Department of Health Care Policy and Financing
FY 08-09 Budget Request

Budget Narrative

NOVEMBER 1, 2007

TABLE OF CONTENTS

(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' FTE and funding requests. The FY 08-09 Request column consists of estimated expenditures from the FY 07-08 Personal Services appropriation, plus all related out-year legislative impacts and any Common Policy impacts such as the 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 and the Personal Services Appropriation/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 and include PERA, Medicare, State temporary employees' salaries, contractual services, termination and retirement payouts, and unemployment insurance. I.C is the total of the position detail (I.A) and the Other Personal Services (I.B).

POTS expenditures, (totaled in I.D.) are added to include: Salary Survey, Performance Achievement 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 Achievement 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 08-09 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 (II.K) and the Base Personal Services Subtotal (I.E). The difference is shown for the Estimate and Request year columns.

The Position Detail summarizes actual expenditures for FY 05-06 and FY 06-07. Then, the FY 07-08 Estimate and the FY 08-09 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 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 $2,723,387 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 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 $13,328,202 (I.A.);
- Other Personal Services (I.B) totaling $2,392,233 for items such as PERA, Medicare, Temporary Services, and Contractual Services; and,
- POTS expenditures of $856,616 (I.D) that consist of Health/Life/Dental, Short Term Disability Insurance, Amortization Equalization Disbursement per SB 04-257 and Supplemental Amortization Equalization Disbursement. Expenditures for Salary Survey and Senior Executive Services of $459,483 are non-add items as they are included in the salary costs in I.A above.

The FY 07-08 Appropriation column shows no detail for this piece of the calculation, but is the amount appropriated for base salaries plus other personal services through the Long Bill and Special Bills passed during the 2007 legislative session (I.C). POTS are not included.

The FY 07-08 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 Achievement Pay Awards (July 1, 2007 salaries times 12), yielding $15,804,344 for 257.3 FTE. The next step was to add Other Personal Services (I.B), of $2,991,559. This amount includes:

- PERA of $1,604,141 calculated using 10.15% of the $15,804,344 above;
- Medicare of $229,163 calculated using 1.45% of the $15,804,344 above;
- State Temporary Services of $60,000 incorporating existing Personnel Action Requests and estimates provided by program managers;
- Other Temporary Services, which includes contracted temporary services, estimated at $30,000 using current Department contracts as well as estimates provided by program managers;
- Contractual Services estimated at $1,000,000 considering prior year actuals and current Department contracts and estimates provided by program managers;
- Termination/Retirement Payouts estimated at $40,000 for unused vacation/sick time accumulated during employment – estimated based on anticipated or previously announced retirements;
- Unemployment Insurance of $27,505 based on an average of expenditures for FY 05-06 and FY 06-07; and
- Employee incentives of $750 based on anticipated expenditures for FY 07-08 provided by management.

POTS expenditures of $1,127,180 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 $19,923,083 for 257.3 FTE. The Supplemental Amortization Equalization Disbursement of $34,950 is also shown but is considered a non-add item as it reduces the total Salary Survey appropriation. The appropriated amount for Salary Survey and Performance Based Pay of $515,873 and $206,506 are listed, but not added, as they have been included in the salaries delineated in the Position Detail. Even though there is a separate appropriation for Salary Survey and Performance Based Pay, 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 07-08 Estimate column, current 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 (257.3) 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 54 vacant positions and each was reduced from 1.0 FTE to

0.45 FTE. This does not mean that these 54 positions will be exactly 0.45 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.

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 (II.K). 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 to the appropriation.

The FY 08-09 Request column shows the positions' salary costs as reflected in the FY 07-08 Estimate column, with some minor adjustments. These adjustments include a net increase of 2.2 FTE and $135,593 due to: 1) the annualization of 4.0 FTE appropriated in SB 07-001, the Colorado Cares Prescription Drug Program (added 1.5 FTE), 2) the annualization of 1.0 FTE appropriated in SB 07-196, the Health Information Technology legislation (added 0.5 FTE), and 3) the annualization of 1.0 FTE appropriated in SB 07-211, Improving Health Care for Children (added 0.2 FTE).

Other Personal Services amounts (I.B) are identical to the ones used in the FY 07-08 Estimate column bringing the total to $3,007,288 with the following exceptions:

- PERA increase of $13,763 for Salary Survey and range adjustments in FY 08-09 due to the increase of 2.2 FTE, and
- Medicare increase of $1,966 for the same factors.

POTS (I.D) expenditures are not a component in this calculation, since they are requested in their distinct line items. (I.E) is the Base Personal Services total and is calculated by adding (I.C) and (I.D). (I.G) then lists Request Year Decision Items. The Personal Services Detail (Position Detail) Total then combines the totals of (I.E), (I.F), and (I.G) to arrive at the total.

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 (II.K). 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 Appropriation/Request

The second method calculates the official FY 08-09 Personal Services Appropriation/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 08-09 Budget Request for this line, calculated as outlined in the budget request instructions issued by the Office of State Planning and Budgeting June 27, 2007

(Chapter 8, pages 6-8). These adjustments include special bills, Supplemental appropriations, Salary Survey, range adjustments, and Performance Achievement Pay. These are the numbers that feed into the Schedule 2. A number of Change Requests have been submitted that affect this line item.

The next section (II.A) delineates the specific legislation that adjusts the Department's appropriation.

For the FY 05-06 Actual column (II.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.).
- 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.
- SB 07-163, codified the transfer of $825,000 in personal services funding to the Non-Emergency Medical Transportation appropriation for FY 05-06 due to cost overruns in that program. This was previously approved in a 1331 Emergency Supplemental on June 20, 2006.
- HB 06-1385, FY 06-07 Long Bill 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). Additionally, funding for a General Professional III FTE 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.
- HB 05-1243, Consumer Directed Care through the Home and Community Based Services model, increased total funds by $26,570 and 0.5 FTE.
- HB 05-1262, tobacco tax implementation from the Tobacco Tax Cash Fund implemented pursuant to Section 21 of Article 10 of the Colorado Constitution which increased total funds by $381,199 and 6.3 FTE.

The final appropriation for FY 05-06 was $14,491,914 with 212.4 FTE.

The following items were included to develop the appropriation contained in the FY 06-07 Long Bill (HB 06-1385).

- The Joint Budget Committee authorized the Department to include 5.7 FTE and $310,824 total funds in its budget request, as it determined that the Department was understaffed, and the transfer of $41,696 and 0.5 FTE to the Executive Director's Office from the Indigent Care Long Bill group for the FTE working on the Indigent Care program.
- The following annualizations were included in the Long Bill: $42,064 and 0.8 FTE for changes in the plan of the federally required Payment Error Rates Measurement Project, $33,928 and 0.8 due to a timing change in the required certification of public expenditures, $33,928 for the establishment of a drug rebate program for the Old Age Pension Fund, $112,172 and 2.0 FTE to address audit recommendations related to prescription drugs in the Medicaid Management Information System, a reduction of 0.8 FTE and $100,936 to remove one time funding associated with HB 05-1262, the Tobacco Tax bill, and annualization of $16,536 and 0.5 FTE for a Customer Service Intern approved in Joint Budget Committee Figure Setting, March 15, 2005, page 21.
- Other annualization that affected the Long Bill included, the incorporation of the FY 05-06 Salary Survey for $394,534, removal of one time funding associated with SB 04-177 (Home-And Community-Based Services For Children With Autism) for $29,900, removal of one time funding associated with the Medicare Modernization Act for $507,354, removal of one time funding associated with the Colorado Benefits Management System for $480,980, restoration of a one time transfer of $825,000 to the Non-Emergency Medical Transportation appropriation in FY 05-06, and the Office of State Planning and Budgeting 0.2% cost reduction that equated to $29,218.

For the FY 06-07 Actual column (II.A.), the calculation is as follows:

- The FY 06-07 Long Bill appropriation (HB 06-1385) for Personal Services consists of $15,154,208 total funds with 222.7 FTE (III.A.).
- SB 07-163, the FY 06-07 Supplemental Bill, appropriated an additional $159,939, and 4.3 FTE, comprised of the following; $149,327 and 4.0 FTE for an Exceeding Processing Guidelines Unit that was approved in an Emergency 1331 Supplemental on September 20, 2006, funding of $25,244 and 0.5 FTE for implementation of the Deficit Reduction Act and HB 06S-1023, a reduction of $14,751 and 0.3 FTE due to delayed implementation of the federal rule for the Payment Error Rate Measurement Project, and $120 of additional funds for Commercial Leased Space.
- SB 06-239, FY 07-08 Long Bill Add-ons, adjusting FY 06-07 funding allocated $48,720 and increased the FTE count by 0.8 FTE, to implement the Governor's Executive Order for a Preferred Drug List. Since this was included as a supplemental in the FY 07-08 Long Bill, as an Add-on, the annualization is already included in the FY 07-08 appropriation.
- HB 06-1270, Medicaid eligibility sites at schools, allotted $49,656, and 1.0 FTE to write and enforce contracts with the school districts, assist in convening the advisory committee, and assist the advisory committee in proposal reviews, requests for federal approval, and answer Colorado Benefits Management System and program eligibility questions.

- SB 06-128, Services for the Disabled under the State Medical Assistance Program, also appropriated $49,656 and 1.0 FTE to review the proposal, write and submit a federal waiver, draft a contract, review and write reports, implement the program, maintain voluntary enrollment, and evaluate the program.
- SB 06-165, implemented the Telemedicine Pilot Project with $54,171 and 1.0 FTE to submit a federal waiver to reimburse for telemedicine in FY 06-07 at existing fee-for-service rates and implement the telemedicine chronic conditions pilot programs; assist with establishing new reimbursement rates for telemedicine transmission costs; assist with drafting new rules; prepare and issue the Request for Proposal; and manage, monitor, evaluate and report on the progress of the pilot program.
- SB 05-219, the Health Care Policy and Financing re-organization, appropriated $55,000 and 1.0 FTE for county administration to oversee the counties on work performed, including Medicaid eligibility determinations, the Children's Basic Health Plan, Old Age Pension State Medical Fund, and Low Income Subsidy.

The total appropriation for FY 06-07 was $15,571,350 with 231.8 FTE.

The following items were included to develop the FY 07-08 Long Bill (SB 07-239) appropriation.

- Annualization of SB 06-128, the pilot program for people with disabilities, of $4,514, annualization of HB 06-1270 School Based Medicaid determinations, for $4,514, $75,736 and 1.5 FTE associated with the immigration reform legislation, $29,504 and 0.5 FTE associated with further modifications to the Payment Error Rate Measurement program, and $146,158 and 2.2 FTE due to annualization of the Governor's Executive order creating a Preferred Drug List.
- $75,200 to perform an internal audit of the Primary Care Fund, $20,000 for an actuarial contract for the managed care incentive program.
- The incorporation of the FY 06-07 Salary Survey for $459,483, an unfunded 2.0 FTE request for the Department, and a 0.5% reduction of $80,483 based on the Office of Sate Planning and Budgeting's instructions.

For the FY 07-08 Estimate, the spending authority calculation (II.A.) is calculated the same way as the FY 06-07 appropriation column, which includes the Long Bill appropriation of $16,305,976 and 238.0 FTE and Special Bills that consist of:

- HB 07-1021, to implement the Prescription Drug Consumer Information and Technical Assistance Act for $58,616 and 1.0 FTE.
- SB 07-001, for the Colorado Cares Rx program $140,495 and 2.5 FTE (1 General Professional V for the full fiscal year, 1 General Professional IV, 1 Accountant II, and 1 Customer Support Intern, each for one half of the fiscal year) to develop rules for the Medical Services Board, contract with both a program contract and participating pharmacies, answer stakeholder questions, maintain files, and perform accounting functions.
- SB 07-004, for Early Intervention Services for Children $58,616 and 1.0 FTE to implement and administer the Act. The Cash Funds Exempt portion is from Short Term Innovative Health Program Grant Fund.

- SB 07-130, Medical Homes for Children, $57,773 and 1.0 FTE Statistical Analyst II to develop standards and a measurement system.
- SB 07-196, for Health Information Technology $29,308 and 0.5 FTE to implement telemedicine for home health and home and community-based health care services.
- SB 07-211, Improving Health Care for Children $64,806 and 1.3 FTE; 0.5 FTE for GP II to produce reports for the General Assembly, 0.8 FTE for General Professional IV to develop standards and methods for collecting, analyzing, and disclosing health information.

The total of the Long Bill and Special Bills is included at II.A and is $16,715,590 and 245.3 FTE. This is shown in II.E, Total Appropriation. However, in the FY 07-08 Estimate column, adjustments to spending authority (II.F) are made for a June 20, 2007 Emergency 1331 Supplemental request of $1,312,941 and 12.0 FTE for costs associated with the Office of Colorado Benefits Management System Staff re-allocation. The total of these adjustment results in a Total FY 07-08 Estimate of $18,028,531 and 257.3 FTE. Including the allocated POTS for Salary Survey, Performance Achievement Pay, Health, Life, Dental, Short Term Disability, and Amortization Equalization Disbursement is estimated to total $1,849,559 for FY 07-08. The Supplemental Amortization Equalization Disbursement is not included in this total as it is already shown in the Salary Survey amount and will be "carved" out of that appropriation at the proper time. This brings the FY 07-08 Estimate to $19,878,090 and 257.3 FTE

A statewide indirect cost allocation is also 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. 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 07-08 allocation and the FY 08-09 allocation is shown, including fund splits. The incremental difference between the two years' General Fund is an increase of $223,338. 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 07-08 Allocation from State Controller’s Office	$0	($561,752)	$14,703	$547,049
FY 08-09 Allocation from State Controller’s Office	$0	($338,414)	$75,635	$262,779
Incremental Difference	$0	$223,338	$60,932	($284,270)

The FY 08-09 Request is essentially the same as the FY 07-08 Estimate column. However, the FY 08-09 figure includes annualization of the FY 07-08 Long Bill and Special Bills, and the Office of State Planning and Budget mandated 0.2% reduction. SB 07-001 is annualized for the three half year positions mentioned previously for a total annualization of 1.5 FTE and $72,612, SB 07-196 which is annualizes with an additional $158,057 and 0.5 FTE from 0.5 FTE appropriated in FY 07-08, and $14,655 and 0.2 FTE

associated with annualization of SB 07-211 improving Health Care for Children. The Office of State Planning and Budget 0.2% reduction reduces the total request by $37,797 total funds. These totals are added to FY 07-08 Salary Survey and Performance Achievement Pay, to arrive at the total Request of $18,860,743 and 259.5 FTE.

Line Item: Personal Services	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$13,420,083**	**$14,491,914**	**$15,571,350**	**$16,715,590**
Joint Budget Committee Adjustment	$6	$0	$0	$0
Removal of funding related to HB 05-1262	($49,617)	$0	$0	$0
Annualization of SB 04-028	($43,482)	$0	$0	$0
Annualization of SB 04-206	($44,000)	$0	$0	$0
SB 04-177 (Children with Autism)	$81,874	($29,900)	$0	$0
Annualization of HB 04-1219 (Community, Transition Services for HCBS for the Elderly, Blind, and Disabled)	$2,685	$0	$0	$0
HB 05-1262 (Tobacco Tax Bill – removal of one time funding)	$0	($100,936)	$0	$0
Annualization of Customer Service Intern from Figure Setting March 15, 2005, page 21	$0	$16,536	$0	$0
Medicare Modernization Act of 2003, (SB 05-209) and Figure Setting 3/15/05	$635,710	($507,354)	$0	$0
Reversal of CBMS Funding (HB 06-1217)	$0	($480,980)	$0	$0
Joint Budget Committee Action to add 5.7 FTE (HB 06-1217)	$0	$310,824	$0	$0
Payment Error Rate Measurement Project (HB 06-1217)	$54,768	$42,064	$0	$0
BA-4, Establish Old Age Pension Drug Rebate Program	$0	$33,928	$0	$0
BA-2, Change in Certification timing of Public Expenditures for Medical Services Premiums	$0	$33,928	$0	$0
BRI-4, Implementation of Drug Rebate Analysis and Management System	$0	$112,172	$0	$0

Line Item: Personal Services	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Primary Care FTE moved from Indigent Care Long Bill Group (HB 06-1385)	$0	$41,696	$0	$0
Annualization of SB 07-163 FY 05-06 Add-ons	$0	$825,000	$0	$0
Annualization of SB 06-128, Quality of Care for People with Disabilities Pilot Program	$0	$0	$4,514	$0
Annualization of HB 06-1270, School Based Medicaid Eligibility Determinations	$0	$0	$4,514	$0
Annualization of SB 07-163 (FY 06-07 Supplemental Bill)	$0	$0	$105,240	$0
Performance Based Pay	$136,130	$0	$0	$165,205
DI-12, Internal Audit of Primary Care Fund	$0	$0	$75,200	$0
BA-5, Actuary Contract for Managed Care Incentive Program	$0	$0	$20,000	$0
Executive Order - Preferred Drug List (D 007 04)	$0	$0	$146,158	$0
Salary Survey	$248,845	$394,534	$459,483	$480,923
OSPB 0.2% Reduction (0.5% for FY 07-08)	($27,505)	($29,218)	($80,483)	$(37,797)
SB 07-001 (Colorado Cares Rx Program) Annualization	$0	$0	$0	$72,612
SB 07-239 Long Bill Annualization	$0	$0	$0	($95,200)
SB 07-196 (Health Information Technology) Annualization	$0	$0	$0	$158,057
SB 07-211 (Improving Health Care for Children) Annualization	$0	$0	$0	$14,655
Annualization of Emergency 1331 Supplemental, Elimination of the Office of Colorado Benefits Management (June 20, 2007)	$0	$0	$0	$1,351,748
FY 07-08 Supplemental Amortization Equalization Disbursement	$0	$0	$0	$34,950
Long Bill Appropriation / Request	**$14,415,497**	**$15,154,208**	**$16,305,976**	**$18,860,743**
HB 04-1219 (Community Transition Services for HCBS for the Elderly, Blind, and Disabled)	$0	$0	$0	$0

Line Item: Personal Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
SB 04-138 (Repeal of the Authority to Charge a Monthly Fee to Families whose Children are Enrolled in HCBS Waiver Program)	$0	$0	$0	$0
SB 04-028 (Substance Abuse for Treatment for Native Americans)	$0	$0	$0	$0
SB 04-206 (Hospice Care for Persons Who are Eligible Under the "Colorado Medical Assistance Act")	$0	$0	$0	$0
SB 05-112 Supplemental Bill	$0	$0	$0	$0
HB 06-1217 Supplemental Bill	$448,832	$0	$0	$0
HB 06-1385 Add-ons	$17,583	$0	$0	$0
HB 05-1066 (Obesity Bill)	$27,233	$0	$0	$0
HB 05-1243 (Consumer Directed Care)	$26,570	$0	$0	$0
HB 05-1262 (Tobacco Tax Bill)	$381,199	$0	$0	$0
SB 07-163 FY 05-06 Add-ons	($825,000)	$0	$0	$0
SB 06-165 (Telemedicine)	$0	$54,171	$0	$0
SB 06-128 (Pilot to improve quality of care for people with disabilities)	$0	$49,656	$0	$0
SB 06-219 (Heath Care Policy and Financing Re-organization)	$0	$55,000	$0	$0
HB 06-1270 (School eligibility determination sites)	$0	$49,656	$0	$0
SB 07-163 FY 06-07 Supplemental Bill	$0	$159,939	$0	$0
SB 07-239 FY 06-07 Add-ons	$0	$48,720	$0	$0
SB 07-001 (Colorado Cares Rx Program)	$0	$0	$140,495	$0
SB 07-004 (Early Intervention for Children)	$0	$0	$58,616	$0
HB 07-1021 (Prescription Drug Consumer Information and Technical Assistance Act)	$0	$0	$58,616	$0
SB 07-211 (Improving Health Care for Children)	$0	$0	$64,806	$0
SB 07-196 (Health Information Technology)	$0	$0	$29,308	$0
SB 07-130 (Medical Homes for Children)	$0	$0	$57,773	$0

Line Item: Personal Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$14,491,914**	**$15,571,350**	**$16,715,590**	**$18,860,743**
General Fund	$5,933,098	$6,587,102	$7,261,822	$7,768,653
Cash Funds	$0	$0	$140,495	$212,681
Cash Funds Exempt	$967,237	$506,203	$592,486	$2,121,195
Federal Funds	$7,591,579	$8,478,045	$8,720,787	$8,758,214
FTE	212.4	231.8	245.3	259.5

FY 08-09 Base Request Cash Funds Exempt Allocation								
Transfer from the Department of Human Services	Short Term Innovative Health Program	Coordinated Care for People with Disabilities Fund	Primary Care Fund	Children's Basic Health Plan Trust Fund	Autism Treatment Fund	Old Age Pension Fund	Health Care Expansion Fund	Total Cash Funds Exempt Requested
$1,576,915	$31,150	$28,712	$52,106	$219,012	$28,362	$45,738	$139,200	$2,121,195

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). Since FY 05-06 the State has been increasing its proportionate percentage of the costs for this benefit. For FY 05-06 the State reimbursed 66% of the market average as determined by the Department of Personnel and Administration, in FY 06-07 the reimbursement was 75% of the market average, and FY 07-08 the State increased the reimbursement to 85% of the market average.

