Department of Health Care Policy and Financing
Assumptions and Calculations
FY 07-08

Budget Request

NOVEMBER 1, 2006

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(1) EXECUTIVE DIRECTOR'S OFFICE

PERSONAL SERVICES

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

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

During that time, some of the Department's Personal Services appropriations (Colorado Benefits Management System, Indigent Care Program Administration and HIPAA Staffing Costs) had their Operating Expenses and Personal Services combined under one appropriation. At the Department's request, during FY 03-04 Figure Setting, the Joint Budget Committee recommended that all Personal Services within the Department be combined into one line item and all operating expenses be separated into one appropriation (FY 03-04 Figure Setting, March 11, 2003, page 163). By combining all Personal Services under the Executive Director's Office Long Bill group, the Department gained flexibility in the utilization of funding and FTE.

The Schedule 3 delineates the Personal Services' request of FTE and funding. Please note that the FY 07-08 Request column consists of estimated expenditures from the FY 06-07 Personal Services appropriation, plus all related out-year legislative impacts and any Common Policy impacts such as the 0.2% base reduction, increases for prior year's Salary Survey, and minimum range adjustments.

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

I. Position Detail Calculation

The first calculation method used is the Position Detail, labeled "I" in the Schedule 3. The Position Detail is a summary of State employee wages and FTE by position title (totaled at "I.A."), with "Other Personal Services" separately stated (totaled in "I.B."). "Other Personal Services" are costs not included in the base salaries calculation that typically include PERA, Medicare, State temporary employees' salaries, contractual services, termination and retirement payouts, and unemployment insurance. Central POTS, (totaled in I.D.) are added to include: Salary Survey, Performance-based Pay, Senior Executive Service, Amortization Equalization Disbursement, Supplemental Amortization Equalization Disbursement, Health/Life/Dental, and Short-term Disability that were expended or are estimated for this line item for the Actual and Estimate years. Salary Survey/Senior Executive Service,

Supplemental Amortization Equalization Disbursement, and Performance-based Pay expenditures are "non-add" items because the salaries listed by position should already reflect these costs.

The Position Detail method assumes continuation of the existing staffing pattern in the FY 07-08 Base Request year; however, it includes any annualization of FTE. The calculation starts with actual salaries and then adds other anticipated costs such as benefits and contractual obligations. The Position Detail method ends with a "Difference" row (I.F.) that presents the difference between the Personal Services Reconciliation Total (III) and the Base Personal Services Subtotal (I.E.). The difference is shown for the Estimate and Request year columns.

The first method summarizes actual expenditures for FY 04-05 and FY 05-06. Then, the FY 06-07 Estimate and the FY 07-08 Base Request are broken out in the same manner. This section of the Schedule 3 does not represent the Department's Personal Services Request. The following is a description for the Position Detail (I) FTE and total funds described by column.

The FY 04-05 Actual column reflects actual expenditures after the close of period 13 in the Colorado Financial Reporting System as summarized below:

- The Department's Executive Director's Office by position salary cost of $10,835,787 (I.A.);
- Other Personal Services (I.B.) totaling $2,344,429 for items such as PERA, Medicare, Temporary Services, and Contractual Services; and,
- POTS expenditures of $427,221 (I.D.) that consist of Health/Life/Dental and Short Term Disability Insurance. Expenditures for Salary Survey and Senior Executive Services of $248,845 and Performance-based Pay of $136,130, and are "non-add" items as they are included in the salary costs in I.A. above.

The FY 05-06 Actual column reflects actual expenditures after the close of period 13 in the Colorado Financial Reporting System as summarized below:

- The Department's Executive Director's Office by position salary cost of $11,424,988 (I.A.);
- Other Personal Services (I.B.) totaling $2,754,600 for items such as PERA, Medicare, Temporary Services, and Contractual Services; and,
- POTS expenditures of $561,001 (I.D.) that consist of Health/Life/Dental, Short Term Disability Insurance and the Amortization Equalization Disbursement per SB 04-257. Expenditures for Salary Survey and Senior Executive Services of $394,534 are non-add items as they are included in the salary costs in I.A. above.

The FY 06-07 Appropriation column shows no detail for this piece of the calculation, but is the amount appropriated for base salaries plus other personal services (I.C.). POTS are not included.

The FY 06-07 Estimate column shows the current positions' salary costs (I.A.). Calculations for this section start with the current positions' salary costs including Salary Survey and Performance-based Pay Awards (July 1, 2006 salaries times 12), yielding $13,455,610 for 230.7 FTE. The next step was to add Other Personal Services, of $3,004,600. This amount includes:

- PERA of $1,365,744 calculated using 10.15% of the $13,455,610 above;
- Medicare of $195,106 calculated using 1.45% of the $13,455,610 above;
- State Temporary Services of $50,000 incorporating existing Personnel Action Requests and estimates provided by program managers;
- Other Temporary Services, which includes contracted temporary services, estimated at $40,000 using current Department contracts as well as estimates provided by program managers;
- Contractual Services estimated at $1,200,000 considering prior year actuals and current Department contracts and estimates provided by program managers;
- Excess Short-term Disability estimated at zero because past actuals have been zero;
- Termination/Retirement Payouts estimated at $123,000 for unused vacation/sick time accumulated during employment – estimated on an average of FY 04-05 and FY 05-06 payouts;
- Unemployment Insurance of $30,000 based on an average of expenditures for FY 04-05 and FY 05-06; and
- Employee incentives of $750 estimated according to actuals from FY 05-06.

POTS expenditures of $741,072 for Health/Life/Dental Insurance, Short-term Disability Insurance and Amortization Equalization Disbursement are then added to bring the Base Personal Services total (I.E.) to $17,201,282 for 230.7 FTE. The appropriated amount for Salary Survey of $459,483 is listed, but not added, as it has been included in the salaries delineated in the Position Detail. Even though there is a separate appropriation for Salary Survey, actual wages for State employees are tracked and paid out of the Personal Services line; therefore, these amounts are included in each position's salary amount for the estimate year.

Not all positions are filled all twelve months of the year. To account for this in the FY 06-07 Estimate column, currently vacant positions that do not have immediate fills pending are reduced by an incremental FTE count and dollar adjustment in order to ensure that the appropriated FTE (230.7) is not exceeded. Since these positions will not be the same positions vacant throughout the year, this is considered a budgeting adjustment only. The adjustment included 50 vacant positions and each was reduced from 1.0 FTE to 0.4 FTE. This does not mean that these 50 positions will be exactly 0.4 FTE, or that all filled positions will be 1.0 FTE, but the adjustment allows the Department to accurately balance to the total appropriated FTE. The corresponding dollars are reduced accordingly through the same methodology (I.A.).

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

The FY 07-08 Request column shows the positions' salary costs as reflected in the FY 06-07 Estimate column, with some minor adjustments. These adjustments include a net decrease of 3.8 FTE and $167,580 due to: 1) the annualization of an FTE appropriated in the Long Bill for the federally required Payment Error Rate Measurement program (added 0.2 FTE), and the removal of 4.0 FTE for a 1331 Emergency Supplemental approved by the Joint Budget Committee on September 20, 2006.

Other Personal Services amounts (I.B.) are identical to the ones used in the FY 06-07 Estimate column with the following exceptions, bringing the total to $3,315,161:

- PERA decrease of $17,009 for Salary Survey and range adjustments in FY 07-08 due to the decrease of 3.8 FTE;
- Medicare decrease of $2,430 for the same factors;
- State Temporary Services increase of $30,000 incorporates estimates provided by program managers; and
- Contractual Services increased $300,000 based on current Department contracts and estimates of anticipated needs provided by program managers.

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

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

II. Personal Services Request

The second method calculates the official FY 07-08 Personal Services Base Request (labeled as "II" in the Schedule 3) based on aggregate adjustments to the previous year's Long Bill appropriation. This is the Department's FY 07-08 Budget Request for this line, calculated as outlined in the budget request instructions issued by the Office of State Planning and Budgeting June 1, 2005 (Chapter 8, page 8). These adjustments include special bills, Supplemental appropriations, Salary Survey, range adjustments, Medicare Differential, Performance-based Pay, and the Office of State Planning and Budgeting 0.2% vacancy savings base adjustment. These are the numbers that feed into the Schedule 2A. A number of Change Requests have been submitted that affect this line item.

A. The FY 07-08 Base Request before POTS is derived in the table below by applying the legislative and Common Policy adjustments to the FY 06-07 Long Bill (HB 06-1385). To calculate Section II.A., special bill adjustments are made, including annualization for some bills.

B. The FY 06-07 Salary Survey (II.B.) is included. The Salary Survey amount is the FY 06-07 appropriated amount of $459,483. Both exempt (the Executive Director) and classified employees are included in Salary Survey.

C. Range adjustments are calculated by starting with the June 2007 estimated salaries for currently filled or approved to fill positions. There is 1.0 FTE identified below the pay range minimum after the computation of FY 06-07 Salary Survey. Positions that do not meet the minimum pay requirement per the FY 06-07 Annual Compensation Survey Report issued by the Department of Personnel and Administration on August 1, 2005 are increased to equal the minimum salary requirement.

D. FY 06-07 Performance-based Pay is then added. For FY 06-07, there was no appropriation for this line. Performance-based Pay is not allocated to exempt employees.

E. Medicare and PERA rates are calculated on Base Salary, Salary Survey, and Range Adjustments. The Medicare differential of $7,605 is the portion of the Medicare calculation pertaining to employees exempt from the Medicare deduction due to a date of hire prior to April 1, 1986 (per Common Policy Instructions for the FY 07-08 Budget Submission, issued August 1, 2006, page 5). Currently there are 7 employees within the Department whose salaries should not be included in the Medicare calculation. Therefore, in FY 07-08, $7,605 is backed out from the total Medicare calculation. This amount is based on base salaries, Salary Survey, and Performance-based Pay for these 7 individuals.

F. Annualization of funding for the Payment Error Rate Measurement program incorporated in the FY 06-07 Long Bill, HB 06-1385.

G. After a FY 07-08 subtotal has been calculated on components A – F, a 0.2% reduction is taken on the subtotal as the Office of State Planning and Budgeting requires.

H. Lastly, the incremental statewide indirect cost allocation is applied. The statewide indirect adjustment is a departmental allocation developed by the State Controller's Office, distributed to the State departments with the Common Policies (August 16, 2006). This allocation offsets statewide General Fund costs with proportionate amounts from federal funds, Cash Funds, or Cash Funds Exempt. The purpose is to allocate the unbilled costs of central service agencies to individual programs. The incremental difference between the FY 06-07 allocation and the FY 07-08 allocation is shown, including fund splits. The incremental difference between the two years' General Fund is an increase of $239,861. The difference between the current and Request year funding splits distribution is shown below:

Statewide Indirect Cost Allocation	Total Funds	General Fund	Cash Funds Exempt	Federal Funds
FY 06-07 Allocation from State Controller's Office	$0	($801,613)	$15,639	$785,974
FY 07-08 Allocation from State Controller's Office	$0	($561,752)	$14,703	$547,049
Incremental Difference	$0	$239,861	($936)	($238,925)

I. This results in the total Base Request for FY 07-08. Section II.I does not include any Decision Items that the Department has submitted that would have an affect on funding for FY 07-08.

FY 07-08 Base Request Cash Funds Exempt Allocation								
Coordinated Care for People with Disabilities Fund	Primary Care Fund	Breast and Cervical Cancer Trust Fund	Children's Basic Health Plan Trust Fund	Transfer from the Department of Public Health and Environment	Autism Treatment Fund	Old Age Pension Fund	Health Care Expansion Fund	Total Cash Funds Exempt Requested
$27,031	**$46,633**	**$8,877**	**$206,212**	**$28,074**	**$26,704**	**$42,982**	**$131,059**	**$517,572**

J. Decision Items that impact Personal Services are included here to build to the Department's Personal Services Request Total (II) for FY 07-08.

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

Line Item: Personal Services	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$13,141,014**	**$13,420,083**	**$15,316,914**	**$15,362,691**
Reinstate impact related to SB 04-138	$9,700	$0	$0	$0
Remove funding for 2.3 FTE appropriated in HB 04-1265 which transferred the Medicaid Mental Health program to the Department	($259,274)	$0	$0	$0
CBMS Reductions	($169,658)	$0	$0	$0
HB 04-1320 (remove FY 03-04 one-time Supplemental)	($86,029)	$0	$0	$0
SB 03-011 (Prescription Drugs Under Medicaid)	$13,683	$0	$0	$0
Joint Budget Committee Adjustment	$0	$6	$0	$0
Removal of funding related to HB 05-1262	$0	($49,617)	$0	$0
Annualization of SB 04-028	$0	($43,482)	$0	$0
Annualization of SB 04-206	$0	($44,000)	$0	$0
SB 04-177 (Children with Autism)	$0	$81,874	($29,900)	$0
Annualization of HB 04-1219 (Community, Transition Services for HCBS for the Elderly, Blind, and Disabled)	$0	$2,685	$0	$0
HB 05-1262 (Tobacco Tax Bill – removal of one time funding)	$0	$0	($100,936)	$0
Annualization of Customer Service Intern from Figure Setting March 15, 2005, page 21	$0	$0	$16,536	$0
Medicare Modernization Act of 2003	$0	$635,710	($507,354)	$0
Reversal of CBMS Funding (HB 06-1217)	$0	$0	($480,980)	$0
Joint Budget Committee Action to add 5.7 FTE	$0	$0	$310,824	$0
Payment Error Rate Measurement Project	$0	$54,768	$42,064	$0
BA-4, Establish Old Age Pension Drug Rebate Program	$0	$0	$33,928	$0
BA-2, Change in Certification timing of Public Expenditures for Medical Services Premiums	$0	$0	$33,928	$0
BRI-4, Implementation of Drug Rebate Analysis and Management System	$0	$0	$112,172	$0
Primary Care FTE moved from Indigent Care Long Bill Group	$0	$0	$41,696	$0

Line Item: Personal Services	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Annualization of SB 06-128, Quality of Care for People with Disabilities Pilot Program	$0	$0	$0	$4,514
Annualization of HB 06-1270, School Based Medicaid Eligibility Determinations	$0	$0	$0	$4,515
Annualization of Payment Error Rate Measurement Project (S-8)	$0	$0	$0	$14,022
Performance Based Pay	$0	$136,130	$0	$0
Medicare Differential	$0	$0	$0	$7,605
Range Adjustment	$0	$0	$0	$24
Salary Survey	$0	$248,845	$394,534	$459,483
OSPB 0.2% Reduction	($25,298)	($27,505)	($29,218)	($31,706)
Long Bill Appropriation / Request	**$12,624,138**	**$14,415,497**	**$15,154,208**	**$15,821,148**
HB 04-1219 (Community Transition Services for HCBS for the Elderly, Blind, and Disabled)	$19,444	$0	$0	$0
SB 04-138 (Repeal of the Authority to Charge a Monthly Fee to Families whose Children are Enrolled in HCBS Waiver Program)	($38,797)	$0	$0	$0
SB 04-028 (Substance Abuse for Treatment for Native Americans)	$43,482	$0	$0	$0
SB 04-206 (Hospice Care for Persons Who are Eligible Under the "Colorado Medical Assistance Act")	$44,000	$0	$0	$0
SB 05-112 Supplemental Bill	$678,199	$0	$0	$0
HB 06-1217 Supplemental Bill	$0	$448,832	$0	$0
HB 06-1385 Add-ons	$0	$17,583	$0	$0
HB 05-1066 (Obesity Bill)	$0	$27,233	$0	$0
HB 05-1243 (Consumer Directed Care)	$0	$26,570	$0	$0
HB 05-1262 (Tobacco Tax Bill)	$49,617	$381,199	$0	$0
SB 06-165 (Telemedicine)	$0	$0	$54,171	$0
SB 06-128 (Pilot to improve quality of care for people with disabilities)	$0	$0	$49,656	$0
SB 06-219 (Heath Care Policy and Financing Re-organization)	$0	$0	$55,000	$0

Line Item: Personal Services	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
HB 06-1270 (School eligibility determination sites)	$0	$0	$49,656	$0
Final Appropriation / Request	**$13,420,083**	**$15,316,914**	**$15,362,691**	**$15,821,148**
General Fund	$6,013,050	$6,345,598	$6,493,748	$6,931,815
Cash Funds Exempt	$221,790	$967,237	$506,203	$517,572
Federal Funds	$7,185,243	$8,004,079	$8,362,740	$8,371,761
FTE	202.8	212.4	226.7	226.9

III. Personal Services Reconciliation

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

The Reconciliation Difference (IV) subtracts the Personal Services Detail Total (or Position Detail in I) from the Reconciliation Personal Services Total (III).[1] The Reconciliation Difference (IV) is used to balance the two calculations.

For the FY 04-05 Actual column (III.A.), the calculation is as follows:

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

- SB 05-112, the Supplemental Bill which moved Mental Health Administration funding to Personal Services to be consistent with having all Personal Services within the appropriation, adding $678,199 and 7.0 FTE plus,
- HB 04-1219, Community Transition Services for Home and Community Based Services for the Elderly, Blind, and Disabled, increased total funds by $19,444 and 0.4 FTE; plus,
- SB 04-028, Substance Abuse for Treatment for Native Americans increased total funds by $43,482; plus,
- SB 04-138, repealed authority to charge a monthly fee to families of Home and Community Based Services waiver children, decreased funds by $38,797 and 1.0 FTE; plus,

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

- SB 04-206, Hospice Care for Persons who are Eligible Under the "Colorado Medical Assistance Act", increased total funds by $44,000; and finally,
- HB 05-1262, tobacco tax implementation funding for three positions for one month in FY 04-05, adding $49,617 and 0.3 FTE.

A roll forward to FY 05-06 for $31,263 was approved for the following programs: funding for an 1115 waiver for the Pediatric Hospice Care Program for $27,163 and $4,100 for Health Policy Solutions training contract with the Children's Basic Health Plan.

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

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

For the FY 05-06 Actual column (III.A.), the calculation is as follows:

The FY 05-06 Long Bill appropriation (SB 05-209) for Personal Services consists of $14,415,497 total funds with 206.1 FTE (III.A.). It includes statewide indirect costs, Common Policy adjustments of 0.2%, Colorado Benefits Management System reductions, and the reinstatement of the impact related to SB 04-138 since it was not considered to be removed in FY 03-04 until after the FY 04-05 Long Bill was signed into law; plus,

- HB 06-1217, the Department's Supplemental Bill, allocated $448,832 and reduced the FTE count by a net of 0.5 FTE, due to the following: appropriated funding and 0.25 FTE to coordinate the change in timing of the Upper Payment Limit in the Medical Services Premiums, funding and 0.25 FTE to coordinate the Old Age Pension drug rebate program, removal of funding and 1.0 FTE due to the delay by the federal government of the Payment Error Rate Measurement program, and funding related to the Colorado Benefits Management System Court Order.
- HB 06-1385 Add-ons also adjusted funding for programs that pertain to FY 05-06 in the amount of $17,583 and reduced the FTE by 0.5. This change was due to the federal government picking up 100% of the Medicare Modernization Act administrative costs during this period, and not receiving enough gifts, grants or donations to implement the obesity program authorized in HB 05-1066 (see below), and finally, providing funding for a General Professional III FTE funding was left out of the appropriation clause for HB 05-1262.
- HB 05-1066, obesity treatment for people with body mass indexes exceeding 30%, increased total funds by $27,233 and 0.5 FTE; plus,

- HB 05-1243, Consumer Directed Care through the Home and Community Based Services model, increased total funds by $26,570 and 0.5 FTE; plus,
- HB 05-1262, tobacco tax implementation from the Tobacco Tax Cash Fund implemented pursuant to Section 21 of Article 10 of the Colorado Constitution which increased total funds by $381,199 and 6.3 FTE;

In addition to the appropriated amounts above, spending authority was reduced by $63,926 for the following roll forwards to FY 06-07: $34,026 for Colorado Benefits Management System enhancements to implement changes associated with services for legal immigrants, and $29,900 due to the federal government delaying the approval of the Home and Community Based Services Children's Autism waiver. Spending Authority was reduced due to a late 1331 Emergency Supplemental Request on June 20, 2006 to use $825,000 in vacancy savings funding in this line for Non-Emergency Medical Transportation in (5) Other Medical Services.

The total spending authority for FY 05-06 was $14,459,251 with 212.4 FTE.

For the FY 06-07 Estimate, the spending authority calculation (III.A.) is calculated the same way as the FY 06-07 appropriation column. However, in the Estimate column, the rollforward of $63,926 and the September 20, 2006 1331 Emergency Supplemental to establish an Exceeds Processing Guidelines unit within the Department for $149,327 are included. Also, the Executive Director's Office portion of POTS (III.C.) is added, totaling $1,200,555 ($459,483 Salary Survey, $629,640 Health/Life/Dental, $14,888 Short-term Disability, and $96,544 for Amortization Equalization Disbursement). POTS plus the Spending Authority Authorization (III.A.) equals the "III. Reconciliation Personal Services Total."

The Request FY 07-08 Column (III.) repeats the Department's Request from "II. Personal Services Request Total."

HEALTH, LIFE, AND DENTAL

This insurance benefit is part of the POTS component paid jointly by the State and State employees on a predetermined rate based on the type of package that each employee selected (e.g., Employee, Employee + 1, Employee + Spouse, etc).

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

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

The FY 05-06 appropriation of $476,625 used different rates for each plan as provided in the Common Policies instructions issued by the Office of State Planning and Budgeting on August 3, 2004. The calculation for the Health, Life, and Dental appropriation included two different calculations: one for July to December 2005 and the other for January to June 2006. Each calculation uses different plan designations (Employee, Employee + 1, Employee + Spouse, etc) and rates. The plans were then summarized by type and fund. The funding is in accordance to each employee's salary fund splits. In the FY 05-06 appropriation of $476,625, the rates for each plan were lower than those used to calculate the FY 04-05 appropriation. However, the number of participants was higher.

The FY 06-07 appropriation of $629,640 also used different rates for each plan provided in the Supplement to FY 06-07 Common Policies Instructions issued by the Office of State Planning and Budgeting on August 2, 2005. Additionally, the plan year was changed to coincide with the State's fiscal year. Therefore, there was only one calculation for this line item. Other changes to the plan included the expansion of coverage options (employee, employee plus spouse, employee plus child or family).

The FY 07-08 Request of $877,922 is based on Common Policies and employees with coverage as of June 2006. The FY 07-08 Base Request reflects both an increase in rates paid by the State and participation by employees.

Line Item: Health, Life, and Dental	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**N/A**	**$362,296**	**$429,879**	**$476,625**	**$629,640**
Common Policy Adjustment	$0	$51,096	$46,746	$153,015	$248,282
POTS for Mental Health Administration (9.0 FTE)	$0	$16,487	$0	$0	$0
Long Bill Appropriation / Request	**$363,665**	**$429,879**	**$476,625**	**$629,640**	**$877,922**
HB 03-1316 (State Employee Total Compensation Modifications)	($1,369)	$0	$0	$0	$0
Final Appropriation / Request	**$362,296**	**$429,879**	**$476,625**	**$629,640**	**$877,922**
General Fund	$161,222	$196,262	$212,656	$272,418	$385,020
Cash Funds Exempt	$1,944	$2,247	$10,156	$11,294	$27,462[2]
Federal Funds	$199,130	$231,370	$253,813	$345,928	$465,440

[2] Of this amount, $11,659 is from the Children's Basic Health Plan Trust Fund, $10,214 is from the Health Care Expansion Fund, $1,863 is from the Autism Treatment fund and $3,726 is from the Primary Care Fund.

SHORT-TERM DISABILITY

This is one of the components of POTS expenditure that provides partial payment of an employee's salary in the event that an individual becomes disabled and cannot perform his or her work duties. It is calculated on a calendar year basis per the Common Policy instructions, page 7, issued August 1, 2006. The year-to-year estimated rate is set by the Department of Personnel and Administration. If the actual rate for the fiscal year differs substantially from the estimated rate, the Department of Personnel and Administration will submit a statewide Supplemental Request to adjust the appropriation.

The Budget Request for this line is computed per the Office of State Planning and Budgeting's budget instructions. A given rate by the Department of Personnel and Administration is used against the sum of base salaries, Salary Survey, range adjustments, and Performance-based Pay. Prior to FY 02-03, the Short-term Disability request was calculated using the same rate for the entire fiscal year. The final FY 02-03 appropriation, after incorporating adjustments from special legislation and the Supplemental Bill, was $11,697 total funds.

In FY 03-04, the Long Bill appropriated $16,770 for this line item reflecting Common Policy adjustments of $5,073. The Short-term Disability rate of 0.15% was provided in July by the Department of Personnel and Administration for the first six months of the fiscal year (calendar year 2004), and the rate of 0.16% was used for the last six months of FY 04-05 (calendar year 2005). The FY 04-05 Long Bill appropriated $18,843 after a Common Policy adjustment of $1,435 (an increase in the Personal Services line item results in a change to the Short-term Disability line, per a March 13, 2004 Figure Setting memorandum on technical changes, page 3), and an increase of $638 to account for the 9.0 Mental Health FTEs transferred to the Department. Incorporating a Common Policy rate of 0.16%, the FY 05-06 appropriation was $19,332. This amount now included personnel under the Medicaid Mental Health Community Programs, Program Administration line.

The FY 05-06 Long Bill amount for this appropriation was $19,332 which reflected a Common Policy adjustment of $489 over the prior year's final spending authority.

For FY 06-07, the Department's Base Request of $19,836 was based on Common Policy instructions issued by the Office of State Planning and Budgeting on July 15, 2005 and used a rate of 0.155%. However, this requested amount was adjusted during Figure Setting by the Joint Budget Committee and was ultimately appropriated in the FY 06-07 Long Bill at $14,888. This amount was based on a rate of 0.113% adopted during by the Joint Budget Committee during Figure Setting on March 3, 2006.

For FY 06-07 the Department submitted an Emergency 1331 Supplemental Budget Request on June 20, 2006 to fund the acquisition of needed Commercial Leased Space. At the time the Joint Budget Committee did not approve the request as they believed it did not meet the criteria for an Emergency 1331. However, the Committee approved the concept that the Department would proceed using funding from other appropriations, as allowed as a result of the Headnote lawsuit, until a regular Supplemental could be funded. This

space was temporarily funded through the Department's Health, Life, and Dental appropriation until the passage of the supplemental bill.

The FY 07-08 Base Request of $18,090 is based on Common Policy instructions from the Office of State Planning and Budgeting issued on August 1, 2006 and uses a rate of 0.113%.

Line Item: Short-term Disability	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**$11,697**	**$16,770**	**$18,843**	**$19,332**	**$14,888**
Common Policy Adjustment	$5,073	$1,435	$489	($4,444)	$3,202
POTS for Mental Health Administration (9.0 FTE)	$0	$638	$0	$0	$0
Final Appropriation / Request	**$16,770**	**$18,843**	**$19,332**	**$14,888**	**$18,090**
General Fund	$7,338	$8,494	$8,563	$6,173	$8,080
Cash Funds Exempt	$191	$193	$294	$458	$499[3]
Federal Funds	$9,241	$10,156	$10,475	$8,257	$9,511

SB 04-257 AMORTIZATION EQUALIZATION DISBURSEMENT

The Amortization Equalization Disbursement increases the employer contribution to the PERA Trust Fund to amortize the unfunded liability in the Trust Fund beginning in January 2006. The Budget Request for this line is computed per the Office of State Planning and Budgeting's budget instructions. The rate is provided by the Department of Personnel and Administration and is calculated using the sum of base salaries, Salary Survey and range adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The FY 05-06 Amortization Equalization Disbursement used a rate of 0.5% of payroll beginning January 1, 2006. This amount will remain at this level until January 1, 2007 when it is increased to 1%. The rate is projected to increase to 3% over seven years. Due to mid-year increases, for FY 06-07, the Amortization Equalization Disbursement was calculated using an effective rate of 0.75%. FY 06-07 will be the first full year this program will be in effect. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation, and includes all employees eligible for State retirement benefits. The table below summarizes this request.

[3]Of this amount, $379 is from the Children's Basic Health Plan Trust Fund, $96 is from the Health Care Expansion Fund and $24 is from the Autism Treatment Fund.

For the FY 07-08 Base Request, the Department used the rates provided by the Office of State Planning and Budgeting's Common Policy instructions dated August 1, 2006. The rates used to calculate the Request were 1.0% for July to December 2007, and 1.4% for the January to June 2008.

Line Item: Amortization Equalization Disbursement	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**N/A**	**$27,857**	**$96,544**
Common Policy Adjustment	$0	$68,687	$71,965
Final Appropriation / Request	**$27,857**	**$96,544**	**$168,509**
General Fund	$12,168	$38,697	$75,261
Cash Funds Exempt	$500	$3,043	$4,644[4]
Federal Funds	$15,189	$54,804	$88,604

SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. It is similar to the Amortization Equalization Disbursement discussed above; however, this item is considered "non-add" and is included here for informational purposes only. This amount is ultimately paid through the Salary Survey and Senior Executive Services line item, through a defined percentage of the employee's raise for each of the next six years.

The Budget Request for this line is computed per the Office of State Planning and Budgeting's budget instructions. The rate is provided by the Department of Personnel and Administration and is calculated using the sum of base salaries, Salary Survey and range adjustments. During the 2006 legislative session, the General Assembly passed SB 06-235 which included creation of the Supplemental Amortization Equalization Disbursement as a sub-line of the Salary Survey and Senior Executive Services line item in all departments to fund these expenses. The Supplemental Amortization Equalization Disbursement rate will be first implemented in FY 07-08 and will use a rate of 0.5% of payroll beginning January 1, 2008. This rate will increase by 0.5% per year, in each calendar year until 2013. Due to the mid-year creation of this line item, for FY 07-08 the Supplemental Amortization Equalization Disbursement will effectively be 0.25%. The Supplemental Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation, and includes all employees eligible for State retirement benefits.

[4] Of this amount, $3,528 is from the Children's Basic Health Plan Trust Fund, $896 is from the Health Care Expansion Fund and $220 is from the Autism Treatment Fund.

Line Item: Supplemental Amortization Equalization Disbursement	Total Funds	General Funds	Cash Funds Exempt	Federal Funds
FY 07-08 Base Request (non-add)	$35,107	$15,679	$968[5]	$18,460

SALARY SURVEY AND SENIOR EXECUTIVE SERVICE

The Salary Survey and Senior Executive Service appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the job and wage classification survey performed annually by the Department of Personnel and Administration.

Funding for this appropriation in FY 03-04 was initially determined based on the "FY 03-04 Annual Compensation Survey" from the Department of Personnel and Administration," and was appropriated in SB 03-258; however, this amount was later removed from the Department's budget with the passage of SB 03-273, resulting in a $0 appropriation.

The FY 04-05 Base Request was initially $235,928 for the Department and was based on the Common Policies adopted February 24, 2004; however, a late increase during the 2004 legislative session of $12,917 was made to include pay increases for the 9.0 mental health FTE transferred from the Department of Human Services, resulting in a final Long Bill appropriation of $248,845. This increase was equal to a 2.0% raise across all job classes for Department employees.

The FY 05-06 appropriation was computed according to the Office of State Planning and Budgeting's budget instructions and was appropriated through the Long Bill (SB 05-209) for $394,534 which equated to a 3.0% increase for all employees.

In the Common Policy instructions for FY 06-07, the State Personnel Director did not originally recommend the Department to funding salary survey increases, but rather requested only Performance-based Pay funding. This, however, was adjusted by the General Assembly during caucus sessions, and ultimately resulted in a Long Bill appropriation of $459,483 for the Department. The appropriation for FY 06-07 was based on tiered raises, with each occupational class receiving a different amount, ranging from 2.0% to 3.7% for employees within the Department (FY 06-07 Total Compensation Summary, July 1, 2006).

The FY 07-08 Base Request incorporates results of the "FY 07-08 Annual Compensation Survey" recommendation provided by the Department of Personnel and Administration (August 1, 2006) which reflects percentage adjustments by occupational group. Each employee title or class is matched to an occupational group for a percentage increase. This percentage is then multiplied by the

[5] Of this amount, $735 is from the Children's Basic Health Plan Trust Fund, $187 is from the Health Care Expansion Fund and $46 is from the Autism Treatment Fund.

employee's estimated salary as of June 2007 to come up with the Salary Survey amount. In the Department, most of the employees fall into the following occupational groups: financial services, administrative support and related, or professional services. There were a few FTE that were identified below the pay range minimum after the computation of salary survey. Those FTEs were adjusted to reflect the minimum compensation according to the Proposed Compensation Plan Pay Structure for FY 06-07. Applicable PERA and Medicare amounts are added into the Salary Survey calculations.

The FY 07-08 Base Request of $566,815 includes $35,107 to be used for the Supplemental Amortization Equalization Disbursement mentioned in the narrative above.

Line Item: Salary Survey and Senior Executive Services	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**N/A**	**$0**	**$248,845**	**$394,534**	**$459,483**
Common Policy Adjustment	$0	$235,928	$0	$64,949	$107,332
POTS for Mental Health Administration (9.0 FTE)	$0	$12,917	$0	$0	$0
Long Bill Appropriation	**$378,592**	$0	$0	$0	$0
SB 03-273 (State Employees' Salary Increase)	($378,592)	$0	$0	$0	$0
Joint Budget Committee Recommendation from January 2006, to increase all salaries by 3%	$0	$0	$145,689	$0	$0
Final Appropriation / Request	**$0**	**$248,845**	**$394,534**	**$459,483**	**$566,815**
General Fund	$0	$112,580	$172,506	$198,893	$254,461
Cash Funds Exempt	$0	$1,393	$8,260	$11,087	$15,628[6]
Federal Funds	$0	$134,872	$213,768	$249,503	$296,726

PERFORMANCE-BASED PAY

This line item replaced the Anniversary Increases budget line item in FY 02-03. Performance-based pay represents the annual amount appropriated for periodic salary increases for State employees based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work. According to the Department of Personnel and Administration, initial steps toward performance-based pay were taken as early as 1980 as published in Stateline Volume 21, Number 5, May, 2001. In 1996, HB 96-1262 was adopted that mandated a performance-based pay system be implemented by July 1, 2000. Subsequently, the Colorado Peak Performance System was developed in response to this legislation. Before Colorado Peak Performance could be implemented,

[6] Of this amount, $11,798 is from the Children's Basic Health Plan Trust Fund, $3,268 is from the Health Care Expansion Fund and $562 is from the Autism Treatment Fund

SB 00-211 repealed the law that created it, HB 96-1262. This legislation not only repealed the mandate, but also directed that a new plan be developed by September 1, 2000. The new plan was published and modified based upon feedback from State employees. The final plan was given to the Joint Budget Committee on August 31, 2000, as required by law. The new legislation mandated that performance management be effective July 2001. The law required the State Personnel Director to submit a plan to the Joint Budget Committee by September 1, 2000. The report submitted to the Joint Budget Committee in accordance with the law stated that payouts would occur on July 1, 2001. The Personnel Director subsequently delayed the payout date to July 1, 2002, due to the State's fiscal situation. However, the performance management component of the new system began on July 1, 2001.

In FY 03-04, no funding was appropriated due to statewide budget constraints. However, performance-based pay of $130,514 for FY 04-05 was calculated per the Department of Personnel and Administration Common Policy adjustment. A fund increase of $5,616 also occurred to transfer funds to the Department for the Mental Health 9.0 FTE, resulting in a total FY 04-05 appropriation of $136,130.

In FY 05-06, the Joint Budget Committee adopted a Common Policy of no performance-based pay awards for FY 05-06. For FY 06-07, with the passage of Referendum C, the State Personnel Director recommended funding for performance based pay at an average of 3.64% of base salaries. The General Assembly however, did not approve this recommendation, and instead allocated funds for this purpose to Salary Survey, therefore there was no performance-based pay for FY 06-07.

For FY 07-08 the Department's Request reflects the Common Policy instructions from the Office of State Planning and Budgeting, dated August 1, 2006 and uses a rate of 0.92% and is based on salaries including the occupational and market adjustment, and range minimum adjustment if applicable.

Line Item: Performance-Based Pay	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$0**	**$136,130**	**$0**	**$0**
Common Policy Adjustment	$130,514	$0	$0	$126,818
POTS for Mental Health Administration (9.0 FTE)	$5,616	$0	$0	$0
Joint Budget Committee Recommendation from January 2005	$0	($136,130)	$0	$0
Final Appropriation / Request	**$136,130**	**$0**	**$0**	**$126,818**
General Fund	$61,418	$0	$0	$56,613
Cash Funds Exempt	$795	$0	$0	$3,527[7]
Federal Funds	$73,917	$0	$0	$66,678

[7] Of this amount, $2,679 is from the Children's Basic Health Plan Trust Fund, $681 is from the Health Care Expansion Fund and $167 is from the Autism Treatment Fund

WORKERS' COMPENSATION

Workers' Compensation is a statewide allocation to each Department based upon historic usage. This line item provides funding for payments made to the Department of Personnel and Administration to support the State's self-insured program. The cost basis is developed relative to estimated claim payouts, purchased professional services (actuarial and broker costs), and Common Policy adjustments. The Department of Personnel and Administration's actuaries determine departmental allocations. In FY 03-04, the Long Bill appropriation allocated the Department $36,186 at 50% federal funds. The FY 04-05 appropriation was increased by $7,069 due to the Common Policy allocation issued August 8, 2003 by the Department of Personnel and Administration, and by $1,412 due to SB 05-112, the Department's FY 04-05 Supplemental Bill, which resulted in a total appropriation of $44,667. The final FY 05-06 appropriation reflected the Common Policy calculation by the Department of Personnel and Administration on August 9, 2004 which reflected a reduction of $14,366 over the previous year's appropriation for an allocated dollar amount of $30,301. Additionally, HB 06-1217 increased this appropriation by $9,103 for a final FY 05-06 appropriation of $39,404. For FY 06-07, the appropriation increased by $3,430 on March 15, 2006 during the Department of Personnel and Administration's Figure Setting. The FY 07-08 Base Request is the Department's allocated amount from the Department of Personnel and Administration in the amount of $44,831, and reflects a Common Policy adjustment of $1,997.

Line Item: Workers' Compensation	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$57,674**	**$36,186**	**$44,667**	**$39,404**	**$42,834**
Common Policy Adjustment	($21,488)	$7,069	($14,366)	$3,430	$1,997
Long Bill Appropriation / Request	**$36,186**	**$43,255**	**$30,301**	**$42,834**	**$44,831**
SB 05-112 (FY 04-05 Supplemental for Common Policies)	$0	$1,412	$0	$0	$0
HB 06-1217 (FY 05-06 Supplemental for Common Policies)	$0	$0	$9,103	$0	$0
Final Appropriation / Request	**$36,186**	**$44,667**	**$39,404**	**$42,834**	**$44,831**
General Fund	$18,093	$22,334	$19,702	$21,417	$22,416
Federal Funds	$18,093	$22,333	$19,702	$21,417	$22,415

OPERATING EXPENSES

In addition to funding office supplies and furniture costs associated with the Department's staff, this appropriation also supports a number of annual costs such as in and out-of-State travel, building maintenance and repairs, storage of records, telephone and postage costs for the Department's call center, subscriptions of federal publications, etc. For items such as telephones, computers, office furniture, and employee supplies, the Department requests funding in this appropriation using Common Policy amounts set by the Office of State Planning and Budgeting.

In FY 03-04, at the Department's request, the Joint Budget Committee merged all operating budgets within the Department into one appropriation. This action placed five separate operating budgets into one titled Operating Expenses under the Executive Director's Office Long Bill group. Therefore, the FY 03-04 Long Bill (SB 03-258) appropriated $954,308 for FY 03-04. This amount was later revised by two partially offsetting Supplemental Bills, HB 04-1320 and the Add-ons section of HB 04-1422, which increased the appropriation by $1,727 and decreased it later by $2,532, respectively. In addition, there were four Special Bills during the 2003 and 2004 legislative sessions that altered funding in this appropriation, including SB 03-011, SB 03-259, SB 03-266, and SB 04-138. The net result of all legislation mentioned above resulted in a final FY 03-04 appropriation of $965,755.

The final FY 04-05 and FY 05-06 appropriations resulted in total funding of $935,976 and $1,115,801, respectively.

The FY 06-07 appropriation of $1,020,609 is the sum of the Long Bill appropriation of $1,002,013, plus various Special Bills including: HB 06-1270 public school eligibility determinations for medical benefits; SB 06-128 concerning services for the disabled; SB 06-165 concerning efforts for a telemedicine pilot project; and SB 06-219 the Department's re-organization bill. The FY 07-08 Base Request removes one-time funding for these same programs, for items such as computers and office equipment.

The Department's FY 06-07 estimate differs from the Long Bill appropriation due to the approval of the Department's September 20, 2006 1331 Emergency Supplemental for permanent staff to work on medical cases exceeding processing guidelines and rollforwards from the prior year. The two rollforwards are for furniture purchases that were ordered, but not delivered to the Department in FY 05-06.

Line Item: Operating Expenses	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$965,755**	**$935,976**	**$1,115,801**	**$1,020,609**
Statewide Common Policy for Truth in Telecommunication Rates (NP-2, November 3, 2003)	($674)	$0	$0	$0
Joint Budget Committee action to reduce funding in this appropriation to support new line item called Web Portal Maintenance (Figure Setting March 9, 2004, pages 26-27)	($2,000)	$0	$0	$0
Removal of one-time funding for new FTE in FY 03-04 associated with the Colorado Benefits Management System (DI-4, November 1, 2002)	($2,610)	$0	$0	$0

Line Item: Operating Expenses	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Removal of one-time funding for FTE associated with the Early and Periodic Screening, Diagnosis and Treatment program	($16,400)	$0	$0	$0
Removal of one-time funding for FTE for Hearing and Orthodontia	($3,280)	$0	$0	$0
Removal of one-time funding for FTE appropriated per SB 03-011	($3,184)	$0	$0	$0
Removal of one-time funding for FTE appropriated per SB 03-259	($3,280)	$0	$0	$0
Removal of one-time funding for FTE appropriated per SB 03-266	($653)	$0	$0	$0
Removal of prior year 1331 Emergency Supplemental for costs associated with FTE administering the Children's Basic Health Plan	($1,727)	$0	$0	$0
Reinstate FY 03-04 reduction from SB 04-138	$1,889	$0	$0	$0
Funding associated with FTE appropriated per SB 03-266	$2,532	$0	$0	$0
Joint Budget Committee adjustment (Memo, March 15, 2004, page 5)	($1,421)	$0	$0	$0
Funding for FTE appropriated per SB 04-177 (Children with Autism Bill)	$0	$4,739	$0	$0
Removal of one-time funding for FTE appropriated per HB 04-1219	$0	($949)	$0	$0
Funding associated with FTE for Payment Error Rate Measurement Project (BA-6, January 24, 2005)	$0	$4,149	$0	$0
Joint Budget Committee action for additional funds related to Medicare Modernization Act implementation (Figure Setting, March 15, 2005, page 28)	$0	$115,294	$0	$0
Joint Budget Committee action to move HIPAA Security Rule on-going maintenance to this appropriation (Figure Setting, March 15, 2005, page 28)	$0	$11,290	$0	$0
Removal of funding from HB 05-1262, as this bill was not passed until after the FY 05-06 Long Bill, and was not annualized through this process (FY 06-07 amount is part of $138,903 reduction in Figure Setting, March 15, 2006)	$0	($238)	($22,221)	$0
Remove one-time funding for Medicare Modernization Act implementation (part of $138,903 reduction in Figure Setting, March 15, 2006)	$0	$0	($113,394)	$0
Removal of one-time funding for FTE appropriated per HB 05-1243 (part of $138,903 reduction in Figure Setting, March 15, 2006)	$0	$0	($3,288)	$0
Removal of one-time funding due to the Colorado Benefits Management System court order (action happened after March 15, 2006 Figure Setting)	$0	$0	($6,360)	$0
Annualization of Request to delay FTE associated with the Payment Error Rate Measurement Project (BA-6, January 3, 2006)	$0	$0	$3,657	($2,788)

Line Item: Operating Expenses	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Annualization of Request for FTE to assist in changing timing of certification of public expenditures (BA-2, January 3, 2006)	$0	$0	($2,635)	$0
Annualization of Request for FTE to assist in establishing an Old Age Pension Drug Rebate Program (BA-4, January 3, 2006)	$0	$0	($4)	$0
Joint Budget Committee action to transfer funds for FTE from Primary Care Fund line to Operating Expenses (Figure Setting, March 13, 2006, page 32)	$0	$0	$620	$0
Joint Budget Committee action to increase operating funds for Joint Budget Committee action to add 5.7 FTE (Figure Setting, March 13, 2006, page 32)	$0	$0	$22,088	$0
Funding for implementation of Drug Rebate Analysis and Management System, as requested (BRI-4, November 15, 2005)	$0	$0	$7,749	($6,010)
Removal of one-time funding for FTE appropriated per HB 06-1270	$0	$0	$0	($9,006)
Removal of one-time funding for FTE appropriated per SB 06-128	$0	$0	$0	($2,975)
Removal of one-time funding for FTE appropriated per SB 06-165	$0	$0	$0	($3,005)
Adjustment to FY 07-08 Base to reflect actual federal funds reimbursement for Public School Health Services administration (corresponds to a like reduction to the SB 97-101 Public School Health Services appropriation)	$0	$0	$0	$972
Long Bill Appropriation / Request	**$934,947**	**$1,070,261**	**$1,002,013**	**$997,797**
HB 04-1219, Community Transition Services for Home and Community Based Services	$2,256	$0	$0	$0
SB 04-138, Repeal of the Authority to charge Monthly Fee to Families Whose Children are Enrolled in Home-and Community Based Services	($7,555)	$0	$0	$0
SB 05-112, Move Mental Health Administrative funding to EDO Operating Expense. Funding is for 7.0 FTE at $870 per person	$6,090	$0	$0	$0
HB 05-1262, Operating Expenses associated with 5.1 FTE, and 7 network connections, to implement tobacco tax legislation	$238	$27,446	$0	$0
HB 05-1243, Consumer Directed Care, expenses for 0.5 FTE to write waiver, assess Medicaid Management Information System and monitor case management agencies	$0	$3,762	$0	$0
HB 05-1066, Expenses for 0.5 FTE to manage obesity treatment pilot program	$0	$3,988	$0	$0

Line Item: Operating Expenses	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
HB 06-1217, Payment Error Rate Measurement Project, remove funding due to delay in implementation; operating for temporary staff for emergency call center associated with Colorado Benefits Management System court order; operating for Accountant II to coordinate Old Age Pension drug rebate program; operating for Accountant II to coordinate change in timing of Upper Payment Limit	$0	$9,594	$0	$0
HB 06-1385 Add-ons, Removal of $3,988 for obesity pilot program as no gifts, grants or donations were received, plus an increase of $4,738 to correct errors in the original appropriation clause for HB 05-1262	$0	$750	$0	$0
HB 06-1270, School Eligibility Determinations	$0	$0	$9,876	$0
SB 06-128, Care for People with Disabilities Pilot Program	$0	$0	$3,845	$0
SB 06-165, Telemedicine Pilot Program	$0	$0	$3,875	$0
SB 06-219, Department of Health Care Policy and Financing Re-organization	$0	$0	$1,000	$0
Final Appropriation / Request	**$935,976**	**$1,115,801**	**$1,020,609**	**$997,797**
General Fund	$462,319	$521,585	$493,252	$482,848
Cash Funds Exempt	$928	$28,465	$14,393	$12,905[8]
Federal Funds	$472,729	$565,751	$512,964	$502,044

LEGAL SERVICES AND THIRD PARTY RECOVERY LEGAL SERVICES

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

The FY 03-04 appropriation was $814,768, a continuance of 13,403 legal services hours at the blended hourly rate of $60.79 per hour (per FY 03-04 Figure Setting, March 2003, page 44). A continuation base of 13,403 hours at the $60.79 allowable blended

[8] Of this amount, $701 is from the Children's Basic Health Plan Trust Fund, $4,365 is from the Health Care Expansion Fund, $63 is from the Breast and Cervical Cancer Treatment Fund, $3,876 is from the Old Age Pension Fund, $620 is from the Primary Care Fund, $435 is from the Coordinated Care for People with disabilities Fund, $475 is from a transfer from the Department of Public Health and Environment, and $2,370 is from the Autism Treatment Fund

attorney/paralegal hourly rate was requested for FY 04-05. During the 2004 Figure Setting process, final legal service rates for FY 04-05 were established at $61.57 per hour for 12,684 legal hours, resulting in a total appropriated amount of $780,953.

The FY 05-06 appropriation used a blended attorney/paralegal rate of $64.45 per hour for 12,684 hours for a total appropriation of $817,483. The FY 06-07 appropriation used the blended attorney/paralegal rate of $67.77 per hour established during Figure Setting for the Department of Law on March 15, 2006. The FY 06-07 appropriation was still based on 12,684 hours of usage; therefore the FY 06-07 appropriation totaled $859,595.

The FY 07-08 Base Request is for continued funding for 12,684 hours at the blended rate of $67.77, for total funding of $859,595. Of this, $348,589 is General Fund, $72,375 Cash Funds, $5,945 Cash Funds Exempt, and $432,686 is federal funds.

Line Item: Legal Services and Third Party Recovery Legal Services	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$814,768**	**$814,768**	**$780,953**	**$817,483**	**$859,595**
Common Policy Adjustment	$0	($33,815)	$36,530	$42,112	$0
Final Long Bill Appropriation / Request	**$814,768**	**$780,953**	**$817,483**	**$859,595**	**$859,595**
General Fund	$334,740	$316,901	$331,724	$348,589	$348,589
Cash Funds	$65,003	$65,849	$68,929	$72,375	$72,375
Cash Funds Exempt	$5,349	$5,409	$5,662	$5,945	$5,945[9]
Federal Funds	$409,676	$392,794	$411,168	$432,686	$432,686

ADMINISTRATIVE LAW JUDGE SERVICES

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

[9] Of this amount, $5,945 is from the Children's Basic Health Plan Trust Fund.

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

For FY 04-05, during Common Policy Figure Setting (March 11, 2004, page 2), it was determined the annual total costs for the Administrative Law Judge Services were higher than the Department of Personnel and Administration had requested. As a result, the Department's allocation was increased in the FY 04-05 Long Bill for an appropriation of $676,943 in HB 04-1422. This amount was later decreased by $67,300 through a Supplemental Common Policy adjustment contained in SB 05-112 to $609,643.

The FY 05-06 appropriation was increased to $674,931 through a Common Policy adjustment and was based on the FY 05-06 Department's Administrative Law Judge Services allocation released on August 9, 2004 by the Department of Personnel and Administration. It was based on FY 03-04 actual utilization, which equaled 17.48% of the total usage of Administrative Law Judge Services (the Department's FY 03-04 usage divided by total FY 03-04 usage). However, HB 06-1217, the Department's FY 05-06 Supplemental Bill reduced this appropriation to $505,921 due to the latest projections regarding proportional usage.

For FY 06-07, the Department's appropriation is $540,855, which reflected an increase of $34,934 due to Common Policy allocations issued March 15, 2006.

The FY 07-08 Base Request of $398,743 (or 9.53% of the total usage) reflects amounts calculated by the Department of Personnel and Administration through Common Policies. Below is a summary of the last four year's appropriations and the FY 07-08 Base Request by fund split.

Line Item: Administrative Law Judge Services	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$536,986**	**$660,591**	**$609,643**	**$505,921**	**$540,855**
Common Policy Adjustment	$2,143	$16,352	$65,288	$34,934	($146,278)
Annualization of HB 06-1270	$0	$0	$0	$0	$4,166

Line Item: Administrative Law Judge Services	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Long Bill Appropriation / Request	**$539,129**	**$676,943**	**$674,931**	**$540,855**	**$398,743**
Supplemental SB 03-203	$0	$0	$0	$0	$0
Supplemental HB 04-1320	$121,462	$0	$0	$0	$0
Supplemental SB 05-112	$0	($67,300)	$0	$0	$0
Supplemental HB 06-1217	$0	$0	($169,010)	$0	$0
Final Appropriation / Request	**$660,591**	**$609,643**	**$505,921**	**$540,855**	**$398,743**
General Fund	$330,296	$304,822	$252,961	$270,428	$199,372
Federal Funds	$330,295	$304,821	$252,960	$270,427	$199,371

PURCHASES OF SERVICES FROM COMPUTER CENTER

This appropriation represents funding for the Department's use of centralized computer services. The Department of Personnel and Administration operates a computer center as a service to other departments in State government. This computer center, formerly known as the General Government Computer Center, has the Medicaid Management Information System computer and printing costs and Long-term Care computer and printing costs. The total need to fund the General Government Computer Center is multiplied by a prior year's usage ratio for each State department. The Department of Personnel and Administration and the Office of State Planning and Budgeting calculate and communicate these allocations through the Common Policies' instructions.

In the past, a portion of General Government Computer Center costs were billed directly to the Department. The balance was paid on behalf of the Department of Health Care Policy and Financing by the Department of Human Services through an Interagency Agreement for the Client Oriented Information Network. The Cash Funds Exempt portion of the funding is from the Old Age Pension Fund (not to be confused with Old Age Pension Health and Medical Fund).

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

For FY 04-05, in addition to renaming this line item to "Purchases of Services from Computer Center," HB 04-1422 (the FY 04-05 Long Bill) appropriated $296,415 to the Department. This FY 04-05 appropriated amount continued to include funding to pay for the

old Client Oriented Information Network since the exact implementation date for the new Colorado Benefits Management System was unknown when the FY 04-05 budget was prepared. This appropriation was however reduced by $133,467 later in the year, through a Common Policy adjustment included in the Department's FY 04-05 Supplemental Bill (SB 05-112), bringing the final appropriation to $162,948.

For FY 05-06, the Department was appropriated $156,311 based on Common Policies developed by the Department of Personnel and Administration. This appropriation was later reduced to $93,436 through a Common Policy adjustment based on the latest available usage data and approved during the Joint Budget Committee's Supplemental meeting on January 20, 2006. For FY 06-07, the appropriation of $94,815 total funding calculated by the Department of Personnel and Administration and approved during Figure Setting on March 15, 2006 was the share for the Department's portion of these costs.

For FY 07-08, the Department's Base Request reflects a significant reduction to this line. The reason for this reduction is due to the fact that the amount of billing for FY 07-08 is based on actual usage from FY 05-06, when the Department's utilization of the Client Oriented Information Network first ended. Therefore, the FY 07-08 Base Request is for this line is only $19,310.

Please note that because of the significant reduction in allocated central computer services beginning in FY 07-08, the Department has revised its need of Cash Funds Exempt funding from the Old Age Pension Fund. The FY 07-08 Old Age Pension Fund amount was reduced using a two-year average of the ratio between Cash Funds Exempt to total funds for FY 05-06 and FY 06-07 ($3,337 = $16,235/(($93,436+$94,815)/2)). Therefore, the Department will require only $3,337 from the Old Age Pension Fund. Additionally, the Department has corrected the amount of federal match for this appropriation in this Base Request. Since a portion of this money is to support centralize computer functions associated with the Old Age Pension State Medical Program, which is a 100% State only program, no federal funding should be drawn on this State funding. All changes were made as part of the FY 07-08 Base Request as this line item is set through Common Policies, and only in total funds. Each department is responsible for determining the appropriate funding splits.

Line Item: Purchases of Services from Computer Center	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation / Request	**N/A**	**$259,342**	**$162,948**	**$93,436**	**$94,815**
Common Policy Adjustment	$0	$37,073	($6,637)	$1,379	($75,505)
Long Bill Appropriation / Request	**$228,468**	**$296,415**	**$156,311**	**$94,815**	**$19,310**
HB 04-1320 Supplemental Adjustment	$30,874	$0	$0	$0	$0
SB 05-112 Supplemental Adjustment	$0	($133,467)	$0	$0	$0
HB 06-1217 Supplemental Adjustment	$0	$0	($62,875)	$0	$0

Line Item: Purchases of Services from Computer Center	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Final Appropriation / Request	**$259,342**	**$162,948**	**$93,436**	**$94,815**	**$19,310**
General Fund	$113,436	$65,239	$30,483	$31,173	$7,986
Cash Funds Exempt	$16,235	$16,235	$16,235	$16,235	$3,337
Federal Funds	$129,671	$81,474	$46,718	$47,407	$7,987

PAYMENTS TO RISK MANAGEMENT AND PROPERTY FUNDS

Payment to Risk Management and Property Funds is an allocation appropriated to each department based on a shared statewide risk formula for two programs, the Liability Program and the Property Program. The Department does not participate in the Property Program; therefore this appropriation is for the Liability Program only. The FY 03-04 Long Bill, SB 03-258, appropriated $78,312 to the Department. HB 04-1422, the FY 04-05 Long Bill, appropriated $67,493; however the Department of Personnel and Administration issued a Supplemental Common Policy adjustment to reduce this funding by $8,698 (SB 05-112). The FY 05-06 appropriation was $63,618. Another Supplemental Common Policy adjustment reduced this appropriation to $21,976 due to modifications to the State's reserve funding levels. For FY 06-07, the appropriation was increased to $58,143 with the passage of HB 06-1385.

The FY 07-08 Base Request is $78,288 and is based on Common Policies issued on August 16, 2006 by the Department of Personnel and Administration.

Line Item: Payment to Risk Management and Property Funds	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$75,733**	**$78,312**	**$58,795**	**$21,976**	**$58,143**
Common Policy Adjustment	$2,579	($10,819)	$4,823	$36,167	$20,145
Long Bill Appropriation / Request	**$78,312**	**$67,493**	**$63,618**	**$58,143**	**$78,288**
Supplemental SB 05-112	$0	($8,698)	$0	$0	$0
Supplemental HB 06-1217	$0	$0	($41,642)	$0	$0
Final Appropriation / Request	**$78,312**	**$58,795**	**$21,976**	**$58,143**	**$78,288**
General Fund	$39,156	$29,398	$10,988	$29,072	$39,144
Federal Funds	$39,156	$29,397	$10,988	$29,071	$39,144

CAPITOL COMPLEX LEASED SPACE

Capitol Complex Leased Space is appropriated based on usable square footage utilized by each State department. Currently, for the Department of Health Care Policy and Financing, this includes 31,512 square feet of space at 1570 Grant Street.

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

In FY 04-05, there was a Common Policy adjustment increase of $14,677 which resulted in a total appropriation of $285,179 for 27,661 square feet at $10.31 per square foot. This amount was increased further due to a Common Policy technical adjustment generated by the Department of Personnel and Administration (Supplemental NP-S3, January 3, 2005). This increase of $54,000 was reflected in the Department's FY 04-05 Supplemental Bill (SB 05-112) for a final appropriation of $339,179.

The FY 05-06 appropriation was based on the "FY 05-06 Recommendations for Capitol Complex Leased Space by Agencies" report released by the Department of Personnel and Administration on August 9, 2004. The request totaled $276,498 for the Department and was based on 27,661 square feet times $10 per square foot. Due to rounding in the Department of Personnel and Administration's calculations, there is a $112 difference between the Department's Request and the actual calculation. This amount was increased by $62,881 through a Common Policy Budget amendment submitted by the Office of State Planning and Budgeting, and then reduced by $2,722 through Common Policy adjustments made by the Department of Personnel and Administration. The sum of these adjustments led to the final FY 05-06 Long Bill appropriation of $336,457. However, HB 06-1217, the Department's FY 05-06 Supplemental Bill, later reduced the appropriation for Common Policy adjustments by an additional $3,542, for a final appropriation of $332,915.

For FY 06-07, the Department's Base Request of $341,249 was based on the Common Policy allocation developed by the Department of Personnel and Administration issued August 8, 2005. It was calculated by multiplying the Department's useable square feet of 31,512 times $10.83 per square foot (due to rounding the amounts do not match). The Department's useable square feet increased during FY 05-06 due to a change in the calculation method used by the Department of Personnel and Administration. However, a Common Policy adjustment late in Figure Setting adjusted this appropriation by $2,773, for a final FY 06-07 Long Bill appropriation to the Department equal to $344,022.

The Department's FY 07-08 Base Request of $361,021 is based on the Common Policy allocation developed by the Department of Personnel and Administration issued August 16, 2006. This allocation uses the same square footage as used for FY 06-07; however, the cost per square foot charged by the Department of Personnel and Administration has increased to $11.46 per useable square foot.

Line Item: Capitol Complex Leased Space	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**N/A**	**$270,502**	**$339,179**	**$332,915**	**$344,022**
Common Policy Adjustment	$0	$14,677	($2,722)	$11,107	$16,999
Long Bill Appropriation / Request	**$308,468**	**$285,179**	**$336,457**	**$344,022**	**$361,021**
SB 03-203 Supplemental Adjustment	$0	$0	$0	$0	$0
HB 04-1320 Supplemental Adjustment	($37,966)	$0	$0	$0	$0
SB 05-112 Supplemental Adjustment FY 04-05	$0	$54,000	$0	$0	$0
HB 06-1217 FY 05-06 Supplemental Adjustment	$0	$0	($3,542)	$0	$0
Final Appropriation / Request	**$270,502**	**$339,179**	**$332,915**	**$344,022**	**$361,021**
General Fund	$135,251	$169,590	$166,458	$172,011	$180,511
Federal Funds	$135,251	$169,589	$166,457	$172,011	$180,510
Base Request[10]	**$308,468**	**$285,179**	**$276,498**	**$341,249**	**$361,021**

COMMERCIAL LEASED SPACE

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

In late FY 02-03, after other funding had been appropriated, the Department moved into new space at 1570 Grant Street. Once the Department moved into the new building, workspace was found for the new program staff within the appropriated Capitol Complex Leased Space at no additional cost. Therefore, the Department did not pursue the rental of commercial leased space. Supplemental Request S-8 was submitted on January 2, 2004 to return the appropriation, and was approved by the Joint Budget Committee.

[10] Due to Rounding of the Rate per square foot, the calculated numbers will not match.

Funding in FY 03-04 was reduced to $0 via Supplemental Bill HB 04-1320. For FY 04-05 there was no appropriation for this line item.

Due to the effects of the Medicare Modernization Act of 2003, the Department required additional staffing and associated space to house employees. Therefore, for FY 05-06, the legislature appropriated $36,278 with 50% federal match through the Long Bill (SB 05-209) to house 15 temporary staff working on the Medicare Modernization Act of 2003 implementation. The Tobacco Tax Bill (HB 05-1262) further increased this funding by $9,548 to provide 434 square feet of work space for employees. Additionally, the appropriation included additional funding associated with two 1331 Emergency Supplementals: 1) $4,400 authorized by the State Controller Office on June 21, 2005 to provide space for the additional FTE contained in the bill; and, 2) $24,955 is to house temporary staff working at the Colorado Benefits Management System emergency call center which is court ordered and authorized by the State Controller Office on September 20, 2005. These two 1331's were officially appropriated via the passage of HB 06-1385 (in the Add-on section) and HB 06-1217, the Department's FY 05-06 Supplemental Bill. The total FY 05-06 appropriation was for $75,181.

For FY 06-07, the Department's total appropriation is $49,510. This amount incorporated the removal of one-time funding for implementing the Medicare Modernization Act of 2003 and temporary funding associated with the emergency call center equal to $36,278 and $24,955, respectively. Additionally, this amount was also reduced by $2,948 due to the out-year effects of the tobacco tax implementation. However, the Long Bill appropriation did include new funds based on the approval of a Department request to acquire space at 225 E. 16th Street. This Stand Alone Budget Amendment was heard by the Joint Budget Committee on January 24, 2006, and provided an additional $38,510.

In addition to the official appropriation in the FY 06-07 Long Bill, on September 20, 2006, a Joint Budget Committee action added $8,580 for Commercial Leased Space to the Department's Emergency 1331 Supplemental Request for a new Exceeds Processing Guidelines unit. This amount increases the Department's FY 06-07 spending authority, but does not increase the appropriated funds, until it is written into an official piece of legislation.

The FY 07-08 Base Request is for continuation funding of the FY 06-07 Long Bill, equal to $49,510. A Change Request has been submitted for this line item.

Line Item: Commercial Leased Space	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$0**	**$75,181**	**$49,510**
Removal of one-time funding for implementation of the Medicare Modernization Act	$0	($36,278)	$0
Removal of one-time funding for implementation of HB 05-1262	$0	($2,948)	$0
Removal of one-time funding for the emergency call center per the CBMS Court Order	$0	($24,955)	$0
Funding for new space at 225 E. 16th Avenue (January 24, 2006, BA-8)	$0	$38,510	$0
Long Bill Appropriation / Request	**$36,278**	**$49,510**	**$49,510**
HB 05-1262 – One-time funding for implementation of the tobacco tax bill	$9,548	$0	$0
HB 06-1217 – One-time funding for emergency call center	$24,955	$0	$0
HB 06-1385 Add-ons – Adjustment to Emergency Supplemental funding for HB 05-1262	$4,400	$0	$0
Final Appropriation / Request	**$75,181**	**$49,510**	**$49,510**
General Fund	$18,139	$19,255	$19,255
Cash Funds Exempt	$31,929	$5,500	$5,500[11]
Federal Funds	$25,113	$24,755	$24,755

TRANSFER TO THE DEPARTMENT OF HUMAN SERVICES FOR RELATED ADMINISTRATION

The Department of Health Care Policy and Financing has an Interagency Agreement with the Department of Human Services to support 1.0 FTE to staff the Information Technology Help Desk for the Baby Care/Kids Care Program. In FY 02-03, Decision Item #11 was approved to transfer 3.0 FTE from the Department of Human Services to the Department of Health Care Policy and Financing. This request was cost neutral and was in response to the June 2001 State Auditor's Office audit which recommended improvements in the management of Medicaid long term care community clients involved in the Single Entry Point system. Effective July 1, 2002, 1.0 FTE remains at the Department of Human Services, staffing the Information Technology Help Desk for the Baby Care/Kids Care Program. The FY 03-04 Long Bill, SB 03-258, appropriated $58,303 for this line item. The FY 04-05 request (November 3, 2003) was initially $58,303. However, in March 2004, the Department of Human Services unofficially requested an additional $16,261 to accommodate salary and POTS increases. The FY 04-05 Long Bill, HB 04-1422, appropriated $74,564 for this line item. This amount remained the same for FY 05-06 and FY 06-07. Continuation funding of $74,564 was requested for FY 07-08.

[11] Of this amount, $5,500 is from the Health Care Expansion Fund.

Line Item: Transfer to the Department of Human Services for Related Administration	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Appropriation	**$58,303**	**$74,564**	**$74,564**	**$74,564**
FY 02-03 Decision Item #11 to transfer 3.0 FTE	$0	$0	$0	$0
Department of Humans Services request for increase in Salary and POTS	$16,261	$0	$0	$0
Long Bill Appropriation / Request	**$74,564**	**$74,564**	**$74,564**	**$74,564**
Final Appropriation / Request	**$74,564**	**$74,564**	**$74,564**	**$74,564**
General Fund	$37,282	$37,282	$37,282	$37,282
Federal Funds	$37,282	$37,282	$37,282	$37,282

Inquiries related to the FY 07-08 Base Request for this FTE should be directed to the Department of Human Services. The corresponding appropriation in the Department of Human Services budget can be found under Office of Information Technology Services, Personal Services.

MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT

The Medicaid Management Information System is nationally recognized as an automated claim, capitation processing and reporting system. In Colorado, the Medicaid Management Information System processes or adjudicates claims and capitations based on edits that determine payment or payment denial. Warrants are produced by the State based on the information electronically transmitted from the Medicaid Management Information System.

The State must competitively bid the role of the State's fiscal agent for the operations of the Medicaid Management Information System once every three years. The only exception to this rule is if the State would wish to exercise its right to grant extensions of the contract, which are allowed on a year-by-year basis, up to five years in total. The Department has contracted with Affiliated Computer Services (formerly Consultec, Inc.) to perform as the State's fiscal agent since December 1, 1998, and has now exercised every optional one-year extension allowable under federal regulations, to extend the current contract through November 31, 2006. However, due to work related to reprocurement activities progressing slower than originally anticipated, the Department requested and received approval from the Centers for Medicare and Medicaid Services for an extension of the current contract to July 1, 2007. For more information on the reprocurement process, refer to the narrative for (1) Executive Director's Office, MMIS Reprocurement.

The Medicaid Management Information System Contract line item covers costs for running claims through the processing system and for certain administrative functions contracted to the fiscal agent. The dollars paid to providers of health services are appropriated separately in the Medical Services Premiums Long Bill group. Monies for the claims processing include:

- General Fund for regular Medicaid claims;
- Cash Funds Exempt for Old Age Pension State Medical Program claims;
- Cash Funds Exempt for Breast and Cervical Cancer Prevention and Treatment claims with funds from the Tobacco Litigation Settlement Fund;
- Nurse Home Visitor Program claims (as Cash Funds Exempt transferred from the Department of Public Health and Environment which are from the Tobacco Litigation Settlement Fund);
- Children's Basic Health Plan funding as Cash Funds Exempt to assist in support of the fixed price contract;
- Cash Funds Exempt from the Colorado Autism Treatment Fund;
- Cash Funds Exempt from the Health Care Expansion Fund authorized by HB 05-1262; and,
- Matching federal funds.

Claims processing expenditures for School Health claims are funded with 100% federal funds that are matched with certified local public expenditures. Postage expenditures reflect 50% General Fund and 50% federal funds. Pharmacy prior authorization reviews are approved for 50% federal financial participation with the State match from General Fund, but with Cash Funds Exempt for the expanded programs funded by the Health Care Expansion Fund. Programming changes, or "Development Costs," are funded at either 75% federal financial participation or 90% federal financial participation if approved by the federal Centers for Medicare and Medicaid Services. The Drug Rebate Analysis and Management System (DRAMS) was added in FY 06-07 with 25% General Fund and 75% federal funds.

Beginning March 1, 2004, the Medicaid Management Information System contract was converted to a fixed price contract. For one fixed amount, the contract covers all claims processing, provider enrollment and notification, as well as most prior authorization reviews and system changes. Items that were not included in fixed price include: postage costs, review of specifically identified pharmacy prescriptions and development costs.

The Tobacco Tax Bill, HB 05-1262, contributed a significant amount of funding to the Medicaid Management Information System Contract. A portion of this funding in FY 05-06 was for one-time development costs and other one-time purchases including additional centralized processing unit disk space for the Decision Support System. The funding authorized by HB 05-1262 was annualized in FY 06-07 and will be ongoing.

Line Item: Medicaid Management Information System	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Appropriation	**$18,961,320**	**$21,983,967**	**$23,032,048**	**$23,185,837**
Remove development costs for change client copays	($85,000)	$0	$0	$0
Remove development costs for mail order prescriptions	($12,500)	$0	$0	$0
Remove development costs for consumer directed care for the elderly	($110,112)	$0	$0	$0
SB 03-011 annualization of generic drug prior authorization review	$521,223	$0	$0	$0
SB 03-294 annualization of drug prior authorization review	$6,075	$0	$0	$0
Annualization of federal mandate for managed care	$10,022	$0	$0	$0
Remove balance of funding for therapeutic counseling program	($478,700)	$0	$0	$0
Remove funding to support new line called Health Insurance Portability and Accountability Act of 1996 (HIPAA) Web Portal Implementation - JBC Recommendation	($160,000)	$0	$0	$0
HB 04-1422 to remediate the Medicaid Management Information System (BAS-1, January 23, 2004)	$1,414,344	$0	$0	$0
HB 04-1422 add maintenance for Decision Support System (BAS-1, January 23, 2004)	$196,326	$0	$0	$0
Remove one-time funding for bulletin board service in FY 04-05	$0	($14,357)	$0	$0
Remove development costs for updates to drug prior authorization reviews	$0	($20,000)	$0	$0
SB 04-177 claims processing for children with autism	$0	$3,098	$0	$0
SB 04-177 prior authorization reviews for children with autism	$0	$2,220	$0	$0
SB 04-177 development costs for children with autism	$0	$122,500	$0	$0
HB 04-1219 annualize claims processing for community transition services for the elderly, blind, and disabled	$0	$76	$0	$0
HB 04-1219 development costs for community transition services for the elderly, blind, and disabled	$0	$75,000	$0	$0
Adjust school based health claims requested in Supplemental Request #S-4, submitted January 3, 2005	$0	$8,073	$0	$0

Line Item: Medicaid Management Information System	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Adjust old age pension claims as requested in Supplemental Request #S-4, Submitted January 3, 2005	$0	($48,886)	$0	$0
Add funding for non-specified claims in fixed price agreement (S-4, January 3, 2005)	$0	$780,884	$0	$0
JBC action to add $244 to make up for shorted funding in Supplemental Bill SB 05-112	$0	$244	$0	$0
JBC action to reduce prior authorization review funding due to the Medicare Modernization Act	$0	($272,761)	$0	$0
JBC action to add one-time funding for development costs for the Medicare Modernization Act	$0	$73,279	$0	$0
HB 05-1015 one-time development costs for substance abuse treatment (also in Long Bill)	$0	$44,450	$0	$0
Remove One-Time Funding for delayed HIPAA Billing	$0	($469,740)	$0	$0
Annualize funding for Tobacco Tax Bill authorized by HB 05-1262	$0	$0	$319,717	$0
Remove one-time development costs for children with autism authorized by SB 04-177	$0	$0	($122,500)	$0
Remove development costs for community transitions for elderly, blind, and disabled authorized by HB 04-1219	$0	$0	($75,000)	$0
Remove one-time development costs for Medicare Modernization Act funded by JBC recommendation	$0	$0	($73,279)	$0
Remove one-time development costs for substance abuse treatment authorized by HB 05-1015	$0	$0	($44,450)	$0
Remove one-time development costs for Consumer Directed Care authorized by HB 05-1243	$0	$0	($170,688)	$0
Remove one-time development costs for asset test removal for health care expansion population	$0	$0	($34,925)	$0
Annualize reduction of drug prior authorization reviews due to Medicare Modernization Act (S-6, January 3, 2006)	$0	$0	($204,570)	$0
Adjust Children's Basic Health Plan funding for fixed price (assumed 50% federal funds rather than 65%)	$0	$0	$11,589	$0

Line Item: Medicaid Management Information System	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Drug Rebate Analysis and Management System (DRAMS) (BRI-4, November 15, 2005)	$0	$0	$375,000	$0
Annualize Drug Rebate Analysis and Management System (DRAMS) (BRI-4, November 15, 2005)	$0	$0	$0	($75,000)
Remove one-time development costs for residential child health care HB 06-1395	$0	$0	$0	($46,336)
Remove one-time development costs for services for people with disabilities SB 06-128	$0	$0	$0	($73,279)
Remove one-time development costs for telemedicine pilot programs SB 06-165	$0	$0	$0	($53,280)
Long Bill Appropriation / Request	**$20,262,998**	**$22,268,047**	**$23,012,942**	**$22,937,942**
HB 04-1219 add claims processing for community transition for elderly, blind, and disabled clients	$224	$0	$0	$0
SB 05-112 add one-time funding for continued bulletin board services (S-4, January 3, 2005)	$14,357	$0	$0	$0
SB 05-112 add funding for fixed price (S-4, January 3, 2005)	$1,236,648	$0	$0	$0
SB 05-112 funding for billing delayed from prior year for HIPAA remediation (S-4, January 3, 2005)	$469,740	$0	$0	$0
HB 05-1262 one-time cost for central processing unit disk storage for Decision Support System	$0	$43,000	$0	$0
HB 05-1262 central processing unit disk storage for the Prescription Drug Card System (PDCS)	$0	$18,000	$0	$0
HB 05-1262 claims processing for anticipated additional caseload	$0	$685,420	$0	$0
HB 05-1262 add pharmacy prior authorization reviews associated with anticipated caseload	$0	$38,568	$0	$0
HB 05-1086 one-time development costs for treatment of obesity	$0	$31,750	$0	$0
HB 05-1086 pharmacy prior authorization reviews for treatment of obesity	$0	$5,795	$0	$0
HB 05-1243 one-time development costs for consumer directed care	$0	$170,688	$0	$0

Line Item: Medicaid Management Information System	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
HB 06-1217 reduction of drug prior authorization reviews due to implementation of Medicare Modernization Act (S-6, January 3, 2006)	$0	($204,570)	$0	$0
HB 06-1385 Add-ons adjust development costs funding appropriated in HB 05-1262 to remove asset test for claims processing	$0	$34,925	$0	$0
HB 06-1385 Add-ons reduction for funding from HB 05-1262 (1331 Supplemental submitted June 2005)	$0	($22,030)	$0	$0
HB 06-1385 Add-ons remove obesity funding due to lack of grants and gifts	$0	($37,545)	$0	$0
HB 06-1395 one-time development costs for residential child health care	$0	$0	$46,336	$0
SB 06-128 one-time development costs for services for people with disabilities	$0	$0	$73,279	$0
SB 06-165 one-time development costs for telemedicine pilot program	$0	$0	$53,280	$0
Final Appropriation / Request	**$21,983,967**	**$23,032,048**	**$23,185,837**	**$22,937,942**
General Fund	$5,576,258	$5,549,271	$5,486,108	$5,442,455
Cash Funds Exempt	$365,073	$560,375	$629,859	$611,540
Federal Funds	$16,042,636	$16,922,402	$17,069,870	$16,883,947

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT

The current contract with Affiliated Computer Services, the fiscal agent for the Medicaid Management Information System Contract, expires November 30, 2006. The federal Centers for Medicare and Medicaid Services is requiring that the contract be reprocured. The reprocurement process is vital to the Department because the selected fiscal agent will operate the Medicaid Management Information System over three to eight years that the new contract will be in effect. This line item covers funding for a contracted consultant to oversee the following functions: issuing the request for proposals, evaluation of proposals received leading to the selection of the contracted fiscal agent, transition from the previous contracted fiscal agent to the new contracted fiscal agent, and other enhancements agreed upon with the new contracted fiscal agent. Oversight by a contracted consultant is necessary to insure that this process is completed in an efficient manner.

A Supplemental and Budget Amendment Request (S-5, BA-2) submitted January 3, 2005 adjusted funding splits from the original funding requested in a 1331 Emergency Request submitted May 21, 2004. An official appropriation for this FY 04-05 spending

authority was achieved by the Department's Supplemental Bill, SB 05-112. The out-year of this request was appropriated in the FY 05-06 Long Bill, SB 05-209.

