federal Medical Assistance Percentage, FMAP) expenditures by 2.95% for the fourth quarter of FY 02-03 and all of FY 03-04. Only a portion of the Safety-Net Provider Payments line item, the University Hospital Indigent Care Program payments and High Volume Payments transferred to providers as reimbursement for Colorado Indigent Care Program services were eligible for this enhancement. The increased FMAP was budget neutral to the total fund appropriation. This adjustment was automatic with the application of the "M" Provision so an official appropriation was not made. These adjustments are shown in the Schedule 3.

In FY 04-05, the Department requested continuation funding of $255,976,646. The Joint Budget Committee recommended, and the General Assembly approved, a 25% reduction in General Fund for this line item of $3,144,162, or $6,288,324 in total funds. The final appropriation for FY 04-05 was $249,688,322 in total funds, consisting of $9,432,484 in General Fund, $115,400,000 in Cash Funds Exempt, and $124,855,838 in federal funds.

The following table outlines the budget history of appropriated total funds amounts for the Safety-Net Provider Payments line item.

Line Item: Safety-Net Provider Payments	FY 02-03 Previous Line Items	FY 03-04	FY 04-05
Previous Fiscal Year Final Appropriation	$240,417,339	$233,394,277	$255,976,646
Denver Indigent Care Program Line Item	$36,137,947	$0	$0
University Hospital Indigent Care Program Line Item	$28,715,326	$0	$0
Out-state Indigent Care Program Line Item	$23,812,224	$0	$0
Disproportionate Share Payment to Hospitals Line Item	$130,115,868	$0	$0
Pre-Component 1 Disproportionate Share Payments to Hospitals Line Item	$4,771,714	$0	$0
SB 03-203 One-time Payment to the Denver Indigent Care Program	$5,339,798	($5,339,798)	$0
SB 03-203 One-time Payment to the University Hospital Indigent Care Program	$4,501,400	($4,501,400)	$0
FY 03-04 Decision Item #6 – Change in Financing Methodology for the Indigent Care Program	$0	$32,423,567	$0
FY 04-05 Joint Budget Committee Recommended Reduction	$0	$0	($6,288,324)
Final Appropriation / Request	**$233,394,277**	**$255,976,646**	**$249,688,322**

For FY 05-06, the Department is requesting continuation funding of $249,688,322. Please refer to the table below for fund splits.

	FY 05-06 Request
Total Funds	**$249,688,322**
General Fund	$9,432,484
Cash Funds Exempt	$115,400,000
Federal Funds	$124,855,838

THE CHILDREN'S HOSPITAL, CLINIC BASED INDIGENT CARE

The Children's Hospital, Clinic Based Indigent Care line item began in FY 02-03, with a Long Bill appropriation of $6,119,760 (50% federal funds, 50% General Fund), and is comprised of both General Fund and federal funds from the private Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies as a Major Teaching Hospital, however, because the hospital is privately owned, General Fund is required to draw down the matching federal funds. From this appropriation, The Children's Hospital distributes all but $60,000 in total funds to the participating clinics. This $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to the clinics in the program for a given fiscal year is based on a percentage of uncompensated indigent care costs as reported in the Colorado Indigent

Care Program Annual Report, and increased for two years using the Consumer Price Index - All Workers, Denver Medical Costs for July of the most recent year.

This line item was affected by the federal government's temporary increase of the federal share for Medicaid service expenditures. The Federal Medical Assistance Percentage (FMAP) was increased by 2.95% for the fourth quarter of FY 02-03 and all of FY 03-04. These adjustments are shown on the Schedule 3.

Funding for FY 03-04 and FY 04-05 remained at the same total funds of $6,119,760, and fund splits as were originally appropriated.

The Department is requesting continuation funding in FY 05-06 for this line item of $6,119,760, which consists of equal amounts of General Fund and federal funds, or $3,059,880 each.

DENVER INDIGENT CARE PROGRAM

Beginning in FY 03-04, this line item no longer exists, and was replaced by the Safety-Net Provider Payments line item, per Decision Item #6 from the November 1, 2002 Budget Request for FY 03-04. As such, there is no FY 05-06 budget request for funding. The following history is provided for informational support, and describes past budget allowances and fund allocations.

The funding mechanism for this line item, as well as the "University Hospital Indigent Care Program" line item, was Medicaid dollars authorized under the Major Teaching Hospital federal regulations. From FY 94-95 through FY 98-99, the appropriation for this line item was financed by General Fund and federal Medicaid funds and remained unchanged except for adjustments in the funding split due to changes in the federal match rate.

Effective with an FY 99-00 Supplemental appropriation, the methodology for calculating and financing the appropriation was changed significantly. The original calculation methodology was replaced with a calculation based on the Medicare estimated "Upper Payment Limit," the estimated difference between what Medicaid pays for hospital services and what Medicare would have paid. The Medicare Upper Payment Limit amount is the maximum payment allowed for Major Teaching Payments under federal regulations. As a result of this change in methodology, the total payment amount increased substantially. In concert with the payment methodology change, the financing of the State share of the payment replaced General Fund with Cash Funds Exempt based on the certification of public expenditures by Denver Health Medical Center. Using the certification methodology, the hospital received payments for the federal share (currently at a 50% match rate) of their certified public expenditures. The result of these changes was that the net amount of Major Teaching Hospital payments to Denver Health have been increased over pre-FY 98-99 levels and the General Fund cost to the State was eliminated starting in FY 99-00. Major Teaching Hospital payments were additionally increased for FY 02-03 with the approval of a late Supplemental Request on February 3, 2003, addressing calculation errors related to the amount of Upper Payment Limit available for certification. Under this newly calculated limit, $5,339,798 in additional funding

became available through SB 03-258 for the Denver Indigent Care Program, with federal funds matching the $2,669,899 provided by certified public expenditure dollars.

Portions of this line item were affected by the federal government's temporary increase of the federal share for Medicaid service expenditures. The Federal Medical Assistance Percentage (FMAP) was increased by 2.95% for the fourth quarter of FY 02-03. This increase was an internal adjustment between the fund splits and is budget neutral to the total amount of the appropriation. This adjustment is shown in the Schedule 3s.

UNIVERSITY HOSPITAL INDIGENT CARE PROGRAM

Beginning in FY 03-04, this line item no longer exists, and was replaced by the Safety-Net Provider Payments line item, per Decision Item #6 from the FY 03-04 Budget Request, submitted November 1, 2002. As such, there is no request for FY 05-06 funding. The following history is provided for informational support, and describes past budget allowances and fund allocation.

As described in the Denver Indigent Care Program detail above, the funding mechanism for this line item was also Medicaid dollars authorized under the Major Teaching Hospital federal regulations. Similar to the Denver Indigent Care Program, Major Teaching Hospital payments were also increased for the University Hospital Indigent Care Program in FY 02-03 via SB 03-258, and resulted in $4,501,400 in additional funding, with federal funds matching the $2,250,700 provided by certified public expenditures. These contributions for FY 02-03 were also a one-time savings due to calculation adjustments.

Portions of this line item were affected by the federal government's temporary increase of the federal share for Medicaid service expenditures. The Federal Medical Assistance Percentage (FMAP) was increased by 2.95% for the fourth quarter of FY 02-03. This increase was an internal adjustment between the fund splits and is budget neutral to the total amount of the appropriation. This adjustment is shown in the Schedule 3s.

OUT-STATE INDIGENT CARE PROGRAM

Beginning in FY 03-04, this line item no longer exists, and was replaced by the Safety-Net Provider Payments line item, per Decision Item #6 from the FY 03-04 Budget Request. As such, there is no request for FY 05-06 funding. The following history is provided for informational support, and describes past budget allowances and fund allocation.

Formerly the "Specialty and Out-State Programs" line item, this program provided funding to hospitals, located primarily outside the Denver metropolitan area that were enrolled in the Colorado Indigent Care Program, but did not qualify for the ongoing Component 1A Disproportionate Share Hospital adjustment payment program. Funding for this program originated from Medicaid dollars under a Disproportionate Share Hospital adjustment payment approved by the Centers for Medicare and Medicaid Services effective in FY 94-95. No hospital contributions were collected under this program.

The FY 02-03 appropriation was intended to cover 30% of the participants' uncompensated costs for services provided to medically indigent patients. Because the reimbursement level to hospitals participating in the Out-State Indigent Care Program was significantly lower than that provided to the other Colorado Indigent Care Program hospitals qualifying for the Component 1A Disproportionate Share Hospital program, the Department's policy had been to give priority to funding the Out-State Indigent Care Program under the Disproportionate Share Hospital federal funds caps. FY 02-03 Actuals are shown in the Schedule 3s.

Starting in FY 01-02, the General Assembly approved major changes in the reimbursement methodology and financing mechanism for the Out-State Indigent Care Program.

Reimbursement Methodology Changes: The previous reimbursement methodology was to pay the hospitals and clinics participating in the Specialty and Out-State Indigent Care Program a pro-rata share of the appropriation based upon their final actual uncompensated costs of providing services to indigent persons for the appropriation year. The providers received interim payments based on estimates during the course of the year and final payments were adjusted once the uncompensated costs for all the providers were finalized. This was problematic in that final uncompensated costs were not finalized for all providers until six to nine months after the end of the fiscal year and payments to individual providers were affected by the costs incurred by all the other providers. Providers did not know if they would receive an additional payment or would owe money back to the Department until costs were finalized. Because of this uncertainty, this methodology was replaced by a prospective reimbursement methodology based on historical costs. Beginning in FY 01-02, reimbursement to the hospitals in the program for a given fiscal year was based on a percentage of actual uncompensated indigent care costs as reported in the Colorado Indigent Care Program Annual Report for two fiscal years prior and increased for two years using the Consumer Price Index - All Workers, Denver Medical Costs for July of the most recent year. Thus, for FY 02-03, reimbursement was based on a percentage of the uncompensated costs from the FY 00-01 Colorado Indigent Care Program Annual Report increased for two years by the July 2001 Consumer Price Index. The information used to calculate the base for requesting appropriations for this line item was the same as that used for the Component 1A Disproportionate Share Hospital plan funded in the Disproportionate Share Payments to Hospitals line item.

Financing Mechanism Changes: The previous financing mechanism for the Out-State hospital providers used General Fund as the State match for Federal Medicaid funds under a Disproportionate Share Hospital State Plan Amendment. Starting in FY 01-02, the hospitals were separated into two groups, private hospitals and public hospitals. The financing of the State share for the private hospital was General Fund and Disproportionate Share Hospital federal funds. The financing of the State share to match federal funds for the public hospital was Cash Funds Exempt from the certification of public expenditures by public hospitals and, to the extent possible, federal fund revenue was earned by using the Medicare Upper Payment Limit mechanism for inpatient services. Any remaining shortfall in federal fund revenues required to achieve the desired reimbursement rate was from the capped Disproportionate Share Hospital federal funds. Using the Medicare Upper Payment Limit enabled more of the Disproportionate Share Hospital capped federal funds to flow to payments under the other Disproportionate Share Hospital State Plans. The public hospitals were paid the federal share (50%) of the expenditures that were certified. Under the federal match rate of 50%, in order for the private and public

hospitals to receive the same monetary net reimbursement from the State for a portion of their uncompensated medically indigent costs, the rate applied to the public hospitals would have to be double that applied to the private hospitals.

The Upper Payment Limit portions of this line item were affected by the federal government's temporary increase of the federal share for Medicaid service expenditures. The Federal Medical Assistance Percentage (FMAP) was increased by 2.95% for the fourth quarter of FY 02-03. This increase was an internal adjustment between the fund splits and is budget neutral to the total appropriation. This adjustment is shown in the Schedule 3s.

DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS

Beginning in FY 03-04, this line item no longer exists, and was replaced by the Safety-Net Provider Payments line item, per Decision Item #6 from the November 1, 2002 Budget Request. As such, there is no request for FY 05-06 funding. The following history is provided for informational support, and describes past budget allowances and fund allocations.

This line item funded ongoing payments to qualifying hospitals under a Medicaid Disproportionate Share Hospital State Plan Amendment first approved in FY 91-92 known as Component 1A. To qualify, hospitals needed (1) to have been a participant in the Colorado Indigent Care Program; and (2) their Medicaid inpatient days must have been at least one standard deviation above the mean Medicaid days divided by total days for all hospitals that served Medicaid clients. Under federal law (42 CFR § 447.253), these hospitals were deemed Disproportionate Share Hospitals and states were required to provide additional compensation to these providers. Whereas the State was already in compliance with the federal regulations with another Disproportionate Share Hospital allotment, (see narrative for Pre-Component 1 Disproportionate Share Payments to Hospitals), the primary purpose of the Component 1A State Plan Amendment was to refinance and provide additional reimbursement to the qualifying Colorado Indigent Care Program hospitals for a portion of their uncompensated costs incurred to provide medical services to indigent persons.

Reimbursement to the hospitals in the Component 1A Disproportionate Share Hospital program for a given fiscal year was based on a percentage (up to 100%) of actual uncompensated indigent care costs as reported in the Colorado Indigent Care Program Annual Report for two fiscal years prior, increased for two years using the Consumer Price Index - All Workers, Denver Medical Costs for July of the most recent year. Under this financing mechanism, Disproportionate Share Hospital federal funds were matched with General Fund dollars for eligible private hospitals, and Cash Funds Exempt for Colorado's qualifying public hospitals - Denver Health Medical Center and University Hospital.

FY 02-03 Actuals are shown in the Schedule 3s.

PRE-COMPONENT 1 DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS

Beginning in FY 03-04, this line item no longer exists, and was replaced by the Safety-Net Provider Payments line item, per Decision Item #6 from the FY 03-04 Budget Request, submitted November 1, 2002. As such, there is no request for FY 05-06 funding. The following history is provided for informational support, and describes past budget allowances and fund allocation.

This line item was added for FY 00-01 via a Supplemental appropriation in SB 01-212. It funded Disproportionate Share Hospital payments made to hospitals under the State's original (first) Disproportionate Share Hospital allocation. The purpose of this original allocation was to comply with federal regulations (42 CFR 447.253) that required states to pay additional compensation to hospitals providing services to a disproportionate share of Medicaid patients and low-income persons. Hospital providers paid under the State Plan needed to qualify as a Disproportionate Share Hospital under the federal definitions and did not need to participate in the Colorado Indigent Care Program, although most were in both. Payments were made on a sliding scale as an "add-on" percentage to payments for inpatient hospital services provided to Medicaid clients. In addition, Disproportionate Share Hospital payments were made to the qualifying hospitals for inpatient hospital services provided to Medicaid clients enrolled in managed care plans.

Prior to October 1, 1997, disproportionate share payments to hospitals based on services provided to Medicaid clients through a managed care organization were reflected in capitation rates to the health maintenance organizations. Effective October 1, 1997, the federal Centers for Medicare and Medicaid Services required that these payments be made directly to the hospitals. Prior to FY 00-01, funding for this plan was included in the "Medical Services Premiums" Long Bill group and line item, and not shown discreetly. Starting in FY 00-01, this new line item was added to the Indigent Care Program Long Bill group to segregate these payments from other Medicaid payments for services to eligible clients. Given that reimbursement was driven by payments for Medicaid inpatient services, the request for this line item was likely to be affected by changes in Medicaid caseload and inpatient hospital utilization by Medicaid clients. Under the then current Medicaid State Plan provisions related to funding for this line item, hospitals deemed eligible for a Disproportionate Share Payment received a payment adjustment proportional to their level of Medicaid inpatient utilization. A specified percentage increase which was added to Medicaid inpatient hospital payments was based on a scale of the relative proportion of inpatient services rendered to Medicaid clients compared to each qualifying hospital's total inpatient services, as dictated by the existing State Plan. Funding for this line item was General Fund and Federal Medicaid funds, while federal funds were being held subject to the federal Disproportionate Share Hospital allotment caps.

FY 02-03 Actuals are shown in the Schedule 3s.

History and Background Information - HB 97-1304 Children's Basic Health Plan

In 1997, the Children's Basic Health Plan was enacted in Colorado via HB 97-1304. Later that year, Title XXI of the Social Security Act, which created the State Children's Health Insurance Program, was enacted through the Congressional Budget Reconciliation Act of 1997. HB 98-1325 authorized Colorado's participation in Title XXI. Colorado's program finances basic health insurance coverage for uninsured children of families with incomes under 185% of the federal poverty level. Unlike Medicaid, an asset test is not required for establishing eligibility in the Plan. The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be 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. A dental benefit, offered in a capitated managed care environment, was added in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes less than 185% of the federal poverty level. With the exception of pregnant women, families pay a nominal annual enrollment fee, based on family size and income, to participate in the Plan. All State expenditures for benefits are matched with 65% Title XXI federal funds, up to the federal allocation available for each state. Based on a Memorandum of Understanding with the Centers for Medicare and Medicaid Services, Colorado's administrative expenditures are matched differently (as described further on in this document), and may not exceed 10% of total expenditures.

The Children's Basic Health Plan consists of several distinct line items in the Department's Long Bill appropriation. Effective in FY 00-01 via Supplemental Bill SB 01-183, the line items and appropriations were moved from the "Other Medical Services" Long Bill group to the "Indigent Care Program" Long Bill group. In the Long Bill for FY 03-04, the Children's Basic Health Plan Medical Premiums line item (for children) and the Prenatal and Delivery line item created in HB 02-1155 (for pregnant women) were combined into a single Long Bill line item: Children's Basic Health Plan Premium Costs.

In response to a weak economy and budget constraints, actions were taken to curtail growth in program expenditures in FY 02-03 and FY 03-04. During this period, General Fund appropriations to the Children's Basic Health Plan Trust Fund were the lowest they had ever been. These actions are summarized and discussed in detail in the sections that immediately follow. The Children's Basic Health Plan Prenatal and Delivery Program was closed to new enrollment effective from the first week of May 2003, until July 1, 2004. However, a state only program continued to cover those enrolled as of May 5, 2003 through delivery and two months post-partum.

The FY 03-04 appropriated enrollment for children in SB 03-291 was set on the assumption that no new applicants would be admitted into the Plan from November 2003 through June 2004. During this period, enrolled children scheduled for annual redetermination were permitted to renew, provided they chose to do so and met eligibility criteria at that time. Although enrollment for the Children's Basic Health Plan's children and pregnant women programs was limited, reimbursement rates were appropriated at levels recommended by a contracted actuary and requested by the Department.

The enrollment cap for women and children was lifted in July 2004. The appropriations for FY 04-05 reflect both an increase in enrollment for both children and women and adjustments in reimbursement rates to levels recommended by a contracted actuary.

HB 97-1304 CHILDREN'S BASIC HEALTH PLAN TRUST

This line item is for contributions to the Trust. The Trust Fund balance funds the State's share of the other line items for the Plan. By statute, at the end of any given fiscal year, unspent appropriations remain in the Trust rather than revert to the General Fund. Moreover, funds in the Trust that are not appropriated to other lines also earn interest each year. Thus, the appropriations displayed below do not reflect the balance of the fund. Common sources of funding for appropriations to the Trust are General Fund, Cash Funds from the collection of annual enrollment fees from families, and Cash Funds Exempt from the Tobacco Litigation Settlement Trust Fund.

Each year, the Department requests the Cash Funds appropriation for annual enrollment fees in its Change Request for the Children's Basic Health Plan Premium Costs line. The methodology and calculations for that amount are discussed in each year's Change Request.

Prior to the supplemental for FY 01-02 (HB 02-1370), the Trust had been appropriated $8,603,720 in General Fund each year. HB 02-1370 removed all General Fund appropriated through the FY 01-02 Long Bill (SB 01-212). Since that year, General Fund appropriations have not followed a predictable pattern. In FY 02-03, the final General Fund appropriation was $2,598,210, while the General Fund appropriation for FY 03-04 was less than one half of the prior year's appropriation, at $1,143,543. The Long Bill (HB 04-1422) increased the initial FY 04-05 appropriation to $3,296,346.

During FY 01-02, SB 01-164 reduced the annual Cash Funds Exempt appropriation to the Trust from the Tobacco Litigation Settlement Cash Fund from $10 million to $9,800,000. This $200,000 difference was appropriated to the Department of Public Health and Environment to finance the Dental Loan Repayment program created in SB 01-164. The final appropriation to the Trust for FY 01-02 follows:

Final Trust Fund Appropriation for FY 01-02

Bill Reference	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
SB 01-212 Long Bill	$8,603,720	$246,275	$10,000,000	$0	$18,849,995
HB 02-1370 Supplemental Bill	($8,603,720)	$38,970	$0	$0	($8,564,750)
SB 01-164 Dental Loan Repayment Program	$0	$0	($200,000)	$0	($200,000)
Final Appropriation	**$0**	**$285,245**	**$9,800,000**	**$0**	**$10,085,245**

In FY 02-03, HB 02-1155 appropriated an additional $7,700,000 from the Tobacco Litigation Settlement Cash Fund to the Children's Basic Health Plan Trust Fund for the Program's prenatal/delivery expansion. This brought the total Tobacco Litigation Settlement Cash Funds Exempt Appropriation to the Trust Fund to $17,500,000. The final appropriation for FY 02-03 follows:

Final Trust Fund Appropriation for FY 02-03

Bill Reference	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
HB 02-1420 Long Bill	$6,603,720	$336,560	$9,800,000	$0	$16,740,280
HB 02-1155, Establish the Prenatal and Delivery Program	$0	$0	$7,700,000	$0	$7,700,000
SB 03-203, Supplemental Bill	($421,269)	($125,545)	$0	$0	($546,814)
SB 03-258, Long Bill Add-On	($3,584,241)	$0	$0	$0	($3,584,241)
Final Appropriation	**$2,598,210**	**$211,015**	**$17,500,000**	**$0**	**$20,309,225**

SB 03-190 is also of importance. While this bill did not specifically address the *appropriation* to the Trust Fund, it did reduce the Trust's *balance* by $2,001,125 in FY 02-03. The legislation instructed the State Treasurer to deduct this amount from the $17.5 million received in Tobacco Settlement Funds and transfer the stated amount to the State's General Fund. This action was also one-time and did not carry forward in future years.

The FY 03-04 appropriation is presented below, followed by a discussion of the bills.