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 used different plan designations (Employee, Employee + 1, Employee + Spouse, etc) and rates. The plans were then summarized by type and fund. The funding was in accordance with 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 than originally projected; therefore this appropriation was over expended by $43,631.

Similarly, the FY 06-07 appropriation of $629,640 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 + Spouse, Employee + Child or Family). However, due to increased staff size and participation by employees, the Department over expended this appropriation by $118,669.

The FY 07-08 appropriation of $929,293 reflected both an increase in the portion of the rate paid by the State and additional employees participating in the program. The FY 08-09 Base Request of $1,051,422 is based on Common Policy instructions and was developed using employees with coverage as of June 2007.

Line Item: Health, Life, and Dental	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$429,879**	**$476,625**	**$629,640**	**$929,293**
Common Policy Adjustment	$46,746	$153,015	$299,653	$116,370
Long Bill Appropriation / Request	**$476,625**	**$629,640**	**$929,293**	**$1,051,422**
Final Appropriation / Request	**$476,625**	**$629,640**	**$929,293**	**$1,051,422**
General Fund	$212,656	$272,418	$414,460	$456,357
Cash Funds Exempt	$10,156	$11,294	$37,568[1]	$71,371[2]
Federal Funds	$253,813	$345,928	$477,265	$523,694

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. 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 based on 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 Achievement Pay. Prior to FY 02-03, the Short-term Disability request was calculated using the same rate for the entire

[1] Of this amount, $12,383 is from the Children's Basic Health Plan Trust Fund, $19,596 is from the Health Care Expansion Fund, $1,863 is from the Autism Treatment Fund and $3,726 is from the Primary Care Fund.

[2] Of this amount, $18,493 is from the Children's Basic Health Plan Trust Fund, $7,025 is from the Health Care Expansion Fund, $2,097 is from the Autism Treatment Fund, $39,561 is from a transfer from the Department of Human Services, and $4,195 is from the Primary Care Fund.

fiscal year. The FY 05-06 appropriation incorporated a Common Policy rate of 0.16. The FY 05-06 Long Bill amount for this appropriation was $19,332, reflecting 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, using 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.

The FY 07-08 final appropriation of $19,548 is based on Common Policy instructions from the Office of State Planning and Budgeting issued on August 1, 2006, using a rate of 0.13%. The FY 08-09 Base Request reflects the Common Policies issued by the Department of Personnel and Administration again using a rate of 0.13%. The Cash Funds Exempt portion was adjusted due to the elimination of the Breast and Cervical Cancer Treatment Fund pursuant to Section 25.5-5-308 (9) (c), C.R.S. (2007).

Line Item: Short-term Disability	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$18,843**	**$19,332**	**$14,888**	**$19,548**
Common Policy Adjustment	$489	($4,444)	$4,660	$0
Long Bill Appropriation / Request	**$19,332**	**$14,888**	**$19,548**	**$19,761**
Final Appropriation / Request	**$19,332**	**$14,888**	**$19,548**	**$19,761**
General Fund	$8,563	$6,173	$8,509	$8,784
Cash Funds Exempt	$294	$458	$635[3]	$981[4]
Federal Funds	$10,475	$8,257	$10,404	$9,996

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

[3]Of this amount, $267 is from the Children's Basic Health Plan Trust Fund, $170 is from the Health Care Expansion Fund, $60 from the Primary Care Fund, $56 from the Old Age Pension Fund, $35 from the Coordinated Care for People with Disabilities Fund, $35 is from the Autism Treatment Fund, and $12 is from the Breast and Cervical Cancer Treatment Fund.

[4]Of this amount, $279 is from the Children's Basic Health Plan Trust Fund, $61 is from the Health Care Expansion Fund, $86 from the Primary Care Fund, $517 from a transfer from the Department of Human Services, and $38 is from the Autism Treatment Fund.

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 remained at this level until January 1, 2007 when it was 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 was the first full year this program was 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.

For FY 07-08, 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. The FY 08-09 Base Request uses 1.4% for July to December 2008, and 1.8% for the January to June 2009, which is effectively a 1.6% for the fiscal year. In addition, an adjustment to the Cash Funds Exempt portion was made due to the elimination of the Breast and Cervical Cancer Treatment Fund pursuant to Section 2.5-5-308 (9) (c), C.R.S. (2007). The table below summarizes this request.

Line Item: Amortization Equalization Disbursement	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**N/A**	**$27,857**	**$96,544**	**$178,339**
Common Policy Adjustment	$0	$68,687	$81,795	$64,867
Long Bill Appropriation / Request	**$27,857**	**$96,544**	**$178,339**	**$243,206**
Final Appropriation / Request	**$27,857**	**$96,544**	**$178,339**	**$243,206**
General Fund	$12,168	$38,697	$76,448	$108,110
Cash Funds Exempt	$500	$3,043	$5,855[5]	$12,071[6]
Federal Funds	$15,189	$54,804	$96,036	$123,026

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.

[5] Of this amount, $2,467 is from the Children's Basic Health Plan Trust Fund, $1,568 is from the Health Care Expansion Fund, $557 from the Primary Care Fund, $515 from the Old Age Pension Fund, $323 from the Coordinated Care for People with Disabilities Fund, $106 from the Breast and Cervical Cancer Treatment Fund, and $319 is from the Autism Treatment Fund.

[6] Of this amount, $3,430 is from the Children's Basic Health Plan Trust Fund, $756 is from the Health Care Expansion Fund, $1,060 from the Primary Care Fund, $6,358 is from a transfer from the Department of Human Services, and $467 is from the Autism Treatment Fund.

However, this item is funded through a reduction of the proposed Salary Survey increases for the upcoming fiscal year. This amount is ultimately paid through the Personal Services line item, through a defined percentage of the employee's raise.

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 created 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 was first implemented in FY 07-08 uses 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 was effectively 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. For FY 08-09 the calculation is based on the average contribution rate of 0.75% (0.5 % from July to December 2008, and 1.0% from January to June 2009). The FY 08-09 Base Request was developed using the Office of State Planning and Budgeting's budget instructions. An adjustment to the Cash Funds Exempt portion was made due to the elimination of the Breast and Cervical Cancer Treatment Fund pursuant to Section 25.5-5-308 (9) (c), C.R.S. (2007).

Line Item: Supplemental Amortization Equalization Disbursement	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$0**	**$34,950**
Common Policy Adjustment	$34,950	$42,922
Long Bill Appropriation / Request	**$34,950**	**$77,872**
Final Appropriation / Request	**$34,950**	**$77,872**
General Fund	$13,722	$34,615
Cash Funds Exempt	$1,220[7]	$3,866[8]
Federal Funds	$20,008	$39,391

SALARY SURVEY AND SENIOR EXECUTIVE SERVICES

The Salary Survey and Senior Executive Services 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. 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 fund salary survey increases, but rather requested only Performance Achievement 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).

Each employee title or class is matched to an occupational group for a percentage increase. This percentage is then multiplied by the employee's estimated salary as of June 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

[7] Of this amount, $514 is from the Children's Basic Health Plan Trust Fund, $327 is from the Health Care Expansion Fund, $116 from the Primary Care Fund, $107 from the Old Age Pension Fund, $67 from the Coordinated Care for People with Disabilities Fund, $22 from the Breast and Cervical Cancer Treatment Fund, and $67 is from the Autism Treatment Fund.

[8] Of this amount, $1,098 is from the Children's Basic Health Plan Trust Fund, $242 is from the Health Care Expansion Fund, $340 from the Primary Care Fund, $2,037 is from a transfer from the Department of Human Services, and $149 is from the Autism Treatment Fund.

Medicare amounts are added into the Salary Survey calculations.

The FY 07-08 appropriation was $480,923 and did not include the $34,950 that was "carved" out and allocated to the Supplemental Amortization Equalization Disbursement mentioned in the narrative above. The FY 08-09 Base Request was computed according to the Office of State Planning and Budgeting's budget instructions, again based on employee title or class, and is matched to an occupational group to determine the percentage increase. The calculation reflects a Common Policy increase of $119,547 bringing this appropriation to $600,470.

Line Item: Salary Survey and Senior Executive Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$248,845**	**$394,534**	**$459,483**	**$480,923**
Common Policy Adjustment	$0	$64,949	$21,440	$119,547
Joint Budget Committee Recommendation from January 2006, to increase all salaries by 3%	$145,689	$0	$0	$0
Final Appropriation / Request	**$394,534**	**$459,483**	**$480,923**	**$600,470**
General Fund	$172,506	$198,893	$217,149	$266,581
Cash Funds Exempt	$8,260	$11,087	$15,225[9]	$30,417[10]
Federal Funds	$213,768	$249,503	$296,726	$303,472

PERFORMANCE ACHIEVEMENT PAY

This line item replaced the Anniversary Increases budget line item in FY 02-03. Performance Achievement 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 Achievement 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 Achievement Pay system be implemented by July 1, 2000. The Colorado Peak Performance System was developed in response to this legislation. Before Colorado Peak Performance could be implemented, 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

[9] Of this amount, $8,621 is from the Children's Basic Health Plan Trust Fund, $3,065 is from the Health Care Expansion Fund, $1,156 is from the Primary Care Fund, $982 is from the Department of Public Health and Environment, $891 is from the Autism Treatment Fund, and $510 is from the Comprehensive Primary and Preventive Care Fund.

[10] Of this amount, $8,320 is from the Children's Basic Health Plan Trust Fund, $1,882 is from the Health Care Expansion Fund, $2,719 is from the Primary Care Fund, $1,199 is from the Autism Treatment Fund, and $16,297 is from a transfer from the Department of Human Services.

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

For FY 07-08 the Department's appropriation reflected the Common Policy instructions from the Office of State Planning and Budgeting, dated August 1, 2006 using a rate of 0.92%. The appropriation was based on salaries including the occupational and market adjustment, and range minimum adjustment if applicable. However, this amount was modified during Figure Setting on March 8, 2007 to provide a 1% base building increase to all employees rated satisfactory or above, and a 2% non-base building award for the Department's Peak Performers. The FY 08-09 Base Request was developed according to the Office of State Planning and Budgeting's budget instructions and uses a recommended rate of 1.4% resulting in a Request of $234,203.

Line Item: Performance Achievement Pay	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$136,130**	**$0**	**$0**	**206,506**
Common Policy Adjustment	$0	$0	$126,818	$27,697
Joint Budget Committee Recommendation from January 2005	($136,130)	$0	$0	$0
Joint Budget Committee Recommendation from March 2007	$0	$0	$79,688	$0
Final Appropriation / Request	**$0**	**$0**	**$206,506**	**$234,203**
General Fund	$0	$0	$92,725	$104,107
Cash Funds Exempt	$0	$0	$6,484[11]	$11,625[12]
Federal Funds	$0	$0	$107,297	$118,471

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. The 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. However, this appropriation was reduced by $17,074 through SB 07-163 for a final appropriation $25,760. The FY 07-08 appropriation is the Department's allocated amount from the Department of Personnel and Administration, equal to $24,247, and reflects a Common Policy reduction of $1,513. The FY 08-09 Base Request reflects the Common Policy amount developed by the Department of Personnel and Administration and allocated to the Department.

[11] Of this amount, $3,553 is from the Children's Basic Health Plan Trust Fund, $1,429 is from the Health Care Expansion Fund, $487 is from the Primary Care Fund, $386 is from the Department of Public Health and Environment, $367 is from the Autism Treatment Fund, and $262 is from the Primary and Preventive Care Fund.

[12] Of this amount, $3,303 is from the Children's Basic Health Plan Trust Fund, $728 is from the Health Care Expansion Fund, $1,021 is from the Primary Care Fund, $6,124 is from the Department of Human Services, and $449 is from the Autism Treatment Fund.

Line Item: Workers' Compensation	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$44,667**	**$39,404**	**$25,760**	**$24,247**
Common Policy Adjustment	($14,366)	$3,430	($1,513)	$8,616
Long Bill Appropriation / Request	**$30,301**	**$42,834**	**$24,247**	**$32,863**
HB 06-1217 (FY 05-06 Supplemental for Common Policies)	$9,103	$0	$0	$0
SB 07-163 (FY 06-07 Supplemental for Common Policies)	$0	($17,074)	$0	$0
Final Appropriation / Request	**$39,404**	**$25,760**	**$24,247**	**$32,863**
General Fund	$19,702	$12,880	$12,124	$16,432
Federal Funds	$19,702	$12,880	$12,123	$16,431

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.

The FY 05-06 appropriation provided total funding of $1,115,801.

The FY 06-07 final appropriation of $1,267,171 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; and SB 07-163 the Supplemental Bill which included one time funding for office equipment when the Department expanded its offices.

The Department's FY 06-07 final appropriation 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 FY 07-08 appropriation removes the one time funding for these items. However, the appropriation differs from the Long Bill appropriation due to Special Bills including the Governor's Executive Order for the Prescription Drug Plan that was incorporated into SB 07-001. The FY 08-09 Base Request reflects the FY 07-08 final appropriation with annualization of bills and removal of one time funding. Additionally, the FY 08-09 Base Request includes $11,400 in funding from the Emergency 1331 Supplemental eliminating the Office of Colorado Benefits Management System. Change Requests have been submitted for this line.

Line Item: Operating Expenses	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$935,976**	**$1,115,801**	**$1,267,171**	**$1,039,465**
Funding for FTE appropriated per SB 04-177 (Children with Autism Bill)	$4,739	$0	$0	$0
Removal of one-time funding for FTE appropriated per HB 04-1219	($949)	$0	$0	$0
Funding associated with FTE for Payment Error Rate Measurement Project (BA-6, January 24, 2005)	$4,149	$0	$0	$0
Joint Budget Committee action for additional funds related to Medicare Modernization Act implementation (Figure Setting, March 15, 2005, page 28)	$115,294	$0	$0	$0
Joint Budget Committee action to move HIPAA Security Rule on-going maintenance to this appropriation (Figure Setting, March 15, 2005, page 28)	$11,290	$0	$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)	($238)	($22,221)	$0	$0
Remove one-time funding for Medicare Modernization Act implementation (part of $138,903 reduction in Figure Setting, March 15, 2006)	$0	($113,394)	$0	$0

Line Item: Operating Expenses	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Removal of one-time funding for FTE appropriated per HB 05-1243 (part of $138,903 reduction in Figure Setting, March 15, 2006)	$0	($3,288)	$0	$0
Removal of one-time funding due to the Colorado Benefits Management System court order (action happened after March 15, 2006 Figure Setting)	$0	($6,360)	$0	$0
Annualization of Request to delay FTE associated with the Payment Error Rate Measurement Project (BA-6, January 3, 2006)	$0	$3,657	$0	$0
Annualization of Request for FTE to assist in changing timing of certification of public expenditures (BA-2, January 3, 2006)	$0	($2,635)	$0	$0
Annualization of Request for FTE to assist in establishing an Old Age Pension Drug Rebate Program (BA-4, January 3, 2006)	$0	($4)	$0	$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	$620	$0	$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	$22,088	$0	$0
Funding for implementation of Drug Rebate Analysis and Management System, as requested (BRI-4, November 15, 2005)	$0	$7,749	$0	$0
Remove one-time funding for HB 06-1270 Remove funding for the advisory committee and annualization of operating expenses. JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	($6,010)	$0
Remove one-time funding for SB 06-128 Annualization of operating expenses for 1.0 FTE (GP IV). JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	($2,975)	$0
Remove one-time funding for SB 06-165 Annualization of operating expenses for 1.0 FTE (GP IV). JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	($3,005)	$0

Line Item: Operating Expenses	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Remove one-time funding for FY 06-07 budget items. Removal of the operating expenses for FTE related to HB 06-1385. In addition, removal of $10,000 for the Late Supplemental for the Executive Order for the PDL. This funding was for one-time costs associated with the 3.0 FTE positions. JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	($19,026)	$0
Technical Adjustment for Public School Administration JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	$972	$0
SB 07-163 Annualization S - 8 Commercial Leased Space - removal of $214,856 in one-time build out costs. Annualization of 1331 for EPG out year - removal of $12,020. For one time funding for computers and office furniture for 4 FTE. Annualization of PERM removal of $2,530 of one-time funding related to the Contract Manager. DI - 4 Annualization HB 06S - 1023 Immigration Reform - removal of $7,056 in one-time funding related to 2 FTE. JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	($236,462)	$0
Annualize cost of Executive Order for PDL Pay for operating expenses for the 3.0 FTE for the PDL. JBC Figure Setting, Feb 14, 2007, Pages 34-35	$0	$0	$2,850	$0
Annualization of SB 07-211 Improving Health Care for Children	$0	$0	$0	($4,509)
Annualization of SB 07-196 Health Information Technology	$0	$0	$0	($2,530)
Annualization of SB 07-130 Medical homes for Children	$0	$0	$0	($3,005)
Annualization of SB 07-001 Colorado RX Cares Program	$0	$0	$0	($10,595)
Annualization of HB 07-1021 Prescription Drug Consumer Information & Technical Assistance Act	$0	$0	$0	($3,006)
Annualization of SB 07-004 Early Intervention for Children	$0	$0	$0	($3,280)
Emergency 1331 Supplemental, elimination of OCBMS	$0	$0	$0	$11,400
Long Bill Appropriation / Request	**$1,070,261**	**$1,002,013**	**$1,003,515**	**$1,023,940**
HB 05-1262, Operating Expenses associated with 5.1 FTE, and 7 network connections, to implement tobacco tax legislation	$27,446	$0	$0	$0

Line Item: Operating Expenses	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
HB 05-1243, Consumer Directed Care, expenses for 0.5 FTE to write waiver, assess Medicaid Management Information System and monitor case management agencies	$3,762	$0	$0	$0
HB 05-1066, Expenses for 0.5 FTE to manage obesity treatment pilot program	$3,988	$0	$0	$0
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	$9,594	$0	$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	$750	$0	$0	$0
HB 06-1270, School Eligibility Determinations	$0	$9,876	$0	$0
SB 06-128, Care for People with Disabilities Pilot Program	$0	$3,845	$0	$0
SB 06-165, Telemedicine Pilot Program	$0	$3,875	$0	$0
SB 06-219, Department of Health Care Policy and Financing Re-organization	$0	$1,000	$0	$0
HB 06-1385 FY 06-07 Long Bill funded the Department's request operating expenses related to 3 Technician IIIs and 1 GP III for the full year of FY 06-07. The Department had spending authority through a September 20, 2006 1331 Emergency Supplemental. This funding is one-time for computer and office furniture. On-going funding $370 for telephone costs and $500 for supplies per FTE. This funding is for the EPG Unit created by the bill. Of the $15,500 only $3,480 will be continuation funding into FY 07-08.	$0	$15,500	$0	$0

Line Item: Operating Expenses	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
HB 06-1385 FY 06-07 Long Bill S-8 Increase Funding for Commercial Leased Space - Funding was at the Department's request for expenses related to purchasing equipment and furniture for the new space. In FY 07-08 the JBC removed the entire amount of $214,856 because it is for one-time funding. (January 23, 2007 JBC FY 06-07 Supplemental, Page 46-48)	$0	$214,856	$0	$0
HB 06-1385 FY 06-07 Long Bill S-5 Revised Federal Rule for Payment Error Rate Measurement Program - Reduced funding for Contract Manager hire on January 1, 2007 (rather than October 2006 as originally budgeted). In FY 07-08 the JBC removed $2,530 in one-time funding. (January 23, 2007 JBC FY 06-07 Supplemental, Page 34-36)	$0	($238)	$0	$0
HB 06-1385 FY 06-07 Long Bill S-4 Implementation of HB 06S-1023 and Deficit Reduction Act of 2005 - Added funding for the requested GP IV in Eligibility Operations and GP II in IT Support anticipated to be hired March 1, 2007. In FY 07-08 the JBC removed $7,056 in one-time funding. (January 23, 2007 JBC FY 06-07 Supplemental, Page 28-31)	$0	$6,444	$0	$0
HB 06-1385 FY 06-07 Long Bill funding for Executive Order for Prescription Drug List. Funds 3 FTE for a quarter of a year for the operating expenses related to a Pharmacy III, GP III, and Statistical Analyst III. JBC Figure Setting Feb. 14, 2007 Page 34.	$0	$10,000	$0	$0
SB 07-001 Colorado RX Cares Program	$0	$0	$14,395	$0
SB 07-004 Early Intervention for Children	$0	$0	$4,230	$0
HB 07-1021 Prescription Drug Consumer Information and Technical Assistance Act	$0	$0	$3,956	$0
SB 07-130 Medical homes for Children	$0	$0	$3,955	$0
SB 07-196 Health Information Technology	$0	$0	$3,480	$0
SB 07-211 Improving Health Care for Children	$0	$0	$5,934	$0
Final Appropriation / Request	**$1,115,801**	**$1,267,171**	**$1,039,465**	**$1,023,940**

Line Item: Operating Expenses	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
General Fund	$521,585	$615,384	$494,229	$486,342
Cash Funds	$0	$0	$14,395	$3,800
Cash Funds Exempt	$28,465	$14,393	$14,546[13]	$27,093[14]
Federal Funds	$565,751	$637,384	$516,295	$506,705

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.

