Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 1, 2006
Priority Number:	DI-1	**OSPB Approval:**		**Date:**	
Program:	Medical Assistance Office	**Statutory Citation:**	25.5-4-104 (1), and 25.5-5-101 (1), C.R.S. (2006)		
Request Title:	Request for FY 07-08 Medical Services Premiums				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual	Appropriation	Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	**FY 05-06**	**FY 06-07**	**FY 06-07**	**FY 06-07**	**FY 07-08**	**FY 07-08**	**FY 07-08**	**FY 07-08**	**FY 07-08**	**FY 08-09**
Total of All Line Items	**Total**	1,996,264,308	2,111,287,559	0	2,111,287,559	2,125,566,186	149,426,166	2,274,992,352	0	2,274,992,352	149,426,166
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	714,906,452	740,721,857	0	740,721,857	746,875,977	53,959,687	800,835,664	0	983,161,159	53,959,687
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	0	0
	CF	0	76,512	0	76,512	76,512	(38,256)	38,256	0	76,512	(38,256)
	CFE	23,713,210	55,563,806	0	55,563,806	56,549,000	19,753,332	76,302,332	0	70,828,581	19,753,332
	FF	996,344,645	1,058,825,384	0	1,058,825,384	1,065,964,697	75,751,403	1,141,716,100	0	1,047,277,523	75,751,403
(2) Medical Services Premiums											
	Total	1,996,264,308	2,111,287,559	0	2,111,287,559	2,125,566,186	149,426,166	2,274,992,352	0	2,274,992,352	149,426,166
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	714,906,452	740,721,857	0	740,721,857	746,875,977	53,959,687	800,835,664	0	983,161,159	53,959,687
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	0	0
	CF	0	76,512	0	76,512	76,512	(38,256)	38,256	0	76,512	(38,256)
	CFE	23,713,210	55,563,806	0	55,563,806	56,549,000	19,753,332	76,302,332	0	70,828,581	19,753,332
	FF	996,344,645	1,058,825,384	0	1,058,825,384	1,065,964,697	75,751,403	1,141,716,100	0	1,047,277,523	75,751,403

Letter Notation:

Cash Fund name/Number, Federal Fund Grant Name: CF: Provider Fees and Service Fees CFE: Certified Public Expenditures, Breast and Cervical Cancer Prevention and Treatment Fund, Health Expansion Fund, and Prevention, Early Detection, and Treatment Fund (Transferred from the Department of Public Health and Environment). FF: Title XIX

IT Request: o Yes X No (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: o Yes X No (If Yes, List Other Departments Here:)

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 1, 2006
Priority Number:	DI-2	**OSPB Approval:**		**Date:**	
Program:	Behavioral Health Benefits	**Statutory Citation:**	25.5-5-308, C.R.S. (2006); 25.5-5-408, C.R.S. (2006);		
Request Title:	Request for FY 07-08 Medicaid Community Mental Health Programs		25.5-5-411, C.R.S. (2006);		

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	1331 Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	205,064,728	223,825,281	0	223,825,281	223,825,281	10,181,652	234,006,933	0	234,006,933	10,181,652
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	88,888,902	93,941,318	0	93,941,318	93,941,318	5,088,974	99,030,292	0	99,030,292	5,088,974
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	27,190,916	33,783,245	0	33,783,245	33,783,245	(1,857,803)	31,925,442	0	31,925,442	(1,857,803)
	FF	88,984,910	96,100,718	0	96,100,718	96,100,718	6,950,481	103,051,199	0	103,051,199	6,950,481
(3) Medicaid Mental Health Community Programs (A) Mental Health Capitation Payments	**Total**	164,839,222	178,184,177	12,275,081	190,459,258	178,184,177	26,167,116	204,351,293	0	204,351,293	26,167,116
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	82,328,858	86,935,767	6,137,541	93,073,308	86,935,767	11,229,312	98,165,079	0	98,165,079	11,229,312
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	85,498	2,153,241	0	2,153,241	2,153,241	1,846,986	4,000,227	0	4,000,227	1,846,986
	FF	82,424,866	89,095,169	6,137,540	95,232,709	89,095,169	13,090,818	102,185,987	0	102,185,987	13,090,818
(3) Medicaid Mental Health Community Programs (B) Other Medicaid Mental Health Payments (1) Medicaid Mental Health Fee for Service Payments	**Total**	1,231,390	1,736,019	0	1,736,019	1,736,019	(5,594)	1,730,425	0	1,730,425	(5,594)
	FTE	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	0.00	0.00
	GF	615,695	868,010	0	868,010	868,010	(2,797)	865,213	0	865,213	(2,797)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	615,695	868,009	0	868,009	868,009	(2,797)	865,212	0	865,212	(2,797)

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 1, 2006
Priority Number:	DI-2	**OSPB Approval:**		**Date:**	
Program:	Behavioral Health Benefits	**Statutory Citation:**	25.5-5-308, C.R.S. (2006); 25.5-5-408, C.R.S. (2006);		
Request Title:	Request for FY 07-08 Medicaid Community Mental Health Programs		25.5-5-411, C.R.S. (2006);		

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	1331 Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
(3) Medicaid Mental Health Community Programs (B) Other Medicaid Mental Health Payments (3) Medicaid Anti-Psychotic Pharmaceuticals	**Total**	27,105,418	31,630,004	0	31,630,004	31,630,004	(3,704,789)	27,925,215	0	27,925,215	(3,704,789)
	FTE	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	27,105,418	31,630,004	0	31,630,004	31,630,004	(3,704,789)	27,925,215	0	27,925,215	(3,704,789)
	FF	0	0	0	0	0	0	0	0	0	0
(6) Department of Human Services – Medicaid Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding; Mental Health Community Programs, Goebel Lawsuit	**Total**	11,888,698	12,275,081	(12,275,081)	0	12,275,081	(12,275,081)	0	0	0	(12,275,081)
	FTE	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	0.00	0.00
	GF	5,944,349	6,137,541	(6,137,541)	0	6,137,541	(6,137,541)	0	0	0	(6,137,541)
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	5,944,349	6,137,540	(6,137,540)	0	6,137,540	(6,137,540)	0	0	0	(6,137,540)

Letter Notation:

Cash Fund name/number, Federal Fund Grant name:

CFE: Breast and Cervical Cancer Prevention and Treatment Fund - Fund 15D — FF: Title XIX

CFE: Health Care Expansion Fund - Fund 18K — FF: Title XIX

CFE: Cessation, Prevention, and Detection Fund — FF: Title XIX

IT Request: Yes No (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: Yes **X** No (If Yes, List Other Departments Here:) Department of Human Services

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI -3	**OSPB Approval:**		**Date:**
Program:	Child Health Plan Plus Division	**Statutory Citation:**	25.5-8-105, C.R.S. (2006), 25.5-8-109, C.R.S. (2006), 25.5-8-107 (1) (a) (I)-(II), C.R.S. (2006), 24-22-117 (2) (a) (II) (A), C.R.S. (2006)	
Request Title:	Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	100,719,869	76,476,908	0	76,476,908	76,583,486	26,150,907	102,734,393	0	102,734,393	26,403,265
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,000,000	0	0	0	0	4,481,968	4,481,968	0	4,481,968	4,541,129
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	191,726	192,072	0	192,072	192,396	47,163	239,559	0	239,559	47,487
	CFE	52,544,592	26,824,539	0	26,824,539	26,861,939	7,598,277	34,460,216	0	34,460,216	7,666,204
	FF	45,983,551	49,460,297	0	49,460,297	49,529,151	14,023,499	63,552,650	0	63,552,650	14,148,445
(4) Indigent Care Program: HB 97-1304 Children's Basic Health Plan Trust	**Total**	29,431,057	192,072	0	192,072	192,396	4,529,131	4,721,527	0	4,721,527	4,588,616
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,000,000	0	0	0	0	4,481,968	4,481,968	0	4,481,968	4,541,129
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	191,726	192,072	0	192,072	192,396	47,163	239,559	0	239,559	47,487
	CFE	27,239,331	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0
(4) Indigent Care Program: Children's Basic Health Plan Premium Costs	**Total**	65,919,891	70,371,177	0	70,371,177	70,466,778	20,913,747	91,380,525	0	91,380,525	21,106,620
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	23,426,139	24,754,759	0	24,754,759	24,788,430	7,350,467	32,138,897	0	32,138,897	7,418,394
	FF	42,493,752	45,616,418	0	45,616,418	45,678,348	13,563,280	59,241,628	0	59,241,628	13,688,226
(4) Indigent Care Program: Children's Basic Health Plan Dental Benefit Costs	**Total**	5,368,921	5,913,659	0	5,913,659	5,924,312	708,029	6,632,341	0	6,632,341	708,029
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	1,879,122	2,069,780	0	2,069,780	2,073,509	247,810	2,321,319	0	2,321,319	247,810
	FF	3,489,799	3,843,879	0	3,843,879	3,850,803	460,219	4,311,022	0	4,311,022	460,219

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	CF: Annual Enrollment fees of CBHP enrollees CFE: Tobacco Litigation Settlement and Fund 11G (CBHP Trust Fund) and Fund 18K (The Health Care Expansion Fund) FF: Title XXI
IT Request: **No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: **No**	(If Yes, List Other Departments Here:)

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-3
Change Request Title:	Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes
Long Bill Line Item(s)	(4) Indigent Care Program: HB 97-1304 Children's Basic Health Plan Trust, (4) Indigent Care Program: Children's Basic Health Plan Premium Costs, and (4) Indigent Care Program: Children's Basic Health Plan Dental Benefit Costs
State and Federal Statutory Authority:	The Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj) 25.5-8-105, C.R.S. (2006), 25.5-8-109, C.R.S. (2006), 25.5-8-107 (1) (a) (I)-(II), C.R.S. (2006), 24-22-117 (2) (a) (II) (A), C.R.S. (2006)

Summary of Request (Alternative A): This request is to increase the total funds appropriation for the Children's Basic Health Plan Premium Costs by $20,913,747 from the FY 07-08 Base Request of $70,446,778. The requested caseload in FY 07-08 is 50,143 children and 27,256 prenatal member months. This request also seeks to increase the Children's Basic Health Plan Dental Benefit Costs appropriation by $708,029 from the FY 07-08 Base Request of $5,924,312. The adjustments requested for FY 07-08 are the net result of increased caseload estimates and higher medical and dental costs. Cash Funds Exempt funding is drawn from the Children's Basic Health Plan Trust Fund and the Health Care Expansion Fund. This request also seeks to increase the appropriation of Cash Funds for annual enrollment fees into the Children's Basic Health Plan Trust Fund by $47,163, as well as a General Fund appropriation to the Children's Basic Health Plan Trust Fund in the amount of

$4,481,968 for FY 07-08 in order to balance the Trust Fund due to increased expenditures for traditional clients.

Alternative A {Recommended alternative}:

Problem or Opportunity Description:

The Children's Basic Health Plan, marketed as the Child Health Plan Plus, is a program that provides affordable health insurance to children under the age of 19 in low-income families (up to 200% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration. The federal government implemented this program in 1997, giving states an enhanced match on State expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. The Plan also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization.

In October 2002, under an expansion authorized by HB 02-1155 and a federal demonstration waiver, the program began offering health benefits to pregnant women earning up to 185% of the federal poverty level who are not eligible for Medicaid. Due to budget balancing, enrollment into the Prenatal and Delivery Program was suspended from May 2003 through June 2004, with SB 03-291. The Prenatal and Delivery Program stopped funding care in November 2003, when the remaining prenatal care, deliveries, and postpartum care became a responsibility of the State-Only Prenatal Program, until all enrolled women had delivered and received two months postpartum care. Also, the children's program was capped in November 2003. In July 2004, both programs began accepting new applicants again.

HB 05-1262 (Tobacco Tax bill) contained several provisions that affected enrollment in the Children's Basic Health Plan. The following have had, and will continue to have, fiscal and caseload impacts through FY 07-08:

- Increase eligibility to 200% of the federal poverty level, which was implemented on July 1, 2005;
- Provide funding for enrollment above the FY 03-04 enrollment level;
- Provide funding for cost-effective marketing, which began on April 1, 2006, and;
- Remove the Medicaid asset test effective July 1, 2006, which has moved clients from the Children's Basic Health Plan to Medicaid.

The FY 06-07 Long Bill (HB 06-1385) appropriation for the Children's Basic Health Plan Premium Costs was based on projected enrollment of 42,590 children and 1,578 adult prenatal clients per month. HB 06-1385 appropriated $70,371,177 in total funds to the Children's Basic Health Plan Premium Costs.

The dental benefit for children was added to the Children's Basic Health Plan on February 1, 2002. This benefit is managed through a capitated contract with Delta Dental, a dental plan administrator. As such, the contracted administrator bears the risk associated with the dental benefit. The plan administrator has an extensive statewide network with over seven hundred providers. The Children's Basic Health Plan (CBHP) dental benefit is comprehensive, and limits each child to $500 worth of services per year.

The FY 06-07 Long Bill (HB 06-1385) appropriation for the Children's Basic Health Plan Dental Benefit costs was based on projected enrollment of 37,053 clients per month. HB 06-1385 appropriated $5,913,659 in total funds for the Children's Basic Health Plan Dental Benefit Costs. Provisions in the Tobacco Tax Bill (HB 05-1262) that have affected the Premiums line also affect the Dental Benefits line.

General Description of Alternative:

This Alternative seeks:

- The funding necessary to allow natural enrollment growth for children and pregnant women;
- To adjust the rates for medical and dental services in accordance with actuarial projections, and;

- To adjust the Cash Funds appropriation to the Children's Basic Health Plan Trust Fund for a revised estimate of enrollment fees, as well as the General Fund appropriation to balance the Trust Fund.

Summary of Requested Changes for Children	FY 06-07 Appropriation	FY 06-07 Revised Estimate	FY 07-08 Request	Percent Change in Rate/ Caseload
Base Children's Caseload (with Marketing)	51,612	57,994	67,890	31.6%
Remove Medicaid Asset Test	(12,979)	(12,045)	(22,841)	-
Increase Children's Eligibility to 200% FPL	3,955	3,306	5,094	28.8%
Total Children's Caseload	42,590	49,255	50,143	17.7%
Children's Blended Rate[1]	$104.14	$105.88	$112.68	8.5%
Dental Caseload (78.9% of the Premiums Caseload)	37,053	38,862	39,563	6.8%
Dental Rate	$13.30	$13.30	$13.97	5.0%

Summary of Requested Changes for Prenatal Program	FY 06-07 Appropriation	FY 06-07 Revised Estimate	FY 07-08 Request	Percent Change in Rate/ Caseload
Traditional Prenatal Member Months (with Marketing)	1,428	1,428	1,428	-
Expansion Prenatal Member Months	17,508	17,913	25,828	47.5%
Total Prenatal Member Months	18,936	19,341	27,256	43.9%
Prenatal Rate	$905.54	$1,045.44	$865.10	-4.5%

Calculations to support this request can be found at Attachment 1 behind this document.

[1] The children's blended rate consists of a weighted average of the HMO rate (58%) and the rate for the Self-Insured Managed Care Network (42%).

I. Description of Alternative Related to CBHP Children's Premiums

Caseload (see Table G of Attachment 1)

The current appropriation for FY 06-07 includes funding for an average monthly enrollment of 42,590 children, consisting of 38,635 traditional and 3,955 expansion clients. This request projects the FY 06-07 average monthly enrollment to be 49,225, with 45,949 traditional and 3,306 expansion clients. The traditional children projection is 18.9% higher than the appropriated caseload and the expansion projection is 16.4% lower than the appropriation, resulting in a total children's caseload projection that is 15.6% higher than appropriated. However, enrollment at the end of FY 06-07 is projected to be 43,781. The forecasted decrease in enrollment over the course of FY 06-07 is the anticipated result of removing the Medicaid asset test on July 1, 2006. The FY 07-08 average monthly enrollment is projected to be 50,143, comprised of 45,049 traditional and 5,094 expansion children. This represents a 2.0% decline in the traditional children caseload and 54.1% growth in expansion children, leaving growth of 1.8% in total children's caseload.

Implementation of the Medicaid Asset Test Removal (see Table G of Attachment 1)

HB 05-1262 (Tobacco Tax bill) removed the Medicaid asset test for low-income children and families. Medicaid eligibility extends to 133% of the federal poverty level for children up to 5 years of age, and to 100% of the federal poverty level for children over the age of 5. Historically, about 39.5% of the clients in the Children's Basic Health Plan would be income eligible for Medicaid, except for the Medicaid asset test. In calculating the impact of removing the asset test, the Department assumes that this percentage is constant for FY 06-07 and FY 07-08.

The Centers for Medicare and Medicaid Services indicated clients should only become eligible for the medical assistance programs after a complete eligibility redetermination. The Children's Basic Health Plan requires an annual eligibility redetermination for each client on the anniversary date they entered the program. This effectively means the asset

test removal will be implemented gradually over the course of FY 06-07 as clients come up for their annual eligibility redetermination. The Department's projection of the number of children transitioning to Medicaid is shown in Table G of Attachment 1 behind this document. In developing this projection, the Department assumed that redeterminations are spread evenly throughout the year, and that a uniform percentage of the caseload will transition to Medicaid every month. For FY 07-08, all clients will have undergone redetermination, so the adjustment is constant.

Marketing the Children's Basic Health Plan (see Table G of Attachment 1)

HB 05-1262 (Tobacco Tax bill) provides funding for cost effective marketing of the Children's Basic Health Plan. A contract with Maximus was executed in January 2006, and marketing started on April 1, 2006. The Department assumes that the impact of marketing on children's caseload will be high at the beginning of the fiscal year, as the campaign is new and reaches a large number of potential clients. The effectiveness is expected to decrease over the course of the year as the pool of potential clients who have not been exposed to the campaign declines. The marketing impact for the prenatal caseload is calculated using similar assumptions. However, due to the size of the population, the Department assumes that marketing will be twice as effective and that the campaign will have a more lasting impact on the rate of growth.

A new marketing campaign will be launched for the beginning of FY 07-08, so the impact is expected to increase. However, the Department assumes that the effectiveness will decrease in the second year of the campaign, as the number of potential new clients has decreased by the number who were enrolled in the Children's Basic Health Plan in the previous year. The adjustments for both the children's and prenatal populations in FY 07-08 are thus assumed to be lower than in FY 06-07, and exhibit the same pattern of declining effectiveness described above.

Traditional Children's Basic Health Plan Caseload (Table G of Attachment 1)

The methodology used in determining the Children's Basic Health Plan caseload at this time is to count capitations. Because the Children's Basic Health Plan uses accrual based accounting, these capitations include five months of retroactivity. As a result, caseload for FY 05-06 is not yet final. Traditional children's population (to 185% of the federal poverty level) enrollment for the remainder of FY 05-06 is projected using a six month average count of retroactive capitations. Including retroactivity, there were 45,948 children enrolled in the program in this income range in January 2006.

Between January 2005 and January 2006, caseload in this income range increased by an average of 663 members per month. Given this recent trend and incorporating the estimated marketing impact, the Department has estimated the traditional children's caseload to grow by 1,201 clients in July 2006, decreasing to 731 clients per month by the end of the fiscal year. In addition, the Deficit Reduction Act of 2005, which does not apply to the Children's Basic Health Plan, is expected to add an annual average of 172 children as they lose Medicaid eligibility due to the identification. As more data becomes available, the caseload estimates will be revised.

Building from this projection, for FY 07-08 the Department assumes that monthly base growth will decrease as the economy continues to recover, and children and families no longer meet the income requirements. Monthly base growth is projected to decline by 10% to 597 traditional children. Incorporating the estimated marketing impact, the traditional children's caseload is projected to grow by 1,081 clients in July 2007, decreasing to 658 clients per month by the end of the fiscal year. As in FY 06-07, the Deficit Reduction Act is projected to add clients in FY 07-08.

Children to 200% of the Federal Poverty Level (Table G of Attachment 1)

On July 1, 2005, the Department implemented the HB 05-1262 provision that increased eligibility for children in the program from 185% of the federal poverty level to 200% of the federal poverty level. As with the traditional children, the FY 05-06 caseload for this

income range is not yet final. Expansion population enrollment for the remainder of FY 05-06 is projected using a three month average count of retroactive capitations. Including retroactivity, there were 1,638 children enrolled in the program in this income range in January 2006.

Between July 2005 and January 2006, enrollment in this income range increased by an average of 150 members per month. Given this recent trend and incorporating the estimated marketing impact, the Department is forecasting the expansion children's caseload to grow by 169 clients in July 2006, decreasing to 153 per month by the end of the fiscal year.

Building from this projection, for FY 07-08 the Department assumes that monthly base growth will decrease as the economy continues to recover, and children and families no longer meet the income requirements. Monthly base growth is projected to decline by 10% to 135 expansion children. Incorporating the estimated marketing impact, the expansion children's caseload is projected to grow by 152 clients in July 2007, decreasing to 138 per month by the end of the fiscal year.

Final Children's Caseload Projection

The final children's caseload projection for FY 06-07 is an average monthly enrollment of 49,255. This is the base caseload projection including the impact of marketing, less the reduction in caseload from the removal of the Medicaid asset test, plus the expansion to 200% of the federal poverty level and the increase due to the Deficit Reduction Act. Monthly growth in FY 07-08 in the children's caseload including marketing is projected to decline by 10% from FY 06-07 level, resulting in a base average monthly enrollment of 67,890. Adjusting down for the removal of the Medicaid asset test and adding in the average monthly enrollment of the expansion children leaves a final caseload projection for FY 07-08 of 50,143. See the summary table below.

HB 05-1262 directed that the expansion clients (186% to 200% of the federal poverty level) be financed with monies from the Health Care Expansion Fund. For traditional

children (up to 185% of the federal poverty level), caseload beyond the FY 03-04 level of 560,328 member months is financed by the Health Care Expansion Fund rather than the Children's Basic Health Plan Trust Fund. The Department is forecasting that traditional children caseload will not reach this level in either FY 06-07 or FY 07-08.

Children's Caseload Summary	FY 06-07 Appropriated Caseload	FY 06-07 Revised Caseload	FY 07-08 Request Caseload
Traditional Base Caseload with Marketing	51,612	57,994	67,890
Impact of Removing the Medicaid Asset Test	(12,979)	(12,045)	(22,841)
Traditional Children Subtotal	**38,635**	**45,949**	**45,049**
Increase eligibility to 200% Federal Poverty Level	3,955	3,306	5,094
Final Caseload Forecast	**42,590**	**49,255**	**50,143**

Children's Rates

Children's Basic Health Plan clients are serviced by either a health maintenance organization (HMO) at a fixed monthly cost, or by Anthem, which is a no-risk provider that bills the State directly for all costs incurred (self-funded). The average per month cost for each HMO client is projected to be $95.44 in FY 06-07, which is 26.0% lower than the $120.30 expended on average for each self-funded client. Based on FY 05-06 actual and projected caseload, the Department assumes that 42% of all clients in the traditional and expansion populations are in the self-funded plan, and the remainder is served by the health maintenance organizations (58%). Applying this ratio to the actuarial rates developed yields a blended rate of $105.88 on average per client per month across all populations in the Children's Basic Health Plan Premiums group for FY 06-07. The FY 06-07 appropriated rate assumed that 35% of clients were in the self-funded plan and 65% were in an HMO. The change in the assumption regarding plan ratios results in a revised blended rate estimate for FY 06-07 that is 1.7% higher than the appropriation.

The Children's Basic Health Plan is responsible for all costs incurred by its members, including any extraordinary health care services. While the per member per month medical cost includes some variability in costs per client, a single child with catastrophic health care claims (such as for a life-threatening illness or severe auto accident) could cost the program potentially hundreds of thousands of dollars. Unlike Medicaid, the Children's Basic Health Plan is not an entitlement program and the Department does not have overexpenditure authority for this program; the Children's Basic Health Plan must pay all claims incurred through its annual appropriation. Presently, the Department mitigates this risk by purchasing reinsurance. Reinsurance protects insurers from catastrophic claims by paying for claims over a predetermined dollar amount. Reinsurance premiums are paid by a per member per month charge. Like the State, health maintenance organizations are responsible for covering claims for catastrophic cases enrolled in their plans, and often use reinsurance coverage to mitigate their financial risk in this area as well.

In developing the actuarial rates for the self-funded group, these notable assumptions were made:

- Denied claims were not included;
- Claims for newborns with mothers enrolled under the Children's Basic Health Plan Prenatal Program were removed if services were performed within 15 days of birth, and;
- Claim cost projections assumed to grow at 8.2%.

The self-funded rate per person for FY 06-07 of $120.30 is 11.1% greater than the rate used in FY 05-06 ($108.30). The FY 06-07 rate includes $27.44 in administrative costs and $2.59 in risk insurance per client per month in the self-funded program.

The health maintenance organization (HMO) rate for FY 06-07 of $95.44 is a decrease of 2.1% from the capitated rate paid to HMO providers in FY 05-06 ($97.44 per member per month). The same basic assumptions that were used for the development of the self-

funded rate were also used to derive the HMO rate. However, it should be noted that the HMOs define their own benefit structures and, as such, can offer more benefits than the Department requires. In calculating the rates, the contracted actuary disregarded the additional benefits and costs of services provided above and beyond those required by the Department.

For rates effective in FY 07-08, the Department contracted with the same actuary to develop the health maintenance organization and self-funded network blended rate. The assumptions used in the FY 06-07 determination of rates were used in the FY 07-08 determination, with the claim cost projected to grow by 7.2%, down from 8.2% in FY 06-07. However, the contracted actuary identified two factors that could have a significant impact on estimated rates for FY 07-08. First, the removal of the Medicaid asset test will move any Children's Basic Health Plan client under 100% or 133% of the federal poverty level onto Medicaid (depending on the age of the child), thus decreasing the FY 07-08 caseload. Second, both membership data and claims data were used to identify the income level of clients, which effects the calculation of rates.

According to the contracted actuary, the self-funded (Anthem) program is projected to spend $124.00 per member per month in FY 07-08, which is a 3.1% increase over the previous fiscal year's rate of $120.30. The new FY 07-08 rate includes an estimated $29.00 in administrative costs and $2.43 in risk insurance costs per client per month in the self-funded program. The contracted actuary assumed that health care costs would grow at an estimated 7.15% based on other industry reports.

As with the FY 06-07 calculation of the health maintenance organization rate, the FY 07-08 calculation did not include costs and benefits above and beyond those required by the Department. The projected rate for HMOs in FY 07-08 is $104.48 per member per month, which is a 9.4% increase over the FY 06-07 HMO rate of $95.44. A history of the health maintenance organization and the self-funded network rates can be found in the table at the end of Section III (page 17). Assuming the HMO and self-funded ratios used for FY 06-07 are constant for FY 07-08, the blended rate is $112.68.

II. Description of Alternative Related to the Prenatal Program

Traditional Prenatal Caseload (Table H of Attachment 1)

The methodology used in determining the Children's Basic Health Plan caseload is to count capitations. Because the Children's Basic Health Plan uses accrual based accounting, these capitations include five months of retroactivity. As a result, caseload for FY 05-06 is not yet final. The traditional prenatal population enrollment for the remainder of FY 05-06 is projected using a six month average count of retroactive capitations.

Enrollment in the prenatal program was suspended in May of 2003, and reopened in July 2004. Since the program was reopened, caseload in this income range (including retroactivity) has grown to 1,107 clients enrolled in January 2006. From February 2005 to December 2005, caseload grew by an average of 32 clients per month. As there are a finite number of women in the State who may qualify for this program, the Department assumes that growth will slow as enrollment nears a saturation point. As such, the FY 06-07 forecast assumes that base growth will decrease by 10% after 6 months. Given this and the estimated marketing impact, the Department is forecasting the traditional prenatal caseload to grow by 51 clients in July 2006, decreasing to 37 clients per month by the end of the fiscal year.

As the program continues to mature, the FY 07-08 projection assumes that enrollment growth for women up to 185% of the federal poverty level will continue to slow, by 10% for the first half of the fiscal year, and a further 10% in the second half. Given this and the estimated marketing impact, the Department is forecasting the traditional prenatal caseload to grow by 43 clients in July 2007, decreasing to 30 clients per month by the end of the fiscal year.

Increase Prenatal eligibility to 200% of the Federal Poverty Level (Table H of Attachment 1)

On July 1, 2005, the Department implemented an increase in eligibility for prenatal women in the program from 185% of the federal poverty level to 200% of the federal poverty level. As with the traditional prenatal population, the FY 05-06 caseload for this income range is not yet final. The expansion prenatal population for the remainder of FY 05-06 is projected using a three month average count of retroactive capitations. There were 118 women enrolled in the program in this income range in January 2006, the most recent month of capitations including all retroactivity. Due to the newness of this program, monthly growth is projected using caseload without retroactivity. From July 2005 to June 2006, caseload without retroactivity grew by an average of 12 clients per month. As there are a finite number of women in the State who may qualify for this program, the Department assumes that growth will slow as enrollment nears a saturation point. The FY 06-07 forecast assumes that base growth will decrease by 10% after 6 months. Given this and the estimated marketing impact, the Department is forecasting the expansion prenatal caseload to grow by 22 clients in July 2006, decreasing to 16 clients per month by the end of the fiscal year.

As the program continues to mature, the FY 07-08 projection assumes that enrollment growth for women in this income range will continue to slow, by 10% for the first half of the fiscal year, and a further 10% in the second half. Given this and the estimated marketing impact, the Department is forecasting the expansion prenatal caseload to grow by 19 clients in July 2007, decreasing to 14 clients per month by the end of the fiscal year.

Final Prenatal Caseload Projection

The final prenatal caseload projection for FY 06-07 is a total of 19,341 member months, or an average monthly enrollment of 1,612. This is the base caseload projection plus the expansion to 200% of the federal poverty level including the impact of marketing. FY 07-08 growth in the prenatal caseload including marketing is projected to decline by 10%

from the end of FY 06-07, resulting in a final prenatal caseload projection for FY 07-08 of 27,256 member months, or an average monthly enrollment of 2,271. This includes both the traditional caseload and the expansion to 200% of the federal poverty level. See the summary table below.

HB 05-1262 directed that the expansion clients (186% to 200% of the federal poverty level) be financed with monies from the Health Care Expansion Fund. For traditional prenatal (up to 185% of the federal poverty level), caseload beyond the FY 03-04 level of 1,428 member months is financed by the Health Care Expansion Fund rather than the Children's Basic Health Plan Trust Fund. The Department is forecasting the traditional prenatal caseload to reach this level early in FY 06-07 and exceed it for all of FY 07-08.

Prenatal Caseload Summary	**FY 06-07 Appropriated Caseload**	**FY 06-07 Revised Caseload**	**FY 07-08 Request Caseload**
Traditional base caseload with marketing	16,899	16,325	21,840
Increase eligibility to 200% Federal Poverty Level	2,037	3,016	5,416
Final caseload forecast	**18,936**	**19,341**	**27,256**

Prenatal Rates

The prenatal rate developed by the contracted actuary for FY 06-07 was $1,045.44 per client per month. All of the clients in the prenatal program are served by the self-funded program (Anthem) and the costs of their services are billed directly and in full to the State. The assumptions that were used to develop the rates for the self-funded prenatal clients were used in the development of the prenatal rates with one significant exception: services for newborns with mothers enrolled in the Children's Basic Health Plan children's program were included for the prenatal rate calculation, but were not included in the premiums calculations. The FY 06-07 prenatal rate of $1,045.44 includes $30.04 per member per month in administrative and risk insurance costs (see Children's Rates, Section I). The appropriated FY 06-07 rate assumed that the average length of stay in the

prenatal program (which includes 2 months postpartum) was 9 months, and all clients delivered while in the program. Updated actuarial analysis assumes that the average length of stay for FY 06-07 is 6 months, and that 85% of pregnant women deliver while in the program. These changes in assumptions result in a revised rate for FY 06-07 that is 15.4% higher than the appropriation.

In FY 07-08, the projected cost for a prenatal client estimated by the contracted actuary was considerably less than FY 06-07's projection. The new rate of $865.10 per member per month reflects a 17.3% decrease from the $1,045.44 rate in the previous year due to the following factors:

- Previous program enrollment rates had been based on a short period of enrollment, which was then closed for a time, and then reopened. This created a distortion in the data, and;
- Changes in unit costs reflect underlying fee schedules and variation in the "blend" of services received by clients.

A summary of the prenatal rates from FY 05-06 through FY 07-08 can be found in the table at the end of Section III (page 18).

III. Description of Alternative Related to the Children's Dental Benefit Costs

Caseload Adjustment

Children who qualify for the Children's Basic Health Plan are eligible to receive dental benefits as well as medical benefits. There are consistently fewer members enrolled in the dental program than in the medical plan, because new members do not receive dental coverage during their pre-HMO enrollment period. Previous estimates indicated that 87% of the children enrolled in the Children's Basic Health Plan were enrolled in the dental program. However, between July 2005 and January 2006, the average monthly ratio of dental capitations to medical capitations was 78.9%. The Department assumes that this ratio stays constant for FY 06-07 and FY 07-08, and estimates that dental

caseload will be 78.9% of the medical caseload. The average monthly enrollment in the medical plan is projected to be 49,255 and 50,143 clients in FY 06-07 and FY 07-08, respectively. The FY 06-07 and FY 07-08, dental projection for average monthly enrollment is therefore 78.9% of these figures, or 38,862 and 39,563, respectively. The growth from FY 05-06 to FY 06-07 is slower than that in the medical plan due to the decline in the estimated ratio between dental enrollment and medical enrollment.

Children's Dental Rates

In 2002, dental benefits were added to the Children's Basic Health Plan under a capitated contract with Delta Dental. Benefits for children enrolled in the Children's Basic Health Plan are comprehensive, though there is a $500 spending ceiling per client. A year's worth of data through March 2004 was used to determine the FY 06-07 rate, based on a number of assumptions by the actuary that include:

- All denied claims should be excluded from the calculation;
- Annual trend rate of 6.3% growth for calculations, and;
- Administrative fees grew at the same rate as the adjusted Consumer Price Index for Denver (2000-2004).

The final rate for FY 06-07 is projected to be $13.30 per member per month, which includes $1.03 in average administrative fees per client. Previously, the capitated dental rate in FY 05-06 was calculated to be $11.82 per member per month. Budget Amendment #10 of the February 15, 2006 Supplemental Request (which was approved) asked that funding be adjusted to reflect the new rate of $13.30 and requested an additional $462,134 in total funding for Children's Basic Health Plan dental benefits.

The dental rate estimated by the contracted actuary for FY 07-08 increased by 5% over the previous year's final estimate of $13.30. In developing the estimate of $13.97 per member per month, the contracted actuary assumed that there was no change in the amount of benefits that a client on the Children's Basic Health Plan would receive. However, because the contracted actuary believes the Delta Dental membership data is

incomplete, an industry trend was used instead of historical data to establish a reasonable rate change. All rates for FY 05-06, FY 06-07, and FY 07-08 can be found in the following table:

Summary of All Rates	FY 05-06 Assumption for Appropriation	FY 06-07 Assumption for Estimate	FY 07-08 Request	Percent Change from FY 06-07 to FY 07-08
Health Maintenance Organization Rates	$97.74	$95.44	$104.48	9.4%
Self-funded Provider (Anthem) Rate	$108.30	$120.30	$124.00	3.1%
Prenatal Rates	$969.29	$1,045.44	$865.10	-17.3%
Dental Benefit Rates	$11.82	$13.30	$13.97	5.0%

IV. Description of Alternative Related to the Trust Fund

The Children's Basic Health Plan Trust Fund is funded primarily through Tobacco Master Settlement appropriations and General Fund (when necessary); however, enrollment fees from clients of the program and interest earnings on the Fund's balance also serve to subsidize the Trust. In FY 05-06, $900,000 was refunded to the Trust in January of 2006, as repayment for a 2002 transfer to the Department of Treasury used to reduce the State's General Fund deficit.

A revised estimate of the FY 07-08 Tobacco Master Settlement allocation to the Trust Fund was provided by Legislative Council Staff in June 2006, in the amount of $21,465,077. Based on total projected program expenses of $74,871,205 for FY 07-08 and total revenues (including the beginning balance and federal funds matching) of $70,284,359, there would be a Trust Fund balance shortfall of $4,586,846 for FY 07-08. Due to the fact that the monies will collect interest while in the Trust, the Department estimates a need of $4,481,968 in General Fund for FY 07-08 (see Table A of Attachment 1).

There were several factors that had a significant impact on the FY 07-08 Trust Fund balance and the projected General Fund need, including the difference between actual

and projected traditional caseload in FY 05-06 and FY 06-07, legislative action, and updated rate and traditional caseload projections for FY 07-08.

The Children's Basic Health Plan serves traditional clients whose costs are paid through the Trust, as well as expansion clients whose costs are covered by tobacco tax revenues from the Health Care Expansion Fund. However, because the funding for the expansion clients is sufficient, only the increases in caseload and rates for traditional clients will have an impact on the Trust Fund balance. The number of traditional clients served by the Children's Basic Health Plan in FY 05-06 (including projected retroactivity) is 45,239, 6.3% higher than the appropriated caseload of 42,547. Due to a change in the assumption regarding the ratio between dental enrollment and medical enrollment, dental caseload is expected to be 3.5% lower than the appropriation.

Changes in caseload and rates in FY 06-07 are expected to have a much greater effect on the Trust Fund balance than in FY 05-06. The FY 06-07 appropriation estimates a total of 38,635 traditional clients per month at $104.14 each (see March 13, 2006 Figure Setting, page 198). For example, the Department's updated traditional caseload for FY 06-07 of 45,949 members per month is 18.9% higher than the appropriated amount. In addition to the increase in caseload, the blended rate for the traditional population is expected to increase 1.7% from $104.14 per member per month to $105.88 per member per month. Accounting for both caseload and rate increases, FY 06-07 expenditures for the traditional children are projected to be $10,107,429 higher than appropriated (see Table J of Attachment 1). The total Cash Funds Exempt needed due only to increased caseload and rates for premiums and dental costs (excluding enrollment fees) is $3,734,512 for FY 06-07.

In addition to the costs associated with the increase in caseload, the Children's Basic Health Plan Trust was affected by SB 05-211. This legislative action caused a transfer of $8.1 million from the Trust to the General Fund on June 30, 2006. The Trust Fund's beginning balance in FY 06-07 after the $8.1 million transfer from the Children's Basic Health Plan Trust to the General Fund was $4,411,882 (see Attachment 1, Table A, Row M).

A portion of the funding that the Children's Basic Health Plan receives comes from the Tobacco Master Settlement Agreement. The Master Settlement Agreement transfer was estimated in Figure Setting (page 186) to be $20,973,924 for FY 06-07. However, the actual amount of money received from the Master Settlement Agreement was $19,248,927. Given this difference and the impact from increased caseload and rates, the Department estimates that $1,473,078 in General Fund will be needed in FY 06-07 to bring the Children's Basic Health Plan Trust Fund balance to zero for the beginning of FY 07-08 (see Table J of Attachment 1).

The Department projects a decrease in the traditional children's caseload due to the removal of the Medicaid asset test from the FY 06-07 revised estimate to FY 07-08. However, the FY 07-08 projected caseload of 45,049 traditional children is 16.6% higher than the FY 06-07 appropriation. The blended premiums rate for children for FY 07-08 is 6.6% higher than the FY 06-07 revised rate, and 8.2% higher than the FY 06-07 appropriation. The total difference between the projected FY 07-08 expenditures and the FY 06-07 appropriation due to the caseload and rate increases is $12,612,498 (see Table J of Attachment 1). The dental caseload and rates for FY 07-08 are projected to be 5.9% and 5.0% higher than the FY 06-07 appropriation, respectively. The combined result of these increases is a $599,520 increase in projected expenditures over the FY 06-07 appropriation. The prenatal rate for FY 07-08 is 5.6% lower than the FY 06-07 appropriation, resulting in projected expenditures $57,748 lower than appropriated.

The Children's Basic Health Plan's portion of the Colorado Benefits Management System eligibility processing costs have previously been funded with General Fund. Per the FY 06-07 Long Bill (HB 06-1385), Colorado Benefit Management System costs of $408,266 for the Children's Basic Health Plan eligibility processing are now funded from the Trust Fund. This cost is expected to carry over into FY 07-08 as well (see Table E of Attachment 1).

Expenditures from the Trust Fund include program expenses from the Children's Basic Health Plan premiums, dental, and administration line items, as well as a portion of the

Department's internal administration expenses allocated to the Children's Basic Health Plan. The State's share of these expenses is presented in Table E of Attachment 1 behind this document.

This alternative also requests an increase to the appropriation of Cash Funds received through annual enrollment fees of $47,163 for FY 07-08 above the Base Request of $192,396. Table D of Attachment 1 calculates the revenue projection for FY 07-08 at $239,559. Enrollment fees of $25 per year are collected from families above 150% of the federal poverty level with one child enrolled in the program. For families with more than one child and incomes above 150%, the annual enrollment fee is $35. The FY 07-08 Base Request for Cash Funds is calculated using an average annual enrollment fee collection of $3.78[2] per enrollee for clients under 185% of the federal poverty level, and at an average of $13.57[3] per enrollee for members between 185% and 200% of the federal poverty level.

In summary, the following affected the Trust Fund balance for FY 07-08:

FY 05-06

- $8.1 million in funding removed per SB 05-211, and;
- Increases of 6.3% in traditional caseload projection over the FY 05-06 appropriation.

FY 06-07

- Increases of 18.9% in forecasted traditional children's premium caseload and 7.9% in dental caseload over the FY 06-07 appropriation;
- 1.7% increase in premium rates over the FY 06-07 appropriated rates;
- $1.7 million reduction in the Master Settlement Agreement transfer estimate from Figure Setting and the actual amount, and;
- Colorado Benefits Management System funding of $408,266.

[2] $3.78 is based on FY 05-06 actuals and is derived by dividing the actual fee collections of $171,152 by the caseload estimate of 45,239.

[3] $13.57 per enrolled child is based on the cost of $35 for a family above 150% of the federal poverty line with more than one child divided by the average number of children in those households, calculated as 2.58 ($13.57 = $35 / 2.58).

FY 07-08

- Increases of 16.6% in children's premium caseload and 5.9% in dental caseload over the FY 06-07 appropriation, and;
- Increases of 8.2% medical premium rates and 5.0% in dental rates over the FY 06-07 appropriation.

V. Description of Alternative Related to Reconciliation of Overdrawn Administrative Expenditures

When the federal government enacted the State Children's Health Insurance Plan, it stipulated that administrative costs *up to* 10% of total program expenditures would be matched by the federal government. The Children's Basic Health Plan is the State of Colorado's version of the State Children's Health Insurance Plan and in the early years, the Department experienced administrative costs that were in excess of the 10% cap and was therefore entitled to claim the entire amount of federal matching funds available. In subsequent years, however, the Department continued to draw federal matching funds on 10% of its budgeted program expenditures, even though actual administrative costs as a portion of total expenditures decreased considerably. As a result, the Department has recently quantified that it received federal matching funds in excess of what it was entitled to for FY 04-05 and FY 05-06. If not corrected, the Department will have a liability to the federal government for receiving funds in excess of what it was due.