Trust Fund Appropriation for FY 03-04

Bill Reference	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
SB 03-258 Long Bill	$6,182,451	$220,514	$17,500,000	$0	$23,902,965
SB 03-291, Enrollment Cap	($5,822,908)	$0	$0	$0	($5,822,908)
SB 03-291 and SB 03-101 Savings (see below)	$300,000	$0	$0	$0	$300,000
SB 03-291 and SB 03-107 Savings (see below)	$484,000	$0	$0	$0	$484,000
SB 03-282, Tobacco Reallocation Bill	$0	$0	$1,000,000	$0	$1,000,000
SB 03-019, Audit Tobacco Programs	$0	$0	($23,459)	$0	($23,459)
HB 04-1331, Net Reduction from SB 03-019 (see below)	$0	$0	($15,848)	$0	($15,848)
Final Appropriation	**$1,143,543**	**$220,514**	**$18,460,693**	**$0**	**$19,824,750**

The $1 million Cash Funds Exempt appropriation from the Tobacco Litigation Settlement Cash Fund in SB 03-282 was one-time only in nature. The reduction from SB 03-019 will continue each year, to cover expenses of the State Auditor's Office associated with auditing programs that are funded with the Tobacco Master Settlement monies. Note however, that the amount attributable to SB 03-019 will change slightly each year based on statutory formula. HB 04-1331 (the Supplemental Bill for the Department of Public Health and Environment) increased the SB 03-019 reductions by $15,848 [from ($23,459) to ($39,307)] for the oversight of the tobacco-funded programs. SB 03-107, Concerning the Number of Days Simulcast Facilities may Broadcast Out-Of-State Greyhound Races, generated fiscal savings that were used, in part, in SB 03-291 to offset budget reductions to the Children's Basic Health Plan. SB 03-101, Concerning the Stabilization of Employer Contributions to the Public Employees' Retirement Association, also generated savings that were used in SB 03-291. Although SB 03-101 was vetoed by the Governor, the appropriations clause in SB 03-291 remained intact.

The FY 04-05 Long Bill appropriation includes $3,296,346 in General Fund, which was needed to support increasing caseload in the absence of an enrollment cap, and to adjust reimbursement rates to levels recommended by a contracted actuary. Cash Funds from annual enrollment fees were also updated within HB 04-1422 for caseload projections and revised estimates for collections per client. The FY 04-05 Long Bill Cash Funds Exempt appropriation was $17,476,396. The $1,000,000 appropriated in FY 03-04 through SB 03-282 did not continue in FY 04-05. HB 04-1421 allocated an additional $3,472,958 Cash Funds Exempt from Tobacco Master Settlement funds to the Trust. The final appropriation for FY 04-05 is shown in the following table. However, the most recent projections of Tobacco Settlement funds provided by the Office of State Planning and Budgeting project that the Children's Basic Health Plan Trust Fund allocation will be $20,620,238 in FY 04-05. This is shown in the Estimate column of the Schedule 3 in this November 1, 2004 binder.

Trust Fund FY 04-05 Appropriation

	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
HB 04-1422 Long Bill	$3,296,346	$210,400	$17,476,396	$0	$20,983,142
HB 04-1421 Tobacco Bill	$0	$0	$3,472,958	$0	$3,472,958
FY 04-05 Appropriation	**$3,296,346**	**$210,400**	**$20,949,354**	$0	**$24,456,100**

The Base Request for FY 05-06 is based on assumptions in current law, and assumes no continuation of General Fund because in recent years, the General Fund contribution has not followed a predictable pattern. The General Fund contribution recently has been the minimum necessary to fund the projected expenditures. The FY 05-06 Base Request for the Trust therefore consists of Cash Funds Exempt of $21,283,686 from Tobacco Master Settlement funding and Cash Funds of $210,400 from annual enrollment fees. With these revenues and the Trust Fund's projected FY 04-05 ending balance, there will be sufficient funds available to continue funding the State's share of the base appropriation for the Children's Basic Health Plan Administration, the Children's Basic Health Plan Premium Costs and the Children's Basic Health Plan Dental Benefits Cost line items. However, with no increase in funding to support the projected increase in caseload and the need to adjust rates, enrollment into the Prenatal and Delivery Program would need

to be limited. This is because the federal waiver for the prenatal program prohibits any decrease in children's benefits if adults are being served. The Tobacco Master Settlement funding of $21,283,686 is the latest projection of tobacco revenue provided by the Office of State Planning and Budgeting in August 2004. The annual enrollment fees of $210,400 are carried forward at the FY 04-05 appropriated level.

Trust Fund FY 05-06 Base Request

	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
FY 05-06 Base Request	$0	$210,400	$21,283,686	$0	$21,494,086

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

This line item funds the private contracts for administrative services associated with operation of the Children's Basic Health Plan, also called External Administration. Most administrative services are contracted out to a primary private vendor that provides marketing, enrollment, and customer services to members of the Plan. Auxiliary administrative functions are separately contracted out to various vendors for professional services such as actuarial analysis, claim audit, and quality assurance. The actuarial analysis is used to update capitation rates and project claims incurred but not yet reported. The quality assurance includes collecting Health Plan Employer Data and Information Set (HEDIS) client satisfaction data. The claims audit is necessary to meet the State Auditor's evaluation requirements.

Under federal law, children eligible for Medicaid may not enroll in the Plan. Many of the children who apply for the Children's Basic Health Plan are determined to be Medicaid-eligible. Thus, much of the costs of eligibility processing and enrollment functions provided by the Plan's primary administrative services contractor are attributable to the Medicaid Program. Based on a study that identified the portion of workload generated by Medicaid, the Department and the Centers for Medicare and Medicaid Services have agreed upon a cost allocation methodology for charging costs to the correct program. The following table illustrates Colorado's cost allocation matrix used for determining which federal funds related to administration of the Children's Basic Health Plan are reimbursed by Medicaid (Title XIX) and which are reimbursed by the State's Child Health Insurance Program (Title XXI). The federal match under the Medicaid program is 50%, while the federal match available under Title XXI is 65%. Note that while total federal funds are referenced in appropriation clauses of legislation, the share of Title XXI and Title XIX is not. This split is provided for informational purposes only.

Cost Allocation Plan for Federal Funds

Administrative Function	Title XXI Share of Federal Funds	Title XIX Share of Federal Funds
Marketing and Outreach Component	77.3%	22.7%
Eligibility and Enrollment Component	12.0%	88.0%
Professional Services and Other Administration Component	100.0%	0.0%
Children's Basic Health Plan Prenatal and Delivery Components	100.0%	0.0%

FY 01-02 Appropriation

The Long Bill (SB 01-212) appropriation for FY 01-02 was $5,014,295. HB 01-1331 eliminated the Children's Basic Health Plan Policy Board, reducing the costs of the program by $18,750. Thus, the final appropriation for FY 01-02 was $4,995,545. The State share of the funding for this line is Cash Funds Exempt appropriated from the Children's Basic Health Plan Trust Fund. Federal funds are from Title XXI (State Children's Health Insurance Program) and Title XIX (Medicaid).

FY 01-02 Appropriation for Administration of the Children's Program			
Calculations for Administration of the Children's Program	**Total**	**Title XXI Funds @ 65% Federal Match**	**Title XIX Funds @ 50% Federal Match**
Marketing and Outreach	$1,349,468	$1,043,138	$306,330
Eligibility Determination and Enrollment	$3,024,350	$362,922	$2,661,428
Other Administration	$621,727	$621,727	$0
Total Administration	**$4,995,545**	$2,027,787	$2,967,758
Federal Funds Match	$2,801,940	$1,318,061	$1,483,879
Cash Funds Exempt from Trust Fund	$2,193,605	$709,726	$1,483,879

FY 02-03 Appropriation

The Long Bill appropriation for the Children's (non-Prenatal) administration for FY 02-03 follows:

FY 02-03 Long Bill (HB 02-1420) Appropriation for Administration of the Children's Program			
Calculations for Administration of Children's Program	**Total**	**Title XXI Funds @ 65%**	**Title XIX Funds @ 50%**
Marketing and Outreach	$1,304,359	$1,008,270	$296,089
Eligibility Determination and Enrollment	$3,498,044	$419,765	$3,078,279
Other Administration	$285,000	$285,000	$0
Total Children's Administration	**$5,087,403**	$1,713,035	$3,374,368
Federal Funds Match	$2,800,657	$1,113,473	$1,687,184
Cash Funds Exempt from Trust Fund	$2,286,746	$599,562	$1,687,184

The final appropriation for FY 02-03 is the sum of the Long Bill appropriation for that year (HB 02-1420) and HB 02-1155, which expanded coverage of the Children's Basic Health Plan to pregnant women for prenatal and delivery care and services. The administrative appropriation for HB 02-1155, taken from the fiscal note, is presented below. The federal match for these funds was solely Title XXI.

Prenatal Portion of Administration Line for FY 02-03 and FY 03-04		
Breakdown of HB 02-1155 Administration Appropriation	**FY 02-03**	**FY 03-04**
Evaluation	$100,000	$25,000
Marketing/Development of New Advertising Campaign	$75,000	$0
Eligibility and Enrollment - Systems Modifications	$86,450	$0
Number of Adult Women Enrolling	*2,928*	*3,198*
Marketing and Outreach to Adult Women @$26.95/Enrollee	$78,921	$86,178
Eligibility and Enrollment of Adult Women @$72.28/Enrollee	$211,666	$231,130
Number of Newborn Enrollees	*879*	*959*
Eligibility and Enrollment of Children @$72.28/Enrollee	$63,500	$69,339
Total Prenatal Administration	**$615,536**	**$411,647**
Federal Funds Match	$400,099	$267,569
Cash Funds Exempt from Trust Fund	$215,437	$144,078

Totals may not add due to rounding

The total FY 02-03 appropriation for the Administrative line was:

Final Appropriation for Administration for FY 02-03

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
HB 02-1420 Long Bill	$5,087,403	$0	$0	$2,286,746	$2,800,657
HB 02-1155	$615,536	$0	$0	$215,437	$400,099
Final Appropriation	**$5,702,939**	**$0**	**$0**	**$2,502,183**	**$3,200,756**

FY 03-04 Appropriation

The Long Bill for FY 03-04, SB 03-258, carried forward the Long Bill appropriation for FY 02-03 (HB 02-1420) for the children's program, plus HB 02-1155's appropriation for the prenatal program in FY 03-04, and included a Change Request submitted

November 1, 2002, #DI-3, Request for Children's Basic Health Plan Administrative Contract, for an additional $30,000 to contract with an independent actuary to recommend rates for the Children's dental benefit. The actuary will recommend a rate each year, thus the additional funding for actuary services carries into future years.

Breakdown of SB 03-258 Appropriation

Bill Reference	Total Funds	Cash Funds Exempt	*Title XXI Funds*	*Title XIX Funds*	Total Federal Funds (Sum of Title XIX and XXI Funds)
Base from HB 02-1420	$5,087,403	$2,286,746	*$1,113,473*	*$1,687,184*	$2,800,657
HB 02-1155 (Out-year impact)	$411,647	$144,078	*$267,569*	*$0*	$267,569
November 1, 2002 DI-3 Children's Basic Health Plan Administrative Services Contract	$30,000	$10,500	*$19,500*	*$0*	$19,500
Total Long Bill SB 03-258	**$5,529,050**	**$2,441,324**	*$1,400,542*	*$1,687,184*	**$3,087,726**

SB 03-291, which closed the Children's Basic Health Plan to new applicants in May 2003 for pregnant women and November 2003 for new child enrollees, reduced the administration line accordingly. The final appropriation for FY 03-04 is displayed below.

FY 03-04 Appropriation for Administration

Bill Reference	Total Funds	Cash Funds Exempt	*Title XXI Funds*	*Title XIX Funds*	Total Federal Funds (Sum of Title XIX and XXI Funds)
SB 03-258 Long Bill	$5,529,050	$2,441,324	*$1,400,542*	*$1,687,184*	$3,087,726
SB 03-291, Children's Basic Health Plan Bill	($368,899)	($129,116)	*($239,783)*	*$0*	($239,783)
Total Appropriation	**$5,160,151**	**$2,312,208**	*$1,160,759*	*$1,687,184*	**$2,847,943**

FY 04-05 Appropriation

The FY 04-05 Long Bill (HB 04-1422) appropriation includes $100,500 for limited outreach and client education, but does not include any funding for marketing and advertising. The Long Bill also includes $144,178 to re-open the prenatal program in July 2004. This item is for FY 04-05 only and does not carry into the FY 05-06 Base Request. The source for the items in the table below is the Figure Setting document dated March 9, 2004, page 124.

FY 04-05 Long Bill (HB 04-1422) Appropriation for Administration			
Calculations for Administration of Children's Program	**Total**	**Title XXI Funds @ 65%**	**Title XIX Funds @ 50%**
Outreach and Client Education	$100,500	$77,687	$22,813
Eligibility Determination and Enrollment	$3,638,229	$436,587	$3,201,642
Prenatal Implementation	$144,178	$144,178	$0
Prenatal Operational Costs	$125,478	$125,478	$0
Other Administration	$317,000	$317,000	$0
Total Children's Administration	**$4,325,385**	**$1,100,930**	**$3,224,455**
Federal Funds Match	$2,327,833	$715,605	$1,612,228
Cash Funds Exempt from Trust Fund	$1,997,552	$385,325	$1,612,227

The FY 04-05 appropriation also includes HB 04-1447, which covers children who will no longer be eligible for Medicaid due to the planned implementation of SB 03-176 on January 1, 2005, which eliminates eligibility for legal immigrants. HB 04-1447 increases the FY 04-05 appropriation by $6,455 total funds for one-time administrative costs related to transferring clients from Medicaid for the Children's Basic Health Plan.

FY 04-05 Appropriation for Administration

Bill Reference	**Total Funds**	**Cash Funds Exempt**	*Title XXI Funds*	*Title XIX Funds*	**Total Federal Funds** (Sum of Title XIX and XXI Funds)
HB 04-1422 (Long Bill)	$4,325,385	$1,997,552	*$715,605*	*$1,612,228*	$2,327,833
HB 04-1447	$6,455	$2,260	*$4,195*	*$0*	$4,195
Total Appropriation	**$4,331,840**	**$1,999,812**	*$179,800*	*$1,612,228*	**$2,332,028**

FY 05-06 Request

For FY 05-06, the Department requests continuation funding of the FY 04-05 Long Bill appropriation, but excludes the prenatal implementation costs of $144,178.

FY 05-06 Base Request for Administration

Bill Reference	Total Funds	Cash Funds Exempt	*Title XXI Funds*	*Title XIX Funds*	Total Federal Funds (Sum of Title XIX and XXI Funds)
HB 04-1422 (Long Bill)	$4,325,385	$1,997,552	*$715,605*	*$1,612,228*	$2,327,833
Remove One-Time Funding (Prenatal Implementation)	($144,178)	($50,463)	*($93,715)*	*$0*	($93,715)
Total Request	**$4,181,207**	**$1,947,089**	*$621,890*	*$1,612,228*	**$2,234,118**

CHILDREN'S BASIC HEALTH PLAN PREMIUM COSTS

This line item funds the costs of medical services provided to eligible children enrolled in the Plan, and, beginning in FY 03-04, medical premiums for prenatal and delivery services for pregnant women. The calculations for the premium, presented in footnote each year in the Long Bill, define the legislative intent for the average monthly enrollment in the Plan and a monthly average rate for payment of medical services provided.

The Department establishes annual enrollment projections. Each year the actuary contracted by the Department for the Children's Basic Health Plan recommends a per-member-per-month rate for health maintenance organizations and the self-insured network. The rate noted in footnote of the Long Bill for any year is a "blended" rate based on the ratio of the number of children expected to be enrolled in health maintenance organizations to the number of children in the Plan's self-insured network. The rate includes the expected costs of providing medical benefits to enrollees, as well as medical management services, such as claims management

The State share of the funding for medical premiums is Cash Funds Exempt appropriated from the Children's Basic Health Plan Trust Fund and the federal funds are from Title XXI (State Children's Health Insurance Program). Title XXI provides a 65% match on State funds for medical care. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund as Cash Funds. They are spent in the medical premiums line as Cash Funds Exempt. However, a federal match is not provided on the annual enrollment fees collected from families. Thus, these fees are subtracted from the calculations below when computing the line item funding split.

FY 01-02 Appropriation for Children's Basic Health Plan Medical Premiums

The FY 01-02 Long Bill (SB 01-212) appropriated $35,281,378 for Children's Basic Health Plan Medical Premiums. The Supplemental Bill (HB 02-1370) increased the appropriation to $36,116,890 for adjustments in the rate and caseload. The following table shows illustrates the calculations for the Supplemental Bill.

FY 01-02 Appropriation for Children's Medical Premiums

Calculations for Medical Premiums	FY 01-02 Appropriation including Supplemental (HB 02-1370)
HMO Benefits (per member per month)	**$69.67**
Components of Non-HMO Benefits (per member per month)	
A. Self-Insured Network (non-HMO) Benefits	$57.93
B. Reinsurance	$2.89
C. Medical and Pharmacy Claims Management	$14.75
D. Behavioral Claims and Network Management	$0.93
E. Provider Network Management	$7.82
Total Non-HMO Benefit and Delivery Cost (per member per month)	**$84.32**
Appropriated, Blended Rate (per member per month)	**$73.48**
Average Monthly Enrollment	40,960
Total Medical Premiums	$36,116,890
Less Client Annual Enrollment Fees	$285,245
Subtotal for Federal Funds Match	$35,831,645
Federal Funds Match @ 65%	$23,290,569
35% from Trust Fund (Cash Funds Exempt)	$12,541,076
Plus Client Enrollment Fees	$285,245
Total from Trust Fund (Cash Funds Exempt)	$12,826,321

Source: Joint Budget Committee Figure Setting document for the FY 01-02 Supplemental, January 24, 2002, pp. 12 – 14. Totals do not add due to rounding.

FY 02-03 Appropriation for Children's Medical Premiums

The FY 02-03 appropriation for the Medical Premiums line was the sum of the appropriation from the Long Bill (HB 02-1420) for the "core" (non-prenatal) component of the Plan, the appropriation from HB 02-1155 to cover the medical costs of the infants enrolling in the plan associated with the prenatal/delivery expansion of the program, and appropriations for supplemental funding. Costs for medical care for the pregnant women were appropriated to a new line item, "Children's Basic Health Plan Prenatal and Delivery Costs," in FY 02-03. The Long Bill (HB 02-1420) appropriated $46,404,003 in total funds to cover an average monthly enrollment of 48,398 children at an average monthly rate of $79.90 (see Figure Setting document for the FY 02-03 Long Bill, March 11, 2002, pages 237–238). A Supplemental Bill SB 03-203 increased the average monthly rate to $80.74, which increased the total funds to $46,893,529.

SB 03-203 Supplemental Appropriation for Children's Medical Premiums

Calculations for Medical Premiums	SB 03-203 Supplemental Appropriation for Children's Program
HMO Benefits (per member per month)	**$76.48**
Components of Non-HMO Benefits (per member per month)	
A. Self-Insured Network (Non-HMO) Benefits	$65.35
B. Reinsurance	$3.59
C. Medical Management Services	$22.88
Total Non-HMO Benefit and Delivery Cost (per member per month)*	**$90.69**
Appropriated, Blended Rate (per member per month)	**$80.74**
Average Monthly Enrollment	48,398
Total Medical Premiums Calculated Under SB 03-203	$46,893,529
Total Medical Premiums Appropriated Under HB 02-1420	$46,404,003
Incremental Difference Appropriated in SB 03-203	**$489,526**
Federal Funds	$399,795
Cash Funds Exempt (from Trust Fund)	$89,731

Source: Joint Budget Committee Figure Setting for FY 02-03 Supplemental Recommendation, January 17, 2003, p. 13. Includes rounding.
*The components for the non-HMO rate do not add to $90.69 because the reinsurance and administrative services rates were not in effect for the entire fiscal year. Note that the following functions pertaining to the non-HMO rate are now bid under a single contract for Medical Management Services: Medical and Pharmacy Claims Management; Behavioral Claims and Network Management; and, Provider Network Management.

The appropriation from HB 02-1155, the prenatal/delivery expansion bill, is shown below. Since annual enrollment fees are not charged to families enrolled through the Prenatal and Delivery Program until they renew the following year, the Title XXI match was 65% exactly.

Breakdown of HB 02-1155 Medical Premiums Appropriation	FY 02-03
Number of Newborn Enrollees	879
Number of Member Months of Newborns Enrolling in the Plan	5,710
Medical Premiums per Newborn Enrollees Up to Age 1	$167.78
Total Medical Premiums for Newborn Enrollees	**$958,024**
Federal Funds Match @ 65%	$622,716
35% from Trust Fund (Cash Funds Exempt)	$335,308

Note: The total appropriation for children's caseload was 879 newborns from HB 02-1155 plus the initial 48,398 appropriated under HB 02-1420, for a total average monthly enrollment of 49,277.

SB 03-258, in a Long Bill Add-on, added funding for an additional 763 children.

SB 03-258 Supplemental Appropriation for Children's Medical Premiums

Additional Children's Caseload	763
Appropriated, Blended Rate (per member per month)	$80.74
Total Appropriation	**$739,255**
Federal Funds Match @ 65%	$480,516
35% from Trust Fund (Cash Funds Exempt)	$258,739

Children's Caseload Appropriated for FY 02-03

HB 02-1420 Long Bill	48,398
HB 02-1155 Newborn Enrollees	879
SB 03-258 Long Bill Add-On	763
Total Caseload	**50,040**

In summary, below is the final appropriation for FY 02-03.

Appropriation for Children's Medical Premiums for FY 02-03

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
SB 02-1420 Long Bill	$46,404,003	$0	$0	$16,460,165	$29,943,838
SB 03-203 Supplemental Bill	$489,526	$0	$0	$89,731	$399,795
SB 03-258 Long Bill Add-On	$739,255	$0	$0	$258,739	$480,516
HB 02-1155 New Born Enrollees	$958,024	$0	$0	$335,308	$622,716
Appropriation	**$48,590,808**	**$0**	**$0**	**$17,143,943**	**$31,446,865**

FY 03-04 Appropriation for Medical Premiums

In FY 03-04, the Children's Basic Health Plan Medical Premiums line item (for children) and the Prenatal and Delivery line item created in HB 02-1155 (for pregnant women) were combined into a single Long Bill line item, "Children's Basic Health Plan Premium Costs." The intended appropriation and average monthly enrollment was outlined in an appropriations clause from SB 03-291. The clause set the average medical premium per child at $87.65 per month and assumed an estimated average monthly caseload of 52,965 children.