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 based on 12,684 hours of usage for a total appropriation of $859,595. The FY 07-08 appropriation continued funding for 12,684 hours at the blended rate of $67.77, for total funding of $859,595. A common policy adjustment increased this by $54,034 to $913,629. This effectively raised the blended attorney/paralegal rate to $72.03. Per Chapter 4 of the Common Policies Instructions, dated August 1, 2007 the Department's FY 08-09 Base Request reflects the FY 07-08 appropriation amount which is comprised of 12,684 hours at the blended rate of $72.03.

[13] Of this amount, $2,115 is from the Short Term Care Initiative Fund, $701 is form the Children's Basic Health Plan Trust Fund, $4,365 is from the Health Care Expansion Fund, $2,370 is from the Autism Treatment Fund, $3,876 is from the Old Age Pension Fund, $620 is from the Primary Care Fund, $63 is from the Breast and Cervical Cancer fund, and $436 is from the Coordinated Care for People with Disabilities Fund.

[14] Of this amount, $475 is from the Short Term Care Initiative Fund, $701 is form the Children's Basic Health Plan Trust Fund, $4,365 is from the Health Care Expansion Fund, $2,370 is from the Autism Treatment Fund, $3,876 is from the Old Age Pension Fund, $620 is from the Primary Care Fund, $436 is from the Coordinated Care for People with Disabilities Fund, and $14,250 is a transfer from the Department of Human Services.

Line Item: Legal Services and Third Party Recovery Legal Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$780,953**	**$817,483**	**$859,595**	**$913,629**
Common Policy Adjustment	$36,530	$42,112	$54,034	$0
Final Long Bill Appropriation / Request	**$817,483**	**$859,595**	**$913,629**	**$913,629**
General Fund	$331,724	$348,589	$370,501	$370,501
Cash Funds	$68,929	$72,375	$76,924	$76,924
Cash Funds Exempt	$5,662	$5,945	6,319[15]	6,319[16]
Federal Funds	$411,168	$432,686	$459,885	$459,885

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.

Based on this methodology, the FY 05-06 appropriation was calculated to be $674,931 through a Common Policy adjustment of $65,288 over FY 04-05 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. This appropriation 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, the Department's FY 05-06 Supplemental Bill (HB 06-1217) reduced this appropriation to $505,921 due to the latest projections regarding proportional usage.

For FY 06-07, the Department's appropriation was $540,855, which reflected an increase of $34,934 due to Common Policy allocations issued March 15, 2006. However, SB 07-163 reduced this appropriation by $159,925 to a final appropriation of $380,930.

[15] Of this amount, $6,319 is from the Children's Basic Health Plan Trust Fund.
[16] Of this amount, $6,319 is from the Children's Basic Health Plan Trust Fund.

The FY 07-08 appropriation of $407,509 reflects amounts calculated by the Department of Personnel and Administration through Common Policies.

The FY 08-09 Base Request of $453,207 reflects an increase of $45,698 due to additional utilization, and is based on Common Policies issued by the Department of Personnel and Administration on August 15, 2007.

Line Item: Administrative Law Judge Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$609,643**	**$505,921**	**$380,930**	**$407,509**
Common Policy Adjustment	$65,288	$34,934	$26,579	$45,698
Long Bill Appropriation / Request	**$674,931**	**$540,855**	**$407,509**	**$453,207**
Supplemental HB 06-1217	($169,010)	$0	$0	$0
Supplemental SB 07-163	$0	($159,925)	$0	$0
Final Appropriation / Request	**$505,921**	**$380,930**	**$407,509**	**$453,207**
General Fund	$252,961	$190,465	$203,755	$226,604
Federal Funds	$252,960	$190,465	$203,754	$226,603

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 Care Fund).

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, an

appropriation of $94,815 was approved during Figure Setting on March 15, 2006 for the Department's portion of these costs. However, this appropriation was reduced to $0 through SB 07-163 the FY 06-07 Supplemental Bill.

For FY 07-08, the Department's appropriation reflects a significant reduction to this line. The reason for this reduction is 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. The Department was under the impression that all billing for this line item would cease beginning in FY 07-08. However, during the Joint Budget Committee's Common Policy Figure Setting process for FY 07-08, the Department was appropriated $18,516 for FY 07-08, (JBC Common Policy Figure Setting, March 15, 2007 Page 5). Therefore, the FY 07-08 appropriation is for this line is only $18,516.

Please note that because of the significant reduction in allocated central computer services beginning in FY 07-08, the Department has revised its need for 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 $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.

The FY 08-09 Base Request of $17,250 reflects a further decrease in usage and is reflected in the Common Policy decrease of $1,266.

Line Item: Purchases of Services from Computer Center	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$162,948**	**$93,436**	**$0**	**$18,516**
Common Policy Adjustment	($6,637)	$1,379	$18,516	($1,266)
Long Bill Appropriation / Request	**$156,311**	**$94,815**	**$18,516**	**$17,250**
HB 06-1217 Supplemental Adjustment	($62,875)	$0	$0	$0
SB 07-163 Supplemental Adjustment	$0	($94,815)	$0	$0
Final Appropriation / Request	**$93,436**	**$0**	**$18,516**	**$17,250**
General Fund	$30,483	$0	$7,590	$6,957
Cash Funds Exempt	$16,235	$0	$3,337	$3,337[17]
Federal Funds	$46,718	$0	$7,589	$6,956

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. Prior to FY 07-08, the Department did not participate in the Property Program. However, for FY 07-08, the Department of Personnel and Administration adjusted it policy and began billing the Department for the Property portion of this program.

The FY 05-06 appropriation was $63,618. A Supplemental Common Policy adjustment reduced this appropriation to $21,976. This reduction was due to modifying the State's reserve fund levels. For FY 06-07, the appropriation was increased to $58,143 with the passage of HB 06-1385. The FY 07-08 appropriation was reduced during Common Policy Figure Setting (JBC Figure Setting, March 15, 2007, page 15) to $91,727. The increase to the FY 07-08 appropriation for participating in the Property Program was insignificant.

The FY 08-09 Base Request of $72,367 reflects Common Policy adjustments issued by the Department of Personnel and Administration on August 15, 2007. The Property Program portion of this Base Request totals $1,016.

[17] Of this amount $3,337 is from the Old Age Pension Fund.

Line Item: Payment to Risk Management and Property Funds	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$58,795**	**$21,976**	**$101,811**	**$91,727**
Common Policy Adjustment	$4,823	$36,167	($10,084)	($19,360)
Long Bill Appropriation / Request	**$63,618**	**$58,143**	**$91,727**	**$72,367**
Supplemental HB 06-1217	($41,642)	$0	$0	$0
Supplemental SB 07-163	$0	$43,668	$0	$0
Final Appropriation / Request	**$21,976**	**$101,811**	**$91,727**	**$72,367**
General Fund	$10,988	$50,906	$45,864	$36,184
Federal Funds	$10,988	$50,905	$45,864	$36,183

LEASED SPACE

Previously called 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.

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, spending authority 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 Long Bill appropriation was $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, and a reduction of $2,948 due to the out-year effects of the tobacco tax implementation. A Stand Alone Budget Amendment, approved by the Joint Budget Committee on January 24, 2006, provided an additional $38,510 to lease space at 225 E. 16th Street.

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. Additionally, the Department submitted a FY 06-07 Supplemental funding request for $115,672 to pay for Leased Space that it had previously acquired based on verbal feedback from the Joint Budget Committee. Both the Emergency 1331 for the Exceeds Processing Guidelines unit and this Request were incorporated into SB 07-163 (the FY 06-07 Supplemental Bill).

The FY 07-08 appropriation increased funding to $272,318 due to annualization of the increased Funding for Commercial Leased Space Request. The FY 08-09 Base Request reflects continuation funding. A Change Request has been submitted for this line item.

Line Item: Leased Space	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$0**	**$75,181**	**$173,762**	**$272,318**
Removal of one-time funding for implementation of the Medicare Modernization Act	$0	($36,278)	$0	$0
Removal of one-time funding for implementation of HB 05-1262	$0	($2,948)	$0	$0
Removal of one-time funding for the emergency call center per the CBMS Court Order	$0	($24,955)	$0	$0
Funding for space at 225 E. 16th Avenue (January 24, 2006, BA-8)	$0	$38,510	$0	$0
Long Bill Appropriation / Request	**$36,278**	**$49,510**	**$173,762**	**$272,318**
HB 05-1262 – One-time funding for implementation of the tobacco tax bill	$9,548	$0	$0	$0
HB 06-1217 – One-time funding for emergency call center	$24,955	$0	$0	$0
HB 06-1385 Add-ons – Adjustment to Emergency Supplemental funding for HB 05-1262	$4,400	$0	$0	$0
Emergency 1331 Supplemental - Cases Exceeding Processing Guidelines (incorporated in SB 07-163 FY 06-07 Supplemental Bill)	$0	$8,580	$0	$0
S-8, January 23, 2007 Increased Funding for Commercial Leased Space (incorporated in SB 07-163 FY 06-07 Supplemental Bill)	$0	$115,672	$0	$0
Annualization S-8, Increased Funding for Commercial Leased Space	$0	$0	$98,556	$0

Line Item: Leased Space	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$75,181**	**$173,762**	**$272,318**	**$272,318**
General Fund	$18,139	$80,750	$130,659	$130,659
Cash Funds Exempt	$31,929	$5,500	$5,500[18]	$5,500[19]
Federal Funds	$25,113	$87,512	$136,159	$136,159

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 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 final appropriation of $391,079 is based on a Common Policy increase 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 increased to $12.41 per useable square foot.

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

The FY 08-09 Base Request is based on Common Policies issued by the Department of Personnel and Administration on August 15, 2007 and reflects a rate increase to $12.51 per useable square foot.

Line Item: Capitol Complex Leased Space	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$339,179**	**$332,915**	**$344,022**	**$391,079**
Common Policy Adjustment	($2,722)	$11,107	$47,057	$3,293
Long Bill Appropriation / Request	**$336,457**	**$344,022**	**$391,079**	**$394,372**
HB 06-1217 FY 05-06 Supplemental Adjustment	($3,542)	$0	$0	$0
Final Appropriation / Request	**$332,915**	**$344,022**	**$391,079**	**$394,372**
General Fund	$166,458	$172,011	$195,540	$197,186
Federal Funds	$166,457	$172,011	$195,539	$197,186

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. The FY 05-06 Long Bill ((SB 05-209) appropriated $74,564 for this line item. This amount remained the same for FY 06-07 and FY 07-08. The Department is requesting continuation funding of $74,564 for FY 08-09.

Line Item: Transfer to the Department of Human Services for Related Administration	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$74,564**	**$74,564**	**$74,564**	**$74,564**
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 08-09 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 exception to this rule is when the State exercises 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. During FY 06-07, reprocurement of the Medicaid Management Information System operational responsibilities was completed, and Affiliated Computer Services was reselected as the fiscal agent. Effective July 1, 2007, a new contract began that will carry forward for the next three years with the option to renew for five additional years.

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 Centers for Medicare and Medicaid Services. The Drug Rebate Analysis and Management System (DRAMS) was added in FY 06-07 with 50% General Fund and 50% federal funds. Ongoing maintenance costs for the Prescription Drug List are funded at 25% General Fund and 75% federal funds. Payment Error Rate Measurement Project (PERM) maintenance costs are split between Medicaid and the Children's Basic Health Plan. The Colorado Cares RX ongoing costs are totally cash funded.

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. Beginning with the reprocured contract effective July 1, 2007, DRAMS is also covered under fixed price. Items that are not included in fixed price include: postage costs, development costs, Prescription Drug List maintenance costs, the Payment Error Rate Measurement maintenance costs, and the Colorado Cares RX ongoing 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 is ongoing.

Changes during FY 06-07 added components to the Medicaid Management Information System Contract. The Preferred Drug List was established by Executive Order D 004 07 issued January 4, 2007, followed by development costs in a late supplemental request, and annualized in the Long Bill (SB 07-239). Funding for the Payment Error Rate Measurement Project was requested in BA-1 submitted January 4, 2007, approved in the Department's Supplemental Bill, SB 07-163, and annualized in the FY 07-08 Long Bill (SB 07-239). The Colorado Cares Rx program began with SB 07-001.

For FY 07-08 calculations, certain adjustments were made to remove funding that applied to the prior year only, primarily for one time development costs resulting from special bills and for one time only funding supplied by the Supplemental Bill, SB 07-163. Also excess funding of $1,775,102 for fixed price that resulted from lower costs negotiated during reprocurement was removed. New development costs for Children's Basic Health Plan Premiums Assistance Program, known as CBHP+ at Work, were added to allow employers of parents who have children enrolled in the program to transmit enrollment fees deducted from the parent's paychecks.

Similarly, for FY 08-09, adjustments to the requested amount included adjustments for effects of special bills.

Line Item: Medicaid Management Information System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Appropriation	**$21,983,967**	**$23,032,048**	**$26,646,420**	**$22,306,209**
Remove one-time funding for bulletin board service in FY 04-05	($14,357)	$0	$0	$0
Remove development costs for updates to drug prior authorization reviews	($20,000)	$0	$0	$0
SB 04-177 claims processing for children with autism	$3,098	$0	$0	$0
SB 04-177 prior authorization reviews for children with autism	$2,220	$0	$0	$0
SB 04-177 development costs for children with autism	$122,500	$0	$0	$0
HB 04-1219 annualize claims processing for community transition services for the elderly, blind, and disabled	$76	$0	$0	$0
HB 04-1219 development costs for community transition services for the elderly, blind, and disabled	$75,000	$0	$0	$0
Adjust school based health claims requested in Supplemental Request #S-4, submitted January 3, 2005	$8,073	$0	$0	$0
Adjust old age pension claims as requested in Supplemental Request #S-4, Submitted January 3, 2005	($48,886)	$0	$0	$0
Add funding for non-specified claims in fixed price agreement (S-4, January 3, 2005)	$780,884	$0	$0	$0
Joint Budget Committee action to add $244 to make up for shorted funding in Supplemental Bill SB 05-112	$244	$0	$0	$0
Joint Budget Committee action to reduce prior authorization review funding due to the Medicare Modernization Act	($272,761)	$0	$0	$0
Joint Budget Committee action to add one-time funding for development costs for the Medicare Modernization Act	$73,279	$0	$0	$0
HB 05-1015 one-time development costs for substance abuse treatment (also in Long Bill)	$44,450	$0	$0	$0
Remove One-Time Funding for delayed HIPAA Billing	($469,740)	$0	$0	$0
Annualize funding for Tobacco Tax Bill authorized by HB 05-1262	$0	$319,717	$0	$0

Line Item: Medicaid Management Information System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Remove one-time development costs for children with autism authorized by SB 04-177	$0	($122,500)	$0	$0
Remove development costs for community transitions for elderly, blind, and disabled authorized by HB 04-1219	$0	($75,000)	$0	$0
Remove one-time development costs for Medicare Modernization Act funded by Joint Budget Committee recommendation	$0	($73,279)	$0	$0
Remove one-time development costs for substance abuse treatment authorized by HB 05-1015	$0	($44,450)	$0	$0
Remove one-time development costs for Consumer Directed Care authorized by HB 05-1243	$0	($170,688)	$0	$0
Remove one-time development costs for asset test removal for health care expansion population	$0	($34,925)	$0	$0
Annualize reduction of drug prior authorization reviews due to Medicare Modernization Act (S-6, January 3, 2006)	$0	($204,570)	$0	$0
Adjust Children's Basic Health Plan funding for fixed price (assumed 50% federal funds rather than 65%)	$0	$11,589	$0	$0
Drug Rebate Analysis and Management System (DRAMS) (BRI-4, November 15, 2005)	$0	$375,000	$0	$0
Remove unused funding from Prescription Drug Prior Authorization Reviews per JBC staff recommendation (Figure Setting, page 48, February 14, 2007)	$0	$0	($290,000)	$0
Annualize Drug Rebate Analysis and Management System (DRAMS) (BRI-4, November 15, 2005)	$0	$0	($75,000)	$0
Remove one-time development costs for residential child health care HB 06-1395	$0	$0	($46,336)	$0
Remove one-time development costs for services for people with disabilities SB 06-128	$0	$0	($73,279)	$0
Remove one-time development costs for telemedicine pilot programs SB 06-165	$0	$0	($53,280)	$0

Line Item: Medicaid Management Information System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Remove one-time costs for implementation of Systematic Alien Verification of Entitlement (SAVE) that were requested in S-4, submitted January 4, 2007 and approved by Supplemental Bill SB 07-163. See Figure Setting, page 15, February 14, 2007	$0	$0	($1,020)	$0
Remove one-time costs of implementation of the Payment Error Rate Measurement Project (PERM), originally requested in S-5, submitted January 4, 2007, and approved by Supplemental Bill SB 07-163. See Figure Setting, pages 16 and 47, February 14, 2007	$0	$0	($37,800)	$0
Remove Transition Costs from after reprocurement, originally requested by S-7, submitted January 4, 2007, and approved by SB -7-163. See Figure Setting, page 48, February 14, 2007	$0	$0	($2,826,714)	$0
Remove development costs for Colorado Cares Rx SB 07-001	$0	$0	($79,927)	$0
Remove development costs for extend Medicaid eligibility for foster care SB 07-002	$0	$0	($34,650)	$0
Remove development costs for Preferred Drug List. See Figure Setting, page 49, February 14, 2007	$0	$0	($170,371)	$0
Annualize Payment Error Rate Measurement (PERM) maintenance costs as originally requested in S-5, submitted January 4, 2007. See Figure Setting, page 47, February 14, 2007	$0	$0	$10,080	$0
Remove excess fixed price contract funding after reprocurement as requested by BA-1, submitted January 24, 2007, and approved in Long Bill SB 07-239. See Figure Setting, page 48, February 14, 2007	$0	$0	($1,775,102)	$0
Add development costs for Children's Basic Health Plan Premiums Assistance Program (CBHP+ at Work) per BA-4, submitted January 24, 2007, and approved by Long Bill (SB 07-239). See Figure Setting, page 48, February 14, 2007	$0	$0	$180,558	$0
Restore funding to Prescription Drug Prior Authorization Reviews for use by the Preferred Drug List program per JBC staff recommendation (Figure Setting, page 49, February 14, 2007)	$0	$0	($290,000)	$0
Ongoing maintenance costs for Preferred Drug List. See Figure Setting, page 49, February 14, 2007	$0	$0	$50,880	$0

Line Item: Medicaid Management Information System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Remove developments costs for Children's Basic Health Plan Premiums Assistance Program (CBHP+ at Work). See Figure Setting, page 48, February 14, 2007	N/A	N/A	N/A	($180,558)
Remove SB 07-130 development costs for medical homes for children	N/A	N/A	N/A	($56,400)
Remove SB 07-196 development costs for health information technology	$0	$0	$0	($94,500)
Remove SB 07-097 reallocation of Tobacco Settlement Funds for development costs related to changes in eligibility in Children's Basic Health Plan	$0	$0	$0	($91,980)
Annualize costs for Colorado Cares RX, SB 07-001	$0	$0	$0	$934,778
Long Bill Appropriation / Request	**$22,268,047**	**$23,012,942**	**$21,694,358**	**$22,817,549**
HB 05-1262 one-time cost for central processing unit disk storage for Decision Support System	$43,000	$0	$0	$0
HB 05-1262 central processing unit disk storage for the Prescription Drug Card System (PDCS)	$18,000	$0	$0	$0
HB 05-1262 claims processing for anticipated additional caseload	$685,420	$0	$0	$0
HB 05-1262 add pharmacy prior authorization reviews associated with anticipated caseload	$38,568	$0	$0	$0
HB 05-1086 one-time development costs for treatment of obesity	$31,750	$0	$0	$0
HB 05-1086 pharmacy prior authorization reviews for treatment of obesity	$5,795	$0	$0	$0
HB 05-1243 one-time development costs for consumer directed care	$170,688	$0	$0	$0
HB 06-1217 reduction of drug prior authorization reviews due to implementation of Medicare Modernization Act (S-6, January 3, 2006)	($204,570)	$0	$0	$0
HB 06-1385 Add-ons adjust development costs funding appropriated in HB 05-1262 to remove asset test for claims processing	$34,925	$0	$0	$0
HB 06-1385 Add-ons reduction for funding from HB 05-1262 (1331 Supplemental submitted June 2005)	($22,030)	$0	$0	$0

Line Item: Medicaid Management Information System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
HB 06-1385 Add-ons remove obesity funding due to lack of grants and gifts	($37,545)	$0	$0	$0
HB 06-1395 one-time development costs for residential child health care	$0	$46,336	$0	$0
SB 06-128 one-time development costs for services for people with disabilities	$0	$73,279	$0	$0
SB 06-165 one-time development costs for telemedicine pilot program	$0	$53,280	$0	$0
One time funding for implementation of Systematic Alien Verification of Entitlement (SAVE) as required by HB 06S-1023 but requested in S-4 submitted January 4, 2007 and approved by Supplemental Bill, SB 07-163	$0	$1,020	$0	$0
One time funding for implementation of the Payment Error Rate Measurement Project (PERM) requested in S-5 and approved by Supplemental Bill, SB 07-163	$0	$37,800	$0	$0
Transition costs following reprocurement of the Medicaid Management Information System Contract as requested by S-7 submitted January 4, 2007 and approved by Supplemental Bill, SB 07-163	$0	$2,826,714	$0	$0
Additional fixed price approved by Supplemental Bill, SB 07-163	$0	$310,101	$0	$0
SB 07-001 development costs for Colorado Cares Rx	$0	$79,927	$0	$0
SB 07-002 development costs to extend Medicaid eligibility for foster care	$0	$34,650	$0	$0
SB 07-239 Add-On for development costs of Preferred Drug List per Joint Budget Committee Figure Setting, February 14, 2007, page 45	$0	$170,371	$0	$0
SB 07-130 development costs for medical homes for children	$0	$0	$56,400	$0
SB 07-196 development costs for health information technology	$0	$0	$94,500	$0
SB 07-097 reallocation of Tobacco Settlement Funds for development costs related to changes in eligibility in Children's Basic Health Plan	$0	$0	$91,980	$0
Ongoing costs for Colorado Cares Rx, SB 07-001	$0	$0	$368,971	$0

Line Item: Medicaid Management Information System	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$23,032,048**	**$26,646,420**	**$22,306,209**	**$22,817,549**
General Fund	$5,549,271	$6,427,497	$5,265,858	$5,228,266
Cash Funds	$0	$0	$368,971	$1,303,749
Cash Funds Exempt	$560,375	$645,137	$706,330	$610,809
Federal Funds	$16,922,402	$19,573,786	$15,965,050	$15,674,725

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT

The previous contract with Affiliated Computer Services, the fiscal agent for the Medicaid Management Information System Contract, expired November 30, 2006. The Centers for Medicare and Medicaid Services required that the contract be reprocured. The reprocurement process was 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 ensure that this process is completed in an efficient manner. The reprocurement was completed, and the same fiscal agent was selected.