In addition, concerns still remain as to whether or not expenditures have been booked properly into administrative costs, which could significantly alter any estimate of the Department's overdraw. The Department regrets this error and is taking immediate steps to correct the federal draw going forward.

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request for Children's Basic Health Plan Trust Fund	**Total Funds**	**General Fund**	**Cash Funds**	**Cash Funds Exempt**
FY 06-07 Long Bill Appropriation	$21,165,996	$0	$192,072	$20,973,924
HB 06-1310 (Simplify Tobacco Money Distribution)	($20,973,924)	$0	$0	($20,973,924)
Final FY 06-07 Appropriation (Column 2)	$192,072	$0	$192,072	$0
Annualization of HB 06-1270 (Public School Eligibility Determination)	$324	$0	$324	$0
FY 07-08 Base Request (Column 5)	$192,396	$0	$192,396	$0
FY 07-08 Incremental Need (Column 6)	$4,529,131	$4,481,968	$47,163	$0
FY 07-08 Final Appropriation (Column 7)	**$4,721,527**	**$4,481,968**	**$239,559**	**$0**

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request for Children's Basic Health Plan Premiums Costs	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 06-07 Appropriation (Column 2)	$70,371,177	$24,754,759	$45,616,418
Annualization of HB 06-1270 (Public School Eligibility Determination)	$95,601	$33,671	$61,930
FY 07-08 Base Request (Column 5)	$70,466,778	$24,788,430	$45,678,348
FY 07-08 Estimated Need (Column 6)	$20,913,747	$7,350,467	$13,563,280
FY 07-08 Revised Request (Column 7)	**$91,380,525**	**$32,138,897**	**$59,241,628**

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request for Children's Basic Health Plan Dental Benefit Costs	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
FY 06-07 LB Appropriation (Column 2)	$5,913,659	$2,069,780	$3,843,879
Annualization of HB 06-1270 (Public School Eligibility Determination)	$10,653	$3,729	$6,924
FY 07-08 Base Request (Column 5)	$5,924,312	$2,073,509	$3,850,803
FY 07-08 Incremental Need (Column 6)	$708,029	$247,810	$460,219
FY 07-08 Revised Request (Column 7)	**$6,632,341**	**$2,321,319**	**$4,311,022**

Impact on Other Areas of Government: The Department of Human Services administers the Children's Basic Health Plan's portion of the Colorado Benefits Management System eligibility processing costs, which are now funded through the Children's Basic Health Plan Trust Fund. This Change Request does not affect this appropriation.

Assumptions for Calculations: Table A of Attachment 1 behind this document develops the Children's Basic Health Plan Trust Fund projection for FY 07-08. The General Fund requested for the Children's Basic Health Plan Trust in FY 07-08 can be found in row P. Table D of Attachment 1 provides the revised enrollment fee revenues projection for FY 07-08. Table G of Attachment 1 develops the children's caseload projection calculations. Graph 1 of Attachment 1 depicts the children's enrollment developed in Table G. The prenatal caseload projections are developed in Table H of Attachment 1.

Assumptions for Children's Caseload Projection

FY 06-07 and FY 07-08 Enrollment Projections (Table G of Attachment 1)

- Calculations supporting the impact of removing the Medicaid asset test are shown at the bottom of Table G in Attachment 1 on page 9. The removal of the Medicaid asset test began on July 1, 2006. The affected clients will transition to Medicaid after their

annual redetermination, which will all occur during FY 06-07. The Department assumes that redeterminations are spread evenly throughout the year, and that a uniform percentage of the caseload will transition to Medicaid every month. Using the assumption from the HB 05-1262 fiscal note that 39.5% of the clients in the Children's Basic Health Plan would qualify for Medicaid except for the asset test, 3.3% of the children's caseload is assumed to transition to Medicaid every month (39.5% / 12 = 3.3%). This results in a total of 22,841 children moving from Children's Basic Health Plan to Medicaid, or an annual average of 12,045 in FY 06-07. Because the base caseload projection for FY 07-08 includes clients affected by the Medicaid asset test removal, a constant adjustment of the entire 22,841 is necessary every month in FY 07-08.

- To calculate the impact of marketing on enrollment, the Department compared average monthly growth during a period with marketing to a period without. The average monthly growth rate from July 2001 and December 2002, during which there was marketing, was 1.93%, versus average monthly growth of 0.76% from January 2003 to June 2003, after marketing ceased. The Department estimates that, for children, the growth attributed to marketing is 1.93% minus 0.76%, or 1.17% per month. The percentage impact from marketing is applied to the January 2006 final caseload (the most recent month of capitations with all retroactivity) to estimate the level impact on the children's caseload for the beginning of FY 06-07. The Department assumes that growth in new Children's Basic Health Plan clients will be high at the beginning of marketing, as the campaign is new and reaches a large number of potential clients. The effectiveness is expected to decrease over the course of the year as the pool of potential clients who have not been exposed to the campaign declines. The level impact is thus assumed to decrease by 50% every quarter. A new marketing campaign will be launched for the beginning of FY 07-08, so the impact is expected to increase. However, the Department assumes that the effectiveness will decrease in the second year of the campaign, as the pool of potential new clients has decreased by the number who were enrolled in the Children's Basic Health Plan in the previous year. The adjustments for the children's populations in FY 07-08 are

thus assumed to be 10% lower than in FY 06-07, and exhibit the same pattern of decline over the course of the year.

- The FY 06-07 caseload projection for traditional children (under 185% of the federal poverty level) is based on actual enrollment (including retroactivity) for January 2005 through January 2006. During this period, caseload increased by an average of 663 clients per month ((45,948 minus 37,989) / 12 months). Given this and the estimate for the marketing impact, the Department projects the traditional children's caseload to grow by 1,201 clients in July 2006, decreasing to 731 clients per month by the end of the fiscal year. With an improving economy, this trend is expected to decrease by 10% in FY 07-08, and the caseload is expected to increase by 1,081 clients in July 2007, and decrease to 658 new clients at the end of the fiscal year.

- Monthly enrollment for expansion children (between 185% and 200% of the federal poverty level) grew on average 150 members per month between July 2005 and January 2006 ((1,638 minus 812) / 6 months). Given this and the estimate for the marketing impact, the Department projects the expansion children's caseload to grow by 169 clients in July 2006, decreasing to 153 clients per month by the end of the fiscal year. With an improving economy, this trend is expected to decrease by 10% in FY 07-08, and the caseload is expected to increase by 152 clients in July 2007, and decrease to 138 new clients at the end of the fiscal year.

Assumptions for Prenatal Caseload Projections

FY 06-07 and FY 07-08 Enrollment Projections (Table H of Attachment 1)

- The marketing impact for the prenatal caseload is calculated using similar assumptions as for children. However, due to the size of the population, the Department assumes that marketing will be twice as effective, and the growth attributed to marketing is 1.17% times 2 = 2.34% per month. As with the children's caseload, the percentage impact is applied to the January 2006 prenatal caseload (the most recent month of capitations with all retroactivity) to estimate the level impact

for the beginning of FY 06-07. Due to the size and newness of the prenatal population, the campaign is assumed to have a more lasting impact on the rate of growth. Thus, the marketing impact is assumed to decline by half of that for children, or only 25% every quarter. The impact from marketing is calculated for the total prenatal caseload, and the effect on the expansion prenatal caseload is then separated from that for the traditional population. As the expansion prenatal population is much smaller and newer than the traditional population, marketing is expected to reach a relatively large portion of the potential client base. Thus, the impact for the expansion prenatal population, which constitutes 11.8% of the total prenatal caseload, is 35.4% of the total prenatal marketing impact. As with the marketing impact for children, the FY 07-08 impact is assumed to rise with the new campaign, but to levels 10% lower than those for FY 06-07.

- The FY 06-07 caseload projection for traditional prenatal (up to 185% of the federal poverty level) is based on actual enrollment (including retroactivity) from February 2005 through December 2005. During this period, caseload increased by an average of 32 clients per month (1,038 minus 714 / 10 months). As there are a finite number of women in the State who may qualify for this program, the Department assumes that growth will slow as enrollment nears the saturation point. The FY 06-07 forecast assumes that base growth will decrease by 10% after 6 months. Given this and the estimate for the marketing impact, the Department projects the traditional prenatal caseload to grow by 51 clients in July 2006, decreasing to 37 clients per month by the end of the fiscal year. For FY 07-08, base trend is assumed to continue to decline by 10% every 6 months. Given this and the estimated marketing impact, the traditional prenatal caseload is expected to increase by 43 clients in July 2007, and decrease to 30 new clients per month by the end of the fiscal year.

- Due to the newness of the prenatal population up to 200% of the federal poverty level, monthly growth is projected using caseload without retroactivity. From July 2005 to June 2006, caseload without retroactivity grew by an average of 12 clients per month. As there are a finite number of women in the State who may qualify for this program, the Department assumes that growth will slow as enrollment nears the

saturation point. The FY 06-07 forecast assumes that base growth will decline by 10% in the second half of the fiscal year. Given this and the estimate for the marketing impact, the Department projects the expansion prenatal caseload to grow by 22 clients in July, decreasing to 16 clients per month by the end of the fiscal year. For FY 07-08, base trend is assumed to continue to decrease by 10% every 6 months. Given this and the estimated marketing impact, the expansion prenatal caseload is expected to increase by 19 clients in July 2007, and decrease to 14 new clients per month by the end of the fiscal year.

Assumptions for the Dental Caseload Projections

The dental caseload projection is estimated to be 78.9% of the children's caseload projection. The 78.9% factor was estimated by comparing actual enrollment in the dental program to enrollment in the medical program for the first part of FY 05-06 (through January 2006, the most recent month of capitations including all retroactivity). Reimbursement for medical care through Children's Basic Health Plan's self-insured managed care network is allowed from the date the application is complete; however, capitated benefits through Children's Basic Health Plan's health maintenance organizations and dental program are not. Enrollment into these capitated plans is dependent upon the date of application approval. For those who apply and are found eligible on or before the 21st of the month, enrollment begins the first day of the next month. Capitation payments are paid concurrently to health maintenance organizations and the dental contractor in the middle of the month of the client's enrollment. For those determined eligible after the 21st of the month, capitations and enrollment into these plans does not occur until the first day of the following month. Thus, the dental capitation is always paid for fewer children than are actually enrolled in the Children's Basic Health Plan. The average ratio of dental enrollment to medical enrollment for the first part of FY 05-06 was 78.9%. This ratio is assumed to stay constant for FY 06-07 and FY 07-08.

Concerns or Uncertainties of Alternative: There is room for error in the Trust Fund's ending balance projection in FY 06-07 as the ending balance depends on both the accuracy of expenditure forecast and revenue forecasts. Revenues from interest earnings and annual enrollment fees can vary from

projections causing the Trust to run short on funds despite under spending the program appropriations. The Department believes it is advantageous to carry a reserve balance in the Trust to avoid this situation.

Children's Basic Health Plan caseload estimates for FY 06-07 and FY 07-08 project the impact of the removal of the Medicaid asset test and marketing without the benefit of actual data. As actual data becomes available, the Department will revise its assumptions and estimates. This may have a material effect on the FY 07-08 Budget Request.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: With this alternative there would be no change in funding for FY 07-08. With no change in the appropriation, the Cash Funds Exempt appropriation for FY 07-08 would be insufficient to cover forecasted caseload and rate changes for the expansion and non-expansion clients. For FY 07-08, projected expenditures including federal match dollars of $74,871,205 (see Attachment 1, Table A, Row N) exceeds projected revenues of $70,284,359 by $4,586,846. After correcting for the interest that would be earned on this money, the Department projects an over-expenditure in the amount of $4,481,968.

Because the Department does not have overexpenditure authority for this program, enrollment in the Children's Basic Health Plan would need to be capped. If revenues are insufficient to pay for the traditional children, the prenatal program would be suspended because it is an optional program. However, the $432,377 (see Table D of Attachment 1) in Cash Funds Exempt that could be taken from the prenatal program would be much less than the amount needed to cover the $4,481,968 shortfall, and an additional cap of children's enrollment would be required at the beginning of FY 07-08. Because expansion clients cannot be funded to the exclusion of any of the traditional clients, the Department would no longer be able to spend money from the Health Care Expansion Fund (Tobacco Tax money) for costs associated with expansion clients.

Children may be capped two ways. First, the program may be closed to new applicants, and redeterminations would be allowed to continue. The attrition rate of this method

would be slower than a strict cap on the program as those who are still eligible at their redetermination would be allowed to stay on the program. However, the date to apply the cap would have to be sooner. Second, the program may be closed to new clients as well as redeterminations. Clients would be disenrolled in the program when they came up for redetermination. The attrition rate of this method is faster than the previous method and may allow the Department to implement the cap later in the year.

Calculations for Alternative's Funding: There would be no change in funding with this alternative.

Concerns or Uncertainties of Alternative: *Concerns Related to Capping the Program*

- Since the prenatal program is an optional federal program, enrollment of both traditional and expansion prenatal clients would have to be capped. Without funding to cover prenatal care, the medical cost for newborns could increase.
- In order to treat children uniformly, the expansion populations would need to be capped if the traditional population is capped, despite the fact that there is adequate funding for the expansion populations. Therefore, the Department would be unable to spend the full appropriation from the Health Care Expansion Fund.

Supporting Documentation

Analytical Technique: Cost/Benefit Analysis

FY 07-08 Cost Benefit Analysis	Incremental Costs	Benefits
Alternative A: Recommended	The costs of Alternative A are as follows: $4,481,968 in General Fund $7,598,488 in Cash Funds Exempt, including $3,002,604 from the Health Care Expansion Fund $47,163 in Cash Funds	Alternative A will provide medical services for an estimated 50,143 children, dental services for 39,563 children, and 27,256 member months of prenatal benefits.
Alternative B: Not Recommended	There are no incremental costs associated with Alternative B.	Alternative B does not provide adequate funds to keep the prenatal program running, and the entire Children's Basic Health Plan would have to be capped. The Department projects that medical services for 7,617 traditional children and 861 expansion children, as well as dental benefits for a total of 6,690 children, would be denied.

Quantitative Evaluation of Performance - Compare all Alternatives:

In total, Alternative A would provide 50,143 children with medical benefits, 39,563 children with dental benefits, and 27,256 member months of prenatal benefits. The Department estimates that, excluding administrative costs, the enhanced federal match is approximately 64.2%. Adjusting for this rate, the $4,481,968 shortfall results in a loss of $12,521,576 in total funds for traditional clients funded through the Children's Basic Health Plan Trust Fund. Because revenues are insufficient to pay for the traditional children, the prenatal program would be suspended as it is an optional program, and the $1,235,363 in total funds initially allocated for the program would be used to fund premiums for traditional children. Because there would still be a shortfall of $11,286,213 in total funds, the entire Children's Basic Health Plan would have to be capped. The Department estimates that the $11,286,213 deficit would require the denial of medical benefits for 7,617 traditional children, and dental benefits for a corresponding 6,010 children. Because expansion clients cannot be funded while traditional clients are not, the Department would no longer be able to spend monies from the Health Care Expansion Fund for their care, and enrollment would have to be capped along with the

traditional clients. The Department estimates that this would result in the denial of medical benefits for 861 expansion children, and dental benefits cot a corresponding 680 children.

Total Clients Served	Alternative A	Alternative B	Difference
Traditional Children	45,049	37,432	7,617
Traditional Dental	35,544	29,534	6,010
Expansion Children	5,094	4,233	861
Expansion Dental	4,019	3,340	680
Traditional Prenatal Member Months	1,428	0	1,428
Expansion Prenatal Member Months	25,828	0	25,828

Statutory and Federal Authority:

Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj). SEC. 2101. [42 U.S.C. 1397aa] (a) PURPOSE-*The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage…*

25.5-8-105 C.R.S. (2006) (1) *A fund to be known as the Children's Basic Health Plan Trust is hereby created… all monies deposited in the trust and all interest earned on the moneys in the Trust shall remain in the Trust for the purposes set forth…*

25.5-8-109 C.R.S. (2006) (3) *The Department may establish procedures such that children with family incomes that exceed one hundred eighty-five percent of the federal poverty guidelines may enroll in the plan, but are not eligible for subsidies from the Department; …*(5) (a) (I),*. . .Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty*

days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan . . .

25.5-8-107 (1) (a) (II), C.R.S. (2006) (1) *In addition to any other duties pursuant to this article, the department shall have the following duties: (a) (II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that: (A) An adequate number of dentists are willing to provide services to eligible children; and (B) The financial resources available to the program are sufficient to fund such services.*

24-22-117 (2) (a) (II), C.R.S. (2006) …*moneys in the Health Care Expansion Fund shall be annually appropriated by the general assembly to the Department of Health Care Policy and Financing for the following purposes: (A) To increase eligibility in the Children's Basic Health Plan, Article 19 of Title 25.5, C.R.S., for Children and Pregnant women from one hundred eighty-five percent to two hundred percent of the federal poverty level; (B) To remove the asset test under the Medical Assistance program, Article 4 of Title 25.5, C.R.S., for children and families; … (F) To pay for enrollment increases above the average enrollment for state fiscal year 2003-04 in the Children's Basic Health Plan, Article 19 of Title 25.5, C.R.S.*

Department Objectives Met if Approved: 1.4 To assure delivery of appropriate, high quality health care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

3.2 To improve customer satisfaction with programs, services, and care.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 1, 2006
Priority Number:	DI-4	**OSPB Approval:**		**Date:**	
Program:	Operations and Finance	**Statutory Citation:**	HB 06S-1023 (24-76.5-101 through 24-76.5-103); SB 06-219; Pub. L. 109-171, Sec. 6036 (42 U.S.C. 1396b); and Pub. L. 104-193 (8 U.S.C. 1612).		
Request Title:	Implementation of HB 06S-1023 and Deficit Reduction Act of 2005				

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items											
	Total	2,045,732,198	2,151,690,766	0	2,151,690,766	2,166,405,362	3,031,963	2,169,437,325	0	2,169,437,325	3,031,963
	FTE	194.35	226.70	0.00	226.70	226.90	3.00	229.90	0.00	229.90	3.00
	GF	723,633,597	753,144,253	0	753,144,253	759,726,036	979,398	760,705,434	0	760,705,434	979,398
	GFE	261,325,647	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	256,100,000	0
	CF	191,726	268,584	0	268,584	268,908	0	268,908	0	268,908	0
	CFE	52,222,191	62,267,954	0	62,267,954	63,263,029	576,871	63,839,900	0	63,839,900	576,871
	FF	1,008,359,037	1,079,909,975	0	1,079,909,975	1,087,047,389	1,475,694	1,088,523,083	0	1,088,523,083	1,475,694
(1) Executive Director's Office, Personal Services											
	Total	13,785,054	15,362,691	0	15,362,691	15,821,148	149,543	15,970,691	0	15,970,691	149,543
	FTE	194.35	226.70	0.00	226.70	226.90	3.00	229.90	0.00	229.90	3.00
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	74,772	7,006,587	0	7,006,587	74,772
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	507,578	506,203	0	506,203	517,572	0	517,572	0	517,572	0
	FF	6,996,916	8,362,740	0	8,362,740	8,371,761	74,771	8,446,532	0	8,446,532	74,771
(1) Executive Director's Office, Operating Expenses											
	Total	978,207	1,020,609	0	1,020,609	997,797	2,610	1,000,407	0	1,000,407	2,610
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	446,865	493,252	0	493,252	482,848	1,305	484,153	0	484,153	1,305
	GFE	25,366	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	14,076	14,393	0	14,393	12,905	0	12,905	0	12,905	0
	FF	491,900	512,964	0	512,964	502,044	1,305	503,349	0	503,349	1,305

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 1, 2006
Priority Number:	DI-4	**OSPB Approval:**		**Date:**	
Program:	Operations and Finance	**Statutory Citation:**	HB 06S-1023 (24-76.5-101 through 24-76.5-103); SB 06-219; Pub. L. 109-171, Sec. 6036 (42 U.S.C. 1396b); and Pub. L. 104-193 (8 U.S.C. 1612).		
Request Title:	Implementation of HB 06S-1023 and Deficit Reduction Act of 2005				

		1	2	3	4	5	6	7	8	9	10
		Prior-Year Actual		Supplemental Request	Total Revised Request	Base Request	Decision/ Base Reduction	November 1 Request	Budget Amendment	Total Revised Request	Change from Base in Out Year
	Fund	FY 05-06	Appropriation FY 06-07	FY 06-07	FY 06-07	FY 07-08	FY 07-08	FY 07-08	FY 07-08	FY 07-08	FY 08-09
(1) Executive Director's Office, County Administration	**Total**	0	18,306,628	0	18,306,628	18,306,628	2,849,689	21,156,317	0	21,156,317	2,849,689
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	5,435,396	0	5,435,396	5,435,396	895,039	6,330,435	0	6,330,435	895,039
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	3,717,918	0	3,717,918	3,717,918	569,938	4,287,856	0	4,287,856	569,938
	FF	0	9,153,314	0	9,153,314	9,153,314	1,384,712	10,538,026	0	10,538,026	1,384,712
(2) Medical Services Premiums	**Total**	1,996,264,308	2,111,287,559	0	2,111,287,559	2,125,566,186	8,805	2,125,574,991	0	2,125,574,991	8,805
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	714,906,453	740,721,857	0	740,721,857	746,875,977	1,349	746,877,326	0	746,877,326	1,349
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	256,100,000	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	23,713,210	55,563,806	0	55,563,806	56,549,000	0	56,549,000	0	56,549,000	0
	FF	996,344,645	1,058,825,384	0	1,058,825,384	1,065,964,697	7,456	1,065,972,153	0	1,065,972,153	7,456
(4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust	**Total**	29,431,057	192,072	0	192,072	192,396	6,933	199,329	0	199,329	6,933
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,000,000	0	0	0	0	6,933	6,933	0	6,933	6,933
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	191,726	192,072	0	192,072	192,396	0	192,396	0	192,396	0
	CFE	27,239,331	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0	0

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:**	November 1, 2006
Priority Number:	DI-4	**OSPB Approval:**		**Date:**	
Program:	Operations and Finance	**Statutory Citation:**	HB 06S-1023 (24-76.5-101 through 24-76.5-103); SB 06-219; Pub. L. 109-171, Sec. 6036 (42 U.S.C. 1396b); and Pub. L. 104-193 (8 U.S.C. 1612).		
Request Title:	Implementation of HB 06S-1023 and Deficit Reduction Act of 2005				

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
(4) Indigent Care Program, Children's Basic Health Plan Administration	**Total**	5,273,572	5,521,207	0	5,521,207	5,521,207	14,383	5,535,590	0	5,535,590	14,383
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	747,996	2,465,634	0	2,465,634	2,465,634	6,933	2,472,567	0	2,472,567	6,933
	FF	4,525,576	3,055,573	0	3,055,573	3,055,573	7,450	3,063,023	0	3,063,023	7,450

Letter Notation:			
Cash Fund name/number, Federal Fund Grant name:	CFE: Children's Basic Health Plan Trust; Local County Share; FF: Title XIX and Title XXI		
IT Request: ☐ **Yes** ☑ **No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)		
Request Affects Other Departments: ☑ **Yes** ☐ **No**	If Yes, List Other Departments Here:	Department of Human Services	

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-4
Change Request Title:	Implementation of HB 06S-1023 and Deficit Reduction Act of 2005
Long Bill Line Item(s)	(1) Executive Director's Office, Personal Services; Operating Expenses; County Administration; (2) Medical Services Premiums; (4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust; and Children's Basic Health Plan Administration
State and Federal Statutory Authority:	HB 06S-1023 (24-76.5-101 through 24-76.5-103); SB 06-219; Pub. L. 109–171, Sec. 6036 (42 U.S.C. 1396b); and Pub. L. 104-193 (8 U.S.C. 1612)

Summary of Request (Alternative A): This Decision Item is for $3,031,963 in FY 07-08 to implement the requirements of two immigration laws that became effective in 2006: Section 6036 of the federal Deficit Reduction Act of 2005 (Pub. L. 109-171, Section 6036) and Colorado HB 06S-1023. Both of these acts require the Department to implement new procedures to verify the identity and legal presence of applicants for public benefits. The Deficit Reduction Act of 2005 prohibits the State from receiving federal reimbursement for non-emergency medical assistance provided under Medicaid to an individual declaring to be a U.S citizen or national who has not produced satisfactory documentary evidence of citizenship or nationality. HB 06S-1023 requires the Department to verify identity and obtain affidavits of lawful presence for applicants of public benefits (regardless of citizenship) under all of its programs (not just Medicaid) who are natural persons 18 years of age or older.

Clarification is also provided in this Decision Item about the role and interaction of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, P.L. 104-193, which applies only to non-citizens, and requires verification of identity and lawful presence for Medicaid eligibility. Even though PRWORA bears no additional fiscal impact to the Department in FY 07-08, it is important to understand the roles of all three immigration acts in order to clarify the assumptions for calculations used below to estimate the additional funding needed for the Department to implement the Deficit Reduction Act of 2005 and HB 06S-1023 in FY 07-08.

Alternative A {Recommended alternative}:

Problem or Opportunity Description:

The Deficit Reduction Act of 2005 was signed into law on February 8, 2006 and the provisions requiring evidence of identity and citizenship status became effective July 1, 2006. Section 6036 of this legislation requires the Department to screen Medicaid clients to verify identity and U.S. citizenship prior to providing services. The State is prohibited under this Act from receiving federal reimbursement for non-emergency medical assistance provided to an individual who declares to be a U.S. citizen or national but has not produced satisfactory documentary evidence. Section 6036 applies only to state medical assistance programs under Title XIX of the Social Security Act; i.e., only to Medicaid, not to the Department's state-only programs or Children's Health Plan Plus which operates under Title XXI of the Social Security Act. Exempt from the Act's documentation requirements are Medicaid applicants who are:

- eligible for Medicaid and entitled to or enrolled for Medicare benefits (dual eligibles);
- eligible for Medicaid on the basis of receiving Supplemental Security Income benefits; or
- eligible for Medicaid on another basis specified by the U.S. Secretary of Health and Human Services.

Colorado HB 06S-1023 has similar provisions to Section 6036 of the Deficit Reduction Act of 2005. HB 06S-1023 was enacted July 31, 2006 with an effective date of August 1, 2006. It requires the Department to verify the identity of all applicants for benefits (including clients, contractors, providers and grantees) who are natural persons age 18 and older, and obtain from them a signed affidavit of lawful presence. Affidavits from lawfully present non-citizens must be verified through the federal Systematic Alien Verification of Entitlement (SAVE) program. Client populations exempt from HB 06S-1023 include those exempted by federal law (such as those covered under the Deficit Reduction Act of 2005) and applicants for prenatal care or emergency care not related to an organ transplant.

Most Medicaid populations exempt from the Deficit Reduction Act of 2005 may not be subject to HB 06S-1023. Populations exempt from the Deficit Reduction Act of 2005, listed by Department client category, are: dual eligibles, Supplemental Security Income recipients, Foster Care recipients, and needy newborns. Of these, all but those in the Foster Care category are assumed exempt from the requirements of HB 06S-1023 because:

- dual eligible and Supplemental Security Income clients may not be subject to any additional citizenship or identification requirements already required for federal programs, as the Deficit Reduction Act describes this as an intent of Congress; and
- needy newborns do not meet the age requirement.

Foster Care applicants age 18 and older are assumed subject to HB 06S-1023 because until determined eligible for Foster Care under Title IV-E of the Social Security Act, they are not automatically eligible for Medicaid. In addition, the Centers for Medicare and Medicaid Services requires the Department to keep copies of documentation proving identity and lawful presence in its Medicaid files for Foster Care clients. Foster care applicants consist of three groups relevant to this Decision Item: (1) those eligible for Foster Care under Title IV-E age 18 and older; (2) Title IV-E eligibles under age 18; and (3) all non-IV-E Foster Care eligibles. Those in the first group, Title IV-E eligibles 18

and older, are assumed subject to HB 06S-1023. Those in the second group are exempt from both acts, and those in the third group are assumed subject to the Deficit Reduction Act of 2005. At this time, the Department is unable to distinguish between IV-E eligible Foster Care clients and non-IV-E eligible Foster Care clients in all of the relevant aid categories within the Foster Care eligibility type. In addition, a class action lawsuit including plaintiffs whose Medicaid eligibility is derived from their Foster Care eligibility under Title IV-E has been filed in the U.S. District Court for the Northern District of Illinois. This lawsuit claims that the Secretary of the U.S. Department of Health and Human Services violated Section 6036 of the Deficit Reduction Act of 2005 in regulations passed to implement Section 6036 (Bell, et al. vs. Michael Leavitt, Secretary of the U.S. Department of Health and Human Services, U.S. District Court for the Northern District of Illinois, Case # 06 C 3520). Therefore, the Department has not included the non-IV-E eligibles in its calculations of fiscal impact under the Deficit Reduction Act of 2005.

Although the Department has not yet confirmed that IV-E Foster Care eligibles age 18 and older are subject to HB 06S-1023, the Department will assume that they are unless or until it learns otherwise. Also, due to the Department's current inability to determine the number of non-IV-E eligibles in its Foster Care client category, it assumes no fiscal impact for these clients in FY 07-08 under the Deficit Reduction Act of 2005.

PRWORA also established strict requirements for verification of identity and lawful presence for Medicaid eligibility. However, PRWORA applies only to non-citizens under Medicaid, and like HB 06S-1023, it requires the Department to confirm lawful immigration status through the SAVE program which the Department is currently doing. Through the process of researching the impacts of all three immigration acts, the Department discovered improvements that could be made to its application procedures, to the Colorado Benefits Management System, and to its Medical Services Board rules for implementing PRWORA most efficiently. The costs for making these improvements can be absorbed within the Department's existing resources and components of this request, and since the Department is already following the requirements of PRWORA, this Act requires no additional funding.

Both the Deficit Reduction Act of 2005 and HB 06S-1023 require the Department to follow new procedures which have increased costs since July 2006 related to: processing applications, revising application materials, making changes to computer systems, instituting temporary compliance procedures before automated methods could be employed, conducting audits to ensure compliance, and providing training to those responsible for processing applications. To comply with the Deficit Reduction Act of 2005, the Department promulgated more stringent rules effective July 1, 2006 requiring specific documentary evidence of citizenship or nationality for Medicaid (10 CCR 2505-10, Section 8.100.53 A2). This was an unfunded federal mandate, and unbudgeted State resources have been applied to meet the Act's requirements, including systems changes, staff analysis and reporting, and new procedures for staff at the county departments of social services and medical assistance sites. Since the Deficit Reduction Act of 2005 applies only to U.S. citizens applying for Medicaid, it does not overlap with PRWORA requirements for non-citizens. HB 06S-1023, however, overlaps with both PRWORA and the Deficit Reduction Act of 2005 since it applies to *all* applicants 18 years of age or older who are natural persons. Since the Department is directed by State law to comply with federal requirements to qualify for federal funds under Title XIX of the Social Security Act, wherever PRWORA or the Deficit Reduction Act of 2005 intersect with HB 06S-1023, the applicable federal law is assumed to control.

PRWORA intersects with HB 06S-1023 for all non-citizens who apply for Medicaid (except Foster Care applicants, described above); therefore, PRWORA applies to non-citizen Medicaid applicants instead of HB 06S-1023.

To summarize the information above, Medicaid applicants for whom the Department must apply the requirements of the Deficit Reduction Act of 2005 include:

- Non-Dual Eligible and non-SSI Medicaid Adults 65 and Older (OAP-A)
- Non-Dual Eligible and non-SSI Disabled Adults 60 to 64 (OAP-B)
- Non-Dual Eligible and non-SSI Disabled Individuals to 59 (AND/AB)

- Categorically Eligible Low-Income Adults (AFDC-A)
- Health Care Expansion Fund Low-Income Adults
- Breast and Cervical Cancer Program
- Eligible Children (AFDC-C/BC)
- Baby Care Program-Adults
- Medicaid non-Title IV-E Foster Care

Applicants subject to HB 06S-1023 include clients age 18 and older applying for benefits under the following programs:

- Old Age Pension State Medical Program
- Medicaid Title IV-E Foster Care
- Children's Health Plan Plus
- Colorado Indigent Care Program
- Comprehensive Primary and Preventive Care Program

Other applicants subject to HB 06S-1023 include:

- Medicaid Providers
- non-Medicaid Providers
- Primary Care Fund Providers
- Contractors
- Grantees applying for funding or benefits under any of the Department's programs

The following applicants are exempt from the Deficit Reduction Act of 2005 and HB 06S-1023:

- Dual Eligible Clients (clients with Medicare and Medicaid)
- Supplemental Security Income clients

General Description of Alternative: This request is for $3,031,963 in FY 07-08 to implement the identity and citizenship verification requirements of the Deficit Reduction Act of 2005 and HB 06S-1023. The

Department began complying with these acts upon their effective dates in FY 06-07 by revising and passing emergency Medical Services Board rules; issuing new policies and procedures to staff, counties and medical assistance sites; and communicating relevant information to all interested parties. Both acts require additional changes to the Colorado Benefits Management System, Medicaid Management Information System, application forms, and guidelines for eligibility determinations. These changes will also contribute to increased efficiency in implementing the requirements of PRWORA, as the Department's legal research for the implementation of the Deficit Reduction Act of 2005 and HB 06S-1023 resulted in the identification of system changes necessary for PRWORA as well. In addition, the Department will need to hire FTE in three sections (Eligibility Operations, Audits, and Information Technology Support) by January 2007. Until then, the Department expects it can continue to absorb costs related to FTE and operating expenses. Since counties and medical assistance sites will require additional time to process applications and make eligibility determinations, additional funding is needed for County Administration and Children's Basic Health Plan Administration. Additional funding is also needed for Medical Services Premiums (which funds SAVE transaction costs) and for Web portal maintenance to accommodate the Department's additional SAVE users.

For the system changes, staff resources and operating expenses described above that are planned for FY 06-07, the Department will request funds separately, through a regular supplemental for FY 06-07. Since FTE and operating expenses will be needed prior to the scheduled submission date for FY 06-07 supplemental requests, the Department will proceed with the hiring process with the understanding that layoffs may be necessary if the Department does not receive approval for the requested FTE and operating expenses. Likewise, if approval is not received for additional funding for changes to the Colorado Benefits Management System and Medicaid Management Information System, other system changes that have been previously planned may need to be postponed.

A detailed description of the estimated funding needed for FY 07-08 is provided below.

(1) Executive Director's Office, Personal Services and Operating Expenses

The Department began using existing staff and operating resources to implement the Deficit Reduction Act of 2005 and HB 06S-1023 in July and August of 2006, respectively, when each act became effective. Personnel in various sections of the Department's Executive Director's Office, Medical Assistance Office, and Operations and Finance Office have worked to develop internal policies, procedures, and implementation plans; pass emergency Medical Services Board rules; instruct and coordinate with counties and medical assistance sites; respond to requests for information from the public; and establish interim compliance systems for both acts. Interim systems, including manual verification procedures, were needed immediately so the Department could begin verifying the identification and lawful presence of all required applicants.

As stated previously, the Department plans to hire 3.0 additional FTE by January 2007 to ensure that its programs continue to operate efficiently while complying with the requirements of both the Deficit Reduction Act of 2005 and HB 06S-1023. The Department will request approval for these FTE in January 2007 through a regular supplemental change request for FY 06-07. If approval is not received, staff layoffs may be necessary. Total funds of $149,543 are requested for these 3.0 FTE as continuation funding in FY 07-08. The FTE are needed for the following positions:

- **1.0 FTE (General Professional IV)** is needed in the Eligibility Operations Section to serve as the Department's lead for ensuring compliance with PWORA, the Deficit Reduction Act of 2005 and HB 06S-1023 identification and citizenship requirements. This position would define operational requirements pertaining to the new eligibility criteria and coordinate changes to the Colorado Benefits Management System. The position would be considered the Department authority on identification and citizenship operational issues, including identification and verification of legal presence requirements and training. Other duties of this position would include providing customer service support to and monitoring of counties, medical assistance sites, applicants, and clients.

- **1.0 FTE (General Professional III)** is needed in the Audit Section to audit counties, medical assistance sites, and Colorado Indigent Care Program providers to ensure they are meeting the new federal and state requirements. This position would ensure compliance by auditing a sample of case files and client information for Medicaid, Children's Basic Health Plan, Colorado Indigent Care Program, and the Old Age Pension State Medical Program. The position would report findings and identify best practices and areas of concern, and recommend areas for further emphasis and training. If mandated requirements were not being fully met, this position would be responsible for following-up and ensuring corrective action is taken.

- **1.0 FTE (General Professional II)** is needed in the Information Technology Support Section to serve as Security Administrator to oversee the large volume of additional SAVE system users needed to comply with HB 06S-1023. (A complete description of the SAVE system requirements is provided below, under the subheading "2) Medical Services Premiums, Federal Systematic Alien Verification of Entitlement (SAVE) Program.") All additional SAVE system users would be licensed for access by the Department of Human Services, however, the Department would need to ensure all new users are monitored and supported. This position would therefore be responsible for administering user access and system security, and for conducting end-user support, training, and reporting functions.

  The additional SAVE system users who will need Department monitoring and support from the 1.0 FTE (General Professional II) in Information Technology Support are estimated as follows: There are approximately 145 health care providers who participate in the Colorado Indigent Care Program and the Comprehensive Primary and Preventive Care Fund. To comply with HB 06S-1023, each provider will need access to the SAVE system to verify the legal presence of immigrant clients, and each provider is estimated to need two sets of user identification codes and passwords, resulting in an estimated 290 new SAVE system users. An estimated five additional users will be needed at the office of the Department's fiscal agent, Affiliated

Computer Services (ACS), to verify the legal presence of medical providers age 18 and older who are natural persons applying for direct reimbursement through the Medicaid Management Information System. In addition, the Department estimates it will need one additional user on staff to periodically access the SAVE system to verify the legal presence of a small number of contractors and non-Medicaid providers who are sole proprietors, or to verify the legal presence of temporary staff not hired in the usual manner through the State-certified staffing agency. Since the majority of the Department's contracted staff are hired through a staffing agency certified by the Colorado Department of Personnel and Administration as complying with the requirements of HB 06S-1023, very few SAVE verifications will need to be made per year for this purpose.

A total of $2,610 in Operating Expenses is requested to support the 3.0 FTE described above in FY 07-08.

(1) Executive Director's Office, County Administration

Additional funding in the amount of $2,849,689 is requested for County Administration in FY 07-08 due to the extra time it will take technicians to process applications due to the identification and citizenship verification requirements of both acts. Prior to passage of the new legislation, it took an average of 47.4 minutes to research and complete eligibility determinations for all client eligibility types (Source: the Department's March 23, 2006 fiscal note for the revised version of HB 06S-1186 with L.004 amendments). The Department assumes it will take an additional 5 minutes per application to comply with the provisions of the Deficit Reduction Act of 2005 and HB 06S-1023, or 10.55% longer than it took previously. This is consistent with the federal guidance for implementing the Deficit Reduction Act of 2005: "We estimate it will take each State 5 minutes to obtain acceptable documentation, verify citizenship and maintain current records on each individual" (71 Fed. Reg. 39220, July 12, 2006). This 5 minutes is meant to account for all county costs including copying, staff time, additional calls, and storage.

Please note, that the counties have expressed valid concerns about storage requirements and complications, but those concerns have not been addressed yet through this request.

Application Processing Costs for Medical Assistance Sites

In addition to counties, the Department has two medical assistance sites that process applications for eligibility under its programs: ACS and Denver Health Medical Center. ACS processes approximately 50% of Children's Health Plan Plus applications (see Table 3 on page 20); these processing costs are funded through the "Children's Basic Health Plan Administration" appropriation under Long Bill group (4) Indigent Care Program. ACS costs are described beneath this section heading on page 16.

Denver Health Medical Center application processing costs are reimbursed as part of its overall medical assistance site-related activities, via outstationing payments made by the Department. Outstationing payments are based on final, audited cost reports from Denver Health Medical Center for a prior year. The activities itemized in the cost reports do not provide specific detail to determine which costs are related to processing applications or accessing the SAVE system. Because of the recent Decision Item and Supplemental funded for Outstationing ("Denver Health Medical Center Medicaid Outstationing Alternative Financing Plan," DI-10, November 15, 2005 and S-10, January 3, 2006), Denver Health Medical Center is now at the maximum it can draw for outstationing and that methodology will continue into the future.

(2) Medical Services Premiums

Federal Systematic Alien Verification of Entitlement (SAVE) Program

The Department's Medical Services Premiums appropriation currently funds all SAVE transaction costs incurred by counties and medical assistance sites that access SAVE. This access is provided via federal license to the Department of Human Services, which invoices the Department for transaction costs attributed to Medicaid clients. The

Department pays for these costs out of its Medical Services Premiums appropriation using 100% federal funds as a Cash Funds Exempt transfer to the Department of Human Services. Since funding for SAVE verifications for Medicaid eligibility determinations is already built into the Department's base budget for Medical Services Premiums, the Department can absorb any additional SAVE transaction costs incurred to comply with the Deficit Reduction Act of 2005; this Decision Item only requests additional funding for SAVE transactions needed to comply with HB 06S-1023. Paragraph (7) of section 24-76.5-103 of HB 06S-1023 requires the Department to use the SAVE system, operated by the U.S. Department of Homeland Security, to verify the lawful presence of all applicants (including clients, contractors, temporary staff not hired through the State-certified staffing agency, providers and grantees) who submit signed affidavits indicating they are legal immigrants. These cost estimates are described below.

Estimated SAVE Transaction Costs in FY 07-08 to Comply with HB 06S-1023

Costs incurred for access to the SAVE system are based on a per transaction charge of $0.26 for the first verification, and $0.48 for second or subsequent verifications of the same applicant. There is no cost to the Department other than the FTE requested above for generating user identifications and passwords so that its providers and other required users can access SAVE.

The number of SAVE transactions conducted by counties and medical assistance sites will increase for Title IV-E Foster Care, Old Age Pension State Medical Program, and Children's Health Plan Plus applicants under HB 06S-1023. In addition, providers who participate in the Colorado Indigent Care Program will need access to the SAVE system, via license from the Department of Human Services, to verify the legal presence of aliens applying for benefits. The Department's fiscal agent also will need access to the SAVE system to verify the legal presence of providers applying for direct payment through the Medicaid Management Information System.

