Department of Health Care Policy and Financing
Assumptions and Calculations
FY 06-07

Budget Request

NOVEMBER 15, 2005

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ORGANIZATION

This document is presented in Long Bill line item order. However, it begins with a discussion of Amendment 35 to the state Constitution, anecdotally known as "the tobacco tax" because of its significant impact on the Department's budget. A discussion of the temporary increase in the Federal Medical Assistance Percentage is also included since it affected several line items 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.

TOBACCO TAX FUNDING

Overview

In the fall of 2004, the citizens of Colorado voted in favor of Amendment 35 to the State Constitution, increasing taxes on tobacco products purchased within the State. This tax increase went into effect January 2005 and was projected to increase State revenues by $62.9 million in FY 04-05 and $169.2 million in FY 05-06. All revenues collected from tobacco taxes are deposited into the Tobacco Tax Cash Fund and are dispersed to other cash funds in the following manner:

- 46% to the Health Care Expansion Fund, administered by the Department of Health Care Policy and Financing
- 19% to the Primary Care Fund, administered by the Department of Health Care Policy and Financing
- 16% to the Tobacco Education Programs Fund, administered by the Department of Public Health and Environment
- 16% to the Prevention, Early Detection, and Treatment Fund, administered by the Department of Public Health and Environment
- 3% to the Cash Fund for Health-Related Purposes to provide revenue for the State's General Fund, the Old Age Pension Fund, and for municipal and county governments.

HB 05-1262, signed by the Governor on May 31, 2005, specifies how the monies in each of the Cash Funds are to be used and provides an appropriation to the State departments for the purpose of implementing the legislation. The Health Care Expansion Fund and The Primary Care Fund are administered by the Department; however, the Department is also appropriated funds from the Prevention, Early Detection, and Treatment Fund and the Cash Fund for Health Related Purposes.

The Health Care Expansion Fund

The Health Care Expansion Fund receives 46% of the tobacco tax monies which was estimated at $28.9 million in FY 04-05 and at $77.8 million in FY 05-06. HB 05-1262 specifies that The Health Care Expansion Fund shall be used for the following purposes:

(A) Increase eligibility in the Children's Basic Health Plan for children and pregnant women from 185% to 200% of the federal poverty level.

The Department's fiscal note assumed that this provision could be implemented by July 1, 2005 and that an additional 4,246 children would enroll in FY 05-06. This fiscal note also estimated that the number of member months in the Prenatal and Delivery Program would increase by 3,684 for FY 05-06.

(B) Remove the Medicaid asset test.

The fiscal note assumed that this provision could be implemented by October 1, 2005. Removing the Medicaid asset test is an expansion to Medicaid eligibility, as clients who were previously found ineligible for Medicaid due to assets would now qualify. Because the Children's Basic Health Plan does not apply an asset test as a condition of eligibility, many of the clients affected by the asset test provision were already enrolled in the Children's Basic Health Plan. Approximately 39.5% of clients enrolled in the Children's Basic Health Plan had incomes low enough to qualify for Medicaid, but were denied for Medicaid due to the asset test. A provision in HB 05-1262 allows the Department to seek federal approval to continue providing benefits to these children under the Children's Basic Health Plan network until July 1, 2006; however, the children will be Medicaid eligible and will draw a 50% federal match under Title XIX. This provision is designed to assure patient continuity of care and provider network stabilization.

(C) Expand children's enrollment under the Children's Home and Community-Based Services Waiver and the Children's Extensive Support Waiver programs.

Due to funding constraints these programs have been capped to allow a limited number of children to be enrolled. There is a waiting list to enter the programs because the demand for these programs far exceeds the capacity. HB 05-1262 expands the capacity of these two waiver programs by the number of children on the waiting list as of January 1, 2005. At that time there were 148 children on the Children's Extensive Support Waiver Program and 478 children on the Children's Home and Community Based Services waiting list.

(D) Increase Medicaid eligibility to parents of enrolled children up to at least 60% of the federal poverty level.

Through Section 1931 of the federal Medicaid statutes, parents are eligible for Medicaid benefits up to approximately 36% of the federal poverty level. HB 05-1262 provides funding to increase the eligibility for low income parents of enrolled children up to at least 60% of the federal poverty level. This provision is planned to take effect on July 1, 2006, except that the Department may delay the effective date until January 1, 2007 if it is necessary to achieve federal approval of a waiver to deliver streamlined health care to families and children.

(E) Fund Medicaid to legal immigrants.

SB 03-176 eliminated Medicaid coverage for certain optional legal immigrant populations; however the implementation of this bill was delayed due to a court order stay. Through the passage of HB 05-1086 and SB 05-209, $2,638,343 was appropriated in FY 04-05 and $6,216,752 for FY 05-06, as the State's share of funding for Medicaid coverage for the optional legal immigrant population. Both of these amounts were funded from Tobacco Tax funds. As a result, the legal immigrant population received continuous eligibility in Medicaid. HB 05-1262 also contains a provision to provide funding from the Health Care Expansion Fund for this population on an ongoing basis.

(F) Pay for enrollment increases above the FY 03-04 level in the Children's Basic Health Plan.

Due to budget constraints, enrollment into the Prenatal and Delivery Program was suspended during FY 03-04. As a result, there were 1,428 member months for pregnant women in FY 03-04. All enrollments of pregnant women above this level will be funded by the Health Care Expansion Fund. In addition, the FY 03-04 average monthly enrollment for children was 46,694, so any client count above this level will be considered an expansion population, and may be funded with monies from the Health Care Expansion Fund. However, due to the impact of removing the Medicaid asset test (discussed above), the children's caseload is not expected to exceed this level for several years.

(G) Provide cost-effective marketing of the Children's Basic Health Plan.

Resuming marketing in the Children's Basic Health Plan is expected to increase enrollments in both the Children's Basic Health Plan and in Medicaid, as new applicants to the Children's Basic Health Plan are first screened for Medicaid eligibility. Any additional caseload as a result of this marketing effort may be funded with Health Care Expansion Fund monies.

(H) Provide presumptive eligibility to pregnant women in Medicaid.

Presumptive eligibility for Medicaid was discontinued on September 1, 2004. Through the passage of HB 05-1262, the Department reinstated the presumptive eligibility process and will fund the State's share of these costs with Tobacco Tax monies.

Health Care Expansion Fund Appropriation

For FY 04-05 the Department's Executive Director's Office Long Bill group was appropriated $23,381 from the Health Care Expansion Fund, 26,474 in federal funds, for a total of $49,855 in total funds and 0.30 FTE. For FY 05-06, the following table summarizes the appropriation for the provisions discussed above, by line item in the Department's budget.

FY 05-06 Appropriation for HB 05-1262 from the Health Care Expansion Fund	FTE	Total Funds	Cash Funds Exempt from the Health Care Expansion Fund	Other Cash Funds Exempt	Cash Funds from annual enrollment fees	General Fund	Federal Funds
(1) Executive Director's Office - Personal Services	5.30	$326,733	$149,966	$0	$0	$0	$176,767
(1) Executive Director's Office - Operating Expenses	0.00	$27,446	$10,416	$0	$0	$0	$12,792

FY 05-06 Appropriation for HB 05-1262 from the Health Care Expansion Fund	**FTE**	**Total Funds**	**Cash Funds Exempt from the Health Care Expansion Fund**	**Other Cash Funds Exempt**	**Cash Funds from annual enrollment fees**	**General Fund**	**Federal Funds**
(1) Executive Director's Office - Commercial Leased Space	0.00	$9,548	$4,774	$0	$0	$0	$4,774
(1) Executive Director's Office - Acute Care Utilization Review	0.00	$8,560	$2,140	$0	$0	$0	$6,420
(1) Executive Director's Office - Long-Term Care Utilization Review	0.00	$76,858	$38,429	$0	$0	$0	$38,429
(1) Executive Director's Office - Medicaid Management Information Systems Contract	0.00	$785,207	$206,073	$0	$0	$0	$578,915
(1) Executive Director's Office - Medical Identification Cards	0.00	$21,131	$10,508	$0	$0	$0	$10,508
(1) Executive Director's Office - SB 97-05 Enrollment Broker	0.00	$45,589	$22,795	$0	$0	$0	$22,794
(1) Subtotal Executive Director's Office Total Request	**5.30**	**$1,296,500**	**$445,101**	**$0**	**$0**	**$0**	**$851,399**
(2) Medical Services Premiums - Medical Services Premiums	0.00	$45,539,358	$26,572,855	$0	$0	($3,803,176)	$22,769,679
(3) Mental Health Community Programs - Mental Health Programs	0.00	$3,858,412	$1,929,208	$0	$0	$0	$1,929,204
(4) Indigent Care Program - HB 97-1304 Children's Basic Health Plan Trust	0.00	($2,169,514)	$0	$0	$85,486	($2,255,000)	$0
(4) Indigent Care Program – Children's Basic Health Plan Administration	0.00	$1,396,000	$545,405	$0	$0	$0	$850,595

FY 05-06 Appropriation for HB 05-1262 from the Health Care Expansion Fund	**FTE**	**Total Funds**	**Cash Funds Exempt from the Health Care Expansion Fund**	**Other Cash Funds Exempt**	**Cash Funds from annual enrollment fees**	**General Fund**	**Federal Funds**
(4) Indigent Care Program – Children's Basic Health Plan Premium Costs	0.00	($4,289,242)	$8,297,098	($9,742,767)	$0	$0	($2,843,573)
(4) Indigent Care Program – Children's Basic Health Plan Dental Benefit Costs	0.00	($700,968)	$253,385	($498,724)	$0	$0	($455,629)
(5) Other Medical Services - S.B. 97-101 Public School Health Services	0.00	$1,385,188	$0	$692,594	$0	$0	$692,594
(6) Department of Human Services Medicaid-Funded Programs (B) Office of Information Technology Services - Medicaid Funding - Colorado Benefits Management Systems	0.00	$304,508	$150,884	$0	$0	$0	$153,624
(6) Department of Human Services Medicaid-Funded Programs (H) Services for People with Disabilities - Medicaid Funding, Community Services Program Costs and CCMS Replacement - Medicaid Funding	0.00	$161,320	$26,820	$0	$0	$53,840	$80,660
(6) Department of Human Services Medicaid-Funded Programs (H) Services for People with Disabilities - Medicaid Funding, Services for Children and Families - Medicaid Funding	0.00	$2,370,114	$392,235	$0	$0	$792,822	$1,185,057

FY 05-06 Appropriation for HB 05-1262 from the Health Care Expansion Fund	FTE	Total Funds	Cash Funds Exempt from the Health Care Expansion Fund	Other Cash Funds Exempt	Cash Funds from annual enrollment fees	General Fund	Federal Funds
Total FY 05-06 Appropriation for HB 05-1262 from the Health Care Expansion Fund	**5.30**	**$49,151,676**	**$38,612,991**	**($9,548,897)**	**$85,486**	**($5,211,514)**	**$25,213,610**

[1] Other Cash Funds Exempt are from the Children's Basic Health Plan Trust Fund.
[2] Other Cash Funds Exempt are certified public expenditures from school districts.

The Primary Care Fund

The Primary Care Fund receives 19% of the tobacco tax monies which was estimated at $11,951,000 for FY 04-05 and $32,148,000 for FY 05-06. The total amount of revenue for both years ($44,099,000) was appropriated for use in FY 05-06. The Department will annually allocate monies in the Primary Care Fund to all eligible qualified providers in the State. The basis of the allocation will be the number of uninsured or medically indigent patients served by the qualified providers. $99,000 of the $44,099,000 is to fund administrative expenses including Personal Services and Operating Expenses for 1.0 FTE. The remaining $44,000,000 will be allocated to providers.

Primary Care Fund Appropriation	FTE	Cash Funds Exempt*
Personal Services	1.00	$0
Comprehensive Primary Care Program Administration	0.00	$99,000
Comprehensive Primary Care Program	0.00	$44,000,000
Total FY 05-06 Appropriation	**1.00**	**$44,099,000**

* Cash Funds Exempt are from the Primary Care Fund.

The Prevention, Early Detection, and Treatment Fund

The Prevention, Early Detection and Treatment Fund receives 16% of the tobacco tax monies which is estimated at $10.1 million for FY 04-05 and $27.1 million for FY 05-06. This fund is administered by the Department of Public Health and Environment; however, HB 05-1262 provides for a transfer of funds to the Department of Health Care Policy and Financing for the following two purposes:

- ***Medicaid Disease Management Programs***
  The table below shows the FY 05-06 appropriation for Disease Management Programs.

Appropriation for the Medicaid Disease Management Program	FTE	Total Funds	Cash Funds Exempt*	Federal Funds
Personal Services	1.00	$54,466	$27,233	$27,233
Operating Expenses	0.00	$4,238	$2,119	$2,119
Medical Services Premiums	0.00	$3,940,776	$1,970,388	$1,970,388
Total FY 05-06 Appropriation	**1.00**	**$3,999,480**	**$1,999,740**	**$1,999,740**

* Cash Funds Exempt are transferred from the Department of Public Health and Environment and come from the Prevention, Early Detection, and Treatment Fund.

- ***Breast and Cervical Cancer Treatment***
  HB 05-1262 also provides additional monies for cancer screenings. As additional women are screened, the number of women who need to be treated due to a positive diagnosis will increase. The appropriation for the Breast and Cervical Cancer Treatment is based on an increase in caseload of 91 clients in FY 05-06.

Appropriation for the Breast and Cervical Cancer Treatment	Total Funds	Cash Funds Exempt*	General Fund	Federal Funds
Medicaid Management Information System	$0	$219	($219)	$0
Medical Identification Cards	$115	$41	$0	$74
Medical Services Premiums	$2,588,425	$905,884	$0	$1,682,541
Mental Health Programs	$12,635	$4,422	$0	$8,213
Total FY 05-06 Appropriation	**$2,601,175**	**$910,566**	**($219)**	**$1,690,828**

* Cash Funds Exempt are transferred from the Department of Public Health and Environment and come from the Prevention, Early Detection, and Treatment Fund.

Cash Fund for Health-Related Purposes
The Cash Fund for Health-Related Purposes receives 3% of the tobacco tax monies which is estimated at $1,887,000 for FY 04-05 and $5,076,000 for FY 05-06.

- HB 05-1262 allocates 50% of the funds in the Cash Fund for Health-Related Purposes to the Supplemental Old Age Pension Health and Medical Care Fund.

Appropriation from the Cash Fund for Health-Related Purposes	Cash Funds Exempt*	
	FY 04-05	FY 05-06
Supplemental Old Age Pension Health and Medical Care Fund	$943,500	$2,538,000

*Cash Funds Exempt are transferred from the Cash Fund for Health-Related Purposes

- 20% of the funds in the Cash Fund for Health-Related Purposes will be allocated to the State's General Fund for Health-Related Purposes. Beginning in FY 06-07, the Department's Pediatric Specialty Hospital Fund will be appropriated 50% of the portion going to the State's General Fund for the purpose of augmenting hospital reimbursement rates for regional Pediatric Trauma Centers.

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 to 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 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. Additionally, starting in FY 03-04, 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, 2005.

The Schedule 3 delineates the Personal Services appropriation, request of FTE, and request of Personal Services funding. The "FY 05-06 Estimate" and "FY 06-07 Request" columns consist of estimated expenditures of the FY 05-06 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. Central POTS (totaled in "I.D.") are added to include: 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 annualization 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 03-04 and FY 04-05. Then, the FY 05-06 Estimate and the FY 06-07 Base 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 03-04 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 $10,277,443 (I.A.); plus,
- Other Personal Services (I.B.) totaling $2,121,442 for items such as PERA, Medicare, Temporary Services, and Contractual Services, plus,
- POTS expenditures (I.D.) of $365,245 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 04-05 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 $10,835,787 (I.A.);
- Other Personal Services (I.B.) totaling $2,344,429 for items such as PERA, Medicare, Temporary Services, and Contractual Services; plus,
- POTS expenditures of $427,221 (I.D.) that consist of Health/Life/Dental and Short Term Disability Insurance. Expenditures for Salary Survey and Senior Executive Services of $248,845 and Performance-based Pay of $136,130, and are non-add items as they are included in the salary costs in I.A. above.
- Shift Differential is not applicable to Health Care Policy and Financing.

The FY 05-06 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 05-06 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, 2005 salary x 12), yielding $11,953,720 with 213.4 FTE. The next step was to add Other Personal Services, of $3,783,803. This amount includes:

- PERA of $1,213,303 calculated using 10.15% of the $11,953,720 above;
- Medicare of $173,329 calculated using 1.45% of the $11,953,720 above;
- State Temporary Services of $60,000 incorporating existing Personnel Action Requests and estimates provided by program managers;
- Other Temporary Services, which includes contracted temporary services, estimated at $1,113,412 considering current Department contracts as well as estimates provided by program managers including one time funding in the amounts of $507,354 for the Medicare Modernization Act in SB 05-209 and $480,980 for temporary staffing for the Colorado Benefits Management System court order compliance approved by the Joint Budget Committee on September 20, 2005;
- Contractual Services estimated at $1,026,092 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 $160,000 for unused vacation/sick time accumulated during employment – estimated on an approximate ratio of FY 04-05 payouts and FY 05-06 salary base;
- Unemployment Insurance of $33,667 based on FY 04-05 actual expenditure ratios applied against the FY 05-06 salary base; and
- Employee incentives of $4,000 estimated according to actuals from FY 04-05.

POTS expenditures of $495,957, 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 $16,628,014 for the 213.4 FTE. Appropriated amounts for Salary Survey of $394,534 and Performance-based Pay Awards of $0 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 05-06 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 (213.4) 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 8 vacant positions and each was reduced from 1.0 FTE to 0.36 FTE. This does not mean that these 8 positions will be exactly 0.36 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 06-07 Request column shows the positions' salary costs as reflected in the FY 05-06 Estimate column, including the FY 05-06 Salary Survey and Performance-based Pay Awards increases. The difference in these amounts reflects a net reduction of 0.3 FTE and $24,368 due to the impacts of HB 05-1262, the Tobacco Tax bill, a reduction of 0.8 FTE and $40,904, and an increase of 0.5 FTE and $16,536 due to the Medicare Modernization Act

Other Personal Services amounts (I.B.) are identical to the ones used in the FY 05-06 Estimate column with the following exceptions, bringing the total to $2,787,392:

- PERA decrease of $2,474 for Salary Survey, Range Adjustments, and Performance-based Pay increases in FY 06-07 based on the reduction of 0.3 FTE from FY 05-06 to FY 06-07;
- Medicare decrease of $353 for the same factors;
- State Temporary Services increase of $24,650 based on program management projections;
- Other Temporary Services decreased to exclude $1,018,234 one-time funding only applicable for FY 05-06. The decrease reflected $29,900 for SB 04-177 Treatment of Autism, $507,354 for temporary employees working on the Medicare Modernization Act, and $480,980 for the temporary staffing associated with the Colorado Benefits Management System court ordered compliance approved by the Joint Budget Committee on September 20, 2005.

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 06-07 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 06-07 Budget Request for this line, calculated as outlined in the Budget Request Instructions issued June 1, 2005 (page 8-8). These adjustments include special bills, Supplemental appropriations, Salary Survey, Range Adjustments, Medicare Differential, Performance-based Pay, 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 06-07 Base Request before POTS is derived in the table below by applying the legislative and Common Policy adjustments to the FY 05-06 Long Bill (SB 05-209). To calculate Section II.A., special bill adjustments are made, including annualization for some bills.

B. The FY 05-06 Salary Survey (II.B.) is included. The Salary Survey amount is the FY 05-06 appropriated amount of $394,534. Both exempt (the Executive Director) and classified employees are included in Salary Survey.

C. Range Adjustments are calculated by starting with the June 2006 estimated salaries for currently filled or approved to fill positions. There are 52 FTE identified below the pay range minimum after the computation of FY 06-07 salary survey. Any positions that do not meet the minimum pay requirement per the FY 06-07 Annual Compensation Survey Report issued by the Department of Personnel and Administration on August 1, 2005, are increased to equal the minimum salary requirement.

D. FY 05-06 Performance-based Pay is then added. This amount equals the FY 05-06 appropriated amount of $0. Performance-based Pay is not allocated to exempt employees.

E. Medicare and PERA rates are calculated on Base Salary, Salary Survey, and Range Adjustments. The Medicare Differential of $9,593 is the portion of the Medicare calculation pertaining to employees exempt from the Medicare deduction due to a date of hire prior to April 1, 1986 (per Common Policy Instructions for the FY 06-07 Budget Submission, issued July 15, 2005, page 5). Currently there are 9 employees within the Department whose salaries should not be included in the Medicare calculation. Therefore, in FY 06-07, $9,593 is backed out from the total Medicare calculation. This amount is based on base salaries, Salary Survey, and Performance-based Pay for these 9 individuals.

F. Removal of one time funding of $29,900 for temporaries to support changes to the Colorado Benefits Management System promulgated by SB 04-177, these funds have been incorporated in the FY 05-06 Long Bill.

G. Removal of one time funding of $490,818 and 15 temporary staff positions associated with implementation of the Medicare Modernization Act of 2003, and the annualization of the 0.5 FTE for customer service.

H. 26-4-532, CRS, (2005) required statutory changes in funding splits associated with the Breast and Cervical Cancer Treatment program. This has no net effect on the total appropriation, it merely transfers funding from the General Fund to Cash Fund Exempt. HB 04-1416 revised this statute in 2004 requiring 8.75% of funding for this program to come from the Breast and Cervical Cancer Prevention and Treatment fund in FY 06-07.

I. After a FY 06-07 subtotal has been calculated on components A – H, a 0.2% reduction is taken on the subtotal as the Office of State Planning and Budgeting requires.

J. Lastly, the incremental Statewide Indirect Cost allocation is applied. The "Statewide Indirect" adjustment is a departmental allocation developed by the State Controller's Office, distributed to the State departments with the Common Policies (August 8, 2005). 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 05-06 allocation and the FY 06-07 allocation is shown, including fund splits. The incremental difference between the two years' General Fund is a decrease of $148,090. 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 05-06 Allocation from State Controller's Office	$0	($653,523)	$17,517	$636,006
FY 06-07 Allocation from State Controller's Office	$0	($801,613)	$15,639	$785,974
Incremental Difference between the 2 years	$0	($148,090)	($1,878)	$149,968

It is important to know the sources of Cash Funds Exempt requested in the line item (II.K.). The following table shows how the Cash Funds Exempt is allocated by program:

FY 06-07 Base Request Cash Funds Exempt Allocation					
Breast and Cervical Cancer Trust Fund	Children's Basic Health Plan Trust Fund	Autism Treatment Fund	Grants, Gifts and Donations	Tobacco Expansion Fund	Total Cash Funds Exempt Requested
$9,021	$202,426	$26,392	$13,779	$134,073	$385,691

The following table delineates the sum of all adjustments:

Personal Services Activity from FY 05-06 to FY 06-07 Base Request

	Total Funds	General Fund	Cash Funds Exempt	Federal Funds	FTE
FY 05-06 Long Bill SB 05-209	**$14,415,497**	**$6,378,415**	**$275,340**	**$7,761,742**	**206.1**
HB 05-1262 (Tobacco Tax Bill)	$381,199	$0	$177,199	$204,000	6.3
HB 05-1243 (Consumer Directed Care)	$26,570	$13,285	$0	$13,285	0.5
HB 05-1066 (Treatment of Obesity)	$27,233	$0	$13,617	$13,616	0.5
FY 05-06 Appropriation Before Special Bills	**$14,850,499**	**$6,391,700**	**$466,156**	**$7,992,643**	**213.4**
HB 05-1262 (Tobacco Tax Bill – out year removal of one time funding)	($100,936)	$0	($45,237)	($55,699)	(0.8)
SB 04-177 (Treatment of Autism – out year removal of one time funding for staff to work on CBMS changes)	($29,900)	$0	($14,950)	($14,950)	0.0
Annualization of Customer Service Intern, From Figure Setting March 15, 2005, page 21	$16,536	$8,268	$0	$8,268	0.5
Medicare Modernization Act of 2003 – out year removal of one time funding for temporary customer service staff	($507,354)	($253,677)	$0	($253,677)	0.0
FY 06-07 Base Request Before Common Policy Adjustments	**$14,228,845**	**$6,146,291**	**$405,969**	**$7,676,585**	**213.1**
B. FY 05-06 Salary Survey	$394,534	$172,506	$8,260	$213,768	0.0
C. Range Adjustment	$0	$0	$0	$0	0.0
D. FY 05-06 Performance Based Pay	$0	$0	$0	$0	0.0
E. Medicare Differential	($9,593)	($3,904)	$0	($5,689)	0.0
H. Statutorily Required Change to Funding Splits for the Breast and Cervical Cancer Treatment	$0	$25,832	($25,832)	$0	0.0
Subtotal Base Before OSPB 0.2% Reduction	**$14,613,786**	**6,340,725**	**$388, 397**	**$7,884,664**	**213.1**
H. Less OSPB Base Adjustment of 0.2%	($29,227)	($12,630)	($828)	($15,769)	0.0
I. Incremental Indirect Cost Allocation	$0	($148,090)	($1,878)	$149,968	0.0
Total FY 06-07 Base Request	**$14,584,559**	**$6,180,005**	**$385,691***	**$8,018,863**	**213.1**

*Of this amount, $204,426 is from the Children's Basic Health Plan Trust, $9,021 is from the Breast and Cervical Cancer Prevention Treatment Fund, $13,779 is from Gifts, Grants and Donations, $134,073 is from the Tobacco Expansion Fund, and $26,392 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 03-04 Actual (III.A.) 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,
- 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,
- 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, Transition Medicaid Mental Health Services from the Department of Human Services to the Department, appropriated 2.3 FTE and $259,274 total funds; $112,415 General Fund and $146,859 federal funds.
- SB 04-138, Repeal of the Children's HCBS Waiver Program Fees included in SB 03-259 for families participating the Home and Community Based Services program, decreased total funds by $9,700 at 50% General Fund and 50% federal funds 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.

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

In 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 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 04-05 Actual, the calculation is as follows:

The FY 04-05 Long Bill appropriation (HB 04-1422) for the Executive Director's Office Personal Services consisted of $12,624,138 total funds and 196.1 FTE (III.A.); plus,

- SB 05-112, the Supplemental Bill which moved Mental Health Administration funding to Personal Services to be consistent with having all Personal Services within the appropriation, adding $678,199 and 7.0 FTE 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, 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"), increased total funds by $44,000.
- HB 05-1262, Tobacco Tax Implementation, funding for three positions for one month in FY 04-05, adding $49,617 and 0.3 FTE.

A roll forward in FY 04-05 for $31,263 was approved for the following programs: funding for a 1115 waiver for the Pediatric Hospice Care Program for $27,163 and $4,100 for Health Policy Solutions training contract with the Children's Basic Health Plan.

In 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 05-06 Appropriation Column is as follows:

The FY 05-06 Long Bill (SB 05-209) for the new Executive Director's Office Personal Services consists of $14,415,497 total funds with 206.1 FTE (III.A.). It includes 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 05-1066, Obesity Treatment for people with Body Mass Indexes exceeding 30%, increased total funds by $27,233 and 0.5 FTE; plus,
- HB 05-1243, Consumer Directed Care through the Home and Community Based Services model, increased total funds by $26,570 and 0.5 FTE; plus,
- HB 05-1262, Tobacco Tax implementation from the Tobacco Tax Cash Fund implemented pursuant to section 21 of Article 10 of the Colorado Constitution which increased total funds by $381,199 and 6.3 FTE;

The total appropriation for FY 05-06 is $14,850,499 with 213.4 FTE. No POTS are added in the Appropriation column.

For the FY 05-06 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 $31,263 and two Emergency 1331 Supplementals, one for HB 05-1262 authorized by the State Controller's Office on June 21, 2005 in the amount of $44,816, and the other for the Colorado Benefits Management System court order authorized by the State Controller's Office on September 20, 2005 in the amount of $480,980. Also, the Executive Director's Office portion of POTS (III.C.) is added, totaling $890,491 ($394,534 Salary Survey, $0 Performance Based Pay Awards, $476,625 Health/Life/Dental, and $19,332 Short-term Disability). POTS plus the Spending Authority Authorization (III.A.) equals the "III. Reconciliation Personal Services Total."

The Request FY 06-07 Column (III.) repeats the Department's Request from "II. Personal Services Request Total."

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 + 1, Employee + Spouse, 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 appropriation of $476,625 used 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 appropriation included 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 were then summarized by type and fund. The funding is in accordance to each employee's salary fund splits. In the FY 05-06 appropriation of $476,625, the rates for each plan were lower than those used to calculate the FY 04-05 Appropriation. However, the number of participants is higher.

The FY 06-07 Base Request also uses different rates for each plan provided in the Common Policies Supplement issued by the Office of State Planning and Budgeting. Additionally, the plan year now coincides with the State's fiscal year. Therefore, there is only one calculation for this line item. Other changes to the plan include the expansion of coverage options (employee, employee plus spouse, employee plus child or employee plus Spouse and Child). The Health, Life, and Dental request is based on employees with coverage as of June 2005. The FY 06-07 base request reflects both an increase in rates and participation by employees.

Health, Life, and Dental	Total Funds	General Fund	Cash Fund Exempt	Federal Funds
FY 05-06 Appropriation	**$476,625**	**$212,656**	**$10,156**	**$253,813**
Common Policy Adjustment	$153,015	$59,762	(1,138)	$92,115
FY 06-07 Base Request	**$629,640**	**$272,418**	**$11,294***	**$345,928**

***Of this amount, $11,294 is from the Children's Basic Health Plan Trust Fund.

SHORT-TERM DISABILITY

This is one of the components of POTS expenditure that 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, 2005. The appropriated amount is reflected in the Appropriation 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. 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 Appropriation was $19,332. This amount included calculations for personnel currently under the Medicaid Mental Health Community Programs, Program Administration line.

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). 0.16% was the estimated rate reflected in the Department's FY 05-06 Request.

The FY 06-07 Base Request for $19,836 is based on the Short-term Disability rate of 0.15% per Common Policy instructions issued by the Department of Personnel and Administration July 15, 2005, page 7. The Cash Funds Exempt portion increased due to the affect of HB 05-1262, the Tobacco Expansion Fund.

Short Term Disability	Appropriation/Request	General Fund	Cash Fund Exempt	Federal Funds
FY 05-06 Appropriation, SB 05-209	$19,332	$8,563	$294	$10,475
FY 06-07 Base Request	**$19,836**	**$8,704**	**$498***	**$10,634**

* Of this amount, $261 is from the Children's Basic Health Plan Trust Fund, $12 is from the Breast and Cervical Cancer Prevention and Treatment Fund, $18 is from Gifts, Grants, and Donations obtained through HB 05-1066 Treatment of Obesity, $173 is from the Tobacco Expansion Fund and $34 is from the Autism Treatment Fund.

SB 04-257 AMORTIZATION EQUALIZATION DISBURSEMENT

The Amortization Equalization Disbursement increases the employer contribution to the PERA Trust Fund to amortize the unfunded liability in the Trust Fund beginning in January 2006. The Budget Request for this line is computed per the Office of State Planning and Budgeting's Budget Instructions. The rate is provided by the Department of Personnel and Administration and is calculated using the sum of Base Salaries, Salary Survey and Range Adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The Amortization Equalization Disbursement rate is 0.50% of payroll for all divisions in FY 05-06, which is the first year of the appropriation. This rate will increase to 3.00% over seven years. For FY 06-07, the Amortization Equalization Disbursement increased to 0.75%. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation, and includes all employees eligible for State retirement benefits. The table below summarizes this request.

Amortization Equalization Disbursement	Appropriation/Request	General Funds	Cash Funds Exempt	Federal Funds
FY 05-06 Appropriation, SB 05-209	$27,857	$12,168	$500	$15,189
FY 06-07 Base Request	**$95,982**	**$42,119**	**$2,408***	**$51,455**

* Of this amount, $1,270 is from the Children's Basic Health Plan Trust Fund, $56 is from the Breast and Cervical Cancer Prevention and Treatment Fund, $86 is from Gifts, Grants, and Donations obtained through HB 05-1066 Treatment of Obesity, $832 is from the Tobacco Expansion Fund and $164 is from the Autism 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.

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 was 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.

In the Common Policy Instructions for FY 06-07, the State Personnel Director did not recommend funding salary increases, therefore there is no request for this line item.

Salary Survey Line Item	Appropriation/Request	General Fund	Cash Funds Exempt	Federal Funds
FY 05-06 Appropriation, SB 05-209	$394,534	$172,506	$8,260	$213,768
FY 06-07 Base Request	**$0**	**$0**	**$0**	**$0**

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 was 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.

In FY 05-06, the Joint Budget Committee adopted a Common Policy of no performance-based pay awards for FY 05-06. For FY 06-07, with the passage of Referendum C, the State Personnel director recommended funding for performance based pay at an average of 3.64% of base salaries.

Line Item: Performance-Based Pay	**Appropriation/Request**	**General Fund**	**Cash Fund Exempt**	**Federal Funds**
FY 03-04 Long Bill Appropriation	$0	$0	$0	$0
Common Policy	$130,514	$58,610	$795	$71,109
POTS for Mental Health Administration (9.0 FTE)	$5,616	2,808	$0	$2,808
FY 04-05 Long Bill HB 04-1422	$136,130	$61,418	$795	$73,917
FY 05-06 Appropriation	$0	$0	$0	$0
FY 06-07 Base Request	**$501,611**	**$220,118**	**$12,583**	**$268,910**

WORKERS' COMPENSATION

Workers' 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 appropriation reflected the Common Policy allocated dollar amount of $31,587 distributed by the Department of Personnel and Administration on August 9, 2004, plus the effects of SB 05-112 which reduced this appropriation by $1,286. For FY 06-07, the Request increased by $11,387 due to the Common Policy allocation issued August 10, 2005 by the Department of Personnel and Administration.

Line Item: Workers' Compensation	Appropriation/Request	General Fund	Cash Funds Exempt	Federal Funds
FY 03-04 Long Bill, SB 03-258	$36,186	$18,093	$0	$18,093
FY 04-05 Long Bill, HB 04-1422	$43,255	$21,628	$0	$21,627
SB 05-209, FY 05-06 Appropriation	$30,301	$15,151	$0	$15,150
FY 06-07 Base Request	**$41,688**	**$20,844**	**$0**	**$20,844**

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 $935,976 respectively. The FY 05-06 appropriation of $1,105,457 includes various Supplemental and Special Bills affecting the appropriation, most notably the Tobacco Tax and Medicare Modernization Act. See details in the table below. The FY 06-07 Base Request removes one time funding for these same programs, such as computers and office equipment.

The Department's FY 05-06 estimate differs from the appropriation due to one time appropriations. They are for two 1331 Emergency Supplementals that were approved by the Joint Budget Committee for HB 05-1262, the Tobacco Tax bill, authorized by the State Controller's Office on June 21, 2005 in the amount of $4,738 and $6,360 for Colorado Benefits Management System changes related to the court order authorized by the State Controller Office on September 20, 2005 which also approved rollforwards of $55,727 for cubicles and wiring of staff offices.

Line Item: Operating Expenses	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 03-04 Long Bill SB 03-258	**$954,308**	**$472,387**	**$0**	**$832**	**$481,089**
SB 03-266 Nursing Facility Provider Fees	$2,532	$0	$1,899	$0	$633
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 03-011 Prescription Drugs under Medicaid	$4,054	$1,013	$0	$0	$3,041
HB 04-1320 for 1331 Emergency Supplemental for Children's Basic Health Plan, dated August 5, 2003	$1,727	$0	$0	$0	$1,727
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)
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
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)
FY 03-04 Final Appropriation	**$965,755**	**$476,233**	$0	**$832**	**$488,690**
NP-2 (Truth in Rates), January 23, 2004	($674)	($337)	$0	$0	($337)
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)
Removal of annualized of one-time expenses (***see next table***)	***($30,023)***	($13,917)	$0	$0	($16,106)
Reinstate impact related to the FY 03-04 reduction from SB 04-138	$1,889	$945	$0	$0	$944
FY 04-05 Long Bill HB 04-1422	**$934,947**	**$461,924**	$0	**$832**	**$472,191**
HB 04-1219 Community Transition Services for HCBS	$2,256	$1,128	$0	$0	$1,128
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)
SB 05-112 Move Mental Health Administrative funding to EDO Operating Expense. Funding is for 7.0 FTE @ $870 per person	$6,090	$3,045	$0	$0	$3,045
HB 05-1262 Operating Expense for 3.0 FTE for one month in FY 04-05	$238	$0	$0	$96	$142

Line Item: Operating Expenses	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 04-05 Appropriation	**$935,976**	**$462,319**	**$0**	**$928**	**$472,729**
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
Removal of one time funding for HB 04-1219 Concerning Community Transition Services	($949)	($474)	$0	$0	($475)
HB 05-1262 was not passed prior to the Long Bill, and was not annualized through this process	($238)	$0	$0	($96)	($142)
BA #4 (Payment Error Rate Measurement Project, January 24, 2005)	$4,149	$1,876	$0	$0	$2,273
Medicare Modernization Act Adjustment due to JBC Action, additional funding for staffing related to Medicare Modernization Act implementation, Department of Health Care Policy and Financing Figure Setting, March 15, 2005, page 28.	$115,294	$57,647	$0	$0	$57,647
Move HIPAA Security Rule on-going maintenance to the Departmental Operating Expense, Department of Health Care Policy and Financing, Figure Setting, March 15, 2005, page 28.	$11,290	$5,476	$0	$119	$5,695
FY 05-06 Long Bill SB 05-209	**$1,070,261**	**$526,844**	**$0**	**$3,321**	**$540,096**
HB 05-1262 Operating Expenses associated with 5.1 FTE, and 7 network connections, to implement Tobacco Tax legislation	$27,446	$0	$0	$12,535	$14,911
HB 05-1243 Consumer Directed Care, expenses for 0.5 FTE to write waiver, assess MMIS and monitor case management agencies	$3,762	$1,881	$0	$0	$1,881
HB 05-1066 Treatment of Obesity, expenses for 0.5 FTE to manage pilot program	$3,988	$0	$0	$1,994	$1,994

Line Item: Operating Expenses	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 05-06 Appropriation	**$1,105,457**	**$528,725**	**$0**	**$17,850**	**$558,882**
Payment Error Rate Measurement Project, Remove one time funding, Public law 107-300	($3,280)	$0	$0	($1,483)	($1,797)
Medicare Modernization Act, Remove one time funding, Public Law 108-173	($113,394)	($56,697)	$0	$0	($56,697)
Tobacco Tax, Remove one time funding, HB 05-1262	($22,221)	$0	$0	($10,064)	($12,157)
Treatment of Obesity, Remove one time funding, HB 05-1066	($3,513)	$0	$0	($1,757)	($1,756)
Consumer Directed Care, Remove one time funding, HB 05-1243	($3,288)	($1,644)	$0	$0	($1,644)
Breast and Cervical Cancer Treatment, Statutory change in funding splits	$0	$187	$0	($187)	$0
FY 06-07 Base Request	**$959,761**	**$470,571**	**$0**	**$4,359**	**$484,831**

Removal of Annualized One Time Expenses in FY 04-05 of $30,023	**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

This Common Policy line item is billed to each department for legal services provided by the Department of Law. For FY 02-03, $801,499 was appropriated to the Department consisting of 13,403 hours at the $59.80 allowable blended attorney/paralegal hourly rate. 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 appropriation used a blended attorney/paralegal rate of $64.45 per hour for 12,684 hours for a total appropriation of $817,483. Of this, $331,724 is General Fund, $68,929 is Cash Funds, $5,662 is Cash Funds Exempt, and $411,168 is federal funds.

The FY 06-07 Base Request uses the same blended attorney/paralegal rate of $64.45 per hour established by the Common Policy Instructions on page 9, issued July 15, 2005. The FY 06-07 Base Request remains at 12,684 hours. The FY 06-07 Base Request is $817,483.

HMO LAWSUIT EXPENSES

In FY 02-03, three separate lawsuits related to the health maintenance organizations capitated rates were expected to go to trial. An Emergency Supplemental Request, #S-1, dated December 10, 2002 was submitted to support the Department's defense of 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), to 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 06-07.

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, two health maintenance organizations that contracted with the Department. These two health maintenance organizations 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 one-time appropriation for this line item in FY 03-04 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 06-07.

ADMINISTRATIVE LAW JUDGE SERVICES

This line item includes funding for services typically provided by administrative law judges and paralegals from the Office of Administrative Courts. 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 request year. 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 appropriated an additional $121,462, for a final appropriation amount of $660,591, per Supplemental Bill HB 04-1320.

For FY 04-05, 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 an appropriation of $676,943 in HB 04-1422. This amount was decreased by $67,300 through a Supplemental Common Policy adjustment contained in SB 05-112 to $609,643

The FY 05-06 appropriation was increased to $674,931 through a Common Policy adjustment and was based on the FY 05-06 Department's Administrative Law Judge Services allocation released on August 9, 2004 by the Department of Personnel and Administration. It was 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).

For FY 06-07, the Department's Request is for $517,208 which reflects a decrease of $157,723 due to the Common Policy allocation issued August 8, 2005. Below is a summary of the last three year's appropriations and the FY 06-07 Base Request by fund split.

Line Item: Administrative Law Judge Services	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
General Fund	$330,296	$304,822	$337,466	$258,604
Federal Funds	$330,295	$304,821	$337,465	$258,604
Appropriation/Request	**$660,591**	**$609,643**	**$674,931**	**$517,208**

PURCHASES OF SERVICES FROM COMPUTER CENTER

Prior to FY 04-05, this line item, Purchases of Services from Computer Center 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 are 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, costs of services provided, and cover 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. 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. This appropriation was reduced by $133,467 through a Common Policy adjustment (SB 05-112, FY 04-05 Supplemental Bill) to $162,948 total funds.

For FY 05-06, the Department was appropriated $156,311 based on Common Policies developed by the Department of Personnel and Administration. For FY 06-07, the Request amount of $92,289 total funding provided through Common Policies on August 9, 2004, was the share for the Department of Health Care Policy and Financing. This cost was calculated by the Department of Personnel and Administration.

Please see the following table for a specific reconciliation.

Description	FY 05-06 to Health Care Policy and Financing	FY 06-07 to Health Care Policy and Financing
General Government Computer Center - Medicaid Management Information System	$142,268	$75,822
General Government Computer Center - Long Term Care	$427	$232
Subtotal	**$142,695**	**$76,054**
Old Age Pension Services	$13,616	$16,235
Subtotal	**$13,616**	**$16,235**
TOTAL APPROPRIATION BASE / REQUEST	**$156,311**	**$92,289**
General Fund	$61,921	$29,910
Cash Funds Exempt (Old Age Pension)	$16,235	$16,235
Federal Funds	$78,155	$46,144

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 new cost methodologies and 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 with 50% federal match; however, an interagency agreement between the Department of Health Care Policy and Financing and Department of Human Services funds $16, 235 from the Old Age Pension fund.

PAYMENTS 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 Department does not participate in the Property Program; therefore this appropriation is for the Liability Program. 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 FY 05-06 appropriation was $63,618. The FY 06-07 Base Request is based on the Common Policies issued by the Department of Personnel and Administration, dated August 10, 2005, is $28,486.

Line Item: Payment to Risk Management and Property Funds	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Appropriation/ Request: Total Funds	$75,733	$78,312	$58,795	$63,618	$28,486
General Fund	$37,866	$39,156	$29,398	$31,810	$14,243
Federal Funds	$37,867	$39,156	$29,397	$31,808	$14,243

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 31,512 square feet at 1570 Grant Street.

In FY 02-03, the Department 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 for 27,661 square feet at $10.31 per square foot. This amount was increased further by $54,000 through SB 05-112, FY 04-05 Supplemental Bill for a final appropriation of $339,179. The FY 04-05 funding was increased due to a Common Policy Technical adjustment generated by the Department of Personnel and Administration (NP-S3, January 3, 2005).

The FY 05-06 appropriation was based on 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 request totaled $276,498 based on 27,661 square feet times $10 per square foot. 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. This amount was increased by $62,881 through a Common Policy Budget amendment submitted by OSPB, and then reduced by $2,722 through Common Policy adjustments made by the Department of Personnel and Administration.

For FY 06-07, the Department's Request of $341,249 is based on the Common Policy Allocation developed by the Department of Personnel and Administration issued August 8, 2005. It is calculated by multiplying the Department's useable square feet of 31,512 times $10.83 per square foot. The Department's useable square feet increased during FY 05-06 due to a change in the calculation method used by the Department of Personnel and Administration.

Line Item: Capitol Complex Leased Space	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
Square footage 1570 Grant	31,335	27,661	27,661	31,512
Rate	$9.8442	$10.31	$10.00	$10.83
Total Request	**$308,468**	**$285,179**	**$276,498**	**$341,249**
HB 04-1320 Supplemental Adjustment	($37,966)	$0	$0	$0
SB 05-112 Supplemental Adjustment FY 04-05	$0	$54,000	$0	$0
OSPB Budget Amendment FY 05-06, December 4, 2004	$0	$0	$62,881	$0
Common Policy Adjustment	$0	$0	($2,722)	$0
Adjustment to match Appropriation	$0	$0	($200)	$0

Line Item: Capitol Complex Leased Space	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Final Appropriation/Request	**$270,502**	**$339,179**	**$336,457**	**$341,249**

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 Early and Periodic Screening, Diagnosis, and Treatment administration program instead of the Department of Public 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 did not pursue the rental of commercial leased space. Supplemental Request #S-8 was submitted on January 2, 2004 to return the appropriation, and was approved by the Joint Budget Committee. Funding in FY 03-04 was reduced to $0 via Supplemental Bill HB 04-1320. For FY 04-05 there was no appropriation for this line item.

Due to the effects of the Medicare Modernization Act of 2003 the Department required additional staffing and associated space to house the employees. Therefore, for FY 05-06 the legislature appropriated $36,278 with 50% federal match through the Long Bill (SB 05-209) to house 15 temporary staff working on the Medicare Modernization Act of 2003 implementation. The Tobacco Tax bill (HB 05-1262) further increased this funding to provide 434 square feet of work space for the employees. The total FY 05-06 appropriation was for $45,826.

The FY 05-06 estimate reflects additional funding associated with two 1331 Emergency Supplementals, one for $4,400 authorized by the State Controller Office on June 21, 2005 to provide space for the additional FTE contained in the bill. The other for $24,955 is to house temporary staff working at the Colorado Benefits Management System emergency call center which is court ordered and authorized by the State Controller Office on September 20, 2005.

For FY 06-07, the Department's request is for $11,000 total funding as shown in the table below. This is due to the removal of $36,278 in one time funding for the temporary employees working on the Medicare Modernization Act of 2003. This amount is offset slightly due to the out-year effects of the Tobacco Tax implementation which results in an increase of $1,452 for an additional 66 square feet of space to house additional staff.

Line Item: Commercial Leased Space	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 04-05 Final Appropriation	**$0**	**$0**	**$0**	**$0**
FY 05-06 Long Bill (SB 05-209) One time Funding for MMA	$36,278	$18,139	$0	$18,139
HB 05-1262 Tobacco Tax Bill One Time Funding	$9,548	$0	$4,774	$4,774
FY 05-06 Final Appropriation	**$45,826**	**$18,139**	**$4,774**	**$22,913**
Removal of One time Funding for MMA	($36,278)	($18,139)	$0	($18,139)
HB 05-1262 Out year Funding	$1,452	$0	$726	$726
FY 06-07 Base Request	**$11,000**	**$0**	**$5,500**	**$5,500**

TRANSFER TO 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 June 2001 State Auditor's Office audit which recommended improvements in the management of Medicaid long term care community clients involved in the Single Entry Point 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. This amount remained the same for FY 05-06.

The Department of Human Services has stated that continuation funding of $74,564 is requested for FY 06-07. The table below shows the history of appropriations for the line.

Line Item: Transfer to the Department of Human Services for Related Administration	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
General Fund	$29,152	$29,152	$37,282	$37,282	$37,282
Federal Funds	$29,151	$29,151	$37,282	$37,282	$37,282
Appropriation/Request: Total Funds	**$58,303**	**$58,303**	**$74,564**	**$74,564**	**$74,564**

Inquiries related to the FY 06-07 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.

MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT

The Medicaid Management Information System is nationally recognized as an automated claim, 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 payment denial. Warrants are produced by the State based on the information electronically transmitted from the Medicaid Management Information System. The State 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. Federal regulations require that reprocurment of the contract be completed by December 1, 2006. However, reprocurement work activities are progressing slowly. The Department will most likely need to extend the contract with the current fiscal agent to July 1, 2007.

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 Medicaid 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 Treatment 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. Also including funding from the Tobacco Litigation Settlement Fund)
- Children's Basic Health Plan funding as Cash Funds Exempt to assist in support of the fixed price contract
- Cash Funds Exempt from the Colorado Autism Treatment Fund and,
- Cash Funds Exempt from the Health Care Expansion Fund authorized by HB 05-1262.

Claims processing expenditures for School Health claims are funded with 100% federal funds that are matched with certified local public expenditures. Postage expenditures reflect 50% General Fund and 50% federal funds. Pharmacy prior authorization reviews are approved for 50% federal financial participation with the State match from General Fund, but with Cash Funds Exempt for the expanded programs funded by the Health Care Expansion Fund. Programming changes, called, "Development Costs," are funded at either 75% federal financial participation or 90% federal financial participation if approved by the federal Centers for Medicare and Medicaid Services.

Beginning March 1, 2004, the Medicaid Management Information System contract was converted to a fixed price contract. (Previously, each work activity in the contract was billed separately.) For one fixed amount, the contract covers all claims processing, provider enrollment and notification, as well as most prior authorization reviews and system changes. Postage costs are actual costs that are not contained in the fixed contract amount. Review of specifically identified pharmacy prescriptions are not contained in this fixed contract amount.

The Tobacco Tax Bill, HB 05-1262, contributed a significant amount of funding to the Medicaid Management Information System Contract. A portion of this funding in FY 05-06 was for one-time Development Costs and other one-time purchases including additional centralized processing unit disk space for the Decision Support System. Most of the funding was for claims processing or pharmacy prior authorization reviews that began in FY 05-06 but continue in FY 06-07.

Please see the following table for an extensive reconciliation of past appropriations as well as the FY 06-07 base request.