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 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. Given that the same fiscal agent was selected, the necessary consulting hours were substantially reduced. Therefore, the funding for FY 06-07 was reduced by $170,603. The reduction was approved in the Add-on of Long Bill (SB 07-239.)

Decision Item DI-4, submitted November 15, 2005, also requested an additional $55,200 for consulting hours in FY 07-08. The additional funding was necessary to cover the costs of the consultant remaining with the project until all transition and enhancement tasks have been completed. However, since the same fiscal agent was selected, no consulting hours were required in FY 07-08. Therefore, FY 07-08 funding was removed by Joint Budget Committee recommendation during Figure Setting, February 14, 2007, page 50.

No funding is requested for FY 08-09 for this line item.

Line Item: Medicaid Management Information System Reprocurement	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$642,600**	**$579,600**	**$569,497**	**$0**
Annualization of Supplemental S-5	($63,000)	$0	$0	$0
Annualize Base Funding, Joint Budget Committee Figure Setting, March 6, 2006, page 50	$0	($252,000)	$0	$0
Additional Consulting Hours and Independent Verification and Validation (IV and V) Work (DI-4, November 15, 2005)	$0	$412,500	$0	$0
Long Bill Appropriation / Request	**$579,600**	**$740,100**	**$0**	**$0**
SB 07-239 Add-On Reduction of funding due to same fiscal agent reselected	$0	($170,603)	$0	$0
Removal of funding for FY 07-08 per Joint Budget Committee Figure Setting, February 14, 2007, page 50	$0	$0	($569,497)	$0
Final Appropriation / Request	**$579,600**	**$569,497**	**$0**	**$0**
General Fund	$132,120	$114,412	$0	$0
Cash Funds Exempt	$6,086	$5,980	$0	$0
Federal Funds	$441,394	$449,105	$0	$0

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). This appropriation was for one-time funding. Therefore, no money is being requested for FY 08-09.

Line Item: CBMS Eligibility Audit – Transfer to the State Auditor	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**N/A**	**$68,250**	**$0**	**$0**
Removal of one-time funding from FY 05-06	$0	($68,250)	$0	$0
Long Bill Appropriation / Request	**$0**	**$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	$0
Final Appropriation / Request	**$68,250**	**$0**	**$0**	**$0**
General Fund	$0	$0	$0	$0
Cash Funds Exempt	$34,125	$0	$0	$0
Federal Funds	$34,125	$0	$0	$0

MEDICARE MODERNIZATION ACT OF 2003-COLORADO BENEFITS MANAGEMENT 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. The Centers for Medicare and Medicaid Services require the State to submit a monthly report of the number of dual eligible clients (clients both Medicare and Medicaid eligible) 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) adding fields to the Medicare Expense table to accommodate the Medicare Part D information, and 3) developing 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. No funding for FY 08-09 is being requested.

Line Item: Medicare Modernization Act of 2003 – Colorado Benefit Management System Development Costs	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Previous Fiscal Year Final Appropriation	**$0**	**$488,000**	**$0**	**$0**
Removal of one-time funding	$0	($488,000)	$0	$0
Long Bill Appropriation / Request	**$488,000**	**$0**	**$0**	**$0**
Final Appropriation / Request	**$488,000**	**$0**	**$0**	**$0**
General Fund	$244,000	$0	$0	$0
Federal Funds	$244,000	$0	$0	$0

HIPAA WEB PORTAL MAINTENANCE

This line item was first established in FY 04-05. The Department's web portal became operational in 2003 and was initiated as part of the Health Insurance Portability and Accounting Act of 1996 (HIPAA) requirement to implement the federal Transaction and Code Set Rule. The web portal is used to insure privacy and electronic security, as required by HIPAA, for transmission of data to and from the Medicaid Management Information System, the Colorado Benefits Management System, the Business Utilization System (BUS), medical providers, and the Centers for Medicare and Medicaid Services. The largest amount of transmission activity is to the Medicaid Management Information System generated by the Department's contracted medical providers.

Reports, files, and transaction responses are transmitted by Affiliated Computer Services, Inc., the fiscal agent for the Medicaid Management Information System, back to the medical providers. However, the contractor for the web portal, CGI Information Systems and Management Consultants, Inc. (hereafter referred to as CGI), is independent of the fiscal agent, Affiliated Computer Services, Inc. The Department also uses this portal for medical assistance site workers who require access to other Department systems.

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). For FY 05-06 and each year thereafter, base funding for this line item has continued at $312,900. During FY 06-07, a Supplemental request, S-4, submitted January 4, 2007, asked for $1,900 as one time funding for implementation of the connections to verify immigration status in the Systematic Alien Verification of Entitlement Program (SAVE). This connection was necessary because the web portal is the access mechanism for the Medicaid Management Information System and the Colorado Benefits Management System through the Department's website. The supplemental request was approved through SB 07-163.

The FY 08-09 Base Request is for continuation funding.

Line Item: HIPAA Web Portal Maintenance	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$312,900**	**$312,900**	**$314,8900**	**$312,900**
Remove one time funding for SAVE implementation	$0	$0	($1,900)	$0
Long Bill Appropriation / Request	**$312,900**	**$312,900**	**$312,900**	**$312,900**
Supplemental Request S-4 for SAVE, approved by SB 07-163	$0	$1,900	$0	$0
Final Appropriation	**$312,900**	**$314,800**	**$312,900**	**$312,900**
General Fund	$78,225	$78,700	$78,225	$78,225
Federal Funds	$234,675	$236,100	$234,675	$234,675

HIPAA NATIONAL PROVIDER IDENTIFIER ASSESSMENT AND IMPLEMENTATION

Colorado Medicaid provider identification numbers used to process Medicaid claims were not 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. To achieve compliance with federal requirements released on January 23, 2004, the Department updated its Medicaid Management Information System to accept these new National Provider Identifiers. The expectation to this federal requirement is to provide a unique identifier for every health care provider in the country.

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. 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 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). Cash Funds Exempt were provided from the Children's Basic Health Plan.

Initial assessment revealed that the changes needed to implement the National Provider Identifier in the Medicaid Management Information System were so extensive that additional funding was required for all the work. A supplemental request, S-9, was submitted January 4, 2007 for $1,339,621, and the request was approved with funding in the Supplemental Bill, SB 07-163. The Centers for Medicare and Medicaid Services approved 90% federal funds participation for the implementation funding.

The Department met the federal requirement to incorporate a unique identifier for each medical provider in the Department's claims processing system, the Medicaid Management Information System, by the 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.

Line Item: HIPAA National Provider Identification Assessment and Implementation	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation / Request	**$0**	**$109,100**	**$2,030.583**	**$0**
Annualization of assessment funding and for independent verification and validation (BA-5, January 3, 2006)	$0	$581,862	$0	$0
Removal of funding for completion of project (federal deadline: May 23, 2007)	$0	$0	($2,030,583)	$0
Long Bill Appropriation / Request	**$0**	**$690,962**	**$0**	$0
SB 05-112 Initial funding for assessment of system changes (S-12, January 3, 2006)	$109,100	$0	$0	$0
SB 07-163 Supplemental funding for implementation (S-9, January 4, 2007)	$0	$1,339,621		$0
Final Appropriation / Request	**$109,100**	**$2,030,583**	**$0**	$0
General Fund	$26,457	$211,033	$0	$0
Cash Funds Exempt	$1,146	$7,255	$0	$0
Federal Funds	$81,497	$1,812,295	$0	$0

MEDICAL IDENTIFICATION CARDS

Plastic identification cards were put into use beginning September 2003. Prior to that time, paper identification cards were used. Since paper cards were not durable, they were reissued each month, causing high annual expenditures. Additionally, the paper 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.

In FY 03-04, Base Reduction Item BRI-2 submitted November 1, 2002 implemented the process of issuing a plastic card to all eligible clients which are reissued only when replacements are needed or new clients become eligible. Based on this change, medical providers are now required to verify Medicaid eligibility electronically after viewing the client's plastic card. The plastic

identification cards have 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. Converting to plastic cards has reduced costs significantly.

Old Age Pension State Medical Program clients have always received Medicaid authorization cards. However, prior to FY 03-04, 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.

In FY 05-06, the Department requested continuation funding of $355,601. 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.

The Tobacco Tax Bill (HB 05-1262) was passed during the 2005 legislative session. When signed into law on June 2, 2005, HB 05-1262 added $21,131 from a newly created cash fund called the Health Care Expansion Fund to support the needs of anticipated expansion clients. Because the appropriated amount in this bill was slightly off, 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 was requested for FY 07-08. However, during Figure Setting February 14, 2007 through Joint Budget Committee action, funding for the Medical Identification Cards was reduced by $70,892 due to decreased caseload forecasts, resulting in total funding for FY 07-08 of $120,000. Continuation funding of $120,000 is requested for FY 08-09.

Line Item: Medical Identification Cards	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$355,601**	**$382,697**	**$190,892**	**$120,000**
Joint Budget Committee Action during Figure Setting, March 15, 2005	$6,984	$0	$0	$0
Reduction of funding due to plastic cards (BRI-1, November 15, 2005)	$0	($192,231)	$0	$0
HB 05-1262 for expansion populations	$0	$426	$0	$0
Joint Budget Committee Action during Figure Setting, February 14, 2007, page 54, to reduce funding due to falling caseload forecasts	$0	$0	($70,892)	$0
Long Bill Appropriation / Request	**$362,585**	**$190,892**	**$120,000**	**$120,000**
HB 05-1262 Increase for expansion populations	$21,131	$0	$0	$0
HB 06-1385 Add-ons adjustment to original appropriation in HB 05-1262	($1,019)	$0	$0	$0
Final Appropriation / Request	**$382,697**	**$190,892**	**$120,000**	**$120,000**
General Fund	$180,534	$84,418	$48,444	$48,444
Cash Funds Exempt	$11,556	$11,764	$12,352	$12,352
Federal Funds	$190,607	$94,710	$59,204	$59,204

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 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 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 was for $4,304,925. This amount reflected 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 had 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 Colorado Legislature held a special session during FY 06-07 and passed HB 06S-1023. This legislation required providers to conduct additional immigration checks at an additional cost to the State. Therefore, the appropriation clause for this bill contained one-time funding of $4,780. Finally, the Department submitted non-prioritized Supplemental NP – S6 to the Joint Budget Committee on January 16, 2007 to adjust fund splits in the Facility Survey and Certification for expenses that were not eligible to receive the enhanced 75% federal match. This request decreased federal participation by $128,011 and increased General Fund participation by the same amount. In total, the Facility Survey and Certification line was appropriated $4,309,705 in FY 06-07.

The FY 07-08 Long Bill (SB 07-239) appropriated $4,539,038 to the Department of Public Health and Environment – Facility Survey and Certification line. This amount reflects the removal of the $4,780 one-time funding and the addition of $135 in base funding due to the passage of HB 06S-1023. Finally, SB 07-239 includes an increase of $233,978 in base-building funds in FY 07-08 for Common Policy items. The Department has requested $4,840,759 for the FY 08-09 Base Request, which includes an increase of $264,889 for Common Policies, and $37,700 for the changes required for SB 07-196 (Health Information Technology).

Line Item: DPHE Facility Survey and Certification	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Previous Fiscal Year Final Appropriation	$4,000,636	$4,079,161	$4,309,705	$4,539,038
POTS, Personal Services, and Indirect Costs Adjustments	$78,525	$225,764	$233,978	$264,889
HB 06S-1023	$0	$4,780	-$4,645	$0
Health Information Technology (SB 07-196)	$0	$0	$0	$37,700
Long Bill Appropriation / Request	**$4,079,161**	**$4,309,705**	**$4,539,038**	**$4,841,627**
General Fund	$1,020,479	$1,272,408	$1,346,102	$1,290,506
Cash Funds	$0	$0	$0	$0
Federal Funds	$3,058,682	$3,037,297	$3,192,936	$3,551,121

The following table provides a breakdown of the FY 08-09 Base Request, based on the anticipated need for each area of expenditure.

FY 08-09 Base Request	Total Funds	General Fund	Federal Funds
Salary Survey	$108,818	$32,645	$76,173
Health/Life/Dental	$219,013	$65,704	$153,309
Short Term Disability	$4,306	$1,292	$3,014
Performance Based Pay	$51,023	$15,307	$35,716
Amortization Equalization Disbursements	$52,999	$15,900	$37,099
Vehicle Lease Payments	$15,475	$4,642	$10,833
Personal Services	$3,588,676	$1,073,296	$2,515,380
Operating Expenses	$227,667	$68,167	$159,500
Indirect Costs (Only Federal Share is Billed to the Department)	$535,951	$0	$535,951
Health Information Technology (SB 07-196)	$37,700	$13,553	$24,147
Total FY 08-09 Base Request	**$4,841,627**	**$1,290,506**	**$3,551,121**

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.

In FY 05-06, HB 05-1262 (Tobacco Tax Bill) added $8,560 for additional prior authorization reviews for low income adults and children to the Long Bill appropriation of $1,309,826. This funding was from the Health Care Expansion Fund, showing up in the Department's Budget as Cash Funds Exempt, and matching federal funds. 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 request was for continuation funding of $1,375,906 that was approved by the Long Bill (SB 07-239).

Although the same funding is requested for FY 08-09, $725 will shift between Cash Funds Exempt and General Fund for the Breast and Cervical Cancer Program as required by the original statute. This will complete the change so that the program is only using General Fund for the State portion of the funding beginning in FY 08-09.

Line Item: Acute Care Utilization Review	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Appropriation	**$1,309,826**	**$1,368,066**	**$1,375,906**	**$1,375,906**
Annualization of Tobacco Tax Bill (HB 05-1262)	$0	$7,840	$0	$0
Long Bill Appropriation / Request	**$1,309,826**	**$1,375,906**	**$1,375,906**	**$1,375,906**
Tobacco Tax Bill - HB 05-1262	$8,560	$0	$0	$0
HB 06-1385 Add-ons to adjust HB 05-1262 appropriation	$49,680	$0	$0	$0
Final Appropriation / Request	**$1,368,066**	**$1,375,906**	**$1,375,906**	**$1,375,906**
General Fund	$342,529	$344,703	$344,703	$345,428
Cash Funds Exempt	$17,459	$17,245	$17,245	$16,520
Federal Funds	$1,008,078	$1,013,958	$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 appropriation for FY 02-03 through FY 04-05 was $1,668,108. The Tobacco Tax Bill (HB 05-1262) 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.

Both FY 06-07 and FY 07-08 appropriations were for $1,744,966. The same amount is requested for FY 08-09.

Line Item: Long-Term Care Utilization Review	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Appropriation	**$1,668,108**	**$1,744,966**	**$1,744,966**	**$1,744,966**
Long Bill Appropriation / Request	**$1,668,108**	**$1,744,966**	**$1,744,966**	**$1,744,966**
Tobacco Tax Bill, HB 05-1262	$76,858	$0	$0	$0
Final Appropriation / Request	**$1,744,966**	**$1,744,966**	**$1,744,966**	**$1,744,966**
General Fund	$598,813	$598,813	$598,813	$598,813
Cash Funds Exempt	$38,429	$38,429	$38,429	$38,429
Federal Funds	$1,107,724	$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 that may include termination of Medicaid participation. The quality review contractor researches information in this process.

SB 07-211 added $70,000 to the FY 07-08 appropriation to consult with clinical advisors, develop clinical standards and methods of collecting, analyzing, and disclosing clinical performance information to assess children's health outcomes. The work will be completed during FY 07-08. Therefore, the $70,000 will be removed for succeeding years and the funding requested for FY 08-09 reverts to the prior amount of $812,193.

Line Item: External Quality Review	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Previous Year Appropriation	**$812,193**	**$812,193**	**$812,193**	**$882,193**
SB 07-211 Improvements to Health Care for Children	$0	$0	$70,000	($70.000)
Final Appropriation / Request	**$812,193**	**$812,193**	**$882,193**	**$812,193**
General Fund	$203,048	$203,048	$220,548	$203,048
Federal Funds	$609,145	$609,145	$661,645	$609,145

DRUG UTILIZATION REVIEW

42 C.F.R. Section 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.

In FY 05-06, the Long Bill (SB 05-209) appropriated $648,025 for this line item to fund a 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.

Change Request, BRI–2, submitted November 1, 2006, asked for a reduction in funding for FY 07-08 to the amount for which there were actual vendor contracts at the time. The reduction of $84,832 was approved by the Long Bill (SB 07-239). However, HB 07-1021 created the Prescription Drug Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients, and this special bill added $16,950 to the total appropriation for Drug Utilization Review in FY 07-08. Continuation funding is requested for FY 08-09.

Line Item: Drug Utilization Review	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$648,025**	**$372,025**	**$372,025**	**$304,143**
BRI-2 submitted November 1, 2006 and approved by Long Bill (SB 07-239)	$0	$0	($84,832)	$0
Long Bill Appropriation / Request	**$648,025**	**$372,025**	**$287,193**	**$304,143**
HB 06-1217 Reduction due to implementation of Medicare Modernization Act of 2003 (S-6, January 3, 2006)	($276,000)	$0	$0	$0
HB 07-1021 Prescription Drug Consumer Information and Technical Assistance Program	$0	$0	$16,950	$0
Final Appropriation / Request	**$372,025**	**$372,025**	**$304,143**	**$304,143**
General Fund	$90,256	$90,256	$76,036	$76,036
Federal Funds	$281,769	$281,769	$228,107	$228,107

MENTAL HEALTH EXTERNAL QUALITY REVIEW

The Department conducts federally-required external quality review activities that receive 75% federal financial participation. 42 C.F.R. Section 456.1 requires a statewide utilization control program of all Medicaid services. 42 C.F.R. 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 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 08-09 Base Request.

Line Item: Mental Health External Quality Review	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$352,807**	**$352,807**	**$352,807**	**$352,807**
General Fund	$88,202	$88,202	$88,202	$88,202
Federal Funds	$264,605	$264,605	$264,605	$264,605

ACTUARIAL ANALYSIS PAYMENT 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 began 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 involved the Department and the Department of Human Services in reviewing and commenting on the scope of work in the request for proposals. The Office of the State Auditor was responsible for selecting the outside contractor following the bid solicitation process and managing 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 were transferred to the Office of the State Auditor as Cash Funds Exempt. The project was completed during FY 06-07. No funds are requested for FY 08-09.