For applicants to the Department's Comprehensive Primary and Preventive Care grants; contractors who are sole proprietors indicating they are legal immigrants; and temporary staff not hired through the State-certified staffing agency, SAVE verifications will be conducted by Department staff. This applies also to an estimated five contractors per year who apply as sole proprietors and indicate they are legal immigrants. The Department will conduct these SAVE verifications internally, and can absorb the additional SAVE transaction cost.

The Department's additional SAVE transaction costs would be paid for using the Department's existing arrangement with the Department of Human Services, as described above. The Department would receive 100% federal financial participation for these costs except for verifications conducted for the Old Age Pension State Medical Program, which would be paid for using 100% General Fund. The total estimated additional costs needed for SAVE transactions under the Medical Services Premiums appropriation in FY 07-08 are $8,805 (see Table 8 on page 24).

(4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust

The Department requests a total of $6,933 in General Fund for the Children's Basic Health Plan Trust, so that this amount can be transferred as cash funds exempt to Children's Basic Health Plan Administration for the purposes described below. This funding is needed because the balance in the Children's Basic Health Plan Trust is fully expended in FY 07-08 (November 1, 2006 Budget Request, DI-3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes").

(4) Indigent Care Program, Children's Basic Health Plan Administration

Approximately half of all applicants for Children's Health Plan Plus begin their eligibility determinations at the counties, where the application process is funded through the County Administration line item described above. Funding for applicants not processed by counties, but instead processed by ACS, occurs through the line item "Children's

Basic Health Plan Administration" in Long Bill group (4) Indigent Care Program. Additional application processing costs for ACS are estimated to total $14,383 with $6,933 in cash funds exempt from the Children's Basic Health Plan Trust and $7,450 in federal funds. These costs are calculated and described in Table 6 (Row 15) and Table 7 (Row 4) on pages 22-24. This line item receives federal financial participation at both the Medicaid rate of 50% and the Children's Basic Health Plan rate of 65%. The blend is based on the weights determined in the Children's Basic Health Plan cost allocation study.

Implementation Schedule:

Task	Month/Year
First phase of Deficit Reduction Act Medical Services Board Emergency Rules Passed	March 10, 2006
Counties and Medical Assistance Sites Informed of Interim Procedures for Deficit Reduction Act of 2005	July 2006
Department Policy Direction Implemented	July 25, 2006
Emergency Meeting of the Medical Services Board for CICP, OAPSMP, CBHP Emergency Rules for HB 06S-1023 Passed*	July 31, 2006
Temporary Identification and Affidavit Verification Procedures Implemented for HB 06S-1023	August 1, 2006
Second phase of Deficit Reduction Act Medical Services Board Emergency Rules Passed	August 11, 2006
FTE Hired**	January 2007
CBMS Modifications begin**	November 2006
CBMS Modifications complete**	April 2007
MMIS provider letters produced and mailed**	April 2007

* Colorado Indigent Care Program (CICP), Old Age Pension State Medical Program (OAPSMP), and Children's Basic Health Plan (CBHP).

**Funding for tasks scheduled for FY 06-07 will be requested in a regular supplemental for FY 06-07. If approval is not received, layoffs may be necessary and other system changes which have been previously planned may need to be postponed.

Calculations for Alternative's Funding:

Table 1 - Summary of Request FY 07-08 - Matches Schedule 6, Column 6 and Recommended Request				
	Total Funds	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Request	$3,031,963	$979,398	$576,871	$1,475,694
Executive Director's Office, Personal Services	$149,543	$74,772	$0	$74,771
Executive Director's Office, Operating Expenses	$2,610	$1,305	$0	$1,305
Executive Director's Office, County Administration	$2,849,689	$895,039	$569,938	$1,384,712
Medical Services Premiums	$8,805	$1,349	$0	$7,456
Indigent Care Program, Children's Basic Health Plan Trust	$6,933	$6,933	$0	$0
Indigent Care Program, Children's Basic Health Plan Administration	$14,383	$0	$6,933	$7,450

Table 2 - Personal Services and Operating Expenses for FY 07-08*					
PERSONAL SERVICES		**General Professional IV (Eligibility Operations)**	**General Professional III (Audits)**	**General Professional II (Information Technology Support)**	***GRAND TOTAL***
Number of PERSONS / class title		1.00	1.00	1.00	
Calculated FTE per classification		**1.00**	**1.00**	**1.00**	**3.00**
Annual base salary (monthly * 12)		$52,524	$43,224	$37,356	
Number months working in FY 07-08		12	12	12	
Salary		$52,524	$43,224	$37,356	$133,104
PERA	10.15%	$5,331	$4,387	$3,792	$13,510
FICA	1.45%	$762	$627	$542	$1,931
AED	0.75%	$394	$324	$280	$998
Subtotal Personal Services		**$59,011**	**$48,562**	**$41,970**	**$149,543**
OPERATING					
Supplies @ $500/$500	$500	$500	$500	$500	$1,500
Computer @ $959/$0	$690	$0	$0	$0	$0
Office Suite Software @ $300/$0	$294	$0	$0	$0	$0
Office Equipment @ $2,021 /$0	$2,021	$0	$0	$0	$0
Telephone Base (Annual)	$370	$370	$370	$370	$1,110
Subtotal Operating		**$870**	**$870**	**$870**	**$2,610**
GRAND TOTAL ALL COSTS		$59,881	$49,432	$42,840	$152,153

*The costs in this table reflect continuation funding only, as the Department will request funding to hire each of these FTE in FY 06-07 through a regular supplemental.

Table 3 - Total FY 05-06 Medicaid and Children's Health Plan Plus Clients Processed*						
	Column >	A	B	C	D	E
Row >		**Medicaid Only**	**Medicaid and Children's Health Plan Plus**	**Children's Health Plan Plus Only**	**Total**	**Notes/ Formula**
1	Total Application Cases	71,256	88,115	6,750	166,121	Count of unique case IDs
2	Total Application Clients	102,821	208,764	16,334	327,919	Count of unique client IDs
3	Client Approvals	58,377	-	5,515	-	Count of unique client IDs approved
4	Denial/ Non-Complete Rate	43.22%	-	66.24%	-	(Row 2 minus Row 3) divided by Row 2
5	Clients Per Case (Applications)	1.44	2.37	2.42	-	Row 2 divided by Row 1
6	Redetermination Cases	124,737	1,037	8,475	134,249	Count of unique case IDs
7	Redetermination Clients	179,621	2,457	20,510	202,588	Row 6 multiplied by Row 5
8	**Total Clients Processed**	282,442	211,221	36,844	**530,507**	Row 2 plus Row 7
9	New Applications Processed by ACS	21,518	28,191	3,040	52,749	Count of unique client IDs
10	Redetermination Cases Processed by ACS	399	387	6,286	7,072	Count of unique case IDs
11	Redetermination Clients Processed by ACS	575	917	15,212	16,704	Row 10 multiplied by Row 5
12	Total Clients Processed by ACS	22,093	29,108	18,252	69,453	Row 9 plus Row 11
13	**Percent Processed by ACS**	7.82%	13.78%	**49.54%**	13.09%	Row 12 divided by Row 8

*Detailed assumptions for the calculations in this table are described on pages 25-27.

Table 4 - Assumed Ratios and Growth Rates for Calculations*

	Column >	A	B	C	D
Row >		Medicaid Only	Children's Health Plan Plus Only	Medicaid and Children's Health Plan Plus Blended	Old Age Pension State Medical Program
1	FY 05-06 Unique Client Ratios	1.18-2.38	1.45	-	1.22
2	FY 05-06 Denial/ Non-complete Rates	43.22%	66.24%	-	43.22%
3	FY 06-07 Growth Rate	7.06%	6.23%	6.97%	9.18%
4	FY 07-08 Growth Rate	5.65%	3.04%	5.38%	9.18%

*See the Assumptions for Calculations section on page 27 for details on how these figures were derived and applied.

Table 5 - Affected Number of Clients from FY 07-08 Projected Caseload, Adjusted for Distinct Clients and Application Denial

	Column >	A	B	C	D	E	F	G	H	I	L	M	N
Row >	Item	Medicaid Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categor-ically Eligible Low-Income Adults (AFDC-A)	Health Care Expansion Fund Low-Income Adults	Breast and Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care age 18+	Baby Care Program-Adults	Old Age Pension State Medical Program	CHP+ age 18+	Total
1	Deficit Reduction Act	6,518	2,066	11,907	151,709	14,123	671	527,492	-	19,605	-	-	734,091
2	HB 06S-1023*	-	-	-	-	-	-	-	1,411	-	10,561	7,640	19,612

*Since the total number of affected clients from all relevant eligibility categories is needed to estimate the cost of implementing HB 06S-1023, data describing the Old Age Pension State Medical Program and Children's Health Plan Plus are included in the same table as data describing Medicaid. The other populations subject to HB 06S-1023, i.e., Colorado Indigent Care Program applicants 18 years of age or older; and Comprehensive Primary and Preventive Care Program applicants 18 years of age or older are not included in Table 5 because their applications are neither processed by counties nor medical assistance sites, nor are these populations included in the Department's regular caseload categories.

Table 6 - Additional Application Processing Costs			
Row >	**Item**	**Total**	**Notes/Formula**
1	FY 06-07 Executive Director's Office, County Administration[1]	$18,306,628	HB06-1385 Long Bill Appropriation
2	FY 07-08 Children's Basic Health Plan Administration	$3,638,229	November 1, 2006 CBHP Change Request, DI-3, Table F, Attachment 1, Page 7.
3	Total 06-07 Administration Funding	$21,944,857	Row 1 plus Row 2
4a	FY 05-06 Unique Applicants Processed for Medicaid and Children's Health Plan Plus	530,507	New Applicants and Redeterminations. See Table 3, Column D, Row 8.
4b	FY 07-08 Unique Applicants Processed for Medicaid and Children's Health Plan Plus	598,014	Row 4a multiplied by FY 06-07 and FY 07-08 Medicaid and Children's Health Plan Plus blended growth rates. See Table 4.
5	FY 05-06 Old Age Pension State Medical Program Clients	5,076	The Department's November 1, 2006 Budget Request (page number not yet available).
6a	FY 05-06 Unique Old Age Pension State Medical Program Applicants	8,869	Row 5 multiplied by distinct client ratio and Medicaid denial/incomplete rate. See Table 4.
6b	FY 07-08 Unique Old Age Pension State Medical Program Applicants[2]	10,572	Row 6a multiplied by FY 06-07 and FY 07-08 Old Age Pension State Medical Program growth rates. See Table 4.
7	Total FY 07-08 Processed Applicants	608,586	Row 4b plus Row 6b.
8	Per Applicant County Administration Cost	$36.06	Row 3 divided by Row 7.
9	Average Processing Time per Application (minutes) [3]	47.4	Weighted average amount of time for eligibility determinations for all client types.
10	Additional Time to Process Application (Minutes) [4]	5	Time for county technicians to process additional documentation requirements.

Table 6 - Additional Application Processing Costs			
11	Percent of Additional time	10.55%	Row 10 divided by Row 9.
12	Additional Per Application Administration Cost	$3.80	Row 8 multiplied by Row 11.
13a	FY 07-08 Projected Applicants Affected by Deficit Reduction Act of 2005	734,091	See Table 5, Column N, Row 1.
13b	FY 07-08 Projected Applicants Affected by HB 06S-1023	19,612	See Table 5, Column N, Row 2.
14	Children's Health Plan Plus Applicants Processed by ACS	3,785	Table 3, Column C, Row 13 multiplied by Table 5, Column M, Row 2.
15	Additional ACS Cost (Applies Only to HB 06S-1023)	$14,383	Row 12 multiplied by Row 14.
16a	Additional County Administration Cost for Applicants Affected by Deficit Reduction Act of 2005	$2,789,546	Row 13a multiplied by Row 12.
16b	Additional County Administration Cost for Applicants Affected by HB 06S-1023	$60,143	Row 13b minus Row 14 multiplied by Row 12.
17	Total Costs to Process Documentation from Both Acts	$2,864,072	Row 15 plus Row 16a plus Row 16b.
[1] The Department assumes continuation funding will be appropriated in the same amount for FY 07-08. [2] This number of unique applicants (10,572) differs from the number of affected clients in Table 5, Column L, Row 2 (10,561) because the latter is a distinct client count. [3] From the Department's revised Fiscal Note for HB 06-1186 with L. 004 amendments, March 23, 2006.			
[4] The federal guidance for implementing the Deficit Reduction Act of 2005 (71 Fed. Reg. 39220, July 12, 2006) estimated it would "take each State 5 minutes to obtain acceptable documentation, verify citizenship and maintain current records on each individual."			

Table 7 - Program Splits for Additional Application Processing Costs			
Row >	**Item**	**Total**	**Notes/Formula**
1	Total Additional Cost	$2,864,072	Table 6, Row 17.
2	Old Age Pension State Medical Program (100% GF)	$40,132	Table 6, Row 12 multiplied by 10,561 Old Age Pension State Medical Program clients (see Table 5, Column L, Row 2).
3	County Portion (20% Local Match/30% GF/50% FF):	$2,809,557	Table 6, Row 16a and 16b minus Table 7, Row 2.
4	ACS Portion (Blend of 50% GF/50% FF + 35% GF/65% FF):	$14,383	Table 6, Row 15.

Table 8 - Systematic Alien Verification of Entitlement Costs – Funded from Medical Services Premiums						
Item	**Foster Care**	**Old Age Pension State Medical Program***	**Children's Health Plan Plus**	**Colorado Indigent Care Program**	**Medicaid Management Information System Providers**	**Totals**
Affected Number of Clients/Providers in FY 07-08	1,411	10,561	7,640	205,868	1,988	227,468
Percent Immigrant Clients/Providers	0.25%	35.89%	1.35%	10.00%	12.50%	-
Number Immigrant Clients/Providers	4	3,790	103	20,587	249	24,732
Initial Verification @ $0.26 each	$1	$985	$27	$5,353	$65	$6,430
Estimated Number requiring 2nd verification (20%)	1	758	21	4,117	50	4,946
2nd verifications @ $0.48 each	$0	$364	$10	$1,976	$24	$2,374
Total cost for verifications	**$1**	**$1,349**	**$37**	**$7,329**	**$88**	**$8,805**

* All costs incurred for the Old Age Pension State Medical Program are funded with 100% General Fund.

Assumptions for Calculations:

Assumptions for calculations are described below for Tables 3-8 (Tables 1-2 are designed to be self explanatory).

Table 3

Table 3 derives the total number of applicants processed annually by counties and ACS to estimate their additional administrative costs to implement the Deficit Reduction Act of 2005 and HB 06S-1023. To calculate the number of unique applicants in Medicaid and the Children's Health Plan Plus programs, the Department used case and client level data from the Colorado Benefits Management System for FY 05-06, where clients are processed as either a new applicant or a redetermination for benefits. The Department assumes that once an individual provides satisfactory identification, they will not be required to do so again if their initial application is denied and they reapply.

As Table 3 illustrates, the applications are separated into three categories: Medicaid only, Medicaid and Children's Health Plan Plus, and Children's Health Plan Plus only. This is necessary to accurately count the applications, as a child can apply for both Medicaid and Children's Health Plan Plus benefits on the same application, and the Children's Health Plan Plus application will be denied if the child is determined Medicaid eligible. Application totals in Table 3 are counts of unique case or client IDs.

Applications received through State Data Exchange are for applicants receiving Supplemental Security Income benefits, so these were omitted from the analysis. Once a client is approved for benefits, a corresponding record is created for a redetermination. There is a direct correspondence between redetermination data and newly approved clients for Medicaid, and a near one-to-one correspondence for Children's Health Plan Plus clients. These newly approved cases are retained in the application data and omitted from the redetermination data in order to prevent double counting.

In the application data, a count of the number of unique clients per case is calculated (see Table 3: Row 5 = Row 2 / Row 1). The redetermination data is at the case level, so the

Department assumes that the client per case ratio is equal to that from the application data. The number of redetermination clients is equal to the redetermination cases multiplied by this client per case ratio (Row 7 = Row 6 x Row 5). The total number of Medicaid and Children's Health Plan Plus clients processed is 530,507 (Table 3, Column D, Row 8), and is the new applications plus redeterminations (Row 8 = Row 2 + Row 7).

The new application and redetermination data also includes information on where the application originated. To ensure that counties and ACS receive funds according to their share of clients processed, the number of new applicants originating at ACS was counted (Table 3, Row 9). The number of redetermination cases originating at ACS (Row 10) is multiplied by the clients per case ratio from the application data (Row 5) to estimate the redetermination clients processed by ACS (Row 11). The total number of clients processed by ACS (Row 12) is equal to the number of new applicants (Row 9) plus the redetermination clients (Row 11). It follows that the percentage of clients processed at ACS (Row 13) is the number of clients originating at ACS (Row 12) divided by the total clients processed (Row 8). This percentage is assumed to be constant through FY 07-08, and is used to estimate the additional funding needed for County Administration and ACS for additional application processing time.

Other assumptions used in Table 3 include:

- The "Total Application Clients" data reported in Row 2 were calculated using unique client identification numbers from the Colorado Benefits Management System FY 05-06 "Application and Applicants" file. The Medicaid and Children's Health Plan Plus category includes cases which included applications for Medicaid only, or for both Medicaid and Children's Health Plan Plus. The Children's Health Plan Plus Only category includes individuals applying for Children's Health Plan Plus that did not have an application in the system for Medicaid. Clients who apply for both programs and are Medicaid eligible are denied Children's Health Plan Plus eligibility, which artificially inflates the denial rates. In addition, applicants who receive Supplemental Security Income benefits are omitted as they are not processed for eligibility determinations.

- All new Medicaid approvals are reported in the Colorado Benefits Management System FY 05-06 "Redetermination" file; only some Children's Health Plan Plus clients have redetermination records. These clients were omitted from the redetermination count to avoid double counting.
- The Redetermination file is reported at the case level, rather than the client level. The average number of clients per case for new applications is assumed to equal the number of clients per case for redeterminations.
- Data from the Colorado Benefits Management System FY 05-06 "Applications and Applicants" are reported in Row 9 to show the number of new applicants originally processed at the Department's medical assistance site, ACS, rather than the county. In addition, data from the "Redetermination" file shows the total number of Redeterminations processed by ACS. The total number of clients processed by ACS was calculated assuming the same ratio of clients per case as for Colorado Benefits Management System applications.

Table 4

Table 4 shows ratios and growth rates that are used in the analysis for this Decision Item. Row 1 displays distinct client ratios, which were calculated by comparing FY 05-06 unique client identification numbers to caseload. Ratios within the range listed in Column A, Row 1 are categorically specific for Medicaid, and are applied to corresponding FY 07-08 projected caseload to estimate distinct clients in each eligibility category. Row 2 displays denial/ non-complete rates calculated in Table 3. The denial/ non-complete ratio for the Old Age Pension State Medical Program is assumed to be equal to that for Medicaid. Rows 3 and 4 include growth rates for FY 06-07 and FY 07-08, respectively. The Medicaid and Children's Health Plan Plus blended growth rate is calculated according to the respective caseload shares. The growth rate for Old Age Pension State Medical Program is estimated using average annual growth for FY 04-05 and FY 05-06. This trend is assumed to stay constant for FY 06-07 and FY 07-08.

Table 5

Table 5 applies the information from Tables 3 and 4, i.e., number of distinct clients per case, denial/non-complete rates, and redetermination cases to FY 07-08 projected caseload figures. This table is used to show the total projected number of affected clients by the Deficit Reduction Act of 2005 and HB 06S-1023. Assumptions used in Table 5 include:

- FY 07-08 Medicaid projections are from November 1, 2006 Budget Request, Exhibit B, Page EB-1. Children's Health Plan Plus projected caseload is from November 1, 2006 DI-3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes," Attachment 1 Tables G and H. The Old Age Pension State Medical Program caseload is from November 1, 2006 Budget Request (page number not yet available).
- Dual eligibles (clients receiving both Medicare and Medicaid) are not included in Table 5 because they are exempt from both acts since they provide proof of identification when determined eligible for Medicare.
- In FY 05-06, 11.58% of distinct Eligible Children were "Needy Newborns," defined as children up to age 1 born to mothers who were Medicaid eligible at the time of birth (25,854 Needy Newborns / 223,304 Eligible Children = 11.58%). The Eligible Children caseload is deflated by this percent to exclude these clients, as they are not subject to either act. (Source: BOA query 8/16/06.)
- All projections were inflated to adjust for denials, incomplete applications, and distinct clients per application (see Tables 3 and 4).
- Distinct client ratios were calculated by comparing FY 05-06 unique client identification numbers to caseload. This ratio is categorically specific for Medicaid (see Table 4).
- Foster Care is not inflated for denied/incomplete applications as this group is "automatically entitled" to Medicaid.
- Old Age Pension State Medical Program denial/incomplete rate is assumed to be equal to that for Medicaid.

Table 6

Table 6 calculates the additional estimated cost to counties and to ACS to implement the provisions of each act based on the total number of projected applicants from Table 5 (Column N, Rows 1 and 2) multiplied by the "Additional Per Application Administration Cost" in Table 6 (Row 12).

Table 7

Table 7 shows the funding splits between General Fund and federal funds for the additional application processing costs. All costs for the Old Age Pension State Medical Program must be paid using 100% General Fund, as shown in Row 2. All other county administration costs receive 20% local county share, 30% General Fund and 50% federal financial participation. ACS application processing costs are paid out of the Children's Basic Health Plan Administration appropriation, and receive a blend of federal financial participation as allocated under Titles XIX and XXI of the Social Security Act: 12% of total funds spent on eligibility and enrollment functions receive 35% General Fund and 65% federal financial participation under Title XXI; and 88% of total funds spent on eligibility and enrollment functions receive 50% General Fund and 50% federal financial participation under Title XIX (November 1, 2006 FY 07-08 Budget Request, DI-3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes," Table F).

Table 8

Table 8 calculates the transaction costs that will be incurred for SAVE verifications under both acts. Assumptions used in Table 8 include:

- As with the County Administration costs described above, since all costs for the Old Age Pension State Medical Program must be funded with 100% General Fund, this applies to the SAVE transaction costs for this program as well. These are included in

the Medical Services Premiums line item in the amount of $1,349 using 100% General Fund.

- The time required to verify the legal presence of aliens using the federal SAVE system is included in the 5-minute additional processing time per application estimated above.
- For the Colorado Indigent Care Program, of the estimated 205,868 new clients, the Department estimates 10% will require first level SAVE verifications and an even smaller number may require second and third level verifications resulting in an annual cost of approximately $7,329. With respect to the Comprehensive Primary and Preventive Care Fund, the Department will need to revise its grant application form and application instructions to incorporate the requirements of these acts. This can be done with existing staff and operating resources, however, as there is only one application form and set of instructions to revise. Also, due to the limited number of grantees in the program (approximately 8 or 9 per year), the Department can absorb any mailing, printing, or photocopying costs incurred to comply with the legislation.

Impact on Other Areas of Government: This alternative will require additional funding to the Department of Human Services for SAVE transaction costs in Cash Funds Exempt from the Department's Medical Services Premiums appropriation. The Department of Human Services has an appropriation for "Systematic Alien Verification for Eligibility" in the 2006 Long Bill, HB 06-1385, under the Department of Human Services (7) Office of Self Sufficiency (C) Special Purpose Welfare Programs (8) Systematic Alien Verification for Eligibility. Footnote K to this line item indicates that $28,620 is a Cash Funds Exempt transfer from the Department of Health Care Policy and Financing in FY 06-07. The Department requests this footnote be changed to reflect an increase in funding of $8,805 in FY 07-08 for a total of $37,425 as a Cash Funds Exempt transfer from the Department of Health Care Policy and Financing.

There will also be a need for additional funding to the Department of Human Services for modifications to the Colorado Benefits Management System in FY 06-07, however, this funding will be requested separately in a regular supplemental for FY 06-07 and is not included in this FY 07-08 Decision Item.

Concerns or Uncertainties of Alternative: Calculations within this request are based on assumptions that specific populations are subject to either the Deficit Reduction Act of 2005 or HB 06S-1023; or that they are subject to neither. To the extent any of these assumptions change, the fiscal impact to the Department for implementing these acts may also change.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: Alternative B would result in no increase in funding for the Department to implement the Deficit Reduction Act of 2005 and HB 06S-1023. It is likely that without the funding requested in Alternative A, a disproportionate share of the financial burden will fall on counties, medical assistance sites, and Colorado Indigent Care Program providers in order to comply with these acts. Without the requested FTE, the Department would not be able to assist counties, medical assistance sites, providers, applicants or clients in following the new requirements without creating additional backlog in existing customer service areas. In addition, Department supervisory and management staff in various Department divisions would be required to postpone other responsibilities in order to monitor and ensure compliance with the Deficit Reduction Act of 2005 and HB 06S-1023. Also, if increased funding is not received for SAVE verifications of legal immigrants, the Department of Human Services would likely be required to absorb the majority of additional transaction costs.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: It is possible that eligibility determinations will not be made in a timely manner due to increased workload on counties without an increase in funding. In addition, since the Department plans to begin making modifications to the Colorado Benefits Management System in November 2006 and hire FTE by January 2007, staff layoffs may be needed and system changes which have already been planned may need to be postponed. Furthermore, contracts with medical providers, contract workers for Departmental

personal services or other services, and grantees receiving grants from the various Departmental programs could be delayed or invalidated if adequate provisions for checking citizenship of the providers, contractors, and grantees are not available. Delays in approving applications for medical assistance eligibility or incorrect approvals of medical assistance applications might occur. Such delays could cause a hardship for people who do qualify for medical assistance, while incorrect approvals would waste state funding and, perhaps, cause a need to recoup payment for services provided to clients not really eligible to receive the services. As a result, the Department could be subject to lawsuits, penalties or fines, or could lose federal financial participation from the Centers for Medicare and Medicaid Services for all of its federally-matched programs (not just the programs affected by the Deficit Reduction Act of 2005 and HB 06S-1023). Therefore, Alternative B is not recommended.

Supporting Documentation

Analytical Technique: Considering return of investment analysis can show how an administrative investment can save additional costs at a later time.

Total Investment	Cost Avoidance
$3,031,963	Potential litigation costs if sued by any group claiming Department incorrectly provided services to non-eligible clients: estimated $500,000
	Delays in awarding Departmental administrative contracts or contracts invalidated by lack of proof of citizenship: estimated $8,727,841 ($87,278,411 in Budget Long Bill Group for Executive Director's Office x 10%)
	Failure to comply with HB 06S-1023 would also be failure to comply with similar provisions in federal Deficit Reduction Act of 2005, with potential to cause loss of total federal financial participation for the Department: $1,622,333,441 or more (total amount of federal funds in FY 06-07 Long Bill HB 06-1385)
	Shifting costs of $3,031,963 to counties, medical assistance sites, and indigent care provider sites could lead to requests for increases in budget for county administration line items, thus, not saving the costs but simply moving to different line items in the budget.

Quantitative Evaluation of Performance: Alternative A requests an additional $3,031,963 in total funds to implement the Deficit Reduction Act of 2005 and HB 06S-1023, with $979,398 coming from General Fund. The cost avoidance is many times over the implementation costs. The Department would be using the least expensive alternative by investing in compliance.

Statutory and Federal Authority: HB 06S-1023, section 24-76.5-103 (1) Verification of lawful presence - … *on and after August 1, 2006, each agency or political subdivision of the state shall verify the lawful presence in the United States of each natural person eighteen years of age or older who applies for state or local public benefits or for federal public benefits for the applicant.*

HB 06S-1023, section 24-76.5-103 (4) … *an agency or a political subdivision shall verify the lawful presence in the United States of each applicant eighteen years of age or older for federal public benefits or state or local public benefits by requiring the applicant to: (a) produce: … a valid … [i]dentification card.…; and (b) execute an affidavit stating: (i) that he or she is a United States citizen or legal permanent resident; or (ii) that he or she is otherwise lawfully present in the United States pursuant to federal law.*

SB 06-219, Section 122. Appropriation - adjustments to 2006 long bill - *(1) … there is hereby appropriated, to the department of health care policy and financing, executive director's office, for county administration, the sum of eighteen million three hundred six thousand six hundred twenty-eight dollars ($18,306,628), or so much thereof as may be necessary, for the implementation of this act.*

Pub. L. 109–171, Sec. 6036 (42 U.S.C. 1396b) Improved Enforcement of Documentation Requirements - *(a) … Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended …(C) by inserting after paragraph (21) the following new paragraph: ''(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.''; and (2) by adding at the end the following new subsection: ''(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual. ''(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title— ''(A) and is entitled to or enrolled for benefits under any part of title XVIII; ''(B) on the basis of receiving supplemental security income benefits under title XVI; or ''(C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented. …. (b) EFFECTIVE*

DATE.—The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(z) of the Social Security Act, as added by such amendments, was not previously met.

Pub. L. 104-193 (8 U.S.C. 1612), Subtitle A, Eligibility for Federal Benefits SEC. 401 - Aliens Who Are Not Qualified Aliens Ineligible for Federal Public Benefits. *(a) … Notwithstanding any other provision of law and except as provided in subsection (b), an alien who is not a qualified alien (as defined in section 431) is not eligible for any Federal public benefit (as defined in subsection (c)). (b) EXCEPTIONS.— (1) Subsection (a) shall not apply with respect to the following Federal public benefits: (A) Medical assistance under title XIX of the Social Security Act (or any successor program to such title) for care and services that are necessary for the treatment of an emergency medical condition (as defined in section 1903(v)(3) of such Act) of the alien involved and are not related to an organ transplant procedure, if the alien involved otherwise meets the eligibility requirements for medical assistance under the State plan approved under such title (other than the requirement of the receipt of aid or assistance under title IV of such Act, supplemental security income benefits under title XVI of such Act, or a State supplementary payment).*

Department Objectives Met if Approved:

1.2 To support timely and accurate client eligibility determination.

1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI - 5	**OSPB Approval:**		**Date:**
Program:	Executive Director's Office	**Statutory Citation:**	24-1-107, C.R.S. (2006); 25.5-1-104 (2) and (4), C.R.S. (2006)	
Request Title:	Increase Funding for Commercial Leased Space			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	33,228	49,510	0	49,510	49,510	222,808	272,318	0	272,318	226,670
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,561	19,255	0	19,255	19,255	111,404	130,659	0	130,659	113,335
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	15,053	5,500	0	5,500	5,500	0	5,500	0	5,500	0
	FF	16,614	24,755	0	24,755	24,755	111,404	136,159	0	136,159	113,335
(1) Executive Director's Office, Commercial Leased Space	**Total**	33,228	49,510	0	49,510	49,510	222,808	272,318	0	272,318	226,670
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	1,561	19,255	0	19,255	19,255	111,404	130,659	0	130,659	113,335
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	15,053	5,500	0	5,500	5,500	0	5,500	0	5,500	0
	FF	16,614	24,755	0	24,755	24,755	111,404	136,159	0	136,159	113,335

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: CFE: Health Care Expansion Fund, FF: Title XIX

IT Request: ☐ Yes ☑ No (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 5
Change Request Title:	Increase Funding for Commercial Leased Space
Long Bill Line Item(s)	(1) Executive Director's Office: Commercial Leased Space
State and Federal Statutory Authority:	24-1-107, C.R.S. (2006); 25.5-1-104 (2) and (4), C.R.S. (2006)

Summary of Request (Alternative A): This Request is for $222,808 in FY 07-08 to continue leasing commercial leased space at 225 E. 16th Avenue. This lease, which the Department entered into based on verbal approval of funding by the Joint Budget Committee on June 20, 2006, will continue through June 30, 2012.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department of Health Care Policy and Financing is the second largest budget in State government and one of the smallest departments in terms of staff size. With the Department's ever-growing caseload, expenditures, and programs, the staff have been increasing, but the space that the Department has appropriated to house these staff has not grown to the same degree.

In May 2003, the Department moved to its current location at 1570 Grant Street. From the time of this move up to the present, the programs for which the Department is responsible have grown both in size and complexity, resulting in additional FTE

appropriations. For FY 06-07, the Department was appropriated $344,022 for space at 1570 Grant Street. This space currently has a capacity of 223 workstations.

The table below shows the historical FTE count for each fiscal year since the Department moved to its current location at 1570 Grant Street in May 2003. This table indicates that FTE appropriations have increased a total of 19.3% since the Department moved to its location. This count does not include contracted temporary staff such as those associated with implementation of the Medicare Modernization Act of 2003 and the Colorado Benefits Management System court order.

Year	Long Bill FTE Appropriation / Request	Special Bill FTE Appropriations	Total FTE
FY 02-03	193.3	1.2	194.5
FY 03-04	196.6	3.8	200.4
FY 04-05	196.1	6.7	202.8
FY 05-06	207.1	6.3	213.4
FY 06-07	222.7	8.0	230.7

The table shows the number of appropriated FTE, not the number of positions. The Department currently has approximately 269 full time positions projected for FY 06-07, not including temporary, intern staff, or auditors. In addition, the Department employs a number of temporary staff to comply with legislation and to complete special projects. For example, in FY 05-06, the Department employed roughly 40 different temporary staff.

The Department recently completed an analysis that showed that it has been reverting an unsatisfactory level of Personal Services funding, while experiencing high turnover and staff strain. In December 2005, during the Department's Joint Budget Committee Hearing, the Committee voiced concerns about the Department's staffing levels. This led to the decision to recommend 5.7 FTE in the Department's FY 06-07 Long Bill appropriation. In a separate action, in February 2006, the Department decided to hire twelve additional positions to avoid reversions and to staff up to appropriated levels. The impact of this decision was not experienced in time to prevent a Personal Services

reversion in FY 05-06, but the Department plans to much more aggressively manage to its appropriation in the future.

In addition, based on similar complaints of a lack in space expressed in a Stand Alone Budget Request Amendment submitted to the Joint Budget Committee on January 24, 2006, the Department has an additional $49,510 appropriated in Commercial Leased Space for FY 06-07. This space is located across the street from the Department's main location, at 225 E. 16th Avenue. The space can currently hold 15 personnel.

The Department submitted an emergency 1331 Supplemental Request on June 20, 2006 to the Joint Budget Committee requesting funding for this leased space. While this 1331 Supplemental Request was not approved by the Joint Budget Committee as it was determined not to meet the criteria for an Emergency 1331 Supplemental Request, verbal approval was given to proceed with acquiring the leased space at 225 E. 16th Avenue. Based on this discussion and direction the Department proceeded to acquire the leased space. Department staff has been occupying this space since October 1, 2006.

Finally, the Department received $8,580 in additional Commercial Leased Space funding through a Joint Budget Committee staff recommendation to the Department's 1331 Emergency Supplemental for 4.0 FTE to process Medicaid cases exceeding processing guidelines, submitted September 20, 2006.

General Description of Alternative: This Request is for Commercial Leased Space funding in the amount of $222,808 total funds in FY 07-08 to occupy the first and second floors at 225 E. 16th Avenue. The Department began occupying this space on October 1, 2006.

The Department used a rare opportunity to expand without undertaking a large scale move in the fall of 2006. New space became available in the same location where the Department had previously acquired Commercial Leased Space. This large amount of space has kept the Department housed in two contiguous locations that are close to the Capitol. These two locations, 1570 Grant and 225 E. 16th Avenue, are literally across the street from each other, and the landlord has been accommodating and responsive to the

Department's needs. Since October 1, 2006, the Department's Audits Section and the Eligibility Operations Section have occupied the 2nd floor of this leased space. Beginning November 1, 2006, the first floor, which required some additional build-out, was occupied by the Long Term Care Division, which includes the Community Based Long Term Care, Nursing Facilities and the Systems Change unit.

When the Department moved to 1570 Grant Street in 2003, it was apparent that the Department would not be able to accommodate much growth. With continued funding of this alternative, the Department believes that it will have an efficient, 5-year plan that easily addresses current needs and can continue to accommodate growth without separate budget requests to the General Assembly.

There are several reasons why continued funding is needed for this space:

1. The Department had planned to expand into its basement space at 1570 Grant Street to accommodate its growth. In fact, the Medicare Modernization Act Call Center and CBMS Emergency Call Center had been housed in the basement since other space in the building was not available. The Department met with the State Architect and building management personnel from the Department of Personnel and Administration in March of 2006 to discuss further modifications to the building that the Department would need to make to accommodate the increased staffing needs. However, on April 3, 2006, the Department of Personnel and Administration issued a letter to the Executive Director of the Department identifying life and safety liability concerns regarding staff in the basement. Recommendations were to cease using these areas for staff purposes. As a result, staff located in the basement had to be relocated into the upper floors of the building. The potential for the Department to use the basement space is no longer feasible.

2. The Department had converted all open space at 1570 Grant Street into employee cubes. The Department had converted its mail room into staff work space. A one cube office was converted to house four staff working on tables. The Department was in the practice of moving new staff around the entire building as vacancies occur, in

order to supply a work space for hired staff. The Department believes that this "musical chairs" has been one factor contributing to the Department's high turnover rate.

3. The Department needs meeting space. Two meeting rooms formerly existed in the basement of 1570 Grant Street but had to be terminated for this purpose upon receipt of the Department of Personnel and Administration's letter referenced above. The Department converted a kitchen into a meeting room. Even with that conversion, there are only two meeting rooms at 1570 Grant Street. These rooms were constantly booked, and staff often crammed into small offices to have meetings. The Department had nowhere to house auditors, which are almost continuously working in the Department. Accommodations were constantly a struggle for meetings and auditors. This makes the workplace incredibly inefficient, as staff spent time attempting to access meeting space in other buildings and spent time traveling to off-site locations. Additionally, there is no room large enough to meet with all or a majority of the staff or to house the Medical Services Board in the 1570 Grant Street building.

The space at 225 E. 16th Avenue has addressed all of these needs. The space holds 10 offices, 49 cubes (including the 5th floor), and 2 meeting rooms (one large enough for public meetings, Department meetings, and the Medical Services Board). Because of this space, space conditions have vastly improved at 1570 Grant Street. Temporary projects are now accommodated easily, and staff does not need to be moved around to accommodate new hires. Sections and work units are staying together. There is appropriate meeting space for staff to hold professional meetings with external customers, and large enough for staff to have internal problem-solving meetings.

The Department worked with the Staubach Company and the Department of Personnel and Administration on this space. The Department has moved forward on this issue, based upon the Joint Budget Committee’s approval of Staff recommendation on June 20, 2006 when the Department submitted a 1331 Emergency Supplemental. While Staff did not recommend the Emergency Request as it did not meet emergency criteria, Staff’s

recommendation did indicate that the Department should proceed with obtaining this space, using existing funding in other Common Policy line items as allowed by a recent ruling to the Headnote lawsuit, and that the Committee should anticipate a normal Supplemental Request in January for this issue.

The Department has been able to lease the 13,056 square feet at a rate of $16.77 per rentable square foot in FY 07-08 for an additional total lease cost of $218,950 (see Table A). This price per square foot included minor tenant finishes; the cost of $212,156 (see Table B) is being spread across a 5 year renewable contract, which would expire June 30, 2012. Should the State not renew this contract for the full five years, the balance of this cost would be due to the lessor. The Department considers this new space to be a long term solution to its staff housing needs.

In addition, the Department submitted a letter to the Joint Budget Committee on October 5, 2006 requesting guidance on maintaining the current lease for the fifth floor at 225 E. 16th Avenue. While the Department understands that the Joint Budget Committee could not respond to this request without having another meeting, and that the Committee would also prefer an official Supplemental for this request, the Department felt that the letter was appropriate as there was a need to move forward based on a very short timeframe due to issues with rent and vacating the space, yet wanting to continue the level of transparency that exists in its Budget today.

While the Department did receive feedback from Joint Budget Committee staff following the Department's October 5, 2006 letter, recommending that all FTE requests include Commercial Leased Space funding, the Department is concerned that this methodology would not allow it to acquire necessary space. This concern is largely based around the Department's inability to lease out space one cubicle at a time.

Therefore, please note that savings from terminating the fifth floor lease that were initially anticipated to offset the cost of acquiring the new space on the first and second floors in the same building, as communicated in the Department's June 20, 2006 1331 Emergency Request, are no longer included in this Request. This is due largely to

receiving final build-out plans for the first and second floors, and the realization that these two new floors alone could not support the Department's long term plan for growth. Based on three additional Decision Items presented in this November 1, 2006 Budget Request (Decision Items DI-4, DI-8 and DI-13), the Department believes that this action was the best solution to the Department's growing staffing requirements. Rather than seek Commercial Leased Space funding individually in each of these requests, the Department identified a need for expansion and felt that it should not release existing, finished space that could support this growth.