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Fiscal Year 02-03	
Prior year beginning amount	$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 Developments 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
HB 02-1420 approved Budget Amendment #1 titled "Medicaid Management Information System Contract Adjustment" submitted January 2, 2002 for FY 02-03 in the amount of $951,612 to cover additional claims processing	$951,612
Total FY 02-03 Long Bill Appropriation HB 02-1420	$18,324,459

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

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 Balance Reduction 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) approved by 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) approved by 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) approved by 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 Development Costs) approved by SB 03-203 (Program was later terminated and the funding removed.)	$25,000
The Federal Mandate for Medicaid Managed Care Program for $109,978 was added, as requested by Supplemental Request #S-11 titled "Conform to Federal Mandate for Medicaid Managed Care Program" submitted January 2, 2003, approved by SB 03-203	$109,978
Supplemental Request, #NP-S6, 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 Add-On Section	$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 03-258	($25,000)
Annual 8-Drug Limit Therapeutic Consultation (in additional 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 Health and Environment's Figure Setting, March 6, 2003, page 95	$9,388

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Add Development Costs for changing the co-payment amounts of Medicaid clients to save on Medical Services Premiums of $85,000 per the Department's Figure Setting, March 13, page 55; SB 03-258	$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 the Medicaid Management Information System" to Move Orthodontia Prior Authorization Reviews Funding from Medical Services Premiums 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 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	$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)

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

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 #S-13 submitted January 29, 2002	$10,022
Remove Balance of Funding for Therapeutic Counseling Program	($478,700)
Remove Funding to Support Separate line item called Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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
Resulting 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	$224
Supplemental Request #S-4, Submitted January 3, 2005, titled "Fiscal Agent Adjustments" to add One-Time Funding for continued Bulletin Board Services and appropriated in SB 05-112	$14,357
Supplemental Request #S-4, Submitted January 3, 2005, titled "Fiscal Agent Adjustments" to add funding for Fixed Price and appropriated in SB 05-112	$1,236,648
Supplemental Request #S-5, Submitted January 3, 2005, titled "Fiscal Agent Adjustments" to include funding for billing delayed from prior year for HIPAA remediation in Medicaid Management Information System and appropriated in SB 05-112	$469,740
FY 04-05 Final Appropriation	**$21,983,967**
FY 05-06	
Before Adjustments	$21,983,967
Remove One-Time Funding for delayed HIPAA Billing	($469,740)

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Remove One-Time Funding for Bulletin Board Service in FY 04-05	($14,357)
Remove Development Costs for Updates to Drug Prior Authorization Reviews - SB 03-294	($20,000)
Add Claims Processing for Children with Autism - SB 04-177	$3,098
Add Prior Authorization Reviews for Children with Autism - SB 04-177	$2,220
Add Development Costs for Children with Autism - SB 04-177	$122,500
Annualize Claims Processing for Community Transition Services for the Elderly, Blind, and Disabled - HB 04-1219	$76
Add Development Costs for Community Transition Services for the Elderly, Blind, and Disabled - HB 04-1219	$75,000
Add Adjustment for School Based Health Claims as requested in Supplemental Request #S-4, Submitted January 3, 2005	$8,073
Adjust Old Age Pension Claims as requested in Supplemental Request #S-4, Submitted January 3, 2005	($48,886)
Add Funding for Non-Specified Claims in Fixed Price as requested in Supplemental Request #S-4, Submitted January 3, 2005	$780,884
JBC Action to add $244 to Medicaid Management Information System as make up for Shorted Funding in Supplemental Bill 05-112	$244
JBC Action to reduce Pharmacy Prior Authorization Reviews by $272,761 as an Offset to One-Time Funding for Development Costs for the Medicare Modernization Act	($272,761)
JBC Action to add $73,279 One-Time Funding for Development Costs for the Medicare Modernization Act	$73,279
Add $44,450 One-Time Development Costs for Substance Abuse Treatment as Authorized by HB 05-1015	$44,450
FY 05-06 Appropriation in Long Bill SB 05-209	**$22,268,047**
Add One-Time Cost for Central Processing Unit Disk Storage for Decision Support System per Tobacco Tax Bill, HB 05-1262	$43,000
Add Central Processing Disk Storage for the Drug Prescription Card System per Tobacco Tax Bill, HB 05-1262	$18,000
Add Claims Processing for Additional Caseload Associated with the Tobacco Tax Bill, HB 05-1262	$685,420
Additional Pharmacy Prior Authorization Reviews Associated with Caseload Associated with the Tobacco Tax Bill, HB 05-1262	$38,568

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM

Add One-Time Development Cost for Treatment of Obesity - HB 05-1066 (Contingent on receiving gifts and grants to cover)	$31,750
Add Pharmacy Prior Authorization Reviews for Treatment of Obesity - HB 05-1066 (Contingent on receiving gifts and grants to cover)	$5,795
Add One-Time Development Costs for Consumer Directed Care - HB 05-1243	$170,688
FY 05-06 Total Appropriated Long Bill Plus Special Bills	**$23,261,268**
FY 06-07	
Before Adjustments	$23,261,268
Remove One-Time Funding for Disk Storage for Decision Support System - HB 05-1262	($43,000)
Annualize Pharmacy Prior Authorization Reviews for Tobacco Tax Bill - HB 05-1262	$18,136
Annualize Claims Processing for Tobacco Tax Bill – HB 05-1262	$322,551
Annualize Pharmacy Prior Authorization Reviews for Treatment of Obesity - HB 05-1243	$5,794
Remove One-Time Development Costs for Children with Autism - SB 04-177	($122,500)
Remove One-Time Development Costs for Community Transitions for Elderly, Blind, and Disabled - HB 04-1219	($75,000)
Remove One-Time Development Costs for Medicare Modernization Act funded by JBC Recommendation	($73,279)
Remove One-Time Development Costs for Substance Abuse Treatment - authorized by HB 05-1015 but appropriated in Long Bill SB 05-09	($44,450)
Remove One-Time Development Costs for Consumer Directed Care - HB 05-1243	($170,688)
Remove One-Time Development Costs for Treatment of Obesity - HB 05-1066	($31,750)
FY 06-07 Base Request	**$23,047,082**
General Fund	$5,572,025
Cash Funds Exempt	$611,540
Federal Funds	$16,863,517

MMIS REPROCUREMENT

The current contract with Affiliated Computer Services, the fiscal agent for the Medicaid Management Information System Contract, expires November 30, 2006. The federal Centers for Medicare and Medicaid Services is requiring that the contract be reprocured. The reprocurement process is vital to the Department because the selected fiscal agent will operate the Medicaid Management

Information System over three to eight years that the new contract will be in effect. This line item covers funding for a contracted consultant to oversee the following functions: Issuing the Request for Proposals, evaluation of proposals received leading to the selection of the contracted fiscal agent, transition from the previous contracted fiscal agent to the new contracted fiscal agent, and other enhancements agreed upon with the new contracted fiscal agent. Oversight by a contracted consultant is necessary to insure that this process is completed in an efficient, quality manner.

If the current fiscal agent, Affiliated Computer Services, is reselected, the transition could be completed by FY 06-07 year end. If another fiscal agent is selected, the transition processes will take longer and may extend into FY 07-08.

A Supplemental and Budget Amendment Request, #S-5/ BA-2, submitted January 3, 2005, titled "Medicaid Management Information System Federally-Mandated Reprocurement," adjusted funding splits from the original funding requested in the 1331 Request submitted May 21, 2004. Approval for FY 04-05 was achieved by the Supplemental Bill, SB 05-112. Approval for FY 05-06 was achieved through the Long Bill, SB 05-209. FY 06-07 Base Request represents the expected out-year impact. Funding for reprocurement of the Medicaid Management Information System is usually at 75% federal financial participation. However, the federal Centers for Medicare and Medicaid Services occasionally approve funding at 90% federal financial participation for enhancements to the system. In this instance, the Department did receive approval from the Centers for Medicare and Medicaid Services for partial funding of enhancements at 90%, with regular reprocurement work activities approved for 75% federal financial participation. The Department is submitting a Decision Item that reflects the combination of 90% and 75% federal financial participation.

The Cash Funds Exempt portion of the funding is from the Children's Basic Health Plan Trust Fund. Medicaid contributes 97% of the costs, and the Children's Basic Health Plan contributes 3% of the total costs. These 97% and 3% contributions derive from other projects in the Department where the same percentages of contributions have been used historically, such as the current Medicaid Management Information System Contract that processes capitation payments for the Children's Basic Health Plan. The funding split for the Children's Basic Health Plan amount is 35% Cash Funds Exempt and 65% federal financial participation.

Funding history and Base Request for FY 06-07 for this line item follows.

HISTORY OF APPROPRIATIONS
MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT

Fiscal Year	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 04-05	$642,600	$146,481	$6,747	$489,372
FY 05-06	$579,600	$132,120	$6,086	$441,394
FY 06-07	$327,600	$74,677	$3,440	$249,483

HIPAA IMPLEMENTATION CONTRACT COSTS

This line item was created in FY 02-03 as the result of FY 02-03 Budget Amendment #3B (HIPAA Implementation), submitted January 24, 2002. The intent of this line item was to fund the implementation of the HIPAA Privacy and Transaction and Code Sets rules upon completion of a feasibility study. 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 through SB 03-203 with a reduction of $3,250,330 total funds. This occurred via a Joint Budget Committee action on January 22, 2003 and FY 03-04 Figure Setting (page 57, March 13, 2003), that related to contract costs associated with implementation of the HIPAA Transaction and Code Set rules. Based on the Joint Budget Committee recommendation these expenditures were delayed from FY 02-03 to FY 03-04 because the federally required effective date during the FY 03-04 was October 16, 2003. Another adjustment in SB 03-203 resulted from Supplemental #S-9/BA-5 that was submitted on January 2, 2003 for FY 02-03. This supplemental approved the capture of revised funding splits based upon a federally approved Advanced Planning Document and resulted in a reduction of $1,492,248 for the General Fund and $2,973 for the Cash Funds Exempt, as well as an increase of $1,495,221 in federal funds.

The FY 03-04 Long Bill Appropriation for this line item was $4,835,784. Additionally, $3,339,021 total funds were rolled forward from FY 02-03, of which $323,885 were General Fund Exempt, $35,060 were Cash Funds Exempt, and $2,980,076 were federal funds. 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 FY 02-03 for unencumbered contractual funds. The Joint Budget Committee approved an increase of $1,832,300 total funds with the passage of Supplemental Bill HB 04-1320. These funds were to finance the Web Portal Implementation, the Decision Support System licenses, and the operation of a dual operating system for providers for the first six months of the fiscal year. This was necessary to ensure the completion of the federally mandated Transaction and Code Set rule by October 16, 2003.

No funding for FY 04-05 was requested, although a $616,662 rollforward from FY 03-04 was approved. The Children's Basic Health Plan Trust Fund contributed 3% or $18,500 of these funds, with $6,475 being Cash Funds Exempt and the rest being Title XIX federal funds. The remaining 97% of these funds, or $598,162, was Medicaid administrative funding. 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 funding was requested or appropriated in FY 05-06.

No new funding is requested for FY 06-07. Refer to the chart below for historical 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**
Total Funds - Long Bill	**$11,530,545**	**$4,835,784***
General Fund	$2,753,374	$733,295
Cash Funds Exempt	$180,967	$52,218
Federal Funds	$8,596,204	$4,050,271
SB 03-203 - Reduction FY 02-03, restored FY 03-04	**($3,250,330)**	**$0**
General Fund	($315,282)	$0
Cash Funds Exempt	($34,129)	$0
Federal Funds	($2,900,919)	$0
SB 03-203 Fund Splits Adjustment from #S-9, #BA-5	**$0**	**$0**
General Fund	($1,492,248)	$0
Cash Funds Exempt	($2,973)	$0
Federal Funds	$1,495,221	$0
Revised Appropriation (subtotal)	**$8,280,215**	**$4,835,784**
General Funds	$945,844	$733,295
Cash Funds Exempt	$143,865	$52,218
Federal Funds	$7,190,506	$4,050,271
Rollforward from FY 02-03 to FY 03-04	**($3,339,021)**	**$3,339,021**
General Fund	($323,885)	$0
General Fund Exempt	$0	$323,885
Cash Funds Exempt	($35,060)	$35,060
Federal Funds	($2,980,076)	$2,980,076
1331 Emergency Supplemental - Approved by HB 04-1320	**$0**	**$1,832,300**
General Funds	$0	$212,478
Cash Funds Exempt	$0	$31,717
Federal Funds	$0	$1,588,105

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.

HIPAA IMPLEMENTATION CENTRAL STATE APPROPRIATIONS

This new line item in FY 02-03 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 for this line item was $2,214,057, which included a one-time estimated expenditure for the Privacy and Transaction and Code Sets rules as follows: $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) to SB 03-203 transferred the Privacy Officer to the HIPAA Implementation Staffing Costs line item, and adjusted 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, $662,500 in total funds was appropriated in the Long Bill (SB 03-258) for the Security Rule Feasibility Study per Figure Setting dated March 13, 2003, page 59. Of the $662,500 total funds, $450,000 was designated for Health Care Policy and Financing, and $212,500 for other departments. The $450,000 for Health Care Policy and Financing was apportioned at 97% Medicaid with a 75% federal match rate and 3% Children's Health Plan Plus with a 65% federal match rate. In addition, $731,041 total funds associated with the HIPAA Transaction and Code Set Rule for the Governor's Office of Innovation and Technology, the HIPAA Independent Validation and Verification contractor, and the Quality Assurance contractor were rolled forward from FY 02-03.

The Governor's Office of Innovation and Technology, which oversaw the implementation of the Independent Validation and Verification contract for the Transaction and Code Set Rule, 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 additional funds related to expenses such as professional services, legal support, office rent, printers and other unforeseen expenditures. These costs had initially been funded in FY 02-03 but were reverted. The Joint Budget Committee approved the Emergency Supplemental Request and increased this line item by $115,991 total funds through HB 04-1320, the Supplemental Bill.

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

In FY 03-04 the funding for this line item 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". This funding was approved in the Add-On section

of the FY 04-05 Long Bill, HB 04-1422. No funding for FY 04-05 and FY 05-6 was requested, and there is no request for FY 06-07. 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

*Does not include the rollforward $731,041 from FY 02-03 to FY 03-04

PAYMENT ERROR RATE MEASUREMENT PROJECT

This is a new line item in FY 05-06. The federal Improper Payments Information Act of 2002 requires the Department to conduct an annual review of those Medicaid services that may be susceptible to significant erroneous payments, to estimate the amount of improper payments made, and to report on those estimates. The Payment Error Rate Measurement Project is in response to the Improper Payments Act of 2002 and is the culmination of three separate federal pilot programs collectively referred to as the Payment Accuracy Measurement Projects. The Department participated in the Payment Accuracy Measurement Pilot Project for federal Fiscal Year 03-04 and was awarded a Payment Error Rate Measurement pilot grant on September 29, 2004 from the Centers for Medicare and Medicaid services for the federal Fiscal Year 04-05. This project focused on both fee-for-service and managed care claims in Medicaid and the Children's Basic Health Plan and produced state specific payment error estimates as required by the Centers for Medicare and Medicaid Services and the Improper Payment Information Act of 2002.

Under the proposed rules for the Payment Error Rate Measurement Project (final federal regulations are estimated to be issued in 2006) the Department is required to report improper payment estimates to the Centers for Medicare and Medicaid Services. An improper payment is defined by the federal Improper Payments Information Act of 2002 as "any payment made that should not have been made or that was made in an incorrect amount including overpayments and underpayments", and "includes any payment to an ineligible recipient; any payment for an ineligible service; any duplicate payment; payments for services not received; and any payment that does not account for credit for applicable discounts." To determine such errors, the Centers for Medicare and Medicaid Services anticipate a need for an annual sample size of between 800 and 1200 claims each for Medicaid and the Children's Basic Health Plan. The Department is required to submit a sampling plan to the Centers for Medicare and Medicaid Services for approval prior to beginning the sampling. The Department's use of RAT-STATS, a statistical audit tool in use at the federal Office of Audit Services, for determining this sample size was approved. This is to assure that the payment error rate is within +/- 3% of the true population error rate at a 95% confidence interval, a federal requirement.

The Payment Error Rate Measurement Project requires both Department oversight and a contractor to perform the statistical sampling and error calculations on a yearly basis. Consequently, a request for proposals was issued by the Department in FY 04-05 and the contract was awarded to Navigant Consulting. A portion of the cost of this contract was assumed to generate savings as corrective actions are taken to reduce payment errors. It is not known if the program will cause the cost of services to increase or decrease or stay the same. However, if insufficient recoveries are received to cover administrative costs, a supplemental request will be made.

Under the proposed federal rules, the Department was required to begin the full Payment Error Rate Measurement Project on October 1, 2005, the start of the federal fiscal year. Therefore, the Department submitted a FY 05-06 Stand Alone Budget Amendment Request (January 24, 2005, #BA-4, "Federally Required Payment Error Rate Measurement Project"), requesting funding for this line item in the amount of $1,171,632 for nine months of contractor costs to perform the statistical sampling and error calculations for the

Payment Error Rate Measurement Project and was appropriated through SB 05-209 Long Bill. In FY 06-07, the annualized request amount is $1,562,176 ($1,171,632 divided by 9 months multiplied by 12 months=$1,562,176) for this federally mandated program.

MEDICARE MODERNIZATION ACT OF 2003 COLORADO BENEFITS MANAGEMENT SYSTEM DEVELOPMENT COSTS

Congress passed Public Law 108-173, the Medicare prescription drug, Improvement and Modernization Act, that was signed into law, December 2003. This Act caused the implementation of prescription drug coverage for clients of Medicare, including dual eligible people who also have previously had drug coverage under Medicaid. The implementation date will be January 1, 2006. In order for Colorado Medicaid to identify the dual eligible clients who had their drug coverage converted to Medicare, the Department requested the Colorado Benefits Management System to change programming code for the system screens and monthly reports. This line item was the funding for the development work necessary in the Colorado Benefits Management System and was for one year only, FY 05-06. The funding splits are detailed in the chart below. There is no request for FY 06-07.

Fiscal Year	Total Funds	General Fund	Federal Funds
FY 05-06	$488,000	$244,000	$244,000

HIPAA WEB PORTAL MAINTENANCE

This line item was first established for FY 04-05. During FY 03-04, the Health Insurance Portability and Accountability (HIPAA) web portal development and implementation was contracted to an outside vendor, CGI Information Systems and Management Consultants, Inc. (effective September 30, 2004, the legal name for CGI Information Systems and Management Consultants, Inc. became CGI-AMS Inc.). Related expenditures were paid through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Implementation Contract Costs line item.

This infrastructure serves the Department's Internet and Intranet web sites and 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. Specific reports and files (such as claim responses for medical providers) are also transmitted from Affiliated Computer Services, Inc., the Department's fiscal agent. It is important to note, however, that the contract with CGI-AMS, Inc. for the web portal maintenance 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, in the amount of $312,900. The request was approved, and funding appeared in Long Bill HB 04-1422.

A rollforward from FY 03-04 to FY 04-05 taken from the Health Insurance Portability and Accountability Act of 1996 Implementation Contract Costs line item resulted in total funding in FY 04-05 of $929,562 ($312,900 from the Long Bill, HB 04-1422, plus $616,662 rollforward). During FY 05-06, the funding for this line item was $312,900 appropriated through the Long Bill,

SB 05-209. A rollforward from FY 04-05 to FY 05-06 for $20,605 also occurred. The FY 06-07 Base Request is for continuation funding of $312,900. Expenditures for this line receive a 75% federal match.

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, policy planning and procedures writing were not approved. These work activities were recommended to 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. Compliance with the HIPAA Security Rule was implemented on April 18, 2005.

During FY 04-05, several computer and security services were purchased for the security rule implementation. These items had higher costs for initial purchases, followed by lower costs for ongoing licensing fees for software and security services needed for new employees. Since implementation was completed in FY 04-05, the Department entered into maintenance mode in FY 05-06 because the HIPAA rules require permanent continuation of the security measures. Funding in FY 05-06 for ongoing maintenance costs equal $11,290 and was moved into Operating Expenses. This same arrangement is expected to continue in future years. Therefore, there is no request for separate funding for FY 06-07.

MEDICAL IDENTIFICATION CARDS

Historically, Medicaid eligibility was automatically tied to cash assistance provided through the Department of Human Services. 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 authorization card to medical providers when services were sought. 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 the Department of Health Care Policy and Financing.

The old monthly Medicaid Authorization Card guaranteed the client's eligibility to receive Medicaid benefits for the month indicated on the card. The client's Medicaid Authorization Card was presented to the medical provider as proof of Medicaid eligibility. Providers relied on Medicaid clients having this card with them when requesting services and would, at times, refuse to provide services if the client could not present the card at the time that medical services were rendered. For FY 03-04, Change Request #BRI-2 was submitted November 1, 2002 to implement a new process to produce the card. This new process consisted of a plastic card being issued to all eligible clients and reissued only when replacements were needed or new clients became eligible. This procedure was implemented for FY 03-04 as authorized in the FY 03-04 Long Bill, SB 03-258. Based on this change, medical providers are now required to verify Medicaid eligibility electronically after viewing the client's plastic card. This new identification card reduced the

Department's liability from a one-month guarantee of eligibility to only the exact periods of eligibility. The new card also allowed 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 as defined by the federal definition of what constitutes a household. 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 received their own cards, even if they lived with others who were also Medicaid eligible. The result of the "one card per household" was that not every client received a card. 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.

As previously stated, the Department began using plastic cards that were considered to be more durable in FY 03-04. The new cards, termed "Medical Identification Cards" instead of "Medical Authorization Cards", were initially produced for every client with Medicaid and Old Age Pension State Medical Program eligibility. These plastic identification cards are permanent for each client, and are to be used when the client is eligible for Medicaid programs 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 of production results in overall cost savings.

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 was 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 Program clients. Since these clients are not Medicaid eligible, no federal match is available for these funds.

The history of the appropriation for this line item is as follows. 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 Medicaid Authorization Cards, along with additional funding for other line items. 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. Supplemental Request #5, submitted January 2, 2002, titled "Inflation Increase for Medicaid Authorization Card Production," requested $71,416 additional funding. However, a $65,842 increase 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 funding was requested for card production by the General Government Computer Center 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 Protection" requested $204,027 additional funding for FY 02-03. The total increase for the General Government Computer Center, as well as card stock and postage would have resulted in $1,332,769 new appropriation (see page 80 in Figure Setting of March 11, 2002). However, after a reduction of $9,669 to the requested increase by Joint Budget Committee when Figure Setting was final, the appropriation for FY 02-03 was $1,323,100,as reflected in the FY 02-03 Long Bill HB 02-1420. Supplemental Request #S-8, submitted January 2, 2003, titled "Increase for Medicaid Authorization Card Production," requested $27,501 to be added for FY 02-03 and that amount was approved with the passage of 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 for 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, titled "New Medical Identification Card Process," requested a total reduction of $487,371 based on 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 approved for the production and mailing of cards for 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. No Supplemental request was made for FY 03-04.

In FY 03-04, the old paper authorization cards were produced for July and August. The new plastic identification cards were put into use beginning in September 2003. Since the plastic identification cards were used for the duration of FY 04-05, funding needs decreased for FY 04-05. FY 04-05 Base Reduction Item, #BRI-1, submitted November 3, 2003, titled "Revision of Medical Identification Cards" requested a reduction of $615,814. However, on recommendation of the Joint Budget Committee staff, 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. However, a large reversion occurred in FY 04-05 showing that the level of funding was still too high.

A request of $355,601 was made for FY 05-06. However, during Figure Setting on March 15, 2005, page 52, the amount was increased by $6,984 to allow for an increased caseload, resulting in a total amount of $362,585 per FY 05-06 Long Bill, SB 05-209. A Special Bill, the Tobacco Tax Bill, HB 05-1262, signed into law on June 2, 2005, added $21,131 from a newly created Cash Fund called the Health Care Expansion Fund with Cash Funds Exempt and federal matching funds for FY 05-06.

Annualization of HB 05-1262 reduces FY 06-07 funding by a total of $563, resulting in a Base Request for FY 06-07 of $383,123.

See the chart below for the appropriation history for this line item. The line is funded with General Fund or Cash Funds Exempt and matching federal funds, with the exception of the cards for the Old Age Pension State Medical Program clients who receive cards funded entirely with State Cash Funds with no federal match.

Medical Identification Cards (formerly known as Medicaid Authorization Cards)						
Fiscal Year	**Bill**	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
	Final Appropriation for FY 01-02	**$1,188,142**	**$594,071**	**$0**	**$0**	**$594,071**
FY 02-03	HB 02-1370 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, 2000)	$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 Request 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

Medical Identification Cards (formerly known as Medicaid Authorization Cards)						
Fiscal Year	**Bill**	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**	**Federal Funds**
	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 (matches Schedule 3 submitted November 3, 2003)	$846,041	$417,693	$10,656	$0	$417,692
	BRI-1 Submitted November 3, 2003 but revised during Figure Setting, March 9, 2004	($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 (matches Schedule 3 submitted November 1, 2004)	$355,601	$177,042	$1,517	$0	$177,042
	Revision during Figure Setting, March 15, 2005	$6,984	$3,492	$0	$0	$3,492
	SB 05-209 Long Bill	$362,585	$180,534	$1,517	$0	$180,534
	HB 05-1262, Tobacco Tax Bill	$21,131	$0	$0	$10,549	$10,582
	Total for FY 05-06	**$383,716**	**$180,534**	**$1,517**	**$10,549**	**$191,116**
FY 06-07	Begin FY 06-07	$383,716	$180,534	$1,517	$10,549	$191,116
	Annualization of HB 05-1262, Tobacco Tax Bill	($593)	$0	$0	($302)	($291)
	Base Request for FY 06-07	**$383,123**	**$180,534**	**$1,517**	**$10,247**	**$190,825**

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 for $4,081,464, which incorporated a Joint Budget Committee staff recommendation for an increase of $106,793 for personal services, operating expenses, and indirect costs above the Department's Base Request (see during Figure Setting, March 11 2002, page 126). HB 02-1457 reduced FY 02-03 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. 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, March 6, 2003, page 111.

The FY 04-05 Long Bill appropriation (HB 04-1422) was $4,000,636. The change from FY 04-05 was due to an increase of $301,877 in indirect costs associated with POTS.

For FY 05-06 Long Bill appropriation was $4,079,161. An increase of $78,525 was due to increases in POTS and Common Policy funding based on information received from the Department of Public Health and Environment.

The FY 06-07 Budget Request by the Department of Public Health and Environment is $4,144,404. The requested funds reflect an increase of $126,767 in the Personal Services and Indirect Costs.

Please see the following tables which reconcile to the Department of Public Health and Environment's Budget Request for the FY 02-03 through FY 06-07.

Line Item: DPHE Facility Survey and Certification	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Appropriation	FY 06-07 Base Request
Base	**$3,974,671**	**$3,809,175**	**$3,698,759**	**$4,000,636**	**$4,079,161**
General Fund	$1,072,732	$500,401	$927,349	$1,000,288	$1,020,479
Cash Funds	$0	$558,514	$0	$0	$0
Federal Funds	$2,901,939	$2,750,260	$2,771,410	$3,000,348	$3,058,682
POTS, Personal Services, and Indirect Adjustment	$0	$0	**$301,877**	**$78,525**	**($61,524)**
General Fund	$0	$0	$72,939	$20,191	$19,753
Federal Funds	$0	$0	$228,938	$58,334	($81,277)
JBC Staff Recommendation at Figure Setting - Personal Services, Operating Expenses and Indirect Costs	**$106,793**	**($110,416)**	**$0**	**$78,525**	**$0**
General Fund	$52,128	$426,948	$0	$20,191	$0
Cash Funds	$0	$(558,514)	$0	$58,334	$0
Federal Funds	$54,665	$21,150	$0	$0	$0
Total POTS, Personal Services and Indirect Adjustment	$0	$0	$0	$0	**$126,767**
General Fund	$0	$0	$0	$0	$36,680
Federal Funds	$0	$0	$0	$0	$90,088
Total Funds – Long Bill	**$4,081,464**	**$3,698,759**	**$4,000,636**	**$4,079,161**	**$4,144,404**
General Fund	$1,124,860	$927,349	$1,000,288	$1,020,479	$1,076,912
Federal Funds	$2,956,604	$2,771,410	$3,000,348	$3,058,682	$3,067,493
Total Funds - HB 02-1457 Reduction	**($89,506)**	**$0**	**$0**	**$0**	**$0**
General Fund	($22,376)	$0	$0	$0	$0
Federal Funds	($67,130)	$0	$0	$0	$0
Total Funds - SB 03-175 (Nursing Home Penalty Cash Fund)	**$0**	**$0**	**$0**	**$0**	**$0**
General Fund	($558,514)	$0	$0	$0	$0
Cash Funds	$558,514	$0	$0	$0	$0
Total Funds - SB 03-197 (Pay Date Shift)	**($229,734)**	**$0**	**$0**	**$0**	**$0**
General Fund	($57,434)	$0	$0	$0	$0
Federal Funds	($172,300)	$0	$0	$0	$0
Total Funds – SB 03-203 (Supplemental - Budget	**($42,555)**	**$0**	**$0**	**$0**	**$0**

Line Item: DPHE Facility Survey and Certification	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Appropriation	FY 06-07 Base Request
Reductions)					
General Fund	($8,511)	$0	$0	$0	$0
Federal Funds	($34,044)	$0	$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**	**$0**
General Fund	$22,376	$0	$0	$0	$0
Federal Funds	$67,130	$0	$0	$0	$0
Total Funds – Appropriation/Request	**$3,809,175**	**$3,698,759**	**$4,000,636**	**$4,079,161**	**$4,144,404**
General Fund	$500,401	$927,349	$1,000,288	$1,020,479	$1,076,911
Cash Funds	$558,514	$0	$0	$0	$0
Federal Funds	$2,750,260	$2,771,410	$3,000,348	$3,058,682	$3,067,493

DPHE Facility Survey and Certification

POTS, Personal Services, and Indirect Adjustment	Total Funds	General Fund	Federal Funds
Performance Based Pay	$102,158	$29,559	$72,599
Health/Life/Dental	$163,533	$47,318	$116,215
Short Term Disability	$4,130	$1,195	$2,935
Amortization Equalization	$19,988	$5,783	$14,205
Vehicle Lease	$15,475	$5,365	$10,110
Personal Services	$3,177,406	$919,370	$2,258,036
Operating Expenses	$225,763	$68,321	$157,442
Indirect Costs	$435,951	$0	$435,951
Total POTS, Personal Services, and Indirect Adjustment	**$4,144,404**	**$1,076,911**	**$3,067,493**

ACUTE CARE UTILIZATION REVIEW

Acute care utilization review includes performing prior authorization and post payment reviews for specified services to determine medical necessity and appropriateness for these services. These reviews result in cost avoidance and recoveries of payments to providers. History of appropriations for this line item is as follows.

For FY 03-04, the 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. This was per annualization of SB 01S2-12 pertaining to Prior Authorization Reviews for this program. With this appropriation increase, the FY 03-04 Long Bill, SB 03-258, Acute Care Utilization Review line item is $1,309,826 in total funds. There was no change in total to the base amount for FY 04-05.

The Tobacco Tax Bill, HB 05-1262, added $8,560 total funds to the base amount for additional prior authorization reviews for low income adults and children, funded through the Health Care Expansion Fund with Cash Funds Exempt and federal financial participation. The total FY 05-06 amount is $1,318,386.

For FY 06-07, Tobacco Tax funding is annualized by adding $57,520 Cash Funds Exempt, or $1,375,906 total funding to the Base Request. The additional Tobacco Tax funding was discussed in Table 4 of the 1331 Supplemental Request, "Technical Correction to Adjust Appropriations for HB 05-1262", submitted June 3, 2005.

Line Item: Acute Care Utilization Review	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**
Prior Year Appropriation	$1,302,604	$1,309,826	$1,309,826	$1,318,386
General Fund	$342,529	$342,529	$342,529	$342,529
Cash Funds Exempt	$1,093	$2,899	$2,899	$5,039
Federal Funds	$958,892	$964,398	$964,398	$970,818
Annualization of SB 01S2-12 (Prior Authorization Reviews)	$7,222	$0	$0	$0
Cash Funds Exempt	$1,806	$0	$0	$0
Federal Funds	$5,416	$0	$0	$0
Tobacco Tax Bill - HB 05-1262	$0	$0	$8,560	$57,520
Cash Funds Exempt (Health Care Expansion Fund)	$0	$0	$2,140	$14,380
Federal Funds	$0	$0	$6,420	$43,140
Final Appropriation/Request	**$1,309,826**	**$1,309,826**	**$1,318,386**	**$1,375,906**
General Fund	$342,539	$342,529	$342,529	$344,703
Cash Funds Exempt	$2,899	$2,899	$5,039	$17,245
Federal Funds	$964,398	$964,398	$970,818	$1,013,958

LONG-TERM CARE UTILIZATION REVIEW

The long-term care 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 higher or inappropriate payments to providers. In addition, the Single Entry Point contractors perform pre-admission screening for Medicaid clients seeking admittance to nursing facilities and home and community based long-term care programs, as well as annual continued stay reviews of these clients. Some of the reviews for long-term care programs are required by federal regulations.

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

- Uniform Long Term Care 100.2 Form (ULTC 100.2) 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.

Dual Diagnosis Management (DDM) is another contractor that maintains a long term care database and performs prior authorization reviews for long term care clients. The results of the prior authorization reviews are transmitted electronically to the Department's fiscal agent. Dual Diagnosis Management also conducts reviews for the Pre-Admission Screening and Annual Resident Review Program (PASAAR).

The final FY 03-04 appropriation in the Long Bill, SB 03-258, for the Long-Term Care Utilization Review line item was $1,668,108 total funds. The FY 04-05 appropriation, and the FY 05-06 Base Request was for continuation funding from FY 03-04. However, Tobacco Tax Bill, HB 05-1262, added $76,858 total funds to the line item for FY 05-06, with $38,429 Cash Funds Exempt from the Health Care Expansion Fund and $38,429 matching federal funds. Tobacco Tax funds allow the elimination of the wait list for Children's Extensive Support Waiver. HB 05-1262 additions continue at the same level into FY 06-07.

Line Item: Long-Term Care Utilization Review	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
Tobacco Tax Bill, HB 05-1262	$0	$0	$76,858	$76,858
Cash Funds Exempt	$0	$0	$38,429	$38,429
Federal Funds	$0	$0	$38,429	$38,429
Final Appropriation/Request	**$1,668,108**	**$1,668,108**	**$1,744,966**	**$1,744,966**
General Fund	$598,813	$598,813	$598,813	$598,813

Line Item: Long-Term Care Utilization Review	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Cash Funds Exempt	$0	$0	$38,429	$38,429
Federal Funds	$1,069,295	$1,069,295	$1,107,724	$1,107,724

EXTERNAL QUALITY REVIEW

Health Services Advisory Group, Inc., the contractor for this line item, validates performance improvement projects (PIP) and performance measures for managed care organization health plans, collects performance measures for fee-for-service physicians, and provides an annual report of the year's activities and recommendations. 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. This credentialing process can also reveal potential problems requiring investigation. An internal physician monitoring process has been implemented to determine if medical licenses have been revoked or suspended, or sanctions against physicians have been enacted. If such actions from physician regulatory boards have been recommended, the Department staff suggests further actions which may include termination of Medicaid participation. The quality review contractor researches information in this process.

The External Quality Review FY 03-04 appropriation was $812,193, with 75% federal financial participation, due to FY 03-04 November 1, 2002 Change Request #BRI-3. The appropriation has remained the same amount since FY 03-04, and the FY 06-07 Base Request is for continuation funding.

Line Item: External Quality Review	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Total Funds - Long Bill	**$812,193**	**$812,193**	**$812,193**	**$812,193**
General Fund at 25%	$203,048	$203,048	$203,048	$203,048
Federal Funds at 75%	$609,145	$609,145	$609,145	$609,145

DRUG UTILIZATION REVIEW

42 Code of Federal Regulations, §456.703, requires that each state have 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 are 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.

The appropriation for this line item was $233,025 (FY 03-04 November 1, 2002 Change Request #BRI-3 for details) effective July 1, 2003. During the 2003 legislative session, two bills increased funding in FY 03-04 for the Drug Utilization Review line item. SB 03-011, regarding Prescription Drugs under Medicaid, increased the line item base appropriation by $300,000 total funds, of which

$75,000 were General Fund and $225,000 were federal funds. In addition, SB 03-294, regarding Drug Rebates, Discounts and Management, increased the line item appropriation by $80,000 total funds, of which $20,000 were General Fund and $60,000 were federal funds. This funding is authorized to contract for a professional medical evaluation of the most effective drug classes for implementation of the drug utilization review.

The FY 04-05 Base Request 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 to encourage use of generic prescriptions as much as possible. During FY 04-05, the number of drugs requiring prior authorization reviews by the fiscal agent increased. Consequently, the fiscal agent for the Medicaid Management Information System Contract needed additional funding to cover future pharmacy prior authorization reviews.

A Supplemental Request, #S-10, submitted on January 3, 2005 requested a partial reduction in the 75% federal financial participation. This was because pharmacy prior authorization reviews are approved for 50% federal financial participation by the federal Centers for Medicare and Medicaid Services. This funding shift was accomplished by the Supplemental Bill, SB 05-112. The final appropriation for FY 04-05 was $648,025.

A pharmacy utilization plan has been implemented in phases. The purpose of the plan is to limit dosage based on federal Drug Administration guidelines, drug manufacturer guidelines, and to recommend less expensive alternative prescriptions when available. Phase I, effective December 15, 2003, developed prior authorization reviews for certain sleeping agents, a non-steroid, anti-inflammatory, short-term pain medication, certain anti-migraine products, and certain anti-nausea products. Phase II, effective March 4, 2004, included certain atypical antipsychotics, two narcotic pain medications and COX-2 pain inhibitors. Phase III, effective February 2005, was for two asthma treatment drugs and three skin infection drugs for which less expensive alternative prescriptions exist. Cost savings occur when less expensive alternate prescriptions are used. The Department submits a report on the Pharmacy Utilization plan to the Health and Human Services Committee in the General Assembly each year to update the drugs covered and the cost savings achieved.

The Long Bill for FY 05-06, SB 05-209, continued the combination of the two functions within the line item, with funding for the traditional drug utilization review functions at 75% federal funds participation and the fiscal agent prior authorization review functions at 50% federal financial participation.

The FY 06-07 Base Request is for continuation of the same level of funding as was appropriated in FY 05-06 at $648,025 total.

See the table below for the details for the combination of required functions.

Combination of Functions for Drug Utilization Review	Total Funds	General Fund	Federal Funds
Drug Utilization Review through contracts and research of other state programs, drug treatment, therapies, cost comparison of various therapies, determining appropriate pricing and uses as well as written codes and educational topics. 75% federal financial participation.	$383,025	$95,756	$287,269
Additional Pharmacy Prior Authorization Reviews by the fiscal agent. 50% federal financial participation.	$265,000	$132,500	$132,500
Total FY 06-07 Base Request	**$648,025**	**$228,256**	**$419,769**

The following table details the history of this line item appropriation.

Line Item: Drug Utilization Review	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Starting Base	$233,025	$613,025	$648,025	$648,025
General Fund	$58,256	$153,256	$228,256	$228,256
Federal Funds	$174,769	$459,769	$419,769	$419,769
SB 03-011 - Prescription Drugs Under Medicaid	$300,000	$300,000	$0	$0
General Fund	$75,000	$75,000	$0	$0
Federal Funds	$225,000	$225,000	$0	$0
SB 03-294 - Drug Rebates, Discounts and Management	$80,000	$0	$0	$0
General Fund	$20,000	$0	$0	$0
Federal Funds	$60,000	$0	$0	$0
Supplemental #S-10 - approved by SB 05-112	$0	($265,000)	$0	$0
General Fund	$0	$0	$0	$0
Federal Funds	$0	($265,000)	$0	$0
Final Appropriation/Request	$613,025	$648,025	$648,025	$648,025
General Fund	$153,256	$228,256	$228,256	$228,256
Federal Funds	$459,769	$419,769	$419,769	$419,769

MENTAL HEALTH EXTERNAL QUALITY REVIEW

The Department conducts federally-required external quality review activities that receive 75% federal financial participation. Section 456.1 of the 42 Code of Federal Regulations requires "a statewide program of control of the utilization of all Medicaid services". Section 438.350 requires that either the state or an External Quality Review Organization (EQRO) validate the performance measures, performance improvement projects, and regulation compliance of all contracted managed care organizations and prepaid inpatient health plans. This line item is specific to mental health services.

The Department's responsibility for the Mental Health External Quality Review program began in FY 04-05. Prior to the passage of HB 04-1265, the Department of Human Services managed Medicaid mental health programs, including the External Quality Review Organization for mental health. HB 04-1265 transferred this responsibility to the Department of Health Care Policy and Financing as well as the funding for the External Quality Review Organization to the Medicaid Mental Health Community Programs-Program Administration line item. SB 05-112 established a $352,807 appropriation for Mental Health External Quality Review in the Executive Director's Office Long Bill group for FY 04-05, transferring it from the Medicaid Mental Health Community Programs-Program Administration line item. The amount was based on historical costs.

The Department contracts with an External Quality Review Organization to perform the services listed above. The following table shows the appropriation history of this line item as well as the FY 06-07 Base Request.

Line Item: Mental Health External Quality Review	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Request**
General Fund at 25%	$0	$88,202	$88,202	$88,202
Federal Funds at 75%	$0	$264,605	$264,605	$264,605
Total Funds - Long Bill*	**$0**	**$352,807**	**$352,807**	**$352,807**

*Does not include rollforward of $30,000 from FY 04-05 to FY 05-06

MENTAL HEALTH ACTUARIAL SERVICES

This one-time appropriation in the FY 04-05 Add-On section of SB 05-209 funded an actuarial certification of the 3.25% rate increase in the FY 05-06 Medicaid Mental Health Capitation Base Payments. Actuarial certification was required for the Centers for Medicare and Medicaid Services to approve the rates for the State to receive 50% federal funding. The project was completed during FY 04-05. No funds were requested subsequently.

Line Item: Mental Health Actuarial Services	FY 04-05	FY 05-06	FY 06-07 Base Request
Total Funds - Long Bill	**$25,000**	**$0**	**$0**
General Fund at 50%	$12,500	$0	$0
Federal Funds at 50%	$12,500	$0	$0

ACTUARIAL ANALYSIS PAYMENTS FOR TRANSFER TO THE STATE AUDITOR'S OFFICE

This one-time appropriation funds an actuarial evaluation to be coordinated by the Office of the State Auditor during FY 05-06. The Office of the State Auditor has begun the process to gather background and statistical information from the Department as well as the Division of Mental Health within the Department of Human Services. The Office of the State Auditor plans to involve the Department and the Department of Human Services in review and comment on the scope of work in the Request for Proposal and on the scope of additional work the Office of the State Auditor might elect to do to supplement the work of the outside contractor. The Office of the State Auditor selects the outside contractor following a bid solicitation process and manages the overall evaluation. The funds are transferred to the Office of the State Auditor as Cash Funds Exempt. The project should be completed during FY 05-06. No funds are requested for FY 06-07.

Line Item: Actuarial Analysis Payments for Transfer to the State Auditor's Office	FY 05-06	FY 06-07 Base Request
General Fund at 50%	$50,000	$0
Federal Funds at 50%	$50,000	$0
Total Funds - Long Bill	**$100,000**	**$0**

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 Program services of outreach and case management in a manner that is consistent with federal regulations as specified in 42 CFR 441.50-441.61. These 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 eligible clients, 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.

Prior to FY 03-04, administration of the Early and Periodic Screening, Diagnosis and Treatment Program was housed at the Department of Public Health and Environment. In FY 02-03, $3,058,718 was appropriated in the Long Bill (HB 02-1420) to the Department of Public Health and Environment for this line item. During FY 02-03, the Department of Public Health and Environment proposed budget reductions in the amount of $313,328 for the Early and Periodic Screening, Diagnosis, and Treatment Program 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.

Action by the Joint Budget Committee during the 2003 Legislative Session transferred the Early and Periodic Screening, Diagnosis, and Treatment Program management to the Department of Health Care Policy and Financing. Funding for five positions was appropriated to the Department to manage the program. These positions are located in the Executive Director's Office, Personal Services Long Bill line. The funding for medical services provided under the Early and Periodic Screening, Diagnosis, and Treatment Program remain in the Medical Services Premiums line. The administrative and outreach services are funded by this line item and no funds are transferred to the Department of Public Health and Environment. Services are provided by contracted staff at the county level, primarily county health department staff, but may include other local outreach providers such as the Northwest Visiting Nurses Association.

In the FY 03-04 Long Bill (SB 03-258), $2,624,222 was appropriated for the Early and Periodic Screening, Diagnosis and Treatment Program. A Supplemental Request (#NP-S21) was submitted on February 4, 2004 to reduce the appropriation to the identified funding 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 and into FY 05-06 through the Long Bill, SB 05-209. The request for FY 06-07 is a continuation of the final FY 05-06 appropriation level of $2,468,383, which is split at 50% federal funds and 50% General Fund.

The following table details the appropriation history and Departmental responsibility for the Early and Periodic Screening, Diagnosis and Treatment Program.

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**	**FY 06-07 Base Request**
Department Responsible for Administration	DPHE	DPHE	HCPF	HCPF	HCPF	HCPF
Prior Year Final Appropriation/Request	**$3,084,350**	**$3,078,818**	**$2,721,758**	**$2,468,383**	**$2,468,383**	**$2,468,383**
Joint Budget Committee Action during Figure Setting	$0	($20,100)	$0	$0	$0	$0
Savings from program transfer back to the Department of Health Care Policy and Financing	$0	$0	($97,536)	$0	$0	$0
Long Bill	**$3,084,350**	**$3,058,718**	**$2,624,222**	**$2,468,383**	**$2,468,383**	$0
HB 02-1370 Supplemental	($5,532)	$0	$0	$0	$0	$0
SB 03-197 Pay Date Shift	$0	($23,632)	$0	$0	$0	$0
SB 03-203 Budget Balancing	$0	($313,328)	$0	$0	$0	$0
HB 04-1422 Long Bill Add-On (Supplemental #NP-S21)	$0	$0	($155,839)	$0	$0	$0
Final Appropriation/Request	**$3,078,818**	**$2,721,758**	**$2,468,383**	**$2,468,383**	**$2,468,383**	**$2,468,383**

NURSING FACILITY AUDITS

The Department of Health Care Policy and Financing contracts with an independent accounting firm to conduct audits of nursing facility cost reports. These audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary cost of providing care to Medicaid clients in these facilities, in accordance with State and federal statutes. The audit services contract is competitively bid every five years.

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 was based on the FY 99-00 five-year contract amount of $864,150. However, the winning bid for the five-year contract came in $233,350 higher than appropriated due to increased technical audit requirements and costs on the part of the contractor. SB 05-112 increased funding for this program to $1,097,500 (Supplemental Request # 6, January 3, 2005) . Fund splits are 50% General Fund and 50% federal funds for this line. The funding request for FY 06-07 is $1,097,500, the same as the FY 05-06 appropriation.

Line Item: Nursing Facility Audits	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
Prior Year Final Appropriation / Request	$879,530	$864,150	$1,097,500	$1,097,500
Adjustment to the base for one-time funding for two year	($15,380)	$0	$0	$0

Line Item: Nursing Facility Audits	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
project ($1,120 +$15,380=$16,500)				
SB 05-112 (FY 04-05 Supplemental Bill)	$0	$233,350	$0	$0
Supplemental (4% Budget Balancing SB 03-203)	$0	$0	$0	$0
Final Appropriation / Request	**$864,150**	**$1,097,500**	**$1,097,500**	**$1,097,500**

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 the Medicaid program, and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. Most of the hospital audits are completed from the Medicare cost report audit and are tailored to Medicaid requirements. The independent accounting firm provides the following services to the Department: 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 are based on the results of these audits, and are set to cover the reasonable and necessary costs of an efficiently run hospital, federally qualified health center and rural health center per federal and State law.

Audits have produced savings of over $5 million in Medical Services Premiums in each year with a base appropriation of $250,000 to perform desk audits of over 200 hospitals and federally qualified health clinics. The Department believed the current level of auditing could be expanded to increase recoveries. Therefore, funding was increased to $350,000 to include site audits as part of the program to provide greater accuracy in identifying actual costs ("Funding for Hospital and Federally Qualified Health Clinics Audits to Increase Recoveries", DI-11, November 11, 2004, page G. 11-1). This was based, in part, on the results of a partial site audit that disallowed $9 in expenses for every $1 of audit costs incurred. With the additional funding, the Department's contractor was able to perform 25 site audits, 7 of which covered hospitals and 18, federally qualified health clinics, in addition to the regularly scheduled desk audits previously mentioned. Fund splits for this line are 50% General fund and 50% federal funds. The Base Request for FY 06-07 is $350,000.

Line Item: Hospital and Federally Qualified Health Clinic Audits	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Base Appropriation	$250,000	$250,000	$250,000	$350,000
Supplemental Request # 13, January 2, 2002, pg. CR-163	$0	$0	$0	$0
Supplemental Request # 11, November 1, 2004 (DI-11) pg. G.11-1	$0	$0	$100,000	$0
Total	**$250,000**	**$250,000**	**$350,000**	**$350,000**

DISABILITY DETERMINATION SERVICES

Federal law mandates that disability determinations be conducted for clients who are eligible for Medicaid due to a disability. Prior to July of 2004, the Disability Determination Services line provided Medicaid funding to the Department of Human Services to conduct disability determinations for individuals waiting for eligibility determination of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, were potentially eligible for Medicaid due to a disability.

For FY 04-05, a June 7, 2004 Emergency Change Request was approved by the Joint Budget Committee that transferred the administration of disability determinations for Medicaid eligible persons from the Department of Human Services to the Department of Health Care Policy and Financing. This Change Request was made official by the implementation of SB 05-112. Specifically, funding for Medicaid disability determinations is now included in the Department's Executive Director's Office Long Bill group. Starting July 1, 2004, client applications received by the counties are now forwarded to the Department of Health Care Policy and Financing and then sent to a contractor for processing. Prior to the transfer of the appropriation to the Department, the Joint Budget Committee incorporated a base reduction of 0.2% or $2,305 into the Long Bill.

For FY 05-06, the Department requested, and was appropriated $1,163,662 in total funds, of which $581,831 was General Fund, and $581,831 was federal funds. An additional $10,000 in total funds was appropriated with the implementation of SB 04-177, which authorizes the Children with Autism Waiver program. A $5,000 Cash Funds Exempt transfer from the Autism Treatment Fund (originating from the Tobacco Cash Settlement Fund) is matched with federal funds for disability determinations of autistic clients.

For FY 06-07, the Department is requesting continuation funding of $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.
History of the appropriation for this line item is as follows:

Department of Health Care Policy and Financing

Fiscal Year/Bill	Description	Total Funds
FY 04-05, SB 05-112 Supplemental	Transfer Program from Department of Human Services	$1,163,662
FY 05-06, SB 05-209 Long Bill	Long Bill Appropriation	$1,163,662
FY 05-06, SB 04-177	Children with Autism Waiver	$10,000
FY 05-06	Final Appropriation	$1,173,662
FY 06-07	**Base Request**	**$1,173,662**

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 individuals with major mental illness or developmental disabilities. The federal financial participation rate for this activity is 75%.