SB 03-291 Appropriation for Children's Medical Premiums for FY 03-04

Average Monthly Enrollment	52,965
Appropriated Medical Premiums (per member per month)	$87.65
Total (Calculation: 52,965 x $87.65 x 12 months)	$55,708,587

Appropriations Clause from SB 03-291 for Prenatal and Delivery

1	Number of Deliveries	342
2	Delivery Cost	$3,965.00
3	Total Delivery Costs (row 1 x row 2)	$1,356,030
4	Member Months of Women's Medical Care	2,417
5	Cost of Women's Medical Care (per member per month)	$363.00
6	Total Medical Care for Women (row 4 x row 5)	$877,371
7	Total Prenatal Expenditures Estimated (row 3 + row 6)	$2,233,401

A 1331 Supplemental Request entitled "Prevent a Children's Basic Health Plan Enrollment Cap in FY 03-04" was submitted on August 1, 2003 to increase the appropriated caseload for children from 52,965 (set in SB 03-291) to 57,281, and increase the number of deliveries from 342 to 446. However, this request was not approved. So as not to exceed the appropriated caseload, new applicants were not accepted in the program between November 2003 and June 2004. SB 03-282 allocated additional Tobacco settlement funding to the Children's Basic Health Plan, however due to the enrollment cap set in SB 03-291, the additional funding was not needed and could not be used in FY 03-04.

SB 03-107, Concerning the Number of Days Simulcast Facilities may Broadcast Out-Of-State Greyhound Races, generated fiscal savings that were used, in part, in SB 03-291 to offset budget reductions to the Children's Basic Health Plan. SB 03-101, Concerning the Stabilization of Employer Contributions to the Public Employees' Retirement Association, also generated savings that were used in SB 03-291. Although SB 03-101 was vetoed by the Governor, the appropriations clause in SB 03-291 remained intact.

Appropriation for Premium Costs for FY 03-04

Bill Reference	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
SB 03-258 Long Bill	$0	$0	$26,249,622	$48,339,774	$74,589,396
SB 03-291, Children's Basic Health Plan Enrollment Cap Bill	$0	$0	($5,773,344)	($10,312,402)	($16,085,746)
SB 03-291 and SB 03-101 Savings (PERA Bill)	$0	$0	$266,526	$494,977	$761,503
SB 03-291 and SB 03-107 Savings (Greyhound Race Bill)	$0	$0	$429,976	$798,527	$1,228,503
SB 03-282 Tobacco Bill	$0	$0	$886,825	$1,646,961	$2,533,786
Final Appropriation	**$0**	**$0**	**$22,059,605**	**$40,967,837**	**$63,027,442**

FY 04-05 Appropriation for Medical Premiums

The FY 04-05 Long Bill (HB 04-1422) appropriation was set assuming the enrollment cap for pregnant women and children would be lifted in July 2004. The Department submitted a Change Request in the November 3, 2003 Legislative Budget Request (#DI-2) to adjust the caseload for caseload and rate changes. The appropriation for the caseload is footnote 41 of HB 04-1422. The following tables display the assumptions used to set the Long Bill appropriation for the Medical Premiums from Figure Setting, March 9, 2004, page 122.

Calculations for Children's Medical Premiums	FY 04-05 Long Bill (HB 04-1422) Appropriation for Children's Program
HMO Benefits (per member per month)	**$87.29**
Components of Non-HMO Benefits (per member per month)	
A. Self-Insured Network (Non-HMO) Benefits	$73.69
B. Reinsurance	$2.39
C. Medical and Pharmacy Claims Management	$23.32
Total Non-HMO Benefit and Delivery Cost (per member per month)	**$99.40**
Appropriated, Blended Rate (per member per month)	**$90.92**
Average Monthly Enrollment	47,600
Total Medical Premiums	$51,933,503
Federal Funds Match @ 65%	$33,756,777
35% from Trust Fund (Cash Funds Exempt)	$18,176,726

Funding for the Prenatal and Delivery Program was appropriated in the Long Bill (HB 04-1422) using the following calculations.

	Calculations for Prenatal and Delivery	HB 04-1422
1	Number of Deliveries	874
2	Rate per Delivery	$3,965.00
3	Total for Deliveries (row 1 x row 2)	$3,465,410
4	Member Months for Women	9,565
5	Rate per Member Month	$345.30
6	Total for Prenatal / Postpartum Care (row 4 x row 5)	$3,302,795
7	Total for Prenatal and Delivery Program (row 3 + row 6)	$6,768,205
	Federal Funds at 65% match	$4,399,333
	Cash Funds Exempt from the Trust Fund	$2,368,872

The following table adds the Children's Medical Premiums and the Prenatal and Delivery appropriation to get the total Long Bill Appropriation for FY 04-05.

HB 04-1422 Long Bill

	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
Children's Medical Premiums	$0	$0	$18,176,726	$33,756,777	$51,933,503
Prenatal and Delivery Program	$0	$0	$2,368,872	$4,399,333	$6,768,205
Long Bill Appropriation for Children's Basic Health Plan Premium Costs	$0	$0	$20,545,598	$38,156,110	$58,701,708

HB 04-1447 increased the FY 04-05 appropriation to cover an additional 568 legal immigrants who are anticipated to no longer be covered under Medicaid due to the planned implementation of SB 03-176 on January 1, 2005. Using the $90.92 blended rate from the Long Bill, at six months each for 568 children, the FY 04-05 appropriation was increased by $309,855. The FY 04-05 appropriation is displayed in the table below.

Appropriation for Premium Costs for FY 04-05

Bill Reference	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
HB 04-1422 Long Bill	$0	$0	$20,545,598	$38,156,110	$58,701,708
HB 04-1447 (SB 03-176 Children to Children's Basic Health Plan)	$0	$0	$108,449	$201,406	$309,855
Appropriation	**$0**	**$0**	**$20,654,047**	**$38,357,516**	**$59,011,563**

FY 05-06 Base Request for Children's Medical Premiums

The Base Request for FY 05-06 continues the FY 04-05 Long Bill appropriation and annualizes to a full 12 months for the children covered under HB 04-1447. See the Legislative Council fiscal note, April 29, 2004, page 2, regarding the annualization calculation. The fund splits are shown in the table below.

Base Request for Children's Basic Health Plan Premium Costs for FY 05-06

Bill Reference	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Total Funds
HB 04-1422 Long Bill	$0	$0	$20,545,598	$38,156,110	$58,701,708
HB 04-1447 (SB 03-176 Children to Children's Basic Health Plan)	$0	$0	$216,899	$402,812	$619,711
Base Request	**$0**	**$0**	**$20,762,497**	**$38,558,922**	**$59,321,419**

CHILDREN'S BASIC HEALTH PLAN DENTAL BENEFIT COSTS

In FY 01-02, the Department issued a Request for Proposals to provide dental services to all children enrolled in the Children's Basic Health Plan (pregnant women are excluded) at a capitated rate of $10.95 per member per month. This amount assumed a dental benefit cost per eligible of $9.95 per month (derived by dividing Medicaid dental costs by the number of Medicaid clients eligible for dental services) and administrative costs of $1.00 per eligible, per month (see March 15, 2001 Figure Setting, page 263). The Department selected the vendor that offered the most complete dental benefit package, a $500 yearly maximum benefit per client, and a statewide network with several hundred participating dentists and contracts with Essential Community Providers. The rate was increased to $11.31 per member per month in the FY 04-05 Long Bill (HB 04-1422) appropriation, based an actuarial review of historical costs. As is the case with Children's Basic Health Plan Medical Premiums, Title XXI funds provide 65% of the total funding need while the remaining 35% State share is Cash Funds Exempt from the Children's Basic Health Plan Trust Fund.

FY 01-02 Appropriation

The Long Bill (SB 01-212) appropriation for FY 01-02 was set at $4,144,324 for the full year. SB 01-164 increased the total appropriation by $276,838 in anticipation of increased dental services resulting from the implementation of a state loan repayment program for dentist and dental hygienists serving underserved populations. Supplemental Bill (HB 02-1370) reduced the total appropriation to $2,379,008 to remove the impact of SB 01-164 and to address caseload reductions.

	Total Funds	General Fund	Cash Funds Exempt
SB 01-212 Long Bill	$4,144,324	$2,693,811	$1,450,513
SB 01-164 Dental Bill	$276,838	$179,945	$96,893
HB 02-1370 Supplemental	($2,042,154)	($1,327,401)	($714,753)
Total FY 01-02 Appropriation	$2,379,008	$1,546,355	$832,653

The Children's Basic Health plan was not implemented until February of 2002, so the Supplemental Bill (HB 02-1370) reduced the total appropriation to $2,379,008 based on 43,452 children and 5 months of care.

	Calculations for Dental Benefits	FY 01-02 Appropriation
1	5-Month Average Enrollment	43,452
2	Dental Benefit (per member per month)	$10.95
3	Subtotal (row 1 x row 2 rounded up)	$475,802
4	Number of Months Operational	5
5	**Final FY 01-02 Appropriation (row 3 x row 4)**	**$2,379,008**
	Federal Funds Match @ 65%	$1,546,355
	35% from Trust Fund (Cash Funds Exempt)	$832,653

Includes rounding

FY 02-03 Appropriation

The FY 02-03 appropriation was the sum of the Long Bill appropriation for FY 02-03 (HB 02-1420), the appropriation from HB 02-1155 to cover newborns resulting from the Prenatal and Delivery Program, and a supplemental from an add-on to the Long Bill for FY 02-03, SB 03-258. This supplemental also covered increased enrollment.

The tables below illustrate supporting calculations for each of these bills.

	Calculations for Dental Benefit -- Long Bill (HB 02-1420)	**FY 02-03**
1	Average Monthly Enrollment	48,398
2	Cost Per Member Per Month	$10.95
3	Annualized Cost (row 2 x 12 months)	$131.40
4	Total Dental Benefits (row 1 x row 3)	$6,359,497
	Federal Funds @ 65%	$4,133,673
	Cash Funds Exempt from Trust @ 35%	$2,225,824

Note that pregnant women are not eligible for the dental benefit. Thus, the appropriation was based only on the number of infants delivered under this expansion.

	Breakdown of Prenatal (HB 02-1155) Dental Appropriation	**FY 02-03**
1	Number of Newborn Enrollees	879
2	Number of Member Months of Newborns Enrolling in the Plan	5,710
3	Monthly Dental Costs per Newborn Enrollees Up to Age 1	$10.95
4	Total Dental Costs for Newborn Enrollees Up to Age 1 (row 2 x row 3)	$62,525
	Federal Funds @ 65%	$40,641
	Cash Funds Exempt from Trust @ 35%	$21,884

A supplemental for FY 02-03, via a SB 03-258 Long Bill Add-on, increased caseload for the Children's Basic Health Plan by 763 children. The dental benefit appropriation was increased accordingly. Note, however, that the appropriation appeared to have been based on 765 additional children, not the appropriated level of 763.

Breakdown of SB 03-258 Dental Appropriation	FY 02-03
Increased Caseload *Assumed for Calculation Purposes*	765
Monthly Dental Costs Per Enrollee	$10.95
Total Dental Costs for Additional Caseload	$100,521
Federal Funds @ 65%	$65,339
Cash Funds Exempt from Trust @ 35%	$35,182

Appropriation for Dental Benefit Costs for FY 02-03

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
SB 02-1420 Long Bill	$6,359,497	$0	$0	$2,225,824	$4,133,673
HB 02-1155 Newborn Enrollees	$62,525	$0	$0	$21,884	$40,641
SB 03-258 Long Bill Add-On	$100,521	$0	$0	$35,182	$65,339
Appropriation	**$6,522,543**	**$0**	**$0**	**$2,282,890**	**$4,239,653**

FY 03-04 Appropriation

The table below displays the appropriation for the dental benefit in FY 03-04. SB 03-107, Concerning the Number of Days Simulcast Facilities may Broadcast Out-Of-State Greyhound Races, generated fiscal savings that were used, in part, in SB 03-291 to offset budget reductions to the Children's Basic Health Plan. SB 03-101, Concerning the Stabilization of Employer Contributions to the Public Employees' Retirement Association, also generated savings that were used in SB 03-291. Although SB 03-101 was vetoed by the Governor, the appropriations clause in SB 03-291 remained intact. SB 03-282 allocated additional Tobacco Settlement funding to the Children's Basic Health Plan, however due to the enrollment cap set in SB 03-291, the additional funding was not needed and could not be used in FY 03-04.

Appropriation for Dental Benefit for FY 03-04

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
SB 03-258 Long Bill	$6,766,213	$0	$0	$2,368,174	$4,398,039
SB 03-291, Children's Basic Health Plan Bill	$227,289	$0	$0	$79,552	$147,737
SB 03-291 and SB 03-101 Savings (PERA Bill)	$95,134	$0	$0	$33,297	$61,837
SB 03-291 and SB 03-107 Savings (Greyhound Bill)	$153,475	$0	$0	$53,716	$99,759
SB 03-282 Tobacco Bill	$322,806	$0	$0	$112,982	$209,824
Final Appropriation	**$7,564,917**	**$0**	**$0**	**$2,647,721**	**$4,917,196**

FY 04-05 Appropriation

The FY 04-05 Long Bill (HB 04-1422) increased the capitation rate from $10.95 per member per month to $11.31 per member per month based on BAS-4 "Rate Increase for Children's Basic Health Plan" in the Department's January 23, 2004 Legislative Budget Request for Stand Alone Budget Amendments. There are consistently fewer members enrolled in the dental program than in the medical plan, because new members do not receive dental coverage during their pre-HMO enrollment period. For this reason, the caseload used in the FY 04-05 Long Bill dental appropriation was assumed to be 87% of the children's caseload assumed in the Children Basic Health Plan's Premium Costs Long Bill appropriation. The FY 04-05 appropriation is the total of HB 04-1422 (Long Bill) and HB 04-1447, which increased funding to cover 568 additional legal immigrants who are anticipated to no longer be covered under Medicaid due to the planned implementation of SB 03-176 on January 1, 2005. HB 04-1447 increases average monthly caseload by 284, or 568 times 6 months, divided by 12 months.

FY 04-05 Dental Appropriation	HB 04-1422 Long Bill	HB 04-1447	FY 04-05 Appropriation
Average Monthly Caseload	41,412	284	41,696
Monthly Dental Costs Per Enrollee	$11.31	$11.31	$11.31
Total Dental Costs for Additional Caseload	$5,620,437	$38,544	$5,658,981
Federal Funds @ 65%	$3,653,284	$25,053	$3,678,337
Cash Funds Exempt from Trust @ 35%	$1,967,153	$13,491	$1,980,644

FY 05-06 Base Request

The FY 05-06 Base Request is the FY 04-05 Long Bill (HB 04-1422) plus the full 568 children from HB 04-1447.

FY 05-06 Dental Base Request	HB 04-1422 Long Bill	HB 04-1447	FY 05-06 Base Request
Average Monthly Caseload	41,412	568	41,980
Monthly Dental Costs Per Enrollee	$11.31	$11.31	$11.31
Total Dental Costs for Additional Caseload	$5,620,437	$77,089	$5,697,526
Federal Funds @ 65%	$3,653,284	$50,107	$3,703,391
Cash Funds Exempt from Trust @ 35%	$1,967,153	$26,982	$1,994,135

CHILDREN'S BASIC HEALTH PLAN PRENATAL AND DELIVERY COSTS

In October 2002, the Program began serving pregnant women earning up to 185% of the federal poverty level who are not eligible for Medicaid. This expansion was authorized under HB 02-1155. The Plan covers prenatal care and postpartum care for up to 60 days after the birth of the child. These women are not eligible for dental benefits. The pregnant woman is exempt from payment of the annual enrollment fee. Upon birth, the child is automatically enrolled in the Children's Basic Health Plan. Upon redetermination, the family begins paying annual enrollment fees. New enrollment was suspended in May 2003 under SB 03-291, however, women who were enrolled before the cut off date remained in the program through their delivery and postpartum period. The next table displays the final appropriation for FY 02-03. Details follow in the tables below.

Prenatal and Delivery Appropriation for FY 02-03

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
HB 02-1155 Prenatal Bill	$16,425,520	$0	$0	$5,748,932	$10,676,588
SB 03-203 Supplemental Bill	($1,203,627)	$0	$0	($421,629)	($781,998)
SB 03-258 Long Bill Add-On	($10,979,944)	$0	$0	($3,842,980)	($7,136,964)
Final Appropriation	**$4,241,949**	**$0**	**$0**	**$1,484,323**	**$2,757,626**

The following assumptions, taken from the fiscal note for HB 02-1155, were used to set the original appropriation for the program in FY 02-03.

Breakdown of HB 02-1155 Prenatal and Delivery Appropriation	FY 02-03
Number of Adult Women Enrolling	2,928
Global Labor and Delivery Fee Per Woman	$3,964.94
Subtotal Labor and Delivery Fees	$11,611,010
Number of Member Months of Adult Women Enrolling	15,372
Monthly Other Medical Costs Per Woman Enrolling	$313.20
Subtotal Other Medical Costs for Women Enrolling	$4,814,510
Total Prenatal and Delivery Costs for Women Enrolling	$16,425,520
Federal Funds @ 65%	$10,676,588
Cash Funds Exempt from Trust @ 35%	$5,748,932

The above calculations include rounding.

A FY 02-03 Supplemental appropriation, SB 03-203, reduced the appropriation established under HB 02-1155 to account for the delayed start of the program (Joint Budget Committee Supplemental Recommendation, January 17, 2003, pp. 13-14). The fiscal note

had assumed that the program would be operational by July when in fact, it was not operational until October. The following calculation explains the $1,203,627 negative supplemental.

Calculations for SB 03-203 Negative Supplemental

Average Number of Women Enrolled Per Month	1,281
Number of Months Delayed	3
Cost of Medical Care Per Month	$313.20
Total Savings	($1,203,627)

In FY 02-03, another supplemental adjustment was made through a Long Bill add-on (SB 03-258). The following assumptions were used to derive the SB 03-258 negative supplemental.

Calculations for SB 03-258 Negative Supplemental

1	Member Months of Women's Medical Care	5,721
2	Cost of Medical Care Per Month	$413*
3	Total Women's Medical Care Costs (row 1 x row 2)	$2,364,894
4	Number of Newborns	777
5	Delivery Cost	$3,965.00
6	Total Delivery Costs (row 4 x row 5)	$3,080,681
7	Total Prenatal Expenditures Estimated (row 3 + row 6)	$5,445,576
8	Total Appropriated under HB 02-1155	$16,425,520
9	Savings Under SB 03-258 (row 7 - row 8)	($10,979,944)

Note: The above calculations include rounding.
*Estimated expenditures of $213,294 divided by women enrolled in January (516).

In FY 03-04, the Children's Basic Health Plan Medical Premiums line item (for children) and the Prenatal and Delivery line item created in HB 02-1155 (for pregnant women) were combined into a single Long Bill line item, "Children's Basic Health Plan Premium Costs." This line item no longer exists and there is no request for FY 05-06.

STATE ONLY PRENATAL PROGRAM

This line item was created under SB 03-291. While it is part of the Indigent Care Program Long Bill group, it is not associated with the Children's Basic Health Plan.

This temporary program was authorized under SB 03-291 for FY 03-04 only, and funded solely with General Fund. Constraints of the federal demonstration waiver for the Children's Basic Health Plan's Prenatal and Delivery Program prevent the Plan from serving

pregnant women if children's enrollment or benefits are restrained. New enrollment was discontinued in the Children's Basic Health Plan's Prenatal and Delivery Program in May 2003. The program was completely suspended on November 1, 2003, so that a cap on new enrollment for children could be put in place. However, women who were enrolled at that time were permitted to remain covered for their deliveries and prenatal/postpartum care. Thus, from May 2003 through June 2004, the Children's Basic Health Plan's Prenatal and Delivery Program had no new enrollees. While the majority of women had delivered and completed their postpartum care by November, some had not. These remaining women were transferred into the State Only Prenatal Program, which covered their delivery and postpartum care costs. The calculations and initial appropriation for this program follow.

Appropriations Clause from SB 03-291 for State Only Prenatal – 100% General Fund

1	Number of Deliveries	8
2	Delivery Cost	$3,965.00
3	Total Delivery Costs (row 1 x row 2)	$31,720
4	Member Months of Women's Medical Care	33
5	Cost of Women's Medical Care (per member per month)	$363.00
6	Total Medical Care for Women (row 4 x row 5)	$11,980
7	Total Prenatal Estimated Expenditures (row 3 + row 6)	$43,700

The above calculations include rounding

Revised estimated expenditures were addressed in a 1331 Emergency Supplemental submitted to the Joint Budget Committee on August 1, 2003. The request was approved, and the appropriation was increased under HB 04-1320, the Supplemental Bill. Estimates for SB 03-291's fiscal note had assumed that new enrollment in the Children's Basic Health Plan's Prenatal and Delivery Program would cease by mid-April, 2003, but the bill was not signed until the first week in May. Consequently, more women were enrolled in the Children's Basic Health Plan's Prenatal and Delivery Program at the time of November 1 than originally projected, resulting in more women rolling over into the State-Only Prenatal Program in November. The 1331 Emergency Supplemental assumed that 52 deliveries would be covered under this program, when the appropriation from SB 03-291 had assumed 8.

Supplemental Appropriation (HB 04-1320) for State-Only Prenatal Program	
Number of Deliveries	52
Cost Per Delivery	$3,965.00
Total Delivery Costs	$206,180
Number of Prenatal/Postpartum Months	215
Women's Medical Care per member per month	$363.00
Total Prenatal/Postpartum Medical Care	$77,864
Total Prenatal State Only Estimate	$284,044
Additional Funding for State-Only Appropriated in the Emergency Supplemental	**$240,344**

The above calculations include rounding

There was no appropriation in FY 04-05, and there is no request for FY 05-06.

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE FUND

The Comprehensive Primary and Preventive Care Fund line item receives monies from the Tobacco Litigation Settlement Cash Fund as Cash Funds Exempt, then transfers these funds to the Comprehensive Primary and Preventive Care Grant line item to be expended. As a result, final appropriation amounts for the Comprehensive Primary and Preventive Care Fund and the Comprehensive Primary and Preventive Care Grants line items are commensurate. Senate Bill 00-71, Concerning the Use of Monies Received Pursuant to the Tobacco Litigation Settlement, created the Comprehensive Primary and Preventive Care Fund as one of eight funds that receive monies from the Tobacco Litigation Settlement Cash Fund. According to statute 26-4-1007, C.R.S, "Beginning with the 2000-01 fiscal year, and for each fiscal year thereafter, the General Assembly shall appropriate to the fund six percent of the total amount of moneys received by the State pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year; except that the amount so appropriate to the fund shall not exceed six million dollars in any fiscal year." Recent legislation (HB 04-1421) decreased the maximum appropriated funds to three percent of the total monies, not to exceed five million in any fiscal year. Each year the Office of State Planning and Budgeting and the Legislative Council forecast the annual appropriations for each tobacco funded program based on an estimate of the total master settlement payment that the State will receive. The Legislative Council prepares a "Tobacco Trust Fund Balance and Annual Appropriations" report that delineates the funds available for all of the tobacco programs including the Comprehensive Primary and Preventive Care Fund. Each year the forecasted and actual amounts vary depending on the actual master settlement payments that the State receives. When this occurs, the General Assembly adjusts the Department's final appropriation to incorporate the most recent information through the supplemental process. Due to this continual variance between the appropriation and the supplemental adjustment initiated by the Joint Budget Committee, the chronological fiscal year final appropriations do not reconcile. The following table shows the Long Bill appropriation, as well as those adjustments resulting from legislation, for the past four fiscal years.