Calculations for Alternative's Funding:

Summary of Request FY 07-08	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
FY 07-08 Requested Increase	$222,808	$111,404	$0	$111,404
FY 07-08 Needed Funding for Commercial Leased Space	**$272,318**	**$130,659**	**$5,500**	**$136,159**
FY 07-08 New Commercial Leased Space	$218,950	$109,475	$0	$109,475
FY 07-08 Base Request Increase Commercial Leased Space	$3,858	$1,929	$0	$1,929
FY 07-08 Base Request for Commercial Leased Space	$49,510	$19,255	$5,500	$24,755

Summary of Request FY 08-09	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
FY 08-09 Requested Increase	$226,670	$113,335	$0	$113,335
FY 08-09 Needed Funding for Commercial Leased Space	**$276,180**	**$132,590**	**$5,500**	**$138,090**
FY 08-09 New Commercial Leased Space	$218,950	$109,475	$0	$109,475
FY 08-09 Base Request Increase Commercial Leased Space	$7,720	$3,860	$0	$3,860
FY 07-08 Base Request for Commercial Leased Space	$49,510	$19,255	$5,500	$24,755

Table A1 – New Commercial Leased Space Costs for FY 07-08 and FY 08-09			
	Square Feet	**Price per Square Foot**	**Costs**
New Commercial Leased Space	7,239 rentable square feet - 1st Floor	$16.77	$121,398
New Commercial Leased Space	5,817 rentable square feet - 2nd Floor	$16.77	$97,552
	Total New Commercial Leased Space		**$218,950**

Table A2 – Current Commercial Leased Space Costs for FY 07-08 and FY 08-09			
	Square Feet	**Price per Square Foot**	**Costs**
FY 06-07 Current Commercial Leased Space	3,511 rentable square feet	$14.10	$49,510
FY 07-08 Current Commercial Leased Space	3,511 rentable square feet	$15.20	$53,368
	Incremental Difference for FY 07-08		**$3,858**
FY 06-07 Current Commercial Leased Space	3,511 rentable square feet	$14.10	$49,510
FY 08-09 Current Commercial Leased Space	3,511 rentable square feet	$16.30	$57,230
	Incremental Difference for FY 08-09		**$7,720**

Table B - Tenant Finish Plan	
Demolition	$7,680
Gypsum Wall - Drywall and framing - patch and repair	$8,371
Paint	$14,168
Wood Doors	$2,825
Hardware	$2,890
*Acoustic Ceiling - Ceiling tile replacement	$4,280
Millwork	$2,800
Glass	$7,975
Carpet, base, and tile	$34,490
Electrical	$24,060
Plumbing	$4,390
HVAC	$26,310
Specialty – Dalite recessed screen	$5,800
Fire Protection - Fire Sprinkler	$2,400
Overhead, Profit, and General Conditions	$25,235
2.5% Contingency on above amounts	$4,342
Signage allowance	$1,500
Architectural and engineering fees	$32,640
Total Amount to Build Into the Rate (from prior page)	**$212,156**
Number of Square Feet to Spread Finishing Costs Across	13,056
Estimated Cost Per Square Foot if All Paid in Year One (= $212,156 / 13,056 Square Feet)	$16.25

Table B - Tenant Finish Plan	
Allowance from the Leasing Company Used to Offset Finishing Costs Equal to $5.00 per Square Foot Leased	($5.00)
Estimated Cost Per Square Foot After Base Adjustment (= $16.25 - $5.00)	$11.25
Incremental Cost Per Square Foot to Add to the Base Rent Rate Every Year (= $11.25 / 5 years)	**$2.25**

Table C – FY 06-07 Estimated Build-Out Costs	
(1) Executive Director's Office, Personal Services	
Contract for Movers	$6,500
Electrical Installation	$4,000
Subtotal Personal Services	**$10,500**
(1) Executive Director's Office, Operating Expenses	
Purchase and Installation of 13 Cubicles at rate of $6,303.00 per Cube (First Floor)	$81,943
Purchase and Installation of 21 Cubicles at rate of $4,271.86 per Cube (Second Floor)	$89,709
Purchase and Installation of 15 Cubicles at rate of $4,271.86 per Cube (Fifth Floor – original cubicles moved to first floor)	$64,078
20 Additional Chairs at $400 per Chair (the Department had some available)	$7,980
Conference Room Furnishings (3 Large Tables, 65 Chairs (45 are Stackable), and 2 Cabinets)	$18,285
Printers and Fax Machines	$4,795
Telephone Installation and Equipment	$2,100
Wiring for Data Equipment	$4,250
Data Equipment – Ethernet Switch and Panel Patch	$5,794
Subtotal Operating Expenses	**$278,934**
Total for All Non-Rent Related Costs	**$289,434**

Table D – Commercial Leased Space Rent FY 06-07	
Second Floor Square Footage (Occupied October 1, 2006)	5,817
First Floor Square Footage (Occupied November 1, 2006)	7,239
Leased Space Cost at $15.50 per Square Foot = (5,817 * 9 / 12 + 7,239 * 8 / 12) * $15.50	**$142,426**

Impact on Other Areas of Government: None

Assumptions for Calculations: The Department moved into its current space on October 1, 2006. The following assumptions are for the ongoing annualized costs as well as the estimated amounts needed for build-out and furnishing in FY 06-07.

Space

Staubach, the company that contracted with the Department of Personnel and Administration to work directly with the Department on space issues, has negotiated with the Lessor of 225 E. 16th Ave. These negotiations have resulted in a five year lease with the management company at a rate of $16.77 per square foot, except in the first year of the agreement, where the Lessor agreed to a rate of $15.50 per square foot. Both rates include the build out costs outlined in Table C in this request. This flexibility in the rate for the first year has allowed the Department to offset some of the costs associated with furnishing and relocating to this space. In addition, the existing fifth floor space has increasing price per square foot costs associated with the lease. Therefore, a $1.10 increase per square foot, per year is being requested from FY 06-07 forward. At this time, the estimated FY 06-07 costs include the items listed in Table D in the Calculations section of this request. These numbers will be finalized in the Department's January 2, 2007 Supplemental Request.

All furniture was purchased in FY 06-07 is through Juniper Valley per the Statewide mandate. As the Department used existing cubicles from the 5th floor space in 225 E. 16th Ave. to offset the total number of cubicles needed on the first floor, the Department was required to purchase these same cube models for the rest of this floor, to allow for these units to fit together structurally. Unfortunately, the cost of these cubicles is more than the cubicles that could be purchased for the second and fifth floors. The actual cost of these other floors' cubicles from the required vendor were considerably greater than the amount estimated in the June 20, 2006 Emergency Supplemental Request. All amounts used are actual costs provided by Juniper Valley and include the costs for design and installation.

Tenant Finishes
The tenant improvement costs total $212,156, or $16.25/rsf if they would all be paid for in one year (this is a real estate portrayal of the costs), once all costs are considered. The base rent includes a tenant improvement allowance for carpet and paint of approximately $5.00/rsf. Therefore, this adjustment revises the $16.25/rsf to $11.25. The $11.25 has been spread across 5 years (divided by 5), which adds $2.25/rsf/yr to the starting lease rate.

Concerns or Uncertainties of Alternative: None

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would maintain the Department's current space at 1570 Grant Street and the appropriated space at 225 E. 16th Avenue at $49,510.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Under this alternative, the Department would be forced to stop hiring and only hire positions as they became available for a seating location. Additionally, the Department may also have to lay off employees as there would be no space to accommodate them at 1570 Grant Street. The Department has already attempted all re-configuration possibilities at its current location in an effort to accommodate past staffing needs.

The consequences of this action will be that federal and state requirements are not accomplished in a timely manner and turnover could increase as the work environment becomes less tolerable.

Supporting Documentation

Analytical Technique: Cost/Risk Analysis Benefit

Alternative	Costs	Risk	Description
A	$222,808	None	The Department would be able to lease an additional 13,056 square feet (7,239 + 5,817) of office space at an incremental cost of $222,808.
B	$0	High	If funding is not approved, the Department would be forced to stop hiring, and possibly lay off current staff, jeopardizing the completion of required projects.

Quantitative Evaluation of Performance - Alternative A has zero risk and is also a long-term, low cost solution. The General Fund need is $111,404.

Statutory and Federal Authority: 24-1-107, C.R.S. (2006). Internal organization of department - allocation and reallocation of powers, duties, and functions - limitations. *In order to promote economic and efficient administration and operation of a principal department and notwithstanding any other provisions of law, except as provided in section 24-1-105, the head of a principal department, with the approval of the governor, may establish, combine, or abolish divisions, sections, and units other than those specifically created by law and may allocate and reallocate powers, duties, and functions to divisions, sections, and units under the principal department, but no substantive function vested by law in any officer, department, institution, or other agency within the principal department shall be removed from the jurisdiction of such officer, department, institution, or other agency under the provisions of this section.*

25.5-1-104 (2) and (4), C.R.S. (2006). Department of health care policy and financing created - executive director - powers, duties, and functions…*(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director … (4) The*

department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in part 2 of this article.

Department Objectives Met if Approved:

2.1 To build and maintain a high quality, customer-focused team.

4.4 To pursue options for improved physical space for our employees.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI-6	**OSPB Approval:**		**Date:**
Program:	Medical Assistance Office	**Statutory Citation:**	25.5-4-104 (1), C.R.S. (2006) and 25.5-5-101 (1), C.R.S. (2006)	
Request Title:	Provider Rate Increases			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	2,001,841,793	2,136,256,533	0	2,136,256,533	2,150,041,601	14,212,732	2,164,254,333	0	2,164,254,333	23,732,028
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	720,483,939	749,488,426	0	749,488,426	755,395,767	7,009,313	762,405,080	0	762,405,080	11,669,511
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	256,100,000	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	23,713,210	59,281,724	0	59,281,724	60,266,918	138,113	60,405,031	0	60,405,031	273,563
	FF	999,133,387	1,071,309,871	0	1,071,309,871	1,078,202,404	7,065,306	1,085,267,710	0	1,085,267,710	11,788,954
(1) Executive Director's Office											
Non-Emergency Transportation Services	**Total**	5,577,485	5,068,722	0	5,068,722	4,575,163	110,000	4,685,163	0	4,685,163	110,000
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	5,577,486	2,534,361	0	2,534,361	2,287,582	55,000	2,342,582	0	2,342,582	55,000
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	2,788,742	2,534,361	0	2,534,361	2,287,581	55,000	2,342,581	0	2,342,581	55,000
(1) Executive Director's Office											
County Administration	**Total**	0	18,306,628	0	18,306,628	18,306,628	366,133	18,672,761	0	18,672,761	366,133
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	5,435,396	0	5,435,396	5,435,396	183,067	5,618,463	0	5,618,463	183,067
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	3,717,918	0	3,717,918	3,717,918	0	3,717,918	0	3,717,918	0
	FF	0	9,153,314	0	9,153,314	9,153,314	183,066	9,336,380	0	9,336,380	183,066
(1) Executive Director's Office											
County Administration – Administrative Case Management Payment to Counties	**Total**	0	1,593,624	0	1,593,624	1,593,624	31,872	1,625,496	0	1,625,496	31,872
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	796,812	0	796,812	796,812	15,936	812,748	0	812,748	15,936
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	796,812	0	796,812	796,812	15,936	812,748	0	812,748	15,936
(2) Medical Services Premiums	**Total**	1,996,264,308	2,111,287,559	0	2,111,287,559	2,125,566,186	13,704,727	2,139,270,913	0	2,139,270,913	23,224,023
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	714,906,453	740,721,857	0	740,721,857	746,875,977	6,755,310	753,631,287	0	753,631,287	11,415,508
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	256,100,000	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	23,713,210	55,563,806	0	55,563,806	56,549,000	138,113	56,687,113	0	56,687,113	273,563
	FF	996,344,645	1,058,825,384	0	1,058,825,384	1,065,964,697	6,811,304	1,072,776,001	0	1,072,776,001	11,534,952

Letter Notation:

Cash Fund name/number, Federal Fund Grant name:

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** If Yes, List Other Departments Here:

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-6
Change Request Title:	Provider Rate Increases
Long Bill Line Item(s)	(2) Medical Services Premiums
State and Federal Statutory Authority:	25.5-4-104 (1), C.R.S. (2006) and 25.5-5-101 (1), C.R.S. (2006)

Summary of Request (Alternative A): This Change Request increases funding for the Department's Executive Director's Office Long Bill group, Medical Services Premiums Long Bill group, and Department of Human Services Medicaid-Funded Programs Long Bill group by $14,212,732 in FY 07-08 and $23,732,028 in FY 08-09 to: maintain inpatient hospital rates at 90% of Medicare's rates; increase reimbursement to single entry point agencies; increase rates for medical procedures and services which are paid substantially below cost or have not received a rate increase over an extended period of time; and, provide an increase for county administration and administrative case management payments to counties..

Alternative A {Recommended alternative}:

Problem or Opportunity Description: 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 Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX. As part of its annual Budget Request, the Department includes a Decision Item (DI-1) for caseload and utilization increases in its line item for Title XIX services, Medical Services Premiums. The Department's Request

for Medical Services Premiums, however, does not include any rate increases to providers who participate in the Medicaid program; the requested increases only account for additional clients, and changes in utilization patterns.[1]

As such, providers in Medicaid who are paid based on the fee-schedule maintained by the Department do not receive any increase in rates in the Department's annual request for Medical Services Premiums. Beginning in FY 05-06, the General Assembly has appropriated funds to provide rate increases to some Medicaid providers. In SB 05-209, the General Assembly appropriated $18,866,498 for rate increases to Medicaid providers for FY 05-06 in the following way:

- In Footnote 37 of SB 05-209, the General Assembly appropriated $7,365,778 for a 2% increase to inpatient hospital services provided to Medicaid clients. The Department applied the 2% rate increase to every hospital's inpatient rate, effective July 1, 2005.
- In Footnote 39 of SB 05-209, the General Assembly appropriated $6,831,445 with the intent of "[increasing] reimbursement rates for the top five physician procedure codes up to eighty percent of the Medicare rate" (SB 05-209, Footnote 39). With the available funds, the Department was able to increase reimbursement for the top nine office-based evaluation and management procedure codes to 80% of the Medicare rate effective July 1, 2005.
- In Footnote 40 of SB 05-209, the General Assembly appropriated $4,669,275 for a 2% rate increase for home and community based waiver services, private duty nursing services, and home health services. The Department applied the rate increase to those services effective July 1, 2005.

During FY 05-06, the General Assembly approved a Supplemental bill, HB 06-1369, for the Department, which also contained rate increases for Medicaid providers. HB 06-1369 provided rate increases in the following way:

[1] Some providers, such as outpatient hospitals, pharmacies, federally qualified health care centers, and nursing facilities are paid based on incurred costs, or via cost-based rates, most as required by federal regulation or state statute. Such providers are not included in this Change Request.

- In Footnote 37a of HB 06-1369, the General Assembly appropriated $831,000 for a 1% rate increase for inpatient hospital services. HB 06-1385 included $3,604,228 to annualize the rate increase in FY 06-07 (Figure Setting, March 13, 2006, page 146).[2] The Department implemented the rate increase by increasing each hospital's inpatient rate by 1%, effective April 1, 2006.
- In Footnote 40a of HB 06-1369, the General Assembly appropriated $5,100,000 for rate increases to long-term care community providers. HB 06-1385 included $20,812,658 to annualize the rate increase in FY 06-07 (Figure Setting, March 13, 2006, page 146).[3] The Department increased rates to long-term care community providers effective April 1, 2006 in the following way: assisted living facilities, 15.07%; day care services, 3.57%; skilled nursing, 7.20%; home health aides, 4.20%; physical therapy, 36.30%; speech therapy, 35.90%; occupational therapy, 29.20%; private duty registered nursing, 3.80%; private duty licensed nursing, 8.00%; personal care homemaker, 10.00%; and, all other providers, 2.57%.
- In Footnote 42a of HB 06-1369, the General Assembly appropriated $309,000 for a 2% rate increase for durable medical equipment rates. HB 06-1385 included $1,311,382 to annualize the rate increase in FY 06-07 (Figure Setting, March 13, 2006, page 146).[4] The Department implemented the rate increase by increasing all Medicaid fee-for-service durable medical equipment billing codes 2.25%, and excluding durable medical equipment services that are paid by invoice plus 19%, effective April 1, 2006.

In HB 06-1385, the General Assembly approved rate increases for FY 06-07 in the following way:

- In Footnote 26 of HB 06-1385, the General Assembly appropriated $9,917,925 for a 3.25% rate increase for primary care providers, including: physician; dental; Early

[2] The Figure Setting document does not reflect the final action by the Joint Budget Committee. The annualization amount was adjusted based on Joint Budget Committee motions, and the final annualization total is reflected in a Joint Budget Committee staff memorandum on March 16, 2006.
[3] See footnote 2.
[4] See footnote 2.

Periodic Screening, Diagnosis, and Treatment; lab and x-ray; and, durable medical equipment. In response, starting with the total funds available, the Department determined the dollar amount available if the 3.25% were applied to all applicable physician codes. This amount ($6,861,522) was then applied to the top twenty-five most frequently billed Evaluation and Management (E&M) physician services codes. These E&M codes correspond to the most common primary care physician services provided. The remaining allocated funds ($3,056,403) were used to apply a 3.25% to all Medicaid fee-for-service dental and Durable Medical Equipment (DME) codes. DME services that are paid by-invoice plus 19% were restored to plus 20% which was the by-invoice payment methodology prior to rate decreases that went into effect in 2004. These rate increases were effective July 1, 2006.

- In Footnote 27 of HB 06-1385, the General Assembly appropriated $11,713,742 for a 3.25% rate increase for inpatient hospital services provided to Medicaid clients, beginning July 1, 2006. The Department implemented the rate increase by increasing inpatient hospital rates 3.25%, effective July 1, 2006.
- In Footnote 28 of HB 06-1385, the General Assembly appropriated $4,138,750 for rate increases to long-term care community providers, effective April 1, 2007, in the following way: assisted living facilities, 12.50%; day care services, 1.00%; skilled nursing, 23.60%; physical therapy, 23.60%; speech therapy 23.60%; occupational therapy, 23.60%; private duty registered nursing, 23.40%; and, private duty licensed nursing, 23.60%. The Department intends to implement the rate increases on April 1, 2007.

To date, the rate increases appropriated by the General Assembly have targeted programs with high utilization that comprise a large part of Medicaid expenditure. These rate increases have helped to offset the effects of rate cuts during FY 02-03, FY 03-04, and FY 04-05.

For FY 07-08, the Department is targeting six types of providers: inpatient hospital; single entry points; specialty providers, emergency transportation, non-emergency transportation, and county administration.

Inpatient Hospital

Under State budgeting principles, inpatient hospital rates are currently required to remain budget neutral to FY 02-03 rates, only allowing for an increase in utilization, unless a Change Request is approved. This is supported in the Department's Medicaid State Plan. The methodology used to calculate the Medicaid inpatient hospital base rates does not apply any inflationary increase, such as Medicare's hospital market basket index, without a budget action. Since Medicare's rates have an annual inflationary component factor, Colorado Medicaid's inpatient hospital base rates continue to become a smaller percentage of Medicare's rates every year. For FY 03-04, the first year that Medicaid rates were based on Medicare's rates, Medicaid rates were set at 97.9% of Medicare's rates in order to be budget neutral to FY 02-03 expenditures. In FY 04-05, Medicaid rates fell to 92.6% of Medicare's rates; in FY 05-06 Medicaid rates were set at 90% of Medicare's rates; and, in FY 06-07, Medicaid rates were set at 92% of Medicare's rates, including the rate increases provided in HB 06-1369 and HB 06-1385. Total reimbursement for inpatient hospitals in FY 05-06 (not including upper payment limit financing) was $296,800,124 (Exhibits for Medical Services Premiums, Exhibit N, page 2).

Specialty Providers and Emergency Transportation

In the Medicaid program, there are a large number of procedures which have relatively low utilization. For example, although in total, surgical procedures account for a significant amount of total spending, individual surgical codes have relatively low utilization compared to other physician codes. In many cases, procedures codes still pay at the same rate as when the code was entered into the system, even for the codes that were entered into the system in 1979. Emergency transportation rates have not been adjusted since 2002.

In many cases, the price the Department pays for the service no longer covers the cost of a provider to perform that procedure. This is especially true for specialty providers and services, such as surgery, anesthesia, adult immunizations, therapy services, durable

medical equipment repair, adult immunizations, and intrauterine devices. In some cases, the lack of available specialists may cause harm to clients, while in other cases, the lack of routine preventative care or the ability to repair durable medical equipment may cause the client to require more expensive services.

In FY 05-06, reimbursement for adult immunizations totaled $157,871; reimbursement for anesthesia totaled $6,302,981; reimbursement for intrauterine devices totaled $280,643; reimbursement for therapy services totaled $12,093,452; reimbursement for surgical procedures totaled $47,824,788. These services are primarily contained in the Department's Physician Services and EPSDT, and Outpatient Hospital (therapy services) service categories in the Medical Services Premiums line item. Total reimbursement for Physician Services and EPSDT in FY 05-06 was $144,266,423 (Exhibits for Medical Services Premiums, Exhibit N, page 2). Total reimbursement for Outpatient Hospital in FY 05-06 was 105,213,743 (Exhibits for Medical Services Premiums, Exhibit N, page 2).

In FY 05-06, reimbursement for durable medical equipment repair totaled $336,682. Equipment repair is contained in the Department's Durable Medical Equipment service category of the Medical Services Premiums line item. Total reimbursement for Durable Medical Equipment in FY 05-06 was $58,652,169 (Exhibits for Medical Services Premiums, Exhibit N, page 2).

In FY 05-06, reimbursement for Emergency Transportation totaled $3,611,441 (Exhibits for Medical Services Premiums, Exhibit N, page 2).

Single Entry Points

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home and Community Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care

facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965 (25.5-6-106 (3) (b), C.R.S. (2006)).

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability (25.5-6-106 (3) (c), C.R.S. (2006)). Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

Single entry point agencies are paid a case management fee for each client admitted into a community based service program. This funding is shown as "Single Entry Points" under Service Management in Exhibit N of the February 15, 2006 Budget Request, and is the funding addressed by this Change Request. Again, because the Department does not budget by service category, there is no budgeted amount and only actuals and calculations are reported. Single entry point agencies also receive payment for services provided in connection with the development and management of long term home health prior authorization requests, for work associated with client appeals and for utilization review services related to HCBS and nursing facilities. In this case, the single entry point is functioning as a provider and the costs are reflected under "Community Based Long Term Care" on the same Exhibit N. Such costs are not affected by this Request.

In FY 03-04, due to budget reductions, the per-client rate for single entry points was reduced from $855 to $795. At the same time, additional duties were added to the single entry point agency contract: authorizing long term home health and representing the Department for client appeals. The per client payment rate of $795.00 was increased by 10% for these additional responsibilities, to the current rate of $874.50.

In FY 05-06, reimbursement for Single Entry Points totaled $16,547,063 (Exhibits for Medical Services Premiums, Exhibit N, page 2).

Non-Emergency Transportation Services

The Department provides non-emergency transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation throughout all sixty-four counties in Colorado. Section 25.5-5-202 (2), C.R.S. (2006) and 42 C.F.R. § 431.53 requires the Department to provide non-emergency medical transportation to eligible clients under the state Medical Assistance Program. The type of transportation authorized is determined by the distance to be traveled and treatment facilities available, and the physical condition and welfare of the client. Non-emergency medical transportation services include transportation between the client's home and Medicaid covered benefits, and when applicable, the cost of lodging and food when an overnight stay is necessary for an escort. There are also administrative costs related to non-emergency medical transportation including, but not limited to, the intake of client calls, determining eligibility, and authorizing and arranging transportation.

Prior to FY 03-04, funding for non-emergent medical transportation, approximated to be $12,041,460, was contained in the Medical Services Premiums line within the Department's Budget. However, due to difficult economic conditions in FY 02-03, the General Assembly reduced this funding by $7,640,682 in an effort to reduce General Fund expenditures (Figure Setting, Setting Supplemental Briefing Hearing, Long Bill Narrative, FY 03-04, page 110-111).

In FY 03-04, the Department received legislative authority via HB 04-1220 to administer non-emergency medical transportation as an administrative program rather than an optional Medicaid service in an effort to maintain cost savings. As a result of this action, $4,400,778 was transferred from the Department's Medical Services Premiums Long Bill group and created a new line item under the Executive Director's Office Long Bill group titled "Non-Emergency Medical Transportation".

The Department currently employs two mechanisms to meet non-emergency medical transportation needs for Medicaid clients. In 56 counties within the State, the county departments of social services are responsible for authorizing and arranging the transportation. In eight front-range counties, the Department contracts directly for the necessary services and administration with a broker.

On June 20, 2006, the Joint Budget Committee approved a 1331 Emergency Supplemental due to increase in contract costs, increasing total funding to the Department by $296,497. LogistiCare was awarded the winning bid for a fixed price contract which began June 1, 2006.

County Administration and County Administration – Administrative Case Management Payment to Counties

The County Administration line provides Medicaid funding for county departments of social services to administer several programs including food stamps, adult protection, adult assistance payment programs, and Medicaid eligibility determination (Figure Setting, March 8, 2006, page 76). With the passage of SB 06-219, the oversight of the Medicaid portion of county administration transferred to the Department of Health Care Policy and Financing's Executive Director's Office two new appropriation lines, County Administration, and County Administration – Administrative Case Management Payment to Counties.

As of July 1, 2006, the Department now has a direct relationship with county governments which provide much of the administrative functions regarding Medicaid eligibility determinations and client case management. Previously, counties were reimbursed for both their Medicaid and non-Medicaid related costs associated with eligibility determinations and case management for public assistance programs from the Department of Human Services. The total amount in the Department of Human Services budget to reimburse these county governments included Medicaid funding that was transferred from the Department of Health Care Policy and Financing to the Department

of Human Services. Beginning in FY 06-07, all Medicaid funding will remain in the Department's budget, and the Department will pay the counties directly for this work.

General Description of Alternative: This Alternative requests additional funding to maintain inpatient hospital rates at 90% of Medicare rates; increase the cost-per-client payment for single entry points; and, increase rates to non-emergency medical transportation, emergency transportation, county administration, and specialty providers.

Inpatient Hospital

The Department recommends fixing the inpatient hospital rates to 90% of Medicare's rates, with certain exceptions. Under current methodology, inpatient hospital rates are expected to fall below 90% of Medicare's rates, due to the requirement that inpatient hospital rates remain budget neutral to FY 02-03 rates. If Medicaid rates were instead calculated at a fixed percentage of Medicare's rates, the resulting increase in expenditures could be budgeted for on an annual basis. The Medicaid rates that take effect every year on July 1 are calculated from Medicare's October 1 rates from the prior year. Since the Centers for Medicare and Medicaid Services (CMS) announces the final increase to the October 1 Medicare rates in August according to the Medicare Hospital Market Basket Index, the Department would be able to incorporate Medicare's inpatient hospital rate increases for the following fiscal year.

In addition, the Department recommends fixing the inpatient hospital rates for hospitals classified in the Urban Safety Net Group to 10% above the current percent of the Medicare rate, not to exceed 100% of the Medicare rate. Under this alternative, this would put Urban Safety Net hospitals at 100% of the Medicare rate. If the General Assembly appropriated additional funding which brought inpatient rates to a higher percentage of the Medicare rates, no Urban Safety Net hospitals would exceed its Medicare rate. In the event that inpatient hospital rates fall below 90% of Medicare's rates, any Urban Safety Net hospital would receive 10% above the current base. For example, if inpatient hospital rates were set at 85% of Medicare's rates, any Urban Safety Net hospital would receive 95% of its Medicare rate.

As part of this alternative, the Department will also investigate changing the methodology on which inpatient rates are calculated for inpatient rehabilitation facilities. In 2002, Medicare switched from paying inpatient rehabilitation facilities on a cost-based reimbursement system to a prospective payment system rate. As part of the transfer, Medicare implemented a separate method for calculating payments based on the diagnostic related grouper. Currently, Medicaid rates for inpatient rehabilitation facilities are calculated using Medicare cost per discharge and case mix index, based on the old Medicare methodology. This methodology does not take into account the relative weights of services performed by inpatient rehabilitation facilities, and results in these facilities being underpaid. The Department intends to work with the provider community to establish a more equitable rate methodology, based on the Medicare diagnostic related grouper. The Department anticipates that total reimbursement to inpatient rehabilitation facilities will not exceed current reimbursement plus 15%; this is reflected in the Department's Request.

The Department recommends an appropriation of $2,162,874 in FY 07-08 to maintain inpatient hospital rates at 90% of Medicare's rates. This total reflects the fact that due to recent actions by the General Assembly, in FY 06-07, the Department has been able to set inpatient hospital rates to 92% of Medicare rates. In FY 07-08, due to Medicare inflation factors, this percentage will drop to approximately 89.3% of Medicare rates, and thus the request is only for additional funding to increase the rates from 89.3% to 90%. In subsequent years, in order to maintain funding at 90%, the Department would require an additional appropriation to cover the entire amount of the percentage increase by Medicare. For FY 08-09, the Department estimates that an appropriation of $11,682,170 would be required to maintain the rates at 90% of Medicare's rates.

Single Entry Points

The per-client rate for single entry points was originally calculated on a set scope of services. However, since that time, numerous responsibilities have been added to single entry point contracts. These responsibilities include: creating and maintaining the

statutorily required Community Advisory Committee and the Resource Development Committee; conduct applicant screening and referral; determine and apply client cost neutrality; review and authorize payment for clients receiving the Community Transitions Services benefit; calculate client post-eligibility treatment of income; process wait list information to expedite emergency client placement; ensure proper notice for client transfer; termination or discharge; coordinate special services for clients experiencing a crises or emergency which may include additional assessment, hospitalization or coordination with protective services; receive and act upon complaints of neglect and abuse; investigate and report serious incidents; and, purchase and maintain a data management system to collect, analyze, report and maintain required information.

The Department recommends an appropriation of $3,852,887 in order to raise per-client rates paid to single entry points by $179, to $1,053.50. This 20.5% increase would more appropriately fund these additional activities single entry point agencies are required to perform, but for which no increase in the per-client rate has been granted.

Emergency Transportation

The majority of ambulance codes have not been increased since 2002, when emergency transportation providers received a 5.0% rate cut. In the most recent actions by the General Assembly, emergency transportation providers were not included, and did not receive any rate increase. Just as critically, ambulance providers are deeply affected by rising fuel prices; according to the Energy Information Administration, the price of regular conventional retail gasoline has increased from $1.385 per gallon on July 1, 2002 to $2.899 per gallon on July 3, 2006.[5] The cost of operating an ambulance has increased by 109% due to fuel costs alone since FY 02-03. The Department recommends an appropriation of $300,000 to fund a 5% rate increase, and restore these procedure codes to the level before the cuts.

[5] http://www.eia.doe.gov/oil_gas/petroleum/data_publications/wrgp/mogas_history.html. The Energy Information Administration (EIA) is a statistical agency of the U.S. Department of Energy, created by Congress in 1977.

Specialty Providers and Procedures

Most physicians' and other practitioners' services are reimbursed using Relative Value Units (RVU) and conversion factors. The relative value of a particular service (called a "procedure") is a measure of its complexity and resource-intensity. The Department assigns every practitioner procedure a relative value. These relative values are multiplied by a conversion factor, which turns them into dollar amounts per procedure.

Anesthesia

The conversion factor for anesthesia was increased last in 1999 to $14.33. The base values assigned to the code are the values recommended in the Relative Values for Physicians Guide which is used by Medicare. For new codes entered into the system, the Department set rates at 70% of the Medicare rate for the procedure in question. However, without an increase, this percentage falls every year. The Colorado Society of Anesthesiologists disagrees with this methodology for anesthesia codes claiming that Medicare only pays anesthesiologists 30% of the average commercial payments. The Society also points out that the Department pays dental anesthesia codes at a much higher base value then physician anesthesia base values. The Department recommends an appropriation of $3,000,000 to increase reimbursement anesthesia providers, which would enable the Department to increase the conversion factor to $21.49, a 50% increase.

Surgical Procedures

There are 5,368 surgical procedure codes that are a benefit in Colorado Medicaid. The base value for 2,922 of these codes was set in 1979 or earlier. The conversion factor for surgical codes was last increased in 1990 to $33.43. For new codes entered into the system, the Department set rates at 70% of the Medicare rate for the procedure in question. However, without an increase, this percentage falls every year. The constant advancement of surgical procedures necessitating the more recent release of some surgical codes has enabled some procedures to be paid relatively competitively. For example an open appendectomy was priced in 1979 whereas a laparoscopic appendectomy was priced in 2000. In FY 04-05 laparoscopic appendectomies ranked 47 of the highest volume of surgical procedures paid for by Medicaid where appendectomies

ranked 141. However there remains a high volume of surgical procedures that are continuing to be reimbursed at rates set more than 8 years ago. Notably, four of the top five surgical procedures paid for in FY 04-05 were priced in 1997. By applying the recommended increase to the surgical conversion factor the rate increase would positively impact the surgical procedures being used no matter when the base price was developed. The Department recommends an appropriation of $1,650,000 to increase the conversion factor for surgical procedure codes to $34.58, a 3.45% increase.

Physical, Occupational & Speech Therapy

In FY 05-06, HB 06-1369 contained rate increases for Community Based Long Term Care, including increases to therapy rates as part of the Home Health provider rate increases. The majority of the rates for therapy that occurs in outpatient settings outside the home were set in 2003. The need to provide therapies in an outpatient setting continues to grow rapidly as clients are discharged from acute care setting early in the recovery phase. The current rates for outpatient therapies are frequently criticized by the professional organizations of the therapists and it is becoming more and more difficult to find therapists who will accept Medicaid clients. The Department recommends an appropriation of $1,000,000 to increase outpatient therapy rates by 9.05%.

Adult Immunizations

Immunizations are a benefit for adult clients ages 21 and older when medically necessary, when needed to enter the work force or when needed to attend school. Pricing for immunizations has been set at a fixed price for each immunization. For the most frequently used adult immunizations the reimbursement rate is $6.50. This is the same amount that the Department reimburses for administration alone to the practitioners for children's vaccines they receive for free through the Vaccines for Children's (VFC) program. The Department recommends an appropriation of $600,000 to alter the pricing for immunizations to average wholesale price plus 10%, plus a $2 administration fee.

Durable Medical Equipment Repairs

Durable medical equipment (DME) providers are reluctant to travel to clients' locations to repair malfunctioning equipment that has been purchased by Medicaid. The

Department has been told by providers that the main reason for their reluctance is that the current reimbursement does not cover the labor and travel costs of the providers. The Department has been advised by the Centers for Medicare and Medicaid Services (CMS) that while a separate procedure code for travel is not allowed, travel costs may be considered as a component when setting the rate for the repair procedure code. Therefore, the Department recommends an appropriation of $500,000 to increase the rate for wheelchair repair to $35.48 per 15 minutes, in order to adequately reimburse providers for both travel and labor. Currently, the Department reimburses at $15.35 per 15 minutes.

Intrauterine Devices

The Department receives frequent communications from the manufacturer of and providers who insert these devices. One OB/GYN practice that provides services to a large volume of Medicaid clients has stopped offering this service to Medicaid clients, as the cost of providing the device is not covered by the Medicaid reimbursement rate. The current cost to the provider for this product is $377.00, while the Department reimburses at $301.64. The Department recommends an appropriation of $90,000 to increase the rate for intrauterine devices to $398.37, a 32.07% increase.

Health Maintenance Organization

Rates paid to Health Maintenance Organizations (HMO) are required by state law to be calculated based on "…the direct health care cost of providing these same services on an actuarially equivalent population" 25.5-5-408 (1) (b), C.R.S. (2006). When rates are raised for services in the fee-for-service program, these increases have a corresponding effect on HMO rates. The Department cannot increase rates to fee-for-service providers without a corresponding increase in HMO rates. The Department recommends an appropriation of $398,966 to increase HMO rates. This increase is based on the increase to inpatient hospital, emergency transportation, and specialty providers, and does not include the effects of rate increases for county administration or single entry points.

Non-Emergency Transportation Services

The Department's request does not affect its fixed-price contract in the Denver-metro area. Rates for the non-emergency transportation services were set in 2002. These codes are for reimbursement for the use of private vehicles, mileage, lodging, escorts and meals. Transportation by private vehicle is commonly used by clients in the remote counties of Colorado. Just as for emergency transportation, non-emergency transportation providers are deeply affected by rising fuel prices; according to the Energy Information Administration, the price of regular conventional retail gasoline has increased from $1.385 per gallon on July 1, 2002 to $2.899 per gallon on July 3, 2006.[6] The cost of operating a vehicle has increased by 109% due to fuel costs alone since FY 02-03. The Department recommends an appropriation of $110,000, which would provide a 31% increase in non-emergency transportation rates.

County Administration

During Figure Setting for the Department of Human Services, the Joint Budget Committee staff wrote "…there is a shortfall in County Administration; counties have consistently over-expended the County Administration appropriation since FY 2000-01" (Department of Human Services Figure Setting, March 8, 2006, page 79). During FY 06-07, the Department of Human Services is undertaking a workload study with the goal of establishing what the appropriate level of funding is for County Administration. However, it is uncertain at this time when the results of such as study will be available. While rates have increased via cost-of-living adjustments in FY 04-05 and FY 05-06, it is still anticipated that the amount that the State will contribute to County Administration will not fully compensate counties for the services that they provide. In the interim, the Department recommends an appropriation of $366,133 to County Administration and an appropriation of $31,872 to County Administration – Administrative Case Management Payments to Counties, which would provide a 2% cost-of-living adjustment to both lines.

Implementation Schedule: The new rates will be effective July 1, 2007.

[6] http://www.eia.doe.gov/oil_gas/petroleum/data_publications/wrgp/mogas_history.html. The Energy Information Administration (EIA) is a statistical agency of the U.S. Department of Energy, created by Congress in 1977.

Calculations for Alternative's Funding:

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Health Care Expansion Fund**	**Federal Funds**
Total of All Line Items	**$14,212,732**	**$7,009,313**	**$138,113**	**$7,065,306**
(1) Executive Director's Office Non-Emergency Transportation Services (column 6)	**$110,000**	**$55,000**	**$0**	**$55,000**
(1) Executive Director's Office County Administration (column 6)	**$366,133**	**$183,067**	**$0**	**$183,066**
(1) Executive Director's Office Administrative Case Management Payment to Counties (column 6)	**$31,872**	**$15,936**	**$0**	**$15,936**
(2) Medical Services Premiums **Incremental FY 07-08 Request (column 6)**	**$13,704,727**	**$6,755,310**	**$138,113**	**$6,811,304**
Increase to Inpatient Hospital Rates	$2,162,874	$1,050,893	$30,545	$1,081,436
Increase to Emergency Transportation	$300,000	$145,763	$4,237	$150,000
Increase to Adult Immunizations	$600,000	$291,527	$8,473	$300,000
Increase to Anesthesia	$3,150,000	$1,530,515	$44,485	$1,575,000
Increase to Durable Medical Equipment Repair	$500,000	$242,939	$7,061	$250,000
Increase to Intrauterine Devices(1)	$90,000	$8,746	$254	$81,000
Increase to Surgical Procedures	$1,650,000	$801,698	$23,302	$825,000
Increase to Therapy Services	$1,000,000	$485,878	$14,122	$500,000
Increase to Health Maintenance Organizations	$398,966	$193,849	$5,634	$199,483
Increase to Single Entry Points(2)	$3,852,887	$2,003,502	$0	$1,849,385
(1) Intrauterine devices qualify for a 90% federal match, as Family Planning.				
(2) 4% of Single Entry Points is General Fund only. The remaining 96% receives a 50% federal match.				

Summary of Request FY 08-09 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Health Care Expansion Fund**	**Federal Funds**
Total of All Line Items	**$23,732,028**	**$11,669,511**	**$273,563**	**$11,788,954**
(1) Executive Director's Office Non-Emergency Transportation Services (column 10)	**$110,000**	**$55,000**	**$0**	**$55,000**
(1) Executive Director's Office County Administration (column 10)	**$366,133**	**$183,067**	**$0**	**$183,066**
(1) Executive Director's Office Administrative Case Management Payment to Counties (column 10)	**$31,872**	**$15,936**	**$0**	**$15,936**
(2) Medical Services Premiums **Incremental FY 08-09 Total Request (column 10)**	**$23,224,023**	**$11,415,508**	**$273,563**	**$11,534,952**
Increase to Inpatient Hospital Rates	$11,682,170	$5,676,108	$164,978	$5,841,084
Increase to Emergency Transportation	$300,000	$145,763	$4,237	$150,000
Increase to Adult Immunizations	$600,000	$291,527	$8,473	$300,000
Increase to Anesthesia	$3,150,000	$1,530,515	$44,485	$1,575,000
Increase to Durable Medical Equipment Repair	$500,000	$242,939	$7,061	$250,000
Increase to Intrauterine Devices(1)	$90,000	$43,729	$1,271	$45,000
Increase to Surgical Procedures	$1,650,000	$801,698	$23,302	$825,000
Increase to Therapy Services	$1,000,000	$485,878	$14,122	$500,000
Increase to Health Maintenance Organizations	$398,966	$193,849	$5,634	$199,483
Increase to Single Entry Points(2)	$3,852,887	$2,003,502	$0	$1,849,385
(1) Intrauterine devices qualify for a 90% federal match, as Family Planning.				
(2) 4% of Single Entry Points is General Fund only. The remaining 96% receives a 50% federal match.				

Table 1
Calculation of Impact to Inpatient Hospital

Row	Item	FY 07-08	FY 08-09	
A	FY 05-06 Expenditure for Inpatient Hospital	$296,800,124		Section E, Exhibits for Medical Services Premiums, Exhibit M, page EM-1.
B	Estimated Increase in Caseload from FY 05-06 to FY 06-07	7.06%		Section E, Exhibits for Medical Services Premiums, Exhibit B, page EB-1.
C	Estimated "Prior-Year" Expenditure	$317,760,767	$337,889,589	FY 07-08: Row A + (1 + Row B) FY 08-09: Row G of FY 07-08
D	Estimated Caseload Increase	5.65%	1.69%	Section E, Exhibits for Medical Services Premiums, Exhibit B, page EB-1.
E	Estimated Base Year Expenditure	$335,726,715	$343,593,224	Row C * (1 + Row D)
F	Estimated Percent Increase Required to Reach 90% of Medicare Rates	0.64%	3.40%	August 18, 2006 *Federal Register*, and August 1, 2006 Medicare Press Release(1)
G	Estimated FY 07-08 Expenditure at 90% of Medicare Rates	$337,889,589	$355,275,394	Row E * (1 + Row F)
H	**Total Request**	**$2,162,874**	**$11,682,170**	**Row G - Row E**

(1) http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1921

Table 2
Estimated Percentage Increase by Service Category

Service Category	FY 07-08 Estimated Reimbursements[(1)]	Requested Increase	Estimated Reimbursements with Increase	Percentage Increase
Non-Emergency Transportation Services	$354,432	$110,000	$464,432	31.04%
Emergency Transportation	$2,488,964	$300,000	$2,788,964	12.05%
Adult Immunizations	$157,871	$600,000	$757,871	380.06%
Anesthesia	$6,302,981	$3,150,000	$9,452,981	50.00%
Durable Medical Equipment Repair	$336,682	$500,000	$836,682	148.51%
Intrauterine Device	$280,643	$90,000	$370,643	32.07%
Surgical Procedures	$47,824,788	$1,650,000	$49,474,788	3.45%
Therapy Services	$11,050,598	$1,000,000	$12,050,598	9.05%
Total	**$57,746,361**	**$6,400,000**	**$64,146,361**	**11.08%**

(1) Calculated using paid claims from the Department's Medicaid Management Information System.