Funding for reprocurement of the Medicaid Management Information System is usually at 75% federal financial participation. However, the federal Centers for Medicare and Medicaid Services occasionally approve funding at 90% federal financial participation for enhancements to the system. In this instance, the Department did receive approval from the Centers for Medicare and Medicaid Services for partial funding of enhancements at 90%, with regular reprocurement work activities approved at 75% federal financial participation. Decision Item DI-4, submitted November 15, 2005, requested the combination of 90% and 75% federal financial participation. This same request asked for an increase of $412,500 for additional consulting hours and funding for independent verification and validation work in FY 06-07, and an additional $55,200 for consulting hours in FY 07-08. The additional funding is necessary to cover the consultant remaining with the project until all transition and enhancement tasks have been completed. FY 06-07 funding was authorized by the Long Bill (HB 06-1385). Funding for FY 07-08 was approved with the Joint Budget Committee recommendation of the FY 06-07 Decision Item (DI-4), which included an out-year amount.

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

Solutions Consulting LLC d/b/a Public Knowledge LLC was hired as the consultant. With the assistance of Public Knowledge LLC, a request for proposals to secure an ongoing fiscal agent was prepared and released to the public on June 16, 2006. Responses from interested parties were received by the Department on August 9, 2006. On August 31, 2006, it was announced that the incumbent, Affiliated Computer Services, was reselected as the Department's fiscal agent. The new contract will be effective July, 1, 2007.

Line Item: Medicaid Management Information System Reprocurement	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$0**	**$642,600**	**$579,600**	**$740,100**
Annualization of Supplemental S-5	$0	($63,000)	$0	$0
Annualize Base Funding	$0	$0	($252,000)	$0
Additional Consulting Hours and Independent Verification and Validation (IV and V) Work (DI-4, November 15, 2005)	$0	$0	$412,500	$0

Line Item: Medicaid Management Information System Reprocurement	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Annualization of Consulting Hours and Removal of IV and V Funds	$0	$0	$0	($357,300)
Long Bill Appropriation / Request	$0	**$579,600**	**$740,100**	**$382,800**
SB 05-112 Funding for Reprocurement Consultant (S-5, January 3, 2005)	$642,600	$0	$0	$0
Final Appropriation / Request	**$642,600**	**$579,600**	**$740,100**	**$382,800**
General Fund	$146,481	$132,120	$155,783	$80,575
Cash Funds Exempt	$6,747	$6,086	$7,771	$4,019
Federal Funds	$489,372	$441,394	$576,546	$298,206

PAYMENT ERROR RATE MEASUREMENT PROJECT

The Payment Error Rate Measurement Project was established in response to the federal Improper Payments Act of 2002, and was the culmination of three separate federal pilot programs collectively referred to as the Payment Accuracy Measurement Projects. The federal Improper Payments Information Act of 2002 required the Department to conduct an annual review of those Medicaid services that may be susceptible to significant erroneous payments, to estimate the amount of improper payments made, and to report on those estimates. The Improper Payments Information Act of 2002 defined an improper payment as "any payment made that should not have been made or that was made in an incorrect amount including overpayments and underpayments." The definition further stated that these payments would "include any payment to an ineligible recipient; any payment for an ineligible service; any duplicate payment; payments for services not received; and any payment that does not account for credit for applicable discounts."

The Department participated in the Payment Accuracy Measurement Pilot Project for federal fiscal year (FFY) 03-04 and was awarded a payment error rate measurement pilot grant on September 29, 2004 from the Centers for Medicare and Medicaid Services for FFY 04-05. This project focused on both fee-for-service and managed care claims in Medicaid and the Children's Basic Health Plan and produced state-specific payment error estimates as required by the Centers for Medicare and Medicaid Services and the Improper Payment Information Act of 2002. To determine improper payment estimates, the Centers for Medicare and Medicaid Services anticipated in its August 27, 2004 proposed rule that an annual sample size of between 800 and 1,200 claims would be needed each for Medicaid and the Children's Basic Health Plan. A request for proposals to review a sampling of payments and to calculate the improper payment estimates was issued by the Department in FY 04-05, and the contract was awarded to Navigant Consulting.

Due to the expiration of the federal pilot grant funding for the Payment Error Rate Measurement Project in September 2005, the Department was appropriated moneys from the General Fund for FY 05-06 for the State match required to continue the project using a

contractor and receive federal financial participation. Under the proposed federal rules, the Department was required to begin the full payment error rate measurement project on October 1, 2005, at the start of FFY 05-06. Therefore, the Department submitted a FY 05-06 Stand Alone Budget Amendment Request (BA-4, January 24, 2005) to request funding for this line item in the amount of $1,171,632 for nine months of contractor costs to perform the federally required statistical sampling and payment error calculations. These funds were appropriated through the FY 05-06 Long Bill (SB 05-209).

On October 5, 2005, the Centers for Medicare and Medicaid Services issued an interim final rule with a revised approach to the payment error rate measurement project in which a federal contractor would be hired to complete the data processing and medical reviews and calculate the state-specific error rates. Because the State-hired contractor would not be needed, the Department requested a reduction in funding to zero out this line item in FY 05-06.

Under the revised approach in the October 5, 2005 interim final rule, the Department requested a reversal of the contractor funding for FY 06-07, and instead requested funding for 0.75 FTE in Personal Services and Operating Expenses to coordinate with the federal contractor (S-8 and BA-6, January 3, 2006). This request was approved and appropriated in the Department's Supplemental Bill (HB 06-1217).

At this time, the Department's FY 07-08 Base Request is $0. However, in response to comments to its October 5, 2005 interim final rule, the Centers for Medicare and Medicaid Services recently issued an August 28, 2006 interim final rule confirming that federal contractors would be hired to calculate national error rates and review states' fee-for-service and managed care payments for Medicaid and State Children's Health Insurance Programs. Under this August 28, 2006 rule, each state will be required to calculate its state-specific eligibility error rates. This rule also requires each state to now be responsible for measuring its improper payments once every three years, so that all states are reviewed on a rotating basis, with 17 states reviewed per federal fiscal year. Colorado will be required to conduct eligibility and payment error reviews for Medicaid and the Children's Basic Health Plan for FFY 06-07.

COLORADO BENEFITS MANAGEMENT SYSTEMS ELIGIBILITY AUDIT-TRANSFER TO THE STATE AUDITOR

This appropriation was for one-time funding in FY 05-06 as part of the statewide single audit for FY 04-05, conducted by the Office of the State Auditor. This was one of two audits regarding the Colorado Benefits Management System in FY 05-06. Funding for this appropriation originated partially in the Office of the State Auditor's budget, where the State share of total expenditures was appropriated as General Fund. These funds were transferred to the Department, appearing as Cash Funds Exempt in this appropriation, and were matched with Title XIX federal funds, before being transferred back the Office of the State Auditor's budget.

This appropriation was to fund sampling and county site visits as part of an audit required by the federal Office of Management and Budget Circular A-133. Specifically, the Office of the State Auditor is required under the statewide single audit to audit major federal

programs and the Office of Management and Budget Circular A-133 required audits of recipients of federal moneys based on expenditures, generally above $500,000 (Department of Human Services Supplemental Hearing document, January 13, 2006 page 15).

This audit focused largely on whether payments were made to eligible individuals, and if payments were both appropriate and allowable under federal and State law. This funding was also to cover costs associated with auditors visiting seven counties: three large, two medium, and two small-sized counties. Visits were to identify how program delivery was conducted at the county level, in addition to review of: 1) county methodologies for defining and tracking the time-frame required for the application process; 2) county policies and tracking methods regarding applicants who do not have required documentation at the initial application; and 3) county methodologies for tracking and eliminating backlogs related to applications and redeterminations (Department of Human Services Supplemental Hearing document, January 13, 2006 page 15).

Funding in FY 05-06 was equal to $68,250 and was determined by the Office of the State Auditor. Funding was appropriated through the passage of HB 06-1217, the Department's FY 05-06 Supplemental Bill, based upon the Department's request (non-prioritized Supplemental S-2, January 3, 2006).

Line Item: CBMS Eligibility Audit – Transfer to the State Auditor	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**N/A**	**$68,250**	**$0**
Removal of one-time funding from FY 05-06	$0	($68,250)	$0
Long Bill Appropriation / Request	**$0**	**$0**	**$0**
HB 06-1217 Initial funding for SAS-70 audit to be performed by the Office of the State Auditor (non-prioritized Supplemental S-2, January 3, 2006)	$68,250	$0	$0
Final Appropriation / Request	**$68,250**	**$0**	**$0**
General Fund	$0	$0	$0
Cash Funds Exempt	$34,125	$0	$0
Federal Funds	$34,125	$0	$0

MEDICARE MODERNIZATION ACT OF 2003-COLORADO BENEFITS MANGEMENT SYSTEM DEVELOPMENT COSTS

This appropriation was created through a Joint Budget Committee staff recommendation on March 15, 2005, to fund system changes to the State's eligibility system. Due to a federal requirement for reporting the number of dual eligible clients (clients both Medicare and Medicaid eligible) in the State each month for purposes of calculating the monthly Clawback payment (see Assumptions and Calculations for Long Bill group (5) Other Medical Services, MMA of 2003 State Contribution Payment for a description of this payment), Joint Budget Committee staff recommended $488,000 for an estimated 1,572 programming hours at an average cost of

$310.43 per hour (Figure Setting, March 15, 2005, page 48). System changes that were required included: 1) adding a screen for Medicare Part D clients that qualify for a low-income subsidy, 2) add fields to the Medicare Expense table to accommodate the Medicare Part D information, and 3) develop a query to generate and send a monthly dual eligible file (and low-income subsidy file) to the Social Security Administration.

One-time funding in FY 05-06 was appropriated through the Long Bill (SB 05-209) equal to $488,000. There is no FY 07-08 Base Request for this purpose.

HIPAA WEB PORTAL MAINTENANCE

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

This infrastructure serves the Department's internet and intranet web sites and provides an application for claims to be submitted to the Medicaid Management Information System. Users with appropriate security clearance can also link to the Colorado Benefits Management System web page from the Department's general web site. Specific reports and files (such as claim responses for medical providers) are also transmitted from Affiliated Computer Services, Inc., the Department's fiscal agent. It is important to note, however, that the contract with CGI-AMS, Inc. for the web portal maintenance is completely independent of, and has no legal or financial connection with, Affiliated Computer Services, Inc.

Initial funding for the web portal was requested as a separate line item through a Stand Alone Budget Amendment in the amount of $312,900 (BAS-2, January 23, 2004). The request was approved and funding appeared in the Department's FY 04-05 Long Bill (HB 04-1422). In addition to this appropriated amount, this line received additional spending authority from a FY 03-04 roll-forward taken from the Health Insurance Portability and Accountability Act of 1996 Implementation Contract Costs line item. While this was not an official change to the appropriation, the addition of this amount increased total spending authority for the web portal to $929,562 in FY 04-05.

For FY 05-06 and each year thereafter, funding for this line item has continued at $312,900. The FY 07-08 Base Request is again for continuation funding.

Line Item: HIPAA Web Portal Maintenance	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**N/A**	**$312,900**	**$312,900**	**$312,900**
Long Bill Appropriation / Request	**$312,900**	**$312,900**	**$312,900**	**$312,900**
General Fund	$78,225	$78,225	$78,225	$78,225
Federal Funds	$234,675	$234,675	$234,675	$234,675

HIPAA NATIONAL PROVIDER IDENTIFIER ASSESSMENT AND IMPLEMENTATION

Colorado Medicaid provider identification numbers used to process Medicaid claims are not currently compatible with National Provider Identifier standards. A Medicaid provider may be an individual, or organization such as a health plan, a health maintenance organization, or a health care clearing house. In order to achieve compliance with recent federal requirements released on January 23, 2004, the Department must update its Medicaid Management Information System to accept these new National Provider Identifiers. The expectation of this federal requirement is to provide a unique identifier for every health care provider in the country.

The requirement to incorporate a unique identifier for each medical provider in the Department's claims processing system, the Medicaid Management Information System, is expected to be met by the federally required implementation date of May 23, 2007. Going forward, the National Provider Identifier remains as a continuing requirement in claims processing, but no additional funding need is anticipated because inclusion of the National Provider Identifier becomes simply a regular operations procedure.

This line item was first requested through a Decision Item in the Department's FY 06-07 Budget Request (DI-7, November 15, 2006). This request sought funding for assessment and development costs associated with updating the Medicaid Management Information System, and also requested funding to complete an independent verification and validation of the changes by the Governor's Office of Information Technology.

However, in order to allow sufficient time for a thorough implementation, the Department realized that work on this line item needed to begin in FY 05-06. Therefore, the Department submitted a Supplemental Request and Budget Amendment, to reallocate $109,100 of FY 06-07 funding to the current year (FY 05-06) to begin work early (S-12 and BA-5, January 3, 2006). This request was approved by the Joint Budget Committee and was appropriated in the Department's Supplemental Bill (SB 05-112) and the FY 06-07 Long Bill (HB 06-1385).

Due to the timing requirement of implementing this change no later than May 23, 2007, no funding is being requested for FY 07-08.

Line Item: HIPAA National Provider Identification Assessment and Implementation	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**$0**	**$109,100**	**$690,962**
Annualization of assessment funding and for independent verification and validation (BA-5, January 3, 2006)	$0	$581,862	$0
Removal of funding for completion of project (federal deadline is May 23, 2007)	$0	$0	($690,962)
Long Bill Appropriation / Request	**$0**	**$690,962**	**$0**
SB 05-112 Initial funding for assessment of system changes (S-12, January 3, 2006)	$109,100	$0	$0
Final Appropriation / Request	**$109,100**	**$690,962**	**$0**
General Fund	$26,457	$167,558	$0
Cash Funds Exempt	$1,146	$7,255	$0
Federal Funds	$81,497	$516,149	$0

HIPAA SECURITY RULE IMPLEMENTATION

This line item was requested by a late Change Request (NP-S19) submitted January 22, 2004. The request was for $196,350 in FY 03-04. During Figure Setting on March 9, 2004 (page 44), the amount was reduced to $125,600. Funding for disaster recovery, policy planning and procedures writing were not approved. These work activities were recommended to be handled by departmental staff rather than outside contractors. First-time funding in the amount of $125,600 was established in the FY 04-05 Long Bill, HB 04-1422, and included a series of administrative, technical, and physical security procedures for HIPAA-covered entities to use in order to assure confidentiality of electronic protected health information. Compliance with the HIPAA Security Rule was implemented on April 18, 2005.

During FY 04-05, several computer and security services were purchased for the security rule implementation. These items had higher costs for initial purchases, followed by lower costs for ongoing licensing fees for software and security services needed for new employees. Since implementation was completed in FY 04-05, the Department entered into maintenance mode in FY 05-06 because the HIPAA rules require permanent continuation of security measures. Funding in FY 05-06 for ongoing maintenance costs was $11,290 and was moved into Operating Expenses. This same arrangement is expected to continue in future years. Therefore, there was no request for separate funding for FY 06-07, and there is no request for funding in FY 07-08.

MEDICAL IDENTIFICATION CARDS

Historically, Medicaid eligibility was automatically tied to cash assistance provided through the Department of Human Services. Prior to September 2003, each Medicaid recipient or family was mailed a monthly Medicaid authorization card to reflect eligibility for

Medicaid. The client would present this authorization card to medical providers when services were sought. With the implementation of the Electronic Benefits Transfer Service by the Department of Human Services, pursuant to HB 95-1144, cash assistance eligibility and Medicaid eligibility were separated. At that time, production and mailing of Medicaid cards became the responsibility of the Department of Health Care Policy and Financing.

The old monthly Medicaid authorization card guaranteed the client's eligibility to receive Medicaid benefits for the month indicated on the card. The client's Medicaid authorization card was presented to the medical provider as proof of Medicaid eligibility. Providers relied on Medicaid clients having this card with them when requesting services and would, at times, refuse to provide services if the client could not present the card at the time medical services were rendered. For FY 03-04, Base Reduction Item BRI-2 submitted November 1, 2002 implemented a new process to produce the card. This new process consisted of a plastic card being issued to all eligible clients and was reissued only when replacements were needed or new clients became eligible. This procedure was implemented for FY 03-04 as authorized in the FY 03-04 Long Bill, SB 03-258. Based on this change, medical providers are now required to verify Medicaid eligibility electronically after viewing the client's plastic card. This new identification card reduced the Department's liability from a one-month guarantee of eligibility to only the exact periods of eligibility. The new card also allowed clients to move on and off covered programs without receiving a new card each time.

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

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

The FY 02-03 Long Bill amount of $1,332,100 was equal to the sum of: 1) the final FY 01-02 appropriated amount of $1,188,142; less, 2) $65,842 from the prior year Supplemental that was not carried forward; plus, 3) the addition of $204,027 from the Department's Decision Item DI-2; plus 4) a $6,442 increase for card production by the General Government Computer Center (Figure Setting, March 11, 2002, page 80); and lastly, 5) a reduction of $9,669 by Joint Budget Committee after Figure Setting was final. This

Long Bill amount was later revised through the passage of the Department's Supplemental Bill (SB 03-203) based on a Department request for an additional $27,501 (S-8, January 2, 2003). The final appropriation for FY 02-03 was $1,350,601.

The FY 03-04 Long Bill (SB 03-258) appropriation of $846,041 was based upon the prior year's final appropriation, less a Joint Budget Committee's action to reduce this line item by $504,560 in response to the Department's Base Reduction Item to convert to durable plastic cards (BRI-2, November 1, 2002). In addition to these changes, a new funding source was added to the Long Bill appropriation, which now contained $10,656 in Cash Funds for the production and mailing of cards for Old Age Pension State Medical Program clients.

In FY 03-04, the old paper authorization cards were produced for July and August. The new plastic identification cards were put into use beginning September 2003. Since the plastic identification cards were used for the duration of FY 04-05, funding needs decreased for FY 04-05. FY 04-05 Base Reduction Item BRI-1, submitted November 3, 2003, therefore requested a reduction of $615,814. However, on recommendation of the Joint Budget Committee staff, that amount was modified to a net reduction of $490,440 to allow for a higher caseload and more replacement cards (Figure Setting March 9, 2004, page 49). The result was $355,601 approved in the FY 04-05 Long Bill, HB 04-1422.

A continuation request of $355,601 was made for FY 05-06. However, during Figure Setting (March 15, 2005, page 52), Joint Budget Committee staff recommended that the Department's request be increased by $6,984 to allow for increased caseload. The resulting appropriation in the FY 05-06 Long Bill (SB 05-209) was $362,585. This amount also included a Joint Budget Committee action which converted $1,517 for Old Age Pension State Medical Program clients from Cash Funds to Cash Funds Exempt.

Later in the 2005 legislative session, HB 05-1262 (Tobacco Tax Bill) was also passed and when signed into law on June 2, 2005, added $21,131 from a newly created cash fund called the Health Care Expansion Fund with Cash Funds Exempt and federal matching funds for FY 05-06, to support the needs of anticipated expansion clients. Unfortunately, the appropriated amount in this bill was slightly off. Therefore, the Department submitted a 1331 Supplemental Request on June 3, 2005 for a reduction of $1,019 which was enacted into law with the passage of HB 06-1385 Add-ons. The resulting FY 05-06 final appropriation was $382,697.

For FY 06-07 funding, Base Reduction Item BRI-1 was submitted November 15, 2005 to remove no longer needed General Government Computer Center funding of $113,077 and $79,154 for production and mailing of the cards by the outside vendor since fewer replacement cards than originally forecast have proved to be necessary. The total reduction requested was $192,231, and it became effective with the Long Bill, HB 06-1385. The out year impact of the Tobacco Tax Bill, HB 05-1262, also added $428 to bring the total FY 06-07 funding to $190,892. Continuation funding of $190,892 is requested for FY 07-08.

Line Item: Medical Identification Cards (formerly known as Medicaid Authorization Cards)	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**$1,188,142**	**$1,350,601**	**$846,041**	**$355,601**	**$382,697**	**$190,892**
Reversal of prior year Supplemental	($65,842)	$0	$0	$0	$0	$0
Inflation increase for card protection (DI-2, November 1, 2001)	$204,027	$0	$0	$0	$0	$0
Joint Budget Committee action to reduce proposed appropriation after Figure Setting	($9,669)	$0	$0	$0	$0	$0
Savings due to implementation of plastic cards (BRI-2, November 1, 2002)	$0	($504,560)	$0	$0	$0	$0
Savings due to implementation of plastic cards (BRI-1, November 3, 2003 – not as requested)	$0	$0	($490,440)	$0	$0	$0
Joint Budget Committee action for caseload adjustment during Figure Setting	$0	$0	$0	$6,984	$0	$0
Further reduction of funding due to plastic cards (BRI-1, November 15, 2005)	$0	$0	$0	$0	($192,231)	$0
HB 05-1262 for expansion populations	$0	$0	$0	$0	$426	$0
Long Bill Appropriation / Request	**$1,323,100**	**$846,041**	**$355,601**	**$362,585**	**$190,892**	**$190,892**
SB 03-203 Supplemental Bill	$27,501	$0	$0	$0	$0	$0
HB 05-1262 Increase for expansion populations	$0	$0	$0	$21,131	$0	$0
HB 06-1385 Add-ons adjustment to original appropriation in HB 05-1262	$0	$0	$0	($1,019)	$0	$0
Final Appropriation / Request	**$1,350,601**	**$846,041**	**$355,601**	**$382,697**	**$190,892**	**$190,892**
General Fund	$675,301	$417,693	$177,042	$180,534	$84,418	$84,418
Cash Funds	$0	$10,656	$1,517	$0	$0	$0
Cash Funds Exempt	$0	$0	$0	$11,556	$11,764	$11,764
Federal Funds	$657,100	$417,692	$177,042	$190,607	$94,710	$94,710

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT FACILITY SURVEY AND CERTIFICATION

This line item funds the survey and certification of nursing facilities (including Alternative Care Facilities), hospices, home health agencies, and Home and Community Based Services agencies, and pays the Medicaid share to maintain and operate the Minimum

Data Set system used for nursing facility case mix reimbursement methodology. The Department contracts with the Department of Public Health and Environment through an interagency agreement for these functions. Federal financial participation is broken up into two categories: those qualifying for a 75% federal match for skilled professionals and expenditures related to long-term care facilities, and those qualifying for the State's normal 50% federal match. The Centers for Medicare and Medicaid Services also requires that the State be in compliance with Medicare requirements for home health and licensure for hospice agencies. Facility surveys associated with these requirements are also performed by the Department of Public Health and Environment; however, they are not Medicaid funded.

The Health Facilities and Emergency Medical Services sub-division of the Department of Public Health and Environment receives funding from the Department to survey a variety of facilities that service Medicaid patients. Based on the survey, the Department of Public Health and Environment makes a recommendation to the Department as to whether a facility or provider is in compliance with applicable regulations and should be Medicaid certified.

The FY 03-04 Long Bill appropriation was $3,698,759, and includes a decrease of $110,416 from the prior year for Personal Services, Operating Expenses, and indirect costs reductions, as recommended by the Joint Budget Committee during Figure Setting (March 6, 2003, page 111). The FY 04-05 Long Bill appropriation (HB 04-1422) was $4,000,636. Changes from FY 04-05 to FY 05-06 were due to an increase of $301,877 in indirect costs associated with POTS. The FY 05-06 Long Bill appropriation was $4,079,161, and just like the prior two fiscal years, this change in funding was due to increases in POTS and Common Policies.

The FY 06-07 Long Bill (HB 06-1385) appropriation is for $4,304,925. This amount reflects an increase of $225,764 in Personal Services and indirect costs; however, not all of this funding was due solely to changes in Common Policies. Due to the growth of the number of facilities that need to be inspected, the Department of Public Health and Environment has fallen behind in its surveying, particularly with regards to Home and Community Based Services surveys, which have increased 68% (Figure Setting, March 6, 2006, page 101). Based on this information, the Department of Public Health and Environment requested an additional $182,718, of which $109,631 was Medicaid funding, to support 3.1 FTE to reduce the survey backlog and keep up with a projected higher future work level. The Department submitted a corresponding Schedule 6 in support of this request in its FY 06-07 Budget Request, and this amount was approved by the Joint Budget Committee (non-prioritized Budget Amendment BA-14, November 15, 2005).

The FY 07-08 Base Request is for $4,440,317 which includes an increase of $135,392 for Common Policies.

Line Item: DPHE Facility Survey and Certification	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Previous Fiscal Year Final Appropriation	**$3,809,175**	**$3,698,759**	**$4,000,636**	**$4,079,161**	**$4,304,925**
POTS, Personal Services, and Indirect Costs Adjustments	($110,416)	$301,877	$78,525	$225,764	$135,392
Long Bill Appropriation / Request	**$3,698,759**	**$4,000,636**	**$4,079,161**	**$4,304,925**	**$4,440,317**
General Fund	$927,349	$1,000,288	$1,020,479	$1,142,007	$1,166,161
Cash Funds	$0	$0	$0	$0	$0
Federal Funds	$2,771,410	$3,000,348	$3,058,682	$3,162,918	$3,274,156

The following table provides a breakdown of the FY 07-08 Base Request, based on the anticipated need for each area of expenditure.

FY 07-08 Base Request	Total Funds	General Fund	Federal Funds
Salary Survey	$152,823	$45,860	$106,963
Health/Life/Dental	$168,576	$49,882	$118,694
Short Term Disability	$4,586	$1,376	$3,210
Performance Based Pay	$32,387	$9,720	$22,667
Amortization Equalization Disbursements	$42,728	$12,822	$29,906
Vehicle Lease Payments	$15,475	$5,365	$10,110
Personal Services	$3,360,124	$972,239	$2,387,885
Operating Expenses	$227,667	$68,897	$158,770
Indirect Costs (Only Federal Share is Billed to the Department)	$435,951	$0	$435,951
Total FY 07-08 Base Request	**$4,440,317**	**$1,166,161**	**$3,274,156**

ACUTE CARE UTILIZATION REVIEW

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

For FY 03-04, the Acute Care Utilization Review budget line received an increase of $7,222 of which $1,806 was Cash Funds Exempt and $5,416 was federal funds associated with the Breast and Cervical Cancer Prevention and Treatment Program. This was per

annualization of SB 01S2-12 pertaining to prior authorization reviews for this program. With this increase, the FY 03-04 Long Bill, (SB 03-258) appropriation for Acute Care Utilization Review was $1,309,826. There was no change to this amount for FY 04-05.

In FY 05-06, HB 05-1262 (Tobacco Tax Bill) added $8,560 for additional prior authorization reviews for low income adults and children. This funding was from the Health Care Expansion Fund, showing up in the Department's Budget as Cash Funds Exempt, and matching federal funds. Unfortunately, due to a number of last minute changes with this legislation, the appropriations clause for HB 05-1262 was inadvertently set incorrectly. Therefore, on June 3, 2005, the Department submitted a 1331 Emergency Request to request that these amounts be revised. With the passage of the FY 06-07 Long Bill Add-ons, this appropriation was increased by $49,680. Therefore, the final FY 05-06 appropriation was $1,368,066.

For FY 06-07, tobacco tax funding was annualized for anticipated caseload growth of expansion populations, adding $7,840 to the Department's Budget. The result of this increase brought the FY 06-07 Long Bill appropriation to $1,375,906. This additional tobacco tax funding was discussed in Table 4 of the Department's 1331 Emergency Request submitted June 3, 2005. In addition to this change, this appropriation experienced a shift of $2,174 between Cash Funds Exempt and General Fund for the Breast and Cervical Cancer Program as required by the original statute for the program.

The FY 07-08 Base Request is for continuation funding of $1,375,906.

Line Item: Acute Care Utilization Review	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Appropriation	**$1,302,604**	**$1,309,826**	**$1,309,826**	**$1,368,066**	**$1,375,906**
FY 02-03 Budget Balancing (SB 03-203)	$0	$0	$0	$0	$0
Annualization of SB 01S2-12 (Prior Authorization Reviews)	$7,222	$0	$0	$0	$0
Annualization of Tobacco Tax Bill (HB 05-1262)	$0	$0	$0	$7,840	$0
Long Bill Appropriation / Request	**$1,309,826**	**$1,309,826**	**$1,309,826**	**$1,375,906**	**$1,375,906**
Tobacco Tax Bill - HB 05-1262	$0	$0	$8,560	$0	$0
HB 06-1385 Add-ons to adjust HB 05-1262 appropriation	$0	$0	$49,680	$0	$0
Final Appropriation / Request	**$1,309,826**	**$1,309,826**	**$1,368,066**	**$1,375,906**	**$1,375,906**
General Fund	$342,529	$342,529	$342,529	$344,703	$344,703
Cash Funds Exempt	$2,899	$2,899	$17,459	$17,245	$17,245
Federal Funds	$964,398	$964,398	$1,008,078	$1,013,958	$1,013,958

LONG-TERM CARE UTILIZATION REVIEW

The purpose of this program is to perform prior authorization reviews for certain services to determine medical necessity, level of care, and target population determinations as well as periodic reviews of continued appropriateness for these services. These reviews result in cost avoidance of higher or inappropriate payments to providers. In addition, the Single Entry Point contractors (case management agencies and community centered boards) perform pre-admission screening for Medicaid clients seeking admittance to nursing facilities and home and community based long-term care programs, as well as annual continued stay reviews of these clients. Some of the reviews for long-term care programs are required by federal regulations. The Single Entry Point agencies and other contractors perform the following functions with funding from this line item:

- Screening and referrals;
- Uniform Long-Term Care 100.2 Form (ULTC 100.2) assessments for needed level of care;
- Preliminary Level I Pre-Admission Screening and Annual Resident Reviews for the target population determinations;
- Hospital Back-Up Program approvals;
- Children's Extensive Support Waiver expedited reviews;
- Ability to return home (versus remaining in a nursing home) screens;
- Private Duty Nursing approvals;
- Data Management; and,
- Training of Case Managers.

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

The FY 03-04 Long Bill (SB 03-258) appropriation for the Long-Term Care Utilization Review was $1,668,108. The FY 04-05 and FY 05-06 Long Bill amounts were for continuation funding. However, HB 05-1262 (Tobacco Tax Bill) added $76,858 to this line item beginning in FY 05-06, with $38,429 in Cash Funds Exempt from the Health Care Expansion Fund and $38,429 in matching federal funds. This amount was for 148 expansion clients to be added to the Children's Extensive Support waiver, to reduce the number of wait list clients for this program.

The FY 06-07 Long Bill and the Department's FY 07-08 Base Request include continuation funding of the final FY 05-06 appropriation.

Line Item: Long-Term Care Utilization Review	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**$0**	**$1,668,108**	**$1,668,108**	**$1,744,966**	**$1,744,966**
Long Bill Appropriation / Request	**$1,668,108**	**$1,668,108**	**$1,668,108**	**$1,744,966**	**$1,744,966**
Tobacco Tax Bill, HB 05-1262	$0	$0	$76,858	$0	$0
Final Appropriation / Request	**$1,668,108**	**$1,668,108**	**$1,744,966**	**$1,744,966**	**$1,744,966**
General Fund	$598,813	$598,813	$598,813	$598,813	$598,813
Cash Funds Exempt	$0	$0	$38,429	$38,429	$38,429
Federal Funds	$1,069,295	$1,069,295	$1,107,724	$1,107,724	$1,107,724

EXTERNAL QUALITY REVIEW

Health Services Advisory Group, Inc., the contractor for this line item, validates performance improvement projects and performance measures for managed care organizations, collects performance measures for fee-for-service physicians, and provides an annual report of the year's activities and recommendations. The Department, through the external quality review contract, began requiring both existing and new physicians to have their credentials verified and updated every three years, with approximately one third of all physicians credentialed annually through this ongoing process. This credentialing process can also reveal potential problems requiring investigation. An internal physician monitoring process has been implemented to determine if medical licenses have been revoked or suspended, or sanctions against physicians have been enacted. If such actions from physician regulatory boards have been recommended, the Department staff suggests further actions which may include termination of Medicaid participation. The quality review contractor researches information in this process.

The FY 03-04 External Quality Review appropriation was $812,193, and has remained level since this time. The FY 07-08 Base Request is for continuation funding.

Line Item: External Quality Review	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Final Appropriation / Request	**$812,193**	**$812,193**	**$812,193**	**$812,193**	**$812,193**
General Fund	$203,048	$203,048	$203,048	$203,048	$203,048
Federal Funds	$609,145	$609,145	$609,145	$609,145	$609,145

DRUG UTILIZATION REVIEW

42 CFR, §456.703, requires that each state have a drug utilization review function. The purpose of the Drug Utilization Review program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary, and are not likely to result in adverse medical effects. Programs must consist of prospective and retrospective drug use reviews, the application of explicit predetermined standards, and an educational program. The Department submits a report on the pharmacy utilization plan to the Health and Human Services Committee in the General Assembly each year to update the drugs covered and the cost savings achieved.

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

The Long Bill appropriation for this line item was initially set at $233,025 per a Base Reduction Item submitted by the Department in its FY 03-04 Budget Request (BRI-3, November 1, 2002). This FY 03-04 appropriation, however, was later increased during the 2003 legislative session, due to the approval of two additional bills. SB 03-011, regarding prescription drugs under Medicaid, increased the appropriation by $300,000 total funds, of which $75,000 was General Fund and $225,000 was federal funds. In addition, SB 03-294, regarding drug rebates, discounts and management, increased the line item appropriation by $80,000 total funds, of which $20,000 was General Fund and $60,000 was federal funds. This funding was authorized to contract for a professional medical evaluation of the most effective drug classes for implementation of the drug utilization review. The final FY 03-04 appropriation was $613,025.

In FY 04-05, annualization of SB 03-011 increased the new Long Bill amount by $300,000 to encourage use of generic prescriptions as much as possible. Therefore, the FY 04-05 Long Bill (HB 04-1422) was for $913,025. This amount was later revised during the fiscal year with passage of the Department's Supplemental Bill (SB 05-112), which decreased federal funds by $265,000. The reason for a federal fund reduction was due to the allowable match rate for prior authorization reviews at 50%, versus the utilization review match rate of 75%. Due to increases in the number of drugs requiring prior authorization reviews by the fiscal agent, the Department submitted a Supplemental Request for FY 04-05 to utilize a portion of existing General Fund in this appropriation for prior authorization reviews, thereby forfeiting the enhanced federal match (S-10, January 3, 2005). Therefore, the final appropriation for FY 04-05 was $648,025.

In FY 05-06, SB 05-209 continued funding at $648,025 as well as continued the combination of drug utilization reviews and drug prior authorization reviews within the line item, with funding for traditional drug utilization reviews at 75% federal funds participation and the fiscal agent prior authorization review functions at 50% federal financial participation.

However, this FY 05-06 amount was calculated to be too great based upon the implementation of the Medicare Modernization Act of 2003 which was implemented on January 1, 2006, transferring nearly one half of all Medicaid prescription drug costs to the federal government's Medicare program. Since the State was responsible for a significantly smaller portion of the State's prescription drug need, it was assumed that corresponding drug prior authorization reviews would also decline. As the Medicaid Management Information System contained sufficient funding for this purpose based on new estimates, the Department submitted a Supplemental Request to remove all remaining drug prior authorization review funding in this appropriation (S-6, January 3, 2006). The total reduction requested by the Department for the drug prior authorization review was $276,000, and was accomplished through the Department's FY 05-06 Supplemental Bill (HB 06-1217). FY 06-07 funding was appropriated at continuation funding.

The Department's FY 07-08 Base Request is for $372,025. A Change Request has been submitted for this line item.

Line Item: Drug Utilization Review	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$0**	**$613,025**	**$648,025**	**$372,025**	**$372,025**
Annualization of SB 03-011 - Prescription Drugs Under Medicaid	$0	$300,000	$0	$0	$0
Long Bill Appropriation / Request	**$233,025**	**$913,025**	**$648,025**	**$372,025**	**$372,025**
SB 03-011 - Prescription Drugs Under Medicaid	$300,000	$0	$0	$0	$0
SB 03-294 - Drug Rebates, Discounts and Management	$80,000	$0	$0	$0	$0
SB 05-112 Reduction of federal funds to use some funding for prior authorization reviews at 50% federal financial participation (S-10, January 2, 2005)	$0	($265,000)	$0	$0	$0
HB 06-1217 Reduction due to implementation of Medicare Modernization Act of 2003 (S-6, January 3, 2006)	$0	$0	($276,000)	$0	$0
Final Appropriation / Request	**$613,025**	**$648,025**	**$372,025**	**$372,025**	**$372,025**
General Fund	$153,256	$228,256	$90,256	$90,256	$90,256
Federal Funds	$459,769	$419,769	$281,769	$281,769	$281,769

MENTAL HEALTH EXTERNAL QUALITY REVIEW

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

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

The Department contracts with an external quality review organization to perform the services listed above. The following table shows the appropriation history of this line item as well as the FY 07-08 Base Request.

Line Item: Mental Health External Quality Review	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Final Appropriation / Request	**$352,807**	**$352,807**	**$352,807**	**$325,807**
General Fund	$88,202	$88,202	$88,202	$88,202
Federal Funds	$264,605	$264,605	$264,605	$264,605

ACTUARIAL ANALYSIS PAYMEMT FOR TRANSFERS TO STATE AUDITORS OFFICE

This one-time appropriation funded an actuarial evaluation to be coordinated by the Office of the State Auditor during FY 05-06; however, a roll forward was approved into FY 06-07. In FY 06-07, the Office of the State Auditor has begun the process of gathering background and statistical information from the Department and the Division of Mental Health within the Department of Human Services. The Office of the State Auditor plans to involve the Department and the Department of Human Services in review and comment on the scope of work in the request for proposals and on the scope of additional work the Office of the State Auditor might elect to do to supplement the work of the outside contractor. The Office of the State Auditor selects the outside contractor following a bid solicitation process and manages the overall evaluation. When the request for proposals was issued in FY 05-06, no contractor responded. As a result, the Office of the State Auditor was authorized to narrow the scope of work so contractors would be able to

complete the contract within the funding allotted. The funds are to be transferred to the Office of the State Auditor as Cash Funds Exempt. The project should be completed during FY 06-07. No funds are requested for FY 07-08.

Line Item: Actuarial Analysis Payments for Transfer to the State Auditor's Office	FY 05-06	FY 06-07	FY 07-08 Base Request
Long Bill Appropriation / Request	**$100,000**	**$0**	**$0**
General Fund	$50,000	$0	$0
Federal Funds	$50,000	$0	$0

MENTAL HEALTH ACTUARIAL SERVICES

This one-time appropriation in the FY 04-05 Long Bill funded an actuarial certification of the 3.25% rate increase approved by the General Assembly for the FY 05-06 Medicaid Mental Health Capitation Base Payments. Actuarial certification was required by the Centers for Medicare and Medicaid Services to approve rates for the State to receive 50% federal financial participation. The project was completed during FY 04-05. Since FY 05-06, actuarial certification of rate increases have been funded from the (1) Executive Director's Office, Personal Services appropriation. No funds have been specifically requested for this line item since FY 04-05 and subsequent years.

Line Item: Mental Health Actuarial Services	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Long Bill Appropriation / Request	**$25,000**	**$0**	**$0**	**$0**
General Fund	$12,500	$0	$0	$0
Federal Funds	$12,500	$0	$0	$0

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

The Department is required to ensure Early and Periodic Screening, Diagnosis, and Treatment Program services of outreach and case management in a manner that is consistent with federal regulations as specified in 42 CFR 441.50-441.61. These outreach and case management services are aimed at the promotion of health, the prevention of disease, and improved access to health care services and include, but are not be limited to:

- Contacting eligible clients to provide in-depth explanation of the program and its importance;
- Offering assistance and information to eligible clients and helping to overcome barriers which might impede access to services;
- Clarifying the role of primary care providers, dentists, and the managed care/prepaid health plans, including health maintenance organizations;

- Emphasizing the client's obligation to maintain the linkage between the child/youth and the primary care physician;
- Maintaining periodic contact with the client to encourage the utilization of services needed or promoted by referrals and assisting with referrals as needed;
- Contacting clients not currently receiving assistance under the "Colorado Works Act" to inform them of the possibility of continued eligibility for Medicaid;
- Initiating collaborative activities with other child-related health and social services agencies and resources within each county and referring Early and Periodic Screening, Diagnosis, and Treatment clients as needed to those agencies and resources; and,
- Including assistance provided by the outreach and case managers with the program and managed care information process, as well as referring applicants to the enrollment broker at the time of application for Medicaid in local social service agencies and presumptive eligibility sites in selected counties.

Prior to FY 03-04, administration of the Early and Periodic Screening, Diagnosis and Treatment Program was housed at the Department of Public Health and Environment. The final appropriation for FY 02-03 for that sister agency was $2,721,758.

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

In the FY 03-04 Long Bill (SB 03-258), $2,624,222 was appropriated for the Early and Periodic Screening, Diagnosis and Treatment Program. A late Supplemental reduced the appropriation to the identified funding needs of the Department (NP-S21, February 4, 2004). The final appropriation for FY 03-04, adjusted by Add-on section of HB 04-1422, was $2,468,383. The appropriation has remained at this level since FY 03-04. The FY 07-08 Base Request is for continuation funding.

Line Item: Early and Periodic Screening, Diagnosis, and Treatment Program	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Appropriation	**$2,721,758**	**$2,468,383**	**$2,468,383**	**$2,468,383**	**$2,468,383**
Savings from program when transferred from the Department of Public Health and Environment to the Department of Health Care Policy and Financing	($97,536)	$0	$0	$0	$0

Line Item: Early and Periodic Screening, Diagnosis, and Treatment Program	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Long Bill Appropriation / Request	**$2,624,222**	**$2,468,383**	**$2,468,383**	**$2,468,383**	**$2,468,383**
HB 04-1422 Add-ons (Supplemental NP-S21)	($155,839)	$0	$0	$0	$0
Final Appropriation/Request	**$2,468,383**	**$2,468,383**	**$2,468,383**	**$2,468,383**	**$2,468,383**
General Fund	$1,234,192	$1,234,192	$1,234,192	$1,234,192	$1,234,192
Federal Funds	$1,234,191	$1,234,191	$1,234,191	$1,234,191	$1,234,191

NURSING FACILITY AUDITS

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

During FY 03-04, the Department solicited bids for a new five-year contract to begin in FY 04-05. The FY 04-05 appropriation was based on the FY 99-00 five-year contract amount of $864,150. However, the winning bid for the five-year contract came in $233,350 higher than appropriated due to increased technical audit requirements and costs on the part of the contractor. Therefore, SB 05-112 increased funding for this program to $1,097,500 (S-6, January 3, 2005). This appropriation has remained level since FY 04-05. The FY 07-08 Base Request is a continuation of the FY 06-07 appropriation of $1,097,500.

Line Item: Nursing Facility Audits	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$879,530**	**$864,150**	**$1,097,500**	**$1,097,500**	**$1,097,500**
Removal of one-time funding for two year project	($15,380)	$0	$0	$0	$0
SB 05-112 (FY 04-05 Supplemental Bill)	$0	$233,350	$0	$0	$0
Long Bill Appropriation / Request	**$864,150**	**$1,097,500**	**$1,097,500**	**$1,097,500**	**$1,097,500**
General Fund	$432,075	$548,750	$548,750	$548,750	$548,750
Federal Funds	$432,075	$548,750	$548,750	$548,750	$548,750

HOSPITAL AND FEDERALLY QUALIFIED HEALTH CLINIC AUDITS

The Department contracts with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers and rural health centers that participate in the Medicaid program, and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. Most of the hospital audits are completed from

the Medicare cost report audit and are tailored to Medicaid requirements. The independent accounting firm provides the following services to the Department: contract review and reimbursement, final settlements, rebasing calculations, consultation and assistance on cost report interpretation, and meetings with providers to resolve problems. The annual rates of reimbursement are based on the results of these audits, and are set to cover the reasonable and necessary costs of an efficiently run hospital, federally qualified health center and rural health center per federal and State law.

Prior to FY 05-06, an appropriation of $250,000 for desk audits of over 200 hospitals and federally qualified health clinics produced annual savings of over $5 million in Medical Services Premiums. This funding was increased to $350,000 in FY 05-06 through the Long Bill, SB 05-209, to include site audits as part of the program to provide greater accuracy in identifying actual costs. With the additional funding appropriated in FY 05-06, the Department's contractor recovered $13,938,704 from hospitals and $2,498,982 from federally qualified health clinics for a total savings from site audits of $16,437,686. An additional $17,850 was added to this appropriation in FY 06-07 through the Long Bill, HB 06-1385, to include a cost of living adjustment for the contractor. Fund splits for this line are 50% General Fund and 50% federal funds. The FY 07-08 Base Request for continuation of funding is $367,850.

Line Item: Hospital and Federally Qualified Health Clinic Audits	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$250,000**	**$250,000**	**$250,000**	**$350,000**	**$367,850**
Addition of site audits (DI-11, November 1, 2004)	$0	$0	$100,000	$0	$0
Cost-of-living adjustment (DI-11, November 15, 2005)	$0	$0	$0	$17,850	$0
Long Bill Appropriation / Request	**$250,000**	**$250,000**	**$350,000**	**$367,850**	**$367,850**
General Fund	$125,000	$125,000	$175,000	$183,925	$183,925
Federal Funds	$125,000	$125,000	$175,000	$183,925	$183,925

DISABILITY DETERMINATION SERVICES

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

For FY 04-05, a 1331 Emergency Change Request on June 7, 2004 was approved by the Joint Budget Committee that transferred the administration of disability determinations for Medicaid eligible persons from the Department of Human Services to the Department

of Health Care Policy and Financing. This Emergency Request was made official by the implementation of SB 05-112. Starting on July 1, 2004 client applications received by the counties were forwarded to the Department and sent to a contractor for processing.

For FY 05-06, the Department requested $1,173,662. This request included $10,000 for the out-year impact of SB 04-177, which authorized the Children with Autism waiver program. A Cash Funds Exempt transfer of $5,000 from the Colorado Autism Treatment Fund (originating from Tobacco Master Settlement Agreement funding) is matched with federal funds for disability determinations of autism clients.

For FY 06-07, the Department requested and was appropriated continuation funding of $1,173,662, of which $581,831 is General Fund, $5,000 is Cash Funds Exempt, and $586,831 is federal funds. The FY 07-08 Base Request is for continuation funding.

Line Item: Disability Determination Services	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$0**	**$1,163,662**	**$1,173,662**	**$1,173,662**
Out-year impact of SB 04-177 (Autism Bill)	$0	$10,000	$0	$0
Long Bill Appropriation / Request	**$0**	**$1,173,662**	**$1,173,662**	**$1,173,662**
SB 05-112 (FY 04-05 Supplemental Bill)	$1,163,662	$0	$0	$0
Final Appropriation / Request	**$1,163,662**	**$1,173,662**	**$1,173,662**	**$1,173,662**
General Fund	$581,831	$581,831	$581,831	$581,831
Cash Funds Exempt	$0	$5,000	$5,000	$5,000
Federal Funds	$581,831	$586,831	$586,831	$586,831

NURSING HOME PREADMISSION AND RESIDENT ASSESSMENTS

This line item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing home placements for individuals with major mental illness or developmental disabilities. The federal financial participation rate for this activity is 75%.

All admissions to nursing facilities with Medicaid certified beds are subject to preadmission screening and all current residents are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility. This is a federal requirement to receive Medicaid funds.

There are two levels of preadmission resident reviews. Level I pre-screening is comprised of a series of questions related to the diagnosis of a developmental disability or mental illness. It also explores the use of psychotropic medicine in the absence of a justifiable neurological disorder or diagnosis completed in the actual text of the Uniform Long-Term Care 100.2, a form completed by the Single Entry Point agency to determine the level of care (see Long-Term Care Utilization Review). If the Level I screening identifies a mental illness or developmental disability with the need for specialized services, a referral is made to the community mental health center for a Level II evaluation. An individual may be diverted from the Level II evaluation if he/she is determined to not have a major depression.

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

Each year, the Department studies the adequacy of rates and efficiencies in the program by conducting workgroups with the provider community. A forecast of utilization is developed each June and September to assess trends and to adjust the budget accordingly.

The 4.0% Budget Balancing Plan for FY 02-03 projected growth in the number of Level I, Level II and partial evaluations for FY 03-04, with resulting expenditures to grow $91,920 over those of the prior year. This increase was appropriated in the Long Bill, SB 03-258 for FY 03-04, at $1,010,040. The appropriation for this line has remained static since that time, as utilization forecasts have indicated this total budget amount to be adequate. Based on this, continued funding of $1,010,040 for FY 07-08 is requested.

Line Item: Nursing Home Preadmission and Resident Assessments	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$918,120**	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**
SB 03-258 (4% Budget Balancing)	$91,920	$0	$0	$0	$0
Long Bill Appropriation / Request	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**
General Fund	$252,510	$252,510	$252,510	$252,510	$252,510
Federal Funds	$757,530	$757,530	$757,530	$757,530	$757,530

NURSE AIDE CERTIFICATION

Federal regulations under Title 42, §483.150 (b) requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients. The Department of Regulatory Agencies administers the program under an interagency agreement with the Department of Health Care Policy and Financing and the Department of Public Health and Environment. The program is funded from both Medicaid and Medicare dollars. Pursuant to 12-38-101, C.R.S., the Colorado State Board of Nursing in the Department of Regulatory Agencies oversees regulation of certified nurse aides practicing in medical facilities throughout the State. This regulation is carried out under the Nurse Aide Certification program, which includes application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered within the Division of Registrations and is directly overseen by a five member Nurse Aide Advisory Committee.

The Department of Regulatory Agencies is required to conduct the Nurse Aide Certification program in such a way that: 1) there will be established standards for training curriculum to assure that nurse aides receive federally required training, and 2) that there is regular testing of nurse aides to assure competency. The Department of Regulatory Agencies is also responsible for administering a nurse aide registry program which allows for investigations into allegations of abuse by nurse aides, when necessary. The registery also tracks the mandatory criminal background check required for these nursing aides per the passage of HB 95-1266.

State funding for this program is received from General Fund and collected fees from nurse aides directly as part of a cost sharing of the required criminal background check. These State funds are then used to draw down federal matching funds. Specifically, 12-38.1-103 (6), C.R.S. (2006) requires the Department of Public Health and Environment and the Department of Health Care Policy and Financing to pursue federal dollars under Medicare and Medicaid, respectively, to help pay the costs associated with this program.

The following table delineates the Department of Regulatory Agencies' budget for this program for the most recent four years. The Medicaid portion of these amounts has been 48.64% of the total, as determined by a Department of Regulatory Agencies' allocation between Title XVIII (Medicare), Title XIX (Medicaid), and license only certifications.

Purpose of Funds for the Nurse Aide Certification Program

Line Item: Nurse Aide Certification Program	FY 06-07 Appropriation	FY 07-08 Base Request
Personal Services	$241,903	$281,583
Operating	$10,930	$17,000
Hearings	$0	$2,172
Indirect Costs	$252,497	$252,497
Health/Life/Dental	$14,582	$14,040
Short-term disability	$368	$373

Line Item: Nurse Aide Certification Program	FY 06-07 Appropriation	FY 07-08 Base Request
Salary Survey/Pay for Performance	$15,685	$11,676
Worker's Comp	$573	$455
Legal Services	$58,745	$60,000
Administrative Law Judge	$0	$0
General Government Computer Center	$1,545	$1,320
Risk Management	$915	$603
Hardware/Software Maintenance (DLS)	$0	$0
IT Asset Maintenance	$0	$0
Leased Space	$37,103	$27,211
Total Costs	**$634,846**	**$668,930**
Department of Health Care Policy and Financing's Share	$308,766	$325,343

Appropriation History

The FY 04-05 Long Bill (HB 04-1422) appropriation was $297,769, based upon the prior year's final appropriation of $310,330, less $12,561 for a technical adjustment requested in a Department Stand-Alone Budget Amendment (BA-5, January 23, 2004) to true-up the appropriated amounts between the Department and the Department of Regulatory Agencies.

The FY 05-06 Long Bill appropriation was $319,088, which includes adjustments from the FY 04-05 Long Bill appropriation for POTS increases totaling $21,329. This amount was later revised with the passage of the Department's FY 05-06 Supplemental Bill (HB 06-1217) which incorporated a Department request (non-prioritized Supplemental S-1, January 3, 2006) to again realign the two department's appropriated amounts for this program, and to use an existing fund balance administered by the Department of Regulatory Agencies to cover the State's share of these expenditures for the next two fiscal years. The final FY 05-06 appropriation was $293,623.

The FY 06-07 Long Bill was for $308,766. This new appropriation included an increase of $15,143 for Common Policy items, as outlined in the "Purpose of Funds for the Nurse Aide Certification Program" table above.

The FY 07-08 Base Request for this line is $325,343, reflecting an increase of $16,577 for Common Policy items. In addition, this Base Request reflects the need to use General Fund again for the State's share of these expenditures. As mentioned above, the cash fund for fees collected by nurse aides is anticipated to be nearly exhausted after the end of FY 06-07. As such, this funding source must be returned to normal levels, bringing the anticipated Cash Funds Exempt amount to $14,652.

Line Item: Nurse Aide Certification	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$310,330**	**$297,769**	**$293,623**	**$308,766**
True-up of appropriation with Department of Regulatory Agencies (BA-5, January 23, 2004)	($12,561)	$0	$0	$0
Adjustments for Common Policies	$0	$21,329	$15,143	$16,577
Long Bill Appropriation / Request	**$297,769**	**$319,098**	**$308,766**	**$325,343**
HB 06-1217 – Utilization of cash fund at the Department of Regulatory Agencies to eliminate General Fund for two fiscal years, and reduction of funds to re-align the two departments' budgets (non-prioritized Supplemental S-1, January 3, 2006)	$0	($25,475)	$0	$0
Final Appropriation / Request	**$297,769**	**$293,623**	**$308,766**	**$325,343**
General Fund	$136,041	$0	$0	$148,020
Cash Funds Exempt	$12,844	$146,812	$154,383	$14,652
Federal Funds	$148,884	$146,811	$154,383	$162,671

DEPARTMENT OF REGULATORY AGENCY IN-HOME SUPPORT REVIEW

In October 2004, the Department incorporated a new method of service under the Elderly, Blind and Disabled and Children's Home and Community Based Services waivers to allow Medicaid clients who are eligible for In-Home Support Services to direct, select and train their own attendant care. In-Home Support Services includes health maintenance activities, support for activities of daily living or instrumental activities of daily living, personal care service and homemaker services. Additionally, core independent living skills are provided. These skills include: a) cross-disability peer counseling, b) information and referral services, c) independent living skills training, and d) individual and systems advocacy.

In-Home Support Services' agencies are a new Medicaid provider type. In order to qualify as an agency, an entity must offer independent living core services, provide 24-hour back-up services, and contract with or have on staff a health professional that will be responsible for oversight of training of attendants. Each In-Home Support Services' agency must submit a provider enrollment application and participate in an on-site survey conducted by the Colorado Department of Public Health and Environment. Attendants selected by the clients will be employed by an In-Home Support Services agency of their choice.

Because these agencies are a new provider type, the Department of Regulatory Agencies is required to conduct a study of this new profession and/or occupation, as stated in 24-34-104.1, C.R.S. (2006). This is accomplished by the Office of Policy, Research and Regulatory Reform within the Department of Regulatory Agencies. This office will commence a literature review including statutory

analysis of State and federal laws, and review of documentation on similar programs in other states. Stakeholders, agency staff, and other interested parties will be surveyed and agency records and files will be reviewed, as appropriate.

Per the Department of Regulatory Agencies, a review of this type will take approximately 150 hours in FY 06-07 for the research and for a portion of the production of the report. This estimate is based on previous reviews of similar programs. The hourly rate used in estimating FY 06-07 totals was $40.08, which was the billable rate used by the Department of Regulatory Agencies in FY 05-06. Work will continue into FY 07-08, with the sunset report to be completed and presented to the General Assembly by October 2008.

The FY 06-07 Long Bill appropriated $6,000 to the Department which will be transferred to the Department of Regulatory Agencies.

The FY 07-08 Base Request is for $4,000 to complete the review. Both of these amounts were requested based on an August 12, 2006 letter from Bruce Harrelson, Director of the Office of Policy, Research and Regulatory Reform at the Department of Regulatory Agencies (non-prioritized Stand Alone Budget Amendment BA-11, January 24, 2006).

Line Item: Department of Regulatory Agency In-Home Support Review	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$0**	**$6,000**
Annualization of In-Home Support Review (NP-BA11, January 24, 2006)	$0	($2,000)
Long Bill Appropriation / Request	**$6,000**	**$4,000**
General Fund	$3,000	$2,000
Federal Funds	$3,000	$2,000

NURSING HOME QUALITY ASSESSMENT

This function was mandated by the Omnibus Budget Reconciliation Act of 1990 and provides funding for quality assessment reviews of nursing homes. This program is administered by the Department of Public Health and Environment for enforcement of federal quality assessment regulations. Pursuant to SB 89-005, 83% of this line is for the Department's enforcement of federal quality assessment regulations, including the Department's legal expenses with payment to the Department of Law, and 17% is for other reimbursable expenses. The line item supports legal costs related to the Department of Public Health and Environment Facility Survey and Certification line item. This appropriation also covers any litigation that might result from findings of facility survey reports. HB 02-1370 reduced the FY 01-02 appropriation by $272 as part of the Department of Public Health and Environment's 1.0% reduction. The federal financial participation is 75%.

There were no Medicaid expenditures at all for this line during FY 02-03 or FY 03-04. Per Joint Budget Committee action during the 2005 Figure Setting session for the Department of Public Health and Environment, this appropriation was discontinued, due to the lack of utilization of funds. Therefore, there was no appropriation in FY 05-06 and FY 06-07. There is no Base Request for FY 07-08.

Line Item: Nursing Home Quality Assessments	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**$26,955**	**$26,955**	**$26,954**	**$26,954**	**$0**	**$0**
Adjustment to tie to Long Bill	$0	($1)	$0	$0	$0	$0
POTS and Administrative Costs	$0	$0	$0	($26,954)	$0	$0
Long Bill Appropriation / Request	**$26,955**	**$26,954**	**$26,954**	**$0**	**$0**	**$0**
Final Appropriation / Request	**$26,955**	**$26,954**	**$26,954**	**$0**	**$0**	**$0**
General Fund	$6,739	$6,738	$6,738	$0	$0	$0
Federal Funds	$20,216	$20,216	$20,216	$0	$0	$0

NURSING FACILITY APPRAISALS

Nursing facility appraisals occur once every four years. The Department contracts with an independent firm to conduct these appraisals, with the underlying result being the determination of "fair rental value." Fair rental value, or appraised value, means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. The fair rental (property) value determination is used in the process of rate setting, which is governed by statute at 25.5-6-203, C.R.S. (2006). The per diem rate paid to nursing facilities is based in part on the fair rental value of the facility. The last time the Department received funding for this purpose was in FY 01-02 for a total of $272,992, 50% General Fund and 50% federal funds. However, the work and funding was rolled forward into FY 02-03. There were 194 nursing facilities appraised in FY 02-03 with actual expenses to the Department of $266,171. FY 06-07 is the next fiscal year for nursing facility appraisals to occur, for which the Department requested funding of $266,171, equal to the amount expended in FY 02-03, in its FY 06-07 Budget Request on November 15, 2006. The Department, however, received a total appropriation of $279,746 for this line item through a Joint Budget Committee action to account for a 5.1% inflation factor. Continuation funding will not be requested for this line item in FY 07-08, as nursing facility appraisals will not be conducted again until FY 10-11.

PRIMARY CARE PROVIDER RATE TASK FORCE AND STUDY

The Department was appropriated $58,000 with the passage of the FY 06-07 Long Bill (HB 06-1385) for the Primary Care Provider Rate Task Force and Study. The goal of this task force is to work with the provider community to examine any issues of rate disparity

and rate shortfalls for physician and acute care providers. The appropriated funds are intended to cover the expenses of any task force the Department may assemble and for any temporary staffing costs that may be incurred for conducting such a study. A report for preliminary findings has been requested by November 1, 2006 per Footnote 22 in the Long Bill. The final report is due by November 1, 2007; and, because work may extend though FY 07-08, this line has an out-year base request of $19,334, which is a three month annualization of the FY 06-07 appropriation. These funds will be used to cover expenses germane to the completion of this study.

Line Item: Primary Care Provider Rate Task Force and Study	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**$0**	**$58,000**
Annualization of HB 06-1385	$0	($38,666)
Long Bill Appropriation / Request	**$58,000**	**$19,334**
General Fund	$29,000	$9,667
Federal Funds	$29,000	$9,667

ESTATE RECOVERY

The estate recovery program, authorized in 26-4-403.3, C.R.S. and established by HB 91S2-1030, is operated by a contractor under supervision of the Department. The program recovers funds from estates and places liens on real property held by Medicaid clients in nursing facilities or client's who are over the age of 55. The contractor pursues the recoveries on a contingency fee basis. The recoveries are an offset to the Medical Services Premiums line.

Each year, the estate recovery program has grown. The appropriation for this line item has been adjusted to fit the estimated recoveries by the contractor. From FY 92-93 through FY 95-96, the Estate Recovery program was on a contractual fee basis. In FY 96-97, a supplemental appropriation, as well as Change Request DI-11, submitted November 1, 1996, brought the maximum contingency fee amount for FY 97-98 to $500,000. In FY 96-97 and FY 97-98, the contractor was paid a fee of 16%. From FY 98-99 to FY 00-01, the appropriation was still set at $500,000, although the contingency fee was reduced from 16% to 13.5%.

In FY 00-01, the appropriation of $500,000 was reduced by $78,125. Program recoveries in FY 00-01 however, totaled $4,904,163 and required a supplemental appropriation in FY 00-01 because the reduced appropriation fell short of the amount necessary to continue the payment of the contract fee. This supplemental appropriation adjusted the maximum contingency fee amount to $700,000. If the appropriation is set too low, the contractor must stop recoveries until it is adjusted by the General Assembly. Therefore, the maximum contingency fee total has been held at $700,000 in order to accommodate above-average levels of recoveries. Since FY 00-01, the appropriation for Estate Recovery remained at $700,000, with a split of 50% Cash Funds, and 50% federal funds.

From FY 03-04 onward, a negotiated rate of 10.9% has been paid to the contractor. Since implementation, the estate recovery program has recovered a net amount of $36,185,697 for Medicaid. The total net estate recoveries for FY 05-06 were $5,740,617. The current contingency fee allows for maximum recoveries of $6,422,018. The Department's FY 07-08 Base Request is for continuation funding of $700,000.

Line Item: Estate Recovery	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Long Bill Appropriation / Request	**$700,000**	**$700,000**	**$700,000**	**$700,000**	**$700,000**
Cash Funds	$350,00	$350,000	$350,000	$350,000	$350,000
Federal Funds	$350,00	$350,000	$350,000	$350,000	$350,000

Estate Recovery - History of Net Recoveries				
Year	**Amount Recovered**	**Number of Cases**	**Fees Paid**	**Net Recoveries**
FY 92-93	$5,575	3	$273,883	($268,308)
FY 93-94	$418,224	41	$308,708	$109,516
FY 94-95	$883,217	63	$251,560	$631,657
FY 95-96	$1,989,421	141	$360,000	$1,629,421
FY 96-97	$2,559,513	167	$409,522	$2,149,991
FY 97-98	$2,727,744	152	$436,439	$2,291,305
FY 98-99	$2,596,736	132	$350,559	$2,246,177
FY 99-00	$3,376,330	175	$455,805	$2,920,525
FY 00-01	$4,904,163	149	$662,062	$4,242,101
FY 01-02	$3,845,730	195	$521,992	$3,323,738
FY 02-03	$3,878,211	172	$530,164	$3,348,047
FY 03-04	$4,750,954	201	$528,127	$4,222,827
FY 04-05	$4,767,493	209	$541,822	$4,225,671
FY 05-06	$5,740,617	165	$627,588	$5,113,029
Total	**$42,443,928**	**1,965**	**$6,258,231**	**$36,185,697**

SINGLE ENTRY POINT ADMINISTRATION

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

From FY 01-02 to FY 02-03, the funding remained static at $65,900. In FY 03-04, the Joint Budget Committee recommended a 10% reduction in the appropriation to help in balancing the statewide budget shortfall (Figure Setting, March 13, 2003, page 73) which was approved in the FY 03-04 Long Bill SB 03-258. The appropriation remained at $59,310. However, to bring the funding level more in line with actual historical expenditures, the Joint Budget Committee recommended a reduction to this line item in FY 05-06 of $6,310, bringing the total appropriation to $53,000 total funds (Figure Setting, March 15, 2005, page 70). Continuation funding of $53,000 was appropriated in FY 06-07, and is requested at the same amount for FY 07-08.

Line Item: Single Entry Point Administration	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**$65,900**	**$59,310**	**$59,310**	**$53,000**	**$53,000**
FY 03-04 Joint Budget Committee Action	($6,590)	$0	$0	$0	$0
FY 05-06 Joint Budget Committee Action	$0	$0	($6,310)	$0	$0
Long Bill Appropriation / Request	**$59,310**	**$59,310**	**$53,000**	**$53,000**	**$53,000**
General Fund	$29,655	$29,655	$26,500	$26,500	$26,500
Federal Funds	$29,655	$29,655	$26,500	$26,500	$26,500

SINGLE ENTRY POINT AUDITS

This line item funds annual audits of Single Entry Point agencies. Prior to FY 04-05, the Department of Human Services' field audit staff, through an interagency agreement with the Department, performed these audits. During FY 02-03 and FY 03-04, the Department of Human Services performed these audits with an appropriation of $35,339 and $35,340, respectively. In FY 04-05 however, the Department of Human Services' field audit staff was reduced by 4.0 FTE, and due to this reduced appropriation, the Department of Human Services could no longer conduct the Single Entry Point audits. Therefore, in FY 04-05, the Department retained an outside contractor to review Single Entry Point agency cost reports provided by the 25 Single Entry Point agencies. However, the work and funding was rolled forward to FY 05-06.

The outside contractor has continued to perform these cost report reviews, although funding levels did not support conducting on-site reviews. Due to limited time and funding, during FY 05-06 the contractor reviewed each cost report and determined which agencies posed the highest risk. On-site audits were then performed on any agency measuring at the highest risk level to the extent that funds allowed. State auditors determined that the Single Entry Point Audit program had been out of federal compliance for the past three years due to not conducting the required annual audits of the 25 Single Entry Point agencies, not conducting them in a timely manner,

and not recouping improper payments. In order to bring the audits into compliance with State auditor findings, to increase the accuracy of Single Entry Point agency bills, and to potentially recoup greater amounts of improper payments, the Department requested additional funding of $76,660 for FY 06-07 (DI-5, November 15, 2005). Total funds of $112,000 were appropriated for Single Entry Point Audits in FY 06-07, and the Department requests continuation funding of this amount for FY 07-08.

Line Item: Single Entry Point Audits	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**$35,340**	**$35,340**	**$35,340**	**$35,340**	**$112,000**
Additional funding to bring into compliance with federal and State regulations (DI-5, November 15, 2005)	$0	$0	$0	$76,660	$0
Long Bill Appropriation / Request	**$35,340**	**$35,340**	**$35,340**	**$112,000**	**$112,000**
General Fund	$17,670	$17,670	$17,670	$56,000	$56,000
Federal Fund	$17,670	$17,670	$17,670	$56,000	$56,000

SB 97-05 ENROLLMENT BROKER

Funding for a Medicaid managed care enrollment broker was appropriated to the Department through SB 97-05. The enrollment broker is charged with providing information on basic Medicaid benefits offered through all health plans. The Department's enrollment broker contract was awarded in 1998 to Maximus, Inc.

Maximus, Inc. contacts newly eligible Medicaid clients to inform clients of Medicaid plan choices. If a client chooses the Primary Care Physician Program or a health maintenance organization, Maximus will enroll the client in the plan. Maximus also enrolls and disenrolls clients from the managed care plans following Medicaid rules. Maximus does this work under the name of Health*Colorado*.

During the 2002 legislative session, HB 02-1292 was passed, making changes to the State's managed care system. These changes included new mailing requirements for client notices. Specifically, HB 02-1292 eliminated the requirement to send two notices informing Medicaid clients of their choices for managed care (either the Primary Care Physician Program or a health maintenance organization). It also reduced the time period for Medicaid clients to notify the Department through the enrollment broker of their choice from 65 days to 30 days.

Budget Balancing also affected this line. For FY 02-03, the Department submitted a base reduction in Supplemental Request #4 to the enrollment broker as part of the 4% Budget Balancing on November 15, 2002, that would reduce administrative costs for the enrollment broker by 6.5%. The estimated impact to this line was a reduction of $69,260 total funds. Also included in Supplemental

Bill SB 03-203 was the impact of a Change Request submitted January 2, 2003 (S-11 and BA-6) to fund the implementation of new federal managed care rules. These federal rules required the development of a client handbook and mailings for the Primary Care Physician Program. In FY 02-03, this resulted in an increase of $15,440 for design costs, open enrollment, and enrollment broker system changes. The net impact for these two Supplementals was $53,820. Also in the 2003 legislative session, SB 03-187 resulted in a FY 02-03 contract reduction of $254,860. Staffing and overhead were reduced for FY 03-04 and included in the base budget for future years.

In FY 03-04, one-time funding of $460,089 was appropriated via SB 03-258 to pay for the following: printing and mailing client information; production and mailing of the Primary Care Physician Program client handbook; monthly mailings to new voluntary clients; and additional system changes. This appropriation had two parts, with the first being for on-going monthly mailings and the second for one-time only projects in FY 03-04.

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

In FY 05-06, the Base Request was $875,756, the same as FY 04-05. With the implementation of HB 05-1262, the Tobacco Tax Bill, the appropriation was increased by $45,589 to fund enrollment letter printing and mailing costs to an additional 23,524 clients. However, a technical correction for FY 05-06 in the Add-Ons to the 2006 Long Bill (HB 06-1385) reduced this increase by $2,211 for a revised spending authority of $919,134. (See also the Department's 1331 Emergency Supplemental Request for this correction dated June 2, 2005.) Only $875,756 was actually expended for this line item in FY 05-06 because implementation of the caseload expansion was delayed until July 2006.

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

The Department requests continuation funding of $942,784 for FY 07-08. The federal financial participation rate for enrollment broker is 50%. Of the State's portion, $33,514 will be paid from Cash Funds Exempt (from the Health Care Expansion Fund) and the remainder, $437,878, is requested as General Fund.

Line Item: SB 97-05 Enrollment Broker	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$702,781**	**$1,162,870**	**$875,756**	**$919,134**	**$942,784**
Impact of Managed Care (S-11and BA-6, January 2, 2003)	$460,089	($287,114)	$0	$0	$0
Annualization of impact from HB 05-1262 expansion	$0	$0	$0	$23,650	$0
Long Bill Appropriation / Request	**$1,162,870**	**$875,756**	**$875,756**	**$942,784**	**$942,784**
HB 05-1262 – Expansion population increase	$0	$0	$45,589	$0	$0
HB 06-1385 Add-Ons – Adjust appropriation in HB 05-1262	$0	$0	($2,211)	$0	$0
Final Appropriation / Request	**$1,162,870**	**$875,756**	**$919,134**	**$942,784**	**$942,784**
General Fund	$581,435	$437,878	$437,878	$437,878	$437,878
Cash Funds Exempt	$0	$0	$21,689	$33,514	$33,514
Federal Fund	$581,435	$437,878	$459,567	$471,392	$471,392

HB 01-1271 MEDICAID BUY-IN

HB 01-1271 authorized a Medicaid Buy-in Program for disabled individuals who were not otherwise eligible for Medicaid due to their level of employment earnings. This Colorado program was intended to tie in with the federal "Ticket to Work and Work Incentives Improvement Act of 1999." The Department was directed to study the feasibility of this plan and to seek federal approval. Grants, gifts, and donations were to be deposited in the Medicaid Buy-In Cash Fund created by legislation to fund the program and all program expenditures were to be classified as Cash Funds Exempt. Premiums, set in accordance with an actuarial analysis of the population, were to be structured to offset program costs in order to assure budget neutrality. HB 01-1271 allocated $209,400 total funding including $80,000 Cash Funds Exempt and $129,400 federal funds in FY 01-02.

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

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

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

To implement the legislation, a request for proposals for a feasibility study was issued in FY 01-02. A contract for $100,000 for the actuarial feasibility study was executed in December 2002, requiring an actuarial report to be completed in April 2003.

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

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

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

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

The new proposal was approved for continued funding in the amount of the original grant. With the grant extended to December 31, 2004, all elements of the revised grant were accomplished. A report on options to implement personal care as a Medicaid state plan benefit was completed. The grant staff also designed the consumer friendly written and electronic materials about Medicaid benefits and programs for adults with disabilities, as well as the development of the Community-Based Personal Assistance Services and Supports Navigators project and self-assessment tool.

Appropriation History:
In FY 01-02, HB 01-1271 appropriated $209,400 total funding including $80,000 Cash Funds Exempt and $129,400 federal funds. HB 02-1420 appropriated total funds of $327,427 (100% federal funds) for FY 02-03. In FY 03-04, $37,519 (100% federal funds) was appropriated through SB 03-258. In FY 04-05, the final appropriation was $65,081, all of it federal funds. In FY 04-05, all activity for this line item ceased. There was no request for FY 05-06 and FY 06-07. There is no Base Request for FY 07-08.

NON-EMERGENCY TRANSPORTATION SERVICES

The Department provides non-emergency transportation to and from medically necessary services for clients who have no other means of transportation throughout all sixty-four counties in Colorado. Section 26-4-302 (1.5), C.R.S. 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 Transportation Services."

The Department 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.

Beginning in October 2002, Arapahoe County Transportation Services performed the transportation "broker" function for the eight counties. In September 2004, Arapahoe County Transportation Services closed down, and the Department was required to enter into an emergency contract with LogistiCare for October 1, 2004 through June 30, 2005. This provided support for the eight Front Range counties for the remainder of FY 04-05.

During the same fiscal year, on September 3, 2004, the Department of Health Care Policy and Financing and the Department of Human Services submitted a 1331 Emergency Supplemental to the Joint Budget Committee to transfer funds from the Developmental Disability Services waiver from the Department of Human Services to the Department of Health Care Policy and Financing. The transfer was necessary to fund State Plan services for waiver clients that were previously being paid out of the waiver. This was a condition for renewal with the Centers for Medicare and Medicaid Services for the Comprehensive Services waiver for individuals with developmental disabilities. The Joint Budget Committee approved the 1331 Emergency Supplemental on September 21, 2004. The Supplemental also included a transfer of funds for non-emergency transportation.

While the transfer of funds helped in providing services for individuals with developmental disabilities, it did not resolve the issue of providing services for the remaining population. The Department issued a request for proposals on March 22, 2005 for the broker responsibilities for the eight front-range counties to begin in FY 05-06. The bid was again awarded to LogistiCare; however, LogistiCare refused to sign the contract citing concerns about spikes in utilization and inadequate funding. The end result of this was a failed procurement. Since the Department is required by the Centers for Medicare and Medicaid Services to provide non-emergency medical transportation for Medicaid clients with no other means of transportation, LogistiCare agreed to continue providing the services through March 31, 2006 under an emergency nine-month contract from July 1, 2005 through March 31, 2006 for $3,595,777. In FY 05-06, the Department submitted and was awarded a 1331 Emergency Supplemental on June 20, 2006 for $1,121,497. This amount was necessary due to increased contract costs as a result of the request for proposals, and while it was not an official appropriation, this increase did provide the Department with temporary spending authority to cover the anticipated shortfall at year-end.

In FY 06-07, $5,068,722 was appropriated for non-emergency medical transportation. This Long Bill appropriation included a Joint Budget Committee action for a 2.57% rate increase equal to $127,002, and approval of a Department request to transfer $485,732 from the (6) Department of Human Services – Medicaid Funded Programs, (D) County Administration line item for administration work being performed by the transportation broker in the 8 Front Range counties (DI-9, November 15, 2006). The prior year's 1331 Emergency Supplemental amount was not included, as it was requested after the Long Bill was enacted.

Also during the 2006 legislative session, SB 06-165 was enacted which directs the Department to conduct research on ways to implement a telemedicine pilot program in FY 06-07, and carry out the actual implementation of the telemedicine pilot program in FY 07-08. Unfortunately, the appropriations clause of this piece of legislation inadvertently applied the anticipated $493,559 in savings to the Department's Medical Services Premiums line item. As a result, the Non-Emergency Transportation Services appropriation does not reflect any reductions for anticipated savings until FY 07-08.

The Department's FY 07-08 Base Request is for $4,575,163. This amount includes continuation funding from the prior year, less the out-year reduction of $493,599 per SB 06-165.

Line Item: Non-Emergency Transportation Services	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation / Request	**$4,400,778**	**$4,421,479**	**$4,455,988**	**$5,068,722**
Annualization of separating Developmental Disability waivered services from State Plan services per 1331 Emergency Supplemental (September 2, 2004)	$0	$34,509	$0	$0
Joint Budget Committee action for a 2.57% rate increase	$0	$0	$127,002	$0
Transfer of funding from County Administration	$0	$0	$485,732	$0
Annualization of SB 06-165	$0	$0	$0	($493,559)
Long Bill Appropriation / Request	**$4,400,778**	**$4,455,988**	**$5,068,722**	**$4,575,163**
SB 05-112 – Official appropriation of 1331 Emergency Supplemental (September 2, 2004) to separate Developmental Disability waivered services and State Plan services	$20,701	$0	$0	$0
Final Appropriation / Request	**$4,421,479**	**$4,455,988**	**$5,068,722**	**$4,575,163**
General Fund	$2,210,740	$2,227,994	$2,534,361	$2,287,582
Federal Funds	$2,210,739	$2,227,994	$2,534,361	$2,287,581

SCHOOL DISTRICT ELIGIBILITY DETERMINATION

During the 2006 legislative session, the General Assembly passed HB 06-1270 which recognized that many children that were being served through the National School Lunch Act could also be served by Medicaid or the Children's Basic Health Plan. The General Assembly found that only half of all eligible children were enrolled in the Children's Basic Health Plan and that many of the children that receive free or reduced-cost lunches under the National School Lunch Act are also eligible for benefits under Medicaid or the Children's Basic Health Plan. Currently, school districts are authorized to make eligibility determinations for the National School

Lunch Program. In order to increase enrollment into Medicaid or the Children's Basic Health Plan, HB 06-1270 creates a demonstration project to authorize qualified medical personnel to make eligibility determinations for medical benefits under Medicaid or the Children's Basic Health Plan. HB 06-1270 instructs the Department to convene an advisory committee to do the following:

- Develop a model application form that includes federally required eligibility information, a notification of whether or not the child qualifies for Medicaid or the Children's Basic Health Plan, a request for applicant's consent to share the information on the form, a listing of the eligibility requirements, and information regarding Medicaid and the Children's Basic Health Plan;
- Establish criteria for the selection of school districts to be used in the pilot program;
- Solicit and review proposals from schools to participate in the demonstration project; and,
- Make recommendations to the Department's Executive Director as to which schools will participate on or before March 1, 2007.