Line Item: Actuarial Analysis Payments for Transfer to the State Auditor's Office	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$100,000**	**$0**	**$0**	**$0**
General Fund	$50,000	$0	$0	$0
Federal Funds	$50,000	$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 outreach and case management services in a manner consistent with the federal regulations set forth at 42 CFR Sections 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. The services 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, 5.0 Department of Public Health and Environment FTE managed the Early and Periodic Screening, Diagnosis and Treatment Program. The final appropriation for FY 02-03 for that sister agency was $2,721,758.

During the 2003 legislative session, action by the Joint Budget Committee transferred management of the Early and Periodic Screening, Diagnosis, and Treatment Program to the Department of Health Care Policy and Financing. Funding for the 5.0 FTE was appropriated to the Department with the transfer of the program. Two of the 5.0 FTE continue to manage the program. These FTE 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 contracted primarily by 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 to the Department 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 08-09 Base Request is for continuation funding.

Line Item: Early and Periodic Screening, Diagnosis, and Treatment Program	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$2,468,383**	**$2,468,383**	**$2,468,383**	**$2,468,383**
Final Appropriation / Request	**$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
Federal Funds	$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 08-09 Base Request is a continuation of the FY 07-08 appropriation of $1,097,500.

Line Item: Nursing Facility Audits	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$1,097,500**	**$1,097,500**	**$1,097,500**	**$1,097,500**
Final Appropriation / Request	**$1,097,500**	**$1,097,500**	**$1,097,500**	**$1,097,500**
General Fund	$548,750	$548,750	$548,750	$548,750
Federal Funds	$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) with approval of the Department's Decision Item DI-11, 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.

In FY 07-08, the appropriation was further increased by $131,350 to raise the hourly contract rate and fund additional site audits for a new total contract amount of $499,200 appropriated in the Long Bill (SB 07-239. The additional site audits are estimated to net an additional $497,147 in savings to Medical Services Premiums as a result of increased recoveries.

The FY 08-09 Base Request for continuation of funding is $499,200.

Line Item: Hospital and Federally Qualified Health Clinic Audits	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$250,000**	**$350,000**	**$367,850**	**$499,200**
Addition of site audits (DI-11, November 1, 2004)	$100,000	$0	$0	$0
Cost-of-living adjustment (DI-11, November 15, 2005)	$0	$17,850	$0	$0
Increase funding for new contract (BRI-1, September 1, 2006)	$0	$0	$131,350	$0
Long Bill Appropriation / Request	**$350,000**	**$367,850**	**$499,200**	**$499,200**
Final Appropriation / Request	**$350,000**	**$367,850**	**$499,200**	**$499,200**
General Fund	$175,000	$183,925	$249,600	$249,600
Federal Funds	$175,000	$183,925	$249,600	$249,600

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. In July 2004, administration of disability determinations for Medicaid eligible persons was transferred from the Department of Human Services to the Department of Health Care Policy and Financing.

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 was appropriated continuation funding of $1,173,662, which is again being requested for FY 08-09.

Line Item: Disability Determination Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$1,163,662**	**$1,173,662**	**$1,173,662**	**$1,173,662**
Out-year impact of SB 04-177 (Autism Bill)	$10,000	$0	$0	$0
Final Appropriation / Request	**$1,173,662**	**$1,173,662**	**$1,173,662**	**$1,173,662**
General Fund	$581,831	$581,831	$581,831	$581,831
Cash Funds Exempt	$5,000	$5,000	$5,000	$5,000
Federal Funds	$586,831	$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. In 2007, it was determined that training is needed to ensure that community health centers understand and follow correct screening and review procedures and comply with all State and federal requirements. These trainings are funded in the Preadmission Screening and Resident Review line item.

The appropriation for this line has remained static at $1,010,040 since FY 03-04, as utilization forecasts have indicated this total budget amount to be adequate. Based on this, continuation funding of $1,010,040 for FY 08-09 is requested.

Line Item: Nursing Home Preadmission and Resident Assessments	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**
Final Appropriation / Request	**$1,010,040**	**$1,010,040**	**$1,010,040**	**$1,010,040**
General Fund	$252,510	$252,510	$252,510	$252,510
Federal Funds	$757,530	$757,530	$757,530	$757,530

NURSE AIDE CERTIFICATION

42 C.F.R. Section 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 and the Department of Public Health and Environment. The program is funded from both Medicaid and Medicare dollars. Pursuant to Section 12-38-101, C.R.S., (2007), 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. The regulation of nurse aides 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 there will be established standards for training curriculum to assure that nurse aides receive federally required training, and regular testing of nurse aides to assure competency. The Department of Regulatory Agencies is also responsible for administering a nurse aide registry program that allows investigations into allegations of abuse by nurse aides, when necessary. The registry also tracks the mandatory criminal background check required for nurse 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, Section 12-38.1-103 (6), C.R.S. (2007) requires the Department of Public Health and Environment and the Department 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 from FY 06-07 through the FY 08-09. The Medicaid portion of these amounts has been 48.64% of the total, as determined by the 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**	**FY 07-08**	**FY 08-09 Budget Request**
Personal Services	$241,903	$281,583	$281,583
Operating	$10,930	$17,000	$17,000
Hearings	$0	$2,172	$2,172
Indirect Costs	$252,497	$252,497	$252,497

Purpose of Funds for the Nurse Aide Certification Program			
Line Item: Nurse Aide Certification Program	**FY 06-07**	**FY 07-08**	**FY 08-09 Budget Request**
Health/Life/Dental	$14,582	$14,040	$14,040
Short-term disability	$368	$373	$373
Salary Survey/Pay for Performance	$15,685	$11,676	$11,676
Worker's Comp	$573	$455	$455
Legal Services	$58,745	$60,000	$60,000
Administrative Law Judge	$0	$0	$0
General Government Computer Center	$1,545	$1,320	$1,320
Risk Management	$915	$603	$603
Hardware/Software Maintenance (DLS)	$0	$0	$0
IT Asset Maintenance	$0	$0	$0
Leased Space	$37,103	$27,211	$27,211
Total Costs	**$634,846**	**$668,930**	**$668,930**
Department of Health Care Policy and Financing's Share (48.64%)	$308,766	$325,343	$325,343

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 NP-S1, 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 Nurse Aide Certification appropriation for FY 06-07 was $308,766. This 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 amount appropriated for FY 07-08 mirrored the Base Request for this line as submitted in the Department's November 1, 2006 Budget Request. The total amount of $325,343 reflects an increase of $16,577 over the final FY 06-07 appropriation for Common Policy items. Continuation funding of $325,343 is being requested for the FY 08-09 Base Request.

Line Item: Nurse Aide Certification Program	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	$297,769	$293,623	$308,766	$325,343
True-up of appropriation with Department of Regulatory Agencies (BA-5, January 23, 2004)	$0	$0	$0	$0
Adjustments for Common Policies	$21,329	$15,143	$16,577	$0
Long Bill Appropriation / Request	**$319,098**	**$308,766**	**$325,343**	**$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)	($25,475)	$0	$0	$0
Final Appropriation / Request	**$293,623**	**$308,766**	**$325,343**	**$325,343**
General Fund	$0	$0	$148,020	$148,020
Cash Funds Exempt	$146,812	$154,383	$14,652	$14,652
Federal Funds	$146,811	$154,383	$162,671	$162,671

DEPARTMENT OF REGULATORY AGENCIES 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 cross-disability peer counseling, information and referral services, independent living skills training and individual and systems advocacy.

In-Home Support Services' agencies are a new Medicaid provider type. 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 was required to conduct a study of this new profession and/or occupation, pursuant to Section 24-34-104.1, C.R.S. (2007). This was accomplished by the Office of Policy, Research and Regulatory Reform within the Department of Regulatory Agencies. This office conducted 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 were surveyed and agency records and files were reviewed, when appropriate.

Per the Department of Regulatory Agencies, the research and a portion of the production of the report took approximately 150 hours in FY 06-07. This estimate was based on previous reviews of similar programs. The hourly rate used to estimate FY 06-07 totals was $40.08, which was the billable rate used by the Department of Regulatory Agencies in FY 05-06. Work is continuing in 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 appropriation 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). No funding is requested for FY 08-09.

Line Item: Department of Regulatory Agencies In-Home Support Review	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$0**	**$6,000**	**$0**
Annualization of In-Home Support Review (NP-BA11, January 24, 2006)	$0	($2,000)	$0
Final Appropriation / Request	**$6,000**	**$4,000**	**$0**
General Fund	$3,000	$2,000	$0
Federal Funds	$3,000	$2,000	$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 Section 25.5-6-203, C.R.S. (2007). The per diem rate paid to nursing facilities is based in part on the fair rental value of the facility. In FY 02-03, there were 194 nursing facilities appraised at a cost of $266,171. For the appraisals conducted in FY 06-07, the Department requested continuation funding of $266,171. However, ultimately, of $279,746 was appropriated in FY 06-07, due to a Joint Budget Committee action to account for a

5.1% inflation factor. In FY 06-07, 191 nursing facilities were appraised with actual expenses to the Department of $279,746. Continuation funding will not be requested for this line item in FY 08-09, as nursing facility appraisals will not be conducted again until FY 10-11.

Line Item: Nursing Facility Appraisals	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$0**	**$0**	**$0**	**$0**
Final Appropriation / Request	**$0**	**$279,746**	**$0**	**$0**
General Fund	$0	$139,873	$0	$0
Federal Funds	$0	$139,873	$0	$0

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 was 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 were intended to cover the expenses of any task force the Department may assemble and any temporary staffing costs that may be incurred for conducting such a study. A report containing the preliminary findings was requested by November 1, 2006 per Footnote 22 in the Long Bill. The final report is due by November 1, 2007. Because work extended to the next fiscal year, this line was appropriated $19,334 in FY 07-08. This was a three month annualization of the FY 06-07 appropriation. These funds were used to cover expenses germane to the completion of the study. The Department has not requested any continuation funding for this line for FY 08-09.

Line Item: Primary Care Provider Rate Task Force and Study	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$0**	**$58,000**	**$19,334**
Annualization of HB 06-1385	$0	($38,666)	($19,334)
Long Bill Appropriation / Request	**$58,000**	**$19,334**	**$0**
Final Appropriation / Request	**$58,000**	**$19,334**	**$0**
General Fund	$29,000	$9,667	$0
Federal Funds	$29,000	$9,667	$0

ESTATE RECOVERY

The estate recovery program, authorized in 25.5-4-302, C.R.S. (2007) 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. Since FY 03-04, the contingency rate has been 10.9%, with the remaining recoveries acting as an offset to the Medical Services Premiums line.

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
FY 06-07	$4,656,903	205	$507,730	$4,149,173
Total	**$47,100,831**	**2,170**	**$6,765,961**	**$40,334,870**

Since implementation, the estate recovery program has recovered a net amount of $40,334,870 for Medicaid, including the total net estate recoveries for FY 06-07 of $4,656,903. The current contingency fee allows for maximum recoveries of $6,422,018. The Department’s FY 08-09 Base Request is for continuation funding of $700,000.

Line Item: Estate Recovery	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Long Bill Appropriation / Request	**$700,000**	**$700,000**	**$700,000**	**$700,000**
Cash Funds	$350,000	$350,000	$350,000	$350,000
Federal Funds	$350,000	$350,000	$350,000	$350,000

SINGLE ENTRY POINT ADMINISTRATION

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

Beginning in FY 05-06, the Department has received an appropriation of $53,000, which included a Joint Budget Committee recommendation to reduce this line item by $6,310 (Figure Setting, March 15, 2005, page 70). Continuation funding of $53,000 is requested at the same amount for FY 08-09.

Line Item: Single Entry Point Administration	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$59,310**	**$53,000**	**$53,000**	**$53,000**
FY 05-06 Joint Budget Committee Action	($6,310)	$0	$0	$0
Long Bill Appropriation / Request	**$53,000**	**$53,000**	**$53,000**	**$53,000**
General Fund	$26,500	$26,500	$26,500	$26,500
Federal Funds	$26,500	$26,500	$26,500	$26,500

SINGLE ENTRY POINT AUDITS

This line item funds annual audits of Single Entry Point agencies provided through a contractor. From FY 03-04 through FY 05-06, the total appropriation was $35,340. Since this amount was insufficient to conduct on-site reviews of the 25 Single Entry Point agencies, the scope of work was limited to reviews of cost reports. To the extent that funds allowed, on-site audits were conducted for agencies that posed the highest risk. The Department requested additional funding of $76,660 for this line item in its FY 06-07 Budget Request (DI-5, November 15, 2005) because State auditors determined the Single Entry Point Audit program was out of federal compliance, and had been so for the previous three years. This was due to not conducting on-site audits for all 25 Single Entry Point agencies, not conducting them in a timely manner, and not recouping improper payments. To bring the audits into compliance with State auditor findings, to increase the accuracy of Single Entry Point agency bills, and potentially increase recovery of improper

payments, the appropriation was increased to $112,000 in FY 06-07. The same amount was appropriated for this line item in FY 07-08, and the Department requests continuation funding in FY 08-09.

Line Item: Single Entry Point Audits	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$35,340**	**$35,340**	**$112,000**	**$112,000**
Additional funding to bring into compliance with federal and State regulations (DI-5, November 15, 2005)	$0	$76,660	$0	$0
Long Bill Appropriation / Request	**$35,340**	**$112,000**	**$112,000**	**$112,000**
General Fund	$17,670	$56,000	$56,000	$56,000
Federal Fund	$17,670	$56,000	$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*.

In FY 05-06, the Base Request was $875,756, the same as FY 04-05. With the implementation of the Tobacco Tax Bill (HB 05-1262), 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 resulted in a final 06-07 appropriation of $942,784.

During FY 07-08 Figure Setting, Joint Budget Committee staff recommended a reduction of $33,514 to the Enrollment Broker line item based on decreases in managed care caseload (Figure Setting, February 14, 2007, page 74). A discussion of managed care caseload between Joint Budget Committee staff and Joint Budget Committee members followed. The discussion resulted in the Joint Budget Committee reducing funding for the Enrollment Broker contract to $700,000 for FY 07-08.

The Department's FY 08-09 Base Request is for continuation funding of $700,000. 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, $350,000, is requested as General Fund.

Line Item: SB 97-05 Enrollment Broker	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$875,756**	**$919,134**	**$942,784**	**$700,000**
Annualization of impact from HB 05-1262 expansion	$0	$23,650	$0	$0
FY 07-08 Figure Setting – Decreases in Managed Care Caseload	$0	$0	($242,784)	$0
Long Bill Appropriation / Request	**$875,756**	**$942,784**	**$700,000**	**$700,000**
HB 05-1262 – Expansion population increase	$45,589	$0	$0	$0
HB 06-1385 Add-ons – Adjust appropriation in HB 05-1262	($2,211)	$0	$0	$0
Final Appropriation / Request	**$919,134**	**$942,784**	**$700,000**	**$700,000**
General Fund	$437,878	$437,878	$316,486	$316,486
Cash Funds Exempt	$21,689	$33,514	$33,514	$33,514
Federal Fund	$459,567	$471,392	$350,000	$350,000

COUNTY ADMINISTRATION

Funding in the County Administration appropriation provides for partial reimbursement to local county departments of social/human 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 for two General Professional IVs, appropriated in the Personal Services line item. One position acts as a liaison between the Department and local governments, and the second conducts county audits. However, one position was transferred to the Department of Human Services for Home Care Allowance and Adult Foster Care, for a net increase of 1.0 FTE for the Department. The Department absorbed accounting and budgeting functions for this appropriation with existing resources.

As part of the Department's fiscal note for the 2006 legislation, the Department and the Department of Human Services agreed 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 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.

Starting in FY 06-07, the Department worked with the Department of Human Services to draft an allocation letter for this program, indicating the amount of the total Medicaid appropriation each county would be allocated. In FY 06-07, prior to allocating available funds, the Department and the Department of Human Services carved out a total of $500,000 ($168,456 in Medicaid funds) from State appropriated funds, to perform a workload study to assist the State in determining whether current funding levels were sufficient to costs experienced at the county level.

The workload study was completed in June 2007. The study concluded that the counties' actual costs for County Administration were $85.2 million, $28.2 million above the $57 million appropriated in FY 06-07. In addition, the study found that the total expenditures related to medical expenses administered by the Department, including the proportional funding for opening doors, is equal to $35,004,134, which is $11,247,925 above the $23,756,209 FY 07-08 appropriation.

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 to assist in this interagency transfer of spending authority.

In FY 06-07, SB 06-219 provided $18,306,628 to the Department from the Department of Human Services. In addition, the Department was appropriated $2,808,505 in its Supplemental Bill (SB 07-163). This funding provided additional resources to counties to implement the Deficit Reduction Act and HB 06S-1023 which increased the application processing time required to verify citizenship or lawful presence (January 23, 2007, Joint Budget Committee FY 06-07 Supplemental document, Pages 28-31). The final FY 06-07 appropriation was $21,115,133.

In FY 07-08, the Department's appropriation was increased to $23,756,209 which is $2,641,076 above the final FY 06-07 appropriation. The increase resulted from a Governor's Budget Amendment that provided an additional $2,209,022 to the counties as a bridge until the workload study could be completed, amongst other items. In addition, $317,344 was provided to the counties from the 1.5% provider rate increase, and $41,184 for the annualization of SB 07-163 related to the Deficit Reduction Act and HB 06S-1023 (Joint Budget Committee, Figure Setting document, March 8, 2007, Pages 108-110). Finally, with the passage of the Colorado Cares Rx Program (SB 07-011), an additional $73,526 was provided to County Administration to process 15,160 clients for six months at a cost of $4.85 per county referral. The Department is currently assessing how and when the program will be implemented in light of the fact that the City and County of Denver has implemented a similar program. Any budgetary impact will be addressed through the regular budget process.

For FY 08-09, the Department has requested $23,803,133, an increase of $46,924 over the FY 07-08 appropriation due to the annualization of funding for the Colorado Cares Rx Program (SB 07-001). The Department estimates that a total of 24,835 clients will be served in one year.

Line Item: County Administration	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**N/A**	**$21,115,133**	**$23,756,209**
Governor's Budget Amendment #2 submitted February 5, 2007	$0	$2,209,022	$0
Provider Rate Increase – Decision Item #6 submitted November 1, 2006	$0	$317,344	$0
SB 07-163 Supplemental Bill Annualization of S-4 submitted January 4, 2007	$0	$41,184	$0
SB 07-001 Colorado Cares Rx Program Annualization	$0	$0	$46,924
Long Bill Appropriation / Request	**$0**	**$23,682,683**	**$23,803,133**
SB 06-219, Transfer to (1) Executive Director's Office Long Bill group in the Department's budget	$18,306,628	$0	$0
SB 07-163 Supplemental Bill (S-4)	$2,808,505	$0	$0
SB 07-001 Colorado Cares Rx Program	$0	$73,526	$0

Line Item: County Administration	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$21,115,133**	**$23,756,209**	**$23,803,133**
General Fund	$6,302,837	$7,248,943	$7,248,943
Cash Funds	$0	$73,526	$120,450
Cash Funds Exempt	$4,272,508	$4,632,531	$4,632,531
Federal Funds	$10,539,788	$11,801,209	$11,801,209

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.

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.

The Department was appropriated $1,593,624 in FY 06-07. However, due to SB 07-219, the Department and the Department of Human Services have the authority to transfer General Fund spending authority between the departments to ensure that federal financial participation is maximized. As a result, in FY 06-07 the Department of Human Services transferred $633,935 in General Fund, which allowed the Department to receive matching federal funds, and provide for a final spending authority of $2,861,494.

In FY 07-08, the Department was provided continuation funding of $1,593,624. However, the Department assumes that this amount will not be sufficient and therefore anticipates that an additional transfer of General Fund will be required from the Department of Human Services during FY 07-08. The Department's FY 08-09 request is for continuation funding of $1,593,624. However, a Decision Item has also been submitted for additional resources.

Line Item: Administrative Case Management	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**N/A**	**$1,593,624**	**$1,593,624**
Long Bill Appropriation / Request	**$0**	**$1,593,624**	**$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	$0
Final Appropriation / Request	**$1,593,624**	**$1,593,624**	**$1,593,624**
General Fund	$796,812	$796,812	$796,812
Federal Funds	$796,812	$796,812	$796,812

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.

In an effort to increase enrollment into Medicaid or the Children's Basic Health Plan, HB 06-1270 created a demonstration project authorizing qualified medical personnel to make eligibility determinations for medical benefits under Medicaid or the Children's Basic Health Plan. HB 06-1270 instructed 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.

Pursuant to Section 25.5-4-205, C.R.S. (2007), the Department secured contracts with the following three schools in both rural and urban areas to participate in the demonstration project: Jefferson County Public School District R-1, Pueblo School District 60, and Adams Arapahoe 28J School District (Aurora Public Schools). 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 determinations. If the State receives sufficient gifts, grants, or donations, the Department will contract with an independent evaluation of the project, the results of which will be given to the Health and Human Services Committee for review before January 15, 2010.