Table 3

Calculation of Impact to County Administration and County Administration - Administrative Case Management Payments to Counties

Row	Item	Total	Source / Notes
A	November 1, 2006 Request for County Administration	$18,306,628	November 1, 2006 Request, Section D, Page D.1-123
B	Requested Increase	2.00%	
C	Total Request with Increase	$18,672,761	Row A * 1.02
D	**Total Increase to County Administration**	**$366,133**	**Row C - Row A**
E	November 1, 2006 Request for County Administration - Administrative Case Management Payments to Counties	$1,593,624	November 1, 2006 Request, Section D, Page D.1-126
F	Requested Increase	2.00%	
G	Total Request with Increase	$1,625,496	Row A * 1.02
H	**Total Increase to County Administration**	**$31,872**	**Row C - Row A**

Table 4
Calculation of Impact to Single Entry Points

Row	Item	Total	Source / Notes
A	Current Rate for Single Entry Point Services	$874.50	Narrative
B	Portion of Single Entry Point Rate for Long Term Home Health Prior Authorization Review	$39.75	Narrative
C	Current Rate for Single Entry Point Services in Medical Services Premiums	$834.75	Row A - Row B
D	Requested Increase in Rate	$179.00	Narrative
E	Requested New Rate (Less payment for Long Term Home Health Prior Authorization Review)	$1,013.75	Row C + Row D
F	Percent Increase	21.44%	(Row E - Row C) / Row C
G	Portion of FY 07-08 Medical Services Premiums Request Attributable to Single Entry Points	$17,967,584	Section E, Exhibits for Medical Services Premiums, Exhibit I, page EI-2.
H	Including Rate Increase	$21,820,471	Row G * (1 + Row F)
I	**Total Increase**	**$3,852,887**	**Row H - Row G**

Table 5
Calculation of Impact to Health Maintenance Organizations

Row	Item	Total	Source / Notes
A	FY 07-08 Projected Acute Care	$1,343,618,940	Section E, Exhibits for Medical Services Premiums, Page EA-2; Subtotal for Acute Care, Includes HMO
B	Estimated Percentage of Acute Care Services Included in HMO Rate	78.92%	Derived from Section E, Exhibits for Medical Services Premiums, Page EM-1. Total Acute Care Request less Health Maintenance Organizations, Rural Health Centers, Other Medical Services, Home Health, and Presumptive Eligibility. Based on FY 05-06 expenditure history.
C	Portion of Acute with HMO Related Services	$1,060,370,344	Row A * Row B
D	FY 07-08 Requested Rate Increases Affecting Acute Care	$9,452,874	Includes Inpatient Hospital, Emergency Transportation, and Specialty Providers
E	FY 07-08 Projected Acute Care with Rate Increases	$1,069,823,218	Row C + Row D
F	Projected Increase	0.89%	(Row E - Row C) / (Row C)
G	FY 05-06 HMO Expenditure, Less Expenditure for Providers No Longer Participating in the Program	$39,564,707	Information from the Department's Colorado Financial Reporting System (COFRS), paid in FY 05-06 with non-active providers removed.
H	Estimated Increase in Caseload from FY 05-06 to FY 07-08	13.12%	Derived from Section E, Exhibits for Medical Services Premiums, Exhibit B, page EB-1.
I	Estimated FY 07-08 HMO Expenditure without Rate Increase	$44,753,785	Row G * Row H
J	Estimated FY 07-08 HMO Expenditure with Rate Increase	$45,152,751	Row I * (1 + Row G)
K	**Estimated Effect of Rate Increase**	**$398,966**	**Row J - Row I**

Impact on Other Areas of Government: There is no impact on other areas of government.

Assumptions for Calculations: For all requests except Single Entry Points and County Administration, the impact to the Health Care Expansion Fund is calculated based on the percentage of the Department's FY 07-08 Request for Medical Services Premiums (Acute Care) is from the Health Care Expansion Fund, specifically 3.08% (Exhibits for Medical Services Premiums, Exhibit A, page 2). Rate increases for services are applied without respect to eligibility category. When a client in an eligibility category (or other population group) which is funded from the Health Care Expansion Fund (such as the Health Care Expansion Low-Income Adults) utilizes a service which has received a rate increase, the additional expenditure must also come from the Health Care Expansion Fund.

Inpatient Hospital
The Department has estimated the increase required to maintain inpatient hospital rates at 90% of Medicare rates, based on a number of factors that may change. These factors include, but are not limited to: the actual increase in Medicare hospital rates, the number of discharges per hospital, case-mix indices, and actual reported costs. The cost inflator is based on the Medicare Economic Index, which is the cost inflator used by Medicare to set hospital base rates. This number is published each year on October 1 in the Federal Register.

Emergency Transportation and Non-Emergency Transportation Services
The Department has estimated the percentage increase to emergency transportation and non-emergency transportation services based on the requested change in funding. The Department calculated the estimate by analyzing claims at the procedure code level, inflating for increases in caseload, and applying the rate increase. This methodology assumes that utilization rates will remain constant.

Specialty Providers and Procedures
The Department has estimated the percentage increase to these services based on the requested change in funding. The Department calculated the estimate by analyzing

claims at the procedure code level, inflating for increases in caseload, and applying the rate increase. This methodology assumes that utilization rates will remain constant.

Concerns or Uncertainties of Alternative: The Department has calculated the estimated appropriation required based on actual experience from FY 01-02 through FY 05-06. Unforeseen increases in caseload or utilization could cause the Department to require an additional appropriation in the future for these services. Any such request would be included in the Department's annual February Supplemental Request for Medical Services Premiums.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would maintain the current reimbursement rates for single entry points, emergency transportation, anesthesia, surgical procedures, physical therapy, occupational therapy, speech therapy, adult immunizations, durable medical equipment repair, intrauterine devices, non-emergency transportation services, and county administration. In addition, the Department would continue its current methodology in setting inpatient hospital rates. Inpatient hospital rates would continue to be subject to budget neutrality requirements.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: By maintaining current rates and rate setting methodology, the Department risks having providers exit the program for lack of adequate reimbursement. Without adequate access to these services, clients are more likely to experience adverse health events which are more expensive to the Department.

Supporting Documentation

Analytical Technique: Multi-Criteria Analysis

The Department reviewed and compared both alternatives and their ability to meet criteria that is valuable to the Department in making management decisions. The Department established a three-tiered ranking score: 1 = does not meet criteria; 2 = minimally meets criteria; 3 = successfully meets criteria. Based on these criteria and this scoring technique, the Department believes that Alternative A is the preferred alternative. Each criterion was weighted the same as it was determined that all items were equally important.

Criteria	**Alternative A (Preferred)**	**Alternative (Status Quo)**
Maintain Client Access to Primary and Emergency Health Care	By providing inflationary increases to inpatient hospitals, the Department ensures that primary and emergency care will continue to be available to Medicaid clients.	Inflationary pressures cause the price of providing services for inpatient hospitals to increase. If Medicaid rates do not increase in response, the Department risks providers leaving the program.
	3	**1**
Maintain Client Access to Specialty Providers	By providing rate increases to Single Entry Points and specialty services, the Department ensures that clients will have access to case management services, therapy services, surgical procedures, and other specialty services.	Under the current reimbursement levels, the Department has found that specialty providers are already leaving the program due to inadequate reimbursement. Given this information, is it clear that the status quo will not maintain client access to health care for these services.
	3	**1**

Criteria	**Alternative A (Preferred)**	**Alternative (Status Quo)**
Prevent Adverse Health Outcomes	Increasing reimbursement rates will allow providers to continue with the Medicaid program, without being forced to perform services at a financial loss.	Without rate increases, critical providers such as ambulances, inpatient hospitals, anethesiologists, and surgeons may refuse to accept Medicaid clients. Without access to these vital providers, clients may not receive timely care, resulting in further complications or death.
	2	**1**
Minimize Usage of General Fund	This alternative requires an increase in General Fund, but is likely to prevent utilization of higher-cost services as substitutes.	This alternative does not require an increase in General Fund.
	2	**3**
Total Score	**10**	**6**

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative	FY 07-08 Cost	FY 08-09 Cost
A	$14,212,732	$23,732,028
B	$0	$0

Statutory and Federal Authority:

25.5-4-104, C.R.S. (2006). Program of medical assistance - single state agency.
(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

25.5-5-101, C.R.S. (2006). Mandatory provisions - eligible groups - repeal.
(1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203.

Department Objectives Met if Approved:

1.1 To maximize the opportunity to preserve health care services through the purchase of services in the most cost-effective manner possible.

1.4 To assure delivery of appropriate, high quality health care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome- based contracting and dedicated contract management.

3.2 To improve customer satisfaction with programs, services, and care.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI - 7	**OSPB Approval:**		**Date:**
Program:	Acute Care Benefits Section	**Statutory Citation:**	25.5-5-202 (1) (s) (II) (2), C.R.S. (2006)	
Request Title:	Increased Funding for Non-Emergency Medical Transportation			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	5,577,485	5,068,722	0	5,068,722	4,575,163	1,464,796	6,039,959	0	6,039,959	1,464,796
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,788,743	2,534,361	0	2,534,361	2,287,582	732,398	3,019,980	0	3,019,980	732,398
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	2,788,742	2,534,361	0	2,534,361	2,287,581	732,398	3,019,979	0	3,019,979	732,398
(1) Executive Director's Office, Non-Emergency Transportation Services	**Total**	5,577,485	5,068,722	0	5,068,722	4,575,163	1,464,796	6,039,959	0	6,039,959	1,464,796
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	2,788,743	2,534,361	0	2,534,361	2,287,582	732,398	3,019,980	0	3,019,980	732,398
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	2,788,742	2,534,361	0	2,534,361	2,287,581	732,398	3,019,979	0	3,019,979	732,398

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	FF: Title XIX
IT Request: ☐ **Yes** ☑ **No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☐ **Yes** ☑ **No**	If Yes, List Other Departments Here:

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Emergency Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 7
Change Request Title:	Increased Funding for Non-Emergency Medical Transportation Services
Long Bill Line Item(s)	(1) Executive Director's Office, Non-Emergency Transportation Services
State and Federal Statutory Authority:	25.5-5-202 (1) (s) (II) (2), C.R.S. (2006) and 42 C.F.R. Section 431.53

Summary of Request (Alternative A): This Request is to seek additional funding of $1,464,796 to the Executive Director's Office, Non-Emergency Transportation Services line item for the administration of non-emergency medical transportation. The additional funding is required due to increases in contractor and county costs to administer non-emergency medical transportation.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department of Health Care Policy and Financing provides non-emergency transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation throughout all sixty-four counties in Colorado. Section 25.5-5-202 (1) (s) (II) (2), C.R.S. (2006) and 42 C.F.R. Section 431.53 requires the Department to provide non-emergency medical transportation to eligible clients under the state Medical Assistance Program. The type of transportation authorized is determined by the distance to be traveled and treatment facilities available, and the physical condition and welfare of the client. Non-emergency medical transportation services include transportation between the client's home and Medicaid covered benefits, and when applicable, the cost of lodging and food when an

overnight stay is necessary for an escort. There are also administrative costs related to non-emergency medical transportation including, but not limited to, the intake of client calls, determining eligibility, and authorizing and arranging transportation.

Prior to FY 03-04, funding for non-emergent medical transportation, approximated to be $12,041,460, was contained in the Medical Services Premiums line within the Department's Budget. However, due to difficult economic conditions in FY 02-03, the General Assembly reduced this funding by $7,640,682 in an effort to reduce General Fund expenditures (FY 03-04 Figure Setting, March 11, 2002, page 110-111).

In FY 03-04, the Department received legislative authority via HB 04-1220 to administer non-emergency medical transportation as an administrative program rather than an optional Medicaid service in an effort to maintain cost savings. As a result of this action, $4,400,778 was transferred from the Department's Medical Services Premiums Long Bill group and created a new line item under the Executive Director's Office Long Bill group titled "Non-Emergency Medical Transportation".

The Department currently employs two mechanisms to meet non-emergency medical transportation needs for Medicaid clients. In 56 counties within the State, the county departments of social services are responsible for authorizing and arranging the transportation. In eight front-range counties, the Department contracts directly for the necessary services and administration with a broker.

On June 20, 2006, the Department requested and received FY 05-06 1331 Emergency Supplemental funding of $1,121,497 for increases in contract costs. Due to a failed request for proposals, the Department entered into an emergency nine month contract with the existing contractor, which included an administrative increase of $30,000 per month, until a new request for proposals could be completed. The revised request for proposals was an open-ended request, meaning no dollar amount was specified. As a result of this request for proposals, the existing contractor, LogistiCare, was awarded the winning bid for a fixed price contract beginning July 1, 2006. This fixed price contract was negotiated for $446,992 per month, or $5,363,904 per fiscal year.

Similar to contract obligations increasing, utilization and caseload in the 56 counties has required a greater portion of the total appropriation to be allocated to the non-Front Range counties. Looking at a snapshot of expenditures between October 1, 2004 and June 30, 2005, the average monthly expenditures for the 56 counties equaled $83,941. Comparatively, looking at the period of July 1, 2005 to November 31, 2005, the average monthly expenditure has grown by 14.5%, to $96,131.

The FY 06-07 appropriation for Non-Emergency Transportation Services is $5,068,722. This appropriated amount, along with the out-year reduction to this appropriation of $493,559 from SB 06-165, which requires the Department to implement and expand a pilot program for telemedicine anticipated to reduce the need for non-emergent transportation, reduces the FY 07-08 base budget for this line to $4,575,163.

General Description of Alternative:

This Request is for $1,464,796 in (1) Executive Director's Office, Non-Emergency Transportation Services line item. Due to the contractor costs for the fixed price agreement of $446,992 per month experienced in FY 06-07, the Department estimates that funding for non-emergency medical transportation will not be adequate for FY 07-08. While implementing SB 06-165 is anticipated to save the State $493,599 in non-emergency medical transportation costs in FY 06-07, this reduction only partially offsets increases in contractor obligations.

56 Counties Need

Based on the Department's 1331 Emergency Supplemental submitted on June 20, 2006, the Department estimated that $1,169,654 was needed for FY 05-06 to pay for services for the remaining 56 counties. However, due to SB 06-165, this amount should be appropriately reduced due to increased efforts in telemedicine; therefore, the Department estimates that the need for FY 06-07 and forward will be $1,081,300. While the Department believes that utilization and caseload growth are drivers for these expenditures; and therefore, will increase demand on this funding, the Department is not asking for additional funding for this purpose. As the Department requested, and received legislative authority to administer this line as an administrative program, rather

than an optional Medicaid service with the passage of HB 04-1220, the Department will manage to this amount in the FY 07-08 base appropriation for the 56 counties.

Contractor Need

Based on the fixed price contract of $446,992 per month that was implemented for FY 06-07, assuming no increase for inflation, $5,363,904 will be required annually for a contractor to provide administration and services in the eight Front Range counties. However, this again needs to be adjusted for the savings estimated from SB 06-165. Therefore, the final contractor need for FY 07-08 is estimated at $4,958,659. Assuming $3,493,863 would be remaining in the FY 07-08 base appropriation after carving out the necessary funding for the 56 counties described above, this would indicate that a shortfall of $1,464,796 currently exists.

Summary

Total funding need is projected to be $6,039,959 ($4,958,659 + $1,081,300) for both contractor and county administration costs in FY 07-08. Based on FY 07-08 base funding of $4,575,163, a shortfall of $1,464,796 exist.

Calculations for Alternative's Funding:

(1) Executive Director's Office, Non-Emergency Medical Transportation Services			
Summary of Request FY 07-08	**Total Funds**	**General Fund**	**Federal Funds**
FY 07-08 Total Need	$6,039,959	$3,019,980	$3,019,979
Additional Contractor Need	$1,464,796	$732,398	$732,398
FY 07-08 Base Request	$4,575,163	$2,287,582	$2,287,581
SB 06-165 Reduction*	($493,559)	($246,779)	($246,780)
FY 06-07 Long Bill Appropriation	$5,068,722	$2,534,361	$2,534,361

* $493,559 has been reduced from the total appropriation due to the implementation of telemedicine and resulting costs savings in non-emergency medical transportation per SB 06-165.

(1) Executive Director's Office, Non-Emergency Medical Transportation Services			
Summary of Out-Year Request for FY 08-09	**Total Funds**	**General Fund**	**Federal Funds**
Additional Contractor Need from FY 07-08 Base	$1,464,796	$732,398	$732,398

Table 1: Contractor Cost for Eight Front Range Counties	
Contract Period	**Contract Provision**
FY 06-07 Monthly Fixed-Price Contract Cost	$446,992
Contractor Costs for FY 07-08 Before Reduction for Savings from SB 06-165 ($446,992 * 12)	$5,363,904
Total Savings Anticipated from SB 06-165 (Telemedicine Bill)	$493,599
Percent of Savings Estimated to Occur in the Eight Front Range Counties	82.10%
Savings from SB 06-165 Anticipated to Occur in the Eight Front Range Counties	($405,245)
Total Contractor Costs for FY 07-08 Including Savings from Telemedicine Bill (SB 06-165)	**$4,958,659**

Table 2: Costs for Remaining 56 Counties	
Total Costs for 56 Counties (per June 20, 2006 1331 Emergency Supplemental for FY 05-06)	$1,169,654
Total Savings Anticipated from SB 06-165 (Telemedicine Bill)	$493,599
Percent of Savings Estimated to Occur in the Eight Front Range Counties	17.90%
Savings from SB 06-165 Anticipated to Occur in the Eight Front Range Counties	($88,354)
	$1,081,300

Table 2: Summary of Request	
Total Contractor Costs (Table 1)	**$4,958,659**
Total Costs for 56 Counties (per June 20, 2006 1331 Emergency Supplemental for FY 05-06)	**$1,081,300**
Estimated Total Costs for Non-Emergency Medical Transportation	**$6,039,959**
FY 07-08 Base Request	$4,575,163
Estimated Shortfall (Matches Schedule 6, Column 6 and Column 10)	**$1,464,796**

Assumptions for Calculations:

56 Counties

For the 56 counties, the Department used actual and estimated expenditures to calculate the total costs per the 1331 Emergency Supplemental for FY 05-06 as the base amount for

FY 07-08. The total county need was estimated at $1,169,654 based on nine months of actual data from FY 05-06, projected for the fiscal year, and included the estimated payable, as there is a 120 day allowance for submitting claims through the Medicaid Management Information System. Details of the calculation can be found on pages 8 - 10 of the Department's June 20, 2006 1331 Emergency Supplemental Request. This amount was then adjusted downward due to anticipated savings from SB 06-165. The impact of SB 06-165 was assumed to follow the same pattern as the current allocation of dollars between the 56 counties and the eight Front Range Counties prior to this legislation (i.e. the 17.90% allocation is equal to the ratio of the pre SB 06-165 need for the 56 counties of $1,169,654 over the estimated total need for this appropriation pre SB 06-165 equal to $6,533,558).

Contractor

For the eight metropolitan counties managed by LogistiCare, the monthly fixed-price contract is equal to $446,992. This flat amount is a full risk agreement with the contractor, and includes both the administration of non-emergent medical transportation for all 64 counties in the State and the actual transportation services for clients in the eight Front Range counties. The total need for FY 07-08 is therefore calculated at $5,363,904 ($5,363,904 = $446,992 * 12). This was then adjusted for anticipated savings from SB 06-165 based on the amount not allocated to the 56 counties ($493,599 - $88,354 for 56 counties = $405,245).

Concerns or Uncertainties of Alternative: The Department has estimated potential costs for the remaining 56 counties, which are billed fee-for-service under accrual accounting. If the actual costs, including services provided prior to June 30 but billed after the fiscal year, are different than estimated for the 56 counties, the Department will need to find ways to manage to the appropriation.

Additionally, the contractor for the eight Front Range counties might not accept the re-negotiated fixed price contract based on the anticipated savings from SB 06-165.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: Funding for non-emergency medical transportation would remain at $4,575,163 for the (1) Executive Director's Office, Non-Emergency Medical Transportation appropriation.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Contractor obligations alone are anticipated to exceed the current FY 07-08 base appropriation. If no additional funding is appropriated, the Department would not be able to continue the current contractor, and would need to submit another request for proposals. As the original request for proposals failed because it did not contain enough funding to attract any vendors, an open ended request was released, and resulted in the award of the current, higher contractor costs. Therefore, there is little chance that the Department could obtain a new vendor for less than the current contractor.

Per 25.5-5-202 (1) (s) (II) (2), C.R.S. (2006) and 42 C.F.R. Section 431.53, the Department is required to provide non-emergency medical transportation. If sufficient funding does not exist to support either the contractor or the 56 counties and transportation services are not available to Medicaid clients, the State's federal financial participation for this program could be withheld by the federal Centers for Medicare and Medicaid Services.

Supporting Documentation

Analytical Technique: For this Emergency Supplemental Request, a Risk/Benefit Analysis was used. Scoring for this analysis were based on the following: 1 = risks are more prevalent causing negative implications to the State, 2 = no risks or benefits are realized by the State, 3 = benefits are greater than risks.

Description of Risks/Benefits	Alternative A	Alternative B
Benefit: The Department would be able to pay all of its providers for the administration and transportation costs associated with the State's eligible Medicaid clients. **Risk:** If there is a funding shortfall, transportation services for Medicaid clients to get to appointments might not be available, leaving some clients without a means for obtaining their assessments or to be seen by their physician for a routine check-up. These missed medical treatments may lead to sicker clients; and therefore, increase Medicaid medical costs in the future.	3	1
Benefit: The Department would be in compliance with all State and federal citations regarding the provision of this transportation benefit. **Risk:** Loss of federal matching funds for this appropriation could be withheld by the federal Centers for Medicare and Medicaid Services.	3	1

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A requires $732,398 General Fund to allow the Department to pay contractor obligations in FY 07-08. Alternative B does not require any General Fund, but would not allow for services to continue through the end of the fiscal year. Alternative A is the preferred alternative.

Statutory and Federal Authority:

25.5-5-202 (1) (s) (II) (2), C.R.S. (2006). Basic services for the categorically needy – optional services. *In addition to the services described in subsection (1) of this section and subject to continued federal financial participation, Colorado has selected to provide transportation services as an administrative cost.*

42 C.F.R. Section 431.53. Assurance of transportation. *A State plan must--(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and (b) Describe the methods that the agency will use to meet this requirement.*

Department Objectives Met if Approved:

1.4 To assure delivery of appropriate, high quality health care. To design programs that would improve health status for clients served and to improve health outcomes. To

ensure that the Department's programs are responsive to the service needs of enrolled clients in a cost-effective manner.

1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI - 8	**OSPB Approval:**		**Date:**
Program:	Eligibility Operations	**Statutory Citation:**	25.5-4-205 (1) (a), C.R.S. (2006)	
Request Title:	Funding to Continue Efforts on Cases Exceeding Processing Guidelines			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	1331 Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	14,763,261	16,383,300	164,827	16,548,127	16,818,945	152,807	16,971,752	0	16,971,752	152,807
	FTE	194.35	226.70	4.00	230.70	226.90	4.00	230.90	0.00	230.90	4.00
	GF	6,727,174	6,987,000	41,785	7,028,785	7,414,663	38,737	7,453,400	0	7,453,400	38,737
	GFE	25,617	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	521,654	520,596	28,440	549,036	530,477	26,367	556,844	0	556,844	26,367
	FF	7,488,816	8,875,704	94,602	8,970,306	8,873,805	87,703	8,961,508	0	8,961,508	87,703
(1) Executive Director's Office; Personal Services	**Total**	13,785,054	15,362,691	149,327	15,512,018	15,821,148	149,327	15,970,475	0	15,970,475	149,327
	FTE	194.35	226.70	4.00	230.70	226.90	4.00	230.90	0.00	230.90	4.00
	GF	6,280,279	6,493,748	37,855	6,531,603	6,931,815	37,855	6,969,670	0	6,969,670	37,855
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	507,578	506,203	25,766	531,969	517,572	25,766	543,338	0	543,338	25,766
	FF	6,996,916	8,362,740	85,706	8,448,446	8,371,761	85,706	8,457,467	0	8,457,467	85,706
(1) Executive Director's Office; Operating Expenses	**Total**	978,207	1,020,609	15,500	1,036,109	997,797	3,480	1,001,277	0	1,001,277	3,480
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	446,895	493,252	3,930	497,182	482,848	882	483,730	0	483,730	882
	GFE	25,336	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	14,076	14,393	2,674	17,067	12,905	601	13,506	0	13,506	601
	FF	491,900	512,964	8,896	521,860	502,044	1,997	504,041	0	504,041	1,997

Letter Notation:

Cash Fund name/number, Federal Fund Grant name: CFE: Autism Fund, Health Care Expansion Fund, Primary Care Fund, Breast and Cervical Cancer Prevention and Treatment Fund, Children's Basic Health Plan Trust, FF: Title XIX and Title XXI

IT Request: ☐ Yes ☑ No (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ Yes ☑ No

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Emergency Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 8
Change Request Title:	Funding to Continue Efforts on Cases Exceeding Processing Guidelines
Long Bill Line Item(s)	(1) Executive Director's Office: Personal Services, (1) Executive Director's Office: Operating Expenses
State and Federal Statutory Authority:	25.5-4-205 (1) (a), C.R.S. (2006), 42 C.F.R. Part 435, Sec. 911

Summary of Request (Alternative A): This Request is to maintain funding in the Department's Personal Services and Operating Expenses lines by $152,807 and 4.0 FTE to continue to reduce medical program applications that are exceeding processing guidelines.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: In an effort to comply with a court order imposed shortly after the implementation of the Colorado Benefits Management System, the Department, along with the Department of Human Services, submitted a 1331 Emergency Supplemental for FY 04-05 requesting additional funding for centralized data entry, client correspondence, legal services, and an emergency call center (see page 45 of the Department of Human Services Figure Setting document dated March 8, 2005).

Within that request for centralized data entry, there was funding for the Department of Human Services to create a group known as CDET (or the Centralized Data Entry Team) to process food stamp and other non-Medicaid cases that were exceeding processing

requirements. Similarly, the Department of Health Care Policy and Financing requested funding to contract with two entities, Document Solutions Group and Affiliated Computer Services, to address the out-of-compliance Medicaid and Children's Basic Health Plan applications. Total funding for both departments for centralized data entry was $2,668,084, and was officially appropriated to the Department in HB 05-1315.

With approval from the Joint Budget Committee and the State Controller on September 20, 2005, the Department received a second 1331 Emergency Supplemental, this time for FY 05-06 spending authority, for continuation of the Centralized Data Entry Team. Again, this was due to compliance with a court order. However, while this unit was still managed by the Department of Human Services, it was responsible for processing both non-Medicaid and Medicaid applications, as the Department of Health Care Policy and Financing elected to end its contract with Document Solutions Group. Counties were therefore instructed to continue forwarding cases to this team, along with the appropriate documentation, in an effort to reduce the average length of time it was taking to determine eligibility for these public assistance programs.

On April 3, 2006, the Department elected to process its own cases exceeding guidelines, rather than delegate the function to another state agency. The Department hired temporary staff to work with counties and medical assistance sites to process cases. This allowed Health Care Policy and Financing to become responsible for its own cases. Using funding previously forwarded to the Department of Human Services, the Department used FY 05-06 funding from the Colorado Benefits Management System line item for this purpose.

For FY 06-07 the Department did not submit a request because a trial set for the week of June 5, 2006 had been planned. However, Joint Budget Committee staff did recommend funding for legal services and other court order resources, including funding for temporary staff to process cases exceeding processing guidelines, and this recommendation was approved by the Joint Budget Committee on March 8, 2006 during Figure Setting (see page 71 of the March 8, 2006 Figure Setting document). The recommended amount was for $192,000 for Personal Services and $13,000 for Operating

Expenses within the Department's Budget, for a total of $205,000. However, the Joint Budget Committee reversed this decision on March 22, 2006. Therefore, there are no FY 06-07 resources appropriated to the Department's Personal Services and Operating Expenses appropriations, and no funding within the Colorado Benefits Management System dedicated to continuing the work needed to process these cases.

At the June 20, 2006 Joint Budget Committee meeting, the Department had submitted an Emergency Supplemental Request for this same need. At that meeting, the Committee indicated to the Department that there needed to be additional collaboration with the Department of Human Services, as the Department of Human Services had also submitted a request for resources to address out of compliance cases. However, unlike the Department's request which was to address only Medicaid cases, the Department of Human Services' request was to continue resources that would address both Health Care Policy and Financing programs and non-Medicaid programs run by the Department of Human Services, and would use the Colorado Benefits Management System funding splits to allocate the necessary resources. Therefore, the Joint Budget Committee requested that the two departments work together on this issue, before submitting another request.

On September 20, 2006 the Department submitted its updated 1331 Emergency Supplemental to request funding for these employees performing this function. That request was approved by the Joint Budget Committee. This request is to continue funding for this unit in FY 07-08.

General Description of Alternative: This Request is for continued funding of $152,807 and four permanent FTE within the Department to process cases exceeding processing guidelines that was initially approved on September 20, 2006.

As mentioned above, the Department had expected to go to trial on the CBMS case on June 5, 2006. In March 2006, the Department of Health Care Policy and Financing and the Department of Human Services decided to enter into mediated negotiations in an attempt to settle the case. During these negotiations, plaintiffs wanted to continue the

June trial date and the Departments wanted a June hearing on their motion to dissolve the preliminary injunction. Through mediation, the parties reached a joint stipulation that altered the preliminary injunction on terms favorable to the departments and vacated the June trial without setting a new date. In addition, the five main points of the January 14, 2005 injunction were revisited, and the following was concluded in the joint stipulation:

1. The benefit freeze flags may be lifted for inactive cases, but active cases would be cleansed by the State.

2. Absent a material change in circumstances, enforcing of the court order regarding noticing would be postponed until the trial of the case.

3. Beginning June 1, 2006, overpayments could be collected by the State according to federal or state law, and the State would submit a report of established overpayment claims. The State agreed to suspend collection if a wide-spread system-caused problem was identified.

4. The Departments' emergency processing units would cease effective June 30, 2006, but the Departments would still process cases needing immediate attention. The Departments agreed to provide procedures to the plaintiffs.

5. Absent a material change in circumstances, enforcement of the court order regarding timely processing of applications would be postponed until the trial of the case, but it was understood that the Departments have the obligation to process cases with applicable federal and state timelines as the Departments are ultimately responsible for compliance with federal processing guidelines. The Departments agreed to provide regular reports.

This joint stipulation was signed April 6, 2006. To comply with the stipulation and in the event of a trial, it was, and still is, very important to contain the number of cases exceeding processing guidelines. While the potential trial for the Colorado Benefits Management System brought this issue to the forefront, maintaining a low number of

cases exceeding processing guidelines should be part of the Department's normal business practice.

Applications Exceeding Processing Guidelines												
	Nov 2004	**Feb 2005**	**Apr 2005**	**Jun 2005**	**Aug 2005**	**Oct 2005**	**Dec 2005**	**Feb 2006**	**Apr 2006**	**May 2006**	**Jun 2006**	**Jul 2006**
HCPF Applications	16,745	6,669	6,847	2,721	1,868	3,022	2,194	2,716	2,681	1,863	2,150	3,005
Percent Change from Prior month		-60.17%	2.67%	-60.26%	-31.35%	61.78%	-27.40%	23.79%	**-1.29%**	**-30.5%**	15.41%	39.77%

Data used is from the Federal Statistical Report of Applications that was used in the CBMS Court Case
HCPF Cases = Cases for Medicaid and CHP+ expected to be processed by counties and medical assistance sites

HCPF starts working HCPF Cases

June and July Turnover in Temporary Staff

This Request is in response to item #5 above. Since the implementation of CBMS, and the findings at the December 2004 hearing that 29,361 cases were exceeding processing guidelines (for both Departments combined), the Departments have been applying dedicated resources to ensure that the number of cases is in substantial compliance with the federal and state guidelines (either 45 or 90 days after receipt of a complete application). As described above, until April 2006, the Centralized Data Entry Team and staff at Health Care Policy and Financing worked on cases and with counties to reduce the December 2004 number. Since April 2006, the Department took this same activity on internally, using temporary staff. However, as the Department is the Single State Agency for Medicaid and is ultimately responsible for meeting federal processing guidelines for Medicaid, the Department requires permanent staff to ensure county and medical assistance compliance with State and federal requirements. Experience has proven that without a dedicated, permanent resource, it cannot ensure substantial compliance with case processing timelines. Therefore, the Department is requesting the permanent continuation of its current resources of four staff.

The Department discussed these events with the Office of State Planning and Budgeting and Joint Budget Committee staff in April 2006. It was decided that due to the nature of the previously ongoing temporary funding, the changing facts in the case, and the need to know the funding intent for the court-related stipulation before spring of next year, it was decided that an emergency supplemental was prudent. Therefore, the Department submitted an Emergency Supplemental Request on June 20, 2006 to the Joint Budget Committee to address the need for permanent staff. Unfortunately, there was confusion regarding a similar request from the Department of Human Services, with an overlap in Medicaid funding, which resulted in both requests being tabled until these issues could be addressed. On September 20, 2006 the Department and the Department of Human Services submitted coordinated Emergency Supplemental Requests that were approved and funded for FY 06-07. This Request is to continue that funding to insure ongoing compliance with regulations.

The Department explicitly decided to move away from funding these resources out of the CBMS appropriation, and rather funding is now requested in the Department's Personal Services and Operating Expenses appropriations. This is due to the fact that this is not a systems related issue, but rather it is an ongoing resource need to ensure timely processing and substantial compliance with the processing guidelines.

The Department requests 1.0 FTE General Professional III to process inquiries and analyze results, identify trends, train counties on processing procedures and to develop county specific procedures and to assist 3.0 FTE Technician III positions whose primary jobs will be to handle these inquiries in a timely manner. The unit is to monitor county processing of pending applications. The Unit will perform a weekly analysis of cases exceeding processing guidelines applications and determine the cause of the delay in approving the applications. The staff will interact with counties and medical assistance sites to make these determinations and perform appropriate follow-up. If necessary, the Unit would contact clients with incomplete applications to request they provide the necessary documentation to complete the application. The Department assumes these four positions would be able to process 24 applications per person, per day. Although the JBC did not approve this request on June 20, 2006, the Committee did state its intent to

approve it once the coordination issues with DHS were resolved. Therefore, the Department has proceeded in developing positions and hiring for permanent positions, and continuing to use temporary staff until the permanent positions are filled. However, the Department is having a difficult time keeping skilled temporary staff in these positions as shown in the table on page 6. If approved, the Department will use funding in this request to cover the temporary costs.

Calculations for Alternative's Funding:

Summary of Request FY 07-08 and FY 08-09 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Request [Items below total to this]	$152,807	$38,737	$26,367	$87,703
(1) Executive Director's Office: Personal Services	$149,327	$37,855	$25,766	$85,706
(1) Executive Director's Office: Operating Expenses	$3,480	$882	$601	$1,997

Table 1: Development of Fund Splits*				
	Total Funds	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Personal Services (Sum to 100%)	$149,327	$37,855	$25,766	$85,706
- Medicaid Funded (50.7%)	*$75,709*	*$37,855*	*$0*	*$37,854*
- Children's Basic Health Plan Funded (49.3%)	*$73,618*	*$0*	*$25,766*	*$47,852*
Operating Expenses (Sum to 100%)	$3,480	$882	$601	$1,997
- Medicaid Funded (50.7%)	*$1,764*	*$882*	*$0*	*$882*
- Children's Basic Health Plan Funded (49.3%)	*$1,716*	*$0*	*$601*	*$1,115*

* Percentages are based on the ratio of the average number of cases that exceeded processing guidelines from May 1, 2005 through April 30, 2006

Table 2: Estimated Staff Processing Abilities		
Number of positions requested		4
Estimated inquiries processed per position per day		24
Number of inquiries that can be handled per day (= 4 * 24)		96
Number of inquiries per month processed (= 96 * 5 days * 4 weeks)		**1,920**

FTE and Operating Costs				*GRAND TOTAL*
Fiscal Year(s) of Request		FY 07-08	FY 07-08	FY 07-08
PERSONAL SERVICES	Title:	Technician III	General Professional III	To two decimal points
Number of PERSONS / class title		3.00	1.00	
Calculated FTE per classification		3.00	1.00	4.00
Annual base salary (monthly * 12)		$31,080	$39,672	
Number months working in FY FY 07-08 and FY 08-09		12	12	
Salary		$ 93,240	$ 39,672	$ 132,912
PERA	10.15%	$ 9,464	$ 4,027	$ 13,491
AED	0.75%	$ 699	$ 298	$ 997
FICA	1.45%	$ 1,352	$ 575	$ 1,927
Subtotal Personal Services		$ 104,755	$ 44,572	$ 149,327
OPERATING				
Supplies @ $500/$500 each year	$ 500	$ 1,500	$ 500	$ 2,000
Telephone Base (Annual)	$ 370.0	$ 1,110	$ 370	$ 1,480
Subtotal Operating	$ 870	$ 2,610	$ 870	$ 3,480
GRAND TOTAL ALL COSTS		$ 107,365	$ 45,442	$ 152,807

Impact on Other Areas of Government: The Department of Human Services can not finance these same types of services through the Department of Health Care Policy and Financing as that would be drawing federal matching funds for the same activity.

Assumptions for Calculations: It is assumed that each position would process approximately 24 inquiries per day. At this staffing level, the Department would have the capacity to process approximately 1,920 inquiries per month (see Table 2). This, however, does not account for time spent training, analyzing data, developing reports, traveling to counties and providing assistance to counties and Medicaid assistance sites.

All Personal Services and Operating Expenses funding assumes the level of funding as outlined in common policy instructions. Start-up operating expenses associated with these four requested FTE have already been approved by the Joint Budget Committee in FY 06-07, through the approval of the Department's September 20, 2006 1331 Emergency Supplemental Request. Therefore, only continuation funding is being requested for supplies and telephone costs.

For July 2006, there were 3,005 medical applications that exceeded processing guidelines. Of that total, 1,481 applications were for the Children's Basic Health Plan, and 1,524 applications were related to Medicaid. Costs associated with processing Children's Basic Health plan applications are paid from the Children's Basic Health Plan Trust as Cash Funds Exempt. Consequently, 49.3% (49.3% = 1,481 / 3,005) of the costs in this Request will be paid from the Children's Basic Health Plan Trust.

Concerns or Uncertainties of Alternative: None

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would result in no dedicated resources in FY 07-08 to ensure that counties and medical assistance sites process cases in a timely manner. The Department would monitor timeliness and train counties, but would not directly intervene to ensure cases are processed in a timely fashion. It is expected that in a short period of time, the cases exceeding processing guidelines would fall out of substantial compliance.

Calculations for Alternative's Funding: No change in funding with this alternative. However, since Supplemental funding was appropriated in FY 04-05, FY 05-06 and FY 06-07, this alternative would result in an increased number of cases that exceed federally required processing guidelines. The Department would also not be in compliance with the provisions contained in the Joint stipulation agreement between the Department, the plaintiffs, and the Department of Human Services, which could result in additional litigation costs to the Department.

Concerns or Uncertainties of Alternative: Federal regulations stipulate that states must process Medicaid applications within the forty-five or ninety day timeframes. If found to be consistently delinquent in achieving these processing timelines, the State is at risk of the plaintiffs seeking to enforce the court order, of additional lawsuits, or of federal audits and deferrals.

Supporting Documentation

Analytical Technique: A return on investment analysis was used to compare the two alternatives.

Return on Investment Analysis - FY 07-08		
Investment:	Cost Avoidance A:	Cost Avoidance B:
Additional Cost of 4.0 FTE: $152,807	Probable pursuit by plaintiffs of enforcement of court order, with additional legal costs. Spending authority for legal costs for one year, using FY 05-06 = $515,000 (both Departments); assuming 35% is HCPF per calculator: $180,250	Reduced administrative cost from prior year, using FY 05-06 spending authority for Centralized Data Entry = $2,108,768; assuming 35% is HCPF per calculator: $738,069
$152,807	**Approximately $180,250**	**Approximately $738,069**
	ROI = 1.18	**ROI = 4.83**

Quantitative Evaluation of Performance - Compare all Alternatives: Please see the Efficiency and Effectiveness Analysis above.

Statutory and Federal Authority:

25.5-4-205 (1) (a), C.R.S. (2006) Application - verification of eligibility - demonstration project - rules - repeal. *The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f), C.R.S., and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility.*

42 C.F.R. Section 435.911 Timely determination of eligibility. *(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and (2) Forty-five days for all other applicants. (b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant. (c) The agency must determine eligibility within the standards except in unusual circumstances, for example—(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or (2) When there is an administrative or other emergency beyond the agency's control. (d) The agency must document the reasons for delay in the applicant's case record. (e) The agency must not use the time standards—(1) As a waiting period before determining eligibility; or (2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).*

Department Objectives Met if Approved:

1.2 To support timely and accurate client eligibility determination.

1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.

2.1 To build and maintain a high quality, customer focused team.

3.2 To improve customer satisfaction with programs, services, and care.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI - 9	**OSPB Approval:**		**Date:**
Program:	Finance Division	**Statutory Citation:**	25.5-5-318 (8) (a), C.R.S. (2006)	
Request Title:	Public School Health Services Federal Corrections			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	32,431,406	46,898,652	0	46,898,652	47,357,109	184,520	47,541,629	0	47,541,629	184,520
	FTE	194.35	226.70	0.00	226.70	226.90	0.00	226.90	0.00	226.90	0.00
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	0	6,931,815	0	6,931,815	184,520
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	9,757,010	16,513,224	0	16,513,224	16,524,593	0	16,524,593	0	16,524,593	0
	FF	16,393,836	23,891,680	0	23,891,680	23,900,701	184,520	24,085,221	0	24,085,221	0
(1) Executive Director's Office, Personal Services	**Total**	13,785,054	15,362,691	0	15,362,691	15,821,148	384,520	16,205,668	0	16,205,668	384,520
	FTE	194.35	226.70	0.00	226.70	226.90	0.00	226.90	0.00	226.90	0.00
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	0	6,931,815	0	6,931,815	184,520
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	507,578	506,203	0	506,203	517,572	0	517,572	0	517,572	0
	FF	6,996,916	8,362,740	0	8,362,740	8,371,761	384,520	8,756,281	0	8,756,281	200,000
(5) Other Medical Services, SB 97-101 Public School Health Services	**Total**	18,646,352	31,535,961	0	31,535,961	31,535,961	(200,000)	31,335,961	0	31,335,961	(200,000)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	9,249,432	16,007,021	0	16,007,021	16,007,021	0	16,007,021	0	16,007,021	0
	FF	9,396,920	15,528,940	0	15,528,940	15,528,940	(200,000)	15,328,940	0	15,328,940	(200,000)

Letter Notation: $384,520 is from federal funds revenue earned in the SB 97-101 Public School Health Services appropriation from claims submitted by the school districts. $184,520 is to be transferred to the Department of Education for its administrative costs assoicated with this program.

Cash Fund name/number, Federal Fund Grant name: CFE: Certification of Public Expenditures FF: Title XIX

IT Request: ☐ Yes ☑ No (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ Yes ☑ No **If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑Decision Item
☐ Base Reduction Item
☐ Emergency Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 9
Change Request Title:	Public School Health Services Corrections
Long Bill Line Item(s)	(1) Executive Director's Office, Personal Services; (5) Other Medical Services, SB 97 - 101 Public School Health Services
State and Federal Statutory Authority:	25.5-5-318 (8) (a), C.R.S. (2006), 42 C.F.R. Sec. 433.51

Summary of Request (Alternative A): This Request seeks the following:

1. A transfer of $200,000 in federal funds to the Executive Director's Office, Personal Services line with a corresponding reduction to Other Medical Services, SB 97-101 School Based Health Services, in order to adopt the recommendations contained in an audit conducted by the Centers for Medicare and Medicaid Services from July to November 2004.
2. To eliminate the double-counted transfer of funds to the Department of Education for health care services that are paid directly to school districts.
3. A technical adjustment to transfer federal funding through the Department's Personal Services line item in the amount of $184,520 to appropriately draw the federal funds before they are transferred to the Department of Education for its administrative oversight of this program.