School districts in the demonstration program are allowed to seek reimbursement from the State or federal government for costs associated with Medicaid or Children's Basic Health Plan eligibility determination. The Department will advise schools as to whether or not they are eligible to receive federal participation funds for costs associated with the same eligibility determinations. If the State receives sufficient gifts, grants, or donations, the Department will contract for an independent evaluation of the project, the results of which will be given to the Health and Human Services Committees for review before January 15, 2010.

In FY 06-07, funding for the School District Eligibility Determination program is expected to total $59,532. The Legislature projects that the Department will receive a federal participation rate of 50% and that only $29,766 in General Fund will be required. Of the entire Long Bill appropriation, Personal Services will receive $49,656 and 1.0 full time equivalent (FTE), and Operating Expenses will receive $9,876.

In FY 07-08, the Department's Base Request totals is expected to total $227,292 in State Funds, of which $79,269 is General Fund, $25,854 is Cash Funds Exempt, and $122,169 is federal funds. The federal portion of the appropriation is more than 50% of total expenditures because State expenditures through the Children's Basic Health Plan receive a 65% federal match rate. The following table details the appropriation to the School District Eligibility Determination program in FY 06-07 and FY 07-08.

Line Item: School District Eligibility Determination	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$0**
Annualization of HB 06-1270	$227,292
Long Bill Appropriation / Request	**$227,292**
General Fund	$79,269
Cash Funds Exempt	$25,854
Federal Funds	$122,169

COUNTY ADMINISTRATION

Funding in the County Administration appropriation provides for partial reimbursement to local county departments of social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to July 1, 2006, this funding was included in the Department of Human Services budget, showing up as Cash Funds Exempt through an interagency transfer, and was combined with the corresponding appropriation for non-Medicaid programs such as food stamps and cash assistance programs administered by this sister agency. However, with the passage of SB 06-219, oversight and funding for the Medicaid portion of county administration was transferred to the Department, beginning in FY 06-07, thereby establishing a direct relationship between the Department and the counties performing these functions. To assist in this change in oversight, the Department received funding from the Department of Human Services for 1.0 FTE at a General Professional IV level, appropriated in the Personal Services line item, to act as a liaison between the Department and the local governments. In addition, the Department absorbed the accounting and budgeting functions for this appropriation with existing resources.

As part of the Department's fiscal note for this new 2006 legislation, it was agreed upon by the Department and the Department of Human Services that the allocation and reimbursement methodology would remain the same prior to July 1, 2006. This included: 1) using the existing random moment sampling model performed by the Department of Human Services to determine the allocation of expenditures between programs administered by the Department and those administered by the Department of Human Services; 2) continuing the cost-sharing allocation that existed between the State and local governments at 80% and 20% respectively; 3) continuing to utilize the County Financial Management System (CFMS) for counties to have one-stop billing; and 4) utilizing interagency transfers of State General Fund to maximize Medicaid reimbursement to the counties, thereby maximizing reimbursement of county expenditures.

For FY 06-07, the Department worked with the Department of Human Services to coordinate an allocation letter for this program, which indicated the amount each county would be allocated of the total Medicaid appropriation. In this initial year, prior to allocating available funds, the Department and the Department of Human Services carved out a total of $500,000 (only $168,456 is Medicaid funds) from State appropriated funds, to perform a workload study that will assist the State in determining if current funding levels are sufficient to experienced costs at the county level. The remaining funds, however, were allocated as follows:

- First, each county received a "base" allocation of $67,715 (only $22,814 is Medicaid) to allow the county departments of social services enough funding just to be ready for business and open their doors. The sum of these individual county amounts is $1,460,096.
- Second, each county was allocated a portion of the remaining funding based on the previous fiscal year's allocation percentages. These percentages were based upon a previous workload study, which will be updated once the new workload study is complete.

- Third, each county's allocation was adjusted to account for the use of a transportation broker being used to provide administration and non-emergency transportation in eight Front Range counties (the eight Front Range counties' percentages were lowered, and the remaining 56 counties' percentages were increased). Using these updated percentages, the sum of all county administration funding for the 64 counties was $16,475,396.
- Lastly, there was $202,680 for county administration funding associated with low-income subsidy determinations (required by the Medicare Modernization Act of 2003) that was appropriated without any additional cost-sharing to the counties. As such, this money is split 50% General Fund and 50% federal funds. The Department allocated this funding separately from the $16,475,396 above, using the ratio of an individual county's dual eligible population (clients both Medicare and Medicaid eligible) to the total State dual eligible population.

All counties are paid either through electronic fund transfers or warrants. Reimbursement is always done in arrears of random moment sampling collection. If a need for additional General Fund exists to maximize Medicaid reimbursement, the Department of Human Services has agreed assist in this interagency transfer of spending authority.

Additional details about the programs' appropriation history prior to FY 06-07 for County Administration can be found in the Department's narrative for Long Bill group (6) Department of Human Services, Medicaid Funded Programs, (D) County Administration. Funding in FY 06-07 is equal to the FY 06-07 Long Bill appropriation for the original Department of Human Services – Medicaid Funded transfer line. The Department has requested continuation funding for FY 07-08.

Line Item: County Administration	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**N/A**	**$18,306,628**
Long Bill Appropriation / Request	**$0**	**$18,306,628**
SB 06-219, Transfer to (1) Executive Director's Office Long Bill group in the Department's budget	$18,306,628	$0
Final Appropriation / Request	**$18,306,628**	**$18,306,628**
General Fund	$5,435,396	$5,435,396
Cash Funds Exempt	$3,717,918	$3,717,918
Federal Funds	$9,153,314	$9,153,314

COUNTY ADMINISTRATION–ADMINISTRATIVE CASE MANAGEMENT PAYMENTS TO COUNTIES

With the passage of SB 06-219, the oversight of administrative case management related to programs administered by the Department was transferred from the Department of Human Services, beginning July 1, 2006. This appropriation is the sum of funding that initially appeared in the State's budget beginning in FY 05-06, which was included in both the Department of Human Services'

Division of Child Welfare and Family and Children's Programs. Medicaid funding for these programs, prior to FY 06-07, was transferred through interagency transfers, originating in the Department's Long Bill group (6) Department of Human Services – Medicaid Funded Programs appropriations.

Funding for administrative case management includes reimbursement for staff and operating costs associated with State supervision and county administration of programs that protect and care for children, including out-of-home placement, subsidized adoptions, child care, and burial reimbursements. Medicaid funding for these costs was identified through a contingency based contract held between the Governor's Office of State Planning and Budgeting and the Public Consulting Group (PCG).

Similar to the County Administration appropriation narrated above, State appropriated funding for these services must be allocated across all 64 counties. The Department and the Department of Human Services agreed that the best allocation for this new revenue was to base funding on the current allocation percentages used in the Child Welfare program administered by the Department of Human Services. Also similar to the County Administration appropriation, the Department of Human Services has agreed to provide additional General Fund spending authority, to maximize Medicaid reimbursement. This allows the State to maximize available matching federal funds. There is no county share associated with these dollars.

Additional details about the programs' appropriation history prior to FY 06-07 can be found in the Department's narrative for Long Bill group (6) Department of Human Services, Medicaid Funded Programs, (E) Child Welfare Services, and Family and Children's Program. The Department's FY 07-08 request is for continuation funding of $1,593,624.

Line Item: County Administration - Administrative Case Management Payments to Counties	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**N/A**	**$1,593,624**
Long Bill Appropriation / Request	**$0**	**$1,593,624**
SB 06-219, Transfer to (1) Executive Director's Office Long Bill group in the Department's budget	$1,593,624	$0
Final Appropriation / Request	**$1,593,624**	**$1,593,624**
General Fund	$796,812	$796,812
Federal Funds	$796,812	$796,812

(2) MEDICAL SERVICES PREMIUMS

I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, disabled, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year. The first section of the Assumptions and Calculations for the Medical Services Premiums describes the Medicaid caseload projection. The second section describes the development of the per capita cost, the application of per capita caseload and bottom line adjustments. A series of exhibits in this Budget Request support these Assumptions and Calculations.

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

1. Adjustments have been made to caseload and per capita costs for estimated impacts due to HB 05-1262, the Tobacco Tax Bill. The costs are calculated through normal Medical Services Premiums per capita cost methodology. Expenditure for the programs included in HB 05-1262 is from Cash Funds Exempts sources other than the General Fund. Adjustments to ensure that funding is requested from the Health Care Expansion Fund are incorporated into Exhibit A, pages EA-1 and EA-2. Pages EA-3 through EA-6 provide detail on the components of the fund splits.

2. The implementation of the Medicare Modernization Act on January 1, 2006 impacts prescription drug estimates in the FY 06-07 Budget Request. Cost savings estimates for prescription drugs have been accounted for in the per capita estimates.

3. The Department is currently contracting with one managed care plan as a managed care organization and with another health plan to provide services to clients as an administrative service organization (ASO). An ASO receives a monthly administrative fee per client and is not at risk for the cost of services. The Department did not renew its contract with one ASO in May, 2006, and one managed care plan did not renew its contract with the Department, in September, 2006.

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

5. The elimination of presumptive eligibility for Medicaid pregnant women on September 1, 2004, which was reinstated by HB 05-1262, effective July 1, 2005.

6. The Department implemented a policy of "Passive Enrollment" in May 2006, which requires most clients in Adams, Arapahoe, Denver, and Jefferson counties to choose between the fee-for-service program, primary care physician program, or managed-care program. Clients who do not make a selection are defaulted into an assigned managed-care program.

7. The Deficit Reduction Act of 2005 and HB 06S-1023 require individuals to provide documentary evidence of citizenship and identity prior to the receipt of public benefits. Though the caseload impact is indeterminate because the State provides Medicaid benefits only to lawful citizens or nationals of the United States, these Acts will increase the costs and processing times of Medicaid applications.

The Department's exhibits for Medical Services Premiums remain largely the same as the February 15, 2006 Budget Request. Specific changes to exhibits are as follows:

1. The calculation of the Department's Budget Request including the Clawback payment has been removed from Exhibit A. The Clawback payment is now a separate line item.

2. A comprehensive summary of the Department's Budget Request has been added to Exhibit E. This summary compares individual pieces of the Department's Budget Request to the components of the Long Bill (HB 06-1385), as determined by the Department's March 13, 2006 Figure Setting and subsequent actions by the Joint Budget Committee, and the General Assembly.

3. The Department's "year-to-date" exhibits from February have been replaced with comparisons of per capita and expenditure costs between the first and second half of FY 05-06. The Department anticipates the "year-to-date" exhibits returning in the February 15, 2006 Budget Request, when actuals for the first half of FY 06-07 are available.

4. The Department has added an additional sheet of trend factors for Acute Care (Exhibit F), where trend factors are calculated without prescription drug and drug rebate expenditure. This sheet is useful in light of the Medicare Modernization Act, which has skewed per capita cost and expenditure trends in Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (AND/AB) by the removal of a large percentage of prescription drug expenditure.

5. The Department has altered the methodology used to calculate the Prenatal State-Only expenditure, Breast and Cervical Cancer Program per capita, and Family Planning expenditure, all contained in Exhibit F.

6. The Department has adjusted actuals for FY 02-03 through FY 05-06 to include the Prenatal State-Only program exclusively in the Non-Citizens aid category. This change is described in section III, under Exhibit M.

7. The Department has revised Exhibit Q (Impact of the Medicare Modernization Act) to reflect FY 05-06 actuals.

Details of the changes to individual exhibits are contained in the relevant section for each exhibit in section III.

II. MEDICAID CASELOAD

INTRODUCTION

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

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

Historic caseload data are used in conjunction with economic data to project caseload in each category. To make a projection, the Department uses several different statistical techniques (as described in the Methodology section below), and chooses the projection that best fits the data. After projections are chosen for each category, the Department presents its recommendations to the Office of State Planning and Budgeting. Independently, the Office of State Planning and Budgeting develops its own categorical caseload projections. The Department then meets with the Office of State Planning and Budgeting, and the two agencies agree on an Executive caseload proposal. It is important to note that the methodology the Department used to generate its projections is not wholly reflected by the Executive caseload proposal presented in this document since those figures are often the result of compromises with the Office of State Planning and Budgeting. In addition, the Department is not privy to the methodologies used by the Office of State Planning and Budgeting, so information in this document refers only to methods used by the Department.

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

If the Department had applied the accounting conversion to the FY 03-04 caseload projection, this would have produced a synthetic drop in caseload relative to the prior year when retroactivity was still applicable. To control for this manufactured decrease in caseload, and to develop a more accurate portrayal of history, the Department recreated ten years of Medicaid caseload history without retroactivity. By rebuilding the caseload without retroactivity, the Department was able to put the FY 03-04 projection in perspective, and test the historical data for accuracy. Medicaid eligibility, retroactive back to the date of application, is still in effect. However it is no longer reported in caseload. For a complete explanation of how the historical data was rebuilt and tested, refer to the November 3, 2003 Budget Request, pages K-98 and K-99.

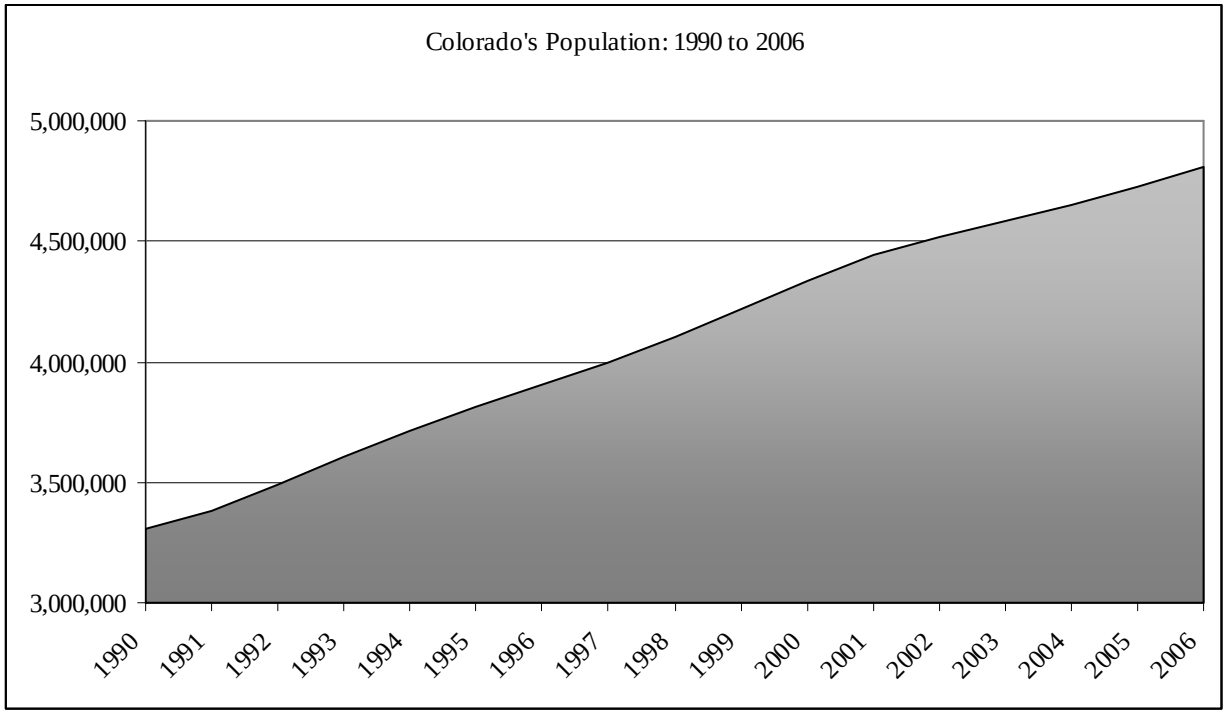
Recent Caseload History

Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 95-96 to FY 05-06. Projections for FY 06-07, FY 07-08 and FY 08-09 are also presented in the table and will be discussed in the Categorical Projections section of this document (projections for FY 08-09 are presented for informational purposes, but will not be discussed). A graphical representation of aggregate Medicaid caseload history for the same period can be found in Exhibit R, page ER-1. Aggregate growth from FY 93-94 to FY 99-00 was stable, and in some years even declined. From FY 99-00 to FY 04-05, the State sustained positive and significant growth in caseload ranging from 6.6% to 11.1%. Even more notable is the fact that Medicaid in Colorado had double-digit growth rates in FY 02-03, FY 03-04 and FY 04-05 of 10.8%, 10.7% and 11.1%, respectively. Reasons for these recent growth rates will be discussed below, but having a reference for this unprecedented growth is important.

The charts found in Exhibit R, page ER-2, show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 95-96 and FY 05-06. As a percentage of the entire Medicaid caseload, Eligible Children have increased by ten percentage points, the largest gain when compared with all other categories. The percentages of overall caseload in the Adults 65 and Older (OAP-A) and Disabled Individuals to 59 (AND/AB) categories have declined by 3 and 6 percentage points, respectively. This change in case mix implies that increases in a less expensive category (Eligible Children) have been coupled with decreases in more expensive categories (Adults 65 and Older (OAP-A) and Disabled Individuals to 59 (AND/AB) over the last ten years.

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. Therefore, projections represent the net effect of what the Department expects will happen. Each factor and its expected impact on the Medicaid caseload are discussed below.

Population - Colorado's total population increased 23.1% from July of 1996 to July of 2006. The Department of Local Affairs forecasts that Colorado's population will increase a further 4.2% from July of 2006 to July of 2008. As the overall population has grown, so too has the Medicaid caseload. This positive correlation implies that if population is projected to grow in the future, Medicaid caseload should also increase.



Source: Department of Local Affairs, Demography Division

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

In-State Migration - Like population, in-state migration is positively correlated to Medicaid caseload. As more individuals move to Colorado from other states, Medicaid caseloads will increase. During economic downturns, people usually move from states with worse economic conditions to states with better conditions in search of jobs. Although most experts agree that Colorado experienced some of the worst economic conditions in the United States during the recent recession, net migration remained positive in 2003 at 26,048[12]. An increase of 26,048 persons in a population of over 4 million may not be significant, but a positive migration rate means more people who could conceivably be eligible for Medicaid. Conversely, as the economy recovers, in-state migration is expected to increase. Net migration grew to an estimated 30,499 in 2005, and is projected to overtake natural increase (births minus deaths) as the major component of population growth in 2006.

Age - The age of the population can provide some insight as to why Medicaid caseloads have been increasing. As the population ages, so too does the demand for medical care. Generally, as individuals age their health becomes more fragile and the more likely they are to seek health care. From 1996 to 2006, Colorado's median age increased by 1.86 years.[13] This may be the result of retirees moving to the State, increased longevity, or fewer births. Regardless of the reason, an aging population has a direct effect on the demand for medical services, though not necessarily Medicaid. A July 2004 study at Georgetown University estimated the future impact of an aging population for each state. Population estimates from the U.S. Census Bureau are used to calculate the ratio of elderly to working aged adults for 2001 to 2025. Colorado ranked first in the study as having the highest percent change in this ratio, implying that Colorado will have the fastest aging population of the States.[14] This suggests that Colorado will have more working adults per one elderly adult in 2025 than any other state. As of 2006, Colorado has not yet felt the impact of an aging population in the Medicaid caseload, particularly in the categories that include long-term care. This may be the result of demographic factors, such as the elderly population working longer and the baby-boom generation not yet reaching retirement age.

Length of Stay- The severity and length of the recent economic downturn has prolonged the average amount of time clients remain on the Medicaid caseload. The table below shows that the average number of months of eligibility for adults and children on Medicaid increased by 15.7% and 8.5% respectively from FY 99-00 to FY 03-04. The average number of months on Medicaid dropped by 10.5% for adults and 8.4% for children in FY 04-05, and in FY 05-06 increased to levels near those for FY 03-04. The length of stay estimates have changed from those previously reported due to a change in methodology. To obtain a better estimate of the average

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

length of stay, the eligibility span is now measured in days, rather than full months. This yields a more accurate estimate, as clients who are eligible for only a portion of the month were previously counted as eligible for the entire month.

Average Number of Months on Medicaid

Fiscal Year	Categorically Eligible Low-Income Adults	Eligible Children
FY 99-00	6.78	8.29
FY 00-01	6.87	8.29
FY 01-02	7.20	8.51
FY 02-03	7.66	8.71
FY 03-04	7.84	8.99
FY 04-05	7.01	8.23
FY 05-06	7.85	8.72

Economic Conditions - Economic indicators help partially explain why some Medicaid caseload trends occur. Since Medicaid is a needs-based program where clients must meet income and resource limits, it follows that caseload for families and children should be countercyclical to economic conditions. For example, as the State experiences recessionary conditions, the Medicaid caseload will increase. After the recession that ended in the early 1990s, Colorado enjoyed almost ten years of economic expansion. The terror attacks on the United States in 2001 combined with the bursting of the stock market bubble in late 2000 brought that expansion to a halt. For the first time in more than a decade, Colorado experienced significant job losses coupled with falling wages. In mid 2003, the Colorado economy hit bottom after the decline that started in early 2001. Due to seasonal fluctuations and wide confidence intervals for over the month changes, employment data is best analyzed by comparing the same month for different years. The first post-recession over the year gain in non-agricultural employment occurred in March of 2004. The State officially entered an expansionary period in early 2006, as employment surpassed the late 2000 peak. The recovery period lasted thirty months, one of the longest on record. As of July 2006, the over the year gain was estimated to be 44,500, or 2.0%. Job growth is projected to be about 2.4 percent throughout the forecast period.

The table that follows shows historical and projected unemployment rates, non-agricultural employment, and job growth statistics.[15]

Year	Wage and Salary Income (millions)	Non-Agricultural Employment	Unemployment Rate
2001	$88,297	2,226,900	3.8%
2002	$86,938	2,184,200	5.7%
2003	$87,835	2,151,100	6.1%
2004	$91,839	2,179,600	5.6%
2005	$98,269	2,225,500	5.0%
2006	$104,260	2,272,600	4.7%
2007	$110,682	2,325,800	4.5%
2008	$118,034	2,382,300	4.5%

While the data in the table above is promising for the State as a whole, it is less encouraging for Medicaid for several reasons. First, the timing of an economic cycle is important in estimating the impact on the Medicaid caseload. As the economy recovers from a downturn, workers need to find jobs in order to withdraw from the Medicaid rolls. Jobs that primarily affect family and children Medicaid populations[16] are hourly and concentrated in the service industry. These employment types are often the last to benefit from improving economic conditions. Therefore, any economic impact on the Medicaid caseload will have a lagged affect. Second, as workers find jobs they do not instantaneously lose their Medicaid eligibility. Since 1990, states have been federally required to provide Transitional Medicaid benefits, up to one year, to families who lost eligibility because of increased income due to employment. This policy was directed at clients who potentially might turn down employment for fear of losing their Medicaid benefits. To be eligible for Transitional Medicaid, a client must have been eligible in at least three of the preceding six months. Clients may receive Transitional Medicaid as long as their income is below 185% of the federal poverty level. Another small group of clients are eligible for Transitional Medicaid services that would otherwise lose their Medicaid benefits due to child or spousal support payments. Families in this group receive a four-month extension. Although this program has been set to expire many times, it has been renewed regularly. A provision in the Deficit Reduction Act of 2005 renewed the program through December 31, 2006. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 06-07 and FY 07-08. As illustrated in the following table, the average number of adults and children on Transitional Medicaid increased dramatically in FY 04-05. The Department suspects that the high growth in FY 04-05 and FY 05-06 may be partially related to large monthly increases that occurred around the implementation of the Colorado Benefits Management System. Given that monthly caseload has been declining since December 2005, the Department does not expect high growth to continue for FY 06-07 or

[15] Source: Office of State Planning and Budgeting, June 2006 *Colorado Economic Perspective*
[16] Projecting elderly and disabled client populations does not prioritize economic variables.

FY 07-08. Due to an improvement in the methodology used to count clients on Transitional Medicaid, the historical caseload has changed from that previously reported.

Fiscal Year	Average Number of Adults on Transitional Medicaid	Average Number of Eligible Children on Transitional Medicaid
FY 01-02	3,859	6,679
FY 02-03	4,719	7,831
FY 03-04	4,776	7,805
FY 04-05	6,676	11,937
FY 05-06	10,949	18,654

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

- Personal Responsibility and Work Opportunity Act of 1996, Public Law 104-193: This act de-linked eligibility between welfare (formerly called Aid to Families with Dependent Children) and Medicaid. States were permitted to adjust their income and resource standards for Medicaid at that time, but they could not fall below the standard applied on May 1, 1988.
- Balanced Budget Act of 1997, Public Law 105-33: This act restored Medicaid eligibility to legal immigrants who entered the country before August 22, 1996 and later became disabled. Children who lost their Supplemental Security Income eligibility due to the Personal Responsibility and Work Opportunity Act continued to receive Medicaid. Coverage for refugees and asylees was extended from five to seven years.
- Foster Care Independence Act of 1999, Public Law 106-169: This Act allowed states to provide Medicaid benefits to children in foster care up to age 21 who were previously eligible under Title IV-E before turning 18.
- Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354: Establishes a new group of eligibility for women under 65 who have been screened under the Centers for Disease Control and Prevention Board and need treatment for either diagnosis.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003: This act will cause more potential beneficiaries to be screened for Medicaid when they apply for this Medicare benefit.
- Presumptive eligibility for Medicaid pregnant women was abolished on September 1, 2004. It was re-established on July 1, 2005.
- HB 06S-1023 requires all individuals over aged 18 or over to produce satisfactory documentary evidence of citizenship and identity prior to the receipt of public benefits, including Medicaid. The impact on caseload is indeterminate, as the State provides Medicaid benefits only to lawful citizens or nationals of the United States.

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

- Children's Home and Community Based Waiver, 25.5-6-901, C.R.S. (2006): Formerly known as the Katie Beckett waiver, this program serves disabled children in the home who are at risk of nursing facility or hospital placement.
- Brain Injury Waiver, 25.5-6-701-706, C.R.S. (2006): Serves persons with brain injury within a specific diagnosis code. Clients must be in the process of discharging from a hospital, rehabilitation hospital, or rehabilitation facility.
- Persons Living with AIDS, 25.5-6-501-508, C.R.S. (2006): Serves persons diagnosed with HIV/AIDS.
- Elderly, Blind and Disabled Waiver 25.5-6-301-313, C.R.S. (2006): Serves persons who have a functional impairment, are blind, or are physically disabled.
- Consumer Directed Care, 25.5-6-1101-1103, C.R.S. (2006): Allows eligible clients to receive vouchers to direct their own care.
- Children with Autism Waiver, 25.5-6-801-805, C.R.S. (2006): was authorized by SB 04-177. The Centers for Medicare and Medicaid Services approved the Department's plan on December 28, 2005, though it was not implemented in FY 05-06.

During the 2004 legislative session, SB 04-028 authorized the Substance Abuse Treatment for Native Americans Waiver. The Department submitted a waiver application to the Centers for Medicare and Medicaid Services for approval. Until the Centers for Medicare and Medicaid Services approves or denies this waiver, the impact on caseload is indeterminate; therefore, no adjustments were made for the FY 06-07 and FY 07-08 caseload projections.

Legislation Affecting Caseload

Oftentimes, a forecast cannot instantaneously incorporate policy changes even with the use of dummy or indicator variables. When this occurs, adjustments are made to the forecast off-line. Off-line adjustments were made to the FY 06-07 and FY 07-08 forecasts to account for the implementation of HB 05-1262, the Tobacco Tax Bill, the Deficit Reduction Act of 2005, and HB 06-1270, Public School Eligibility Determinations. Detailed accountings of offline adjustments are in Exhibit B, page EB-2.

The Department projects that the Deficit Reduction Act of 2005 will have a small and immediate impact on multiple Medicaid caseload categories. Section 6036 of the Act requires States to obtain satisfactory documentary evidence of citizenship and identity for all Medicaid applicants who have declared that they are citizens or nationals of the United States. The section exempts individuals that are eligible for Medicaid and entitled to or enrolled in Medicare, and those eligible for Medicaid by virtue of receiving Supplemental Security Income benefits, from the identification requirement. The Department estimates declines in the five Medicaid caseload categories that will be affected by this provision, and an increase in the Non-Citizens (Emergency Services) category. The estimates are based on a February 2006 report by The Kaiser Commission of Medicaid and the Uninsured which details a

Congressional Budget Office estimate that this provision will result in 35,000 Medicaid enrollees losing coverage nationwide[17]. The Kaiser Family Foundation's State Medicaid Fact Sheet reports that in FY 2003, Colorado had 473,700 of the 48,609,600 Medicaid enrollees in the 46 states that do not currently require documentation of citizenship for Medicaid applicants, or 0.97%[18]. This results in an estimate of 340 Medicaid clients in Colorado losing eligibility in FY 06-07. This estimate is allocated proportionally across the affected Medicaid categories, with a total negative adjustment of 228 clients in Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, Eligible Children, and Baby Care Program-Adults. The Department assumes that one-half of the adults losing eligibility will seek emergency services, resulting in a positive adjustment in the Non-Citizens category.

HB 05-1262, the Tobacco Tax Bill is expected to add clients to four eligibility categories for a variety of reasons. The details are as follows.

The Department estimates that the Eligible Children group will add the most clients of any category. The increase will be due to the removal of the asset test for children and families. This change was set to be effective at the start of FY 05-06 but, because of delays in gaining approval from the Centers for Medicare and Medicaid Services, was implemented at the beginning of FY 06-07. Using a similar methodology to the fiscal note for HB 05-1262 with current data, 12,045 clients are expected to move from the Children's Basic Health Plan to Medicaid in FY 06-07 due to the removal of the asset test. All clients will have undergone redetermination by the end of FY 06-07, and a total of 22,841 clients are assumed to move to Medicaid. Because these clients are not incorporated into the base population, the FY 07-08 adjustment is the entire 22,841 clients assumed to have moved.

A total of 2,891 clients for FY 06-07 and 5,482 for FY 07-08 are added to the estimates for Categorically Eligible Low Income Adults because of removal of the asset test. These are parents of children in the Children's Basic Health Plan, so will be screened for Medicaid eligibility as the children are redetermined. The adjustments were lowered from the original estimates because of the delay in implementation, as well as updated data.

In addition, the Department created a new category called Health Care Expansion Fund Low Income Adults due to a change in the income guideline used to establish eligibility, which was increased from 36% to 60% of the federal poverty level. Using data from the current population survey, the Department projects this category to grow to 3,223 adults in FY 06-07 and 6,072 in FY 07-08.

The Tobacco Tax Bill also expanded the number of children that can be enrolled in the Children's Home and Community Based Services and the Children's Extensive Support Waiver programs. A total of 527 expansion slots, consisting of 478 in the Children's Home and Community Based Services program and 49 in the Children's Extensive Support program, were opened and started to be

[17] Source: "Deficit Reduction Act of 2005: Implications For Medicaid." The Kaiser Commission on Medicaid and the Uninsured, February 2006 <http://www.kff.org/kcmu>.
[18] Source: The Kaiser Family Foundation <http://www.statehealthfacts.org>

filled in FY 05-06. Funding was allocated for an additional 230 expansion slots, with 200 in the Children's Home and Community Based Services program and 30 in the Children's Extensive Support program. The Department expects federal approval for this second waiver expansion in late 2006. Based on FY 05-06 enrollment, the Department estimates that HB 05-1262 will add 550 clients to the Disabled Individuals to 59 (AND/AB) eligibility category in FY 06-07. For FY 07-08, the increase is 755 clients, as nearly all expansion waivers are expected to be filled.

HB 06-1270, Public School Eligibility Determinations Bill, directs the Department to establish medical assistance sites in public schools to allow qualified personnel to make Medicaid eligibility determinations. Based on the fiscal note for HB 06-1270, which assumes the participation of three school districts, 306 clients were added to estimates for the Eligible Children category for FY 07-08.

The combination of the aforementioned factors has led to significant growth in the Medicaid caseload since FY 99-00. Between FY 99-00 and FY 05-06, Medicaid caseload increased by 146,451 clients, growth of 57.83%. In the February 15, 2006, Final Request for Medical Services Premiums, page MSP-33, the Department projected growth of 0.4% in the FY 05-06 Medicaid caseload. Actual figures show that caseload fell by 0.8% in FY 05-06, the first decline since FY 97-98. The Department believes that this decline is in part due to the Medicaid Management Information System cleaning its records related to the Colorado Benefits Management System. In doing so, many client cases were closed either because they did not complete the redetermination, renewal, or recertification process, or because they were found to no longer be eligible for Medicaid. This occurred in June 2005, and Medicaid caseload fell by 14,743. The Department estimates that without this one-time clean up, annual average caseload may have grown by as much as 3.0%. The Department expects that growth in the Medicaid caseload will slow as economic conditions improve, but that an overall decrease in caseload will not occur in either FY 06-07 or FY 07-08. Caseload is projected to reach 427,933 in FY 06-07, a 7.06% increase over FY 05-06. In FY 07-08, caseload is forecasted to increase by 5.65% and reach 452,128. The following table shows actual and projected aggregate Medicaid caseload from FY 02-03 through FY 07-08.

Fiscal Year	Medicaid Caseload	Level Growth	Growth Rate
FY 02-03	327,395	31,982	10.83%
FY 03-04[19]	362,531	35,136	10.73%
FY 04-05	402,802	40,271	11.11%
FY 05-06	399,705	(3,097)	-0.77%
FY 06-07 projection	427,933	28,228	7.06%
FY 07-08 projection	452,128	24,195	5.65%

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

METHODOLOGY

The Department's caseload projections utilize statistical forecasting methodologies to predict the Medicaid caseload by eligibility category. Historical monthly caseload data from July 1993 to June 2006 and historical and forecasted economic and demographic data that were revised in June 2006 were used. Two forecasting methodologies were used: trend and regression. The software used by the Department for developing trend and regression forecasts is *Forecast Pro XE.*

Trend Models

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

Exponential Smoothing

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

Box Jenkins

As compared to Exponential Smoothing models, Box-Jenkins models are more complex, but often produce results that are more accurate with a the time-series that is longer and stable. Box-Jenkins models identify Autoregressive Integrated Moving Average processes that provide a good fit to a stationary time-series. The optimal model can contain numerous autoregressive terms, moving average terms, or combinations thereof, causing the Box-Jenkins models to be much more complex than their Exponential Smoothing counterparts. A minimum of 50 observations is recommended to perform a Box-Jenkins forecast.

Regression Models

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

In June 2006, the Office of State Planning and Budgeting and the Colorado Department of Local Affairs' Demography Division supplied actual and forecasted values of the following independent variables, which were used in the regression models:

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

Trend vs. Regression Models

After several different forecasts are produced, the Department normally chooses one for each category. In most eligibility categories, trend and regression projections are considered. In the case of the breast and cervical cancer category, a statistical model could not be applied and the estimate was based on historical analysis, programmatic research, and judgment.

To determine which model is the best, the Department evaluates each model's forecast on two criteria: goodness of fit and expected growth patterns. *Forecast Pro XE* performs several statistical tests that evaluate the goodness of fit. These tests include: serial correlation of first and multiple orders, heteroskedacticity, robustness of error terms, and collinearity. Each model is judged on its statistical soundness, and models that perform poorly are eliminated. Elimination is purely subjective, and directly related to the model's statistical performance. Finally, the Department is left with a reduced menu of forecasts to consider. Historical patterns, along with economic and policy expectations are considered, and one model is chosen to be the best. In some cases, the forecasts that are produced by the models are adjusted upward or downward based on information that is not internal to the model.

CATEGORICAL PROJECTIONS

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

Adults 65 and Older

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

The graph on Exhibit R, page ER-3 shows that historically, this category has displayed relatively flat growth. Over the past ten years, the caseload has increased by an average of 36 clients per month. Historical growth rates are stable and fluctuate between 1% and 2%. The Department suspects that the high growth rate in FY 04-05 is due to a Colorado Benefits Management System related level shift, and that growth has returned to its long-term trend in FY 05-06.
This population is affected by provisions in the Deficit Reduction Act of 2005 which deal with the treatment of annuities and assets, which will likely promote low growth. Due to this, as well as a strengthening economy and the fact that the baby-boom generation will not effect this group until approximately 2011, the Department projects growth of 1.68% in FY 06-07 and 1.24% in FY 07-08.

In the February 15, 2006 Budget Request, the Department estimated that the Medicare Modernization Act of 2003 would increase the annual average caseload by 243 clients in FY 05-06 and 970 clients in FY 06-07. This increase was expected to occur because low-income Medicare Part D clients are now screened for Medicaid as they apply for the low-income subsidy. However, the Department believes that the impact of the Medicare Modernization Act is much lower than originally expected. Given that the caseload has not experienced the expected growth to date, and that the deadline for initial enrollment into the Medicare Part D program has passed, the Department is not recommending a specific adjustment for the Medicare Modernization Act in this category.

Adults 65 and Older Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	34,485	569	1.68%
FY 03-04	34,149	(336)	-0.97%
FY 04-05	35,615	1,466	4.29%
FY 05-06	36,219	604	1.70%
FY 06-07 projection	36,827	608	1.68%
FY 07-08 projection	37,284	457	1.24%

25.5-5-101 (1), C.R.S. (2006)
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions.

25.5-5-201 (1), C.R.S. (2006)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement;
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.

Disabled Adults 60 to 64

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

Growth in FY 01-02 was unusually low, partially due to the movement of approximately 400 clients out of this category into the Old Age Pension State Medical Program and due to the elimination of the "Med-9" disability determination process for those under age 65 (see the Disabled Individuals to 59 (AND/AB) section for a complete description of the Med-9). Growth in FY 04-05 was unusually

high due to a Colorado Benefits Management System related level shift, and FY 05-06 recorded the first ever caseload decline in this category. The Department does not expect the negative trend in this eligibility type to continue, as the 60 to 64 population is projected to be the fastest growing age group in the state during the forecast period.

Historically, this category has displayed consistently slow growth, with caseload increasing by an average of 13 clients per month over the last 10 years. This population, like the Adults 65 and Older category, will be affected by the asset and annuities provisions in the Deficit Reduction Act of 2005, which would promote low growth. This category will begin to be effected by the baby-boom generation beginning in 2006, which may pull growth up. The impact of these factors, however, are likely to be mitigated because the clients in this category are disabled, and thus less likely to gain or lose eligibility due to policy changes or economic and demographic conditions. Given these factors, the Department is forecasting growth of 1.2% in FY 06-07 and 2.46% in FY 07-08.

Disabled Adults 60 to 64 Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	5,456	272	5.25%
FY 03-04	5,528	72	1.32%
FY 04-05	6,103	575	10.40%
FY 05-06	6,048	(55)	-0.91%
FY 06-07 projection	6,120	72	1.20%
FY 07-08 projection	6,271	151	2.46%

25.5-5-101 (1), C.R.S. (2006)
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions.

25.5-5-201 (1), C.R.S. (2006)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement.

Disabled Individuals to 59

Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. With a few exceptions, recipients must be United States citizens. This category includes the disabled

portion of this group to age 59. These individuals are blind, have a physical or mental impairment that keeps them from performing substantial work expected to last 12 months or result in death, or are children who have a marked and severe functional limitation expected to last 12 months or until death. Children were added to the Title XVI Act in 1972. In addition, states may extend coverage to individuals with incomes too high for Supplemental Security Income, and who meet the nursing facility level of care. Referred to as "300 Percenters", these clients have incomes no more than three times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home. Often, 300 Percenters are enrolled in a Home and Community Based waiver program.

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

As the graph in Exhibit R, page ER-5 shows, high growth rates continued through FY 96-97, then dropped dramatically. From FY 97-98 to FY 03-04, caseload remained relatively constant, with absolute changes less than 1%. The elimination of the Med-9 disability determination has also contributed to slower growth. In July 2001, the Med-9 disability determination application process was disbanded due to federal requirements. This process lets individuals under 65 who were seeking Medicaid coverage because of a disability experience an expeditious application process as compared to other applicants. By discontinuing the Med-9, clients underwent a more rigorous eligibility determination, and caseload fell slightly. The caseload increased at a faster rate in FY 04-05, due largely to higher growth in the first half of the fiscal year. Small monthly increases returned in the second half of FY 04-05 and continued through the next fiscal year, leading to a small decline in FY 05-06. As this category is disabled, economic conditions have a small impact on this group. Before adjustments, the Department anticipates growth rates in line with historical trends.

HB 05-1262 expanded the number of children that can be enrolled in the Children's Home and Community Based Service (CHCBS) Waiver Program and the Children's Extensive Support (CES) Waiver Program. The original expansion was 527 slots, which started to be filled in FY 05-06. Funding was appropriated in FY 06-07 for an additional 230 expansion slots, which the Department expects to receive federal approval for in late 2006. For FY 06-07, 550 of these expansion slots are anticipated to be filled. The adjustment

increases to 755 in FY 07-08 as nearly all of the expansion waivers are expected to be filled. The projected growth rates including adjustments are 1.77% in FY 06-07 and 0.93% in FY 07-08.

Disabled Individuals to 59 Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	46,378	29	0.06%
FY 03-04	46,565	187	0.40%
FY 04-05	47,626	1,061	2.28%
FY 05-06	47,565	(61)	-0.13%
FY 06-07 projection	48,405	840	1.77%
FY 07-08 projection	48,854	449	0.93%

25.5-5-101 (1), C.R.S. (2006)
(f) Individuals receiving supplemental security income;
(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under Public Law 92-336
(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April, 1977;
(k) Disabled widows or widowers fifty through sixty years of age who have become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c.

25.5-5-201 (1), C.R.S. (2006)
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.

Categorically Eligible Low-Income Adults

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

Medicaid. Therefore, the Categorically Eligible Low-Income Adults category includes adults who receive Medicaid under Section 1931 and those families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid. Also included in this category are adults receiving Transitional Medicaid. Transitional Medicaid is available to adults in families who have received 1931 Medicaid in three of the past six months and become ineligible due to an increase in earned income. Adults may receive Transitional Medicaid benefits for up to one year. In FY 05-06, there was an average of 10,767 adults in this program. Transitional Medicaid benefits were extended through December 31, 2006, and the Department's forecast assumes that the Transitional Medicaid program will continue in FY 06-07 and FY 07-08.

The graph in Exhibit R, page ER-6, shows that before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash assistance for welfare and Medicaid was broken. When the Department implemented this change into the Client Oriented Information Network eligibility data system, it was estimated that 46,006[20] clients had their cases closed in error. In reaction, the Tatum lawsuit was brought against the State. Starting in May 2001, the Department began to reinstate clients who inadvertently lost their Medicaid eligibility. This may help to explain why from 1997 to 1999 caseload fell, and may have contributed to a spike in caseload in FY 01-02 (this spike can clearly be seen on the graph). For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Budget Request, pages A-37 to A-38.

Growth rates in this category have been unprecedented since FY 00-01. From fiscal year 2001 to 2005, caseload grew by an average of 19.2% per year, which the Department believes is largely due to the state of the economy. The rate of growth fell drastically to 2.3% in FY 05-06. In FY 04-05, caseload in this category increased by an average of 1,073 per month; in FY 05-06, caseload declined by an average of 439 clients per month. The Department suspects that this change is largely due the Medicaid Management Information System cleaning its records related to the Colorado Benefits Management System. In doing so, many client cases were closed either because they did not complete the redetermination, renewal, or recertification process, or because they were found to no longer be eligible for Medicaid. Discounting these months, the Department estimates that caseload increased by about 230 clients per month in FY 05-06.

Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of adults aged 18 to 59. Growth in the 18 to 59 population dropped from nearly 3.0% per year from FY 95-96 to FY 01-02 to 1.2% per year from FY 02-03 to FY 04-05. The growth in this population is projected to rebound to approximately 1.5% this year and in each of the next two years[21]. Projections from the Office of State Planning and Budgeting indicate that the economy will continue to improve throughout the forecast period, with nonagricultural employment to grow by approximately 2.3% per year. Similarly,

[20] Source: November 1, 2001 Budget Request, page A-37
[21] Source: Department of Local Affairs, Demography Division.

unemployment is expected to remain steady, and wage and salary income is projected to grow by around 6.5% per year. Given the strengthening economy and relatively low population growth, the Department anticipates slowing caseload growth rates before adjustments.

HB 05-1262, the Tobacco Tax Bill is expected to add 2,891 clients to this category in FY 06-07 and 5,482 in FY 07-08. This bill allows for the removal of the Medicaid asset test for children and families, effective July 1, 2006. As a result, more adults will meet the income requirements for Medicaid. As children currently enrolled in the Children's Basic Health Plan undergo redetermination, the family will be screened for Medicaid, and some parents will be found to be eligible. With these adjustments, the Department is forecasting growth of 6.69% in FY 06-07 and 5.77% in FY 07-08.

Categorically Eligible Low-Income Adults Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	40,021	6,674	20.01%
FY 03-04	46,754	6,733	16.82%
FY 04-05	56,453	9,699	20.74%
FY 05-06	57,754	1,301	2.30%
FY 06-07 projection	61,618	3,865	6.69%
FY 07-08 projection	65,174	3,555	5.77%

25.5-5-101 (1), C.R.S. (2006)
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;
(c) Qualified pregnant women . . . who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(m) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government.

25.5-5-201 (1), C.R.S (2006)
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706.

Health Care Expansion Fund for Low Income Adults

The Department has created a new category to track Categorically Eligible Low-Income Adults that are newly eligible because of HB 05-1262, the Tobacco Tax Bill. This category is known as the Health Care Expansion Fund for Low Income Adults. HB 05-1262 allows for expanding Medicaid eligibility to parents of enrolled children from 36% up to 60% of the federal poverty level. The increase in the percentage of allowable federal poverty level was being implemented on July 1, 2006. This is inconsistent with the April 25, 2005 fiscal note for this bill that incorrectly stated that implementation would occur a year earlier. The fiscal note also calculated the caseload adjustment for this category assuming that the new income limit would be 75% of the federal poverty level. As shown in Exhibit B, based on the new implementation date and income limits, the Department estimates that this category will add 3,220 clients on average for FY 06-07 and 6,067 in FY 07-08.

This group will not receive prenatal benefits, which results in a lower per capita than Categorically Eligible Low Income Adults. The difference in per capita costs warranted the creation of a new eligibility category. In addition, the Health Care Expansion Fund for Low Income Adult clients are paid for through matching federal funds and HB 05-1262 money, which is classified as Cash Funds Exempt. The existing low-income adult category is funded by a combination of General Fund and federal funds.

Health Care Expansion Fund Low Income Adults

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 06-07 projection	3,220	-	-
FY 07-08 projection	6,067	2,847	88.42%

25.5-5-201 (1), C.R.S (2006)
(m) (I) Parents of children who are eligible for the medical assistance program or the Children's Basic Health Plan… whose family income does not exceed a specified percent of the federal poverty level… which percentage shall not be less than sixty percent.

Breast and Cervical Cancer Program

The Breast and Cervical Cancer Treatment program was authorized under SB 01S2-012 and began enrolling eligible women in July 2002. Women under this optional coverage group were screened using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer. These women are under the age of 65, uninsured, and otherwise not eligible for Medicaid. The Colorado Medical Services Board establishes the income and resource eligibility requirements for this program. To date, all 50 states have approved the option of covering these women under Medicaid.

Forecasting for this eligibility category cannot be accomplished with any degree of confidence through statistical modeling. The estimate for this category is based on historical analysis, programmatic research, and judgment. HB 05-1262 (Tobacco Tax Bill) directed funding

aimed at increased cancer screenings through the Department of Public Health and Environment. The Department had forecasted an additional 116 clients directly attributable to the bill for FY 06-07, but now believes that the impact of the bill has been incorporated into the population and that a specific adjustment is no longer warranted. The Department projects that caseload in this small category will increase by 36.70% in FY 06-07 and 32.30% in FY 07-08.

The graph in Exhibit R, page ER-7 shows caseload steadily increasing from July of 2002 to December of 2004. At this point, the reported caseload decreased dramatically because of an issue within the Medicaid Management Information System that was used to report the data. Because of this issue within the Medicaid Management Information System, a more reliable source was utilized to create caseload figures. Until the problem was resolved, the Department obtained a caseload report directly from raw data in the Colorado Benefits Management System. This report was used from July 2005 through March 2006, when the reports from the Medicaid Management Information System and the Colorado Benefits Management System were synchronized. All subsequent monthly caseload data are obtained from the Medicaid Management Information System report that is used to report all other categories of Medicaid caseload. The caseload counts for the six months from January through June 2005 were left as originally reported. This explains the six months of unusually low figures that are shown in the graph in Exhibit R, page ER-7. The same series of caseload figures were used to produce the following table.

Breast and Cervical Cancer Program Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	46	N/A	N/A
FY 03-04	103	57	123.91%
FY 04-05	86	(17)	(16.50%)
FY 05-06	188	102	118.60%
FY 06-07 projection	257	69	36.70%
FY 07-08 projection	340	83	32.30%

25.5-5-201 (1), C.R.S. (2006)
(i) Persons who are eligible for the breast and cervical cancer prevention and treatment program pursuant to section 25.5-5-308.

Eligible Children

One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to Families with Dependent Children program was discontinued. Aid to Families with Dependent Children was replaced by the Temporary Assistance for Needy Families welfare program (referred to as Colorado Works)

on July 16, 1996, and clients under the Temporary Assistance for Needy Families program were no longer automatically eligible for Medicaid.

This category also includes children on Transitional Medicaid. Transitional Medicaid is available to children in families who have received 1931 Medicaid three of the past six months and become ineligible due to an increase in earned income. Children may receive Transitional Medicaid benefits for up to one year. In FY 05-06, there was an average of 17,137 children on Transitional Medicaid. Authorization for Transitional Medicaid benefits was extended through December 31, 2006, and the Department's forecast assumes that Transitional Medicaid will continue in FY 06-07 and FY 07-08.

Children who are born to women enrolled in the Baby Care/ Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby Care/ Kid Care in Colorado, this program was authorized through the Medicare Catastrophic Coverage Act of 1988. The program enrolls Baby Care women (see the Baby Care Adults section of this document for information on women) and Kid Care children. Kid Care children are born to women with incomes up to 133% of the federal poverty level, and are covered up to age six. The Baby Care/ Kid Care Program serves a much higher income level than the 1931 Families program, and pregnant mothers are not subject to resource or asset limitations to qualify for the program. Moreover, the Baby Care Program has never had a cash-assistance component and was unaffected by welfare reform in 1996.
In previous years, this caseload was adjusted to include Ribicoff children. Ribicoff children were children aged six to 19, with incomes up to 100% of the federal poverty level with resources limited to $1,000 who were born after September 30, 1983. Beginning with age six, a new age cohort was phased-in each year. Caseload was adjusted upwards to include these children. However, the final cohort of children was phased-in during FY 02-03, so no further caseload adjustments are needed. Therefore, the Eligible Children category includes: children in families who receive Medicaid under Section 1931, children in families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid, children who are eligible for Kid Care, Ribicoff children, and children who receive Transitional Medicaid.

The graph in Exhibit R, page ER-8, shows that from 1993 to 1999 caseload in this category fell. This can be attributed to economic expansion and effects from the Tatum lawsuit (see Categorically Eligible Low-Income Adults section for more information on the lawsuit). When the Children's Basic Health Plan program was enacted in 1998, it required that children be screened for Medicaid at the same time. As more children applied, many were found to be Medicaid eligible and were enrolled in Medicaid. From fiscal year 2001 to 2005, caseload in this category grew by an average of 14.98% per year, which the Department believes is largely due to the state of the economy. The rate of growth fell drastically in FY 05-06, and the caseload actually contracted by 3.17%. In FY 04-05, caseload in this category increased by an average of 1,469 per month; in FY 05-06, caseload declined by an average of 717 clients per month. The Department suspects that this change is largely due the Medicaid Management Information System cleaning its records related to the Colorado Benefits Management System. In doing so, many client cases were closed either because they did not

complete the redetermination, renewal, or recertification process, or because they were found to no longer be eligible for Medicaid. Discounting these months, the Department estimates that caseload increased by about 1,334 clients per month in FY 05-06.

Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of children aged 0 to 18. Growth in the 0-18 population dropped from around 2.5% per year from FY 95-96 to FY 01-02 to about 1.0% per year from FY 02-03 to FY 04-05. The expansion in this age group is projected to rebound to approximately 1.3% in FY 05-06 and 1.7% in each of the next two years.[22] Forecasts from the Office of State Planning and Budgeting indicate that the economy will continue to improve throughout the forecast period, with nonagricultural employment projected to grow by approximately 2.3% per year. Similarly, unemployment is expected to remain steady, and wage and salary income is projected to grow by around 6.5% per year. As with Categorically Eligible Low-Income Adults, the Department anticipates slowing caseload growth rates before adjustments given the strengthening economy and the relatively low population growth.

HB 05-1262, the Tobacco Tax Bill is expected to add 12,045 clients to this category in FY 06-07 and 22,841 in FY 07-08. This bill allows for the removal of the Medicaid Asset Test for children and families, effective July 1, 2006. As a result, it is anticipated that more children will meet the income requirements for Medicaid. As children currently enrolled in the Children's Basic Health Plan undergo redetermination, the family will be screened for Medicaid, and some children will be found to be eligible. With these adjustments, the Department is forecasting growth of 7.64% in FY 06-07 and 6.25% in FY 07-08.

Eligible Children Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	166,537	22,628	15.72%
FY 03-04	192,048	25,511	15.32%
FY 04-05	220,592	28,544	14.86%
FY 05-06	213,600	(6,992)	(3.17%)
FY 06-07 projection	229,917	16,317	7.64%
FY 07-08 projection	244,291	14,374	6.25%

25.5-5-101 (1), C.R.S. (2006)
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

[22] Department of Local Affairs, Demography Division.

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

25.5-5-103 (1), C.R.S. (2006)
(a) The program known as the baby and kid care program which provides medical assistance for pregnant women and children, as specified in section 25.5-5-205.

25.5-5-201 (1), C.R.S. (2006)
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings,
(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.

Foster Care

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

Caseload in this category is affected by programmatic changes initiated by the Department of Human Services who oversee the Child Welfare system. In January 2001, the Department of Human Services converted to a new data reporting system for children in foster care called Trails. The conversion may be partially responsible for the unusually slow growth experienced in this category in FY 01-02. Legislation in 2003 (HB-03-1004) made the manufacturing of controlled substances in the presence of children a felony, and

deemed such actions child abuse. This may positively affect caseload in subsequent years, as more children are placed into state custody.

Caseload in this category is only weakly correlated with population of children aged 0 to 18 and economic indicators. The graph in Exhibit R, page ER-9, shows that growth rates in this category since FY 02-03 have been positive and declining over the last three years. Continuing this trend, the Department is anticipating growth rates in this category to moderate slightly, to 2.98% in FY 06-07 and 3.50% in FY 07-08.

Foster Care Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	13,843	722	5.50%
FY 03-04	14,790	947	6.84%
FY 04-05	15,669	879	5.94%
FY 05-06	16,311	642	4.10%
FY 06-07 projection	16,797	486	2.98%
FY 07-08 projection	17,385	588	3.50%

25.5-5-101, C.R.S. (2006)
(e) Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the "Social Security Act", as amended.

25.5-5-201 (1), C.R.S. (2006)
(l) Children for whom subsidized adoption assistance payments are made by the state pursuant to Article 7 of Title 26, C.R.S, but who do not meet the requirements of Title IV-E of the "Social Security Act", as amended.

Baby Care Adults

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

Caseload trends for this category shown in Exhibit R, page ER-10, are erratic. From 1993 to 1998, overall caseload decreased, but was mired by numerous spikes. This overall decrease may have been due to economic expansion, but the presence of caseload spikes complicates that theory. Again, the graph shows an overall increase since 1999, but jagged peaks in the caseload are distributed across this period. In an attempt to explain the erratic caseload pattern, the Department investigated the trends of several contributing variables. From 1990 to 2000, the number of female- headed households increased 14.7% and the number of births per thousand Colorado women has increased 24.3%.[23] However, from 1991 to 2002 teen pregnancy rates in Colorado fell 19%.[24] Economic indicators may also affect caseload trends in this category.

Future projections for this category are affected by the return of presumptive eligibility for pregnant women. Presumptive eligibility allows pregnant women who had applied for Medicaid to receive services based on self-declaration until the status of their application has been determined. The State paid for all Medicaid costs during this time regardless of whether or not the woman was eventually found to be Medicaid eligible or not. On September 1, 2004, the Department discontinued this procedure, which explains the drop of nearly 2,500 clients in September and October 2004, as well as the corresponding decline in fiscal year average caseload. Presumptive eligibility was reinstated by HB 05-1262, the Tobacco Tax Bill, effective July 1, 2005. Caseload increased by an average of 36 clients per month in FY 05-06, compared with an average decline of 301 clients per month in FY 04-05. The annual average change for FY 05-06 is misleading since the caseload was at a low for the year at the end of FY 04-05. Specifically, the June 2005 caseload figure stood at 4,846 while the June 2006 caseload is 8.8% higher at 5,273. This caused annual average caseload to decline in FY 05-06, despite the return of presumptive eligibility.

The Department is forecasting a relatively strong growth rate of 10.03% in FY 06-07, given the reinstatement of presumptive eligibility as well as the relatively strong client gains at the end of FY 05-06. The pace is expected to be moderate to 4.89% in FY 07-08, as the caseload returns to pre-FY 2005 levels.

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

Baby Care Adults Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	7,579	448	6.28%
FY 03-04	8,203	624	8.23%
FY 04-05	6,110	(2,093)	(25.52%)
FY 05-06	5,050	(1,060)	(17.35%)
FY 06-07 projection	5,556	507	10.03%
FY 07-08 projection	5,828	272	4.90%

25.5-5-103 (1), C.R.S. (2006)
(a) The program known as the baby and kid care program which provides medical assistance for pregnant women and children, as specified in section 25.5-5-205. (m) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government.

Non-Citizens

Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived in the United States after August 22, 1996. Full Medicaid coverage of individuals for the first five years is optional. Per federal regulations, states must provide mandatory full coverage for:

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

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

In April 2001, an eligibility policy change was implemented such that clients are now only counted as eligible in the months they receive emergency medical care. Prior to this policy change, eligibility for this group continued as it would for any other category,

although only for emergency medical services. For example, a Non-Citizen with an emergency visit on April 2000 could be eligible in that month, and continue to be eligible for as many months as he/she met other eligibility criteria. The same client would only be eligible for one month, had the emergency service occurred in April 2001. Thus, caseloads presented from April 2001 and forward are much lower than in previous years. This explains the large decline in FY 01-02, as seen on the graph in Exhibit R, page ER-11.

The graph also illustrates that the caseload in this category has had a positive trend since FY 01-02. Caseload trends should be correlated with economic conditions and migration trends. As the economy recovers, more immigrants are expected to migrate to the State. In addition, research shows that immigrants are living longer than natives of the United States.[25] With gradual improvement in the economy and increased longevity, the Department projects that the caseload in this category will continue to display significant growth.

The Department is estimating that the identification requirements in the Deficit Reduction Act of 2005 will have a small positive impact on this category. Some of the individuals that are denied Medicaid eligibility in other categories are expected to seek emergency services, thus increasing the Non-Citizens caseload. The Department estimates that half of the adult clients losing eligibility in other categories will seek emergency services, resulting in a positive adjustment of 28 in FY 06-07 and 29 in FY 07-08. Including this adjustment, the Department is forecasting growth of 13.78% in FY 06-07 and 9.00% in FY 07-08.

Non-Citizens Caseload History

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	4,101	73	1.81%
FY 03-04	4,604	503	12.27%
FY 04-05	4,976	372	8.08%
FY 05-06	5,959	983	19.75%
FY 06-07 projection	6,780	821	13.78%
FY 07-08 projection	7,390	610	9.00%

25.5-5-103 (3), C.R.S. (2006)

(a) Emergency medical assistance shall be provided to any person who is not a citizen of the United States, including undocumented aliens, aliens who are not qualified aliens, and qualified aliens who entered the United States on or after August 22, 1996, who has an emergency medical condition and meets one of the categorical requirements set forth in section 25.5-5-101; except that such persons shall not be required to meet any residency requirement other than that required by federal law.

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

Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries

Medicare eligible beneficiaries who have incomes at a certain federal poverty level and limited resources may qualify to have Medicaid cover some of their out-of-pocket expenses, such as their Medicare Part B premiums and other coinsurance and deductibles. The two groups of clients that qualify for this cost-sharing program are Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries. Qualified Medicare Beneficiaries have incomes at or below 100% of the federal poverty level, and resources twice the standard allowed under the federal Supplemental Security Income program. These clients receive hospital insurance and supplementary medical insurance premium coverage along with Medicare coinsurance and deductibles. Special Low Income Medicare Beneficiaries have incomes greater than 100% of the federal poverty level, but less than 120%. For Special Low Income Medicare Beneficiaries, Medicaid only pays the supplementary medical insurance premiums.

The graph in Exhibit R, page ER-12, illustrates that caseload growth in this category was positive and steady between FY 99-00 and FY 03-04. Caseload experienced an unprecedented contraction on FY 04-05, due to large monthly declines that occurred around the implementation of the Colorado Benefits Management System. Growth rebounded in FY 05-06, and caseload increased by an average of 217 clients per month. The Department speculates that a portion of this growth may be related to the Medicare Modernization Act of 2003. Under this Act, Medicare Part D clients are screened for Medicaid as they apply for the low-income subsidy. In the February 15, 2006 Budget request, the Department estimated offline adjustments of 913 clients in FY 05-06 and 3,650 in FY 06-07 in this category. Given that the FY 05-06 growth was not significantly higher than long-term trends, and that the deadline for initial enrollment in the Medicare Part D program have passed, the Department believes that the impact of the Medicare Modernization Act is much lower than originally expected, and an offline adjustment is no longer necessary for FY 06-07.

Caseload trends are somewhat correlated with economic indicators. The assets and annuities provisions in the Deficit Reduction Act of 2005 may also contribute to growth in this category, as some clients who might have qualified for the Adults 65 and Older category now have too much income or assets. The Department is forecasting growth of 12.93% in FY 06-07 and 6.50% in FY 07-08.

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

Fiscal Year	Caseload	Change Over Prior Year	Percent Change
FY 02-03	8,949	521	6.18%
FY 03-04	9,787	838	9.36%
FY 04-05	9,572	(215)	(2.20%)
FY 05-06	11,012	1,440	15.05%
FY 06-07 projection	12,436	1,424	12.93%
FY 07-08 projection	13,244	808	6.50%

25.5-5-101 (1), C.R.S. (2006)
(l) Individuals with income and resources at a level which qualifies them as Medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act";

25.5-5-103 (1), C.R.S. (2006)
(c) The program for qualified Medicare beneficiaries, as specified in section 25.5-5-104.

SUMMARY

The Department estimates that the Medicaid caseload will reach 427,933 in FY 06-07, a growth of 7.06%. Much of the overall increase is due to HB 05-1262, the Tobacco Tax Bill, as the rate of growth before offline adjustments is forecasted to be 2.43%. Growth is expected to slow to 5.65% in FY 07-08, as the Tobacco Tax Bill is fully implemented, and caseload is projected to reach 452,128. Prior to adjustments, the grow rate is expected to fall to 1.82%, reflecting the continuing economic recovery. See Exhibit B for complete information.

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts. Inherent in the per capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, preexisting condition, etc.), generally healthy clients are less costly to serve (lower "risk") than clients with severe acute or chronic medical needs requiring medical intervention (higher "risk"). For example, on average, a categorically eligible low income child is substantially less costly to serve than a disabled person each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change that was experienced across actual expenditure reference periods is applied to the future in order to

estimate the premiums that will be needed for FY 06-07 and FY 07-08, the Base Request year. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

A detailed discussion of how the projection was prepared for this budget request follows.

Analysis of the Rate of Change in the Services:

In regards to the annual rates of change in each individual service within the Medical Services Premiums Long Bill Group, an interesting observation relates to the issue of eligibility mix. Note that in the years when caseload overall was rising (i.e., FY 99-00 through FY 04-05), the per capita cost decreased or rose nominally overall. This illustrates that the majority of growth in these years was in the least costly populations. It may also illustrate that caseloads tend to rise during stress economic times, and there are less chances for provider rate increases during these times. It is not possible to review the per capita cost change over time in isolation to check for the reasonableness of the budget. One must look further into the per capita cost change by eligibility category (Exhibit EC-1). See the following history of premium rates of growth.

Calculation of Rate of Change in Expenditures for Medical Services to Clients						
Fiscal Year	**Premium Expenditures**	**Caseload**	**Per Capita**	**% Change in Expenditures**	**% Change in Caseload**	**% Change in Per Capita**
FY 95-96	$991,235,479	254,083	$3,901.23	N/A	N/A	N/A
FY 96-97	$1,127,919,788	250,098	$4,509.91	13.79%	(1.57%)	15.60%
FY 97-98	$1,104,970,992	238,594	$4,631.18	(2.03%)	(4.60%)	2.69%
FY 98-99	$1,176,233,410	237,598	$4,950.52	6.45%	(0.42%)	6.90%
FY 99-00	$1,308,420,106	253,254	$5,166.43	11.24%	6.59%	4.36%
FY 00-01	$1,416,535,408	275,399	$5,143.57	8.26%	8.74%	(0.44%)
FY 01-02	$1,536,804,691	295,413	$5,202.22	8.49%	7.27%	1.14%
FY 02-03	$1,651,670,874	327,395	$5,044.89	7.47%	10.83%	(3.02%)
FY 03-04	$1,841,738,922	362,531	$5,080.22	11.51%	10.73%	0.70%
FY 04-05	$1,893,285,566	402,802	$4,700.29	2.80%	11.11%	(7.48%)
FY 05-06	$1,982,396,076	399,705	$4,959.65	4.71%	(0.77%)	5.52%
FY 06-07 Projection	$2,115,146,212	427,933	$4,942.70	6.70%	7.06%	(0.34%)
FY 07-08 Projection	$2,256,354,575	452,128	$4,990.52	6.68%	5.65%	0.97%

Upper Payment Limit financing is excluded from this table.

IV. RATIONALE FOR GROUPING SERVICES FOR PROEJCTION PURPOSES

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to cluster services that have like characteristics (e.g., community based long term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physician services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

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

Acute Care Services:

- Physicians Services and Early and Periodic Screening, Diagnosis, and Treatment Program
- Emergency Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Administrative Service Organizations – Services Provided
- Inpatient Hospital
- Lab and X-ray
- Durable Medical Equipment
- Outpatient Hospital
- Prescription Drugs
- Prescription Drug Rebates
- Rural Health Clinics
- Federally Qualified Health Centers
- Title XVIII (Medicare Coinsurance and Deductible)
- Home Health
- Breast and Cervical Cancer Treatment (authorized by SB 01S2-012, services to clients began July 1, 2002).
- Presumptive Eligibility

***Community Based Long Term Care Services*:**

- Home and Community Based Services -- Elderly, Blind and Disabled Client Services, including In-Home Support Services

- Home and Community Based Services -- Elderly, Blind and Disabled Mentally Ill
- Children's Home and Community Based Services, or Model 200 Program (formerly called Katie Beckett Waiver), include In-Home Support Services.
- Home and Community Based Services -- Persons Living With AIDS
- Consumer Directed Attendant Support Waiver
- Consumer Directed Care for the Elderly Waiver (projected to start by July 1, 2007)
- Private Duty Nursing (often seen together with home health for budget purposes prior to FY 02-03)
- Hospice
- Home and Community Based Services for Persons with Brain Injuries

Long Term Care Services *(a summary of the totals of individual service calculations, not a grouped calculation):*
- Class I Nursing Facilities
- Class II/IV Nursing Facilities
- Program for the All-inclusive Care for the Elderly

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

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

FEDERAL MATCH CALCULATIONS (Exhibit A)

Calculation of Federal Match (pages EA-1 and EA-2)

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

Bottom line adjustments are made for legislation that mandates fees for HB 03-1292 (ICF-MR Fee), Upper Payment Limit financing, outstationing payments, and the impact of Referendum C funding. These items are all discussed further in this narrative. They are

included as bottom line adjustments because they need to be excluded from the trend of expenditures. Only expenditures for medical services to clients are included in the trend of expenditures.

The total request for FY 06-07 is compared to the FY 06-07 Long Bill plus Special Bills appropriation. The total request for FY 07-08 is compared to the total request of FY 06-07 and the FY 07-08 Base Amount (incorporating FY 06-07 Long Bill plus Special Bills and out year impacts).

A checklist of items that have other than the standard calculation of program match rates is provided and is as follows:

- Family Planning: There is 90% federal financial participation available for all documented family planning expenditures. This includes those services that are rendered through the health maintenance organizations. Please see Exhibit F, page EF-10.

- Prenatal Costs: A portion of Acute Care expenditure is for prenatal care for Non-Citizens. This is a state-only program and therefore must be funded through 100% General Fund. Please see Exhibit F, page EF-9.

- Health Care Expansion Fund Programs: Expenditures for clients granted eligibility through HB 05-1262 are funded through the Health Care Expansion Fund. Separate adjustments are made to Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management. In addition, in instances where the Department cannot isolate certain expenditures, the Department performs a bottom line adjustment to allocate expenditure to the Health Care Expansion Fund. Please see Exhibit A, pages EA-3 through EA-6 for calculation of the fund split for the Health Care Expansion Fund.

- Breast and Cervical Cancer Program: At the onset of this program, the federal match for this program was 65% federal and 35% Cash Funds Exempt, from interest earnings from the Tobacco Litigation Settlement Cash Fund. HB 04-1416 (Funding Split for Breast and Cervical Cancer Treatment) continued this funding through FY 04-05. Beginning in FY 05-06, the funding split is 65% federal, 17.5% Cash Funds Exempt from interest earnings from the Tobacco Litigation Settlement Cash Fund, and 17.5% General Fund. The fund split is modified again beginning FY 06-07 and continuing in FY 07-08 to 65% federal funds, 8.75% Cash Funds Exempt, and 26.25% General Fund. In addition, for clients who have gained eligibility through additional screenings funded by HB 05-1262, expenditure is allocated as 65% federal funds, 35% Cash Funds Exempt from the Prevention, Early Detection, and Treatment fund.

- Indian Health Services: The federal match for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.

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

- Single Entry Point: A portion of this line item is for private pay clients (4%) and is not matched with Medicaid federal financial participation. Instead this portion must be funded through 100% General Fund.

- Tobacco Tax Funded Disease Management Programs: HB 05-1262 authorized the Department to enhance its Disease Management program, by creating programs that address cancer, heart disease and lung disease. The Department receives funding as a transfer from the Department of Public Health and Environment from the Prevention, Early Detection, and Treatment fund.

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

  a. Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
  b. Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
  c. Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.
  d. Outstationing payments for the Denver Health Medical Center federally qualified health centers. Federal funds are drawn to reimburse the Denver Health Medical Center federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund.

Health Care Expansion Fund (pages EA-3 through EA-6)

The caseload impacts of the Health Care Expansion Fund from HB 05-1262 are already included in the Medicaid caseload projections. See Exhibit B page EB-1 through EB-3 for additional information. The Medical Services Premiums request is based on these caseload projections and per capita costs, as described in detail below. The overall request for each service category (Acute Care, Community Based Long Term Care, Long Term Care and Insurance, and Service Management) is split out in the Federal Match Calculation, Exhibit A, pages EA-1 and EA-2 splitting the request by General Fund, Cash Funds Exempt, and federal funds accordingly by line item. To isolate certain expenditures, the Department performs bottom line adjustments to allocate expenditure to the Health Care Expansion Fund. For simplicity, pages EA-3 through EA-6 show the fund split adjustments that need to be made to the General Fund amounts shown in each section of the Calculation of Federal Match exhibits (page EA-1 and EA-2). The following programs are funded via the Health Care Expansion Fund:

a. Health Care Expansion Fund Low-Income Adults
b. Presumptive eligibility
c. Legal Immigrants
d. Medicaid asset test (children expansion)
e. Medicaid asset test (adult expansion)
f. Children's Home and Community Based Services – State Plan and waiver services
g. Children's Extensive Support – State Plan services

The items above are summed for each fiscal year and a single line adjustment is included in each service category in the Calculation of Match exhibits to correct the funding splits.

Historically, the FY 07-08 Projection over the FY 06-07 Appropriation plus Special Bills request row on the Federal Match Calculations sheet (page EA-2 of Exhibit A) did not equal Column 6 + Column 8 of the Schedule 6 due the annualization of specials bills from the prior Legislative Session. Beginning with the FY 06-07 Budget Request, and continuing with this Budget Request, the annualizations have been included to this exhibit so the amounts correspond with the Schedule 6.

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

HISTORY OF PER CAPITA COSTS – Cash Based Per Capita, Total Expenditures, and Caseload (Exhibit C)
Medical Services Premiums per capita costs history (through FY 05-06) and projections are included for historical purpose and comparison, and are calculated off of cash-based accounting.

SUMMARY OF REQUEST BY ELIGIBILITY CATEGORY (Exhibit D)
The exhibit displays the Medical Services Premiums caseload, per capita costs and expenditure projections for FY 06-07 and FY 07-08 by eligibility category. Projections include Upper Payment Limit Financing and financing bills. Caseload is non-retroactive.

SUMMARY OF PREMIUM REQUEST by SERVICE GROUP (Exhibit E)
Page EE-1 of this exhibit is a summary of the requests by service grouping (Acute Care, Long Term Care, Community Based Long Term Care) and by eligibility category for estimated FY 06-07, and the projected FY 07-08.

Pages EE-2 through EE-6 of this exhibit contains a detailed summary of the Department's Budget Request, by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation, as determined by the Department's March 13, 2006 Figure Setting and subsequent actions by the Joint Budget

Committee, and the General Assembly. This exhibit includes all bottom line impacts and financing, but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 6.

ACUTE CARE CALCULATIONS (Exhibit F, page EF-1 through EF-5)

Acute Care services are calculated in a series of steps. At the top of page EF-1, historical expenditures are provided (yearly change in expenditure and percentage change is provided on page EF-4). Historical per capita costs and their percent changes are provided. The first step of the calculation is to select a historical per capita percent change rate, if possible, to trend the last actual per capita (FY 05-06 in this case) to the next year. Finally, bottom line adjustments for legislation and Change Requests are made. Total expenditures after bottom line adjustments are divided by the projected caseload to obtain a final per capita cost for FY 06-07. To calculate the FY 07-08 request, the same methodology is applied to the projected FY 06-07 per capita, including a per capita trend factor and bottom line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom line impacts to generate the total request for Medical Services Premiums. There is no separate request for Acute Care.

In light of the Medicare Modernization Act of 2003, the Department has added a separate page of trends on page EF-2. On this page, expenditures for pharmacy and drug rebate recoveries have been removed from the historical expenditure. This page is particularly relevant, as FY 05-06 per capitas for eligibility categories with significant amounts of dual-eligibles are skewed by the new Part D benefit. In OAP-A, OAP-B, and AND/AB, the per capita costs experienced a significant downturn as Medicare has become responsible for most pharmacy. Selecting trends that incorporate FY 05-06 would clearly be erroneous. This new exhibit enables the Department to analyze and select trends without the effect of pharmacy, which has historically been a significant cost driver.

Calculation of Per Capita Percent Change:

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 99-00 through FY 05-06. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-3, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 03-04, FY 04-05, and FY 05-06. Typically, the same percentage selected to modify current year per capita costs (FY 05-06 for instance) were used to modify the request year per capita costs. This method was not utilized in all cases for the FY 07-08 Request.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category. This year, a new table at the end of Exhibit F was used to assist in the November percent selection.

The table below describes the trend selections for FY 06-07, and FY 07-08. In most cases though not all, the Department has held the trend constant between the two years. On Exhibit F, the selected trend factors have been bolded for clarification. By convention, any trend factor selected based on expenditure without prescription drugs and drug rebate is labeled "Without RX."

The selected trend factors for FY 06-07 and FY 07-08, with the rationale for selection, are as follows:

Eligibility Category	FY 06-07 Acute Care Trend Selection	FY 07-08 Acute Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	4-Year Average of FY 02-03 Through FY 05-06 (Without RX) 0.79%	4-Year Average of FY 02-03 Through FY 05-06 (Without RX) 0.79%	Without prescription drugs, the FY 05-06 trend for this aid category is negative, although prior two years are positive. Trend factors are influenced by large per capita changes in FY 02-03 (negative) and FY 04-05 (positive). In light of the erratic history, a moderate long-term trend factor is justified, as the variations between the years are smoothed. This selection will be augmented by bottom line impacts, resulting in a higher overall trend.
Disabled Adults 60 to 64 (OAP-B)	4-Year Average of FY 02-03 through FY 05-06 (Without RX) 1.97%	4-Year Average of FY 02-03 through FY 05-06 (Without RX) 1.97%	Without prescription drugs, the last four years for this aid category have oscillated between positive and negative trends. In FY 05-06, expenditure increased, although caseload did not. Caseload is projected to have a moderate increase, and expenditure should follow. In light of the erratic history, a moderate long-term trend factor is justified, as the variations between the years are smoothed. This selection will be augmented by bottom line impacts, resulting in a higher overall trend.
Disabled Individuals to 59 (AND/AB)	2-Year Average of FY 04-05 through FY 05-06 (Without RX) 0.58%	2-Year Average of FY 04-05 through FY 05-06 (Without RX) 0.58%	Without prescription drugs, 4 out of the last 6 years have been positive. Negative years have served to keep long- and short-term trend factors low. The overall percent change in per capita from FY 03-04 to FY 05-06 was less than 1%. In light of the recent history, a moderate trend selection is justified. This selection will be augmented by bottom line impacts, resulting in a higher overall trend.

Eligibility Category	FY 06-07 Acute Care Trend Selection	FY 07-08 Acute Care Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	4-Year Average of FY 02-03 through FY 05-06 2.64%	4-Year Average of FY 02-03 through FY 05-06 2.64%	Recent history in this aid category is erratic, with a small increase in FY 05-06 after a large per capita decline, and two large per capita increases. In light of the erratic history, a moderate long-term trend factor is justified, as the variations between the years are smoothed. This selection will be augmented by bottom line impacts, resulting in a higher overall trend.
Health Care Expansion Fund Low-Income Adults (HELI-A)	0.00%	AFDC-A 4-Year Average of FY 02-03 through FY 05-06 2.64%	The HELI-A per capita is set at 69% of the AFDC-A per capita, per the fiscal note for HB 05-1262, and has no reason to change that assumption until actual experience can provide more information. This population gained coverage effective July 1, 2006.
Breast & Cervical Cancer Program	0.00%	0.00%	The Department experienced significant expenditure growth in this eligibility category in FY 05-06, well above expectations from the Department's February 15, 2006 Budget Request. At this time, there is no evidence to support a factor that continues this trend, although until the causes of the per capita increase are well understood, it is unreasonable to select a negative trend factor. The Department will revisit this selection in February, when more actual experience will be helpful to discern how the trend has changed.