All admissions to nursing facilities with Medicaid certified beds are subject to preadmission screening and all current residents are subject to an annual review. The purpose of these assessments 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. This is a federal requirement to receive Medicaid funds.

There are two levels of Preadmission Resident Reviews. A Level I pre-screening is comprised of a series of questions related to the diagnosis of a developmental disability or mental illness. It also explores the 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 screening identifies a mental illness or developmental disability with the need for 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 be diverted from the Level II evaluation if he/she is determined to not have a major depression.

Upon diagnosis of a Level II developmental disability, the client is referred to the Department of Human Services and community center boards. Each Level II client is sent to the state mental health or mental retardation authority, as appropriate, to determine placement. These extensive evaluations also provide recommendations to assist the nursing facility in developing an appropriate plan of care for necessary services and are coordinated by the nursing facility with mental health providers. Level II evaluations to determine a course of treatment and depression diversion screenings by mental health centers are funded in the (Preadmission Screening and Resident Review) line item.

A reassessment is completed annually. In addition, a telephone review is completed at the time of significant changes in the individual's mental health or developmental disability status. These reviews are categorized as partial evaluations.

Line Item: Nursing Home Preadmission and Resident Assessments	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
Prior Year Final Appropriation	**$1,042,612**	**$1,162,705**	**$918,120**	**$1,010,040**	**$1,010,040**	**$1,010,040**
Adjustment to the base for prior year one-time expenditures	$0	($120,093)	$0	$0	$0	$0
FY 02-03 Budget Amendment 9A Utilization	$0	$82,294	$0	$0	$0	$0

Line Item: Nursing Home Preadmission and Resident Assessments	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
Increase for Nursing Home Pre-Admission and Resident Assessments, January 2, 2002 page CR-151						
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	$0
4% Budget Balancing SB 03-258	$0	$0	$91,920	$0	$0	$0
Long Bill	**$1,042,612**	**$1,240,534**	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**
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	$0
4% Budget Balancing SB 03-203	$0	($322,414)	$0	$0	$0	$0
Total Appropriation/Request	**$1,162,705**	**$918,120**	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**
General Fund at 25%	$290,676	$229,530	$252,510	$252,510	$252,510	$252,510
Federal Funds at 75%	$872,029	$688,590	$757,530	$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. At that time, the Department of Health Care Policy and Financing became responsible for managing the preadmission screenings and annual resident reviews at the previous years' appropriation levels. Rates for these assessments were reviewed across the State in order to become 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 remain within that new appropriation. The General Assembly approved an increase of $120,093 total funds (via HB 02-1370 with $30,023 in General Fund and $90,070 in federal funds), bringing the appropriation to approximately the same level as appropriations in prior years.

For FY 02-03, the General Assembly approved an additional $197,922 ($82,294 + $115,628), $49,481 of which was General Fund. This increase 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 resulted in revised expenditure forecasts. A new projection was developed and submitted for the 4% Budget Balancing Plan for FY 02-03. 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 growth in the number of Level I, Level II and partial evaluations, with resulting expenditures to grow by $91,920. This increase was appropriated in the Long Bill, SB 03-258 for FY 03-04, at $1,010,040.

Each year the Department studies the adequacy of rates and efficiencies in the program by conducting workgroups with the provider community. A forecast of utilization is developed each June and September to assess trends and to adjust the budget accordingly. For FY 04-05 and FY 05-06, the forecast has indicated a slight shift in the categories of reviews, but the total budget amount was estimated to be adequate. Therefore, the appropriations remained static. Based on this, continued funding of $1,010,040 for FY 06-07 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. The $14,652 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 Cash Funds Exempt transfer to the Department of Regulatory agencies for apportionment between the Division of Registrations and the Executive Director's office. HB 95-1266 required criminal background checks on nurse aides. In FY 06-07, the criminal background checks are estimated to be $14,652. 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.

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 from 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 FY 05-06 appropriation is for $319,098, which includes adjustments from the FY 04-05 Long Bill appropriation for POTS increases totaling $21,329. For the FY 06-07 Budget Request, the Department is requesting an appropriation of $308,766. This is a

decrease of $10,332 from the FY 05-06 as reflected in the table below. The tables present the changes per line item as reported by the Department of Regulatory Agencies.

Line Item: Nurse Aide Certification	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Base Request	**$310,330**	**$310,330**	**$310,330**	**$297,769**	**$319,098**
DORA Adjustment to Nurse Aide Certification - Budget Amendment, #BAS-5, January 23, 2004	$0	$0	($12,561)	$0	$0
POTS Base Adjustments	$0	$0	$0	$21,329	($10,332)
Total Funds – Long Bill Appropriation / Request	**$310,330**	**$310,330**	**$297,769**	**$319,098**	**$308,766**
General Fund	$142,321	$142,321	$136,041	$144,897	$139,731
Cash Funds Exempt	$12,844	$12,844	$12,844	$14,652	$14,652
Federal Funds	$155,165	$155,165	$148,884	$159,549	$154,383

Change in funds for the Nurse Aide Certification Program

Nurse Aide Certification Program	FY 04-05 Expenditures	FY 05-06 Appropriation	FY 06-07 Base Request	Change[1]
Personal Services	$368,382	$272,382	$241,903	($30,479)
Operating	$17,538	$19,000	$10,930	($8,070)
Hearings	$12	$100	$0	($100)
Indirect Costs	$217,698	$213,909	$252,497	$38,588
Health/Life	$0	$6,143	$14,582	$8,439
Short-term disability	$0	$346	$368	$22
Salary Survey/Pay for Performance	$0	$6,579	$15,685	$9,106
Worker's Comp	$730	$675	$573	($102)
Legal Services	$44,551	$68,000	$58,745	($9,255)
Administrative Law Judge	$0	$1,225	$0	($1,225)
General Government Computer Center	$1,611	$3,426	$1,545	($1,881)
Risk Management	$949	$1,126	$915	($211)
Hardware/Software Maintenance (DLS)	$21,868	$19,682	$0	($19,682)
IT Asset Maintenance	$2,587	$199	$0	($199)
Leased Space	$40,668	$37,103	$37,103	$0

Nurse Aide Certification Program	FY 04-05 Expenditures	FY 05-06 Appropriation	FY 06-07 Base Request	Change[1]
Total Costs	**$716,594**	**$649,895**	**$634,846**	**($15,049)**
HCPF Share	$351,848	$319,098	$308,766	($10,332)
Total Funds – Long Bill Appropriation/Request	**$297,769**	**$319,098**	**$308,766**	**($10,332)**

[1]The change between FY 06-07 Base Request and FY 05-06 Appropriation

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 Department of Public Health and Environment 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. There were no expenditures for FY 04-05. Since the inception there have been no expenditures for this line item. Per Joint Budget Committee action during the 2005 Figure Setting session for the Department of Public Health and Environment, this appropriation was discontinued, due to recent reversions of this funding. Therefore, there was no appropriation in FY 05-06 and no FY 06-07 Base Request.

Line Item: Nursing Home Quality Assessments	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Total Funds – Long Bill	**$26,954**	**$26,954**	**$0**	**$0**
General Fund	$6,738	$6,738	$0	$0
Federal Funds	$20,216	$20,216	$0	$0
Total Funds – HB 02-1370 Supplemental	**$0**	**$0**	**$0**	**$0**
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Total Funds - Appropriation	**$26,954**	**$26,954**	**$0**	**$0**
General Fund	$6,738	$6,738	$0	$0
Federal Funds	$20,216	$20,216	$0	$0

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." Fair rental value or appraised value means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. 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. (2005). 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 was no continuation request submitted, as this process is appropriated only once every four fiscal years after facilities are appraised. Since FY 06-07 is the next year for Nursing Facility Appraisals, a Change Request has been submitted that affects this line.

ESTATE RECOVERY

Authorized by 26-4-403.3, C.R.S. (2005) and established by HB 91S2-1030, this program recovers Medicaid expenditures from the estates of long-term care Medicaid recipients 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. Before the offset occurs to the Medical Services Premiums, the Cash Funds needed to fund these contingencies is deducted.

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) occurred in FY 00-01 and required a supplemental appropriation in 2001 that brought the maximum contingency fee amount to $700,000. Because the contractor is only paid the amount equal to the recoveries multiplied by the contracted fee, if the appropriation is set too low 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 $31,072,668 for the Medicaid program.

Year	Amount Recovered	Number of Cases	Fees Paid	Net Recoveries
FY 92-93	$5,575	3	$273,883	($268,308)
FY 93-94	$418,224	41	$308,708	$109,516
FY 94-95	$883,217	63	$251,560	$631,657
FY 95-96	$1,989,421	141	$360,000	$1,629,421
FY 96-97	$2,559,513	167	$409,522	$2,149,991
FY 97-98	$2,727,744	152	$436,439	$2,291,305
FY 98-99	$2,596,736	132	$350,559	$2,246,177
FY 99-00	$3,376,330	175	$455,805	$2,920,525
FY 00-01	$4,904,163	149	$662,062	$4,242,101
FY 01-02	$3,845,730	195	$521,992	$3,323,738
FY 02-03	$3,878,211	172	$530,164	$3,348,047
FY 03-04	$4,750,954	201	$528,127	$4,222,827
FY 04-05	$4,767,493	209	$541,822	$4,225,671
Total	**$36,703,311**	**1,800**	**$5,630,643**	**$31,072,668**

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 06-07.

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 02-03, 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 budget balancing. The federal match rate for Single Entry Point Administration is 50%. For FY 04-05, the appropriation stayed at $59,310 through the appropriation contained in the Long Bill HB 04-1422. To bring the funding level more in line with actual historical expenditures, the Joint Budget Committee in the FY 05-06 Figure Setting, March 15, 2005, page 70, recommended a reduction to this line item of $6,310, bringing the total appropriation to $53,000 total funds.

The Department's FY 06-07 Base Request is for continuation funding of $53,000.

Line Item: Single Entry Point Administration	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Prior Year Appropriation	$65,900	$65,900	$59,310	$59,310	$53,000
FY 03-04 Joint Budget Committee Recommended, SB 03-258	$0	($6,590)	$0	$0	$0
FY 05-06 Joint Budget Committee Recommended, SB 05-209	$0	$0	$0	($6,310)	$0
Appropriation /Request	**$65,900**	**$59,310**	**$59,310**	**$53,000**	**$53,000**

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 these 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. Due to this lower appropriation, the Department of Human Services could no longer conduct the Single Entry Point audits. Therefore, in FY 04-05 the Department retained an outside contractor to review Single Entry Point Agency cost reports provided by the 25 Single Entry Point Agencies. For FY 05-06, the outside contractor continued to perform the cost report reviews. Funding levels did not support conducting site reviews of the Single Entry Point agencies. The FY 05-06 appropriation includes 50% federal financial participation and will not be transferred to the Department of Human Services. The FY 06-07 Base Request is for continuation funding of $35,340. A Change Request has been submitted that affects this line.

Line Item: Single Entry Point Audits	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Total Funds	**$35,339**	**$35,340**	**$35,340**	**$35,340**	**$35,340**
General Fund	$17,669	$17,670	$17,670	$17,670	$17,670
Federal Funds	$17,670	$17,670	$17,670	$17,670	$17,670

SB 97-05 ENROLLMENT BROKER

Funding for a Medicaid Managed Care Enrollment Broker was appropriated to the Department through SB 97-05. The Enrollment Broker is charged with providing information on basic Medicaid benefits offered through all health plans.

The initial contract for Colorado's Enrollment Broker was awarded to Maximus, Inc. HealthColorado is the name for Medicaid's managed care initiative. Medicaid Managed Care enrollment and disenrollment services began on May 18, 1998.

In the FY 02-03 legislative session, HB 02-1292 was passed, making changes to the State's managed care system. These included changes to the mailing requirements for client notices, a responsibility of the Enrollment Broker, operated by Maximus, Inc. Specifically, HB 02-1292 eliminated the requirement to send two notices informing Medicaid clients of their choices for managed care (either health maintenance organization or the Primary Care Physician Program). It also reduced the time period (from 65 days to 30 days) for Medicaid clients to notify the Department through the Enrollment Broker of their choice. 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 affects this line. 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 Supplemental Bill SB 03-203 was the impact of a Change Request submitted January 2, 2003 (S-11, BA-6) to fund the implementation of new federal managed care rules. These federal rules required the development of a client handbook and mailings for the Primary Care Physician Program. 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 in total funds. Also in the 2003 legislative session, SB 03-187 resulted in a FY 02-03 contract reduction of $254,860. Staffing and overhead were 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 to pay for the following: Printing and mailing client information; production and mailing of the Primary Care Physician Program Client Handbook; monthly mailings to new voluntary clients; and, additional system changes. This appropriation had two parts, with the first being for on-going monthly mailings and the second for one-time only projects in FY 03-04.

For FY 04-05, the Long Bill appropriation of $875,756 included funding of $188,415 for annualization of monthly mailing for the January 2, 2003 Change Request S-11/ BA-6.

In FY 05-06, the Base Request was $875,756, the same as FY 04-05. With the implementation of HB 05-1262, the Tobacco Tax Bill, the appropriation was increased by $45,589 to fund enrollment letter printing and mailing costs to an additional 23,524 clients. However, technical corrections associated with the Emergency 1331 Change Request dated June 2, 2005, reduced this increase by $2,211 for a revised spending authority of $919,134.

For FY 06-07, the assumptions in the Department's Fiscal Note for HB 05-1262 forecasted a caseload increase of 12,825 clients above the FY 05-06 forecast, resulting in an annualization of the costs for the Enrollment Broker program of an additional $23,650. This brought the Request in FY 06-07 to $942,784.

Line Item: SB 97-05 Enrollment Broker	FY 03-04	FY 04-05	FY 05-06	FY 06-07 Base Request
Previous year Final Appropriation	**$702,781**	**$1,162,870**	**$875,756**	**$919,134**
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)	$0	$0
HB 05-1262 Tobacco Tax Bill	$0	$0	$45,589	$23,650
Emergency 1331 Change Request for FY 05-06, June 2, 2005*	$0	$0	($2,211)	$0
Final Appropriation/ Request	**$1,162,870**	**$875,756**	**$919,134**	**$942,784**

*Until this Emergency 1331 Request is approved through a bill, this amount is not an official appropriation.

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 who were 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 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 three years. This award enabled the Department to design a more comprehensive program than was originally envisioned when the fiscal note was prepared for HB 01-1271. The Department was to determine if it was cost effective to purchase or pay health care premiums to 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 a feasibility study was issued in FY 01-02. A contract for $100,000 for the actuarial feasibility study was executed in December 2002, requiring an actuarial report to be completed in April 2003.

In FY 02-03, HB 02-1420, the Long Bill, appropriated total funds of $327,427 (100% federal funds), for the grant award and the actuarial study. Upon completion of the actuarial analysis 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 further to implement the program as originally planned. The actual expenditures were $82,000 in FY 02-03.

<u>The Revised Grant:</u>
Based on a request from the Centers for Medicare and Medicaid Services, the Department submitted an amendment to the original grant on July 31, 2003 and requested a no-cost extension. The new grant proposal identified three main strategies for improving Medicaid services and supports. These were:

- 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 these goals 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 programs and benefits for adults with disabilities. Grant funds were also to be used to contract with an experienced project manager and other consultants with various backgrounds that included health education, literacy, Medicaid services, outreach and marketing, graphic design and production, and disability issues. The proposal recommended hiring 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 were to be used to contract with a community organization to provide training and support to a number of community members to become consultants as Community-Based Personal Assistance Services and Supports Navigators, as well as to develop a tool that consumers would use to 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 new proposal was approved for continued funding in the amount of the original grant. With the grant extended to December 31, 2004, all elements of the revised grant were accomplished. A report on options to implement personal care as a Medicaid state plan benefit was completed. The grant staff also designed the consumer friendly written and electronic materials about Medicaid benefits and programs for adults with disabilities, as well as the development of the Community-Based Personal Assistance Services and Supports Navigators project and self-assessment tool.

The Appropriations:
In FY 01-02, HB 01-1271 appropriated $209,400 total funding including $80,000 Cash Funds Exempt and $129,400 federal funds. HB 02-1420 appropriated total funds of $327,427 (100% federal funds) for FY 02-03. In FY 03-04, $37,519 (100% federal funds) was appropriated through SB 03-258. In FY 04-05, the final appropriation was $65,081, all of it federal funds. In FY 04-05, all activity for this line item ceased. There was no request for FY 05-06 and there is none for FY 06-07.

NON-EMERGENCY TRANSPORTATION SERVICES
Federal regulations require that states offer Medicaid clients necessary transportation to access care for their non-emergency medical needs. States may choose to offer these services as either an administrative or medical service. Prior to the passage of HB 04-1220, Colorado offered non-emergency transportation services as an optional medical service in the Medical Services Premiums line item. HB 04-1220 changed non-emergency transportation from an optional medical service to an administrative service. HB 04-1220 did not include an appropriation clause, but funding was defended in a Legislative Council footnote, page 2, on February 2, 2004. The reduction in Medical Services Premiums of $4,400,778 and subsequent 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 04-05, the Department of Health Care Policy and Financing issued a Request for Proposal for a transportation broker to provide non-medical transportation and administrative services to Medicaid clients residing in the eight front-range counties, those being Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, and Larimer. A contract was awarded. The administrative costs addressed in the contract include intake of client calls, determining eligibility for services, and authorizing and making arrangements to provide clients with non-emergency transportation. Funding traditionally provided to counties to help manage non-emergency transportation resides in the Department of Human Services Medicaid Funded Programs Long Bill group, in the County Administration line item. An estimate of what these counties would have been paid was calculated and these funds help pay the transportation broker's administrative costs.

The Department of Health Care Policy and Financing and the Department of Human Services submitted an 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 request for FY 06-07 is $4,455,988. A Change Request has been submitted that affects this line item.

FY 06-07 Non-Emergency Transportation Services Funding:

Non-Emergency Transportation Services	Total Funds	General Fund	Federal Funds
FY 01-02 Cash-Based Actuals*	$8,862,235	$4,431,564	$4,430,671
FY 02-03 Cash-Based Actuals*	$5,640,392	$2,786,536	$2,853,855
FY 03-04 Cash-Based Actuals*	$2,616,352	$1,230,890	$1,385,462
FY 04-05 Long Bill Appropriation (HB 04-1422)	$4,400,778	$2,200,389	$2,200,389
Developmental Disability Services Waiver 1331 Emergency Supplemental (SB 05-112)	$20,701	$10,351	$10,350
Final FY 04-05 Appropriation	$4,421,479	$2,210,740	$2,210,739
Annualization of Developmental Disability Service Waiver 1331 Emergency Supplemental (FY 05-06)	$34,509	$17,254	$17,255
FY 05-06 Long Bill (SB 05-209)	$4,455,988	$2,227,994	$2,227,994
FY 06-07 Base Request	**$4,455,988**	**$2,227,994**	**$2,227,994**

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

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 one-time savings in FY 02-03. SB 03-196 also appropriated $500,000 total funds (of which 50% were General Fund and 50% were federal funds) to this line item 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 existing 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 06-07.

(2) MEDICAL SERVICES PREMIUMS

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. The first section of the Assumptions and Calculations for the Medical Services Premiums describes the Medicaid caseload projection. The second section describes the development of the per capita cost, the application of per capita caseload and bottom line adjustments. A series of exhibits in Volume 1 of this Budget Request support these Assumptions and Calculations.

Several key points should be made evident before further discussion. These change-producing issues cause this line item to be complicated to project. They are summarized as follows:

1. Adjustments have been made to caseload and per capita costs for estimated impacts due to HB 05-1262 (Tobacco Tax Bill). The costs are calculated through normal Medical Services Premiums per capita cost methodology. However, since the expenditures for HB 05-1262 are funded through the Health Care Expansion Fund or Prevention, Early Detection, and Treatment Fund an exhibit has been added (Exhibit A, pages EA-5 through EA-8) to show the financing by Cash Funds Exempt.

2. The implementation of the Medicare Modernization Act on January 1, 2006 impacts Medicaid caseload and prescription drug estimates (Acute Care) in the FY 06-07 Budget Request. Adjustments have been made to caseload to account for the estimated number of clients added to Medicaid through the mandatory screening of all Medicare clients. Cost savings estimates for prescription drugs have been accounted for in the per capita estimates.

3. The Department is currently contracting with two managed care plans as health maintenance organizations and is contracting with two health plans to provide services to clients as an Administrative Service Organization, or ASO. An ASO receives a monthly administrative fee per client and is not at risk for the cost of services.

4. SB 03-176 eliminated services for legal immigrants and originally cut $11 million from the budget. After a year of litigation, it was budgeted during Figure Setting 2004 to be implemented on January 1, 2005. HB 05-1086 repealed SB 03-176. Therefore, no adjustment is made in this projection.
5. FY 98-99 is excluded from expenditure trends because of the unstable nature of the data during the transition from Blue Cross/Blue Shield claims processing system to the current Medicaid Management Information System in December 1998.

6. The Colorado Benefit Management System was implemented on September 1, 2004, affecting eligibility processes, including:

- The implementation of the Benefits Freeze Flag, now required by court order to be maintained "until further notice;"
- Revealing backlogged applications in counties and Medicaid eligibility sites;
- Interface complexities with the Medicaid Management Information System;
- Inexperience in the accurate system processing of cases by county and eligibility site staff;
- Movement from a historically human-based system to a rules-driven decision making information system; and
- Reporting procedures still in development and refinement.

During FY 04-05, these processes affected Medicaid caseload resulting in an increase in reported caseload figures, while expenditures tracked relatively steady. Unfortunately, these estimates of February 15, 2005 were too conservative in accounting for an increasing caseload and the Department reverted approximately $46.5 million dollars for FY 04-05.

7. The elimination of presumptive eligibility for Medicaid pregnant women on September 1, 2004, which was reinstated by HB 05-1086.

Specific changes to exhibits are as follows:

1. The exhibits have been reorganized. The fund split summaries, previously Exhibit P, is now Exhibit A. The other summary pages such as History of Per Capita Costs, Summary of Request by Eligibility category, and Summary of Premium Request by Service Group have also been moved to the beginning of the exhibits. The caseload exhibit is now Exhibit B, rather than Exhibit A. All service category exhibits have been combined into the same exhibit tab. For example, Exhibit F contains the Acute Care request, Antipsychotic Drug Projection, Prenatal Care Cost for Non-Citizens, and Family Planning calculations.

2. A new service category, Service Management, has been added for the administrative cost types of categories within the Medical Services Premiums budget. Single Entry Point agencies, per member per month fees for Administrative Service Organizations and disease management have been added to this group. Expenditures for FY 04-05 for these items have been moved to the new category, and the estimates for FY 05-06 and FY 06-07 have been moved as well.

3. A new eligibility category titled Health Care Expansion Fund Low-Income Adults has been added to caseload and exhibits. HB 05-1262 includes a clause to expand Medicaid parents to 75% of federal poverty level beginning FY 06-07. This eligibility category's per capita estimate does not include delivery costs, which are included in the Baby Care Adult's per capita, so it is estimated at a lower per capita cost than the other Adult categories. Since this population is new, and the estimated per capita costs were lower compared to the Category Eligible Low-Income Adults, the Department felt it was necessary to add the new eligibility category. Similar considerations were made for the expansion population in Category Eligible Low-Income Adults and Eligible Children due to the asset test removal; however, the per capita costs were so close in comparison that the existing eligibility categories and estimated per capita costs were utilized for the request.

4. The methodology for the Breast and Cervical Cancer per capita has been modified. Since more costs are incurred for new clients compared to existing clients, it is more logical to develop two per capita costs, calculate the estimated expenditures and divide by the total Breast and Cervical Cancer Treatment clients to develop a single per capita. See Exhibit F, page EF-5 for additional details.

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 limits, and some have additional criteria such as age, resource 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 criteria. 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 its 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 without 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. Medicaid eligibility, retroactive back to the date of application, is still in effect. However it is no longer reported in caseload. For a complete explanation of how the historical data was rebuilt and tested, refer to the November 3, 2003 Budget Request, pages K-98 and K-99.

Recent Caseload History

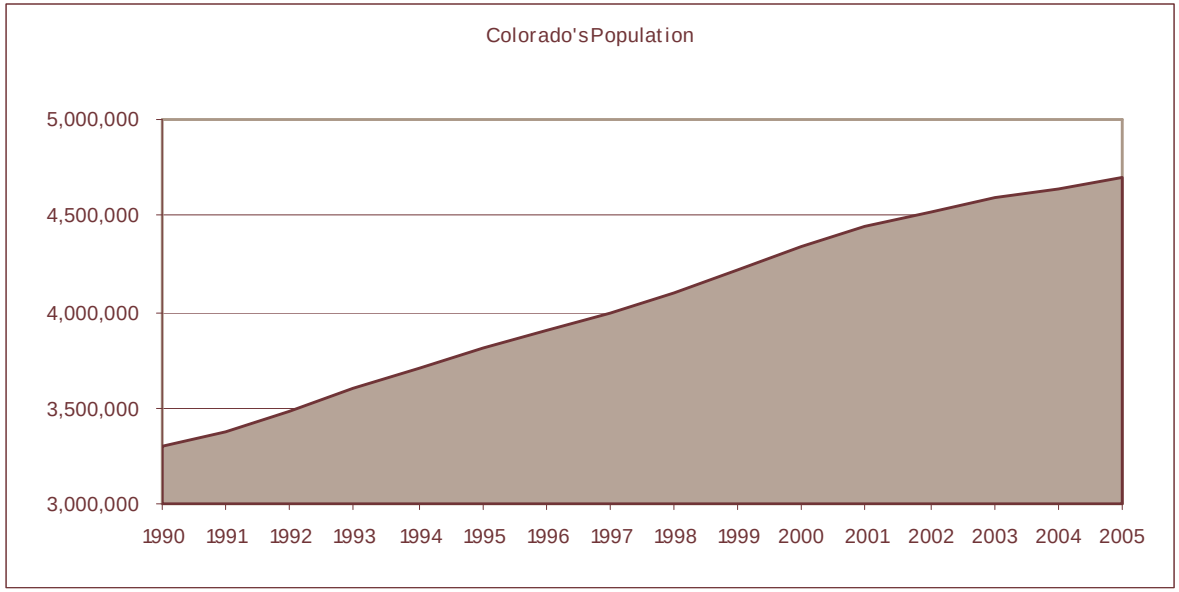
Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 95-96 to FY 04-05. Projections for FY 05-06 and FY 06-07 are also presented in the table and will be discussed in the Categorical Projections section of this document. A graphic representation of aggregate Medicaid caseload history for the same period can be found in Exhibit R, page ER-1. Aggregate growth from FY 93-94 to FY 99-00 was stable, and in some years even declined. From FY 99-00 to FY 04-05 the State sustained positive and significant growth in caseload ranging from 6.6% to 11.1%. Even more notable is the fact that Medicaid in Colorado had double-digit growth rates in FY 02-03, FY 03-04 and FY 04-05 of 10.8%, 10.7% and 11.1%, respectively. Reasons for these recent growth rates will be discussed below, but having a reference for this unprecedented growth is important. Over the past six fiscal years, growth rates have not shown any signs of abatement.

The charts found in Exhibit R, page ER-2, show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 94-95 through FY 04-05. As a percentage of the entire Medicaid caseload, Eligible Children have increased by 8%, 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 4% respectively. This 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 23.6% from July of 1995 to July of 2005. The Department of Local Affairs forecasts that Colorado's population will increase 3.4% from July of 2005 to July of 2007. 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.



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.[2] 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.

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 1995 to 2005, the mean population in Colorado increased by 1.86 years.[3] 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.[4] This infers that Colorado will have more working adults per one elderly adult in 2025 than any other state. As of 2005, Colorado has not yet felt the impacts of an aging population 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. The table below shows that the average number of months of eligibility for adults and children on Medicaid has increased 31.91% and 2.57% respectively from FY 99-00 to FY 04-05. The Department expects the average length of stay to decrease as economic conditions become more robust. The recent decline in length of stay for Eligible Children is a promising sign.

[2] Source: Dwyer, Kelly. "New Residents, Jobs on the Rise in Colorado." The Denver Post. 11 July 2004.
[3] Source: Department of Local Affairs, Demography Division
[4] Source: "Medicaid an Aging Population." Georgetown University Long Term Care Financing Project. July 2004. <http://www.ltc.georgetown.edu>

Fiscal Year	Categorically Eligible 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
FY 04-05	9.59	8.78

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 combined with the bursting of the stock market bubble in 2000 brought that expansion to a halt. For the first time in over a decade, Colorado lost a significant number of jobs coupled with falling wages. In mid 2003, the Colorado economy hit bottom after the decline that started in 2000. A comparison of change in non-agricultural employment to the same month in the previous year shows that it has trended upward ever since the bottom in mid 2003. Because of seasonal fluctuations and wide confidence intervals for over the month changes, employment data is best analyzed by comparing the same month for different years. The first recorded over the year gain since the recession occurred in March of 2004. As of July 2005, the gain was estimated to be 50,000. It is likely that this estimate will be revised upward. Job growth in Colorado is at its fastest rate since the beginning of the downturn which started in the beginning of 2001. The growth rate is forecasted to be about 3 percent throughout the forecast period.

The table that follows shows historical and projected unemployment rates, non-agricultural employment, and job growth statistics.[5]

Year	Wage and Salary Income (millions)	Non-Agricultural Employment	Unemployment Rate
2001	$88,297	2,225,400	3.9%
2002	$86,807	2,182,500	5.9%
2003	$87,747	2,151,000	6.2%
2004	$91,437	2,178,900	5.5%
2005	$96,219	2,228,000	5.0%

[5] Source: Office of State Planning and Budgeting, June 2005 *Colorado Economic Perspective*

Year	Wage and Salary Income (millions)	Non-Agricultural Employment	Unemployment Rate
2006	$101,867	2,293,800	4.8%
2007	$108,708	2,366,800	4.4%

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[6] 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 September 30, 2005, as it has been several times. The federal government has reauthorized this program till September 30, 2006. 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 increased dramatically in FY 04-05. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 05-06 and FY 06-07.

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
FY 04-05	7,299	14,723

The combination of the aforementioned factors has led to significant growth in the Medicaid caseload since FY 99-00. The Department is projecting a FY 05-06 caseload of 439,069 and a FY 06-07 caseload of 475,214. From the actual FY 04-05 caseload figures, this translates into a 9% growth rate in FY 05-06. In the February 15, 2005, Final Request for Medical Services Premiums, page MSP-29, the Department predicted an 11.7% growth in the FY 04-05 Medicaid caseload. Actual figures show that caseload

[6] Projecting elderly and disabled client populations does not prioritize economic variables.

grew 11.1% in FY 04-05, relatively steady from the prior year's growth of 10.7%. 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 05-06 or FY 06-07. The following table shows actual and projected aggregate Medicaid caseload from FY 02-03 through FY 06-07.

Fiscal Year	Medicaid Caseload	Level Growth	Growth Rate
FY 02-03 actual	327,395	31,984	10.8%
FY 03-04 actual[7]	362,531	35,136	10.7%
FY 04-05 actual	402,802	40,271	11.1%
FY 05-06 projection	439,069	36,267	9.0%
FY 06-07 projection	475,214	36,145	8.2%

Policy Changes- 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.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003: This Act will cause more potential beneficiaries to be screened for Medicaid when they apply for the Low Income Subsidy.
- Presumptive eligibility for Medicaid pregnant women was abolished on September 1, 2004. It was re-established on July 1, 2005.

[7] 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.

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 05-06 and FY 06-07 forecasts to account for the implementation of HB 05-1262 *(Tobacco Tax Bill)* and the Medicare Modernization Act of 2003. Both of these laws will add to the caseload. Detailed accountings of offline adjustments are in Exhibit B, page EB-2.

The Department projects that the Medicare Modernization Act of 2003 will add a significant number of clients to two Medicaid caseload categories. These categories are Supplemental Security Income 65+ and Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries. These clients will be dually eligible for both Medicare and Medicaid. When clients apply for their Medicare Part D benefit, they will be screened for Medicaid. Many of these clients will be found to be eligible. The Department estimates that for FY 05-06, this will add an additional 4,620 clients. The Department anticipates a similar increase for FY 06-07, the first full year of the program. These additions are included in the estimates. The methodology that the Department used to estimate this increase was based on information from page 4486 of the January 28, 2005 Federal Register where the Centers for Medicare and Medicaid Services estimated that 1.1 million Medicaid beneficiaries nationally will be added to the rolls in 2006. "Medicaid Enrollment in 50 States", an October 2004 publication by the Kaiser Commission on Medicaid and the Uninsured (page 8), states that Colorado had 340,000 of the nations 40,553,200 Medicaid enrollees in 2003, or 0.84%. The Department estimated that half of these new enrollees would begin coverage in FY 05-06 and the other half would begin coverage in FY 06-07. The Centers for Medicare and Medicaid Services estimated that 21% of the new enrollees would be in Supplemental Security Income 65+ and 79% would be in Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries. The percentage of Medicaid enrollees that are in Colorado of the 1.1 million and the Centers for Medicare and Medicaid Services and the percentage breakout between the caseload categories were used to perform the Department's estimate.

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. (2005): 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, 26-4-681 to 687, C.R.S. (2005): 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. (2005): Serves persons diagnosed with HIV/AIDS.
- Elderly, Blind and Disabled Waiver 26-4-601-612, C.R.S. (2005): Serves persons who have a functional impairment, are blind, or are physically disabled.
- Consumer Directed Care, 26-4-1301 to 1303, C.R.S. (2005): Allows eligible clients to receive vouchers to direct their own care.

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 05-06 and FY 06-07 caseload projections. However, a bottom-line adjustment has been made in the Premiums projection for SB 04-177.
HB 05-1262 (Tobacco Bill) is expected to add clients to five eligibility categories for a variety of reasons. The details are as follows.

The Department estimates that the Eligible Children group will add the most clients of any category. Most of the increase will be because the asset test will be removed for children and families. Eligibility will also increase because of marketing of the Children's Basic Health Plan. Some of the additional clients that apply for the Children's Basic Health Plan will be found eligible for Medicaid. Based on the fiscal note for HB 05-1262, in FY 05-06, the bill is expected to add 14,332 clients because of the removal of the asset test and 844 because of marketing. For FY 06-07, the fiscal note for HB 05-1262 indicated that there would be additions of 24,371 clients related to the removal of the asset test and 2,402 additional clients because of marketing of the Children's Basic Health Plan. The numbers for FY 06-07 are a total increase and not in addition to the FY 05-06 estimate.

A total of 3,440 clients for FY 05-06 and 5,849 clients for FY 06-07 were added to the estimates for Categorically Eligible Low Income Adults because of removal of the asset test. In addition, the Department adjusted for 4,886 adults to be added in FY 06-07 because of an increase in the allowable income percentage of the federal poverty level being increased to 75 percent.

The Baby Care Adults eligibility category is expected to increase significantly because the bill restored presumptive eligibility. The Department increased caseload by an average of 1,470 clients in FY 05-06 and 1,549 in FY 06-07.

Based on the fiscal note for HB 05-1262, the bill will add 527 clients to the Supplemental Security Income for Disabled Individuals eligibility category. The clients were on the waiting lists for Home and Community Based Services and the Children's Extensive Support Waiver program.

The Breast and Cervical Cancer Treatment is also expected to increase because of HB 05-1262. The Department's caseload reflects an addition of 91 clients for FY 05-06 and projects and additional 116 for FY 06-07. The increase is due to funding being provided to the Department of Public Health and Environment for cancer screenings.

Colorado Benefits Management System - 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 become objective and uniform under the new system. This significant change has affected the Medical Services Premiums line item. Certain phenomena changed data results or caseload reporting including:

- Clients who were erroneously made eligible or ineligible in the past were corrected;

- There was a backlog of applications for much of FY 04-05;
- There were delayed determinations and redeterminations of eligibility;
- There was and still is a learning curve and cultural change for county workers and Medical Assistance Site workers;
- There was a Benefit Freeze Flag.

In summary, Colorado's economy is recovering at a faster rate, but an impact on Medicaid clients will take more time to actualize. Accounting for these economic conditions, the passage of HB 05-1262 and the fact that population and age continue to increase, the Department has revised its FY 05-06 projection from the February 15, 2005 submission upwards.

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 June 2005 and historical and forecasted economic and demographic data that were revised in June 2005 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 Treatment 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.

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 2005, 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;
- 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 normally chooses one for each category. In most eligibility categories, trend and regression projections are considered. In the case of the Breast and Cervical Cancer category, a statistical model could not be applied and the estimate was based on the program staff recommendation.

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. In some cases, the forecasts that are produced by the models are adjusted upward or downward based on information that is not internal to the model.

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 R, pages ER-3 to ER-12.

SERVICES FOR SUPPLEMENTAL SECURITY INCOME ADULTS 65 and OLDER (SSI 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 meet the nursing home level of care. 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. Three-hundred 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 R, page ER-3 shows that growth in this category has increased along with population. 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. SB 03-176 never was implemented. The Department estimates that the Medicare Modernization Act of 2003 will add an average of 970 clients in FY 05-06 and 1,940 clients in FY 06-07. This increase will occur because low-income Medicare Part D clients will be screened for Medicaid as they apply for the low-income subsidy. The Department projected a positive growth rate in FY 05-06 and FY 06-07 prior to increases related to Medicare Modernization Act of 2003.

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	35,615	1,466	4.29%
FY 05-06 projection	37,636	2,021	5.67%
FY 06-07 projection	39,248	1,612	4.28%

26-4-201, C.R.S. (2005)
(j) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions.

26-4-301, C.R.S. (2005)
(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.

SERVICES FOR SUPPLEMENTAL SECURITY INCOME ADULTS 60 to 64 Years of Age (SSI 60-64)
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 (ER-4). 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. This was 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).

Caseload is correlated with the population of adults aged 60-64. This group is growing much faster than population as a whole and that trend is expected to accelerate over the next three years. The Department anticipates that steady growth will resume.

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	6,103	575	10.40%
FY 05-06 projection	6,266	163	2.67%
FY 06-07 projection	6,608	342	5.46%

26-4-201, C.R.S. (2005)
(j) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions.

26-4-301, C.R.S. (2005)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement.

QUALIFIED MEDICARE BENEFICIARIES (QMBs) AND SPECIAL LOW-INCOME MEDICARE BENEFICIARIES (SLIMBs)
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 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 R, page ER-5, illustrates that growth rates in this category have been positive and steady between FY 99-00 and FY 03-04. Caseload trends are somewhat correlated with economic indicators. This eligibility category will have the largest expansion related to the Medicare Modernization Act of 2003. The Department added 3,650 cases on average in FY 05-06 and 7,300 in FY 06-07 based on calculations in the fiscal note for HB 05-1262. This increase will occur because Medicare Part D clients will be screened for Medicaid as they apply for the low income subsidy. The Department projected a positive growth rate in FY 05-06 and FY 06-07 prior to increases related to Medicare Modernization Act of 2003.

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	9,572	-215	-2.20%
FY 05-06 projection	13,219	3,647	38.10%
FY 06-07 projection	17,195	3,976	30.08%

26-4-201, C.R.S. (2005)
(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"

SERVICES FOR 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 meet the nursing facility level of care. Referred to as 300 Percenters, these clients have incomes no more than three 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 category exhibited unprecedented growth rates. Factors contributing to this surge were: intensified outreach efforts to those with substance abuse problems; catching up 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 R, page ER-6, shows that caseload dramatically increased from 1993 to 1997. From FY 96-97 to FY 03-04, caseload remained relatively constant. The caseload increased at a faster rate in FY 04-05. The FY 04-05 level of increase is not expected to continue. 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. HB 05-1262, the Tobacco Tax Bill, is expected to add 527 clients to the category based on the fiscal note for HB 05-1262. This bill expands the number of children that can be enrolled in the Children's Home – Community – Based Service (HCBS) Waiver Program and the Children's Extensive Support (CES) Waiver Program. The Department anticipates that caseload will rise near typical historical levels during the forecast period.

+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	47,626	1,061	2.28%
FY 05-06 projection	47,930	304	0.64%
FY 06-07 projection	48,072	142	0.30%

26-4-201, C.R.S. (2005)
(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. (2005)
(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.

SERVICES FOR CATEGORICALLY ELEIGBILE 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. Transitional Medicaid Benefits were extended through September 30, 2005. The Department has not received news from the federal government as of September 30, 2005 if this program will be extended or not. The Department's forecast assumes that the Transitional Medicaid program continues in FY 05-06 and FY 06-07.

Growth rates in this category have been unprecedented since FY 00-01. The graph in Exhibit R, page ER-7, 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[8] 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 Budget Request, pages A-37 to A-38.

From 2001 to 2005, caseload has grown by an average of 19.2% per year. Caseload trends in this category are highly affected by economic conditions, and correlated to the population of adults aged 18 to 59. The 18-59 population is projected to grow by 1.4% each of the next two years. The average gain from 1991-2004 was 2.7%. As compared to all other categories, this caseload is more

[8] Source: November 1, 2001 Budget Request, page A-37

sensitive to job growth, unemployment, and wages than any other, with the exception of Eligible Children. For FY 05-06 and FY 06-07, the Department projects decreasing growth rates due a direct correlation with economic expectation as forecast by the Office of State Planning and Budgeting.

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	56,453	9,699	20.74%
FY 05-06 projection	64,504	8,051	14.26%
FY 06-07 projection	70,194	5,690	8.82%

26-4-201, C.R.S. (2005)
(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. (2005)
(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.

SERVICES FOR HEALTH CARE EXPANSION FUND FOR LOW INCOME ADULTS
Prior to FY 05-06, there was no caseload in this category. The Department has created a new category to track Categorically Eligible Low-Income Adults that are newly eligible because of HB 05-1262, the Tobacco Tax Bill. This is known as the Health Care Expansion Fund for Low Income Adults. HB 05-1262 allows for expanding Medicaid to parents of enrolled children up to 75% of the federal poverty level, although the estimate is based on 60%. The Department estimates that by increasing the federal poverty level threshold to 60%, approximately 4,886 clients will be included for FY 06-07 and FY 07-08 as shown in Exhibit B. The increase in the percentage of allowable federal poverty level is scheduled to be implemented on July 1, 2006. Hence, there is no adjustment for FY 05-06. This is inconsistent with the April 25, 2005 Fiscal Note for this bill that estimated an implementation of November, 1, 2005. this group would not receive prenatal benefits which resulted in a lower per capita than category Low Income Adults. The difference

in per capita costs warranted a new eligibility category to be updated. The Health Care Expansion Fund for Low Income Adult clients are paid for through federal funds and HB 05-1262 money. This tobacco tax money is cash funds exempt.

SERVICES FOR 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 R, page ER-8, 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. 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%.[9] However, from 1991 to 2002 teen pregnancy rates in Colorado fell 19%.[10] Economic indicators may also affect caseload trends in this category.

Future projections for this category are affected by the return of presumptive eligibility for pregnant women. Presumptive eligibility allows pregnant women who had applied for Medicaid to receive services based on self-declaration until the status of their application has been determined. The State paid for all Medicaid costs during this time regardless of whether or not the woman was eventually found to be Medicaid eligible or not. On September 1, 2004, the Department discontinued this procedure. Presumptive eligibility was reinstated by HB 05-1262, the Tobacco Tax Bill, effective July 1, 2005. The fiscal note for that bill estimated that this change will add 1,470 clients in FY 05-06 and 15,549 clients in FY 06-07 on an annual average basis. Without the return of presumptive eligibility, the Department estimated that caseload would increase slightly on a monthly basis before leveling off toward the end of the forecast period. The annual average change is exaggerated for FY 05-06 since the caseload was at a low for the year at the end of FY 04-05. Specifically, the June caseload figure stood at 4,846 while the FY 05-06 annual average estimate is 42% higher at 6,889.

[9] Source: Female headed households - U.S. Census Bureau, Number of Colorado births - Department of Local Affairs, Demography Division.
[10] 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	6,110	-2,093	-25.52%
FY 05-06 projection	6,889	779	12.75%
FY 06-07 projection	7,248	359	5.21%

26-4-201, C.R.S. (2005)
(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.

SERVICES FOR SB 01S2-12 BREAST AND CERVICAL CANCER TREATMENT CLIENTS

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.

Forecasting for this eligibility category cannot be accomplished with any degree of confidence through statistical modeling. The estimate for this category is derived from a combination of anticipated increases by the program staff and anticipated increases because of HB 05-1262 (ER-9). The anticipated increases that are attributable to HB 05-1262 are because of increased cancer screenings through the Department of Public Health and Environment. The additional clients directly attributable to the bill are 91 for FY 05-06 and 116 for FY 06-07.

Breast and Cervical Cancer Treatment Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	46	-	-
FY 03-04	103	57	123.9%
FY 04-05	86	-17	-16.5%
FY 05-06 projection	220	134	155.8%
FY 06-07 projection	350	130	59.1%

26-4-301, C.R.S. (2005)
(q) The breast and cervical cancer prevention program pursuant to section 26-4-532.

SERVICES FOR ELIGBILE 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.

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. Authorization for Transitional Medicaid Benefits was extended through September 30, 2005. The Department's forecast assumes that Transitional Medicaid will continue in FY 05-06 and FY 06-07.

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 or 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.

The graph in Exhibit R, page ER-10, shows that from 1993 to 1999 caseload in this category fell. This can be attributed to economic expansion 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. 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 16.79%. 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 by 20.1% from 1995 to 2005.[11] 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).

HB 05-1262, the Tobacco Tax Bill, is expected to add 15,176 clients in FY 05-06 and 26,773 in FY 06-07 to the caseload. The FY 06-07 is a cumulative estimate and not in addition to the 15,176 added the previous year. The gain is primarily because of the elimination of the asset test but gains are also anticipated to occur because of marketing of the Children's Basic Health Plan. When potential clients apply for the Children's Basic Health Plan, they will be screened for Medicaid and some of them will be found to be eligible. Before considering the additional clients that are anticipated to be added because of HB 05-1262, the Department anticipated that the growth rate would slow before leveling off due to improvements in economic conditions as forecasted by the Office of State Planning and Budgeting.

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	220,592	28,544	14.86%
FY 05-06 projection	240,507	19,915	9.03%
FY 06-07 projection	258,638	18,131	7.54%

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

26-4-201, C.R.S. (2005)
(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. (2005)
(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.

SERVICES FOR FOSTER CHILDREN
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. 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 R, page ER-11, 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 05-06 and FY 06-07, the Department expects growth rates to decrease slightly.

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	15,669	879	5.94%
FY 05-06 projection	16,499	830	5.30%
FY 06-07 projection	17,029	530	3.21%

26-4-201, C.R.S. 2005
(h) Children for whom adoption assistance or foster care maintenance payments are made.

SERVICES FOR 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 full 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. Full Medicaid coverage of individuals for the first five years is optional except for emergency services. Per federal regulations, states must provide mandatory full 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.

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 R, page ER-12.

The graph also illustrates that the growth rate in this category has had a positive trend 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.[12] With gradual improvement in the economy and increased longevity, the Department projects that the caseload in this category will continue to rise significantly.

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	4,976	372	8.08%
FY 05-06 projection	5,399	423	8.50%
FY 06-07 projection	5,746	347	6.43%

26-4-201, C.R.S. (2005)
(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.

SUMMARY
The Department estimates that the Medicaid caseload will reach 439,069 in FY 05-06 and 475,214 in FY 06-07, without retroactivity. The increases in overall caseload are primarily due to program growth and legislation including HB 05-1262 (the Tobacco Tax Bill) and the Medicare Modernization Act of 2003. Projections will be updated in February 2006 to include the most recent economic conditions, more current actuals, and the progress of HB 05-1262 implementation. See Exhibit B for complete information.

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

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts. Inherent in the 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 child is substantially less costly to serve than a disabled person each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita of each of the kinds of clients who will be served. 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 05-06 (current year) and FY 06-07, the request year. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

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 04-05), the per capita cost decreased or rose nominally overall. This illustrates that the majority of growth in these years was in the least costly populations. It may also illustrate that caseloads tend to rise during stress economic times, and there are less chances for provider rate increases during these times. It is not possible to review the per capita cost change over time in isolation to check for the reasonableness of the budget. One must look further into the per capita cost change by eligibility category (Exhibit EB-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**	**Caseload**	**Per capita**	**% Change in Expenditures**	**% Change in Caseload**	**% Change in Per capitas**
FY 95-96	$991,235,479	254,083	$3,901.23	N/A	N/A	N/A
FY 96-97	$1,127,919,788	250,098	$4,509.91	13.79%	(1.57%)	15.60%
FY 97-98	$1,104,970,992	238,594	$4,631.18	(2.03%)	(4.60%)	2.69%
FY 98-99	$1,176,233,410	237,598	$4,950.52	6.45%	(0.42%)	6.90%
FY 99-00	$1,308,420,106	253,254	$5,166.43	11.24%	6.59%	4.36%
FY 00-01	$1,416,535,408	275,399	$5,143.57	8.26%	8.74%	(0.44%)

Calculation of Rate of Change in Expenditures for Medical Services to Clients						
Fiscal Year	**Premium Expenditures**	**Caseload**	**Per capita**	**% Change in Expenditures**	**% Change in Caseload**	**% Change in Per capitas**
FY 01-02	$1,536,804,691	295,413	$5,202.22	8.49%	7.27%	1.14%
FY 02-03	$1,651,670,874	327,395	$5,044.89	7.47%	10.83%	(3.02%)
FY 03-04	$1,841,738,922	362,531	$5,080.22	11.51%	10.73%	0.70%
FY 04-05	$1,893,285,566	402,802	$4,700.29	2.80%	11.11%	(7.48%)
FY 05-06 Projection	$2,045,792,851	439,069	$4,659.39	8.06%	9.00%	(0.87%)
FY 06-07 Projection	$2,157,905,163	475,214	$4,540.91	5.48%	8.23%	(2.54%)

The Upper Payment Limit financing in FY 01-02 through FY 05-06 is excluded from this table. The Clawback payment of $30,984,982 in FY 05-06 and $61,469,964 in FY 06-07 was excluded from their respective fiscal year projections.

Rough Five Year Projection:

Due to extreme unpredictabilities experienced at this time, a five-year projection of caseload and per capita cost is not included in this submission. However, a rough estimate of caseload for FY 07-08 is provided in Exhibit B and a rough estimate of per capita is provided in Exhibit C. These are only rough estimates based on a basic trend from FY 99-00 to the projected FY 06-07. The FY 07-08 projections are computed in a straight-line fashion from historic actual caseload growth and expenditure growth. They do not include program policy changes, Decision Items or Base Reduction items, economic changes, and/or impacts on enrollment and eligibility. These projections do not represent an official Budget Request for Medical Services Premiums.