There is no General Fund impact.

Alternative A {Recommended alternative}:

Problem or Opportunity Description:

The Colorado Medicaid Expanded School Health Program reimburses authorized public school districts, Boards of Cooperative Education, and State K-12 educational institutions for qualified expenses. Allowable Medicaid expenses for this program, generated at the educational institutional level, are matched by the federal government dollar-for-dollar in Colorado. The process used to earn this federal revenue is known as certification of public expenditures. Under the certification process, a public entity incurs costs for providing services to Medicaid clients which are allowable for reimbursement for federal matching funds. As such, the public entity, which in this case is most often a public school district, completes a certification form stating that it truly incurred these costs and submits this certification to the Department. This certification, which shows up in the Department's budget as Cash Funds Exempt, serves as the State's portion of these Medicaid reimbursable expenditures. The State portion is then matched by Title XIX federal funds, and as the Single State Agency for Medicaid, these funds are drawn down through the Department's budget. The Department then passes this earned revenue back to the providers as reimbursement for 50% of the expenditures already incurred. As federal funding is a portion of this program's funding, the Colorado Medicaid Expanded School Health Program is subject to federal oversight by the Centers for Medicare and Medicaid Services.

In 2004, as part of the statewide revenue maximization contract with the Office of State Planning and Budgeting (OSPB), Public Consulting Group (PCG) was invited to review the Medicaid reimbursement rate-setting methodology for the School Health Services program. The purpose of this review was to determine if there was any opportunity to increase the reimbursement rates using all allowable costs and according to the method set forth in the Medicaid State Plan. The review identified several errors in the rate calculation that unintentionally lowered the reimbursement rates paid to school districts. PCG corrected the errors and submitted a retroactive correction claim for FFY 02-03 and FFY 03-04 totaling over $11 million in additional Medicaid reimbursement. The Centers for Medicare and Medicaid Services rejected this claim and Colorado is pursuing an

appeal with the Departmental Appeals Board. PCG's involvement with the Departmental Appeals Board appeal continues under the OSPB contract through FY 05-06.

Also in 2004, the Centers for Medicare and Medicaid Services performed an audit on the certification of public expenditures and a review of Colorado's Medicaid School Based Services Programs. Among the recommendations submitted in its report, the Centers for Medicare and Medicaid Services requested that the State complete an annual reconciliation of interim payments reported on the certifications of public expenditures to actual incurred expenditures at the individual school level. This recommendation is to ensure that the State is only reimbursing providers for actual incurred costs according to federal requirements and as outlined in Colorado's State Plan.

In addition for the need to have an independent auditor review the certification process, the Centers for Medicare and Medicaid Services also recommended that the rates used in the Colorado Medicaid Expanded School Health Program be cost-based, district specific, and should incorporate an annual time study. The Centers for Medicare and Medicaid Services requests that Colorado provide more information showing that established rates for the program represent only actual costs incurred at the individual provider level, and substantiated this request by citing the Colorado State Plan (section 4.19-B) where the State established that it would assure rates only include incurred costs.

The second issue in the request involves eliminating the transfer of funds for medical services to the Department of Education. In recent history, the Joint Budget Committee has eliminated several Cash Funds Exempt line items in order to decrease double counting in the State budget. The history of why this was done for this program appears to be informative, so that the Department of Education can be aware of the medical expenditures for the School Based Services Program, but the Department of Education does not utilize this funding for any administrative or service activity.

The third issue is in regards to establishing a transfer of funds from Health Care Policy and Financing to the Department of Education, rather than a direct appropriation. This issue was first raised in a November 1, 2002 Budget Request, but due to the complexity

of issues being presented, and the scope of the budget reductions occurring at the time, the request was not implemented in the budget. Correcting this technical error was planned for the next time a School Based Services request was submitted, which is at the current time.

General Description of Alternative: This Request is for an appropriation of $200,000 in federal funds to the (1) Executive Director's Office, Personal Services line item, and a corresponding reduction in the (5) Other Medical Services, SB 97-101 Public School Health Services appropriation. These funds are to comply with audit recommendations. Additionally, this Request is to eliminate an informational transfer of funds to the Department of Education in the amount of $15,528,941. Lastly, this request is for an increase of $184,520 in federal funds to the Department's Personal Services line to appropriately draw the federal funds in the Single State Agency before they are transferred to the Department of Education, as this funding does not currently appear anywhere in the Department's budget.

There is no General Fund impact.

1. Fund Audit Recommendations

As a result of recent Centers for Medicare and Medicaid Services (CMS) guidance, the Department is seeking a contractor to assist with developing an updated School Health Services rate setting methodology, specifically in the areas of district specific rates and a cost-settlement process to compare actual costs to payments made to participating School Health Services providers. Planning and administering time studies to support the rate-setting methodology will be included in the expected scope of work. The contractor shall also assist the Department in drafting a revised State Plan Amendment (SPA) that includes all proposed changes to the School Health Services rate-setting methodology, and the training of school staff. Additionally, based on audit findings presented to the Department by the Centers for Medicare and Medicaid Services, the contractor is to develop the audit process and materials to facilitate program reviews at the school level in order to insure compliance.

Responsibilities will include the contractor drafting a State Plan Amendment that adheres to the new Centers for Medicare and Medicaid Services requirements, defining allowable costs, and setting requirements for client eligibility. In addition, it will conduct a statewide random moment time study (RMTS) to develop district specific rates. Finally, the contractor will provide assistance in the certification of the public expenditures process, and provide a transition plan and training to both the Department and school staff.

As the combined departments' administrative costs are well within the 10% limit, this Request is requesting to re-appropriate $200,000 in federal funding, by reducing the federal funds in the SB 97-101 Public School Health Services appropriation, and increasing the Personal Services appropriation by the like amount. Appropriating these dollars to the Department's Personal Services appropriation will then allow for an outside contractor to be hired, to address federal directives.

The anticipated timelines in the table below reflect the Department's actions to hire a contractor beginning in FY 06-07 and to allow for the Department to hire a contractor using the request for proposals selection process by July 1, 2007. In order to meet the July 1, 2007 start date, the Department needs to submit a request for proposals by January 2007.

For FY 06-07, the Department proceeded with a sole source contract, which was awarded to Public Consulting Group (PCG) with a start date of October 1, 2006. In 2004, as part of the statewide revenue maximization contract with the Office of State Planning and Budget, Public Consulting Group was invited to review the Medicaid reimbursement rate-setting methodology for the School Health Services program. The purpose of this review was to determine if there was any opportunity to increase the reimbursement rates using all allowable costs and according to the method set forth in the Medicaid State Plan. Public Consulting Group was also asked to develop school based health rates prospectively for FY 05-06, and provisional rates have been established with the results of time studies conducted by Public Consulting Group.

Based on this experience, Public Consulting Group has gained a comprehensive understanding of the rate-setting process. This consultant is uniquely positioned to work with the Department based on the previous work with Colorado's School Health Services program and their expertise working with the Centers of Medicare and Medicaid Services in other states. The Department expects that with Public Consulting Group's assistance, pertinent methodology and processes developed in FY 06-07 will position the department to release a request for proposals for a new vendor in FY 07-08. Public Consulting Group's history with the Department and the work they have completed to date on rate revision, time study activities, and their past and potential contributions to the appeals board are critical to the continued improvement and compliance of the School Health Services Program.

2. Eliminate Transfer of Medical Services Funding

As shown in the Calculations for Alternative's Funding, the Department of Education receives $15,713,461 in Cash Funds Exempt for FY 06-07. The Department of Education requires $184,520 of this amount to fund its administrative costs. $15,528,941 in federal funds is paid directly to school districts by Health Care Policy and Financing. Apparently, the showing the $15,528,941 as Cash Funds Exempt in the Department of Education budget is for informational purposes. However, this transfer creates a budgetary double count that serves no purpose other than to be informational, since the Department of Education does not distribute this money. The Department is therefore requesting that this double count be eliminated.

3. Transfer Department of Education Administration through Health Care Policy and Financing

As stated in the Problem or Opportunity Description above, all Medicaid allowable expenditures at the educational institution level are reimbursable at a 50% federal financial participation rate. However, if one was to look at the current appropriation for SB 97-101 Public School Health Services, it is apparent that the fund splits in this budgetary line are not at 50% Cash Funds Exempt and 50% federal funds. This is

because 25.5-5-318 (8) (a), C.R.S. (2006) states that allowable State administrative costs for contracts for both the Department and the Department of Education can be compensated with earned federal revenue, so long as this amount does not exceed ten percent of the total federal funds in the program.

The chart below outlines the anticipated FY 07-08 administrative costs that are carved out of the reimbursement line item SB 97-101 Public School Health Services, and appropriated to other appropriations within the Department's budget. To date, the Department's Long Bill appropriation for SB 97-101 Public School Health Services has not identified the transfer of federal revenue from this appropriation to either internal or external administration areas. Yet, the federal revenue does appear in the Department's administration line items, aside from the Cash Funds Exempt amount transferred to the Department of Education.

FY 07-08 Base Request for SB 97-101 Public School Health Services			
	Total Funds	Cash Funds Exempt*	Federal Funds
Anticipated Expenditures at the Educational Institution Level	$32,014,041	$16,007,021	$16,007,020
Carve-out of Administrative Costs			
Personal Services	$99,060	$0	$99,060
Operating Expenses	$1,478	$0	$1,478
Medicaid Management Information Services Contract	$193,022	$0	$193,022
Administration at the Department of Education	$184,520	$0	$184,520
Appropriation for Reimbursement to Educational Institutions	$31,535,961	$16,007,021	$15,528,940

* Aside from $100,854 from Tobacco Tax revenue, Cash Funds Exempt represents expenditures at the educational institution level and is therefore not additional revenue for the institutions. All federal funding for the administrative carve-outs are appropriated as federal funds in the indicated line items.

Based on this information, the Department is requesting that $184,520 federal funds be added to the (1) Executive Director's Office, Personal Services appropriation, which would then be transferred to the Department of Education as Cash Funds Exempt through an interagency agreement. This funding is already earned federal revenue from school claims, and has already been reduced from the (5) Other Medical Services, SB 97-101 Public School Health Services appropriation. Because the Department is the Single State

Agency and must authorize all Medicaid federal funds before delegation to another agency, the Department is asking for this technical adjustment.

Implementation Schedule:

Task	Month/Year
Draft Request for Proposals Written	December 2006
Request for Proposals Released	January 2007
Contractor Selected	April 2007
Contract Awarded/Signed	May/June 2007
Contractor Start-up Date	July 1, 2007

Calculations for Alternative's Funding:

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Request FY 07-08 (Column 6)	$184,520	$0	$184,520
(1) Executive Director's Office – Personal Services	$384,520	$0	$384,520
(5) Other Medical Services – SB 97-101 Public School Health Services	($200,000)	$0	($200,000)

Summary of Request FY 08-09 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Request FY 08-09 (Column 10)	$184,520	$0	$184,520
(1) Executive Director's Office – Personal Services	$384,520	$0	$384,520
(5) Other Medical Services – SB 97-101 Public School Health Services	($200,000)	$0	($200,000)

Impact on Other Areas of Government: The Department of Education's budget will be affected.

Department of Education Budget Impact	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
S.B. 97-101 Public School Health Service As appropriated in HB 06-1385, page 40	$15,713,461	$0	$15,713,461	$0
Removal of Funds for Schools Paid directly from Health Care Policy and Financing to school districts	($15,528,941)	$0	($15,528,941)	$0
Net Remaining for FY 07-08 Budget Request With corrected letternote	$184,520	$0	$184,520[(e)]	$0

[e]This amount shall be from federal Medicaid funds transferred from the Department of Health Care Policy and Financing for administrative expenditures incurred by the Department of Education.

Assumptions for Calculations:

The Department's estimated cost for an outside contractor of $200,000 is based on an estimate provided by Public Consulting Group which was produced to address the requirements outlined by the Centers for Medicare and Medicaid Services (CMS). In this estimate, it is assumed that $25,000 would be required to define Medicaid allowable costs at the school level, set requirements for client eligibility, and assist the Department in drafting and defending a State Plan Amendment to the federal Centers for Medicare and Medicaid Services. As recently as July 2006, the Department received notification of denial from CMS for modification to the reimbursement methodology in this program through a State Plan Amendment. Therefore, this funding would also include support for challenging federal disallowances and the U.S. Health and Human Services appeals board, in addition to funding updates to the State Plan each year for new CMS guidelines and revisions to include a cost based reconciliation.

In addition, the estimated contractor costs include $40,000 to conduct a statewide random moment time study. This statewide study would take place over roughly twelve weeks, and would generate the necessary data to assist in producing reimbursement rates. To develop district specific rates based on cost and in accordance with the revised State Plan Amendment, the Department estimates that this effort will require $70,000 and will entail assessing indirect and direct costs, create templates to incorporate old and new data

sources, and prepare an analysis of the impact between old and new rates across all school districts.

Finally, the estimate includes $65,000 for the contractor to assist the Department and providers in the certification of the public expenditures process, providing a transition plan and training to employees of the Department on an on-going basis, and allow for general consulting to maintain the program within federal guidelines.

The Department will develop the requests for proposals for the contractor with existing resources; therefore, no funding is requested for this purpose.

Concerns or Uncertainties of Alternative: Contractor costs are estimated above and the request for proposals might not attract a satisfactory contractor. However, the Department believes that this estimate will be sufficient compensation for the tasks required, and does not believe that this scenario is very likely.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alternative would maintain current funding levels in the SB 97-101 Public School Health Services appropriation, and not appropriate some of the federal funds revenue generated from the certification of public expenditure process to the Department's Personal Services appropriation. However, the Department would proceed with hiring a contractor to address recommendations made by the Centers for Medicare and Medicaid Services as outlined in Alternative A. However, proceeding without a specific budget action would force the Department to spend directly from the Public School Health Services line, which does not provide for budget transparency for administrative expenditures. As the Department is well below the 10% statutory allowance for administration costs of this program, the Department has sufficient room to accommodate this need within the existing appropriation. The FY 06-07 administrative amounts for this program currently total to $478,080 and include: $99,060 in Personal Services,

$1,478 in Operating Expenses, $193,022 in Medicaid Management Information Systems Contract, and $184,520 transferred to the Department of Education.

Considering actual expenditures in the SB 97-101 School Based Health Services appropriation were equal to $18,646,352 in FY 05-06, which is a shortened fiscal year due to the passage of SB 06-129 (Cash Accounting Bill), current administration is only 2.6% of the program line ($478,080 / $18,646,352 = 2.6%). Including an additional $200,000 for a contractor will therefore increase administration expenditures to 3.6%.

Alternative B also would continue to transfer the medical services funding, which are 100% federal funds in the Department's budget, to the Department of Education as Cash Funds Exempt. This continues to double count over $15 million in the State budget.

Lastly, this alternative would not appropriate the additional $184,520 in federal revenue to the Department's (1) Executive Director's Office, Personal Services appropriation, nor add a letternote stating that these funds are transferred to the Department of Education.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Unlike all other administration associated with this program, where the federal revenue has been appropriated to the appropriate line items within the Department's budget, and corresponding federal revenue has been carved out of the SB 97-101 Public School Health Services appropriation, this alterative would leave some administrative costs lumped in with the reimbursement passed along to the school districts. This alternative would also continue to omit the level of clarity that should be included in the Department's budget regarding the administration costs associated with this program.

Supporting Documentation

Analytical Technique: Please see the Cost – Benefit Analysis below.

Quantitative Evaluation of Performance -

Alternative	General Fund Cost	Benefit
A	$0	The Department would hire the contractor to address audit recommendations by the Centers for Medicaid and Medicaid Services and would pay for all expenditures related to these services out of the Department's (1) Executive Director's Office, Personal Services appropriation. Under this alternative, budget clarity would continue, reporting all administration for the School Based Health Services program outside of the SB 97-101 School Based Health Services line item that has typically only denoted actual reimbursement to the schools. In addition, this alternative would add $184,520 in federal funds to the Department's Personal Services appropriation, with a letternote indicating that this funding is transferred to the Department of Education. With the addition of these funds and letternote, the Department's budget would more accurately reflect the costs associated with administering the School Based Health Services program.
B	$0	Under this alternative, there continues to be no costs associated with hiring a contractor to address the Centers for Medicare and Medicaid Services. However, this alternative would not continue the clarity experienced in the budget for prior fiscal years. Rather, this alternative would continue to report some administration outside of the SB 97-101 School Based Health Services appropriation, and some (the contractor costs) within the appropriation. Alternative B maintains a double count in the State budget. Alternative B would also continue to exclude $184,520 federal funds in the Department's budget, and would not accurately reflect the amount of funding used in administering this program.

Statutory and Federal Authority:

25.5-5-318 (8) (a), C.R.S. (2006) Health Services – Provision by School Districts. *Under the contract entered into pursuant to this section, a contracting school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.*

42 C.F.R. Section 433.51 Public funds as the State share of financial participation. - *(a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section. (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section. (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.*

Department Objectives Met if Approved:

1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

2.3 To audit expenditures for fraud, abuse, client eligibility, and accuracy in third party payments both internally and with the use of contingency contractors.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI-10	**OSPB Approval:**		**Date:**
Program:	Office of Medical Assistance	**Statutory Citation:**	25.5-5-316, C.R.S. (2006), 25.5-6-106, C.R.S. (2006)	
Request Title:	Move Administrative Contracts in Medical Services Premiums to the Executive Director's Office Long Bill Group			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	1,996,676,191	2,111,287,559	0	2,111,287,559	2,125,566,186	0	2,125,566,186	0	2,125,566,186	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	715,113,459	740,721,857	0	740,721,857	746,875,977	0	746,875,977	0	746,875,977	0
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	256,100,000	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	23,713,210	55,563,806	0	55,563,806	56,549,000	0	56,549,000	0	56,549,000	0
	FF	996,549,521	1,058,825,384	0	1,058,825,384	1,065,964,697	0	1,065,964,697	0	1,065,964,697	0
(2) Medical Services Premiums	**Total**	1,996,676,191	2,111,287,559	0	2,111,287,559	2,125,566,186	(22,705,084)	2,102,861,102	0	2,102,861,102	(22,705,084)
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	715,113,459	740,721,857	0	740,721,857	746,875,977	(10,722,460)	736,153,517	0	736,153,517	(10,722,460)
	GFE	261,300,000	256,100,000	0	256,100,000	256,100,000	0	256,100,000	0	256,100,000	0
	CF	0	76,512	0	76,512	76,512	0	76,512	0	76,512	0
	CFE	23,713,210	55,563,806	0	55,563,806	56,549,000	(985,194)	55,563,806	0	55,563,806	(985,194)
	FF	996,549,521	1,058,825,384	0	1,058,825,384	1,065,964,697	(10,997,430)	1,054,967,267	0	1,054,967,267	(10,997,430)
(1) Executive Director's Office Disease Management (new line)	**Total**	0	0	0	0	0	4,949,482	4,949,482	0	4,949,482	4,949,482
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	1,489,547	1,489,547	0	1,489,547	1,489,547
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	985,194	985,194	0	985,194	985,194
	FF	0	0	0	0	0	2,474,741	2,474,741	0	2,474,741	2,474,741
(1) Executive Director's Office Single Entry Point Case Management (new line)	**Total**	0	0	0	0	0	17,755,602	17,755,602	0	17,755,602	17,755,602
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	9,232,913	9,232,913	0	9,232,913	9,232,913
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	0	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	8,522,689	8,522,689	0	8,522,689	8,522,689

Letter Notation:

Cash Fund name/number, Federal Fund Grant name:

IT Request: ☐ **Yes** ☑ **No** (If yes and request includes more than 500 programming hours, attach IT Project Plan)

Request Affects Other Departments: ☐ **Yes** ☑ **No** If Yes, List Other Departments Here:

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI-10
Change Request Title:	Move Administrative Contracts in Medical Services Premiums to the Executive Director's Office Long Bill Group
Long Bill Line Item(s)	(1) Executive Director's Office, Disease Management (new line); (1) Executive Director's Office, Single Entry Point Case Management (new line); (2) Medical Services Premiums
State and Federal Statutory Authority:	25.5-5-316, C.R.S. (2006) 25.5-6-106, C.R.S. (2006)

Summary of Request (Alternative A): This Change Request is to move a total of $22,705,084 of administrative costs from the Medical Services Premiums Long Bill group to the Executive Director's Office Long Bill group. This request incorporates expenditures for the Department's disease management programs and the Department's single entry point program. For both programs, the service provided is primarily administrative in nature.

Alternative A {Recommended alternative}:

Problem or Opportunity Description:

Disease Management

Beginning in July 2002 the Department of Health Care Policy and Financing implemented several targeted disease management pilot programs, as permitted in HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization

or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316 (2) C.R.S. (2006)). Initially, pilot programs were funded solely by pharmaceutical companies and began and ended at different times between July 2002 and December 2004.

During the pilot program, the Department initiated seven disease management programs to identify the most appropriate strategies to contain rising health care costs, improve access to services and improve the quality of care for the fee-for-service Medicaid clients. The targeted disease conditions included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, female clients with breast and cervical cancer, and clients with chronic obstructive pulmonary disease. Additionally, the Care Management Organization pilot was established to coordinate all of the disease management programs and to establish a means for additional fee-for-service clients to obtain intensive case management or health counseling.

The pilot programs revolved around three key managed care principles: appropriate and timely access to health care services, evaluation and support for adherence to appropriate medical regimens/treatments and provision of nationally recommended practice guidelines for each chronic disease. The pilot programs enabled the Department to obtain actual Colorado Medicaid disease management data and experience to be utilized for future program development.

As a result of the pilot programs, the Department has entered into permanent contracts with two disease management companies for two health conditions: clients with asthma, and clients with diabetes. In FY 05-06, the Department's appropriation for Medical Services Premiums contained $627,778 total funds ($313,889 General Fund) for these disease management contracts (Figure Setting, March 13, 2006, page 128).

For clients with asthma, the Department contracts with Alere Medical Incorporated to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits. For clients with diabetes, the Department contracts with

McKesson Health Solutions to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits. In addition, funding for disease management programs above the FY 05-06 level was authorized in HB 05-1262, and comes from the Tobacco Tax Cash Fund. Section 24-22-117 (2) (d) (IV) (A) C.R.S. (2006) specifies that the funding from the Department of Public Health and Environment shall be used "…for medicaid disease management programs… that address cancer, heart disease, and lung disease." The Department is currently in the process of adopting programs which meet these requirements.

During Figure Setting for FY 06-07, the Joint Budget Committee estimated that disease management contracts would cost $4,568,554 total funds. Of this estimate, $310,876 is General Fund, $1,000 is from the Health Care Expansion Fund, $584 is from the Breast and Cervical Cancer Prevention and Treatment Fund, $1,970,388 is a transfer from the Department of Public Health and Environment, and $2,285,707 is from federal funds (Figure Setting, March 13, 2006, Appendix B, page 11).

In addition, in SB 06-165, the Department received authorization "…to conduct pilot programs to investigate the feasibility of managing and treating recipients with specified chronic medical conditions using telemedicine whenever appropriate." The Department's authority to conduct these pilot programs is repealed effective July 1, 2010. In FY 06-07, the Department was appropriated $33,280 for Medicaid Management Information Systems changes to implement pilot programs, and in FY 07-08, the Department was appropriated $380,928 for pilot programs, with a related offset for expected savings in Medical Services Premiums.

When reporting actuals, costs for disease management programs are reported under Service Management, such as in Exhibit N of the February 15, 2006 Budget Request. However, since the Department budgets the Medical Services Premiums by eligibility category, not by service category, there is no budgeted amount for FY 06-07 or "base request" for FY 07-08.

In current contracts, the Department's disease management contractors operate on a fixed budget (specified in the contract), and client enrollment may not exceed a fixed number of clients that the Department has determined shall be managed on that budget. Contractors accept new clients only up to the enrollee limit as specified in the contract. The Department anticipates that new contracts as a result of Tobacco Tax funding and funding from the Telemedicine pilot programs will be subject to the same requirements.

Single Entry Points

The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients (25.5-6-105, C.R.S. (2006)). A single entry point agency is an agency in a local community through which persons eighteen years or older, who are in need of long-term care services, can access needed long-term care services (25.5-6-106 (3) (a), C.R.S. (2006)).

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home and Community Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965 (25.5-6-106 (3) (b), C.R.S. (2006)).

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability (25.5-6-106 (3) (c), C.R.S. (2006)). Single entry point

agencies also serve as the utilization review coordinator for all community based long term care services.

Single entry point agencies are paid a case management fee for each client admitted into a community based service program. This funding is shown as "Single Entry Points" under Service Management in Exhibit N of the February 15, 2006 Budget Request, and is the funding addressed by this Change Request. Again, because the Department does not budget by service category, there is no budgeted amount and only actuals and calculations are reported. Single entry point agencies also receive payment for services provided in connection with the development and management of long term home health prior authorization requests, for work associated with client appeals and for utilization review services related to HCBS and nursing facilities. In this case, the single entry point is functioning as a provider and the costs are reflected under "Community Based Long Term Care" on the same Exhibit N. Such service costs are not affected by this Request.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for single entry point agencies. However, in preparing this Change Request, it came to light that the process described in the footnote report is not being used. Instead, individual single entry point agency contract amounts are determined using data from each single entry point agency's previous year's history of client and activity counts. At the end of the contract year the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to single entry point agencies for services delivered in excess of funds received, or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjusts for underpayment up to the amount allocated. This payment methodology, combined with close Department oversight, encourages single entry point agencies to enroll only those clients who are appropriate for community based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and that to assure single entry point agency

compliance with general accounting principles and Federal OMB circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

The Department considers the contract terms, fiscal and quality reviews to be incentives for single entry point agencies to serve clients appropriately.

General Description of Alternative:

Disease Management

The Department requests to move appropriated dollars for administrative costs of the disease management program from the Department's Medical Services Premiums Long Bill group to a new line item in the Department's Executive Director's Office Long Bill group, called Disease Management. This request is budget neutral.

Unlike other services in the Department's Medical Services Premiums Long Bill group, the Department does not request yearly utilization or cost-per-client (per capita) increase for disease management programs. Calculating an increase in utilization or per capita would not accurately reflect the nature of the contracts. The Department's contractors for disease management have accepted contracts based on their ability to handle a certain fixed caseload. Simply increasing the contract amount would not enable the Department's contractors to handle additional caseload.

The disease management programs are similar in nature to other programs in the Department's Executive Director's Office Long Bill group, such as Drug Utilization Review, Acute Care Utilization Review, Long–Term Care Utilization Review, External Quality Review, and the Early Periodic Screening, Diagnosis, and Treatment Program. Although these programs deal with managing a client's medical services, they are not medical services. Similarly, disease management programs offer services such as assessments of the status of the client's disease and medical history, care plan evaluation, interaction with appropriate medical providers, and telephone contact with the client or the client's parent. Such services are not best suited to include in the Department's Medical Services Premiums Long Bill group, due to their inherently administrative nature. Including these costs in the Medical Services Premiums Long Bill group can

skew the actual utilization and per capita trends by including fixed price contracts in overall expenditures, providing an inaccurate picture of how Medical Services Premiums is changing over time.

Single Entry Points

The Department requests to move appropriated dollars for administrative costs of the single entry point agencies from the Department's Medical Services Premiums Long Bill group to a new line item in the Department's Executive Director's Office Long Bill group, called Single Entry Point Case Management.

Contracted payments to a single entry point agency are based upon the number of clients the single entry point agency actually serves with an artificial overall cap on the expenditures. However, before the actual caseload is known, the Department makes estimated payments to the single entry point agency until such time as the final caseload is available. Once the Department verifies the caseload, the Department reconciles with each agency, to ensure that the single entry point agency has been paid appropriately, and not over- or under-paid for services rendered. Under the cash accounting system of Medical Services Premiums (as specified by 25.5-4-201 (1), C.R.S. (2006)), reconciliations with single entry point agencies are performed in a future fiscal year. These reconciliations are unknown and impact request year projections. In an administrative line, however, the Department would be able to manage the reconciliation under generally accepted accounting principles, by allowing the Department to record a payable to account for the reconciliation.

Additionally, under an administrative line, the Department would be able to fully manage funding for single entry points to its appropriation. Currently, under Medical Services Premiums, a single entry point agency may exceed its contracted value by taking on a large number of additional clients above the projected caseload number. A single entry point agency could maximize revenue by performing long term case assessments and case management on as many clients as possible, whether or not such services are necessary. By placing single entry points into an administrative line item, single entry points lose any incentive that they might have to seek out additional clients to try to evaluate for

entry into long term care programs. Single entry points gain an incentive to carefully choose clients to evaluate for long term care programs, as a single entry point that does not carefully manage its caseload will not be reimbursed for such services above the contract amounts.

Unlike other services in the Department's Medical Services Premiums Long Bill group, the Department does not request yearly utilization or cost-per-client (per capita) increase for single entry point agencies. The Department's Request for Medical Services Premiums includes only an increase for the expected increase in caseload. However, these caseload adjustments are rudimentary and reconciled on an inconsistent basis.

The functions that single entry point agencies perform under the Medical Services Premiums Long Bill group are similar in nature to the services that these same agencies perform under the Department's line item for Long Term Care Utilization Review, in the Executive Director's Office Long Bill group (and similar line items mentioned above). Under the Long Term Care Utilization Review line item, the single entry point agency performs long term care assessments, pre-admission screening, and private duty nursing approvals, among other functions. Under the Medical Services Premiums Long Bill group, the single entry point agency perform such services as case management, outreach efforts to those most at risk of institutionalization, and coordination of resources. While necessary, such services are primarily administrative in nature, and not best suited for inclusion in the Department's Medical Services Premiums Long Bill group. Similar to disease management, including these costs in the Medical Services Premiums Long Bill group can skew the actual utilization and per capita trends by including administrative expenditure contracts in the overall percent changes, providing an inaccurate picture of how Medical Services Premiums is changing over time.

It is anticipated that when the Department requires a change in funding for single entry point agencies or for disease management, the Department will seek a revised appropriation via the Change Request process.

Calculations for Alternative's Funding:

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(2) Medical Services Premiums (move Disease Management and Single Entry Points)	($22,705,084)	($10,722,460)	($985,194)	($10,997,430)
(1) Executive Director's Office Disease Management (new line)	$4,949,482	$1,489,547	$985,194	$2,474,741
(1) Executive Director's Office Single Entry Point Case Management (new line)	$17,755,602	$9,232,913	$0	$8,522,689
Total Incremental FY 07-08 Request	$0	$0	$0	$0

Summary of Request FY 08-09 Matches Schedule 6 and Recommended Request	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
(2) Medical Services Premiums (move Disease Management and Single Entry Points)	($22,705,084)	($10,722,460)	($985,194)	($10,997,430)
(1) Executive Director's Office Disease Management (new line)	$4,949,482	$1,489,547	$985,194	$2,474,741
(1) Executive Director's Office Single Entry Point Case Management (new line)	$17,755,602	$9,232,913	$0	$8,522,689
Total Incremental FY 08-09 Request	$0	$0	$0	$0

Table 1 **Disease Management Funding**					
	Total Funds	General Fund	Cash Funds Exempt	Federal Funds	Notes
Base Disease Management	$627,778	$313,889	$0	$313,889	50% General Fund, 50% Federal funds
HB 05-1262 Tobacco Tax Disease Management	$3,940,776	$0	$1,970,388	$1,970,388	50% Cash Funds Exempt, 50% Federal funds(1)
HB 06-165 Telemedicine Disease Management	$380,928	$190,464	$0	$190,464	50% General Fund, 50% Federal funds
Total	**$4,949,482**	**$504,353**	**$1,970,388**	**$2,474,741**	
(1) Cash Funds Exempt from the Health Care Expansion Fund					

Table 2 **Single Entry Point Funding**					
	Total Funds	General Fund	Cash Funds Exempt	Federal Funds	Notes
Base Single Entry Point(1)	$16,747,227	$8,708,559	$0	$8,038,668	4% of Total is State Only, Remainder is 50% General Fund, 50% Federal funds.
HB 05-1243 Consumer Directed Care(2)	$1,008,375	$524,355	$0	$484,020	4% of Total is State Only, Remainder is 50% General Fund, 50% Federal funds.
Total	**$17,755,602**	**$9,232,914**	**$0**	**$8,522,688**	
(1) Total Request from Section E, Exhibits for Medical Services Premiums, Exhibit I, Page 2.					
(2) Consumer Directed Care from Section E, Exhibits for Medical Services Premiums, Exhibit I, Page 2.					

Impact on Other Areas of Government: There is no impact on other areas of government. Although the Disease Management program receives a fund transfer from the Department of Public Health and Environment, that transfer will not be affected by this Change Request.

Assumptions for Calculations:

Disease Management

Totals for Disease Management are taken from table 1, above. The calculations are also included in Section E of this Budget Request (Exhibits for Medical Services Premiums), exhibit I, page 5. Totals are held constant, as they will not increase without an additional appropriation. Disease Management funding includes $3,940,776 from the Health Care Expansion Fund, originally appropriated in HB 05-1262 and appropriated in FY 06-07 in the Long Bill (HB 06-1385), and increased funding of $380,928 for Telemedicine programs (SB 06-165). For FY 08-09, the FY 07-08 estimate is held constant.

Single Entry Points

Totals for single entry points for FY 07-08 are taken from table 2, above. Rates paid to single entry points will not change without an additional appropriation. The Department's estimate for FY 07-08 included increased funding of $1,008,375 for Consumer Directed Care (HB 05-1243), expected to start July 1, 2007. For FY 08-09, the FY 07-08 estimate is held constant. It is anticipated that the Department will request a Supplemental Request in FY 07-08 to ensure that proper funding relative to caseload is available.

Since a portion of the case management cost for single entry points is for non-Medicaid clients, the federal share is calculated at 50% of 96% of the total.

In the event that this Change Request is approved, this Change Request will supersede the Department's Request for Medical Services Premiums in regard to Disease Management and Single Entry Points. For clarity, Attachment 1 of this Change Request is a revised copy of Exhibit A from the Request for Medical Services Premiums, with funding for Disease Management and Single Entry Points removed.

Concerns or Uncertainties of Alternative: The Department has estimated Single Entry Point program costs using the estimated increase in caseload the past. If the caseload rises significantly, or the proportion of the population which uses services at single entry points changes, the Department will request funding through the Change Request process rather than through the Medical Services Premiums calculation.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: This alterative would retain the funding for the administrative costs for disease management and single entry points within Medical Services Premiums.

Calculations for Alternative's Funding:

Disease Management
No change in funding with this alternative.

Single Entry Points
Under Medical Services Premiums, the Department would continue to request additional funding for estimated caseload increases as part of the overall estimate for Medical Services Premiums, instead of as a separate Change Request. Under current methodology, the Department calculates the estimated increase in single entry point expenditure for each aid category by inflating the most recent completed year of expenditure by the estimated percent increase in caseload from the base year to the request year.

Under Alternative B, the Department would experience an increase in funding of $221,982 total funds from the amount in Alternative A of this Request. Attachment 2 of this Change Request, which is also contained in Section E of this Budget Request (Exhibits for Medical Services Premiums), exhibit I, pages 2 and 3, calculates the total estimate for Single Entry Points under the current methodology. The estimate under the current methodology is $17,967,584, which includes an increase for estimated caseload. The Department's Request in Alternative A is $17,755,602, a difference of $221,982.

Alternative B would increase expenditures consistent with caseload trends in its November 1, 2006 Budget Request.

Concerns or Uncertainties of Alternative: This alternative would continue to fund the administrative costs for disease management and single entry points within the appropriation for Medical Services Premiums. The Department's Request for Medical Services Premiums would not accurately reflect medical services trends, due to the inclusion of the administrative services provided by the disease management and single entry point programs. Under the cash accounting system, payments made would occur in the year following the year where original expenditures occurred. Under the Medical Services Premiums Long Bill group, neither the single entry point program nor the disease management program would have its own appropriation, and the Department could not manage these programs to a fixed appropriation.

Supporting Documentation

Analytical Technique:

Disease Management

Because the costs are fixed in both alternatives, the Cost-Effectiveness Analysis is used. Alternative A is more effective because, for the same cost, it:

- Creates budget clarity for disease management programs;
- Provides for transparency in the Department's budget for these administrative services;
- Is less administratively burdensome; and
- Provides for cleaner analysis of medical services.

Alternative B provides none of this effectiveness.

Single Entry Points

For single entry points, a risk and probability analysis shows the potential impact to the State for allowing single entry point services to remain in Medical Services Premiums. Under the preferred alternative, Alternative A, the probability of the Department making

a large Supplemental Request due to an unexpected increase in caseload is extremely low. With a fixed appropriation, single entry point agencies would be required to manage to contract amounts fixed by the Department's total appropriation. In the event of a large increase in caseload, the single entry point agency would have to be selective about the clients it evaluates.

Under the status quo, Alternative B, a large increase in caseload would drive a larger expenditure for Medical Services Premiums. In 3 of the last 4 years, the Department has experienced double digit caseload growth. In 6 of the last 7 years, the Department has experiences caseload growth of at least 6.59%. In those six years, caseload growth has averaged 9.21%. Because increases to single entry points are determined as a function of caseload growth, and assuming this pattern of caseload growth continues, this implies that there is a very strong chance, 86%, that the Medical Services Premiums will include a significant increase due to single entry points.

Under Alternative A, the General Assembly can explicitly choose whether or not to fund any Change Request providing additional funding for single entry points.

Quantitative Evaluation of Performance - Compare all Alternatives:

Disease Management

There are no quantifiable outcomes with Alternative A. They are all qualitative benefits as described in the Analytical Technique and the General Description of Alternative.

Single Entry Points

Alternative	Cost
A	$0
B	$211,982

Statutory and Federal Authority:

25.5-5-316, C.R.S. (2006). Legislative declaration - state department - disease management programs authorization - report.

(2) The state department is authorized to develop and implement disease management programs, for fee-for-service and primary care physician program recipients, that are designed to address over- or under-utilization or the inappropriate use of services or prescription drugs and that may affect the total cost of health care utilization by a particular medicaid recipient with a particular disease or combination of diseases. The disease management programs shall target medicaid recipients who are receiving prescription drugs or services in an amount that exceeds guidelines outlined by the state department. The state department shall not restrict a medicaid recipient's access to the most cost-effective and medically appropriate prescription drugs or services. The state department may contract on a contingency basis for the development or implementation of the disease management programs authorized in this subsection (2).

25.5-6-106, C.R.S. (2006). Single entry point system - authorization - phases for implementation - services provided.
(1) Authorization. The medical services board is hereby authorized to adopt rules providing for the establishment of a single entry point system that consists of single entry point agencies throughout the state for the purpose of enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

Department Objectives Met if Approved: 1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI - 11	**OSPB Approval:**		**Date:**
Program:	Safety-Net Financing Section	**Statutory Citation:**	25.5-2-101 (2), C.R.S. (2006); 24-22-117 (1) (c) (II), C.R.S. (2006)	
Request Title:	Technical Adjustment to Old Age Pension State Medical Program			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	14,426,967	14,262,663	0	14,262,663	13,055,483	725,468	13,780,951	0	13,780,951	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	14,426,967	14,262,663	0	14,262,663	13,055,483	725,468	13,780,951	0	13,780,951	0
	FF	0	0	0	0	0	0	0	0	0	0
(5) Other Medical Services, Services for Old Age Pension State Medical Program Clients	**Total**	14,426,967	14,262,663	0	14,262,663	13,055,483	725,468	13,780,951	0	13,780,951	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	14,426,967	14,262,663	0	14,262,663	13,055,483	725,468	13,780,951	0	13,780,951	0
	FF	0	0	0	0	0	0	0	0	0	0

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	CFE: Supplemental Old Age Pension Health and Medical Care Fund
IT Request: ☐ **Yes** ☑ **No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☐ **Yes** ☑ **No**	**If Yes, List Other Departments Here:**

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ 1331 Emergency Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 11
Change Request Title:	Technical Adjustment to Old Age Pension State Medical Program
Long Bill Line Item(s)	(5) Other Medical Services: Services for Old Age Pension State Medical Program Clients
State and Federal Statutory Authority:	25.5-2-101 (2), C.R.S. (2006); 24-22-117 (1) (c) (II), C.R.S (2006); State Constitution Title XXIV

Summary of Request (Alternative A): This Request is to appropriate the $725,468 expected to be remaining in the Supplemental Old Age Pension Health and Medical Care Fund at the end of FY 06-07. The Request, if approved, would drive this fund balance to zero assuming expenditures for FY 07-08 come in as anticipated.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: 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. 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. 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. Funding for the Old Age Pension State Medical Program is comprised of three main funding sources: 1) the Colorado Constitution, Article XXIV, $10,000,000 appropriated annually, 2) the Supplemental Old Age Pension Health and Medical Care Fund, $750,000 also appropriated annually beginning in FY 03-04, and 3) Cash Fund for Health Related Purposes appropriated through the passage of HB 05-1262 (this amount is anticipated to equal $2,389,500 in FY 06-07).

Over the past three years the program has had increased volatility in the provider's reimbursement rates to help ensure the program did not exceed its spending authority. Since July 2003, the program changed reimbursement rate seven different times. Recently, the Department reviewed the reimbursement rates for FY 06-07 based on an August 11, 2006 Medical Services Board meeting, and based upon this review, has implemented rate decreases for FY 06-07 to ensure that the program stays within its spending authority.

The Department is in the process of reviewing the Old Age Pension State Medical Program. This review is to redesign the program to meet the needs of the clients while staying within the spending authority with more stability in the payment structure. This review is being conducted at the request of the Joint Budget Committee through footnote 33 in the FY 06-07 Long Bill (HB 06-1385) that stated "The Department is requested to submit a report by November 1, 2006 recommending changes to the benefit structure or eligibility criteria for the Old Age Pension State Medical Program…"

As the Department considers and implements changes to the program to ensure the long term stability, the program will continue to adjust reimbursement rates to ensure the program does not exceed its spending authority. However, during this transition period, the Department is requesting an appropriation of the remaining funds in the Supplemental Old Age Pension Health and Medical Care Fund in order to help limit the volatility of the reimbursement rates.

Supplemental Fund Balance

The Supplemental Old Age Pension State Health and Medical Care Fund receives annual funding from two sources, as previously described: 1) $750,000 in General Fund appropriated by the General Assembly, and 2) based on HB 05-1262, 50% of the 3% of total tobacco tax revenues allocated each year from the Cash Fund for Health Related Purposes. The Supplemental Fund also receives any funds that are reverted from the program appropriation because of underexpenditures.