Funding for the School District Eligibility Determination program was $59,532 in FY 06-07 but was appropriated under Personal Services and Operating Expenses. The Department hired 1.0 FTE in FY 06-07 to write and enforce contracts with the school districts, assist the advisory committee and answer program eligibility questions. The Department received 50% federal financial participation and $29,766 in General Fund support for these FY 06-07 appropriations. No additional FY 06-07 appropriations were made as the school districts were in the process of being chosen. In FY 07-08, the Department's Base Request was $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 due to a blended rate combining the Medicaid 50% federal financial participation with the Children's Basic Health Plan 65% federal financial participation.

The Department's FY 08-09 Base Request is for continuation funding of $227,292.

Line Item: School District Eligibility Determination	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$0**	**$59,532**	**$227,292**
Annualization of HB 06-1270		$227,292	$0
Long Bill Appropriation / Request	**$59,532**	**$227,292**	**$227,292**
General Fund	$29,766	$79,269	$79,269
Cash Funds Exempt	$0	$25,854	$25,854
Federal Funds	$29,766	$122,169	$122,169

PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

In 2004, the Centers for Medicare and Medicaid Services performed an audit on the certification of public expenditures and a review of Colorado's Public School Health Services Program. The Centers for Medicare and Medicaid Services' report requested that the State complete an annual reconciliation of interim payments reported on the certifications of public expenditures to actual incurred expenditures at the individual school level to ensure that the State is only reimbursing providers for actual incurred costs according to the federal requirements outlined in Colorado's Medicaid State Plan.

As a result of the audit findings, the Department contracted with Public Consulting Group to assist with developing an updated Public School Health Services rate-setting methodology, specifically in the areas of district-specific rates and a cost settlement process to compare actual costs to payments made to participating Public School Health Services providers. Public Consulting Group's scope of work also includes planning and administering time studies to support the rate-setting methodology, assisting the Department in drafting a State Plan Amendment that includes all proposed changes to the Public School Health Services rate-setting methodology, and training school staff. Further contract responsibilities include defining allowable costs and setting requirements for client eligibility, providing assistance in the certification of public expenditures process, and developing a transition plan from the current to the new rate setting methodology.

To compensate Public Consulting Group pursuant to the contract, the Department submitted a Supplemental request to re-appropriate $200,000 in federal funding by reducing the federal funds in the SB 97-101 Public School Health Services line item and correspondingly increasing the (1) Executive Director's Office, Personal Services appropriation by the same amount (FY 06-07, Supplemental Requests, January 4, 2007). Additionally, within the Supplemental, the Department requested a technical adjustment to properly document the $184,520 transferred as Cash Funds Exempt for the Department of Education's administrative costs. The Joint Budget Committee approved the Department's request, and with the passé of SB 07-163, the Department received $384,520 in its Executive Director's Office Long Bill group.

During the Department's FY 07-08 Figure Setting, the Joint Budget Committee recommended an additional $7,176 POTS increase at the Department of Education figure setting increased funding for this line item by $7,176 (Department of Educations' Figure Setting, March 8, 2007, page 114).

For FY 08-09, the Department is requesting $396,561 for this appropriation. The request reflects an increase of $4,865 for additional POTS funding and indirect cost assessments from the Department of Education. The contract funding for Public Consulting Group remains at $200,000. With this change, the FY 08-09 appropriation will be $396,561 in federal funds.

Line Item: Public School Health Services Administration	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**N/A**	**$384,520**	**$391,696**
FY 06-07, Supplemental #11, Public Consulting Group contract	$200,000	$0	$0
FY 06-07, Supplemental #11, Technical adjustment	$184,520	$0	$0
Joint Budget Committee's decision for Department of Education's Figure Setting on March 1, 2007	$0	$7,176	$0
Requested adjustments for Personal services and indirect cost assessment, Department of Education	$0	$0	$4,865
Long Bill Appropriation / Request	**$384,520**	**$391,696**	**$396,561**
Federal Funds	$384,520	$391,696	$396,561

PAYMENT ERROR RATE MEASUREMENT PROJECT CONTRACT

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 requires the Department to conduct an annual review of those Medicaid services that may be susceptible to significant erroneous payments, to estimate the amount of improper payments made, and to report on those estimates. The Improper Payments Information Act of 2002 defines 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 states that these payments "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."

In FFY 03-04 and 04-05, the Centers for Medicare and Medicaid Services awarded the Department grants to participate in the payment accuracy measurement pilot project and the payment error rate measurement pilot project, respectively. The federal grant funding for the payment error rate measurement pilot project expired in September 2005. To continue the project and receive federal financial participation, the Department was appropriated moneys from the General Fund for FY 05-06. Under proposed federal rules, the Department was required to begin the full payment error rate measurement project on October 1, 2005. Therefore, the Department submitted a FY 05-06 Stand Alone Budget Amendment Request (BA-4, January 24, 2005) in the amount of $1,171,632. The Budget Request covered 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 which superseded the previous proposed rule. The interim final rule substantially revised the approach to the payment error rate measurement project and required

that a federal contractor 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 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).

On August 28, 2006, the Centers for Medicare and Medicaid Services issued another 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 the August 28, 2006 rule, each state is required to calculate its state-specific eligibility error rates and measure 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.

In response to the August 28, 2006 interim final rule, the Department requested funding for a contractor for a total of $392,940 in FY 06-07 and $1,178,820 in FY 07-08. The contractor will create and populate a database to review and verify the accuracy of provided documentation (S-1 and BA-1, January 4, 2007). Joint Budget Committee staff recommended funding less than the Department's request based on an average cost per case of $415.61 rather than the Department estimated average cost per case of $1,110.00 (Figure Setting, February 14, 2007, page 85). As a result, the Department received total funds of $147,126 for FY 06-07 (Supplemental Bill, SB 07-163) and $441,375 for FY 07-08 (Long Bill, SB 07-239). The FY 07-08 appropriated funds are $294,249 higher than the FY 06-07 appropriated funds because the FY 07-08 Payment Error Rate Measurement contract encompasses a full year of services (Figure Setting, February 14, 2007, page 84). No money is being requested for FY 08-09 due to the three year review cycle.

Line Item: Payment Error Rate Measurement Project Contract	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$0**	**$0**	**$147,126**	**$441,375**
BA-1 PERM Eligibility Contract	$0	$0	$294,249	$0
Long Bill Appropriation	**$1,171,632**	**$0**	**$441,375**	**$441,375**
HB 06-1217 Supplemental Bill	$(1,171,632)	$0	**$0**	$0
SB 07-163 Supplemental Bill	$0	$147,126	$0	$0
Removal of funding because project is only required once every three years	$0	$0	$0	($441,375)

Line Item: Payment Error Rate Measurement Project Contract	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation / Request	**$0**	**$147,126**	**$441,375**	**$0**
General Fund	$0	$36,783	$110,348	$0
Cash Funds Exempt	$0	$25,747	$77,240	$0
Federal Funds	$0	$84,596	$253,787	$0

NON-EMERGENCY TRANSPORTATION SERVICES

The Department provides non-emergency medical transportation to and from medically necessary services for clients who have no other means of transportation throughout all sixty-four counties in Colorado. Section 25.5-5-202(1) (s) (2), C.R.S. (2007) and 42 C.F.R. Section 431.53 require 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 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-emergency 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 the 56 non-Front Range counties, the county departments of social/human services are responsible for authorizing and arranging the transportation. In the 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 in the eight Front Range counties. In September 2004, Arapahoe County Transportation Services closed down. The Department was required to enter into an emergency contract with LogistiCare from October 1, 2004 to June 30, 2005. This allowed the continuation of non-emergency medical transportation services in the eight Front Range counties for the remainder of FY 04-05.

On September 3, 2004, the Department and Department of Human Services submitted an Emergency 1331 Supplemental request to the Joint Budget Committee to transfer funds from the Developmental Disability Services waiver from the Department of Human Services to the Department's Non-Emergency Transportation Services line item. 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 from the Centers of Medicare and Medicaid Services for the Comprehensive Services waiver for individuals with developmental disabilities. The Joint Budget Committee approved the Emergency 1331 Supplemental Request on September 21, 2004.

The transfer of funds from the Department of Human Services helped to provide services for individuals with developmental disabilities; it did not address the issue of providing services to the remaining population of non-emergency transportation clients. 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 beginning July 1, 2005 for a total cost of $3,595,777. Given the additional need, the Department submitted and subsequently received 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 was officially appropriated to the Department through the passage of SB 07-163. The sum of this funding and the FY 05-06 Long Bill appropriation of $4,455,988 yielded a final FY 06-07 appropriation of $5,577,485.

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 (FY 06-07, Budget Request, November 15, 2005, Volume 1 of 2, DI-9). The prior year's 1331 Emergency Supplemental amount of $1,121,497 was not included, as it was requested after the Long Bill was enacted.

During the 2006 legislative session, SB 06-165 was enacted which directed the Department to conduct research on ways to implement a telemedicine pilot program in FY 06-07, and implement the pilot program in FY 07-08. Unfortunately, the appropriations clause of

SB 06-165 inadvertently applied the anticipated $493,559 in savings to the Department's Medical Services Premiums line item. As a result, the Non-Emergency Medical Transportation Services appropriation does not reflect any cost-savings until FY 07-08.

In August 2006, the Department received correspondence from LogistiCare concerning unpaid monies for claim lag adjustments for the period from July 2005 through March 2006. With the assistance of the State Attorney General's Office and Governor's Counsel, the Department negotiated a settlement amount of $1,048,608 with LogistiCare. The General Fund need was reduced by $491,431 in an accounts payable line. On January 23, 2007, the Department requested and subsequently received a FY 06-07 late supplemental in the amount of $557,177 for the remaining lawsuit settlement agreement (February 14, 2007, Executive Director's Office Figure Setting, page 78).

In FY 06-07, the Department submitted Supplemental #6 and Budget Amendment #2 (FY 06-07 Supplemental Request, FY 07-08 Budget Request Amendments with Supplementals, January 4, 2007, S-6 and BA-2) for increases in caseload and utilization in the 56 non-Front Range counties. The Department included anticipated savings from SB 06-165 of $277,627 in S-6. The Department's supplemental request for FY 06-07 was approved by the Joint Budget Committee and increased the appropriation by $1,957,862. This amount combined with the late supplemental of $557,177 increased the final FY 06-07 appropriation to $7,583,761 (Figure Setting, February 14, 2007, page 14).

Due to increased contractor and county administration costs, the Department submitted DI-7 for increased funding of $1,464,796 for FY 07-08 (FY 07-08, Budget Request, November 1, 2006, Volume 1 of 2, DI-7). Included within DI-7 was the reduction of $493,559 for the anticipated savings from SB 06-165 in FY 07-08. Additionally, as part of the Department's November 1, 2006 Budget Request, non-emergency medical transportation providers received a rate increase due to rising fuel costs. This increase was included as part of DI-6 and amounted to $110,000 or 31% (March 8, 2007, Figure Setting, page 48). With the approval of S-6 and BA-2 by the Joint Budget Committee, the FY 07-08 appropriation was increased by the difference in total funds of $162,718. Finally, the Department was required to remove the one-time funding from the late supplemental of $557,177 from the FY 07-08 appropriation. These changes resulted in a final FY 07-08 appropriation in the amount of $7,299,302.

The Department's FY 08-09 Base Request is for continuation funding of $7,299,302.

Line Item: Non-Emergency Transportation Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$4,421,479**	**$5,557,485**	**$7,583,761**	**$7,299,302**
Annualization of separating Developmental Disability waivered services from State Plan services per 1331 Emergency Supplemental (September 2, 2004)	$34,509	$0	$0	$0
Joint Budget Committee action for a 2.57% rate increase	$0	$127,002	$0	$0
Transfer of funding from County Administration	$0	$485,732	$0	$0
Annualization of Supplemental Bill SB 07-163 Add-ons	$0	($1,121,497)	$0	$0
Eliminate one-time funding, late supplemental	$0	$0	($557,177)	$0
Decision Item #6 (rate increase)	$0	$0	$110,000	$0
Decision Item #7/Budget Amendment #2 (contract increase)	$0	$0	$162,718	$0
Long Bill Appropriation / Request	**$4,455,988**	**$5,068,722**	**$7,299,302**	**$7,299,302**
Supplemental Bill SB 07-163 Add-ons	$1,121,497	$0	$0	$0
Supplemental Bill SB 07-163 (S-6)	$0	$1,957,862	$0	$0
Late supplemental request	$0	$557,177	$0	$0
Final Appropriation / Request	**$5,557,485**	**$7,583,761**	**$7,299,302**	**$7,299,302**
General Fund	$2,788,743	$3,791,881	$3,649,651	$3,649,651
Federal Funds	$2,788,742	$3,791,880	$3,649,651	$3,649,651

PREPAID INPATIENT HOSPITAL PLAN FEASIBILITY STUDY

One-time funding for a Medicaid prepaid inpatient hospital plan feasibility study was appropriated to the Department through HB 07-1346 for FY 07-08. The contractor hired to complete the feasibility study is charged with investigating the administrative issues surrounding increasing the number of prepaid inpatient health plans. These issues include:

- Investing the need for system changes to allow contractors to bill the Department electronically for services provided;
- Evaluating the Department's current staffing levels and recommending changes to accommodate required administrative tasks such as calculating the quality incentive payments and program integrity and quality assurance programs;
- Gauging interest in the provider community; and
- Investigating compliance issues with federal and state regulations regarding managed care.

The Department received $75,000 in total funds in FY 07-08 through HB 07-1346. This includes $37,500 in Cash Funds exempt and matching federal funds. No funding is being requested for FY 08-09.

Line Item: Prepaid Inpatient Hospital Plan Feasibility Study	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**N/A**	**$75,000**
Removal of funding because project is one-time only	$0	($75,000)
Long Bill Appropriation / Request	**$0**	**$0**
HB 07-1346 Prepaid Inpatient Health Plans MCOs	$75,000	$0
Final Appropriation / Request	**$75,000**	**$0**
Cash Funds Exempt	$37,500	$0
Federal Fund	$37,500	$0

COLORADO CARES RX PROGRAM – CBMS APPROPRIATION

During the 2007 legislative session, the Colorado Legislature passed SB 07-001, which created the Colorado Cares Rx Program. The program is intended to provide prescription drug coverage to citizens of Colorado who are not eligible for Medicaid, the Children's Basic Health Plan, or Medicaid Part D Drug Plan, and who have income under 300% of the federal poverty level. Eligibility for the Colorado Cares Rx program will be determined through the Colorado Benefits Management System, which currently processes eligibility for 36 of Colorado's medical, food, and financial assistance programs. For FY 07-08, the Department has been appropriated $66,000 General Fund to cover the costs associated with making the system changes required for the Colorado Benefits Management System to determine and track eligibility for this program. There is no federal match for these changes as the Colorado Cares Rx Program is a State-only program.

For FY 08-09, the Department has been appropriated $323,146 in Cash Funds that are expected to be generated from the fees collected from Colorado Care Rx Program participants. These funds will be used to finalize Colorado Benefits Management System changes and pay for eligibility processing as the Colorado Cares Rx Program enters into its operational phase.

Line Item: Colorado Cares Rx Program - CBMS Appropriation	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**N/A**	**$66,000**
Annualization of SB 07-001	$0	$257,146
Long Bill Appropriation / Request	**$0**	**$323,146**
SB 07-001 Colorado Cares Rx Program	$66,000	$0
Final Appropriation / Request	**$66,000**	**$323,146**
General Fund	$66,000	$0
Cash Funds	$0	$323,146

COLORADO CARES RX PROGRAM – THIRD PARTY VENDOR

Funding for the Colorado Cares Rx Program third party vendor was appropriated to the Department through SB 07-001. The program will provide a discount pharmacy card for uninsured Coloradans who qualify and pay a year application fee to participate. The application fees will pay for a contractor who will accept and process applications, collect fees, determine eligibility and produce program identification cards.

The Department received $1,333,420 in total funds in FY 07-08 through SB 07-001. All funding for this program comes from Cash Funds Exempt through the Colorado Cares Rx Fund. The Department's FY 08-09 Base Request of $1,896,085 assumes that participation and yearly application fees collected will grow, and is consistent with the fiscal note annualization of SB 07-001.

Line Item: Colorado Cares Rx Program – Third Party Vendor	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$N/A**	**$1,333,420**
Annualization of SB 07-001 Colorado Rx Cares Program	$0	$562,665
Long Bill Appropriation / Request	**$0**	**$1,896,085**
SB 07-001 Colorado Rx Cares Program	$1,333,420	$0
Final Appropriation / Request	**$1,333,420**	**$1,896,085**
Cash Funds Exempt	$1,333,420	$1,896,085

(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 Medical Services Premiums Budget Narrative 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 the Narrative.

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-2 and EA-3. Pages EA-4 through EA-7 provide detail on the components of the fund splits. Additional information is available in the Department's Tobacco Tax Update in this Budget Request.

2. The implementation of the Medicare Modernization Act on January 1, 2006 impacts prescription drug totals in the FY 05-06 and FY 06-07 actuals. 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 a prepaid inpatient health plan. A prepaid inpatient health plan 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 administrative services organization in May 2006, and one managed care plan did not renew its contract with the Department in September 2006.

4. In February 2007, the Department re-titled the Qualified Medicare Beneficiaries/Special Low-Income Medicare Beneficiaries aid category to "Partial Dual Eligibles." This more accurately reflects the benefit package afforded to these clients, who receive only coinsurance and the Supplemental Medicare Insurance Benefit. The title change does not imply any change to the services provided for these clients.

5. 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 the managed-care program.

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

7. 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.

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.

The Department's exhibits for Medical Services Premiums remain largely the same as previous Budget Requests. Of note, the following changes have been made since the previous Budget Request:

1. To better identify the type of services being performed, the Department has re-titled several service categories:

Service Group	Old Title	New Title
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community Based Long Term Care	Home and Community Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community Based Long Term Care	Home and Community Based Services - Mentally Ill	HCBS - Mental Illness
Community Based Long Term Care	Home and Community Based Services-Children	HCBS - Disabled Children
Community Based Long Term Care	Home and Community Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community Based Long Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community Based Long Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

2. A one-page summary of the Department's Request has been added to Exhibit A, on page EA-1, titled "Calculation of Request". Pages EA-2 and EA-3 now show only the calculation of the fund splits.

3. The Department's year-to-date expenditure exhibits from February have been replaced with a comparison of expenditure for each half of FY 06-07. The Department anticipates the year-to-date expenditure exhibits returning in the November 1, 2007 Budget Request.

4. The Department has substantially revised the methodology used in calculations in numerous places, including: the Breast and Cervical Cancer Treatment Program, the Program of All-Inclusive Care for the Elderly, the Supplemental Medicare Insurance Benefit, and Single Entry Points. Changes are discussed in detail for each program in each program's respective section in this Budget Narrative.

5. The Department has removed the exhibit on the Impact of the Medicare Modernization Act, formerly Exhibit Q.

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

In addition to estimating the funding need for the Medical Services Premiums line item, Medicaid caseload is used to determine the funding need for the Medicaid Mental Health Community Programs. Comprehensive mental health services are available to eligible Medicaid clients. Thus, the Medicaid Mental Health caseload is the Medicaid caseload less Partial Dual Eligibles and Non-Citizens,

which are not eligible for full Medicaid benefits. The following table displays a comparison of historical caseloads in Medicaid Medical Services Premiums and Mental Health.