IV. RATIONALE FOR GROUPING SERVICES FOR PROJECTION PURPOSES

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, 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, physician services, etc.). Adversely, 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
- Prescription Drugs
- Prescription Drug Rebates
- Rural Health Clinics
- Federally Qualified Health Centers
- Title XVIII (Medicare Coinsurance and Deductible)
- Home Health
- Breast and Cervical Cancer Treatment (authorized by SB 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 October 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 (a summary of the totals of individual service calculations, <u>not a grouped calculation</u>):

- Class I Nursing Facilities (independent calculation)
- Class II/IV Nursing Facilities (independent calculation)
- Program for the All-inclusive Care for the Elderly (independent calculation)

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

Service Management (a summary of the totals of individual calculations, not a grouped calculation):
- Single Entry Point Agencies (independent calculation)
- Disease Management (independent calculation)
- Administrative Services Organizations.

FEDERAL MATCH CALCULATIONS (Exhibit A)

The federal match calculations reflect the match information provided from the federal Centers for Medicare and Medicaid Services, as reported through the Federal Register. The federal financial participation rate for Medicaid is recomputed by the Federal Funds Information Service each year and is based on a statewide per capita earnings formula that is set in federal policy.

Bottom line adjustments are made for new legislation that mandates fees for HB 03-1292 (ICF-MR Fee) and the Upper Payment Limit financing. These items are all discussed further in this narrative. They are included as bottom line adjustments because they need to be excluded from the trend of expenditures. Only expenditures for medical services to clients are included in the trend of expenditures.

The total request for FY 05-06 is compared to the FY 05-06 Long Bill plus Special Bills appropriation. The total request for FY 06-07 is compared to the total request of FY 05-06 and the FY 06-07 Base Amount (incorporating FY 05-06 Long Bill plus Special Bills and out year impacts). There are two calculation worksheets for each fiscal year, one with excluding the Clawback Payment and the other including it. The Department is requesting the Clawback Payment be removed from the Medical Services Premiums Long Bill group and moved to Other Medical Services.

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 F, page EF-9.

- 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. Please see Exhibit F, page EF-8.

- Breast and Cervical Cancer Treatment: At the outset of this program, the federal match for this program was 65% federal and 35% Cash Funds Exempt, from interest earnings from the Tobacco Litigation Settlement Cash Fund. HB 04-1416 (Funding Split for Breast and Cervical Cancer Treatment) continued this funding through FY 04-05. Beginning in FY 05-06, the funding split is 65% federal, 17.5% Cash Funds Exempt from interest earnings from the Tobacco Litigation Settlement Cash Fund, and 17.5% General Fund. The fund split is modified again beginning FY 06-07 to 65% federal, 8.75% Cash Funds Exempt, and 26.25% General Fund.

- Obesity Treatment pilot program: The funding for the program is to be split 50% federal and 50% Cash Funds Exempt from gifts, grants, and donations received by the Department of Health Care Policy and Financing for the purpose of this Act.

- 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. 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 matched with Medicaid federal financial participation. Instead this must be funded through 100% General Fund.

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

- 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 Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
  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.
  c. Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

- Fund Transfer and Health Care Expansion Fund: The caseload impacts of the Health Care Expansion Fund (HB 05-1262) are already included in the Medicaid caseload projections. See Exhibit B page EB-1 through EB-3 for additional information. The Medical Services Premiums request is based on these caseload projections and per capita costs, as described in detail below. The overall request for each service category (Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management) is rolled into the Federal Match Calculation, Exhibit A, pages EA-1 through EA-4, splitting the request by General Fund, Cash Funds Exempt, and federal funds accordingly by line item. For simplicity, the Fund Transfer and Health Care

Expansion Fund (page EA-5 through EA-8) show the fund split adjustments that need to be made to the General Fund amounts shown in the top section of the Calculation of Match exhibits (page EA-1 through EA-4). The following include a list of adjustments and their funding split:

a. Breast and Cervical Cancer Treatment Expansion Population – 50% federal funds, 50% Cash Funds Exempt from the Prevention, Early Detection, and Treatment Fund to be administered by the Department of Public Health and Environment.

b. Disease Management – 50% federal funds, 50% Cash Funds Exempt from the Prevention, Early Detection, and Treatment Fund to be administered by the Department of Public Health and Environment.

c. Impact on Medicaid from marketing the Children's Basic Health Program, Medicaid asset test (children expansion), Medicaid asset test (adult expansion), presumptive eligibility, Single Entry Point costs for Children's Home Community Based Services Wait List, Single Entry Point costs for Children's Extensive Support waiting list, Children's Extensive Support waiting list State Plan services, Children's Home Community Based Services waiting list State Plan services, Children's Home Community Based Waiver services, legal immigrants, Medicaid parents expansion (FY 06-07 – itemized in request under Health Care Expansion Fund Low-Income Adults eligibility category) – 50% federal funds, 50% Health Care Expansion Fund.

The items above are summed for each fiscal year and a single line adjustment is included in on the Calculation of Match exhibits to correct the funding splits.
Historically, the FY 06-07 Projection over the FY 05-06 Appropriation plus Special Bills request row on the Federal Match Calculations sheet (page EA-3 and EA-4 of Exhibit A) did not equal Column 6 + Column 8 of the Schedule 6 due the annualization of specials bills from the prior Legislative Session. Beginning with the FY 06-07 request, the annualizations have been included to this exhibit so the amounts correspond with the Schedule 6.

MEDICAID CASELOAD PROJECTION AND REQUEST WITHOUT RETROACTIVITY (Exhibit B)
This exhibit is described in the Caseload Assumptions and Calculations.

HISTORY OF PER CAPITA COSTS – Cash Based Per Capita, Total Expenditures, and Caseload (Exhibit C)
Medical Services Premiums per capita costs, expenditure and caseload history (through FY 04-05) and projections are included for historical purpose and comparison.

SUMMARY OF REQUEST BY ELIGIBILITY CATEGORY (Exhibit D)
The exhibit displays the Medical Services Premiums caseload, per capita costs and expenditure projections for FY 05-06 and FY 06-07 by eligibility category. Projections include Upper Payment Limit Financing and financing bills. The projections do not include the Medicare Prescription Drug Clawback payment. Caseload is non-retroactive.

SUMMARY OF PREMIUM REQUEST by SERVICE GROUP (Exhibit E)

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.

ACUTE CARE CALCULATIONS (Exhibit F, page EF-1 through EF-4)

Acute Care services are calculated in a series of steps. At the top of the first page, historical expenditures with dollar and percent changes are provided. Then historical per capita costs and their percent changes are provided. The first step of the calculation is to select a historical per capita percent change rate, if possible, to trend the last actual per capita (FY 04-05 in this case) to the next year. Finally, bottom line adjustments for legislation and Change Requests are made. Total expenditures after bottom line adjustments are divided by the projected caseload to obtain a final per capita cost.

Calculation of Per Capita Percent Change:

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 99-00 through FY 04-05, 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. 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. Historically the same percentage selected to modify current year per capita costs (FY 05-06 for instance) were used to modify the request year per capita costs. This method was not utilized in all cases for the FY 06-07 Request.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category. The percent trends selected for FY 05-06, with the rationale, are as follows:

FY 05-06

Because of various events occurring during FY 04-05, percentages selected to trend the FY 04-05 per capita amounts to FY 05-06 were analyzed by eligibility category and selected based on historical trend of expenditures. Percentages selected in Exhibit F have been bolded for clarification.

- **Supplemental Security Income Adults 65 and Older** (OAP-A): The 3-year average (FY 02-03, FY 03-04, and FY 04-05) was selected at 1.54% since the per capita cost modifier of 0.76% would seem to result in too low of an estimate and 4.17% in too high of an estimate. The 1.54% seems appropriate as it is close to the overall increase to expenditures in FY 04-05 of 1.65%. The legislative impact to this eligibility category for FY 05-06 is estimated to be a reduction of $21,184,395. Before the legislative

impacts, the 1.54% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 6.44%, as compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 1.54% resulted in a decrease in estimated expenditures for FY 05-06 of 8.11%, compared to FY 04-05 actual expenditures.

- **Supplemental Security Income Adults 60 to 64** (OAP-B): The 3-year average (FY 01-02, FY 02-03, and FY 03-04) was selected at 4.99%. Expenditures in this eligibility category have fluctuated significantly from year to year, and this is a moderate growth rate considering. The percentages calculated to modify the FY 04-05 per capita ranged from 0.67% through 10.83%. The legislative impact to this eligibility category for FY 05-06 is estimated to be a reduction of $3,569,511. Before the legislative impacts, the 4.99% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 7.32%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 4.99% resulted in an increase in estimated expenditures for FY 05-06 of 0.26%, compared to FY 04-05 actual expenditures.

- **Supplemental Security Income Disabled Individuals** (AND/AB): A 5-year average (FY 00-01 through FY 04-05) of 4.37% was selected. Similar to Supplemental Security Income Adults 60 to 64, expenditures in this eligibility category have fluctuated significantly from year to year. The 4.37% results in an estimated expenditure of $421,836,270, pre-legislative impacts, an increase of $20,532,579 over FY 04-05. This is lower than the dollar increase experienced between FY 01-02 through FY 03-04. The legislative impact to this eligibility category for FY 05-06 is estimated to be a reduction of $29,179,908. Before the legislative impacts, the 4.37% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 4.44%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 4.37% resulted in a decrease in estimated expenditures for FY 05-06 of 2.83%, compared to FY 04-05 actual expenditures.

- **Categorically Eligible Low-Income Adults** (1931 clients, formerly called AFDC-A): The 2-year average of 3.88% for FY 01-02 and FY 03-04 was selected for this category. With the exception of FY 04-05, this eligibility category has experienced large increases in expenditures year to year (Exhibit F, page EF-4). The average percentage change FY 96-97 through FY 04-05 is 10.22%. The selected percentage tames this growth with the FY 04-05 experience. The legislative impact to this eligibility category for FY 05-06 is estimated to be $3,173,356. Before the legislative impacts, the 3.88% increase applied to the FY 04-05 per capita cost would result in an increase in estimated expenditures for FY 05-06 of 18.59%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 3.88% would result in an increase in estimated expenditures for FY 05-06 of 20.31%, compared to FY 04-05 actual expenditures.

- **Health Care Expansion Fund Low-Income Adults:** Not applicable for this fiscal year.

- **Breast and Cervical Cancer Treatment:** Based on the new methodology for forecasting this eligibility category as described earlier, there was no percentage selected to modify the FY 04-05 per capita. However, the percentage reduction of 11.39%

selected to modify per capita line in Exhibit F, page EF-2, represents the percentage change between the FY 04-05 per capita and the estimated FY 05-06 per capita.

- **Eligible Children** (1931 children and Baby Care/Kids Care children): The 3-year average of 3.87% for FY 99-00 through FY 01-02 was selected for this eligibility category. This was the only positive trend result for this category, and the Department does not believe that the per capita cost for this category will go down. The legislative impact to this eligibility category for FY 05-06 is estimated to be $4,767,576. Before the legislative impacts, the 3.87% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 14.67%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts the 3.87% resulted in an increase in estimated expenditures for FY 05-06 of 14.87%, compared to FY 04-05 actual expenditures.

- **Foster Care**: The 3-year average of 4.31% (FY 01-02, FY 02-03, and FY 03-04) was selected for this category. This average is appropriate since there is no dramatic variance from year to year. The legislative impact for this eligibility category in FY 05-06 is estimated to be $665,892. Before the legislative impacts, the 4.31% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 9.60%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 4.31% resulted in an increase in estimated expenditures for FY 05-06 of 11.17%, compared to FY 04-05 actual expenditures.

- **Baby Care Adults**: The 3-year average (FY 02-03, FY 03-04, and FY 04-05) of 12.86% was selected for this category. This category has experienced a wide variance of increases. This large increase over FY 04-05 is supported due to the reinstatement of presumptive eligibility, effective July 1, 2005. The legislative impact to this eligibility category for FY 05-06 is estimated to be $598,360. Before the legislative impacts, the 12.86% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 27.16%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 12.86% resulted in an increase in estimated expenditures for FY 05-06 of 28.70%, compared to FY 04-05 actual expenditures.

- **Non-Citizens**: For this category, the per capita increase between FY 95-96 and FY 96-97 of 15.11% was selected. The Department does not anticipate a significant reduction in the eligibility category so the negative 6.23% was not considered an option. The 2.97% was believed to result in an approximate increase in expenditures of $4.5 million, seemingly lower than historical expenditure patterns experienced. The 31.71% would result in too large of an increase in expenditures. The legislative impact for this eligibility category in FY 05-06 is estimated to be $501,294. Before the legislative impacts, the 15.11% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 24.87%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 15.11% resulted in an increase in estimated expenditures for FY 05-06 of 26.18%, compared to FY 04-05 actual expenditures.

- **Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries:** The 2-year average (FY 00-01 and FY 01-02) of 1.54% was selected for this category. Reasons for this selection are: 1) this was the only positive modifier; 2) the Medicare Modernization Act may impact this category resulting in an increase in expenditures; and 3) it is not anticipated a decrease in expenditures will occur. The legislative impact for this eligibility category in FY 05-06 is estimated to be a reduction of $7,133. Before the legislative impacts, the 1.54% increase applied to the FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 40.20%, compared to FY 04-05 actual expenditures. Due to post-legislative impacts, the 1.54% resulted in an increase in estimated expenditures for FY 05-06 of 39.83%, compared to FY 04-05 actual expenditures.

Calculation of the Base:

Once a per capita percent change percentage is selected, it is applied to the actual FY 04-05 per capita cost to generate the estimated FY 05-06 per capita cost. Change Requests and legislative adjustments are applied at this stage and a revised estimated FY 05-06 total is calculated. The dollar amount is divided by the estimated FY 05-06 caseload for a revised estimated FY 05-06 per capita.

Change Requests and Other Adjustments (See V. Additional Calculation Considerations section below for additional information on the legislative impacts.):

- 2005 Legislative Impact for FY 05-06 for addition of outpatient to Substance Abuse was authorized in HB 05-1015 and funded in SB 05-209. This is an increase to Acute Care of $3,202,485, which represents six months of estimated expenditures.
- 2005 Legislative Impact for FY 05-06 for Implementation of Obesity Treatment pilot was authorized in HB 05-1066 and funded in SB 05-209. This is an increase to Acute Care of $81,898.
- 2005 Legislative Impact for FY 05-06 for implementation of a 2% Inpatient and Home Health provider rate increase recommended by the Joint Budget Committee, approved by the General Assembly, and funded in SB 05-209. This is an increase to Acute Care of $8,972,252.
- 2005 Legislative Impact for FY 05-06 for implementation of a 2% physician provider rate increase recommended by the Joint Budget Committee, approved by the General Assembly, and funded in SB 05-209. This is an increase to Acute Care of $6,831,445.
- Anticipated prescription drug savings per Medicare Modernization Act funded in SB 05-209. This is a decrease to Acute Care of $62,394,408 million. The savings represents a half-year impact since the Medicare Modernization Act is effective January 1, 2006.
- FY 05-06 Decision Item #11 included in the November 1, 2004 Budget Request - Hospital and Federally Qualified Health Clinic Audits to Increase Recoveries funded in SB 05-112. This is a decrease to Acute Care of $100,000.
- FY 05-06 Budget Amendment - Federally Required Payment Error Rate Measurement (PERM) Project funded in SB 05-209. This is a decrease to Acute Care of $796,710.
- The sum of the impacts above decreased the estimated FY 05-06 Acute Care projection by $44,203,038.
- The revised estimated FY 05-06 Acute Care total request is $1,282,692,169.

FY 06-07

Similar to FY 05-06, a per capita percent change growth factor is selected to trend the revised FY 05-06 per capita amounts to FY 06-07. Each growth factor was analyzed by eligibility category and selected based on historical trend of expenditures. Where applicable, the percentages selected in Exhibit F have been highlighted and italicized for clarification.

The percent trends selected for FY 06-07, with the rationale, are as follows:

- **Supplemental Security Income Adults 65 and Older** (OAP-A): The same 3-year average of 1.54% (FY 02-03, FY 03-04, and FY 04-05) selected to modify the FY 04-05 per capita for FY 05-06 was used for FY 06-07. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $17,972,636. Before the legislative impacts, the 1.54% increase applied to the revised estimate FY 05-06 per capita cost would result in an estimated increase in expenditures for FY 06-07 of 5.89%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 1.54% would result in a reduction in estimated expenditures for FY 06-07 of 7.54%, compared to revised estimated FY 05-06 expenditures.

- **Supplemental Security Income 60 to 64** (OAP-B): The same 3-year average of 4.99% (FY 01-02, FY 02-03, and FY 03-04) selected to modify the FY 04-05 per capita for FY 05-06 was selected for FY 06-07. Expenditures in this eligibility category have fluctuated significantly from year to year. The percentages calculated to modify the FY 04-05 per capita ranged from 0.67% through 10.83%. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $3,279,334. Before the legislative impacts, the 4.99% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 10.72%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 4.99% would result in an increase in estimated expenditures for FY 06-07 of 3.74%, compared to revised estimated FY 05-06 expenditures.

- **Supplemental Security Income Disabled Individuals** (AND/AB): The 2-year average of 3.75% (FY 01-02 and FY 03-04) was selected to modify the revised estimated FY 05-06 per capita. This is a slightly lower increase than the increase of FY 05-06 over FY 04-05. A twenty million dollar estimated growth in expenditures, prior to legislative impacts, does not seem likely two fiscal years in a row, based on historical expenditure patterns. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $26,986,032. Before the legislative impacts, the 3.75% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 4.06%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 3.75% would result in a reduction in estimated expenditures for FY 06-07 of 2.86%, compared to revised estimated FY 05-06 expenditures.

- **Categorically Eligible Low-Income Adults** (1931 clients, formerly called AFDC-A): The same 2-year average of 3.88% for FY 01-02 and FY 03-04 selected to modify the FY 04-05 per capita for FY 05-06 was selected for this FY 06-07. The legislative

impact to this eligibility category for FY 06-07 is estimated to be a reduction of $4,443,588. Before the legislative impacts, the 3.88% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 13.04%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 3.88% would result in an increase in estimated expenditures for FY 06-07 of 11.05%, compared to revised estimate FY 05-06 expenditures.

- **Health Care Expansion Fund Low-Income Adults:** No change was selected since the category will take effect July 1, 2006.

- **Breast and Cervical Cancer Treatment**: Based on the new methodology in forecasting the actual per capita for this eligibility category there was no percentage selected to modify the FY 05-06 per capita. The percentage of negative 7.72% on Exhibit F, page EF-2, represents the percentage change between the FY 05-06 per capita and the estimated FY 06-07 per capita. Again, the Department anticipates the new methodology will prove to be more effective. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $559. Before the legislative impacts, the reduction of 7.72% applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 46.81%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the negative 7.72% would result in an increase in estimated expenditures for FY 06-07 of 46.80%, compared to revised estimate FY 05-06 expenditures.

- **Eligible Children** (1931 children and Baby Care/Kids Care children): The same 3-year average of 3.87% (FY 99-00, FY 00-01, and FY 01-02) selected to modify the FY 04-05 per capita for the FY 05-06 per capita was selected for FY 06-07. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $4,914,437. Before the legislative impacts, the 3.87% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 11.71%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 3.87% would result in an increase in estimated expenditures for FY 06-07 of 10.24%, compared to the revised estimate FY 05-06 expenditures.

- **Foster Care**: The same 3-year average of 4.31% (FY 01-02, FY 02-03, and FY 03-04) was selected to modify the revised estimated FY 05-06 per capita. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $3,373,134. Before the legislative impacts, the 4.31% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 7.66%, compared to the revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 4.31% would result in an increase in estimated expenditures for FY 06-07 of 0.50%, compared to revised estimate FY 05-06 expenditures.

- **Baby Care Adults**: The same 3-year average (FY 02-03, FY 03-04, and FY 04-05) of 12.86% was selected to modify the FY 04-05 per capita for the FY 05-06 per capita. It is assumed the anticipated increase in FY 05-06 will continue into FY 06-07 due to the reinstatement of presumptive eligibility, effective July 1, 2005. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $247,402. Before the legislative impacts, the 12.86% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 18.73%, compared to the revised

estimated FY 05-06 expenditures. Due to post-legislative impacts, the 12.86% would result in an increase in estimated expenditures for FY 06-07 of 18.24%, compared to the revised estimate FY 05-06 expenditures.

- **Non-Citizens**: The 3-year average of 2.97% (FY 01-02 through FY 03-04) selected to modify the FY 04-05 per capita for the FY 05-06 per capita. The legislative impact to this eligibility category for FY 06-07 is estimated to be $2,288. Before the legislative impacts, the 2.97% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 9.59%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 2.97% would result in an increase in estimated the expenditures for FY 06-07 of 9.59%, compared to the revised estimate FY 05-06 expenditures.

- **Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries:** The same 2-year average (FY 00-01 and FY 01-02) of 1.54% was selected to modify the revised estimated FY 05-06 per capita. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $24,581. Before the legislative impacts, the 1.54% increase applied to the Revised Estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 32.08%, compared to the revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 1.54% would result in an increase in estimated expenditures for FY 06-07 of 31.15%, compared to the revised estimate FY 05-06 expenditures.

Calculation of the Base:

Once the per capita percentage change growth factor is selected, it is applied to the revised estimated FY 05-06 per capita cost to generate the estimated FY 06-07 per capita cost. Change Requests and legislative adjustments are applied at this stage and a revised estimated FY 06-07 total is calculated. The dollar amount is divided by the estimated FY 06-07 caseload for a revised estimated FY 06-07 per capita.

Change Requests and Other Adjustments (See V. Additional Calculation Considerations section below for additional information on the legislative impacts.):

Adjustments to FY 06-07 include the following:

- 2005 annualized legislative impact for FY 05-06 for addition of outpatient to Substance Abuse was authorized in HB 05-1015 and funded in SB 05-209. This is an incremental increase to Acute Care of $1,423,458.
- 2005 annualized legislative impact for FY 05-06 for implementation of Obesity Treatment pilot was authorized in HB 05-1066 and funded in SB 05-209. This is an incremental increase to Acute Care of $81,897.
- FY 05-06 Budget Amendment - Federally Required Payment Error Rate Measurement (PERM) Project funded in SB 05-209. This is a decrease of $350,362 to Acute Care due to annualization.
- Anticipated Prescription Drug savings per Medicare Modernization Act funded in SB 05-209. This is an incremental decrease to Acute Care of $62,394,408 million due to annualization. The savings represents the second half of the impact since the Medicare Modernization Act is not effective until January 1, 2006.

- The sum of the impacts above decreased the estimated FY 06-07 Acute Care projection by $61,239,415.
- The revised estimated FY 06-07 Acute Care total request is $1,351,577,016.

BREAST AND CERVICAL CANCER TREATMENT (Exhibit F, page EF-5)

Based on the fact that new clients to the Breast and Cervical Cancer Treatment incur additional costs during the first year of treatment, the per capita costs for these clients would be higher during the first year and reduced throughout the remainder of their treatment. In an attempt to incorporate this scenario into the budget, the per capita estimate methodology for the Breast and Cervical Cancer Treatment has been revised. Essentially, two per capita costs are calculated for 1) new clients and 2) existing clients, and blended together for the estimated per capita utilized in the request.

To determine the number of new clients, the actual Breast and Cervical Cancer Treatment caseload for FY 02-03 and FY 03-04 (Exhibit B) was used. The difference between FY 03-04 and FY 02-03 is 57 clients that would be considered "new" during FY 03-04. Actual expenditures for FY 03-04 were $2,668,859 for the Breast and Cervical Cancer Treatment. An amount of $1,770,443, estimated new client cost of $31,060.41 multiplied by 57 clients, was reduced from the FY 03-04 actual expenditures equaling $898,416. This amount was divided by 46 (103 clients – 57 clients = 46 clients), resulting in an existing client per capita of $19,530.78. These two per capita amounts ($31,060.41–new and $19,530.78-existing) were applied to the FY 05-06 and FY 06-07 estimated caseloads, when determining the amount of new clients and existing clients. The Health Care Expansion Fund clients are accounted for as new clients.

CALCULATION OF ANTIPSYCHOTIC DRUGS (Exhibit F, page EF-6 through EF-7)

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 service category. Exhibit F, page EF-6 through EF-7, is a rough projection of antipsychotic drug expenditures for FY 05-06 and FY 06-07. The FY 05-06 pre-rebate projection is based on the average growth percentage of FY 03-04 and FY 04-05 (26%). The implementation of the Medicare Modernization Act on January 1, 2006 will impact the pre- and post-rebate expenditures, reducing the prescription drugs paid for by Medicaid and transferring the liability to Medicare. An estimated Medicare Modernization Act impact of 53.43% is calculated utilizing the Department's estimated prescription drug expenditures ($302,529,912) for FY 05-06 (see Exhibit Q for details) and the estimated Medicare Modernization Act prescription drug costs (pre-rebate of $161,641,759) from the Department's FY 06-07 Revision to the Medicare Modernization Act Change Request. The amount is divided in half to represent a half-year impact. The FY 06-07 estimated expenditures are calculated using the estimated FY 05-06 expenditures as a base and increasing them by the average percentage increase of FY 02-03 and FY 04-05 (29.52%). An estimated 25.43%, the same percentage used by the Department to calculate the Medicare Modernization Act Part D Drug Expenditure impact in the FY 06-07 Revision to the Medicare Modernization Act Change Request, was used to calculate the Estimated Rebate for both FY 05-06 and FY 06-07.

This projection is done only for this service category because it is necessary to establish the informational line item under the Medicaid Mental Health Community Programs Long Bill group. The Department urges much caution in reviewing Exhibit F, page EF-6 through EF-7, as trending on service category has proved unstable over time. Also note that technically these dollars are doubled-counted, albeit as Cash Funds Exempt, in the Medicaid Mental Health Community Programs Long Bill group. The most important observation in this area is that the growth in antipsychotics continues to grow well beyond other service categories in Medicaid.

CALCULATION OF 100% GENERAL FUND PRENATAL CARE COSTS FOR NON-CITIZENS (Exhibit F, page EF-8)

Pursuant to 26-4-203(3)(a), C.R.S. (2002), Colorado opted to provide prenatal care at its sole expense for Non-Citizens. SB 03-176 eliminated this service for legal immigrants, however HB 05-1086 reinstated the services. Therefore, there was no interruption in services. The FY 05-06 Estimated Expenditures are based on an estimated 11.41% increase in expenditures over FY 04-05. The 11.14% is the average percentage change in expenditures from FY 02-03 and FY 03-04. The estimated FY 05-06 total is increased by the same 11.14% for a total fund FY 06-07 Request of $3,613,852.

CALCULATION OF ENHANCED FAMILY PLANNING MATCH RATE (Exhibit F, page EF-9)

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. The services are provided through fee-for-service and beginning in late FY 01-02, the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. A portion of the payments, $2,311,115, were disallowed due to family planning activities that did not qualify for enhanced federal financial participation, resulting in a repayment of federal funds to the federal government in FY 04-05.

Calculations for fee-for-service and health maintenance organizations are done independently. The fee-for-service estimate for FY 05-06 is based on an increase in FY 04-05 expenditures of 11.34%, the average percentage change from FY 98-99 through FY 03-04. The same percentage was applied to the FY 05-06 Estimated Total resulting in a FY 05-06 Request of $8,461,702. Since the percentage change amounts for the health maintenance organizations are negative for each fiscal year the estimate for FY 05-06 is based on the caseload increase in Baby Care Adults between FY 04-05 and FY 05-06 of 12.75%. The Baby Care Adults caseload increase between FY 05-06 and FY 06-07 of 5.21% was applied to the estimated FY 05-06 amount to result in the FY 06-07 request of $1,227,420.

COMMUNITY-BASED LONG TERM CARE DETAIL (Exhibit G)

The increased emphasis on utilizing community based services has served to keep the census in Class I nursing facilities relatively flat. In FY 81-82, with the implementation of the first wave of 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. The census has generally

remained in this range despite nearly 2.5% per year increases in the elderly population of the State. In response to budget balancing in FY 02-03, rules were passed by the Medical Services Board to improve utilization management, which resulted in a reduction of per capita spending. Among these changes, the Department clarified the requirements necessary to meet the level of care screen required to qualify for nursing facility care and Home and Community Based Services. In addition, 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. Although home health costs are in the Acute Care portion of the Premiums calculation, long term home health costs do correlate to community based long term care costs. High cost clients in the community were reviewed by Single Entry Points and transitioned to less expensive alternatives if their care plans and services did not assure that all services being provided were required. The assessment, which was a functional assessment to determine whether a client meets the long term care level of care, was redone with the help of providers, Single Entry Points, and clients. Responsibilities were shifted to ensure that Single Entry Points are the primary entities through which clients access long term care. Additionally, responsibilities required Single Entry Points to have tools and the authority to act as gatekeepers for long term care benefits. Federal requirements were more completely enforced, insuring that clients regularly receive Home and Community Based Services waiver services in order to retain eligibility for the waiver.

Calculation of Per Capita Percent Change:
The per capita percent change for several different years are computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 99-00 through FY 04-05. Similar to Acute Care above, the per capita percentage change excludes FY 98-99. See the Acute Care section above for greater detail. Historically the same percentage selected to modify current year per capita (FY 05-06 for instance) was used to modify the request year per capita. This method was not utilized in all cases for the FY 06-07 Request.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. Because the aid categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category. The percent trends selected for FY 05-06, with the rationale, are as follows:

FY 05-06
Because of erratic events occurring during FY 04-05, percentages selected to trend the FY 04-05 per capita amounts to FY 05-06 were analyzed by eligibility category and selected based on historical trend of expenditures. Percentages selected in Exhibit G have been highlighted for clarification.

- **Supplemental Security Income Adults 65 and Older** (OAP-A): The 2-year average (FY 02-03 and FY 03-04) was selected at 0.04%. During the past five fiscal years, FY 00-01 through FY 04-05, there has been a large fluctuation between percent change in actual expenditures ranging from -8.39% to 39.56%. All the other modifiers would result in a much larger increase that would not be justifiable in light of the utilization controls that remain in place. The legislative impact to this eligibility category for FY 05-06 is estimated to be $360,359. Before the legislative impacts, the 0.04% increase applied to the actual FY 04-05 per capita

cost resulted in an increase in estimated expenditures for FY 05-06 of 5.71%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 0.04% resulted in an increase in estimated expenditures for FY 05-06 of 6.90%, compared to actual FY 04-05 expenditures.

- **Supplemental Security Income Adults 60 to 64** (OAP-B): The 3-year average (FY 02-03, FY 03-04, and FY 04-05) was selected at 0.09%. Similar to Supplemental Security Income Adults 65 and Older, during the past five years, FY 00-01 through FY 04-05, Supplemental Security Income Adults 60 to 64 experienced a large fluctuation in percentage change of actual expenditures. The legislative impact to this eligibility category for FY 05-06 is estimated to be $39,263. Before the legislative impacts, the 0.09% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 2.77%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts the 0.09% resulted in an increase in estimated expenditures for FY 05-06 of 3.84%, compared to actual FY 04-05 expenditures.

- **Supplemental Security Income Disabled Individuals** (AND/AB): The caseload percent change between FY 04-05 and FY 05-06 for Supplemental Security Income Disabled Individuals of 0.64% was selected. Historically, expenditures were on the rise in this eligibility category, until FY 04-05. Although caseload increased by 2.28% between FY 03-04 and FY 04-05, expenditures decreased by 0.01%. The percentage change seems to swing from a large increase in one year to a significantly lower increase the next. The legislative impact to this eligibility category for FY 05-06 is estimated to be $810,410. Before the legislative impacts, the 0.64% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 1.28%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 0.64% resulted in an increase in estimated expenditures for FY 05-06 of 3.03%, compared to actual FY 04-05 expenditures.

- **Categorically Eligible Low-Income Adults** (1931 clients, formerly called AFDC-A): The 3-year average of 4.72% for FY 01-02 through FY 03-04 was selected for this category. All the other modifiers were significantly higher which may have resulted in an overestimated request. The legislative impact to this eligibility category for FY 05-06 is estimated to be $662. Before the legislative impacts, the 4.72% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 19.65%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 4.72% resulted in an increase in estimated expenditures for FY 05-06 of 20.18%, compared to actual FY 04-05 expenditures.

- **Health Care Expansion Fund Low-Income Adults:** This is not applicable for this fiscal year.

- **Breast and Cervical Cancer Treatment:** There is no change since this service category is not utilized by this population.

- **Eligible Children** (1931 children and Baby Care/Kids Care children): The caseload percent change between FY 04-05 and FY 05-06 for Eligible Children of 9.03% was selected. This eligibility category has a relatively low amount of expenditures and experiences large caseload increases. This has skewed the historical per capita change percentages too much so they are not a

reliable modifier to use for future projections, hence the reason the caseload change was selected. The legislative impact to this eligibility category for FY 05-06 is estimated to be $836. Before the legislative impacts, the 9.03% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 18.87%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 9.03% resulted in an increase in estimated expenditures for FY 05-06 of 18.99%, compared to actual FY 04-05 expenditures.

- **Foster Care**: The caseload percent change between FY 04-05 and FY 05-06 for Foster Care of 5.30% was selected. Similar to the Eligible Children category, the historical per capita percent change fluctuated too significantly, ranging from negative 8.25% to 3,616.13% to use for future projections and caseload increase resulted in a more reliable growth amount. Utilizing any of these modifiers would seem to result in an overstated estimated expenditure for FY 06-07. The legislative impact to this eligibility category for FY 05-06 is estimated to be $11,928. Before the legislative impacts, the 5.30% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 10.88%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 5.30% resulted in an increase in estimated expenditures for FY 05-06 of 11.20%, compared to actual FY 04-05 expenditures.

- **Baby Care Adults**: The caseload percent change between FY 04-05 and FY 05-06 for Baby Care Adults of 12.75% was selected. The majority of the growth factors were negative and the Department does not expect there will be a negative growth in this category. There were no estimated legislative impacts to this eligibility category for FY 05-06. The 12.75% resulted in an estimated percentage increase of 27.11%.

- **Non-Citizens**: There is no change since this service category is not utilized by this population.

- **Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries:** There is no change since this service category is not utilized by this population.

Change Requests and Other Adjustments (See V. Additional Calculation Considerations section below for additional information on the legislative impacts.):

Adjustments to FY 05-06 include the following:

- FY 05-06 annualization for a 2004 Legislative Impact, SB 04-177 Home and Community Based Services for Children with Autism. This is an increase to Home and Community Based Services of $626,750 that represents a 6-month impact.
- FY 05-06 annualization for a 2004 Legislative Impact, HB 04-1219 Community Transition Services for Home and Community Based Services for the Elderly, Blind and Disabled. This represents a savings to the Home and Community Based Services, increasing the estimate by $41,466.
- FY 05-06 annualization for a FY 04-05 1331 Emergency Supplemental for adjusting the Developmentally Disabled Waiver funded in SB 05-112. The increase to Home and Community Based Services is $540,983.

- 2005 Legislative Impact for FY 05-06 for Implementation of Authority of a pharmacist to redispense specified unused medications was authorized in HB 05-1131 and funded in SB 05-209. This represents an estimated savings to Home and Community Based Services of $57,195, decreasing the FY 05-06 Estimated Total Expenditures.
- 2005 Legislative Impact for FY 05-06 to extend the option of receiving Home and Community Based Services through the consumer directed care service model was authorized in HB 05-1243 and funded in SB 05-209. This represents an estimated savings of $2,012,790.
- 2005 Legislative Impact for FY 05-06 for Implementation of a 2% Provider Rate Increase recommended by the Joint Budget Committee, approved by the General Assembly, and funded in SB 05-209. This is an increase to Home and Community Based Care Services of $3,062,801.
- The sum of the impacts above increased the estimated FY 05-06 Home and Community Based Services projection by $2,202,015.
- The revised estimated FY 05-06 Community-Based Long Term Care total request is $169,669,334.

FY 06-07

Similar to FY 05-06, percentages selected to trend the FY 05-06 per capita amounts to FY 06-07 were analyzed by eligibility category and selected based on historical trend of expenditures. Where applicable, the percentages selected in Exhibit G have been highlighted and italicized for clarification.

The percent trends selected for FY 06-07, with the rationale, are as follows:

- **Supplemental Security Income Adults 65 and Older** (OAP-A): The caseload percent change between FY 05-06 and FY 06-07 for Supplemental Security Income Adults 65 and Older of 4.28% was selected. The 5-year average between FY 00-01 through FY 04-05 of 7.29% results in a higher FY 06-07 estimate of approximately $3.0 million. The 2-year average of 0.04% (FY 02-03 and FY 03-04) seemed too low. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $6,253,077. Before the legislative impacts, the 4.28% increase applied to the revised estimated FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 8.75%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 4.28% would result in an increase in estimated expenditures for FY 06-07 of 1.98%, compared to revised estimated FY 05-06 expenditures.

- **Supplemental Security Income Adults 60 to 64** (OAP-B): The 3-year average (FY 02-03, FY 03-04, and FY 04-05) was selected at 0.09%. The same modifier was selected for FY 06-07 that was selected for FY 05-06. The legislative impact to this eligibility category for FY 06-07 is estimated to be a deduction of $501,331. Before the legislative impacts, the 0.09% increase applied to the revised estimated FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 5.56%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 0.09% would result in a decrease of 0.03% in expenditures for FY 06-07 compared to revised estimated FY 05-06 expenditures.

- **Supplemental Security Income Disabled Individuals** (AND/AB): The 2-year average of 7.32% for FY 01-02 and FY 03-04 was selected for this category. The legislative impact to this eligibility category for FY 06-07 is estimated to be a reduction of $2,312,526. Before the legislative impacts, the 7.32% increase applied to the revised estimated FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 7.64%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 7.32% would result in an increase in estimated expenditures for FY 06-07 of 3.97%, compared to revised estimated FY 05-06 expenditures.

- **Categorically Eligible Low-Income Adults** (1931 clients, formerly called AFDC-A): The 3-year average of 4.72% for FY 01-02, FY 02-03, and FY 03-04 was selected for this category. Utilizing the same per capita percent change modifier that was used for FY 05-06 appeared to be a good selection, since this eligibility category experienced large increases in expenditures year to year and an approximate increase of $2.0 million would not be too out of line compared to historical trends. The legislative impact to this eligibility category for FY 06-07 is estimated to be $573. Before the legislative impacts, the 4.72% increase applied to the revised estimated FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 13.95%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 4.72% would result in an increase in estimated expenditures for FY 06-07 of 14.33%, compared to revised estimated FY 05-06 expenditures.

- **Health Care Expansion Fund Low-Income Adults:** This is not applicable.

- **Breast and Cervical Cancer Treatment:** There is no change since this service category is not utilized by this population.

- **Eligible Children** (1931 children and Baby Care/Kids Care children): The caseload percent change between FY 05-06 and FY 06-07 for Eligible Children of 7.54% was selected. The per capita percent change modifiers appear too high to produce a justifiable estimate. The legislative impact to this eligibility category for FY 06-07 is estimated to be $836. Before the legislative impacts, the 7.54% increase applied to the revised estimated FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 15.65%, compared to revised estimate FY 05-06 expenditures. Due to post-legislative impacts, the 7.54% would result in an increase in estimated expenditures for FY 06-07 of 15.75%, compared to revised estimated FY 05-06 expenditures.

- **Foster Care**: The caseload percent change between FY 05-06 and FY 06-07 for Foster Care of 3.21% was selected. With the exception of the two negative per capita percent change modifiers, the majority of the historical per capita percent change modifiers appear too high to produce a justifiable estimate. The legislative impact to this eligibility category for FY 06-07 is estimated to be $11,928. Before the legislative impacts, the 3.21% increase applied to the revised estimated FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 6.53%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 3.21% would result in an increase in estimated expenditures for FY 06-07 of 6.82%, compared to revised estimated FY 05-06 expenditures.

- **Baby Care Adults**: The caseload percent change between FY 05-06 and FY 06-07 for Baby Care Adults of 5.21% was selected. The FY 04-05 actual per capita for FY 05-06 caseload percentage change was selected for FY 06-07. The per capita percent change modifiers were negative. It is assumed that the increase over FY 04-05 will continue into FY 06-07 with the reinstatement of presumptive eligibility, effective July 1, 2005. There are no legislative impacts to this eligibility category for FY 06-07.

- **Non-Citizens**: There is no change since this service category is not utilized by this population.

- **Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries:** There is no change since this service category is not heavily utilized by this population.

Calculation of the Base:
Once a per capita percent change is selected, it is applied to the revised estimated FY 05-06 per capita cost to generate the estimated FY 06-07 per capita cost. Change Requests and legislative adjustments are applied at this stage and a revised estimated FY 06-07 total is calculated. The dollar amount is divided by the estimated FY 06-07 caseload for a revised estimated FY 05-06 per capita.
FY 06-07
Similar to FY 05-06, percentages selected to trend the FY 05-06 per capita amounts to FY 06-07 were analyzed by eligibility category and selected based on historical trend of expenditures. Where applicable, the percentages selected in Exhibit G have been highlighted and italicized for clarification.

The percent trends selected for FY 06-07, with the rationale, are as follows:

Calculation of the Base:
Once a per capita percent change is selected it is applied to the revised estimated FY 05-06 per capita cost to generate the estimated FY 06-07 per capita cost. Change Requests and legislative adjustments are applied at this stage and a revised estimated FY 06-07 total is calculated. The dollar amount is divided by the estimated FY 06-07 caseload for a revised estimated FY 05-06 per capita.

Change Requests and Other Adjustments (See V. Additional Calculation Considerations section below for additional information on the legislative impacts.):
Adjustments to FY 06-07 include the following:
- FY 06-07 annualization for a 2004 Legislative Impact, SB 04-177 Home and Community Based Services for Children with Autism. This is an increase to Home and Community Based Services of $626,750 that represents a 6 month impact.
- Annualization of 2005 Legislative Impact for FY 05-06 for Implementation of Authority of a pharmacist to redispense specified unused medications was authorized in HB 05-1131. This represents an estimated savings to Home and Community Based Services of $18,955, decreasing the FY 06-07 Estimated Total Expenditures.

- Annualization of 2005 Legislative Impact for FY 05-06 to extend the option of receiving Home and Community Based Services through the consumer directed care service model was authorized in HB 05-1243. This represents an estimated savings of $9,661,392, decreasing the FY 06-07 Estimated Total Expenditures.
- The sum of the impacts above decreased the estimated FY 05-06 Home and Community Based Services projection by $9,053,597.
- The revised estimated FY 06-07 Community-Based Long Term Care total request is $174,441,454.

LONG TERM CARE AND INSURANCE SERVICES (Exhibits H)

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)
- Program for All-inclusive Care for the Elderly
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy In

Summary of Long Term Care and Insurance Request (Exhibit H, page EH-1): This exhibit summarizes the total requests from the worksheets within Exhibit H on pages EH-2 through EH-14.

Class I Nursing Facilities (Exhibit H, page EH-2 through EH-4): 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 traditional strategy for estimating the cost of these services is to predict the costs driven by the estimated Medicaid reimbursement methodology (Estimated weighted average per diem allowable Medicaid rate, and estimated average patient payment), estimated utilization by clients (patient days without hospital backup and out of state placement), estimated cost offsets from refunds and recoveries, and expected adjustments due to legislative impacts.

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 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 2000 – June 2005 (FY 00-01, FY 01-02, FY 02-03, FY 03-04, and FY 04-05). Patient days are calculated using monthly historical number of days, weighted the heaviest on the most recent twelve months, trended forward using a linear trend. The monthly amounts are averaged for an annual estimate.

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

- To convert back to cash accounting, a completion factor of 92.0% is applied to the total estimated costs for FY 05-06 days of service to estimate the claims payment for FY 05-06. The remaining 8% estimated cost will become the Estimated Claim Payments for Prior Year Dates of Service in FY 06-07. 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 06-07.

- Other, non-rate factors are then added or subtracted from the gross budget estimate. These include the hospital back up program and out of state placements, estimated estate and income trust recoveries, recoveries from Department Overpayment Review, savings from HB 04-1219 (Home and Community Based Services—Elderly, Blind and Disabled Community Transition), and savings from HB 05-1243 (Authority of a pharmacist to redispense specified unused medications, 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.

- Summary of FY 05-06 and FY 06-07 Request (for additional details refer to Exhibit H, pages EH-2 and EH-4):

FY 05-06 Request	**Amount**
Estimated Expenditures for FY 05-06 Dates of Service	$422,098,385
Estimated Expenditures for Prior Year Dates of Service	$36,740,583
Sub-Total	**$458,838,968**
Adjustments	($2,560,605)
Total Estimated FY 05-06 Expenditures	**$456,278,362**
FY 06-07 Request	**Amount**
Estimated Expenditures for FY 06-07 Dates of Service	$441,908,705
Estimated Expenditures for Prior Year Dates of Service	$36,818,768
Sub-Total	**$478,727,472**
Adjustments	($152,035)

FY 06-07 Request	Amount
Total Estimated FY 06-07 Expenditures	**$478,575,437**

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 H, page EH-5 and EH-6): This exhibit does not represent the Department's request for Class I nursing facilities. This Exhibit displays the trend of expenditures in Class I nursing facilities since FY 95-96. The calculation was computed by applying average per capita change percentages to FY 04-05 actual per capita to estimate FY 05-06 per capita, and then to FY 05-06 to estimate FY 06-07. The exhibit is provided as a reasonableness check of the request.

The trends and their rationale utilized for Exhibit H, page EH-5 and EH-6 are as follows:

- **Supplemental Security Income Adults 65 and Older (OAP-A):** The 6-year average of FY 99-00 through FY 04-05 yielded 2.22%. This trend fit the historical pattern of expenditures. The legislative impact to this eligibility category for FY 05-06 is estimated to be a deduction of $1,504,673. Before the legislative impacts, the 2.22% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 8.04%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 2.22% resulted in an increase in estimated expenditures for FY 05-06 of 7.60%, compared to actual FY 04-05 expenditures.

- **Supplemental Security Income Adults 60 to 64 (OAP-B):** The 5-year average of FY 00-01 through FY 04-05 of 8.91% was used for this category. The legislative impact to this eligibility category for FY 05-06 is estimated to be a deduction of $74,735. Before the legislative impacts, the 8.91% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 11.82%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 8.91% resulted in an increase in estimated expenditures for FY 05-06 of 11.44%, compared to actual FY 04-05 expenditures.

- **Supplemental Security Income Disabled Individuals (AND/AB):** This category was trended with a 3-year average of FY 02-03, FY 03-04, and FY 04-05 of 3.44%. The legislative impact to this eligibility category for FY 05-06 is estimated to be a deduction

of $279,796. Before the legislative impacts, the 3.44% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 4.10%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 3.44% resulted in an increase in estimated expenditures for FY 05-06 of 3.65%, compared to actual FY 04-05 expenditures.

- **Categorically Eligible Low Income Adults (AFDC-A)**: The 4-year average of FY 00-01 through FY 03-04 of 4.31% was used for this category. The legislative impact to this eligibility category for FY 05-06 is estimated to be a deduction of $55. Before the legislative impacts, the 4.31% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 19.18%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 4.31% resulted in an increase in estimated expenditures for FY 05-06 of 19.08%, compared to actual FY 04-05 expenditures.

- **Qualified Medicare Beneficiaries/Special Low-Income Medicare Beneficiaries**: Because all the trends were negative, the 3-year average of FY 01-02, FY 02-03, and FY 03-04 for Supplemental Security Income Adults 65 and Older of 4.57% was used. The legislative impact to this eligibility category for FY 05-06 is estimated to be a deduction of $121. Before the legislative impacts, the 4.57% increase applied to the actual FY 04-05 per capita cost resulted in an increase in estimated expenditures for FY 05-06 of 44.41%, compared to actual FY 04-05 expenditures. Due to post-legislative impacts, the 4.57% resulted in an increase in estimated expenditures for FY 05-06 of 42.54%, compared to actual FY 04-05 expenditures.

- **Health Care Expansion Fund Low-Income Adults, Breast and Cervical Cancer Treatment, Eligible Children, Foster Care, Baby Care Adults, and Non-Citizens** show no change since Class I nursing facilities are not used by these populations.

Adjustments to FY 05-06 include the following (See V. Additional Calculation Considerations section below for additional information on the legislative impacts.):

- Annualized savings from Home and Community Based Services for the Elderly, Blind, and Disabled Community Transition (HB 04-1219) of $1,182,604, decreasing the estimated FY 05-06 expenditures.
- 2005 Legislative Impact – Savings on authority of a pharmacist to redispense specified unused medications (HB 05-1243) of $676,775, decreasing the estimated FY 05-06 expenditures.

The FY 06-07 trends and their rationale utilized for Exhibit H, page EH-5 and EH-6 are as follows:

- **Supplemental Security Income Adults 65 and Older (OAP-A):** The per capita cost increase of 2.22%, 6-year average of FY 99-00 through FY 04-05, was utilized for this category to project the FY 06-07 per capita cost. The legislative impact to this eligibility category for FY 06-07 is estimated to be a deduction of $181,497. Before the legislative impacts, the 2.22% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of

6.60%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 2.22% would result in an increase in estimated expenditures for FY 06-07 of 6.55%, compared to revised estimated FY 05-06 expenditures.

- **Supplemental Security Income Adults 60 to 64 (OAP-B):** The per capita cost increase of 8.91%, 5-year average of FY 00-01 through FY 04-05, was utilized for this category to project the FY 06-07 per capita cost. The legislative impact to this eligibility category for FY 06-07 is estimated to be a deduction of $9,015. Before the legislative impacts, the 8.91% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 14.86%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 8.91% would result in an increase in estimated expenditures for FY 06-07 of 14.82%, compared to revised estimated FY 05-06 expenditures.

- **Supplemental Security Income Disabled Individuals (AND/AB):** The per capita cost increase of 3.44%, 3-year average of FY 02-03, FY 03-04, and FY 04-05, was utilized for this category to project the FY 06-07 per capita cost. The legislative impact to this eligibility category for FY 06-07 is estimated to be a deduction of $33,750. Before the legislative impacts, the 3.44% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 3.75%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 3.44% would result in an increase in estimated expenditures for FY 06-07 of 3.69%, compared to revised estimated FY 05-06 expenditures.

- **Categorically Eligible Low Income Adults (AFDC-A)**: The per capita cost increase of 4.31%, 4-year average of FY 00-01 through FY 03-04, was utilized for this category to project the FY 06-07 per capita cost. The legislative impact to this eligibility category for FY 06-07 is estimated to be a deduction of $7. Before the legislative impacts, the 4.31% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 13.51%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 4.31% would result in an increase in estimated expenditures for FY 06-07 of 13.50%, compared to revised estimated FY 05-06 expenditures.