The following table provides a detailed account of all the transactions associated with the Supplemental Fund from FY 03-04 through FY 05-06:

Cash Fund Revenue and Expenditure Trend Information			
	Actual	**Actual**	**Actual**
	FY 2003-04	**FY 2004-05**	**FY 2005-06**
Beginning Balance	**$0**	**$163,143**	**$2,982,052**
Transfer from Department of Human Services to Create the Initial Fund Balance	$163,143	$0	$0
Reversions from the Prior Fiscal Year	$0	$316,729	$0
Annual Tobacco Tax Funding	$0	$1,002,180	$2,546,580
Annual Transfer from Department of Revenue	$0	$750,000	$750,000
Transfer from Department of Revenue for FY 03-04 Missed Contribution	$0	$750,000	$0
Total Revenue	**$163,143**	**$2,818,909**	**$3,296,580**
Annual Transfer from Department of Revenue	$0	$0	$750,000
Tobacco Tax Funding	$0	$0	$2,538,000
Approved 1331 Emergency Supplemental from June 20, 2006	$0	$0	$1,140,484
Total Estimated Expenditures	**$0**	**$0**	**$4,428,484**
Estimated Ending Balance	**$163,143**	**$2,982,052**	**$1,850,148**

In FY 05-06, the Department, received an appropriation of $2,538,000 in tobacco tax funds from the Supplemental Old Age Pension Health and Medical Care Fund to the Services for Old Age Pension State Medical Program Clients line item. In addition, on June 20, 2006 the Joint Budget Committee approved an Emergency Request that provided an additional appropriation of $1,140,484 from the Supplemental Old Age Pension Health and Medical Care Fund to this line. This request was prefaced with a response in the Department's January 5, 2006 Joint Budget Committee Hearing, where the Department indicated that the FY 05-06 appropriation could potentially fall short of projected obligations, if reimbursement rates continued.

The Joint Budget Committee actions during the Department's March 13, 2006 Figure Setting session and the June 20, 2006 1331 Emergency Supplemental were thought to have eliminated nearly all of the existing fund balance in the Supplemental Old Age Pension Health and Medical Care Fund. However, at the time of the June 20, 2006 the Department did not communicate to the Joint Budget Committee that an extra $750,000 was transferred from the Department of Revenue per an audit requirement. This was because the Department did not know if these funds would need to be returned. This was due to the fact that the Department of Revenue had provided the Department with an additional $750,000 in spending authority in FY 03-04, but it had not been in the Supplemental Fund, but rather in the Services for Old Age Pension State Medical Program Clients line directly, and the Department was not certain at the time of the June 20, 2006 meeting that this money would ultimately need to be refunded to the Department of Revenue

Based on these additional increases in spending authority in the Services for Old Age Pension State Medical Program Clients line item, the Joint Budget Committee and the Department have reduced some of the surplus that exists in this Supplemental Fund, and has passed it along to the provider population. However, as the chart above indicates, there is still a fund balance that can be appropriated.

General Description of Alternative: This Request is for the estimated $725,468 anticipated to be remaining in the Supplemental Old Age Pension Health and Medical Care Fund at the end of FY 06-07.

At their August meeting, the Medical Services Board authorized the Department to implementing rate reductions in order to manage the Old Age Pension State Medical Program within the statutory and constitutional spending authority of the program. Without the proposed rate reduction, the Department forecasted that expenditures would exceed the program's FY 06-07 spending authority by $9.9 million. The approved provider rate reductions are expected to allow the Department to stay within the $14,262,663 appropriation to the Old Age Pension State Medical Program for FY 06-07. The reimbursement to Old Age Pension State Medical Program providers, which are based on the Medicaid reimbursement, are as follows:

Service Type	Rate as a Percent of Medicaid Effective 7/1/06	Rate as a Percent of Medicaid 9/1/06	Rate as a Percent of Medicaid 11/1/06
Pharmacy	100%	100%	70%
Inpatient Hospital	10%	10%	10%
Outpatient Services	62%	40%	40%
Practitioner/Physician	100%	40%	40%
Emergency Dental	100%	40%	40%
Independent Laboratory and X-ray	100%	40%	40%
Medical Supply	100%	40%	40%
Hospice and Home Health	100%	40%	40%
Emergency Transportation	100%	40%	40%

The Department is requesting that the fund balance of $725,468 be appropriated to the program for FY 07-08 so the rates effective 11/1/06 can be maintained through FY 07-08. The Department is forecasting that without the additional appropriation, further rate reductions for all services, except pharmacy and inpatient hospital, will need to be implemented on July 1, 2007. Without the additional appropriation, all services, except pharmacy and inpatient hospital, will need to be reimbursed at 36% of the Medicaid reimbursement.

Calculations for Alternative's Funding:

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt**	**Federal Funds**
Total Request (matches column 7)	$13,780,951	$13,780,951	$0
Emergency Supplemental Request (matches column 6)*	$725,468	$725,468	$0
FY 06-07 Appropriation (matches column 5)	$13,055,483	$13,055,483	$0

*Funds would come from the Supplemental Old Age Pension Health and Medical Care Fund.

Supplemental Old Age Pension Health and Medical Care Fund	
	Estimate
	FY 06-07
FY 06-07 Beginning Balance (FY 05-06 Ending Balance)	**$1,850,148**
Projected Tobacco Tax Revenue	$2,389,500
Annual Transfer from Department of Revenue	$750,000
Total Estimated Revenue	$3,139,500
Expenditures from Funds Transferred from the Department of Revenue	$750,000
Expenditures from Projected Tobacco Tax Funding to the Old Age Pension Health and Medical Care Fund	$2,389,500
Expenditures Based on JBC Action to Appropriate Some of the Existing Fund Balance (Figure Setting March 13, 2006, page 209)	$976,180
Expenditures to Reconcile to the FY 06-07 Long Bill (HB 06-1385) Appropriation (page 63 of HB 06-1385, footnote (a))	$148,500
Total Estimated Expenditures	$4,264,180
Estimated Ending Balance	**$725,468**

Impact on Other Areas of Government: None.

Assumptions for Calculations: In FY 04-05 the Department of Revenue transferred $1,500,000 to the Supplemental Old Age Pension Health and Medical Care Fund, instead of the usual $750,000. The reason

for this was that in FY 03-04 the Department received $10,750,000 in appropriations to the Services for Old Age Pension State Medical Program Clients appropriation, all from the Old Age Pension Constitutional source. However, the Department of Revenue provided the entire appropriated amount to the program with none of these funds being appropriated to the Supplemental Fund first. An audit conducted by the State Auditor in FY 04-05 discovered this error and required the Department of Revenue to provide an additional $750,000 to the Supplemental Old Age Pension Health and Medical Care Fund for FY 03-04, which ultimately occurred in period 13 of FY 04-05. Therefore, the Department is now confident that the additional $750,000 appropriated into the Supplemental Fund is available for appropriation.

In addition, the Joint Budget Committee took action during the Department's March 13, 2006 Figure Setting session to appropriate $976,180 in one-time funding from the projected Supplemental Old Age Pension Health and Medical Care Fund balance. This adjustment was made to appropriate some of the remaining balance of the Supplemental Old Age Pension Health and Medical Care Fund for FY 06-07 (Figure Setting, March 13, 2006, page 211).

Lastly, the FY 06-07 Long Bill (HB 06-1385) appropriated $2,580,180 to the Supplemental Fund; however based on the Office of State Planning and Budgeting June 2006 Revenue Forecast the total tobacco tax revenue will be only $159.3 million. Based on HB 05-1262, 50% of the 3% of total tobacco tax revenues allocated each year to the Cash Fund for Health Related Purposes, resulting in a revised estimate of $2,389,500 for Supplemental Fund.

Reducing the $1,850,148 FY 06-07 beginning fund balance by the $976,180 appropriated by the Joint Budget Committee, and the $148,500 of Supplemental Fund Balance used to reconcile with the FY 06-07 Long Bill (HB 06-1385), yields the $725,468 being requested.

The $725,468 is requested to allow rates effective 11/1/06 to continue through FY 07-08. The Department is forecasting that without the additional appropriation, the further rate

reductions for all services, except pharmacy and inpatient hospital, will need to be implemented on July 1, 2007. Without the additional appropriation, all services, except pharmacy and inpatient hospital, will need to be reimbursed at 36% of the Medicaid reimbursement.

Concerns or Uncertainties of Alternative: The Department assumes that all anticipated Tobacco Tax funds will be expended for FY 06-07 and FY 07-08. Deviations from the anticipated amounts may result in this request, if approved, to not completely zero out the Supplemental Old Age Pension Health and Medical Care Fund balance. In addition, the estimate assumes that the decreases in the reimbursement rates made during FY 06-07 will not have an impact to the utilization rate of the services provided by the Old Age Pension State Medical Program Clients.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: No changes are made to the FY 07-08 appropriation for Services for Old Age Pension State Medical Program Clients.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: Under this alternative, existing fund balance in the Supplemental Old Age Pension Health and Medical Care Fund would sit idle which could be passed on to providers. The Department recently cut reimbursement rates to new lows in FY 06-07, and while the Department's reviewing the entire structure of this benefit, the current program providers could benefit from the additional revenue.

Supporting Documentation:

Analytical Technique: This is a technical correction so an analytical technique was not utilized. This funding will allow providers to receive greater reimbursement with no impact to the General Fund.

Quantitative Evaluation of Performance - Compare all Alternatives:

Alternative A increases the appropriation to the Old Age Pension State Medical Program by $725,468 of Cash Funds Exempt from the existing balances of the Supplemental Old Age Pension Health and Medical Care Fund and is therefore the recommended alternative.

Statutory and Federal Authority:

25.5-2-101 (2), C.R.S. (2006) Old age pension health and medical care fund - supplemental old age pension health and medical care fund. *Any moneys remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension recipients and after establishment and maintenance of the old age pension stabilization fund in the amount of five million dollars shall be transferred to a fund to be known as the old age pension health and medical care fund, which is hereby created. The state board shall establish and promulgate rules for administration of a program to provide health and medical care to persons who qualify to receive old age pensions…*

24-22-117 (1) (c) (II), C.R.S (2006) *Fifty percent of the moneys specified in this paragraph (c) to the supplemental old age pension health and medical care fund to provide services under the supplemental health and medical care program, section 26-2-117 (3), C.R.S., for persons who qualify to receive old age pensions*

Department Objectives Met if Approved:

1.4 To assure delivery of appropriate, high quality care. To design programs that result in improved health status for clients served and to improve health outcomes. To ensure the Department's programs are responsive to the service needs of enrolled clients in a cost effective manner.

3.2 To improve customer satisfaction with programs, services, and care.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI-12	**OSPB Approval:**		**Date:**
Program:	Safety-Net Financing Section	**Statutory Citation:**	25.5-3-102, et seq, C.R.S. (2006)	
Request Title:	Internal Audit of Primary Care Fund			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	57,826,933	48,302,649	0	48,302,649	44,995,806	0	44,995,806	0	44,995,806	0
	FTE	194.35	226.70	0.00	226.70	226.90	0.00	226.90	0.00	226.90	0.00
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	0	6,931,815	0	6,931,815	0
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	(163)	0	0	0	0	0	0	0	0	0
	CFE	44,549,620	33,446,161	0	33,446,161	29,692,230	0	29,692,230	0	29,692,230	0
	FF	6,996,916	8,362,740	0	8,362,740	8,371,761	0	8,371,761	0	8,371,761	0
(1) Executive Director's Office, Personal Services	**Total**	13,785,054	15,362,691	0	15,362,691	15,821,148	75,200	15,896,348	0	15,896,348	0
	FTE	194.35	226.70	0.00	226.70	226.90	0.00	226.90	0.00	226.90	0.00
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	0	6,931,815	0	6,931,815	0
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	507,578	506,203	0	506,203	517,572	75,200	592,772	0	592,772	0
	FF	6,996,916	8,362,740	0	8,362,740	8,371,761	0	8,371,761	0	8,371,761	0
(4) Indigent Care Program, Primary Care Fund Program	**Total**	44,041,879	32,939,958	0	32,939,958	29,174,658	(75,200)	29,099,458	0	29,099,458	0
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	(163)	0	0	0	0	0	0	0	0	0
	CFE	44,042,042	32,939,958	0	32,939,958	29,174,658	(75,200)	29,099,458	0	29,099,458	0
	FF	0	0	0	0	0	0	0	0	0	0

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	CFE: Primary Care Fund
IT Request: ☐ Yes ☑ No	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☐ Yes ☑ No	If Yes, List Other Departments Here:

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 12
Change Request Title:	Internal Audit of the Primary Care Fund
Long Bill Line Item(s)	(4) Indigent Care Program: Primary Care Fund Program
State and Federal Statutory Authority:	Article X, Section 21 (5) (b), Colorado Constitution, 25.5-3-102 et. seq., C.R.S. (2006)

Summary of Request (Alternative A): The Request is for $75,200 Cash Funds Exempt from the Primary Care Fund for administrative costs to hire a contractor to audit the rules, policies and procedures established by the Department to allocate the Primary Care Fund monies.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: As a result of Amendment 35 approved by Colorado voters in November 2004, Section 21 of Article X of the State Constitution increased Colorado's tax on cigarettes and tobacco products effective January 1, 2005 and created a cash fund that was designated for health related purposes. House Bill 05-1262 divided the Tobacco Tax cash fund into separate funds, assigning 19% of the moneys to the Primary Care Fund and set forth how the funds will be allocated. The Department of Health Care Policy and Financing is the designated administrator of the Primary Care Fund. The State Constitution directs the Department to annually allocate the funds appropriated to the Primary Care Fund to all eligible qualified providers in the State who comply with reporting requirements proportionate to the number of uninsured or medically indigent patients served by the qualified provider.

To be eligible for an allocation, the provider must meet either of the following criteria: (a) the provider must be a Community Health Center as defined in federal regulations; or (b) at least 50% of the patients served by the provider must be uninsured or medically indigent patients, or are patients who are enrolled in Medicaid or the Children's Basic Health Plan.

The Department initially proposed rules for the Primary Care Fund to the State Medical Services Board on October 14, 2005. Rules were adopted by the Medical Services Board and became effective February 1, 2006. The initial application for awards was released on November 7, 2005 and was updated on December 13, 2005 following input from stakeholders and the Medical Services Board. The first payments of the awards from the Primary Care Fund were made in March 2006.

General Description of Alternative: This Request is for $75,200 in Cash Funds Exempt from the Primary Care Fund to hire an outside contractor to review the administration of the Primary Care Program.

The Department believes the rules and processes established to distribute fund moneys to qualified providers are in compliance with State Constitutional and statutory provisions. However, there are risks that there could be flaws in the rules and procedures and/or that the information submitted by providers applying for an allocation is inaccurate that could cause the funds to be improperly allocated. Because the Primary Care Fund is only in its second year of operation and the amount of funds the Department is charged with allocating annually is significant ($44 million for FY 05-06 and nearly $33 million for FY 06-07), the Department believes it would be prudent and useful to have a one-time independent implementation review (audit) of the administration of the Primary Care Fund. The intent of the review would be to detect if flaws in the processes used to distribute Primary Care Fund appropriations exist and, if discovered, to provide recommendations to correct any problems. In addition, the review would examine the economy and efficiency of the Department's operation of the Primary Care Fund to see if there are possibilities for improvement. Having a review performed relatively early in

the history of the Primary Care Fund will allow any corrections or improvements to be implemented sooner.

The Department would solicit competitive bids for a comprehensive performance audit of the Primary Care Fund program for expenditures in FY 05-06 and FY 06-07. The audit would include several components including: an evaluation of the Department's implementation (rules, policies and procedures) to determine if it meets the intent of State constitutional and statutory provisions; an evaluation of the efficiency and effectiveness of the Primary Care Fund including recommendations for changes to improve the process of allocating the moneys; a financial review at both the provider level and Department level to determine if providers are completing applications accurately and abiding by rules; and if the Department's final allocations to providers are calculated accurately and according to legislative intent. State statutes provide for up to 3% of the Primary Care Fund to be used for administrative costs associated with the program. The Department's FY 07-08 Base Request does not contain funding for an internal audit of the Primary Care Fund. This Request is therefore asking that an appropriation be made to the Department's (1) Executive Director's Office, Personal Services line item with a corresponding reduction to the (4) Indigent Care Program, Primary Care Fund Program appropriation, to separate these administrative costs from the amount for distribution to providers.

Implementation Schedule:

Task	Month/Year
Internal Research/Planning Period	July - August 2007
Request for Proposals Issued	September 1, 2007
Contract Awarded	October 15, 2007
Contract Written	November 1, 2007
Contract Signed	November 15, 2007
Start-Up Date	December 1, 2007
Report to Department	March 31, 2008

Calculations for Alternative's Funding:

Summary of Request FY 07-08 Matches Schedule 6 and Recommended Request	**Total Funds**	**Cash Funds Exempt (from Primary Care Fund)**
Total Request [Items below total to this]	$0	$0
(1) Executive Director's Office: Personal Services	$75,200	$75,200
(4) Indigent Care Program, Primary Care Fund Program	($75,200)	($75,200)

Audit Review Tasks	**Estimated Staff Hours**	**Total Costs**
Evaluation of Department Implementation	120	$9,600
Review of rules, policies and procedures established to distribute the Primary Care Fund and verify that they comply with State Constitutional and Statutory provisions.		
Efficiency and Effectiveness Analysis	120	$9,600
Search for opportunities to improve the funding distribution process to make it more economical and efficient for both the Department and qualifying providers.		
Financial Review – Department	200	$3,200
Analysis of provider application information and computation of Primary Care Fund awards.		
Financial Review - Top 10 Qualified Providers	300	$18,800
On site review of data and methodology used to support information submitted on applications by the 10 largest qualifying providers. This accounts for 85% of the moneys distributed.		
Other Application Reviews for Smaller Providers	120	$1,600
Prepare Final Report and Recommendations	80	$3,200
Total Estimated Hours and Cost of Audit (Assumes $80 per Hour)	**940**	**$75,200**

FY 07-08 Primary Care Fund Administrative Costs	**Amount**
Primary Care Fund Base Request	$32,939,958
3% Adminitsrative Cap	**$988,199**
Estimated Cost of Audit	$75,200
Personal Services (Base Request)	$48,120
Operating (Base Request)	$620
Total Administrative Costs in Department's FY 07-08 Budget Request	**$123,940**

Impact on Other Areas of Government: A number of the qualified providers are government owned and could incur costs to respond to requests for information or documentation by the contract auditor. However, the Department estimates the costs will be nominal compared to the allocations received from the Primary Care Fund.

Assumptions for Calculations: The Department assumes the average hourly rate per staff person will be $80 per hour for the level of expertise that will be required to perform a useful audit of the Primary Care Fund. Three recent audits have been done for the Department in the areas of nursing facilities, implementing a program for all inclusive care for the elderly, and the Colorado Benefits Management System. Rates for these three audits averaged $42, $60, and $75 per hour, respectively. However, this audit will require the contractor to have experience in interpreting legal documents, knowledge of the health care industry and terminology, as well as financial analytical skills. As such, the Department assumes that the diverse skill set required will demand a greater hourly reimbursement rate, though this is not fully known. This $80 hourly rate also corresponds to the rate assumed for hospital and federally qualified health clinic audits for FY 07-08.

Based on the FY 07-08 Base Request for the Primary Care Program Fund of $32,939,958, the Department's total administrative need of $123,940 is well within the 3% administrative cap of $988,199.

Concerns or Uncertainties of Alternative: None are anticipated.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative:	This alternative does not transfer $75,200 in Cash Funds Exempt from the (4) Indigent Care Program, Primary Care Fund Program appropriation to the Department's (1) Executive Director's Office, Personal Services appropriation. Under this alternative, the audit would not be performed.
Calculations for Alternative's Funding:	No change in funding with this alternative.
Concerns or Uncertainties of Alternative:	Without an outside independent review, there is a risk that there could be weaknesses in the allocation of the Primary Care Fund appropriation. Given the level of funds allocated to providers, this could lead to significant costs in litigation, if the allocation model is found to not comply with statutory and / or constitutional provisions.

Supporting Documentation

Analytical Technique	Cost-Benefit Analysis

Quantitative Evaluation of Performance -
Compare all Alternatives

	Alternative A	Alternative B
Cost	$0	$0
Benefit	Benefits to the State and the Department include an increased level of assurance that the methodology used to distribute Primary Care Fund moneys complies with State constitutional and statutory provisions and is done in an economical and efficient manner for both the Department and qualified provider applicants. In addition, this alternative assures the Department that the information from provider applicants is correct. If any compliance flaws are detected, this alternative allows for these flaws to be corrected in the early stages of the administration of the Primary Care Fund. This alternative is also proactive.	While there are no additional costs for this alternative, the Department would not have the benefit of additional assurance that it is in compliance with State constitutional and statutory provisions and would miss any opportunity to correct any flaws in rules, policies or procedures that might be discovered. The Department would also have a lower level of assurance that provider supplied information upon which qualification and the level of awards are based is accurate. Finally, this alternative does not reduce the risk of possible litigation if a flaw is discovered. This alternative would be reactive as funding allocation review would not occur until the Office of the State Auditor reviews it.

Statutory and Federal Authority:

Colorado Constitution, Article X, Section 21 (5): *The revenues generated by operation of subsection (2) shall be appropriated annually by the general assembly only in the following proportions and for the following health related purposes: (b) Nineteen percent (19%) of such revenues shall be appropriated to fund comprehensive primary care through any Colorado qualified provider, as defined in the "Colorado Medical Assistance Act", article 4 of title 26, Colorado Revised Statutes…*

25.5-3-102 (1) and (3), C.R.S. (2006) Annual allocation - primary care services - qualified provider. *(1) The state department shall annually allocate the moneys appropriated by the general assembly to the primary care fund created in section 24-22-117, C.R.S., to all eligible qualified providers in the state who comply with the requirements of subsection (2) of this section. The state department shall allocate the*

moneys in amounts proportionate to the number of uninsured or medically indigent patients served by the qualified provider. For a qualified provider to be eligible for an allocation pursuant to this section, the qualified provider shall meet either of the following criteria:

(a) The qualified provider is a community health center, as defined in section 330 of the federal "Public Health Services Act", 42 U.S.C. sec. 254b; or

(b) At least fifty percent of the patients served by the qualified provider are uninsured or medically indigent patients, or patients who are enrolled in the medical assistance program, article 4 of title 26, C.R.S., or the children's basic health plan, article 19 of title 26, C.R.S., or any combination thereof.

(3) The state department shall make annual direct allocations of the total amount of money annually appropriated by the general assembly to the primary care fund pursuant to section 24-22-117, C.R.S., minus three percent for the administrative costs of the program, to all eligible qualified providers.

Department Objectives Met if Approved: 1.3 To assure payments in support of the programs are accurate and timely, and to procure an effective fiscal agent.

1.5 To accurately project, report, and manage budgetary requirements to affect Executive and Legislative intent with program and budget development and operations. To accurately record and monitor expenditures for programs managed by the Department so there may be accurate financial reporting at all times.

2.5 To hold accountable the Department's administrative contractors, including other State and local agencies, through outcome- based contracting and dedicated contract management.

Schedule 6
Change Request for FY 07-08

Department:	Health Care Policy and Financing	**Dept. Approval by:**	John Bartholomew	**Date:** November 1, 2006
Priority Number:	DI - 13	**OSPB Approval:**		**Date:**
Program:	Executive Director's Office	**Statutory Citation:**	24-1-107, C.R.S. (2006); 25.5-1-104 (2) and (4), C.R.S. (2006)	
Request Title:	Technical Correction to FTE Count			

		1	2	3	4	5	6	7	8	9	10
	Fund	Prior-Year Actual FY 05-06	Appropriation FY 06-07	Supplemental Request FY 06-07	Total Revised Request FY 06-07	Base Request FY 07-08	Decision/ Base Reduction FY 07-08	November 1 Request FY 07-08	Budget Amendment FY 07-08	Total Revised Request FY 07-08	Change from Base in Out Year FY 08-09
Total of All Line Items	**Total**	13,785,054	15,362,691	0	15,362,691	15,821,148	0	15,821,148	0	15,821,148	0
	FTE	194.35	226.70	0.00	226.70	226.90	12.80	239.70	0.00	239.70	12.80
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	0	6,931,815	0	6,931,815	0
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	507,578	506,203	0	506,203	517,572	0	517,572	0	517,572	0
	FF	6,996,916	8,362,740	0	8,362,740	8,371,761	0	8,371,761	0	8,371,761	0
(1) Executive Director's Office, Personal Services	**Total**	13,785,054	15,362,691	0	15,362,691	15,821,148	0	15,821,148	0	15,821,148	0
	FTE	194.35	226.70	0.00	226.70	226.90	12.80	239.70	0.00	239.70	12.80
	GF	6,280,279	6,493,748	0	6,493,748	6,931,815	0	6,931,815	0	6,931,815	0
	GFE	281	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0	0
	CFE	507,578	506,203	0	506,203	517,572	0	517,572	0	517,572	0
	FF	6,996,916	8,362,740	0	8,362,740	8,371,761	0	8,371,761	0	8,371,761	0

Letter Notation:	
Cash Fund name/number, Federal Fund Grant name:	CFE: Autism Fund, Health Care Expansion Fund, Primary Care Fund, Breast and Cervical Cancer Prevention and Treatment Fund, Children's Basic Health Plan Trust, FF: Title XIX and Title XXI
IT Request: ☐ **Yes** ☑ **No**	(If yes and request includes more than 500 programming hours, attach IT Project Plan)
Request Affects Other Departments: ☐ **Yes** ☑ **No**	If Yes, List Other Departments Here:

CHANGE REQUEST for FY 07-08
EFFICIENCY AND EFFECTIVENESS ANALYSIS

SELECT ONE (click on box):
☑ Decision Item
☐ Base Reduction Item
☐ Supplemental Request Criterion:
☐ Budget Request Amendment Criterion:

Priority Number:	DI - 13
Change Request Title:	Technical Correction to FTE Count
Long Bill Line Item(s)	(1) Executive Director's Office: Personal Services
State and Federal Statutory Authority:	24-1-107, C.R.S. (2006); 25.5-1-104 (2) and (4), C.R.S. (2006)

Summary of Request (Alternative A): This technical Request is to increase the appropriated full time equivalent (FTE) count of the Department by 12.8, without a corresponding increase in appropriated funding.

Alternative A {Recommended alternative}:

Problem or Opportunity Description: The Department of Health Care Policy and Financing is the second largest budget in the State, yet the Department is one of the smallest departments in terms of staff size. With the Department's ever-growing caseload, expenditures, and programs, there is a corresponding need for additional FTE to manage these responsibilities.

Over the past four fiscal years, the Department's Long Bill appropriations have grown by 15.04%, yet the corresponding FTE to manage these dollars has only grown by 13.12%. The following table illustrates the growth of Personal Services funding versus FTE counts from FY 03-04 to FY 06-07 using recent Long Bill appropriations.

Fiscal Year	Total Appropriation[1]	% Change from Previous Year	FTE Appropriation[2]	% Change from Previous Year
FY 03-04	$2,943,122,330		200.4	
FY 04-05	$3,073,903,029	4.44%	202.8	1.19%
FY 05-06	$3,256,303,708	5.93%	213.4	5.22%
FY 06-07	$3,385,826,300	3.97%	226.7	6.23%
Total Change FY 03-04 to FY 06-07		**15.04%**		**13.12%**

While the table would indicate that the average dollar amount per FTE has increased during this period, implying a greater responsibility per FTE, it does not measure the additional complexity in administering these projects. For instance, beginning July 1, 2002 the Centers for Medicare and Medicaid Services coordinated a new group of individuals to scrutinize all State Plan Amendments for Medicaid reimbursement pertaining to inpatient hospital services and long-term care services. This group is called the National Institutional Reimbursement Team (NIRT). Since July 1, 2002, the Department has now faced greater scrutiny of all requests to change or amend existing language in Colorado's State Plan. The average time for preparation of State Plan Amendments has increased, as has the amount of elapsed time between receiving questions from the NIRT, and formulating the State's responses. All of these additional demands on Departmental resources are not reflected in the table above.

Other examples of additional complexity in the Department's administration include recent responsibilities associated with assisting the Department of Human Services in redesigning the Residential Treatment Center and the Developmentally Disabled Waiver Services programs, and wrapping Goebel benefits and child placement services into the Medicaid mental health capitation rate. The school based health services Public Consulting Group (PCG) initiative has also added responsibilities to the Department, as there is still an effort to challenge the Centers for Medicare and Medicaid Services on this issue.

[1] Figures are from the Department's FY 06-07 and FY 07-08 Budget Requests, Schedule 2 submitted on November 15, 2005 and November 1, 2006, respectively.
[2] FTE is reported in the Department's November 1, 2006 Strategic Plan for all fiscal years.

While the above examples are both short and long-term demands on the Department's resources, from actual FY 03-04 to appropriated FY 06-07, caseload alone has grown by 18.4% (FY 06-07 = 429,222, FY 02-03 = 362,531), making it one of the most significant contributors to the Department's resource needs. However, FTE increases have not kept pace with all of these demands, and there has been a resulting decrease in morale and high turnover. While there is a small benefit from this high turnover, as new employees can generally be hired at a lower wage than seasoned employees, essentially freeing up Personal Services dollars, this only adds to the Department's difficulties in managing to the appropriated FTE count.

In an effort to alleviate some of the Department's recent staffing issues, in December 2005 during the Department's Joint Budget Committee Hearing, the Joint Budget Committee voiced concerns about the Department's staffing levels. This concern led to a Joint Budget Committee recommendation to add 5.7 FTE in the Department's FY 06-07 Long Bill appropriation, with corresponding funding for these positions. In addition to this action, on February 2006, the Department's Executive Director approved an additional twelve positions around the Department to be funded from the base appropriation, in areas where there has been substantial increases in workload.

While all these additional resources will help with the growing responsibilities placed upon the Department, there needs to be some additional true-up of the Department's appropriation to align dollars and FTE counts to usable levels.

General Description of Alternative: The Department is requesting to increase its Personal Services FTE appropriation by 12.8 to address critical functions that the Department must perform. Based on analysis of the Personal Services appropriation, the Department estimates that it can absorb an increase of 12.8 FTE without requiring additional dollar appropriations.

Based on the FY 06-07 appropriation to the Department, it has been determined that the Department's authorized FTE count is insufficient to fully expend the total dollars appropriated to the Department. Since the Department consolidated its Personal Services

appropriation in FY 03-04, it has been reverting Personal Services funding due to consistently under-spending its appropriation by over $700,000 each year.

With the intent to stop the pattern of reverting funding in its Personal Services appropriation, the Department performed an analysis of the FY 06-07 appropriation. The analysis resulted in the Department deciding to hire twelve additional positions in February 2006, in an attempt to avoid reversions and to staff up to levels that are more in line with the appropriation. Unfortunately, the impact of this decision was not experienced in time to prevent a Personal Services reversion in FY 05-06; however, the Department plans to be much more aggressive in managing to its appropriation in the future.

In addition, there appears to be a fundamental problem with contractor requests being included in the Department's (1) Executive Director's Office, Personal Services appropriation. When the Department has requested increased funding for Personal Services dollars to fund new contractor obligations, these requested increases are only dollar increases to this appropriation, with no corresponding FTE increase. However, every year the Department is required to convert contractor dollars / hours into a FTE equivalent assuming a 2,088 hourly work year on the FTE template (submitted on September 1, 2006 for FY 07-08). As these contractor costs are converted to a FTE basis, and included in the calculation of the Department's total FTE appropriation, there is little chance for the Department to stay within the appropriated FTE every year, unless the Department continues to experience high turnover rates and large periods of vacancies.

Calculations for Alternative's Funding:

(1) Executive Director's Office, Personal Services					
Summary of Request FY 07-08 and FY 08-09 Matches Schedule 6 and Recommended Request	**FTE**	**Total Funds**	**General Fund**	**Cash Funds Exempt**	**Federal Funds**
Total Request (Matches Column 7)	239.7	$15,821,148	$6,931,815	$517,572	$8,371,761
FY 07-08 Request (Matches Columns 6 and 10)	12.8	$0	$0	$0	$0
FY 07-08 Base Request (Matches Column 5)	226.9	$15,821,148	$6,931,815	$517,572	$8,371,761

Table 1 - FY 05-06 Turnover Experience	
	Number of Days
Average number of days before request to fill is submitted to Human Resources once a position is vacated	15
Average number of days for Human Resources to review the prior authorization request, post an announcement, receive and grade applications, test applicants, and return a referral letter to the hiring manager	44
Average number of days for the hiring manager to arrange interview times, screen applicants, check references, and allow for the chosen candidate to provide notice to his/her current employer of a new career	60
Average total number of days a position is vacant in the Department	119
Number of working days per fiscal year (= 2,088 hours per year and an 8 hour work day)	261
Percent of working year that the average position that experiences a vacancy is vacant	**45.6%**
Number of vacancies experienced in FY 05-06 (only includes terminations as a result of resignations, retirements, transfers out of the Department, and dismissals)	47
Number of positions in FY 05-06 (excluding grant funded FTE, 12 new positions approved by the Executive Director, and 5 eliminated positions)	232
Percent of positions in FY 05-06 that experienced a vacancy	**20.3%**
Percent of all positions assumed to be vacant (= 45.6% * 20.3%)	**9.2%**

Table 2 - Estimated Number of Positions and Funding Needed in FY 07-08		
	Positions / FTE	**Salary, PERA, and Medicare Contribution**
Positions as of July 1, 2007 (excluding 5.7 new FTE approved by the Joint Budget Committee and the 12 new positions added by the Department's Executive Director)	250.8	$16,211,211
Additional FTE appropriated by the Joint Budget Committee (Funding includes actual starting salary for 2.7 of the 5.7 FTE, plus PERA and Medicare amounts and is therefore higher than the $320,077 appropriated. Remaining FTE not yet hired are assumed at minimum.)	5.7	$361,631
Additional positions approved by the Department's Executive Director in February 2006	12.0	$672,332
Number of positions and costs estimated for FY 07-08 assuming no vacancies	**268.5**	**$17,245,174**
Percent of all positions assumed to be vacant from Table 1		9.2%
Number of positions and costs estimated for FY 07-08 assuming vacancies	**243.7**	**$15,652,291**
Additional Personal Services costs not related to FTE – Contracts and Temporary Services	N/A	$320,000
FY 07-08 estimated FTE and expenditures	**243.7**	**$15,972,291**

Table 3 – FY 07-08 Base Request Versus Estimated Need		
	FTE	**Total Funds**
FY 06-07 Long Bill plus special bills appropriation	226.7	$15,362,691
September 20, 2006 Emergency Supplemental for Exceeding Processing Guidelines Staff	4.0	$149,327
Annualization of partial year funding		
Payment Error Rate Measurement FTE from January 3, 2006 Budget Amendment #6	0.2	$14,022
FTE from HB 06-1270 (dollars only – full FTE appropriated in FY 06-07)	0.0	$4,515
FTE from SB 06-128 (dollars only – full FTE appropriated in FY 06-07)	0.0	$4,514
Salary Survey, Minimum Range, Medicare Differential and 0.2% Vacancy Factor	0.0	$435,382
FY 07-08 Base Request with September 20, 2006 Emergency Supplemental	**230.9**	**$15,970,451**
FY 07-08 estimated need for FTE and expenditures	**243.7**	**$15,972,291**
Estimated shortfall (no additional funding requested)	**12.8**	**N/A**

Impact on Other Areas of Government: None

Assumptions for Calculations: Based on the number of positions within the Department as of July 1, 2006, including the Joint Budget Committee's Figure Setting recommendation of an additional 5.7 FTE, the Department has projected that an additional 12.8 FTE could be supported assuming no additional funding. This estimate was calculated using the following assumptions:

Prior Year Turnover Experience

The Department has collected data from FY 05-06 regarding actual staffing experience, and has applied this information to estimate the total amount of time a position is vacant, if it becomes vacant. Initially, the Department estimated the amount of time a position is vacant. This estimate includes: 1) the average amount of time it takes to submit a request to fill once a position is empty, 2) the estimated amount of time that is required for the Department's Human Resources section to review a professional description questionnaire, qualify applications, set-up testing, and produce a referral list to the hiring manager, and 3) the estimated time it takes the hiring manager to arrange and perform interviews, check references, and elapsed time until the new employee begins work. The sum of these days was calculated to equal 119, and when applied to a 261 day working year (or 2,088 hours per year divided by 8 hours per day), this equated to a position, once it has been vacated, being vacant 45.6% of the working year.

The Department then needed to determine the total percentage of positions in the Department that experience a vacancy at some point and time during a 12 month period. Positions were included in this analysis only if they were vacated due to a resignation, retirement, transfer outside of the Department, or a dismissal. Based on a rough estimate of FY 05-06, the Department had 47 positions experience a vacancy at some point in time during that fiscal year. This was of a total of 232 positions (this number excludes all grant funded FTE, the 12 new positions the Executive Director approved in February 2006, and 5 positions that were eliminated). Thus, the percent of all Department positions that were vacated at some point in time during FY 05-06 is equal to 20.3% (or 47 divided by 232).

Finally, the product of these two percentages (the percent of a fiscal year that a position is vacant if it is known to be vacated, and the percentage of positions within the Department that experienced a vacancy during the year) equals the average amount of time of time any one position would be vacant during a fiscal year. The Department calculated this to be 9.2% of all positions, on average, would experience a vacancy savings.

FY 07-08 Estimated Number of Positions and Required Funding

Based on hiring practices and the number of positions active as of July 1, 2006, the Department calculated a total funding need of $17,245,174 for 268.5 employees, assuming no vacancies. This estimate includes 250.8 positions in addition to the 5.7 FTE appropriated by the Joint Budget Committee and the 12 positions approved by the Department's Executive Director in February 2006. Estimated funding for these positions includes anticipated PERA and Medicare contributions.

Then, in order to convert the total estimated positions above into FTE, the Department applies the vacancy rate of 9.2% calculated in Table 1 to both the total dollars and the number of estimated positions. As a result, the FY 07-08 estimated FTE assuming vacancies is 243.7, requiring supporting funding of $15,652,291. Adding in anticipated annual contract services of $320,000 to this funding total, the total estimated funding needed in Personal Services was calculated at $15,972,291.

FY 07-08 Estimated FTE Increase

As shown in Table 3, the FY 06-07 Long Bill plus special bills provided an appropriation of 226.7 FTE. This was then increased by 4.0 FTE on September 20, 2006 from an Emergency Supplemental for Exceeding Processing Guidelines Staff, and 0.2 FTE from the annualization of partial year funding from the January 3, 2006 Budget Amendment #6 for Payment Error Rate Measurement, resulting in a FY 07-08 Base Request including the September 20, 2006 Emergency Supplemental of 230.9 FTE. Compared to the FY 07-08 estimated need for FTE and expenditures calculated in Table 2 of 243.7, the FY 07-08 Base Request of 230.9 is 12.8 FTE below the corresponding funding level.

Concerns or Uncertainties of Alternative: There are no concerns with this position as this would only allow the Department to expend existing funding, yet remain within its budgetary FTE count.

Alternative B {Status quo; no change in funding; not recommended}:

General Description of Alternative: The requested increase to the Department's FTE count is not approved.

Calculations for Alternative's Funding: No change in funding with this alternative.

Concerns or Uncertainties of Alternative: The Department would continue to revert dollars in its Personal Services appropriation. Staffing levels may need to be adjusted to stay within the authorized limit, with consequences being that federal and state requirements might not be accomplished in a timely manner.

Supporting Documentation

Analytical Technique: Cost – Effectiveness

Quantitative Evaluation of Performance -

	Costs	Benefits
Alternative A	$0	For no additional funding, the Department would get 12.8 additional FTE to perform critical functions. This would also assist the Department in issues regarding turnover that it has experienced in the past.
Alternative B	$0	No benefits. The Department would either continue to revert Personal Services funding every year or exceed its FTE count, and there would be no positive impact to the current turnover the Department is experiencing.

Statutory and Federal Authority: 24-1-107, C.R.S. (2006). Internal organization of department - allocation and reallocation of powers, duties, and functions - limitations. *In order to promote economic*

and efficient administration and operation of a principal department and notwithstanding any other provisions of law, except as provided in section 24-1-105, the head of a principal department, with the approval of the governor, may establish, combine, or abolish divisions, sections, and units other than those specifically created by law and may allocate and reallocate powers, duties, and functions to divisions, sections, and units under the principal department, but no substantive function vested by law in any officer, department, institution, or other agency within the principal department shall be removed from the jurisdiction of such officer, department, institution, or other agency under the provisions of this section.

25.5-1-104 (2) and (4), C.R.S. (2006). Department of health care policy and financing created - executive director - powers, duties, and functions…*(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director … (4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in part 2 of this article.*

Department Objectives Met if Approved: 2.1 To build and maintain a high quality, customer-focused team.

4.2 To develop enhanced training and retention strategies for Departmental staff.

Children's Basic Health Plan

Contents of Attachment 1

Table A
Children's Basic Health Plan Trust Fund Analysis

For FY 07-08 Change Request DI-3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes"

		Actual	Actual	Estimated	Requested	
	TRUST REVENUES	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**Source**
A	Beginning Balance	$5,389,901	$9,025,270	$4,411,882	($0)	Actual and O
B	General Fund Appropriation/ FY 06-07 Estimated Need [6]	$3,296,346	$2,000,000	$1,473,078	$0	Appropriations, Footnote 1
C	January, 2006 transfer from the State Controller	$0	$900,000	$0	$0	Footnote 2
D	Tobacco Master Settlement Appropriation to Trust	$20,629,548	$20,927,529	$19,248,927	$21,465,077	Appropriations and Estimate from Legislative Council, June 2006
E	Interest Earnings	$587,893	$752,518	$566,545	$507,888	Table B Attachment I
F	Annual Enrollment Fees	$122,626	$191,726	$218,700	$239,559	Footnote 3
G	Accounts Payable Reversions from Prior Year	$156,901	$45,896	$0	$0	Actual
H	Federal Match Earnings	$40,591,093	$41,801,325	$46,430,785	$48,071,835	Footnote 4
I	**Total Revenues**	**$70,774,308**	**$75,644,264**	**$72,349,917**	**$70,284,359**	Sum A:H
	TRUST EXPENDITURES					
J	Program Cash Funds Exempt Estimated Expenditures	$20,723,603	$20,944,551	$25,041,079	$25,895,466	Footnote 5
K	Internal Administration Cash Funds Exempt Estimated Expenditures	$434,342	$386,506	$878,053	$903,904	Table E Attachment 1
L	Federal Match Expenditures	40,591,093	$41,801,325	$46,430,785	$48,071,835	Footnote 4
M	SB 05-211 Transfer $8.1 Million to General Fund	$0	$8,100,000	$0	$0	
N	**Total Expenditures**	**$61,749,038**	**$71,232,382**	**$72,349,917**	**$74,871,205**	Sum J:M
O	**Remaining Balance**	**$9,025,270**	**$4,411,882**	**($0)**	**($4,586,846)**	I-N
P	Total General Fund Requested				$4,481,968	
Q	Additional Interest Earnings if General Fund is Appropriated				$104,878	Table B Attachment 1
R	Final Ending Balance of Trustfund				($0)	Sum O:Q

Notes

1. The FY 06-07 amount is an estimated need from Table J of Attachment 1. The FY 07-08 money is the amount requested herein. FY 04-05 and FY 05-06 are actual appropriations, while FY 06-07 and FY 07-08 are projected amounts.
2. In 2002, the Department transferred funds from the CBHP Trust Fund to the State Treasury to reduce the General Fund deficit. In January 2006, $900,000 was refunded to the Trust.
3. Annual enrollment fees for FY 06-07 and FY 07-08 were estimated using the FY 05-06 experience of $3.78 per average monthly enrollment.
4. Figures for FY 04-05 and FY 05-06 are actuals, while figures for FY 06-07 and FY 07-08 are projections. See Table C and D in Attachment I.
5. The FY 07-08 request assumes that the Children's Basic Health Plan is appropriated an additional $1,711,911 for FY 06-07, or that the program is capped for FY 06-07 to keep expenditures within the appropriated amount.