Appropriation History for Comprehensive Primary and Preventive Care Fund					
	FY 01-02	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06 Request**
HB 02-1370 Supplemental Bill	$5,156,532	$0	$0	$0	$0
Long Bill Appropriation	$0	$5,939,047	$5,939,047	$5,239,789	$0
SB 03-190 Tobacco Reallocation	$0	($679,130)	$0	$0	$0
SB 03-019 Allocation of State Auditor's Fees	$0	$0	($7,942)	$0	$0
SB 03-282 Tobacco Reallocation	$0	$0	($508,494)	$0	$0
HB 04-1331 Department of Public Health and Environment Supplemental Appropriation	$0	$0	($3,566)	$0	$0
HB 04-1421 Tobacco Reallocation	$0	$0	$0	($2,621,120)	$0
TOTAL COMPREHENSIVE PRIMARY AND PREVENTIVE CARE FUND	**$5,156,532**	**$5,259,917**	**$5,419,045**	**$2,618,669**	**$2,660,461**

Although the Comprehensive Primary and Preventive Care Fund was authorized through SB 00-71, there was no appropriation for FY 00-01. During that fiscal year, the Comprehensive Primary and Preventive Care Grants Program was appropriated directly from the Tobacco Litigation Settlement Fund. In FY 01-02, when the Comprehensive Primary and Preventive Care Fund was established, the final appropriation to the Comprehensive Primary and Preventive Care Fund was $5,156,532.

In FY 02-03, the Long Bill appropriation (HB 02-1420) was $5,939,047. The General Assembly determined that the FY 02-03 budget would be constrained by revenue shortfalls. To help balance the budget, SB 03-190, which reallocated monies from the Tobacco Litigation Settlement Cash Fund to augment the General Fund, became law. Several cash funds were diminished to allow more money to be transmitted to the General Fund, one of which was the Comprehensive Primary and Preventive Care Fund, and by extension, the Comprehensive Primary and Preventive Care Grants Program. The FY 02-03 appropriation was reduced by $679,130 to $5,259,917. $201,934 was also reverted that year, due to two reasons. First, grantees failed to meet all of the contracted deliverables, and secondly, due to the uncertainty of the amount of tobacco funds each year, grants are not made equal to the total appropriation.

Similarly, the FY 03-04 budget was constrained by revenue shortfalls and further legislation was enacted to supplement the General Fund. For FY 03-04, the Long Bill appropriation (HB 03-258) was $5,939,047. Senate bills 03-019 and 03-282 both reduced the appropriation for the Comprehensive Primary and Preventive Fund line item. SB 03-019 revised the mechanism in which the State Auditor's Office is remunerated for auditing the tobacco settlement programs. The methodology was changed from a fixed proportion of the total amount received by each program to 10% of the total amount of monies received by the State pursuant to the master settlement agreement. This amount, appropriated to the State Auditor's Office, comes from a proportional reduction in the annual appropriation amounts of each tobacco settlement program scheduled to be audited. For FY 03-04, the first year the bill took affect, the total auditor's fees for all programs was $98,743, of which $7,942 came from the Comprehensive Primary and Preventive Care Fund. SB 03-282 was comparable to SB 03-190 in that it reallocated the Tobacco Litigation Settlement Cash Funds to augment the General Fund, but in FY 03-04, rather than FY 02-03. The Comprehensive Primary and Preventive Care Fund was reduced by $508,494 to reflect the impact of SB 03-282. In addition, HB 04-1331, the Department of Public Health and Environment's Supplemental Bill reduced the final FY 03-04 appropriation by $3,566 to $5,419,045. The Department of Public Health and Environment is statutorily authorized to provide oversight to all tobacco-funded programs.

For FY 04-05, the Long Bill appropriation (HB 04-1422) was $5,239,789. Budgetary constraints led to the passage of HB 04-1421, which reallocated the funds in the Tobacco Litigation Settlement Cash Fund to allow for additional General Fund alleviation. This resulted in an appropriation of 3% of the total Tobacco Master Settlement monies, not to exceed $5 million in any fiscal year thereafter. The FY 04-05 appropriation was reduced to $2,618,669. As denoted on the Schedule 3, the FY 04-05 estimate is $2,577,530. This estimate was provided by the Office of State Planning and Budgeting in June 2004, and differs from the appropriation because of variance between the projected and actual Tobacco Settlement payments received.

The FY 05-06 estimate of the Tobacco Litigation Settlement Fund allocation for the Comprehensive Primary and Preventive Fund was provided by the Office of State Planning and Budgeting in June 2004. The initial estimate for the Comprehensive Primary and Preventive Care Fund is $2,660,461, which includes reductions for audit and Department of Public Health and Environment services. Therefore, the Department's request for FY 05-06 is $2,660,461, all Cash Funds Exempt.

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANTS PROGRAM

The Comprehensive Primary and Preventive Care Grants Program derives its funds from the Comprehensive Primary and Preventive Care Fund as Cash Funds Exempt and disperses these funds to providers through a grant process. The Comprehensive Primary and Preventive Care Grants Program is authorized by the addition of Part 10 to the Medical Assistance Act, 26-4-1001 through 26-4-1007, C.R.S. The concept of the program was to bestow grants to health care providers to expand primary, preventive health care services to low income, uninsured residents of Colorado. The program receives transmitted funds from the Comprehensive Primary and Preventive Care Fund (see the Comprehensive Primary and Preventive Care Fund above for the funding mechanism), which receives its funding from the Tobacco Litigation Settlement Fund.

The Comprehensive Primary and Preventive Care Grants Program was created to expand health care services to Colorado's uninsured or medically indigent populations at or below 200% of the federal poverty level (or $37,700 for a family of four in 2004). The enabling legislation (SB 00-71) specifies that the program should not supplant or expand State Medicaid, the Children's Basic Health Plan, or the Colorado Indigent Care Program.

Grants are awarded through an application process, with input from an Advisory Council appointed by the Executive Director of the Department of Health Care Policy and Financing. The Department can spend up to 1% of the funding for administration purposes. Grants are awarded to providers who use the funds to:

- Increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by qualified providers;
- Create new services or augment existing services provided to uninsured or medically indigent patients; or,
- Establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.

The majority of grant money has been spent on expanding clinics and increasing the availability of primary care services for the uninsured or medically indigent by hiring additional staff and purchasing equipment and supplies. Other projects include establishing a drug subsidy program, creating a diabetic program, increasing the availability of pharmaceuticals for indigent patients, and opening new facilities to provide dental services. Applicants can request grant funding for one to three years depending on available funding.

The following table shows the grant award history for the Comprehensive Primary and Preventive Care Grants Program.

Grant Award History for the Comprehensive Primary and Preventive Grants Program				
	FY 02-03	**FY 03-04**	**FY 04-05**	**FY 05-06**
Total Number of Grants Awarded	18	21	15	
Total Number of Providers	14	14	9	
Type of Grants				
Medical Services Grants	8	9	7	
Dental Services Grants	1	3	2	
Construction Grants	5	5	0	
Construction and Medical Services Grants	1	1	1	
Construction and Dental Services Grants	2	2	2	
Construction, Medical, and Dental Services Grants	1	1	1	
Construction and Mental Health Services Grants	0	0	1	
Medical and Mental Health Services Grants	0	0	1	
Multi-year Grants	$2,166,498 for FY 03-04 $1,190,170 for FY 04-05	$150,000 for FY 04-05 $100,000 for FY 05-06	$397,096 for FY 05-06 $298,842 for FY 06-07	
Total Multiple Year Grant Awarded Prior to Start of Fiscal Year	N/A	$2,166,498	$1,340,170	$497,096
Number of Medical Patients Served	12,607	15,400	4,648	
Number of Medical Visits	33,094	28,897	14,906	
Number of Dental Patients Served	3,000	5,500	2,500	
Number of Dental Visits	8,369	7,400	5,280	

In FY 02-03, 18 grants were awarded to 14 unique providers. These grants included eight medical service grants, one dental service grant, five construction grants, and four grants with combination purposes. Multiple year grants were awarded in FY 02-03 that reserved $2,166,498 in funding for projects that would be completed in FY 03-04 and $1,190,170 for projects that would be completed in FY 04-05. Consequently, the amount of funding available for new grants in FY 03-04 and FY 04-05 was reduced by those amounts. Medical and dental services were provided to 12,607 and 3,000 patients respectively.

In FY 03-04, the number of grants increased to 21 even though the number of unique providers was static from FY 02-03. Multiple year grants were awarded in FY 03-04 that reserved funding for $150,000 to projects that would be completed in FY 04-05 and $100,000 to projects that would be completed in FY 05-06. Consequently, the amount of funding available for new grants in FY 04-

05 was reduced by $1,340,170 ($1,190,170 from FY 02-03 contracts plus $150,000 from FY 03-04 contracts). Medical and dental services were provided to approximately 9,443 and 3,040 patients respectively.

In FY 04-05, 15 grants were awarded to nine unique providers. Multiple year grants were awarded in FY 04-05 that reserved $397,096 in funding for projects that would be completed in FY 05-06 and $298,842 for projects that would be completed in FY 06-07. Consequently, the amount of funding available for new grants in FY 05-06 was reduced by $497,096 ($100,000 from FY 03-04 contracts plus $397,096 from FY 04-05 contracts). Medical and dental services will be provided to an estimated 4,648 and 2,500 patients respectively.

The following table illustrates the funding history of the Comprehensive Primary and Preventive Care Grants Program. As summarized above, the funding was originally appropriated directly to the Comprehensive Primary and Preventive Care Grants Program in SB 00-71 in FY 00-01, and then through the Comprehensive Primary and Preventive Care Fund in the Long Bill each year thereafter. Due to the continual variance between the appropriation and the supplemental adjustment initiated by the Joint Budget Committee for the Tobacco Litigation Settlement Funds, the chronological fiscal year final appropriations do not reconcile.

Appropriation History for Comprehensive Primary and Preventive Grants Program					
	FY 01-02	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06 Request**
Long Bill Appropriation	$5,191,389	$5,939,047	$5,939,047	$5,239,789	$0
HB 02-1370 Supplemental Appropriation	($34,857)	$0	$0	$0	$0
SB 03-190 Tobacco Reallocation	$0	($679,130)	$0	$0	$0
SB 03-019 Allocation for State Auditor's Fees	$0	$0	($7,942)	$0	$0
SB 03-282 Tobacco Reallocation	$0	$0	($508,494)	$0	$0
HB 04-1331 Department of Public Health and Environment Supplemental	$0	$0	($3,566)	$0	$0
HB 04-1421 Tobacco Reallocation	$0	$0	$0	($2,621,120)	$0
Total for Comprehensive Primary and Preventive Care Grants Program	**$5,156,532**	**$5,259,917**	**$5,419,045**	**$2,618,669**	**$2,660,461**

ESSENTIAL COMMUNITY PROVIDERS GRANTS PROGRAM

The purpose of this line item was to award grants to providers deemed Essential Community Providers in order to help maintain access to care for uninsured low-income Colorado residents. Direct financial support was given to those providers who provided health care services to these individuals. Created by SB 97-05, the grants were used in a variety of ways to meet the intent of the legislation. Essential community providers used grant funds to implement efficient and cost effective access to services including enhancement of administrative systems, marketing efforts aimed at managed care organizations, and infrastructure and expansion

efforts. In FY 02-03, the Long Bill (HB 02-1420) appropriated $114,051 to the Essential Community Providers Grants Program, equivalent to that of the FY 01-02 appropriation. The funding source for this line item was 100% General Fund. During the 2002 legislative session, HB 02-1292 repealed the Essential Community Provider Grants Program, thus eliminating the Long Bill line item and the subsequent General Fund appropriation. The Schedule 3 shows FY 02-03 Actuals. There is no FY 05-06 request.

(5) OTHER MEDICAL SERVICES

OLD AGE PENSION STATE MEDICAL PROGRAM

The Old Age Pension State Medical Program Long Bill line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical care for non-Medicaid individuals receiving Old Age Pension grants. Eligible recipients for program benefits are over the age of sixty, but do not meet the Supplemental Security Income criteria, and are therefore ineligible for Medicaid. This population could be disabled to some degree, but not sufficiently enough to qualify for Supplemental Security Income. This Program is funded through the $10 million Old Age Pension Health and Medical Care Fund established in the State's constitution and Colorado Revised Statutes (article 24 of the Colorado Constitution and 26-2-117 (2), C.R.S.). In FY 02-03, HB 02-1276 created an additional fund in the amount of $1,000,000 (the Supplemental Old Age Pension Health and Medical Fund), however the funding was reduced to $750,000 in FY 03-04 via SB 03-299. Joint Budget Committee action during FY 04-05 Figure Setting,[30] combined the two funding sources into a single line item for FY 04-05 for a total of $10,750,000. This program is 100% State-funded program and is not an entitlement. Thus, the authorized cap of $10,750,000 per year (including the Supplemental Program) cannot be exceeded.

History of Program[31]

The Old Age Pension was established in 1936 by an amendment to the State constitution, creating article XXIV. This article was later amended in 1956 to add the Health and Medical Care Program and Fund in section 7 of the article. The Old Age Pension benefits specified in article XXIV of the State constitution require that a health and medical program be provided to anyone who qualifies to receive an Old Age Pension cash payment and who is not a patient in an institution for tuberculosis or mental disease. Certain sources of General Fund, primarily excise taxes, must be earmarked to cover the costs of the Old Age Pension benefits. As stated above, the amount of the revenue deposited in the Old Age Pension Health and Medical Care Fund is $10,750,000. Via SB 03-022, effective July 1, 2003, the Department of Health Care Policy and Financing received statutory authority to administer the Old Age Pension Health and Medical Care Program, the Old Age Pension Health and Medical Care Fund, the Supplemental Old Age Pension Health and Medical Care Program, and the Supplemental Old Age Pension Health and Medical Care Fund. The Department of Human Services continues to have the statutory authority to administer the Old Age Pensions, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund. In these budget documents, the Old Age Pension Health and Medical Care Program is referred to as the "Old Age Pension State Medical Program," in line with the FY 04-05 Long Bill, HB 04-1422.

[30] Page 139 Figure Setting March 9, 2004

[31] Source of this paragraph is the Office of Legislative Legal Services, February 7, 2003, in a letter to Senator Steve Johnson.

History of Program Administration

Prior to FY 02-03, the appropriation for the Old Age Pension State Medical Program had been made directly from the Old Age Pension Health and Medical Care Fund to the Department of Health Care Policy and Financing, which at that time also handled program administration. Upon assessment of the situation, the departments of Health Care Policy and Financing and Human Services realized that this was in conflict with current statute. Effective January 4, 2002 programmatic authority, including responsibility for managing, monitoring, and forecasting for this appropriation was transferred to the Department of Human Services. Via General Assembly action effective July 1, 2002, all Old Age Pension funds were consolidated in an appropriation to the Department of Human Services. However, both the amounts for administration and for services were still "transferred" as Cash Funds Exempt to Health Care Policy and Financing. This is documented in letternote "a" on page 60 of HB 02-1420 (FY 02-03 Long Bill).

In FY 02-03, under an Interagency Agreement, Health Care Policy and Financing's responsibilities with regard to this appropriation were changed to process claims, produce Medicaid Authorization Cards for the affected population, and provide data that could assist the Department of Human Services to calculate projections for the program. At that time, the Department of Human Services transferred funding to Health Care Policy and Financing for various administrative costs ($146,867), with the remaining funding ($9,853,133) transferred to the Department's Medical Services Premiums line item as Cash Funds Exempt for payment of claims. This transfer of funds to the Medical Services Premiums line item group was not necessary for the payment of claims, but did allow the dollars to be tracked in the Health Care Policy and Financing budget. However, the presence of the state only program in the Medical Services Premiums created some confusion since it is not a Medicaid program. SB 03-022 transferred the Old Age Pension State Medical Program, created in section 26-2-117 (2), C.R.S. (2004) from the Department of Human Services to the Department of Health Care Policy and Financing effective July 1, 2003.

The "Other Medical Services" Long Bill group is more suitable than the Medical Services Premiums for three main reasons: 1) this is a non-Medicaid program; 2) this program is not subject to overexpenditure authority; and, 3) this program is not affected by the cash accounting changes authorized in SB 03-196. SB 02-299 transferred this program to the Long Bill group "Medical Services Premiums." Starting in FY 03-04, this line item resides in the "Other Medical Services" Long Bill group.

The growing demand for health care services by this client population almost caused the program to exceed its $10,750,000 million cap four times in the last five years. Reduction actions were necessary when expenditures under the Old Age Pension State Medical Program were expected to exceed the available spending authority. The following actions have been taken since FY 99-00 to contain costs for the program:

- Effective October 1, 1999, inpatient hospital rates for all hospitals statewide were reduced to 80% of the Medicaid rate.
- Effective January 1, 2002, medical backdating was permanently eliminated.

- Effective February 1, 2002, inpatient hospital coverage and emergency medical transportation services were eliminated for the remainder of FY 01-02.
- Effective February 1, 2002, all provider payments, such as payments for practitioners and outpatient services, were reduced to 80% of the Medicaid rate and the maximum client copayment was increased from $100 to $300 per year.
- Effective July 1, 2002, most providers of the Old Age Pension State Medical Program were reimbursed at 82% of the Medicaid rate. The exceptions were pharmacists paid at the Medicaid reimbursement rate and inpatient hospitals were reimbursed at 68% of the Medicaid rate.
- Effective August 30, 2002, the health maintenance organizations discontinued Old Age Pension State Medical Program clients after the Department of Human Services advised them the rates in FY 02-03 would have to be 18% lower than the FY 01-02 rates.
- Effective August 30, 2002, clients were no longer able to enroll in managed care options, including the Primary Care Physician Program.
- Effective January 1, 2004 inpatient hospital services were suspended. In addition, all provider reimbursement rates for outpatient hospital, outpatient clinic, practitioner/physician, emergency dental, laboratory, medical supply, home health, and transportation services decreased from 82% of the Medicaid rate to 50%. Pharmacists were paid at the Medicaid reimbursement rate.
- Effective, October 15, 2004, the reimbursement rate for physician and practitioner services; emergency transportation services; medical supply services; hospice services; and home services and supplies were restored to 82% of the Medicaid rate. In addition, the inpatient hospital benefit was restored only at those hospitals that participate in the Colorado Indigent Care Program. Inpatient services to the clients covered under the Old Age Pension Health and Medical Care Program are limited to those inpatient services available under the Colorado Indigent Care Program. The reimbursement for inpatient benefits was set at 10% of the Medicaid reimbursement rate.

Administrative Costs Affecting this Line Item

The appropriation has also been affected by changes in the way that administrative costs have been handled for the Program. Medical provider claims for serving Old Age Pension State Medical Program clients have historically been processed through the Medicaid Management Information System. To cover the processing costs, a Cash Funds Exempt appropriation was made to the Medicaid Management Information System line item, after reducing the Old Age Pension State Medical Program line item by the same amount. The Cash Funds Exempt amount was $146,867 historically and has remained at that amount for several years. Over the past five fiscal years, however, this amount has been more than was needed for processing fees. In FY 02-03, the Department of Human Services submitted a Supplemental Request[32] to refinance administrative costs to allow more of the $10,750,000 to be used for medical services, instead of funding claims processing by the Medicaid Management Information System, as was originally

[32]As cited in the Joint Budget Committee Staff's Supplemental Document for the Department of Human Services, January 15, 2003, page 10. The corresponding change in Health Care Policy and Financing was NP-S5 "Refinancing Administrative Costs of the Old Age Pension Health Care Program."

appropriated. Effective July 1, 2003, via SB 03-258, this cost was funded directly from the Old Age Pension Fund, and does not result in a corresponding reduction to the Old Age Pension State Medical Program.

Another administrative cost that involves these clients is Medicaid Authorization/Identification Cards. These cards have been provided to Old Age Pension State Medical Program clients so medical providers can check identification and eligibility of the clients to ensure payment by the State. No Cash Funds Exempt were appropriated in years prior to FY 03-04 to cover the costs of providing the cards to the Old Age Pension State Medical Program clients. However, beginning with FY 03-04, $10,656 was requested, and was appropriated from the Old Age Pension State Medical Program. The FY 04-05 Long Bill (HB 04-1422) reduced the appropriation for this administrative cost to $1,517 due to the efficiencies achieved with the new plastic cards. The FY 05-06 base request assumes a continuation of funding of $1,517 for this administrative cost.

See Table 1 below for a history of administrative costs funded through the Old Age Pension Health and Medical Care Fund.

Table 1
Old Age Pension State Medical Program Reductions for Administration Costs

	Medical Management Information System		Medical Identification Cards	
Fiscal Year	**Appropriation**	**Expenditure**	**Appropriation/Request**	**Expenditure**
FY 98-99	$146,867	$104,569	$0	$0
FY 99-00	$146,867	$75,021	$0	$0
FY 00-01	$146,867	$69,248	$0	$0
FY 01-02	$146,867	$87,692	$0	$0
FY 02-03	$146,867	$86,857	$0	$0
FY 03-04	$0	$0	$10,656	$3,825
FY 04-05	$0	$0	$1,517	N/A
FY 05-06	$0	$0	$1,517	N/A

Caseload History

Table 2 delineates the caseload history for this program since FY 90-91. The average increase in caseload was 6.46% per year between FY 99-00 and FY 03-04. A base caseload was projected for FY 04-05 using the 6.46% growth rate. However, special legislation was passed in SB 03-176 that is expected to increase caseload even further. SB 03-176 repealed the Medicaid eligibility for legal immigrants who were an optional population under federal law. The FY 04-05 Long Bill assumed a January 2005 implementation of SB 03-176, and that 464 legal immigrants would drop off Medicaid at that time. The base caseload was adjusted for this program to include these legal immigrants to arrive at the total caseload projection of 4,768 for FY 04-05 and 5,293 for FY 05-

06. The FY 04-05 Long Bill caseload of 3,979 was estimated in a similar manner in the Assumptions and Calculations section of the November 1, 2003 Legislative Budget Request. The revised projection presented below is higher due to caseload growing faster than initial projections and the adjustment for the legal immigrants discussed above.