Fiscal Year	Medical Services Premiums Caseload	Less: Mental Health Ineligible Categories	Mental Health Caseload
FY 02-03	327,395	(13,050)	314,345
FY 03-04	362,531	(14,391)	348,140
FY 04-05	402,802	(14,548)	388,254
FY 05-06	399,705	(16,971)	382,734
FY 06-07	393,077	(18,032)	375,045

Recent Caseload History

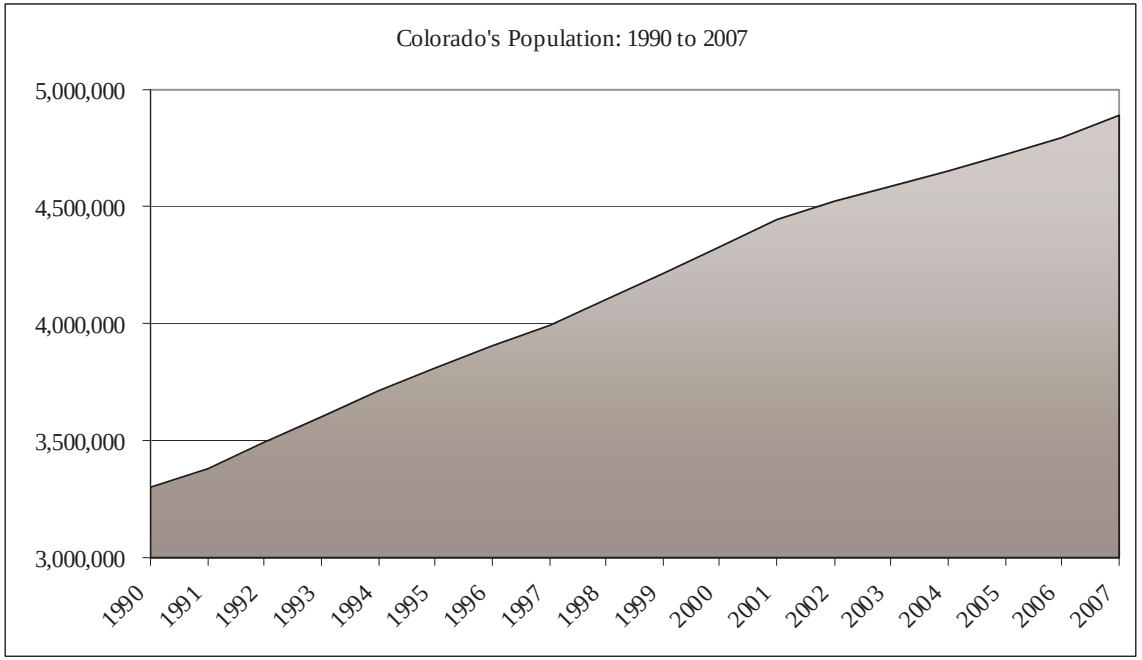
Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 95-96 to FY 06-07. Projections for FY 07-08 and FY 08-09 are also presented in the table and will be discussed in the Categorical Projections section of this document. A graphical representation of aggregate Medicaid caseload history for the same period can be found in Exhibit Q, page EQ-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. These unprecedented growth rates ceased in FY 05-06, and caseload declined by 0.77% in FY 05-06 and by a further 1.66% in FY 06-07. Reasons for these recent growth rates will be discussed below.

The charts found in Exhibit Q, page EQ-2, show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 96-97 and FY 06-07. As a percentage of the entire Medicaid caseload, Eligible Children have increased by nine percentage points, the largest gain when compared with all other categories. The percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined six percentage points, and Baby Care Adults and Non-Citizens have each declined by one percentage point. This change in case mix implies that increases in a less expensive category (Eligible Children) has been coupled with decreases in more expensive categories (Disabled Individuals to 59 (AND/AB), Baby Care Adults, and Non-Citizens) 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 22.7% from July of 1997 to July of 2007. The Department of Local Affairs forecasts that Colorado's population will increase a further 4.2% from July of 2007 to July of 2009. 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 may also increase.

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.



Source: Department of Local Affairs, Demography Division

In-State Migration - Like population, in-State migration is positively correlated with 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[20]. 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 32,000 in 2006, and is projected to overtake natural increase (births minus deaths) as the major component of population growth in 2007.

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 1997 to 2007, Colorado's median age increased by 2.07 years.[21] 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 with the highest percent change in this ratio, implying that Colorado will have the fastest aging population of the States.[22] This suggests that Colorado will have more elderly adults per one working adult in 2025 than any other state. As of 2007, Colorado has not yet felt significant impacts from 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 15.6% and 8.4% respectively from FY 99-00 to FY 03-04. The average number of months on Medicaid dropped by 10.6% for adults and 8.5% for children in FY 04-05, and in FY 05-06 increased to levels near those for FY 03-04. As caseload declined in FY 06-07, the average length of stay has also dropped from FY 05-06.

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

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

Fiscal Year	Categorically Eligible Low-Income Adults	Eligible Children
FY 04-05	7.01	8.23
FY 05-06	7.85	8.72
FY 06-07	7.73	8.57

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 2007, the over the year gain was estimated to be 45,000, or 2.0%. Job growth is projected to be approximately 1.8% throughout the forecast period.

The table that follows shows historical and projected unemployment rates, non-agricultural employment, and job growth statistics.[23]

Year	Wage and Salary Income (billions)	Non-Agricultural Employment	Employment Growth	Unemployment Rate
2001	$88.3	2,226,900	0.6%	3.8%
2002	$86.9	2,184,200	-1.9%	5.7%
2003	$88.0	2,151,100	-1.5%	6.1%
2004	$92.1	2,175,900	1.2%	5.6%
2005	$97.3	2,226,000	2.3%	5.0%
2006	$104.4	2,278,800	2.4%	4.3%
2007	$110.8	2,319,900	1.8%	3.7%
2008	$118.2	2,364,100	1.9%	3.9%
2009	$125.3	2,405,300	1.7%	4.1%

[23] Source: Office of State Planning and Budgeting, June 2007 *Colorado Economic Perspective*

While this is promising for the State as a whole, it is less encouraging for Medicaid for several reasons. First, the timing of an economic cycle is important in estimating the impact on the Medicaid caseload. As the economy recovers from a downturn, workers need to find jobs in order to withdraw from the Medicaid rolls. Jobs that primarily affect family and children Medicaid populations[24] 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 effect. 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, most recently through December 31, 2007. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 07-08 and FY 08-09. 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. Monthly caseload has been declining since December 2005, and the Department expects that the declines will continue in FY 07-08 and FY 08-09 with the improved economy.

Fiscal Year	Average Number of Adults on Transitional Medicaid	Average Number of Eligible Children on Transitional Medicaid
FY 01-02	3,866	6,638
FY 02-03	4,689	7,645
FY 03-04	4,709	7,349
FY 04-05	6,586	10,776
FY 05-06	10,745	16,749
FY 06-07	9,968	16,065

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 2000.

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

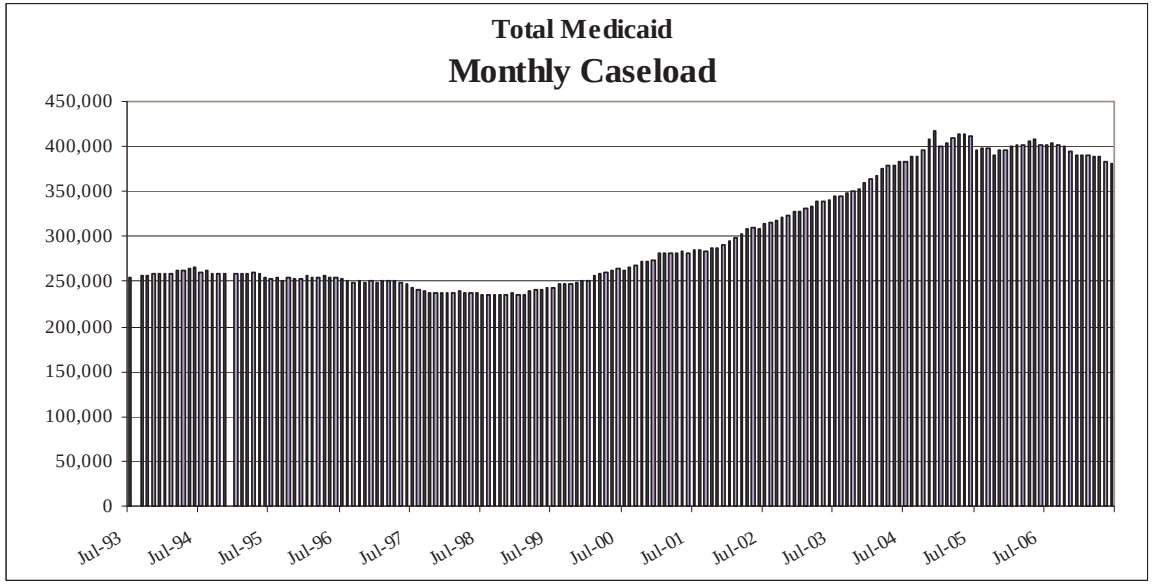
- Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354: Established a new group of eligibility for women under 65 who have been screened under the Centers for Disease Control and Prevention Board and need treatment for either diagnosis.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003: This act causes 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 by HB 05-1262 on July 1, 2005.
- HB 05-1262, the Tobacco Tax bill: This bill provided funding for the removal of the Medicaid asset test, the expansion of the income guideline used to establish eligibility for parents of children eligible for either Medicaid or the Children's Basic Health Plan to 60% of the federal poverty level (known as Expansion Adults), and to expand the number of children that can be enrolled in the Home and Community Based Services and the Children's Extensive Support Waiver programs.
- Deficit Reduction Act of 2005: This Act contains provisions related to premiums and cost sharing, benefits, and asset transfers that will have implications for Medicaid beneficiaries. In addition, the Deficit Reduction Act contains a provision requiring 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.

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 Eligible Children forecasts to account for the implementation of HB 06-1270 *(Public School Eligibility Determinations)*. This 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, estimates for the Eligible Children category were increased by 230 clients in FY 07-08 and 306 in FY 08-09. Off-line adjustments were also made to the FY 07-08 and FY 08-09 Foster Care forecasts to account for the recent passage of SB 07-002 *(Foster Care Eligibility)*. This bill expands Medicaid eligibility through age 20 for children whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act. Based on the fiscal note for SB 07-002, estimates for the Foster Care category were increased by 1,226 clients in FY 07-08 and 1,678 in FY 08-09. Detailed accountings of off-line adjustments are in Exhibit B, page EB-2.

The combination of the aforementioned factors led to significant growth in the Medicaid caseload between FY 99-00 and FY 04-05. During this time, Medicaid caseload increased by 149,548 clients, growth of 59.1%. Caseload decreased in the subsequent years, resulting in a decline of 9,725, or 2.4%, between FY 04-05 and FY 06-07. The Department believes that the improving economic conditions are the driving factor in this decrease, as consistent monthly declines have occurred in Categorically Eligible Low-Income Adults and Eligible Children, which are expected to be most affected by the economy. Given the recent trends, the Department is

forecasting total Medicaid caseload to decrease by 3.40% in FY 07-08 to 379,715. This forecasted annual decline is largely a function of the monthly decreases experienced in FY 06-07, which is leaving the caseload at a lower point at the beginning of FY 07-08. In FY 08-09, the trend is projected to moderate, and caseload is forecasted to increase by 0.88% and reach 383,067. The following table shows actual and projected aggregate Medicaid caseload from FY 02-03 through FY 08-09.

Fiscal Year	Medicaid Caseload	Level Growth	Growth Rate
FY 02-03	327,395	31,982	10.83%
FY 03-04[25]	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	393,077	(6,628)	-1.66%
FY 07-08 projection	379,715	(13,362)	-3.40%
FY 08-09 projection	383,067	3,352	0.88%



[25] 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 2007 and historical and forecasted economic and demographic data that were revised in June 2007 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 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 effect 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 2007, 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 Expansion Adults category, a statistical model could not be applied and the estimate was based on the growth experienced in FY 06-07.

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 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.

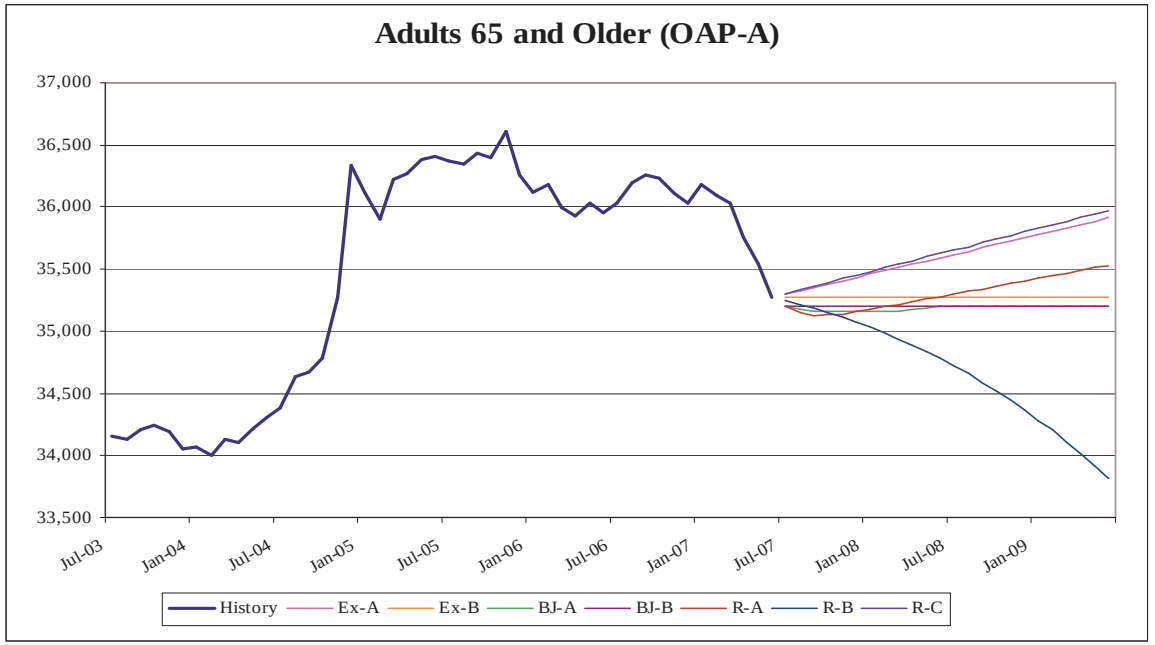
CATEGORICAL PROJECTIONS

This section details the caseload projections by eligibility category. For each category, the following are presented: a discussion of the category, model results, rationale for the forecast, statutory authority, and historical caseload and forecasts. FY 09-10 projections are included for informational purposes. For a graphical representation of caseload history by category, see Exhibit Q, pages EQ-3 to EQ-12.

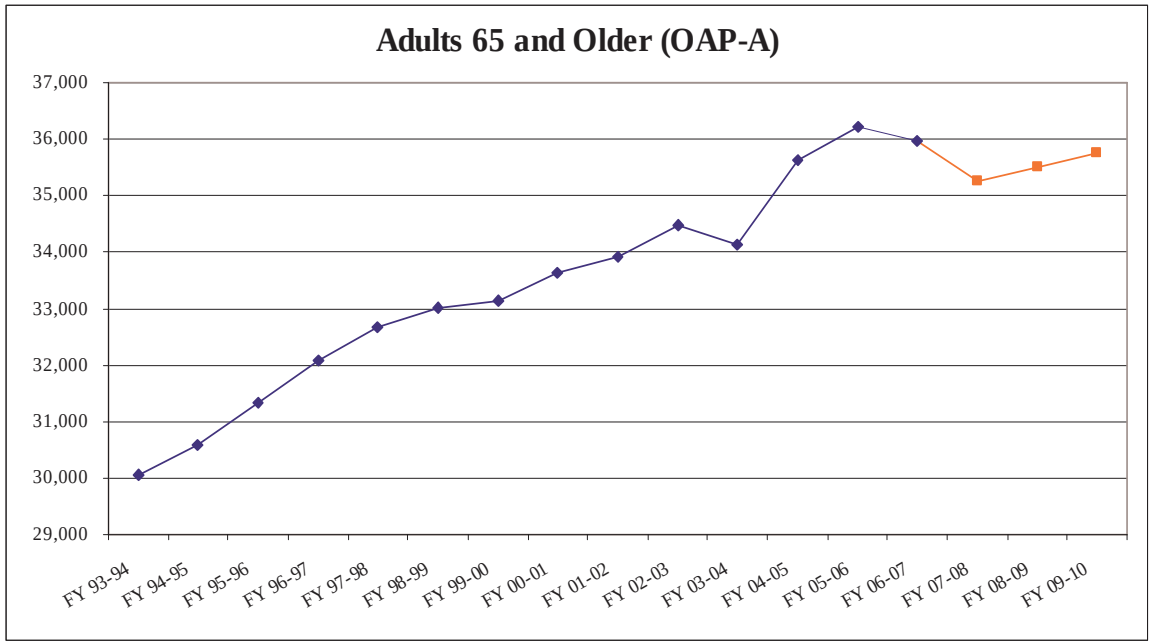
Adults 65 and Older

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. 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 Three-hundred 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. Three-hundred Percenters constitute greater than half of the enrollees in the Home and Community Based Services, Elderly, Blind, and Disabled waiver program.

Adults 65 and Older: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A*	0.9939	
Exponential Smoothing A*	0.9687	
Box-Jenkins A	0.9945	
Box-Jenkins B	0.9717	
Regression A	0.9946	OAP-A [-1], OAP-A [-2], CBMS Dummy, Auto [-1]
Regression B	0.9942	OAP-A [-1], CBMS Dummy, Population 65+
Regression C	0.9943	OAP-A [-1], CBMS Dummy, Total Population, Constant



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	36,219	35,977	-1.48%	35,445	(532)	27
Exponential Smoothing B*	**36,219**	**35,977**	**-1.96%**	**35,272**	**(705)**	**0**
Box Jenkins A	36,219	35,977	-2.23%	35,175	(802)	(6)
Box Jenkins B	36,219	35,977	-2.16%	35,200	(777)	(6)
Regression A	36,219	35,977	-2.19%	35,189	(788)	1
Regression B	36,219	35,977	-2.61%	35,038	(939)	(41)
Regression C	36,219	35,977	-1.42%	35,466	(511)	29

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	35,977	35,272	0.91%	35,593	321	27
Exponential Smoothing B*	35,977	35,272	0.00%	35,272	0	0
Box Jenkins A	35,977	35,272	0.08%	35,300	28	0
Box Jenkins B	35,977	35,272	0.00%	35,272	0	0
Regression A	**35,977**	**35,272**	**0.64%**	**35,498**	**226**	**21**
Regression B	35,977	35,272	-2.09%	34,535	(737)	(80)
Regression C	35,977	35,272	0.98%	35,618	346	29

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	35,272	35,498	0.89%	35,814	316	27
Exponential Smoothing B*	35,272	35,498	0.00%	35,498	0	0
Box Jenkins A	35,272	35,498	0.00%	35,498	0	0
Box Jenkins B	35,272	35,498	0.00%	35,498	0	0
Regression A	**35,272**	**35,498**	**0.71%**	**35,750**	**252**	**21**
Regression B	35,272	35,498	-3.73%	34,174	(1,324)	(131)
Regression C	35,272	35,498	0.95%	35,835	337	28

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Adults 65 and Older: Trend Selections

FY 07-08: -1.96%
FY 08-09: 0.64%
FY 09-10: 0.71%

Adults 65 and Older: Justifications

- This population is not affected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, until approximately CY 2011.
- Regression analysis indicates that the caseload for this population is not significantly correlated with the size of the over-65 population in general. In FY 06-07, approximately 30.8% of this eligibility type received Supplemental Security Income and were automatically eligible for Medicaid (Source: Medicaid Management Information System query).
- This population may be effected by provisions in the Deficit Reduction Act of 2005, notably sections 6011 (lengthening of look-back period), 6012 (treatment of annuities), 6014 (disqualification of individuals with substantial home equity), 6015 (reform of

asset test rules). These provisions may decrease the long-term growth rates as fewer people may now be eligible due to these provisions.

- The graph on Exhibit Q, page EQ-3 shows that historically, this category has displayed relatively flat growth. Over the past ten years, the caseload has increased by an average of 24 clients per month. Historical growth rates are stable and tend to fluctuate between 1% and 2%. The Department suspects that the high growth rate in FY 04-05 is due to the court order regarding the Colorado Benefits Management System, and that growth returned to its long-term trend in FY 05-06. The Department speculates that the decline in FY 06-07 may be indicative that the effects of the asset and annuities provisions in the Deficit Reduction Act may be stronger than expected.
- Growth in FY 06-07 was much lower than the Department's February 2007 forecast, in which the caseload was projected to be 36,154. The selected trend for FY 07-08 is lower than the February 2007 forecast, and would yield average growth of 0 clients per month in FY 07-08. This lower forecasted growth rate reflects the moderating growth experienced over the course of FY 06-07, and the large declines at the end of FY 06-07 which leaves caseload at a lower starting point for FY 07-08.
- Out-year trends are moderately positive to reflect the aging population, and are slightly lower than long-term trends to reflect a relatively good economy and the Deficit Reduction Provisions which may negatively affect caseload.