- **Qualified Medicare Beneficiaries/Special Low-Income Medicare Beneficiaries**: The per capita cost increase of 4.57%, 3-year average of FY 01-02, FY 02-03, and FY 03-04 for Supplemental Security Income Adults 65 and Older of 4.57%, was utilized for this category to project the FY 06-07 per capita cost. The legislative impact to this eligibility category for FY 06-07 is estimated to be a deduction of $15. Before the legislative impacts, the 4.57% increase applied to the revised estimate FY 05-06 per capita cost would result in an increase in estimated expenditures for FY 06-07 of 36.02%, compared to revised estimated FY 05-06 expenditures. Due to post-legislative impacts, the 4.57% would result in an increase in estimated expenditures for FY 06-07 of 35.87%, compared to revised estimated FY 05-06 expenditures.

- **Health Care Expansion Fund Low-Income Adults, Breast and Cervical Cancer Treatment, Eligible Children, Foster Care, Baby Care Adults, and Non-Citizens** show no change since Class I nursing facilities are not used by these populations.

Adjustments to FY 06-07 include the following (See V. Additional Calculation Considerations section below for additional information on the legislative impacts.):

- Annualization of 2005 Legislative Impact – Savings on authority of a pharmacist to redispense specified unused medications (HB 05-1243) of $224,283, decreasing the FY 06-07 estimated expenditures.
- Hospital Backup Program and Out of State Placements - $6,330,017.
- Estate and Income Trust Recoveries – ($5,880,582).
- Recoveries from Department Overpayment Reviews – ($377,187).

This spreadsheet is included for historical purposes and offers an alternate calculation to the one presented in Exhibit H, page EH-2. This is not an official request from the Department.

Class II Nursing Facility (Exhibit H, page EH-7 and EH-8): 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 traditional nursing facilities to more appropriate care settings in that department's developmental disabilities system. The deinstitutionalization strategy was completed in April of FY 97-98. Beginning 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.

For FY 05-06, the FY 04-05 Actual Expenditures for this service category were trended using the percent change in actual expenditures from FY 03-04 and FY 04-05 of 25.25%. For FY 06-07, the estimated FY 05-06 Expenditures for this service category was increased by the average 3-year percentage change of FY 02-03, FY 03-04, and FY 04-05 of 13.12%.

Program for the All-inclusive Care for the Elderly (PACE) (Exhibit H, page EH-9 and EH-10): The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs.

The FY 05-06 and FY 06-07 projections for the Program for the All-inclusive Care for the Elderly were computed by applying the average of the FY 00-01 and FY 04-05 total expenditures of 15.75% to each fiscal year. More PACE sights are scheduled to be built and it is expected expenditures will likely increase over the next two years.

Supplemental Medicare Insurance Benefit (Exhibit H, page EH-11 and EH-12): 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. Only Premiums are paid here; co-payments and deductibles are paid under Acute Care. The Part A premium payments are made for the Qualified Medicare Beneficiary eligibility group only. The

Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types (Specified Low-Income Medicare Beneficiaries, Qualified Individuals (1), and Qualified Medicare Beneficiary clients), and Part A payments for Qualified Medicare Beneficiary clients. 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).

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 end September 30, 2003. However, eligibility was extended. This population was referred to as Medicare Qualified Individual 1. Legislation for the second group, referred to as Medicare Qualified Individual 2, comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired 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 calculate FY 05-06 and FY 06-07, the 5-year average of FY 00-01 through FY 04-05 of 12.58% was used. Using this percentage, the increase in actual expenditures is expected to be approximately $7 to $9 million dollars per fiscal year.

Health Insurance Buy-In [26-4-518.5, C.R.S. (2005)] (Exhibit H, page EH-13 and EH-14): The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective. The Health Insurance Buy-In FY 04-05 per capita were increased by applying various per capita percent change amounts from FY 99-00 through FY 04-05.

The percent trends selected for FY 05-06 and FY 06-07, with the rationale, are as follows: (Note: There were no legislative impacts to this service category).

- **Supplemental Security Income Adults 65 and Older (OAP-A):** The 2-year average of FY 00-01 and FY 01-02 was selected at 0.69%.

- **Supplemental Security Income Adults 60 to 64 (OAP-B):** The 5-year average of FY 00-01 through FY 04-05 of 10.26% was selected.

- **Supplemental Security Income Disabled Individuals (AND/AB):** The 3-year average of FY 99-00, FY 00-01, and FY 01-02 was selected at 2.85%.

- **Categorically Eligible Low Income Adults:** The 2-year average of FY 00-01 and FY 01-02 of 4.62% was selected.

- **Health Care Expansion Fund Low-Income Adults:** There is no change since this service is not used by this population.

- **Breast and Cervical Cancer Treatment:** There is no change since this service is not used by this population.

- **Eligible Children**: The 5-year average from FY 00-01 through FY 04-05 was selected at 12.19%.

- **Foster Care**: The 5-year average from FY 00-01 through FY 04-05 was selected at 11.07%.

- **Baby Care Adults:** The 5-year average from FY 00-01 through FY 04-05 was selected at 12.83%.
- **Non-Citizens**: The 3-year average of FY 99-01, FY 00-01, and FY 01-02 was selected at 5.30%.

- **Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries:** The 3-year average of FY 02-03, FY 03-04 & FY 04-05 was selected at 23.87%.

SERVICE MANAGEMENT (Exhibits I)

Service Management Summary (Exhibit I, page EI-1): A new category has been set up to account for the administrative like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, Disease Management, and Administrative Service Organizations – Administrative Fee. This exhibit is a brief summary of the FY 05-06 and FY 06-07 estimated expenditures.

Single Entry Point Services (Exhibit I, page EI-2): Single Entry Point agencies, 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 include case management services that are classified as an administrative cost matchable at 50% federal financial participation by the federal government. However, since 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 of its administrative nature, Single Entry Points are not trended by eligibility category, which the Department elected to change beginning with the February 15, 2005 Budget Request. Instead, a per capita methodology is used to estimate FY 05-06 and FY 06-07 and account for a caseload increase and not an increase in utilization. The FY 04-05 per capita and caseload for each eligibility category is utilized to estimate FY 05-06. The preliminary FY 05-06 estimate is $18,089,045. There were three 2005 legislative impacts. The first is to extend the option of receiving consumer directed care services through the Home and Community Based Services model (HB 05-1243) increasing the FY 05-06 Single Entry Point estimate by $1,008,375. The second was the addition of children to the Children's Extensive Support Waiver program waiting list (HB 05-1262), adding $3,675 to the FY 05-06

estimate. The third was the addition of children to the Children's Home and Community Based Services waiting list (HB 05-1262), which added $35,850 to the FY 05-06 estimate. (Additional information on the HB 05-1262 additions can be found in section V. Additional Calculations Consideration section of this Assumption and Calculations document.) The revised FY 05-06 estimate is $19,136,945. A revised per capita is calculated based on the estimated FY 05-06 caseload and estimated expenditures. The FY 05-06 per capita is multiplied by the estimated FY 06-07 caseload resulting in the estimated FY 06-07 expenditures of $19,864,153.

Disease Management (Exhibit I, page EI-4): The Department has contracted with McKesson Health Solutions, Inc. to manage a Diabetes Disease Management Program. The purpose of the program is to demonstrate overall cost savings from claims payments, increase the enrollees' medical adherence to care plans, and improve enrollees' outcomes and self-management. McKesson Health Solutions, Inc. is responsible for diabetes disease management activities including education, introductory enrollment calls, assessment calls, coaching calls, alert notification, community based education and provider education. The Department also has a contract with National Jewish Research and Medical Center to manage an Asthma Disease Management Program. The goals are to increase the enrollees' medical compliance, reduce the overall medical expenditures for hospitalization and emergency room use, reduce inpatient, outpatient and practitioner/physician claims for enrollees with asthma as the primary diagnosis and improve outcomes and self-management. National Jewish Research and Medical Center is responsible for asthma disease management activities including enrollee and physician education, use of an entry questionnaire, telephonic interventions, access to Lung Line, On-Line Learning Center, My Asthma, Asthma Wizard, Reactive Care line and follow-up six-month program extension. Both of these contracts are for an eighteen month period which began in FY 04-05.

The FY 05-06 estimate of $627,778 is the remainder of the contractual obligation of the eighteen month contracts with each provider mentioned above. There were two 2005 legislative impacts to disease management; 1) Tobacco Tax Bill (HB 05-1262), and 2) Obesity Treatment pilot program (HB 05-1066). Included in the Tobacco Tax Bill (HB 05-1262), there is a clause for a portion of the Tobacco Tax allocation to go towards early detection and treatment for the prevention services division of the Department of Public Health and Environment for cancer, cardiovascular disease and chronic pulmonary disease prevention (24-22-117 (2)(d)(V)). Due to the administrative nature of this clause, it has been grouped into the Service Management section. Cash Funds Exempt is to be transferred annually from the Prevention, Early Detection, and Treatment Fund to be administered by the Department of Public Health and Environment. The FY 05-06 estimated expenditure of $3,940,776 is based on the analysis that was done for the fiscal note for this program (SB 05-090). The obesity treatment pilot is to begin in FY 05-06, having an impact of $140,925. The revised FY 05-06 estimate is $4,929,312. A per capita is calculated utilizing the revised estimated FY 05-06 expenditures and estimated FY 05-06 caseload. The per capita is then multiplied against the estimated FY 06-07 caseload for an estimated FY 06-07 expenditure. The annualization of the obesity treatment pilot, totaling $140,925, is added to the FY 06-07 estimate, resulting in a revised estimate for FY 06-07 of $5,070,237.

Administrative Organization Services Administrative Fee (Exhibit I, page EI-5): Administrative service organizations are an increasingly popular alternative to traditional health maintenance organizations. They offer the case management and care

coordination services of a health maintenance organization in a manner that is administratively less expensive. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 04-05. There are currently two administrative service organizations, Rocky Mountain Health Plans and Southwest who contract with the Department. Each organization receives a fixed amount administrative fee per client. Exhibit EI-5 depicts only the fee expenditures. The service costs for these organizations are included in Acute Care. A per capita methodology is utilized to forecast the FY 05-06 and FY 06-07 estimates, accounting for an increase due to caseload, and not utilization. The FY 05-06 estimate is $4,443,171, 3.69% over FY 04-05. The FY 06-07 estimate is $4,573,691, 2.94% over the estimated FY 05-06 expenditures.

FY 05-06 ACTUAL EXPENDITURES THROUGH SEPTEMBER 30, 2005 - Cash-based (Exhibit J)

This exhibit displays the FY 05-06 year-to-date expenditures and the cash flow pattern of actual FY 04-05 expenditures for the first period of FY 04-05, to determine a rough estimate of FY 05-06 if the cash flow pattern remained the same as FY 04-05. Note: this section and exhibit will be updated with actual expenditures through September 30, 2005 for the November 15, 2005 submission.

UPPER PAYMENT LIMIT CALCULATIONS (Exhibit K)

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.

Funds received through the Upper Payment Limit for outpatient hospital services are used to offset General Fund expenditures. These offsets started in FY 01-02 during the Budget balancing activities. 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 expenditures that are relatively small by comparison, and will experience little impact relating to changes in reimbursement rates.

Projections for all provider types are provided at Exhibit K. Although the FY 05-06 estimate of $27,868,520 appears to be an increase of 2.50% over the actual FY 04-05 Upper Payment Limit expenditures of $27,189,205, it is actually a decrease of (2.17%). The FY 05-06 request includes an adjustment of $634,955 for outpatient hospital expenditures not recorded during FY 04-05. Without this adjustment the request for FY 05-06 would be FY $26,598,610. The FY 06-07 estimate equals $26,598,610.

APPROPRIATIONS AND EXPENDITURES FOR FY 04-05 (Exhibit L)

This exhibit displays the FY 04-05 final actual total expenditures for the Medical Services Premiums, including 1) fund splits, 2) remaining balance of FY 04-05 appropriation, and 3) per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

ACTUAL FINAL EXPENDITURES FY 04-05 THROUGH FY 95-96 (Exhibit M)

Actual final expenditure data for the past ten years are included for historical purpose and comparison. This history is 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 "REX01/COLD (MARS) 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, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management (new section for Single Entry Point agencies and disease management).

While trying to recreate the past history of expenditures in a cash-based environment, some documents and spreadsheets with the history of adjustments were 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.

ANNUAL RATES OF CHANGE IN MEDICAL SERVICES PREMIUMS (Exhibit N)

Annual rates of change in medical services by service group from FY 04-05 through FY 95-96 final actual expenditures are included in this Budget Request for historical purpose and comparison.

COMPARISON OF APPROPRIATION TO BUDGET REQUEST (Exhibit O)

This exhibit displays the comparison of the FY 05-06 November 15, 2005 Budget Request to the Department's FY 05-06 request from November 1, 2004, February 15, 2005, and the FY 05-06 appropriation. The totals in this exhibit exclude the Upper Payment Limit financing estimates.

GLOBAL REASONABLENESS TESTS (Exhibit P)

This exhibit displays several global reasonableness tests as a comparison to the projection in this budget request.

CASHFLOW ANALYSIS (Exhibit Q)

This exhibit displays the FY 05-06 year-to-date expenditures through July 31, 2005. A rough estimate is calculated by applying the FY 04-05 cash pattern.

CASELOAD GRAPHS (Exhibit R)

This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

A few of the bills passed during the 2004 legislative session that impacted the Medical Services Premiums for FY 04-05 had an annualization impact to FY 05-06. Also, several bills passed during the 2005 legislative session affecting the Department of Health Care Policy and Financing. Each of these circumstances relate to the construction of the Medical Services Premiums:

HB 04-1219 – Concerning Community Transition Services for eligible persons under the "Home and Community-Based Services for the Elderly, Blind, and Disabled Act", and making and appropriation in connection therewith. - 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. 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.

The following are the estimated impacts to Medical Services Premiums by fiscal year based on the appropriation clause in the bill. The annualization between FY 04-05 and FY 05-06 is also included to show the impact accounted for in the Home and Community Based Services request in Exhibit G.

Community Based Long Term Care	Total Funds	General Fund	Federal Funds
FY 04-05*			
Total Community Transition Services	$124,398	$62,199	$62,199
Estimated Savings in Class I Nursing Facilities	($204,047)	($102,024)	($102,023)
Total FY 04-05 Estimated Impact to Community Based Long Term Care	**($79,649)**	**($39,825)**	**($39,824)**
FY 05-06			
Total Community Transition Services	$165,864	$82,932	$82,932
Estimated Savings in Class I Nursing Facilities	($1,182,604)	($591,302)	($591,302)
Total FY 05-06 Estimated Impact to Community Based Long Term Care	**($1,016,740)**	**($508,370)**	**($508,370)**

*FY 04-05 estimates are based on the fiscal note impacts estimated in the bill.

Annualization between FY 04-05 and FY 05-06	Total Funds	General Fund	Federal Funds
Total Community Transition Services	$41,466	$20,733	$20,733
Estimated Savings	($978,557)	($489,278)	($489,279)
Total FY 05-06 Impact to Community Based Long Term Care (amount included in Community Based Long Term Care Request – Exhibit G, page EG-2)	**($937,091)**	**($468,545)**	**($468,546)**

SB 04-177 – Concerning Home and Community-Based Services under the State's Medicaid Program for children with autism- 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,[13] a hospital, or a nursing facility and not receiving services from any of the alternatives to long-term care waiver programs. The Department is seeking 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 the Single Entry Point Agencies for services. Administrative costs for the Community Centered Boards are capped at 15%.

A fund was created to pay for services and administrative costs up to $1,000,000, which was transferred to the Department from the Tobacco Litigation Settlement Cash Fund to the Colorado Autism Treatment Fund. The Act took effect January 1, 2005. No funding was appropriated for FY 04-05.

The fiscal note assumed that a 1915c waiver would be written with existing resources and submitted to the 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. Appropriation began in FY 05-06. Only the Medical Services Premiums costs are reflected.

SB 04-177	Total Funds	Cash Funds Exempt*	Federal Funds
FY 05-06 Impact to Community Based Long Term Care			
(2) Medical Services Premiums	$545,000	$272,500	$272,500
(2) Medical Services Premiums – Single Entry Point contract with Community	$81,750	$40,875	$40,875

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

SB 04-177	Total Funds	Cash Funds Exempt*	Federal Funds
Centered Boards (15%)			
Total (included in Community Based Long Term Care – Exhibit G)	**$626,750**	**$313,375**	**$313,375**

*Cash Funds Exempt from the Colorado Autism Treatment Fund.

HB 05-1015 – Concerning substance abuse treatment under the "Colorado Medical Assistance Act." – The bill adds outpatient substance abuse treatment as an optional service to the State's Medicaid program. The following are the estimated impacts to Medical Services Premiums by fiscal year based on the appropriation clause in the bill. The annualization between FY 05-06 and FY 06-07 is also included to show the impact accounted for in the Acute Care request in Exhibit F.

Description	FY 05-06	FY 06-07
Medicaid caseload eligible for Outpatient Substance Abuse Treatment	4,479	4,668
Annual estimated cost per client	$1,430	$1,513
Net Amount	$6,404,970	$7,062,684
FY 05-06 Impact (Represents ½ year due to January 1, 2006 implementation.)	$3,202,485	$0
Anticipated savings in Medical Services Premiums due to addition of Outpatient Substance Abuse Treatement	$0	($2,436,741)
Fiscal Year Impact	**$3,202,485**	**$4,625,943**

Acute Care Line Item	Total Funds	General Fund	Federal Funds
Total FY 05-06 Estimated Total Impact (included in Acute Care FY 05-06 adjustment section of Exhibit F, page EF-2)	$3,202,485	$1,601,243	$1,601,242
Total FY 06-07 Estimated Total Impact	$4,625,943	$2,312,972	$2,312,971
Annualization between FY 05-06 and FY 06-07 (amount included in Acute Care – Exhibit F, page EF-3 for FY 06-07)	**$1,423,458**	**$711,729**	**$711,729**

HB 05-1066 – Treatment of Obesity under the "Colorado Medical Assistance Act"- The bill implements an obesity treatment pilot program to Medicaid recipients with a body mass index that is equal to or greater than thirty and who have a comorbidity related to their obesity, including but not limited to diabetes, hypertension, and coronary heart disease.

Description	FY 05-06	FY 06-07
Counseling/Behavior Modification Sessions	$35,120	$70,240
Prescription Drugs for Medicaid Clients	$46,778	$93,555
Disease Management Contract	$140,925	$281,851
Fiscal Year Impact	**$222,823**	**$445,646**

Acute Care Line Item	Total Funds	General Fund	Federal Funds
Total FY 05-06 Estimated Total Impact (included in Acute Care FY 05-06 adjustments – Exhibit F, page EF-2)	$222,823	$111,412	$111,411
Total FY 06-07 Estimated Total Impact	$445,646	$222,823	$222,823
Annualization between FY 05-06 and FY 06-07 (amount included in Acute Care – Exhibit F, page EF-3 for FY 06-07)	**$222,823**	**$111,412**	**$111,412**

HB 05-1131 – Authority of a Pharmacist to redispense specified unused medications. – Allows a patient of a licensed facility, or the patient's family, to return unused prescriptions, individually. It also allows pharmacists to accept and distribute medications to nonprofit organizations that provide Medicaid care. In addition, pharmacists must reimburse the Department for the cost of medications that the Department has paid if the medications are available to be dispensed to another person.

Description	FY 05-06	FY 06-07
Assisted Living Facilities savings (Community Based Long Term Care)	($57,195)	($76,150)
Nursing Facilities savings (Long Term Care - Class I Nursing Facilities)	($676,775)	($901,058)
Fiscal Year Impact	**($733,970)**	**($977,208)**

Community Based Long Term Care	Total Funds	General Fund	Federal Funds
Total FY 05-06 Estimated Total Impact (included in Community Based Long Term Care FY 05-06 adjustment – Exhibit G, page EG-2)	($57,195)	($28,597)	($28,598)
Total FY 06-07 Estimated Total Impact	($76,150)	($38,075)	($38,075)
Annualization between FY 05-06 and FY 06-07 (amount included in Community Based Long Term Care – Exhibit G for FY 06-07)	**($18,955)**	**($9,478)**	**($9,477)**

Long Term Care (Class I Nursing Facilities)	Total Funds	General Fund	Federal Funds
Total FY 05-06 Estimated Total Impact (included in the Long Term Care - Class I Nursing Facilities – Exhibit H, page EH-2 and EH-6)	($676,775)	($338,387)	($338,388)
Total FY 06-07 Estimated Total Impact	($901,058)	($450,529)	($450,529)
Annualization between FY 05-06 and FY 06-07 (amount included in Long Term Care – Class I Nursing Facilities – Exhibit H, page EH-2 and EH-6 for FY 06-07)	**($224,283)**	**($112,142)**	**($112,141)**

HB 05-1243 – Extends the option of receiving Home and Community Based Services through the consumer directed care service model. – As amended by House Health and Human Services Committee, February 14, 2005, the bill extends the option of receiving Home and Community Based Services through the consumer directed care service model to all Medicaid recipients who are enrolled in a Home and Community Based Service waiver for which the Department of Health Care Policy and Financing has federal waiver authority.

Description	FY 05-06	FY 06-07
Service Management (Single Entry Point)	$1,008,375	$1,008,375
Community Based Long Term Care savings	($2,012,790)	($11,674,182)
Fiscal Year Impact	**($1,004,415)**	**($10,665,807)**

Service Management (Single Entry Point Agencies)	Total Funds	General Fund	Federal Funds
Total FY 05-06 Estimated Total Impact	$1,008,375	$504,188	$504,187
Total FY 06-07 Estimated Total Impact	$1,008,375	$504,188	$504,187
Annualization between FY 05-06 and FY 06-07 (amount included in Service Management – Single Entry Point - Exhibit I for FY 06-07)	**$0**	**$0**	**$0**

Community Base Long Term Care	Total Funds	General Fund	Federal Funds
Total FY 05-06 Estimated Total Impact	($2,012,790)	($1,006,395)	($1,006,395)
Total FY 06-07 Estimated Total Impact	($11,674,182)	($5,837,091)	($5,837,091)
Annualization between FY 05-06 and FY 06-07 (amount included in Community Based Long Term Care – Exhibit G for FY 06-07)	**($9,661,392)**	**($4,830,696)**	**($4,830,696)**

HB 05-1262 – Concerning the implementation of Tobacco Taxes for health-related purposes pursuant to Section 21 of Article X of State Constitution, and making an appropriation therefore. – The Tobacco Tax Bill requires expansion of existing Medicaid programs to be funded through the Health Care Expansion Fund and the Prevention, Early Detection, and Treatment Fund to provide revenue for the State's General Fund, the Old Age Pension Fund and for municipal and county governments. Appropriations from the Health Care Expansion Fund and the Prevention, Early Detection, and Treatment Fund are made to the Medical Services Premiums Long Bill line item. The following are explanations of the impacts each have to the Medical Services Premiums request for FY 05-06 and FY 06-07.

Prevention, Early Detection, and Treatment Fund: The fund is administered by the Department of Public Health and Environment; however, HB 05-1262 provides for a transfer of funds to the Department for two programs: 1) Breast and Cervical Cancer, and 2) Disease Management. Since the Premiums projection, made in each service category, assumes a 50% General Fund and 50% federal fund match, unless otherwise stated on Exhibit A, page EA 1-4, estimates below represent the full dollar amount estimate for each fiscal year to accurately adjust the fund split for Cash Funds Exempt for the Health Care Expansion Fund (Exhibit EA page 5-8).

Breast and Cervical Cancer Treatment: HB 05-1262 appropriates $3,588,425 in revenue to the Prevention, Early Detection, and Treatment Fund, for FY 05-06, to fund additional cancer screenings. As additional women are screened, there is the potential for an increase in positive diagnosis. The estimated increase in clients is 91 and 116 during FY 05-06 and FY 06-07, respectively. Rather than utilizing the analysis the fiscal note assumptions were based on, the Department estimated a new client per capita of $31,060.41 (see Exhibit F, page EF-5) for FY 05-06 and FY 06-07 to project the fiscal year impact. The Health Care Expansion Fund covers only the amount that would have been funded by General Fund. The portion to be funded by General Fund for FY 05-06 and FY 06-07 is 17.5% and 26.25%, respectively. This bill assumed a July 1, 2005 implementation date.

Breast and Cervical Cancer Treatment	FY 05-06	FY 06-07
Estimated New Clients	91	116
Breast and Cervical Cancer Treatment Per Capita for New Clients[(1)]	$31,060.41	$31,060.41
Total[(2)(3)]	**$2,826,497**	**$3,603,008**

(1) See Exhibit F, page EF-5 for further details.
(2)Amounts are included in the Acute Care, Breast and Cervical Cancer Treatment request. The 116 estimated new clients for FY 06-07 does not include the 91 estimated clients from FY 05-06. No annualization is necessary.
(3) The amount funded through the Health Care Expansion Fund for FY 05-06 and FY 06-07 is $494,637 and $945,789, respectively.

Disease Management: The Department of Public Health and Environment will transfer Cash Funds Exempt in the amount of $3,940,776 for FY 05-06 and FY 06-07 to the Department from the Prevention, Early Detection, and Treatment Fund. The purpose of assisting in the implementation of the State's strategic plans regarding cancer and cardiovascular disease to provide a cohesive approach to cancer, cardiovascular disease, and chronic pulmonary disease prevention, early detection, and treatment in Colorado. The program criteria shall address at least one of the following program criteria; 1) translating evidence-based strategies regarding the prevention and early detection of cancer, cardiovascular disease, and chronic pulmonary disease into practical application in healthcare, workplace, and community settings; 2) providing appropriate diagnosis and treatment services for anyone who has abnormalities discovered in screening and early detection programs; 3) implementing education programs for the public and health care providers regarding the prevention, early detection, and treatment of cancer, cardiovascular disease, and chronic pulmonary disease; and 4) providing evidence-based strategies to overcome health disparities in the prevention and early detection of cancer, cardiovascular disease, and chronic pulmonary disease. The amount funded through the Health Care Expansion fund each fiscal year will be $1,970,388.

Health Care Expansion Fund: This fund is administered by the Department of Health Care Policy and Financing. Items funded include 1) the additional Categorically Eligible Low-Income Adults and Eligible Children estimated to become eligible for Medicaid due to the removal of the Medicaid asset test, 2) expansion of child enrollment under the Children's Home and Community Based Services Waiver and the Children's Extensive Support Waiver programs, 3) fund Medicaid to legal immigrants, 4) increase in Eligible Children due to the impact from marketing the Children's Basic Health, and 5) provide presumptive eligibility to pregnant women in Medicaid. The request differs from the analysis in the fiscal note due to updating the per capita costs to those in the request. The following itemizes each expansion and explains the request calculation.

Remove the Asset Test: Approximately 39.5% of the clients enrolled in the Children's Basic Health Plan had incomes low enough to qualify for Medicaid, but were denied based on the Medicaid asset test. Upon federal approval, the Medicaid asset test would be removed and clients who were previously found ineligible for Medicaid potentially would qualify. This would move the clients in the Children's Basic Health Plan out, and into Medicaid. The federal match for these clients would be reduced to 50% federal match under Title XIX, rather than the 65% federal match under the Children's Basic Health Plan. The Department estimates the impact to Eligible Children and Category Eligible Low-Income Adults would result in an increase of 14,332 and 3,440, respectively. Each estimate is multiplied by the requested per capita for each eligibility category:

Medicaid Asset Test – Eligible Children Expansion	**FY 05-06**	**FY 06-07**
Estimated New Clients – without retroactivity (Exhibit 4 of HB 05-1262 Fiscal Note)	14,332	24,371
Per Capita Cost for Eligible Children[(1)]	$1,403.83	$1,439.03
Total[(2)]	**$20,119,630**	**$35,070,542**

(1) See Exhibit C for further details.

(2)Amounts are included in the all Medical Services Premiums service categories since the caseload amount was included in the Medicaid Caseload projections on Exhibit C. To accurately project the fund split shift from General Fund to Cash Funds Exempt the full dollar amounts are recognized in this table. 50% of the total amount will be funded through the Health Care Expansion Fund (FY 05-06 - $10,059,815 and FY 06-07 - $17,535,272).

Medicaid Asset Test – Adult Expansion	**FY 05-06**	**FY 06-07**
Estimated New Clients – without retroactivity (Table 2 of the Colorado Legislative Council Fiscal Note for HB 05-1262, dated April 25, 2005)	3,440	5,849
Per Capita Cost for Category Eligible Low-Income Adults[(1)]	$3,471.33	$3,541.88
Total[(2)]	**$11,940,265**	**$20,716,445**

(1) See Exhibit C for further details.

(2)Amounts are included in all the Medical Services Premiums categories since the caseload amount was included in the Medicaid Caseload projections on Exhibit C. To accurately project the fund split shift from General Fund to Cash Funds Exempt the full dollar amounts are recognized in this table. 50% of the total amount will be funded through the Health Care Expansion Fund (FY 05-06 - $5,970,133 and FY 06-07 - $10,358,223).

Expansion of child enrollment under the Children's Home and Community Based Services Waiver and the Children's Extensive Support Waiver Programs: These waivers have caps limiting the number of children enrolled, resulting in a waiting list for these services. HB 05-1262 expands the cap amount to the cover the current children on the waiting lists as of January 1, 2005. There were 148 children on the Children's Extensive Support Waiver Program (as of January 1, 2005, 49 clients were not currently Medicaid eligible and 99 were currently Medicaid eligible) and 478 children (all new to Medicaid) on the Children's Home and Community Based Services waiting list. An estimated payment of $75 per client is calculated for Utilization Review and Case Management cost for 49 clients for the Children's Extensive Support Waiver and 478 clients for the Children's Home and Community Based Services waiting list. Service costs for lifting the Children's Extensive Support Home and Community Based Services waiting list for 49 children and Children's Home and Community Based Service waiting list for 148 children are based on estimated costs per client for each group, which vary each fiscal year. The calculations for all by fiscal year are as follows:

Children's Extensive Support Waiver Program Waiting List[(1)]	**FY 05-06**	**FY 06-07**
Number of children added	49	0
Cost per child	$75.00	$0
Total[(1)(2)]	**$3,675**	**$0**

(1) The 49 clients were added to the Medicaid caseload estimates for FY 05-06. A bottom-line adjustment for the $3,675 estimate was added to the Service Management-Single Entry Point Agency exhibit (EI-1), varying from the method used in the fiscal note.
(2) 50%, or $1,838, is to be funded by the Health Care Expansion Fund.

Children's Home and Community Based Services Waiting List[(1)]	**FY 05-06**	**FY 06-07**
Number of children added	478	0
Cost per child	$75.00	$0
Total[(1)(2)]	**$35,850**	**$0**

(1) The 49 clients were added to the Medicaid caseload estimates for FY 05-06. A bottom-line adjustment for the $35,850 estimate was added to the Service Management-Single Entry Point Agency exhibit (EI-1), varying from the method used in the fiscal note.
(2) 50%, or $17,925, is to be funded by the Health Care Expansion Fund.

Children's Extensive Support Home and Community Based Services Waiting List	**FY 05-06**	**FY 06-07**
Estimated Clients	49	49
Estimated Cost	$34,420	$39,287
Total[(1)]	**$1,686,593**	**$1,925,061**

(1) 50% is to be funded by the Health Care Expansion Fund. (FY 05-06 - $843,297 and FY 06-07 – $962,531)

Children's Home and Community Based Services Waiting List – Children's Waiver Services	**FY 05-06**	**FY 06-07**
Estimated Clients	478	488
Estimated Cost	$301	$492
Sub-Total	**$143,816**	**$235,380**
Total[(1)]	**$9,873,244**	**$11,700,832**

(1) 50% of the total is funded by the Health Care Expansion Fund ($4,936,622 and $5,850,416 for FY 05-06 and FY 06-07, respectively).

Medicaid Legal Immigrants: SB 03-176 eliminated Medicaid coverage to legal immigrants. However the implementation of the bill was delayed. During the delay Tobacco Tax funds funded the expenditures for these clients resulting in continuous coverage for this population. HB 05-1086 reinstated Medicaid coverage for legal immigrants and a provision was added to HB 05-1262 to provide funding from the Health Care Expansion Fund on an ongoing basis. Due to the reinstatement of services to legal immigrants granted by HB 05-1086, $2,638,343 was funded through the Health Care Expansion Fund for FY 04-05. A fund split correction was needed in the Premiums exhibits (Exhibit A, EA5-6) for this adjustment. The amount to be funded by the Health Care Expansion Fund for FY 05-06 and FY 06-07 is $6,216,752.

Impact on Medicaid due to cost effective marketing of the Children's Basic Health Plan: It is assumed that with resuming marketing in the Children's Basic Health Plan, Medicaid enrollment will increase, since applicants to the Children's Basic Health Plan are screened for Medicaid eligibility first. The addition to Medicaid caseload would be funded through the Health Care Expansion Fund. An estimated 844 and 2,402 increases for FY 05-06 and FY 06-07, respectively, in Eligible Children would be experienced in Medicaid. The Eligible Children per capita costs for each respective year is utilized to calculate the impact and Health Care Expansion Fund portion of the costs as a result.

Impact on Medicaid from Marketing the Children's Basic Health Plan	FY 05-06	FY 06-07
Estimated Clients	844	2,402
Estimated per capita cost for Eligible Children(1)	$1,403.83	$1,439.03
Total(2)	**$1,184,829**	**$3,456,544**

(1) See Exhibit C.

(2) Amounts are included in the all Medical Services Premiums service categories since the caseload amounts were added to the Medicaid Caseload projections on Exhibit C. To accurately project the fund split shift from General Fund to Cash Funds Exempt the full dollar amounts are recognized in this table. 50% of the total amount will be funded through the Health Care Expansion Fund (FY 05-06 - $592,414 and FY 06-07 - $1,728,272).

Presumptive Eligibility: The Department of Health Care Policy and Financing discontinued Medicaid presumptive eligibility on September 1, 2004. Through the passage of HB 05-1262 the Department reinstated the presumptive eligibility process. The estimated number of clients is 1,470 and 1,549 for FY 05-06 and FY 06-07, respectively. The estimated costs were originally based on member months times per member per month amount. Costs exclude delivery charges. Member months were converted to client count by dividing each amount by 12 (months in the year). The per capita amount was based on the total expenditures divided by the caseload. Per capita amounts differ from the Medicaid per capita amounts due to the exclusion of the delivery charges.

FY 05-06 Description	Presumptive Eligibility Member Month	Average Per Member Per Month Cost	Total
Women who are on Presumptive Eligibility and are ultimately determined not eligible for Medicaid and are not eligible for Emergency Medical coverage either.	8,067	$417	$3,363,914
Women who are on Presumptive Eligibility and are ultimately determined not eligible for Medicaid but are eligible for Emergency Medical coverage due to their undocumented status.	9,577	$433	$4,242,439
Total(1)	**17,644**		**$7,606,353**

(1) 50% of the total estimated cost ($3,803,177) will be funded by the Health Care Expansion Fund.

FY 06-07 Description	Presumptive Eligibility Member Month	Average Per Member Per Month Cost	Total
Women who are on Presumptive Eligibility and are ultimately determined not eligible for Medicaid and are not eligible for Emergency Medical coverage either.	8,497	$417	$3,543,211
Women who are on Presumptive Eligibility and are ultimately determined not eligible for Medicaid but are eligible for Emergency Medical coverage due to their undocumented status.	10,087	$433	$4,468,561
Total[(1)]	**18,584**		**$8,011,772**

(1) 50% of the total estimated cost ($4,005,886) will be funded by the Health Care Expansion Fund.

Per capita calculation	FY 05-06	FY 06-07
Estimated Expenditures	$7,606,353	$8,011,772
Estimated clients	1,470	1,549
Per Capita Cost[(1)]	**$5,173.22**	**$5,173.34**

(1) 50% of the total estimated costs will be funded by the Health Care Expansion Fund (FY 05-06 - $3,803,177 and FY 06-07 - $4,005,886).

(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Medicaid Mental Health Community Programs.

History and Background Information

Early legislative history of the Medicaid Mental Health Community Programs began in the 1990's. In 1992, HB 92-1306 authorized the Department and Colorado Department of Human Services to develop a pilot program to provide comprehensive mental health services to eligible Medicaid clients through a capitated managed care system. 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 1995, SB 95-078 revised the reporting and termination dates of the pilot program and directed the Department and Colorado Department of Human Services to implement a statewide mental health managed care program. In 1997, SB 97-005 authorized the Department to provide mental health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Colorado Medicaid Mental Health Capitation Program in fifty-one counties of the State was complete, with the remaining twelve counties added in 1998. Through a competitive bid process, eight Mental Health Assessment and Service Agencies (MHASAs) were awarded contracts to be a service provider in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five Behavioral Health Organizations (with new rates) effective January 1, 2005.

Each Behavioral Health Organization is responsible for providing or arranging any medically necessary mental health services to Medicaid-eligible elders, disabled, adults and children enrolled with a Behavioral Health Organization. Services provided by the Behavioral Health Organization include, but is not limited to, inpatient hospitalization; psychiatric care; rehabilitation and outpatient care; clinic services, case management, medication management and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also currently includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted Behavioral Health Organizations for these services for each eligible Medicaid recipient enrolled in the Behavioral Health Organization. Payments may vary across each Behavioral Health Organization, as well as each eligibility category.

Since the inception of the Medicaid Mental Health Capitation 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, HB 04-1265 transferred the administration and programmatic duties, including, but not limited to, budget projections and accounting for the program, site reviews of the institutions, and contract negotiations, from the Colorado Department of Human Services to the Department, with the exception of the Goebel lawsuit, which the Colorado Department of Human Services retained. The transfer was effective on April 1, 2004 for

the administrative responsibilities, which HB 04-1265 appropriated in the Executive Director's Office Long Bill group, and on July 1, 2004 for Community Programs. The transfer also resulted in a new Long Bill group for the Department in the FY 04-05 Long Bill (HB 04-1422), including a section for Program Administration. Subsequently, SB 05-112 transferred (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Medicaid Mental Health Community Programs – Program Administration to the Executive Director's Office Long Bill group, (2) Single Entry Point case management services from Medicaid Mental Health Fee for Service Payments to Medical Services Premiums, and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee for Service appropriations within the Department. As a result, it is only the Medicaid Mental Health Community Program expenditures that are addressed in this section.

A historical perspective of the Mental Health Community Program is summarized as follows:

- Within the appropriation for Mental Health Community Programs, Mental Health Capitation and Performance Incentive Awards, HB 02-1420 provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because it was discovered in 2001 that capitation-based payment for Medicaid clients did not cover bed costs at the Mental Health Institute. This funding was continued by SB 03-258. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 04-05 Long Bill HB 04-1422 and the FY 04-05 Long Bill Add-On SB 05-209. New contracts with Behavioral Health Organizations effective January 1, 2005 began fully covering the negotiated bed cost at the Mental Health Institute in new capitation rates via payments withheld from the Behavioral Health Organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 05-06.

- HB 02-1420 also provided funding for 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 at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through Mental Health Assessment and Service Agencies, Community Mental Health Centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation line, separate appropriations were made in the FY 04-05 Long Bill HB 04-1422 and the FY 04-05 Long Bill Add-On SB 05-209. Funding for Alternatives to Inpatient Hospitalization and Aftercare Programs was incorporated into the capitation base during the Request for Proposal process for contracts effective January 1, 2005. Due to this new contractual provision with Behavioral Health Organizations, separate appropriations were no longer needed as of FY 05-06.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in one-time savings of

approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 02-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services should have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's current prospective per capita budget methodology did not require the use of historical data prior to FY 02-03.

- SB 03-282 gave the Department and Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 03-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. and the remaining $500,000 was from federal funds for mental health capitation and performance incentive awards.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 02-03 and the entire FY 03-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate 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. Increasing caseload for Mental Health and incorporating funding for alternative programs to inpatient hospitalization tempered the effect the reductions have had on the capitation budget.

- HB 04-1422 reorganized the Mental Health Community Program Long Bill appropriation line items. Under the Medicaid Mental Health Community Programs Long Bill group, the following sections were created:

    1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item.

    2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee for Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were 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. Summaries appear at the end

of the Medicaid Mental Health Community Programs section. SB 05-209 did not change these line items. They remain the same.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that will provide capitated mental health benefits to an increased population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund and the Cessation, Prevention, and Detection Fund are included in the FY 06-07 Request and are elaborated below.

- The federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, commonly known as the Medicare Modernization Act, will be in effect January 1, 2006. This legislation provides seniors and individuals with disabilities, including "dual-eligibles" who are eligible for both Medicare and Medicaid, with a prescription drug benefit. The number of Medicare beneficiaries being screened for the Low-Income Subsidy program is expected to increase the Medicaid caseload. Increased caseload projections are included in the Department's FY 06-07 Request, as discussed below. Additional information is also available in the Medical Services Premiums Assumptions and Calculations.

Program Administration

The FY 04-05 Long Bill (HB 04-1422) included a line item for Medicaid Mental Health Community Programs - Program Administration. However, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration into the Executive Director's Office Long Bill group, as reflected in the lines for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health. The FY 06-07 Request is reflected and described there.

(A) MENTAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed care providers contracted by the Department.

As the result of the competitive procurement, the number of managed care providers was recently reduced from eight Mental Health Assessment and Service Agencies to five Behavioral Health Organizations. New contracts were effective on January 1, 2005. Capitation rates and services were updated. Old line items from FY 04-05, the Mental Health Institute Rate Refinance and Alternatives to Inpatient Hospitalization and Aftercare, were incorporated into the main line item.

The responsibility of the Behavioral Health Organization is to provide or arrange all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. Actuarially certified rates are paid by the Department to the Behavioral Health Organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactivity in eligibility is covered. Payments may vary across Behavioral Health Organizations, as well as eligibility categories.

The Medicaid populations that are eligible for mental health services covered by capitation are combined into the following 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 and Health Care Expansion Fund Low-Income Adults (AFDC-A), Baby Care Program – Adults and Breast and Cervical Cancer Treatment Program participants
Eligible Children (AFDC-C/BC)
Foster Children

Analysis of Historical Expenditure Allocations across Eligibility Categories:

At the beginning of a contract cycle Behavioral Health Organization capitation rates are entered in the Medicaid Management Information System. Monthly payments are paid based on eligibility categories. The Medicaid Management Information System provides detail expenditures by Behavioral Health Organization and eligibility category. However, the only source that includes all actual expenditure activity is the Colorado Financial Reporting System. The drawback is the Colorado Financial Reporting System provides total expenditures by Behavioral Health Organization, not by eligibility category. Since an allocation must be calculated to determine the amount of the expenditures across the eligibility categories, a ratio is calculated for each Behavioral Health Organization by dividing the Medicaid Management Information System eligibility category expenditures by the total Medicaid Management Information System expenditures. The ratio is multiplied by the Behavioral Health Organization's total expenditures from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each Behavioral Health Organization and eligibility category.

Description of Previous Methodology:

Member month budget methodology was used when the administration of Medicaid Mental Health Community Programs was transferred to the Department. Historical expenditures were divided by the capitation rates for the region served by each Mental Health Assessment and Service Agency to estimate the number of member months for which capitation payments were made. Caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity.

The FY 04-05 Supplemental Request and FY 05-06 Budget Request Amendment presented to the Joint Budget Committee on February 15, 2005 began moving towards the current per capita methodology. The FY 04-05 Supplemental Request relied upon a regional analysis of actual expenditures for the first half of the year and regionally projected member months multiplied by capitation rates for the second half of the year. The FY 05-06 Budget Request Amendment grew from an analysis of trended statewide per capita costs, leading to the per capita costs selected to estimate FY 05-06 expenditures, which were multiplied by the adjusted Medical Services Premiums caseload.

Medicaid Mental Health Community Programs Historical and Future Projection Overview (Exhibit AA):

Exhibit AA demonstrates the growth in spending and caseload for Medicaid Mental Health Community Programs. The expenditures are those reported in the Colorado Financial Reporting System. Medicaid Medical Services Premiums caseload is shown with an adjustment for the eligibility categories excluded from Mental Health Community Programs, namely Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, and Non-Citizens. The chart illustrates a comparison in the growth of Medical Services Premiums Caseload for Mental Health compared to the growth in capitated expenditures.

General Fund, Cash Funds, and Federal Funds Match Calculation, FY 06-07 Request (Exhibit BB):

Exhibit BB presents the fund splits for the FY 06-07 Request. For most of the capitation payments, the funding is 50% General Fund and 50% federal funds. Beyond capitation payments, Medicaid Mental Health Fee for Service Payments also receive 50% General Fund and 50% federal funds. The Mental Health Child Placement Agency and Anti-Psychotic Pharmaceuticals are reported as Cash Funds Exempt to avoid double counting General Fund appropriations that are included in the Department of Human Services Child Welfare line item, and the Department's Medical Services Premiums line item, respectively. Summaries of the Other Medicaid Mental Health Payments follow the Mental Health Capitation Payments discussion.

However, exceptions to the fund split of 50% General Fund and 50% federal funds for capitation payments exist for the Breast and Cervical Cancer Program and HB 05-1262 Tobacco Tax impacts. While a separate exhibit, Exhibit GG, has been prepared to develop the complex Tobacco Tax impact to the FY 06-07 Request, a separate exhibit was not necessary for the Breast and Cervical Cancer Program. Hence, a description of the Breast and Cervical Cancer Program follows immediately. Since Exhibit BB also introduces the FY 04-05 overexpenditure, an explanation is included below.

Mental Health Services for Breast and Cervical Cancer Patients (Exhibit BB):

SB 01S2-12, adopted during the second special session in 2001, created the Breast and Cervical Cancer Prevention and Treatment Program. Annual designations of General Fund contributions to program costs were specified. Pursuant to Section 26-4-532 (7), C.R.S. (2005), and as illustrated in Exhibit BB, the General Fund contributes 50% of the state share in FY 05-06, increasing to 75% during FY 06-07 and FY 07-08. Because federal funds cover 65% of the cost, the fund split in FY 05-06 is 65% federal funds, 17.5% General Fund and 17.5% Cash Funds Exempt. During FY 06-07 and FY 07-08, the fund split is 65% federal funds, 26.25% General Fund and 8.75% Cash Funds Exempt. SB 05-209 incorporates funding for the Breast and Cervical Cancer Treatment into the

appropriation for the capitation payments effective with the FY 05-06 budget. The source for Cash Funds Exempt continues to be the Breast and Cervical Cancer Prevention and Treatment Fund.

Breast and Cervical Cancer Treatment mental health care is managed through the capitation contracts with the Behavioral Health Organizations. Therefore, the budget is based on the Mental Health caseload for the Breast and Cervical Cancer Treatment eligibility category. The same capitation rate is paid for Breast and Cervical Cancer Treatment participants as the one paid for Category Eligible and Health Care Expansion Fund Low-Income Adults and Baby Care Program – Adults. These categories are separated in Exhibit BB because of the different fund splits.

Explanation of FY 04-05 Overexpenditure (Exhibit BB):

The FY 04-05 overexpenditure of $2,382,301 arose from several factors. Of the $2,382,301, higher per capita costs in specific categories than projected accounted for $1,969,796. Higher per capita costs were primarily attributed to actual per capita costs for children during the second half of FY 04-05. Actual per capita costs for children during the second half of FY 04-05 were approximately $5.51 higher than projected, times an average of 224,708 children during that time, resulting in an overexpenditure of $1,238,299. Additionally, per capita fluctuations contributed $947,525 for adults and $98,506 for foster children, offset by lower per capita results of $220,600 for the disabled and $93,934 for the elderly. The actual recoupment of the Institute payment disallowance was $448,858. This was $25,688 less than the $474,546 factored into the appropriation. Greater Institutional Rate Refinance payments than projected added $451,723 to this line item. The increases were partly offset by $64,906 due to actual caseload being less than projected. The Department requests that the overexpenditure restriction be released in FY 05-06. See the Schedule 6.

Medicaid Mental Health Community Programs Summary (Exhibit CC):

Exhibit CC presents a summary of Medical Services Premiums caseload for Mental Health and capitation expenditures itemized by eligibility category as well as a summary of the rest of Mental Health Community Programs. The summary reflects the overall growth in capitation expenditures from $152,435,998 during FY 04-05 to $179,871,237 for FY 06-07. At the same time, total Mental Health program expenditures increased from $202,207,076 in FY 04-05 to $227,269,323 for FY 06-07. During that time frame, capitation rose from 75% to 79% of total Medicaid Mental Health Community Program expenditures.

The capitation payments include recurring events, such as the recoupment of payment for clients later deemed ineligible for Medicaid, but not one-time events, such as the impact of a prior year overexpenditure restriction. In this manner, recurring events become part of the capitation base. One-time events are separately identified and are not folded into trended analyses by eligibility category. One-time adjustments not incorporated into trended capitation expenditures are listed in Exhibit CC.

One-Time Rate Relief:

If the Department was to request the potential deferral of the one-time rate relief in its Request, it would appear in Exhibit CC. However, no adjustment has been made for the disapproval by the Centers for Medicare and Medicaid Services of the contract

amendment containing the $3,695,817 one-time rate adjustment. The one-time rate relief stemmed from a May 1, 2004 contract amendment that increased capitation payments for the month of May 2004 only. The Department met with the Centers for Medicare and Medicaid Services staff numerous times regarding the amendment and informed them that $3,695,817 had been paid accordingly. As stated in the letter dated March 3, 2005 from the Centers for Medicare and Medicaid Services, the Department can expect a disallowance. However, the Department has not been notified of any further action. If the Centers for Medicare and Medicaid Services pursues the disallowance and if only the federal portion is recovered, no change to General Fund will be required. The Department may pursue other action at the time of the disallowance. The impact of this item will be updated in the February 15, 2006 Budget Request.

Medical Services Premiums Caseload for FY 06-07 Projection and Historical Per Capita Calculation (Exhibit DD):
One of the strengths of per capita budget methodology is that it uses the Medicaid caseload in Exhibit B. Certain eligibility categories are excluded from Medicaid mental health care, namely Qualified Medicare Beneficiaries, Special Low-Income Medicare Beneficiaries and Non-citizens. Otherwise, Mental Health caseload ties to the Medicaid caseload. Please see the Medicaid Caseload section of the Medical Services Premiums Assumptions and Calculations for further discussion of caseload projections. Please see Exhibit DD for detailed Mental Health caseload data reported by eligibility category.

Per Capita History and FY 06-07 Budget Projection for Mental Health Capitation Payments (Exhibit EE):
The Department has adopted a "per capita" budget methodology that incorporates the Medicaid caseload from Exhibit B and Mental Health Capitation Program expenditures. Per capita methodology has been used to estimate FY 05-06 costs and to develop the FY 06-07 Request. Per capita budget methodology is a zero-based budget tool in that it examines the cost per eligible Medicaid client and multiplies that unit cost by the number of clients expected. Historical data presented in Exhibit EE began in FY 02-03 because non-equivalent data from previous years would not have contributed to the understanding of current per capita costs. Prior data not only had a different accounting basis, but reflect different rates, services, and provider groupings.