Table 2
Old Age Pension State Medical Program Caseload History and Projection

		Percent Change	Base Caseload	Legal Immigrants	Total Caseload	Percent Change	Source
FY 90-91	Actual		3,586		3,586		February 14, 2003 Budget Request, Exhibit B, "Caseload History and Projections with Rates of Change"
FY 91-92	Actual	-1.28%	3,540		3,540	-1.28%	
FY 92-93	Actual	-2.66%	3,446		3,446	-2.66%	
FY 93-94	Actual	-12.62%	3,011		3,011	-12.62%	
FY 94-95	Actual	1.49%	3,056		3,056	1.49%	
FY 95-96	Actual	3.08%	3,150		3,150	3.08%	
FY 96-97	Actual	0.06%	3,152		3,152	0.06%	
FY 97-98	Actual	2.00%	3,215		3,215	2.00%	
FY 98-99	Actual	-2.02%	3,150		3,150	-2.02%	
FY 99-00	Actual	-2.67%	3,066		3,066	-2.67%	Source is Business Object America queries ran on 7/1/04
FY 00-01	Actual	4.76%	3,212		3,212	4.76%	
FY 01-02	Actual	17.75%	3,782		3,782	17.75%	
FY 02-03	Estimated*	1.77%	3,849		3,849	1.77%	
FY 03-04	Estimated*	10.70%	4,261		4,261	10.70%	
FY 04-05	Forecast	6.46%	4,536	232	4,768	11.92%	Forecast in August 2004
FY 05-06	Forecast	6.46%	4,829	464	5,293	11.03%	Forecast in August 2004
Average FY 99-00 through FY 03-04 = 6.46%							

*Caseload includes retroactivity; actual caseload number will not be final until FY 05-06, as caseload does not close for 24 months.

Despite the outcome of caseload forecasts, the Department will manage to the appropriation in accordance with statutory and constitutional expectations. As described above, reductions may be made in scope of services to ensure that the appropriation is not exceeded. It is expected that the Department will have to adjust benefits or payments to ensure that the appropriation is not exceeded.

Expenditure History and Request

Table 3 delineates historical expenditures and includes the appropriation for FY 04-05. Drug rebates are an offset to expenditures and help to defray the cost of medical services. These expenditures do not include the administrative costs displayed in Table 1.

Table 3					
Old Age Pension State Medical Program Expenditure History and Projection					
Year	**All Expenditures, Before Drug Rebate**	**Drug Rebate**	**All Expenditures, After Drug Rebate**	**Average Number of Clients**	**Average Cost**
FY 99-00 Actual	$9,681,696	($663,715)	$9,017,981	3,066	$2,941.29
FY 00-01 Actual	$10,639,144	($803,201)	$9,835,943	3,212	$3,062.25
FY 01-02 Actual	$10,468,408	($930,753)	$9,537,655	3,782	$2,521.85
FY 02-03 Actual	$11,241,636	($495,571)	$10,746,065	3,849	$2,791.91
FY 03-04 Actual	$11,447,158	($700,984)	$10,746,174	4,261	$2,521.98
FY 04-05 Appropriation	N/A	N/A	$10,748,483	3,979	$2,701.30
FY 05-06 Request	N/A	N/A	$10,748,483	5,293	$2,030.70

The FY 05-06 Request continues to be the maximum allowed under current law, minus the administrative costs of the Medical Identification Cards.

OLD AGE PENSION SUPPLEMENTAL HEALTH AND MEDICAL CARE PROGRAM

Since July 1, 2002, the Old Age Pension State Medical Program fund has included two pieces: the main program appropriated at $10 million and an additional $1 million Supplemental Old Age Pension Health and Medical Care Program established via HB 02-1276. As of July 1, 2003, the $1 million Supplemental Program was reduced to $750,000 as a result of SB 03-299. In the FY 04-05 Figure Setting document, page 141 on March 9, 2004 the Joint Budget Committee approved combining the Supplemental Old Age Pension Health and Medical Care Program and shifting funds to the Old Age Pension State Medical Program. Therefore, there is no distinct request for this line item for FY 05-06.

HOME CARE ALLOWANCE

Home Care Allowance, first authorized in 1979 by Section 26-2-122.3, C.R.S. is a State and county funded program, which provides direct payments to eligible individuals, subject to available appropriations, for the purchase of services related to activities of daily living that are necessary to enable the client to remain at home and prevent more restrictive, expensive placements. It is a non-

Medicaid program. Section 25.5-1-201, C.R.S. (2004) authorizes administration of Home Care Allowance by the Department of Health Care Policy and Financing.

A Single Entry Point case manager determines whether the client meets the functional need and determines the authorized monthly amount. A county eligibility technician determines if the client is financially eligible and how much the client will receive based on his/her income. The Department of Human Services maintains the Volume III Regulations that limit access to the Home Care Allowance program based on a needs standard. The income limits depend on the standard of need category and the authorized Home Care Allowance amount. For example, in FY 03-04, a client under the age of 60 with income from Social Security Disability Income exceeding $545 had a "need standard" equal to the Aid to the Needy and Disabled of $269. This was added to the authorized Home Care Allowance amount to determine the client's total needs standard. If the client's income exceeded the total needs standard, then he/she was not eligible for Home Care Allowance. Similarly, for clients over 60, the needs standards were either $582 or $602, depending on work history. Home Care Allowance payments currently range from $1 per month to a maximum of $403 per month, depending on the client's income; however, 26-2-122.3 (1) (b), C.R.S. (2004) allows for the amounts paid to eligible persons to be adjusted as necessary to manage within the funds appropriated by the General Assembly.

Therefore, the maximum a client can earn who is under 60 would be the following:

$269 Aid to the Needy and Disabled Need Standard
+$403 Maximum Home Care Allowance Amount
$672 Maximum Income Allowed

For a client over 60, the maximum is as follows:

$582 Old Age Pension Need Standard
+$403 Maximum Home Care Allowance Amount
$985 Maximum Income Allowed

After eligibility and monthly allowance amount have been determined, the counties and the Department of Human Services send out the payments. The Department then reimburses the Department of Human Services for the General Fund expenditures.

The funding split calculation is 95% General Fund and up to 5% local matching funds. The statutes contain a hold harmless provision for counties in which their annual increase for a program area cannot exceed five percent over the prior year. Section 26-4-525 (1) (c), C.R.S. (2004) provides that the local funding match is calculated as the lower of either the prior year local match times 5% or the base recommendation times 5%.

Below is the appropriation history since FY 99-00.

Line Item: Home Care Allowance Appropriation History	Total Funds	General Fund	Cash Funds Exempt
FY 04-05 Long Bill HB 04-1422	**$10,880,411**	**$10,336,390**	**$544,021**
FY 03-04 Final Appropriation	**$10,880,411**	**$10,336,390**	**$544,021**
FY 03-04 Supplemental HB 04-1320	($1,831,995)	($1,739,645)	($92,350)
FY 03-04 Long Bill SB 03-258	$12,712,406	$12,076,035	$636,371
FY 03-04 Figure Setting March 13, 2003 (page 155)	($315,000)	($300,000)	($15,000)
FY 02-03 Final Appropriation	**$13,027,406**	**$12,376,035**	**$651,371**
FY 02-03 Supplemental SB 03-203	($2,363,745)	($2,245,558)	($118,187)
FY 02-03 Long Bill HB 02-1420	$15,391,151	$14,621,593	$769,558
FY 01-02 Final Appropriation	**$15,391,151**	**$14,621,593**	**$769,558**
FY 01-02 Supplemental HB 02-1370	($727,943)	($691,547)	($36,396)
FY 01-02 Long Bill SB 01-212	$16,119,094	$15,313,140	$805,954
FY 01-02 Figure setting March 15, 2001 (page 273)	$294,114	$279,409	$14,705
FY 00-01 Final Appropriation	**$15,824,980**	**$15,033,731**	**$791,249**
FY 00-01 Supplemental SB 01-183	($650,695)	($618,160)	($32,535)
FY 00-01 Long Bill HB 00-1451	$16,475,675	$15,651,891	$823,784
FY 00-01 Figure Setting March 6, 2000 (page 171)	$323,067	$306,913	$16,154
FY 99-00 Final Appropriation	**$16,152,608**	**$15,344,978**	**$807,630**
FY 99-00 Supplemental HB 00-1400	($609,544)	($587,071)	($22,473)
FY 99-00 Long Bill SB 99-215	$16,762,152	$15,932,049	$830,103

Prior to the Supplemental Bill for FY 02-03 (SB 03-203) adjustments to the Home Care Allowance appropriation were primarily the result of Change Requests aimed at adjusting for caseload or changes in the average monthly payment based on recent experience. In FY 02-03, the Home Care Allowance program was included in the Department's mandatory 4% budget reductions. The 4% cut reduced the appropriation by $2,363,745. To accomplish this reduction, a freeze on new enrollment was implemented on July 1, 2002. Due to the 45-day timeline for processing applications, the freeze on enrollment had no real impact until September 2002. After that, the freeze reduced program enrollment, compounding the already declining caseload sparked by the rise in recent Medicaid Home and Community Based Services. Program expenditures were monitored throughout FY 02-03 to assess the status of budget reductions. In December 2002, it was realized that the enrollment freeze was not achieving the results originally anticipated, partially due to the later than anticipated effect of the freeze on enrollment. To meet the reduced appropriation, the Department reduced client payments by 33% for the months of April, May, and June 2003. Additionally, the Department of Human Services, which issues the Home Care Allowance payments, identified expungements (uncashed checks) that had been credited to their programs. A portion of these expungements belonged to the Department of Health Care Policy and Financing. Expungements for FY 02-03 totaled $258,779, and

were credited back to the program's appropriation in the Colorado Financial Reporting System during Period 13. Due to the reduction in client payment and the expungements, $474,041 of the appropriation went unspent.

As a result of further budget balancing reductions for FY 03-04, the Home Care Allowance program was reduced by another $315,000; $300,000 General Fund, and $15,000 in county funds (see page 155 of the March 13, 2003 Figure Setting document). With this adjustment, the FY 03-04 Long Bill appropriation was $12,712,406.

The enrollment cap instituted in FY 02-03 caused caseload to decline faster than initially anticipated. As a result, the Department requested a reduction to the FY 03-04 Long Bill appropriation in the January 2, 2004 Supplemental Request (#S-7 Decrease Appropriation for Adult Foster Care and Home Care Allowance for Caseload). The FY 03-04 Supplemental Bill (HB 04-1320) reduced the appropriation by $1,831,995. On page 31 of the Joint Budget Committee staff's Supplemental document dated January 21, 2004, the final FY 03-04 appropriation of $10,880,411 was calculated using an average enrollment of 4,087 and an average monthly payment of $221.85.

In the November 3, 2003 Budget Request, the Department submitted a Base Reduction Item (#BRI-2 Targeted Base Review – Home Care Allowance and Adult Foster Care Reduction for Caseload) to reduce the appropriation for FY 04-05 to $8,568,604 due to the continuing decline in caseload. However, the request was declined due to concerns over the Maintenance of Effort agreement that the State has with the federal Social Security Administration. This agreement requires the State to maintain spending levels on Supplemental Security Income clients on a calendar year basis. Failure to meet the Maintenance of Effort agreement would put the federal match for all of Medicaid at risk. For this reason, the FY 04-05 appropriation was left unchanged from FY 03-04 at $10,880,411 (see March 9, 2004 Figure Setting page 142). The Department will manage to the FY 04-05 appropriation by removing the enrollment cap effective September 2004. The FY 05-06 Base Request assumes continuation funding at the FY 04-05 level.

The table delineates the actual historical caseload and expenditures, followed by the appropriation for FY 04-05 and FY 05-06 request.

Home Care Allowance	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**
Caseload	5,852	5,757	5,642	5,060	4,052
Average Monthly Payment	$223.72	$226.52	$226.35	$206.74	$215.32
Long Bill Appropriation	$16,762,152	$16,475,675	$16,119,094	$15,391,151	$12,712,406
Supplemental	($609,544)	($650,695)	($727,943)	($2,363,745)	($1,831,995)
Reversion	($442,169)	($176,303)	($66,857)	($474,041)	($410,930)
Total Funds (Actuals)	$15,710,439	$15,648,677	$15,324,294	$12,553,365	$10,469,481
General Fund	$14,929,172	$14,866,361	$14,558,079	$11,925,697	$9,945,080
Cash Funds Exempt (Local)	$781,267	$782,316	$766,215	$627,668	$524,401

Home Care Allowance	FY 04-05 Appropriation	FY 05-06 Request
Caseload	4,087	4,087
Average Monthly Payment	$221.85	$221.85
Appropriation/Starting Base	$10,880,411	$10,880,411
General Fund	$10,336,390	$10,336,390
Cash Funds Exempt (Local)	$544,021	$544,021

ADULT FOSTER CARE

Adult Foster Care was first authorized in 1977 by Section 26-2-122.3 C.R.S. It is a non-federally funded program providing 24 hour supervised residential non-medical supervision. Services include room and board, recreational activities, supervision of medications, protective oversight, and some assistance with activities of daily living. The client's own income (less $50 for personal needs) covers the cost of the room and board. The State pays for the cost of services. The services amount is added to the cash benefit check to make up the difference between the client's income and the Adult Foster Care rate.

Generally, clients receiving Adult Foster Care are also receiving either Supplemental Security Income or Old Age Pension. The only additional requirement is that the client must meet the appropriateness of placement screening, which is determined by a Single Entry Point case manager. A county eligibility technician determines the financial eligibility for Adult Foster Care clients.

The funding split calculation is 95% General Fund and 5% local matching funds. However, the statutes contain a hold harmless provision for counties in which their annual increase for a program area cannot exceed five percent over the prior year. Section 26-4-525 (1) (c), C.R.S. (2004) provides that the local funding match is calculated as the lower of either the prior year local match times 5% or the base recommendation times 5%.

Line Item: Adult Foster Care Appropriation History	Total Funds	General Fund	Cash Funds Exempt
FY 04-05 Long Bill HB 04-1422	**$157,469**	**$149,596**	**$7,873**
FY 03-04 Final Appropriation	**$157,469**	**$149,596**	**$7,873**
FY 03-04 Supplemental HB 04-1320	($86,341)	($82,024)	($4,317)
FY 03-04 Long Bill SB 03-258	$243,810	$231,620	$12,190
FY 02-03 Final Appropriation	**$243,810**	**$231,620**	**$12,190**
FY 02-03 Long Bill HB 02-1420	$243,810	$231,620	$12,190
FY 01-02 Final Appropriation	**$243,809**	**$231,619**	**$12,190**
FY 01-02 Supplemental HB 02-1370	($119,660)	($113,677)	($5,983)
FY 01-02 Long Bill SB 01-212	$363,469	$345,296	$18,173

Line Item: Adult Foster Care Appropriation History	Total Funds	General Fund	Cash Funds Exempt
FY 01-02 Figure setting March 15, 2001 (page 275)	$19,944	$18,948	$996
FY 00-01 Final Appropriation	**$343,525**	**$326,348**	**$17,177**
FY 00-01 Supplemental SB 01-183	($91,585)	($87,006)	($4,579)
FY 00-01 Long Bill HB 00-1451	$435,110	$413,354	$21,756
FY 00-01 Figure Setting March 6, 2000 (page 174)	($26,021)	($24,720)	($1,301)
FY 99-00 Final Appropriation	**$461,131**	**$438,074**	**$23,057**
FY 99-00 Supplemental HB 00-1400	($87,710)	($83,424)	($4,286)
FY 99-00 Long Bill SB 99-215	$548,841	$521,498	$27,343

The caseload in Adult Foster Care has been in a steady decline since FY 99-00. This is due to the fact that most clients are moving to alternative care facilities, where the reimbursement rate is higher than it is for Adult Foster Care. Due to the declining caseload, the Department has submitted numerous negative Change Requests in recent years. On January 2, 2002, the Department submitted a negative Supplemental Request (#S-19 Reduce Adult Foster Care to Reflect Expected Utilization), which resulted in a $119,660 reduction to the FY 01-02 budget. The resulting appropriation of $243,810 was carried forward into the FY 02-03 Long Bill (HB 02-1420) and into the FY 03-04 Long Bill (SB 03-258). On January 2, 2004, the Department submitted another negative Supplemental Request (#S-7 Decrease Appropriation for Adult Foster Care and Home Care Allowance for Caseload), which resulted in an $86,341 reduction to the FY 03-04 budget. The final FY 03-04 appropriation was $157,469.

In the November 3, 2003 Budget Request, the Department submitted a Base Reduction Item (#BRI-2 Targeted Base Review – Home Care Allowance and Adult Foster Care Reduction for Caseload) to reduce the appropriation for FY 04-05 to $121,311 due to the continuing decline in caseload. However, the request was declined due to concerns over the Maintenance of Effort agreement discussed under Home Care Allowance, above. For this reason, the FY 04-05 appropriation was left unchanged at $157,469 (see March 9, 2004 Figure Setting page 144). The FY 05-06 Base Request assumes continuation funding at the FY 04-05 level.

The table below delineates the actual historical caseload and expenditures, followed by the appropriation for FY 04-05 and FY 05-06 request.

Adult Foster Care	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04
Caseload	165	122	87	73	57
Average Monthly Payment	$218.92	$222.23	$224.66	$219.52	$227.93
Long Bill Appropriation	$548,841	$435,110	$363,469	$243,810	$243,810
Supplemental Bill Adjustment	($87,710)	($91,585)	($119,660)	N/A	($86,341)
Reversion	($27,672)	($18,175)	($9,268)	($51,514)	($1,567)
Total Funds (Actuals)	$433,459	$325,350	$234,541	$192,296	$155,902
General Fund	$411,658	$309,082	$222,814	$182,681	$148,107
Cash Funds Exempt (Local)	$21,801	$16,268	$11,727	$9,615	$7,795

Adult Foster Care	FY 04-05 Appropriation	FY 05-06 Request
Caseload	58	58
Average Monthly Payment	$226.25	$226.25
Appropriation/ Starting Base	$157,469	$157,469
General Fund	$149,596	$149,596
Cash Funds Exempt (Local)	$7,873	$7,873

PRIMARY CARE PHYSICIAN PROGRAM MARKET RATE REIMBURSEMENT

This line item, formerly the "Physicians' Incentive Pool," was originally funded in FY 82-83, "dedicated to equalizing costs which exceed projections in inpatient and outpatient hospital services; the remaining balance to be distributed to the physicians in proportion with the units of service provided by each" (HB 82-1284).

SB 97-05 permitted the Physicians' Incentive Pool funding to support a market-rate based incentive payment to physicians beginning in FY 98-99. The market reimbursement rate (or care management fee) was set at $3.00 per member per month based on a 1998 survey of other states indicating that $3.00 was the average market rate for primary care physicians. Accordingly, this line was renamed "Primary Care Physician Program Market Rate Reimbursement" at some point between Figure Setting and the Long Bill appropriation. A Department report to the Joint Budget Committee, submitted October 1, 2001 to address Footnote #59 of SB 01-212, verified that the $3.00 was then still the market rate. Forty of the fifty states responded to a survey on how they calculated primary care case management payments and what those payments were. Three dollars was the most common payment for programs similar to Colorado's.

The Joint Budget Committee increased the Department's November 1, 2001 request to adjust for caseload growth in the Primary Care Physician Program. The increase was based on the $3.00 per member per month market rate times Primary Care Physician member

months estimated at 649,841 (see FY 02-03 Figure Setting document, page 247) for FY 02-03. The number of Primary Care Physicians Program clients was then estimated to be 54,153 (member months divided by 12 months).

During FY 02-03, caseload in the Primary Care Physician Program increased dramatically and June's payment was temporarily reduced to manage to the appropriation.

This line was also affected by the federal government's temporary increase of the federal share for Medicaid service expenditures. The Federal Medical Assistance Percentage (FMAP) for Colorado was increased by 2.95% for the fourth quarter of FY 02-03 and all of FY 03-04. This increase was an internal adjustment between the funds splits and was budget neutral to the total amount of the appropriation. These adjustments were not made through a budget action, but the accounting adjustments are shown on the Schedule 3.

The appropriation remained level at $1,949,508 in FY 03-04.

During the 2004 Legislative Session, this line was eliminated. A stand-alone Budget Amendment (# BAS-3) was submitted by the Department on January 23, 2004, to move funding from the Primary Care Physician Market Rate Reimbursement line item to the Medical Services Premiums line item for rate increases to physicians. The Joint Budget Committee partially approved the request, but used only 75% of the appropriation for rate increases; the remaining 25% was used as savings.

As this line was eliminated beginning in FY 04-05, there is no request for FY 05-06.

Line Item: Primary Care Physician Program Market Rate Reimbursement	**FY 98-99**	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**
Estimated Number of Primary Care Physician Program Clients	50,000	50,000	49,544	53,000	54,153	72,874
Long Bill Adjustment for Enrollment	$0	$0	($16,410)	$124,410	$41,508	$0
Appropriation	$1,800,000	$1,800,000	$1,783,590	$1,908,000	$1,949,508	$1,949,508

HB 92-1208 IMMUNIZATIONS

This line item has been eliminated. HB 92-1208 established a statewide immunization program for infants up to two years of age and all Medicaid eligible children. This program, financed by Medicaid funds, was operated by the Department of Public Health and Environment under an Interagency Agreement with the Department of Health Care Policy and Financing. All Medicaid providers of vaccines were required to obtain the vaccines from the Department of Public Health and Environment, which in turn, purchased the vaccines at a lower rate. The Department of Public Health and Environment then billed Medicaid for the vaccines administered to the

Medicaid eligible clients. The Department of Public Health and Environment was responsible for budget development and program administration for this line item.

In FY 01-02, the program was modified to cover only children 19-20 years of age as the federal Vaccines for Children Program covers children from birth through 18 years old. As a result, via Supplemental appropriation, this line item was decreased by $114,884 in total funds, of which $57,442 was General Fund. The FY 02-03 request for this line item was computed and requested by the Department of Public Health and Environment. This line item was eliminated as part of the Department of Public Health and Environment's budget reductions in FY 02-03. There is no request for FY 05-06.