Table B	
Estimation of Interest Earnings to the Trust Fund	
FY 04-05	
Interest Earned in FY 04-05	$587,893
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$29,438,421
Ratio of Interest Earned	2.00%
FY 05-06	
Interest Earned in FY 05-06	$752,518
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$32,144,525
FY 06-07	
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$25,352,587
Multiplied by Ratio of Interest Earned to Those Revenues Equals Interest Earnings	$566,545
FY 07-08	
Beginning Balance, Non-Interest Deposits, Appropriations to the Trust	$21,704,636
Multiplied by Ratio of Interest Earned to Those Revenues Equals Interest Earnings	$507,888
Requested General Fund Appropriation	$4,481,968
Multiplied by Ratio of Interest Earned to Those Revenues Equals Interest Earnings	$104,878

Table C

FY 06-07 Children's Medical, Prenatal, Dental, Administration Request and Funding Splits				
FY 06-07 CBHP Children's Medical Expenditures	**Reference**	**CBHP Trust**	**Tobacco Tax**	**Total Expenditures**
FY 06-07 Enrollment Estimate	**Table G**	**45,949**	**3,306**	**49,255**
Medical Premium PMPM[1]		$105.88	$105.88	$105.88
Total Children's Medical Expenditures		**58,380,961**	**4,200,471**	**$62,581,432**
Annual Enrollment Fee Collection Per Enrollee[2]		$3.78	$13.57	
Total Annual Enrollment Fee Collections (Cash Funds[3])		$173,838	$44,862	$218,700
Expenditures To Be Matched by Federal Funds		$58,207,123	$4,155,609	$62,362,732
Title XXI Federal Funds		$37,834,630	$2,701,146	$40,535,776
Cash Funds Exempt[4]		$20,546,331	$1,499,325	$22,045,656
FY 06-07 CBHP Prenatal Services Expenditures	**Table H**	**$1,492,888**	**$18,726,967**	**$20,219,855**
Title XXI Federal Funds		$970,377	$12,172,529	$13,142,906
Cash Funds Exempt		$522,511	$6,554,438	$7,076,949
FY 06-07 Children's Basic Health Plan Premiums Costs		**$59,873,849**	**$22,927,438**	**$82,801,287**
Title XXI Federal Funds		$38,805,007	$14,873,675	$53,678,682
Cash Funds Exempt[4]		$21,068,842	$8,053,763	$29,122,605
FY 06-07 CBHP Dental Expenditures				
FY 06-07 Enrollment Estimate	**Table G**	45,949	3,306	49,255
Percentage of Caseload Capitated for Dental Benefit		78.9%	78.9%	78.9%
Children Capitated for the Dental Benefit		36,254	2,608	38,862
Dental Premium PMPM[1]		$13.30	$13.30	$13.30
Subtotal CBHP Dental Benefit Costs		**$5,786,138**	**$416,237**	**$6,202,375**
Title XXI Federal Funds		$3,760,990	$270,554	$4,031,544
Cash Funds Exempt		$2,025,148	$145,683	$2,170,831
FY 06-07 Children's Basic Health Plan Administration	**Table F**	**$4,181,207**	**$1,340,000**	**$5,521,207**
Title XXI Federal Funds		$621,890	$656,305	$1,278,195
Title XIX Federal Funds		$1,612,228	$165,150	$1,777,378
Cash Funds Exempt		$1,947,089	$518,545	$2,465,634
FY 06-07 Internal Administration Expenditures		**$2,508,723**	**$59,728**	**$2,568,451**
Title XXI Federal Funds		$1,630,670	$38,823	$1,669,493
Cash Funds Exempt[5]	**Table E**	$878,053	$20,905	$898,958
Internal Administration Cash Funds Exempt		$878,053	$20,905	$898,958
All other Cash Funds Exempt		$25,041,079	$8,717,991	$33,759,070
Title XXI and Title XIX Federal Funds		$46,430,785	$16,004,507	$62,435,292
Total Children's Basic Health Plan Expenditures		**$72,349,917**	**$24,743,403**	**$97,093,320**

[1] Please see the narrative for Premiums and Dental for a detailed explanation of these rates. Source: Leif Actuarial Report, July 2005, page 1-2; Self-Funded Rate = $120.30; HMO Rate = $95.44; Rate weights calculated from FY 05-06 YTD Average - Self-Funded Weight = 42%; HMO Weight = 58%.

[2] Annual enrollment fees per enrollee is estimated based on the actual collections for FY 05-06 ($3.78 =$171,152 / 45,239 in enrollment). The $13.57 per enrollee for the Tobacco Tax expansion population is based on the FY 05-06 distinct count of new applications and the aggregate number of children (46,092 clients/ 17,887 cases = 2.58 clients/case). $35 per family with an average of 2.58 children per family = $13.57 / new enrollee.

[3] Cash Funds from annual enrollment fees are not eligible for a federal match.

[4] Cash Funds from annual enrollment fees are included in the Cash Funds Exempt shown here.

[5] This is the State match for Internal Administration. It is paid for through the Trust Fund, but is allocated as Cash Funds Exempt to other line items in the Long Bill.

Table D

FY 07-08 Children's Medical, Prenatal, Dental, Administration Request and Funding Splits				
FY 07-08 CBHP Children's Medical Expenditures	**Reference**	**CBHP Trust**	**Tobacco Tax**	**Total Expenditures**
FY 07-08 Enrollment Estimate	**Table G**	**45,049**	**5,094**	**50,143**
Medical Premium PMPM[1]		$112.68	$112.68	$112.68
Total Children's Medical Expenditures		**60,913,456**	**6,887,903**	**$67,801,359**
Annual Enrollment Fee Collection Per Enrollee[2]		$3.78	$13.57	
Total Annual Enrollment Fee Collections (Cash Funds[3])		$170,433	$69,126	$239,559
Expenditures To Be Matched by Federal Funds		$60,743,023	$6,818,777	$67,561,800
Title XXI Federal Funds		$39,482,965	$4,432,205	$43,915,170
Cash Funds Exempt[4]		$21,430,491	$2,455,698	$23,886,189
FY 07-08 CBHP Prenatal Services Expenditures	**Table H**	**$1,235,363**	**$22,343,803**	**$23,579,166**
Title XXI Federal Funds		$802,986	$14,523,472	$15,326,458
Cash Funds Exempt		$432,377	$7,820,331	$8,252,708
FY 07-08 Children's Basic Health Plan Premiums Costs		**$62,148,819**	**$29,231,706**	**$91,380,525**
Title XXI Federal Funds		$40,285,951	$18,955,677	$59,241,628
Cash Funds Exempt[4]		$21,862,868	$10,276,029	$32,138,897
FY 07-08 CBHP Dental Expenditures				
FY 07-08 Enrollment Estimate	**Table G**	45,049	5,094	50,143
Percentage of Caseload Capitated for Dental Benefit		78.9%	78.9%	78.9%
Children Capitated for the Dental Benefit		35,544	4,019	39,563
Dental Premium PMPM[1]		$13.97	$13.97	$13.97
Subtotal CBHP Dental Benefit Costs		**$5,958,596**	**$673,745**	**$6,632,341**
Title XXI Federal Funds		$3,873,087	$437,934	$4,311,022
Cash Funds Exempt		$2,085,509	$235,811	$2,321,319
FY 07-08 Children's Basic Health Plan Administration	**Table F**	**$4,181,207**	**$1,340,000**	**$5,521,207**
Title XXI Federal Funds		$621,890	$656,305	$1,278,195
Title XIX Federal Funds		$1,612,228	$165,150	$1,777,378
Cash Funds Exempt		$1,947,089	$518,545	$2,465,634
FY 07-08 Internal Administration Expenditures		**$2,582,583**	**$59,728**	**$2,642,311**
Title XXI Federal Funds		$1,678,679	$38,823	$1,717,502
Cash Funds Exempt[5]	**Table E**	$903,904	$20,905	$924,809
Internal Administration Cash Funds Exempt		$903,904	$20,905	$924,809
All other Cash Funds Exempt		$25,895,466	$11,030,385	$36,925,851
Title XXI and Title XIX Federal Funds		$48,071,835	$20,253,889	$68,325,724
Total Children's Basic Health Plan Expenditures		**$74,871,205**	**$31,305,179**	**$106,176,384**

[1] Please see the narrative for Premiums and Dental for a detailed explanation of these rates. Source: Leif Actuarial Report, June 2006, page 1-2; Self-Funded Rate = $124.00; HMO Rate = $104.48; Rate weights calculated from FY 05-06 YTD Average - Self-Funded Weight = 42%; HMO Weight = 58%.

[2] Annual enrollment fees per enrollee is estimated based on the actual collections for FY 05-06 ($3.78 =$171,152 / 45,239 in enrollment). The $13.57 per enrollee for the Tobacco Tax expansion population is based on the FY 05-06 distinct count of new applications and the aggregate number of children (46,092 clients/ 17,887 cases = 2.58 clients/case). $35 per family with an average of 2.58 children per family = $13.57 / new enrollee.

[3] Cash Funds from annual enrollment fees are not eligible for a federal match.

[4] Cash Funds from annual enrollment fees are included in the Cash Funds Exempt shown here.

[5] This is the State match for Internal Administration. It is paid for through the Trust Fund, but is allocated as Cash Funds Exempt to other line items in the Long Bill.

Table E

Internal Administration Appropriation and Request			
Cash Funds Exempt From Children's Basic Health Plan Trust Fund	**FY 06-07 HB 06-1385**	**FY 07-08 Request**	**Source**
Personal Services	$202,359	$235,745	FY 06-07: Letternotes to HB 06-1385 (Long Bill)
Health, Life, and Dental	$11,294	$11,659	
Short-term Disability	$458	$541	
Salary Survey and Senior Executive Survey	$4,685	$4,661	
SB 04-257 Amortization Equalization Disbursement	$3,043	$6,091	
Operating Expenses	$701	$701	
Legal Services and Third Party Recovery Legal Services	$5,945	$5,945	
Fiscal Agent Fixed Price Contract (FY 05-06 Long Bill SB 05-209)	$224,016	$224,016	
Medicaid Management and Information System Federally-Mandated Reprocurement (November 15, 2005 #DI-4)	$7,771	$4,019	FY 07-08: Base Request
HIPAA National Provider Identifier Assessment and Implementation (January 3, 2006 #S-12)	$7,255	$0	
Colorado Benefits Management System	$408,266	$408,266	
Colorado Benefits Management System - SAS 70 Audit	$2,260	$2,260	
Total from the Children's Basic Health Plan Trust Fund	**$878,053**	**$903,904**	

The FY 07-08 request has been updated per Common Policies.

Table F

Children's Basic Health Plan Administration Line Item					
Line	**External Administration Costs**	**FY 06-07 Appropriation**	**FY 07-08 Base Appropriation**	**FY 07-08 Incremental Request**	**FY 07-08 Total Request from DI - 3 in the November 1, 2006 Budget Request**
	Costs paid through the Children's Basic Health Plan Trust Fund				
1	Children's Operating Costs	$3,638,229	$3,638,229	$0	$3,638,229
2	Outreach and Client Education	$100,500	$100,500	$0	$100,500
3	Prenatal Operational Costs Budgeted	$125,478	$125,478	$0	$125,478
4	**Subtotal Primary Administration (sum of lines 1 - 3)**	**$3,864,207**	**$3,864,207**	**$0**	**$3,864,207**
5	Actuary	$92,000	$92,000	$0	$92,000
6	Quality Assurance	$125,000	$125,000	$0	$125,000
7	Claims Audit	$100,000	$100,000	$0	$100,000
8	**Subtotal Professional Services (sum of lines 5 - 7)**	**$317,000**	**$317,000**	**$0**	**$317,000**
9	**Subtotal External Administration (line 4 + line 8) (SB 05-209 Long Bill)**	**$4,181,207**	**$4,181,207**	**$0**	**$4,181,207**
10	**Adjustments from HB 05-1262 (Tobacco Tax)**				
11	Marketing	$1,300,000	$1,300,000	$0	$1,300,000
12	Application Redesign and Printing	$40,000	$40,000	$0	$40,000
13	Cost Allocation Study	$0	$0	$0	$0
14	Actuary	$0	$0	$0	$0
15	**Subtotal External Administration (Sum of lines 11 - 14) (HB 05-1262 Tobacco Tax)**	**$1,340,000**	**$1,340,000**	**$0**	**$1,340,000**
16	**Total External Administration (Line 9 + Line 14)**	**$5,521,207**	**$5,521,207**	**$0**	**$5,521,207**

FY 06-07 External Administration Funding Splits (State Funds from Children's Basic Health Plan Trust)				
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 65%**
Outreach and Client Education (Line 2)	$100,500	77.3%	$77,687	$50,497
Eligibility and Enrollment (Line 1)	$3,638,229	12.0%	$436,587	$283,782
Professional Services (Line 8)	$317,000	100.0%	$317,000	$206,050
Prenatal (Line 3)	$125,478	100.0%	$125,478	$81,561
Total Title XXI (Line 9)	$4,181,207		$956,752	$621,890
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 50%**
Outreach and Client Education (Line 2)	$100,500	22.7%	$22,814	$11,407
Eligibility and Enrollment (Line 1)	$3,638,229	88.0%	$3,201,642	$1,600,821
Professional Services (Line 8)	$317,000	0.0%	$0	$0
Prenatal (Line 3)	$125,478	0.0%	$0	$0
Total Title XIX (Line 9)	$4,181,207		$3,224,456	$1,612,228

FY 06-07 External Administration Funding Splits (State Funds From Heatlh Care Expansion Fund)				
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 65%**
Outreach and Client Education (Line 11)	$1,300,000	77.3%	$1,004,900	$653,185
Eligibility and Enrollment (Line 12)	$40,000	12.0%	$4,800	$3,120
Professional Services (Line 13 + Line 14)	$0	100.0%	$0	$0
Total Title XXI (Line 15)	$1,340,000		$1,009,700	$656,305
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 50%**
Outreach and Client Education (Line 11)	$1,300,000	22.7%	$295,100	$147,550
Eligibility and Enrollment (Line 12)	$40,000	88.0%	$35,200	$17,600
Professional Services (Line 13 + Line 14)	$0	0.0%	$0	$0
Total Title XIX (Line 15)	$1,340,000		$330,300	$165,150

Table F

FY 07-08 External Funding Splits (State funds from Children's Basic Health Plan Trust)				
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 65%**
Outreach And Client Education (Line 2)	$100,500	77.3%	$77,687	$50,497
Eligibility and Enrollment (Line 1)	$3,638,229	12.0%	$436,587	$283,782
Professional Services (Line 8)	$317,000	100.0%	$317,000	$206,050
Prenatal (Line 3)	$125,478	100.0%	$125,478	$81,561
Total Title XXI (Line 9)	$4,181,207		$956,752	$621,890
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 50%**
Outreach And Client Education (Line 2)	$100,500	22.7%	$22,814	$11,407
Eligibility and Enrollment (Line 1)	$3,638,229	88.0%	$3,201,642	$1,600,821
Professional Services (Line 8)	$317,000	0.0%	$0	$0
Prenatal (Line 3)	$125,478	0.0%	$0	$0
Total Title XIX (Line 9)	$4,181,207		$3,224,456	$1,612,228

FY 07-08 External Funding Splits (State Funds From Heatlh Care Expansion Fund)				
Title XXI Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 65%**
Outreach And Client Education (Line 11)	$1,300,000	77.3%	$1,004,900	$653,185
Eligibility and Enrollment (Line 12)	$40,000	12.0%	$4,800	$3,120
Professional Services (Line 13 + Line 14)	$0	100.0%	$0	$0
Total Title XXI (Line 15)	$1,340,000		$1,009,700	$656,305
Title XIX Federal Match	**Request**	**Allocation**	**Dollars Matched**	**@ 50%**
Outreach And Client Education (Line 11)	$1,300,000	22.7%	$295,100	$147,550
Eligibility and Enrollment (Line 12)	$40,000	88.0%	$35,200	$17,600
Professional Services (Line 13 + Line 14)	$0	0.0%	$0	$0
Total Title XIX (Line 15)	$1,340,000		$330,300	$165,150

Table G

Children's Basic Health Plan: Children's Caseload Projection for FY 06-07

Total Capitations Trend

	Historical Monthly Capitations							FY 05-06			FY 06-07 Projection									
	FY 98-99	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	Traditional Caseload	Adjust for CBHP to 200%	Final CBHP Caseload [2]	Projection Including Marketing [3]	Cumulative addition from Medicaid due to DefRA ID requirement	Subtotal with DefRA Impact	Monthly percent of clients moving from CHP+ to Medicaid due to Medicaid Asset Test Removal [5]	Clients moving from CHP+ to Medicaid due to removal of Medicaid Asset Test	Cumulative Clients moving from CHP+ to Medicaid due to removal of Medicaid Asset Test	Subtotal (from CBHP Trust Fund)	Cumulative Subtotal [4]	Expansion population projection Including Marketing [3]	Final CBHP Caseload
Jul	8,263	19,233	25,221	35,741	44,618	51,846	37,159	**40,271**	**736**	**41,007**	52,832	26	52,858	3.3%	(1,739)	(1,739)	51,119	51,119	2,432	53,551
Aug	8,956	20,397	25,489	36,711	45,864	51,844	41,477	**38,687**	**812**	**39,499**	53,943	52	53,995	3.3%	(1,776)	(3,515)	50,480	101,599	2,598	53,078
Sep	9,649	20,889	25,826	37,284	46,857	51,626	41,355	**39,187**	**898**	**40,085**	54,964	78	55,042	3.3%	(1,809)	(5,324)	49,718	151,317	2,761	52,479
Oct	10,347	21,906	26,431	38,344	48,177	52,484	35,354	**41,858**	**1,189**	**43,047**	55,896	104	56,000	3.3%	(1,840)	(7,164)	48,836	200,153	2,921	51,757
Nov	11,082	22,698	27,383	38,977	48,734	50,882	37,303	**43,449**	**1,348**	**44,797**	56,783	131	56,914	3.3%	(1,869)	(9,033)	47,881	248,034	3,079	50,960
Dec	11,704	22,944	27,958	39,247	49,258	49,001	38,036	**44,439**	**1,464**	**45,903**	57,625	158	57,783	3.3%	(1,897)	(10,930)	46,853	294,887	3,235	50,088
Jan	12,649	23,652	28,887	40,052	50,492	47,156	37,989	**45,948**	**1,638**	**47,586**	58,423	185	58,608	3.3%	(1,923)	(12,853)	45,755	340,642	3,390	49,145
Feb	13,798	23,997	30,528	40,324	50,930	44,976	40,610	47,377	1,776	49,153	59,199	212	59,411	3.3%	(1,949)	(14,802)	44,609	385,251	3,544	48,153
Mar	15,074	24,491	31,795	41,646	51,192	42,979	43,337	49,533	1,915	51,448	59,953	239	60,192	3.3%	(1,973)	(16,775)	43,417	428,668	3,697	47,114
Apr	16,603	24,801	33,073	42,690	51,511	41,353	44,175	49,884	2,018	51,902	60,684	266	60,950	3.3%	(1,998)	(18,773)	42,177	470,845	3,850	46,027
May	17,341	25,015	34,163	43,351	51,399	39,111	41,709	50,602	2,137	52,739	61,415	293	61,708	3.3%	(2,022)	(20,795)	40,913	511,758	4,003	44,916
Jun	18,436	25,196	34,907	43,745	51,564	37,069	41,552	51,631	2,263	53,894	62,146	320	62,466	3.3%	(2,046)	(22,841)	39,625	551,383	4,156	43,781
Average Monthly Capitation	12,825	22,935	**29,305**	**39,843**	**49,216**	**46,694**	**40,005**	45,239	1,516	**46,755**	57,822	172	57,994			**(12,045)**	45,949		3,306	**49,255**
Annual Growth [1]		78.8%	27.8%	36.0%	23.5%	-5.1%	-14.3%	13.08%		16.9%	27.8%	0.4%	28.2%			-26.6%			118.0%	5.3%

Supporting Calculations for the Impact of the Removal of the Medicaid Asset Test

FY 06-07	Projection Including Marketing	Monthly percent of clients moving from CHP+ to Medicaid [5]	Clients moving from CHP+ to Medicaid	Cumulative Clients moving from CHP+ to Medicaid
Jul	52,832	3.3%	(1,739)	(1,739)
Aug	53,943	3.3%	(1,776)	(3,515)
Sep	54,964	3.3%	(1,809)	(5,324)
Oct	55,896	3.3%	(1,840)	(7,164)
Nov	56,783	3.3%	(1,869)	(9,033)
Dec	57,625	3.3%	(1,897)	(10,930)
Jan	58,423	3.3%	(1,923)	(12,853)
Feb	59,199	3.3%	(1,949)	(14,802)
Mar	59,953	3.3%	(1,973)	(16,775)
Apr	60,684	3.3%	(1,998)	(18,773)
May	61,415	3.3%	(2,022)	(20,795)
Jun	62,146	3.3%	(2,046)	(22,841)
Impact on Average Monthly Enrollment				**(12,045)**

[1] The annual growth is percentage change in average monthly capitation.

[2] The bold indicates actuals. The February through June numbers include forecasted retroactivity.

[3] Monthly base growth is calculated as a constant 663 clients for traditional and 150 for expansion. The marketing impact is assumed to decline by 50% per quarter. Please see CBHP Change Request Narrative for more details.

[4] Caseload beyond the FY 03-04 level of 560,328 member months is financed by the Health Care Expansion Fund.

[5] The 3.3% monthly rate of clients moving from CHP+ to Medicaid is based on an annualized rate of 39.5%.

Table G

Children's Basic Health Plan: Children's Caseload Projection for FY 07-08

Total Capitation Trend																		
	Historical Monthly Capitations								FY 06-07 Projection			FY 07-08 Projection						
	FY 98-99	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06** [2]	Subtotal (from CBHP Trust Fund)	Adjust for CBHP to 200%	Final CBHP Caseload	Projection Including Marketing [3]	Cumulative addition from Medicaid due to DefRA ID requirement	Clients moving from CHP+ to Medicaid due to removal of Medicaid Asset Test [4]	Subtotal (from CBHP Trust Fund)	Cumulative Subtotal [5]	Expansion population projection Including Marketing [3]	Final CBHP Caseload
Jul	8,263	19,233	25,221	35,741	44,618	51,846	37,159	**41,007**	51,119	2,432	53,551	63,227	26	(22,841)	40,412	40,412	4,308	44,720
Aug	8,956	20,397	25,489	36,711	45,864	51,844	41,477	**39,499**	50,480	2,598	53,078	64,227	52	(22,841)	41,438	81,850	4,457	45,895
Sep	9,649	20,889	25,826	37,284	46,857	51,626	41,355	**40,085**	49,718	2,761	52,479	65,146	78	(22,841)	42,383	124,233	4,604	46,987
Oct	10,347	21,906	26,431	38,344	48,177	52,484	35,354	**43,047**	48,836	2,921	51,757	65,985	104	(22,841)	43,248	167,481	4,748	47,996
Nov	11,082	22,698	27,383	38,977	48,734	50,882	37,303	**44,797**	47,881	3,079	50,960	66,784	130	(22,841)	44,073	211,554	4,890	48,963
Dec	11,704	22,944	27,958	39,247	49,258	49,001	38,036	**45,903**	46,853	3,235	50,088	67,542	156	(22,841)	44,857	256,411	5,030	49,887
Jan	12,649	23,652	28,887	40,052	50,492	47,156	37,989	**47,586**	45,755	3,390	49,145	68,261	182	(22,841)	45,602	302,013	5,170	50,772
Feb	13,798	23,997	30,528	40,324	50,930	44,976	40,610	49,153	44,609	3,544	48,153	68,960	209	(22,841)	46,328	348,341	5,309	51,637
Mar	15,074	24,491	31,795	41,646	51,192	42,979	43,337	51,448	43,417	3,697	47,114	69,639	236	(22,841)	47,034	395,375	5,447	52,481
Apr	16,603	24,801	33,073	42,690	51,511	41,353	44,175	51,902	42,177	3,850	46,027	70,297	263	(22,841)	47,719	443,094	5,585	53,304
May	17,341	25,015	34,163	43,351	51,399	39,111	41,709	52,739	40,913	4,003	44,916	70,955	290	(22,841)	48,404	491,498	5,723	54,127
Jun	18,436	25,196	34,907	43,745	51,564	37,069	41,552	53,894	39,625	4,156	43,781	71,613	317	(22,841)	49,089	540,587	5,861	54,950
Average Monthly Capitation	12,825	22,935	**29,305**	**39,843**	**49,216**	**46,694**	**40,005**	**46,755**	45,949	3,306	**49,255**	67,720	170		45,049		5,094	**50,143**
Annual Growth[1]		78.8%	27.8%	36.0%	23.5%	-5.1%	-14.3%	16.9%		118.0%	5.3%	17.1%	0.3%		-2.0%		54.1%	1.8%

[1] The annual growth is percentage change in average monthly capitation.

[2] The bold indicates actuals. The February through June numbers include forecasted retroactivity.

[3] Monthly base growth is calculated as a constant 597 clients for traditional and 135 for expansion. The marketing impact is assumed to decline by 50% per quarter. Please see CBHP Change Request Narrative for more details.

[4] Total number of clients moved from CHP+ to Medicaid at the end of FY 06-07. Please see FY 06-07 projection for detail.

[5] Caseload beyond the FY 03-04 level of 560,328 member months is financed by the Health Care Expansion Fund.

Table H

Children's Basic Health Plan: Prenatal Caseload Projection for FY 06-07 and FY 07-08

Total Capitations Trend

	Historical Monthly Capitations						FY 06-07 Projection				FY 07-08 Projection			
Capitations in the Prenatal and Delivery Program	FY 02-03	FY 03-04	FY 04-05	FY 05-06 Traditional Population	FY 05-06 Expansion Population	FY 05-06 Total [2]	FY 06-07 Traditional Population Projection including Marketing [3]	Cumulative Traditional Population [4]	Expansion population projection Including Marketing [3]	FY 06-07 Total	FY 07-08 Traditional Population Projection including Marketing [3]	Cumulative Traditional Population [4]	Expansion population projection Including Marketing [3]	FY 07-08 Total
July		409	-	**985**	**28**	**1,013**	1,120	1,120	148	1,268	1,619	1,619	364	1,983
August		335	185	**965**	**40**	**1,005**	1,169	2,289	169	1,338	1,660	3,279	382	2,042
September		250	260	**1,000**	**54**	**1,054**	1,216	3,505	189	1,405	1,700	4,979	399	2,099
October	190	175	299	**1,011**	**68**	**1,079**	1,262	4,767	209	1,471	1,739	6,718	416	2,155
November	388	124	397	**1,018**	**77**	**1,095**	1,307	6,074	228	1,535	1,777	8,495	432	2,209
December	506	81	507	**1,038**	**87**	**1,125**	1,351	7,425	246	1,597	1,814	10,309	447	2,261
January	580	40	608	**1,107**	**118**	**1,225**	1,390	8,815	263	1,653	1,846	12,155	461	2,307
February	631	14	714	1,099	123	1,222	1,428	10,243	280	1,708	1,877	14,032	475	2,352
March	678	-	859	1,065	125	1,190	1,465	11,708	297	1,762	1,907	15,939	489	2,396
April	753	-	933	1,048	143	1,191	1,502	13,210	313	1,815	1,937	17,876	503	2,440
May	586	-	962	1,023	135	1,158	1,539	14,749	329	1,868	1,967	19,843	517	2,484
June	467	-	954	1,069	126	1,195	1,576	16,325	345	1,921	1,997	21,840	531	2,528
Total Member Months (133% to 185% FPL)	**4,779**	**1,428**	**6,678**	**12,428**	**1,124**	**13,552**	**16,325**		**3,016**	**19,341**	**21,840**		**5,416**	**27,256**
Average Member Month	**531**	**179**	**557**	**1,036**	**94**	**1,129**	1,360		251	1,612	1,820		451	2,271
Annual Growth [1]		-70.12%	367.65%	86.10%	9.04%	102.94%	31.36%		168.33%	42.72%	33.78%		79.58%	40.92%

	FY 06-07	FY 07-08
FY 03-04 Enrollment Level (Funded by CBHP Trust Fund)	1,428	1,428
Enrollment above the FY 03-04 Level (Funded by the Health Care Expansion Fund)	17,913	25,828
Total Prenatal Member Months	**19,341**	**27,256**

Total Member Months	19,341	27,256
Actuarial Cost Per Member Month (including delivery costs) [5, 6]	**$1,045.44**	**$865.10**
Projected total expenses for enrollment at the FY 03-04 Level (CFE from CBHP Trust Fund)	$1,492,888	$1,235,363
Projected total expenses for enrollment above the FY 03-04 Level (CFE from Health Care Expansion Fund)	$18,726,967	$22,343,803
Total Prenatal and Delivery Cost	**$20,219,855**	**$23,579,166**

[1] The annual growth is percentage change in average monthly capitation.

[2] The bold indicates actuals. The February through June numbers include forecasted retroactivity.

[3] The traditional prenatal base caseload is projected to increase by 32 capitations per month from July to December 2006, and decrease by 10% every 6 months thereafter, to 23 clients per month from January to June 2008. The expansion prenatal base caseload is projected to increase by 12 capitations per month from July to December 2006, and decrease by 10% every 6 months thereafter, to 9 per month from January to June 2008.

[4] Caseload beyond the FY 03-04 level of 1,428 member months is financed by the Health Care Expansion Fund.

[5] The FY 06-07 requested cost per member month of $1,045.44 was taken from the Leif Actuarial Report dated July 6, 2005 and represents a weighted average of the costs for a member month.

[6] The FY 07-08 requested cost per member month of $865.10 was taken from the Leif Actuarial Report dated June 15, 2006 and represents a weighted average of the costs for a member month..

Graph 1

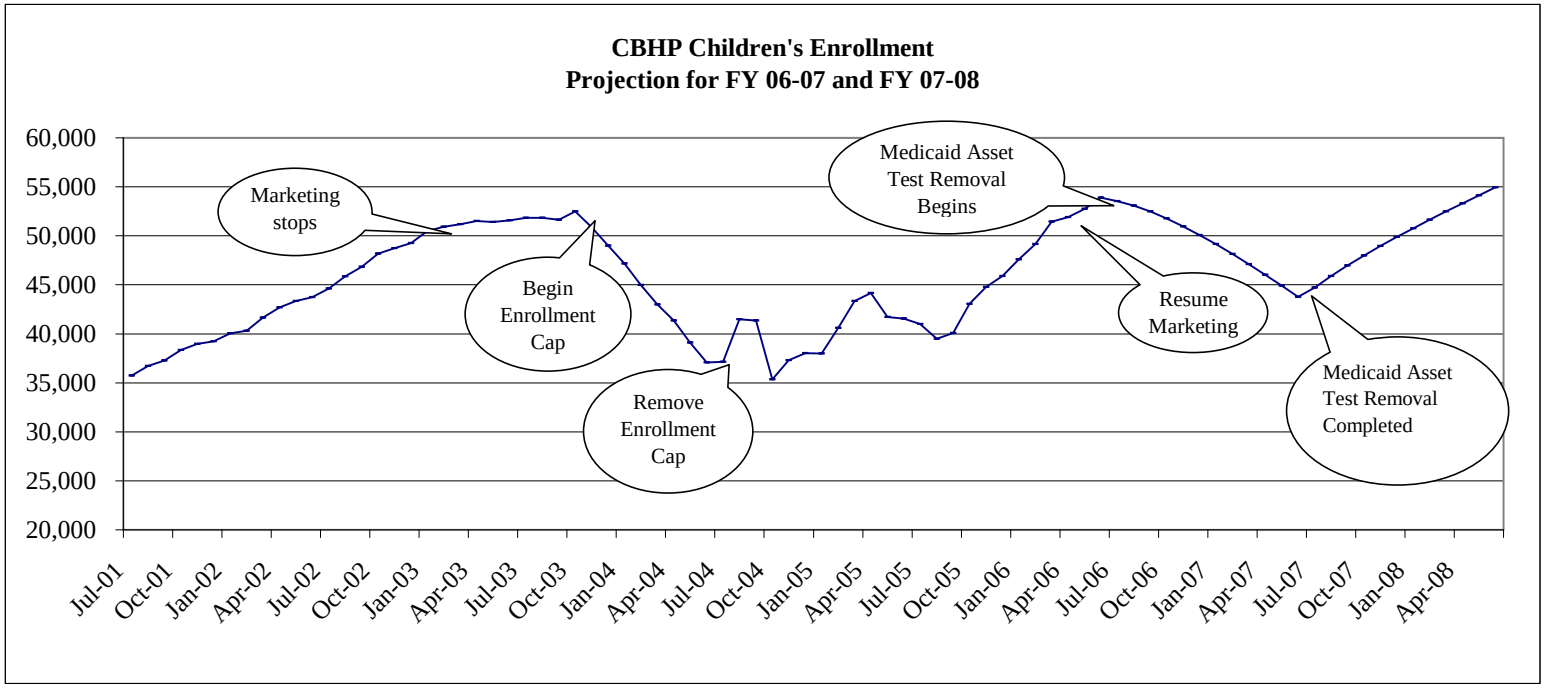
CBHP Children's Enrollment
Projection for FY 06-07 and FY 07-08
60,000
55,000
50,000
45,000
40,000
35,000
30,000
25,000
20,000
Marketing stops
Begin Enrollment Cap
Remove Enrollment Cap
Medicaid Asset Test Removal Begins
Resume Marketing
Medicaid Asset Test Removal Completed
Jul-01
Oct-01
Jan-02
Apr-02
Jul-02
Oct-02
Jan-03
Apr-03
Jul-03
Oct-03
Jan-04
Apr-04
Jul-04
Oct-04
Jan-05
Apr-05
Jul-05
Oct-05
Jan-06
Apr-06
Jul-06
Oct-06
Jan-07
Apr-07
Jul-07
Oct-07
Jan-08
Apr-08

Table I

SCHIP Federal Allotment Forecast for Colorado as of November 1, 2006						
State Fiscal Year (July 1 - June 30)	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
Inflation Rate for Medical Expenses				7.42%	7.42%	7.42%
Prenatal And Delivery Costs						
Women's member months	13,552	19,341	27,256	33,300	38,076	42,252
Monthly Rate	$816.97	$1,045.44	$865.10	$929.32	$998.31	$1,072.42
Subtotal Prenatal and Delivery Costs	$11,071,577	$20,219,855	$23,579,166	$30,946,356	$38,011,652	$45,311,890
Children's Medical Premiums						
Average Children's Caseload for Medical Premiums	46,755	49,255	50,143	59,487	66,732	73,020
Cost Per Child for Medical Premiums	$101.44	$105.88	$112.68	$121.04	$130.03	$139.68
Children's Premiums Total Funds	$56,914,129	$62,581,433	$67,801,359	$86,403,678	$104,125,944	$122,393,203
Less Annual Enrollment Fees (No Federal Match)	($191,726)	($218,700)	($239,559)	($284,200)	($318,813)	($348,854)
Children's Dental Premiums						
Average Children's Caseload for Dental (78.9% of total caseload)	36,890	38,862	39,563	46,935	52,652	57,613
Cost Per Child for Dental	$11.82	$13.30	$13.97	$15.01	$16.12	$17.32
Children's Dental Total Funds	$5,232,478	$6,202,375	$6,632,341	$8,453,932	$10,185,003	$11,974,286
Subtotal Medical Expenses	$73,026,458	$88,784,963	$97,773,307	$125,519,766	$152,003,786	$179,330,525
Administration						
Annual Admin increase				2.37%	2.37%	2.37%
Admin (Estimate)	$6,365,221	$5,533,244	$5,664,382	$5,798,628	$5,936,055	$6,076,740
Total Funds	$79,391,679	$94,318,207	$103,437,689	$131,318,394	$157,939,841	$185,407,265
Federal Funds at 65%	$51,604,591	$61,306,835	$67,234,498	$85,356,956	$102,660,897	$120,514,722

Federal Fiscal Year (Oct - Sep)	**FFY 2006**	**FFY 2007**	**FFY 2008**	**FFY 2009**	**FFY 2010**	**FFY 2011**
Total Funds	$83,123,311	$96,598,078	$110,407,865	$137,973,756	$164,806,697	$185,407,265
Federal Funds Needed	$54,030,152	$62,788,751	$71,765,113	$89,682,941	$107,124,353	$120,514,722
Federal Allotment	$57,951,287	$57,951,287	$57,951,287	$57,951,287	$57,951,287	$57,951,287
Redistributions	$0	$0	$0	$0	$0	$0
Available from Prior Years	$102,056,558	$105,977,693	$101,140,229	$87,326,403	$55,594,749	$6,421,683
Total Federal Funds Available	$160,007,845	$163,928,980	$159,091,516	$145,277,690	$113,546,036	$64,372,970
Unspent / (Amount needed)	**$105,977,693**	**$101,140,229**	**$87,326,403**	**$55,594,749**	**$6,421,683**	**($56,141,752)**

Notes

1.) Caseload and rates for FY 06-07 and FY 07-08 are from Table C and D.

2.) Caseload growth for the Prenatal Program assumes 10 members per month after FY 06-07.

2.) Caseload growth for the Chidlren's Program assumes 420 members per month in FY 07-08 and 300 members per month each year after that. There is a dip in the FY 07-08 average monthly enrollment because the enrollment declines throughout FY 06-07 due to the removal of the Medicaid Asset Test therefore the ending enrollment in FY 06-07 is lower than the average for that year.

4.) The inflation rate used for medical expenses is the average requested increase in average capitation rates from FY 01-02 to FY 05-06.

5.) The inflation rate used for administrative expenses is a ten year average of Colorado CPI running from 1995 through 2004, where 2001 - 2004 were forecasted figures.

6.) The administration estimate for FY 05-06 and FY 06-07 includes grants, the Title XXI allocation of the Administration line item, the CBMS allocation and the allocation of other Internal Administration expenses and is taken from the FFY 2005 annual report to CMS.

7.) Federal Fiscal Years are estimated using 75% of one State Fiscal Year and 25% of the next.

Table J

Estimate of General Fund Need for Children's Basic Health Plan Trust Fund in FY 06-07 [1]

	Children			Dental			Prenatal		
	Caseload	Rates	Expenditures	Caseload	Rates	Expenditures	Caseload	Rates	Expenditures
FY 05-06 Appropriation	42,547	$101.44	$51,779,699	37,016	$11.82	$5,256,272	1,428	$816.97	$1,166,633
FY 05-06 Revised Projection	45,239	$101.44	$55,055,863	35,730	$11.82	$5,073,660	1,428	$816.97	$1,166,633
Difference Due to Caseload	2,692	$101.44	$3,276,164	(1,286)	$11.82	($182,612)	0	$816.97	$0
Difference Due to Rates	45,239	$0.00	$0	35,730	$0.00	$0	1,428	$0.00	$0
FY 05-06 Total Difference Between Projection and Appropriation	**2,692**	**$0.00**	**$3,276,164**	**(1,286)**	**$0.00**	**($182,612)**	**0**	**$0.00**	**$0**
FY 06-07 Appropriation	38,635	$104.14	$48,293,750	33,612	$13.30	$5,377,920	1,428	$905.54	$1,293,111
FY 06-07 Revised Projection	45,949	$105.88	$58,401,179	36,254	$13.30	$5,800,640	1,428	$1,045.44	$1,492,888
Difference Due to Caseload	7,314	$104.14	$9,142,500	2,642	$13.30	$422,720	0	$905.54	$0
Difference Due to Rates	45,949	$1.74	$964,929	36,254	$0.00	$0	1,428	$139.90	$199,777
FY 06-07 Total Difference Between Projection and Appropriation	**7,314**	**$1.74**	**$10,107,429**	**2,642**	**$0.00**	**$422,720**	**0**	**$139.90**	**$199,777**
FY 06-07 Appropriation	38,635	$104.14	$48,293,750	33,612	$13.30	$5,377,920	1,428	$905.54	$1,293,111
FY 07-08 Projection	45,049	$112.68	$60,906,248	35,580	$13.97	$5,977,440	1,428	$865.10	$1,235,363
Difference Due to Caseload	6,414	$104.14	$8,017,500	1,968	$13.30	$314,880	0	$905.54	$0
Difference Due to Rates	45,049	$8.54	$4,594,998	35,580	$0.67	$284,640	1,428	($40.44)	($57,748)
Total Difference Between FY 07-08 Projection and FY 06-07 Appropriation	**6,414**	**$8.54**	**$12,612,498**	**1,968**	**$0.67**	**$599,520**	**0**	**($40.44)**	**($57,748)**

FY 06-07 General Fund Need Calculation	
FY 06-07 Total Funds Required	$10,729,926
FY 06-07 Cash Funds Exempt Required [2]	**$3,737,631**
Tobacco Settlement Estimate from JBC Figure Setting	$20,973,924
Tobacco Settlement Actual	$19,248,927
Additional Need Because of Less Settlement Funding	**$1,724,997**
Internal Administration and Interest [3]	**$422,332**
Total Trust Fund Need	**$5,884,960**
Available Trust Fund Balance	$4,411,882
FY 06-07 General Funds Required	**$1,473,078**

[1] This analysis includes only traditional clients, as expansion clients are funded by the Health Care Expansion Fund rather than the Children's Basic Health Plan Trust Fund.

[2] In calculating the State CFE portion, enrollment fees must be subtracted from the initial total expenditure. Due to differences in enrollment, the Department estimates this amount to be approximately $173,838, whereas Figure Setting uses $122,859.

[3] This amount captures the increase in internal administration funds as well as changes in the amount of interest income received.