The per capita budget methodology is straightforward. Historical per capita costs are developed by dividing total expenditures by the Medicaid caseload for Mental Health (Exhibit DD), in each respective fiscal year and eligibility category, to determine a per capita cost for each year and eligibility category. This represents an average amount spent on each client. Projected per capita costs are then multiplied by the Mental Health caseload to determine total projected expenditures by eligibility category, before adjustments. Adjustments are made for the estimated recoupments for ineligibles, as discussed below. Then, the total before adjustments is added to the adjustments to arrive at total projected costs. Per capita costs following adjustments are the total projected costs divided by the Mental Health caseload.

Since the contractual capitated rates with Behavioral Health Organizations changed uniformly across eligibility categories and across Behavioral Health Organization regions in FY 05-06, the per capita costs was increased uniformly across eligibility categories in Exhibit EE. The 3.25% increase recommended by the Joint Budget Committee and funded in SB 05-209, actuarially certified, and

approved by the Centers for Medicare and Medicaid Services, was applied to the FY 04-05 actual per capita costs. Per capita costs were then multiplied by the Mental Health caseload for FY 05-06 to determine the projected FY 05-06 expenditures before adjustments. Then, a net adjustment called "Rough Estimates of Recoupments in FY 05-06 for FY 03-04 and FY 04-05 Ineligibles" (described below) was added. The revised expenditures were divided by the Mental Health caseload to determine the projected FY 05-06 per capita costs following adjustments, essential to development of the FY 06-07 Request.

The capitated rates with the Behavioral Health Organizations need to be actuarially certified and approved by the Centers for Medicare and Medicaid Services (CMS), thus the Department estimated rate increases that could be reasonably expected to receive actuarial certification and CMS approval for FY 06-07. This is the 2.71% increase applied across all eligibility category per capitas in the FY 06-07 Budget Request.

The growth rate of 2.71% is based on various forecast factors, including the Department's trended cost analysis, the Medicare Economic Index from the Centers for Medicare and Medicaid Services, and the U.S. Department of Labor's Bureau of Labor Statistics consumer price index for local medical costs. The Department's trended cost analysis examined trended mental health cost factors, including those for State Plan services at Community mental health centers, non-State Plan services as approved in the Department's federal 1915 (b) waiver, Colorado mental health institutes, and payments for psychiatric procedure codes to non-community mental health center providers. When cost factors were not available for FY 05-06 or FY 06-07, the Medicare Economic Index factor from the Centers for Medicare and Medicaid Services was used for the appropriate time period. Utilizing the Behavioral Health Organization's encounter data, weighted values were associated with each of the cost factors to determine the overall 2.71% increase. This percentage was compared to the most recent information available from the U.S. Department of Labor's Bureau of Labor Statistics consumer price index for local medical costs, which indicated that medical costs in the Denver metropolitan area increased 2.5% in the first half of 2005 compared to the first half of 2004 and confirmed the reasonableness of the 2.71% increase.

Analysis of the Behavioral Health Organization's encounter data identified four service areas that drive Behavioral Health Organization's costs. The trended cost analysis began by reviewing annual average rate increases for each of the four service areas, namely services provided by community mental health centers, the Colorado mental health institutes at Pueblo and Fort Logan, and non-State Plan services, as well as Medicaid reimbursement for psychiatric procedure codes. (Behavioral Health Organization administrative costs were excluded). Then, the analysis developed estimates of cost increases or cost factors for each of these service areas through FY 06-07, averaged the growth rate for each, applied a weight to each average growth rate, and developed a weighted average growth rate of 2.71% for FY 06-07.

The first cost factor was community mental health center costs. Historically, the average change in rates for community mental health centers has changed dramatically each year. For example, rates declined by 7% in FY 02-03, increased by 17% in FY 03-04, and declined by 12% in FY 04-05. The rate setting process for FY 05-06 rates for the community mental health centers produced an

average rate increase of 17%, which was based on the Behavioral Health Organization's encounter data. The Medicare Economic Index was used to project the FY 06-07 growth rate of 2.2%. The average change in rates from FY 02-03 through FY 06-07 was 4%.

The second cost factor was rate increases for the Colorado mental health institutes at Pueblo and Fort Logan. Historically, the average increase in rates has slowed, but not stopped. FY 02-03 saw rate increases of 16%, followed by 9% in FY 03-04, and 2% in FY 04-05. The Medicare Economic Index was used to estimate the FY 05-06 increase of 2.7% and the FY 06-07 increase of 2.2%. Overall, this resulted in an average increase in rates of 6%.

The third cost factor was the cost of non-State Plan services. Costs per Medicaid-eligible client declined 3.23% during FY 03-04, the first year for which information was available, and remained constant during FY 04-05. However, cost increases approximating the Medicare Economic Index were projected for FY 05-06 and FY 06-07, at 2.7% and 2.2%, respectively. This brought the average change in costs to 0.4% per year.

The fourth cost factor was Medicaid reimbursement for psychiatric procedure codes. These codes are based on the Medicaid Fee Schedule and are not expected to be affected by the 3% primary care provider rate increase.

After an average change in rates was developed for each of the cost factors illustrated above, a weight was applied to each one, leading to the weighted average growth rate of 2.71% for FY 06-07. The weights were developed from analysis utilizing the Behavioral Health Organization's encounter data. Community mental health centers represented 59% of non-administrative Behavioral Health Organization costs, mental health institutes were 8.12%, non-State Plan services received a weight of 17.88%, and other State Plan services (for psychiatric procedure codes) were 14.99%. Applying actuarially based principles, growth rates and service category weights were combined. The sum of these factors was the 2.71% growth rate for FY 06-07.

A net adjustment for FY 06-07 recoupments of FY 05-06 ineligibles was applied, leading to the FY 06-07 Request of $179,871,237.

Significant one-time events are not included in trended expenditures or per capita costs because they are not believed to persist into the future. Page FEE-3 within Exhibit EE presents a reconciliation between total expenditures reported in Exhibit AA and the adjusted expenditures used for analytical purposes. For example, payments related to the Goebel settlement were included in capitation expenditures through FY 02-03; consequently, $12,157,186 was subtracted from total FY 02-03 capitation payments for comparative purposes. The following two adjustments were needed for FY 03-04 capitation expenditures: first, the one-time rate relief payment that was identified as $3,660,985 in FY 03-04 data was subtracted; then, the $3,011,685 overexpenditure from FY 02-03 was subtracted. Next, one adjustment was made to FY 04-05 capitation expenditures to reverse a one-time recoupment totaling $448,858. Finally, one adjustment was made for FY 05-06 capitation expenditures to subtract the $2,382,301 overexpenditure from FY 04-05 that was included in the FY 04-05 actual expenditures.

Mental Health Recoupment of Payments Made for Clients Found to be Ineligible for Medicaid (Exhibit FF):

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the Behavioral Health Organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is done separately. Because this recoupment is a recurring process, it is regarded as part of the capitation base for analytical purposes. Exhibit FF summarizes the expected fiscal impacts.

The Department is tightening the process to recoup capitation payments made for clients later determined to be ineligible for Medicaid benefits (recoupments for ineligibles). Prior to FY 05-06, the recoupment process was done once a year, with a two-year lag. For example, during FY 04-05, the Department recouped $3,131,775 in capitation payments made for retroactively ineligible clients during FY 02-03. Implementation of biannual recoupments with a one-year lag will shorten the time to recoup capitation payments made for retroactively ineligible clients. During FY 05-06 implementation, two years of recoupments for ineligibles are to be processed. During the first half of FY 05-06, the Department plans to conduct its final annual recoupment on the two-year lag, for payments made during FY 03-04, and to recoup payments made during the first half of FY 04-05. During the second half of FY 05-06, the Department expects to recoup payments made during the second half of FY 04-05.

The Department has also worked to reduce the payments to the Behavioral Health Organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. During February 2004, the Department converted to concurrent capitation payments. FY 04-05 was the first full year on a concurrent basis for monthly capitation payments. Recoupments made during FY 05-06 will see the impact of concurrent capitation payments; the amount of money the Department recoups is expected to drop significantly from the past.

The figures presented in Exhibit FF reflect the recoupment process. The Department's rough estimate of FY 05-06 recoupments of payments made during FY 03-04, when concurrent capitation payments were being implemented, is $2,250,000. The Department's rough estimate of FY 05-06 recoupments of payments made during FY 04-05, when concurrent capitation payments were made throughout the year, drops incrementally to $1,600,000. The Department's rough estimate of recoupments in FY 06-07 for payments made during FY 05-06 remains level at $1,600,000.

Tobacco Tax Impacts on General Fund, Cash Funds, and Federal Funds Match Calculations for Medicaid Mental Health Community Programs (Exhibit GG):

As mentioned above, HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health funding to an increased population of Medicaid clients. The funds are the Health Care Expansion Fund and the Cessation, Prevention, and Detection Fund. Exhibit GG presents projected caseload and costs itemized by eligibility category over two pages, one for the FY 05-06 Estimate and another for the FY 06-07 Request. In the FY 06-07 Request, the Health Care Expansion Fund extends Medicaid capitated mental health benefits to 478 disabled clients through the removal of the waiting list for Home and Community Based Services and 49 additional clients through the removal of the waiting list for Children's Extensive Support waiver program. For FY

06-07 the Health Care Expansion Fund also includes the removal of the asset test, adding 5,849 Categorically Eligible Low-Income adults and 24,371 children; resumption of presumptive eligibility for participants in the Baby Care Program – Adults adding 1,549 clients; expansion of parents' eligibility to 60% of the federal poverty level adding 4,886 adults; and, Children's Basic Health Plan marketing efforts paid by the Fund adding 2,402 children to Medicaid. It is projected that the cost of adding these 39,584 total clients will be $7,025,915, as indicated in the exhibit. Additionally, the Cessation, Prevention, and Detection Fund will provide additional cancer screening efforts, which are projected to result in an additional 116 participants in the Breast and Cervical Cancer Program during FY 06-07, at a cost of $17,724 for their capitated mental health benefits. Altogether, the Tobacco Tax is expected to provide capitated mental health benefits to a total of 39,700 clients during FY 06-07, at a total cost of $7,043,639. Exhibit GG also develops the fund splits that are carried forward to Exhibit BB.

Medicaid Mental Health Fee for Service Payments (Exhibit HH):

Development of the FY 06-07 Request for Mental Health Fee-for-Service Payments is presented in Exhibit HH, as discussed in the following section (B) Other Medicaid Mental Health Payments of this document.

Global Reasonableness Test for Mental Health Capitation Payments (Exhibit II):

The Global Reasonableness Test presented in Exhibit II compares the percent change between Mental Health capitation expenditures as reported in Exhibit EE. The exhibit indicates that the FY 05-06 appropriation is 10.49% higher than FY 04-05 actual expenditures. Actual caseload was lower than the projections on which the FY 05-06 appropriation was built. The current FY 05-06 estimate incorporates reduced caseload projections and results in an 8.32% increase over FY 04-05 actual expenditures. The FY 06-07 Request is built upon the FY 05-06 estimate and the current, reduced caseload projections, resulting in a 8.62% increase over the FY 05-06 estimate.

Comparison of FY 06-07 Base Request to FY 05-06 Appropriation:

A comparison of the FY 06-07 Base Request and the FY 05-06 appropriation for Mental Health Capitation Payments is necessary to explain the difference on the Schedule 6.

The FY 05-06 appropriation of $165,044,919 included$13,629,792 for caseload projections and a 3.25% cost-of-living increase for the Behavioral Health Organizations. It also included provisions to recoup for FY 03-04 ineligibles, a net of $881,775, and to restore the one-time Institution Payment Disallowance in the amount of $474,546. When added to the $150,058,806 appropriated for FY 04-05, this explains the $165,044,919 appropriated in SB 05-209. HB 05-1262 Tobacco Tax added $3,871,047 in FY 05-06 to increase the current total FY 05-06 appropriation to $168,915,966.

The FY 06-07 Base Request of $171,378,473 represents the FY 05-06 appropriation of $168,915,966 (SB 05-209 Long Bill + HB 05-1262 Tobacco Tax), annualized by $2,462,507 for the FY 06-07 impact of HB 05-1262. Of the $2,462,507 appropriation, the Health

Care Expansion Fund contributes $1,769,758 for children, $684,860 for adults, and $4,419 for the disabled for a total of $2,459,037. In addition, the Cessation, Prevention, and Detection Fund contributes $3,470 for the expansion of cervical cancer screenings.
In terms of caseload, 410,171 clients were included in the FY 05-06 Long Bill. 24,120 clients were added in FY 05-06 and 18,996 additional clients in FY 06-07 due to HB 05-1262. Thus, the total number of clients grew to 453,287 in the Base Request.

Please see the following tables that reconcile to the Department's FY 06-07 Request.

Medicaid Mental Health Capitation Payments Appropriation

Legislation	Description	FY 04-05 Appropriation	FY 05-06 Appropriation	FY 05-06 Estimate	FY 06-07 Request
	Base	$145,441,193	$150,058,806	$168,915,966	$167,984,978
SB 03-282 Tobacco Litigation Settlement Cash Fund	Tobacco Settlement (one-time funding reversed in FY 04-05)	($1,000,000)	$0	$0	$0
HB 04-1320 Supplemental	Rate Relief for Behavioral Health Organizations (one-time funding reversed in FY 04-05)	($3,695,817)	$0	$0	$0
HB 04-1320 Supplemental	FY 02-03 Overexpenditure (one-time funding reversed in FY 04-05)	($3,011,685)	$0	$0	$0
HB 04-1320 Supplemental	FY 01-02 Recoupment of Over Payments (one-time recoupment reversed in FY 04-05)	$3,775,623	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Forensics Carve-out Adjustments	($928)	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Adjustment for Caseload Projection	$3,857,550	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Incremental Increase for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan	$355,511	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Incremental Increase for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo	$13,272	$0	$0	$0
FY 04-05 Long Bill HB 04-1422	Incremental Increase for Alternatives to the Fort Logan Aftercare Program	$4,959	$0	$0	$0
FY 04-05 Long Bill	Adjustment for Caseload Projection	$7,979,197	$0	$0	$0

Legislation	Description	FY 04-05 Appropriation	FY 05-06 Appropriation	FY 05-06 Estimate	FY 06-07 Request
Add-On SB 05-209					
FY 05-06 Long Bill SB 05-209	Adjustment for Caseload Projection sand 3.25% Rate Increase	$0	$13,629,792	$0	$0
	Subsequent Adjustments for Caseload Projections and 2.71% Rate Increase	$0	$0	($1,556,033)	$8,688,712
FY 04-05 Long Bill Add-On SB 05-209	Revised Breast and Cervical Cancer Patients Amount	($53,748)	$0	$0	$0
FY 05-06 Long Bill SB 05-209	FY 02-03 Recoupments for Ineligible Clients	($3,131,775)	$3,131,775	$0	$0
FY 05-06 Long Bill SB 05-209	ROUGH Estimate of FY 03-04 Recoupments for Ineligible Clients	$0	($2,250,000)	$0	$2,250,000
	ROUGH Estimate of FY 04-05/05-06 Recoupments for Ineligible Clients	$0	$0	($1,600,000)	$0
	FY 04-05 Overexpenditure restriction	$0	$0	$2,382,301	($2,382,301)
HB 05-1262 Tobacco Tax	Incremental Increase from Health Care Expansion Fund	$0	$3,858,412	($158,047)	$3,325,550
HB 05-1262 Tobacco Tax	Incremental Increase from Cessation, Prevention, and Detection Fund	$0	$12,635	$791	$4,298
FY 04-05 Long Bill Add-On SB 05-209	Recoupment of Institution Payment Disallowance	($474,546)	$0	$0	$0
FY 05-06 Long Bill SB 05-209	Restore One-time Institution Payment Disallowance	$0	$474,546	$0	$0
	Final Request	**$150,058,806**[14]	**$168,915,966**	**$167,984,978**	**$179,871,237**

Appropriation Funding Splits for All Lines Included in Capitation Payments for FY 05-06

	Bill	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 05-06	**Long Bill SB 05-209**	**$165,044,919**	**$82,514,992**	**$4,021**	**$82,525,906**
	FY 05-06 Impact of HB 05-1262 Health Care Expansion	$3,858,412	$0	$1,929,208	$1,929,204

[14]The FY 04-05 Appropriation column, $150,058,806, equals Capitation Base Payments for 405,200 Estimated Medicaid Eligible Clients ($146,964,225), Mental Health Services for Breast and Cervical Cancer Patients ($17,427), Mental Health Institute Rate Refinance Adjustment ($1,130,950), 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). SB 05-209 incorporated funding for all of these lines into the Capitation Base Payment line item.

	Bill	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
	Fund				
	FY 05-06 Impact of HB 05-1262 Cessation, Prevention, & Detection Fund	$12,635	$0	$4,422	$8,213
FY 05-06	**Final Appropriation (Long Bill plus Special Bills)**	**$168,915,966**	**$82,514,992**	**$1,937,651**	**$84,463,323**
	Caseload Adjustment	($1,556,033)	($776,736)	($692)	($778,605)
	ROUGH Estimate of FY 04-05 Recoupment for Ineligible Clients in FY 05-06	($1,600,000)	($800,000)	$0	($800,000)
	FY 04-05 Overexpenditure restriction	$2,382,301	$1,191,151	$0	$1,191,150
	HB 05-1262 Incremental Increase from Health Care Expansion Fund	($158,047)	$0	($79,023)	($79,024)
	HB 05-1262 Incremental Increase from Cessation, Prevention, & Detection Fund	$791	$0	$277	$514
FY 05-06	**Estimate**	**$167,984,978**	**$82,129,407**	**$1,858,213**	**$83,997,358**
	Adjustment for Caseload and Rates	$8,688,712	$4,340,040	$1,808	$4,346,864
	Fund Split Change in Breast and Cervical Cancer Patients for FY 06-07	$0	$2,011	($2,011)	$0
	FY 03-04 Recoupment for Ineligible Clients in FY 05-06 (one-time recoupment reversed in FY 06-07)	$2,250,000	$1,125,000	$0	$1,125,000
	FY 04-05 Overexpenditure restriction removal	($2,382,301)	($1,191,150)	$0	($1,191,151)
	HB 05-1262 Incremental Increase from Health Care Expansion Fund	$3,325,550	$0	$1,662,775	$1,662,775
	HB 05-1262 Incremental Increase from Cessation, Prevention and Detection Fund	$4,298	$0	$1,504	$2,794
FY 06-07	**Request**	**$179,871,237**	**$86,405,308**	**$3,522,289**	**$89,943,640**

(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS

Medicaid Mental Health Fee for Service Payments (Exhibit HH):

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

History and Background Information

The nature of Medicaid Mental Health Fee for Service Payments has changed in recent years. Prior to FY 02-03, fee-for-service payments were included in the Medicaid Mental Health Capitation Base appropriation. During FY 02-03, case management services, provided by community mental health centers, were included in the Mental Health Fee for Service Payments appropriation. During FY 03-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee for Service Payments appropriation, but they moved to the Medical Services Premiums appropriation in FY 04-05. Also during FY 04-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Mental Health Fee for Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Home and Community Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the Mental Health Centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 03-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested that these services be transferred to the Medical Services Premiums Long Bill group. SB 05-112 moved Single Entry Point case management from the Mental Health Fee for Service Payments line item to the Medical Services Premiums line item in FY 04-05; this was done effective July 1, 2004.

SB 05-112 also authorized the transfer of Fee for Service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services. This followed a 1331 Emergency Supplemental submitted on September 3, 2004 and approved by the Joint Budget Committee on September 21, 2004 for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Home and Community Based Services as required by the federal Centers for Medicare and Medicaid Services and was made effective October 1, 2004. The Department's FY 05-06 Estimate incorporates an annualization of this appropriation. $122,496 for the last three quarters of FY 04-05 divided by three equals the $40,832 added to annualize the appropriation in FY 05-06.

The Mental Health Fee for Service Payments appropriation was overexpended in FY 04-05 by $158,007. The Department asks that the overexpenditure restriction be released in FY 05-06. See the Schedule 6.

The FY 06-07 Request is based on FY 04-05 actual expenditures, increased by the growth in Mental Health caseload of 8.29% in FY 05-06 and 7.57% in FY 06-07. No rate or utilization increases are forecast. The Department's request incrementally grows the Base Request shown in Column 5 of the Schedule 6, which represents funds appropriated for FY 05-06 in the amount of $1,209,823, by a total of $422,753 due to caseload growth to reach total FY 06-07 projected expenditures of $1,632,576 for Mental Health Fee for Service Payments.

Please see the following tables that reconcile to the Department's FY 06-07 Request.

Medicaid Mental Health Fee for Service Payments

Legislation	Description	FY 04-05 Appropriation	FY 05-06 Appropriation	FY 05-06 Estimate	FY 06-07 Request
HB 04-1422	Base	$2,827,380	$1,221,573	$1,209,823	$1,675,714
SB 05-112 Supplemental	HCBS-MI SEP Case Management to Medical Services Premiums	($1,780,300)	$0	$0	$0
SB 05-112 Supplemental	HCBS-DD Waiver from Department of Human Services: FY 04-05 Impact (last 3 quarters of FY 04-05)	$122,496	$0	$0	$0
FY 04-05 Long Bill Add-On SB 05-209	HCBS-MI SEP Case Management to Medical Services Premiums	($82,627)	$0	$0	$0
FY 04-05 Long Bill Add-On SB 05-209	FY 04-05 Increase in Mental Health Fee for Service (caseload)	$11,000	$0	$0	$0
FY 04-05 Long Bill Add-On SB 05-209	FY 04-05 Increase in Community Mental Health Centers (caseload)	$1,128	$0	$0	$0
FY 04-05 Long Bill Add-On SB 05-209	HCBS-DD Waiver: FY 04-05 Impact (one-time duplicate)	$122,496	($122,496)	$0	$0
FY 05-06 Long Bill SB 05-209	HCBS-DD Waiver: FY 05-06 Annualization	$0	$40,832	$0	$0
FY 05-06 Long Bill SB 05-209	FY 05-06 Increase in Mental Health Fee for Service (caseload)	$0	$41,898	$0	$0
FY 05-06 Long Bill SB 05-209	FY 05-06 Increase in Community Mental Health Centers (caseload)	$0	$4,294	$0	$0
FY 05-06 Long Bill SB 05-209	FY 05-06 2% Provider Increase	$0	$23,722	$0	$0
	FY 04-05 Overexpenditure	$0	$0	$158,007	($158,007)
	FY 05-06 Impact of caseload growth beyond FY 04-05 Actuals	$0	$0	$307,884	$0
	FY 06-07 Impact of caseload growth beyond FY 05-06 Estimate	$0	$0	$0	$114,869
	Final Appropriation/Request (matches Schedule 6)	**$1,221,573**	**$1,209,823**	**$1,675,714**	**$1,632,576**

Appropriation Funding Splits

	Bill	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 04-05	HB 04-1422 Long Bill	$2,827,380	$1,413,690	$0	$1,413,690
	HCBS-MI SEP Case Management transferred to Medical Service Premiums	($1,780,300)	($890,150)	$0	($890,150)
	HCBS-DD Waiver transferred from the Department of Human Services for last three quarters of FY 04-05 in SB 05-112	$122,496	$61,248	$0	$61,248
	HCBS-DD Waiver transferred from the Department of Human Services for last three quarters of FY 04-05 in FY 04-05 Long Bill Add-On SB 05-209	$122,496	$61,248	$0	$61,248
	HCBS-MI SEP Case Management to Medical Services Premiums	($82,627)	($41,313)	$0	($41,314)
	FY 04-05 Increase in Mental Health Fee for Service (caseload)	$11,000	$5,500	$0	$5,500
	FY 04-05 Increase in Community Mental Health Centers (caseload)	$1,128	$564	$0	$564
FY 04-05	**Final Appropriation**	**$1,221,573**	**$610,787**	**$0**	**$610,786**
FY 05-06	Reverse one-time duplicate funding	($122,496)	($61,248)	$0	($61,248)
	Annualization of HCBS-DD Waiver	$40,832	$20,416	$0	$20,416
	FY 05-06 Increase in Mental Health Fee for Service (caseload)	$41,898	$20,949	$0	$20,949
	FY 05-06 Increase in Community Mental Health Centers (caseload)	$4,294	$2,147	$0	$2,147
	2% Provider Increase	$23,722	$11,861	$0	$11,861
FY 05-06	**Final Appropriation**	**$1,209,823**	**$604,912**	**$0**	**$604,911**
	FY 04-05 Overexpenditure	$158,007	$79,003	$0	$79,004
	FY 05-06 Impact of caseload growth beyond FY 04-05 Actuals	$307,884	$153,942	$0	$153,942
FY 05-06	**Estimate**	**$1,675,714**	**$837,857**	**$0**	**$837,857**
	FY 04-05 Overexpenditure Removal	($158,007)	($79,003)	$0	($79,004)
	FY 06-07 Impact of caseload growth beyond FY	$114,869	$57,434	$0	$57,435

	Bill	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
	05-06 Estimate				
FY 06-07	**Request**	**$1,632,576**	**$816,288**	**$0**	**$816,288**

Mental Health Child Placement Agency (Exhibits BB-CC):

This line is included in the Other Medicaid Mental Health Payments appropriation section within the Long Bill for informational purposes only. This program has been a collaborative effort between participating Colorado counties and Behavioral Health Organizations to provide mental health services for foster children placed through Child Placement Agencies. Based on county and Behavioral Health Organization agreements, some General Fund block grant monies were used to draw federal Medicaid funding.

Effective December 1, 2004, Medicaid payments for Child Placement Agencies were discontinued upon instruction from the Centers for Medicare and Medicaid Services. It was determined that the supplemental payments were not allowable since the payments were not a part of the actuarially certified capitated rate as specified in 42 CFR 438.6(c) and that the services might have been considered non-Medicaid services under 42 CFR 435.1002(c). The Centers for Medicare and Medicaid Services also questioned the authority of the Colorado Medicaid Community Mental Health Services Program Section 1915(b) waiver to cover these payments. The Department is working with Behavioral Health Organizations, Colorado counties, the Department of Human Services, and the Centers for Medicare and Medicaid Services on resolution to these matters. Upon resolution, the Department and the Department of Human Services plan to coordinate the submission of any Change Request necessary to adjust the appropriation.

Funding has been through the Department of Health Care Policy and Financing in the Department of Human Services Medicaid-Funded Programs Long Bill group. The Requests for FY 05-06 and 06-07 were 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.

Mental Health Anti-Psychotic Pharmaceuticals (Exhibits BB-CC):

This line is also included in the Other Medicaid Mental Health Payments appropriation section within the Long Bill for informational purposes only. Original funding is in the Medical Services Premiums Long Bill group of the Department's budget. For calculations of the requested amount, see Calculation of Anti-psychotic Drugs under the Medical Services Premiums section (Exhibit F). Through implementation of the Medicare Modernization Act, the cost to the State of Colorado of providing prescription drugs, including anti-psychotic medications, is expected to decline.

(4) INDIGENT CARE PROGRAM

The Indigent Care Program Long Bill group consists of: the Colorado Indigent Care Program, the Children's Basic Health Plan, the Primary Care Fund and the Comprehensive Primary and Preventive Care Fund. These programs are designed to serve Colorado's underinsured and uninsured population. A description of each program, along with budget history and the FY 06-07 funding request amounts, are presented separately in this document.

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 05-06, the program consists of three line items: Safety-Net Provider Payments, The Children's Hospital Clinic Based Indigent Care and Pediatric Specialty Hospital. These 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 at or below 185% of the federal poverty level ($35,797.50 for a family of four in 2005). 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.

The introduction of the federal Balanced Budget Act of 1997 established declining limits of the amount of federal funds available to states for Disproportionate Share Hospital payments. 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. 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.

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 03-04 to FFY 08-09, the State Disproportionate Share Hospital annual limit is set 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 Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. For FY 04-05, this data can be found in Exhibit K, Page EK-5 of Volume I.

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. The primary goal in combining the line items was to create a more simplified system that could be more readily understood by Department staff, the General Assembly and providers. Another goal in combining the line items was to create a system that distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved and overall payments to qualified providers who serve low income individuals increased.

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 four types of payments: Low-Income, Bad Debt, High-Volume, and Low-Income Shortfall. A summary of the 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 federal law.	The State share of payments to public hospitals is from the certification of uncompensated costs incurred from providing medical services to low income, uninsured, and under-insured Colorado residents and is represented as Cash Funds Exempt in the Long Bill. The federal share of payments is from Disproportionate Share Hospital federal funds.	The State share of payments to private hospitals is General Fund. The federal share of payments is from Disproportionate Share Hospital federal funds.
Bad Debt Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of available Disproportionate Share Hospital funds. These funds are contingent upon remaining Disproportionate Share Hospital federal funds available under the limit following the distribution of the Low-Income Payment.	The State share of payments to public hospitals is from the certification of uncompensated bad debt costs incurred from providing medical services to low income, uninsured, and under-insured Colorado residents and is represented in the Long Bill as Cash Funds Exempt. The federal share of payments is from Disproportionate Share Hospital federal funds. The payment is only available to Denver Health Medical Center and University Hospital, who voluntarily distribute a portion of the funding to other qualified providers to maintain equality between providers.	Any payments to qualified private hospital is through Denver Health Medical Center and University Hospital, who voluntarily distribute a portion of the funding to other qualified providers to maintain equality between providers.
High-Volume Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit for inpatient hospital services remaining for certification of public expenditure.	The State share of payments to public hospitals is from the certification of uncompensated costs incurred from providing medical services to Medicaid clients and is represented in the Long Bill as Cash Funds Exempt. The federal share is from the current federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is General Fund. The federal share is from the current federal Medicaid matching rate for Colorado.
Low-Income Shortfall Payment: Payable to medical facilities that provide services to a	The State share of payments to public hospitals is General Fund. The federal share is from the	The State share of payments to private hospitals is General

Payment Type	Public Hospitals	Private Hospitals
large number of Medicaid and low income, underinsured patients, but they do not participate in the Colorado Indigent Care Program. This payment is an allocation of Disproportionate Share Hospital funds available for qualified providers.	current federal Medicaid matching rate for Colorado.	Fund. The federal share is from the current federal Medicaid matching rate for Colorado.

Under the distribution model, the four separate payment calculations (Low-Income payments, Bad Debt payments, High-Volume payments, and Low-Income Shortfall payments) are 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 or Upper Payment Limit for inpatient hospital services 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 05-06 and FY 06-07 for the State to utilize is $87,127,600. The federal limit is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. Payments of this type include Low-Income and Low-Income Shortfall payments, with any additional federal funds available at fiscal year end to be distributed as a Bad Debt payment to providers who treat indigent clients.
The Upper Payment Limit for inpatient hospital services, however, is determined on a hospital-by-hospital basis. Thus, the amount of funds available for federal match is limited to different amounts between providers and is not determined by a set figure for the entire program. The distribution of the Upper Payment Limit for inpatient hospital services is called a High-Volume payment.

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 Joint Budget Committee also recommended, and the General Assembly approved, increased funding for Upper Payment Limit for inpatient hospital services financing for expenses occurred in FY 03-04 and 04-05 at $8,731,182 and $5,593,702 respectively. The

final appropriation for FY 04-05 was $264,013,206 in total funds, consisting of $9,432,484 in General Fund, $122,574,119 in Cash Funds Exempt, and $132,006,603 in federal funds.

In FY 05-06, the Department requested continuation funding of $249,688,322. The one-time payment of $8,731,182 related to Upper Payment Limit was removed. HB 05-1349 (Funding of the Colorado Indigent Care Program) added $6,288,324 through the transfer of interest within the Controlled Maintenance Trust Fund for the purpose of restoring FY 04-05 cuts to General Fund. The final appropriation for FY 05-06 was $261,570,348 in total funds, consisting of $12,576,646 in General Fund, $118,208,528 in Cash Funds Exempt, and $130,785,174 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**	**FY 05-06**	**FY 06-07**
Previous Fiscal Year Final Appropriation	$240,417,339	$233,394,277	$255,976,646	$264,013,206	$261,570,348
Denver Indigent Care Program Line Item	$36,137,947	$0	$0	$0	$0
University Hospital Indigent Care Program Line Item	$28,715,326	$0	$0	$0	$0
Out-state Indigent Care Program Line Item	$23,812,224	$0	$0	$0	$0
Disproportionate Share Payment to Hospitals Line Item	$130,115,868	$0	$0	$0	$0
Pre-Component 1 Disproportionate Share Payments to Hospitals Line Item	$4,771,714	$0	$0	$0	$0
SB 03-203 One-time Payment to the Denver Indigent Care Program	$5,339,798	($5,339,798)	$0	$0	$0
SB 03-203 One-time Payment to the University Hospital Indigent Care Program	$4,501,400	($4,501,400)	$0	$0	$0
FY 03-04 Decision Item #6 – Change in Financing Methodology for the Indigent Care Program	$0	$32,423,567	$0	$0	$0
FY 04-05 Joint Budget Committee Recommended Reduction	$0	$0	($6,288,324)	$0	$0
FY 04-05 Joint Budget Committee Recommended increase for FY 03-04 Funding related to Upper Payment Limit	$0	$0	$8,731,182	$0	$0

Line Item: Safety-Net Provider Payments	FY 02-03 Previous Line Items	FY 03-04	FY 04-05	FY 05-06	FY 06-07
FY 04-05 Joint Budget Committee Recommended increase for FY 04-05 Funding related to Upper Payment Limit	$0	$0	$5,593,702	$0	$0
Removal of one-time funding for Upper Payment Limit	$0	$0	$0	(8,731,182)	$0
HB 05-1349 One-time funding from the transfer of interest within the controlled maintenance.*	$0	$0	$0	$6,288,324	$0
Removal of HB 05-1349 One-time funding from the transfer of interest within the controlled maintenance.*	$0	$0	$0	$0	($6,288,324)
Final Appropriation / Request	**$233,394,277**	**$255,976,646**	**$264,013,206**	**$261,570,348**	**$255,282,024**

* This payment is subject to the availability of earned interest in the Controlled Maintenance Trust Fund. If available, the funds are to be transferred on February 1, 2006. If all of the funding is not available on this date, the remainder will be transferred when available.

For FY 06-07, the Department is requesting continuation funding of $255,282,024. Please refer to the table below for fund splits.

	FY 06-07 Base Request
Total Funds	**$255,282,024**
General Fund	$9,432,484
Cash Funds Exempt	$118,208,528
Federal Funds	$127,641,012

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 and 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 for this payment; 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, FY 04-05 and FY 05-06 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 06-07 for this line item of $6,119,760, which consists of equal amounts of General Fund and federal funds, or $3,059,880 each.

PEDIATRIC SPECIALITY HOSPITAL

This is a new line item that was created by the Joint Budget Committee and funding for this line item was added to the Long Bill (SB 05-209) during the Figure Setting process. The Joint Budget Committee recommendation included $5,452,134 to provide funding to pediatric specialty hospitals to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The funds were redirected to the pediatric specialty hospital line item due to anticipated savings from the removal of the Medicaid asset test in HB 05-1262 (tobacco tax). The Children's Hospital is the only provider qualified for funding from this line item. This funding mechanism is a supplemental Medicaid payment through Upper Payment Limit financing which utilizes General Fund to match the federal funds at the Medicaid federal financial participation rate.

The Pediatric Specialty Hospital line item has spending authority for $5,452,134 in total funds. This is comprised of $2,726,067 in federal funds and $2,726,067 in General Fund. Because legislative intent was for one time funding, the Department is not requesting funding for this line item for FY 06-07.

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, and provided basic health insurance coverage for uninsured children of families with incomes under 185% of the federal poverty level. 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. To participate in the plan, families with incomes over 150% of the federal poverty level (with the exception of pregnant women) pay a nominal annual enrollment fee, based on family size and income. 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 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 titled 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 the sections that 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 in the Prenatal and Delivery Program as of May 5, 2003 for delivery and through 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 enrollment, if it was requested that they do so and they met eligibility criteria at that time. Although enrollment for the Children's Basic Health Plan 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.

In November 2004, the voters of Colorado approved amendment 35, which raised taxes on tobacco products and designated that 46% of this revenue go to the Health Care Expansion Fund administered by the Department. The Health Care Expansion Fund, which expanded the Children's Basic Health Plan and Medicaid, was implemented through HB 05-1262. The bill provided funding to expand eligibility in the Children's Basic Health Plan to families with incomes up to 200% of the federal poverty level, remove the Medicaid asset test and to provide cost effective marketing for the Children's Basic Health Plan. The fiscal impact of these provisions on the Children's Basic Health Plan is summarized below.

HB 97-1304 CHILDREN'S BASIC HEALTH PLAN TRUST

This line item is for contributions to the Children's Basic Health Plan Trust Fund. 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.

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 for the Trust Fund to $17,500,000.

SB 03-190 is also of importance. While this bill did not specifically address the appropriation for 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 a one-time occurrence 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	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
SB 03-258 Long Bill	$23,902,965	$6,182,451	$220,514	$17,500,000	$0
SB 03-291, Enrollment Cap	($5,822,908)	($5,822,908)	$0	$0	$0
SB 03-291 and SB 03-101 Savings (see below)	$300,000	$300,000	$0	$0	$0
SB 03-291 and SB 03-107 Savings (see below)	$484,000	$484,000	$0	$0	$0
SB 03-282, Tobacco Reallocation Bill	$1,000,000	$0	$0	$1,000,000	$0
SB 03-019, Audit Tobacco Programs	($23,459)	$0	$0	($23,459)	$0
HB 04-1331, Net Reduction from SB 03-019 (see below)	($15,848)	$0	$0	($15,848)	$0
Final Appropriation	**$19,824,750**	**$1,143,543**	**$220,514**	**$18,460,693**	**$0**

The $1 million Cash Funds Exempt appropriation from the Tobacco Litigation Settlement Cash Fund in SB 03-282 was also a one-time occurrence. 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, by 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 included $3,296,346 in General Fund. 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. SB 05-209, the FY 05-06 Long Bill add-on, reduced the appropriation of tobacco settlement funding by $327,489. Finally, an additional $7,683 was appropriated through SB 05-249 which adjusted the final FY 04-05 allocation of tobacco settlement monies.

Trust Fund FY 04-05 Appropriation

	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
HB 04-1422 FY 04-05 Long Bill	$20,983,142	$3,296,346	$210,400	$17,476,396	$0
HB 04-1421 Tobacco Settlement Bill	$3,472,958	$0	$0	$3,472,958	$0
SB 05-209 Long Bill Add-on	($327,489)	$0	$0	($327,489)	$0
SB 05-249 Tobacco Settlement Bill	$7,683	$0	$0	$7,683	$0
FY 04-05 Appropriation	**$24,136,294**	**$3,296,346**	**$210,400**	**$20,629,548**	$0

The Department submitted a Change Request in the November 1, 2004, Budget Request (#DI-5) which requested additional General Fund to support projected increases in caseload and adjustments to the capitation rates to levels recommended by a contracted actuary. On page 160 of the March 15, 2005 Joint Budget Committee Figure Setting document, staff recommended a FY 05-06 appropriation of $2,255,000 in General Fund to the Children's Basic Health Plan Trust Fund. SB 05-209 (the FY 05-06 Long Bill) also adjusted Cash Funds received from annual enrollment fees and the Cash Funds Exempt allocation of Tobacco Settlement Monies. As previously noted, HB 05-1262 removed the Medicaid asset test, resulting in a reduction in children's caseload. This reduction is due to all children under 100% of the federal poverty level and children under age six with family incomes under 133% of the federal poverty level now being eligible for Medicaid. Further, HB 05-1262 removed the General Fund appropriation. HB 05-1262 also expanded eligibility in the Children's Basic Health Plan from 185% to 200% of the federal poverty level, thus increasing Cash Funds from annual enrollment fees. The resulting FY 05-06 appropriation is delineated in the table below.

Trust Fund FY 05-06 Appropriation

	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
SB 05-209 FY 05-06 Long Bill	$23,759,524	$2,255,000	$160,256	$21,344,268	$0
HB 05-1262 Tobacco Tax-Remove Medicaid Asset Test	($2,255,000)	($2,255,000)	$0	$0	$0
HB05-1262 Tobacco Tax-Expand Eligibility to 200% of the Federal Poverty level	$85,486	$0	$85,486	$0	$0
FY 05-06 Appropriation	**$21,590,010**	**$0**	**$245,742**	**$21,344,268**	**$0**

The Base Request for FY 06-07 is based on assumptions in current law, and assumes a continuation of zero General Fund. The FY 06-07 Base Request includes $21,437,162 in Cash Funds Exempt from Tobacco Master Settlement funding based on a July 2005 forecast provided by the Office of State Planning and Budgeting and it includes the offset for the Department of Public Health and Environment oversight of $12,637 for a net amount of $21,424,525. The FY 06-07 Base Request further assumes continuation of the

$245,745 in Cash Funds from annual enrollment fees. The Department requests adjustments to the Cash Funds from annual enrollment fees through a Decision Item.

Trust Fund FY 06-07 Base Request

	Total Fund	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
FY 06-07 Base Request	$21,670,267	$0	$245,742	$21,424,525	$0

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

This line item funds private contracts for administrative services associated with the operation of the Children's Basic Health Plan Administration, also called External Administration. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to members of the Plan. Auxiliary administrative functions are contracted out separately 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 that are incurred but not yet reported. The claims audit is necessary to meet the State Auditor's evaluation requirements. Quality assurance services include collecting Health Plan Employer Data and Information Set (HEDIS) client satisfaction data.

Under federal law, children eligible for Medicaid may not enroll in the Children's Basic Health Plan, yet, many of the children who apply for the 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 02-03 Appropriation

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 care and delivery services. The federal match for HB 02-1155 was solely Title XXI.

FY 03-04 Appropriation

The FY 03-04 Long Bill appropriation increased the prior years' appropriation by $30,000 from the approval of DI-3 in the November 1, 2002 Budget Request, and $411,647 due to the annualization of HB 02-1155. HB 02-1155 was for the out-year impact which expanded coverage of the Children's Basic Health Plan to pregnant women for prenatal care and delivery services. DI-3 was to contract with an independent actuary to recommend rates for the Children's dental benefit. The actuary recommends a rate each year, thus the additional funding for actuary services carries into the 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 included $100,500 for limited outreach and client education, but did not include any funding for marketing and advertising. The Long Bill also included $144,178 to re-open the prenatal program in July 2004. This item was for FY 04-05 only and did 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.

The FY 04-05 appropriation also included administrative funding of $6,455 from HB 04-1447, which provided funding for children who would no longer be eligible for Medicaid due to the implementation of SB 03-176, which would have eliminated Medicaid eligibility for optional legal immigrants. However, SB 03-176 was never implemented. Instead HB 05-1086 provided funding to continue Medicaid services to optional legal immigrants, and thus removed the appropriation from HB 04-1447.

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 Legal Immigrants	$6,455	$2,260	$4,195	$0	$4,195
HB 05-1086 Legal Immigrants Tobacco Tax	($6,455)	($2,260)	($4,195)	$0	($4,195)
Total Appropriation	**$4,325,385**	**$1,997,552**	$715,605	$1,612,228	**$2,327,833**

FY 05-06 Appropriation for Administration

For FY 05-06, the Department requested continuation funding of the FY 04-05 Long Bill appropriation reduced by the prenatal implementation costs of $144,178. HB 05-1262 increased funding to the line item by $1,000 for additional actuarial costs associated with increasing eligibility for families with incomes up to 200% of the federal poverty level. The bill also provided $1,300,000 for cost-effective marketing, and $95,000 for application redesign and reprinting associated with removing the Medicaid asset test. The following table shows the allocation of funding between Title XXI and Title XIX.

Children's Basic Health Plan Administrative Costs from SB 05-209 Long Bill	Total	Title XXI @ 65% Federal Funds	Title XIX @ 50% Federal Funds
Outreach and Client Education	$100,500	$77,687	$22,813
Eligibility Determination and Enrollment	$3,638,229	$436,587	$3,201,642
Prenatal Operational Costs	$125,478	$125,478	$0
Other Administration	$317,000	$317,000	$0
Total Children's Administration	**$4,181,207**	**$956,752**	**$3,224,455**
Federal Funds Match	$2,234,118	$621,890	$1,612,228
Cash Funds Exempt from Trust Fund	$1,947,089	$334,862	$1,612,227

HB 05-1262 (Tobacco Tax) increased funding to the line item by $1,000 for additional actuarial costs associated with increasing eligibility to families with incomes up to 200% of the federal poverty level. The bill also provided $1,300,000 for cost-effective marketing, and $95,000 for application redesign and reprinting associated with removing the Medicaid asset test. The following table shows the allocation of funding between Title XXI and Title XIX.

Children's Basic Health Plan Administrative Costs from HB 05-1262 Tobacco Tax	Total	Title XXI @ 65% Federal Funds	Title XIX @ 50% Federal Funds
Actuary Adjustment	$1,000	$1,000	$0
Cost Effective Marketing	$1,300,000	$1,004,900	$295,100
Application Redesign and Printing	$95,000	$11,400	$83,600
Total Children's Administration	**$1,396,000**	**$1,017,300**	**$378,700**
Federal Funds Match	$850,595	$661,245	$189,350
Cash Funds Exempt from the Health Care Expansion Fund	$545,405	$356,055	$189,350

The total FY 05-06 appropriation is shown below.

Bill Reference	Total Funds	Cash Funds Exempt	Title XXI Funds	Title XIX Funds	Total Federal Funds (Sum of Title XIX and XXI Funds)
SB 05-209 Long Bill	$4,181,207	$1,947,089	$621,890	$1,612,228	$2,234,118
HB 05-1262 Tobacco Tax	$1,396,000	$545,405	$661,245	$189,350	$850,595
Total Appropriation	**$5,577,207**	**$2,492,494**	**$1,283,135**	**$1,801,578**	**$3,084,713**

FY 06-07 Base Request

The FY 06-07 Base Request assumes continuation funding for administrative costs paid through the Children's Basic Health Plan Trust Fund totaling $4,181,207.

The Department's fiscal note for HB 05-1262 requested $100,000 in FY 06-07 for a cost allocation study. The cost allocation study is necessary to maintain a fair allocation of administrative expenses between Title XIX Medicaid and Title XXI SCHIP given the extensive programmatic changes implemented through HB 05-1262. The study will be performed in FY 06-07 using the actual experience from FY 05-06. The FY 06-07 Base Request also removes $55,000 for application redesign, and the one time funding of $1,000 for the actuary. The following table shows the allocation of these expenses between Title XIX and Title XXI.

FY 06-07 Children's Basic Health Plan Administration Base Request from Health Care Expansion Fund	Total	Title XXI @ 65% Federal Funds	Title XIX @ 50% Federal Funds
Cost Allocation Study	$100,000	$100,000	$0
Cost Effective Marketing	$1,300,000	$1,004,900	$295,100
Application Printing	$40,000	$4,800	$35,200
Total Children's Administration	**$1,440,000**	**$1,109,700**	**$330,300**
Federal Funds Match	$886,455	$721,305	$165,150
Cash Funds Exempt from the Health Care Expansion Fund	$553,545	$388,395	$165,150

The following table shows the annualization of HB 05-1262 and continuation funding from the FY 05-06 Long Bill (SB 05-209).

Bill Reference	Total Funds	Cash Funds Exempt	Title XXI Funds	Title XIX Funds	Total Federal Funds (Sum of Title XIX and XXI Funds)
SB 05-209 Long Bill (continuation funding requested)	$4,181,207	$1,947,089	$621,890	$1,612,228	$2,234,118
HB 05-1262 Tobacco Tax (annualization)	$1,440,000	$553,545	$721,305	$165,150	$886,455
Total Request	**$5,621,207**	**$2,500,634**	**$1,343,195**	**$1,777,378**	**$3,120,573**

CHILDREN'S BASIC HEALTH PLAN PREMIUM COSTS

This line item funds the costs of medical services provided to eligible children enrolled in the Children's Basic Health Plan and, beginning in FY 03-04, medical premiums for prenatal and delivery services for pregnant women. The calculations for the premium, presented each year in a footnote of the Long Bill, define the legislative intent for average monthly enrollment in the Plan and a monthly average rate for payment of provided medical services.

The Department establishes annual enrollment projections. Each year the actuary contracted by the Department recommends a per-member-per-month rate for health maintenance organizations and the self-insured network. The rate noted in the footnote of the Long Bill each year is a "blended" rate that is 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. This 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 funding for medical premiums is Cash Funds Exempt, appropriated from the Children's Basic Health Plan Trust Fund. Beginning in FY 05-06, the State share of funding includes the Health Care Expansion Fund which funds program expansions created in HB 05-1262, the Tobacco Tax. The federal share of funding is from Title XXI (State Children's Health Insurance Program). Title XXI provides a 65% match on State funds for medical premiums. 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 Premiums Costs 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.

Beginning in FY 05-06, HB 05-1262 provided funding from the Health Care Expansion Fund to increase eligibility in the Children's Basic Health Plan to families with incomes up to 200% of the federal poverty level. In addition, the bill removed the Medicaid asset test. These changes caused children previously enrolled in the Children's Basic Health Plan to become Medicaid eligible.

FY 01-02 Appropriation for Children's Basic Health Plan Premium Costs

The FY 01-02 Long Bill (SB 01-212) appropriated $35,281,378 for Children's Basic Health Plan Premium Costs. The Supplemental Bill (HB 02-1370) increased the appropriation to $36,116,890 for adjustments in the rate and caseload.

FY 02-03 Appropriation for Children's Premiums Costs

The FY 02-03 appropriation for the Premiums Costs 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.

The appropriation from HB 02-1155, the prenatal/delivery expansion bill is shown below. Since annual enrollment fees are not charged to families enrolled in the Prenatal and Delivery Program until they renew the following year, the Title XXI match was 65% exactly.

Breakdown of HB 02-1155 Premiums Costs 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 at $739,255.

In summary, below is the final appropriation for FY 02-03.

Appropriation for Children's Premiums Costs 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 Premiums Costs

In FY 03-04, the Children's Basic Health Plan Medical Premiums line item 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 Premiums Costs 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 titled "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. This request was not approved. As a result, new applicants were not accepted into the program between November 2003 and June 2004 so as not to exceed the appropriated caseload. 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 Premiums Costs for FY 03-04

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
SB 03-258 Long Bill	$74,589,396	$0	$0	$26,249,622	$48,339,774
SB 03-291, Children's Basic Health Plan Enrollment Cap Bill	($16,085,746)	$0	$0	($5,773,344)	($10,312,402)
SB 03-291 and SB 03-101 Savings (PERA Bill)	$761,503	$0	$0	$266,526	$494,977
SB 03-291 and SB 03-107 Savings (Greyhound Race Bill)	$1,228,503	$0	$0	$429,976	$798,527
SB 03-282 Tobacco Bill	$2,533,786	$0	$0	$886,825	$1,646,961
Final Appropriation	**$63,027,442**	**$0**	**$0**	**$22,059,605**	**$40,967,837**

FY 04-05 Appropriation for Premiums Costs

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 Budget Request (#DI-2) to adjust the appropriation 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 Premiums Costs from Figure Setting, March 9, 2004, page 122.