Line Item: HB 92-1208 Immunizations	FY 01-02	FY 02-03
Total Funds – Starting Base	$145,374	$11,362
General Fund	$72,687	$5,681
Federal funds	$72,687	$5,681
Total Funds - HB 02-1370 Supplemental	($114,884)	$0
General Fund	($57,442)	$0
Federal funds	($57,442)	$0
Total Funds – SB 03-203 Budget Balancing	$0	($11,362)
General Fund	$0	($5,681)
Federal funds	$0	($5,681)
Total Funds – Appropriation	$30,490	$0
General Fund	$15,245	$0
Federal funds	$15,245	$0

POISON CONTROL

This line item has been eliminated. FY 02-03 Actuals are presented in the Schedule 3. The line funded the Poison Control Program for statewide poison control services to Colorado residents through a contract with the Rocky Mountain Poison and Drug Center. Oversight of the program was statutorily moved from the Department of Public Health and Environment to the Department effective July 1, 1994. The Department's contract consisted of poison control services including prevention programs, professional education, and toxicology research as well as provided information and treatment recommendations to consumers and medical professionals. A continuation level of funding equal to $1,215,079 was appropriated via the FY 02-03 Long Bill; however, during the 2002 Legislative Session, HB 02-1348 transferred the Poison Control Program appropriation and the powers and duties of the Statewide Poison Control Board from the Department of Health Care Policy and Financing to the Department of Public Health and Environment. There is no request for FY 05-06.

UNIVERSITY OF COLORADO FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The University of Colorado Family Medicine Residency Training Programs line item provides payments to hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The Advisory Commission on Family Medicine at the Department of Higher Education, Health Sciences Center administers the program. Before FY 94-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education. Starting in FY 94-95, the majority of the program's funding was refinanced with a fund split of 50% General Fund and 50% federal funds. This new funding split was due to federal regulations allowing Medicaid financial participation for the payments to the hospitals enrolled in the program. Since federal Medicaid funds were involved, a line item appropriation to the Department of Health Care Policy and Financing was established. There are currently nine hospitals participating in the program and one clinic. Funding for the clinic participant is not included in the Department of Health Care Policy and Financing appropriation as Medicaid's participation in funding is restricted to hospitals.

The following table details the funding history for the University of Colorado Family Medicine Residency Training Programs.

Appropriation History for the University of Colorado Family Medicine Residency Training Programs			
	FY 03-04	**FY 04-05**	**FY 05-06 Request**
Previous Fiscal Year Final Appropriation	$1,905,782	$1,524,626	$1,449,444
FY 03-04 Joint Budget Committee Recommendation	($381,156)	$0	$0
FY 04-05 Non Prioritized Decision Item #11 "Leveraging Additional Federal Medicaid Funds"	$0	$85,868	$0
FY 04-05 Joint Budget Committee Recommendation	$0	($161,050)	$0
Final Appropriation	**$1,524,626**	**$1,449,444**	**$1,449,444**

In FY 03-04, funding for this line item was reduced due to a Joint Budget Committee recommendation to decrease General Fund by 20% for budget balancing. Beginning with an initial Department of Health Care Policy and Financing request of $1,905,782, the 20% reduction of $381,156 resulted in a final FY 03-04 appropriation of $1,524,626.

In late FY 02-03, the federal government increased the federal share of Medicaid expenditures, or the Federal Medical Assistance Percentage, by 2.95%. This increase in federal funding affected only the fourth quarter claims for the year. The FY 03-04 appropriation was $1,524,626; with the increased Federal Medical Assistance Percentage the funding source splits were $807,289 federal funds and $717,337 General Fund. This is an accounting adjustment accomplished with the application of the "M" Provision. As a result, the actual expenditures for this line, as reflected in the Schedule 3, will show different fund splits between the affected years (FY 02-03 and FY 03-04) and subsequent years (FY 04-05 and beyond).

In FY 04-05, a Non Prioritized Decision Item and a Joint Budget Committee recommendation changed the previous fiscal year final appropriation of $1,524,626. The FY 04-05 appropriation was increased for Non Prioritized Decision Item #11 "Leveraging

Additional Federal Medicaid Funds" from the November 1, 2003 Budget Submission which requested permission for the State to leverage $42,934 in additional federal funds by transferring expenses from the Commission on Family Medicine to this line item for a total fund increase of $85,868. Furthermore, a Joint Budget Committee recommendation to reduce the program by 10%, or $161,050 in total funds, decreased the final total appropriation to $1,449,444, consisting of $724,722 in General Fund and federal funds.

The Department of Health Care Policy and Financing FY 05-06 request remains at the FY 04-05 appropriation level of $1,449,444. The fund splits requested are $724,722 in federal funds and $724,722 in General Fund.

ENHANCED PRENATAL CARE TRAINING AND TECHNICAL ASSISTANCE

This line was added in FY 95-96 to permit training of providers in coordinating and evaluating services to at-risk pregnant women, with the goal of reducing low-weight births. This program is supported by Medicaid funds but the Department of Public Health and Environment is responsible for its administration. The federal financial participation rate for this line item is 50%.

The FY 02-03 Long Bill (HB 02-1420) appropriation was $163,852. This represents a decrease of $23,141 from the FY 01-02 final appropriation of $186,993. This reduction was the result of a decrease in the costs associated with the Department's Integrated Registration and Information Systems. This was in accordance with Joint Budget Committee approval of the Department of Public Health and Environment's Decision Item for Operating Expenses (Department of Public Health and Environment's Figure Setting, March 11, 2002, page 109).

For FY 03-04, the Long Bill appropriation was $109,110. This appropriation was due to further reductions from budget balancing of $8,032 total funds, program annualization reduction of $45,622 total funds, and the pay date shift of $1,088 total funds. The $45,622 total funds reduction was in accordance with Joint Budget Committee approval of the Department of Public Health and Environment's Decision Item #6 during Figure Setting (March 11, 2002, page 65).

For FY 04-05, the Department of Public Health and Environment calculated the base request including the following:

- A decrease of $110 total funds for the Health Statistics and Vital Records budget line not implemented in FY 03-04;
- A decrease of $34 total funds related to Women's Health Personal Services budget line as part of the Office of State Planning and Budget's 2% reduction;
- A reduction of $577 total funds for Information Technology services; and
- A decrease of $6,043 total funds from the Health Promotion and Disease Prevention indirect cost budget line as a correction.

These reductions resulted in the FY 04-05 Long Bill appropriation of $102,346 total funds ($51,173 General Fund and $51,173 federal funds). The amount of $102,346 will be sent from the Department of Health Care Policy and Financing to the Department of Public Health and Environment in the form of a Cash Funds Exempt transfer.

At the Department of Public Health and Environment, the amount of $102,346 will be split over a number of different lines. This includes $3,550 in the Health Statistics and Vital Records line, $15,145 in the Information Technology Services line, $1,602 in the Prevention Services Division line, and $82,049 in the Women's Health – Family Planning line.

For several years, the Department of Public Health and Environment had contracted with the Larimer County Health Department to secure the services of an employee to serve as the Enhanced Prenatal Program Coordinator. This arrangement did not allow for the appropriate supervisory responsibilities for the Coordinator or other program staff. When this coordinator resigned, the Department assigned the Enhanced Prenatal Program administrative responsibilities to several staff. The Department of Public Health and Environment would like to consolidate these responsibilities into a single position, which would significantly increase the effectiveness and efficiency of program administration.

For FY 05-06, the Department of Public Health and Environment has submitted a request for $109,357 for this program. These funds would be in the form of a Cash Funds Exempt transfer from the Department of Health Care Policy and Financing. This request represents a 6.85% increase over the FY 04-05 Long Bill appropriation. This change is largely driven by an increase in indirect rates associated with the Indirect Cost Assessment Line in the Prevention Services Division. At the Department of Public Health and Environment, the amount of $109,357 will be split over a number of lines. This includes $3,550 in the Health Statistics and Vital Records line, $15,145 in the Information Technology Services line, $7,339 in the Prevention Services Division line, $81,935 in the Women's Health – Family Planning line, and $1,388 in POTS money. The decrease from the FY 04-05 Long Bill to the FY 05-06 Base Request in the Women's Health – Family Planning line, is a result of the 0.2% base reduction imposed by the Governor's Office of State Planning and Budgeting.

Please note that all Change Requests and Base Reduction Items for the Department of Public Health and Environment are found in the Department of Public Health and Environment's Budget Request.

Line Item: Enhanced Prenatal Care Training Program	FY 04-05	FY 05-06 Request
Final Appropriation from Previous Fiscal Year	$109,110	$102,346
Adjustment to Indirect Cost Assessment during Base Request Calculation for FY 05-06	$0	$5,737
Health Statistics and Vital Records reduction (Medicaid reduction not implemented in FY 03-04)	($110)	$0
Women's Health, Personal Services OSPB 0.2% Reduction	($34)	($114)
Health Promotion and Disease Prevention, Indirect Correction	($6,043)	$0
Reduction to Information Technology Services	($577)	$0
Increase in POTS (information provided by DPHE Staff)	$0	$1,388
Total Funds – Long Bill Appropriation/Request	**$102,346**	**$109,357**
General Fund	$51,173	$54,678
Federal Funds	$51,173	$54,679

NURSE HOME VISITOR PROGRAM

This program was created as a result of SB 00-71 which appropriated Tobacco Settlement funds. This program is intended to provide educational, health and other resources for new, young mothers during pregnancy and the first years of their infant's lives. The program offers home visits by trained nurses to first-time mothers with incomes at or below 200% of the poverty rate. Shortly after implementation, the Department of Public Health and Environment began investigating the possibility of obtaining federal Medicaid matching funds using Tobacco Settlement funds as the State match for the Nurse Home Visitor Program. Accordingly, the Department of Public Health and Environment, working with the Department of Health Care Policy and Financing, researched the possible ways through which federal Medicaid funding could be obtained. Based upon the research, 60% of the program clients were eligible for Medicaid and 79% of the services that the nurses provided qualified for Medicaid reimbursement as Targeted Case Management services. As a result, it was determined that federal Medicaid match could be claimed for the services that the nurses provided to those clients who were Medicaid eligible. By utilizing the additional federal Medicaid funding, the Department of Public Health and Environment would able to expand the number of clients served by the program without increasing State funds.

During the FY 02-03 Figure Setting process, the Colorado Department of Public Health and Environment's Decision Item #12 was approved by the Joint Budget Committee. This request allowed the Department of Public Health and Environment to utilize a portion of the Tobacco Settlement Funds for the program to receive federal Medicaid funding and increase the number of people served by the Program, which had previously operated solely on the Tobacco Settlement funds. However, an oversight during the Figure Setting process for the Department of Health Care Policy and Financing failed to increase the spending authority in the Long Bill (HB 02-1420), and the financing was unable to proceed.

To correct this situation, a FY 02-03 Supplemental and FY 03-04 Budget Amendment request was submitted on January 2, 2003 (#NP-S6, NP-B1) to fund:

- $124,000 total funds ($31,000 Cash Funds Exempt and $93,000 federal funds) in FY 02-03 for program implementation and computer development for the Medicaid Management Information System contract, and
- $3,009,618 total funds at 50% federal match in FY 03-04 for Medicaid services in this line item.

The Supplemental Request and Budget Amendment were both approved by the General Assembly.

There were no expenditures against this line item in FY 03-04. However, the Department did a retroactive federal draw for the Medicaid share of Nurse Home Visitor claims that could have been charged to this line item with dates of service in the first two quarters of FY 03-04, and these funds were reverted to the General Fund. A retroactive federal draw for Nurse Home Visitor claims with service dates in the last two quarters of FY 03-04 will be made and the funds reverted to the General Fund as soon as the necessary information is received and verified. In addition, in February 2004, the Department did a retroactive claim for Medicaid related Nurse Home visitor services back to the federal fiscal quarter that began January 1, 2002. These funds were reverted to the General Fund in FY 03-04. As of July 1, 2004, system changes have been completed, and these services are now being billed, in the typical manner, through the Medicaid Management Information System. For FY 04-05, the Department requested an appropriation of $3,009,618. The Joint Budget Committee added a technical adjustment of $382 to this amount for a final appropriation of $3,010,000 ($1,505,000 Cash Funds Exempt and $1,505,000 federal Medicaid dollars).

The Department of Public Health and Environment is responsible for the administration of this program. See the Department of Public Health and Environment Budget Request for justification and calculations regarding the final request. The federal financial participation for this line item is 50%. For FY 05-06, a continuation request of $3,010,000 is expected from the Department of Public Health and Environment. There currently is no historical data with Medicaid client participation in the program from previous years upon which to estimate a reasonable utilization adjustment from one year to the next.

Line Item: Nurse Home Visitor Program	FY 03-04	FY 04-05	FY 05-06 Request
Final Appropriation / Request	**$3,009,618**	**$3,010,000**	**$3,010,000**
Cash Funds Exempt	$1,504,809	$1,505,000	$1,505,000
Federal Funds	$1,504,809	$1,505,000	$1,505,000

SB 97-101 PUBLIC SCHOOL HEALTH SERVICES

In 1997, the Colorado General Assembly authorized public school districts, Boards of Cooperative Education Services, and State K-12 educational institutions to receive federal matching funds from the Department of Health Care Policy and Financing providing health services to Medicaid eligible students through C.R.S. 26-4-531. The intent of the legislation was to:

- Support local school health and related services;
- Increase access to preventive and primary health care services for low-income, uninsured and under-insured children; and

- Improve coordination of care between schools and health care providers.

The legislation allows districts to finance health services through the receipt of matching federal Title XIX funds for Medicaid services to Medicaid-eligible children. The matching funds must be used to expand health services for all children. However, up to 30% of the reimbursed funds can be used for initiatives to increase access to health care for uninsured and underinsured children. The State match for the federal financial participation is through certified funds from the school districts for ongoing health care services, a conceptual "in-kind" match. The legislative intent is that no General Fund dollars be used to support this program. Funding for this program has increased as more school districts participate.

Although district participation in the program grew significantly while the program was being developed, the Department estimates that participation has leveled off. For FY 04-05, the Department estimates that 135 districts, plus 7 Board of Cooperative Educational Services will participate in the program. This indicates the number of districts that actually participate in the program, not the number of districts that submit local service plans.

Administration of the program occurs jointly between the Department of Health Care Policy and Financing and the Department of Education via an Interagency Agreement. The Department of Health Care Policy and Financing administrative funds pay for processing claims through the Medicaid Management Information System, and personal services. The Department of Education administrative funds pay for providing schools with technical assistance, reviewing and receiving all the local service plans, conducting on-site reviews, submitting annual reports, and personnel. The total administrative costs for both Departments are subtracted “off-the-top” from the federal funds, with the remainder being distributed to the school districts.

Under SB 97-101, the allowable State administrative costs for both the Department of Health Care Policy and Financing and the Department of Education was $200,000 or 2% of the total annual amount of federal funds allocated to the contracts for the entire state, whichever was greater. During March 15, 2001 Figure Setting, page 281, deliberations on SB 01-212, the Joint Budget Committee recommended reductions in the Department’s Medical Programs Administration, Medicaid Management Information System, and Personal Services line items because the Department exceeded the statutory cap by over 140%. HB 01-1199 increased the allowable administrative overhead statewide from the 2% to 10% beginning July 1, 2001.

On January 2, 2003, the Department of Health Care Policy and Financing submitted Supplemental Request #14 and associated Budget Amendment #8. These approved Change Requests reduced the Department of Health Care Policy and Financing’s administrative costs from $401,838 to $365,940. This reduction was the result of decreased Medicaid Management Information System costs and a reduction in FTE from 2.2 to 1.7 from what had been anticipated in HB 01-1199. On November 12, 2002, the Department of Education submitted a memorandum to the Joint Budget Committee requesting an increase in administrative funding from $91,339 to $179,470 for FY 03-04 to increase staffing, consulting services, and training for the school districts. This request was approved as a Stand Alone Budget Amendment for FY 03-04 for the Department of Education.

The following table details the funding history for the SB 97-101 Public School Health Services program.

Appropriation Reconciliation for Public School Health Services Program			
FY 02-03	**Federal Funds**	**Cash Funds Exempt**	**Total Funds**
Total Funding for School Health Services	$11,485,352	$11,485,352	$22,970,704
Executive Director's Office, Medicaid Management Information System	($282,801)	$0	($282,801)
Executive Director's Office, Personal Services	($119,037)	$0	($119,037)
Final Appropriation Other Medical Services, SB 97-101 Public School Health Services	$11,083,514	$11,485,352	$22,568,866
FY 03-04			
Total Funding for School Health Services	$15,131,305	$15,131,305	$30,262,610
Executive Director's Office, Medicaid Management Information System	($273,250)	$0	($273,250)
Executive Director's Office, Personal Services	($91,212)	$0	($91,212)
Executive Director's Office, Operating	($1,478)	$0	($1,478)
Department of Education	($179,470)	$0	($179,470)
Final Appropriation Other Medical Services, SB 97-101 Public School Health Services	$14,585,895	$15,131,305	$29,717,200
FY 04-05			
Total Funding for School Health Services	$15,131,305	$15,131,305	$30,262,610
Executive Director's Office, Medicaid Management Information System	($273,250)	$0	($273,250)
Executive Director's Office, Personal Services	($91,212)	$0	($91,212)
Executive Director's Office, Operating	($1,478)	$0	($1,478)
Department of Education	($179,470)	$0	($179,470)
Final Appropriation Other Medical Services, SB 97-101 Public School Health Services	$14,585,895	$15,131,305	$29,717,200
FY 05-06 Base Request			
Total Funding for School Health Services	$15,131,305	$15,131,305	$30,262,610
Executive Director's Office, Medicaid Management Information System	($273,250)	$0	($273,250)
Executive Director's Office, Personal Services	($85,776)	$0	($85,776)
Executive Director's Office, Operating	($1,478)	$0	($1,478)
Department of Education	($179,470)	$0	($179,470)
Base Request Other Medical Services, SB 97-101 Public School Health Services	$14,591,331	$15,131,305	$29,722,636

The Long Bill appropriation for FY 02-03 was $17,452,488. The appropriation consisted of $8,927,163 in Cash Funds Exempt funding from certification of public expenditures, and $8,525,325 in federal funds after a reduction by the amount of the Department's administrative costs of $401,838. The General Assembly approved Supplemental Request #14 from the January 2, 2003 request that increased the appropriation by $5,116,378 to a total of $22,568,866 for services (SB 03-203). The supplemental request was based on the two prior year's growth rate average equal to 24% of the FY 01-02 expenditures. It was the intent of the Department that administration expenses for both Departments be removed off the top of the federal funds. Expenses for the Department of Education administration were overlooked during Figure Setting.

In late FY 02-03, the federal government increased the federal share of Medicaid, or the Federal Medical Assistance Percentage expenditures by 2.95%. This increase in federal funding affected only the fourth quarter claims for the year. The FY 03-04 appropriation was $29,717,200, the splits were $15,131,305 federal funds and $14,585,895 Cash Funds Exempt. The increased Federal Medical Assistance Percent is budget neutral to the total fund appropriation. The increase in federal funds is countered by an equivalent reduction in the Cash Funds Exempt provided by the participating school districts. This adjustment is automatic with the application of the "M" Provision so is not an official appropriation. As a result, the actual expenditures for this line, as reflected in the Schedule 3, show different fund splits between the affected years (FY 02-03 and FY 03-04).

For FY 03-04 and FY 04-05, the Long Bill appropriation (SB 03-258 and HB 04-1422) was $29,717,200, consisting of $15,131,305 Cash Funds Exempt and $14,585,895 in federal funds. Actual expenditures in FY 03-04 were significantly lower than the appropriation. Expenditures for the program may have been lower due to:

- Changes in Claiming Patterns- After the Centers for Medicare and Medicaid Services submitted its revised guidelines for school based claims, many districts stopped submitting claims for certain services. The Department of Health Care Policy and Financing estimates that in some districts this translates into a 30% reduction in claims submitted. Districts also identified claims that should have been submitted. Overall, the Department of Health Care Policy and Financing is projecting a negative effect on the number of claims; and,
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) Coordination Issues- Following the implementation of HIPAA, all claims codes were changed. Complications have arisen in deciphering the new codes.

In order to reduce variation in billing, and to anticipate problems that districts may have with billing, the Department has scheduled training sessions with the school districts to occur in fall 2004.

The Department's request for FY 05-06 makes an adjustment from the FY 04-05 appropriation level due to personal services common policy. Incorporating the FY 05-06 common policies reduces the personal services funding need in the Executive Director's Office Long Bill group from $91,212 to $85,776. The result is an increase in total funds requested for this line item for FY 05-06 to $29,722,636 with $14,591,331 as federal funds and $15,131,305 as Cash Funds Exempt. Since there is no General Fund in this line

item, and the Department cannot pay more than is appropriately billed by the school districts, the Department believes that enough federal funds should be retained in the appropriation to ensure all billed claims can be paid in a given year.

STATE NURSING FACILITY SERVICE PROGRAM

SB 03-176, passed on March 5, 2003, aimed to eliminate optional legal immigrants as eligible for Medicaid services. This action left a gap in care for a fragile population with high costs in nursing facilities. The General Assembly, with the passage of SB 03-266, provided a financing mechanism to operate a grant program to address this group's medical care. The State Nursing Facility Service Program is for those legal immigrants enrolled in the Medicaid nursing facility program as of March 5, 2003. The eligible population will decrease over time and the program will end when the client population reaches zero. There is no federal match for the program because the clients are not eligible for Medicaid.

The FY 03-04 appropriation of $5,258,508, established in SB 03-266, was not spent, as SB 03-176 was not implemented in FY 03-04 due to legal appeals and a court-ordered stay. During this time, the population was still eligible under Medicaid due to the court ordered stay. HB 04-1415 repealed section two of 26-4-410.2 C.R.S., which discussed funding the program through provider fees. HB 04-1415 also set the appropriation for FY 04-05 for the State Nursing Facility Service Program to be $838,528 of General Fund (see Figure Setting page 155, March 9, 2004). The initial FY 04-05 appropriation is based on implementing the program in January 2005. The FY 05-06 Base Request of $1,157,225 is based on the fiscal note for HB 04-1415, which increased the appropriation by $318,697. The population covered in the program is declining, so the FY 05-06 Base Request is less than the annualized FY 04-05 appropriation ($1,677,056).

State Nursing Facility Service Program	**FY 03-04**	**FY 04-05**	**FY 05-06**
SB 03-266	$5,258,508	$0	$0
HB 04-1422 Long Bill Add On	($5,258,508)	$0	$0
HB 04-1415	$0	$838,528	$1,157,225
Total Appropriation/Request	**$0**	**$838,528**	**$1,157,225**

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Budget Request is for Medicaid funding for services provided or administered by the Colorado Department of Human Services for persons with developmental disabilities, persons with mental illness, high risk (substance abuse) pregnant women, and certain youth who are in the Juvenile Justice system, along with a number of other Child Welfare clients. It also receives the Department of Health Care Policy and Financing's share of the costs of the Colorado Benefits Management System project. Medicaid funds for these programs are sent as cash funds exempt transfers from the Department of Health Care Policy and Financing to the Department of Human Services.