Eligibility Category	FY 06-07 Acute Care Trend Selection	FY 07-08 Acute Care Trend Selection	Justification
Eligible Children (AFDC-C/ BCKC-C)	Average of FY 99-00, FY 00-01, and FY 04-05 5.12%	Per capita change from FY 99-00 to FY 00-01 1.36%	Per capitas for FY 01-02 through FY 03-04 are heavily influenced by budget cuts during that period, and thus skew long-term trend factors. The most recent two years indicate that this eligibility category continues to grow, although it is unlikely that such strong growth will continue. For FY 06-07, recent growth is tempered with the historic growth rates from prior years. For FY 07-08, the Department anticipates that the trend will abate in a manner similar to the slowing of growth in FY 00-01. This selection will be augmented by bottom line impacts, resulting in a higher overall trend in FY 06-07.
Foster Care	Average per capita change for FY 02-03 through FY 05-06, excluding FY 03-04 0.81%	Average per capita change for FY 02-03 through FY 05-06, excluding FY 03-04 0.81%	Three of the last four years in this eligibility category have shown moderate per capita changes; FY 03-04 appears to be an aberration, and is excluded from the 4-year trend factor. The most recent year of growth indicates this eligibility category is growing slowly, and this selection will be augmented by bottom line impacts, resulting in a higher overall trend in FY 06-07.
Baby Care Program - Adults (BCKC-A)	2-Year Average of FY 04-05 through FY 05-06 2.57%	2-Year Average of FY 04-05 through FY 05-06 2.57%	The reimplementation of presumptive eligibility in FY 05-06 added a large amount of expenditure to this category, but without a corresponding caseload increase. Presumptive eligibility is a one-time increase to the expenditure base. Without presumptive eligibility, expenditure growth was relatively flat in FY 05-06 (see page EF-11), and justifies a moderate growth rate. Although the two-year average is composed of a large per capita increase and a large per capita decrease, the change in per capita from FY 03-04 to FY 05-06 considers two periods with presumptive eligibility in effect, and is a reasonable selection for this eligibility category.

Eligibility Category	FY 06-07 Acute Care Trend Selection	FY 07-08 Acute Care Trend Selection	Justification
Non-Citizens	Per capita change from FY 04-05 to FY 05-06 3.33%	Per capita change from FY 04-05 to FY 05-06 3.33%	This eligibility category receives emergency services and prenatal care only. Long term trends in this eligibility category are affected by policy changes, and may not be indicative of future trends. In more recent years, policy regarding this population has been stable, and this is reflected in the moderate growth experienced in FY 05-06. The Department expects this trend to continue.
Qualified Medicare Beneficiaries/ Special Low-Income Medicare Beneficiaries (QMB/SLMB)	3-Year Average of FY 03-04 through FY 05-06 -3.90%	3-Year Average of FY 03-04 through FY 05-06 -3.90%	Recent history in this eligibility category indicates that caseload is growing faster than expenditure, which is primarily on Medicare coinsurance. In FY 05-06, this trend appears to have begun to moderate. Therefore, a more moderate trend factor than FY 05-06 is justified.

FY 06-07 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 06-07 estimate for Acute Care:

- HB 06-1369 (footnote 37a) provided a 1.0% rate increase for inpatient hospital, effective April 1, 2006. The bottom-line impact in FY 06-07 is the annualization amount, funded in HB 06-1385, of $3,604,228.[26]
- HB 06-1369 (footnote 42a) provided a 2.0% rate increase for durable medical equipment, effective April 1, 2006. The bottom-line impact in FY 06-07 is the annualization amount, funded in HB 06-1385, of $1,311,382.[27]

[26] During the Department's FY 06-07 Figure Setting (pg .146), the annualization amount was estimated as $2,766,223. The amount was adjusted after Figure Setting due to Committee changes in per capitas to $3,604,228.

[27] During the Department's FY 06-07 Figure Setting (pg .146), the annualization amount was estimated as $1,031,253. The amount was adjusted after Figure Setting due to Committee changes in per capitas to $1,311,382

- HB 06-1385 (footnote 26) provided a 3.25% rate increase for Acute Care providers, including physician services, Early Periodic Screening, Diagnosis and Treatment (EPSDT), lab and x-ray, and durable medical equipment, effective July 1, 2006. The bottom-line impact in FY 06-07 is $9,917,925.
- HB 06-1385 (footnote 27) provided a 3.25% increase for inpatient hospital, effective July 1, 2006. The bottom-line impact in FY 06-07 is $11,713,742.
- HB 05-1015 added an outpatient substance abuse benefit, and is funded in HB 06-1385. The bottom-line impact in FY 06-07 is $5,843,702 (Figure Setting, March 13, 2006, page 139).
- SB 06-165 authorized the Department to implement treatment via telemedicine. The bottom-line impact in FY 06-07 is $600,060 and reflects only the transmission costs of the program (Legislative Council fiscal note for SB 06-165, April 24, 2006; adjusted. See Section V for the calculation of this impact).
- FY 05-06 Supplemental #8 (January 3, 2006) for the federally required Payment Error Rate Measurement Project (PERM) was funded in HB 06-1385, and is scheduled to begin in October, 2006 (corresponding with the beginning of federal fiscal year 2007). The bottom-line impact in FY 06-07 is a reduction of $796,710.[28]
- FY 06-07 Decision Item #4 (November 15, 2005) for drug rebate savings from the implementation of the Drug Rebate Analysis and Management System (DRAMS). The Joint Budget Committee reduced the Department's requested amount during Figure Setting to an amount of $494,920 in FY 06-07 (Figure Setting, March 13, 2006, page 156).
- Anticipated prescription drug savings per Medicare Modernization Act funded in HB 06-1385. This is a decrease to Acute Care of $72,257,761 million. The savings represents a half-year impact since the Medicare Modernization Act was effective January 1, 2006. The calculation of this impact is located in Exhibit Q, beginning on page EQ-1.

The sum of the bottom line impacts for Acute Care in FY 06-07 decreased the estimated FY 06-07 Acute Care projection by $40,558,352. The revised estimated FY 06-07 Acute Care total expenditure is $1,265,403,764.

FY 07-08 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 07-08 request for Acute Care:

[28] The bottom-line adjustment for PERM are the same as the Department's November 15, 2005 Budget Request. In the Department's Supplemental # 8, the Department informed the Joint Budget Committee that the PERM project had been delayed until October, 2006 and requested administrative funding to be moved to FY 06-07. The Joint Budget Committee approved the Department's Budget Amendment (Figure Setting, March 13, 2006, page 24), but no explicit mention is made in Figure Setting of the savings offset to Medical Services Premiums. Nevertheless, an offset for PERM savings totaling $796,710 was included in the Long Bill.

- HB 05-1015 added an outpatient substance abuse benefit, but assumes that savings are not realized in the first six months of the program. The bottom-line impact in FY 07-08 is a reduction of $1,218,371, and reflects the annualization of the savings assumed in the Legislative Council fiscal note for HB 05-1015.
- SB 06-165 authorized the Department to implement treatment via telemedicine. The bottom-line impact in FY 07-08 is $466,712, and reflects the annualization of the transmission costs of the program (Legislative Council fiscal note for SB 06-165, April 24, 2006).
- SB 06-165 also contains funding for disease management programs. Although the costs of disease management programs are contained in the Service Management section of this request, savings to Acute Care are realized here. The bottom-line impact in FY 07-08 is a reduction of $235,363, and reflects the Acute Care savings due to additional disease management (Legislative Council fiscal note for SB 06-165, April 24, 2006).
- FY 05-06 Supplemental #8 (January 3, 2006), the federally required Payment Error Rate Measurement Project (PERM) was funded in HB 06-1385, and is scheduled to begin in October, 2006 (corresponding with the beginning of federal fiscal year 2007). The bottom-line impact in FY 07-08 is a reduction of $350,362, and reflects the annualization of savings in FY 06-07.

The sum of the bottom line impacts for Acute Care in FY 07-08 decreased the estimated FY 07-08 Acute Care projection by $1,337,384. The revised estimated FY 07-08 Acute Care total expenditure is $1,343,618,940.

BREAST AND CERVICAL CANCER PROGRAM (Exhibit F, page EF-6)

A portion of the Prevention, Early Detection and Treatment Fund established by HB 05-1262 is dedicated to increasing the number of cancer screenings performed by the Department of Public Health and Environment. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. At this time, the Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 monies. The Department suggested that the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" Medicaid.

Per 25.5-5-308 (9) (a) and (b), C.R.S. (2006), state funding for "traditional" Medicaid Breast and Cervical Program clients comes from the Breast and Cervical Cancer Prevention and Treatment Program Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2006), state funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund. All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

This exhibit calculates the portion of Breast and Cervical Cancer Program expenditure that will be allocated to the Prevention, Early Detection, and Treatment Fund, and the amount allocated to the Breast and Cervical Cancer Prevention and Treatment Program Fund. In prior years, this page has calculated per capitas for two groups of clients within the Breast and Cervical Cancer Program: clients who have been on the program for longer than a year, and clients in their first year on the program. As discussed above (under "Acute Care Calculations"), the Department's expenditure and per capita cost for these clients grew at an unexpected rate. At this time the change in the expenditure pattern is not well understood, and the prior methodology is not used to calculate per capita costs. The Department anticipates returning to a similar methodology in the future.

CALCULATION OF ANTIPSYCHOTIC DRUGS (Exhibit F, page EF-7 through EF-8)

Antipsychotic drugs were moved from the Department's premium line to the Department of Human Services for FY 01-02. For FY 03-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-6 through EF-7, is a rough projection of antipsychotic drug expenditures for FY 06-07 and FY 07-08. This projection is done only for this service category because it is necessary to establish the informational line item under the Medicaid Mental Health Community Programs Long Bill group. The Department urges much caution in reviewing Exhibit F, page EF-6 through EF-7, as trending on service category has proved unstable over time. Also note that technically these dollars are doubled-counted, albeit as Cash Funds Exempt, in the Medicaid Mental Health Community Programs Long Bill group. The most important observation in this area is that the growth in antipsychotics continues to grow well beyond other service categories in Medicaid.

The estimate for antipsychotic drugs is impacted by the implementation of the Medicare Modernization Act (MMA), as antipsychotic drugs are covered under the Medicare Part D benefit. The FY 06-07 impact of the Medicare Modernization Act is calculated by comparing the average monthly expenditure for the six months preceding the MMA (July 2005 through December 2005) to the last four months of FY 05-06 (March 2006 through June 2006). Due to the nature of cash accounting, January and February 2006 are omitted from the calculation, as costs for antipsychotic drugs are still reflected in expenditure data. For OAP-A, the average monthly expenditure declined 92.44%. For OAP-B, the average monthly expenditure declined 53.16%. For AND/AB, the average monthly expenditure declined 47.89%. Although a small number of dual-eligibles may exist in other aid categories, for the purpose of this calculation, the Department assumes that there has been no impact to any of these groups. Because the number of dual-eligibles is so small, the impact of the MMA on these aid categories is negligible.

For OAP-A, OAP-B, and AND/AB, FY 06-07 Pre-Rebate Expenditures are calculated utilizing FY 05-06 pre-rebate actuals, increased by the average percentage change in pre-rebate expenditures between FY 03-04 and FY 04-05. FY 05-06 trends are excluded due to the implementation of the Medicare Modernization Act. For all other aid categories, FY 05-06 pre-rebate actuals are inflated by the

average percentage change in pre-rebate expenditures between FY 04-05 and FY 05-06. The percentage increases are held constant in FY 07-08.

CALCULATION OF 100% GENERAL FUND PRENATAL CARE COSTS FOR NON-CITIZENS (Exhibit F, page EF-9)

Pursuant to 26-4-203(3)(a), C.R.S. (2002), Colorado opted to provide prenatal care at its sole expense for Non-Citizens. SB 03-176 eliminated this service for legal immigrants, however HB 05-1086 reinstated the services. Therefore, there was no interruption in services. The Department receives a 50% federal match for any emergency services provided for these clients, in particular, labor and delivery. For this Budget Request, the Department has revised its reporting of expenditure. In prior Budget Requests, the Department's exhibit incorrectly listed the state-only portion of expenditure as the total amount spent on the program.

The FY 06-07 and FY 07-08 estimated expenditures are calculated by trending the FY 05-06 total expenditure by the average growth of FY 03-04 and FY 04-05. The FY 06-07 and FY 07-08 estimated state-only expenditures are calculated by trending the FY 05-06 total state-only expenditure by the average growth in state-only expenditure of FY 03-04 and FY 04-05. The Department did not include FY 05-06 in the trend estimate, as it appears that FY 05-06 expenditure was skewed by the reimplementation of presumptive eligibility. The Department believes that this is a one-time decrease to expenditure, and that the program will continue to trend at its historical rate.

CALCULATION OF ENHANCED FAMILY PLANNING MATCH RATE (Exhibit F, page EF-10)

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided through fee-for-service and beginning in late FY 01-02, the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. A portion of the payments, $2,311,115, were disallowed due to family planning activities that did not qualify for enhanced federal financial participation, resulting in a repayment of federal funds to the federal government in FY 04-05. Totals listed on page EF-10 are taken directly from the Department's requests from the Centers for Medicare and Medicaid Services for enhanced federal funds.

In prior Budget Requests, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals have been combined and a single combined estimate has been produced. The total estimate for FY 06-07 and FY 07-08 is based on the average percentage change from FY 02-03 through FY 05-06 (13.98%).

As of FY 05-06, The Department no longer has any contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department.

ESTIMATE OF FY 05-06 ACUTE CARE EXPENDITURES USING HALF-YEAR EXPENDITURE HISTORY (Exhibit F, page EF-11 and 12)

This exhibit replaces the Department's year-to-date exhibit from the February 15, 2006 Budget Request. Because the Department only has limited experience in FY 06-07, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 05-06 actuals into half-year increments to analyze the changing per capita costs over time. Average caseload for the six month period is derived from the Department's monthly caseload in FY 05-06, listed on page EB-4. The Department allocates the half-year expenditure in the same fashion as in Exhibit M, Cash-Based Actuals.

In this exhibit, the Department compares expenditure, caseload, and per capita cost for the periods of July 2005 through December 2005, and January 2006 through June 2006. Inherent in this comparison are changes in policy which occurred during the fiscal year (such as provider rate increases). The Department does not adjust these policy changes out of the comparison; these changes become part of the base estimate, and it is useful to examine their effects on the trend. For each period, and for each eligibility category, half-year per capitas are calculated, and differences compared.

This is a rough projection utilizing year-to-date expenditure patterns as a guide to predict future expenditures. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

COMMUNITY-BASED LONG TERM CARE DETAIL (Exhibit G)

The increased emphasis on utilizing community based services has served to keep the census in Class I nursing facilities relatively flat. In FY 81-82, with the implementation of the first wave of home and community based service waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The census has generally remained in this range despite nearly 1.7% increases in Medicaid caseload for elders since FY 97-98. In response to budget balancing in FY 02-03, rules were passed by the Medical Services Board to improve utilization management, which resulted in a reduction of per capita spending. Among these changes, the Department clarified the requirements necessary to meet the level of care required to qualify for nursing facility care or Home and Community Based Services. In addition, a requirement was added that in order to be eligible for Long Term Home Health, a client 18 years and over had to meet the level of care. Although home health costs are in the Acute Care portion of the Premiums calculation, long term home health costs do correlate to community based long term care costs. High cost clients in the community were reviewed by Single Entry Points and transitioned to less expensive alternatives if their care plans and services did not assure that all services being provided were required. The assessment, which was a functional assessment to determine whether a client meets the long term care level of care, was redone with the help of providers, Single Entry Points, and clients. Responsibilities were shifted to ensure that Single Entry Points are the primary entities through which clients access long term care. Additionally, responsibilities required Single Entry Points to have tools and the authority to act as gatekeepers for long term care benefits. Federal requirements were more completely enforced, ensuring that clients regularly receive Home and Community Based Services waiver services in order to retain eligibility for the waiver.

Calculation of Per Capita Percent Change:

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 99-00 through FY 05-06. At the top of page EG-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 03-04, FY 04-05, and FY 05-06. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs. This method was not utilized in all cases for the FY 07-08 Request.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category. This year, a new table at the end of Exhibit G was used to assist in the November 2006 percent selection.

The table below describes the trend selections for FY 06-07, and FY 07-08. In most cases though not all, the Department has held the trend constant between the two years. On Exhibit G, the selected trend factors have been bolded for clarification. In selecting trend factors, the Department is aware that rate increases from HB 06-1369 and HB 06-1385 (as described below) will provide for significant per capita growth. In selecting trends, the Department has considered only the baseline change in per capita, and not any bottom line impact.

The selected trend factors for FY 06-07 and FY 07-08, with the rationale for selection, are as follows:

Eligibility Category	FY 06-07 Community Based Long Term Care Trend Selection	FY 07-08 Community Based Long Term Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	2-Year Average of FY 04-05 through FY 05-06 2.54%	2-Year Average of FY 04-05 through FY 05-06 2.54%	Although FY 05-06 had a large per capita increase, this selection is tempered by the fact that expenditure was virtually flat in FY 04-05, causing a per capita decline. Recent history has been marked by periods of sharp increases, and then flat growth or declines. Given that FY 05-06 had sharp expenditure growth, the historical pattern indicates that baseline growth may slow in FY 06-07. The bottom-line impacts in this category will provide for a large overall per capita trend.

Eligibility Category	FY 06-07 Community Based Long Term Care Trend Selection	FY 07-08 Community Based Long Term Care Trend Selection	Justification
Disabled Adults 60 to 64 (OAP-B)	2-Year Average of FY 03-04 through FY 04-05 1.67%	2-Year Average of FY 03-04 through FY 04-05 1.67%	FY 05-06 experienced large expenditure growth, but an analysis of the half-year expenditures indicates that this was a one-time growth. Therefore, FY 05-06 is excluded from the trend. In light of half-year expenditure growth being relatively flat, a moderate trend is chosen. The bottom-line impacts in this category will provide for a large overall per capita trend.
Disabled Individuals to 59 (AND/AB)	2-Year Average of FY 03-04 through FY 04-05 2.59%	2-Year Average of FY 03-04 through FY 04-05 2.59%	FY 05-06 experienced significant expenditure growth, after two years where there was a modest increase and a nominal decline, which resulted in a per capita decrease. In light of the recent history, it appears that FY 05-06 may be a one-time event, and thus is excluded from the trend. The bottom-line impacts in this category will provide for a large overall per capita trend.
Categorically Eligible Low-Income Adults (AFDC-A)	AND/AB 2-Year Average of FY 03-04 through FY 04-05 2.59%	AND/AB 2-Year Average of FY 03-04 through FY 04-05 2.59%	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their eligibility category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. As such, it is appropriate to apply the trend from the Disabled Individuals population to this per capita.
Health Care Expansion Fund Low-Income Adults (HELI-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

Eligibility Category	FY 06-07 Community Based Long Term Care Trend Selection	FY 07-08 Community Based Long Term Care Trend Selection	Justification
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Eligible Children (AFDC-C/ BCKC-C)	AND/AB 2-Year Average of FY 03-04 through FY 04-05 2.59%	AND/AB 2-Year Average of FY 03-04 through FY 04-05 2.59%	Eligible Children only receive private duty nursing and hospice care. Because a very small number of clients receive services, per capita trends are skewed by changes in caseload, and are unreliable. Eligible children using community based long term case services are similar to children in the disabled population, and so the trend from the Disabled Individuals eligibility category is appropriate.
Foster Care	AND/AB 2-Year Average of FY 03-04 through FY 04-05 2.59%	AND/AB 2-Year Average of FY 03-04 through FY 04-05 2.59%	Foster care children only receive private duty nursing and hospice care. Because a very small number of clients receive services, per capita trends are skewed by changes in caseload, and are unreliable. Foster care children using community based long term case services are similar to children in the disabled population, and so the trend from the Disabled Individuals eligibility category is appropriate.
Baby Care Program - Adults (BCKC-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

Eligibility Category	FY 06-07 Community Based Long Term Care Trend Selection	FY 07-08 Community Based Long Term Care Trend Selection	Justification
Qualified Medicare Beneficiaries/ Special Low-Income Medicare Beneficiaries (QMB/SLMB)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

FY 06-07 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 06-07 estimate for Community Based Long Term Care:

- HB 06-1369 (footnote 40a) provided various rate increases for long-term care community providers, effective April 1, 2006. The bottom-line impact in FY 06-07 is the annualization amount, funded in HB 06-1385, of $20,812,658 (Figure Setting, March 13, 2006, page 146).[29]
- HB 06-1385 (footnote 28) provided various rate increases for long-term care community providers, effective April 1, 2007. The bottom-line impact in FY 06-07 is $4,138,750.
- SB 04-177 adds a Home and Community Based Services program for children with autism. The bottom-line impact in FY 06-07 is $940,125, and reflects a program start-date of October 1, 2006 (Legislative Council fiscal note for SB 04-177, April 6, 2004).
- HB 05-1131 authorized pharmacists to redispense specified unused medications. This program started March 30, 2006. The bottom-line impact in FY 06-07 is a reduction of $2,861, and reflects 9 months of the savings estimate from Figure Setting (Figure Setting, March 13, 2006, page 141).

[29] After the Department's FY 06-07 Figure Setting, the Joint Budget Committee approved a different rate increase plan than originally presented (detailed in Section V of this narrative). Although the rate increases were adjusted, the total budgeted amount was left unchanged, and confirmed by the Joint Budget Committee on March 16, 2006.

The sum of the bottom line impacts for Community Based Long Term Care increased the estimated FY 06-07 projection by $25,888,672. The revised estimated FY 06-07 Community-Based Long Term Care total request is $217,320,576.

FY 07-08 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 07-08 request for Community Based Long Term Care:

- HB 06-1385 (footnote 28) provided various rate increases for long-term care community providers, effective April 1, 2007. The bottom-line impact in FY 07-08 is the annualization amount of $12,416,250.
- SB 04-177 adds a Home and Community Based Services program for children with autism. The bottom-line impact in FY 07-08 is $313,375, and reflects the annualization amount and a program start-date of October 1, 2006.
- HB 05-1243 adds consumer directed care as an optional benefit to the Department's home and community based services waivers, pending federal approval. The Department expects the program to begin in July, 2007. The bottom-line impact in FY 07-08 is a reduction of $6,440,928 (Legislative Council fiscal note for HB 05-1243, March 14, 2005).

The sum of the bottom line impacts for Community Based Long Term Care increased the estimated FY 07-08 projection by $6,288,697. The revised estimated FY 07-08 Community-Based Long Term Care total request is $231,880,603.

ESTIMATE OF FY 05-06 COMMUNITY BASED LONG-TERM CARE EXPENDITURES USING HALF-YEAR EXPENDITURE HISTORY (Exhibit G, page EG-4)

This exhibit replaces the Department's year-to-date exhibit from the February 15, 2006 Budget Request. Because the Department only has limited experience in FY 06-07, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 05-06 actuals into half-year increments to analyze the changing per capita costs over time. Average caseload for the six month period is derived from the Department's monthly caseload in FY 05-06, listed on page EB-4. The Department allocates the half-year expenditure in the same fashion as in Exhibit M, Cash-Based Actuals.

In this exhibit, the Department compares expenditure, caseload, and per capita cost for the periods of July 2005 through December 2005, and January 2006 through June 2006. Inherent in this comparison are changes in policy which occurred during the fiscal year (such as provider rate increases). The Department does not adjust these policy changes out of the comparison; these changes become part of the base estimate, and it is useful to examine their effects on the trend. For each period, and for each eligibility category, half-year per capitas are calculated, and the differences are compared.

This is a rough projection utilizing year-to-date expenditure patterns as a guide to predict future expenditures. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

LONG TERM CARE AND INSURANCE SERVICES (Exhibit H)

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

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

SUMMARY OF LONG TERM CARE AND INSURANCE REQUEST (Exhibit H, Page EH-1)

This exhibit summarizes the total requests from the worksheets within Exhibit H on pages EH-2 through EH-23.

CLASS I NURSING FACILITIES (Exhibit H, Page EH-2 Through EH-5)

Class I nursing facility costs are essentially a function of the application and interpretation of rate reimbursement methodology specified in detail in State statutes, the utilization of the services by Medicaid clients and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict the costs driven by the estimated Medicaid reimbursement methodology (estimated weighted average per diem allowable Medicaid rate, and estimated average patient payment), estimated utilization by clients (patient days without hospital backup and out of state placement), estimated cost offsets from refunds and recoveries, and expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 99-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 8.1% (through the estimated FY 06-07 total) since that year. This is due to efforts by the Department to place clients in Home and Community Based Services (HCBS), and in the Department's Program for All-Inclusive Care for the Elderly (PACE). However, since FY 04-05, the Department has begun to experience some small growth in the number of patient days.

Patient payment is primarily a function of client income. As clients have received cost-of-living adjustments in their supplemental security income, patient payment has increased accordingly.

The Department has altered the methodology for calculating the estimated allowable per diem rate. In prior years, the Department used rates effective July 1 to estimate the allowable per diem. However, in FY 06-07, rates effective July 1 are affected by SB 06-131,

which required changes to the rate-setting methodology (described below). The estimated impact of SB 06-131 is added as a bottom line impact. In order not to double count the impact of SB 06-131, the Department has elected to trend prior year rates to produce an estimate of the allowable per diem rate.

For complete information regarding specific calculations, the footnotes in pages EH-3 through EH-5 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[30]:

- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated allowable per diem rate of $163.70 and the estimated patient payment of $28.64 for claims that will be incurred in FY 06-07. The difference between the estimated per diem rate and the estimated patient payment, $135.06, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 06-07. The calculations for these estimates are contained in Exhibit H, on page EH-3, footnotes 1 and 2.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 06-07 (3,556,504). The calculations for these estimates are contained in Exhibit H, on page EH-3, footnote 3.
- The product of the estimated Medicaid reimbursement per day and the estimated number of patient days yields the estimated total reimbursement for claims incurred in FY 06-07, $480,343,565.
- Of the estimated total reimbursement for claims incurred in FY 06-07, only a portion of those claims will be paid in FY 06-07. The remainder is assumed to be paid in FY 07-08. The Department estimates that 91.54% of claims incurred in FY 06-07 will also be paid during FY 06-07. Footnote 5 of Exhibit H, page EH-4, details the calculation of the percentage of claims that will be incurred and paid in FY 06-07. The total amount estimated to be paid in FY 06-07 for claims incurred in FY 06-07 ("current year claims") is $439,686,559.
- During FY 06-07, the Department will also pay for some claims incurred during FY 05-06 ("prior year claims"). In Footnote 7 of Exhibit H, page EH-4, the Department applies the percentages calculated in Footnote 5 to claims incurred during FY 05-06 to calculate an estimate of outstanding claims of $39,127,933 to be paid in FY 06-07.
- The sum of the current year claims and the prior year claims, $478,814,492, is the estimated expenditures in FY 06-07 prior to adjustments ("gross budget estimate").
- Other non-rate factors are then added or subtracted from the gross budget estimate. These include the hospital backup program and out of state placements, estimated estate and income trust recoveries, recoveries from Department Overpayment Review, savings from HB 05-1131, Authority of a Pharmacist to Redispense Specified Unused Medications, and increased costs due to SB 06-131, Changes to Nursing Facility Rate Setting Methodology. For a detailed discussion of bottom-line impacts, see the narrative for the Department's reasonableness projection for Class I Nursing Facilities, located below.

[30] For clarity, FY 06-07 figures are used as an example. The estimate for FY 07-08 is based on the estimate for FY 06-07, and follows the same methodology.

- Once the "non-rate" factors are estimated the sum of the gross budget estimate and the non-rate adjustments yields the total estimated FY 06-07 expenditure ($477,966,274).

For FY 07-08, the same methodology is applied, taking into account the estimate for FY 06-07.

Summary of FY 06-07 Estimate and FY 07-08 Request

FY 06-07 Estimate	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$439,686,559
Estimated Expenditures for FY 05-06 Dates of Service	$39,127,933
Estimated Expenditures in FY 06-07 Prior to Adjustments	**$478,814,492**
Adjustments	($818,218)
Total Estimated FY 06-07 Expenditures	**$477,996,274**
FY 07-08 Request	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$463,121,016
Estimated Expenditures for FY 06-07 Dates of Service	$40,657,006
Estimated Expenditures in FY 07-08 Prior to Adjustments	**$503,778,022**
Adjustments	($4,039,124)
Total Estimated FY 07-08 Expenditures	**$499,738,898**

Incurred But Not Reported Adjustments

As part of the estimates for the allowable per diem rate, patient payment, and patient days, the Department utilizes the most recent 4 years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model which examines past claims by month of service and month of payment to estimate the amount of claims which will be paid in the future. This is known as a "Incurred But Not Reported" (IBNR adjustment). The Incurred But Not Reported adjustments analyze the prior pattern of expenditure (specifically, the lag between the time past claims were incurred and when they were paid), and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate Incurred But Not Reported adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly footnotes 5 and 7 of Exhibit H, page EH-4. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 05-06 which will pay in FY 06-07, and the percentage of claims incurred in FY 06-07 which will be paid in FY 07-08.

Nursing Facility Rate Methodology Changes

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

FY 97-98	8% Health Care Cap and 6% Administrative Cap Implemented
FY 98-99	No change
FY 99-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 00-01	No change
FY 01-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
FY 02-03	Administrative Incentive Allowance removed for three months then reinstated
FY 04-05	8% Health Care Cap reinstated
FY 05-06	No change
FY 06-07	8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131).

CLASS I NURSING FACILITIES (Exhibit H, Page EH-6 Through EH-9)

This exhibit does not represent the Department's request for Class I nursing facilities. This exhibit is for reference only and is provided as a reasonableness check of the request. The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 99-00 through FY 05-06. At the top of page EH-7, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 03-04, FY 04-05, and FY 05-06. Typically, the same percentage selected to modify current year per capita costs (FY 05-06 for instance) were used to modify the request year per capita costs. This method was not utilized in all cases for the FY 07-08 Request.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category. This year, a new table at the end of Exhibit H was used to assist in the November 2006 percent selection. The percent trends selected for FY 06-07, with the rationale, are as follows:

Eligibility Category	FY 06-07 Long Term Care Trend Selection	FY 07-08 Long Term Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	4-Year Average of FY 02-03 through FY 05-06 3.05%	4-Year Average of FY 02-03 through FY 05-06 3.05%	Recent year-to-year trends in this aid category have been erratic, with some positive years and some negatives. Given the significant variation, Department has selected a longer term 4-year trend to minimize the impact of the variation between the years.
Disabled Adults 60 to 64 (OAP-B)	5-Year Average of FY 99-00 through FY 03-04 7.96%	5-Year Average of FY 99-00 through FY 03-04 7.96%	In recent years, expenditure has been growing, but the rate of growth has been declining. In FY 05-06, caseload declined, leading to a high per capita change. Additionally, FY 04-05 experienced a sharp caseload increase. The Department does not anticipate either of these trends continuing. To minimize the impact from more current years, the Department has selected a long term trend ending in FY 03-04, where the Department experienced similar growth levels to the current projection.
Disabled Individuals to 59 (AND/AB)	4-Year Average of FY 02-03 through FY 05-06 3.04%	4-Year Average of FY 02-03 through FY 05-06 3.04%	Historically, this eligibility category has high growth rates, but this has changed over the last several years. As caseload is projected to be relatively stable, a long term trend incorporating the period after the large growth slowed down is justified.
Categorically Eligible Low-Income Adults (AFDC-A)	(100.00%)	(100.00%)	Clients in this eligibility category are not eligible for long term care benefits.

Eligibility Category	FY 06-07 Long Term Care Trend Selection	FY 07-08 Long Term Care Trend Selection	Justification
Health Care Expansion Fund Low-Income Adults (HELI-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for long term care benefits.
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for long term care benefits.
Eligible Children (AFDC-C/ BCKC-C)	(100.00%)	(100.00%)	Clients in this eligibility category are not eligible for long term care benefits.
Foster Care	0.00%	0.00%	Clients in this eligibility category are not eligible for long term care benefits.
Baby Care Program - Adults (BCKC-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for long term care benefits.

Eligibility Category	FY 06-07 Long Term Care Trend Selection	FY 07-08 Long Term Care Trend Selection	Justification
Qualified Medicare Beneficiaries/ Special Low-Income Medicare Beneficiaries (QMB/SLMB)	(50.00%)	(50.00%)	Clients in this eligibility category are not eligible for long term care benefits. However, this group experienced a relatively large increase in expenditure in FY 05-06, which may indicate that some clients are miscoded. The Department expects that expenditure will decline slowly.

FY 06-07 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 06-07 reasonableness check for long term care:

- SB 06-131 provided for changes to the methodology used to calculate class I nursing facility rates, effective July 1, 2006. The bottom-line impact in FY 06-07 is $4,240,697. This figure differs from the Legislative Council fiscal note, as the fiscal note did not incorporate any estimate for the partial removal of the 8% limit on health care costs. For additional information, see footnote 10 in Exhibit H, page EH-4, and section V of this document.
- HB 05-1131 authorized pharmacists to redispense specified unused medications. This program started March 30, 2006. The bottom-line impact in FY 06-07 is a reduction of $33,790, and reflects 9 months of the savings estimate from Figure Setting (Figure Setting, March 13, 2006, page 141).

The sum of the bottom line impacts to Class I Nursing Facilities increases the estimated FY 06-07 projection by $4,206,907. The revised estimated FY 06-07 Long Term Care total projection is $483,483,548. This is not the Department's official request for Class I Nursing Facilities.

FY 07-08 Legislative Impacts and Bottom Line Adjustments

There are no bottom line impacts in FY 07-08.

The estimated FY 07-08 Class I Nursing Facilities total projection is $505,682,794. This is not the Department's official request for Class I Nursing Facilities.

CLASS II NURSING FACILITY (Exhibit H, Page EH-9 through EH-11)

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 97-98. Beginning of FY 98-99, the service category was limited to one facility, Good Shepherd Lutheran, providing services to 16 clients. There are no plans to eliminate this facility as it essentially functions more like a group home than an institutional facility.

For FY 06-07 and FY 07-08, the per capita for Disabled Adults to 59 (AND/AB) was trended using the average of FY 03-04 through FY 05-06 per capita. Additionally, this percentage was applied to the Adults 65 and Older (OAP-A) per capita; there is a single OAP-A client using this facility. The Medicaid census at this facility has remained constant throughout the year, and there is no expectation that there will be a large change in expenditure in this service category.

PROGRAM FOR THE ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) (Exhibit H, Page EH-12 Through EH-14)

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB).

The FY 06-07 and FY 07-08 projections for PACE were computed by applying the Adults 65 and Older (OAP-A) average per capita change from FY 02-03 through FY 05-06 to each aid category. In recent years, growth in PACE enrollment has slowed significantly, indicating that the rapid expenditure growth experienced in prior years will also slow. However, the Department has received applications for additional PACE sites, and program staff indicates that a maximum of approximately 80 clients may enroll. Therefore, the Department maintains a large per capita growth rate, in anticipation of continued growth in this area.

FY 06-07 and FY 07-08 Legislative Impacts and Bottom Line Adjustments

Adjustments to FY 05-06 and FY 06-07 include the following:

- Anticipated prescription drug savings per Medicare Modernization Act related to the PACE program. This is a decrease to PACE of $2,932,339 in FY 06-07. This figure is calculated in Exhibit Q, page EQ-5, and represents a half-year impact since the Medicare Modernization Act was effective January 1, 2006.
- The Department reached a settlement agreement with its PACE provider to correct for instances where the incorrect rate was paid for a particular client. The majority of this settlement is due to the Department paying an incorrect rate to the provider. The Department believes that issues that caused the incorrect rates to be paid have been corrected as of December, 2005. In FY 05-06, the Department recovered $1,462,091 for dates between May 2003 and June 2005. This was a one-time event, and not expected

to occur again for this period; therefore, the total amount recouped is added back to the total so that the estimate for FY 06-07 expenditure is not understated.

- As part of the settlement above, the Department identified $350,902 due to the Department for the period of July 2005 through December 2005. This amount is subtracted from the FY 06-07 estimate, and added back to the FY 07-08 estimate to prevent underestimating expenditure.

The sum of the bottom line impacts to PACE decreases the estimated FY 06-07 projection by $1,821,150. The revised estimated FY 06-07 PACE total is $47,873,238.

The sum of the bottom line impacts to PACE increases the estimated FY 07-08 projection by $350,902. The revised estimated FY 07-08 PACE total is $60,266,183.

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT (Exhibit H, Page EH-15 through EH-17)

The Supplemental Medicare Insurance Benefit consists of two parts: Medicare Part A, the insurance premium for hospital care and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid here; co-payments and deductibles are paid under Acute Care. The Part A premium payments are made for the Qualified Medicare Beneficiary eligibility group only. The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types (Specified Low-Income Medicare Beneficiaries, Qualified Individuals (1), and Qualified Medicare Beneficiary clients), and Part A payments for Qualified Medicare Beneficiary clients. Premiums for Medicare are not federally matchable for clients who do not meet the Supplemental Security Income Limit.

The law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as Medicare Qualified Individual 1. Legislation for the second group, referred to as Medicare Qualified Individual 2, comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

To calculate FY 06-07 and FY 07-08, the increase in the Medicare Part B premium from federal fiscal year 2005 to federal fiscal year 2006 (13.17%) was utilized. Using this percentage, FY 06-07 expenditures are projected to be $80,096,751, and FY 07-08 expenditures are projected to be $90,645,493.

HEALTH INSURANCE BUY-IN (Exhibit H, Page EH-18 through EH-20)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2006). During FY 05-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost effective became ineffective, since the costs of those health plans included a drug benefit. This caused a decrease in HIBI expenditure in FY 05-06. However, this is a one-time adjustment to expenditure, and the Department anticipates expenditure growth rates returning to levels experienced in prior years.

The Health Insurance Buy-In FY 05-06 per capitas were increased by the overall percent change from FY 00-01 through FY 04-05. This trend selection omits the decrease in expenditure due to the implementation of the Medicare Modernization Act. There were no legislative impacts to this service category. Using this percentage, FY 06-07 expenditures are projected to be $558,766, and FY 07-08 expenditures are projected to be $590,676.

ESTIMATE OF FY 05-06 LONG-TERM CARE AND INSURANCE EXPENDITURES USING HALF-YEAR EXPENDITURE HISTORY (Exhibit H, page EF-21 through EH-23)

This exhibit replaces the Department's year-to-date exhibit from the February 15, 2006 Budget Request. Because the Department only has limited experience in FY 06-07, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 05-06 actuals into half-year increments to analyze the changing per capita costs over time. Average caseload for the six month period is derived from the Department's monthly caseload in FY 05-06, listed on page EB-4. The Department allocates the half-year expenditure in the same fashion as in Exhibit M, Cash-Based Actuals.

In this exhibit, the Department compares expenditure, caseload, and per capita cost for the periods of July 2005 through December 2005, and January 2006 through June 2006. Inherent in this comparison are changes in policy which occurred during the fiscal year (such as provider rate increases). The Department does not adjust these policy changes out of the comparison; these chances become part of the base estimate, and it is useful to examine their effects on the trend. For each period, and for each eligibility category, half-year per capitas are calculated, and differences compared.

This is a rough projection utilizing year-to-date expenditure patterns as a guide to predict future expenditures. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

SERVICE MANAGEMENT (Exhibit I)

A new category has been set up to account for the administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for administrative service organizations.

SUMMARY OF SERVICE MANAGEMENT (Exhibit I, Page EI-1)

This exhibit summarizes the total requests from the worksheets within Exhibit I on pages EI-1 through EI-6.

SINGLE ENTRY POINTS (Exhibit I, page EI-2 through EI-4)

Single Entry Point agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. 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. 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 home and community based services and nursing facilities.

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, recently it has come 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 Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

Because of its administrative nature, single entry points are not trended by per capita, which the Department elected to change beginning with the February 15, 2005 Budget Request. Instead, the estimated change in total caseload is applied to the FY 05-06 expenditure to estimate FY 06-07 and FY 07-08, as rates paid to single entry points do not change without an additional appropriation from the General Assembly.

FY 06-07 and FY 07-08 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impact has been included in the FY 06-07 and FY 07-08 calculations for Single Entry Points:

- The Department's Decision Item #5 from November 15, 2005 was approved by the Joint Budget Committee during Figure Setting, to annually audit each single entry point agency. This is a reduction of $76,660 to FY 06-07 (Figure Setting, March 13, 2006, Page 149).
- HB 05-1243 allowed the Department to add consumer directed care to home and community based waiver services. These services must be approved by single entry point agencies. This program is now estimated to be approved by the Centers for Medicare and Medicaid Services (CMS) by July 1, 2007. This is an increase of $1,008,375 to FY 07-08 (Legislative Council fiscal note for HB 05-1243, March 15, 2005).

The sum of the bottom line impacts for Single Entry Points in FY 06-07 is a reduction of $76,660. The revised estimated FY 06-07 Single Entry Points total expenditure is $16,747,227.

The sum of the bottom line impacts for Single Entry Points in FY 07-08 is an increase of $1,008,375. The revised estimated FY 07-08 Single Entry Points total expenditure is $17,967,584.

DISEASE MANAGEMENT (Exhibit I, page EI-5)

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 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 entered into permanent contracts with two disease management companies for two health conditions: clients with asthma, and clients with diabetes. 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 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.

In FY 06-07, the Department's disease management contracts are for a total of $627,778. The Department anticipates that these contracts will continue into FY 07-08.

FY 06-07 and FY 07-08 Legislative Impacts and Bottom Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capitas or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impact has been included in the FY 06-07 and FY 07-08 calculations for Disease Management:

- HB 05-1262 provided funding for disease management programs "…that address cancer, heart disease, and lung disease" 24-22-117 (2) (d) (IV) (A) C.R.S. (2006). The implementation for new programs has been delayed until January, 2007. This is an estimated increase to Disease Management of $1,970,388 in FY 06-07 and $3,940,776 in FY 07-08 (Legislative Council fiscal note for HB 05-1262, April 25, 2005; impact divided by two in FY 06-07 to reflect a half-year impact). This funding is not added into the FY 07-08 base, to provide a clear delineation between the current disease management programs, and programs funded through the Prevention, Early Detection, and Treatment Fund.
- SB 06-165 authorized the Department to implement disease management programs via telemedicine. Savings due to the program are realized in the Acute Care section of this Request. This is an estimated increase to Disease Management of $380,928 (Legislative Council fiscal note for SB 06-165, April 24, 2006).

The sum of the bottom line impacts for Disease Management in FY 06-07 increased the estimated FY 06-07 Disease Management projection by $1,970,388. The revised estimated FY 06-07 Disease Management total expenditure is $2,589,166.

The sum of the bottom line impacts for Disease Management in FY 07-08 increased the estimated FY 07-08 Disease Management projection by $4,321,704. This includes the full estimate for the programs specified in HB 05-1262. This is not added to the base, in order to clarify the source of funding for these programs. The revised estimated FY 07-08 Disease Management total expenditure is $4,949,482.

ADMINSRATIVE SERVICE ORGANIZATIONS ADMINSTRATIVE FEE (Exhibit I, page EI-6)

Administrative service organizations are an increasingly popular alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 03-04. The Department currently contracts with one administrative service organization, Rocky Mountain Health Plans. In FY 05-06, the Department ended its contract with Management Team Solutions. Administrative service organizations receive a fixed amount administrative fee per client. Exhibit EI-6 depicts only the fee expenditures for the Department's current contractor, including estimated cost avoidance payments. The service costs for these organizations are included in Acute Care. Because the administrative fee remains the same in FY 06-07, the Department has used actual enrollment in its current administrative service organization to forecast expenditure in FY 06-07 and FY 07-08.

In addition to a per capita increase, the Department has added bottom-line impacts for the estimated contracted payment to Rocky Mountain Health Plans for cost avoidance in both FY 04-05 and FY 05-06. In FY 06-07, the Department anticipates making a contracted payment, for services rendered in FY 04-05. The FY 04-05 estimated contracted payment is an estimate based on the FY 03-04 cost avoidance payment of $1,070,076, and the percentage enrollment growth in Rocky Mountain Health Plans of 12.02% in FY 04-05. Similarly, in FY 07-08, the Department anticipates making a single contracted payment, for services rendered in FY 05-06. This figure is an estimate based on the percentage enrollment decline of 5.39%. The total contracted payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the FY 03-04 level.

The FY 06-07 estimate for Administrative Service Organizations including cost avoidance payments is $5,077,407. The FY 07-08 estimate is $5,184,518.

FY 05-06 ACTUAL EXPENDITURES THROUGH SEPTEMBER 30, 2006 - Cash-based (Exhibit J)

This exhibit displays the FY 06-07 year-to-date expenditures and the cash flow pattern of actual expenditures for the both the first quarter of FY 05-06 (page EJ-1) to determine a rough estimate of FY 06-07, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

UPPER PAYMENT LIMIT CALCULATIONS (Exhibit K)

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

Funds received through the Upper Payment Limit for outpatient hospital services are used to offset General Fund expenditures. These offsets started in FY 01-02 during the budget balancing activities. Similar methodologies are used for home health and nursing home premiums. While outpatient hospital services and nursing facilities account for a large portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison, and will experience little impact relating to changes in reimbursement rates.

In FY 05-06, the Department only certified expenditure for a half year, due to a federal audit requiring the Department to certify expenditure on a calendar year basis. During Figure Setting in March, 2006, the Department's FY 06-07 Base Reduction Item #2

(November 15, 2005) was approved; starting in FY 06-07, the Department will record exactly the certified amount as Cash Funds Exempt.

Projections for all provider types are provided in Exhibit K. The FY 06-07 estimate equals $15,590,407. This amount includes $1,269,910 in certification of public expenditure from FY 04-05 supplemental Medicaid outpatient hospital payments that were not recorded in FY 04-05 and $296,581 from FY 05-06 that was not recorded due to budget limitations. The FY 07-08 estimate equals $16,260,366.

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

This exhibit displays the FY 05-06 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 05-06 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

ACTUAL FINAL EXPENDITURES FY 05-06 THROUGH FY 95-96 (Exhibit M)

Actual final expenditure data by service category for the past eleven years are included for historical purpose and comparison. This history is built around cash-based accounting; a 12 month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is the Medicaid Management Information System, Management and Administrative Reporting Subsystem report named the "REX01/COLD (MARS) 464600." This report provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

For this Budget Request, the Department has made several changes to both the layout and the content of this exhibit:

- In prior years, the Department provided aggregated information from the REX01/COLD (MARS) 464600 report in exhibit M. For clarity, the Department has elected to remove this information from this exhibit, although the calculations for this exhibit remain the same.
- The Department has adjusted the expenditure history to more properly account for the Prenatal State-Only program. In calculating this Request, it came to light that expenditure for the Prenatal State-Only program was being spread among all the aid categories, and not only to the Non-Citizens aid category. For all the years for which data was available, namely FY 02-03, FY 03-04, FY 04-05, and FY 05-06, the Department has corrected this, and put Prenatal State-Only expenditure in the Non-Citizens aid category.

- In FY 05-06, the Department has reallocated expenditure from the "Administrative Service Organizations – Services" service category to other individual services categories. In the Department's Medicaid Management Information System (MMIS), expenditures for clients enrolled in an administrative service organization (ASO) are grouped together regardless of the type of service. Additionally, the system grouped claims to this service category even if the service was not provided by the ASO. Therefore, claims for home-and-community based services and nursing facilities were being included in this service category, and incorrectly being placed in Acute Care. On page EM-2, the Department has used claims data from the Medicaid Management Information System to allocate these claims by aid category and service category.[31] This methodology is only effective for claims which have been submitted through the MMIS. The totals on this page are added to the reported actuals on page EM-1.

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

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

Annual rates of change in medical services by service group from FY 05-06 through FY 95-96 final actual expenditures are included in this Budget Request for historical purpose and comparison.

COMPARISON OF APPROPRIATION TO BUDGET REQUEST (Exhibit O)

This exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations, for FY 05-06, FY 06-07, and FY 07-08, in the chronological order of the events. Shaded areas indicate that the Request or appropriation has not yet taken place. This exhibit excludes all bottom-line financing, such as upper payment limit financing.

For FY 05-06, this exhibit compares the Department's November 1, 2004, February 15, 2005, November 15, 2005, and February 15, 2006 Budget Requests to the FY 05-06 appropriation, and the FY 05-06 actuals. Actions taken by the General Assembly after the Department's February 15, 2006 Budget Request are added to the February total to ensure a comparable comparison to FY 05-06 actuals.

[31] In the MMIS, when a claim is processed, each claim is assigned a category and subcategory of service. This information is used to calculate a general ledger code for each claim, which is then translated into a COFRS service category. For clients enrolled in an ASO, the system ignored the category and subcategory of service, and assigned the general ledger code for Administrative Service Organization – Services. However, the category and subcategory of service still exists on each claim. Therefore, the Department is able to examine each claim and using the exact logic used by the MMIS, manually reassign each claim to its proper service category.

For FY 06-07, this exhibit compares the Department's November 15, 2005, February 15, 2006, and November 1, 2006 Budget Requests to the FY 06-07 appropriation.

For FY 07-08, this exhibit lists the Department's November 1, 2006 Budget Request.

GLOBAL REASONABLENESS TESTS (Exhibit P)

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

IMPACT TO MEDICAL SERVICES PREMIUMS DUE TO THE MEDICARE MODERNIZATION ACT (Exhibit Q)

This exhibit calculates the impact to Medical Services Premiums due to the Medicare Modernization Act, and calculates the bottom-line adjustments used in Exhibit F (Acute Care) and Exhibit H (Long Term Care, Program of All-Inclusive Care for the Elderly). The Department has revised this exhibit to incorporate the actual change in expenditure due to the Medicaid Modernization Act. Table A (page EQ-1) summarizes the estimated impact of the Medicare Modernization Act. Table B calculates the impact to fee-for-service. Table C calculates the impact to health maintenance organizations. Tables D, E, F, and G provide supporting information for Tables B and C. Table H calculates the impact to the Program of All-Inclusive Care for the Elderly.

The Department does not explicitly take into account the effect of passive enrollment, nor the effect of providers leaving the Department's managed care program. Due to passive enrollment, the last two months of FY 05-06 experienced significantly higher expenditure in the health maintenance organization service category, as clients were enrolled into managed care organizations. As the Department's managed care program recedes, clients will move from managed care to fee-for-service. In both instances, the Department is still experiencing the cost of prescription drugs for these clients. As such, though the estimate does not incorporate the effects of these policy changes. The combined impact of the Medicare Modernization Act on the Department's fee-for-service and managed care program remains the same. Because the Department does not estimate total expenditure by service category, a single bottom-line adjustment in Acute Care, comprising the combined effect on fee-for-service and managed care, incorporates the net effect of policy changes.

Additionally, unlike prior versions of this Exhibit, there is no offset for prescription drugs still covered by the Department. In the past, the Department calculated the impact of the Medicare Modernization Act by removing all prescription drug costs for dual eligibles, then adding back in the cost of drugs not covered by Part D. In this Budget Request, the Department uses actuals to determine the actual percentage reduction in expenditure. This percentage reflects the amount of prescription drugs that the Department still covers for these clients.

Estimate of Reduction in Expenditure due to the Medicare Modernization Act (Table A, Page EQ-1)

In order to estimate the total savings to Medical Services Premiums from the implementation of the Medicare Modernization Act, the Department must estimate savings for three components: fee-for-service, managed care, and the Program of All-Inclusive Care for the Elderly (PACE). This table summarizes the estimated impact of the Medicare Modernization Act. Row C is the total bottom-line impact for Acute Care, while Row D is the total bottom-line impact for PACE.

Estimate of Reduction in Fee-for-Service Prescription Drug Expenditure and Drug Rebate (Table B, Page EQ-1)

In order to calculate the impact of the Medicare Modernization Act to fee-for-service, the Department must compare expenditure from before and after the implementation of the Medicare Modernization Act. In Table B, the Department takes the total pre-rebate expenditure for the first half of FY 05-06, applies trend, and reduces estimated expenditure based on the estimated percent reduction in pre-rebate expenditure. This calculation is performed by eligibility category, as the impact of the Medicare Modernization Act varies by population. Once the reduction in pre-rebate expenditure is calculated, the Department estimates the decrease in drug rebate. This figure is positive, because drug rebate is an offset to drug expenditure. The sum of the impact of the Medicare Modernization Act and the decrease in drug rebate is the total estimated fee-for-service impact of the Medicare Modernization Act.

Estimate of Reduction in Health Maintenance Organization Expenditure (Table C, Page EQ-2)

In order to calculate the impact of the Medicare Modernization Act to health maintenance organizations, the Department must compare expenditure from before and after the implementation of the Medicare Modernization Act. In Table C, the Department takes the total health maintenance organization expenditure for the first half of FY 05-06, applies trend, and reduces estimated expenditure based on the estimated percent reduction in health maintenance organization expenditure. The percentage reduction is significantly smaller than the estimated impact in fee-for-service, as rates paid to health maintenance organizations include many more services than just prescription drugs. This calculation is performed by eligibility category, as the impact of the Medicare Modernization Act varies by population. There is no offset for drug rebate, as the HMO rates are calculated based on net prescription drug cost.

Estimated Monthly Reduction in Fee-for-Service Expenditure (Tables D and E, Page EQ-3)

In Table D, the Department lists the average monthly expenditure by eligibility category for periods before and after the implementation of the Medicare Modernization Act, based on claims information from the Department's Medicaid Management Information System. Table E calculates the change in average monthly expenditure. January 2006 is excluded from the calculation; due to the nature of cash accounting, claims paid in January 2006 included a large amount prescription drugs covered by the Medicare Modernization Act. The percentage change listed on Table E is applied to Table B to calculate the estimated reduction in expenditure.

Estimated Monthly Reduction in Fee-for-Service Expenditure (Tables F and G, Page EQ-4)

In Table F, the Department lists the average payment per client by eligibility category for periods before and after the implementation of the Medicare Modernization Act, based on claims information from the Department's Medicaid Management Information System.

Because of passive enrollment, total expenditure increased significantly in the last months of FY 05-06. Therefore, a comparison of expenditure would be misleading, and understate the impact of the Medicare Modernization Act. Table G calculates the change in average payment per client. January 2006 is not excluded from the calculation, as capitations paid to health maintenance organizations are paid in the same month of service. The percentage change listed on Table G is applied to Table C to calculate the estimated reduction in expenditure.

Estimated Reduction to the Program of All-Inclusive Care for the Elderly Expenditure (Table H, page EQ-5)
Similar to managed care providers in Acute Care, providers in the Department's Program of All-Inclusive Care for the Elderly (PACE) are no longer responsible for pharmaceuticals covered under the Medicare Modernization Act for dual-eligibles. Accordingly, the Department makes a bottom-line adjustment to remove the estimated pharmaceutical cost from PACE expenditures. However, on the same day that the Medicare Modernization Act became effective, the Department also implemented new rates for clients enrolled in the PACE program. Therefore, the impact of the Medicare Modernization Act to PACE cannot be determined by looking at the change in expenditure.

Table H calculates the impact to PACE by comparing the decrease in Acute Care expenditure (reported in Table A) to the service groups included in the calculation of the PACE rates. This includes Acute Care, Community Based Long Term Care, and Class I Nursing Facilities. The Department calculates the percentage impact of the decrease in expenditure due to the Medicare Modernization Act to the total of these service groups, and applies that percentage to the estimated FY 06-07 PACE expenditure before bottom line impacts. This yields the estimated reduction in PACE expenditure to the Medicare Modernization Act, and is applies as a bottom line impact to estimated PACE expenditure in Exhibit H.

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

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

SB 04-177 – Concerning Home and Community-Based Services under the State's Medicaid Program for Children with Autism
Establishes the "Home and Community based Services for Children with Autism Act." The program is for Medicaid children from birth to six years of age with a diagnosis of autism, at-risk of institutionalization in an Intensive Care Facility for the Mentally Retarded (ICF-MR), a hospital, or a nursing facility and not receiving services from any of the alternatives to long-term care waiver programs. The Department is seeking a federal waiver that meets budget neutrality requirements. Services under this waiver are

outlined and limited to $25,000 annually per participant, starting October 2006. Community Centered Boards for persons with developmental disabilities are the single entry point agencies for services. Administrative costs for the Community Centered Boards are capped at 15%.

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

The fiscal note assumed that a 1915(c) waiver would be written with existing resources and submitted to the Centers for Medicare and Medicaid Services in January 2005, with approval slated for July 1, 2005 (FY 05-06) when costs for the program, including system changes would begin and take approximately 6 months to complete. Costs for the waiver development in FY 04-05 are to be absorbed by the Department. The program started in October, 2006. Because the program was originally intended to begin on January 1, 2006, the fiscal note only included costs for six-months. Those figures have been adjusted to account for a 9-month impact. Only the Medical Services Premiums costs are reflected.

SB 04-177	Total Funds	Cash Funds Exempt*	Federal Funds
FY 06-07 Impact to Community Based Long Term Care			
(2) Medical Services Premiums	$1,090,000	$545,000	$545,000
(2) Medical Services Premiums – Single Entry Point contract with Community Centered Boards (15%)	$163,500	$81,750	$81,750
Total (included in Community Based Long Term Care – Exhibit G)	**$1,253,500**	**$626,750**	**$626,750**
FY 06-07 Impact (9 months)	$940,125	$470,063	$470,063
FY 07-08 Impact (3 months)	$313,375	$156,688	$156,688

*Cash Funds Exempt from the Colorado Autism Treatment Fund.

HB 05-1015 – Concerning substance abuse treatment under the "Colorado Medical Assistance Act"

This bill adds outpatient substance abuse treatment as an optional service to the state's Medicaid program. The outpatient benefit includes assessment, alcohol/drug screening and counseling, social ambulatory detox, targeted case management, group therapy, and individual therapy adjusted for the average client. Savings are not expected to be realized until six-months after the program starts. The program began on July 1, 2006.

HB 05-1015	FY 06-07
Estimated Medicaid Caseload Eligible for Outpatient Substance Abuse Treatment	4,668
Annual estimated cost per client	$1,512.87
Net Amount	$7,062,073
Anticipated savings in Medical Services Premiums due to addition of Outpatient Substance Abuse Treatment (6 Months)	($1,218,371)
Total	**$5,843,703**
FY 06-07 Impact (Included in Acute Care, Exhibit F)	$5,843,703
FY 07-08 Impact (Included in Acute Care, Exhibit F)	($1,218,371)

The FY 07-08 impact is the annualization of anticipated savings. Program costs are fully annualized in the FY 07-08 base.

HB 05-1131 – Concerning the Authority of a Pharmacist to Redispense Specified Unused Medications

This bill allows pharmacists to accept and distribute medications to patients or to nonprofit organizations. Pharmacists must reimburse the Department for the cost of medications that the Department has paid if the medications are available to be dispensed to another person. This program began in April, 2006. During Figure Setting, it was determined that the original fiscal note did not adjust estimated savings for the implementation of the Medicare Modernization Act. At the time, the savings estimate was reduced to $48,865 (Figure Setting, March 13, 2006, Pages 141 – 143). This estimate assumed a July 1 implementation. Because the program started in April, 2006, the Department has adjusted the savings to reflect a 9-month impact in FY 06-07.

HB 05-1131	FY 06-07
Assisted Living Facilities savings (Community Based Long Term Care)	($2,861)
Nursing Facilities savings (Long Term Care - Class I Nursing Facilities)	($33,790)
Fiscal Year FY 06-07 Impact	**($36,650)**

HB 05-1243 – Concerning Consumer-Directed Care Under the "Colorado Medical Assistance Act"

This bill extends the option of receiving home and community-based services (HCBS) through the Consumer-Directed care service model to all Medicaid recipients who are enrolled in a home and community-based services waiver for which the Department has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current home and community-based services waiver in order to receive services through the Consumer-Directed care service model. Additionally, the bill specifies that certain professional licensing requirements do not apply to a person who is directly employed by an individual

participating in the Consumer-Directed care service model and who is acting within the scope and course of such employment. The restrictions that apply to this professional licensure exclusion and the circumstances under which the exclusion does not apply are noted in the bill. A consumer of attendant support is allowed to have an authorized representative who has the judgment and ability to assist the consumer in acquiring and using services under the program.

In 2005, the Centers for Medicare and Medicaid Services completely revised the home and community based services waiver application forms, requiring additional components that needed to be researched and addressed by the Department prior to submission. This caused a substantial extension to the timeframe required for the implementation of this bill. The Department anticipates approval for this waiver by March, 2007, and expects the program to being in July, 2007. Savings estimates are taken from the Legislative Council fiscal note for HB 05-1243, on March 15, 2005, which assumes a savings per client of $373.

HB 05-1243	FY 07-08
Single Entry Point Contracts (Single Entry Point, Service Management)	$1,008,375
Community Based Long Term Care Savings	($6,440,928)
Fiscal Year FY 07-08 Impact	**($5,432,553)**

HB 05-1262 – Concerning the Implementation of Tobacco Taxes for Health-Related Purposes Pursuant to Section 21 of Article X of the State Constitution

HB 05-1262 requires expansion of existing Medicaid programs to be funded through the Health Care Expansion Fund and the Prevention, Early Detection, and Treatment Fund to provide revenue for the State's General Fund, the Old Age Pension Fund and for municipal and county governments. Appropriations from the Health Care Expansion Fund and the Prevention, Early Detection, and Treatment Fund are made to the Medical Services Premiums Long Bill line item. The following are explanations of the impacts each have to the Medical Services Premiums request for FY 06-07 and FY 07-08.

The Department has removed the Medicaid impact of marketing on the Children's Basic Health Plan from this section. During Figure Setting, it was determined that increases to Medicaid caseload due to marketing was not eligible for funds from the Health Care Expansion Fund:

> …[S]taff does not believe that the Health Care Expansion Fund can be used for this purpose. The Constitution is specific that the Tobacco Tax monies can only be used to increase eligibility into the Medicaid program. Eligibility is different than enrollment. An eligibility change would make more children eligible (i.e. eliminate asset test, etc. -- not enroll already eligible children). Because **staff does not believe that the Health Care Expansion fund can be used for these "woodwork" children from CBHP marketing**, staff does not recommend funding for the survey. Staff's

position is a reverse of the assumptions that were made when H.B. 05-1262 was passed. (Figure Setting, March 13, 2006, page 25)

These clients are still contained in the Department's caseload, and are funded in the usual way.

Prevention, Early Detection, and Treatment Fund

This fund is administered by the Department of Public Health and Environment; however, HB 05-1262 provides for a transfer of funds to the Department for two programs: the Breast and Cervical Cancer Program; and Disease Management. In each case, the Department makes a fund-split adjustment on Exhibit A, pages EA-1 and EA-2 to request the appropriate amount from the Prevention, Early Detection, and Treatment Fund. For the Breast and Cervical Cancer Program, the Department calculates the required fund-split on Exhibit F, page EF-6. For Disease Management, the fund-split is made directly on pages EA-1 and EA-2.

Breast and Cervical Cancer Program

A portion of the Prevention, Early Detection and Treatment Fund established by HB 05-1262 is dedicated to increasing the number of cancer screenings performed by the Department of Public Health and Environment. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. At this time, the Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 monies. The Department suggested that the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" Medicaid.

A description of the calculation for the Breast and Cervical Center Program is contained in the narrative for Exhibit F, on page 131 of this narrative. The following table is a summary of estimated expenditure from the Prevention, Early Detection, and Treatment Fund:

HB 05-1262 - Breast and Cervical Cancer Program	**Estimated Clients**	**Total Funds**	**Prevention, Early Detection, and Treatment Fund**	**Federal Funds**
Estimated FY 06-07 Health Care Expansion Breast and Cervical Cancer Program	77	$2,846,407	$996,243	$1,850,164
Estimated FY 07-08 Health Care Expansion Breast and Cervical Cancer Program	102	$3,768,302	$1,318,906	$2,449,396

Disease Management

The Department of Public Health and Environment will transfer Cash Funds Exempt in the amount of $1,970,388 for FY 06-07 to the Department of Health Care Policy and Financing from the Prevention, Early Detection, and Treatment Fund. This funding is for the purpose of assisting in the implementation of the State's strategic plans regarding cancer and cardiovascular disease to provide a cohesive approach to cancer, cardiovascular disease, and chronic pulmonary disease prevention, early detection, and treatment in Colorado. The program criteria shall address at least one of the following program criteria; 1) translating evidence-based strategies regarding the prevention and early detection of cancer, cardiovascular disease, and chronic pulmonary disease into practical application in healthcare, workplace, and community settings; 2) providing appropriate diagnosis and treatment services for anyone who has abnormalities discovered in screening and early detection programs; 3) implementing education programs for the public and health care providers regarding the prevention, early detection, and treatment of cancer, cardiovascular disease, and chronic pulmonary disease; and 4) providing evidence-based strategies to overcome health disparities in the prevention and early detection of cancer, cardiovascular disease, and chronic pulmonary disease. The amount funded through the Health Prevention, Early Detection, and Treatment Fund each fiscal year will be $1,970,388. The Legislative Council fiscal note for HB 05-1262 assumed that disease management programs would begin January 1, 2006. The Department now anticipates programs beginning January 1, 2007.

Health Care Expansion Fund

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

Removal of the Medicaid Asset Test

Approximately 39.5% of the clients enrolled in the Children's Basic Health Plan had incomes low enough to qualify for Medicaid, but were denied based on the Medicaid asset test. Effective July 1, 2006, the asset test no longer applies to children and adults. The Department estimates that clients in the Children's Basic Health Plan will transfer into Medicaid. The federal match for these clients would be reduced to 50% federal match under Title XIX, rather than the 65% federal match under the Children's Basic Health Plan.

Medicaid Asset Test – Eligible Children Expansion	FY 06-07	FY 07-08
Estimated Caseload	12,045	22,841
Estimated Per Capita Cost for Eligible Children	$1,551.77	$1,573.09
Total Funds	**$18,691,600**	**$35,931,012**
Health Care Expansion Fund	$9,345,802	$17,965,507
Federal Funds	$9,345,798	$17,965,504

Totals taken from Exhibit A, pages EA-3 and EA-5

Medicaid Asset Test – Adult Expansion	FY 06-07	FY 07-08
Estimated Caseload	2,891	5,482
Estimated Per Capita Cost for Categorically Eligible Low Income Adults	$3,557.73	$3,653.22
Total Funds	**$10,284,976**	**$20,026,385**
Health Care Expansion Fund	$5,142,488	$10,013,193
Federal Funds	$5,142,488	$10,013,193

Totals taken from Exhibit A, pages EA-3 and EA-5

Children's Home and Community Based Services and the Children's Extensive Support Waiver Program Expansion

The Children's Home- and Community-Based Services (CHCBS) and the Children's Extensive Support (CES) waiver programs are programs that use Medicaid funds to serve children that would not qualify for Medicaid under standard eligibility criteria. The waiver programs relax eligibility requirements for certain populations and apply to receive federal matching funds for the program. Upon approval, the Waiver programs are eligible to receive federal matching funds at the Medicaid defined rates for state expenditures, but the clients served by those waivers are not considered part of Medicaid. Once a child is on the waiver, they must receive at least one state-paid service per month to remain on either of the Waiver programs.

Children's Home and Community Based Services (CHCBS) Waiver

Prior to HB 05-1262, 630 clients were actively served by the Children's Home and Community Based Services (CHCBS) waiver program and 478 individuals were on the waiting list. HB 05-1262 provided funding for the Department to take clients from the waitlist and enroll them in the waiver. During Figure Setting, 200 additional expansion waiver slots were added (Figure Setting, March 13, 2006, page 145), increasing the number of available waiver slots funded by the Health Care Expansion Fund to 678. As described in section II of this chapter, Medicaid Caseload, the Department anticipates only 490 of these slots to be filled for FY 06-07, due to the lag between increasing the waiver slots and being able to determine eligibility for the program. By FY 07-08, the Department estimates that 676 of the slots will be full.

Using historical expenditure data for clients enrolled in the program, the Department has estimated the per capita cost for clients enrolled in the CHCBS waiver:

Children's Home and Community Based Services
Historic State Plan and Waiver Services Per Capita

CHCBS	FY 02-03	FY 03-04	FY 04-05	FY 05-06
Per Capita	$19,163.41	$20,721.60	$21,902.73	$19,454.09
Percent Growth	-	8.13%	5.70%	(11.18%)
2-Year Average Growth	-	-	6.92%	(2.74%)
3-Year Average Growth	-	-	-	**0.88%**

The 3-year average growth factor is applied to the FY 05-06 per capita to estimate per capita cost and expenditure for FY 06-07 and FY 07-08:

Children's Home and Community Based Services
Estimated State Plan and Waiver Services Per Capita

CHCBS	Projected	
	FY 06-07	FY 07-08
Per Capita - State Plan and Waiver Services	$19,626.04	$19,799.50
Caseload	490	676
Expenditure	$9,616,760	$13,384,462

Each client will require services at a single entry point agency, and therefore costs for these services are included.

Children's Extensive Support (CES) Waiver

Prior to HB 05-1262, the Children's Extensive Support (CES) waiver program had 212 clients that were being served and 148 that were on the waiting list. Of the 148 clients, only 49 were not Medicaid eligible, and were able to be funded with funding from the Health Care Expansion Fund. HB 05-1262 provided funding for the Department to take these clients from the waitlist and enroll them in the waiver. During Figure Setting, 30 additional expansion waiver slots were added (Figure Setting, March 13, 2006, page 145), increasing the number of available waiver slots funded by the Health Care Expansion Fund to 79. As described in section II of this chapter, Medicaid Caseload, the Department anticipates only 60 of these slots to be filled for FY 06-07, due to the lag between increasing the waiver slots and being able to determine eligibility for the program. By FY 07-08, the Department estimates that all 79 of the slots will be full.

Using historical expenditure data for clients enrolled in the program, the Department has estimated the per capita cost for clients enrolled in the CHCBS waiver. Only state plan services are included, as waiver services for these clients are included in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group:

Children's Extensive Support - Historic State Plan Per Capita

CES	FY 02-03	FY 03-04	FY 04-05	FY 05-06
Per Capita	$31,600.45	$35,613.07	$38,644.18	$36,917.88
Percent Growth	-	12.70%	8.51%	(4.47%)
2-Year Average Growth	-	-	10.60%	2.02%
3-Year Average Growth	-	-	-	**5.58%**

The 3-year average growth factor is applied to the FY 05-06 per capita to estimate per capita cost and expenditure for FY 06-07 and FY 07-08:

Children's Extensive Support - Estimated State Plan Per Capita

CES	Projected	
	FY 06-07	FY 07-08
Per Capita - State Plan Services	$38,978.14	$41,153.38
Caseload	60	79
Expenditure	$2,338,688	$3,251,117

Medicaid Legal Immigrants

SB 03-176 eliminated Medicaid coverage to legal immigrants. However the implementation of the bill was delayed. During the delay Tobacco Tax funds funded the expenditures for these clients resulting in continuous coverage for this population. HB 05-1086 reinstated Medicaid coverage for legal immigrants and a provision was added to HB 05-1262 to provide funding from the Health Care Expansion Fund on an ongoing basis. Due to the reinstatement of services to legal immigrants granted by HB 05-1086, $2,638,343 was funded through the Health Care Expansion Fund for FY 04-05. A fund split correction was needed in the Premiums exhibits (Exhibit A, EA5-6) for this adjustment. In FY 05-06, the Department estimated that $11,596,517 was spent on legal immigrants; the amount funded by the Health Care Expansion Fund was $6,216,752.

Citizenship status is collected to determine which applicants are categorized as legal immigrants versus illegal immigrants in the Colorado Benefits Management System. Illegal immigrants have no documentation and are eligible for emergency services only. Legal immigrants with 5 or more years of residency and 40 or more work quarters are categorized as mandatory Medicaid population receiving full benefits provided they meet the eligibility requirements other than citizenship status. Optional Medicaid legal immigrants are those who have 5 years of residency but less than 40 work quarters also receiving full medical benefits. Currently, the Colorado Benefits Management System does not have the capability to discern who is a mandatory legal immigrant and who is optional. This was clearly expressed in the fiscal note for SB 03-176. When SB 03-176 passed, it was intended to eliminate full Medicaid benefits for optional legal immigrants and provide emergency services only. However, SB 03-176 was never implemented and these clients did not lose their full Medicaid benefits. HB 05-1086 reinstated the benefits for these optional legal immigrants. The Department has identified system changes that can be made within the Colorado Benefits Management System that will enable the Department to track this expansion population. The Department is in the process of making systems modifications.

As a proxy until actual data is available, the Department has estimated the FY 06-07 and FY 07-08 impact of legal immigrants using overall caseload and per capita growth. The original estimate was created in SB 03-176, and has not been updated since that time. The following table is used to calculate the estimate for FY 06-07 and FY 07-08, on pages EA-3 and EA-5:

HB 05-1262 Legal Immigrants	Caseload	Per Capita	Estimated Expenditure	Source
FY 03-04 Estimate (SB 03-176)	3,512	$3,302	$11,596,517	Fiscal Note Calculations for SB 03-176
FY 04-05 Growth	11.11%	(7.48%)	-	Exhibit EB-1 and Exhibit EC-1
FY 05-06 Growth	(0.77%)	5.52%	-	Exhibit EB-1 and Exhibit EC-1
FY 06-07 Projected Growth	7.06%	(0.34%)	-	Exhibit EB-1 and Exhibit EC-1
FY 06-07 Projection	**4,146**	**$3,212.58**	**$13,319,357**	Calculated by inflating FY 03-04 values by FY 04-05, FY 05-06, and FY 06-07 growth.

HB 05-1262 Legal Immigrants	Caseload	Per Capita	Estimated Expenditure	Source
FY 07-08 Projected Growth	5.65%	0.97%	-	Exhibit EB-1 and Exhibit EC-1
FY 07-08 Projection	**4,380**	**$3,243.66**	**$14,207,231**	Calculated by inflating FY 06-07 by FY 07-08 growth.

Presumptive Eligibility

The Department discontinued Medicaid presumptive eligibility on September 1, 2004. Pursuant to HB 05-1262 the Department reinstated the presumptive eligibility process, effective July 1, 2005. Similar to the Children's Basic Health Plan, presumptive eligibility for Medicaid is handled through the Anthem network. Once eligibility is determined, the client will be taken off presumptive eligibility and may go to fee-for-service or another Medicaid health maintenance organization. The Department makes payments based on the estimated cost per client per month, and checks for duplicates to assure that payments are not also made through the Medicaid Management Information System for these clients.

The estimated number of clients is 1,549 for FY 06-07 and 1,625 for FY 07-08. The Department is currently in the process of reconciling the FY 05-06 caseload with Anthem, and does not yet have a final caseload total for FY 05-06. Preliminary estimates indicate that caseload is close to the estimate FY 05-06 caseload of 905 (February 15, 2006 Budget Request, Exhibit A, page EA-5). Given this, the Department is holding constant its caseload estimate for FY 06-07 from the February Budget Request, at 1,549 clients. For FY 07-08, this caseload is inflated by the projected overall increase in Baby Care Adults caseload, 4.90% (Exhibit B, page EB-1), to 1,625 clients.

In addition to caseload, the Department is also reconciling payments made to Anthem for services. For each client enrolled in Anthem, the Department makes a $285.68 per month payment as an estimate for services rendered. At the end of the year, the Department reconciles with Anthem to provide payment for the exact services rendered. The Department is currently in the process of reconciling with Anthem for FY 06-07, but like caseload, preliminary estimates indicate that the current payment was close to Anthem's costs. As such, the Department will continue to pay Anthem $285.68 per client per month in FY 06-07. This is a change from the Department's February Budget Request, where the Department estimated an increase to this rate. For FY 07-08, the Department applies the estimated percent increase in the Baby Care Adults per capita to arrive at a new estimated rate. Costs exclude delivery charges. To calculate the total impact, the Department multiplies the monthly payment by 12 to arrive at a per capita cost. The per capita cost is multiplied by the estimated caseload to arrive at an estimate for total expenditure.

Presumptive Eligibility

Year	Estimated Presumptive Eligibility Caseload	Estimated Monthly Payment Per Client(1)	Estimated Per Capita	Total
FY 06-07	1,549	$285.68	$3,428.16	$5,310,220
FY 07-08	1,625	$293.13	$3,517.56	$5,716,035

(1) The FY 07-08 estimated monthly payment per client is the FY 06-07 estimated payment inflated by 2.61%, the expected per capita growth for Baby Care Adults in FY 07-08.

HB 06-1270 – Concerning the Authority of Public School Personnel to Make Determinations of Eligibility for Certain Public Medical Benefits

This bill creates a demonstration project to make eligibility determinations for Medicaid at the same time that eligibility for free or reduced-cost lunches is determined. The project starts in FY 07-08, and at least three school districts will be selected to participate. In the Legislative Council fiscal note for HB 06-1270, 306 clients were estimated to be added to the caseload for Eligible Children. The Department has incorporated this increase in caseload in Exhibit B, page EB-2. Because this is an increase to caseload, there is no bottom-line impact to the Department's request by service group. The fiscal note estimated increased expenditures of $330,273 to Medical Services Premiums, based on a projected per capita of $1,439.10. Based on the current projected per capita of $1,573.09, the Department estimates that the increase in caseload due to HB 06-1270 will cause increased expenditures of $361,024, a change of $30,751.