Calculations for Children's Premiums Costs	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

Calculations for Children's Premiums Costs	FY 04-05 Long Bill (HB 04-1422) Appropriation for Children's Program
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 calculations to get the total Long Bill appropriation for FY 04-05.

HB 04-1422 Long Bill

	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
Children's Medical Premiums	$51,933,503	$0	$0	$18,176,726	$33,756,777
Prenatal and Delivery Program	$6,768,205	$0	$0	$2,368,872	$4,399,333
Long Bill Appropriation for Children's Basic Health Plan Premium Costs	**$58,701,708**	**$0**	**$0**	**$20,545,598**	**$38,156,110**

HB 04-1447 increased the FY 04-05 appropriation to cover an additional 568 legal immigrants who were 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. HB 05-1086 provided funding from the Health Care Expansion Fund to continue providing Medicaid coverage to legal immigrants. The bill also reduced the

appropriation to the Children's Basic Health Plan Premium Costs line item by $441,871. The final appropriation for FY 04-05 is displayed in the table below.

Appropriation for Premium Costs for FY 04-05

Bill Reference	Total Funds	General Fund	Cash Funds	Cash Funds Exempt	Federal Funds
HB 04-1422 Long Bill	$58,701,708	$0	$0	$20,545,598	$38,156,110
HB 04-1447 (Children's Basic Health Plan Enrollment)	$309,855	$0	$0	$108,449	$201,406
HB 05-1086 (Tobacco Tax funding for Legal Immigrants in Medicaid)	($441,871)	$0	$0	($154,655)	($287,216)
Appropriation	**$58,569,692**	**$0**	**$0**	**$20,499,392**	**$38,070,300**

FY 05-06 Base Request for Premiums Costs

The FY 05-06 Long Bill (SB 05-209) 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 1, 2004 Budget Request (#DI-3) to adjust the appropriation for caseload and rate changes. The appropriation for the caseload is footnote 44 of SB 05-209. The following tables display the assumptions used to set the Long Bill appropriation for the Children's Basic Health Plan Premium Costs from Figure Setting, March 15, 2005, page 152.

Calculations for Children's Premiums Costs	FY 05-06 Long Bill (SB 05-209) Appropriation for Children's Program
HMO Benefits (per member per month)	**$97.74**
Components of Non-HMO Benefits (per member per month)	
A. Self-Insured Network (Non-HMO) Benefits	$80.00
B. Reinsurance	$2.47
C. Medical and Pharmacy Claims Management	$25.83
Total Non-HMO Benefit and Delivery Cost (per member per month)	**$108.30**
Appropriated, Blended Rate (per member per month)	**$101.44**
Average Monthly Enrollment	50,395

Calculations for Children's Premiums Costs	FY 05-06 Long Bill (SB 05-209) Appropriation for Children's Program
Subtotal Children's Medical Premiums	**$61,344,826**
Less annual enrollment fees	($160,256)
Total eligible for federal match	$61,184,570
Federal Funds Match @ 65%	**$39,769,971**
Cash Funds Exempt from the Children's Basic Health Plan Trust Fund (includes the expenditure of annual enrollment fees)	**$21,574,855**

Funding for the Prenatal and Delivery Program was appropriated in the FY 05-06 Long Bill (SB 05-209) using the following calculations.

	Calculations for Prenatal and Delivery	SB 05-209
1	Number of Deliveries	2,140
2	Rate per Delivery	$4,475.47
3	Total for Deliveries (row 1 x row 2)	$9,577,506
4	Member Months for Women	19,170
5	Rate per Member Month	$317.36
6	Total for Prenatal / Postpartum Care (row 4 x row 5)	$6,083,791
7	Total for Prenatal and Delivery Program (row 3 + row 6)	$15,661,297
8	Federal Funds at 65% match	$10,179,843
9	Cash Funds Exempt from the Trust Fund	$5,481,454

The total appropriation from the FY 05-06 Long Bill (SB 05-209) is $77,006,123, comprised of $61,344,826 for children and $15,661,297 the Prenatal and Delivery Program.

HB 05-1262 enacted the following programmatic changes that impact the Children's Basic Health Plan Premium Costs:

1. Removal of the asset test for Medicaid eligibility
2. Funding for cost effective marketing

3. Funding to increase eligibility for families with incomes from 185% to 200% of the federal poverty level (FPL).
4. Funding to increase enrollment above the FY 03-04 level

The following table summarizes the HB 05-1262 fiscal impact to the Children's Basic Health Plan Premium Costs line item for each of these provisions.

FY 05-06 HB 05-1262 Appropriation	Total Funds	Cash Funds Exempt Children's Basic Health Plan Trust Fund	Cash Funds Exempt Health Care Expansion Fund	Total Cash Funds Exempt	Federal Funds
Remove the Medicaid Asset Test	($18,335,889)	($6,417,561)	$0	($6,417,561)	($11,918,328)
Network Stabilization	$1,590,000	$0	$556,500	$556,500	$1,033,500
Children Expansion from 185% to 200% FPL	$5,168,571	$74,305	$1,782,993	$1,857,298	$3,311,273
Pregnant Women expansion from 185% to 200% FPL	$3,093,606	$0	$1,082,762	$1,082,762	$2,010,844
Prenatal and Delivery Costs above the FY 03-04 Level	$0	($4,874,843)	$4,874,843	$0	$0
Impact of marketing on children's enrollment growth	$4,194,470	$1,475,332	$0	$1,475,332	$2,719,138
Total Fiscal Impact	**($4,289,242)**	**($9,742,767)**	**$8,297,098**	**($1,445,669)**	**($2,843,573)**

The following table summarizes the total appropriation for FY 05-06.

Bill Reference	Total Funds	General Fund	Cash Funds	Total Cash Funds Exempt	Federal Funds
SB 05-209 Long Bill	$77,006,123	$0	$0	$27,056,309	$49,949,814
HB 05-1262 Tobacco Tax	($4,289,242)	$0	$0	($1,445,669)	($2,843,573)
Total FY 05-06 Appropriation	**$72,716,881**	**$0**	**$0**	**$25,610,640**	**$47,106,241**

For FY 06-07 the Base Request assumes continuation funding from SB 05-209 (FY 05-06 Long Bill) and the annualization of HB 05-1262 taken from the Department's fiscal note. The following table shows the FY 06-07 annualization of HB 05-1262.

FY 06-07 HB 05-1262 Annualization	Total Funds	Cash Funds Exempt Children's Basic Health Plan Trust Fund	Cash Funds Exempt Health Care Expansion Fund	Total Cash Funds Exempt	Federal Funds
Remove the Medicaid Asset Test	($32,464,208)	($11,362,473)	$0	($11,362,473)	($21,101,735)
Network Stabilization	$1,590,000	$0	$556,500	$556,500	$1,033,500
Children Expansion from 185% to 200% FPL	$6,467,746	$89,303	$2,232,455	$2,321,758	$4,145,988
Pregnant Women expansion from 185% to 200% FPL	$3,430,863	$0	$1,200,802	$1,200,802	$2,230,061
Prenatal and Delivery Costs above the FY 03-04 Level	$0	($7,090,154)	$7,090,154	$0	$0
Impact of marketing on children's enrollment growth	$12,563,412	$4,417,880	$0	$4,417,880	$8,145,532
Total Fiscal Impact	**($8,412,187)**	**($13,945,444)**	**$11,079,911**	**($2,865,533)**	**($5,546,654)**

The following table summarizes the Base Request for FY 06-07.

Bill Reference	Total Funds	General Fund	Cash Funds	Total Cash Funds Exempt	Federal Funds
SB 05-209 Long Bill	$77,006,123	$0	$0	$27,056,309	$49,949,814
HB 05-1262 Tobacco Tax annualization	($8,412,187)	$0	$0	($2,865,533)	($5,546,654)
Total FY 06-07 Base Request	**$68,593,936**	**$0**	**$0**	**$24,190,776**	**$44,403,160**

CHILDREN'S BASIC HEALTH PLAN DENTAL BENEFIT COSTS

In FY 01-02, the Department issued a Request for Proposals to provide dental services for all children enrolled in the Children's Basic Health Plan (pregnant women enrolled in the plan are excluded) at a capitated rate of $10.95 per member per month. This capitated rate assumed a dental benefit cost per eligible client 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 month per client (see March 15, 2001 Figure Setting, page 263). The Department selected the vendor who offered the most complete dental benefit package and established a $500

yearly maximum benefit per client, and a statewide network with several hundred participating dentists and contracts with Essential Community Providers. The capitated rate was increased to $11.31 per member per month in the FY 04-05 Long Bill (HB 04-1422) appropriation and increased again to $11.82 in the FY 05-06 Long Bill (SB 05-209). These increases were based on an actuarial review of historical costs. As is the case with Children's Basic Health Plan Premium Costs, Title XXI funds provide 65% of the total funding need for the Children's Basic Health Plan Dental Benefits Costs, 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 who work with 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. 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 five months of care.

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, which also covered increased enrollment in the program. 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.

A supplemental for FY 02-03, via a SB 03-258 Long Bill Add-on, increased the caseload for the Children's Basic Health Plan by 763 children. The dental benefit appropriation was increased accordingly.

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

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. The final appropriation was $7,564,917.

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 Budget Request for Stand Alone Budget Amendments. 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 because new members do not receive dental coverage during their pre-HMO enrollment period.

HB 04-1447 increased funding to cover 568 additional legal immigrants who were anticipated to no longer be covered under Medicaid due to the implementation of SB 03-176 that was planned for January 1, 2005. HB 04-1447 increased average monthly caseload by 284 (calculated as follows: 568 additional legal immigrants multiplied by six months and divided by 12 months).

HB 05-1086 provided funding from the Health Care Expansion Fund to Medical Services Premiums to provide coverage for legal immigrants. The bill also reversed the appropriation from HB 04-1447 and further reduced the average monthly caseload by 105. (calculated as follows: 242 multiplied by 87%, multiplied by six months and divided by 12 months. Some rounding is involved).

FY 04-05 Dental Appropriation	HB 04-1422 Long Bill	HB 04-1447	HB 05-1086	HB 05-1086	FY 04-05 Appropriation
Average Monthly Caseload	41,412	284	(284)	(105)	41,307
Monthly Dental Costs Per Enrollee	$11.31	$11.31	$11.31	$11.31	$11.31
Total Dental Costs for Additional Caseload	$5,620,437	$38,544	($38,544)	($14,287)	$5,606,150
Federal Funds @ 65%	$3,653,284	$25,053	($25,053)	($9,287)	$3,643,997
Cash Funds Exempt from Trust @ 35%	$1,967,153	$13,491	($13,491)	($5,000)	$1,962,153

FY 05-06 Appropriation

The Department submitted a Change Request in the November 1, 2004 Budget Request (#DI-3) to adjust the appropriation for caseload and rate changes. The FY 05-06 rate was developed by a contracted actuary. The caseload used in the FY 05-06 Long Bill

dental appropriation was assumed to be 87% of the children's caseload assumed in the Children's Basic Health Plan's Premium Costs Long Bill appropriation. The appropriation for the Children's Basic Health Plan Premium Costs caseload is in footnote 44 of SB 05-209 (the Long Bill). The following tables display the assumptions used to set the Long Bill appropriation for the Children's Basic Health Plan Dental Benefit Costs from Figure Setting, March 15, 2005, page 155.

FY 05-06 Long Bill Appropriation	SB 05-209
Average Monthly Caseload	43,844
Monthly Dental Costs Per Enrollee	$11.82
Total Dental Costs for Additional Caseload	$6,218,783
Federal Funds @ 65%	$4,042,209
Cash Funds Exempt from Trust @ 35%	$2,176,574

*Some rounding is involved.

HB 05-1262 Tobacco Tax enacted four significant programmatic changes that impact the Children's Basic Health Plan Dental Benefit Costs. These are: 1) Removal of the Medicaid asset test, 2) Funding for cost effective marketing, 3) Funding to increase eligibility from 185% to 200% of the federal poverty level and, 4) Funding to increase enrollment above the FY 03-04 level. The bill also increased the Cash Funds Exempt appropriation from the Health Care Expansion Fund and decreased the Cash Funds Exempt appropriation from the Children's Basic Health Plan Trust Fund. The FY 05-06 appropriation from HB 05-1262 (Tobacco Tax) and SB 05-209 (Long Bill) were both set assuming a per member, per month rate of $11.82. This amount was recommended by a contracted actuary.

FY 05-06 Appropriation	Average Monthly Enrollment	Total Funds	Cash Funds Exempt Children's Basic Health Plan Trust Fund	Cash Funds Exempt Health Care Expansion Fund	Total Cash Funds Exempt	Federal Funds
SB 05-209 Long Bill	43,844	$6,218,783	$2,176,574	$0	$2,176,574	$4,042,209
HB 05-1262 Medicaid Asset test	(13,105)	($1,858,813)	($650,585)	$0	($650,585)	($1,208,228)
HB 05-1262 CBHP to 200% FPL	3,694	$523,957	$0	$183,385	$183,385	$340,572
HB 05-1262 Marketing	3,059	$433,888	$151,861	$0	$151,861	$282,027

FY 05-06 Appropriation	Average Monthly Enrollment	Total Funds	Cash Funds Exempt Children's Basic Health Plan Trust Fund	Cash Funds Exempt Health Care Expansion Fund	Total Cash Funds Exempt	Federal Funds
HB 05-1262 Network Stabilization	0	$200,000	$0	$70,000	$70,000	$130,000
Final Appropriation	**37,492**	**$5,517,815**	**$1,677,850**	**$253,385**	**$1,931,235**	**$3,586,580**

FY 06-07 Base Request

The FY 06-07 Base Request assumes continuation funding from the FY 05-06 Long Bill (SB 05-209) and annualizes HB 05-1262 (Tobacco Tax) based on the Department's fiscal note. The table below builds to the FY 06-07 base request.

FY 06-07 Base Request Including the Annualization of HB 05-1262	Total Funds	Cash Funds Exempt Children's Basic Health Plan Trust Fund	Cash Funds Exempt Health Care Expansion Fund	Total Cash Funds Exempt	Federal Funds
SB 05-209 Long Bill	$6,218,783	$2,176,574	$0	$2,176,574	$4,042,209
HB 05-1262 Medicaid Asset test	($3,291,792)	($1,152,127)	$0	($1,152,127)	($2,139,665)
HB 05-1262 CBHP to 200% FPL	$655,877	$0	$229,557	$229,557	$426,320
HB 05-1262 Marketing	$1,286,050	$450,118	$0	$450,118	$835,932
HB 05-1262 Network Stabilization	$200,000	$0	$70,000	$70,000	$130,000
Final Base Request	**$5,068,919**	**$1,474,565**	**$299,557**	**$1,774,122**	**$3,294,797**

STATE-ONLY PRENATAL PROGRAM

This temporary program was authorized under SB 03-291 only for FY 03-04. It was in response to constraints of the federal demonstration waiver for the Children's Basic Health Plan Prenatal and Delivery Program that prevented the program from serving pregnant women if their children's enrollment or benefits were restrained. Further, new enrollment was entirely discontinued in the

Children's Basic Health Plan Prenatal and Delivery Program in May 2003 and the program was completely suspended on November 1, 2003 so that a cap on new enrollment for children could be put in place. Thus, from May 2003 through June 2004, the Children's Basic Health Plan Prenatal and Delivery Program had no new enrollees. However, women who were enrolled in the program at that time remained covered for their deliveries and prenatal/postpartum care. 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 were as follows.

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. Initial estimates for SB 03-291's fiscal note had assumed that new enrollment in the Children's Basic Health Plan 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 Prenatal and Delivery Program in November 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 for FY 05-06. There is no request for FY 06-07.

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, and 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. SB 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 receives 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 monies 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 to appropriate to the fund shall not exceed six million dollars in any fiscal year." HB 04-1421 decreased the maximum appropriated funds to 3% of the total monies, not to exceed 5 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 five 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**	**FY 06-07 Base Request**
Prior Year Appropriation						$2,668,034
Long Bill Appropriation	$5,191,389	$5,939,047	$5,939,047	$5,239,789	$2,668,034	
HB 02-1370 Supplemental Appropriation	($34,857)	$0	$0	$0	$0	$0
SB 03-190 Tobacco Reallocation	$0	($679,130)	$0	$0	$0	$0
SB 03-019 Allocation for State Auditor's Fees	$0	$0	($7,942)	$0	$0	$0
SB 03-282 Tobacco Reallocation	$0	$0	($508,494)	$0	$0	$0

Appropriation History for Comprehensive Primary and Preventive Care Fund						
	FY 01-02	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
HB 04-1331 Department of Public Health and Environment Supplemental	$0	$0	($3,566)	$0	$0	$0
HB 04-1421 Tobacco Reallocation	$0	$0	$0	($2,621,120)	$0	$0
SB 05-249 Allocation of Tobacco Settlement	$0	$0	$0	$961	$0	$0
SB 05-209 Add-on	$0	$0	$0	($40,936)	$0	$0
Tobacco Reallocation and Auditor Adjustment	$0	$0	$0	$0	$0	$10,031
Total	**$5,156,532**	**$5,259,917**	**$5,419,045**	**$2,578,694**	**$2,668,034**	**$2,678,065**

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. The amount of $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. SB 03-019 and SB 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 Appropriation 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. As a result, the FY 04-05 appropriation was reduced to $2,618,669.

Subsequently in 2005, the FY 04-05 appropriation was reduced by $40,936 by SB 05-209 and increased by $961 by SB 05-249. The final FY total 04-05 appropriation was $2,578,694. The appropriation for 05-06 is $2,668,034.

The FY 06-07 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 2005. The initial estimate for the Comprehensive Primary and Preventive Care Fund is $2,678,065, which includes reductions for audit and Department of Public Health and Environment services. Therefore, the Department's request for FY 06-07 is $2,678,065, 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 $38,700 for a family of four in 2005). 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.

History for the Comprehensive Primary and Preventive Care Grants Program

	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Total Number of Active Grants	18	21	16	13	7	2
Total Number of Providers	14	14	10	9	5	2
Type of Grants						
Medical Services Only	8	9	8	8	4	2
Dental Services Only	1	3	4	1	0	0
Mental Health Services Only	0	0	0	1	1	0
Medical and Dental Services	1	0	1	0	1	0
Construction and/or Equipment Only	5	6	1	2	0	0
Construction and Medical Services	1	1	0	0	0	0
Construction and Dental Services	2	1	0	0	0	0
Construction, Medical and Dental Services	0	1	0	0	0	0
Construction and Mental Health Services	0	0	1	0	0	0
Medical and Mental Health Services	0	0	1	1	1	0
Total Amount of Awarded Active Grants	$4,965,304[1]	$5,018,980	$2,244,900	$2,532,508	$827,808	$195,152
Total Amount Awarded for Future						

	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
Years						
FY 03-04	$2,166,498	N/A	N/A	N/A	N/A	N/A
FY 04-05	$1,190,170	$1,340,170	N/A	N/A	N/A	N/A
FY 05-06	N/A	$100,000	$547,097	N/A	N/A	N/A
FY 06-07	N/A	N/A	$298,842	$827,808	N/A	N/A
FY 07-08	N/A	N/A	N/A	$195,152	$195,152	N/A
Number of Patients Receiving Medical Services	12,607	15,400	10,010	3,724	2,252	821
Number of Medical Visits	33,094	41,000	22,534	10,848	6,568	2,121
Number of Patients Receiving Dental Services	3,000	5,500	5,525	60	150	0
Number of Dental Visits	8,369	10,500	9,596	96	375	0
Number of Patients Receiving Mental Services	N/A	N/A	76	125	125	0
Number of Mental Visits	N/A	N/A	679	1,043	1,043	0

[1] This amount reflects the decrease in appropriations to tobacco settlement-funded programs that occurred during the 2003 legislative session.

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 in FY 04-05 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 15,400 and 5,500 patients respectively.

In FY 04-05, 16 grants were awarded to ten unique providers. Multiple year grants were awarded in FY 04-05 that reserved $547,097 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 $647,097 ($100,000 from FY 03-04 contracts plus $547,097 from FY 04-05 contracts). Medical and dental services were provided in 04-05 to an estimated 10,010 and 10,500 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. This methodology was changed for the FY 06-07 column.

Appropriation History for Comprehensive Primary and Preventive Care Grants Program						
	FY 01-02	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07 Base Request**
Prior Year Appropriation						$2,668,034
Long Bill Appropriation	$5,191,389	$5,939,047	$5,939,047	$5,239,789	$2,668,034	
HB 02-1370 Supplemental Appropriation	($34,857)	$0	$0	$0	$0	$0
SB 03-190 Tobacco Reallocation	$0	($679,130)	$0	$0	$0	$0
SB 03-019 Allocation for State Auditor's Fees	$0	$0	($7,942)	$0	$0	$0
SB 03-282 Tobacco Reallocation	$0	$0	($508,494)	$0	$0	$0
HB 04-1331 Department of Public Health and Environment Supplemental	$0	$0	($3,566)	$0	$0	$0
HB 04-1421 Tobacco Reallocation	$0	$0	$0	($2,621,120)	$0	$0
SB 05-249 Allocation of Tobacco Settlement	$0	$0	$0	$961	$0	$0
SB 05-209 Add-on	$0	$0	$0	($40,936)	$0	$0
Tobacco Reallocation and Auditor Adjustment	$0	$0	$0	$0	$0	$10,031
Total	**$5,156,532**	**$5,259,917**	**$5,419,045**	**$2,578,694**	**$2,668,034**	**$2,678,065**

PRIMARY CARE FUND

The Primary Care Fund was created in 2005 in section 24-22-117, C.R.S. This fund receives Cash Fund Exempt transfers equal to 19% of the Tobacco Tax revenue from Amendment 35. The Department allocates the monies appropriated to the fund by the General Assembly to qualified providers. This allocation is based on the qualified provider's percent of uninsured or medically indigent patients relative to the total of uninsured or medically indigent patients served by all qualified providers. Qualified providers must meet either of the following criteria:

- Be a Community Health Center as defined under Section 330 of the Public Health Services Act 42 U.S.C. SEC. 254b or
- 50% of total patients served are uninsured, medically indigent or are patients enrolled in the Medicaid or the Children's Basic Health Plan.

FY 05-06 Appropriation

HB 05-1262 appropriated $44,099,000 of Cash Funds Exempt to the Primary Care Fund and 1.0 FTE. $44,000,000 is to be distributed to qualified providers and $99,000 is for personal services and operating expenses related to the 1.0 FTE. These expenditures do not receive a federal match. At this time, distributions are expected to occur in February 2006.

FY 06-07 Base Request

The FY 05-06 appropriation includes revenue collections for January through June 2005, as well as for FY 05-06. Revenues are projected to decline in future years with the decline in tobacco use. The FY 06-07 Base Request is $31,825,000 in Cash Funds Exempt based on a March 2005 Legislative Council Staff revenue forecast found on page 6 of the April 25, 2005, Joint Budget Committee Staff analysis for HB 05-1262. The Base Request for FY 06-07 reduces the FTE for the Primary Care Fund to 0.5.

(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 these 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 is not sufficiently disabled to qualify for Supplemental Security Income. This Old Age Pension State Medical Program is funded through the $10 million Old Age Pension Health and Medical Care Fund established in the State's constitution (article 24) and Colorado Revised Statutes (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. During FY 04-05 Figure Setting,[15] the Joint Budget Committee combined the two funding sources into a single line item for FY 04-05 for a total of $10,750,000. The FY 05-06 appropriation from SB 05-209 continued funding at this level. This program is 100% State-funded and is not an entitlement. Thus, the authorized cap cannot be exceeded.

HB 05-1262 (the tobacco tax) allocates 3% of the tobacco revenue generated through Amendment 35 to the Cash Fund for Health Related Purposes. HB 05-1262 also provides that 50% of the Cash Fund for Health Related Purposes is to be annually appropriated by the General Assembly to the Supplemental Old Age Pension Health and Medical Fund. The appropriations clause for HB 05-1262 increased funding to the Supplemental Old Age Pension Health and Medical Fund by $943,500 in FY 04-05 and by $2,538,000 in FY 05-06. However, the bill's appropriation's clause does not increase the spending authority within the Old Age Pension State Medical Program line item. Therefore, a budget action will be necessary for the Department to spend these funds in FY 05-06. Until such time, the funds will remain in the Supplemental Old Age Pension Health and Medical Fund.

History of Program[16]

The Old Age Pension was established in 1936 by an amendment to the State constitution, creating article XXIV. This article was amended in 1956 to add the Health and Medical Care Program and Fund in section 7. 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 is not a patient in an institution for tuberculosis or mental disease. Specified sources of General Fund, (primarily excise taxes) must be earmarked to cover the costs of Old Age Pension benefits. As previously noted, 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

[15] Page 139 Figure Setting March 9, 2004

[16] Source of this paragraph is the Office of Legislative Legal Services, February 7, 2003, in a letter to Senator Steve Johnson.

have statutory authority to administer the Old Age Pension, 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." This is in line with the FY 05-06 Long Bill, SB 05-209.

History of Program Administration

Prior to FY 02-03, the appropriation for the Old Age Pension State Medical Program was made directly from the Old Age Pension Health and Medical Care Fund to the Department of Health Care Policy and Financing. At that time the Department also handled program administration. Upon review, it was determined by the Department of Health Care Policy and Financing and the Department of Human Services that this was in conflict of 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 the Department of Health Care Policy and Financing. This is documented in letternote "a" on page 60 of HB 02-1420 (FY 02-03 Long Bill).

Under an Interagency Agreement in FY 02-03, the Department of Health Care Policy and Financing's responsibilities for this appropriation were changed to process claims, produce Medicaid Authorization Cards 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 the Department of Health Care Policy and Financing in the amount of $146,867 for various administrative costs, 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 Long Bill group was not necessary for the payment of claims, but did allow the dollars to be tracked in the Department of Health Care Policy and Financing budget. However, the presence of the state only non-Medicaid program in the Medical Services Premiums created some confusion. SB 03-022 transferred the Old Age Pension State Medical Program, created in section 26-2-117 (2), C.R.S. (2005), from the Department of Human Services to the Department of Health Care Policy and Financing effective July 1, 2003.

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 "Other Medical Services" Long Bill group is more suitable than Medical Services Premiums for three main reasons: 1) this is a non-Medicaid program; 2) this program is not subject to over expenditure authority; and, 3) this program is not affected by the cash accounting changes authorized in SB 03-196.

The growing demand for health care services by this client population caused the program to nearly 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. In FY 04-05, spending projections indicated that the appropriation would not be fully utilized. Consequently, actions were taken to increase reimbursement rates in October 2004 and again in July 2005.

Following is a summary of actions taken since FY 99-00 to contain costs for the Old Age Pension State Medical Program:

- Effective October 1, 1999, inpatient 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, (e.g., payments for practitioners and outpatient services) were reduced to 80% of the Medicaid rate and the maximum client co-payment was increased from $100 to $300 per year.
- Effective July 1, 2002, most providers in the Old Age Pension State Medical Program were reimbursed at 82% of the Medicaid rate. The two exceptions to this reimbursement rate were pharmacists who were paid at the Medicaid reimbursement rate, and inpatient hospitals that 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 FY 02-03 rates were 18% lower than FY 01-02 rates.
- Effective August 30, 2002, Old Age Pension State Medical Program 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 for Old Age Pension State Medical Program clients. In addition, all provider reimbursement rates for outpatient hospital, outpatient clinic, practitioner/physician services, emergency dental, laboratory, medical supply, home health, and transportation services were decreased from 82% to 50% of the Medicaid rate. Pharmacists were paid at the Medicaid reimbursement rate.
- Effective October 15, 2004, the reimbursement rate for physician and practitioner services, emergency transportation, medical supplies, hospice services, and home health care services and supplies were restored to 82% of the Medicaid rate. In addition, the inpatient hospital benefit was restored to those hospitals participating in the Colorado Indigent Care Program and limited to only those inpatient services available under the Colorado Indigent Care Program. The reimbursement rate for inpatient benefits was set at 10% of the Medicaid reimbursement rate.
- Effective July 15, 2005, the reimbursement rate was increased from 82% of the Medicaid rate to 100% of the Medicaid rate for the following expenditure categories: practitioner/ physician services, medical supplies, home health care services and supplies and transportation. Additionally, the reimbursement rate was increased from 50% of the Medicaid rate to 100% of the Medicaid rate for dental and independent laboratory claims. Finally, outpatient claims reimbursement was increased from 50% to 62% of the Medicaid rate.

Administrative Costs Affecting this Line Item

The appropriation has also been affected by changes in the way administrative costs have been handled for the Old Age Pension State Medical Program. Medical provider claims for Old Age Pension State Medical Program clients have historically been processed through the Medicaid Management Information System. To cover these 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. Historically, the Cash Funds Exempt amount appropriated was $146,867 and remained at that amount for several years. From FY 98-99 to FY 02-03, the full appropriation was not expended. In FY 02-03, the Department of Human Services submitted a Supplemental Request[17] to refinance administrative costs to allow more of the $10,750,000 appropriation to be used for medical services instead of claims processing by the Medicaid Management Information System. Effective July 1, 2003, via SB 03-258, this cost was funded directly from the Old Age Pension Fund. It does not result in a corresponding reduction to the Old Age Pension State Medical Program.

Another administrative cost for this program area is the issuance of Medical Identification Cards. These cards are provided to Old Age Pension State Medical Program clients, allowing medical providers to check client identification and eligibility for services. No Cash Funds Exempt was appropriated in the years prior to FY 03-04 to cover this administrative cost. However, beginning with FY 03-04, $10,656 was appropriated from the Old Age Pension State Medical Program to do so. 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 identification cards. The FY 05-06 Long Bill (SB 05-209) included a continuation of funding in the amount of $1,517 for this administrative cost. The FY 06-07 Base Request assumes continuation funding of this amount for Medical Identification Cards.

See the table below for a history of administrative costs funded through the Old Age Pension Health and Medical Care Fund.

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	$679
FY 04-05	$0	$0	$1,517	N/A
FY 05-06	$0	$0	$1,517	N/A

[17]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."

Caseload History

The table below delineates the caseload history for this program since FY 90-91. The program's caseload fluctuated over the years, but has risen steadily since FY 02-03. For informational purposes the Department has forecasted caseload for FY 05-06 and FY 06-07 based on the average annual growth from FY 02-03 to FY 04-05.

Old Age Pension State Medical Program Caseload History and Projection			
Year	**Caseload**	**% Change**	**Source**
FY 90-91 Actual	3,586		February 14, 2003 Budget Request, Exhibit B, "Caseload History and Projections with Rates of Change"
FY 91-92 Actual	3,540	-1.28%	
FY 92-93 Actual	3,446	-2.66%	
FY 93-94 Actual	3,011	-12.62%	
FY 94-95 Actual	3,056	1.49%	
FY 95-96 Actual	3,150	3.08%	
FY 96-97 Actual	3,152	0.06%	
FY 97-98 Actual	3,215	2.00%	
FY 98-99 Actual	3,150	-2.02%	
FY 99-00 Actual	3,066	-2.67%	Business Objects America Queries ran on 7/1/04
FY 00-01 Actual	3,212	4.76%	
FY 01-02 Actual	3,782	17.75%	
FY 02-03 Actual	3,794	0.33%	Average of monthly figures gathered from COLD MARS R4600 Reports
FY 03-04 Actual	4,261	11.73%	
FY 04-05 Actual	4,766	12.44%	
FY 05-06 Projection	5,343	12.09%	Average annual grow from FY 02-03 to FY 04-05 12.09%=(11.73%+12.44%)/2
FY 06-07 Projection	5,989	12.09%	

Despite the outcome of caseload forecasts, the Department will manage the appropriation in accordance with statutory and constitutional expectations. Reductions may be made in the scope of services to ensure that the appropriation is not exceeded.

Expenditure History and Request

The following table delineates historical expenditures and includes the appropriation for FY 05-06. 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 the table entitled Old Age Pension State Medical Program Reductions for Administration Costs.

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	3,794	$2,832.38
FY 03-04 Actual	$11,447,158	($700,984)	$10,746,174	4,261	$2,521.98
FY 04-05 Actual	$10,923,336	($924,015)	$9,999,321	4,766	$2,098.05
FY 05-06 Appropriation	N/A	N/A	$10,748,483	4,829	$2,011.69
FY 06-07 Base Request	N/A	N/A	$13,260,983	5,989	$2,214.22

The FY 06-07 Base Request continues to be the maximum allowed under current law, minus the administrative costs of the Medical Identification Cards. The Base Request assumes that the appropriation will be increased by the amount of tobacco tax revenue annually allocated to the Supplemental Old Age Pension Health and Medical Care Fund from the Cash Fund for Health Related Purposes. In FY 05-06, HB 05-1262 (Tobacco Tax) appropriated an additional $2,583,000 to the Fund. Revenue forecasts from March 2005 (Legislative Council Staff) project revenues to decrease slightly in FY 06-07. The funding for FY 06-07 is estimated at $2,512,500. Therefore, the FY 06-07, Base Request is $13,260, 983 ($10,748,483+$2,512,500).

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 that provides direct payments (subject to available appropriations) to eligible individuals 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 placement. It is a non-Medicaid program. Section 25.5-1-201, C.R.S. (2005) authorizes the Department of Health Care Policy and Financing to administrator the Home Care Allowance Program.

Eligibility for the program is determined as follows. A Single Entry Point case manager assesses if the client meets the functional need for the program and ascertains the monthly amount necessary for the services the client needs in order to remain in the home. A county eligibility technician enters data into the Colorado Benefits Management System which determines if the client is financially eligible and, if so, how much the client is entitled to receive based on his or her income. The income limits depend on the standard of

need category and the authorized Home Care Allowance amount. Home Care Allowance payments currently range from $1 per month to a maximum of $439.15 per month, depending on the client's income; however, 26-2-122.3 (1) (b), C.R.S. (2005) allows for the amounts paid to eligible persons to be adjusted as necessary and managed within the funds appropriated by the General Assembly. The Department of Human Services maintains the Volume III Regulations that limit access to the Home Care Allowance program based on the need standard.

Approved payments are sent out by the county offices through the Department of Human Services. The Department of Health Care Policy and Financing 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 previous year. The local funding match is calculated at the lower of either the prior year local match x 5% or the base recommendation x 5% as per Section 26-4-525 (1) (c), C.R.S. (2005).

Below is the appropriation history since FY 99-00.

Line Item: Home Care Allowance Appropriation History	Total Funds	General Fund	Cash Funds Exempt
FY 05-06 Long Bill SB 05-209	**$10,880,411**	**$10,336,390**	**$544,021**
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

Line Item: Home Care Allowance Appropriation History	Total Funds	General Fund	Cash Funds Exempt
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), adjustment to the Home Care Allowance appropriation was primarily the result of Change Requests. These Change Requests were based on recent experience, and aimed at adjusting for changes to caseload numbers or in the average monthly payment. 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 meet this reduction, a freeze on new enrollment was implemented on July 1, 2002. Due to the 45-day timeframe for processing applications, this freeze on enrollment had no real impact until September 2002 at which time the freeze reduced program enrollment. This compounded the already declining caseload for Home Care Allowance that was sparked by the recent rise in Medicaid Home and Community Based Services. Home Care Allowance expenditures were monitored throughout FY 02-03 to assess the status of budget reductions. In December 2002, it was determined that the enrollment freeze was not achieving the results originally anticipated, partially due to the later than anticipated affect of the enrollment freeze. To meet the reduced appropriation, the Department of Health Care Policy and Financing 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 for FY 02-03 totally $258,779 belonged to the Department of Health Care Policy and Financing. These were credited back to the program's appropriation in the Colorado Financial Reporting System during Period 13. Due to the reduction in payments to clients and the credited 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 as follows: $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 clients and an average monthly payment per client 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. This was due

to the continuing decline in caseload. However, the request was denied due to concerns related to the Maintenance of Effort agreement the State has with the federal Social Security Administration which 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 risk the federal match for all Medicaid programs. 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).

As a result of the FY 04-05 appropriation the Department lifted the enrollment cap effective September 2004. It was anticipated that enrollment growth alone would be insufficient to fully expend the appropriation by the end of the fiscal year. Consequently, in addition to removing the enrollment cap, the Department increased the Home Care Allowance payments by $36.15 per member per month beginning in December 2004. Unfortunately, due to the conversion to the Colorado Benefits Management System, the Department of Human Services was unable to report enrollment and expenditure data from September 2004 through February of 2005. When reporting was resumed it was discovered that enrollment in the Home Care Allowance Program had not grown as fast as anticipated, thus causing an under expenditure in FY 04-05.

The FY 05-06 Long Bill appropriation was set at the same level as the FY 04-05 Long Bill.

The table delineates the actual historical caseload and expenditures, followed by the appropriation for FY 05-06 and the Base Request for FY 06-07.

Home Care Allowance	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05***
Caseload	5,852	5,757	5,642	5,060	4,052	3,461
Average Monthly Payment	$223.72	$226.52	$226.35	$206.74	$215.32	$253.07
Long Bill Appropriation	$16,762,152	$16,475,675	$16,119,094	$15,391,151	$12,712,406	$10,880,411
Supplemental	($609,544)	($650,695)	($727,943)	($2,363,745)	($1,831,995)	$0
Reversion	($442,169)	($176,303)	($66,857)	($474,041)	($410,930)	($369,827)
Total Funds (Actuals)	$15,710,439	$15,648,677	$15,324,294	$12,553,365	$10,469,481	$10,510,584
General Fund	$14,929,172	$14,866,361	$14,558,079	$11,925,697	$9,945,080	$9,985,055
Cash Funds Exempt (Local)	$781,267	$782,316	$766,215	$627,668	$524,401	$525,529

* Caseload and average monthly payment information was not available for several months during FY 04-05. The Caseload and Average Monthly Payment information displayed here is from May 2005. The FY 04-05 reversion is an estimate based on the payable booked at the end of FY 04-05.

Home Care Allowance	FY 05-06 Appropriation	FY 06-07 Base 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 for adults. 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 clients' 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 also receive either Supplemental Security Income or Old Age Pension. The only additional requirement is that the client meets the appropriateness of placement screening as determined by a Single Entry Point case manager. A county eligibility technician determines financial eligibility for Adult Foster Care clients.

The funding split calculation for Adult Foster Care 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. (2005) provides that the local funding match is calculated as the lower of either the prior year local match x 5% or the base recommendation x 5%.

Line Item: Adult Foster Care Appropriation History	Total Funds	General Fund	Cash Funds Exempt
FY 99-00 Long Bill SB 99-215	$548,841	$521,498	$27,343
FY 99-00 Supplemental HB 00-1400	($87,710)	($83,424)	($4,286)
FY 99-00 Final Appropriation	**$461,131**	**$438,074**	**$23,057**
FY 00-01 Figure Setting March 6, 2000 (page 174)	($26,021)	($24,720)	($1,301)
FY 00-01 Long Bill HB 00-1451	$435,110	$413,354	$21,756
FY 00-01 Supplemental SB 01-183	($91,585)	($87,006)	($4,579)
FY 00-01 Final Appropriation	**$343,525**	**$326,348**	**$17,177**

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 01-02 Long Bill SB 01-212	$363,469	$345,296	$18,173
FY 01-02 Supplemental HB 02-1370	($119,660)	($113,677)	($5,983)
FY 01-02 Final Appropriation	**$243,809**	**$231,619**	**$12,190**
FY 02-03 Long Bill HB 02-1420	$243,810	$231,620	$12,190
FY 02-03 Final Appropriation	**$243,810**	**$231,620**	**$12,190**
FY 03-04 Long Bill SB 03-258	$243,810	$231,620	$12,190
FY 03-04 Supplemental HB 04-1320	($86,341)	($82,024)	($4,317)
FY 03-04 Final Appropriation	**$157,469**	**$149,596**	**$7,873**
FY 04-05 Long Bill HB 04-1422	**$157,469**	**$149,596**	**$7,873**
FY 05-06 Long Bill SB 05-209	**$157,469**	**$149,596**	**$7,873**

The Adult Foster Care caseload has been in a steady decline since FY 99-00. This is due to most clients moving to alternative care facilities, where the reimbursement rate is higher than it is for Adult Foster Care. Because of 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 denied due to concerns related to the Maintenance of Effort agreement the State has with the federal Social Security Administration which 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 risk the federal match for all Medicaid programs. For this reason, the FY 04-05 appropriation was left unchanged at $157,469 (see March 9, 2004 Figure Setting page 144).

In an effort to manage the FY 04-05 appropriation the Department increased the Adult Foster Care Payments by $70.69 per member per month beginning in December, 2004. Unfortunately, due to conversion to the Colorado Benefits Management System, the Department of Human Services was unable to report enrollment and expenditure data from September 2004 through February of 2005.

When reporting was resumed it was discovered that enrollment had continued to decline despite the increase in payments, thus causing an under expenditure in FY 04-05.

The FY 05-06 Long Bill appropriation was set at the same level as the FY 04-05 Long Bill.

The table delineates the actual historical caseload and expenditures, followed by the appropriation for FY 05-06 and the Base Request for FY 06-07.

Adult Foster Care	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05*
Caseload	165	122	87	73	57	27
Average Monthly Payment	$218.92	$222.23	$224.66	$219.52	$227.93	$377.72
Long Bill Appropriation	$548,841	$435,110	$363,469	$243,810	$243,810	$157,469
Supplemental Bill Adjustment	($87,710)	($91,585)	($119,660)	N/A	($86,341)	N/A
Reversion	($27,672)	($18,175)	($9,268)	($51,514)	($1,567)	($35,087)
Total Funds (Actuals)	$433,459	$325,350	$234,541	$192,296	$155,902	$122,382
General Fund	$411,658	$309,082	$222,814	$182,681	$148,107	$116,263
Cash Funds Exempt (Local)	$21,801	$16,268	$11,727	$9,615	$7,795	$6,119

* Caseload and average monthly payment information was not available for several months during FY 04-05. The Caseload and Average Monthly Payment information displayed here is from May 2005. The FY 04-05 reversion is an estimate based on the payable booked at the end of FY 04-05.

Adult Foster Care	FY 05-06 Appropriation	FY 06-07 Base Request
Caseload	58	25
Average Monthly Payment	$226.25	$524.90
Appropriation/ Starting Base	$157,469	$157,469
General Fund	$149,596	$149,596
Cash Funds Exempt (Local)	$7,873	$7,873

Caseload continued to decline in FY 04-05 as clients moved to alternative care facilities where reimbursement rates are higher. Although the FY 05-06 appropriation assumes a caseload of 58, it is unlikely that caseload will rise to this level. The FY 06-07 Base Request assumes caseload will stabilize at 25 clients. The Department is not requesting a reduction in appropriation as spending against this line item helps to satisfy the Maintenance of Effort Agreement with the federal Social Security Administration. The

Department may increase reimbursement levels to provide an incentive for clients to stay in the program and to fully expend the appropriation.

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 that indicated that this was the average market rate for primary care physicians. Forty of the fifty states responded to this survey indicating 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. Accordingly, this line was renamed "Primary Care Physician Program Market Rate Reimbursement" between Figure Setting and the Long Bill appropriation. A Department report to the Joint Budget Committee, submitted October 1, 2001 addressed Footnote #59 of SB 01-212 and verified that $3.00 was still the market rate at that time.

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 Schedule 3.

The appropriation remained level at $1,949,508 in FY 03-04. Historical appropriation for this line item is as follows:

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

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 was no request for FY 05-06 and there is none for FY 06-07.

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. Currently, there is one clinic and nine hospitals participating in the program.

The following table and subsequent narrative 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**	**FY 06-07 Base Request**
Previous Fiscal Year Final Appropriation	$1,905,782	$1,524,626	$1,449,444	$1,576,502
FY 03-04 Joint Budget Committee Recommendation	($381,156)	$0	$0	$0
FY 04-05 Non Prioritized Decision Item #11 "Leveraging Additional Federal Medicaid Funds"	$0	$85,868	$0	$0
FY 04-05 Joint Budget Committee Recommendation	$0	($161,050)	$0	$0
FY 05-06 Joint Budget Committee Recommendation	$0	$0	$127,058	$0
Final Appropriation/Request	**$1,524,626**	**$1,449,444**	**$1,576,502**	**$1,576,502**

In FY 03-04, funding for this line item was reduced based on a Joint Budget Committee recommendation to decrease General Fund by 20% due to 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.

During 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 fourth quarter claims for the year, adjusting the original fund splits (set at 50% General Fund and 50% federal fund) to $807,289 federal funds and $717,337 General Fund. This was an accounting adjustment accomplished by the application of the "M" Headnote 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 3, 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.

In FY 05-06, the Joint Budget Committee recommended and the General Assembly approved an increase in funding of $127,058. Total funding for this line item for FY 05-06 was $1,576,502 with $788,251 in General Fund and $788,251 in matching federal funds.

The Department of Health Care Policy and Financing's FY 06-07 Base Request remains at the FY 05-06 appropriation level of $1,576,502. The fund splits requested are $788,251 in federal funds and $788,251 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. While this program is supported by Medicaid funds, 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 was 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 was 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 FY 05-06, the Department of Health Care Policy and Financing was appropriated $102,346 for this program which was transferred to the Department of Public Health and Environment in the form of a Cash Funds Exempt transfer. The FY 06-07 Base Request is for continuation funding.

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 Appropriation	FY 06-07 Base Request
Final Appropriation from Previous Fiscal Year	$109,110	$102,346	102,346
Adjustment to Indirect Cost Assessment during Base Request Calculation for FY 05-06	$0	$0	$0
Health Statistics and Vital Records reduction (Medicaid reduction not implemented in FY 03-04)	($110)	$0	$0
Women's Health, Personal Services OSPB 0.2% Reduction	($34)	($0)	($0)
Health Promotion and Disease Prevention, Indirect Correction	($6,043)	$0	$0
Reduction to Information Technology Services	($577)	$0	$0
Increase in POTS (information provided by DPHE Staff)	$0	$0	$0
Total Funds – Long Bill Appropriation/Request	**$102,346**	**$102,346**	**$102,346**
General Fund	$51,173	$51,173	$51,173
Federal Funds	$51,173	$51,173	$51,173

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, but 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 was made and the funds reverted to the General Fund as soon as the necessary information was 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). Continuation funding was appropriated for FY 05-06.

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 06-07, a continuation request of $3,010,000 was received from the Department of Public Health and Environment. Currently, there 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 Appropriation	FY 06-07 Base Request
Final Appropriation / Request	**$3,009,618**	**$3,010,000**	**$3,010,000**	**$3,010,000**
Cash Funds Exempt	$1,504,809	$1,505,000	$1,505,000	$1,505,000
Federal Funds	$1,504,809	$1,505,000	$1,505,000	$1,505,000

COLORADO AUTISM TREATMENT FUND

The Colorado Autism Treatment Fund was created in 2004 in section 26-4-695, C.R.S through the passage of SB 04-177. The purpose of the fund is for paying the State's share of expenditures for Home and Community Based Services for Children with Autism. The primary source of revenue for this fund is an allocation of Tobacco Master Settlement funding in the form of Cash Funds Exempt. Cash Funds Exempt are deposited into the fund at the end of each fiscal year for use in the next fiscal year. The fund may also draw interest. Any interest earnings and monies unexpended at year end remain in the fund and are not transferred to other funds.

Home and Community Based Services for Children with Autism is a waiver program which supports children 0 to 6 years of age with the diagnosis of autism, allowing them to live in the community rather than in an institution, through the provision of waiver benefits. Implementation of the program in FY 05-06 requires implementation of a federal approved waiver, establishing rules, developing eligibility and assessment tools, enrolling providers, determining rates, establishing a payment system and providing oversight. The number of children served is limited by the available funding. Funding is appropriated annually by the General Assembly.

The Cash Funds Exempt is ultimately transferred to the Medical Services Premiums line item and other line items within the Executive Director's Office Long Bill group. The Cash Funds Exempt spent within those line items represents the State's share of the total program expenses. The federal funds match is available under Title XIX of the federal Social Securities Act.

FY 05-06 Appropriation

SB 05-209 (the FY 05-06 Long Bill) appropriated $395,143 of Cash Funds Exempt from Tobacco Master Settlement monies to the Colorado Autism Treatment Fund for FY 05-06. The fiscal note for SB 04-177, estimates that this amount of funding will be sufficient to serve 75 clients at varying rates. For FY 05-06, expenses are being incurred for Personal Services and Operating for 1.0 FTE, modifications within the Medicaid Management Information System and the Colorado Benefits Management System, and the cost for disability determinations for these clients.

FY 06-07 Base Request

The FY 06-07 Base Request for the Colorado Autism Treatment Fund is $999,411 in Cash Funds Exempt. This is based on a July 2005 projection of Tobacco Master Settlement Agreement allocations by the Office of State Planning and Budgeting. The projection

was reduced by an estimated $589 to account for this fund's share of expenses related to the Department of Public Health and Environment's costs for oversight and monitoring of Tobacco Master Settlement programs.

SB 97-101 PUBLIC SCHOOL HEALTH SERVICES

In 1997, the Colorado General Assembly authorized public school districts, Boards of Cooperative Education Services (BOCES), 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. The Department estimates that for FY 06-07, about 134 districts will take part in the program. About 37 of these districts will be represented by 7 BOCES. 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. The Joint Budget Committee staff analyst added this request into the long appropriations bill, SB 03-258 which was approved. 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)

Appropriation Reconciliation for Public School Health Services Program			
FY 04-05	**Federal Funds**	**Cash Funds Exempt**	**Total Funds**
SB 05-112 (FY 04-05 Supplemental Bill) MMIS Reduction	$88,301		$88,301
Final Appropriation **Other Medical Services, SB 97-101 Public School Health Services**	**$14,674,196**	**$15,131,305**	**$29,805,501**
FY 05-06			
Total Funding for School Health Services	$15,131,305	$15,131,305	$30,262,610
Executive Director's Office, Medicaid Management Information System	($193,022)	$0	($193,022)
FY 05-06			
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)
SB 05-209 (FY 05-06 Long Bill)	$14,671,559	$15,131,305	$29,802,864
HB 05-1262 (Tobacco Tax) Children's Extensive Support waiting list buy down	$67,471	$67,471	$134,942
HB 05-1262 (Tobacco Tax) Home and Community Based Services waiting list buy down	$625,123	$625,123	$1,250,246
Final Appropriation **Other Medical Services, SB 97-101 Public School Health Services**	**$15,364,153**	**$15,823,899**	**$31,188,052**
FY 06-07 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	($193,022)	$0	($193,022)
Executive Director's Office, Personal Services	($99,060)	$0	($99,060)
Executive Director's Office, Operating	($1,478)	$0	($1,478)
Department of Education	($184,168)	$0	($184,168)
Subtotal Other Medical Services, SB 97-101 Public School Health Services	$14,653,577	$15,131,305	$29,784,882
HB 05-1262 (Tobacco Tax) Children's Extensive Support waiting list buy down	$81,229	$81,229	$162,458
HB 05-1262 (Tobacco Tax) Home and Community Based Services waiting list buy down	$712,219	$712,219	$1,424,438
Base Request **Other Medical Services, SB 97-101 Public School Health Services**	**$15,447,025**	**$15,924,753**	**$31,371,778**

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 was budget neutral to the total fund appropriation. The increase in federal funds was countered by an equivalent reduction in the Cash Funds Exempt provided by the participating school districts. This adjustment was 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 and FY 04-05 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.