Until FY 01-02, the funding for the Department of Human Services, Medicaid-Funded Programs was appropriated in one line item. In FY 01-02, the General Assembly separated the Department of Human Services appropriations into 18 separate line items to improve expenditure tracking and reconciliation. These lines have changed over time, but a description of each of the 18 line items currently within the Department's budget is included here for the first time. Each line in this section is solely the Medicaid attributable portion of each line item.

The Department of Human Services identifies funding needs and defends the request for this Long Bill group. Inquiries related to the FY 04-05 Request should be directed to that Department. It is important to note that all Change Requests and Base Reduction Items for the Department of Human Services are found in the Department of Human Services' Budget Request, with corresponding Schedule 6s in the Health Care Policy and Financing Request.

EXECUTIVE DIRECTOR'S OFFICE – MEDICAID FUNDING

The Executive Director's Office in the Department of Human Services is responsible for management and administration, performing such functions as budgeting, human resources, and quality control, as well as some program supervision, coordination, and evaluation (Figure Setting, February 16, 2004, page 12). In addition, this line includes funding for specific functions including the Juvenile Parole Board, the Developmental Disabilities Council, child welfare-related training, funding for the Department of Human Services to comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the child welfare administrative review unit, which performs case reviews of children and youth who are placed in out-of-home care. This line item facilitates Medicaid funding for Common Policy adjustments and POTS. The FY 03-04 Long Bill (SB 03-258) appropriation for the Medicaid funding was $8,086,637. The final appropriation for FY 03-04 was $6,008,471 after the impact of Supplemental Bill HB 04-1320. The Department of Human Services has transfer authority to move funds between budget lines per HB 04-1422, footnote 44. Below is a reconciliation for this line item.

In the fourth quarter of FY 02-03 and all of FY 03-04, this line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation, and is reflected in the Schedule 3s.

Currently the line item is not showing at 50% federal financial participation. The Department of Human Services has stated it will submit a Supplemental and Budget Request Amendment to correct this.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$8,086,637**
HB 04-1320	FY 03-04 Supplemental Bill - "Salary Survey Reduction to Department of Human Services Medicaid-Funded Programs" (#S-9, January 2, 2004, page S.9-1)	($2,069,958)
HB 04-1320	FY 03-04 Supplemental Bill - Department of Human Services Risk Management (#NP-S16, January 2, 2004, page S.11-13)	($8,208)
	FY 03-04 Final Appropriation	**$6,008,471**
	1331 Emergency Supplemental,[33] "Title IV-E Payback Plan to the Counties," June 7, 2004	($28,586)
	1331 Emergency Supplemental,[33] "Spending Authority for HIPAA Expenditures from Footnote 56," June 7, 2004	$19,780
	FY 03-04 Final Spending Authority	**$5,999,665**

The following table shows how the FY 04-05 Long Bill appropriation and FY 05-06 Request were built, with information provided by the Department of Human Services. The FY 05-06 Base Request is $10,263,202.

[33]Both 1331 Emergency Supplementals were approved by the Joint Budget Committee on June 21, 2004. An approved 1331 Emergency Supplemental is not an actual appropriation of funds, but rather a grant of temporary spending authority until the full legislative body can review the request.

Description	Total Funds
FY 03-04 Final Appropriation	**$6,008,471**
Return Risk Management Funding that was temporarily removed through HB 04-1320 in FY 03-04	$8,208
Common Policy Adjustments (Department of Human Services Figure Setting, February 10, 2004, pages 12-18), including:	
Salary Survey	$83,628
Performance-Based Pay	$643,574
Shift Differential	$703,534
Short-term Disability	$4,362
Worker's Compensation	$1,213,610
Health, Life, and Dental	$496,726
Risk Management	($37,046)
Decrease for Office of Performance Improvement (per Department of Human Services Budget Office)	($1,764)
0.2% Base Reduction for Personal Services (per Department of Human Services Budget Office)	($335)
Annualize Privacy Officer Salary (Budget Amendment #BASN-2, January 23, 2004, page BAS.6-2)	$19,057
State's Contribution of Health, Life, and Dental, based on 4% Increase (per Department of Human Services Budget Office)	$363,826
Risk Management (Budget Amendment - #BA-NP-8, January 2, 2004, page S.11-13)	($3,288)
FY 04-05 Long Bill HB 04-1422	**$9,502,563**
Adjustment to begin at the Department of Human Services' starting point	($1)
Common Policy Adjustments (per Department of Human Services Budget Office), including:	
Salary Survey	$144,020
Performance-Based Pay	($17,309)
Shift Differential	($24,964)
Short-term Disability	$9,179
Worker's Compensation	$1,314
Health, Life, and Dental	$1,034,317
Risk Management and Property Funds	$22,622
PERA Adjustment	$95,061
0.2% Office of State Planning and Budgeting Reduction	($1,303)
Removal of SB 03-197 Salary Payout (One-Time Funding) (per Department of Human Services Budget Office)	($26,862)
Removal of HIPAA Remediation Funding (per Department of Human Services Budget Office)	($475,435)
FY 05-06 Request	**$10,263,202**
General Fund	$5,132,738
Federal Funds	$5,130,464

COLORADO BENEFITS MANAGEMENT SYSTEM

The State's new computer system that tracks client data, determines eligibility, and calculates benefits for medical, food, and financial assistance programs was implemented September 1, 2004. Both development of the system and continuing operations were and are a

joint effort between the Department of Human Services and the Department of Health Care Policy and Financing. Colorado Benefits Management System replaces six legacy systems: Client Oriented Information Network; Colorado Automated Food Stamps System; Colorado Automated Client Tracking System; Colorado Adult Protection System; Children's Basic Health Plan eligibility determination services; and, Colorado Employment First.

On August 5, 2003, for FY 03-04, a 1331 Emergency Supplemental request for $4,107,297 of funding still available from the Personal Responsibility and Work Opportunity Reconciliation Act, often abbreviated as PRWORA (federal Public Law 104-193, enacted August 22, 1996), was submitted to the Joint Budget Committee, and subsequently appropriated by HB 04-1320, the Department's FY 03-04 Supplemental Bill. The purpose of the PRWORA funding was to provide assistance to the counties to enter client historical data into the automated system. Below is a reconciliation of the appropriations.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$5,299,435**
HB 04-1320	PRWORA Funding for Counties to Enter Client Historical Data (One-Time Funding)	$4,107,297
	FY 03-04 Final Appropriation	**$9,406,732**
	Removal of PRWORA One-Time Funding from HB 04-1320 in FY 03-04 (letter from Joint Budget Committee to State Controller dated September 23, 2003)	($4,107,297)
HB 04-1422	**FY 04-05 Long Bill**	**$5,299,435**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$9,293
	Performance-Based Pay	$6,758
	0.2% Office of State Planning and Budgeting Adjustment	($1,815)
	FY 05-06 Request	**$5,313,671**
	General Fund	$2,779,786
	Cash Funds Exempt	$27,381
	Federal Funds	$2,506,504

OTHER OFFICE OF INFORMATION TECHNOLOGY SERVICES LINE ITEMS

The Other Office of Information Technology Services Line Items line includes Medicaid funding for expenses associated with Department of Human Services Information Systems, but specifically excludes the new Colorado Benefits Management System. The FY 03-04 Long Bill (SB 03-258) appropriation was $500,676. The final appropriation for FY 03-04 was $482,116, after the impact of Supplemental Bill HB 04-1320. Below is the reconciliation for this line item.

In the fourth quarter of FY 02-03 and all of FY 03-04, this line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation, and is reflected in the Schedule 3s.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$500,676**
HB 04-1320	FY 03-04 Supplemental Bill –"Truth In Rates" (#NP-S15, January 2, 2004, page S.11-12)	($18,765)
HB 04-1320	FY 03-04 Supplemental Bill –General Government Computer Center (#NP-S13, January 2, 2004, page S.11-10, revised by the Joint Budget Committee)	$205
	FY 03-04 Final Appropriation	**$482,116**
	Department of Human Services Personal Services Line Item (Figure Setting, February 10, 2004, page 6)	($454)
	Department of Human Services Purchase of Services from Computer Center (HB 04-1422, page 88, letternote "g")	($336)
	Department of Human Services Microcomputer Lease Payments Line Item (Figure Setting, February 10, 2004, page 7)	$25,596
	Department of Human Services Multiuse Network Payments (HB 04-1422, page 89, letternote "o")	$104
HB 04-1422	**FY 04-05 Long Bill**	**$507,026**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$4,286
	Performance-Based Pay	$2,395
	0.2% Personal Services Common Policy Base Reduction	($412)
	FY 05-06 Base Request	**$513,295**
	General Fund	$256,648
	Federal Funds	$256,647

OFFICE OF OPERATIONS

The Office of Operations line contains appropriations for central Department of Human Services functions such as accounting, auditing, contracting, purchasing, vehicle leases, and facility management. The FY 03-04 Long Bill (SB 03-258) appropriation was $5,293,750. The final appropriation for FY 03-04 was $5,390,823. Below is a reconciliation of the line item.

In the fourth quarter of FY 02-03 and all of FY 03-04, this line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation, and is reflected in the Schedule 3s.

Currently the line item is not showing at 50% federal financial participation. The Department of Human Services has stated it will submit a Supplemental and Budget Request Amendment to correct this.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$5,293,750**
HB 04-1320	FY 03-04 Supplemental Bill –Capitol Complex Utilities (#NP-S11, January 2, 2004, page S.11-8)	$117,855
HB 04-1320	FY 03-04 Supplemental Bill –Vehicle Reconciliation (#NP-S14, January 2, 2004, page S.11-11, revised by the Joint Budget Committee)	($20,782)
	FY 03-04 Final Appropriation	**$5,390,823**
	Statewide FY 04-05 Vehicle Lease Reconciliation (#NP-10, November 3, 2003, page H.9-10)	($62,806)
	0.2% Common Policy Base Reduction (Department of Human Services Figure Setting, February 25, 2004, page 2)	($7,179)
	Reconciliation to Long Bill	($93,971)
HB 04-1422	**FY 04-05 Long Bill**	**$5,226,867**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$41,875
	Performance-Based Pay	$41,732
	0.2% Personal Services Common Policy Base Reduction	($7,039)
	FY 05-06 Base Request	**$5,303,435**
	General Fund	$2,651,558
	Federal Funds	$2,651,877

COUNTY ADMINISTRATION

The County Administration line provides Medicaid financing for funding paid to county departments of social services by the Department of Human Services. The Medicaid transfer, in part, funds administration of several programs including Food Stamps, adult protection, adult assistance payment programs, and eligibility determination (Department of Human Services Figure Setting, February 10, 2004, page 50). This line item also includes funding for the coordination of Medicaid non-emergency transportation, paid either to contractors or to the Department of Human Services for payment to county departments.

The FY 03-04 Long Bill (SB 03-258) appropriation was $8,624,879. The same funding was approved for FY 04-05 and is requested for FY 05-06.

Transfer of General Fund pursuant to 24-75-106, C.R.S. (2004) are common under this line and are reflected in the Schedule 3. Fund splits on this line are 50% federal financial participation. The State match is 30% General Fund and 20% local county funds, but the local county funds do not show in the Department's budget.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$8,624,879**
HB 04-1422	**FY 04-05 Long Bill**	**$8,624,879**
	FY 05-06 Request	**$8,624,879**
	General Fund	$3,234,330
	Federal Funds	$5,390,549

DIVISION OF CHILD WELFARE

The Division of Child Welfare line item receives funding for staff and operating costs associated with the State supervision and county administration of programs which protect children from harm and assist families in caring for and protecting their children. Services include out-of-home placement, subsidized adoptions, childcare, and burial reimbursements. The FY 03-04 Long Bill (SB 03-258) appropriation was $77,861,994.

The Federal Medical Assistance Percentage (FMAP) was increased by 2.95% for the fourth quarter of FY 02-03, and all of FY 03-04. This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation. This adjustment is shown in the Schedule 3s.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$77,861,994**
	Child Welfare Services Block Increase (#NP-5, November 3, 2003, page H.9-3)	$1,819,662
	Reversal of FY 03-04 Leap-Year Adjustment (Department of Human Services Figure Setting, Child Welfare Section, March 2, 2004, page 24)	($208,146)
HB 04-1422	FY 04-05 Long Bill	**$79,473,510**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$820
	Performance-Based Pay	$440
	0.2% Personal Services Common Policy Base Reduction	($133)
	FY 05-06 Base Request	**$79,474,637**
	General Fund	$39,737,319
	Federal Funds	$39,737,318

DISABILITY DETERMINATION SERVICES

The Disability Determination Services line provided Medicaid funding to the Department of Human Services for disability determinations for individuals waiting for determinations of Supplemental Security Income, or who were not financially eligible for

Supplemental Security Income but who were potentially eligible for Medicaid due to a disability. The FY 03-04 Long Bill appropriation was $1,165,967.

Following the FY 04-05 Long Bill (HB 04-1422) appropriation of $1,163,662, an Emergency Change Request (submitted to the Joint Budget Committee on June 7, 2004) eliminated spending authority against this appropriation, and moved it into the Department of Health Care Policy and Financing's Executive Director's Office Long Bill Group. The Department of Health Care Policy and Financing is contracting with a vendor to perform these eligibility determination services. For FY 05-06, in line with the FY 05-06 annualization provided in the June 7, 2004 Budget Amendment approved by the Joint Budget Committee, the Department is requesting funding in the new line within the Department's Executive Director's Office group. There is no base request for this line item for FY 05-06.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Final Appropriation**	**$1,165,967**
	Reconcile to Long Bill	($2,305)
HB 04-1422	**FY 04-05 Long Bill**	**$1,163,662**
	Emergency Change Request, June 7, 2004	($1,163,662)
	FY 05-06 Request (per June 7, 2004 Emergency Change Request)	**$0**

MENTAL HEALTH ADMINISTRATION

The Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding, Administration line funds mental health certification activities by the Department of Human Services. HB 04-1265 transferred administration of Medicaid Community Mental Health Services from the Department of Human Services to the Department of Health Care Policy and Financing beginning on April 1, 2004. The FY 03-04 Long Bill (SB 03-258) appropriation was $1,316,654. The final appropriation for FY 03-04 was $1,057,380. The Common Policy adjustment amounts were provided by the Department of Human Services' Budget Office.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$1,316,654**
HB 04-1265	Transferred Administration of Medicaid Community Mental Health Services from Human Services to Health Care Policy and Financing for the last quarter of FY 03-04	($259,274)
	FY 03-04 Final Appropriation	**$1,057,380**
	0.2% Personal Services Common Policy Reduction in Department of Human Services Base Request	($1,607)
	Annualization of Transfer of Administration to Health Care Policy and Financing (Amendment J.091, page 5 to HB 04-1265)	($777,822)
HB 04-1422	**FY 04-05 Long Bill**	**$277,951**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$11,014
	Performance-Based Pay	$10,572
	0.2% Personal Services Common Policy Base Reduction	($534)
	FY 05-06 Request	**$299,003**
	General Fund	$149,502
	Federal Funds	$149,501

GOEBEL LAWSUIT SETTLEMENT

This was a new line created in FY 03-04. The Goebel Lawsuit line funds services for approximately 1,600 mentally ill individuals in northwest Denver. These people suffer from chronic conditions such as bipolar disorder and schizophrenia that seriously impairs their ability to be self-sufficient. The Goebel case combined two class action suits alleging that residents of northwest Denver, with chronic mental illness, were being denied services (Department of Human Services Figure Setting, March 10, 2004, page 66). HB 04-1320, the Supplemental Bill for FY 03-04, established the Goebel Lawsuit as a separate line. Prior to this, payments for the lawsuit were made through the Medicaid Mental Health Community Programs, Mental Health Capitation Payments line. The final appropriation for FY 03-04 was $11,655,586.

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This increase was an accounting adjustment between the fund splits and was budget neutral to the total appropriation; the adjustment is shown in the Schedule 3s.

Continuation funding of $11,655,586, approved for FY 04-05 through the passage of the FY 04-05 Long Bill (HB 04-1422), is again requested for FY 05-06.

Bill	Description	Total Funds
HB 04-1320	**FY 03-04 Supplemental Bill – Establishes Goebel Lawsuit as a Separate Line**	**$12,119,721**
	FY 03-04 Add-on – Joint Budget Committee revision (Department of Human Services Figure Setting, March 10, 2004, page 67)	($464,135)
	FY 03-04 Final Appropriation	**$11,655,586**
HB 04-1422	**FY 04-05 Long Bill**	**$11,655,586**
	FY 05-06 Base Request	**$11,655,586**
	General Fund	$5,827,793
	Federal Funds	$5,827,793

MENTAL HEALTH CAPITATION, FEE FOR SERVICE PAYMENTS, MEDICAID ANTI-PSYCHOTIC PHARMACEUTICALS, MEDICAID MENTAL HEALTH SERVICES FOR BREAST AND CERVICAL CANCER PATIENTS

Actual expenditures for FY 02-03 and FY 03-04 are reported in the Schedule 3s for the following line items: Mental Health Capitation; Fee for Service Payments; Medicaid Anti-Psychotic Pharmaceuticals; and, Medicaid Mental Health Services for Breast and Cervical Cancer Patients. These programs were transferred from the Department of Human Services to the Department of Health Care Policy and Financing on July 1, 2004 with the passage of the FY 04-05 Long Bill (the exception being Mental Health Administration which was transferred to the Department on April 1, 2004, through the passage of HB 04-1265). For information on these lines, please reference the Medicaid Mental Health Community Programs Long Bill group within this request.

In the fourth quarter of FY 02-03 and for all of FY 03-04, some of these lines were affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation; the adjustment is shown in the Schedule 3s.

MENTAL HEALTH INSTITUTES

The Mental Health Institutes provide inpatient hospitalization for seriously mentally ill residents. The facilities provide both evaluation services and treatment for those individuals who cannot function in less restrictive settings. This line item funds these services for Medicaid Clients. The FY 03-04 Long Bill (SB 03-258) appropriation was $3,325,830. HB 04-1320 increased funding by $430,202. This funding allowed for payments to be made to the Department of Human Services during FY 03-04 for June 2003. The final appropriation for FY 03-04 was $5,000,680.

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation. This adjustment is shown in the Schedule 3s.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$3,325,830**
HB 04-1320	FY 03-04 Supplemental Bill – "Mental Health Institutes" (One-Time Funding) (#NP-S6, January 2, 2004, page S.11-2 and HB 04-1320, page 12)	$430,202
HB 04-1422	Long Bill Add-on – "Mental Health Capitation Base Adjustment, Mental Health Institutes, and Mental Health Fee for Service" (Supplemental #NP-S23, March 3, 2004)	$1,244,648
	FY 03-04 Final Appropriation	**$5,000,680**
	Removal of One-Time Funding from HB 04-1320	($430,202)
	Removal of One-Time Funding	($6,651)
	"Mental Health Capitation Base Adjustment, Mental Health Institutes, and Mental Health Fee for Service" (#NP-S23, March 3, 2004) [$1,556,891 of Schedule 6 - $1,244,648 above]	$312,243
HB 04-1422	**FY 04-05 Long Bill**	**$4,876,070**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$56,897
	Performance-Based Pay	$31,968
	0.2% Personal Services Common Policy Base Reduction	($7,352)
	FY 05-06 Request	**$4,957,583**
	General Fund	$2,478,792
	Federal Funds	$2,478,791

ALCOHOL AND DRUG ABUSE DIVISION, HIGH-RISK PREGNANT WOMEN PROGRAM

The High-Risk Pregnant Women Program line provides Medicaid funding for prenatal and postpartum services for women at risk due to alcohol or substance abuse (per Department of Human Services Program Administrator). HB 04-1075 directed the Department of Health Care Policy and Financing to request a waiver from the Centers for Medicare and Medicaid Services to extend the post partum period of services from 60 days to 12 months. The projected implementation date of the expanded program is October 1, 2004. Approval of this waiver request by the Centers for Medicare and Medicaid Services is not guaranteed and the federal review process could delay implementation of these extended services. The FY 03-04 Long Bill (SB 03-258) appropriation was $312,804. The final appropriation for FY 03-04 was $557,208.

For the fourth quarter of FY 02-03, and all of FY 03-04, this line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation; the adjustment is shown in the Schedule 3s.

The fund splits for this line are normally 50% General Fund, 50% federal funds. The fund splits for current FY 04-05 funding and the FY 05-06 Request are subtly different from this. HB 04-1075 added funds for post partum services of $47,902 Cash Funds Exempt and matching federal funds of $47,903; the balance of the appropriation continues at 50% federal financial participation.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$312,804**
HB 04-1320	FY 03-04 Supplemental Bill – "ADAD High Risk Pregnant Women Caseload and FY 02-03 Overexpenditure" (#NP-S8, January 2, 2004, page S.11-5)	$244,404
	FY 03-04 Final Appropriation	**$557,208**
	Removal of One-Time Funding from HB 04-1320 for FY 02-03 Overexpenditure (#NP-S8, January 2, 2004, page S.11-5, column 9 minus column 4)	($85,293)
HB 04-1422	**FY 04-05 Long Bill**	**$471,915**
HB 04-1075	Funding to Extend Post-Partum Services (HB 04-1075, page 2, Section 3(1) (a))	$95,805
	FY 04-05 Final Appropriation	**$567,720**
	Annualization of HB 04-1075 Extension of Post-Partum Services	$31,935
	FY 05-06 Request	**$599,655**
	General Fund	$251,925
	Cash Funds Exempt	$47,902
	Federal Funds	$299,828

RESIDENTIAL TREATMENT FOR YOUTH (HB 99-1116)

The Residential Treatment for Youth line funds services to Medicaid-eligible children residing in residential childcare facilities, as well as children placed in out-of-home placement facilities.

This line item was established in SB 03-282, which identified and disbursed the tobacco funds that provided financial support for this program. For FY 03-04, the amount specified was $355,436 in Medicaid funds.

FY 04-05 funding for the program was again established by the appropriation clauses in HB 04-1421, which disbursed the tobacco settlement funds, and therefore is not in the Long Bill. This program was appropriated a total of $418,132 in Medicaid funds for FY 04-05. Continuation funding is requested for FY 05-06.