HB 06-1270	Legislative Council Fiscal Note	November 1, 2006 Projection
Estimated Number of Participating Clients	306	306
Estimated Number of Months Enrolled	9	9
Estimated FY 07-08 Per Capita	$1,439.10	$1,573.09
Estimated FY 07-08 Expenditure	**$330,273**	**$361,024**

HB 06-1369 and HB 06-1385 – Provider Rate Increases

The Department's Supplemental Bill, HB 06-1369 contained an appropriation to provide rate increases to inpatient, durable medical equipment, and community based long term care providers. Footnotes 37a, 40a, and 42a specified rate increases in the following way effective April 1, 2006:

HB 06-1369			
Provider	**Rate Increase**	**FY 05-06 Appropriation**	**FY 06-07 Long Bill Appropriation**
Inpatient Hospital	1.0%	$831,000	$3,604,228
Durable Medical Equipment	2.0%	$309,000	$1,311,382
Assisted Living Facilities	15.07%	$1,142,490	$4,705,720
Day Care Services	3.57%	$46,367	$189,176
Skilled Nursing	7.20%	$567,960	$1,758,583
Home Health Aides	4.20%	$586,690	$2,393,694
Physical Therapy	36.30%	$286,990	$1,170,919
Speech Therapy	35.90%	$146,664	$598,387
Occupational Therapy	29.20%	$173,356	$707,294
Private Duty Registered Nursing	3.80%	$90,220	$279,350
Private Duty Licensed Nursing	8.00%	$90,218	$279,343
Personal Care Homemaker	10.00%	$1,846,514	$7,533,776
All Other Long-Term Care Community Providers	2.57%	$122,531	$1,196,416
Total		**$6,240,000**	**$25,728,268**
Total Acute Care		$1,140,000	$4,915,610
Total Community Based Long Term Care		$5,100,000	$20,812,658

HB 06-1369 only provided the appropriation for FY 05-06; the FY 06-07 totals included in the Long Bill were contained in a Joint Budget Committee staff memorandum dated March 16, 2006. Additionally, during the Department's FY 06-07 Figure Setting (pg. 146), the annualization amount for inpatient hospital and durable medical equipment were estimated as $2,766,223 and $1,031,253, respectively. The amounts were adjusted after Figure Setting due to Committee changes in per capitas to $3,604,228 and $1,311,382. These values were reflected in the JBC staff memorandum of March 16, but not listed explicitly. In some cases, the annualization values for long-term care community providers were not listed explicitly, and totals in the table have been split proportionally.

The Governor vetoed the footnotes for HB 06-1369, and directed the Department to comply to the extent feasible. The Department complied by raising the inpatient hospital rates and long-term care community provider rates by the amounts specified in the footnote. For durable medical equipment, the Department excluded durable medical equipments that are paid by invoice plus 19%. This allowed the Department to raise all other durable medical equipment rates by 2.25%.

In the Long Bill, HB 06-1385, footnotes 26, 27, and 28 provided rate increases for providers as follows:

HB 06-1385		
Provider	**Rate Increase**	**FY 06-07 Appropriation**
Inpatient Hospital	3.25%	$11,713,742
Physician, Dental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Lab and X-Ray, and Durable Medical Equipment	3.25%	$9,917,925
Assisted Living Facilities	12.50%	$1,216,254
Day Care Services	1.00%	$15,158
Skilled Nursing	23.60%	$1,718,642
Physical Therapy	23.60%	$288,587
Speech Therapy	23.60%	$148,685
Occupational Therapy	23.60%	$205,419
Private Duty Registered Nursing	23.40%	$273,005
Private Duty Licensed Nursing	23.60%	$272,999
Total		**$25,770,416**
Total Acute Care		$21,631,667
Total Community Based Long Term Care		$4,138,750

The Long Bill did not provide totals per service category for the long-term care community providers, and the Joint Budget Committee staff memorandum from March 16, 2006 was not the final action. The Department has used the values listed in the memorandum and the total was proportionally allocated to each category.

The Governor vetoed footnotes 26, 27, 28, and directed the Department to comply to the extent feasible.

In response to footnote 26, 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 Evaluation and Management 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. Durable Medical Equipment 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.

In response to footnote 27, the Department applied the appropriated funds to FY 06-07 inpatient hospital rates. The Department determined that, in order to use the entire appropriation, the Department would need to increase hospital rates above the 3.25% in order to use the entire appropriated amount of $11,713,742 total funds. In order to use the entire $11,713,742 total funds, the FY 06-07 rates were increased until the difference between forecasted FY 06-07 expenditures exceeded budget neutrality expenditures by exactly $11,713,742. The Department increased each hospital's rate over what their rate would have been with the flat 3.25% increase; this equates to the Medicaid rates being set at approximately 92% of their Medicare rate.

Footnote 28 is effective April 1, 2007, and the Department is investigating the feasibility of complying with this footnote. The Department will report to the Joint Budget Committee on June 1, 2007 on the rate plan implemented. Because this rate increase is effective for the fourth quarter of FY 06-07, the Department annualizes the total by multiplying the total increase, $4,138,750, by 3 to reflect the unaccounted three quarters of impact of $12,416,250 in FY 07-08.

In total, the Department has made the following bottom-line adjustments:

HB 06-1369 and HB 06-1385	**FY 06-07**	**FY 07-08**
Acute Care		
HB 06-1369 - Inpatient Hospital	$3,604,228	$0
HB 06-1369 - Durable Medical Equipment	$1,311,382	$0
HB 06-1385 - Inpatient Hospital	$11,713,742	$0
HB 06-1385 - Other Acute Care Providers	$9,917,925	$0
Acute Care Subtotal	**$26,547,277**	**$0**
Community Based Long Term Care		
HB 06-1369 - Long-Term Care Community Providers	$20,812,658	$0
HB 06-1385 - Long-Term Care Community Providers	$4,138,750	$12,416,250
Community Based Long Term Care Subtotal	**$24,951,408**	**$12,416,250**
Grand Total	**$51,498,685**	**$12,416,250**

SB 06-131 – Concerning Reimbursement Under the Medical Assistance Program for Nursing Facility Providers

SB 06-131 created a floor and ceiling for rate increases to class I nursing facilities. For FY 06-07 only, all rates below 85% of the statewide average would be set to the lower of 85% of the statewide average or 110% of the facility's estimated cost-based rate for

that fiscal year. In addition, for FY 06-07 only, SB 06-131 removed the 8% limit on rate increases due to health care services costs for facilities with an average annual Medicaid resident census that exceeds 64% of the facilities total population. The Legislative Council fiscal note for SB 06-131 did not include any estimate for the partial removal of the 8% limit. However, the Office of State Planning and Budgeting used the full impact in balancing the FY06-07 budget. The table below estimates the full impact of SB 06-131.

SB 06-131	
Estimated Number of Facilities Below 85% Statewide Average	20
Estimated Average Per Diem Rate Increase for Facilities below Statewide Average	$7.40
Estimated Number of Patient Days in Facilities below Statewide Average	321,136
Estimated Increase in Reimbursement	$2,376,406
Estimated Number of Facilities With Medicaid Enrollment Greater Than 64% Affected by Removal of 8% Limit	22
Estimated Average Per Diem Rate Increase Due to Removal of 8% Cap	$6.25
Estimated Number of Patient Days in Facilities Affected by Removal of 8% Cap	298,287
Estimated Increase in Reimbursement	$1,864,291
Estimated Total Increase in Reimbursement from SB 06-131	**$4,240,697**

SB 06-165 – Concerning the Use of Telemedicine to Promote Efficiency in the Delivery of Health Care Services, and, in Connection Therewith, Establishing Pilot Programs to Demonstrate Such Efficiency

Beginning July 1, 2006, this bill authorizes the Department to adopt rules implementing telemedicine. As of that date, in-person medical consultations are no longer required under Medicaid, although patients retain the right to choose in-person contact with a health care provider. Telemedicine consultations are also permissible under managed care. Rates for telemedicine services must be at least as great as program rates for comparable in-person services, and the Department is allowed to consider setting the reimbursement rate on a monthly, daily, or per-visit basis. In addition, the Department must establish rates for transmission cost reimbursement, which consider to the extent applicable, reductions in travel costs and access to care.

The Legislative Council fiscal note for SB 06-165 assumes that there will be 80,008 telemedicine consultations in FY 06-07 at $7.50 in transmission costs per consultation. Total expenditure for transmission costs will be $600,060.[32] Additionally, the fiscal note assumed that there would be a savings in non-emergency transportation services of $277,627. However, in FY 05-06, non-emergency transportation services were moved from Medical Services Premiums to the Department's Executive Director's Office Long Bill

[32] The legislative council fiscal note contains a slight rounding error, and lists the total expenditure as $600,058.

group. Therefore, no offset has been made to Medical Services Premiums for non-emergency transportation services. The line-item for non-emergency transportation services is adjusted to reflect the estimated savings.

Beginning July 1, 2007, the Department is anticipated to enter into an agreement with an outside contractor for a pilot program managing and treating recipients with congestive heart failure and diabetes using telemedicine. The Legislative Council fiscal note for SB 06-165 assumes that this program will treat 512 clients, at an average cost of $62 per client per month. Total expenditure for the disease management program will be $380,928. Because of the new disease management programs, the fiscal note estimates that there will be savings to Medical Services Premiums of 50% of current emergency room visits and inpatient hospital stays for clients with chronic obstructive pulmonary disease (COPD), estimated at $235,363. This assumes that the pilot program would reach 2% of clients with COPD.

SB 06-165	**FY 06-07**	**FY 07-08**
Estimated Telemedicine Consultations	80,008	142,236
Estimated Cost Per Consultation	$7.50	$7.50
Estimated Transmission Costs	**$600,060**	**$1,066,770**
Estimated Disease Management Pilot Contract Costs	$0	$380,928
Estimated Savings from Disease Management Pilot Program	$0	($235,363)
Estimated Impact to Acute Care[(1)]	**$600,060**	**$231,347**
Estimated Impact to Disease Management (Service Management)		**$380,928**

(1) In FY 07-08, the impact to Acute Care includes the annualization amount of the transmission costs, or $466,710, and the savings from the disease management pilot program.

(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

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

History and Background Information

Early legislative history of the Medicaid Mental Health Community Programs began in the 1990's. In 1992, HB 92-1306 authorized the Department of Health Care Policy and Financing and the Department of Human Services to develop a pilot program to provide comprehensive mental health services to eligible Medicaid clients through a capitated managed care system. In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the federal Centers for Medicare and Medicaid Services granted the State waivers that allowed the State to implement a pilot managed mental health program. The pilot program operated until 1995. In 1995, SB 95-078 revised the reporting and termination dates of the pilot program and directed the Department and the Department of Human Services to implement a statewide mental health managed care program. In 1997, SB 97-005 authorized the Department to provide mental health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Medicaid Mental Health Capitation Program in fifty-one counties of the State was complete, with the remaining twelve counties added in 1998. A sixty-fourth county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight mental health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005.

Each behavioral health organization is responsible for providing or arranging any medically necessary mental health service to Medicaid-eligible Adults 65 and Older, Disabled Adults 60-64 and Disabled Individuals to 59, Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, and Baby Care Program - Adults, Eligible Children, Foster Care children, and Breast and Cervical Cancer Program Adults enrolled with a behavioral health organization. Services provided by the behavioral health organizations include, but are not limited to, inpatient hospitalization; psychiatric care; rehabilitation and outpatient care; clinic services, case management, medication management and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also currently includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient enrolled in the behavioral health organization. Payments vary across each behavioral health organization, as well as each eligibility category.

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

the program were the responsibility of the Department of Human Services. With the exception of the Goebel lawsuit, which the Colorado Department of Human Services retained, HB 04-1265 transferred the administration and programmatic duties, including, but not limited to, budget projections and accounting for the program, site reviews of the institutions, and contract negotiations, from the Department of Human Services to the Department. The transfer was effective on April 1, 2004 for the administrative responsibilities, which HB 04-1265 appropriated in the Executive Director's Office Long Bill group, and on July 1, 2004 for Community Programs. The transfer also resulted in a new Long Bill group for the Department in the FY 04-05 Long Bill (HB 04-1422), including a section for Program Administration. Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Medicaid Mental Health Community Programs – Program Administration to the Executive Director's Office Long Bill group, (2) Single Entry Point case management services from Medicaid Mental Health Fee for Service Payments to Medical Services Premiums, and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee for Service appropriations within the Department. As a result, only the Medicaid Mental Health Community Programs expenditures are addressed in this section.

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

- HB 02-1420 also provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 04-05 Long Bill (HB 04-1422) and the FY 04-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 05-06.

- In FY 02-03, budget reductions were implemented and Medicaid capitation payments were reduced significantly for FY 02-03 through FY 03-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 02-03 and the entire FY 03-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 04-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 02-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's current prospective per capita budget methodology did not require the use of historical data prior to FY 02-03.

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 03-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. (2005) and the remaining $500,000 was from federal funds for mental health capitation and performance incentive awards.

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

- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group creating the following sections:

    1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 05-06.

2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee for Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However the Department received an order from the Centers for Medicare and Medicaid Services in November 2004 to cease making Child Placement Agency payments as they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December 2004 and the Department began negotiations with the Centers for Medicare and Medicaid Services to reinstate the payments, to date the payments are denied. FY 05-06 Add-Ons and HB 06-1385, the FY 06-07 Long Bill and FY 05-06 Add-Ons removed the line from the Department budget until approval is received. A summary of the Anti-Psychotic Pharmaceuticals line appears at the end of this Medicaid Mental Health Community Programs section.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that will provide capitated mental health benefits to an increased population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund and the Cessation, Prevention, and Detection Fund are included in the FY 07-08 Base Request (including Goebel enhanced services) and are elaborated below.

- The federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, commonly known as the Medicare Modernization Act, went into effect January 1, 2006. This legislation provides seniors and individuals with disabilities, including "dual-eligibles" who are eligible for both Medicare and Medicaid, with a prescription drug benefit. Additional information is also available in the Medical Services Premiums Exhibit Q and Medical Services Premiums Assumptions and Calculations.

- On September 20, 2006, the Joint Budget Committee approved a 1331 Emergency Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately.

  The Goebel Lawsuit Settlement line item was created in FY 03-04 to fund specialized and enhanced mental health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. HB 04-1320, the Supplemental Bill for FY 03-04, established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Medicaid Mental Health Community Programs payments.

On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary, and review of the Goebel-specific encounter and eligibility data, it was determined an actuarially certified payment could be included in the Mental Health Capitation Payments line item.

Program Administration

In FY 04-05, HB 04-1422 included a line item for Medicaid Mental Health Community Programs - Program Administration. This line item was for the administration of the Medicaid Mental Health Community Programs. However, in FY 05-06, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration into the Executive Director's Office Long Bill group, and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The FY 07-08 Base Request (including Goebel enhanced services) for Program Administration is included in the Executive Director's Office Long Bill group.

(A) MENTAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, the number of managed care providers was reduced from eight mental health assessment and service agencies to five behavioral health organizations effective January 1, 2005, and capitation rates and services were updated. Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program, line items, were incorporated into the Mental Health Capitation Payments line item in FY 05-06.

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

The Medicaid populations that are eligible for mental health services covered by capitation are combined into six categories, shown in the table below, for which capitation rates are paid. Qualified Medicare Beneficiaries, Special Low-Income Medicare Beneficiaries, and Non-citizens are ineligible for Medicaid mental health services.

Eligible Medicaid Mental Health Populations

Adults 65 and Older (OAP-A)
Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB)
Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, and Baby Care Program – Adults
Eligible Children (AFDC-C/BC)
Foster Care Children
Breast and Cervical Cancer Treatment Program adults

Analysis of Historical Expenditure Allocations across Eligibility Categories:

At the beginning of a contract cycle, behavioral health organization capitation rates are entered in the Medicaid Management Information System. Monthly payments are paid based on eligibility categories. The Medicaid Management Information System provides detailed expenditures by behavioral health organization and eligibility category but does not include offline transactions and accounting adjustments. The only source that includes all actual expenditure activity is the Colorado Financial Reporting System. The drawback is the Colorado Financial Reporting System provides total expenditures but not by eligibility category. The exception is the Breast and Cervical Cancer Treatment Program eligibility category, which is reported separately in the Colorado Financial Reporting System. Since an allocation must be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio is calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total Medicaid Management Information System expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio is multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each eligibility category. Variance between the two systems is less than 0.5%, so it is assumed distribution by this method will be accurate.

Brief Description of Transition to New Methodology:

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

The FY 04-05 Supplemental Request and FY 05-06 Budget Request Amendment presented to the Joint Budget Committee on February 15, 2005 began moving towards the current per capita methodology. The FY 04-05 Supplemental Request relied upon a

regional analysis of actual expenditures for the first half of the year and regionally projected member months multiplied by capitation rates for the second half of the year. The FY 05-06 Budget Request Amendment was based on an analysis of statewide per capita costs with forecast factors by eligibility type, leading to the per capita costs selected to estimate FY 05-06 expenditures, which were multiplied by the mental health caseload.

Similarly, the FY 06-07 Budget Request presented to the Joint Budget Committee on November 15, 2005 was developed from trended statewide per capita costs to estimate FY 05-06 per capita. The per capita was multiplied by the mental health caseload to arrive at projected expenditures by eligibility category. After an adjustment for recoupments planned for FY 05-06, the final requested per capita was determined by dividing projected net expenditures by the projected mental health caseload.

The FY 05-06 Supplemental Request and FY 06-07 Budget Request Amendment presented to the Joint Budget Committee on February 15, 2006 combined the annualized per capita from the second half of FY 04-05 actual expenditures and first half of FY 05-06 actual expenditures using average monthly caseload for the two periods. Annualized per capita was then determined for each half year and the one most closely reflecting trended data was used to develop the FY 05-06 Supplemental Request. Following the FY 05-06 Budget Request, the FY 06-07 Budget Request Amendment was then developed, using an estimated rate increase of 2.71% for each eligibility category. While the data was from two different fiscal years, this was the first use of actual per capita to develop projected expenditures.

The FY 07-08 Base Request (including Goebel enhanced services) is the first to fully implement the process using previous year actual amounts trended forward by applying a 3.85% increase (from the actuarial certification letter) to the FY 05-06 actual per capita by eligibility category to reflect a comparable change in rates to develop the FY 06-07 Estimate per capita. The FY 06-07 Estimate per capita base is also increased due the inclusion of $12,343,420 for Goebel enhanced services. A transfer of $12,275,081 was approved by the Joint Budget Committee, through the 1331 Emergency Supplemental request of September 20, 2006. The remaining $68,339 is due to rate increases that were implemented July 1, 2006. This was made necessary when the Centers for Medicare and Medicaid Services refused to allow the Department to continue “pass-through” payments for Goebel enhanced services and required actuarially certified rates be used.

The Department determined that the best way to achieve actuarial certification of these services was by including Goebel enhanced service costs in the per capita. Mental health caseload projections were also updated to reflect the most recent data. The updated mental health caseload multiplied by the estimated per capita result in the FY 06-07 Estimate. The same process, using a 3.76% increase, was then used to develop the FY 07-08 Base Request (including Goebel enhanced services) using the FY 06-07 Estimate as the base.

The following narrative describes in greater detail the assumptions and calculations used in developing the FY 07-08 Budget Request for Medicaid Mental Health Community Programs. It should be noted that the data and values in many of the exhibits is contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted. The exhibits being referenced can be found in the Department's November 1, 2006 Budget Request, Volume 1, Section F.

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

Exhibit AA demonstrates the growth in spending and caseload for Medicaid Mental Health Community Programs. The expenditures are those reported in the Colorado Financial Reporting System for completed fiscal years, plus the FY 06-07 Estimate and the FY 07-08 Budget Request (including Goebel enhanced services) as shown in detail in Exhibit EE. One of the strengths of per capita budget methodology is using the mental health caseload shown in Exhibit DD by eligibility category. Certain Medicaid Medical Services Premiums eligibility categories shown in Exhibit B are excluded from the mental health eligibility categories, namely Qualified Medicare Beneficiaries, Special Low-Income Medicare Beneficiaries and Non-citizens.

The mental health caseload excludes the caseload from these categories and ties to the Medicaid Medical Services Premiums caseload. Please see the Medicaid Caseload section of the Medical Services Premiums Assumptions and Calculations for further discussion of Medicaid Caseload projections. The chart in Exhibit AA illustrates a comparison in the growth of the mental health caseload compared to the growth in capitated expenditures. The unusually high increase in FY 06-07 percent change in total capitation and fee-for-service expenditures is due to the incorporation of $12,343,420 for the Goebel enhanced services costs, which is 7.43% of the total increase, into the capitation base. A pre-Goebel increase of 7.76% would be in effect if the Goebel enhanced services costs are not included, which is in line with the FY 05-06 Actuals increase and the FY 07-08 Base Request (including Goebel enhanced services) increase.

General Fund, Cash Funds, and Federal Funds Match Calculation, FY 07-08 Request (including Goebel enhanced services) (Exhibit BB):

Exhibit BB details funds splits for all Mental Health Community Programs budget lines including the fund splits for the FY 06-07 Estimate and the FY 07-08 Base Request (including Goebel enhanced services). For all of the capitation payments, the funding is 50% General Fund and 50% federal funds except the Breast and Cervical Cancer Program, which receives 65% federal funds and 35% State funds and is explained separately below. Beyond capitation payments, Medicaid Mental Health Fee for Service Payments also receive 50% General Fund and 50% federal funds. Anti-Psychotic Pharmaceuticals are reported as Cash Funds Exempt to avoid double counting an appropriation that is included in the Department's Medical Services Premiums line item. The Department continues to recommend removal of this double count, as the amount can be found in the Medical Services Premiums section. A brief summary of the Anti-Psychotic Pharmaceuticals line follows the Mental Health Capitation Payments discussion. The Mental Health Child Placement Agency line was eliminated in HB 06-1385 (FY 06-07 Long Bill and FY 05-06 Add-Ons).

The FY 06-07 Mental Health Estimate table includes a line "Adjustment for Goebel Lawsuit Settlement Appropriation Transfer" which reflects the approval by the Joint Budget Committee to transfer this spending authority into the Mental Health Capitation Payments budget line. This item will be shown as a separate line only during the FY 06-07 budget year. In subsequent years this funding will be included in the capitations line without separate identification.

Exceptions to the fund split of 50% General Fund and 50% federal funds for capitation payments exist for the Breast and Cervical Cancer Prevention and Treatment Program, funded by the Breast and Cervical Cancer Prevention and Treatment Fund (administered by the Department) and the Prevention, Detection, and early Treatment Fund (administered by the Department of Public Health and Environment). A separate exhibit was not necessary for the Breast and Cervical Cancer Program. Hence, a description of the Breast and Cervical Cancer Program follows immediately. Since Exhibit BB would also introduce any FY 05-06 overexpenditure, an explanation of the spending authority transfer that avoided overexpenditure is also included below.

Mental Health Services for Breast and Cervical Cancer Program Adults:

SB 01S2-12, adopted during the second special session in 2001, created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 incorporated funding for the Breast and Cervical Cancer Patients into the appropriation for the capitation payments effective with the FY 05-06 budget. Mental health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the mental health caseload for the Breast and Cervical Cancer Program Adults eligibility category. In addition to different funding splits, a separate per capita is paid for Breast and Cervical Cancer Treatment Program Adults than the one paid for Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, and Baby Care Program – Adults. For this reason, they are shown as a separate eligibility category throughout the budget request.

Annual designations of General Fund contributions to program costs are specified, pursuant to Section 25.5-5-308 (7), C.R.S. (2006), and as shown in Exhibit BB which details funds splits for all Mental Health Community Programs budget lines. Of the 35% State funds for Breast and Cervical Cancer Program Adults, the General Fund contributes 75% and Cash Funds Exempt 25% of State funds for clients already enrolled in the program during FY 06-07 and FY 07-08. Because federal funds cover 65% of the cost, the fund split in FY 06-07 and FY 07-08 is 26.25% General Fund, 8.75% Cash Funds Exempt and 65% federal funds for clients continuing in the program. In addition to clients already enrolled in the program, also called "continuation clients", the Department received funding from the Tobacco Tax Bill, HB 05-1262 to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the "expansion clients", are funded by the Prevention, Detection, and Early Treatment Fund administered by the Department of Public Health and Environment and funded from the Tobacco Tax Bill (see the explanation below and Exhibit GG, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients is 35% Cash Funds Exempt and 65% federal funds

participation. The source for Cash Funds Exempt is the Breast and Cervical Cancer Prevention and Treatment Fund for the continuation clients and the Prevention, Detection, and Early Treatment Fund for the expansion clients.

Explanation of Spending Authority Transfer to Eliminate a FY 05-06 Overexpenditure:

At the end FY 05-06 an overexpenditure of approximately $1.5 million occurred due to two factors. First, planned recoupments equaling a net $0.7 million were intentionally postponed until a Colorado Benefits Management System change effecting retroactive eligibility is completed in FY 06-07. A second factor for overexpenditure was the synchronization between the Colorado Benefits Management System and the Medicaid Management Information System which resulted in approximately $1.2 million of unanticipated retroactive capitations. This synchronization was only completed at the end of FY 05-06 and the resulting retroactive costs were not paid until May and June 2006. The combination of these two factors approximated a total of $1.9 million and resulted in a $1.5 million overexpenditure of the line item. However, in July 2006, the Governor authorized the transfer of $759,858 General Fund from the Home Care Allowance budget line that was matched by a like amount of federal funds. As a result of this transfer, the overexpenditure of $1.5 million did not transpire, and an under expenditure of $43,366 occurred.

Medicaid Mental Health Community Programs Summary (Exhibit CC):

Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The summary reflects the overall growth in capitation expenditures from $164,839,222 during FY 05-06 to $204,351,293 for FY 07-08 Base Request (including Goebel enhanced services). At the same time, total Medicaid Mental Health Community Programs expenditures increased from $193,176,030 in FY 05-06 to $234,006,933 for FY 07-08. During that time frame, capitations rose from 85.3% to 87.3% of total Medicaid Mental Health Community Program expenditures. The FY 06-07 Estimate, Mental Health Capitations budget line includes the addition of $12,343,420 for the Goebel enhanced service clients. This increase is included in the base calculation of the FY 07-08 Base Request (including Goebel enhanced services).

The net capitation payments include recurring events, such as net recoupment of payment for clients later deemed ineligible for Medicaid (explained in detail on page F.FF-2), but not one-time events, such as the impact of a prior year overexpenditure restriction. In this manner, recurring events become part of the capitation base. One-time events are separately identified and are not folded into trended analyses by eligibility category. One-time adjustments not incorporated into trended capitation expenditures are listed in Exhibit CC. In FY 05-06 net recoupments of $0.7 million were planned and budgeted but were never made. For a more complete explanation, please see Spending Authority Transfer to Eliminate a FY 05-06 overexpenditure mentioned above.

Mental Health Caseload for FY 07-08 Projection and Historical Per Capita Calculation (Exhibit DD):
While development of the mental health caseload is described in the Assumptions and Calculations Exhibit AA, Exhibit DD provides detailed mental health caseload data reported by eligibility category. In Exhibit DD the eligibility categories have been combined and reordered, where necessary and appropriate, to reflect the way they are budgeted for throughout the Mental Health Exhibits.

Per Capita History and FY 07-08 Budget Projection for Mental Health Capitation Payments (Exhibit EE):
Exhibit EE provides calculations for exhibits that use FY 05-06 Actuals, FY 06-07 Estimate year, and/or FY 07-08 Base Request (including Goebel enhanced services) data. The calculations for eligibility category expenses and per capita in the FY 05-06 base year, as well as development of the FY 06-07 Estimate year and the FY 07-08 Base Request (including Goebel enhanced services) year are presented in this exhibit. It is from this exhibit that data in other exhibits regarding these years was derived.

The Department has adopted a per capita budget methodology that incorporates the mental health caseload shown in Exhibit DD by eligibility category, and Medicaid Mental Health Capitation Program expenditures. Per capita methodology has been used to calculate the FY 06-07 Estimate and to develop the FY 07-08 Base Request (including Goebel enhanced services). Per capita budget methodology is a zero-based budget tool that examines the cost per eligible Medicaid client and multiplies that unit cost by the number of clients expected. Historical data shown in detail in Exhibit EE began in FY 02-03 because non-equivalent data from previous years would not have contributed to the understanding of current per capita costs. Prior data not only had a different accounting basis, but reflects different rates, services, and provider groupings.

The per capita budget methodology is straightforward. In FY 05-06, the base year, per capita costs were developed by dividing total actual expenditures for each eligibility category by the actual average monthly mental health caseload shown in Exhibit DD to determine a per capita cost for the base year by eligibility category. This represents an average amount spent per client by eligibility category in the base year. This calculation is important since the base year is the most recent year for which actual expenditures and caseload are available. Once the base year amounts were determined, the FY 06-07 Estimate and FY 07-08 Base Request (including Goebel enhanced services) per capita were developed.

Page F.EE-1 shows the development of the base year FY 05-06 data. True expenditures are only available from the Colorado Financial Reporting System, but expenditures by eligibility category, except the Breast and Cervical Cancer Treatment Program are not available in the Colorado Financial Reporting System. The Medicaid Management Information System does have expenditures by eligibility category but does not include offline transactions and accounting adjustments. However the two systems are within 0.5% of each other so data from the Medicaid Management Information System can be used to distribute total expenditures from the Colorado Financial Reporting System across eligibility categories.

A ratio is calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures by the total Medicaid Management Information System expenditures. The ratio is multiplied by the total expenditures from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need estimating. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category. This is the base year information necessary to develop Estimate and Request Year figures. The per capita are then labeled on page F.EE-4 as Per Capita Cost FY 05-06.

Page F.EE-2 is an informational page that shows the build up to an FY 06-07 estimated per capita including the Goebel enhanced services. The development of the Goebel enhanced services contribution to the per capita is from the September 20, 2006 1331 Emergency Supplemental Request titled "Pay Goebel Lawsuit Settlement Costs through Mental Health Capitation". The base per capita prior to Goebel was the per capita from page F.EE-1 plus a 3.85% actuarially certified growth rate discussed below. The Breast and Cervical Cancer Treatment Program expenditures are not included in this exhibit.

Page F.EE-3 shows the development of a growth rate for the FY 07-08 Base Request (including Goebel enhanced services). Since actuarially certified rate increases for FY 07-08 will not be available until spring 2007, a new method was used to estimate the actuarial growth rate for FY 07-08. Per capitas from FY 03-04, FY 04-05 and FY 05-06 actuals and the FY 06-07 Estimate, before the inclusion of the Goebel enhanced services, were used for trending. The same caseload (the FY 06-07 mental health caseload) was used to provide perspective of what total expenditures would be if caseload remained constant. The per capita shows changes due to utilization and capitation rates. The per capita is then multiplied by the caseload to show overall expenditure changes due to rates and utilization. To smooth out volatile fluctuations in individual years, a two year rolling average was calculated and then the per capita for that average was calculated. Finally, the percent increase in the per capita was calculated and the trend (using the mean average of the percent increases) was applied to the FY 07-08 Base Request (including Goebel enhanced services). As more years are available in the future, the trend can be refined for better projections.

Page F.EE-4 shows historical expenditures and per capita, as well as the Estimate for FY 06-07 and FY 07-08 Base Request (including Goebel enhanced services) which are calculated on page F.EE-5. This exhibit shows actual amounts through FY 05-06 and projected amounts for FY 06-07 and FY 07-08 Base Request (including Goebel enhanced services).

Page F.EE-5 shows the calculation of per capita for the FY 06-07 Estimate and the FY 07-08 Base Request (including Goebel enhanced services). Once the base year is determined it becomes the basis for future projections and an estimate for the current fiscal year (FY 06-07) is determined. Since the February 15, 2006, FY 05-06 Supplemental Requests and FY 06-07 Budget Request Amendments were submitted, significant new data has become available. The Department now has FY 05-06 actual expenditures, new

actuarially certified capitation rates being implemented, the Goebel Lawsuit Settlement spending authority has been moved into the Mental Health Capitations Payments appropriation, a revised estimate of recoupments, and updated caseload estimates have been developed.

The general methodology used to calculate the net expenditures and per capita was the same for both the Estimate and Request years. First the actuarially certified growth rate was applied to the base year's net per capita to determine the base per capita for each eligibility category for the Estimate year. This per capita is then multiplied by the applicable caseload to determine the expenditures before adjustments. The growth rate from page F.EE-3 is then applied to the Estimate year per capita and the same process is used to determine the Request year expenditures before adjustments. Adjustments for one time occurrences (one time recoupments, Goebel enhanced services, and any other one time occurrences) is then calculated, resulting in total Estimated/Requested Expenditures overall and by eligibility category. These expenditures are divided by the applicable caseload to get the final Estimated/Requested per capita.

In the FY 06-07 Estimate, the growth rate of 3.85% is based on the actuarially certified rate increase which became effective July 1, 2006. The base FY 06-07 Estimate per capita was the Per Capita Cost for FY 05-06 Actuals for each eligibility category multiplied by one plus the 3.85% growth rate to calculate the FY 06-07 Estimate per capita cost. For FY 06-07 there are two one-time adjustments. First, the Goebel specific estimated expenditures were added to each eligibility category. Finally a negative adjustment of $1.3 million for FY 03-04 for recoupment of payments made for clients found to be ineligible for Medicaid is planned to be made in FY 06-07.

Since the Goebel enhanced services are included in the FY 06-07 net per capita, no adjustments need to be made for them in the FY 07-08 Base Request (including Goebel enhanced services). The FY 07-08 Base Request per capita was the Per Capita Cost for FY 06-07 Estimate for each eligibility category multiplied by one plus the 3.76% growth rate, from page F.EE-3, to calculate the FY 07-08 Base Request per capita. In FY 07-08, the only adjustment is a net $0.3 million for recoupment of payments made for clients found to be ineligible for Medicaid in FY 04-05 and FY 05-06 coupled with the reversal of the recoupment made in FY 06-07.

Actuarially Certified Rates

The determination of capitated rates with the behavioral health organizations need to be actuarially certified and approved by the Centers for Medicare and Medicaid Services, thus actuarially certified rate increases could reasonably be expected to receive approval from the Centers for Medicare and Medicaid Services for FY 06-07. When cost factors were not available for FY 05-06 or FY 06-07, the FY 04-05 data was trended forward using accepted actuarial practices. The trended cost analysis began by reviewing annual average rate increases for various service areas. Then, the analysis was used to develop estimates of cost increases or cost factors for each service area through FY 06-07 and an average growth rate for each was calculated. A weight was applied to each average growth rate, and a weighted average growth of 3.85% for FY 06-07 was developed. The complete document showing the actuarial development of the rate was made available to Joint Budget Committee staff in July 2006. When it was determined an actuarially certified rate was needed so the Goebel clients could be included, a similar process using Goebel specific data was used.

Summary of Adjustments to Actual Expenditures (Exhibit FF):

Significant one-time events are not included in trended expenditures or per capita costs because they are not believed to persist into the future. Page F.FF-1 presents reconciliation between total expenditures reported in Exhibit CC and the adjusted expenditures used for analytical purposes. For example, a one-time adjustment is needed to tie previous projected amounts to the Colorado Financial Reporting System (COFRS) actual amount. From the FY 03-04 capitation expenditures a one-time rate relief payment of $3,660,985 was subtracted and $3,011,685 over-expenditure was subtracted from FY 02-03. Next, an adjustment was made to FY 04-05 capitation expenditures to reverse a one-time recoupment for institute payment disallowance totaling $448,858.

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

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments was completed separately. Because this recoupment is a recurring process, it is regarded as part of the capitation base for analytical purposes. Page F.FF-2 summarizes the expected fiscal impacts..

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. In FY 03-04, the Department's estimate of FY 06-07 recoupment of payments, when concurrent capitation payments were being implemented, was $1.3 million. FY 04-05 was the first full year on a concurrent basis for monthly capitation payments.

Prior to FY 05-06, the recoupment process was done once a year, with a two-year lag. For example, during FY 04-05, the Department recouped $3,131,775 in capitation payments made for retroactively ineligible clients during FY 02-03. Implementation of biannual recoupments with a one-year lag will shorten the time to recoup capitation payments made for retroactively ineligible clients. No recoupments were made during FY 05-06 due to a computer programming change, which will be completely implemented in early 2007. This change will eliminate the ability of county technicians to cancel eligibility retroactively (except in cases of fraud or death) from the Colorado Benefits Management System and will significantly decrease the number of retroactive terminations since terminations will occur in the month they are determined and not be backdated. Since payments will not be made during months where the client was terminated, no recoupments will be necessary for them. Because implementation was begun before any recoupments were made, the Department chose not to process any recoupments in FY 05-06. There will be time for only one year's recoupments to be made for FY 03-04 ineligibles in FY 06-07 and then recoupments for FY 04-05 and FY 05-06 ineligibles will be made in FY 07-08. The Department's estimate of FY 07-08 recoupments of payments made during FY 04-05 and FY 05-06, when concurrent capitation payments were made throughout the year reflects the effect of the change to concurrent recoupments. Changes

due to the change in termination procedures mentioned above will be reflected in future years. Due to these two changes, the amount of money the Department recoups is expected to drop significantly from the past.

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

Exhibit GG is a stand-alone exhibit designed to show the effect of the HB 05-1262 to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category over two pages, page F.GG-1 for the FY 06-07 Estimate and page F.GG-2 for the FY 07-08 Base Request (including Goebel enhanced services). It should be noted that the caseloads shown are the average monthly number over each year and will increase monthly through the year. It also takes time to identify and qualify these clients. These two factors explain the gradual build up to the authorized levels identified below.

HB 05-1262, known as the Tobacco Tax Bill, established two funds, the Health Care Expansion Fund administered by the Department, and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment to provide capitated mental health funding to an increased population of Medicaid clients. The caseload attributable to these clients is included in the mental health caseload in Exhibit DD and, therefore, is included in all exhibits that include caseload.

In the fiscal note submitted for HB 05-1262 it was projected that the Health Care Expansion Fund would provide Medicaid capitated mental health benefits to 478 disabled clients through the removal of the waiting list for the Children's Home and Community Based Services and 49 additional clients through the removal of the waiting list for Children's Extensive Support waiver program for a total of 527 new eligibles. A Joint Budget Committee Staff recommendation in the March 13, 2006 Figure Setting Document (page 145), adopted by the Joint Budget Committee, increased the number of clients qualified through the removal of the waiting list for the Children's Home and Community Based Services by 200 and the number qualified by removal of the waiting list for Children's Extensive Support waiver program by 30 clients for a total of 757 new eligibles.

The fiscal note also included the removal of the asset test, adding 5,849 Categorically Eligible Adults; expansion of parents' eligibility to 60% of the federal poverty level adding 4,886 Health Care Expansion Fund Low-Income Adults; and resumption of presumptive eligibility for 1,549 Baby Care Program - Adults adding a total of 12,284 new eligibles. Finally, the fiscal note also, removed the asset test, adding 24,371 children and the marketing impact on Medicaid of Children's Basic Health Plan added 2,402 children, for a total of 26,773 new eligibles.

The Prevention, Early Detection, and Treatment Fund was projected to provide additional cancer screening efforts, which would result in an additional 116 participants in the Breast and Cervical Cancer Program. Thus, a total of 39,930 new eligibles will be added due to the Tobacco Tax Bill.

In the FY 06-07 Estimate, the Health Care Expansion Fund extends Medicaid capitated mental health benefits to an annual monthly average of 550 total disabled clients, 6,114 adults, and 12,045 children while the Prevention, Early Detection, and Treatment Fund provides Medicaid capitated mental health benefits to 77 Breast and Cervical Cancer Program patients for an annual monthly average of 18,786 total new eligibles. This is an average of more than 47% of the authorized level.

In the FY 07-08 Base Request (including Goebel enhanced services), the Health Care Expansion Fund extends Medicaid capitated mental health benefits to a monthly average of 755 total disabled clients, 11,554 adults, and 22,841 children while the Prevention, Early Detection, and Treatment Fund provides Medicaid capitated mental health benefits to 102 Breast and Cervical Cancer Program patients for a monthly average of 35,252 total new eligibles. This is an average of over 88% of the authorized level. It is projected that the cost in FY 07-08 of these 35,252 total clients will be $7,998,210. By the end of FY 07-08 it is estimated the caseload will be at, or very close to, the authorized level. Exhibit GG also develops the fund splits, which are not separately identified but are included in the funds splits in Exhibit BB.

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

Medicaid Mental Health Fee for Service Payments is a separate budget line item in Medicaid Mental Health Community Programs. This line does have its own exhibit and is, therefore, explained here. The data from Exhibit HH also appears in Exhibits AA, BB, and CC as well as the Schedule 6.

The Medicaid Mental Health Fee for Service Payments appropriation allows both Medicaid clients not enrolled in a behavioral health organization or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or they are services outside the scope of the behavioral health organization contract. Medicare crossover claims also are included in this category. These are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Providers must be qualified and enrolled in Medicaid, and include but are not limited to, hospitals, psychiatrists, psychologists, primary care physicians, and mental health centers. The State also reimburses the providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract.

History and Background Information

The nature of Medicaid Mental Health Fee for Service Payments has changed in recent years. Prior to FY 02-03, fee-for-service payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 02-03, case management services, provided by community mental health centers, were included in the Mental Health Fee for Service Payments appropriation. During FY 03-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee for

Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 04-05. Also during FY 04-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee for Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

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

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a 1331 Emergency Supplemental submitted on September 3, 2004 and approved by the Joint Budget Committee on September 21, 2004 for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the federal Centers for Medicare and Medicaid Services and was effective October 1, 2004.

In FY 05-06 there was a one-time recoupment of $303,492 in the inpatient services area for disallowed payments going back to FY 01-02. The recoupment was added back to get an accurate base for trending forward. The recoupment was then deducted to arrive at a true bottom line expenditure which matches data from the Colorado Financial Reporting System. The expenditures in Exhibit HH are broken out into the three major categories which make up fee-for-service: inpatient services, outpatient services, and physician services.

The FY 06-07 Estimate is based on FY 05-06 actual expenditures, increased by the growth rate in mental health caseload of 6.79% (in place of 8.29% used for the appropriation) to $1,639,083, which is $96,936 under the FY 06-07 appropriation. FY 05-06 Actuals of $1,534,882 (before deduction of the one time recoupment) were $42,379 under the final FY 05-06 appropriation.

The FY 06-07 Estimate is trended forward by the 5.57% mental health caseload growth rate to the $1,639,083 FY 07-08 Base Request. The request amount is an increase of $91,342 over the FY 06-07 Estimate. The Department's request incrementally decreases $5,594 from the FY 06-07 appropriation of $1,736,019 to $1,730,425 in the FY 07-08 Base Request due to a lower caseload growth

percentage and lower than appropriated expenditures. No rate or utilization increases are forecast. Please see the Medicaid Mental Health Fee for Service Payments table below that reconciles to the Department's FY 06-07 Estimate and FY 07-08 Base Request.

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

The Global Reasonableness Test presented in Exhibit II compares the percent change between mental health capitation expenditures as reported in Exhibit EE. The exhibit indicates that the FY 06-07 appropriation is 8.10% higher than FY 05-06 actual expenditures. Actual caseload was lower than the projections on which the FY 06-07 appropriation was built. The current FY 06-07 estimate incorporates reduced caseload projections and carves out Goebel enhanced services (7.49% of the total increase) for comparison which results in a 7.57% increase over FY 05-06 actual expenditures. The FY 07-08 Base Request is built upon the FY 06-07 Estimate but with caseload projections significantly increased by 22,777, a 3.76% per capita growth factor, and carving out the Goebel enhanced services (which comprise 7.19% of the total increase over the FY 06-07 appropriation and 7.22% over the FY 06-07 Estimate), resulting in a 7.50% increase over the FY 06-07 appropriation and 8.02% over the FY 06-07 Estimate. Since the costs of Goebel clients were not included in previous actual years, they were carved out of the FY 06-07 Estimate and FY 07-08 Base Request (including Goebel enhanced services) so the data was not skewed. Thus, the data being evaluated are comparable.

Please see the following tables that reconcile to the Department's FY 07-08 Base Request (including Goebel enhanced services).

Medicaid Mental Health Capitation Payments Appropriation

Line Item: Medicaid Mental Health Capitation Payments	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Appropriation	**$146,964,225**	**$163,362,872**	**$178,184,177**
Rolled Alternatives to Inpatient Hospitalization at Mental Health Institute at Fort Logan into Capitation	$783,191	$0	$0
Rolled Alternatives to Inpatient Hospitalization at Mental Health Institute at Pueblo into Capitation	$852,311	$0	$0
Rolled Mental Health Institute Rate Refinance Adjustment into Capitation	$1,130,950	$0	$0
Rolled Mental Health Services for Breast & Cervical Cancer Patients into Capitation	$17,427	$0	$0
Rolled Alternatives to the Fort Logan Aftercare Program into Capitation	$310,702	$0	$0
Adjustment for Caseload Projections and 3.25% Rate Increase	$13,629,792	$0	$0
FY 02-03 Recoupments for Ineligible Clients	$3,131,775	$0	$0
Estimate of FY 03-04 Recoupments for Ineligible Clients	($2,250,000)	$0	$0
Restore One-time Institution Payment Disallowance	$474,546	$0	$0

Line Item: Medicaid Mental Health Capitation Payments	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Add back one-time removal of FY 05-06 funding associated with FY 03-04 and FY 04-05 recoupments	$0	$2,250,069	$0
2.71% Actuarial Rate Increase	$0	$4,427,270	$0
Caseload and Compounding adjustments	$0	$8,143,965	$0
$1 Adjustment	$0	$1	$0
Adjustment for revised Caseload, Percent Change to 3.76%, and Eligibility Category Mix Changes	$0	$0	$13,359,584
Long Bill Appropriation / Request	**$165,044,919**	**$178,184,177**	**$191,543,761**
HB 05-1262 Tobacco Tax - Incremental Increase from Health Care Expansion Fund	$3,858,412	$0	$0
HB 05-1262 Tobacco Tax - Incremental Increase from Cessation, Prevention, and Detection Fund	$12,635	$0	$0
HB 05-1385 Add Ons - Net Adjustment for Caseload and Per Capita Changes	($5,553,094)	$0	$0
Final Appropriation / Request	**$163,362,872**	**$178,184,177**	**$191,543,761**
General Fund	$81,569,000	$86,935,767	$91,761,313
Cash Funds Exempt	$109,910	$2,153,241	$4,000,227
Federal Funds	$81,683,962	$89,095,169	$95,782,221

Medicaid Mental Health Fee for Service Payments

Line Item: Medicaid Mental Health Fee for Service Payments	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**$1,221,573**	**$1,577,261**	**$1,736,019**
2.0% Provider Rate Increase	$23,722	$0	$0
Increase in Fee For Service	$41,898	$0	$0
Increase in Community Mental Health Centers	$4,294	$0	$0
Annualization of DD Waiver Programs Transfer	$40,832	$0	$0
Removal of double-count	($122,496)	$0	$0
3.70% common policy increase for inpatient rates	$0	$27,427	$0
3.25% common policy increase for physician rates	$0	$846	$0
8.27% Utilization increase with COLA	$0	$130,484	$0
$1 Adjustment	$0	$1	$0
FY 07-08 Impact of caseload growth	$0	$0	($5,594)
Long Bill Appropriation / Request	**$1,209,823**	**$1,736,019**	**$1,730,425**
HB 06-1385 (Long Bill Add-ons)	$367,438	$0	$0
Final Appropriation / Request	**$1,577,261**	**$1,736,019**	**$1,730,425**
General Fund	$788,631	$868,010	$865,213
Federal Funds	$788,630	$868,009	$865,212

(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS

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

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

(4) INDIGENT CARE PROGRAM

The Indigent Care Program Long Bill group consists of: the Colorado Indigent Care Program, Colorado Health Care Services payments, the Children's Basic Health Plan, the Comprehensive Primary Care Program, and the Comprehensive Primary and Preventive Care Grants Program. These programs and payments are designed to serve Colorado's underinsured and uninsured population. A description of each program, along with budget history and the FY 07-08 Base Request amounts are presented separately in this document.

Colorado Indigent Care Program Description:
The Colorado Indigent Care Program provides direct or indirect funding to hospitals and clinics that have uncompensated costs from treating underinsured or uninsured Coloradoans. It is not an insurance program, nor is it an entitlement program. As of FY 06-07, the program consists of the following line items: Safety-Net Provider Payments, The Children's Hospital Clinic Based Indigent Care, and Pediatric Speciality Hospital. These line items allow providers to receive partial compensation for uncompensated costs associated with services rendered to uninsured or underinsured low-income residents who are not eligible for Medicaid or the Children's Basic Health Plan. Clients can have third party insurance, but this resource must be exhausted before any uncompensated costs can be reimbursed.

Established by the "Reform Act for the Provision of Health Care for the Medically Indigent" in 1983, this program was created as a partial solution to the health care needs of Colorado's indigent citizens. The financial eligibility requirement for the Colorado Indigent Care Program was increased from 185% to 200% of the federal poverty level ($37,000 for a family of four in 2006) effective February 1, 2006. As of July 1, 2006, the financial eligibility requirement was increased further to 250% of the federal poverty level. The program directly contracts with hospitals and community health clinics. Providers are statutorily required to prioritize care in the following order: 1) emergency care for the entire year; 2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and 3) any other medical care. Providers are required to provide on-site eligibility and copayment determination. To determine eligibility, providers assign a ranking to clients based on their income and assets. Almost all clients are required to pay a minimal annual copayment, which varies according to services received and client ranking. Presently, annual copayments for any ranking may not exceed 10% of the family's total income and equity in assets.

The majority of the program is funded with two types of federal funds: Disproportionate Share Hospital funds and Medicare Upper Payment Limit funds. Disproportionate Share Hospital funds are paid to qualifying hospitals that are eligible for federal matching funds at the same Medicaid rate paid for services to Medicaid clients. Upper Payment Limit funds are calculated by estimating the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services. The State uses both General Fund and Cash Funds Exempt to draw down these federal funds. The State utilizes certification of public expenditures for all publicly-

owned facilities (seen as Cash Funds Exempt in the Budget) to draw down federal matching funds. Therefore, public entities receive cash payments from the State consisting entirely of federal funds. Private entities, however, may not certify expenditures, so the State must appropriate General Fund to these providers to draw down the federal funds. Any provider who participates in the program is qualified to receive funding from the Disproportionate Share Hospital Allotment and the Medicare Upper Payment Limit. See the line item "Safety-Net Provider Payments" for more detail about funding mechanisms.

The introduction of the federal Balanced Budget Act of 1997 established declining limits of the amount of federal funds available to states for Disproportionate Share Hospital payments. Although these limits were established for each state starting in federal fiscal year (FFY) 1998 based on their previous levels of payments, the impact of these limits was not truly felt until FFY 2003. Under this Act, federal fund limits for Colorado were set at the following: FFY 97-98: $93 million, FFY 98-99: $85 million, FFY 99-00: $79 million, and FFY 00-01 and beyond: $74 million, with limits adjusted by a cost of living factor each year after FFY 01-02. However, federal legislation enacted in December 2000 maintained the FFY 99-00 allotment of $79 million for FFY 00-01 and FFY 01-02, plus increases tied to the Consumer Price Index for all Urban Consumers for those years. The new allotments for FFY 00-01 and FFY 01-02 were $81,765,000 and $83,890,890, respectively. Beginning in FFY 02-03, the Disproportionate Share Hospital Payment limit reverted back to the Balanced Budget Act of 1997 legislation that indicated that Colorado's allotment would regress back to $74 million, plus an inflationary increase. This increase, determined to be 1.5% for FFY 02-03, resulted in a final Disproportionate Share Payment Cap of $75,110,000.

In late 2003, the Medicare Prescription Drug, Improvement, and Modernization Act was passed. Embedded in this federal legislation was further fiscal relief for Disproportionate Share Hospitals beginning in FFY 03-04. From FFY 03-04 to approximately FFY 09-10, the State Disproportionate Share Hospital annual limit is set to be $87,127,600 (or 16% growth over the FFY 2003 Disproportionate Share Payment Cap).

As required by HB 04-1438, the Department must make available in the Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. For FY 05-06 data, this information can be found in Exhibit K, page EK-6 in the Department's FY 07-08 Budget Request, Volume I.

SAFETY NET PROVIDER PAYMENTS

The Safety-Net Provider Payments line item was added to the Indigent Care Program Long Bill group in SB 03-258, starting in FY 03-04. Decision Item DI-6 from the Department's November 1, 2002 Budget Request consolidated the following line items into the new Safety-Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. The primary goal in combining the line items was to create a more simplified system that could be more readily understood by Department staff, the General Assembly and providers. Another goal in combining the line items was to create a system that

distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved and overall payments to qualified providers who serve low income individuals increased.

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

Payment Type	Public Hospitals	Private Hospitals
Low-Income Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Disproportionate Share Hospital federal funds limit imposed by federal law. For FY 05-06 and FY 06-07 this cap is expected to equal $87,127,600. The federal limit is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003.	The State share of payments to public hospitals is from the certification of uncompensated costs incurred from providing medical services to low income, uninsured, and under-insured Colorado residents and is represented as Cash Funds Exempt in the Long Bill. The federal share of payments is from Disproportionate Share Hospital federal funds.	The State share of payments to private hospitals is General Fund. The federal share of payments is from Disproportionate Share Hospital federal funds.

Payment Type	Public Hospitals	Private Hospitals
Bad Debt Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of available Disproportionate Share Hospital funds. These funds are contingent upon remaining Disproportionate Share Hospital federal funds available under the limit following the distribution of the Low-Income Payment.	The State share of payments to public hospitals is from the certification of uncompensated bad debt costs incurred from providing medical services to low income, uninsured, and under-insured Colorado residents and is represented in the Long Bill as Cash Funds Exempt. The federal share of payments is from Disproportionate Share Hospital federal funds. The payment is only available to Denver Health Medical Center and University Hospital, who voluntarily distribute a portion of the funding to other qualified providers to maintain equality between providers.	Any payment to qualified private hospitals is through Denver Health Medical Center and University Hospital, who voluntarily distribute a portion of the funding to other qualified providers to maintain equality between providers.
High-Volume Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit for inpatient hospital services remaining for certification of public expenditure.	The State share of payments to public hospitals is from the certification of uncompensated costs incurred from providing medical services to Medicaid clients and is represented in the Long Bill as Cash Funds Exempt. The federal share is from the current federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is General Fund. The federal share is from the current federal Medicaid matching rate for Colorado.
Low-Income Shortfall Payment: Payable to medical facilities that provide services to a large number of Medicaid and low-income, underinsured patients, but they do not participate in the Colorado Indigent Care Program. This payment is an allocation of Disproportionate Share Hospital funds available for qualified providers.	The State share of payments to public hospitals is General Fund. The federal share is from the current federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is General Fund. The federal share is from the current federal Medicaid matching rate for Colorado.

Under the distribution model, the four separate payment calculations (Low-Income payments, Bad Debt payments, High-Volume payments, and Low-Income Shortfall payments) are used to determine funding available for reimbursement of costs associated with the treatment of the indigent population. Per federally funded program requirements, monies provided by federal match must be allocated as either Disproportionate Share Hospital or Upper Payment Limit for inpatient hospital services funds. Both of these allocation types have limits that restrict the amount of federal match available.

Under the Disproportionate Share Hospital payments, the total federal amount projected to be available for FY 06-07 and FY 07-08 for the State to utilize is $87,127,600. The federal limit is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. Payments of this type include Low-Income and Low-Income Shortfall payments, with any additional federal funds available at fiscal year end to be distributed as a Bad Debt payment to providers who treat indigent clients.

The Upper Payment Limit for inpatient hospital services, however, is determined on a hospital-by-hospital basis. Thus, the amount of funds available for federal match is limited to different amounts between providers and is not determined by a set figure for the entire program. The distribution of the Upper Payment Limit for inpatient hospital services is called a High-Volume payment.

In FY 04-05, the Department requested continuation funding of $255,976,646. However, during Figure Setting on March 9, 2004, the Joint Budget Committee recommended a 25% reduction in General Fund for this line item equal to $3,144,162, or $6,288,324 in total funds (Figure Setting, March 9, 2004, page 113). This reduced the appropriation to a final FY 04-05 Long Bill amount of $249,688,322. This appropriated amount was later revised to reflect the Add-ons Section of the FY 05-06 Long Bill (SB 05-209) which incorporated another Joint Budget Committee recommendation to Upper Payment Limit funding for inpatient hospital services for expenses incurred in FY 03-04 and FY 04-05 at $8,731,182 and $5,593,702, respectively. The General Assembly approved these recommendations, thus the final appropriation for FY 04-05 was $264,013,206.

In FY 05-06, the Department received a Long Bill appropriation of $255,282,024, equaling the final FY 04-05 appropriation of $264,013,206 less the one-time funding of $8,731,182 that related to the Upper Payment Limit for FY 03-04. This amount was increased during the 2005 legislative session with the passage of HB 05-1349 (Funding of the Colorado Indigent Care Program) which added $6,288,324 through the transfer of interest within the Controlled Maintenance Trust Fund (and matching federal funds) for the purpose of restoring FY 04-05 cuts to General Fund. This amount remains in the base for future years as a General Fund appropriation. Finally, the Department's Supplemental Bill (HB 06-1217) increased the appropriation of Cash Funds Exempt to allow public hospitals to certify the local match at an additional $12,862,863 in expenses under the Upper Payment Limit and draw matching federal funds, for a total in funding of $25,725,726 (S-9, January 3, 2006). The final appropriation for FY 05-06 was $287,296,074.

In FY 06-07, the Department requested continuation funding of $287,296,074, however, the Joint Budget Committee recommended, and the General Assembly approved, an increase in total funding for this line of $8,892,556. The increase included $514,136 in General Fund and corresponding matching federal funds which are for the financing of private hospitals under the Upper Payment Limit (Figure Setting, March 13, 2006, page 171). This increase was due to a Joint Budget Committee action which reduced the Pediatric Specialty Hospital line by the same amount. An additional $3,932,142 in Cash Funds Exempt and a corresponding increase in federal funds were also approved for public hospitals under the Upper Payment Limit (Figure Setting, March 13, 2006, page 171). The final appropriation for FY 06-07 is therefore $296,188,630.

For FY 07-08, the Department is requesting continuation funding of $296,188,630. Please refer to the table below for budget history and fund splits.

Line Item: Safety-Net Provider Payments	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$255,976,646**	**$264,013,206**	**$287,296,074**	**$296,188,630**
FY 04-05 Joint Budget Committee recommended reduction	($6,288,324)	$0	$0	$0
Removal of FY 04-05 Joint Budget Committee recommended increase for FY 03-04 funding related to Upper Payment Limit	$0	($8,731,182)	$0	$0
Joint Budget Committee action recommending an increase to Upper Payment Limit funding	$0	$0	$8,892,556	$0
Long Bill Appropriation / Request	**$249,688,322**	**$255,282,024**	**$296,188,630**	**$296,188,630**
SB 05-209 Add-ons - $8,731,182 for FY 03-04 Upper Payment Limit funding (one-time), plus $5,593,702 for FY 04-05 Upper Payment Limit funding (on-going)	$14,324,884	$0	$0	$0
HB 05-1349 involving the transfer of interest from the Controlled Maintenance Trust Fund (with matching federal funds)	$0	$6,288,324	$0	$0
HB 06-1217 increase to Upper Payment Limit financing to allow for greater certification of local match (S-9, January 3, 2006)	$0	$25,725,726	$0	$0
Final Appropriation / Request	**$264,013,206**	**$287,296,074**	**$296,188,630**	**$296,188,630**
General Fund	$9,432,484	$12,576,646	$13,090,782	$13,090,782
Cash Funds Exempt	$122,574,119	$131,071,391	$135,003,533	$135,003,533
Federal Funds	$132,006,603	$143,648,037	$148,094,315	$148,094,315

THE CHILDREN'S HOSPITAL, CLINIC BASED INDIGENT CARE

The Children's Hospital, Clinic Based Indigent Care line item began in FY 02-03 with a Long Bill appropriation of $6,119,760. Funding is comprised of both General Fund and federal funds utilizing the Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies for this payment; however, because the hospital is privately owned, General Fund is required to draw down the matching federal funds. From this appropriation, The Children's Hospital distributes all but $60,000 in total funds to the participating clinics. This $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to the clinics in the program for a given fiscal year is based on a percentage of uncompensated indigent care costs as reported in the Colorado Indigent Care Program Annual Report, and increased for two years using the Consumer Price Index, All Workers, Denver Medical Costs for July of the most recent year.

Funding for FY 03-04 and FY 04-05 remained as continuation funding from FY 02-03 equal to $6,119,760. However, in FY 05-06, due to a Joint Budget Committee action on March 3, 2006, $13,500,000 in General Fund was added to The Children's Hospital Clinic Based Indigent Care line item. This General Fund appropriation was assumed to be matched with federal funds for a total fund increase of $27,000,000 (Figure Setting, March 13, 2006, page 176). The Joint Budget Committee's recommendation was to use this line item to balance the requirements of Referendum C regarding spending on health care services. The original amount of $27,000,000 was later updated after Figure Setting to reflect revised revenue estimates for this funding, ultimately appropriating $30,124,816. Later in the 2006 legislative session, however, SB 06-208 was passed to deduct $200,000 of these funds, with the $100,000 General Fund being used to establish the Health Care Reform Cash Fund to be managed by the Department of Regulatory Agencies. A second bill, SB 06-044, was passed to deduct $29,924,816, reflecting the remainder of the HB 06-1385 Add-on funding from this line item, with the $14,962,408 in General Fund being used to create the Colorado Health Care Services Fund. Therefore, funding for this line item in FY 05-06 was returned to $6,119,760.

For FY 06-07, this line item received continuation funding of $6,119,760. The Department's FY 07-08 Base Request remains at the FY 06-07 is for continuation of funding.

Line Item: The Children's Hospital Based Indigent Care Clinic	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$6,119,760**	**$6,119,760**	**$6,119,760**	**$6,119,760**
Long Bill Appropriation / Request	**$6,119,760**	**$6,119,760**	**$6,119,760**	**$6,119,760**
HB 06-1385 (Long Bill Add-ons)	$0	$30,124,816	$0	$0
SB 06-208 (Health Care Reform)	$0	($200,000)	$0	$0
SB 06-044 (Health Care Services For Adults)	$0	($29,924,816)	$0	$0

Line Item: The Children's Hospital Based Indigent Care Clinic	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Final Appropriation / Request	**$6,119,760**	**$6,119,760**	**$6,119,760**	**$6,119,760**
General Fund	$3,059,880	$3,059,880	$3,059,880	$3,059,880
Federal Funds	$3,059,880	$3,059,880	$3,059,880	$3,059,880

COLORADO HEALTH CARE SERVICES FUND

In FY 05-06, the General Assembly passed SB 06-044, which created the Colorado Health Care Services Fund. The goal of the Colorado Health Care Services Fund is to provide funding for primary care to indigent adults so that the number of emergency room visits, and their associated costs, are decreased. This fund received a FY 05-06 appropriation of $14,962,408. This amount is intended to reimburse three different provider types, beginning in FY 06-07: Denver Health (as the community health clinic for the city and county of Denver), other community health clinics, and private primary care clinics operated by a licensed or certified provider.

There is no appropriation into the Fund for FY 06-07, due to the late creation and deposit into this fund in FY 05-06. However, per the fiscal note for SB 06-044, the Department's FY 07-08 Base Request includes $15,000,000 in Cash Funds Exempt.

Line Item: Colorado Health Care Services Fund	FY 05-06	FY 06-07[33]	FY 07-08 Base Request
Prior Year Appropriation	**$0**	**$14,962,408**	**$0**
Annualization of SB 06-044	$0	($14,962,408)	$15,000,000
Long Bill Appropriation / Request	**$0**	**$0**	**$15,000,000**
SB 06-044 (Health Care Services to Low Income Adults)	$14,962,408	$0	$0
Final Appropriation / Request	**$14,962,408**	**$0**	**$15,000,000**

COLORADO HEALTH CARE SERVICES FUND - DENVER HEALTH

The Denver Health primary payment is one of three payments made from the Colorado Health Care Services Fund. At the time of pricing the fiscal note for SB 06-044 (the bill which created this appropriation) Denver Health was anticipated to have already maximized its federal funds through certification of public expenditures; therefore, moneys appropriated to Denver Health for this purpose are not currently eligible for a federal match. Per SB 06-044, Denver Health's portion of the allocation is 18% of the total

[33] There was no appropriation in FY 06-07 because the unused appropriation from FY 05-06 was carried forward.

Colorado Health Care Services Fund. For FY 06-07, this amount was equal to $2,693,233. The change from FY 06-07 final appropriation to the FY 07-08 Base Request includes $6,767 for the annualization of SB 06-044. The Department's FY 07-08 Base Request is for a total of $2,700,000 Cash Funds Exempt.

Line Item: Colorado Health Care Services Fund - Denver Health	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**N/A**	**$2,693,233**
Annualization of SB 06-044	$0	$6,767
Long Bill Appropriation / Request	**$0**	**$2,700,000**
SB 06-044 (Health Care Services to Low Income Adults)	$2,693,233	$0
Final Appropriation / Request	**$2,693,233**	**$2,700,000**

COLORADO HEALTH CARE SERVICES FUND - CERTIFIED HEALTH CARE PROVIDERS

Payments to community health clinics are the second of three payments made from the Colorado Health Care Services Fund. These community health clinics provide primary care to all patients regardless of their ability to pay, using either a sliding fee schedule, or providing benefits free of charge to the medically indigent. Per SB 06-044, after the allocation of monies to Denver Health from the Colorado Health Care Services Fund, this provider type is to receive 82% of the remaining balance.

The FY 06-07 appropriation per SB 06-044 for certified health care providers was $10,060,723. For FY 07-08 and the two subsequent fiscal years, the yearly projected revenue into the Colorado Health Care Services Fund is anticipated to equal $15,000,000. Therefore, the Department's Base Request for FY 07-08 to community health clinics is equal to $10,086,000. This funding includes $25,277 for the annualization of SB 06-044. All funds from the Health Care Services Fund are appropriated as Cash Funds Exempt. The Department's FY 07-08 Base Request is for $10,086,000.

Line Item: Colorado health Care Services Fund – Certified Health Care Providers	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**N/A**	**$10,060,723**
Annualization of SB 06-044	$0	$25,277
Long Bill Appropriation / Request	**$0**	**$10,086,000**
SB 06-044 (Health Care Services to Low Income Adults)	$10,060,723	$0
Final Appropriation / Request	**$10,060,723**	**$10,086,000**

COLORADO HEALTH CARE SERVICES FUND - PRIMARY CARE CLINICS

Payments to primary care clinics are the final of three payments made from the Colorado Health Care Services Fund. The Colorado Health Care Services Fund's allocation to private primary care clinics is supposed to alleviate some of the costs of providing preventive care to low-income adults, which should decrease the frequency of illness and emergency room visits. Many times, primary care clinics, which are not necessarily eligible to receive Title XIX funds, operate under the umbrella of hospitals that are eligible to receive Medicaid funds. For this reason, the Department anticipates that private primary care clinics will bill their affiliated hospitals, which will in turn request reimbursement from federal funds.

Private primary care clinics, received 14.76%, or $2,208,452, of the total amount of funds appropriated to the Health Care Services Fund in FY 06-07. The change from the FY 06-07 final appropriation to the FY 07-08 Base Request includes $5,548 for the annualization of SB 06-044. The Department's FY 07-08 Base Request is for $2,214,000.

Line Item: Colorado Health Care Providers – Private Primary Care Clinics	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	N/A	$2,208,452
Annualization of SB 06-044	$0	$5,548
Long Bill Appropriation / Request	**$0**	**$2,214,000**
SB 06-044 (Health Care Services to Low Income Adults)	$2,208,452	$0
Final Appropriation / Request	**$2,208,452**	**$2,214,000**

PEDIATRIC SPECIALTY HOSPITAL

This appropriation was recommended during a Joint Budget Committee meeting on March 24, 2005. The Joint Budget Committee recommended adding $5,452,134 to the FY 05-06 Long Bill to provide funding to the State's only pediatric specialty hospital (The Children's Hospital) in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Funding for the Pediatric Specialty Hospital line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing.

In FY 06-07, recommendations by the Joint Budget Committee during the Department's Figure Setting session on March 13, 2006 increased the previous fiscal year appropriation of $5,452,134. These recommendations included an appropriation of $516,036 Cash Funds Exempt originating from the Pediatric Specialty Hospital Fund as General Fund Exempt, and a separate recommendation from the Joint Budget Committee for $623,933 additional General fund. Both recommendations were approved and included matching federal funds, for a net increase of $2,279,938, and a final appropriation of $7,732,072 for FY 06-07 (note that $623,933 Cash Funds Exempt differs from the $514,136 in Figure Setting, March 13, 2006, page 177 due to final tobacco tax revenues coming in slightly

higher than estimated). For FY 07-08, the Department is requesting funding of $7,677,436 due to revised projections of Tobacco Tax revenue as provided by the Office of State Planning and Budgeting in June 2006.

Line Item: Pediatric Specialty Hospital	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation / Request	**$0**	**$5,452,134**	**$7,732,072**
SB 05-209 (FY 05-06 Long Bill)	$5,452,134	$0	$0
Joint Budget Committee recommendation to increase the General Fund appropriation in this appropriation (Figure Setting, March 13, 2006). FY 07-08 is based on revised projections from the Office of State Planning and Budgeting in June 2006.	$0	$1,247,866	($54,636)
Tobacco Tax revenue allocation equal to 20% of 3% of total revenue collected. This amount includes matching federal funds (amount differs slightly from Figure Setting, March 13, 2006 – due to final revenues collected)	$0	$1,032,072	$0
Long Bill Appropriation / Request	**$5,452,134**	**$7,732,072**	**$7,677,436**
General Fund	$2,726,067	$3,350,000	$3,350,000
Cash Funds Exempt	$0	$516,036	$461,400
Federal Funds	$2,726,067	$3,866,036	$3,866,036

H.B. 05-1262 APPROPRIATION FROM THE GENERAL FUND TO PEDIATRIC SPECIALTY HOSPITAL FUND

In 2004, Colorado voters approved an additional tax on the sale of tobacco products. The tobacco tax generates revenues which are allocated among health programs that expand health care services to the citizens of the State. In 2005, the General Assembly passed HB 05-1262 that created rules to govern the allocation of the tobacco tax revenues. New legislation in 24-22-117 (1) (c) (I) (A), C.R.S. (2006) states that of the 3% of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund, 20% of these funds should be appropriated to the General Fund. Per 24-22-117 (1) (c) (I) (B), C.R.S. (2006), 50% of these above mentioned revenues are to be appropriated by the General Assembly to the Pediatric Specialty Hospital Fund. Therefore, in FY 06-07, the amount to be transferred in four quarterly payments is anticipated to total $516,036. This amount differs from the $514,136 in Figure Setting due to updated revenue estimates received after March 13, 2006 and before the Long Bill was signed on May 1, 2006 (Figure Setting, March 13, 2006, page 177). For FY 07-08, the Department's Base Request for $461,400 incorporates the June 2006 Office of State Planning and Budgeting revenue forecast for tobacco taxes.

H.B. 05-1262 APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In 2005, the General Assembly passed HB 05-1262 that created rules to govern the allocation of the tobacco tax revenues. New legislation in 24-22-117 (1) (c) (I) (A), C.R.S. (2006) states that of the 3% of all tobacco tax revenues appropriated into the Tobacco

Tax Cash Fund, 20% of these funds should be appropriated to the General Fund. In FY 06-07, the amount anticipated to be transferred in four quarterly payments was appropriated at $1,032,072. Please note, this amount differs from the $1,028,272 in Figure Setting due to updated revenue estimates received after March 13, 2006 and before the Long Bill was signed on May 1, 2006 (Figure Setting, March 13, 2006, page 178). For FY 07-08, the Department's Base Request for $922,800 incorporates the June 2006 Office of State Planning and Budgeting revenue forecast for tobacco taxes.

PRIMARY CARE FUND PROGRAM

The Primary Care Fund supports payments to providers who serve indigent clients. Each provider seeking assistance from the Primary Care Fund must submit an application and meet other criteria set forth by the Department. The Fund was authorized under 24-22-117, C.R.S. (2006) and distributes money to the providers based on the portion of medically indigent or uninsured patients serviced by them relative to the total amount of medically indigent or uninsured clients served by all qualified providers. In order to be a qualified provider, an entity must:

- Accept all patients regardless of their ability to pay, using either a sliding fee schedule or providing benefits at no charge,
- Serve a population that lacks adequate health care services,
- Provide cost-effective care,
- Provide comprehensive primary care for all ages,
- Screens and reports eligibility for the Medical Assistance Program, Children's Basic Health Plan, and the Indigent Care Program, and
- Be a federally qualified health center per Section 330 of the federal Public Health Services Act or have a patient base that is at least 50% uninsured, medically indigent, a participant in Children's Basic Health Plan, a participant in the Medical Assistance Program, or any combination thereof.

The FY 05-06 appropriation through HB 05-1262 was $44,099,000 Cash Funds Exempt and 1.0 FTE which was appropriated with 18 months of tobacco tax revenue, beginning January 1, 2005 through the end of FY 05-06. Of this amount, $44,000,000 was ear-marked for the providers, and the remaining $99,000 was for Personal Services and Operating Expenses for the 1.0 FTE. Per 25.5-3-102 C.R.S. (2006), 3% of the total funds can be used for administrative costs.

Due to timing, once HB 05-1262 was passed, the FY 05-06 appropriation to this line item reflected nearly 18 months of collected tobacco taxes. Therefore, the FY 06-07 appropriation reflects a significant decrease in Cash Funds Exempt primarily for the reduction of 6 months of additional revenue in the prior year. In addition, administrative costs associated with 0.5 FTE have been removed from this line and appropriated in (1) Executive Director's Office Personal Services and Operating Expenses line items. The final appropriation for FY 06-07 is therefore $32,939,958 (Figure Setting, March 13, 2006, pages 182-183). The Department's FY 07-08

Base Request is $29,174,658, and incorporates the Office of State Planning and Budgeting's June 2006 revenue forecast for tobacco tax funding, after administrative funding is removed (appropriated to Personal Services and Operating Expenses) .

Line Item: Primary Care Fund Program	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**N/A**	**$44,099,000**	**$32,939,958**
Revision of estimated tobacco tax revenues	$0	($11,159,042)	($3,765,300)
Long Bill Appropriation / Request	**$0**	**$32,939,958**	**$29,174,658**
HB 05-1262 (Tobacco Tax Bill)	$44,099,000	$0	$0
Final Appropriation / Request	**$44,099,000**	**$32,939,958**	**$29,174,658**
Cash Funds Exempt	$44,099,000	$32,939,958	$29,174,658

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, the Children's Basic Health Plan was enacted in Colorado via HB 97-1304. Later that year, Title XXI of the Social Security Act, which created the State Children's Health Insurance Program, was enacted through the Congressional Budget Reconciliation Act of 1997. HB 98-1325 authorized Colorado's participation in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes under 185% of the federal poverty level. The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. A dental benefit, offered in a capitated managed care environment was added in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes less than 185% of the federal poverty level. To participate in the plan, families with incomes over 150% of the federal poverty level (with the exception of pregnant women) pay a nominal annual enrollment fee, based on family size and income. All State expenditures for benefits are matched with 65% Title XXI federal funds up to the federal allocation available for each state. Based on a memorandum of understanding with the Centers for Medicare and Medicaid Services, Colorado's administrative expenditures are matched differently than the normal 65% federal financial participation rate for Title XXI, and may not exceed 10% of total expenditures.

The Children's Basic Health Plan consists of several distinct line items in the Department's (4) Indigent Care Program Long Bill group. Effective in FY 00-01 via Supplemental Bill SB 01-183, the line items and appropriations were moved from the "Other Medical Services" Long Bill group to the "Indigent Care Program" Long Bill group. In the Long Bill for FY 03-04, the Children's Basic Health Plan Medical Premiums for children and the Prenatal and Delivery line created in HB 02-1155 for pregnant women were combined into a single Long Bill line item titled Children's Basic Health Plan Premium Costs.

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

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

In November 2004, the voters of Colorado approved Amendment 35, which raised taxes on tobacco products and designated that 46% of this revenue go to the Health Care Expansion Fund administered by the Department. The Health Care Expansion Fund, which expanded the Children's Basic Health Plan and Medicaid, was implemented through HB 05-1262. The bill provided funding to expand eligibility in the Children's Basic Health Plan to families with incomes up to 200% of the federal poverty level, effective July 1, 2005. The bill also provided funding for cost effective marketing, which began April 1, 2006. Funding was also provided to remove the Medicaid asset test, which became effective July 1, 2006. The fiscal impact of these provisions on the Children's Basic Health Plan is summarized below.

HB 97-1304 CHILDREN'S BASIC HEALTH PLAN TRUST

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

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

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

On March 15, 2005, the Joint Budget Committee staff (Figure Setting, March 15, 2005, page 160) recommended a FY 05-06 appropriation of $2,255,000 in General Fund to the Children's Basic Health Plan Trust Fund. As previously noted, HB 05-1262 removed the Medicaid asset test, resulting in a reduction in the Children's Basic Health Plan children's caseload. This reduction is due to all children under 100% of the federal poverty level and children under age six with family incomes under 133% of the federal poverty level now being eligible for Medicaid. HB 05-1262 also expanded eligibility in the Children's Basic Health Plan from 185% to 200% of the federal poverty level, thus increasing Cash Funds from annual enrollment fees by $85,486.

HB 06-1217 (Supplemental Bill) changed the FY 05-06 appropriation from the Tobacco Master Settlement Agreement, reducing revenues by $416,739 for the Children's Basic Health Plan Trust Fund. HB 06-1369 increased funding by $2,000,000 due to a delay in removing the Medicaid asset test. The Centers for Medicare and Medicaid Services indicated that eligible children should only be moved to Medicaid after their annual eligibility redetermination. This allowed a gradual decline in caseload over the course of FY 06-07. The resulting FY 05-06 final appropriation was $23,173,271. Pursuant to SB 05-211, $8,100,000 was transferred from the Children's Basic Health Plan Trust Fund to General Fund on June 30, 2006.

The Department submitted a Change Request in the November 15, 2005 Budget Request (DI-3) which reduced the appropriation of Cash Funds from annual enrollment fees by $53,670 and increased the Cash Funds Exempt appropriation by $46,395 due to higher medical costs and caseload adjustments. Budget Amendment #10 in the February 15, 2006 Budget Request resulted in a General Fund appropriation of $152,570 to balance the Trust Fund. Continuation funding of $2,152,570 in General Fund was removed in HB 06-1385 (FY 06-07 Long Bill), resulting in an appropriation of $21,165,996.

HB 06-1310 eliminated the need to appropriate the funds from the Tobacco Master Settlement Agreement by setting up an automatic transfer to the appropriate agencies, thus removing an appropriation of these funds in subsequent years. The reduction to the Children's Basic Health Plan Trust is $20,973,924 in Cash Funds Exempt. The FY 06-07 appropriation is thus reduced to $192,072 in Cash Funds.