For FY 05-06, funding was increased as a result of HB 05-1262, the Tobacco Bill. The bill provided services to people on the Children's Extensive Support and the Home and Community Based Services waiting lists. This additional funding was for $134,942 and $1,250,246 respectively. The amount allocated for the Medicaid Management Information System decreased from $273,250 to $193,022. The Personal Services allocation was reduced from $91,212 to $85,776. The total appropriation was $31,188,052 with $15,364,153 in federal funds and $15,823,899 in Cash Funds Exempt.

The Department's request for FY 06-07 makes an adjustment from the FY 05-06 appropriation level due to personal services common policy. Incorporating the FY 06-07 common policies increases the personal services funding need in the Executive Director's Office Long Bill group from $85,776 to $99,060. The result is an increase in total funds requested for this line item for FY 06-07 to $31,371,778 with $15,447,025 as federal funds and $15,924,753 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

The State Nursing Facility Service Program no longer exists. In fact, it was never actually implemented. 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 was for those legal immigrants enrolled in the Medicaid nursing facility program as of March 5, 2003. There was no federal match for the program because the clients were 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). HB 05-1086 (Legal Immigrants Bill) eliminated the appropriations. The initial FY 04-05 appropriation was based on implementing the program in January 2005. The FY 05-06 Base Request of $1,157,225 was based on the fiscal note for HB 04-1415, which increased the appropriation by $318,697. There is no request for FY 06-07.

State Nursing Facility Service Program	**FY 03-04**	**FY 04-05**	**FY 05-06**
SB 03-266 Nursing Facility Provider Fees & Program	$5,258,508	$0	$0
HB 04-1422 Long Bill Add On	($5,258,508)	$0	$0
HB 04-1415 Reimbursement of Nursing Facilities	$0	$838,528	$1,157,225
HB 05-1086 Legal Immigrants Bill		($838,528)	($1,157,225)
Total Appropriation/Request	**$0**	**$0**	**$0**

(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 line items currently within the Department's budget is included here. Each line in this section is solely the Medicaid attributable portion of each line item. The Joint Budget Committee has set up new lines for administration starting in FY 05-06 for several of the programs to enable a better understanding of the requested funds for these programs. The new lines will be found in the Division of Child Welfare, Mental Health and Alcohol and Drug Abuse Services, Alcohol and Drug Abuse Division, and Services for People with Disabilities.

The Department of Human Services identifies most funding needs and defends the request for this Long Bill group. Inquiries related to the FY 06-07 Base 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.

(A) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office is responsible for the general policy of the Department of Human Services and contains staff and associated resources for implementing this policy. It is organized into two functional components: General Administration and Special Purpose. General Administration includes the department's Executive Director and administrative staff as well as the department's budgeting office, Public Information Officer, County Liaison, and Field Administration staff (Department of Human Services Figure Setting, February 15, 2005, page 13).

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 $5,971,080 after the impact of Supplemental Bill HB 04-1320 and Supplemental Bill SB 05-112.
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 was budget neutral to the total appropriation, and is reflected in the Schedule 3s.

The change from FY 03-04 final appropriation to the FY 04-05 appropriation was the increase of $37,391 for the 1331 Supplemental Impact. Additional factors were the return of $8,208 for Risk Management funding that was temporarily removed through HB 04-1320 in FY 03-04, increases for $3,108,388 in Common Policy, a decrease of $1,764 for Office of Performance improvement for Department of Human Services Budget Office, a decrease of $335 for 0.2% base reduction for Personal Services, an increase of $19,057 for the annualization of Privacy Officer Salary (#BASN-2, January 23, 2004), an increase of $363,826 for the State's contribution of health, life, and dental insurance, based on a 4% increase, and a decrease of $3,288 for Risk Management. The final adjustment was a decrease of $183,671 for Mental Health POTS and Common Policy adjustment (SB 05-112). The FY 04-05 final appropriation was $9,318,892.

One change from FY 04-05 to the FY 05-06 Long Bill appropriation is an increase of $385,259. The increase is comprised of $780,912 in Common Policy, an increase of $25,654 in Office of Performance Improvement, an additional increase of $81,273 for the Public Employees Retirement Association, and decreases of $26,862 for the removal of a one-time funding for a salary payout (SB 03-197) and $475,720 for removal of Health Insurance Portability and Accountability Act (HIPAA) remediation funding. The FY 05-06 Long Bill appropriation is $9,704,151.

To arrive at the FY 06-07 Base Request of $10,220,269, changes were made to Common Policy for $167,635, increasing the FY 05-06 appropriation. Additional changes were made with an increase of $350,353 to the Amortization Equalization Disbursement and a decrease of $1,870 for the 0.2% base reduction per Office of State Planning and Budgeting.

The following table shows how the FY 03-04 Long Bill appropriation to the FY 06-07 Base Request was built, with information provided by the Department of Human Services.

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)
SB 05-112 Add-on	1331 Emergency Supplemental, "Title IV-E Payback Plan to the Counties," June 7, 2004	($57,171)
SB 05-112 Add-on	1331 Emergency Supplemental, "Spending Authority for Health Insurance Portability and Accountability Act (HIPAA) Expenditures from Footnote 56," June 7, 2004	$19,780
	FY 03-04 Final Appropriation	**$5,971,080**
	Reversing 1331 Emergency Supplemental Impact	$57,171
	Reversing 1331 Emergency Supplemental Impact	($19,780)
	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)
HB 04-1422	**FY 04-05 Long Bill**	**$9,502,563**

Bill	Description	Total Funds
SB 05-112	January 3, 2005 - Mental Health POTS and Common Policy Adjustment	($183,671)
	FY 04-05 Final Appropriation	**$9,318,892**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Salary Survey	$376,803
	Performance-Based Pay	($605,990)
	Shift Differential	$55,397
	Short-term Disability	($3,390)
	Worker's Compensation	($109,906)
	Health, Life, and Dental	$938,908
	Risk Management and Property Funds	$57,937
	Personal Services	$71,153
	Office of Performance Improvement	$25,654
	Public Employees Retirement Association Adjustment	$81,273
	Removal of SB 03-197 Salary Payout -one-time funding (per Department of Human Services Budget Office)	($26,862)
	Removal of Health Insurance Portability and Accountability Act Remediation Funding (per Department of Human Services Budget Office)	($475,720)
	Balancing Adjustment	$2
SB 05-209	**FY 05-06 Long Bill**	**$9,704,151**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	FY 05-06 Salary Survey allocated to other Appropriation lines	($1,240,583)
	FY 05-06 Amortization Equalization Disbursement allocated to other Appropriation Lines	($120,614)
	Pay for Performance	$1,685,586
	Shift Differential	$223,741
	Short-term Disability	$9,494
	Worker's Compensation	($1,165,763)
	Health, Life, and Dental	$786,946
	Risk Management and Property Funds	($11,172)
	Amortization Equalization Disbursement Adjustment	$350,353
	0.2% Office of State Planning and Budgeting Reduction	($1,870)

Bill	Description	Total Funds
	FY 06-07 Base Request	**$10,220,269**
	General Fund	$5,110,135
	Federal Funds	$5,110,134

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES

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. The development of the system and continuing operations were and are a joint effort between the Governor's Office of Colorado Benefits Management System, the Department of Human Services, and the Department of Health Care Policy and Financing. The Colorado Benefits Management System replaced the following 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 Personal Responsibility and Work Opportunity Reconciliation Act funding was to provide assistance to the counties to enter client historical data into the automated system. This funding was one-time only.
For FY 04-05, the Long Bill appropriation (HB 04-1422) was continuation funding from the FY 03-04 Long Bill. However, additional resources were needed to comply with a court order and HB 05-1315 was passed after submission of a Supplemental Request on February 15, 2005, providing $2,908,449 in additional funds. These monies included funding for additional technology staff from February to June 2005, emergency call center mailing costs, and an allocation for data entry, client correspondence, legal expenses and system enhancements. Other increases were for Colorado Benefits Management System Contract (#4 NP-DI) in the amount of $63,975 and an increase in POTS for $6,722.

The Long Bill for FY 05-06 request was for $5,370,182. With the passage of HB 05-1262 "Tobacco Tax Bill", the funding of this program was increased by $304,508 for FY 05-06. Additional changes for FY 05-06 year included passage of Emergency 1331 Supplemental bills on June 21, 2005 and September 20, 2005. The June 21, 2005 Supplemental requested funds in response to the Deloitte audit report for $977,147. On September 20, 2005, an Emergency 1331 Supplemental was passed to cover additional FTE for implementing a management structure for $33,560 and an additional $1,284,561 in relation to a court order to cover impacts due to

litigation and the operational costs for client correspondence. The change in funds also reflected a rollforward for $608,067. The appropriation for FY 05-06 was $8,578,025.

The change from the FY 05-06 appropriation to the FY 06-07 Budget Request is a decrease of $2,311,988. The decrease is comprised of the removal of $178,778 by HB 05-1262 for out-year funds; an increase in Salary Survey of $18,695, an increase in Amortization Equalization Disbursement for $1,811, and a decrease of 0.2% by Office of State Planning and Budgeting for $1,971. Additional decreases are reversals of a rollforward for $608,067 and a decrease for the Governor's Office of Colorado Benefits Management System (from Office of State Planning and Budget on October 24, 2005) for $259,117. The line also declined by $1,284,561 for the removal of one-time funding related to the Emergency Supplemental requested on September 20, 2005. The total request for FY 06-07 is $6,266,037. 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**
HB 04-1320	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**
HB 05-1315	Supplemental for Colorado Benefits Management System	$2,908,449
SB 05-209	**FY 04-05 Final Appropriation**	**$8,207,884**
	Remove impact of HB 05-1315	($2,908,449)
	Increase for POTS	$6,772
	Colorado Benefits Management System Contract Increase (#4 NP-DI)	$63,975
SB 05-209	**FY 05-06 Long Bill**	**$5,370,182**
HB 05-1262	Tobacco Tax Bill	$304,508
	Emergency 1331 Supplemental for Colorado Benefits Management System in response to an audit performed by Deloitte, June 21, 2005	$977,147
	Emergency 1331 Supplemental for Colorado Benefits Management System related to additional 6.6 FTE for implementing a management structure, September 20, 2005	$33,560
	Emergency 1331 Supplemental for Colorado Benefits Management System related to court order, September, 20, 2005	$1,284,561
	FY 05-06 Appropriation	**$7,969,958**
HB 05-1262	Removal of Out-Year funds	($178,778)
	Salary Survey	$18,695

Bill	Description	Total Funds
	Amortization Equalization Disbursement	$1,811
	Removal of one-time funding for Emergency 1331 Supplemental for Colorado Benefits Management System related to court order, September 20, 2005	($1,284,561)
	Governor's Office of Colorado Benefits Management System (from Office of State Planning and Budget, 10/24/2005)	($259,117)
	0.2% Office of State Planning and Budgeting Reduction	($1,971)
	FY 06-07 Base Request	**$6,266,037**
	General Fund	$3,211,454
	Cash Funds Exempt	$93,937
	Federal Funds	$2,960,646

Other Office of Information 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. The change included HB 04-1320 Supplemental Bill "Truth in Rates" (#NP-S15) for a decrease of $18,765 and HB 04-1320 Supplemental Bill "General Government Computer Center" (#NP-S13) for $205.

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.

The change from FY 03-04 final appropriation to FY 04-05 Long Bill was an increase of $24,910 due to a decrease of $454 in Personal Services, a decrease of $336 for purchase of services from the Computer Center, an increase in Microcomputer Lease Payments for $25,596, and an increase in Multi-use Network payments of $104.

Changes from the FY 04-05 Long Bill to the Multi-use Network FY 04-05 final appropriation was due to an increase for the Legacy System shutdown (SB 05-112) for $13,503 and Common Policy Adjustments (SB 05-112) for $19,929. The FY 04-05 final appropriation was $540,458.

The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill was a decrease of $121,644. The change was due to a decrease in the Telecommunication System Lease Payments removal in the amount of $102,350, an increase in Personal Services for $6,250, a decrease of $11,910 for Multi-use Network payments, a decrease of purchases of services from the Computer Center of

$131, and removal of one-time funding for the Legacy System shutdown for $13,503. The FY 05-06 Long Bill appropriation was $418,814.

Changes from the FY 05-06 Long Bill to the FY 06-07 Budget Request totals $6,205 with the majority being attributed to POTS. The FY 06-07 Base Request amount is $425,019.

The following table presents the changes in the Program from FY 03-04 to the FY 6-07 Request.

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**
SB 05-112	Legacy System Shutdown (through Supplemental)	$13,503
SB 05-112	Common Policy Adjustments	$19,929
	F**Y 04-05 Final Appropriation**	**$540,458**
	Common Policy Adjustments (per Department of Human Services Budget Office), including:	
	Multiuse Network Payments	($11,910)
	Purchases of Services from Computer Center	($131)
	Telecommunication System Lease Payments Removed	($102,350)
	Personal Services Adjustment	$6,250
	Removal of One-Time funding for Legacy System Shutdown	($13,503)
SB 05-209	**FY 05-06 Long Bill**	**$418,814**
	Personal Services	$6,057
	Purchase of Services from Computer Center	($38)

Bill	Description	Total Funds
	Amortization Equalization Disbursement	$602
	0.2% Office of State Planning and Budgeting Personal Services reduction	($416)
	FY 06-07 Base Request	**$425,019**
	General Fund	$212,510
	Federal Funds	$212,509

(C) 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. With the passage of HB 04-1320, a net increase of $97,073 affected the Capitol Complex Utilities for an increase of $117,855 and a decrease for the vehicle reconciliation of $20,782. The FY 03-04 final appropriation was $5,390,823.

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.

The changes from the FY 03-04 final appropriation to the FY 04-05 Long Bill were comprised of a decrease in Vehicle Lease Payments of $62,806, and the Office of State Planning and Budgeting 0.2% Base Reduction of $7,179, and a decrease for reconciliation to the Long Bill for $93,971. The FY 04-05 Long Bill appropriation was for $5,226,867.

Change from the FY 04-05 Long Bill to the FY 04-05 final appropriation was a net increase of $109,420. The changes were related to SB 05-112, the Department of Human Services Supplemental Bill, which increased this appropriation by $293,314 for Utility Costs and decreased Common Policy costs for Vehicle Lease Payments by $183,894. The final appropriation for FY 04-05 was $5,336,287.

Change from the FY 04-05 final appropriation to the FY 05-06 Long Bill includes an increase in Personal Services of $93,350, an increase in Operating Expenses of $3,564, a decrease in Vehicle Lease Payments of $9,528, and a decrease in Utilities of $20,800. The FY 05-06 appropriation was $5,402,873.

The changes from FY 05-06 Long Bill to FY 06-07 Budget Request include an increase in Salary Survey for $96,430, an increase in Amortization Equalization Disbursement for $10,117, an Office of State Planning and Budgeting 0.2% reduction of $7,181, and an increase in Common Policy New Vehicle Lease Payments for $59,702. The total FY 06-07 Base Request is $5,561,941. This is an increase of $159,068 over FY 05-06. The FY 06-07 Base Request is for $5,561,941.

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**
SB 05-112	Increase in Utility Costs (#NP-S.8, January 3, 2005)	$293,314
SB 05-112	Common Policy decrease for Vehicle Lease Payments	($183,894)
	FY 04-05 Final Appropriation	**$5,336,287**
	Personal Services	$93,350
	Operating Expenses	$3,564
	Common Policy decrease for Vehicle Lease Payments	($9,528)
	Utilities	($20,800)
	FY 05-06 Long Bill	**$5,402,873**
	Salary Survey	$96,430
	Amortization Equalization Disbursement	$10,117
	0.2% Personal Services Common Policy Base Reduction	($7,181)
	Common Policy New Vehicle Lease Payments	$59,702
	FY 06-07 Base Request	**$5,561,941**
	General Fund	$2,780,971
	Federal Funds	$2,780,970

(D) COUNTY ADMINISTRATION – MEDICAID FUNDING

County Administration – Medicaid Funding

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 adult assistance payment programs and eligibility determination (Department of Human Services Figure Setting, February 15, 2005, page 57). 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.

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.

The FY 03-04 Long Bill (SB 03-258) appropriation was $8,624,879. The same funding was approved for FY 04-05.

For FY 05-06 the fund requirements were increased to $8,797,377. A 2% provider increase was based on Common Polices of the Department of Human Services dated March 8, 2005, page 58. Additionally, a 1331 Supplemental Request has been approved by the Joint Budget Committee, increasing required funds by $172,498 for a 2% provider increase (Department of Human Services Figure Setting, March 8, 2005, page 58).

The FY 06-07 Budget Request is for $8,797,377. This is funded at $3,299,017 General Fund and $5,498,360 federal funds.

Transfers from the General Fund pursuant to 24-75-106, C.R.S. (2005) are common under this line and are reflected in the Schedule 3. Fund splits on this line are 50% federal financial participation, 30% General Fund and 20% local county funds. However, the 20% portion contributed by local county funds is not reported in the Long Bill.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$8,624,879**
	FY 03-04 Final Appropriation	**$8,624,879**
HB 04-1422	**FY 04-05 Long Bill**	**$8,624,879**
	FY 04-05 Final Appropriation	**$8,624,879**
	Joint Budget Committee Action, 2% provider increase (Figure Setting, Department of Human Services, March 8, 2005, page 58)	$172,498
SB 05-209	**FY 05-06 Long Bill**	**$8,797,377**
	FY 06-07 Base Request	**$8,797,377**
	General Fund	$3,299,017
	Federal Funds	$5,498,360

County Administration – Medicaid Funding, Medicare Modernization Act County Administration

The Prescription Drug, Improvement, and Modernization Act of 2003, commonly known as the Medicare Modernization Act (MMA), established a new drug benefit under the Medicare program. The drug benefit program will be administered by the federal

government through the Centers for Medicare and Medicaid Services (CMS) as of January 2006. Medicare beneficiaries will have the option of enrolling in the Medicare Modernization Act drug benefit program. Clients that are dual eligible for the Medicare and Medicaid programs, will automatically be enrolled into the Medicare Modernization Act drug benefit program.

According to the federal law, there are two places where individuals can apply for the low-income subsidy. First, individuals may apply though the Social Security Administration (SSA) either by filing an application by mail, through the internet, or applying in person at a Social Security Administration office. Secondly, individuals may apply at a State Medicaid Eligibility Site. To determine eligibility for the low-income subsidy before the Medicare drug benefit program is implemented, individuals could begin submitting their applications for eligibility beginning on July 1, 2005. Individuals who are currently eligible for Medicaid are automatically assumed eligible for the subsidy and do not need to apply separately. However, all other low-income Medicare beneficiaries are encouraged to apply now for the low-income subsidy so that their eligibility can be established before the drug benefit program is implemented on January 1, 2006. The Department estimates that as many as 4,302 new Medicaid application screens may need to be performed at a cost of $45.63 per application. Because these costs will occur before January 2006, the Department requested that this funding be added as a new line item in an emergency supplemental.

Since the counties perform Medicaid eligibility, they will be responsible for assisting clients with the application process for the low-income subsidy if the client applies through the State, rather than the local Social Security Administration office. The Department has instructed the counties to first determine if the client is eligible for Medicaid benefits. If the client is eligible for Medicaid benefits, then there is no need to continue the application for the low-income subsidy because that client will automatically be eligible for the low-income subsidy. If a client is not eligible for Medicaid benefits, then the Department has instructed the counties to fill out a hard copy application form and submit the form to the Department for eligibility determination.

If clients are found eligible for the low-income subsidy program by the Social Security Administration office, the Social Security Administration office will inform the clients that they could be eligible for Medicaid and to contact the counties for a Medicaid determination. It is possible that the counties will experience an increase in workload associated with performing additional eligibility screens beyond the normal caseload growth.

On September 20, 2005, the Joint Budget Committee approved an Emergency 1331 Supplemental for processing low income subsidies related to the Medicare Modernization Act in the amount of $196,300 to cover costs associated with the anticipated increased workload. Of this amount, $98,150 is from the General Fund and $98,150 is matching federal funds. The Joint Budget Committee also approved a new line item for these funds. The Joint Budget Committee's recommendation is based on the Medicare Modernization Act caseload impact that was approved by the Committee during Figure Setting in March 2005 (page 119 of the Figure Setting Document). A different line item was needed because State law governs the current County Administration appropriation and requires local match. Since this appropriation was for workload relief, a fund split of 50% General Fund was requested and appropriated as a different line item.

County Administration – Medicaid Funding ,Administration Related to CBMS Implementation

This line was added for FY 04-05 with the passage of HB 05-1315 as a one-time funding. However, a 1331 Supplemental was approved by the Joint Budget Committee (June 21, 2005) giving the Department a spending authority in FY 05-06 of $1,396,773. No funds have been requested for FY 06-07.

Bill	Description	Total Funds
HB 05-1315	Supplemental for Colorado Benefits Management System – One-Time Funding	$1,527,318
	FY 04-05 Final Appropriation	**$1,527,318**
	Removal of One-Time Funding in FY 04-05	($1,527,318)
	FY 05-06 Appropriation	**$0**

(E) DIVISION OF CHILD WELFARE

Administration

During the Department of Human Service's FY 05-06 Figure Setting on February 9, 2005, the Joint Budget Committee created a separate line for Administration. To ensure better tracking, funds were removed from the Child Welfare Services program. The change from FY 05-06 Long Bill to the FY 06-07 Base Request includes increases to Salary Survey of $1,634, Amortization Equalization Disbursement of $172, and a decrease of 0.2% Office of State Planning and Budgeting Reduction in the amount of $110 for a request of $62,202. The net change from FY 05-06 Long Bill to FY 06-07 Base Request is an increase of $1,696.

Bill	Description	Total Funds
HB 04-1422	**FY 04-05 Long Bill**	**$60,506**
	FY 04-05 Final Appropriation	**$60,506**
SB 05-209	**FY 05-06 Long Bill**	**$60,506**
	Salary Survey	$1,634
	Amortization Equalization Disbursement	$172
	0.2% Office of State Planning and Budgeting Reduction	($110)
	FY 06-07 Base Request	**$62,202**
	General Fund	$31,101
	Federal Funds	$31,101

Child Welfare Services

The Child Welfare Services 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.

Changes from the FY 03-04 final appropriation to the FY 04-05 Long Bill included an increase of $1,819,662 in the Child Welfare Services for a 2.34% increase in caseload and reversal of the leap-year adjustment of $208,146, leading to $79,473,510 appropriated in the FY 04-05 Long Bill. Further adjustments to this line item included a reduction of $688,226 due to lower costs on vendor contracts approved in the FY 04-05 Long Bill Add-On SB 05-209 and a reduction of $6,806,478 as a Joint Budget Committee action to reduce Residential Treatment Center costs in this appropriation, as approved in SB 05-112, Department's Supplemental Bill. The total FY 04-05 final appropriation was $71,978,806.

The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill results in a net increase of $3,277,424, due to an increase of $1,489,110 as part of the Joint Budget Committee's 2% provider rate increase, an increase of $1,847,566 due to caseload growth, removal of $59,246 of FY 04-05 administration funding now in a new appropriation and a decrease of $6 to balance to the Joint Budget Committee total. The FY 05-06 Long Bill appropriation is $75,256,230. Continuation funding is requested for FY 06-07.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill and Final Appropriation**	**$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**
SB 05-112	Reduction to Residential Treatment Centers	($6,806,478)
SB 05-209 Add-on	Reduction due to lower costs of vendor contracts, (Department of Human Services Figure Setting, page 27, February 9, 2005)	($688,226)
	FY 04-05 Final Appropriation	**$71,978,806**
	0.2% Personal Services Common Policy Base Increase	$1,489,110
	Caseload Growth (NP-DI #3, November 1, 2004)	$1,847,566
	Removal of FY 04-05 Administration Funding	($59,246)

Bill	Description	Total Funds
	Balancing amount to match to the Joint Budget Committee	($6)
SB 05-209	**FY 05-06 Long Bill**	**$75,256,230**
	FY 06-07 Base Request	**$75,256,230**
	General Fund	$37,628,115
	Federal Funds	$37,628,115

OFFICE OF SELF SUFFICIENCY, 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.

The change from the FY 03-04 final appropriation and the FY 04-05 Long Bill is a decrease of $2,305 for an unknown reason. 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. There is no base request for this line item in FY 05-06 or FY 06-07.

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 requested funding in the new line within the Department's Executive Director's Office Long Bill group.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 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 Long Bill (per June 7, 2004 Emergency Change Request)	**$0**
	FY 06-07 Base Request	**$0**

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES-MEDICAID FUNDING

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 after HB 04-1265 transferred the administration of most of these programs from the Department of Human Services to the Department. This reduction was for the last quarter of FY 03-04 in the amount of $259,274.

Beginning in FY 04-05, the majority of program administration was now performed by the Department, thus, the FY 04-05 Long Bill (HB 04-1422) only appropriated $277,951 to this line item. $777,822 of administration costs were moved to the Department at $259,274 per quarter, less $1,607 for Common Policy, adjustments for Salary Survey, performance-based pay, and the 0.2% reduction.

The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill appropriation included increases of $9,778 in Common Policy, and $11,274 in operating expenses. The FY 05-06 Long Bill appropriation is therefore $299,003.

The FY 06-07 Base Request is for a net increase of $9,230 over the FY 05-06 appropriation. The increase is related to Salary Survey in the amount of $8,923, Amortization Equalization Disbursement in the amount of $882, and a decrease of $575 for an Office of State Planning and Budgeting Reduction. The total FY 06-07 Base Request is $308,233.

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)
HB 04-1265	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**
	0.2% Personal Services Common Policy Increase in Department of Human Services Base Request	$9,778
	Increase in Operating (Department of Human Services Figure Setting document, March 10, 2005, page 26	$11,274
	FY 04-05 Final Appropriation	**$299,003**

Bill	Description	Total Funds
SB 05-209	**FY 05-06 Long Bill**	**$299,003**
	Salary Survey	$8,923
	Amortization Equalization Disbursement	$882
	0.2% Office of State Planning and Budgeting Reduction	($575)
	FY 06-07 Base Request	**$308,233**
	General Fund	$154,117
	Federal Funds	$154,116

Mental Health Community Programs, Goebel Lawsuit Settlement

This line was created in FY 03-04 to fund 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 impair their ability to be self-sufficient. The Goebel lawsuit 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.

The FY 04-05 Long Bill (HB 04-1422) was a continuation funding of $11,655,586. Per the Department of Human Services Figure Setting document from March 10, 2005, the Joint Budget Committee approved a 2% provider rate increase, increasing the FY 05-06 Long Bill appropriation to $11,888,698, or $233,112 greater than the FY 04-05 final appropriation. The FY 06-07 Base Request is for continuation funding in the same amount per the Department of Human Services.

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 04-05 Final Appropriation	**$11,655,586**

Bill	Description	Total Funds
	2% Community Provider increase (Department of Human Services Figure Setting, March 10, 2005, page 43)	$233,112
	FY 05-06 Long Bill	**$11,888,698**
	FY 06-07 Base Request	**$11,888,698**
	General Fund	$5,944,349
	Federal Funds	$5,944,349

Mental Health Capitation, Medicaid Mental Health Fee for Service Payments, Medicaid Mental Health Services for Breast and Cervical Cancer Patients

Actual expenditures for FY 03-04 are reported in the Schedule 3s for the following line items: Mental Health Capitation; Fee for Service Payments; 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. Funding being requested for FY 05-06 and FY 06-07 is zero on this line item because the programs were transferred to Health Care Policy and Financing.

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.

Residential Treatment for Youths (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 settlement 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 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. Due to an increase in the number of clients and higher Medicaid costs, $64,274 was requested and approved in SB 05-209 as an Add-On, which was comprised of 50% General Fund and 50% federal match. However, late in the legislative session for 2005, a new tobacco settlement allocation was passed in SB 05-249 and an additional $224 was appropriated. The FY 04-05 final appropriation was $482,630.

The FY 05-06 Long Bill was for $472,423. The FY 05-06 Long Bill reflected a reduction of $190 in Tobacco Settlement funding, a and an adjust for reduction of General Fund need in the amount of $10,017. The Department of Human Services is requesting continuation funding in the same amount for FY 06-07.

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
SB 05-209 Add-On	Increase in number of clients and higher Medicaid costs (Department of Human Services Figure Setting, March 10, 2005, page 45)	$64,274
SB 05-249	Allocation of Tobacco Settlement Monies	$224
	FY 04-05 Final Appropriation	**$482,630**
	Reduction in Tobacco Settlement (Department of Human Services Figure Setting, March 10, 2005, page 46)	($190)
	Adjustment for reduction of General Fund need (Department of Human Services Figure Setting, March 10, 2005, page 46)	($10,017)
SB 05-209	**FY 05-06 Long Bill**	**$472,423**
	FY 06-07 Base Request	**$472,423**
	General Fund	$27,129
	Cash Funds Exempt	$209,083
	Federal Funds	$236,211

Mental Health Institutes

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. Finally, a late Supplemental Request by the Department of Human Services increased this appropriation by $1,244,648 in a HB 04-1422 Add-on for revised shortfalls estimated for Mental Health Assessment and Service Agencies purchasing of beds. 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.

The change between FY 03-04 final appropriation to FY 04-05 Long Bill was a decrease of $124,610. This included a reversal of HB 04-1320 in the amount of $436,853 which included the $430,202 appropriated during FY 03-04, plus $6,651 in additional one-time funds, and an increase of $312,243 for "Mental Health capitation base payments." The FY 04-05 Long Bill appropriation was $4,876,070.

The change between FY 04-05 Long Bill to FY 04-05 final appropriation was due to a decrease in Medicaid fee-for-service payments, which lowered patient revenues/funding from the Department through the FY 04-05 Long Bill Add-On SB 05-209. The FY 04-05 final appropriation was $4,522,820. The FY 05-06 Long Bill and FY 06-07 Base Request are continuations of these funds.

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 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**
HB 04-1320	Removal of One-Time Funding	($430,202)
HB 04-1320	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**
SB 05-209 Add-on	Decrease in Medicaid Fee for Service payments lowered patient revenues/funding from Health Care Policy and Financing (Department of Human Services Figure Setting, March 10, 2005, page 63	($353,250)
	FY 04-05 Final Appropriation	**$4,522,820**
	FY 05-06 Long Bill	**$4,522,820**
	FY 06-07 Base Request	**$4,522,820**
	General Fund	$2,261,410
	Federal Funds	$2,261,410

Alcohol and Drug Abuse Division, Administration

During FY 05-06 Figure Setting, the Joint Budget Committee separated the Administration budget from the High-Risk Pregnant Women Program. The FY 05-06 Long Bill appropriation is $17,213 and includes Personal Services and operating costs associated with administering this program. The FY 06-07 Base Request is $54,088 and includes the annualization of Personal Services and Operating Expenses for a net increase of $36,875.

Bill	Description	Total Funds
SB 05-209	**FY 05-06 Long Bill**	**$17,213**
	Annualization of Personal Services and Operating Expenses	**$36,875**
	FY 06-07 Base Request	**$54,088**
	General Fund	$27,044
	Federal Funds	$27,044

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 postpartum period of services from 60 days to 12 months.

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 FY 03-04 Long Bill (SB 03-258) appropriation was $312,804. The final appropriation for FY 03-04 was $557,208. A Supplemental Bill was appropriated for increases in the high risk women caseload and FY 02-03 overexpenditure (HB 04-1320) for $244,404.

The change from the FY 03-04 final appropriation to the FY 04-05 Long Bill is a decrease of $85,293 due to removal of one-time funding from HB 04-1320 for FY 02-03 overexpenditure (#NP-S8, January 2, 2004).

Changes from the FY 04-05 Long Bill to the FY 04-05 final appropriation increased by a total of $661,752. Changes included HB 04-1075 to extend funding for postpartum services for $95,805 and SB 05-112 to add funding of $565,947 due to increases in caseload. The FY 04-05 Final appropriation was $1,133,667.

To arrive at the FY 05-06 Long Bill amount of $952,986 there was an increase of $31,935 for annualization of HB 04-1075 – extension of postpartum services, $18,686 for a 2.0% provider rate increase, and a decrease of $231,302 due to an overexpenditure restriction (Department of Human Services Figure Setting, March 10, 2005, page 83). The FY 06-07 Base Request is a continuation of funds.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$312,804**
HB 04-1320	**FY 03-04 Supplemental Bill – "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**
SB 05-112	**Additional funding due to increase in caseload (NP.S #13)**	**$565,947**
	FY 04-05 Final Appropriation	$1,133,667
	Annualization of HB 04-1075 Extension of Post-Partum Services	$31,935
	2.0% provider rate increase	$18,686
	Overexpenditure restriction (Department of Human Services Figure Setting, March 10, 2005, page 83)	($231,302)
SB 05-209	**FY 05-06 Long Bill**	**$952,986**
	FY 06-07 Base Request	**$952,986**
	General Fund	$476,493
	Federal Funds	$476,493

(G) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING

Community Services Administration

A Joint Budget Committee action during February 17, 2005 Figure Setting separated the administration funding from program costs for Community Services. Funding in the amount of $2,337,168 was moved out of the Community Services appropriation and created this new line. The requested change from FY 05-06 to FY 06-07 is for $62,038. These changes are due to increases in Salary Survey for $61,094 and Amortization Equalization Disbursement for $5,323, and a decrease of $4,379 for the 0.2% Office of State Planning and Budgeting reduction. The FY 06-07 Base Request is for $2,399,206.

Bill	Description	Total Funds
SB 05-209	**FY 05-06 Long Bill**	**$2,337,168**
	Salary Survey	$61,094
	Amortization Equalization Disbursement	$5,323
	0.2% Office of State Planning and Budgeting Reduction	($4,379)
	FY 06-07 Base Request	**$2,399,206**
	General Fund	$1,199,603
	Federal Funds	$1,199,603

Community Services Adult Program Costs and CCMS Replacement-Medicaid Funding

The Community Services for People with Disabilities line funds services for approximately 7,000 individuals with developmental disabilities. These services are provided in local communities through Community Centered Boards (Department of Human Services Figure Setting, February 15, 2005, page 66). 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, which was approved through the passage of HB 04-1320, and reduced the appropriation by $248,076. The final appropriation for FY 03-04 was $218,495,215.

Changes from FY 03-04 final appropriation to the FY 04-05 Long Bill (HB 04-1422) included a $93,650 decrease for a Supplemental Security Income room and board adjustment, and an increase of $636,753 for developmental disability foster care, emergency, and waiting list resources, along with some Personal Services adjustments. The FY 04-05 Long Bill appropriation was therefore $219,038,318.

However, 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 three lines within the Department's budget, Executive Director's Office–Non-Emergency Transportation Services, Medical Services Premiums, and Medicaid Mental Health Fee for Service Payments. The federal Centers for Medicare and Medicaid Services required this change in order for federal approval of the waiver programs to continue. The reduction to FY 04-05 was approved with the passage of SB 05-112 and reduced the appropriation by $1,130,851. The final FY 04-05 appropriation was therefore $217,907,468.

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.

The FY 05-06 Long Bill appropriation is $223,788,132. This amount reflects an increase of $5,880,664 over the FY 04-05 final appropriation. The increase is reflected in a 2% cost of living adjustment of $4,812,250, an increase for caseload in the amount of $2,366,195, removal of Personal Services of $2,038,821, and Operating Expenses of $147,532, annualization of Supplemental for developmental disability foster care, emergency and waiting list resources increasing funding by $1,265,524 and annualization of the removal of Medicaid State Plan services from waivered services reducing funding by $376,950. The final appropriation for FY 05-06 was $223,949,452. This included HB 05-1262 for funds from the Tobacco Settlement Funds in the amount of $161,320.

The FY 06-07 Base Request is $226,324,751. The change from FY 05-06 appropriation to the FY 06-07 Base Request is $2,375,299. The change requested includes an out-year impact from HB 05-1262 for an increase of $14,665, and the annualization of targeted case management for 84 new adult resources in the amount of $2,360,634.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$218,743,291**
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)	($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)
HB 04-1422	**FY 04-05 Long Bill**	**$219,038,318**
SB 05-112	Revised figures for Developmental Disability Waiver 1331 Emergency Supplemental approved September 21, 2004 by the Joint Budget Committee. (#NP-S16)	($1,130,851)
	Adjustment to balance to Joint Budget Committee	$1
	FY 04-05 Final Appropriation	**$217,907,468**
	Personal Services	($2,038,821)
	Operating Expenses	($147,532)
	Adjustment to balance to Joint Budget Committee	($2)
	2% cost of living adjustment – Joint Budget Committee Action	$4,812,250
	Increase for caseload in adult services – half a year	$2,366,195
	Annualization of Supplemental to increase resources for developmental disability foster care, emergency and waiting list resources, DI #4, (Department of Human Services Figure Setting from	$1,265,524

Bill	Description	Total Funds
	February 23, 2005, page 68)	
	Annualization of the removal of Medicaid State Plan Services from waivered services	($376,950)
SB 05-209	**FY 05-06 Long Bill**	**$223,788,132**
HB 05-1262	Tobacco Tax Bill	$161,320
	FY 05-06 Appropriation	**$223,949,452**
HB 05-1262	Out-year impact for HB 05-1262	$14,665
	Annualization of targeted new case management for 84 new adult resources per FY 05-06 (#DI-2)	$2,360,634
	FY 06-07 Base Request	**$226,324,751**
	General Fund	$113,133,243
	Cash Funds Exempt	$29,133
	Federal Funds	$113,162,375

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 Budget Amendment Request, "Developmental Disabilities Local Match Certification" (#BA-NP5, page S.11-6, January 2, 2004) to increase the local match certification. Additional funds were approved to cover existing direct service costs (#NP-S11) on SB 05-112 in the amount of $3,264,723. The FY 04-05 final appropriation was $19,807,076. The FY 05-06 Long Bill and FY 06-07 Base Request are for continuation funding. The fund splits are $9,903,538 from the General Fund and $9,903,538 from 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.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill - New line item**	$0
HB 04-1320	Supplemental Bill #9. Federally-Matched Local Program Costs - new line item	$15,566,354
	FY 03-04 Final Appropriation	**$15,566,354**

Bill	Description	Total Funds
	NP-S9, Local Match Certification	$975,999
HB 04-1422	**FY 04-05 Long Bill**	**$16,542,353**
SB 05-112	NP-S11 Additional funding to cover existing direct service costs	$3,264,723
	FY 04-05 Final Appropriation	**$19,807,076**
SB 05-209	**FY 05-06 Long Bill**	**$19,807,076**
	FY 06-07 Base Request	**$19,807,076**
	Cash Funds Exempt	$9,903,538
	Federal Funds	$9,903,538

Regional Centers-Medicaid Funding

Regional Centers provide services to individuals with developmental disabilities in both institutional and group home settings. Generally, 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 increased the appropriation by $728,000. However, a supplemental adjustment was made for Supplemental Security Income Room and Board, reducing funds by $21,224. The final appropriation for FY 03-04 was $39,593,264.

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.

The change from the FY 03-04 final appropriation to the FY 04-05 Long Bill was a decrease of 231,044. Changes included an increase to restore funding from HB 04-1320 for $21,224, a decrease in Medicaid funding for increases in client cash revenue for $157,998, a decrease for Medicaid funding for room and board due to client cash revenue of $43,946, an increase for the annualization of HB 03-1292 of $21,840, and a 0.2% Personal Services Common Policy base reduction of $72,164. The FY 04-05 Long Bill appropriation (HB 04-1422) was $39,362,220.

On September 21, 2004, the Joint Budget Committee approved a September 3, 2004 1331 Emergency Supplemental to transfer funding from this line item to the three lines within the Department's budget, Executive Director's Office-Non-Emergency Transportation Services, Medical Services Premiums, and Medicaid Mental Health Fee for Service Payments. 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. On January 10, 2005, #NP-S16 revised the figures for the 1331 Emergency Supplemental (SB 05-112) as a decrease of $723,127. Additionally,

#NP-S12 for Social Security Income Room and Board adjustment, which is due to a Federal Social Security Income cost of living adjustment of 2.7%, decreased the available funds by $25,978. These adjustments brought the FY 04-05 final appropriation to $38,613,115.

The FY 05-06 Long Bill was for $39,351,048. This is an increase of $737,933 over the FY 04-05 final appropriation. The increase is comprised of the following items: a decrease for the annualization of the Developmental Disability Waiver Supplemental for $241,042, a decrease for the annualization of the Supplemental Security Income adjustment for $26,407, an increase in base building POTS for $1,026,473, an increase of $5,037 from the Joint Budget Committee action for a 2.5% medical inflationary increase, a decrease due to additional client cash receipts of $12,890, a decrease to General Fund by $13,280 pursuant to HB 03-1292, and a $42 adjustment to balance with the Joint Budget Committee.

The change from the FY 05-06 appropriation to the FY 06-07 Base Request is an increase of $1,071,170. This is made up of $1,047,750 in Salary Survey, $101,707 for Amortization Equalization Disbursement, and a 0.2% Office of State Planning and Budgeting reduction of $78,287. The FY 06-07 Base Request is $40,422,218.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$38,886,488**
HB 03-1292	Special Bill – Authorized Collection of Service Fees from Intermediate Care Facilities	$728,000
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)
	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
	Medicaid Funding for Increases in Client Cash Revenue (Department of Human Services Figure Setting, February 25, 2004, page 54)	($157,998)
	Medicaid Funding for Room and Board Due to Client Cash Revenue (Department of Human Services Figure Setting, February 25, 2004, page 53)	($43,946)
	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**
SB 05-112	Supplemental Security Income Room and Board Adjustment #NP-S12	($25,978)
SB 05-112	Developmental Disability 1331 Emergency Supplemental revision	($723,127)
	FY 04-05 Final Appropriation	**$38,613,115**

Bill	Description	Total Funds
	Annualization of Developmental Disability Waiver Supplemental (Department of Human Services Figure Setting from February 23, 2005, page 103)	($241,042)
	Supplemental Security Income Adjustment (Department of Human Services Figure Setting, February 23, 2005, page 103)	($26,407)
	Increase in POTS	$1,026,473
	2.5% medical inflationary increase (Department of Human Services Figure Setting from February 23, 2005, page 104)	$5,037
	Additional Client Cash Adjustment (Department of Human Services Figure Setting on February 23, 2005, page 105)	($12,890)
HB 03-1292	Additional General Fund Adjustment (Department of Human Services Figure Setting from February 23, 2005, page 106)	($13,280)
	Adjust to match Joint Budget Committee total	$42
	FY 05-06 Long Bill	**$39,351,048**
	Salary Survey	$1,047,750
	Amortization Equalization Disbursement	$101,707
	0.2% Office of State Planning and Budgeting Reduction	($78,287)
	FY 06-07 Base Request	**$40,422,218**
	General Fund	$19,467,909
	Cash Funds Exempt	$743,200
	Federal Funds	$20,211,109

Regional Center 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. There has been a pattern of annual overexpenditure within the Regional Centers line item. 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. Therefore, this line was established in HB 04-1320 with an appropriation of $1,460,194.

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.

The FY 04-05 Long Bill (HB 04-1422) appropriation provided continuation funding of $1,460,194. This amount was increased for FY 05-06 during Figure Setting when an adjustment to the amount of the General Fund "invested" in depreciation of $38,057 was approved. The FY 05-06 Long Bill amount was $1,498,251 and continuation funding is requested for FY 06-07.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill - New line item**	**$0**
HB 04-1320	Depreciation and Annual Adjustments (# NP-S12)	$1,460,194
	FY 03-04 Final Appropriation	**$1,460,194**
HB 04-1422	**FY 04-05 Long Bill**	**$1,460,194**
	FY 04-05 Final Appropriation	**$1,460,194**
	Adjustment to amount of General Fund "invested" in depreciation (Department of Human Services Figure Setting from February 23, 2005, page 108)	$38,057
SB 05-209	**FY 05-06 Long Bill**	**$1,498,251**
	FY 06-07 Base Request	**$1,498,251**
	General Fund	$749,126
	Federal Funds	$749,125

Services for Children and Families-Medicaid Funding

The Services for Children and Families line provides funding to the 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, it 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 Funds. 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. 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.

This line was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for the last quarter of FY 02-03 and 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.

The Budget Request Amendment (#BA-NP3) stated above, 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. The 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 total fund reduction for 0.2% the Office of State Planning and Budgeting Common Policy reduction. The FY 04-05 Long Bill appropriation was thus $3,745,232. 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 each. 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.

The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill was an increase of $67,845. There was a 2% cost of living adjustment (Department of Human Services Figure Setting on February 23, 2005) in the amount of $32,508 and a 2% provider rate increase per a Joint Budget Committee recommendation in the amount of $35,337. This brought the FY 05-06 Long Bill appropriation to $3,813,077. However, $2,370,114 was added for the expansion of Medicaid Services through HB 05-1262, bringing the total FY 05-06 appropriation to $6,183,191.

The FY 06-07 Budget Request is for $6,433,993. This reflects a total increase of $250,802 for the $215,464 out-year impact of HB 05-1262 and a $35,338 increase in the (November 1, 2004, Budget Request #DI-2) annualization of four new child and family resources.

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
	FY 03-04 Final Appropriation	**$3,745,315**
	0.2% Office of State Planning and Budgeting 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
	FY 04-05 Final Appropriation	**$3,745,232**

Bill	Description	Total Funds
	2% Cost of Living Adjustment from DHS Figure Setting on February 23, 2005, page 111	$32,508
	Increase in 2% Provider rate per JBC Recommendation (Department of Human Services Figure Setting on February 23, 2005, page 111)	$35,337
SB 05-209	**FY 05-06 Long Bill**	**$3,813,077**
HB 05-1262	Tobacco Tax Bill	$2,370,114
	FY 05-06 Appropriation	**$6,183,191**
HB 05-1262	Annualization of Tobacco Tax Bill	$215,464
	Annualization of 4 new child and Family resources (#DI-2)	$35,338
	FY 06-07 Base Request	**$6,433,993**
	General Fund	$2,788,979
	Cash Funds Exempt	$428,018
	Federal Funds	$3,216,966

(H) ADULT ASSISTANCE PROGRAMS – COMMUNITY SERVICES FOR THE ELDERLY - MEDICAID FUNDING

The Adult Assistance Programs - 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 and FY 04-05.

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.

The FY 04-05 Long Bill (HB 04-1422) appropriation amount remained constant at $1,800. SB 05-209, the FY 05-06 Long Bill, continued this level of funding, and continuation funding is requested for FY 06-07. Of this amount, $900 is General Fund and $900 is federal funds.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Long Bill**	**$1,800**
	FY 03-04 Final Appropriation	**$1,800**
HB 04-1422	**FY 04-05 Long Bill**	**$1,800**
	FY 04-05 Final Appropriation	**$1,800**
SB 05-209	**FY 05-06 Long Bill**	**$1,800**

Bill	Description	Total Funds
	FY 06-07 Base Request	**$1,800**
	General Fund	$900
	Federal Funds	$900

(I) DIVISION OF YOUTH CORRECTION-MEDICAID FUNDING

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.

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.

Changes from the FY 03-04 final appropriation to the FY 04-05 Long Bill was an increase of $1,836,072. The change included increases in the mix of Residential Treatment Centers and Residential Child Care Facilities for $2,648,832 and in the Residential Treatment Center rates and providers by $252,082. Additionally, there were decreases for beds at Lookout Mountain for $687,551, annualization of beds at Mount View for $229,184, a leap-year adjustment of $31,117, and a decrease for caseload and miscellaneous adjustments for $116,990. The FY 04-05 Long Bill appropriation was $11,563,845.

Change Requests submitted for FY 04-05 were: #NP-4, "Population Impacts on Contract Bed Placements" submitted on November 3, 2003 (page H.9-2) and #BASN-1, "Population Impacts on Contract Replacements" submitted on January 23, 2004 (page BAS.6-1). The 1331 Emergency Supplemental Request for additional funds for contract beds was appropriated in SB 05-112 for $2,068,379. The FY 04-05 final appropriation was $13,632,224.

The FY 05-06 Long Bill (SB 02-509) was for $15,091,070. This reflects an increase of $1,458,846, comprised of an adjustment to contract placements for $1,414,968, an adjustment to the managed care pilot project for $4,121, and an addition to Personal Services costs of $39,757. A 0.2% Office of State Planning and Budgeting Reduction for $136 was the only change from the FY 05-06 appropriation to the FY 06-07 Base Request. The FY 06-07 Base Request is $15,090,934.

Bill	Description	Total Funds
SB 03-258	**FY 03-04 Final Appropriation**	**$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	$252,082

Bill	Description	Total Funds
	Department of Human Services Figure Setting, February 17, 2004, page 37)	
	Lookout Mountain Beds (Department of Human Services Figure Setting, February 17, 2004, page 37)	($687,551)
	Annualization of Mount View Beds (Department of Human Services Figure Setting, February 17, 2004, page 37)	($229,184)
	Leap Year Adjustment (Department of Human Services Figure Setting, February 17, 2004, page 37)	($31,117)
	Caseload and Miscellaneous Adjustments (Department of Human Services Figure Setting, February 17, 2004, page 37)	($116,990)
HB 04-1422	**FY 04-05 Long Bill**	**$11,563,845**
SB 05-112	1331 Emergency Supplemental – Request for Additional Funds for Contract Beds for FY 04-05	$2,068,379
	FY 04-05 Final Appropriation	**$13,632,224**
	Adjustment to Contract Placements	$1,414,968
	Adjustment to Managed Care Pilot Project	$4,121
	Addition of Personal Services Costs	$39,757
SB 02-509	**FY 05-06 Long Bill**	**$15,091,070**
	0.2% Office of State Planning and Budgeting Reduction	($136)
	FY 06-07 Base Request	**$15,090,934**
	General Fund	$7,545,467
	Federal Funds	$7,545,467