Bill	Description	Total Funds
SB 03-282	FY 03-04 Tobacco Bill – Identified and Disbursed Tobacco Funds for this Program	$355,436
	FY 03-04 Final Appropriation	**$355,436**
HB 04-1421	Tobacco Settlement Allocation Bill – Identified and Disbursed Tobacco Funds for this Program	$418,132
	FY 04-05 Final Appropriation	**$418,132**
	FY 05-06 Base Request	**$418,132**
	Cash Funds Exempt	$209,066
	Federal Funds	$209,066

SERVICES FOR PEOPLE WITH DISABILITIES, COMMUNITY SERVICES

The Community Services for People with Disabilities line funds services for approximately 7,200 individuals with developmental disabilities. These services are provided in local communities through 20 Community Centered Boards (Department of Human Services Figure Setting, February 25, 2004, page 26). The types of services available include supported living services and residential services. The FY 03-04 Long Bill (SB 03-258) appropriation was $218,743,291. A Supplemental Request (#NP-S10, January 2, 2004) requested a reduction in room and board funding due to a caseload smaller than projected. The final appropriation for FY 03-04 was $218,495,215.

A September 3, 2004, 1331 Emergency Supplemental revised both the FY 04-05 spending authority and the FY 05-06 Base Request. This Supplemental transferred funding for Medicaid State Plan Services from the Developmental Disability waiver programs to the Medical Services Premiums Long Bill group. The federal Centers for Medicare and Medicaid Services required this change in order for federal approval of the waiver programs to continue.

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation. This adjustment is shown in the Schedule 3s.

Description	Total Funds
FY 03-04 Long Bill SB 03-258	**$218,743,291**
FY 03-04 Supplemental Bill HB 04-1320 "Supplemental Security Income Room and Board Adjustment for Developmental Disability Services" (#NP-S10, January 2, 2004, page S.11-7)	($248,076)
FY 03-04 Final Appropriation	**$218,495,215**
"Developmental Disability Foster Care, Emergency and Waiting List Resources" (#NP-6, November 3, 2003, page H.9-4) and Personal Services Adjustments. Revised by the Joint Budget Committee, but cannot reconcile because Department of Human Services Figure Setting, February 25, 2004, pages 6-7 shows FY 03-04 appropriation as $218,619,253	$636,753
Supplemental Security Income Room and Board Adjustment for Developmental Disability Services (#BA-NP 6, January 2, 2004, page S.11-7)	($93,650)
FY 04-05 Long Bill HB 04-1422	**$219,038,318**
Adjustment to begin at the Department of Human Services' starting point	($1)
September 3, 2004 1331 Emergency Supplemental -- Transfer of Funds from Department of Human Services for Developmental Disability State Plan Services (revised by the Joint Budget Committee, letter to State Controller, September 21, 2004)	($1,196,639)
FY 04-05 Revised Spending Authority	**$217,841,679**
Common Policy Adjustments (per Department of Human Services Budget Office), including:	
Salary Survey	$36,472
Performance-Based Pay	$20,874
0.2% Personal Services Common Policy Base Reduction	($4,078)
Annualizations Related to Caseload Increases for Comprehensive Resources in FY 04-05 (Department of Human Services Figure Setting, February 25, 2004, page 36)	$1,265,523
Annualization of September 3, 2004 1331 Emergency Supplemental for FY 05-06 -- Transfer of Funds from Department of Human Services Developmental Disability Waiver Program into the Medicaid State Plan (Joint Budget Committee letter to State Controller, September 21, 2004, second page, $1,196,639 ÷ 9 * 3)	($398,880)
FY 05-06 Base Request	**$218,761,589**
General Fund	$109,380,795
Federal Funds	$109,380,794

SERVICES FOR PEOPLE WITH DISABILITIES, REGIONAL CENTERS

The Regional Centers provide services to individuals with developmental disabilities in both institutional and group home settings. Generally, the Regional Centers provide services to people with developmental disabilities when appropriate community programs are not available. The FY 03-04 Long Bill (SB 03-258) appropriation was $38,886,488. Following this legislation, HB 03-1292

authorized the collection of service fees from both public and private intermediate care facilities to allow federal financing. The final appropriation for FY 03-04 was $39,593,264.

HB 04-1422 repealed the provisions regarding the Collection of Service Fees established under HB 03-1292 and a portion of funding was removed from the appropriation.

On September 21, 2004, the Joint Budget Committee approved a September 3, 2004 1331 Emergency Supplemental to transfer $569,510 from this line item to the Medical Services Premiums line item. This funding is related to non-waiver Medicaid services provided to clients in group home type settings under the administration of Regional Centers. This transfer allows funding for State Plan (non-waiver) services to be paid from the Medical Services Premiums line and was required by the Centers for Medicare and Medicaid Services for renewal of a Home and Community Based Services waiver program. The Department has reduced the Base Request for this line item for FY 05-06 by the annualized amount of the Joint Budget Committee approved amount (letter to State Controller, September 21, 2004, third page: $569,510 ÷ 9 * 3).

In the fourth quarter of FY 02-03 and all of FY 03-04, this line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation, and is reflected in the Schedule 3s.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$38,886,488**
HB 04-1320	FY 03-04 Supplemental Bill –Supplemental Security Income Room and Board Adjustment for Developmental Disability Services (#NP-S10, January 2, 2004, page S.11-7)	($21,224)
HB 03-1292	Special Bill – Authorized Collection of Service Fees from Intermediate Care Facilities	$728,000
	FY 03-04 Final Appropriation	**$39,593,264**
	Restore Funding from HB 04-1320 in FY 03-04 for #NP-S10, January 2, 2004	$21,224
HB 04-1422	Medicaid Funding for Increases in Client Cash Revenue (Department of Human Services Figure Setting, February 25, 2004, page 54)	($157,998)
HB 04-1422	Medicaid Funding for Room and Board Due to Client Cash Revenue (Department of Human Services Figure Setting, February 25, 2004, page 53)	($43,946)
HB 04-1422	Annualization of HB 03-1292 in FY 04-05 (Department of Human Services Figure Setting, February 25, 2004, page 51)	$21,840
	0.2% Personal Services Common Policy Base Reduction (Department of Human Services Figure Setting, February 25, 2004, page 51)	($72,164)
HB 04-1422	**FY 04-05 Long Bill**	**$39,362,220**
	September 3, 2004 1331 Emergency Supplemental - Transfer of Funds from Department of Human Services for Developmental Disability Waiver Program into State Plan Services (Joint Budget Committee letter to the State Controller, September 21, 2004)	($569,510)
	FY 04-05 Revised Spending Authority	**$38,792,710**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$754,674
	Performance-Based Pay	$350,343
	0.2% Personal Services Common Policy Base Reduction	($78,262)
	Annualization of September 3, 2004 1331 Emergency Supplemental for FY 05-06 -- Transfer of Funds from Department of Human Services for Developmental Disability State Plan Services	($189,837)
	FY 05-06 Base Request	**$39,629,628**
	General Fund	$19,064,974
	Cash Funds Exempt	$749,840
	Federal Funds	$19,814,814

FEDERALLY-MATCHED LOCAL PROGRAM COSTS

The Federally–Matched Local Program Costs line provides spending authority to enable locally generated funds for developmental disability services to draw down a federal Medicaid match. The Centers for Medicare and Medicaid Services approved Colorado's

certification process to use these funds as the State's share of match for services provided by the Community Centered Boards for individuals enrolled in the Medicaid waiver programs who have developmental disabilities. This line was not included in the FY 03-04 Long Bill (SB 03-258). Rather, funding was established through the passage of the Department's Supplemental Bill (HB 04-1320), which appropriated $15,566,354. The FY 04-05 Long Bill (HB 04-1422) appropriation was $16,542,353, an increase of $975,999. This change was due to the Joint Budget Committee's approval of the Department of Health Care Policy and Financing's Budget Amendment Request, "Developmental Disabilities Local Match Certification" (#BA-NP5, page S.11-6, January 2, 2004) to increase the local match certification. Continuation funding of $16,542,353 is requested for FY 05-06. Of this amount, $8,271,177 is Cash Funds Exempt and $8,271,176 is federal funds.

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for FY 03-04. This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation. This adjustment is shown in the Schedule 3s.

DEPRECIATION AND ANNUAL ADJUSTMENTS

The Depreciation and Annual Adjustments line was created to resolve a discrepancy in expenditure patterns between the Department of Health Care Policy and Financing and the Department of Human Services. With the Regional Centers, there has been a pattern of annual overexpenditure. This occurred, in part, because depreciation amounts have been included in the daily rates the Department of Human Services charged to the Department of Health Care Policy and Financing for Regional Center clients. However, because depreciation is associated with a past expenditure and is not an operating expense included in the Department of Human Services operating budget, the Department of Human Services has never had the authority to spend this money. This line was established in HB 04-1320 with an appropriation of $1,460,194.

The FY 04-05 Long Bill (HB 04-1422) appropriation provided continuation funding of $1,460,194 and the FY 05-06 Base Request is for the same amount. The fund splits for this line are $730,097 General Fund and $730,097 federal funds.

In FY 03-04, this line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation; the adjustment is shown in the Schedule 3s.

SERVICES FOR PEOPLE WITH DISABILITIES, SERVICES FOR FAMILIES AND CHILDREN

The Services for Families and Children line provides funding to the twenty Community Centered Boards to administer early intervention, family support, and extended support services to children and families in community settings (Department of Human Services Figure Setting, February 25, 2004, page 57). The Children's Extensive Support waiver program is funded through this line. The FY 03-04 Long Bill (SB 03-258) appropriation was $3,745,315.

Following the signing of the FY 03-04 Long Bill, there was some legislative activity that, although it did not change the total fund appropriation, did impact funding splits for this line. First, SB 03-259 authorized the Department of Health Care Policy and Financing to collect a monthly fee from families of children enrolled in the Children's Extensive Support waiver program. This legislation added $253,244 in cash funds while reducing $253,244 in General Fund. A Supplemental and Budget Request Amendment (#NP-S7, #BA-NP 3) submitted January 2, 2004 identified errors to the fiscal note for SB 03-259. The estimated fees to be collected were over-estimated and there was an incorrect assumption that the fees collected could be matched with federal funds. The Department's Supplemental Bill, HB 04-1320 increased General Funds by $243,704, and decreased Cash Funds by $234,164 and $9,540 in federal funds; the net result was $0 to the appropriation amount.

The Budget Request Amendment, as reflected in the Long Bill for FY 04-05 (HB 04-1422) corrected the over-estimate of fees collected by modifying the fund splits. General Fund was decreased by $38,202, while Cash Funds from the Children's Home- and Community-Based Services Cash Fund were appropriated at $76,320, and federal funds were decreased by $38,201. The Long Bill for FY 04-05 also included an $83 dollar total fund reduction for 0.2% the Office of State Planning and Budgeting Common Policy reduction. Finally, SB 04-138 repealed the authority of the Department of Health Care Policy and Financing to charge a monthly fee to families whose children were enrolled in the Children's Home- and Community-Based Services or Children's Extensive Support waiver programs. The appropriation for FY 03-04 was adjusted by an increase of $9,540 to both General Fund and federal funds and removed $19,080 from Cash Funds, again for a $0 net impact. For FY 04-05, SB 04-138 removed the balance of the remaining Cash Funds in the FY 04-05 Long Bill appropriation of $76,320, and increased General Fund and federal funds by $38,160. All of this activity fully reversed the initial impact of SB 03-259, and brought the appropriation back to 50% General Fund and 50% federal funds.

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for FY 03-04. This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation, as shown in the Schedule 3s.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$3,745,315**
SB 03-259	Monthly Fee for Participants in Children's Extensive Support Waiver Program	$0
SB 04-138	Repeal of SB 03-259 – Adjusted Fund Splits, Removed Balance of Cash Funds	$0
HB 04-1320	**FY 03-04 Supplemental Bill**, "Adjust (H) Services for People with Disabilities – Services for Families and Children – Medicaid Funding for SB 03-259" (#NP-S7, submitted January 2, 2004, page S.11-3)	**$3,745,315**
	0.2% OSPB Common Policy Reduction (Department of Human Services Figure Setting, February 25, 2004, Page 10)	($83)
HB 04-1422	**FY 04-05 Long Bill**	**$3,745,232**
SB 04-138	Repeal of SB 03-259 – Adjusted Fund Splits, Removed Balance of Cash Funds	$0
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$875
	Performance-Based Pay	$135
	0.2% Personal Services Common Policy Base Reduction	($83)
	FY 05-06 Base Request	**$3,746,159**
	General Fund	$1,873,080
	Federal Funds	$1,873,079

ADULT ASSISTANCE PROGRAMS – COMMUNITY SERVICES FOR THE ELDERLY - MEDICAID FUNDING

The Adult Assistance - Community Services for the Elderly line helps fund the Department of Human Services' State Ombudsman Program. This program provides liaison services between the Department of Human Services and its clients who are being served by the Division of Aging and Adult Services. The FY 03-04 Long Bill (SB 03-258) appropriation was $1,800. However, there were no Medicaid dollars expended during FY 03-04.

The FY 04-05 Long Bill (HB 04-1422) appropriation amount remained constant at $1,800, and continuation funding is requested for FY 05-06. Of this amount, $900 is General Fund and $900 is federal funds.

DIVISION OF YOUTH CORRECTIONS

The Division of Youth Corrections provides management and oversight of juveniles who are detained while awaiting adjudication, and who are committed to the Department of Human Services after adjudication. The FY 03-04 Long Bill (SB 03-258) appropriation was $9,727,773.

Change Requests were submitted for FY 04-05. #NP-4, "Population Impacts on Contract Bed Placements" was submitted on November 3, 2003 (page H.9-2). #BASN-1, "Population Impacts on Contract Replacements" was submitted on January 23, 2004 (page BAS.6-1).

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation; the adjustment is shown in the Schedule 3s.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$9,727,773**
	Change Mix of Residential Treatment Centers and Residential Child Care Facilities (as noted in Department of Human Services Figure Setting, February 17, 2004, page 37)	$2,648,832
	Change Residential Treatment Center Rates and Providers Used in Bed Plan (as noted in Department of Human Services Figure Setting, February 17, 2004, page 37)	$252,082
	Lookout Mountain Beds (as noted in Department of Human Services Figure Setting, February 17, 2004, page 37)	($687,551)
	Annualization of Mount View Beds (as noted in Department of Human Services Figure Setting, February 17, 2004, page 37)	($229,184)
	Leap Year Adjustment (as noted in Department of Human Services Figure Setting, February 17, 2004, page 37)	($31,117)
	Caseload and Miscellaneous Adjustments (as noted in Department of Human Services Figure Setting, February 17, 2004, page 37)	($116,990)
HB 04-1422	**FY 04-05 Long Bill**	**$11,563,845**
	1331 Emergency Supplemental[34] – Request for Additional Funds for Contract Beds for FY 04-05	$1,602,469
	FY 04-05 Spending Authority	**$13,166,314**
	FY 05-06 Base Request	**$13,166,314**
	General Fund	$6,583,157
	Federal Funds	$6,583,157

[34]See memorandum from Joint Budget Committee staff dated June 21, 2004. While this is not an official appropriation for FY 04-05, approval granted temporary spending authority to the Department. Additional funding was based upon unanticipated caseload growth, higher than projected negotiated contract costs, and additional juvenile probation supervision slots in the Judicial Department.

APPROPRIATION CROSSWALK

The following table was developed to compare the FY 04-05 appropriations for the Department of Health Care Policy and Financing directly with the appropriations for the Department of Human Services. It serves as a crosswalk between Long Bills so that the end location of the Medicaid funding is known.

Department of Health Care Policy and Financing's Long Bill Line Items	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Department of Human Services' Long Bill Line Items
(6) DHS MEDICAID- FUNDED PROGRAMS						
(A) Executive Director's Office – Medicaid Funding						**(1) Executive Director's Office**
FY 04-05 Long Bill (HB 04-1422)	$9,502,563	$4,751,283	$0	$0	$4,751,280	Letternote (1) (A) (b) and Letternote (1) (B) (b)
(B) Office of Information Technology Services – Medicaid Funding						**(2) Office of Information Technology Services**
Colorado Benefits Management System						**Colorado Benefits Management System (CBMS)**
FY 04-05 Long Bill (HB 04-1422)	$5,299,435	$2,772,241	$0	$27,406	$2,499,788	Letternote (2) (l)
Other Office of Information Technology Services Line Items						**(2) Office of Information Technology Services**
FY 04-05 Long Bill (HB 04-1422)	$507,026	$253,513	$0	$0	$253,513	Letternotes (2) b, e, g, h, i, o
(C) Office of Operations – Medicaid Funding						**(3) Office of Operations**
FY 04-05 Long Bill (HB 04-1422)	$5,226,867	$2,613,434	$0	$0	$2,613,433	Letternote (3) b
(D) County Administration – Medicaid Funding						**(4) County Administration**
FY 04-05 Long Bill (HB 04-1422)	$8,624,879	$3,234,330	$0	$0	$5,390,549	Letternote (4) a
(E) Division of Child Welfare – Medicaid Funding						**(5) Division of Child Welfare, Child Welfare Services**
FY 04-05 Long Bill (HB 04-1422)	$79,473,510	$39,736,755	$0	$0	$39,736,755	Letternotes (5) a, e
(F) Office of Self Sufficiency, Disability Determination Services- Medicaid Funding						**(7) Office of Self Sufficiency, (E) Disability Determination Services**

Department of Health Care Policy and Financing's Long Bill Line Items	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Department of Human Services' Long Bill Line Items
1331 Emergency Supplemental - Removes this program from DHS Office of Self Sufficiency, and creates as a new line (Disability Determination Services) within the HCPF Executive Director's Office Long Bill Group.	($1,163,662)	(581,831)	$0	$0	(581,831)	
FY 04-05 Long Bill (HB 04-1422)	$1,163,662	$581,831	$0	$0	$581,831	Letternote (7) (E) a
(G) Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding						**(8) Mental Health and Alcohol and Drug Abuse Services, (A) Administration**
Administration						
FY 04-05 Long Bill (HB 04-1422)	$277,951	$138,976	$0	$0	$138,975	Letternote (8) (A) b
Goebel Lawsuit						**(B) (2) Goebel Lawsuit**
FY 04-05 Long Bill (HB 04-1422)	$11,655,586	$5,827,793	$0	$0	$5,827,793	Letternote (8) (B) (2) a
Mental Health Institutes						**(C) Mental Health Institutes**
FY 04-05 Long Bill (HB 04-1422)	$4,876,070	$2,438,035	$0	$0	$2,438,035	DHS Letternote (8) (C) b
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program						**(D) Alcohol and Drug Abuse Division, (2) Community Programs, (a) Treatment Services, High Risk Pregnant Women Program**
FY 04-05 Revised Available Funding	$567,720	$235,957	$0	$47,902	$283,861	
HB 04-1075 Extension of Post-Partum Period of Services	$95,805	$0	$0	$47,902	$47,903	
FY 04-05 Long Bill (HB 04-1422)	$471,915	$235,957	$0	$0	$235,958	Letternote (8) (D) (2) (a) d
Residential Treatment for Youth (HB 99-1116)						**Residential Treatment for Youth (HB 99-1116)**
HB 04-1421 Tobacco Litigation Settlement Cash Fund Distribution	$418,132	$0	$0	$209,066	$209,066	
FY 04-05 Long Bill (HB 04-1422)	$0	$0	$0	$0	$0	Not Included in Long Bill
(H) Services for People with Disabilities – Medicaid Funding						
Community Services-Medicaid Funding						**(9) Services For People With Disabilities, (A) Developmental Disability Services, (1) Community Services, Adult Program Costs**

Department of Health Care Policy and Financing's Long Bill Line Items	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds	Department of Human Services' Long Bill Line Items
FY 04-05 Revised Available Funding	$217,841,679	$108,920,839	$0	$0	$108,920,840	
1331 Emergency Supplemental -- Reduction Related to Transfer of Funds from DD Waiver Program into the Medicaid State Plan (JBC Letter, September 21, 2004)	($1,196,639)	($598,320)	$0	$0	($598,319)	
FY 04-05 Long Bill (HB 04-1422)	$219,038,318	$109,519,159	$0	$0	$109,519,159	Letternotes (9) (A) (1) a, b
Regional Centers-Medicaid Funding						**(9) Services For People With Disabilities, (A) Developmental Disability Services, (2) Regional Centers**
FY 04-05 Revised Available Funding	$38,792,710	$18,646,515	$0	$749,840	$19,396,355	
1331 Emergency Supplemental -- Reduction related to Transfer of Funds from DD Waiver Program into the Medicaid State Plan (JBC Letter, September 21, 2004)	($569,510)	($284,755)	$0	$0	($284,755)	
FY 04-05 Long Bill (HB 04-1422)	$39,362,220	$18,931,270	$0	$749,840	$19,681,110	DHS Letternote (9) (A) (2) b
Federally-Matched Local Program Costs						**(9) Services For People With Disabilities, (A) Developmental Disability Services, (1) Community Services, Federally- Matched Local Program Costs**
FY 04-05 Long Bill (HB 04-1422)	$16,542,353	$0	$0	$8,271,177	$8,271,176	Letternote (9) (A) (1) c
Depreciation and Annual Adjustments						
FY 04-05 Long Bill (HB 04-1422)	$1,460,194	$730,097	$0	$0	$730,097	Not in DHS Long Bill
Services for Families and Children - Medicaid Funding						
FY 04-05 Long Bill (HB 04-1422)	$3,745,232	$1,834,456	$76,320	$0	$1,834,456	Letternote (9) (A) (3) a, b
(I) Adult Assistance Programs; Community Services for the Elderly – Medicaid Funding						**(10) Adult Assistance Programs, (D) Community Services for the Elderly, State Ombudsman Program**
FY 04-05 Long Bill (HB 04-1422)	$1,800	$900	$0	$0	$900	Letternote (10) (D) d
(J) Division of Youth Corrections – Medicaid Funding						**(11) Division of Youth Corrections, (C) Community Programs, Purchase of Contract Placements, and**

Department of Health Care Policy and Financing's Long Bill Line Items	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**	**Department of Human Services' Long Bill Line Items**
						Managed Care Pilot Project
FY 04-05 Revised Available Funding (Includes 1331 Supplemental)	$13,166,314	$6,583,157	$0	$0	$6,583,157	
DHS 1331 Supplemental Request For FY 04-05 on June 21, 2004. Additional Funds for Contract Commitment Beds. JBC Recommends Approval	$1,602,469	$801,235	$0	$0	$801,234	DHS 1331 Supplemental Request For FY 04-05 on June 21, 2004. Additional Funds for Contract Commitment Beds. JBC Recommends Approval.
FY 04-05 Long Bill (HB 04-1422)	$11,563,845	$5,781,922	$0	$0	$5,781,923	Letternote (11) (C) c