The Base Request for FY 07-08 is based on assumptions in current law, and assumes a continuation of zero General Fund. The Base Request assumes continuation of the $192,072 in Cash Funds from enrollment fees. HB 06-1270, Public School Eligibility Determinations, directs the Department to establish medical assistance sites in public schools to allow qualified personnel to make

Medicaid and Children's Basic Health Plan eligibility determinations. Based on the fiscal note for HB 06-1270, 102 clients will be added to the Children's Basic Health Plan in FY 07-08, resulting in $324 in enrollment fees. The total Base Request for FY 07-08 is thus $192,396 in Cash Funds, as outlined below. The Department requests increased General Fund and adjustments to the Cash Funds from annual enrollment fees through a Decision Item.

Line Item: H.B. 97-1304 Children's Basic Health Plan Trust	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$19,824,750**	**$24,136,294**	**$23,173,271**	**$192,072**
FY 04-05 Joint Budget Committee Recommendation to lift children's enrollment cap and reinstate prenatal program	$1,158,392	$0	$0	$0
FY 05-06 DI-5 (November 1, 2004) Children's Basic Health Plan caseload and rate changes	$0	($376,770)	$0	$0
FY 06-07 DI-3 (November 15, 2005) Reduction to anticipated enrollment fees and rate and caseload adjustment	$0	$0	($7,275)	$0
FY 06-07 BA-10 (February 15, 2006) Appropriation to balance Trust Fund due to increased caseload	$0	$0	$152,570	$0
Removal of Prior Year General Fund appropriation as part of Base Request	$0	$0	($2,152,570)	$0
Out-year impact of HB 06-1270 (Public School Eligibility Determinations)	$0	$0	$0	$324
Long Bill Appropriation / Request	**$20,983,142**	**$23,759,524**	**$21,165,996**	**$192,396**
HB 04-1421 Adjustment to Tobacco Master Settlement Agreement revenues	$3,472,958	$0	$0	$0
SB 05-209 Add-ons Adjustment to Tobacco Master Settlement Agreement revenues	($327,489)	$0	$0	$0
SB 05-249 Adjustment to Tobacco Master Settlement Agreement revenues	$7,683	$0	$0	$0
HB 05-1262 Reduction of General Fund need based on removal of Medicaid Asset Test plus additional client enrollment fees	$0	($2,169,514)	$0	$0
HB 06-1217 Tobacco Master Settlement Agreement revenue estimates	$0	($416,739)	$0	$0
HB 06-1369 Due to delay in removal of Medicaid asset test	$0	$2,000,000	$0	$0

Line Item: H.B. 97-1304 Children's Basic Health Plan Trust	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
HB 06-1310 Revisions to Tobacco Master Settlement Agreement revenues and removal of budgetary double counting of funds	$0	$0	($20,973,924)	$0
Final Appropriation / Request	**$24,136,294**	**$23,173,271**	**$192,072**	**$192,396**
General Fund	$3,296,346	$2,000,000	$0	$0
Cash Funds	$210,400	$245,742	$192,072	$192,396
Cash Funds Exempt	$20,629,548	$20,927,529	$0	$0

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

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

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

Cost Allocation Plan for Federal Funds

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

FY 04-05 Appropriation for Administration

The FY 04-05 Long Bill (HB 04-1422) appropriation included $100,500 for limited outreach and client education, but did not include any funding for marketing and advertising. The Long Bill also included $144,178 to re-open the prenatal program in July 2004. This item was for FY 04-05 only and did not carry into the FY 05-06 Base Request (see Figure Setting document dated March 9, 2004, page 124). The FY 04-05 appropriation also included administrative funding of $6,455 from HB 04-1447, which provided funding for children who would no longer be eligible for Medicaid due to the implementation of SB 03-176, which would have eliminated Medicaid eligibility for optional legal immigrants. However, SB 03-176 was never implemented. Instead HB 05-1086 provided funding to continue Medicaid services to optional legal immigrants, and thus removed the appropriation from HB 04-1447. The FY 04-05 final appropriation was $4,325,385, consisting of $1,997,552 in Cash Funds Exempt and $2,327,833 in federal funds.

FY 05-06 Appropriation for Administration

For FY 05-06, the Department requested continuation funding of the FY 04-05 Long Bill appropriation, reduced by the prenatal implementation costs of $144,178. The following table shows the allocation between funds matched at Title XXI and Title XIX federal match rates.

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

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

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

The final appropriation for FY 05-06 was $5,577,207, consisting of $2,492,494 in Cash Funds Exempt and $3,084,713 in federal funds.

FY 06-07 Appropriation for Administration

The FY 06-07 Long Bill provided continuation funding for administrative costs paid through the Children's Basic Health Plan Trust Fund totaling $4,181,207 for the traditional Children's Basic Health Plan program. HB 05-1262 one-time funding of $55,000 for application redesign and $1,000 for actuarial costs were removed from the appropriation from the Health Care Expansion Fund. For the allocation between funds matched at Title XXI and Title XIX federal match rates, please refer to DI-3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes", Attachment 1, Table F, page 7. The FY 06-07 Long Bill appropriation is $5,521,207, with $2,465,634 in Cash Funds Exempt and $3,055,573 in federal funds.

The Department's fiscal note for HB 05-1262 requested $100,000 in FY 06-07 for a cost allocation study. The cost allocation study is necessary to maintain a fair allocation of administrative expenses between Title XIX Medicaid and Title XXI State Child Health Insurance Program funds given the extensive programmatic changes implemented through HB 05-1262. The study was to be performed in FY 06-07 using the actual experience from FY 05-06. However, funding for the study was not appropriated due to the delay in the removal of the Medicaid asset test.

FY 07-08 Base Request for Administration

The FY 07-08 Base Request is for continuation funding of $5,521,207, consisting of $2,465,634 in Cash Funds Exempt and $3,055,573 in federal funds.

Line Item: Children's Basic Health Plan Administration	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Final Appropriation	**$5,160,151**	**$4,325,385**	**$5,577,207**	**$5,521,207**
FY 04-05 Joint Budget Committee Recommendation to lift children's enrollment cap and reinstate prenatal program	($834,766)	$0	$0	$0
Remove FY 04-05 one-time funding for prenatal program implementation costs	$0	($144,178)	$0	$0
Remove HB 05-1262 one-time funding for application redesign and actuarial costs	$0	$0	($56,000)	$0
Long Bill Appropriation / Request	**$4,325,385**	**$4,181,207**	**$5,521,207**	**$5,521,207**
HB 04-1447 (Children's Basic Health Plan Enrollment)	$6,455	$0	$0	$0
HB 05-1086 (Medical Assistance to Legal Immigrants)	($6,455)	$0	$0	$0
HB 05-1262 (Tobacco Tax Implementation)	$0	$1,396,000	$0	$0
Final Appropriation / Request	**$4,325,385**	**$5,577,207**	**$5,521,207**	**$5,521,207**
Cash Funds Exempt from Children's Basic Health Plan Trust Fund	$1,997,552	$1,947,089	$1,947,089	$1,947,089
Cash Funds Exempt from Health Care Expansion Fund	$0	$545,405	$518,545	$518,545
Title XXI Federal Funds	$715,605	$1,283,135	$1,278,195	$1,278,195
Title XIX Federal Funds	$1,612,228	$1,801,578	$1,777,378	$1,777,378

CHILDREN'S BASIC HEALTH PLAN PREMIUM COSTS

This line item funds the costs of medical services provided to eligible children enrolled in the Children's Basic Health Plan and medical premiums for prenatal and delivery services for pregnant women.

The Department establishes annual enrollment projections. Each year the actuary contracted by the Department recommends a per-member-per-month rate for health maintenance organizations and the self-insured network. The rate noted in the footnote of the Long Bill each year is a "blended" rate that is based on the ratio of the number of children expected to be enrolled in health maintenance organizations to the number of children in the Children's Basic Health Plan's self-insured network. This rate includes the expected costs of providing medical benefits to enrollees as well as medical management services such as claims management.

The State share of funding for medical premiums is Cash Funds Exempt, appropriated from the Children's Basic Health Plan Trust Fund. Beginning in FY 05-06, the State share of funding includes the Health Care Expansion Fund which funds program expansions created in HB 05-1262, the Tobacco Tax. The federal share of funding is from Title XXI (State Children's Health Insurance Program). Title XXI provides a 65% match on State funds for medical premiums. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund as Cash Funds. They are spent in the Premiums Costs line as Cash Funds Exempt. However, a federal match is not provided on the annual enrollment fees collected from families. Thus, these fees are subtracted from the calculations below when computing the line item funding split.

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

The elimination of the Medicaid asset test was delayed because the Centers for Medicare and Medicaid did not approve the Department's request to allow all Children's Basic Health Plan children who became eligible for Medicaid without an asset test to be immediately moved to Medicaid. Instead, the Centers for Medicare and Medicaid stated that the children should be moved to Medicaid only after a complete annual eligibility redetermination. The Medicaid asset test removal was implemented on July 1, 2006, and traditional caseload should continue to gradually decrease over the course of FY 06-07 as children undergo their annual eligibility redetermination.

FY 04-05 Appropriation for Premiums Costs

The FY 04-05 Long Bill (HB 04-1422) appropriation was set assuming the enrollment cap for pregnant women and children would be lifted in July 2004. The Department submitted a Change Request in the November 3, 2003 Budget Request (DI-2) to adjust the appropriation for caseload and rate changes. The appropriation for the caseload is footnote 41 of HB 04-1422. The following tables display the assumptions used to set the Long Bill appropriation for Premiums Costs from Figure Setting, March 9, 2004, page 122.

Calculations for Children's Premiums Costs	**FY 04-05 Long Bill (HB 04-1422) Appropriation for Children's Program**
HMO Benefits (per member per month)	**$87.29**
Components of Non-HMO Benefits (per member per month)	
A. Self-Insured Network (Non-HMO) Benefits	$73.69
B. Reinsurance	$2.39
C. Medical and Pharmacy Claims Management	$23.32
Total Non-HMO Benefit and Delivery Cost (per member per month)	**$99.40**
Appropriated, Blended Rate (per member per month)	**$90.92**

Calculations for Children's Premiums Costs	FY 04-05 Long Bill (HB 04-1422) Appropriation for Children's Program
Average Monthly Enrollment	47,600
Total Medical Premiums	**$51,933,503**
Federal Funds Match @ 65%	$33,756,777
35% from Trust Fund (Cash Funds Exempt)	$18,176,726

Funding for the Prenatal and Delivery Program was appropriated in the Long Bill (HB 04-1422) using the following calculations.

	Calculations for Prenatal and Delivery	HB 04-1422
1	Number of Deliveries	874
2	Rate per Delivery	$3,965.00
3	Total for Deliveries (row 1 x row 2)	$3,465,410
4	Member Months for Women	9,565
5	Rate per Member Month	$345.30
6	Total for Prenatal / Postpartum Care (row 4 x row 5)	$3,302,795
7	**Total for Prenatal and Delivery Program (row 3 + row 6)**	**$6,768,205**
8	Federal Funds at 65% match	$4,399,333
9	Cash Funds Exempt from the Trust Fund	$2,368,872

HB 04-1447 increased the FY 04-05 appropriation to cover an additional 568 legal immigrants who were anticipated to no longer be covered under Medicaid due to the planned implementation of SB 03-176 on January 1, 2005. Using the $90.92 blended rate from the Long Bill at six months each for 568 children, the FY 04-05 appropriation was increased by $309,855. HB 05-1086 provided funding from the Health Care Expansion Fund to continue providing Medicaid coverage to legal immigrants. The bill also reduced the appropriation to the Children's Basic Health Plan Premium Costs line item by $441,871. The final appropriation for FY 04-05 was $58,569,692, consisting of $20,499,392 in Cash Funds Exempt and $38,070,300 in federal funds.

FY 05-06 Appropriation for Premiums Costs

The FY 05-06 Long Bill (SB 05-209) appropriation was set assuming the enrollment cap for pregnant women and children would be lifted in July 2004. The Department submitted a Change Request in the November 1, 2004 Budget Request (DI-3) to adjust the appropriation for caseload and rate changes. The appropriation for the caseload was clarified at footnote 44 of SB 05-209. The following tables display the assumptions used to set the Long Bill appropriation for the Children's Basic Health Plan Premium Costs from Figure Setting, March 15, 2005, page 152.

Calculations for Children's Premiums Costs	FY 05-06 Long Bill (SB 05-209) Appropriation for Children's Program
HMO Benefits (per member per month)	**$97.74**
Components of Non-HMO Benefits (per member per month)	
A. Self-Insured Network (Non-HMO) Benefits	$80.00
B. Reinsurance	$2.47
C. Medical and Pharmacy Claims Management	$25.83
Total Non-HMO Benefit and Delivery Cost (per member per month)	**$108.30**
Appropriated, Blended Rate (per member per month)	**$101.44**
Average Monthly Enrollment	50,395
Subtotal Children's Medical Premiums	**$61,344,826**
Less annual enrollment fees	($160,256)
Total eligible for federal match	$61,184,570
Federal Funds Match @ 65%	**$39,769,971**
Cash Funds Exempt from the Children's Basic Health Plan Trust Fund (includes the expenditure of annual enrollment fees)	$21,574,855

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

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

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

1. Removal of the asset test for Medicaid eligibility;
2. Funding for cost effective marketing;
3. Funding to increase eligibility for families with incomes from 185% to 200% of the federal poverty level (FPL); and,
4. Funding to increase enrollment above the FY 03-04 level

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

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

HB 06-1385 (Long Bill Add-ons) decreased the FY 05-06 appropriation due to the delay in the Medicaid asset test removal. The Cash Funds Exempt appropriation from the Health Care Expansion Fund used to fund premiums for the expansion populations (children and pregnant women to 200% of the federal poverty level) was decreased, and the Cash Funds Exempt appropriation from the Children's Basic Health Plan Trust Fund used to fund premiums for the traditional populations (children and pregnant women to 185% of the federal poverty level) was increased.

For the period prior to federal approval, expenditures for the pregnant women from 185% to 200% of the federal poverty level (expansion population) were not eligible for a federal match. SB 06-135 authorized the use of tobacco tax moneys to pay for services provided prior to the federal approval date and increased the Cash Funds Exempt appropriation by $353,161.

The total appropriation for FY 05-06 was $65,932,159, with $23,412,297 in Cash Funds Exempt and $42,519,862 in federal funds.

FY 06-07 Appropriation for Premiums Costs

For FY 06-07 the Long Bill (HB 06-1385) provided funding of $70,371,177. Funding for FY 06-07 was increased by $4,792,180 with the approval of DI-3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes", and BA-10, "Update due to Asset Test Delay and Request Funding for Systems Costs to Implement HB 05-1262" (see Figure Setting, March 13, 2006, pages 187 and 190-197). For FY 06-07, the Department requested a decrease in the traditional children's caseload and an increase of the caseload of the expansion populations (children and pregnant women to 200% of the federal poverty level) in FY 06-07. In addition, the capitation payment was increased from $101.44 to $104.14 and the adult prenatal program medical costs were increased from $806.97 to $905.54.

The Department received federal approval for expanding the prenatal program to 200% of the federal poverty level effective February 1, 2006. All subsequent payments for this expansion population are eligible for federal match, and the one-time funding of $353,162 from SB 06-135 was removed.

FY 07-08 Base Request for Premiums Costs

HB 06-1270, Public School Eligibility Determinations, directs the Department to establish medical assistance sites in public schools to allow qualified personnel to make Medicaid and Children's Basic Health Plan eligibility determinations. Based on the fiscal note for HB 06-1270, 102 clients will be added to the Children's Basic Health Plan in FY 07-08, resulting in an increase of $95,601 in medical premiums. The FY 07-08 Base Request is for continuation funding plus the premiums costs arising from HB 06-1270, for a total of $70,466,788, with $24,788,430 in Cash Funds Exempt and $45,678,348 in federal funds.

Line Item: Children's Basic Health Plan Premiums Costs	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$63,027,442**	**$58,569,692**	**$65,932,159**	**$70,371,177**
FY 04-05 Joint Budget Committee Recommendation to lift children's enrollment cap and reinstate prenatal program	($4,325,734)	$0	$0	$0
FY 05-06 DI-3 (November 1, 2004) Children's Basic Health Plan caseload and rate changes	$0	$18,436,431	$0	$0

Line Item: Children's Basic Health Plan Premiums Costs	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
DI-3 (November 15, 2005) and BA-10 (February 15, 2006) Adjust caseload and rates	$0	$0	$4,792,180	$0
Remove SB 06-135 one-time funding for State Only Prenatal and Delivery	$0	$0	($353,162)	$0
Out-year impact of HB 06-1270 (Public School Eligibility Determinations)	$0	$0	$0	$95,601
Long Bill Appropriation / Request	**$58,701,708**	**$77,006,123**	**$70,371,177**	**$70,466,778**
HB 04-1447 (Children's Basic Health Plan Enrollment)	$309,855	$0	$0	$0
HB 05-1086 (Medical Assistance to Legal Immigrants)	($441,871)	$0	$0	$0
HB 05-1262 (Tobacco Tax Implementation)	$0	($4,289,242)	$0	$0
HB 06-1385 Add-ons Delay in Removal of Asset Test	$0	($7,137,883)	$0	$0
HB 06-135 (State Only Prenatal and Delivery)	$0	$353,161	$0	$0
Final Appropriation / Request	**$58,569,692**	**$65,932,159**	**$70,371,177**	**$70,466,778**
Cash Funds Exempt from Children's Basic Health Plan Trust Fund	$20,499,392	$18,652,016	$17,500,146	$17,533,817
Cash Funds Exempt from Health Care Expansion Fund	$0	$4,760,281	$7,254,613	$7,254,613
Federal Funds	$38,070,300	$42,519,862	$45,616,418	$45,678,348

CHILDREN'S BASIC HEALTH PLAN DENTAL BENEFIT COSTS

In FY 01-02, the Department issued a request for proposals to provide dental services for all children enrolled in the Children's Basic Health Plan (pregnant women enrolled in the plan are excluded) at a capitated rate of $10.95 per member per month. This capitated rate assumed a dental benefit cost per eligible client of $9.95 per month (derived by dividing Medicaid dental costs by the number of Medicaid clients eligible for dental services) and administrative costs of $1.00 per month per client (Figure Setting, March 15, 2001, page 263). The Department selected the vendor who offered the most complete dental benefit package and established a $500 yearly maximum benefit per client, and a statewide network with several hundred participating dentists and contracts with Essential Community Providers. The capitated rate was increased to $11.31 per member per month in the FY 04-05 Long Bill, HB 04-1422 appropriation, to $11.82 in the FY 05-06 Long Bill, SB 05-209, and increased again to $13.30 in the FY 06-07 Long Bill, HB 06-1385. These increases were based on an actuarial review of historical costs. As is the case with Children's Basic Health Plan Premium Costs, Title XXI funds provide 65% of the total funding need for the Children's Basic Health Plan Dental Benefits Costs, while the remaining 35% State share is Cash Funds Exempt from the Children's Basic Health Plan Trust Fund.

FY 04-05 Appropriation for Dental Benefit Costs

The FY 04-05 Long Bill, HB 04-1422, increased the capitation rate from $10.95 per member per month to $11.31 per member per month based on BAS-4 "Rate Increase for Children's Basic Health Plan" in the Department's January 23, 2004 Budget Request for Stand Alone Budget Amendments. The caseload used in the FY 04-05 Long Bill dental appropriation was assumed to be 87% of the estimated children's caseload in the Children Basic Health Plan's Premium Costs Long Bill appropriation because new members do not receive dental coverage during their pre-HMO enrollment period.

HB 04-1447 increased funding to cover 568 additional legal immigrants who were anticipated to no longer be covered under Medicaid due to the implementation of SB 03-176 that was planned for January 1, 2005. HB 04-1447 increased average monthly caseload by 284 (calculated as follows: 568 additional legal immigrants multiplied by six months and divided by 12 months).

HB 05-1086 provided funding from the Health Care Expansion Fund to Medical Services Premiums to provide coverage for legal immigrants. The bill also reversed the appropriation from HB 04-1447 and further reduced the average monthly caseload by 105 (calculated as follows: 242 multiplied by 87%, multiplied by six months and divided by 12 months). The final FY 04-05 appropriation was $5,606,150, consisting of $1,962,153 in Cash Funds Exempt and $3,643,997 in federal funds.

FY 05-06 Appropriation for Dental Benefit Costs

The Department submitted a Change Request in the November 1, 2004 Budget Request (DI-3) to adjust the appropriation for caseload and rate changes. The FY 05-06 rate was developed by a contracted actuary. The caseload used in the FY 05-06 Long Bill dental appropriation was assumed to be 87% of the estimated children's caseload in the Children's Basic Health Plan's Premium Costs Long Bill appropriation (see Figure Setting, March 15, 2005, page 155).

HB 05-1262 Tobacco Tax enacted four significant programmatic changes that impact the Children's Basic Health Plan Dental Benefit Costs, including removal of the Medicaid asset test; funding for cost effective marketing; funding to increase eligibility from 185% to 200% of the federal poverty level and, funding to increase enrollment above the FY 03-04 level. The bill also increased the Cash Funds Exempt appropriation from the Health Care Expansion Fund and decreased the Cash Funds Exempt appropriation from the Children's Basic Health Plan Trust Fund. The FY 05-06 appropriation from HB 05-1262, Tobacco Tax and SB 05-209, FY 05-06 Long Bill, were both set assuming a rate of $11.82 per member per month. This amount was recommended by a contracted actuary.
HB 06-1385 (Long Bill Add-ons) decreased the FY 05-06 Children's Basic Health Plan Dental Benefit Costs appropriation due to the delay in the Medicaid asset test removal. The Cash Funds Exempt appropriation from the Health Care Expansion Fund used to fund dental premiums for the expansion population, children to 200% of the federal poverty level was decreased, and the Cash Funds Exempt appropriation from the Children's Basic Health Plan Trust Fund used to fund dental premiums for the traditional population, children to 185% of the federal poverty level was increased. The final FY 05-06 appropriation was $5,451,524, with $1,908,033 Cash Funds Exempt and $3,543,491 in federal funds.

FY 06-07 Appropriation for Dental Benefit Costs

Funding for FY 06-07 was increased by $462,134 from the FY 05-06 final appropriation with the approval of DI-3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes", and BA-10, "Update due to Asset Test Delay and Request Funding for Systems Costs to Implement HB 05-1262" (see Figure Setting, March 13, 2006, page 199). For FY 06-07, the Department requested a decrease in traditional children's dental caseload and increased the dental caseload of the expansion population (proportionally to the changes in the Children's Basic Health Plan Premiums caseloads), as well as increasing the capitation payment from $11.82 to $13.30 per member per month. The FY 06-07 Long Bill appropriation of $5,913,659 consists of $2,069,780 in Cash Funds Exempt and $3,843,879 in federal funds.

FY 07-08 Base Request for Dental Benefit Costs

HB 06-1270, Public School Eligibility Determinations, directs the Department to establish medical assistance sites in public schools to allow qualified personnel to make Medicaid and Children's Basic Health Plan eligibility determinations. Based on the fiscal note for HB 06-1270, 89 clients will be added to the Children's Basic Health Plan dental program in FY 07-08. The FY 07-08 Base Request is for continuation funding and the dental costs arising from HB 06-1270, for a total of $5,924,312, with $2,073,509 in Cash Funds Exempt and $3,850,803 in federal funds.

Line Item: Children's Basic Health Plan Dental Benefit Costs	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**$7,564,917**	**$5,606,150**	**$5,451,524**	**$5,913,659**
FY 04-05 Joint Budget Committee Recommendation to adjust caseload and rates	($1,944,480)	$0	$0	$0
FY 05-06 DI-4 (November 1, 2004) Children's Basic Health Plan caseload and rate changes	$0	$612,633	$0	$0
DI-3 (November 15, 2005) and BA-10 (February 15, 2006) Adjust caseload and rates	$0	$0	$462,134	$0
Adjustment	$0	$0	$1	$0
Out-year impact of HB 06-1270 (Public School Eligibility Determinations)	$0	$0	$0	$10,653
Long Bill Appropriation / Request	**$5,620,437**	**$6,218,783**	**$5,913,659**	**$5,924,312**
HB 04-1447 (Children's Basic Health Plan Enrollment)	$38,544	$0	$0	$0
HB 05-1086 (Medical Assistance to Legal Immigrants)	($52,831)	$0	$0	$0
HB 05-1262 (Tobacco Tax Implementation)	$0	($700,968)	$0	$0

Line Item: Children's Basic Health Plan Dental Benefit Costs	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
HB 06-1385 Add-ons Delay in Removal of Asset Test	$0	($66,291)	$0	$0
Final Appropriation / Request	**$5,606,150**	**$5,451,524**	**$5,913,659**	**$5,924,312**
Cash Funds Exempt from Children's Basic Health Plan Trust Fund	$1,962,153	$1,837,633	$1,877,566	$1,881,295
Cash Funds Exempt from Health Care Expansion Fund	$0	$70,400	$192,214	$192,214
Federal Funds	$3,643,997	$3,543,491	$3,843,879	$3,850,803

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE FUND

The Comprehensive Primary and Preventive Care Fund was created within SB 00-071. Per 25.5-3-207, C.R.S. (2006), the Comprehensive Primary and Preventive Care Fund is allocated a percentage of the total amount of moneys received by the State from the Tobacco Master Settlement Agreement. Beginning in FY 00-01, the revenue into the fund was equal to 6%, but was not to exceed $6 million. The money transferred into the fund comes from the Tobacco Master Settlement Agreement Cash Fund as Cash Funds Exempt, which was then transferred into the Comprehensive Primary and Preventive Care Grants Program to be spent. Statutory authority now contained in 25.5-3-207, C.R.S. (2006), was previously part of 26-4-1007, C.R.S. (2005) which was amended by HB 04-1421, and beginning with FY 04-05, only 3% of the Tobacco Master Settlement Agreement Fund was to be allocated to this fund, not to exceed $5 million in any fiscal year.

Funding for the Comprehensive Primary and Preventive Care Fund is projected by the Legislative Council. The Tobacco Trust Fund Balance and Annual Appropriations yearly report, prepared by Legislative Council, breaks out the amount of money available to each tobacco related program based on the expected Tobacco Master Settlement Agreement. However, the actual payment can vary from the estimated amount, and the General Assembly adjusts the appropriated funds available to the program accordingly.

In FY 00-01, the year of the Comprehensive Primary and Preventive Care Fund inception, the program was not given an appropriation and the Comprehensive Primary and Preventive Care Grants Program was funded directly by the Tobacco Master Settlement Agreement.

The Long Bill appropriation (HB 02-1420) in FY 02-03 for the Comprehensive Primary and Preventative Care Fund was initially $5,939,047, but during the fiscal year, the General Assembly determined that the State's budget would suffer revenue shortfalls and introduced SB 03-019 to reallocate funds to the General Fund. This bill therefore reduced the Fund's appropriation by $679,130, decreasing the final appropriation of the fund to $5,259,917.

The FY 03-04 Long Bill was appropriated $5,939,047 in anticipation of the amount from the Tobacco Master Settlement Agreement; however, as the State was suffering from the same budget crunch that forced the legislature to re-allocate funds from the Tobacco Master Settlement Agreement in FY 02-03, SB 03-282 reallocated $508,494 that was originally allocated to the Comprehensive Primary and Preventive Care Fund to the General Fund to shore up the projected budget shortfall. Additionally, SB 03-019 restructured the compensation terms for the State Auditor's Office, which is in charge of auditing the programs that receive funds from the Tobacco Master Settlement Agreement. Instead of receiving a fixed proportion of all funds awarded to the State, the State Auditor's Office obtained 10% of the money received by the State per the Tobacco Master Settlement Agreement, which took an additional $7,492 from the Comprehensive Primary and Preventive Care Fund's appropriation in FY 03-04. Finally, HB 04-1331 took $3,566 from the Comprehensive Primary and Preventive Care Fund and reallocated it to the Department of Public Health and Environment to cover costs associated with program monitoring. The net reduction to the original appropriation was therefore $520,002, leaving $5,419,045 for the Comprehensive Primary and Preventive Care Fund in FY 03-04.

The Long Bill appropriation for the Comprehensive Primary and Preventive Care Fund in FY 04-05 was $5,239,789. This appropriation changed with the passage of HB 04-1421 and the amount of funds allocated to the Comprehensive Primary and Preventive Care Program went from 6% of the Tobacco Master Settlement Agreement to only 3%, which decreased the total appropriation by $2,621,120. SB 05-209 further reduced the appropriation by $40,936, which was partially offset by SB 05-249 with an additional allocation of $961, based on revised revenue estimates from Legislative Council. Incorporating these changes yielded a final FY 04-05 appropriation of $2,578,694.

In FY 05-06, the Comprehensive Primary and Preventive Care Fund was appropriated $2,668,034 in the Long Bill (SB 05-209). The Department's Supplemental Bill (HB 06-1217) reduced the amount of funding by $52,093 due to reductions in projected settlement revenue.

The FY 06-07 Long Bill appropriation was slightly higher than the final FY 05-06 final appropriation, resulting in $2,621,740 initially allocated for the Comprehensive Primary and Preventive Care Program. However, in an effort to streamline the funding process for many Tobacco Master Settlement Agreement funded programs, the need for a "double-appropriation" was eliminated by using transfers instead. Thus, with the passage of HB 06-1310, the $2,621,740 in the Long Bill appropriation for the Comprehensive Primary and Preventive Care Fund was eliminated for this year and onward. Instead, money intended for the Comprehensive Primary and Preventive Care Fund will be transferred directly from the Tobacco Master Settlement Agreement funds. The table below shows the appropriation history.

Line Item: Comprehensive Primary and Preventive Care Fund	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**$5,259,917**	**$5,419,045**	**$2,578,694**	**$2,615,941**	**$0**
Adjustment to Prior Year Forecast	$679,130	($179,256)	$89,340	$5,799	$0
Long Bill Appropriation / Request	**$5,939,047**	**$5,239,789**	**$2,668,034**	**$2,621,740**	**$0**
SB 03-190 Tobacco Reallocation	$0	$0	$0	$0	$0
SB 03-019 Allocation for State Auditor's Fees	($7,942)	$0	$0	$0	$0
SB 03-282 Tobacco Reallocation	($508,494)	$0	$0	$0	$0
HB 04-1331 Department of Public Health and Environment Supplemental	($3,566)	$0	$0	$0	$0
HB 04-1421 Tobacco Reallocation	$0	($2,621,120)	$0	$0	$0
SB 05-249 Allocation of Tobacco settlement	$0	$961	$0	$0	$0
SB 05-209 Add-On	$0	($40,936)	$0	$0	$0
HB 06-1217	$0	$0	($52,093)	$0	$0
HB 06-1310	$0	$0	$0	($2,621,740)	$0
Final Appropriation / Request	**$5,419,045**	**$2,578,694**	**$2,615,941**	**$0**	**$0**
Cash Funds Exempt	$5,419,045	$2,578,694	$2,615,941	$0	$0

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANTS PROGRAM

The Comprehensive Primary and Preventive Care Grants Program is authorized by Part 10 of the Medical Assistance Act, 25.5-3-201 through 207, C.R.S. (2006), and provides funds in the form of grants to providers that expand primary and preventive health care services to low income, uninsured residents of Colorado. More specifically, the Comprehensive Primary and Preventive Care Grants Program aims to provide services to families that are at or below 200% of the federal poverty level in Colorado. The program and the services it provides do not replace or substitute for State Medicaid, the Colorado Indigent Care Program, or the Children's Basic Health Plan.

Funds from the Comprehensive Primary and Preventive Care Grants Program can be awarded to qualified providers that demonstrate the intended use of funds to expand services to indigent Colorado residents. Because of this, grant money issued through the program can be used in many ways, though its primary applications are clinic expansion or the hiring of additional staff and purchase of equipment. Grants are available for one to three years on a gradually declining basis, depending on the type of project being funded.

Since FY 00-01, the Comprehensive Primary and Preventive Care Grants Program has received its funding from the Comprehensive Primary and Preventive Care Fund. However, in FY 06-07, the General Assembly took action towards unnecessary double counting in the State budget, and the Comprehensive Primary and Preventive Care Fund appropriation was no longer appropriated funds in the Long Bill. However, while the Comprehensive Primary and Preventive Care Grants Program is still funded by the Comprehensive Primary and Preventive Care Fund, all money is now transferred directly from Tobacco Master Settlement Agreement funds into the Comprehensive Primary and Preventive Care Fund.

In FY 02-03, there were 18 active grants that were awarded to 14 providers servicing Colorado's uninsured population. In total, $4,965,304 was awarded to providers and as a result of their projects, 15,607 residents were able to receive medical, dental, or combined services. In FY 03-04, 21 grants were given to 14 providers that serviced 20,900 patients who averaged 2.46 visits. In FY 03-04, the Comprehensive Primary and Preventive Care Grants Program gave over $5 million in grant money to the providers that was used to maintain staff, purchase equipment, expand clinic space, and administer programs.

The average number of visits per patient and total appropriation slipped to their lowest levels in FY 04-05 when HB 04-1421 cut the appropriation from the Master Tobacco Settlement Agreement to 3% from 6%. In that year, there were 16 grants awarded to 10 different providers that served 17,315 patients with medical, dental, and mental ailments. Full information regarding FY 05-06 is not yet available but it is known that $2,482,507 was awarded to 9 different providers for 13 projects. Preliminary data shows that clients averaged more than 3 visits each. As of October 1, 2006, the only information available regarding grant awards is the amount of money awarded to providers based on previous fiscal year grant agreements, equal to $827,808.

As can be expected from the total amount of funding for active projects for each year in the Comprehensive Primary and Preventive Care Grants Program, the number of overall patients receiving services due to the program has dropped considerably since FY 03-04. In that year, the program's grants were estimated to have provided assistance for more than 20,900 patients, whereas only 17,216 and 3,909 patients were served in FY 04-05 and FY 05-06[34], respectively. Expenditures for the Comprehensive Primary and Preventive Care Grants Program has dropped approximately 49% from its highest level in FY 03-04 equal to $5,064,339 to FY 05-06 expenditures of $2,604,927. The average visit per client declined for the two fiscal years after FY 02-03 (2.65 visits per client), but has since rebounded to approximately 3.06 visits per client in FY 05-06.

The Department's FY 07-08 Base Request is for $2,668,034, to reflect Legislative Council Staff's most recent June 2006 Tobacco Master Settlement Agreement revenue predictions.

[34] As of November 1, 2006. FY 05-06 figures are not final.

Line Item: Comprehensive Primary and Preventive Care Grants Program	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year Appropriation	**$5,259,917**	**$5,419,045**	**$2,578,694**	**$2,615,941**	**$2,621,651**
Adjustment to Prior Year Forecast	$679,130	($179,256)	$89,340	$5,799	$46,383
Long Bill Appropriation / Request	**$5,939,047**	**$5,239,789**	**$2,668,034**	**$2,621,740**	**$2,668,034**
SB 03-190 Tobacco Reallocation	$0	$0	$0	$0	$0
SB 03-019 Allocation for State Auditor's Fees	($7,942)	$0	$0	$0	$0
SB 03-282 Tobacco Reallocation	($508,494)	$0	$0	$0	$0
HB 04-1331 Department of Public Health and Environment Supplemental	($3,566)	$0	$0	$0	$0
HB 04-1421 Tobacco Reallocation	$0	($2,621,120)	$0	$0	$0
SB 05-249 Allocation of Tobacco settlement	$0	$961	$0	$0	$0
SB 05-209 Add-On	$0	($40,936)	$0	$0	$0
HB 06-1217	$0	$0	($52,093)	$0	$0
HB 06-1310	$0	$0	$0	($89)	$0
Final Appropriation / Request	**$5,419,045**	**$2,578,694**	**$2,615,941**	**$2,621,651**	**$2,668,034**
Cash Funds Exempt	$5,419,045	$2,578,694	$2,615,941	$2,621,651	$2,668,034

History of Grants Awarded through the Comprehensive and Preventative Care Grants Program				
	FY 02-03	**FY 03-04**	**FY 04-05**[35]	**FY 05-06**[36]
Total Number of Active Grants	18	21	16	13
Total Number of Providers	14	14	10	9
Total Amount of Awarded Active Grants	$4,965,304	$5,018,980	$2,440,507	$2,604,927
Total Amount Awarded: Future Years				
FY 04-05	$1,190,170	$1,340,170	N/A	N/A
FY 05-06	N/A	$100,000	$497,096	N/A
FY 06-07	N/A	N/A	$298,842	$827,808
FY 07-08	N/A	N/A	N/A	$195,152
Patients Receiving Medical Services	12,607	15,400	10,010	3,724
Number of Medical Visits	33,094	41,000	23,736	10,848
Patients Receiving Dental Services	3,000	5,500	7,130	60
Number of Dental Visits	8,369	10,500	12,389	96
Patients Receiving Mental Services	N/A	N/A	76	125
Number of Mental Visits	N/A	N/A	175	1,043
Average Visits per Patient	2.65	2.46	2.12	3.06

[35] HB 04-1421 changed the appropriation from 6% to 3% due to the Tobacco Master Settlement Agreement.
[36] The number of patients served in FY 05-06 is as of November 1, 2006. Finalized numbers will be available in the February, 2007 Comprehensive Primary and Preventive Care Grants Program Annual Report.

(5) OTHER MEDICAL SERVICES

OLD AGE PENSION STATE MEDICAL PROGRAM

The Old Age Pension State Medical Program Long Bill line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical care for non-Medicaid individuals receiving Old Age Pension grants. This program is 100% State-funded and is not an entitlement. Eligible recipients are over the age of sixty and ineligible for Medicaid due to Supplemental Security Income criteria. The Old Age Pension State Medical Program is funded through the $10 million Old Age Pension Health and Medical Care Fund established in Article 24 of the constitution and 25.5-2-101, C.R.S. (2006).

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 Old Age Pension Health and Medical Care Program and Fund in section 7. Old Age Pension benefits specified in article XXIV of the State constitution require that a health and medical program be provided to anyone who qualifies to receive an Old Age Pension cash payment and is not a patient in an institution for tuberculosis or mental disease. Specified sources of General Fund, (primarily excise taxes) must be earmarked to cover the costs of Old Age Pension benefits. Via SB 03-022, effective July 1, 2003, the Department of Health Care Policy and Financing received statutory authority to administer the Old Age Pension Health and Medical Care Program, the Old Age Pension Health and Medical Care Fund, the Supplemental Old Age Pension Health and Medical Care Program, and the Supplemental Old Age Pension Health and Medical Care Fund. The Department of Human Services continues to have statutory authority to administer the Old Age Pension, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund.

Prior to FY 02-03, the appropriation for the Old Age Pension State Medical Program was made directly from the Old Age Pension Health and Medical Care Fund to the Department of Health Care Policy and Financing. At that time, the Department also handled program administration. Upon review, it was determined by both the Department of Health Care Policy and Financing and the Department of Human Services that this was in conflict of current statute. Effective January 4, 2002, programmatic authority (including responsibility for managing, monitoring, and forecasting) for this appropriation was transferred to the Department of Human Services. Via General Assembly action effective July 1, 2002, all Old Age Pension funds were consolidated in an appropriation to the Department of Human Services. However, both the amounts for administration and for services were still "transferred" as Cash Funds Exempt to the Department of Health Care Policy and Financing. This is documented in letternote "a" on page 60 of HB 02-1420 (FY 02-03 Long Bill).

Under an Interagency Agreement in FY 02-03, the Department of Health Care Policy and Financing's responsibilities for this appropriation were changed to process claims, produce Medicaid Authorization Cards and provide data that could assist the Department of Human Services to calculate projections for the program. At that time, the Department of Human Services transferred funding to the Department of Health Care Policy and Financing in the amount of $146,867 for various administrative costs, with the

remaining $9,853,133 transferred to the Department's Medical Services Premiums line item as Cash Funds Exempt for payment of claims. This transfer of funds to the Medical Services Premiums Long Bill group was not necessary for the payment of claims, but did allow the dollars to be tracked in the Department of Health Care Policy and Financing budget. However, the presence of a State only non-Medicaid program in the Medical Services Premiums created some confusion. Therefore, with the passage of SB 03-022 the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S. (2006) was transferred from the Department of Human Services to the Department of Health Care Policy and Financing effective July 1, 2003.

Starting in FY 03-04, this line item resides in the "Other Medical Services" Long Bill group. The "Other Medical Services" Long Bill group is more suitable than Medical Services Premiums for three main reasons: 1) the program is a non-Medicaid program; 2) the program is not subject to over expenditure authority; and, 3) the program is not affected by the cash accounting changes authorized in SB 03-196. In addition, SB 03-299 reduced the amount of sales and use tax allocated to the Supplemental Old Age Pension Health and Medical Care fund from $1.0 million to $750,000.

The growing demand for health care services by this client population caused the program to nearly exceed its $10,750,000 million cap four times in the last five years. Reduction measures have been necessary when expenditures under the Old Age Pension State Medical Program were expected to exceed the available spending authority. The following is a summary of actions taken since FY 99-00 to contain costs, and in a handful of occasions increase reimbursements, for the Old Age Pension State Medical Program:

- Effective October 1, 1999, inpatient rates for all hospitals statewide were reduced to 80% of the Medicaid rate.
- Effective January 1, 2002, medical backdating was permanently eliminated.
- Effective February 1, 2002, inpatient hospital coverage and emergency medical transportation services were eliminated for the remainder of FY 01-02.
- Effective February 1, 2002, all provider payments, (e.g., payments for practitioners and outpatient services) were reduced to 80% of the Medicaid rate and the maximum client co-payment was increased from $100 to $300 per year.
- Effective July 1, 2002, most providers in the Old Age Pension State Medical Program were reimbursed at 82% of the Medicaid rate. The two exceptions to this reimbursement rate were pharmacists who were paid at the Medicaid reimbursement rate, and inpatient hospitals that were reimbursed at 68% of the Medicaid rate.
- Effective August 30, 2002, the health maintenance organizations dropped Old Age Pension State Medical Program clients after the Department of Human Services advised them the FY 02-03 rates were 18% lower than FY 01-02 rates.
- Effective August 30, 2002, Old Age Pension State Medical Program clients were no longer able to enroll in managed care options, including the Primary Care Physician Program.
- Effective January 1, 2004 inpatient hospital services were suspended for Old Age Pension State Medical Program clients. In addition, all provider reimbursement rates for outpatient hospital, outpatient clinic, practitioner/physician services, emergency dental,

laboratory, medical supply, home health, and transportation services were decreased from 82% to 50% of the Medicaid rate. Pharmacists were paid at the Medicaid reimbursement rate.

- Effective October 15, 2004, the reimbursement rate for physician and practitioner services, emergency transportation, medical supplies, hospice services, and home health care services and supplies were restored to 82% of the Medicaid rate. In addition, the inpatient hospital benefit was restored to those hospitals participating in the Colorado Indigent Care Program and limited to only those inpatient services available under the Colorado Indigent Care Program. The reimbursement rate for inpatient benefits was set at 10% of the Medicaid reimbursement rate.
- Effective July 15, 2005, the reimbursement rate was increased from 82% of the Medicaid rate to 100% of the Medicaid rate for the following expenditure categories: practitioner/ physician services, medical supplies, home health care services and supplies and transportation. Additionally, the reimbursement rate was increased from 50% of the Medicaid rate to 100% of the Medicaid rate for dental and independent laboratory claims. Finally, outpatient claims reimbursement was increased from 50% to 62% of the Medicaid rate.
- Effective May 1, 2006, the reimbursement rate was decreased from 100% of the Medicaid rate to 53% of the Medicaid rate for the following expenditure categories: dental, medical supplies, home health care services, supplies and transportation, and independent laboratory claims. Additionally, the reimbursement rate was decreased from 100% of the Medicaid rate to 70% of the Medicaid rate for practitioner/ physician services. Finally, outpatient claims reimbursement was decreased from 62% to 53% of the Medicaid rate.
- Effective July 1, 2006, the reimbursement rates reverted back to the rates that were put in place on July 15, 2005.

Administrative Costs Affecting this Line Item

The appropriation has also been affected by changes in the way administrative costs have been handled for the Old Age Pension State Medical Program. Medical provider claims for Old Age Pension State Medical Program clients have historically been processed through the Medicaid Management Information System. To cover these processing costs, a Cash Funds Exempt appropriation was made to the Medicaid Management Information System line item after reducing the Old Age Pension State Medical Program line item by the same amount. Historically, the Cash Funds Exempt amount appropriated to the Medicaid Management Information System was $146,867 and remained at that amount for several years. However, from FY 98-99 to FY 02-03, the full appropriation was not expended. In FY 02-03, the Department of Human Services submitted a Supplemental Request[37] to refinance administrative costs to allow more of the $10,750,000 appropriation to be used for medical services instead of claims processing by the Medicaid Management Information System. Effective July 1, 2003, via SB 03-258, this cost was funded directly from the Old Age Pension Fund, and no longer results in a corresponding reduction to the Old Age Pension State Medical Program.

[37] As cited in the Joint Budget Committee Staff's Supplemental Document for the Department of Human Services, January 15, 2003, page 10. The corresponding change in Health Care Policy and Financing was NP-S5 "Refinancing Administrative Costs of the Old Age Pension Health Care Program."

Another administrative cost for this program area is the issuance of Medical Identification Cards. These cards are provided to Old Age Pension State Medical Program clients, allowing medical providers to check client identification and eligibility for services. No funds from Cash Funds Exempt was appropriated in years prior to FY 03-04 to cover this administrative cost. However, beginning with FY 03-04, $10,656 were appropriated from the Old Age Pension State Medical Program to fund this cost. The FY 04-05 Long Bill (HB 04-1422) reduced the appropriation for this administrative cost to $1,517 due to the efficiencies achieved with the new plastic identification cards. The FY 05-06 Long Bill (SB 05-209) and the FY 06-07 Long Bill (HB 06-1385) included a continuation of funding in the amount of $1,517 for this administrative cost. The FY 07-08 Base Request assumes continuation funding of this amount for Medical Identification Cards.

See the table below for a history of administrative costs funded through the Old Age Pension Health and Medical Care Fund.

Old Age Pension State Medical Program Reductions for Administration Costs				
	Medical Management Information System		**Medical Identification Cards**	
Fiscal Year	**Appropriation**	**Expenditure**	**Appropriation/Request**	**Expenditure**
FY 98-99	$146,867	$104,569	$0	$0
FY 99-00	$146,867	$75,021	$0	$0
FY 00-01	$146,867	$69,248	$0	$0
FY 01-02	$146,867	$87,692	$0	$0
FY 02-03	$146,867	$86,857	$0	$0
FY 03-04	$0	$0	$10,656	$3,825
FY 04-05	$0	$0	$1,517	$679
FY 05-06	$0	$0	$1,517	$1,511
FY 06-07	$0	$0	$1,517	N/A
FY 07-08	$0	$0	$1,517	N/A

Caseload History

The table below delineates the caseload history for this program since FY 90-91. The program's caseload fluctuated over the years, but has risen steadily since FY 02-03. For informational purposes, the Department has forecasted caseload for FY 06-07 and FY 07-08 using the average annual growth from FY 04-05 to FY 05-06.

Old Age Pension State Medical Program Caseload History and Projection			
Year	**Caseload**	**% Change**	**Source**
FY 90-91 Actual	3,586		February 14, 2003 Budget Request, Exhibit B, "Caseload History and Projections with Rates of Change"
FY 91-92 Actual	3,540	-1.28%	
FY 92-93 Actual	3,446	-2.66%	
FY 93-94 Actual	3,011	-12.62%	
FY 94-95 Actual	3,056	1.49%	
FY 95-96 Actual	3,150	3.08%	
FY 96-97 Actual	3,152	0.06%	
FY 97-98 Actual	3,215	2.00%	
FY 98-99 Actual	3,150	-2.02%	
FY 99-00 Actual	3,066	-2.67%	Business Objects America Queries ran on 7/1/04
FY 00-01 Actual	3,212	4.76%	
FY 01-02 Actual	3,782	17.75%	
FY 02-03 Actual	3,794	0.33%	Average of monthly figures gathered from COLD MARS R4600 Reports
FY 03-04 Actual	4,261	12.31%	
FY 04-05 Actual	4,766	11.85%	
FY 05-06 Actual	5,076	6.50%	
FY 06-07 Projection	5,542	9.18%	Average annual growth from FY 04-05 to FY 05-06 9.18%=(11.85%+6.50%)/2
FY 07-08 Projection	6,051	9.18%	

Drug Rebate

Drug rebates are used as an offset to expenditures and help defray the cost of medical services. Since the Medicaid Drug Rebate Program began in 1991, the Department has allocated a certain portion of the rebate payment to the Old Age Pension State Medical Program since the purchase of drugs by the Old Age Pension State Medical Program could not be segregated from the Medicaid Management Information System. In October 2003 and November 2005 the Department of Health and Human Services and the Office of the Inspector General released audit reports that ruled that the Department was in violation of Medicaid Drug Rebate Program rules that prohibit inclusion of any drugs paid for under the program funded fully by the State. As a result, the Department was no longer able to allocate a certain percentage of the drug rebate to the Old Age Pension State Medical Program. This led to the creation and request of Supplemental S-11 entitled "Funding to Establish an Old Age Pension Sate Medical Program Drug Rebate Program" submitted by the Department on January 3, 2006 to establish an Old Age Pension State Medical Program Drug Rebate Program. This Supplemental was recommended by the Joint Budget Committee on January 20, 2006 and was passed by the General

Assembly with the Department's Supplemental Bill, HB 06-1217. As of November 1, 2006, the Department is determining the feasibility of implementing an Old Age Pension Health and Medical Drug Rebate Program, and plans to hire a temporary assistant to aid in this study.

Expenditure History and Request

In FY 02-03, HB 02-1276 created the Supplemental Old Age Pension Health and Medical Care Fund in the amount of $1,000,000; however, funding was reduced to $750,000 in FY 03-04 via SB 03-299. During the Department's FY 04-05 Figure Setting session,[38] the Joint Budget Committee combined funding sources into a single line item for FY 04-05 for a total of $10,750,000. The FY 05-06 appropriation from SB 05-209 continued funding at this level.

HB 05-1262 (Tobacco Tax Bill) allocates 3% of tobacco revenue generated through Amendment 35 to the Cash Fund for Health Related Purposes. Of that 3% allocation, 50% is to be annually appropriated by the General Assembly to the Supplemental Old Age Pension Health and Medical Fund. The appropriations clause for HB 05-1262 increased funding to the Supplemental Old Age Pension Health and Medical Fund by $943,500 in FY 04-05 and by $2,538,000 in FY 05-06. However, the bill's appropriation clause did not increase the spending authority within the Old Age Pension State Medical Program line item, thereby making the increased funding unavailable for distribution to providers. Therefore, on January 3, 2006, the Department submitted Supplemental S-4 entitled "Request to Fund the Old Age Pension State Medical Program" to utilize this additional tobacco tax revenue. This request was approved by the Joint Budget Committee on January 20, 2006 and was passed in the Department's Supplemental Bill HB 06-1217. In addition, the Department submitted an Emergency 1331 entitled "Prevent Old Age Pension State Medical Program Overexpenditure" on June 20, 2006 which requested an additional $1,140,484 in FY 05-06 from the existing fund balance of the Supplemental Old Age Pension Health and Medical Care Fund. The request was approved by the Joint Budget Committee and bringing the final FY 05-06 spending authority to $14,426,967.

In addition to the ongoing funding from tobacco tax revenue, the Joint Budget Committee[39] increased the spending authority for FY 06-07 by $976,180. This additional funding is comprised of the $943,500 in tobacco tax revenue that can be attributed to FY 04-05, plus $32,680 from the prior year tobacco tax revenue exceeding revenue projections provided by the Legislative Council. As a result of these changes, the final FY 06-07 appropriation for the Old Age Pension State Medical Program is $14,262,663.

The FY 07-08 Base Request is for $13,055,483, which is a reduction of $1,207,180 from FY 06-07. This reduction includes a removal of the $976,180 of one-time funding in FY 06-07, and a decrease of $231,000 in estimated revenue from the Tobacco Tax Cash Fund based on Legislative Council's June 2006 Revenue Forecast.

[38] Page 139 Figure Setting March 9, 2004
[39] March 13, 2006 Figure Setting, page 209

The following table delineates historical expenditures. These expenditures do not include the administrative costs displayed in the table entitled Old Age Pension State Medical Program Reductions for Administration Costs.

Old Age Pension State Medical Program Expenditure History					
Year	**All Expenditures, Before Drug Rebate**	**Drug Rebate**	**All Expenditures, After Drug Rebate**	**Average Number of Clients**	**Average Cost per Client**
FY 99-00 Actual	$9,681,696	($663,715)	$9,017,981	3,066	$2,941.29
FY 00-01 Actual	$10,639,144	($803,201)	$9,835,943	3,212	$3,062.25
FY 01-02 Actual	$10,468,408	($930,753)	$9,537,655	3,782	$2,521.85
FY 02-03 Actual	$11,241,636	($495,571)	$10,746,065	3,794	$2,832.38
FY 03-04 Actual	$11,447,158	($700,984)	$10,746,174	4,261	$2,521.98
FY 04-05 Actual	$10,923,336	($924,015)	$9,999,321	4,766	$2,098.05
FY 05-06 Actual	$15,182,038	($755,071)	$14,426,967	5,076	$2,842.19

The FY 07-08 Base Request continues to be the maximum allowed under current law, minus the administrative costs of the Medical Identification Cards. The Base Request assumes that the appropriation will be increased by the amount of tobacco tax revenue annually allocated to the Supplemental Old Age Pension Health and Medical Care Fund from the Cash Fund for Health Related Purposes. The Department's FY 07-08 Base Request estimates that the Supplemental Old Age Pension Medical Care Fund will receive $2,307,000 from the Tobacco Tax Cash Fund as projected in Legislative Council's June 2006 Revenue Forecast.

Line Item: Old Age Pension State Medical Program	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Previous Fiscal Year Final Appropriation	**N/A**	**$10,746,174**	**$10,748,483**	**$13,286,483**	**$14,262,663**
Savings related to plastic Medicaid Cards	$0	$2,309	$0	$0	$0
Joint Budget Committee action to reduce existing fund balances in the Supplemental Old Age Pension Health and Medical Care Fund (Figure Setting, Page 209, March 13, 2006)	$0	$0	$0	$976,180	$0
Removal of one-time funding for FY 06-07	$0	$0	$0	$0	($976,180)
Revised estimate of revenue from the Tobacco Tax Cash Fund	$0	$0	$0	$0	($231,000)

Line Item: Old Age Pension State Medical Program	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Long Bill Appropriation / Request	**$9,989,344**	**$10,748,483**	**$$10,748,483**	**$14,262,663**	**$13,055,483**
Transfer from Medicaid Authorization Cards and Identification Cards	$6,830	$0	$0	$0	$0
Joint Budget Committee action to shift funding from the Supplemental Old Age Pension Health and Medical Care Fund to the Old Age Pension State Medical Program	$750,000	$0	$0	$0	$0
HB 06-1217 (Supplemental Bill)	$0	$0	$2,538,000	$0	$0
Final Appropriation / Request	**$10,746,174**	**$10,748,483**	**$13,286,483**	**$14,262,663**	**$13,055,483**
Cash Funds	$10,746,174	$10,748,483	$0	$0	$0
Cash Funds Exempt	$0	$0	$13,286,483	$14,262,663	$13,055,483

HB 05-1262 TRANSFER OF TOBACCO TAX CASH FUND INTO SUPPLEMENTAL OLD AGE PENSION STATE MEDICAL FUND

In 2002, the General Assembly passed HB 02-1276 that created a Supplemental Old Age Pension Health and Medical Care Fund to supplement the program with an additional $1 million because the Colorado constitution caps the revenue deposited into the Old Age Pension Health and Medical Care Fund at $10 million annually. In 2003, the $1 million was reduced to $750,000 during budget reduction actions. With the passage of Amendment 35 in November 2004, the State increased the taxes on tobacco products. Amendment 35 allowed 3% of the new revenue to be allocated to the General Fund, the Old Age Pension Program, and to the counties and cities. With the passage of HB 05-1262 in 2005, the General Assembly allocated 50% of the 3% allocation to the Supplemental Old Age Pension Health and Medical Care Fund.

Prior to FY 06-07, the Supplemental Old Age Pension State Health and Medical Fund had no direct appropriation. In FY 06-07, a Joint Budget Committee action included an appropriation of $2,580,180 from the Tobacco Tax Cash Fund through the Long Bill, HB 06-1385. The Department's FY 07-08 Base Request estimates that the Supplemental Old Age Pension Health and Medical Care Fund will receive $2,307,000 from the Tobacco Tax Cash Fund as projected in the Legislative Council June 2006 Revenue Forecast. The following table shows the appropriation and Base Requests for FY 06-07and FY 07-08 respectively:

Line Item: HB 05-1262 Transfer of Tobacco Tax Cash Fund into Supplemental Old Age Pension State Medical Fund	FY 06-07	FY 07-08 Base Request
Previous Fiscal Year Final Appropriation	**N/A**	**$2,580,180**
Revised Estimate of Tobacco Tax Revenue	$0	($273,180)
Long Bill Appropriation / Request	**$2,580,180**	**$2,307,000**
Final Appropriation / Request	**$2,580,180**	**$2,307,000**
Cash Funds Exempt	$2,580,180	$2,307,000

HOME CARE ALLOWANCE

First authorized in 1979 by Section 26-2-122.3, C.R.S. (2006), Home Care Allowance began as a State and county funded program to provide direct payments (subject to available appropriations) to eligible individuals for the purchase of services related to activities of daily living. In providing for these services, the program enables clients to remain at home and prevent more restrictive, expensive placement. This is a non-Medicaid program, meaning no federal matching funds under Title XIX are used.

Eligibility for the program is determined as follows. A Single Entry Point case manager assesses if the client meets the functional need for the program and ascertains the monthly amount necessary for the services the client needs in order to remain in the home. A county eligibility technician enters data into the Colorado Benefits Management System which determines if the client is financially eligible and, if so, how much the client is entitled to receive based on his or her income. The income limits depend on the standard of need category and the authorized Home Care Allowance amount. Home Care Allowance payments currently range from $1 per month to a maximum of $439.15 per month, depending on the client's income; however, 26-2-122.3 (1) (b), C.R.S. (2006), C.R.S. allows for the amounts paid to eligible persons to be adjusted as necessary and managed within the funds appropriated by the General Assembly. The Department of Human Services maintains the Volume III regulations that limit access to the Home Care Allowance program based on the need standard.

Approved payments are sent out by the county offices through the Department of Human Services. Up until FY 06-07, the Department of Health Care Policy and Financing reimbursed the Department of Human Services for the General Fund expenditures associated with these county payments. The funding split calculation assumed an allocation of 95% General Fund and up to 5% local matching funds. The statutes contain a hold harmless provision for counties in which their annual increase for a program area cannot exceed 5% over the previous year. The local funding match is calculated at the lower of either the prior year local match times 5% or the base recommendation times 5% as per Section 26-4-525 (1) (c), C.R.S. (2006).

Prior to the Supplemental Bill for FY 02-03 (SB 03-203), adjustment to the Home Care Allowance appropriation was primarily the result of Change Requests. These Change Requests were based on recent experience, and aimed at adjusting for changes in caseload or the average monthly payment. In FY 02-03, the Home Care Allowance program was included in the Department's mandatory 4% budget reductions. The 4% cut reduced the appropriation by $2,363,745. To meet this reduction, a freeze on new enrollment was implemented on July 1, 2002. Due to the 45-day timeframe for processing applications, this freeze on enrollment had no real impact until September 2002 at which time the freeze reduced program enrollment. This compounded the already declining caseload for Home Care Allowance that was sparked by the recent rise in Medicaid Home and Community Based Services. Home Care Allowance expenditures were monitored throughout FY 02-03 to assess the status of budget reductions. In December 2002, it was determined that the enrollment freeze was not achieving the results originally anticipated, partially due to the later than anticipated affect of the enrollment freeze. To meet the reduced appropriation, the Department of Health Care Policy and Financing reduced client payments by 33% for the months of April, May, and June 2003. Additionally, the Department of Human Services (which issues the Home Care Allowance payments) identified expungements (uncashed checks) that had been credited to their programs. A portion of these expungements for FY 02-03 totaling $258,779 belonged to the Department of Health Care Policy and Financing. These were credited back to the program's appropriation in the Colorado Financial Reporting System during Period 13. Due to the reduction in payments to clients and the credited expungements, $474,041 of the appropriation went unspent.

As a result of further budget balancing reductions for FY 03-04, the Home Care Allowance program was reduced by another $315,000 as follows: $300,000 General Fund, and $15,000 in county funds (March 13, 2003 Figure Setting document, page 155). With this adjustment, the FY 03-04 Long Bill appropriation was $12,712,406.

The enrollment cap instituted in FY 02-03 caused caseload to decline faster than initially anticipated. As a result, the Department requested a reduction to the FY 03-04 Long Bill appropriation in the January 2, 2004 Supplemental S-7 entitled "Decrease Appropriation for Adult Foster Care and Home Care Allowance for Caseload." The FY 03-04 Supplemental Bill (HB 04-1320) reduced the appropriation by $1,831,995. On page 31 of the Joint Budget Committee staff's Supplemental document dated January 21, 2004, the final FY 03-04 appropriation of $10,880,411 was calculated using an average enrollment of 4,087 clients and an average monthly payment per client of $221.85.

In the November 3, 2003 Budget Request, the Department submitted a Base Reduction Item BRI-2, entitled "Targeted Base Review – Home Care Allowance and Adult Foster Care Reduction for Caseload" to reduce the appropriation for FY 04-05 to $8,568,604. This was due to the continuing decline in caseload. However, the request was denied due to concerns related to the Maintenance of Effort agreement the State has with the federal Social Security Administration which requires the State to maintain spending levels on Supplemental Security Income clients on a calendar year basis. Failure to meet the Maintenance of Effort agreement would risk the federal match for all Medicaid programs. For this reason, the FY 04-05 appropriation was left unchanged at $10,880,411 (March 9, 2004 Figure Setting, page 142).

As a result of the FY 04-05 appropriation, the Department lifted the enrollment cap effective September 2004. It was anticipated that enrollment growth alone would be insufficient to fully expend the appropriation by the end of the fiscal year. Consequently, in addition to removing the enrollment cap, the Department increased the Home Care Allowance payments by $36.15 per member per month beginning in December 2004. Unfortunately, due to the conversion to the Colorado Benefits Management System, the Department of Human Services was unable to report enrollment and expenditure data from September 2004 through February of 2005. When reporting was resumed it was discovered that enrollment in the Home Care Allowance Program had not grown as fast as anticipated, thus causing a reversion in FY 04-05.

FY 05-06 was appropriated at continuation funding of $10,880,411. Actual expenditures for clients during the year equaled $9,967,297 including the 5% local cost sharing. However, due to an internal transfer of General Fund to the Medical Services Premiums Long Bill group, authorized as part of the Governor's annual transfer authority, this appropriation was only $153,256 underspent at year-end.

The FY 06-07 Long Bill appropriation was set at continuation funding from the FY 05-06. However, SB 06-219 eliminated this line for both FY 06-07 and future years. Administrative responsibilities are now transferred to the Department of Human Services.

Line Item: Home Care Allowance	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation / Request	**$15,391,151**	**$13,027,406**	**$10,880,411**	**$10,880,411**	**$10,880,411**	**$0**
Budget Balancing - Figure Setting, March 13, 2003, page 155	$0	($315,000)	$0	$0	$0	$0
Long Bill Appropriation / Request	**$15,391,151**	**$12,712,406**	**$10,880,411**	**$10,880,411**	**$10,880,411**	**$0**
Supplemental SB 03-203	($2,363,745	$0	$0	$0	$0	$0
Supplemental HB 04-1320	$0	($1,831,995)	$0	$0	$0	$0
Reorganization of programs administered by the Department per SB 06-219	$0	$0	$0	$0	($10,880,411)	$0
Final Appropriation / Request	**$13,027,406**	**$10,880,411**	**$10,880,411**	**$10,880,411**	**$0**	**$0**
General Fund	$12,376,035	$10,336,390	$10,336,390	$10,336,390	$0	$0
Cash Funds Exempt	$651,371	$544,021	$544,021	$544,021	$0	$0

The table below delineates historical caseload and expenditures through FY 05-06 which is the last year this appropriation will appear in the Department's budget.

Line Item: Home Care Allowance	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06 [40]
Caseload	5,852	5,757	5,642	5,060	4,052	3,461	3,428
Average Monthly Payment	$223.72	$226.52	$226.35	$206.74	$215.32	$253.07	$242.30
Total Actual Expenditures	$15,710,439	$15,648,677	$15,324,294	$12,553,365	$10,469,481	$10,510,584	$9,967,297

ADULT FOSTER CARE

Adult Foster Care was first authorized in 1977 by Section 26-2-122.3 C.R.S. (2006). It is a non-federally funded program providing 24 hour supervised residential non-medical supervision for adults. Services include room and board, recreational activities, supervision of medications, protective oversight and some assistance with activities of daily living. The client's own income (less $50 for personal needs) covers the cost of the room and board. The State pays for the cost of services. The services amount is added to the clients' cash benefit check to make up the difference between the client's income and the Adult Foster Care rate.

Generally, clients receiving Adult Foster Care also receive either Supplemental Security Income or Old Age Pension. The only additional requirement is that the client meets the appropriate placement screening as determined by a Single Entry Point case manager. A county eligibility technician determines financial eligibility for Adult Foster Care clients.

The funding split calculation for Adult Foster Care is 95% General Fund and 5% local matching funds. However, statute contains a hold harmless provision for counties in which their annual increase for a program area cannot exceed 5% over the prior year. Section 25.5-6-107, C.R.S. (2006) provides that the local funding match is calculated as the lower of either the prior year local match times 5% or the base recommendation times 5%.

The Adult Foster Care caseload has been in a steady decline since FY 99-00. This is due to most clients moving to alternative care facilities, where the reimbursement rate is higher than it is for Adult Foster Care. Because of the declining caseload, the Department has submitted numerous negative Change Requests in recent years. On January 2, 2002, the Department submitted a negative Supplemental S-19 entitled "Reduce Adult Foster Care to Reflect Expected Utilization" which resulted in a $119,660 reduction to the FY 01-02 budget. The resulting appropriation of $243,810 was carried forward into the FY 02-03 Long Bill (HB 02-1420) and into

[40] In FY 05-06 the Governor used his transfer authority to transfer $759,858 of spending authority that would have been reverted from Home Care Allowance into Medicaid Mental Health Community Programs, Capitation Payments to avert an overexpenditure in that budget line.

the FY 03-04 Long Bill (SB 03-258). On January 2, 2004, the Department submitted another negative Supplemental S-7 entitled "Decrease Appropriation for Adult Foster Care and Home Care Allowance for Caseload" which resulted in an $86,341 reduction to the FY 03-04 budget. The final FY 03-04 appropriation was $157,469.

In the November 3, 2003 Budget Request, the Department submitted a Base Reduction Item BRI-2 entitled "Targeted Base Review – Home Care Allowance and Adult Foster Care Reduction for Caseload" to reduce the appropriation for FY 04-05 to $121,311 due to the continuing decline in caseload. However, the request was denied due to concerns related to the Maintenance of Effort agreement the State has with the federal Social Security Administration which requires the State to maintain spending levels on Supplemental Security Income clients on a calendar year basis. Failure to meet the Maintenance of Effort agreement would risk the federal match for all Medicaid programs. For this reason, the FY 04-05 appropriation was left unchanged at $157,469 (March 9, 2004 Figure Setting, page 144).

In an effort to manage the FY 04-05 appropriation the Department increased Adult Foster Care payments by $70.69 per member per month beginning in December, 2004. Unfortunately, due to conversion to the Colorado Benefits Management System, the Department of Human Services was unable to report enrollment and expenditure data from September 2004 through February of 2005. When reporting was resumed it was discovered that enrollment had continued to decline despite the increase in payments, thus causing a reversion in FY 04-05.

The FY 06-07 Long Bill appropriation was set at the same level as appropriated in FY 05-06, which was equal to the amount in the FY 04-05 Long Bill. However, SB 06-219 eliminated this line in the Department's FY 06-07 budget and for future years, and transferred funding and administration to the Department of Human Services.

Line Item: Adult Foster Care	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation / Request	**$243,809**	**$243,810**	**$157,469**	**$157,469**	**$157,469**	**$0**
Supplemental HB 04-1320	$0	($86,341)	$0	$0	$0	$0
Long Bill Appropriation / Request	**$243,810**	**$157,469**	**$157,469**	**$157,469**	**$157,469**	**$0**
Reorganization of programs administered by the Department per SB 06-219	$0	$0	$0	$0	($157,469)	$0
Final Appropriation / Request	**$243,810**	**$157,469**	**$157,469**	**$157,469**	**$0**	**$0**
General Fund	$231,620	$149,596	$149,596	$149,596	$0	$0
Cash Funds Exempt	$12,190	$7,873	$7,873	$7,873	$0	$0

The table below delineates historical caseload and expenditures through FY 05-06, which is the last year this appropriation will appear in the Department's budget.

Line Item: Adult Foster Care	**FY 99-00**	**FY 00-01**	**FY 01-02**	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**
Caseload	165	122	87	73	57		23
Average Monthly Payment	$218.92	$222.23	$224.66	$219.52	$227.93	$377.72	$297.21
Total Actual Expenditures	$433,459	$325,350	$234,541	$192,296	$155,902	$122,382	$82,029

UNIVERSITY OF COLORADO FAMILY MEDICINE RESIDENCY TRAINING PROGRAM

The University of Colorado Family Medicine Residency Training Programs line item provides payments to hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The Advisory Commission on Family Medicine at the Department of Higher Education, Health Sciences Center administers the program. Before FY 94-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education. Starting in FY 94-95, the majority of the program's funding was financed with a fund split of 50% General Fund and 50% federal funds. This new funding split was due to federal regulations allowing Medicaid financial participation for the payments to the hospitals enrolled in the program. Since federal Medicaid funds were involved, a line item appropriation to the Department of Health Care Policy and Financing was established. There are currently nine hospitals participating in the program.

In late FY 02-03, the federal government increased the federal share of Medicaid expenditures, or the federal medical assistance percentage, by 2.95%. This increase in federal funding affected only the fourth quarter claims for the year (and all quarters in the following year). In FY 03-04, funding for this line item was reduced by a Joint Budget Committee action to decrease General Fund by 20% for budget balancing. Beginning with the initial Department's November 1, 2002 request of $1,905,782, the 20% reduction of $381,156 resulted in a final FY 03-04 appropriation of $1,524,626.

In FY 04-05, a Non-Prioritized Decision Item and a Joint Budget Committee recommendation resulted in a net reduction to the previous fiscal year's final appropriation of $1,524,626. The FY 04-05 appropriation was first increased by approval of a Non-Prioritized Decision Item, NP-11 "Leveraging Additional Federal Medicaid Funds" from the November 1, 2003 Budget Request. This Decision Item requested permission for the State to leverage $42,934 in additional federal funds by transferring expenses from the Commission on Family Medicine to this line item for a total fund increase of $85,868. However, this increase was countered by a Joint Budget Committee recommendation to reduce the program by 10%, or $161,050 in total funds, decreased the final total appropriation to $1,449,444.

For FY 05-06, the Joint Budget Committee recommended and the General Assembly approved an increase in funding of $127,058. In June 2005, the Colorado Springs family medicine residency training program was closed. That residency program, which received $127,058 in State funds in FY 04-05, was not connected to a hospital and did not receive matching federal funds and was funded entirely by indirect cost savings in the Department of Higher Education. The FY 05-06 appropriation reallocated $63,529 of the State funding from the Colorado Springs residency program to the other nine family residency programs as General Fund. The remaining residency programs are connected to hospitals and qualify for Medicaid funding, so the General Fund increase is matched by federal funds. The State received a General Fund savings of $63,529 by redirecting the remaining indirect cost recoveries to other General Fund programs. Total funding for this line item for FY 05-06 was $1,576,502.

In FY 06-07, a Non-Prioritized Decision Item and a Joint Budget Committee recommendation increased the previous fiscal year appropriation of $1,576,502. Non-Prioritized Decision Item, NP-1 entitled "Leveraging Additional Federal Matching Funds" reallocated $63,528 in General Fund savings from FY 05-06 that resulted from the closure of the Colorado Springs family medicine residency program back into the remaining nine residency programs. The existing residency programs are eligible for Medicaid funding and draw matching federal funds, for a total fund increase of $127,056. Total funding for this line item for FY 06-07 is therefore $1,703,558.

The Department's FY 07-08 Base Request is for continuation funding of $1,703,558. The following table details the funding history for the University of Colorado Family Medicine Residency Training Programs.

Line Item: University of Colorado Family Medicine Residency Training Programs	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Previous Fiscal Year Final Appropriation	**$2,117,536**	**$1,905,782**	**$1,524,626**	**$1,449,444**	**$1,576,502**	**$1,703,558**
FY 03-04 Joint Budget Committee Recommendation	$0	($381,156)	$0	$0	$0	$0
FY 04-05 Non Prioritized Decision Item #11 "Leveraging Additional Federal Medicaid Funds"	$0	$0	$85,868	$0	$0	$0
FY 04-05 Joint Budget Committee Recommendation	$0	$0	($161,050)	$0	$0	$0
FY 05-06 Joint Budget Committee Recommendation	$0	$0	$0	$127,058	$0	$0

Line Item: University of Colorado Family Medicine Residency Training Programs	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
FY 06-07 Non Prioritized Decision Item #1 "Leveraging Additional Federal Matching Funds"	$0	$0	$0	$0	$127,056	$0
Long Bill Appropriation / Request	**$2,117,536**	**$1,524,626**	**$1,449,444**	**$1,576,502**	**$1,703,558**	**$1,703,558**
Supplemental #28	($211,754)	$0	$0	$0	$0	$0
Final Appropriation / Request	**$1,905,782**	**$1,524,626**	**$1,449,444**	**$1,576,502**	**$1,703,558**	**$1,703,558**
General Fund	**$**952,891	$762,313	$724,722	$788,251	$851,779	$851,779
Federal Fund	$952,891	$762,313	$724,722	$788,251	$851,779	$851,779

ENHANCED PRENATAL CARE TRAINING AND TECHNICAL ASSISTANCE

The Enhanced Prenatal Care Training and Technical Assistance program provides case management, nutrition, and mental health counseling to the Medicaid-eligible pregnant women in Colorado who are assessed to be at high risk for delivering low birth weight infants (5 pounds, 8 ounces or less). These services complement medical prenatal care by addressing the lifestyle, behavioral, and non-medical aspect of a woman's life likely to affect her pregnancy. The Enhanced Prenatal Care program has been effective at increasing the number of women who stop smoking, gain an adequate amount of weight, and resolve psychosocial problems, and have decreased the number of infants who are born at low birth weight.

The program provides care to approximately 21,000 women each year and seven out of every ten Medicaid clients have risks that qualify them for the Enhanced Prenatal Care Program[41]. Enhanced prenatal services are provided at county health departments, county nursing services, community health centers, and private nonprofit agencies. The sites are visited by the Department of Public Health and Environment on a three-year rotation with a mail-in audit chart required every other year. The sites are required to submit a plan addressing identified concerns to the program coordinator and correct any deficiencies.

The Department approved a change in Medicaid reimbursement for the Enhanced Prenatal Care Training and Technical Assistance services effective July 1, 2004. The new Medicaid reimbursement structure pays more for model care, services that provide the best health outcomes for pregnant women and their infants. The new reimbursement structure also encourages early enrollment of women to reduce pregnancy risk factors.

[41] Prenatal Plus Program, 2004 Annual Report, page 3

The FY 02-03 Long Bill (HB 02-1420) appropriation was $163,852. This represented a decrease of $23,141 from the FY 01-02 final appropriation of $186,993. This reduction was the result of a decrease in the costs associated with the Department's Integrated Registration and Information Systems. This was in accordance with Joint Budget Committee approval of the Department of Public Health and Environment's Decision Item for Operating Expenses (Department of Public Health and Environment's Figure Setting, March 11, 2002, page 109).

For FY 03-04, the Long Bill appropriation was $109,110. This appropriation was due to further reductions from budget balancing of $8,032 total funds, program annualization reduction of $45,622 total funds, and the pay date shift of $1,088 total funds. The $45,622 total funds reduction was in accordance with Joint Budget Committee approval of the Department of Public Health and Environment's Decision Item #6 during Figure Setting (March 11, 2002, page 65).

For FY 04-05, the Department of Public Health and Environment calculated the base request including a decrease of $110 for the Health Statistics and Vital Records budget line not implemented in FY 03-04; a decrease of $34 related to Women's Health Personal Services as part of the Office of State Planning and Budget's 0.2% reduction; a reduction of $577 for Information Technology services; and, a decrease of $6,043 indirect costs associated with the Health Promotion and Disease Prevention program.

These reductions resulted in the FY 04-05 Long Bill appropriation of $102,346. All funds transferred from the Department to the Department of Public Health and Environment are in the form of Cash Funds Exempt. For the FY 05-06 Long Bill, the FY 06-07 Long Bill and the FY 07-08 Base Request, continuation funding has been appropriated/requested.

Within the Department of Public Health and Environment, the $102,346 transferred is spread across a number of different lines. This includes $3,550 for the Health Statistics and Vital Records, $15,145 for Information Technology Services, $1,602 for Prevention Services Division, and $82,049 in the Women's Health.

The following table presents the changes in the funding from FY 02-03 to the FY 07-08 Base Request:

Line Item: Enhanced Prenatal Care Training Program	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Final Appropriation from Previous Fiscal Year	**$186,993**	**$154,732**	**$109,110**	**$102,346**	**$102,346**	**$102,346**
Adjustment for HCPF's Integrated Registration and Information System	($23,141)	$0	$0	$0	$0	$0
Program Annualization Reduction	$0	($45,622)	$0	$0	$0	$0
Health Statistics and Vital Records reduction (Medicaid reduction not implemented in FY 03-04)	$0	$0	($110)	$0	$0	$0

Line Item: Enhanced Prenatal Care Training Program	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Women's Health, Personal Services OSPB 0.2% Reduction	$0	$0	($34)	$0	$0	$0
Health Promotion and Disease Prevention, Indirect Correction	$0	$0	($6,043)	$0	$0	$0
Reduction to Information Technology Services	$0	$0	($577)	$0	$0	$0
Long Bill Appropriation / Request	**$163,852**	**$109,110**	**$102,346**	**$102,346**	**$102,346**	**$102,346**
SB 03-197	($1,088)	$0	$0	$0	$0	$0
SB 03-203	($8032)	$0	$0	$0	$0	$0
Final Appropriation / Request	**$154,732**	**$109,110**	**$102,346**	**$102,346**	**$102,346**	**$102,346**
General Fund	$77,366	$54,555	$51,173	$51,173	$51,173	$51,173
Federal Funds	$77,366	$54,555	$51,173	$51,173	$51,173	$51,173

NURSE HOME VISITOR PROGRAM

With the passage of SB 00-71, the General Assembly created the Colorado Nurse Home Visitor Program. Funded with a portion of the money the State receives under the Tobacco Master Settlement Agreement. The program offers regular home visits by specially trained nurses to first-time, low-income mothers during their pregnancies, and provides assistance to an individual woman and her baby through the child's second birthday. A woman is eligible to enter the program if she is pregnant with her first child or first baby is less than one month old, and her gross annual income is less than 200% of the federal poverty level. This is a voluntary program, as the mother must consent to receiving services. According to statute, the overall goal of the program is to serve all low-income, first-time mothers who want to participate by the year 2010 (Performance Audit, May 2006, Pacey Economics Group Boulder, CO, page 7).

Shortly after implementation in 2000, the Department of Public Health and Environment began investigating the possibility of obtaining federal Medicaid matching funds using Tobacco Master Settlement Agreement funds as the State match for the Nurse Home Visitor Program. The Tobacco Master Settlement Agreement was established to resolve all past, present, and future tobacco-related health claims at the state level. Colorado is scheduled to receive annual Tobacco Master Settlement Agreement monies for an estimated period of 25 years or more. Accordingly, the Department of Public Health and Environment, working with the Department of Health Care Policy and Financing, researched the possible ways through which federal Medicaid funding could be obtained. Based upon this research, 60% of the program clients were eligible for Medicaid and 79% of the services that the nurses provided qualified for Medicaid reimbursement as targeted case management services. As a result, it was determined that federal Medicaid match could be claimed for the services that the nurses provided to those clients who were Medicaid eligible. By utilizing the additional federal

Medicaid funding, the Department of Public Health and Environment expanded the number of clients served by the program without increasing State funds.

During the FY 02-03 Figure Setting process, the Colorado Department of Public Health and Environment's Decision Item, DI-12 was approved by the Joint Budget Committee allowing an increase in the number of people served by the Program, which had previously operated solely on Tobacco Master Settlement Agreement funds. However, an oversight during the Figure Setting process for the Department of Health Care Policy and Financing failed to increase the spending authority in the Long Bill (HB 02-1420), and the financing was unable to proceed.

To correct this situation, a FY 02-03 Supplemental and FY 03-04 Budget Amendment request was submitted on January 2, 2003 (NP-S6, NP-B1) to fund $124,000 in FY 02-03 for program implementation and computer development for the Medicaid Management Information System contract, and $3,009,618 at a 50% federal match in FY 03-04 for Medicaid services in this line item. The Supplemental Request and Budget Amendment were both approved by the General Assembly.

There were no expenditures against this line item in FY 03-04. However, the Department did a retroactive federal draw for the Medicaid federal share of Nurse Home Visitor claims that could have been charged to this line item with dates of service in the first two quarters of FY 03-04, but these funds were reverted to the General Fund. In addition, in February 2004, the Department did a retroactive claim for Medicaid related Nurse Home Visitor services back to the federal fiscal quarter that began January 1, 2002. These funds also reverted to the General Fund in FY 03-04. By July 1, 2004, system changes were completed, and services are now billed through the Medicaid Management Information System. For FY 04-05, the Department requested an appropriation of $3,009,618. The Joint Budget Committee added a technical adjustment of $382 for Common Policies for a final appropriation of $3,010,000.

In FY 05-06, the accounting and budgeting for the Nurse Home Visitor Program line was changed to a cash basis, reducing the FY 05-06 appropriation to $2,778,972, resulting in a savings of $231,028. However, this was a one-time reduction, and the FY 06-07 appropriation was returned to $3,010,000 in HB 06-1385. Continuation funding is being requested for FY 07-08.

The Department of Public Health and Environment is responsible for the administration of this program. See the Department of Public Health and Environment Budget Request for justification and calculations regarding the final request. The federal financial participation for this line item is 50%.

The following table presents the changes in the Program from FY 03-04 to the FY 07-08 Base Request:

Line Item: Nurse Home Visitor Program	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Previous Fiscal Year Final Appropriation	**$0**	**$3,009,618**	**$3,009,618**	**$3,010,000**	**$2,778,972**	**$3,010,000**
Joint Budget Committee Technical Adjustment	$0	$0	$382	$0	$0	$0
Reversal of SB 06-129 (Cash Accounting Bill)	$0	$0	$0	$0	$231,028	$0
Long Bill Appropriation / Request	**$0**	**$3,009,618**	**$3,010,000**	**$3,010,000**	**$3,010,000**	**$3,010,000**
FY 02-03 Supplemental	$3,009,618	$0	$0	$0	$0	$0
SB 06-129 (Cash Accounting Bill)	$0	$0	$0	($231,028)	$0	$0
Final Appropriation / Request	**$3,009,618**	**$3,009,618**	**$3,010,000**	**$2,778,972**	**$3,010,000**	**$3,010,000**
Cash Funds Exempt	$1,504,809	$1,504,809	$1,505,000	$1,389,486	$1,505,000	$1,505,000
Federal Funds	$1,504,809	$1,504,809	$1,505,000	$1,389,486	$1,505,000	$1,505,000

STATE NURSING FACILITY SERVICE PROGRAM

The State Nursing Facility Service Program was never implemented. SB 03-176, passed on March 5, 2003, aimed to eliminate optional legal immigrants as eligible for Medicaid services. This action left a gap in care for a fragile population with high costs in nursing facilities. The General Assembly, with the passage of SB 03-266, provided a financing mechanism to operate a grant program to address this group's medical care. The State Nursing Facility Service Program was for those legal immigrants enrolled in the Medicaid nursing facility program as of March 5, 2003. There was no federal match for the program because the clients were not eligible for Medicaid.

The FY 03-04 appropriation of $5,258,508, established in SB 03-266, was not spent, as SB 03-176 was not implemented in FY 03-04 due to legal appeals and a court-ordered stay. During this time, the population was still eligible under Medicaid due to the court ordered stay. HB 04-1415 repealed section two of 26-4-410.2 C.R.S., (2006) which discussed funding the program through provider fees. HB 04-1415 also set the appropriation for FY 04-05 for the State Nursing Facility Service Program to be $838,528 of General Fund (see Figure Setting page 155, March 9, 2004). HB 05-1086 (Legal Immigrants Bill) eliminated the appropriations. The initial FY 04-05 appropriation was based on implementing the program in January 2005. The FY 05-06 Base Request of $1,157,225 was based on the fiscal note for HB 04-1415, which increased the appropriation by $318,697. There was no request for FY 06-07 and none for FY 07-08.

Line Item: Nursing Facility Service Program	FY 03-04	FY 04-05	FY 05-06
Previous Fiscal Year Final Appropriation	**$0**	**$0**	**$0**
Long Bill Appropriation / Request	**$0**	**$0**	**$0**
SB 03-266 Nursing Facility Provider Fees & Program	$5,258,508	$0	$0
HB 04-1422 Long Bill Add On	($5,258,508)	$0	$0
HB 04-1415 Reimbursement of Nursing Facilities	$0	$838,528	$1,157,225
HB 05-1086 Legal Immigrants Bill	$0	($838,528)	($1,157,225)
Total Appropriation / Request	**$0**	**$0**	**$0**

COLORADO AUTISM TREATMENT FUND

The Colorado Autism Treatment Fund was created in 2004 with the passage of SB 04-177. The primary purpose of the fund is to allow children diagnosed with autism who are in danger of being institutionalized to stay home and receive appropriate services. The appropriation represents the State's share of expenditures for the Home and Community Based Services for Children with Autism (HCBS-CWA) waiver that is matched dollar-for-dollar by the federal government through Title XIX of the federal Social Security Act. The money appropriated to the fund comes from the Tobacco Master Settlement Agreement in the form of Cash Funds Exempt. Per 26-4-695, C.R.S., (2006) the Colorado Autism Treatment Fund can be appropriated 15% of the total yearly Tobacco Master Settlement Agreement distribution up to a $1 million cap. Money appropriated to the Colorado Autism Treatment Fund that is not spent at the end of the fiscal year may be invested by the State Treasurer as provided by law, so long as all interest and income derived from those investments is credited back to the fund. The Colorado Autism Treatment Fund allocates its money among several Executive Director's Office line items as well as the Medical Services Premiums line.

Home and Community Based Services for Children with Autism is a waiver for children aged 0 to 6 years old that have been diagnosed with autism. The services that may be provided by the fund are considered behavior therapies. The amount given for the care of any individual child may not exceed $25,000, and the term of care can be no longer than three years, unless the Department of Health Care Policy and Financing grants an optional one year extension.

The Department received federal approval for the program on December 23, 2005. Expenditures from the Colorado Autism Treatment Fund in FY 05-06 were administrative costs that included salary and operating expenses associated with a FTE to be hired to research and write the waiver proposal and manage the program. Per SB 05-209, the FY 05-06 appropriation was $395,143.

Beginning in FY 06-07, there is no longer an appropriation in the Department's budget denoting the amount to be deposited in the Fund. Based on a Joint Budget Committee action during the Department's Figure Setting session on March 13, 2006, this double

counting of funds was eliminated (page 223, Figure Setting Document from March 13, 2006). This appropriation was removed as the Committee noted that the line item does not describe an expenditure, but rather a revenue transfer and does not belong in the Long Bill.

The Department completed full implementation of the program in October 2006, which includes 75 children enrolled in the Home and Community Based Services for Children with Autism waiver. Twenty-five of these children are from the wait lists of the Children's Home and Community Based Services and Children's Extensive Support waivers at a cost of $25,000 per child. Another 25 children are from children already enrolled in the Children's Home and Community Based Services and Children's Extensive Support waivers at a cost of $6,374 per child. The remaining 25 children are from Medicaid through the Supplemental Security Income (SSI) Disabled list at an additional cost of $12,226 per child. Medicaid provides roughly $12,774 per child in aid for these services. Note that additional costs associated with children from the other programs bring the amount of aid to each child for services up to the State limit of $25,000.

Future funding for the Home and Community Based Services for Children with Autism will come from the Tobacco Master Settlement Agreement. The funds available, as described above, can be up to 15% of the Tobacco Master Settlement distribution or $1 million, whichever is less.

Line Item: Colorado Autism Treatment Fund Appropriation History	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Previous Fiscal Year Final Appropriation	**$0**	**$395,143**	**$0**
Joint Budget Committee Action to remove appropriation	$0	($395,143)	$0
Long Bill Appropriation / Request	**$395,143**	**$0**	**$0**
Total Appropriation/Request	**$395,143**	**$0**	**$0**
Cash Funds Exempt	$395,143	$0	$0

SB 97-101 PUBLIC SCHOOL HEALTH SERVICES

Public School Health Services began in 1997 with the passage of SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike other programs, the Public School Health Services program does not use General Fund dollars as a source of funds. Instead, the State can recognize expenditures at the school level for Medicaid-eligible children, which, when certified as public expenditures, can be matched by the federal government through Title XIX of the federal Social Security Act. It is important to note that 70% of the

matched funds spent in this program must help expand health services for all children; the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

Administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing and the Department of Education through an Interagency Agreement. The Department of Health Care Policy and Financing pays for claims processing through the Medicaid Management Information System and Personal Services. The Department of Education provides schools with technical assistance, reviews and receives all the local plans, conducts on-site reviews, submits annual reports, and pays for additional personnel. The costs incurred by the two departments are deducted from the federal match funds.

In SB 97-101, the greater of $200,000 or 2% of the total amount of money spent by the program is given to the departments for administrative expenses. Reductions to the Personal Service, Medical Programs Administration, and Medicaid Management Information Systems were recommended by the Joint Budget Committee in 2001 because the Department exceeded its spending limitations by more than 140%. To alleviate the strain on these departments, HB 01-1199 was passed and increased the State's administrative funding from 2% to 10% of the total amount of funds expended.

The Long Bill appropriation for FY 02-03 was $17,452,488. The appropriation consisted of $8,927,163 in Cash Funds Exempt funding from certification of public expenditures and $8,525,325 in federal funds. The appropriation for any given year is net of the administrative costs expected in that fiscal year. In FY 02-03, for instance, the anticipated amount of the total appropriation was $17,854,326, but $401,838 was taken "off the top" of the federal funds match for administrative expenses. The General Assembly approved Supplemental S-14 in the January 2, 2003 Request that increased the appropriation by $5,116,378 to a total of $22,568,866 for services (SB 03-203). The Supplemental Request was based on the average growth rate for expenditures from FY 00-01 to FY 01-02 equal to 24%. It should be noted that later in FY 02-03, the federal government increased the federal medical assistance percentage by 2.95% but only for the fourth quarter. This increase was budget neutral due to the fact that the increase in federal funds was offset by a reduction in the Cash Funds Exempt provided by the school districts. Essentially, the only effect of the increased federal contribution was a change in the fund split within Public School Health Services.

The Long Bill appropriation in FY 03-04 was $29,717,200 which had $15,131,305 Cash Funds Exempt and $14,585,895 in federal funds. This new amount included an increase in anticipated certified public expenditures with corresponding federal matching funds of $7,291,906. Administrative costs, however, also increased from $401,838 to $545,410. The Department of Education issued a memorandum to the Joint Budget Committee requesting additional funding of $88,131 in FY 03-04 to increase staffing, hire consultant services, and train school districts. This request increased their administrative funding from $91,339 to $179,470 in FY 03-04 with the passage of SB 03-258. Again, because administrative expenses are taken "off the top," the Long Bill appropriation is net of the Department of Education's request.

In FY 04-05, the Long Bill appropriation was for continuation funding for FY 03-04. The Department's Supplemental Bill, SB 05-112 included an additional amount of $88,301 to Public School Health Services, as a lower claims volume of school based claims were running through the Medicaid Management Information System. The final appropriation for FY 04-05 was $29,805,501.
Both FY 03-04 and FY 04-05 under spent their appropriations by a substantial margin. Possible explanations for the gap between actual expenditures and the appropriated amounts could be:

- Changes in Claiming Patterns – A revision to the guidelines for school based claims caused fewer claims to be filed by the school districts. In fact, the Department estimates that in some districts claims dropped by approximately 30%. Even though the guidelines caused some districts to submit more claims, the overall effect was negative.
- Implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was complicated due to the fact that all claims codes were changed.

The FY 05-06 Long Bill appropriation included minor adjustments to the amount transferred to the Department of Education and internal administration amounts in Personal Services and the Medicaid Management Information Systems. The appropriation received additional funds this year from HB 05-1262 (Tobacco Tax Bill) which expanded the slots available for the Children's Extensive Support waiver program by 15 and Children's Home and Community Based Services waiver program by 110 (see FY 06-07 Figure Setting, March 13, 2006, page 220). The Children's Extensive Support and the Children's Home and Community Based Services programs are eligible to receive tobacco tax money through the Health Care Expansion Fund. The additional funds totaled $1,385,188 with Children's Home and Community Based Services receiving $1,250,246 and the Children's Extensive Support waiver receiving the remaining ($134,942). Medicaid Management Information Systems funding also decreased from $273,250 to $193,022, and Personal Services was reduced from $95,212 to $85,776[42]. With the tobacco tax moneys included, the appropriation for FY 05-06 was $31,188,052. This amount was adjusted by SB 06-129 as a one time charge of $5,412,313 decreased the appropriation to $25,775,739 in order to switch to a cash-based accounting system. Finally, HB 06-1217 decreased the appropriation another $4,698 in order to reconcile the Long Bill appropriations between the Department of Education and the Department of Health Care Policy and Financing. After all adjustments, the final appropriation for FY 05-06 was $25,771,041.

The Long Bill appropriation for FY 06-07 is $31,535,961 per HB 06-1385. The funding splits are $16,007,021 Cash Funds Exempt and $15,528,940 federal funds. It is expected that costs for the Department and the Department of Education will remain the same. However, with the additional tobacco tax funding added to this line, fund splits are now roughly 50% Cash Funds Exempt and 50% federal matching funds.

[42] Note that these numbers are administrative costs and taken "off-the-top" of the appropriation. Because of this, the amount allocated to each of these line items in subtracted from the total appropriation.

In FY 07-08, the Department expects that Public School Health Services will require a minor adjustment to the Base Request due to an increase in operating costs. The November 15, 2005 Budget Request allocated $1,478 to the Executive Director's Office for operating expenses when actual operating expenditures are anticipated to be $2,500. The difference of $972 is to be paid with federal funds by transferring the amount from the Public School Health Services to the Executive Director's Office as additional administrative costs. The Department anticipates $32,014,041 in certified public health expenditures and federal matching funds in FY 07-08, as well as $479,052 in total administrative costs. The final appropriation is therefore expected to be $31,534,989, comprised of $16,007,021 Cash Funds Exempt and $15,527,968 in federal matching funds.

Line Item: Public School Health Services	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Appropriation (includes removal of Administration)	**N/A**	**$22,568,866**	**$29,717,200**	**$29,805,501**	**$25,771,041**	**$31,535,961**
Remove Reduction for Prior Year Administration	N/A	$401,838	$545,410	$545,410	$459,746	$478,080
Removal of Administration Appropriated in Prior Year Supplemental Bill	$0	$0	$0	($88,301)	$4,698	$0
Adjustment for Anticipated Additional Claims	N/A	$7,291,906	$0	$0	$0	$0
Reverse SB 06-129 Cash Accounting Bill Impact (one-time only)	N/A	$0	$0	$0	$5,412,313	$0
Anticipated Certified Public Expenditures and Federal Match	$17,854,326	$30,262,610	$30,262,610	$30,262,610	$31,647,798	$32,014,041
Reductions for Administration						
Personal Services	($282,801)	($91,212)	($91,212)	($85,776)	($99,060)	($99,060)
Operating	$0	($1,478)	($1,478)	($1,478)	($1,478)	($1,478)
Medicaid Management Information System	($119,037)	($273,250)	($273,250)	($193,022)	($193,022)	($193,022)
Transfer to Department of Education	$0	($179,470)	($179,470)	($179,470)	($184,520)	($184,520)
Adjustment to Operating Expenditures	$0	$0	$0	$0	$0	($972)
Total Reduction of Federal Funds for Administration	*($401,838)*	*($545,410)*	*($545,410)*	*($459,746)*	*($478,080)*	*($479,052)*

Line Item: Public School Health Services	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
JBC Staff Initiated Caseload Recommendation (increased Children's Home and Community Based Services and Children's Extensive Support Waiver slots by 110 and 15 respectively)	$0	$0	$0	$0	$164,535	$0
HB 05-1262 Children's Extensive Support Waiting List Buy-Down (and out-year)	$0	$0	$0	$0	$27,516	$0
HB 05-1262 Home and Community Based Services Waiting List Buy-Down (and out-year)	$0	$0	$0	$0	$174,192	$0
Long Bill Appropriation / Request	**$17,452,488**	**$29,717,200**	**$29,717,200**	**$29,802,864**	**$31,535,931**	**$31,534,989**
Supplemental Bill (SB 03-203) for Additional Claims	$5,116,378	$0	$0	$0	$0	$0
Supplemental Bill (SB 05-112) for MMIS Claims	$0	$0	$88,301	$0	$0	$0
Supplemental Bill (HB 06-1217) for true-up of Long Bill between Department of Education and the Department	$0	$0	$0	($4,698)	$0	$0
HB 05-1262 Children's Extensive Support Waiting List Buy-Down (and out-year)	$0	$0	$0	$134,942	$0	$0
HB 05-1262 Home and Community Based Services Waiting List Buy-Down (and out-year)	$0	$0	$0	$1,250,246	$0	$0
SB 06-129 Cash Accounting Bill	$0	$0	$0	($5,412,313)	$0	$0
Final Appropriation/Request	**$22,568,866**	**$29,717,200**	**$29,805,501**	**$25,771,041**	**$31,535,961**	**$31,534,989**
Cash Funds Exempt	$11,485,352	$15,131,305	$15,131,305	$13,117,743	$16,007,021	$16,007,021
Federal Funds	$11,083,514	$14,585,895	$14,674,196	$12,653,298	$15,528,940	$15,527,968

MEDICARE MODERNIZATION ACT OF 2003 STATE CONTRIBUTION PAYMENT

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Part D prescription drug benefit, replacing Medicaid prescription drug coverage for clients dually eligible for both Medicare and Medicaid benefits. In lieu of the states' obligation to cover prescription drugs for this population, the federal Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been, had this cost shift not occurred. For calendar year 2006, states are to pay 90% of the federal portion of their average dual eligible drug benefit from calendar year 2003, inflated to 2006 using the National Healthcare Expenditure average growth rate. As each calendar year passes, the 90% factor is reduced by 1.67% each year, until it reaches 75%, where it will remain at 2015 on a go-forward basis.

During the Department's FY 05-06 Figure Setting on March 15, 2005, the Joint Budget Committee approved staff recommendation for $30,984,982 in the Medical Services Premiums appropriation for six months of anticipated Clawback payments, for the months of January – June 2006. However, based on a federal letter received October 14, 2005, the Department was informed by the Centers for Medicare and Medicaid Services that the first payment for January 2006 would not be billed until February 2006. As such, through Supplemental S-6 (submitted January 3, 2006), the Department requested a reduction to this appropriation, to account for the billing delay, assuming that only five payments would actually be made during FY 05-06. On January 20, 2006, as outlined on page 27 of the Department's FY 05-06 Supplemental hearing document, the Joint Budget Committee recommended this reduction in monthly payments, but differed with the Department in the estimated dual eligible caseload to use in this calculation. As a result, the Joint Budget Committee recommended a Clawback amount of $31,500,000, but with the intent of adjusting this amount during Figure Setting in March 2006.

Finally, during the Department's March 13, 2006 Figure Setting, a Joint Budget Committee staff recommendation was approved by the Committee which reduced the $31,500,000 based on an update from the Centers for Medicare and Medicaid Services. In a letter received by the Department on March 3, 2006, the Centers for Medicare and Medicaid Services informed the Department that the anticipated National Healthcare Expenditure average growth rate from calendar year 2003 to 2006 for prescription drugs had declined from 35.54% to 22.46%. Adjusting for this change, the final FY 05-06 appropriation for the Clawback was reduced by $3,057,082, to the new amount of $28,442,918.

However, during conversations with the State Controller's Office in May 2006, the Department learned that both the Department and the Joint Budget Committee had come to the wrong conclusion regarding the delay in billing by the federal government for July 2006. Based on generally acceptable accounting principles, the State Controller's Office deduced that this appropriation must be processed under accrual accounting and all months attributable to FY 05-06 caseload figures must be booked against FY 05-06 appropriations, regardless of when the invoice is received. Therefore, this opinion forced the Department to submit an Emergency 1331 Supplemental for $2,781,716 to include enough funding for the June billing, anticipated in July. This spending authority was approved by the Joint Budget Committee on June 20, 2006.

The FY 06-07 Long Bill (HB 06-1385) appropriation reflects a Joint Budget Committee recommendation to a Department request submitted November 15, 2005 in Base Reduction Item, BRI-3. This recommendation of $73,493,542 reflects twelve payments for 50,226 dual eligible clients, three months at 90% of the inflated 2003 per capita drug cost to 2006, three months at 90% of the inflated 2003 per capita drug costs to 2007, and six months at 88.33% of the inflated 2003 per capita drug cost to 2007 (Figure Setting, March 13, 2006, page 225).

The FY 07-08 Base Request is for $74,091,621. This request is based on an estimated dual eligible client count projected from the Centers for Medicare and Medicaid Services reported caseload included in the July 2006 invoice received by the Department. The full benefit dual eligible caseload used in the Base Request incorporates the July full benefit dual eligible clients (equal to 47,351) plus an estimated 1,500 clients in future retroactivity not yet reported for that month.

The estimated caseload count is then projected using a weighted average monthly growth rate of 0.14% for FY 06-07 and 0.10% for FY 07-08 for eligibility categories - Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 - which include the majority of the State's dual eligible clients. The projected growth rates for each eligibility category can be found in the Department's FY 07-08 Medical Services Premiums' Request, Exhibit EB-1. A six month average of the estimated monthly caseload amounts are used for the latter half of calendar year 2007 and the first half of calendar year 2008. The separate six month averages are needed because the National Health Expenditure growth rates are different for each period, 7.08% and 7.13% for calendar years 2007 and 2008, respectively.

These average caseload figures for full benefit dual eligibles are then multiplied by the inflated per capita costs (using the growth rates indicated by the Centers for Medicare and Medicaid Services website for National Health Expenditure growth), and then reduced by the State phasedown percentage of 88.33% for calendar year 2007 and 86.66% for calendar year 2008.

See the following table for the development of the final FY 07-08 Base Request.

Calculation for FY 07-08 Medicare Modernization Act of 2003 State Contribution Payment	
Payments from July 2007 through December 2007	
Per capita cost based on National Health Expenditure growth rate of 7.08% from calendar year 2006 cost of $127.45	$136.48
Phasedown Percentage for Calendar Year 2007	88.33%
Per Capita Cost multiplied by the Phasedown	$120.56
Average monthly duals eligibles based on monthly growth rates of 0.14% for FY 06-07 and 0.10% for FY 07-08 for three eligibility categories (Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59)	49,784
Total payments for first six months of FY 07-08	$36,011,754

Payments from January 2008 through June 2008	
Calculation for FY 07-08 Medicare Modernization Act of 2003 State Contribution Payment	
Per capita cost based on National Health Expenditure growth rate of 7.13% from calendar year 2006 cost of $136.48	$146.21
Phasedown Percentage for Calendar Year 2008	86.67%
Per Capita Cost multiplied by the Phasedown	$126.72
Average monthly duals eligibles based on monthly growth rates of 0.14% for FY 06-07 and 0.10% for FY 07-08 for three eligibility categories (Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59)	50,084
Total payments for second six months of FY 07-08	$38,079,867
Total Payment for FY 07-08	**$74,091,621**

Line Item: Medicare Modernization Act of 2003 State Contribution Payment	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**N/A**	**$28,442,918**	**$73,493,542**
Adjustments to incorporate first full year (in FY 06-07 only), caseload growth, reduction in State phasedown percentage, and National Health Expenditure inflation	$0	$45,050,624	$598,079
Long Bill Appropriation / Request	**$0**	**$73,493,542**	**$74,091,621**
HB 06-1217 – Transfers funding from (2) Medical Services Premiums Long Bill group to (5) Other Medical Services	$31,500,000	$0	$0
HB 06-1385 Add-Ons	($3,057,082)	$0	$0
Final Appropriation / Request	**$28,442,918**	**$73,493,542**	**$74,091,621**
General Fund	$28,442,918	$73,493,542	$74,091,621

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID – FUNDED PROGRAMS

This section of the Department's FY 07-08 Budget Request is for Medicaid funding for services provided or administered by the Colorado Department of Human Services. Programs include services for persons with developmental disabilities, high risk (substance abuse) pregnant women, and certain youth who are in the juvenile justice system, along with a number of other child welfare clients. The Department of Human Services also receives the Department of Health Care Policy and Financing's share of the costs to support the Colorado Benefits Management System. Medicaid funds for these programs are sent as Cash Funds Exempt transfers from the Department of Health Care Policy and Financing to the Department of Human Services.

Until FY 01-02, Medicaid funding for the Department of Human Services was appropriated in one line item. In FY 01-02, the General Assembly separated the Department of Human Services appropriations into 18 separate line items to improve expenditure tracking and reconciliation. These lines have changed over time, but a description of each of the line items currently within the Department's budget is included in the following pages.

In FY 05-06, the Joint Budget Committee added additional detail to this section of the Department's budget, separating administration appropriations from program appropriations for the following: Child Welfare, Mental Health and Alcohol and Drug Abuse Services, and Services for People with Disabilities.

All funding requests in this Long Bill group originate with the Department of Human Services, inquiries related to the FY 07-08 Request should be directed to this department. The Department of Health Care Policy and Financing is a financing agency for these appropriations, meaning that the Department must validate that the request is for Medicaid allowable purposes as outlined by the federal Centers for Medicare and Medicaid Services.

(A) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office is responsible for the general policy of the Department of Human Services and contains staff and associated resources for implementing this policy. This appropriation in the Department's budget includes Medicaid funding for two sections in the Department of Human Services budget: General Administration and Special Purpose.

This line item funds in part the Department of Human Services' Executive Director and administrative staff, as well as that department's budgeting office, Public Information Officer, County Liaison, and field administration staff (Department of Human Services Figure Setting, March 8, 2006, page 31). In FY 06-07, there was a total appropriation for 22.4 FTE for these functions, of which some or all are partially funded with Medicaid dollars. In addition to these staff, the Department of Human Services requests all Common Policy funding in this appropriation. This includes Salary Survey, Health, Life, and Dental, Workers' Compensation, Short-term Disability, Shift Differential, Payments to Risk Management and Property Funds, Administrative Law Judge Services, and

Amortization Equalization Disbursement. A portion of this funding is transferred throughout the fiscal year to support the FTE appropriated in other areas within the Department of Human Services' Long Bill.

This line also helps fund the Office of Performance Improvement which was appropriated 68.1 FTE in FY 06-07, and a team of 2.0 FTE to perform security remediation for the Health Insurance Portability and Accountability Act of 1996 (FY 06-07 Long Bill, page 86). The Office of Performance Improvement appropriation in the Department of Human Services is for staff to oversee and support four separate functions in the Department of Human Services, including: audits, food stamp quality assurance; human resources; and performance management. Again, not all of these functions are eligible to receive Medicaid funding. The audits section within the Department of Human Services independently verifies, through internal and external audits, that State and federal financial assistance has been distributed in accordance with applicable regulations and laws. The food stamp quality assurance unit performs federally mandated food stamp quality control, including monthly reviews to ensure accurate eligibility determinations and food stamp allotment. The human resources section performs all personnel related activities, and the performance management team ensures programmatic accountability for the Department of Human Services (Department of Human Services Figure Setting, March 8, 2006, page 40).

The Health Insurance Portability and Accountability Act of 1996 Security Remediation component of this line includes 2.0 FTE to complete the development of a system wide risk assessment and the integration of this assessment into the Department of Human Services operations, some or all of these functions receive Medicaid funding. The FTE also conduct periodic evaluations of all systems where technical, environmental, or operational changes have occurred. Operating expenses for this system includes costs associated with protecting health information covered by the security rule, an annual test that details the Department of Human Services' security management processes, and on-going privacy and security training (Department of Human Services Figure Setting, March 8, 2006, pages 53-54).

Appropriation History

As stated above, in addition to this appropriation containing funding to support a small number of FTE within the Department of Human Services for centralized functions, this line item also contains funding to support nearly all Common Policy items within the Department of Human Services. As such, a large contributor for changes in appropriated funding from one year to the next are due to Common Policy adjustments requested by the Department of Personnel and Administration. All changes in funding due to Common Policy adjustments are itemized in the included footnotes of this narrative; however, the accompanying table below will summarize these adjustments together for ease on the reader.

Beginning with the FY 03-04 Long Bill (SB 03-258), Medicaid funding for the Executive Director's Office was $8,086,637. This appropriation was revised later in the fiscal year with the passage of the Department's Supplemental Bill (HB 04-1320) for a decrease of $2,078,166, and with the passage of the Add-on section of the FY 04-05 Long Bill (SB 05-112) for an increase of $19,780 for a roll

forward booked on the Department of Human Services' books but not on Health Care Policy and Financing's books. Finally, the Add-on section of the Long Bill also included a decrease of $57,171 for a reduction in General Fund related to HIPAA funding. The combination of these two bills resulted in the final FY 03-04 appropriation of $5,971,080. Fund splits for this line item were affected by the 2.95% increase in federal medical assistance percentage (FMAP) during the last quarter of FY 02-03, through the end of FY 03-04. This increase was an accounting adjustment only, and was budget neutral to the total appropriation.

The following adjustments were incorporated since the end of FY 03-04 to derive the FY 04-05 Long Bill: Common Policy increases in the amount of $3,468,591[43], restoration of $8,208 for risk management funding that was temporarily removed through HB 04-1320 in FY 03-04 (non-prioritized Supplemental S-16, January 2, 2004), a decrease of $1,764 related to the Office of Performance Improvement due to increases in patient cash collected, an additional $19,057 for the annualization of the Privacy Officer's salary (non-prioritized Budget Amendment BA-2, January 23, 2004); and lastly, reversal of a one-time reduction of $37,391 made in the Department's FY 03-04 Supplemental Bill (SB 05-112) relating to an Emergency 1331 Supplemental titled "Title IV-E Payback Plan to the Counties" and "Spending Authority for Health Insurance Portability and Accountability Act (HIPAA) Expenditures from Footnote 56". The FY 04-05 Long Bill (HB 04-1422) appropriation was therefore $9,502,563. This Long Bill amount was later reduced by $183,671 per the Department's FY 04-05 Supplemental Bill (SB 05-112). This reduction was for Common Policy adjustments equal to $183,671, of which $143,123 was related to the transition of the Medicaid mental health capitation and fee-for-service programs to the Department of Health Care Policy and Financing. The final FY 04-05 appropriation was therefore $9,318,892.

Changes from FY 04-05 final appropriation to the FY 05-06 Long Bill reflected an increase of $385,259. The increase was comprised of Common Policy adjustments equal to $791,034[44], a decrease of $26,862 due to the paydate shift authorized with the passage of SB 03-197, an increase of $71,153 in Personal Services for increases in the Office of Performance Improvement due to reorganization, an increase of $25,654 in the Office of Performance Improvement for one new FTE, and a decrease of $475,720 for removal of the HIPAA Remediation funding for removal of one-time expenditures from FY 04-05 (Department of Human Services Figure Setting, page 27, March 8, 2006). The FY 05-06 Long Bill was therefore equal to $9,704,151. This appropriation was later revised through the Department's FY 05-06 Supplemental Bill (HB 06-1217), reducing this line by $803,678[45], due to changes in Common Policies (see following table for details). The FY 05-06 final appropriation was $8,900,473.

[43] $3,468,591 is comprised of the following amounts: Salary Survey = $83,628, Performance-based Pay = $643,574, Shift Differential = $703,534, Short-term Disability = $4,362, Worker's Compensation = $1,213,610, Health, Life, and Dental = $860,552 and Risk Management = ($40,334).
[44] $791,034 is comprised of the following amounts: Salary Survey = $376,803, Performance-based Pay = ($605,990), Shift Differential = $55,397, Short-term Disability = ($3,390), Workers' Compensation = ($109,906), Health, Life and Dental = $938,908, Risk Management and Property Funds = $57,937, Amortization Equalization Disbursement = $81,273, and $2 balancing adjustment to Long Bill.
[45] ($803,678) is comprised of the following amounts: Risk Management and Property Funds = ($108,034), Workers' Compensation = ($401,770), and Shift Differential = ($293,874). Shift Differential was related to Mental Health Institutes.

The FY 06-07 Long Bill appropriation is equal to $10,129,288. Changes from the final FY 05-06 appropriation included a net decrease of $1,207,623[46] due to changes in Common Policies, an additional $1,469 for HIPAA Remediation ($1,521 for a Salary Survey increase and a decrease of $52 for a 0.2% vacancy savings reduction), $16,270 for the Office of Performance Improvement ($19,524 for Salary Survey and a decrease of $3,254 for a 0.2% vacancy savings reduction), and $3,453 for Personal Services ($4,116 in Salary Survey and a decrease of $443 for a 0.2% vacancy savings reduction).

The FY 07-08 Base Request for this appropriation is $11,437,573. This reflects an increase of $1,308,285[47] from the final FY 06-07 appropriation. This increase is largely due to changes in Common Policies equal to $1,301,203, with the remaining $7,082 related to Personal Services adjustments for an increase of $8,498 in Salary Survey and a decrease of $1,416 for a 0.2% vacancy savings reduction.

Line Item: DHS Medicaid Funded Programs, (A) Executive Director's Office	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$5,971,080**	**$9,318,892**	**$8,900,473**	**$10,129,288**
Common Policy Adjustments	$0	$3,468,591	$791,034	$1,207,623	$1,301,203
Restore Risk Management and Property Funds removed per HB 04-1320	$0	$8,208	$0	$0	$0
Reduce funding in Office for Performance Improvement	$0	($1,764)	$0	$0	$0
Annualize Privacy Officer Salary (Budget Amendment BASN-2, January 23, 2004)	$0	$19,057	$0	$0	$0
Restore funding in HIPAA Remediation appropriation removed per SB 05-112 Add-ons	$0	$37,391	$0	$0	$0
Paydate Shift	$0	$0	($26,862)	$0	$0
Personal Services Adjustments (Reorganization, Salary Survey, and Vacancy Savings)	$0	$0	$71,153	$3,453	$7,082

[46] $1,207,623 is comprised of the following amounts: Risk Management and Property Funds = $68,172, Workers' Compensation = ($933,657), Shift Differential = $517,615, Salary Survey = $594,247, Health, Life and Dental = $786,946, Short-term Disability = ($12,860), and Amortization Equalization Disbursement = $187,160.

[47] $1,308,285 is comprised of the following amounts: Risk Management and Property Funds = $38,490, Workers' Compensation = $22,460, Shift Differential = ($26,925), Salary Survey = $48,542, Short-term Disability = $12,653, Health, Life and Dental = $580,696, Performance-based Pay = $389,490 and Amortization Equalization Disbursement = $242,879.

Line Item: DHS Medicaid Funded Programs, (A) Executive Director's Office	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Adjustment to Office of Performance Improvement Funding	$0	$0	$25,654	$16,270	$0
HIPAA Remediation Funding	$0	$0	($475,720)	$1,469	$0
Long Bill Appropriation / Request	**$8,086,637**	**$9,502,563**	**$9,704,151**	**$10,129,288**	**$11,437,573**
SB 05-112 Add-ons - "Title IV-E Payback Plan to the Counties" – reduction of $57,171 and "Spending Authority for HIPAA Expenditures for Footnote 56" – increase of $19,780	($37,391)	$0	$0	$0	$0
Supplemental Bill Common Policy adjustments	($2,078,166)	($183,671)	($803,678)	$0	$0
Final Appropriation / Request	**$5,971,080**	**$9,318,892**	**$8,900,473**	**$10,129,288**	**$11,437,573**
General Fund	$2,985,540	$4,659,447	$4,450,237	$5,062,597	$5,717,020
Federal Funds	$2,985,540	$4,659,445	$4,450,236	$5,066,691	$5,720,553

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – COLORADO BENEFITS MANAGEMENT SYSTEM

The State's new computer system that tracks client data, determines eligibility, and calculates benefits for medical, food, and financial assistance programs was implemented September 1, 2004. The development of the system and continuing operations were and are a joint effort between the Governor's Office of Colorado Benefits Management System, the Department of Human Services, and the Department of Health Care Policy and Financing. The Colorado Benefits Management System replaced the following six legacy systems: Client Oriented Information Network; Colorado Automated Food Stamps System; Colorado Automated Client Tracking System; Colorado Adult Protection System; Children's Basic Health Plan eligibility determination services; and, Colorado Employment First.

On August 5, 2003, the Department submitted a 1331 Emergency Supplemental request for FY 03-04 equal to $4,107,297 for funding still available from the Personal Responsibility and Work Opportunity Reconciliation Act, often abbreviated as PRWORA (federal Public Law 104-193, enacted August 22, 1996). This amount was subsequently appropriated by HB 04-1320, the Department's FY 03-04 Supplemental Bill. The purpose of the Personal Responsibility and Work Opportunity Reconciliation Act funding was to provide assistance to the counties to enter client historical data into the automated system. This funding was one-time only, and was approved officially in the Department's FY 03-04 Supplemental Bill (HB 04-1320). When combined with the original FY 03-04 Long Bill (SB 03-258) appropriation of $5,299,435, the resulting final appropriation for FY 03-04 was $9,406,732.

For FY 04-05, the Long Bill appropriation (HB 04-1422) was continuation funding from the FY 03-04 Long Bill. However, additional resources were needed to comply with a court order and HB 05-1315 was passed after submission of a Supplemental Request on February 15, 2005, providing $2,908,449 in additional funds. These monies included funding for additional technology staff from February to June 2005, emergency call center mailing costs, and an allocation for data entry, client correspondence, legal expenses and system enhancements. Other increases were for Colorado Benefits Management System Contract (non-prioritized Decision Item DI-4) in the amount of $63,975, and an increase in POTS for $6,722.

The FY 05-06 Long Bill (SB 05-209) appropriation was for $5,370,182. With the passage of HB 05-1262 (Tobacco Tax Bill), also during the 2005 legislative session, funding for this program was increased by an additional $304,508. Additional changes for FY 05-06 included passage of multiple 1331 Emergency Supplementals on June 21, 2005, September 20, 2005, and December 14, 2005. The June 21, 2005 Supplemental requested funds in response to the Deloitte audit report for $977,147. On September 20, 2005, two Emergency 1331 Supplementals were passed to cover additional FTE for implementing a management structure for $33,560, and an additional $1,284,561 in relation to a court order to cover impacts due to litigation and the operational costs for client correspondence. Finally, a 1331 Emergency Supplemental submitted for December 14, 2005 was modified by the Joint Budget Committee, which ultimately provided spending authority for $983,873 for client correspondence. All of these 1331 Emergency Supplemental amounts were officially appropriated in the Department's FY 05-06 Supplemental Bill (HB 06-1217). The final appropriation for FY 05-06 was $8,953,830.

The FY 06-07 Long Bill (HB 06-1385) appropriation is equal to $7,599,713. The decrease in funding from prior year to current year is comprised of the removal of $178,778 for HB 05-1262 one-time funding; an increase of $66,442 due to POTS, and revisions for the following Decision Items: a decrease of $41,930 to reflect an adjustment to programming hours from FY 05-06 (non-prioritized DI-3), a net increase of $53,393 for greater contractor costs over the prior year (non-prioritized DI-7), and removal of $23,958 for one FTE transferred from CBMS to Food Stamps (non-prioritized DI-14). The new Long Bill appropriation also included Joint Budget Committee actions to increase funding by $15,067 over FY 05-06 levels for client correspondence, and a net reduction of $1,412,229 to remove funding from FY 05-06 related to the CBMS court order and lawsuit expenses (originally, Joint Budget Committee staff recommended funding for these purposes, however, due to State budget balancing required to submit a balanced budget, the Joint Budget Committee removed all funding for these purposes on March 22, 2006). Lastly, there was a net increase to continuation funding for the Office of CBMS and the Department of Human Services, equal to $167,876.

The FY 07-08 Base Request is for $7,272,396, which includes POTS adjustments of $22,560 from FY 05-06 for Salary Survey and the 0.2% vacancy savings reduction plus the removal of one-time funding of $349,877 for system enhancements.

Line Item: (B) Office of Information Technology Services, Colorado Benefits Management System	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**
Prior Year Final Appropriation	**N/A**	**$9,406,732**	**$8,207,884**	**$8,953,830**	**$7,599,713**
Removal of one-time funding from PRWORA	$0	($4,107,297)	$0	$0	$0
Removal of one-time funding from HB 05-1315	$0	$0	($2,908,449)	$0	$0
Increase for POTS	$0	$0	$6,772	$66,442	$22,560
Colorado Benefits Management System Contract Increase (non-prioritized DI-4, November 1, 2004)	$0	$0	$63,975	$0	$0
Removal of one-time funding from HB 05-1262	$0	$0	$0	($178,778)	$0
Adjustment for revised programming hours (non-prioritized DI-3, November 15, 2005)	$0	$0	$0	($41,930)	$0
Adjustment for net increase in contractor costs (non-prioritized DI-7, November 15, 2005)	$0	$0	$0	$53,393	$0
Adjustment for change in FTE from CBMS to Food Stamps (non-prioritized DI-14, November 15, 2005)	$0	$0	$0	($23,958)	$0
Joint Budget Committee action to increase funding for client correspondence over FY 05-06 levels	$0	$0	$0	$15,067	$0
Joint Budget Committee action to first include, and then later remove all funding related to CBMS court order and lawsuit funding. Equal to net change in funding from FY 05-06 amounts for these purposes	$0	$0	$0	($1,412,229)	$0
Adjustments to Office of CBMS funding and Department of Human Services base funding	$0	$0	$0	$167,876	$0
Long Bill Appropriation / Request	**$5,299,435**	**$5,299,435**	**$5,370,182**	**$7,599,713**	**$7,622,273**
HB 04-1320 PRWORA Funding for Counties to Enter Client Historical Data (one-time funding per letter from Joint Budget Committee to State Controller dated September 23, 2003)	$4,107,297	$0	$0	$0	$0
Removal of one-time funding for system enhancements from HB 06-1217	$0	$0	$0	$0	($349,877)
HB 05-1315 Supplemental for Colorado Benefits Management System	$0	$2,908,449	$0	$0	$0

Line Item: (B) Office of Information Technology Services, Colorado Benefits Management System	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
HB 05-1262 Tobacco Tax Bill	$0	$0	$304,508	$0	$0
HB 06-1385 Add-ons Official appropriation of four 1331 Emergency Supplemental Requests: one dated June 21, 2005, one dated December 14, 2005, and two dated September 20, 2005	$0	$0	$3,279,140	$0	$0
Final Appropriation / Request	**$9,406,732**	**$8,207,884**	**$8,953,830**	**$7,599,713**	**$7,272,396**
General Fund	$2,772,241	$3,902,024	$4,400,782	$3,501,300	$3,349,194
Cash Funds Exempt	$27,406	$201,402	$322,302	$572,931	552,000
Federal Funds	$6,607,085	$4,104,458	$4,230,746	$3,525,482	$3,371,202

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – COLORADO BENEFITS MANAGEMENT SYSTEM SAS-70

Funding for this purpose began in FY 05-06 per a Department Supplemental (non-prioritized Supplemental S-2, January 3, 2006) which contained a request for funds to allow the Office of the State Auditor to conduct two separate audits of the Colorado Benefits Management System: the eligibility audit, and this Statement on Auditing Standards 70 audit. As this was the first year of funding for these audits, the State share of FY 05-06 costs were appropriated from existing General Fund appropriations contained in the Office of the State Auditor's budget, as results of these audits were to be included in the statewide single audit for FY 04-05. Thus, these General Fund dollars in the Office of the State Auditor's budget were transferred to the Department, appearing as Cash Funds Exempt in the Department's appropriation, and then matched with Title XIX federal funds, and transferred back to the Office of the State Auditor to pay for this review.

Work on the audit funded by this appropriation commenced in August 2005, and focused on: 1) management policies, standards and procedures; 2) state and county staff training and subsequent adherence to standards and procedures; 3) general controls over system development, acquisition, maintenance, and change management; 4) operational controls over change management of software, logical and physical security, and contingency planning; and 5) application controls over source documents, data input, editing and processing, data output, and system access (Department of Human Services Supplemental Hearing document, January 13, 2006 page 15). The audit required an assessment regarding which functions of the CBMS system were operating as intended.

Funding in FY 05-06 was equal to $54,305 and was determined by the Office of the State Auditor. Funding was appropriated through the passage of HB 06-1217, the Department's FY 05-06 Supplemental Bill, based upon the Department's request (non-prioritized Supplemental S-2, January 3, 2006), and was inclusive for both the SAS-70 audit and the Eligibility audit.

The FY 06-07 Long Bill (HB 06-1385) contained on-going funds equal to $51,719. This amount incorporated a Joint Budget Committee reduction of $2,586 to remove Personal Services and Operating Expenses from the prior year's final appropriation, as a third-party contractor was to be responsible for the required audit function. This amount differed from the Department's Budget Amendment (non-prioritized Budget Amendment BA-12, January 24, 2006).

The Department's FY 07-08 Base Request is for continuation funding of $51,719. Fund splits are based upon the federally approved CBMS calculator percentages.

OFFICE OF INFORMATION TECHNOLOGY SERVICES - OTHER OFFICE OF INFORMATION TECHNOLOGY SERVICES LINE ITEMS

The Other Office of Information Technology Services line item appropriation includes Medicaid funding for expenses associated with the Department of Human Services Information Systems, but specifically excludes the Colorado Benefits Management System and Colorado Benefits Management System SAS-70 funding. The Office of Information Technology is responsible for developing and maintaining the major centralized computer systems of the Department of Human Services, including systems that link to all counties in the State. Not all of these systems support Medicaid functions, and therefore all do not receive Medicaid funding. The office supports centralized databases and provides support and training to users, including county staff and private social services providers. The Office of Information Technology Services also helps set policies and strategic directions for de-centralized information technology systems that are operated by individual divisions within the Department of Human Services (Department of Human Services FY 06-07 Budget Request, Volume 1, page C-2-1 and 2).

The Office of Information Technology has a staff of 82.2 FTE, of which some or all receive partial Medicaid funding, and is organized into three functional areas: the Application Systems Team, Technical Operations, and Customer Support Services. The Application Systems Team manages, develops, enhances, and maintains the Department of Human Services application systems. This team is further organized into three separate units, to support the following: 1) institutional and community functions, disability determinations, and Department of Human Services' administrative services; 2) children, youth and families and child support services; and 3) eligibility services. Technical Operations provides support for databases, systems, security, networks, telecommunications and regional/statewide technical services. The Customer Support Services unit is responsible for four primary areas pertaining to information technology: 1) help desk support; 2) financial management; 3) administrative customer support services and 4) application training for users (Department of Human Services FY 06-07 Budget Request, Volume 1, page C-2-1 and 2).

This appropriation is used to support the salaries and operating expenses associated with the FTE mentioned above, as well as for Common Policy items such as Purchases of Services from Computer Center, Microcomputer Lease Payments, and Multi-use Network Payments.

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation was $500,676. This amount was later revised with the Department's FY 03-04 Supplemental Bill (HB 04-1320) which decreased the appropriation by $18,765 due to adjustments in Microcomputer Lease Payments ("Truth in Rates" Supplemental NP-S12, January 2, 2004), with a small offsetting increase of $205 for re-allocation of costs associated with the General Government Computer Center. The final appropriation for FY 03-04 was $482,116. In the fourth quarter of FY 02-03 and all of FY 03-04, this line item was affected by the 2.95% increase in federal medical assistance percentage (FMAP). This increase was an accounting adjustment between the State and federal fund splits, and was budget neutral to the total appropriation.

Changes from the FY 03-04 final appropriation to the FY 04-05 Long Bill was an increase of $24,910. This net increase was a result of a $454 decrease to Personal Services funding, as well as the following Common Policy adjustments: a decrease of $336 for Purchases of Services from Computer Center, an increase of $25,596 for Microcomputer Lease Payments, and an increase of $104 for Multi-use Network payments. The FY 04-05 Long Bill appropriation was therefore $507,026.

Change from the FY 04-05 Long Bill to final funding for FY 04-05 was appropriated in the Department's FY 04-05 Supplemental (SB 05-112) and was due to changes in Common Policies equal to $19,929 comprised of a $38 increase for Purchases of Services from Computer Center and an increase of $19,891 for Multi-use Network Payments. SB 05-112 also appropriated an additional $13,503 in one-time funding for final preparations associated with the Legacy Systems shutdown. The FY 04-05 final appropriation was therefore $540,458.

The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill was a decrease of $121,644. This net changed included removal of the $13,503 for the Legacy Systems shutdown in FY 04-05, and increase of $6,250 for Personal Services, and a decrease of $114,391 for Common Policy adjustments, including Multiuse Network Payments, Purchases of Services from Computer Center, and removal of Telecommunication System Lease Payments. The resulting FY 05-06 Long Bill appropriation was $418,814. This appropriation was later revised with the passage of the Department's FY 05-06 Supplemental Bill (HB 06-1217), which increased the amount of funding for Multiuse Network Payments by $1,072. The final appropriation for FY 05-06 was therefore $419,886.

The FY 06-07 Long Bill of $401,742 incorporated a $443 decrease in Personal Services and a decrease of $17,701 in Common Policy adjustments, which included an increase of $6,057 for Salary Survey, an increase of $46 for Purchases of Services from Computer Center, a decrease of $1,783 for Multiuse Network Payments, and a decrease of $22,021 for Leased Computer Lease Payments.

The FY 07-08 Base Request for this appropriation is $406,241, and includes a net increase of $4,499 in Common Policy adjustments – an increase of $5,148 for Salary Survey, and decreases equal to $433 for Amortization Equalization Disbursement and $216 for Purchases of Services from Computer Center.

Line Item: DHS Medicaid Funded Programs, (B) Office of Information Technology, Other Office of Information Technology Services	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$482,116**	**$540,458**	**$419,886**	**$401,742**
Common Policy Adjustments	$0	$25,364	($114,391)	($23,758)	($216)
Changes to Personal Services	$0	($454)	$6,250	$5,614	$4,715
Removal of One-time Funding for Legacy Systems Shutdown	$0	$0	($13,503)	$0	$0
Long Bill Appropriation / Request	**$500,676**	**$507,026**	**$418,814**	**$401,742**	**$406,241**
Common Policy Adjustments	($18,560)	$19,929	$1,072	$0	$0
SB 05-112 - One-time Funding for Legacy Systems Shutdown	$0	$13,503	$0	$0	$0
Final Appropriation / Request	**$482,116**	**$540,458**	**$419,886**	**$401,742**	**$406,241**
General Fund	$241,059	$270,230	$209,943	$200,871	$203,121
Federal Funds	$241,057	$270,228	$209,943	$200,871	$203,120

(C) OFFICE OF OPERATIONS – MEDICAID FUNDING

The Department's Office of Operations appropriation contains funding for four divisions in the Department of Human Services, including Facilities Management, Accounting, Procurement, and Contract Management, of which some or all are partially funded with Medicaid funding. This appropriation is for the cost of salaries and operating expenses associated with some or all of these positions, as well as for utilities costs and Common Policy items such as Vehicle Lease Payments and Capitol Complex Leased Space.

The Division of Facilities Management consists of 67% of the total Office of Operations' staffing. The Division of Facilities Management is responsible for operating, cleaning, and maintaining all Department of Human Services' facilities, including: youth correctional facilities, two State mental health institute campuses, three regional centers for the developmentally disabled, and all of the Department of Human Services' office buildings. The Department of Human Services operates 301 buildings containing 3,239,775 gross square feet of space (Department of Human Services Figure Setting, February 23, 2006, page 24). The Division of Facilities Management is also responsible for acquisition, operation and management of utility services, planning, design and construction of capital construction and controlled maintenance projects, and the Department of Human Services' commercial and vehicle leases.

The Division of Accounting includes 25% of the total Office of Operations' staff. The Division of Accounting manages all Department of Human Services' financial operations and resources, including payments to counties and service providers throughout

the State for Medicaid, Medicare, and private party billing for the Department of Human Services' various community and institutional programs (Department of Human Services Figure Setting, February 23, 2006, page 25).

The Procurement Division includes 6% of the total Office of Operations' staff. The purchasing department within this division has been delegated autonomous authority by the Department of Personnel and Administration and is responsible for purchasing goods and services for the Department of Human Services' programs in excess of $25 million per year (Department of Human Services Figure Setting, February 23, 2006, page 25).

The Contract Management Division includes 1% of the total Office of Operations' staff. This Division is responsible for managing the contracting process including development, approval, and oversight of performance (Department of Human Services Figure Setting, February 23, 2006, page 25).

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation was $5,293,750. This appropriated amount was revised later in the fiscal year with the passage of the Department's Supplemental Bill (HB 04-1320) to reflect an increase of $97,073. This net increase was the combination of partially offsetting Common Policy adjustments: an increase of $117,855 for Capitol Complex utilities and a decrease of $20,782 for Vehicle Lease Payments. The FY 03-04 final appropriation was $5,390,823. In addition to the appropriated changes during the fiscal year, for the fourth quarter of FY 02-03 and all of FY 03-04, this line received an additional 2.95% in federal medical assistance percentage (FMAP). This increase was an accounting adjustment between the fund splits and was budget neutral to the total appropriation.

Changes from the FY 03-04 final appropriation of $5,390,823 to the FY 04-05 Long Bill consisted of Common Policy reductions for Vehicle Lease Payments of $62,806, the 0.2% vacancy savings adjustment of $7,179, and a decrease of $93,971 for Common Policy adjustments relating to Personal Services. These changes resulted in the FY 04-05 Long Bill appropriation being set equal to $5,226,867. This amount was later revised through the Department's FY 04-05 Supplemental Bill (SB 05-112) for an increase to utilities funding equal to $293,314, and a decrease to Vehicle Lease Payments equal to $183,894. The final appropriation for FY 04-05 was $5,336,287.

Increases in Personal Services funding of $93,350 and in Operating Expenses of $3,564, offset by decreases in Vehicle Lease Payments of $9,528 and utilities equal to $20,800, resulted in an initial appropriation of $5,402,873 in the FY 05-06 Long Bill. This amount was also adjusted per the Department's FY 05-06 Supplemental Bill (HB 06-1217) due to changes in fuel costs which required an additional $4,850, an additional $405,890 for greater utilities costs, and a decrease of $1,189 for Vehicle Lease Payments. Thus, the final FY 05-06 appropriation was $5,812,424.

Building to the FY 06-07 Long Bill, the final FY 05-06 appropriation was increased for Common Policy adjustments including: an additional $74,551 for Vehicle Lease Payments (including $26,866 for vehicle replacements), a $7,585 decrease for the 0.2% vacancy savings adjustment, and an increase of $96,430 for Salary Survey. These changes resulted in the FY 06-07 Long Bill appropriation of $5,975,820.

The FY 06-07 Long Bill appropriation was later adjusted during the 2006 Legislative session with the passage of SB 06-219. SB 06-219: 1) reorganized the Department of Health Care Policy and Financing's statutory citations, 2) transferred the administration of the Home Care Allowance and Adult Foster Care programs to the Department of Human Services, and 3) transferred the administration of all County Administration related to the Department's programs to the Department of Heath Care Policy and Financing. Through this exchange, the Department of Human Services provided funding for the net change of one FTE to the Department of Health Care Policy and Financing. A portion of this funding, $26,976, originated from this appropriation. Therefore, the current FY 06-07 appropriation is $5,948,844.

The FY 07-08 Base Request for this appropriation is $6,029,886 and includes an increase of $53,732 for Vehicle Lease Replacements due to the annualization of a prior budget action (non-prioritized Decision Item DI-10), for vehicle replacements, an increase of $34,573 for Salary Survey, and a reduction of $7,263 for the 0.2% vacancy savings adjustment.

Line Item: DHS Medicaid Funded Programs, (C) Office of Operations	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$5,390,823**	**$5,336,287**	**$5,812,424**	**$5,948,844**
Vehicle Lease Payments	$0	($62,806)	($9,528)	$74,551	$53,732
0.2% Vacancy Savings Adjustment	$0	($7,179)	$0	($7,585)	($7,263)
Salary Survey	$0	$0	$0	$96,430	$34,573
Personal Services	$0	($93,971)	$93,350	$0	$0
Operating Expenses	$0	$0	$3,564	$0	$0
Utilities	$0	$0	($20,800)	$0	$0
Long Bill Appropriation / Request	**$5,293,750**	**$5,226,867**	**$5,402,873**	**$5,975,820**	**$6,029,886**
Common Policy Adjustments	$0	$0	$0	$0	$0
HB 04-1320 - Utilities	$117,855	$0	$0	$0	$0
HB 04-1320 - Vehicle Lease Payments	($20,782)	$0	$0	$0	$0
SB 05-112 – Utilities	$0	$293,314	$0	$0	$0

Line Item: DHS Medicaid Funded Programs, (C) Office of Operations	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
SB 05-112 - Vehicle Lease Payments	$0	($183,894)	$0	$0	$0
HB 06-1217 - Fuel Adjustment	$0	$0	$4,850	$0	$0
HB 06-1217 - Utilities	$0	$0	$405,890	$0	$0
HB 06-1217 - Vehicle Lease Payments	$0	$0	($1,189)	$0	$0
SB 06-219 – Transfer to Health Care Policy and Financing for FTE	$0	$0	$0	($26,976)	$0
Final Appropriation / Request	**$5,390,823**	**$5,336,287**	**$5,812,424**	**$5,948,844**	**$6,029,886**
General Fund	$2,695,412	$2,668,144	$2,906,212	$2,974,422	$3,014,943
Federal Funds	$2,695,411	$2,668,143	$2,906,212	$2,974,422	$3,014,943

(D) COUNTY ADMINISTRATION – COUNTY ADMINISTRATION – MEDICAID FUNDING

This line item provided Medicaid funding for county departments of social services to administer Medicaid eligibility determinations (Department of Human Services Figure Setting, March 8, 2006, page 76). The allocation of Medicaid and non-Medicaid funding in the Department of Human Services' budget was always dynamic, as the Department of Human Services was allowed to incorporate General Fund transfers between these funding streams pursuant to 24-75-106, C.R.S. (2006). If there was a need for greater Medicaid funding, the Department of Human Services would transfer General Fund originally appropriated for non-Medicaid related functions to the Department of Health Care Policy and Financing to draw additional federal matching funds, and then the entire amount would be transferred back to the Department of Human Services. The allocation of expenditures between Medicaid programs and other programs administered by the Department of Human Services that would drive the need for greater Medicaid funding was determined through a federally approved random moment sampling process, performed by the Department of Human Services.

This appropriation assumed 50% federal financial participation, 30% General Fund and 20% from local county funds. However, the Department's appropriation for this line item never displayed the 20% portion contributed by local county funds; therefore, this line item always appeared to be 37.5% General Fund, and 62.5% federal funds.

With the passage of SB 06-219 during the 2006 Legislative session, oversight of the Medicaid portion of county administration and Medicaid funding was transferred to the Department of Health Care Policy and Financing, and this line item was eliminated. A new line appears in the Department's (1) Executive Director's Office Long Bill group for this purpose. The following information is for historical information through FY 06-07 only. There is no FY 07-08 Base Request for this appropriation.

Appropriation History

Beginning with the FY 03-04 Long Bill (SB 03-258), Medicaid funding for County Administration was $8,624,879. While there was no change to the appropriated amount in this fiscal year, for the fourth quarter of FY 02-03 and all of FY 03-04, this line received an additional 2.95% in federal medical assistance percentage (FMAP). This increase was an accounting adjustment between the fund splits and is budget neutral to the total appropriation. The FY 04-05 Long Bill (HB 04-1422) was again $8,624,879.

The FY 05-06 Long Bill appropriation (SB 05-209) of $8,797,377 incorporated a 2.0% provider rate increase above the final FY 04-05 appropriation (Department of Human Services Figure Setting, page 58, March 8, 2005). This amount was later revised through the Department's FY 05-06 Supplemental Bill (HB 06-1217) for two one-time adjustments as well as for new on-going projects. Due to low payment error rates in food stamp distributions made by the Department of Human Services, the State was awarded a one-time federal cash performance bonus of $277,838 (Department of Human Services' Comeback document, January 23, 2006). While this performance bonus did not relate to a Medicaid purpose, the Joint Budget Committee approved the federal award to this appropriation, to pass along the funding to the county level. Somewhat similar to this funding, the State received $2,434,864 in federal funds for administrative case management for both Child Welfare and the Families and Children's Program services (Department of Human Services Supplemental document, page 106, January 20, 2006). This amount was equal to the federal share of administrative case management services during FY 04-05, after a contingency fee was paid to Public Consulting Group (PCG), a contractor for the Office of State Planning and Budgeting. The Joint Budget Committee recommended this one-time funding to be passed along to the counties. The Supplemental Bill also incorporated the $196,300 requested in a September 20, 2005 1331 Emergency Supplemental for some relief to counties due to requirements in the Medicare Modernization Act of 2003 which placed some obligation on the counties to process low-income subsidy applications for the new Part D drug benefit (Department of Human Services Supplemental document, page 97, January 20, 2006). This funding was split 50% General Fund and 50% federal funds, requiring no additional county share. Lastly, the Supplemental Bill reduced County Administration to eliminate all funding related to client correspondence, and transferred this funding to the Colorado Benefits Management System appropriation. This reduction was $183,547 (Department of Human Services Supplemental document, page 63, January 20, 2006). The final FY 05-06 appropriation was therefore equal to $11,522,832.

The net increase of $3,065,878 to the FY 06-07 Long Bill (HB 06-1385) included the following adjustments: an increase of $3,202,623 to realign the allocation of Medicaid and non-Medicaid financing in the Department of Human Service's budget (Department of Human Services Figure Setting, page 81, March 8, 2006); removal of $2,434,864 in one-time funding for the Public Consulting Group initiative (Department of Human Services Figure Setting, page 81, March 8, 2006); a decrease of $277,838 for the removal of one-time funding related to the federal cash performance bonus for the low payment error rates in food stamps; and an increase of $491,826 for a 3.25% cost-of-living adjustment (Department of Human Services Figure Setting, page 77, March 8, 2006). In addition, the FY 06-07 Long Bill included an increase of $2,569,864 due to concerns expressed by the counties that existing funding was not sufficient to cover their costs (Department of Human Services Figure Setting, page 77, March 8, 2006), and a

decrease of $485,733 for administrative costs associated with eight Front Range counties that were incorporated into the transportation broker's contract funded out of the Non-Emergency Transportation Services appropriation in the Department of Health Care Policy and Financing's (1) Executive Director's Office Long Bill group (DI #9, November 15,2005). The FY 06-07 Long Bill appropriation was therefore set at $14,588,710.

This appropriation was later eliminated in the 2006 Legislative session with the passage of SB 06-219. In addition to reorganizing all statutes relating to programs administered by the Department of Health Care Policy and Financing into Title 25.5 C.R.S., SB 06-219 also transferred the Medicaid funding for county administration functions to the Department. All General Fund and federal match in this appropriation, plus the Cash Funds Exempt amount for the 20% county share that only appeared in the Department of Human Services' budget, was therefore transferred to the Department's (1) Executive Director's Office Long Bill group as a new line item. For more information on this program beginning in FY 06-07, please refer to the narrative for this new line item.

Line Item: DHS Medicaid Funded Programs, (D) County Administration	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$8,624,879**	**$8,624,879**	**$11,522,832**	**$0**
2.0% Provider Rate Increase (DHS Figure Setting, March 8, 2005, page 58)	$0	$0	$172,498	$0	$0
Removal of one-time funding for federal cash performance bonus for low payment error rate in food stamps	$0	$0	$0	($277,838)	$0
Removal of one-time federal funding for administrative case management costs in FY 04-05	$0	$0	$0	($2,434,864)	$0
Reallocation of Medicaid and non-Medicaid funding for County Administration	$0	$0	$0	$3,202,623	$0
Increase for County Administration due to concerns of insufficient funds	$0	$0	$0	$2,569,864	$0
3.25% provider rate increase	$0	$0	$0	$491,826	$0
Eliminate funding for 8 Front Range counties for administration related to non-emergency medical transportation	$0	$0	$0	($485,733)	$0
Long Bill Appropriation / Request	**$8,624,879**	**$8,624,879**	**$8,797,377**	**$14,588,710**	**$0**

Line Item: DHS Medicaid Funded Programs, (D) County Administration	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
HB 06-1217 - $277,838 for federal cash performance bonus for low payment error rates in food stamps, one-time funding; $2,434,864 for FY 04-05 administrative case management funding, one-time funding; ($183,547) to remove all client correspondence funding moved to CBMS; and $196,300 for low income subsidy application relief	$0	$0	$2,725,455	$0	$0
SB 06-219 - Transfer Entire Medicaid Amount to Health Care Policy and Financing	$0	$0	$0	($14,588,710)	$0
Final Appropriation / Request	**$8,624,879**	**$8,624,879**	**$11,522,832**	**$0**	**$0**
General Fund	$3,234,330	$3,234,330	$3,467,256	$0	$0
Federal Funds	$5,390,549	$5,390,549	$8,055,576	$0	$0

(D) COUNTY ADMINISTRATION - ADMINISTRATION RELATED TO CBMS IMPLEMENTATION

Added as one-time funding for costs associated with implementing the Colorado Benefits Management System, this line was added in FY 04-05 through the passage of HB 05-1316. However, due to continued need into FY 05-06, a joint 1331 Emergency Supplemental submitted on June 21, 2005 by both the Department of Human Services and the Department of Health Care Policy and Financing, which was approved by the Joint Budget Committee, provided spending authority in FY 05-06 equal to $1,396,773. This amount was officially appropriated in the Department's FY 05-06 Supplemental Bill (HB 06-1217). No funding was requested in FY 06-07 or forward.

Line Item: DHS Medicaid Funded Programs, (D) County Administration, Administration Related to CBMS Implementation	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year's Final Appropriation	**N/A**	**$1,527,318**	**$1,396,773**	**$0**
Removal of one-time funding from prior year	$0	($1,527,318)	($1,396,773)	$0
Long Bill Appropriation / Request	**$0**	**$0**	**$0**	**$0**
HB 05-1315 - Supplemental Bill for Colorado Benefits Management System	$1,527,318	$0	$0	$0

Line Item: DHS Medicaid Funded Programs, (D) County Administration, Administration Related to CBMS Implementation	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
HB 06-1217 - Official appropriation of approved 1331 Emergency Supplemental on June 21, 2005	$0	$1,396,773	$0	$0
Final Appropriation / Request	**$1,527,318**	**$1,396,773**	**$0**	**$0**
General Fund	$763,659	$698,387	$0	$0
Federal Funds	$763,659	$698,386	$0	$0

(E) DIVISION OF CHILD WELFARE-ADMINISTRATION

The Division of Child Welfare supervises the child welfare programs that are administered by Colorado's 64 counties. The Department of Human Services also conducts periodic on-site reviews of children who are in residential care. County responsibilities include receiving and responding to reports of potential child abuse or neglect, and providing necessary and appropriate child welfare services to the child and family, including providing for residential care of a child when the court determines that it is in the best interest of the child to remove him/her from the home (Department of Human Services Figure Setting, March 8, 2006, page 84).

The Colorado children's habilitation residential program waiver is designated as Home and Community Based Services and is designed to promote the community placement and prevent the institutional placement of children with developmental disabilities. The waiver was statutorily authorized through SB 96-178. In prior years, the administrator of the program was a county employee who was loaned and located at the State offices. This position was vacated in June 2005 causing the Department of Human Services to perform an administrative review. The result of the review was to hire the necessary staff to ensure better over site of programs and federal approval of the waiver would have been conditioned on having a State FTE administer the waiver.

The waiver requires the State to approve the entry of a child into the Colorado children's habilitation residential program; annually review the information on the child to determine continued eligibility in the program, maintain a file to ensure timely re-evaluations of the children served; and maintain records of evaluations and re-evaluations of children served. With the assistance of the waiver, the State has been able to return children to Colorado who were placed out-of-state, develop needed resources for developmentally disabled and multiple needs children, provide a broad array of services in out of home placement to improve the functioning of these children, and maximize federal Medicaid revenue at a time the Department was first under the child welfare settlement agreement. From the inception of the Colorado children's habilitation residential program waiver, the State has served 2,164 children (Department of Human Services Figure Setting, March 8, 2006, pages 84-86).

During the Department of Human Services' Figure Setting session on February 9, 2005, (see pages 16-19), a Joint Budget Committee action created a separate line for Child Welfare administration. Administrative functions include providing supervision to the county departments of social services; response to legislation defining policy and fiscal issues; coordinating with other divisions; policy development and subsequent program development, implementation and monitoring; and response to consumers for information (Department of Human Services Figure Setting, March 8, 2006, page 84).

Appropriation History

Through the passage of the FY 05-06 Long Bill (SB 05-209), the regional treatment center's administrator position, previously funded from the now titled Child Welfare Services appropriation through FY 04-05, was moved to this line item with a salary of $56,552, $2,694 for operating expenses, $820 for Salary Survey, and $440 for Performanced-based Pay increases (Department of Human Services, February 9, 2005, page 19).

The FY 06-07 Long Bill (HB 06-1385) added $64,799 to the final FY 05-06 appropriation to include the salary and operating costs of a new FTE at the General Professional V level for the administration of the Colorado Children's Habilitation Residential program waiver, as well as $1,634 for Salary Survey associated with the regional treatment center's administrator position. Total funding for FY 06-07 was appropriated at $126,939.

The FY 07-08 Base Request is for $167,217. This amount is greater than the FY 06-07 Long Bill appropriation by $40,278 due to the following adjustments: a leap year increase for $39,320, an increase in Salary Survey for $1,153, and a decrease of $195 for the 0.2% vacancy savings reduction.

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare Administration	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$60,506**	**$126,939**
Personal Services and Operating Expenses for new GP V	$0	$64,799	$0
Salary Survey Adjustment	$0	$1,634	$1,153
Leap year adjustment	$0	$0	$39,320
0.2% vacancy savings adjustment	$0	$0	($195)
Long Bill Appropriation / Request	**$60,506**	**$126,939**	**$167,217**
General Fund	$30,253	$63,470	$83,609
Federal Funds	$30,253	$63,469	$83,608

(E) DIVISION OF CHILD WELFARE - CHILD WELFARE SERVICES

The Child Welfare Services line item receives funding for staff and operating costs associated with State supervision and county administration of programs that protect children from harm and assist families in caring for and protecting their children. Services include out-of-home placement such as foster care, subsidized adoptions, childcare, and burial reimbursement. Children are placed in the appropriate programs by the county caseworkers (Department of Human Services Figure Setting, March 8, 2006, page 88).

Only 80% of all child welfare services are funded by the State per 26-1-122, C.R.S. (2006). The remaining 20% is funded by the individual counties. Counties receive capped funding allocations for the administration and provision of child welfare services. The Department of Human Services is directed by current statute to annually develop formulas for allocating child welfare funding among the 64 counties through the use of an optimization model. The Department of Human Services receives input from the Child Welfare Allocations Committee. The committee consists of eight members: four members appointed by Colorado Counties, Inc. and four members appointed by Department of Human Services (Department of Human Services Figure Setting, March 8, 2006, page 88).

The Child Welfare appropriation has undergone dramatic changes in the last few years. Prior to FY 06-07, Child Welfare funding was allocated largely to residential treatment centers, and pre-December 2004, to child placement agencies. However, due to compliance issues raised by the Centers for Medicare and Medicaid Services, on December 1, 2004, the State discontinued Medicaid funding for child placement agencies. This termination of funding was based on federal interpretation that these payments were supplemental Medicaid payments, not eligible for federal matching funds. Later, on April 20, 2005, further feedback was received by the Centers for Medicare and Medicaid Services that significant changes were needed to the payments made for residential treatment centers. Specifically, the Centers for Medicare and Medicaid Services communicated that most residential treatment centers being reimbursed using a per diem methodology were not eligible for this form of reimbursement. Rather, most centers needed to bill and receive reimbursement on a fee-for-service basis, as they did not meet the criteria of an inpatient provider, a requirement for providers being eligible for per diem reimbursements. Thus, in FY 06-07, the Department of Human Services and the Department of Health Care Policy and Financing worked together to overhaul the Child Welfare program. As of October 3, 2006 the departments' are awaiting final approval from the Centers for Medicare and Medicaid Services.

With the passage of HB 06-1395, the Child Welfare program was redesigned to include three new provider types, each provider offering a different intensity level of care. These three provider types include: psychiatric residential treatment facilities (PRTF); treatment residential child care facilities (TRCCF); and community based residential child care facilities (CBRCCF).

Psychiatric residential treatment facilities are considered the highest level of care, short of inpatient hospitalization. Children can be referred to this program either by physicians in, or outside of, the Division of Youth Corrections, or by the judicial system. These facilities are reserved predominately for those children having one of the thirteen high-level mental disorders, having some impairment in reality testing or communication, or major impairment in several areas such as work, school, or family relations. Only

a small percentage of youth are estimated to qualify for placement in this program (Department of Human Services Figure Setting, March 8, 2006, page 96).

Treatment residential child care facilities' level of care is similar to that of the prior residential treatment centers' model with the exception that Medicaid funding has been reduced. Specific treatment must now be billed as fee-for-service on behalf of a licensed therapist, with reimbursement rates set by the State Medical Services Board (Department of Human Services Figure Setting, March 8, 2006, pages 96-97).

Community based residential child care facilities' care level is designed to be the least restrictive of the three new provider types. The services are envisioned to be less intensive and designed to allow transition to the home or community. Services are billed for, and reimbursed, using a fee-for-service methodology. Only a minor portion of this total program is eligible for Medicaid funding (Department of Human Services Figure Setting, March 8, 2006, page 97-98).

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation was $77,861,994. While there were no changes to this appropriation for the year, this appropriation did receive an enhanced 2.95% federal medical assistance percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This increase, however, was an accounting adjustment between State and federal fund splits, and was budget neutral to the total appropriation.

To build to the FY 04-05 Long Bill (HB 04-1422), the final FY 03-04 appropriation was increased by $1,819,662 for caseload growth of 2.34%, and a reduction of $208,146 for reversal of a prior leap-year adjustment. These changes resulted in an appropriation of $79,473,510. This amount was later revised through: 1) the Department's FY 04-05 Supplemental Bill (SB 05-112) to remove $6,806,478 related to child placement agencies deemed as Supplemental Medicaid payments by the federal Centers for Medicare and Medicaid Services, and 2) the Add-on section of the FY 05-06 Long Bill (SB 05-209) to remove $688,226 due to reduced vendor contract costs. The resulting FY 04-05 final appropriation was $71,978,806.

The FY 05-06 Long Bill (SB 05-209) was greater than the previous year's appropriation by $3,277,424. This increase was the combination of: $1,489,110 for a 2% provider rate increase, $1,847,566 for caseload growth, the removal of $59,246 for administration funding supporting 1.0 FTE which now resides in the above mentioned newly appropriated line item, and a $6 reduction to balance to the Joint Budget Committee. Therefore, the FY 05-06 Long Bill was appropriated at $75,256,230. This amount was later revised with the passage of the Department's FY 05-06 Supplemental Bill (HB 06-1217) that increased funding by $570,405 for administrative case management. The FY 05-06 final appropriation was $75,826,635.

Beginning in FY 06-07, Medicaid funding for the Child Welfare program was significantly revised to incorporate revisions to the provider structure for this program. As stated above, on April 20, 2005 the Centers for Medicare and Medicaid Services informed the Department that the reimbursement and billing practices for residential treatment centers did not meet federal requirements. This resulted in the Department's Budget Amendment (non-prioritized Budget Amendment BA-15 submitted on January 31, 2006), which reduced the Medicaid funding for this program by $51,486,475. In addition to this restructuring, funding adjustments to the appropriation also included a Joint Budget Committee action for a 3.25% cost-of-living increase equal to $797,450, an increase of $831,948 for population adjustments in this program that were still eligible for Medicaid dollars through non-prioritized Decision Item NP-4, and a transfer of $64,799 associated with the FTE overseeing the Colorado children's habilitation residential program to Child Welfare Services Administration line item through non-prioritized Decision Item NP-12. The sum of changes resulted in a FY 06-07 Long Bill appropriation of $25,904,759.

During the 2006 Legislative session, the General Assembly passed two additional bills, HB 06-1395 and SB 06-219, which modified the existing appropriation. Signed by the Governor on May 26, 2006, HB 06-1395 provided new legislation establishing a new provider type, psychiatric residential treatment facilities, to provide residential child health care. This bill also required that the Medical Services Board promulgate rules to administer the newly restructured program, and for the county share of this program is reduced to FY 04-05 levels until recommendations could be made by the Department of Human Services. The net increase for adding psychiatric residential treatment facilities to the Child Welfare program was $8,787,740. Lastly, SB 06-219 was also passed by the General Assembly. In addition to creating greater clarity in the Department of Health Care Policy and Financing's statutes and transferring the administration of Home Care Allowance and Adult Foster Care to the Department of Human Services, this bill also established two new line items in the Department of Health Care Policy and Financing's budget related to county administrative funding. One of these new appropriations is the combined funding for administrative case management that was paid to the counties from 1) the Child Welfare Services appropriation, and 2) the Families and Children's Program. As such, the Child Welfare Services FY 06-07 appropriation was reduced by $588,944, with a corresponding increase in the Department of Health Care Policy and Financing's new County Administration – Administrative Case Management Payment to Counties line item under the (1) Executive Director's Office Long Bill group.

The Department's FY 07-08 Base Request is for continuation funding of $34,063,555.

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare Services	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$77,861,994**	**$71,978,806**	**$75,826,635**	**$34,063,555**
Block grant increase	$0	$1,819,662	$0	$0	$0
Reversal of FY 03-04 leap year adjustment	$0	($208,146)	$0	$0	$0

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare Services	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Caseload growth	$0	$0	$1,847,566	$0	$0
Transfer of Personal Services and Operating Expenses associated with CHIRP FTE	$0	$0	($59,246)	$0	$0
2.0% Provider Rate increase as part of a Joint Budget Committee action	$0	$0	$1,489,110	$0	$0
Adjustment to match Long Bill	$0	$0	($6)	$0	$0
3.25% cost-of-living adjustment as part of a Joint Budget Committee action	$0	$0	$0	$797,450	$0
Caseload growth	$0	$0	$0	$831,948	$0
Removal of nearly all residential treatment center Medicaid funding	$0	$0	$0	($51,486,475)	$0
Transfer Personal Services and Operating for GP V overseeing Children's Habilitation Residential Program	$0	$0	$0	($64,799)	$0
Long Bill Appropriation / Request	**$77,861,994**	**$79,473,510**	**$75,256,230**	**$25,904,759**	**$34,063,555**
SB 05-112 - Removal of Child Placement Agencies Medicaid Funding	$0	($6,806,478)	$0	$0	$0
SB 05-209 Add-ons - Reduced Contractor Obligations	$0	($688,226)	$0	$0	$0
HB 06-1217 - Administrative case management funding as part of PCG initiative	$0	$0	$570,405	$0	$0
HB 06-1395 - Psychiatric Residential Treatment Facilities Bill	$0	$0	$0	$8,747,740	$0
SB 06-219 - Removal of administrative case management funding	$0	$0	$0	($588,944)	$0
Final Appropriation / Request	**$77,861,994**	**$71,978,806**	**$75,826,635**	**$34,063,555**	**$34,063,555**
General Fund	$38,930,997	$35,989,403	$37,913,318	$17,031,778	$17,031,778
Federal Funds	$38,930,997	$35,989,403	$37,913,317	$17,031,777	$17,031,777

(E) DIVISION OF CHILD WELFARE - CONTINGENCY FEE FOR FEDERAL FUNDS MAXIMIZATION

This line item was added through the Department's FY 05-06 Supplemental (HB 06-1217) to provide spending authority for the Department of Human Services to pay Public Consulting Group a contingency fee associated with a federal revenue maximization

project that enabled the State to claim federal matching funds on administrative case management in both the Child Welfare Services and Families and Children's Program line items. The total contingency fee was appropriated as one-time funding in FY 05-06 equal to $183,269. There is no requested funding for this appropriation in FY 07-08.

Line Item: DHS Medicaid Funded Programs, Contingency Fee for Federal Funds Maximization	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year's Final Appropriation	**N/A**	**$183,629**	**$0**
Removal of one-time funding from prior year		($183,269)	$0
Long Bill Appropriation	**$0**	**$0**	**$0**
HB 06-1217 – Created new line item for contingency fee to contractor	$183,629	$0	$0
Final Appropriation / Request	**$183,629**	**$0**	**$0**
Federal Funds	$183,629	$0	$0

(E) DIVISION OF CHILD WELFARE - FAMILY AND CHILDREN'S PROGRAMS

The Family and Children's program was established in the Department of Human Services budget as a result of the child welfare settlement agreement (finalized in February 2005). This settlement agreement required a number of improvements in the child welfare system, including: an increase in the number of county caseworkers and supervisors; improvements in the amount and types of training provided to caseworkers, supervisors, and out-of-home care providers; the provision of core services to children and families; improvements in investigations, needs assessments, and case planning; improvements in services to children placed in residential care; increased rates for out-of-home care providers; elimination of certain rate disparities and the development of a unitary computerized information system (Department of Human Services' Figure Setting, March 8, 2006, page 100). This program serves children who are dependent and neglected or abused, delinquent or in conflict with their families or communities.

This program only provides "core services" to families with children in imminent risk of placement outside the home, pursuant to Section 19-3-208, C.R.S (2006). Core services are determined to be necessary and appropriate by individualized case plans, and may include: transportation, child care, in-home supportive homemaker diagnostic services, mental health and health care services, drug and alcohol treatment services, after care services to prevent the return to out-of-home placement family support services while a child is in out-of home placement (including home-based services), family counseling, financial services in order to prevent placement, and family preservation services (Department of Human Services Figure Setting, February 9, 2005, pages 31-33). Additional emergency assistance pursuant to Section 26-5.3-105, C.R.S. (2006) shall also be made available. Emergency assistance includes 24-hour emergency shelter facilities, information referral, intensive family preservation services, in-home supportive homemaker services, services used to develop and implement a discrete case plan and day treatment services for children.

Medicaid funding for this program is only attributable to the administrative case management component of the above services and clients.

Appropriation History

Through the passage of the Department's FY 05-06 Supplemental (HB 06-1217), funding for administrative case management related to the Family and Children's Program was appropriated at $973,056. This Supplemental appropriation was the result of an Office of State Planning and Budgeting federal revenue maximization project in which the Governor's Office contracted with Public Consulting Group to assist the State in researching and recovering additional federal matching funds, including Medicaid.

For FY 06-07, funding for this line item was increased above the previous year's appropriated amount to incorporate a 3.25% cost-of-living adjustment equal to $31,624 as part of a Joint Budget Committee action (Department of Human Services' Figure Setting, March 8, 2006, page 103). However, the net amount of these figures was transferred with the passage of SB 06-219, and moved to the Department of Health Care Policy and Financing's (1) Executive Director's Office Long Bill group. Thus, there is no appropriation for this line item in FY 06-07.

The Department's FY 07-08 Base Request does not request an appropriation for this program.

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare - Family and Children's Programs	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$973,056**	**$0**
3.25% cost-of-living adjustment as part of a Joint Budget Committee action	$0	$31,624	$0
Long Bill Appropriation	**$0**	**$1,004,680**	**$0**
HB 06-1217 - Administrative case management funding as part of PCG initiative	$973,056	$0	$0
SB 06-219 - Removal of administrative case management funding	$0	($1,004,680)	$0
Final Appropriation / Request	**$973,056**	**$0**	**$0**
General Fund	$486,528	$0	$0
Federal Funds	$486,528	$0	$0

(E) OFFICE OF SELF SUFFICIENCY, DISABILITY DETERMINATION SERVICES

The Disability Determination Services line provided Medicaid funding to the Department of Human Services for disability determinations for individuals waiting for determinations of Supplemental Security Income, or who were not financially eligible for Supplemental Security Income, but who were potentially eligible for Medicaid due to a disability. The FY 03-04 Long Bill appropriation was $1,165,967.

Change from the FY 03-04 final appropriation to the FY 04-05 Long Bill was a decrease of $2,305 for an unknown reason. Following the FY 04-05 Long Bill (HB 04-1422) appropriation of $1,163,662, a 1331 Emergency Supplemental submitted to the Joint Budget Committee on June 7, 2004 eliminated the spending authority for this appropriation, and moved it into the Department of Health Care Policy and Financing's (1) Executive Director's Office Long Bill group (SB 05-112). Since this time, there has not been an appropriation for this budgetary line. The Department's FY 07-08 Base Request does not request any funding for this purpose.

Line Item: DHS Medicaid Funded Programs, Disability Determination Services	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year's Final Appropriation	**N/A**	**$1,165,967**	**$0**	**$0**	**$0**
Adjustment to appropriation for unknown reason	$0	($2,305)	$0	$0	$0
Long Bill Appropriation	**$1,165,967**	**$1,163,662**	**$0**	**$0**	**$0**
SB 05-112 - transferred responsibility to the Department of Health Care Policy and Financing	$0	($1,163,662)	$0	$0	$0
Final Appropriation / Request	**$1,165,967**	**$0**	**$0**	**$0**	**$0**
General Fund	$582,984	$0	$0	$0	$0
Federal Funds	$582,983	$0	$0	$0	$0

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES –ADMINISTRATION

The Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding, Administration line item funds the Medicaid portion of operating functions associated with the Alcohol and Drug Abuse Division, including: development of policies, standards, rules and regulations; planning, contracting; allocation of resources; program and contract monitoring; technical assistance; program evaluation and outcome measurement; and the development and maintenance of management information systems. For FY 06-07, there were 38.1 FTE appropriated to the Department of Human Services to provide management oversight, budgeting/accounting functions, and program administration for the Alcohol and Drug Abuse Division (Department of Human Services Figure Setting, March 10, 2006, pages 22-23). Some or all of the 38.1 FTE receive Medicaid funding.

Prior to April 1, 2004, this appropriation also included funding for the oversight of the Medicaid portion of the mental health program. However, with the passage of HB 04-1265, both the administration and the program expenditures associated with Medicaid community mental health services was transferred from the Department of Human Services to the Department of Health Care Policy and Financing.

Appropriation History

The FY 03-04 Long Bill (SB 03-258) included an appropriation of $1,316,654 for this program. As stated above, this amount was revised with the passage of HB 04-1265 that transferred the administration of Medicaid mental health programs from the Department of Human Services to the Department of Health Care Policy and Financing. This reduction was for the last quarter of FY 03-04 in the amount of $259,274.

The FY 04-05 Long Bill amount of $277,951 incorporated the two adjustments to the final FY 03-04 appropriation: the remaining three quarters of funding for Medicaid mental health administration equal to $777,822 was transferred from this appropriation to the Department of Health Care Policy and Financing; and a reduction of $1,607 for Common Policy adjustments for Salary Survey, Performance-Based Pay, and the 0.2% vacancy savings.

The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill appropriation included increases of $9,778 in Common Policy, and $11,274 in operating expenses. The FY 05-06 Long Bill appropriation was therefore $299,003.

The FY 06-07 Long Bill was for a net increase in POTS of $8,348 over the FY 05-06 final appropriation. The FY 06-07 Long Bill and final appropriation were $307,351. The FY 07-08 Base Request is for $317,999, reflecting an increase of $11,241 for Salary Survey and a reduction of $593 for the 0.2% vacancy savings.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services, Administration	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$1,057,380**	**$277,951**	**$299,003**	**$307,351**
Annualize transfer of Medicaid mental health administration to the Department of Health Care Policy and Financing for remaining three quarters	$0	($777,822)	$0	$0	$0
Common Policy adjustment for 0.2% vacancy savings	$0	($1,607)	$0	$0	$0
Operating Expenses adjustment	$0	$0	$11,274	$0	$0
Common Policy adjustment for Salary Survey, Pay-for-Performance, and 0.2% vacancy savings	$0	$0	$9,778	$0	$0
Common Policy adjustment for Salary Survey and 0.2% vacancy savings	$0	$0	$0	$8,348	$0
Common Policy adjustment for Salary Survey	$0	$0	$0	$0	$11,241
Common Policy adjustment for 0.2% vacancy savings factor	$0	$0	$0	$0	($593)

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services, Administration	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Long Bill Appropriation	**$1,316,654**	**$277,951**	**$299,003**	**$307,351**	**$317,999**
HB 04-1265 - Transferred one quarter of Medicaid mental health administration funding to the Department of Health Care Policy and Financing	($259,274)	$0	$0	$0	$0
Final Appropriation / Request	**$1,057,380**	**$277,951**	**$299,003**	**$307,351**	**$317,999**
General Fund	$457,711	$138,976	$149,502	$153,676	$159,000
Federal Funds	$599,669	$138,975	$149,501	$153,675	$158,999

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES - GOEBEL LAWSUIT SETTLEMENT

This line was created in FY 03-04 to fund services for approximately 1,600 mentally ill individuals in northwest Denver. Mentally ill individuals suffer from chronic conditions such as bipolar disorder and schizophrenia that seriously impair their ability to be self-sufficient. The Goebel lawsuit combined two class action suits alleging that residents of northwest Denver with chronic mental illness were being denied services (Department of Human Services Figure Setting, March 10, 2004, page 66). As a result of this lawsuit, compliance requirements included (1) service hours required for 1,600 continuously enrolled class members on ten case management teams; (2) comprehensive integrated substance abuse services for 320 clients; (3) reasonable fund raising efforts by the Mental Health Corporation of Denver; and (4) continuing efforts toward providing the least restrictive treatment that meet the needs of four of six surviving named plaintiffs.

The State's obligation under the Goebel lawsuit agreement required that the State successfully meet the requirements for consecutive four-month period blocks for a period of two years. The Attorney General's Office and the plaintiff's attorney signed the stipulation document indicating that the service hour requirement was met in July 2005. The court monitor's February 15, 2006 report found that the State had complied with the last required four-month period for the mental health and dual diagnosis (substance abuse) portion of the services, and the case was dismissed on March 31, 2006.

Prior to FY 06-07, payments for these lawsuit services were made from the Medicaid Mental Health Community Programs, Mental Health Capitation Payments line item. However, the Department's 1331 Emergency Supplemental approved on September 20, 2006 transferred this funding and administration to the Department's Medicaid Mental Health Program beginning in FY 06-07. This action was the result of the Department working with its contracted actuary to review Goebel-specific encounter and eligibility data, to determine if an actuarially certified payment could be included in the Mental Health Capitation Payments line item.

While the FY 07-08 Base Request for this line has continuation funding from the FY 06-07 Long Bill, the Department has requested, through Decision Item #2 in this FY 07-08 Budget Request, for a similar transfer of the appropriation and administration of Goebel payments in FY 07-08 and onward.

Appropriation History

The Department's FY 03-04 Supplemental Bill (HB 04-1320) established $12,119,721 in spending authority for the Goebel Lawsuit as a separate line item in the Department's budget. This amount was later revised through the Add-on section of the FY 04-05 Long Bill (HB 04-1422) to reduce this amount by $464,135 due to the elimination of a double-count of Medicaid moneys for the last four to five years (Department of Human Services, March 10, 2004, page 67). While this amount did not change for the remainder of the year, this line was affected by the 2.95% increase in federal medical assistance percentage (FMAP) for FY 03-04. This increase was an accounting adjustment between State and federal fund splits only, and was budget neutral to the total appropriation.

The FY 04-05 Long Bill (HB 04-1422) was appropriated with continuation funding from FY 03-04. However, this amount was increased for the subsequent fiscal year due to a Joint Budget Committee action to include a 2.0% provider rate increase (Department of Human Services' Figure Setting, March 10, 2005, page 43). This adjustment increased the FY 05-06 Long Bill appropriation to $11,888,698.

A Joint Budget Committee action on March 10, 2006 again increased provider reimbursement rates the following fiscal year, adding an additional 3.25% to the appropriated rates (Department of Human Services Figure Setting, page 53). This adjustment increased the FY 06-07 Long Bill appropriation by $386,383 above the previous fiscal year amount, to a total appropriation of $12,275,081 (Department of Human Services Figure Setting, March 10, 2006, page 53).

On September 20, 2006 the Joint Budget Committee approved the Department's 1331 Emergency Supplemental to transfer this funding from the Department of Human Services, Goebel Lawsuit Settlement line item to the Department of Health Care Policy and Financing's (3) Medicaid Mental Health Community Programs, Mental Health Capitation Payments line item. This action was required to address the Centers for Medicare and Medicaid Services concerns that these payments were "supplemental payments" now that the court order was removed.

While continuation funding of the FY 06-07 appropriated amount has been requested for the Department's FY 07-08 Base Request, the Department has also submitted Decision Item #2 in the FY 07-08 Request to transfer this funding and administration of this Medicaid funding into the Department of Health Care Policy and Financing's (3) Medicaid Mental Health Community Programs, Mental Health Capitation line item.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services - Goebel Lawsuit Settlement	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year's Final Appropriation	**N/A**	**$11,655,586**	**$11,655,586**	**$11,888,698**	**$0**
2.0% provider rate increase	$0	$0	$233,112	$0	$0
3.25% provider rate increase	$0	$0	$0	$386,383	$0
Reversal of 1331 Pay Goebel Lawsuit Settlement Costs through Mental Health Capitation	$0	$0	$0	$0	$12,257,081
Long Bill Appropriation	**$0**	**$11,655,586**	**$11,888,698**	**$12,275,081**	**$12,257,081**
HB 04-1320 - Supplemental Bill creating new line item	$12,119,721	$0	$0	$0	$0
HB 04-1422 Add-on - Reduction due to adjust HB 04-1320 to actual and eliminate double count	($464,135)	$0	$0	$0	$0
1331 Pay Goebel Lawsuit Settlement Costs through Mental Health Capitation appropriation	$0	$0	$0	($12,275,081)	$0
Spending Authority / Request	**11,655,586**	**11,655,586**	**11,888,698**	**$0**	**12,257,081**
General Fund	$5,827,793	$5,827,793	$5,944,349	$0	$6,128,541
Federal Funds	$5,827,793	$5,827,793	$5,944,349	$0	$6,128,540

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES - RESIDENTIAL TREATMENT FOR YOUTH (HB 99-1116)

The Residential Treatment for Youth program provides services to Medicaid-eligible children residing in residential childcare facilities, as well as children placed in out-of-home placement facilities. The program provides funding to assist families in placing their children in treatment residential child care facilities when their children are not categorically eligible for Medicaid based on income criteria not suitable for a placement based on "dependency and neglect" criteria (Department of Human Services Figure Setting, March 10, 2006, page 53). SB 03-083, signed June 5, 2003 extended the repeal date to July 1, 2008.

Appropriation History

Prior to FY 03-04, this appropriation was included in the Department's budget under the Division of Children's Health and Rehabilitation Children's Mental Health Services section, and was funded entirely with General Fund, with federal matching funds. Beginning in FY 03-04, however, SB 03-282 appropriated a new funding source for the State contribution, replacing the General Fund appropriations with Cash Funds Exempt funding from the Tobacco Master Settlement Agreement. The final FY 03-04 appropriation was equal to $355,436.

For FY 04-05, there were two pieces of legislation approved by the General Assembly which included appropriation clauses related to Tobacco Master Settlement Agreement monies, SB 04-065 and HB 04-1421. However, SB 04-065 included in the appropriation clause an override stipulating that if HB 04-1421 was enacted, the appropriation clause of SB 04-065 would not take effect. Therefore, based on the enactment of HB 04-1421, the initial FY 04-05 appropriation was for $418,132. This amount was later revised pursuant to the Add-On section of the FY 05-06 Long Bill (SB 05-209) to increase funding by $64,274 for a greater number of Residential Treatment for Youth clients and higher Medicaid costs (Department of Human Services Figure Setting, March 10, 2005, page 45). This Supplemental increase was comprised of 50% General Fund and 50% federal match. Finally, late in the 2005 Legislative session, a revised Tobacco Master Settlement Agreement projection was passed in SB 05-249, allocating an additional $224 to this program. The FY 04-05 final appropriation was therefore equal to $482,630.

The FY 05-06 Long Bill was for $472,423, reflecting a reduction from the final FY 04-05 appropriation of $190 in Tobacco Master Settlement Agreement funding and an adjustment to reduce General Fund by $10,017 (Department of Human Services Figure Setting, March 10, 2005, page 46). This remained as the final appropriation for the fiscal year.

For FY 06-07, continuation funding from the previous year was increased by $15,354 to reflect a 3.25% provider rate increase that was recommended by the Joint Budget Committee for nearly all State providers. As such, the FY 06-07 Long Bill was set at $487,777.

Note that a September 20, 2006 1331 Emergency Supplemental was recommended by the Joint Budget Committee to remove $393,697 from this line item. This action was the result of the significant changes to the Regional Treatment Centers program, approved with the passage of HB 06-1395. Unfortunately, this line item was overlooked when reviewing the fiscal note for this new legislation. The requested dollar amount reflects the Tobacco Master Settlement Agreement funding that was appropriated to the Department every year, and includes matching federal funds. As the federal Centers for Medicare and Medicaid Services indicated that Title XIX federal funds were not allowed for many of these functions, the Department of Human Services requested that the State portion of these dollars (from the Tobacco Master Settlement Agreement) be appropriated directly to that department. This approved 1331 Emergency Supplemental approved spending authority changes in FY 06-07 only, and does not change the official appropriation for this program until it is written into law.

The Department has requested continuation funding for the FY 07-08 Base Request.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services - Residential Treatment of Youth	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**$0**	**$355,436**	**$482,630**	**$472,423**	**$487,777**
Removal of previous year's Tobacco Master Settlement Agreement funding	$0	($355,436)	$0	$0	$0
Revised Tobacco Master Settlement Agreement funding	$0	$0	($190)	$0	$0
Reduction to General Fund need for caseload beyond Tobacco Master Settlement Agreement funding	$0	$0	($10,017)	$0	$0
3.25% provider rate increase	$0	$0	$0	$15,354	$0
Long Bill Appropriation	**$0**	**$0**	**$472,423**	**$487,777**	**$487,777**
SB 03-282 - Allocation of Tobacco Master Settlement Agreement funding	$355,436	$0	$0	$0	$0
HB 04-1421 - Allocation of Tobacco Master Settlement Agreement funding	$0	$418,132	$0	$0	$0
SB 05-209 Add-ons - Increased Caseload and Medicaid Share (General Fund and federal match only)	$0	$64,274	$0	$0	$0
SB 05-249 Add-ons - Revised allocation of Tobacco Master Settlement Agreement funding	$0	$224	$0	$0	$0
Final Appropriation / Request	**$355,436**	**$482,630**	**$472,423**	**$487,777**	**$487,777**
General Fund	$0	$32,137	$27,183	$34,278	$34,278
Cash Funds Exempt	$177,718	$209,178	$209,029	$209,611	$209,611
Federal Funds	$177,718	$241,315	$236,211	$243,888	$243,888

(F) MENTAL HEALTH AND ALCOHOL AND DRUB ABUSE SERVICES - MENTAL HEALTH INSTITUTES

Mental Health Institutes provide inpatient hospitalization for seriously mentally ill residents. These facilities provide both evaluation services and treatment for those individuals who cannot function in less restrictive settings. The State operates two hospitals for the severely mentally ill: the Fort Logan Mental Health Institute located in Denver, and the Pueblo Mental Health Institute. The institutes provide inpatient psychiatric hospital services to citizens of Colorado (ages five and older) having a major illness such that the individual cannot be expected to function and/or be treated in the community. Both locked and unlocked treatment units are provided with a wide variety of assessment and treatment services offered to patients. Services include: individual, group, and family therapy; treatment goal setting; work therapy; community readiness skills; medication and health education; education programs (ages K-12

and adult); pastoral services; substance abuse education and treatment; and discharge and aftercare planning. (Department of Human Services' Narrative, November 15, 2006, pages C-8-43 to 45).

Appropriation History

The FY 03-04 Long Bill (SB 03-258) included an appropriation of $3,325,830. Through the passage of the Department's FY 03-04 Supplemental Bill (HB 04-1320), this amount was increased with one-time funding equal to $430,202 to support projected expenditures for June 2003 as utilization in the program was higher than originally anticipated (non-prioritized Supplemental NP-S6, submitted January 2, 2004). Additionally, a late Supplemental requested by the Department (non-prioritized Supplemental NP-S23, submitted March 3, 2004) increased the appropriation by $1,244,648 due to revised shortfalls estimated for the Mental Health Assessment and Services Agencies' purchasing of beds. This amount was officially appropriated in the Add-ons section of the FY 04-05 Long Bill (HB 04-1422), and was for only three quarters of the fiscal year. The sum of these changes resulted in a final appropriation for FY 03-04 equal to $5,000,680, of which half was State funded, and half federally funded. While there was no change to the total appropriation, this program was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This enhanced match rate therefore only revised the fund splits for the spending authority in this appropriation, and was merely an accounting function.

In addition to the removal of $430,202 (non-prioritized Supplemental S-6, January 2, 2004) in one-time funding and the annualization of the revised shortfall in purchasing of beds equal to an additional $312,243, the FY 04-05 Long Bill included an adjustment to the final FY 03-04 appropriation for a reduction of $6,651. This adjustment was for a POTS and Salary Survey correction. Therefore, the FY 04-05 Long Bill appropriation became $4,876,070. This amount was revised through the passage of the Add-ons section of the FY 05-06 Long Bill (SB 05-209) due to declining patient revenues collected in the fee-for-service program at the institutes, reducing the Long Bill amount by $353,250, for a final FY 04-05 appropriation of $4,522,820 (Department of Human Services' Figure Setting, March 10, 2005, page 63).

Continuation funding from FY 04-05 was appropriated in the FY 05-06 Long Bill (SB 05-209). The only change between the final FY 05-06 appropriation and spending authority in the FY 06-07 Long Bill was an increase of $423,288 related to patient revenue projections (Department of Human Services' Figure Setting, March 10, 2006, page 61). Therefore, the FY 06-07 Long Bill appropriation was $4,946,108.

Continuation funding is being requested in for the FY 07-08 Base Request.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services – Mental Health Institutes	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08 Base Request
Prior Year's Final Appropriation	**$0**	**$5,000,680**	**$4,522,820**	**$4,946,108**	**$4,946,108**
Removal of one-time funding from S-6 for prior year	$0	($430,202)	$0	$0	$0
Removal of additional one-time funding for a POTS and Salary Survey correction	$0	($6,651)	$0	$0	$0
Annualization for revised shortfall in purchasing beds estimate for one quarter	$0	$312,243	$0	$0	$0
Long Bill Appropriation	**$3,325,830**	**$4,876,070**	**$4,522,820**	**$4,946,108**	**$4,946,108**
HB 04-1320 - One-time funding to support projected expenditures	$430,202	$0	$0	$0	$0
HB 04-1422 Add-ons - Revised shortfall in purchasing beds estimate equal to three quarters	$1,244,648	$0	$0	$0	$0
SB 05-209 Add-ons - Reduced patient revenue in fee-for-service clients	$0	($353,250)	$0	$0	$0
HB 06-1385 Add-ons - Revised estimate for patient revenue in fee-for-service clients	$0	$0	$423,288	$0	$0
Final Appropriation / Request	**$5,000,680**	**$4,522,820**	**$4,946,108**	**$4,946,108**	**$4,946,108**
General Fund	$2,500,340	$2,261,410	$2,473,054	$2,473,054	$2,473,054
Federal Funds	$2,500,340	$2,261,410	$2,473,054	$2,473,054	$2,473,054

(F) MENTAL HEALTH AND ALCOHOL AND DRUB ABUSE SERVICES - ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION

During FY 05-06 Figure Setting, the Joint Budget Committee separated the administration budget from the services budget for the high-risk pregnant women program. Again, some or all of the FTE qualify for Medicaid funding. The appropriation in the Department of Human Services funded in part by Health Care Policy and Financing supports staff activities including: 1) formulating and maintaining alcohol and other drug treatment licensing standards authorized by the State Board of Human Services; 2) investigating complaints and critical incidents involving licensed treatment providers and medical practitioners; 3) partnering with federal, State, county and local agencies to design, initiate and maintain additional treatment and prevention resources; and, 4) managing the statewide involuntary commitment process that includes making treatment recommendations, arranging placements and monitoring progress for persons who are legally committed to the Division by the court because they pose a danger or are incapacitated due to the abuse of alcohol and other drugs. Additionally, this funding also supports 5) maintaining a central registry of

all clients enrolled in opiate replacement treatment programs; 6) developing and expanding specialized substance abuse services for women, pregnant women, and women with dependent children; 7) contract for a survey of 6th, 8th, 10th, and 12th graders to determine their use of alcohol and other drugs; 8) maintains a prevention resource system that provides technical assistance, training materials for school districts, community agencies, and the general public; and, 9) collects, processes, analyzes and provides reports to the State and federal agencies, State and local planning groups, the media and general public on data that measures and evaluates the nature and extent of substance abuse, the existing and needed level of prevention and treatment resources, program activity and the outcome and impact of services (Department of Human Services Budget Narrative, November 15, 2006, Binder 1, page C-8-12 through 16).

Other functions the Alcohol and Drug Abuse staff manages are the federal block grants and contract with the four managed service organizations that subcontract with 41 treatment providers in approximately 621 treatment facilities throughout Colorado. Finally, staff oversees and provides technical assistance to 91 prevention program contracts (Department of Human Services Figure Setting, March 10, 2006, page76).

Appropriation History

FY 05-06 was the first fiscal year that this line item was separated into its own appropriation in the Department of Health Care Policy and Financing's budget. The FY 05-06 Long Bill included $17,213 for Personal Services and Operating Expenses associated 0.3 FTE. This amount annualized to $54,088 in the FY 06-07 Long Bill. The FY 07-08 Base Request is for continuation funding.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services - Alcohol and Drug Abuse Division, Administration	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$17,213**	**$54,088**
Annualization for remaining Personal Services for 0.7 FTE	$0	$35,923	$0
Annualization of Operating Expenses	$0	$952	$0
Long Bill Appropriation	**$17,213**	**$54,088**	**$54,088**
General Fund	$8,607	$27,044	$27,044
Federal Funds	$8,606	$27,044	$27,044

(F) MENTAL HEALTH AND ALCOHOL AND DRUB ABUSE SERVICES - ALCOHOL AND DRUG ABUSE DIVISION, HIGH-RISK PREGNANT WOMEN PROGRAM

The High-Risk Pregnant Women Program, also called "Special Connections", is a program to promote healthy moms and babies, and is a statewide voluntary alcohol and drug treatment program for pregnant substance-involved women who are at risk of a poor birth outcome due to substance abuse. This program was developed with the following goals: (1) produce a healthy infant; (2) reduce or

stop substance using behavior in pregnant woman during and after pregnancy; (3) promote and assure a safe child-rearing environment for the newborn and other children; and (4) maintain the family unit, the mother, infant, and other family members. Low income pregnant women, regardless of Medicaid eligibility, may receive these services from 13 designated treatment providers throughout the State. Services include an in-depth assessment, individual and group counseling, case management services, health education, and urinalysis screening and monitoring. Services are provided primarily in an outpatient setting, but limited residential services are also available. This line provides Medicaid funding for prenatal and postpartum services for women at risk due to alcohol or substance abuse. HB 04-1075 directed the Department of Health Care Policy and Financing to request a waiver from the Centers for Medicare and Medicaid Services to extend the postpartum period of services from 60 days to 12 months. As of September 25, 2006 the amendment to the waiver is still pending with the Centers for Medicare and Medicaid Services.

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation for this program was $312,804. This initial amount was increased with the passage of the Department's FY 03-04 Supplemental Bill (HB 04-1320) to increase spending authority in the current fiscal year due to: 1) an overexpenditure in the prior fiscal year for $85,293, and 2) NP-8 a caseload adjustment of $159,111 per non-prioritized Supplemental S-8, January 2, 2004. Therefore, including this one-time increase of $244,404, the final FY 03-04 appropriation was $557,208. While there was no change to the official appropriation, for the fourth quarter of FY 02-03, and all of FY 03-04, this line was affected by the 2.95% increase in federal medical assistance percentage (FMAP). This adjustment was an accounting function revising the amount of federal funds drawn per State dollar, and did not affect the spending authority in total.

The FY 04-05 Long Bill (HB 04-1422) was appropriated at continuation funding from the final FY 03-04 amount after the removal of the $85,293 in one-time funding associated with overexpenditure relief. This initial FY 04-05 Long Bill appropriation of $471,915 was later revised to include the impact of HB 04-1075 which extended postpartum services from 60 days to 12 months, and the impact of SB 05-112 for increased caseload and relief from FY 03-04 overexpenditure of $231,302. These two bills added $95,805 and $565,947, respectively, increasing the final FY 04-05 appropriation to $1,133,667.

In addition to the $31,935 annualization of HB 04-1075 for extension of post-partum services beyond the 60 day limit, the FY 05-06 Long Bill (SB 05-209) also included a Joint Budget Committee recommendation of $18,686 for a 2.0% provider rate increase, and the removal of $231,302 appropriated in the prior year for overexpenditure relief from FY 02-03 (Department of Human Services' Figure Setting, March 10, 2005, page 83). The sum of these changes resulted in a FY 05-06 Long Bill appropriation of $952,986.

The only adjustment to final FY 05-06 funding to arrive at the FY 06-07 Long Bill (HB 06-1385) appropriation of $983,958 includes a 3.25% provider rate increase recommended by the Joint Budget Committee for most all State providers.

The FY 06-07 Long Bill and the FY 07-08 Base Request are for continuation funding.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services – Alcohol and Drug Abuse Division, High-Risk Pregnant Women	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$557,208**	**$1,133,667**	**$952,986**	**$983,958**
Removal of one-time relief from prior year overexpenditure	$0	($85,293)	$0	$0	$0
Annualization of HB 05-1075 for post-partum benefits beyond 60 day limit	$0	$0	$31,935	$0	$0
2.0% provider rate increase recommended by Joint Budget Committee	$0	$0	$18,686	$0	$0
Relief of overexpenditure restriction from FY 03-04	$0	$0	($231,302)	$0	$0
3.25% provider rate increase recommended by Joint Budget Committee	$0	$0	$0	$30,972	$0
Long Bill Appropriation / Request	**$312,804**	**$471,915**	**$952,986**	**$983,958**	**$983,958**
HB 04-1320 - Caseload growth and one-time relief from FY 02-03 overexpenditure	$244,404	$0	$0	$0	$0
HB 05-1075 - Extension of post-partum benefits from 60 days to 12 months	$0	$95,805	$0	$0	$0
SB 05-112 - Additional funding for caseload growth	$0	$565,947	$0	$0	$0
Final Appropriation / Request	**$557,208**	**$1,133,667**	**$952,986**	**$983,958**	**$983,958**
General Fund	$278,604	$518,931	$476,493	$491,979	$491,979
Cash Funds Exempt	$0	$47,902	$0	$0	$0
Federal Funds	$278,604	$566,834	$476,493	$491,979	$491,979

(G) SERVICES FOR PEOPLE WITH DISABILITIES – SERVICES FOR PEOPLE WITH DISABILITIES – COMMUNITY SERVICES ADMINISTRATION

A Joint Budget Committee action during the Department of Human Services' Figure Setting on February 17, 2005 separated all administrative funding from the services appropriation for Community Services. Funding in the Department's budget is to support a portion of total costs associated with some or all of the 32.4 FTE, including the new FTE for quality assurance, providing oversight to the Division of Developmental Disabilities. Responsibilities for these FTE include: oversight of State programs for persons with developmental disabilities, including services directly administered by community centered boards and services provided in the State-

operated regional centers (Department of Human Services Figure Setting, February 23, 2006, page 68). In addition, this appropriation supports one FTE responsible for quality assurance.

Appropriation History

This appropriation was initially set equal to $2,337,168 with the passage of the FY 05-06 Long Bill (SB 05-209). No changes were made to this amount through the end of the fiscal year. However, to arrive at the FY 06-07 Long Bill (HB 06-1385) amount of $2,438,131, the new fiscal year appropriation included: 1) changes in Common Policies for Salary Survey equal to $61,094 and the 0.2% vacancy savings reduction equal to $4,504, 2) approval of the Department's request to add a quality assurance position, requiring $40,585 in Personal Services and $3,788 in Operating Expenses (non-prioritized Decision Item NP-8, November 15, 2005).

The FY 07-08 Base Request for this appropriation includes two Common Policy adjustments equal to an increase of $59,056 and a decrease of $4,394 for Salary Survey and the 0.2% vacancy savings reduction, respectively. Additional adjustments include a decrease of $3,288 for Operating Expenses and an increase of $3,972 for Personal Services for the Quality Assurance FTE. Therefore, the FY 07-08 Base Request is equal to $2,493,477.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities – Community Services Administration	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$2,337,168**	**$2,438,131**
Add Personal Services associated with new quality assurance FTE	$0	$40,585	$0
Add Operating Expenses associated with new quality assurance FTE	$0	$3,788	$0
Common Policy adjustment for Salary Survey	$0	$61,094	$59,056
Common Policy adjustment for 0.2% vacancy savings factor	$0	($4,504)	($4,394)
Annualization of Operating Expenses for Quality Control	$0	$0	($3,288)
Annualization of Personal Services for Quality Control	$0	$0	$3,972
Long Bill Appropriation / Request	**$2,337,168**	**$2,438,131**	**$2,493,477**
General Fund	$1,168,584	$1,219,066	$1,246,739
Federal Funds	$1,168,584	$1,219,065	$1,246,738

(G) SERVICES FOR PEOPLE WITH DISABILITIES - COMMUNITY SERVICES ADULT PROGRAM COSTS AND CCMS REPLACEMENT

This line item was appropriated to fund Medicaid eligible services for approximately 7,000 clients under the Home and Community Based Services – Comprehensive Developmental Disabilities (Department of Human Services Figure Setting, February 23, 2006, page 66). Case management and utilization review, which includes Pre-Admission Screening and Annual Resident Reviews (PASARR), are provided to clients through 20 community centered boards throughout the State. Waiver services are delivered through community providers, including community centered boards and three State operated regional centers.

Waiver services include: 1) Home and Community Based Services – Comprehensive Developmental Disabilities provides persons with developmental disabilities services and support which allows them to continue to live in the community outside of the family home. These include such things as day habilitation, residential habilitation, and transportation. 2) Home and Community Based Services – Supported Living Services provide persons with developmental disabilities supported living in the home or community. Services include specialized medical equipment and supplies, counseling, dental services, home modifications, and transportation. 3) Children's Extensive Support provides residential services for children with developmental disabilities or delays that are most in need due to the severity of their disability. Services include specialized medical equipment and supplies, community connection services, home modifications, personal assistance, and professional services.

Prior to July 1, 2006, the Department of Human Services operated under a "Systems Change Project" which applied a managed care approach to delivering developmental disability services, allowing community centered boards to negotiate rates with their providers in order to get a better rate for each service. The Department of Human Services used a bundled rate methodology to reimburse the community centered boards through the CCMS for client services. However, based on results of an audit issued by the Centers for Medicare and Medicaid Services on April 26, 2004, indicating a lack of accountability and eligibility of federal Medicaid funding, the State was instructed to establish a new uniform rate setting methodology for the Home and Community Based Services – Developmental Disabilities waiver. In addition, the audit required the State to: 1) provide evidence assuring State administrative authority over the waiver, 2) ensure an effective quality management system to address incidents and other health and welfare issues, and 3) place all financially accountability for waivered programs on the Department of Health Care Policy and Financing.

Based on these audit requirements, the State, in order to address the above mentioned problem areas, organized a steering committee comprised of Department of Human Services and Department of Health Care Policy and Financing representatives, Office of State Planning and Budgeting staff, and members from the community centered boards. Based on committee efforts through much of the second half of FY 05-06, a new seven-tiered services matrix, based upon a fee-for-service reimbursement methodology, was developed and put into use beginning July 1, 2006. Under this new methodology, clients are assigned to one of seven acuity levels according to his/her required service needs, and all providers must bill the State directly or as a contractor of the community centered

board may bill through the community centered boards. However, the community centered boards must now bill through the Medicaid Management Information System (MMIS), to ensure that the required audit trail is established.

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation was $218,743,291. This amount was later reduced by $248,076 through the Department's FY 03-04 Supplemental Bill (HB 04-1320) for a requested reduction in room and board funding due to a reduced caseload. The final appropriation for FY 03-04 was therefore $218,495,215.

Changes from the FY 03-04 final appropriation to the FY 04-05 Long Bill (HB 04-1422) included an additional $93,650 decrease for annualizing the prior year's room and board reduction (non-prioritized Budget Amendment NP-6, submitted January 2, 2004), and an increase of $636,753 for developmental disability foster care, emergency, and waiting list resources, along with some adjustments to administrative costs in Personal Services. Based on these adjustments, the FY 04-05 Long Bill appropriation was set at $219,038,318.

However, based on requirements set by the federal Centers for Medicare and Medicaid Services, on September 3, 2004, the Department of Human Services and the Department of Health Care Policy and Financing submitted a joint 1331 Emergency Supplemental for FY 04-05 to remove all Medicaid State Plan services funding from the Community Services Adult Programs appropriation. With the passage of the Department's FY 04-05 Supplemental Bill (SB 05-112), funding for all Medicaid State Plan services was transferred from the Department of Human Services' appropriation to three existing line items within the Department of Health Care Policy and Financing's budget: (1) Executive Director's Office, Non-Emergency Transportation Services; (2) Medical Services Premiums; and, (3) Medicaid Mental Health Community Programs, Mental Health Fee-for-Service Payments. Therefore, the final FY 04-05 appropriation was equal to $217,907,468.

The FY 05-06 Long Bill (SB 05-209) appropriation reflected an increase of $5,880,664 over the FY 04-05 final appropriation. This increase included a Joint Budget Committee action for a 2.0% provider rate increase equal to $4,812,250, an increase for caseload in the amount of $2,366,195, and removal of administrative costs transferred into their own appropriation, including $2,038,821 for Personal Services and $147,534 for Operating Expenses. Other changes in the $5,880,644 above included the annualization of: 1) $1,265,524 for developmental disability foster care emergency and waiting list resources (Department of Human Services' Figure Setting, February 23, 2005, page 68), and, 2) removal of the remaining funding for Medicaid State Plan services equal to $376,950. Thus, the FY 05-06 Long Bill appropriation was set at $223,788,132.

Due to the passage of Referendum C, and subsequently HB 05-1262, the State elected to reduce the number of waiting list clients for the Children's Home and Community Based Services and Children's Extensive Support waiting lists. As these additional waiver slots met the definition of expansion populations as defined per HB 05-1262, State funding for these new clients was appropriated from tobacco tax revenues and matching federal funds in the amount of $161,320. Also in FY 05-06, a Joint Budget Committee action

which was made official through HB 06-1369 added $803,514 to this appropriation for a provider rate increase for residential and case management equal to $762,584, and 2) $70,930 for the elimination of the early intervention wait list. Finally, with the passage of the Add-on section of the FY 06-07 Long Bill (HB 06-1385), due to delays in obtaining federal approval for additional waiver slots and delays in implementing HB 05-1262, funding was reduced by $48,396, setting the final FY 05-06 appropriation equal to $224,704,570.

Changes from the final FY 05-06 appropriation to the FY 06-07 Long Bill (HB 06-1385) equaled a net increase of $23,490,335. These changes encompass a wide range of purposes including: 1) funding additional waiver slots in the Comprehensive Services and Support Living Services waivers equal to $6,595,650 and $1,015,513, respectively (Joint Budget Committee memo dated March 15, 2006); 2) funding for early intervention case management for 3,735 clients equal to $541,365 (Joint Budget Committee memo dated March 15, 2006); 3) a Joint Budget Committee recommended 3.25% provider rate increase equal to $7,355,735 (Department of Human Services' Figure Setting, February 23, 2006, page 77); 4) base rate increases for comprehensive services equal to $2,426,919 (Joint Budget Committee memo dated March 15, 2006); 5) annualization to HB 05-1262 funding equal to $63,060; and 6) annualization of the prior year's request for caseload and waiting list resources equal to $2,366,192 (Joint Budget Committee memo dated march 15, 2006). Other adjustments that were incorporated into the development of the FY 06-07 Long Bill included a Department of Human Services Change Request for $3,053,115 for additional caseload and waiting list resources (Department of Human Services' Figure Setting, February 23, 2006, page 77), a decrease of $12,298 to adjust funding of resources for the Post Eligibility Treatment of Income (PETI) program, an additional $18,736 for additional case management funding for Children's Extensive Support clients, and a Joint Budget Committee staff technical adjustment for an additional $66,348 for base rate increases. The FY 06-07 Long Bill appropriation was thus equal to $248,194,905.

On June 20, 2006, the Department submitted a corresponding Schedule 6 for a Department of Human Services' 1331 Emergency Supplemental requesting that the General Fund appropriation associated with the Joint Budget Committee's recommended 3.25% provider rate increase for FY 06-07 be appropriated to the Department of Human Services directly, thereby forfeiting the federal matching Medicaid funds, to be able to support existing demands in this program. The Department of Human Services identified this funding source due to the federal Centers for Medicare and Medicaid Services disapproval of requests for expanding the number of waiver slots and concerns with the existing program, which did not allow for the 3.25% provider rate to be distributed as a cost-of-living adjustment. Based on the Joint Budget Committee's approval of this recommendation, the revised spending authority for this program in FY 06-07 is $240,711,455, however, it does not change the official appropriation.

The FY 07-08 Base Request for this appropriation is $252,042,444. Changes from the current FY 06-07 Long Bill include annualization of the prior year's request for additional caseload and waiting list resources for $3,053,114 (non-prioritized Decision Item NP-2, submitted November 15, 2005), and an increase of $794,425 for a leap-year adjustment.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Community Services Adult Program Costs and CCMS Replacement	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$218,495,215**	**$217,907,468**	**$224,704,570**	**$248,194,905**
Annualization of room and board adjustment appropriated in prior year	$0	($93,650)	$0	$0	$0
Annualization of removal of State Plan services funding from prior year	$0	$0	($376,950)	$0	$0
Removal of all administrative funding from this appropriation, transferred to own line item	$0	$0	($2,186,355)	$0	$0
2.0% provider rate increase per Joint Budget Committee action	$0	$0	$4,812,250	$0	$0
Additional emergency and waiting list resources (half year only)	$0	$0	$2,366,195	$0	$0
Emergency and waiting list resources	$0	$636,753	$1,265,524	$2,366,192	$0
Reverse reduction to HB 05-1262 funding from prior fiscal year and annualize per fiscal note	$0	$0	$0	$63,060	$0
Additional emergency and waiting list resources requested for current year (NP-2, November 15, 2005)	$0	$0	$0	$3,053,115	$0
3.25% provider rate increase recommended by Joint Budget Committee	$0	$0	$0	$7,355,735	$0
Addition of 60 new Support Living Services waiver slots	$0	$0	$0	$1,015,513	$0
Addition of 90 new Comprehensive Services waiver slots	$0	$0	$0	$6,595,650	$0
Base rate increase for Comprehensive Services waiver	$0	$0	$0	$2,426,919	$0
Increase for targeted case management for 3,735 early intervention clients	$0	$0	$0	$541,365	$0
Reduction to Post Eligibility Treatment of Income funding	$0	$0	$0	($12,298)	$0

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Community Services Adult Program Costs and CCMS Replacement	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Technical adjustment for Children's Extensive Support resources and for targeted case management	$0	$0	$0	$18,736	$0
Technical adjustment for base rate increase	$0	$0	$0	$66,348	$0
Annualization of emergency and waiting list resources requested in prior year	$0	$0	$0	$0	$3,053,114
Leap year adjustment	$0	$0	$0	$0	$794,425
Long Bill Appropriation / Request	**$218,743,291**	**$219,038,318**	**$223,788,132**	**$248,194,905**	**$252,042,444**
HB 04-1320 - reduction for room and board	($248,076)	$0	$0	$0	$0
SB 05-112 - Removal of funding for State Plan services transferred to Health Care Policy and Financing	$0	($1,130,851)	$0	$0	$0
HB 05-1262 - Additional waiver slots added to Children's Home and Community Based Services and Children's Extensive Support Services waiver programs from tobacco tax revenue	$0	$0	$161,320	$0	$0
HB 06-1369 - Provider rate increase and elimination of early intervention waiting list	$0	$0	$803,514	$0	$0
HB 06-1217 - Revises fund splits for Pre-Admission Screening and Annual Residential Review (PASARR) - no total funds impact	$0	$0	$0	$0	$0
HB 06-1385 Add-ons - Reduction to tobacco tax funding for expansion slots due to delays in implementation and approval of revisions to the waiver from the Centers for Medicare and Medicaid Services	$0	$0	($48,396)	$0	$0
Final Appropriation / Request	**$218,495,215**	**$217,907,467**	**$224,704,570**	**$248,194,905**	**$252,042,444**
General Fund	$109,247,607	$108,953,734	$112,321,761	$124,034,816	$125,958,586
Cash Funds Exempt	$0	$0	$18,774	$32,364	$32,364
Federal Funds	$109,247,608	$108,953,733	$112,364,035	$124,127,725	$126,051,494

(G) SERVICES FOR PEOPLE WITH DISABILITIES - FEDERALLY-MATCHED LOCAL PROGRAM COSTS

The Federally–Matched Local Program Costs line enables the State to use locally generated funds to draw down federal match for services provided to clients enrolled in Home and Community Based Services' Comprehensive Developmental Disabilities, Supported Living Services, and Children's Extensive Support waivers. The Centers for Medicare and Medicaid Services approved Colorado's certification process to use these funds as the replacement for the State's share of General Fund. The intent of the additional funding is to enroll additional eligible individuals into the programs (Department of Human Services Figure Setting, February 23, 2006, page 93).

Appropriation History

This line was not included in the FY 03-04 Long Bill (SB 03-258). Rather, funding was established through the passage of the Department of Health Care Policy and Financing's Supplemental Bill (HB 04-1320), appropriating $15,566,354 for this new program.

The FY 04-05 Long Bill (HB 04-1422) appropriation was slightly higher than the final FY 03-04 appropriation at $16,542,353. This increase in funds was due to the approval of a Department's non-prioritized Budget Amendment to increase the amount of certification for the local share (non-prioritized Budget Amendment BA-5, submitted January 2, 2004). In addition, the Department submitted a non-prioritized Supplemental Request later in the fiscal year to increase funds by $3,264,723 for existing direct service costs that were beyond existing funding (non-prioritized Supplemental S-11, submitted January 3, 2005). This amount was approved through the passage of the Department's FY 04-05 Supplemental Bill (SB 05-112). Thus, the final FY 04-05 appropriation was equal to $19,807,076.

The FY 05-06 Long Bill (SB 05-209) was for continuation funding of $19,807,076. This amount was later increased by $4,474,762 with the approval of another non-prioritized Supplemental Request submitted by the Department (non-prioritized Supplemental S-10, submitted January 3, 2006), and the passage of the Department's FY 05-06 Supplemental Bill (HB 06-1217). The FY 05-06 final appropriation was $24,281,838.

Continuation funding was appropriated for FY 06-07 and is being requested for the FY 07-08 Base Request.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Federally-matched Local Program Costs	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Final Appropriation	**N/A**	**$15,566,354**	**$19,807,076**	**$24,281,838**	**$24,281,838**
Budget Amendment for additional local certification of funds	$0	$975,999	$0	$0	$0
Long Bill Appropriation	**$0**	**$16,542,353**	**$19,807,076**	**$24,281,838**	**$24,281,838**

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Federally-matched Local Program Costs	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
HB 04-1320 - Creation of appropriation using certification of local funds	$15,566,354	$0	$0	$0	$0
SB 05-112 - Additional funding for existing direct services costs	$0	$3,264,723	$0	$0	$0
HB 06-1217 - Allowance for additional local certification of funds	$0	$0	$4,474,762	$0	$0
Final Appropriation / Request	**$15,566,354**	**$19,807,076**	**$24,281,838**	**$24,281,838**	**$24,281,838**
Cash Funds Exempt	$7,783,177	$9,903,539	$12,140,919	$12,140,919	$12,140,919
Federal Funds	$7,783,177	$9,903,537	$12,140,919	$12,140,919	$12,140,919

(G) SERVICES FOR PEOPLE WITH DISABILTIES - REGIONAL CENTERS – MEDICAID FUNDING

Funding in this line item is for support of Colorado's regional centers or intermediate care facilities for the mentally retarded (IFC/MRs). Generally, regional centers provide services to people with developmental disabilities when appropriate community programs are not available. The comprehensive services for adults in the State-operated system are targeted to individuals who have the most intensive needs that can not be adequately met in the community centered board system. These regional centers provide two types of services: 1) residential and support services in large congregate settings; and 2) group homes that provide services for 4-6 people per home in a community setting (commonly referred to as "state-operated group homes"). The State operates three regional centers located in Grand Junction, Pueblo, and Wheat Ridge. The regional centers provide residential services, medical care, and active treatment programs based on individual assessments and habilitation plans (Department of Human Services Figure Setting, February 23, 2006, page 96).

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation was $38,886,488. Another appropriation was made during the 2003 Legislative session with the passage of HB 03-1292, which authorized the collection of service fees from both public and private intermediate care facilities and increased total funds for this program by $728,000. Finally, with the passage of the Department's Supplemental Bill (HB 04-1320), this appropriation was reduced by $21,224 for a Department Supplemental Request for room and board (non-prioritized Supplemental S-10, submitted January 2, 2004). The final appropriation for FY 03-04 was $39,593,264. This line item was affected by the 2.95% increase in Federal Medical Assistance Percentage (FMAP) in the last quarter of FY 02-03 and for the all of FY 03-04. This increase was an accounting adjustment between State and federal fund splits only, and was therefore budget neutral to the total appropriation.

Change from the FY 03-04 final appropriation to the FY 04-05 Long Bill decreased funding in this appropriation by $231,044. These changes included: 1) an increase to restore $21,224 in room and board funding removed in the prior year; 2) a decrease in Medicaid funding for increases in client cash revenue equal to $201,944; 3) an increase of $21,840 for the annualization of HB 03-1292 allowing the State to collect service fees from the intermediate care facilities; and 4) a 0.2% vacancy savings adjustment per Common Policies of $72,164. The FY 04-05 Long Bill appropriation (HB 04-1422) was $39,362,220.

Changes from the FY 04-05 Long Bill to the FY 04-05 final appropriation were the result of two separate actions. Due to a requirement made by the Centers for Medicare and Medicaid Services in order to obtain renewal of the Children's Home and Community Based Services waiver, on September 21, 2004, the Joint Budget Committee approved a 1331 Emergency Supplemental to transfer any funding for Medicaid State Plan services from this line item into the Department's Non-Emergency Transportation, Medical Services Premiums and Mental Health Fee for Service lines, leaving an appropriation for waivered services only. This 1331 Emergency Supplemental was later revised through a normal Supplemental Request, and with the passage of the Department's Supplemental Bill (SB 05-112), the appropriation was officially reduced by $723,127 (non-prioritized Supplemental S-16, submitted January 10, 2005). Lastly, the Department submitted an additional non-prioritized Supplemental Request in support of the Department of Human Services' request for reduced Medicaid funding due to an approved increase in the federal Supplemental Security Income cost-of-living adjustment of 2.7% (non-prioritized Supplemental S-12, submitted on January 3, 2005). This request eventually decreased the appropriation by an additional $25,978 as it was also a part of the Department's Supplemental Bill. These adjustments brought the FY 04-05 final appropriation to $38,613,115.

The FY 05-06 Long Bill was for $39,351,048. This was an increase of $737,933 over the FY 04-05 final appropriation due to the following adjustments: 1) annualization for the last remaining quarter of funding equal to $241,042 for Medicaid State Plan services needing to be transferred out of this appropriation; 2) annualization of the adjustment for incorporating the Supplemental Security Income cost-of-living adjustment for $26,407; 3) an increase due to Common Policy adjustments equal to $1,026,515; 4) an increase of $5,037 due to a Joint Budget Committee action for a 2.5% medical inflationary increase; 5) a decrease due to additional client cash receipts of $12,890; and 6) a decrease to General Fund by $13,280 pursuant to HB 03-1292.

The FY 05-06 Long Bill was later revised though the passage of the Department's FY 05-06 Supplemental Bill (HB 06-1217) and though the Add-on sections of the FY 06-07 Long Bill (HB 06-1385). Pursuant to a Department's Supplemental Request (and the subsequent passage of HB 06-1217) to pass along the Supplemental Security Income cost-of-living increase of 4.1% effective January 1, 2006, Medicaid funding for this appropriation was reduced by $42,754 (Department of Human Services' Supplemental document, January 18, 2006, page 18). In addition, HB 06-1217 included an increase for fuel costs in the amount of $13,094. The appropriation was later revised to include an official appropriation in the Add-ons section of HB 06-1385 for a 1331 Emergency Supplemental of one-time funding equal to $131,764 for overtime (Department of Human Services Figure Setting, page 98, February 23, 2006). Therefore, the final FY 05-06 appropriation for this line was $39,453,152.

The change in Medicaid funding from the final FY 05-06 appropriation to the FY 06-07 Long Bill reflects an increase of $935,776. This net Medicaid increase is comprised of the following adjustments: 1) $27,258 for inflationary increases ranging from 2.01% to 2.05% for contracted and professional medical services; 2) $80,382 reduction due to 0.2% vacancy savings adjustment; and 3) $1,047,750 increase for Salary Survey (Figure Setting, February 23, 2006, page 97). In addition, Medicaid funding for this appropriation 1) was reduced by $131,764 for removal of the one-time overtime appropriation for FY 05-06 through the Add-on section of the Long Bill; 2) was reduced by $43,463 due to incorporation of the federal 4.1% cost-of-living adjustment to Supplemental Security effective January 1, 2006; and 3) increased by $159,131 for reductions in anticipated client cash. Finally, the FY 06-07 Long Bill included a technical correction for a reduction of $42,754 due to a Supplemental Security Income Cost of Living Adjustment of 4.1% (Joint Budget Committee memo dated March 15, 2006). Therefore, the FY 06-07 Long Bill was appropriated at $40,388,928.

The FY 06-07 appropriation was revised later in the 2006 Legislative session with the passage of SB 06-219, which transferred a portion of funding for 1.0 FTE to the Department of Health Care Policy and Financing to support County Administration. This transfer was for $29,024, resulting in the current FY 06-07 appropriation of $40,359,904.

The FY 07-08 Base Request is for $41,853,314. This Request includes increases over the current FY 06-07 appropriation for $1,343,798 related to Salary Survey and an increase of $149,612 for Personal Services due to a leap year adjustment.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Regional Centers	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Annualization of HB 03-1292 authorizing collection of service fees	$0	$21,840	$0	$0	$0
0.2% vacancy savings reduction	$0	($72,164)	$0	($80,382)	$0
Annualization of transfer of Medicaid State Plan services funding from this appropriation	$0	$0	($241,042)	$0	$0
Reduction to Medicaid funding due to annualization of Supplemental Security Income cost-of-living adjustment	$0	$0	($26,407)	($43,463)	$0
Increase for Common Policies	$0	$0	$1,026,515	$0	$0
Joint Budget Committee action to add medical inflationary increase	$0	$0	$5,037	$27,258	$0
Reduction due to collection of service fees	$0	$0	($13,280)	$0	$0

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Regional Centers	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Removal of one-time funding for overtime in prior fiscal year	$0	$0	$0	($131,764)	$0
Increase for Salary Survey	$0	$0	$0	$1,047,750	$1,343,798
Technical adjustment for a Supplemental Security Income cost-of-living adjustment of 4.1% per Joint Budget Committee memo dated March 15, 2006	$0	$0	$0	($42,754)	$0
Additional Personal Services for leap year adjustment	$0	$0	$0	$0	$149,612
Long Bill Appropriation / Request	**$38,886,488**	**$39,362,220**	**$39,351,048**	**$40,388,928**	**$41,853,314**
HB 03-1292 - Authorizing collection of service fees from intermediate care facilities	$728,000	$0	$0	$0	$0
HB 04-1320 - Reduction to Medicaid funding due to room and board adjustments	($21,224)	$0	$0	$0	$0
SB 05-112 - Reduction to Medicaid funding due to incorporating Supplemental Security Income cost-of-living adjustment, and elimination of Medicaid State Plan services funding from this appropriation	$0	($749,105)	$0	$0	$0
HB 06-1217 Increase for fuel costs and reduction to Medicaid funding for incorporating 4.1% Supplemental Security Income cost-of-living increase	$0	$0	($29,660)	$0	$0
HB 06-1385 Add-ons - One-time funding for overtime costs	$0	$0	$131,764	$0	$0
SB 06-219 - Transfer portion of funds to support 1.0 FTE at the Department of Health Care Policy and Financing for County Administration	$0	$0	$0	($29,024)	$0
Final Appropriation / Request	**$39,593,264**	**$38,613,115**	**$39,453,152**	**$40,359,904**	**$41,853,314**
General Fund	$19,068,632	$18,556,718	$18,983,376	$19,436,955	$20,183,660
Cash Funds	$728,000	$0	$0	$0	$0
Cash Funds Exempt	$0	$749,840	$743,200	$742,997	$742,997
Federal Funds	$19,796,632	$19,306,557	$19,726,576	$20,179,952	$20,926,657

(G) REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This appropriation was created to resolve a discrepancy in expenditure patterns between the Department of Health Care Policy and Financing and the Department of Human Services. There has been a pattern of annual overexpenditure within the regional centers line item. This occurred, in part, because depreciation amounts have been included in the daily rates the Department of Human Services charged to the Department of Health Care Policy and Financing for regional center clients. However, because depreciation is associated with a past expenditure and is not an operating expense included in the Department of Human Services' operating budget, the Department of Human Services has never had the authority to spend this money. Therefore, this line was established via passage of the Department's FY 03-04 Supplemental Bill (HB 04-1320) with an appropriation of $1,460,194. Spending authority for this line was affected by the 2.95% increase in federal medical assistance percentage (FMAP) in FY 03-04. This adjustment was an accounting revision between State and federal fund splits, and did not affect the appropriation in total.

The FY 03-04 Supplemental amount was appropriated as continuation funding for the FY 04-05 Long Bill (HB 04-1422). However, for FY 05-06, continuation funding of $1,460,194 was increased during Figure Setting to incorporate an additional $38,057 in total funds. Thus, the FY 05-06 Long Bill (SB 05-209) amount was $1,498,251.

The FY 06-07 Long Bill (HB 06-1385) reflected a Joint Budget Committee action to reduce this line by $29,699 to reflect revised depreciation amounts using a straight-line projection (Department of Human Services' Figure Setting, February 23, 2006, page 105). The FY 06-07 Long Bill appropriation was therefore set at $1,468,552. Continuation funding of this amount has been requested in the Department's FY 07-08 Base Request.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Depreciation and Annual Adjustments	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Appropriation	N/A	$1,460,194	$1,460,194	$1,498,251	$1,468,552
Joint Budget Committee action to increase appropriation	$0	$0	$38,057	$0	$0
Joint Budget Committee action adjusting appropriation to reflect new straight-line projection	$0	$0	$0	($29,699)	$0
Long Bill Appropriation	**$0**	**$1,460,194**	**$1,498,251**	**$1,468,552**	**$1,468,552**
HB 04-1320 - Creation of appropriation for depreciation	$1,460,194	$0	$0	$0	$0
SB 05-112 - Additional funding for existing direct services costs	$0	$0	$0	$0	$0
Final Appropriation / Request	**$1,460,194**	**$1,460,194**	**$1,498,251**	**$1,468,552**	**$1,468,552**
General Fund	$730,097	$730,097	$749,126	$734,276	$734,276
Federal Funds	$730,097	$730,097	$749,125	$734,276	$734,276

(G) SERVICES FOR PEOPLE WITH DISABILITIES - SERVICES FOR FAMILIES AND CHILDREN – MEDICAID FUNDING

The Services for Children and Families line provides funding to the community centered boards to administer early intervention, family support, and extended support services to children and families in community settings (Department of Human Services Figure Setting, February 25, 2004, page 57). The children's extensive support waiver program is funded through this line.

Appropriation History

The FY 03-04 Long Bill (SB 03-258) contained $3,745,315 to support these services. In addition to this appropriation, SB 03-259 was passed during the 2003 Legislative session which authorized the Department of Health Care Policy and Financing to collect a monthly fee from families of children enrolled in the Children's Extensive Support waiver program. While this bill did not add any additional total funds for the program, it did alter fund splits, reducing General Fund by $253,244 and replacing that amount with equal funding of Cash Funds. This initial impact from SB 03-259, however, was later revised with the passage of the Department's Supplemental Bill (HB 04-1320) to reflect an adjustment to the amount of fees anticipated to be collected from families, and for an error in the fiscal note assumption that these fees could be matched with federal funds (non-prioritized Supplemental S-7, submitted January 2, 2004). Therefore, the Supplemental Bill increased General Fund by $243,704, decreased Cash Funds by $234,164 and decreased federal funds by $9,540, for a budget neutral impact to the total appropriation. Finally, late in the 2004 Legislative session, the General Assembly passed another bill, SB 04-138, which ultimately repealed the authority for the State to charge a monthly fee to families whose children were enrolled in the Children's Home and Community Based Services or Children's Extensive Support waiver programs, returning all fund splits to their original FY 03-04 Long Bill appropriated amounts.

This line item was affected by the 2.95% increase in federal medical assistance percentage (FMAP) for the last quarter of FY 02-03 and all of FY 03-04. While this impact did adjust fund splits between State and federal funds, this adjustment was an accounting function, and did not alter the appropriation in total.

The FY 04-05 Long Bill (HB 04-1422) was appropriated after incorporating the partially offsetting impacts from the out-year adjustment of SB 05-259 and the reversal of the prior year's Supplemental adjustment (both of which only changed fund splits), and for a $83 decrease associated with the 0.2% vacancy savings Common Policy adjustment. The FY 04-05 Long Bill appropriation was therefore $3,745,232.

The FY 05-06 Long Bill (SB 05-209) of $3,813,077 reflected an increase of $67,845 above the final FY 04-05 appropriation. This increase included $35,337 for a Joint Budget Committee action to include a 2.0% provider rate increase (Department of Human Services' Figure Setting, February 23, 2005, page 111), and $32,508 for caseload growth requested by the Department (non-prioritized Decision Item DI-2, November 1, 2004). Please note that the amount approved for caseload growth did not match the Department's November 1, 2004 request due to the 2.0% provider rate increase.

The FY 05-06 appropriation was later revised to include $2,370,114 for 148 additional slots (49 new and 99 existing) in the Children's Extensive Support waiver through HB 05-1262, and further revised in the Add-ons section of the FY 06-07 Long Bill for a partial reversal of appropriated HB 05-1262 funding of $711,034 due to difficulties in implementation and receipt of federal approval, bringing the final FY 05-06 appropriation to $5,472,157.

The FY 06-07 Long Bill was for $6,913,658. This appropriated amount reflects a total increase of $1,441,501 which included: 1) $926,499 for the out-year impact of HB 05-1262; 2) $35,337 for the annualization of four new Children's Extensive Support waiver slots (Department of Human Services Figure Setting, page 107, February 23, 2006); 3) $209,105 for a Joint Budget Committee recommendation of a 3.25% provider rate increase (Department of Human Services Figure Setting, page 107, February 23,2006); and 4) $270,560 for 30 new Children's Extensive Support waiver slots for six months, including $22,550 for a Joint Budget Committee staff adjustment made after Figure Setting (Department of Human Services Figure Setting, page 107, February 23, 2006).

The Department's FY 07-08 Base Request is for continuation funding.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Services for Families and Children	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Appropriation	N/A	$3,745,315	$3,745,232	$5,472,157	$6,913,658
0.2% vacancy savings adjustment per Common Policies	$0	($83)	$0	$0	$0
Provider rate increase per Joint Budget Committee action	$0	$0	$35,337	$209,105	$0
Increase for caseload growth	$0	$0	$32,508	$0	$0
Annualization of HB 05-1262 (includes reversal of HB 06-1385 Add-ons in prior year)	$0	$0	$0	$926,499	$0
Annualization of four new Children's Extended Support waiver slots	$0	$0	$0	$35,337	$0
Joint Budget Committee action to add 30 additional Children's Extended Support waiver slots	$0	$0	$0	$270,560	$0
Long Bill Appropriation	**$3,745,315**	**$3,745,232**	**$3,813,077**	**$6,913,658**	**$6,913,658**
SB 03-259 - Approved collection of monthly service fee (replaced General Fund with Cash Funds)	$0	$0	$0	$0	$0
HB 04-1320 - Revised assumptions in fiscal note for SB 03-259 and fund splits only	$0	$0	$0	$0	$0

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Services for Families and Children	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
SB 04-138 - Repealed State's authority for collection of service fees approved in SB 03-259	$0	$0	$0	$0	$0
HB 05-1262 - Increase in traditional and expansion funding for 48 and 99 additional waiver slots, respectively	$0	$0	$2,370,114	$0	$0
HB 06-1385 Add-ons - Revised impact from HB 05-1262 due to delays in implementation	$0	$0	($711,034)	$0	$0
Final Appropriation / Request	**$3,745,315**	**$3,745,232**	**$5,472,157**	**$6,913,658**	**$6,913,658**
General Fund	$1,872,658	$1,872,616	$2,461,514	$2,971,054	$2,971,054
Cash Funds Exempt	$0	$0	$274,565	$485,702	$485,702
Federal Funds	$1,872,657	$1,872,616	$2,736,078	$3,456,902	$3,456,902

(H) ADULT ASSISTANCE PROGRAMS; COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING

This appropriation was created to support funding of the Department of Human Services' State Ombudsman program. This program provides liaison services between the Department of Human Services and its clients who are being served by the Division of Aging and Adult Services. The FY 03-04 Long Bill (SB 03-258) appropriation was $1,800 and has remained at this level since that time. The Department's FY 07-08 Base Request is for continuation funding.

Line Item: DHS Medicaid Funded Programs, (H) Adult Assistance Programs - Community Services for the Elderly	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Long Bill Appropriation / Request	**$1,800**	**$1,800**	**$1,800**	**$1,800**	**$1,800**
General Fund	$900	$900	$900	$900	$900
Federal Funds	$900	$900	$900	$900	$900

(I) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING

The Division of Youth Corrections provides management and oversight to State-operated and private contract residential facilities, as well as for community-based alternative programs, that serve youth between 10 and 20 years of age who have demonstrated delinquent behavior, who are detained while awaiting adjudication, or who are committed to the Division of Youth Corrections after adjudication. The Division's responsibility for committed juveniles extends through a six-month mandatory parole period during which the youth is in the community. Finally, the Division of Youth Corrections allocates funds by random moment sampling to each

judicial district in accordance with SB 91-094 for the development of local alternatives to incarceration (Department of Human Services' Figure Setting, February 17, 2004, page 10). In addition, juveniles may be sentenced as a condition of parole for up to 45 days to a detention facility. While not all are eligible for Medicaid funding, services provided by the Division of Youth Corrections includes: 24-hour supervision, meals, therapy, vocational, and educational assistance (Department of Human Services Figure Setting, March 8, 2006, page 159).

Administration for the Division of Youth Corrections has two facets: 1) responsibility for establishing program policies and procedures for the treatment of juveniles in the custody of the Division including collecting data and providing strategic planning, contract management, and victim notification; and 2) responsibility for victim assistance (Department of Human Services Figure Setting, March 8, 2006, page 158). Only a small portion of administration costs for the 15.4 FTE in the Division are Medicaid eligible. Of the 15.4 FTE indicated above, 3 FTE are management, 9 facilitate research/statistics functions, and 3.4 are support staff. Costs are allocated using a random moment sampling methodology. The most recently known allocation percentage for Medicaid was 0.3395% appropriated for FY 06-07 (Department of Human Services Figure Setting, March 8, 2006, page 158).

Appropriation History

The FY 03-04 Long Bill (SB 03-258) appropriation was $9,727,773. While this amount was not officially revised for FY 03-04, this line item was affected by the 2.95% increase in federal medical assistance percentage (FMAP) for the fourth quarter of FY 02-03, and all of FY 03-04. This increase was budget neutral to the total appropriation.

The FY 04-05 Long Bill (HB 04-1422) was for $11,563,845 or a net increase of $1,836,072 over the final FY 03-04 appropriation. This increase included $2,648,832 for a change in caseload mix between residential treatment centers and residential child care facilities, and $252,082 for increases to residential treatment center rates (Department of Human Services' Figure Setting, February 17, 2004, page 37). Additionally, there were decreases for the number of Medicaid beds at the Lookout Mountain facility for $687,551, annualized reduction to the number of Medicaid beds at the Mount View facility for $229,184, the removal of $31,117 for the prior year's leap-year adjustment, and a decrease for caseload and miscellaneous adjustments equal to $116,990 (Department of Human Services' Figure Setting, February 17, 2004, page 37).

The Long Bill appropriation was later revised based on the passage of the Department's FY 04-05 Supplemental Bill (SB 05-112), to reflect a June 21, 2004 1331 Emergency Supplemental submitted by the Department of Human Services equal to $1,602,469, but was later revised to $2,068,379 through Department of Human Services' Figure Setting on February 2, 2005, (see pages 37-39). The Joint Budget Committee provided more funding than requested to include a 2% provider rate increase and to fully fund the anticipated caseload growth. The FY 04-05 final appropriation was $13,632,224.

The FY 05-06 Long Bill (SB 02-509) was equal to $15,091,070. This amount reflected an adjustment to contract placements for $1,414,968 (Department of Human Services' Figure Setting, February 2, 2005, page 39), an increase to the managed care pilot project for $4,121 and an addition $39,757 for Personal Services. This Long Bill amount was later revised thought the passage of the Department's FY 05-06 Supplemental Bill (HB 06-1217) to incorporate an additional $737,180 for a Joint Budget Committee action adjusting the number of contract placements based upon revised Legislative Council population estimates (Joint Budget Committee memo dated January 19, 2006). The FY 05-06 final appropriation was $15,828,250.

The FY 06-07 Long Bill was $2,418,353. The drastic reduction in funding was largely due to a redesign of the regional treatment centers provider network. On June 30, 2005 the Centers for Medicare and Medicaid Services informed the Department of Human Services that the reimbursement and billing practices for residential treatment centers did not meet federal requirements. This resulted in the Department's Budget Amendment (non-prioritized BA-15) submitted on January 31, 2006, which reduced the Medicaid funding for this program which removed $13,746,108 from this line item, including a $178,822 reduction for the managed care pilot program (Department of Human Services' Figure Setting, March 8, 2006, pages 189 and 193). Additional changes to this line item included an increase of $352,214 for contract placements (Department of Human Services Figure Setting, page 189, March 8, 2006), a decrease of $90,876 related to limited State capacity (Department of Human Services Figure Setting, page 189, March 8, 2006), and an increase of $74,873 per a Joint Budget Committee recommendation for a 3.25% provider rate increase (Department of Human Services Figure Setting, Page 190, March 8, 2006).

The FY 06-07 appropriation was increased by $1,457,874 later in the 2006 Legislative Session with the passage of HB 06-1395, which completed the redesign of the old residential treatment centers and created the new psychiatric residential treatment facilities. The anticipated level of children going through the new psychiatric residential treatment facilities would be 341 children per year for an average of 14.25 days. The final FY 06-07 appropriation is $3,876,227.

The Department's FY 07-08 Base Request is for $4,404,330 and includes: 1) annualization of HB 06-1395 for an additional $513,126 to support 92 placements at a cost of $300 per day; 2) an increase of $1,763 for Common Policy adjustments in Salary Survey; 3) a leap year adjustment for services equal to $13,269; 4) an increase of $90 for the managed care pilot program; and 5) a decrease of $145 for the 0.2% vacancy savings adjustment per Common Policies.

Line Item: DHS Medicaid Funded Programs, (I) Division of Youth Corrections	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Prior Year's Appropriation	N/A	$9,727,773	$13,632,224	$15,828,250	$3,876,227
Change to caseload mix between residential treatment centers and residential child care facilities	$0	$2,648,832	$0	$0	$0

Line Item: DHS Medicaid Funded Programs, (I) Division of Youth Corrections	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
Increase to residential treatment center rates	$0	$252,082	$0	$0	$0
Revision to number of Medicaid beds at Lookout Mountain facility	$0	($687,551)	$0	$0	$0
Revision to number of Medicaid beds at Mount View facility	$0	($229,184)	$0	$0	$0
Removal of leap year adjustment from prior year	$0	($31,117)	$0	$0	$0
Caseload and miscellaneous adjustments	$0	($116,990)	$0	$0	$0
Common Policy adjustment for Personal Services	$0	$0	$39,757	$0	$0
Increase for additional contract placements	$0	$0	$1,414,968	$0	$0
Increase for managed care pilot project	$0	$0	$4,121	$0	$0
Removal of nearly all residential treatment center Medicaid funding	$0	$0	$0	($13,746,108)	$0
Reduction due to limitations of State capacity	$0	$0	$0	($90,876)	$0
3.25% provider rate increase recommended by Joint Budget Committee	$0	$0	$0	$74,873	$0
Increase for additional contract placements	$0	$0	$0	$352,214	$0
Leap year adjustment for services and managed care pilot program	$0	$0	$0	$0	$13,359
Common Policy adjustment for Salary Survey	$0	$0	$0	$0	$1,763
Common Policy adjustment for 0.2% vacancy savings adjustment	$0	$0	$0	$0	($145)
Annualization of HB 06-1395 for an additional 92 placements at $300 per day	$0	$0	$0	$0	$513,126
Long Bill Appropriation	**$9,727,773**	**$11,563,845**	**$15,091,070**	**$2,418,353**	**$4,404,330**
SB 05-112 - Official appropriation of 1331 Emergency Supplemental; however, revised through DHS Figure Setting on February 2, 2005	$0	$2,068,379	$0	$0	$0
HB 06-1217 - Revised Medicaid need due to changes in contract placement needs	$0	$0	$737,180	$0	$0

Line Item: DHS Medicaid Funded Programs, (I) Division of Youth Corrections	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08 Base Request**
HB 06-1395 - Funding to support 341 children at new psychiatric residential treatment facilities at $300 per day	$0	$0	$0	$1,457,874	$0
Final Appropriation / Request	**$9,727,773**	**$13,632,224**	**$15,828,250**	**$3,876,227**	**$4,404,330**
General Fund	$4,863,886	$6,816,112	$7,914,125	$1,938,114	$2,202,165
Federal Funds	$4,863,887	$6,816,112	$7,914,125	$1,938,113	$2,202,165