25.5-5-101 (1), C.R.S. (2007)
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;
(h) Institutionalized individuals who were eligible for medical assistance in December 1973;
(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 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;

25.5-5-201 (1), C.R.S. (2007)
(b) Individuals who would be eligible for cash assistance except for their institutionalized status;
(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;
(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

Adults 65 and Older: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	36,406	-	-
Jul-05	36,376	(30)	-0.08%
Aug-05	36,351	(25)	-0.07%
Sep-05	36,430	79	0.22%
Oct-05	36,396	(34)	-0.09%
Nov-05	36,612	216	0.59%
Dec-05	36,256	(356)	-0.97%
Jan-06	36,116	(140)	-0.39%
Feb-06	36,176	60	0.17%
Mar-06	35,997	(179)	-0.49%
Apr-06	35,925	(72)	-0.20%
May-06	36,032	107	0.30%
Jun-06	35,959	(73)	-0.20%
Jul-06	36,033	74	0.21%
Aug-06	36,190	157	0.44%
Sep-06	36,258	68	0.19%
Oct-06	36,233	(25)	-0.07%
Nov-06	36,105	(128)	-0.35%
Dec-06	36,029	(76)	-0.21%
Jan-07	36,182	153	0.42%
Feb-07	36,095	(87)	-0.24%
Mar-07	36,028	(67)	-0.19%
Apr-07	35,758	(270)	-0.75%
May-07	35,545	(213)	-0.60%
Jun-07	35,272	(273)	-0.77%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			-1.96%

	Caseload	% Change	Level Change
FY 93-94	30,051	-	-
FY 94-95	30,587	1.78%	536
FY 95-96	31,321	2.40%	734
FY 96-97	32,080	2.42%	759
FY 97-98	32,664	1.82%	584
FY 98-99	33,007	1.05%	343
FY 99-00	33,135	0.39%	128
FY 00-01	33,649	1.55%	514
FY 01-02	33,916	0.79%	267
FY 02-03	34,485	1.68%	569
FY 03-04	34,149	-0.97%	(336)
FY 04-05	35,615	4.29%	1,466
FY 05-06	36,219	1.70%	604
FY 06-07	35,977	-0.67%	(242)
FY 07-08	35,272	-1.96%	(705)
FY 08-09	35,498	0.64%	226
FY 09-10	35,750	0.71%	252

February 2007 Trend Selections			
FY 07-08	36,512	0.99%	535
FY 08-09	36,979	1.28%	467

Actuals		
	Monthly Change	% Change
6-month average	(126)	-0.35%
12-month average	(57)	-0.16%
18-month average	(55)	-0.15%
24-month average	(47)	-0.13%

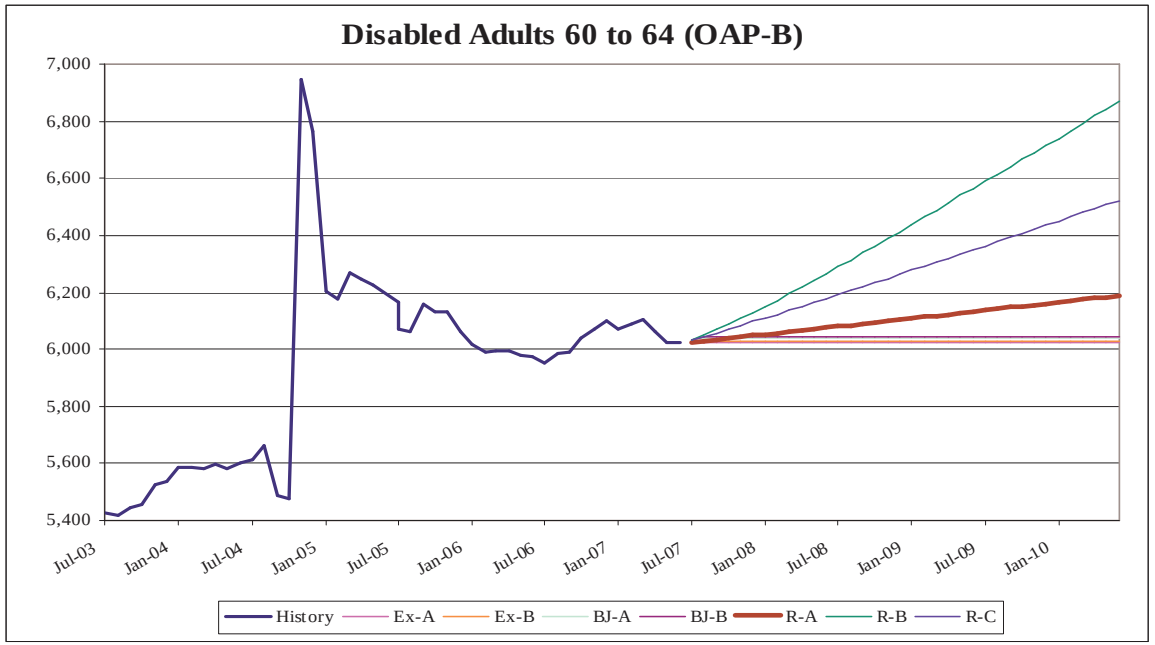
Disabled Adults 60 to 64

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. Disabled adults aged 60 to 64 who are eligible for Supplemental Security Income are included in this

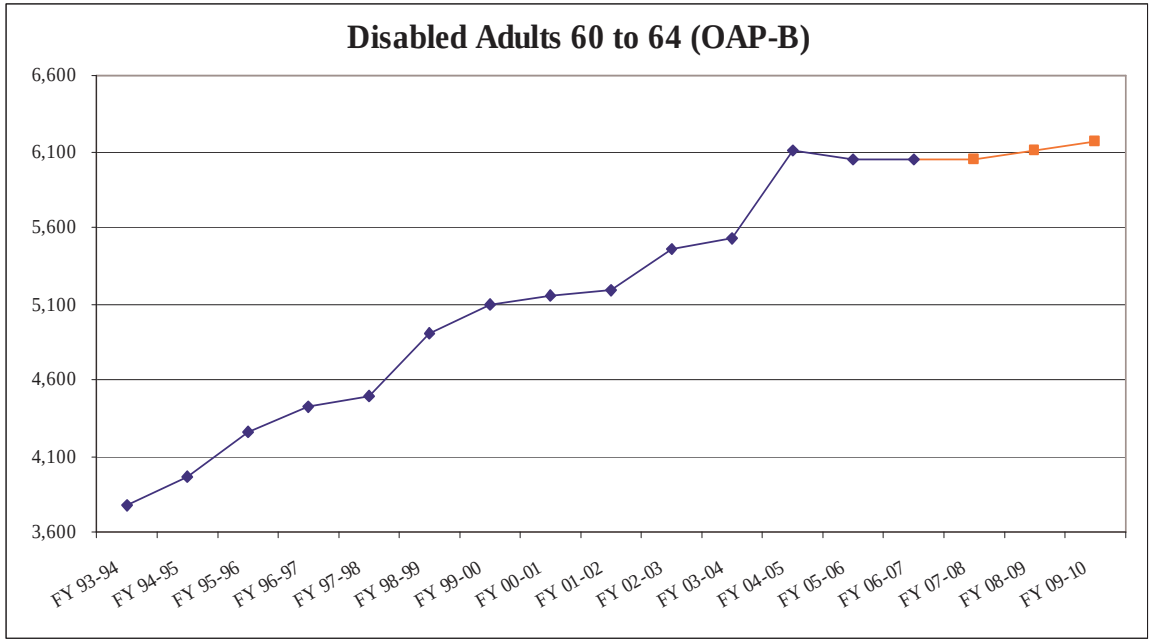
category. In addition, states may extend coverage to individuals with incomes above the Supplemental Security Income limit, and who meet the nursing home level of care. Referred to as Three-hundred Percenters, these clients have incomes no more than three times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home.

Quality control checks are completed from time to time 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.

Disabled Adults 60 to 64: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9697	
Exponential Smoothing A	0.8268	
Box-Jenkins A*	0.9739	
Box-Jenkins B*	0.8734	
Regression A	0.9920	OAP-B [-1], CBMS Dummy
Regression B	0.9934	OAP-B [-1], CBMS Dummy, Population 60-64, Trend
Regression C	0.9946	OAP-B [-1], CBMS Dummy, Total Population, Trend



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	6,048	6,042	-0.35%	6,021	(21)	0
Exponential Smoothing B	6,048	6,042	-0.28%	6,025	(17)	0
Box Jenkins A*	6,048	6,042	-0.08%	6,037	(5)	1
Box Jenkins B*	6,048	6,042	-0.02%	6,041	(1)	2
FY 07-08	**FY 05-06**	**FY 06-07**	**Projected Growth Rate**	**Projected FY 07-08 Caseload**	**Level Change**	**Average Monthly Change [1]**
Regression A	**6,048**	**6,042**	**0.13%**	**6,050**	**8**	**5**
Regression B	6,048	6,042	1.69%	6,144	102	20
Regression C	6,048	6,042	1.03%	6,104	62	13

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	6,042	6,050	0.00%	6,050	0	0
Exponential Smoothing B	6,042	6,050	0.00%	6,050	0	0

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Box Jenkins A*	6,042	6,050	0.02%	6,051	1	0
Box Jenkins B*	6,042	6,050	0.02%	6,051	1	0
Regression A	**6,042**	**6,050**	**0.93%**	**6,106**	**56**	**5**
Regression B	6,042	6,050	4.59%	6,328	278	25
Regression C	6,042	6,050	2.72%	6,215	165	14

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	6,050	6,106	0.00%	6,106	0	0
Exponential Smoothing B	6,050	6,106	0.00%	6,106	0	0
Box Jenkins A*	6,050	6,106	0.00%	6,106	0	0
Box Jenkins B*	6,050	6,106	0.00%	6,106	0	0
Regression A	**6,050**	**6,106**	**0.92%**	**6,162**	**56**	**5**
Regression B	6,050	6,106	4.72%	6,394	288	25
Regression C	6,050	6,106	2.76%	6,275	169	14

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Disabled Adults 60 to 64: Trend Selections

FY 07-08: 0.13%
FY 08-09: 0.93%
FY 09-10: 0.92%

Disabled Adults 60 to 64: Justifications

- 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).
- The 1,615 client caseload spike in November 2004 is directly related to the court order regarding the Colorado Benefits Management System. Of this group, 1,166 clients came from the Disabled Adults (AND/AB) population, while the remainder (449 clients) came from the OAP-A population. This has been corrected for in regressions.
- Historically, this category has displayed consistently slow growth, with caseload increasing by an average of 14 clients per month over the last 10 years. This population, like the Adults 65 and Older category, may 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 affected by the

baby-boom generation, defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in CY 2006, which may support higher growth.

- However, because this population is disabled, the effects of both the baby boom generation and the Deficit Reduction Act are likely to be mitigated. In addition, in FY 06-07, 56.0% of this population received Supplemental Security Income, and are therefore automatically Medicaid eligible (Source: Medicaid Management Information System query). The effect of the Deficit Reduction Act is expected to be smaller in this population than in Adults 65 and Older, where 30.8% of the population received Supplemental Security Income in FY 06-07.
- FY 05-06 recorded the first ever caseload decline in this category. In FY 06-07, the caseload increased by an average of 5 clients per month during the year. This growth was not strong enough to register positive annual growth from FY 05-06, as caseload started from a relatively low level in July 2006. 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.
- Growth in FY 06-07 was lower than the Department's February 2007 forecast in which caseload was projected to be 6,120. The selected trend for FY 07-08 is lower than the February 2007 forecast, and would yield average growth of 5 clients per month in FY 07-08. This lower forecasted growth rate reflects the moderating growth experienced over the course of FY 06-07, which also leaves caseload at a lower starting point for FY 07-08.
- Out-year trends are slightly higher, as this population may become affected by a larger portion of the baby boom generation over the next 5 years.

25.5-5-101 (1), C.R.S. (2007)
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;
(h) Institutionalized individuals who were eligible for medical assistance in December 1973;
(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 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;

25.5-5-201 (1), C.R.S. (2007)
(b) Individuals who would be eligible for cash assistance except for their institutionalized status;
(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;

(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

Disabled Adults 60 to 64: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	6,164	-	-
Jul-05	6,072	(92)	-1.49%
Aug-05	6,060	(12)	-0.20%
Sep-05	6,161	101	1.67%
Oct-05	6,132	(29)	-0.47%
Nov-05	6,134	2	0.03%
Dec-05	6,061	(73)	-1.19%
Jan-06	6,016	(45)	-0.74%
Feb-06	5,990	(26)	-0.43%
Mar-06	5,996	6	0.10%
Apr-06	5,995	(1)	-0.02%
May-06	5,979	(16)	-0.27%
Jun-06	5,975	(4)	-0.07%
Jul-06	5,953	(22)	-0.37%
Aug-06	5,985	32	0.54%
Sep-06	5,990	5	0.08%
Oct-06	6,040	50	0.83%
Nov-06	6,070	30	0.50%
Dec-06	6,098	28	0.46%
Jan-07	6,074	(24)	-0.39%
Feb-07	6,088	14	0.23%
Mar-07	6,107	19	0.31%
Apr-07	6,059	(48)	-0.79%
May-07	6,024	(35)	-0.58%
Jun-07	6,020	(4)	-0.07%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			-0.36%

	Caseload	% Change	Level Change
FY 93-94	3,776	-	-
FY 94-95	3,970	5.14%	194
FY 95-96	4,261	7.33%	291
FY 96-97	4,429	3.94%	168
FY 97-98	4,496	1.51%	67
FY 98-99	4,909	9.19%	413
FY 99-00	5,092	3.73%	183
FY 00-01	5,157	1.28%	65
FY 01-02	5,184	0.52%	27
FY 02-03	5,456	5.25%	272
FY 03-04	5,528	1.32%	72
FY 04-05	6,103	10.40%	575
FY 05-06	6,048	-0.90%	(55)
FY 06-07	6,042	-0.10%	(6)
FY 07-08	6,050	0.13%	8
FY 08-09	6,106	0.93%	56
FY 09-10	6,162	0.92%	56

February 2007 Trend Selections			
FY 07-08	6,285	2.70%	243
FY 08-09	6,431	2.32%	146

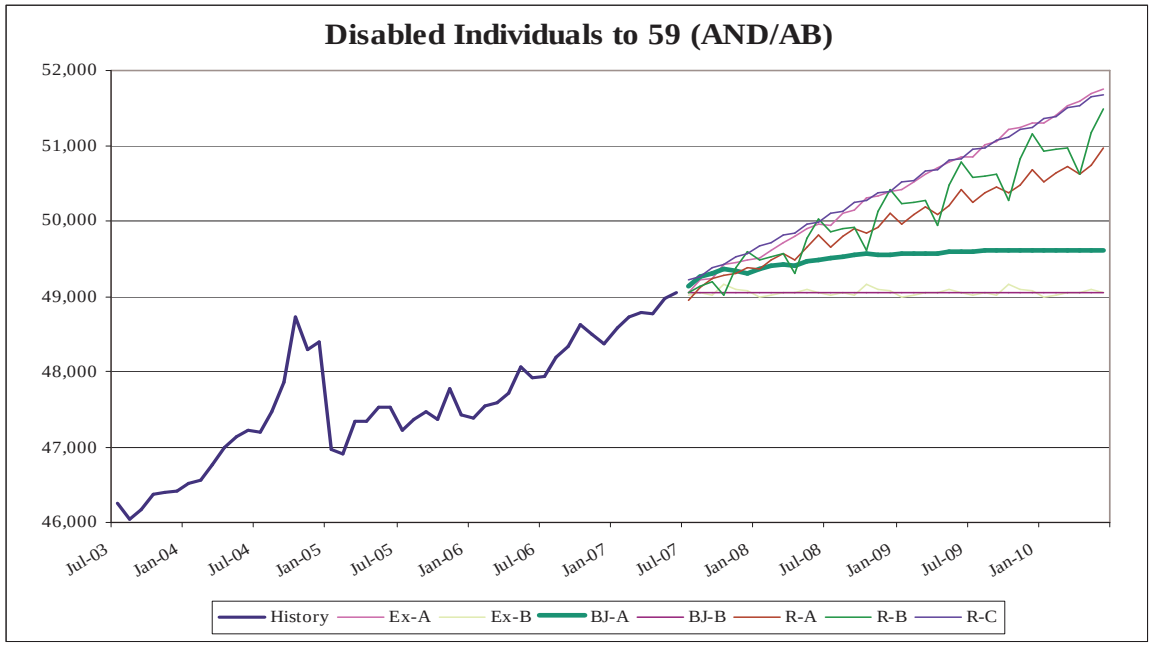
Actuals		
	Monthly Change	% Change
6-month average	(13)	-0.21%
12-month average	4	0.06%
18-month average	(2)	-0.04%
24-month average	(6)	-0.10%

Disabled Individuals to 59

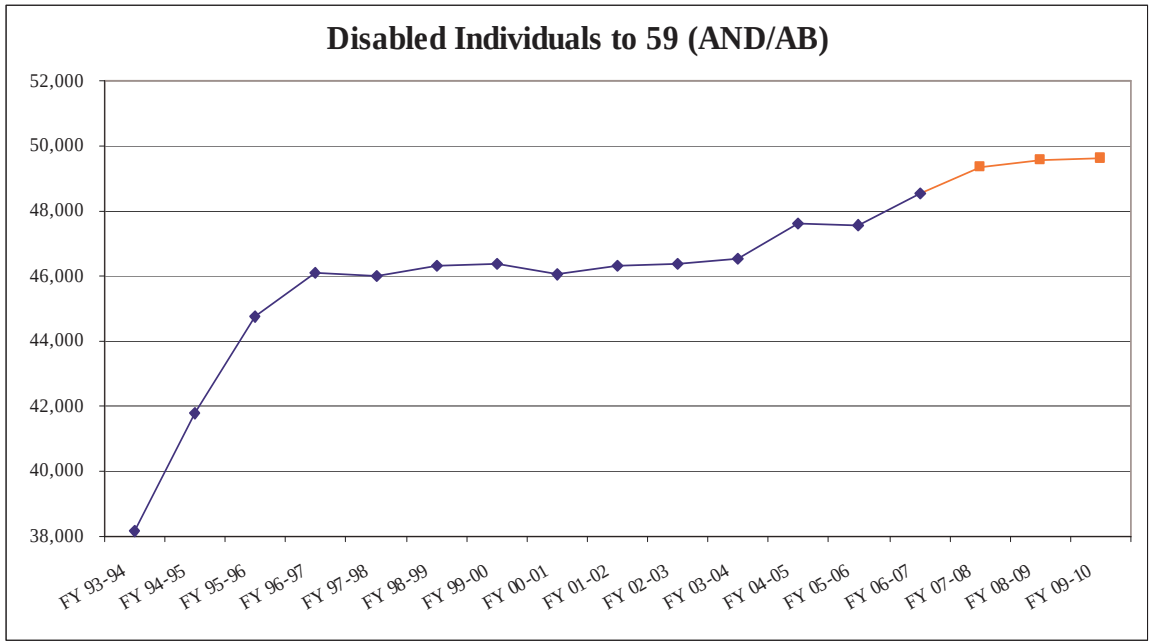
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. 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 Three-hundred 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, Three-hundred 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 his/her 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.

Disabled Individuals to 59: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9928	
Exponential Smoothing A	0.9311	
Box-Jenkins A	0.9923	
Box-Jenkins B	0.9291	
Regression A	0.7238	AND/AB [-6], Auto [-18]
Regression B	0.8868	AND/AB [-6], Migration, Auto [-6]
Regression C	0.9867	AND/AB [-2], Auto [-1]



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	47,565	48,567	1.97%	49,524	957	75
Exponential Smoothing B	47,565	48,567	1.00%	49,053	486	0
Box Jenkins A	**47,565**	**48,567**	**1.62%**	**49,354**	**787**	**35**
Box Jenkins B*	47,565	48,567	1.00%	49,053	486	0
Regression A	47,565	48,567	1.68%	49,383	816	63
Regression B	47,565	48,567	1.76%	49,422	855	81
Regression C	47,565	48,567	2.15%	49,611	1,044	77

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	48,567	49,354	1.82%	50,252	898	75
Exponential Smoothing B	48,567	49,354	0.00%	49,354	0	0
Box Jenkins A	**48,567**	**49,354**	**0.41%**	**49,556**	**202**	**9**
Box Jenkins B*	48,567	49,354	0.00%	49,354	0	0

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Regression A	48,567	49,354	1.27%	49,981	627	51
Regression B	48,567	49,354	1.48%	50,084	730	64
Regression C	48,567	49,354	1.71%	50,198	844	70

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	49,354	49,556	1.78%	50,438	882	75
Exponential Smoothing B	49,354	49,556	0.00%	49,556	0	0
Box Jenkins A	**49,354**	**49,556**	**0.10%**	**49,606**	**50**	**2**
Box Jenkins B*	49,354	49,556	0.00%	49,556	0	0
Regression A	49,354	49,556	1.11%	50,106	550	46
Regression B	49,354	49,556	1.39%	50,245	689	58
Regression C	49,354	49,556	1.68%	50,389	833	71

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Disabled Individuals to 59: Trend Selections

FY 07-08: 1.62%
FY 08-09: 0.41%
FY 09-10: 0.10%

Disabled Individuals to 59: Justifications

- As the graph in Exhibit Q, page EQ-5 shows, high rates of growth continued through FY 96-97, and 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 let individuals under 65 who were seeking Medicaid coverage because of a disability experience an expeditious application process as compared to other applicants. By discontinuing the Med-9, clients underwent a more rigorous eligibility determination, and caseload fell slightly.
- HB 05-1262 expanded the number of children that can be enrolled in the Children's Home and Community Based Service Waiver Program and the Children's Extensive Support Waiver Program. The original expansion was 527 slots, which began to be filled in FY 05-06. During the March 13, 2006 Figure Setting, the number of expansion slots funded under the Tobacco Tax bill was increased by 200 in the Children's Home and Community Based Service Waiver Program and 30 in the Children's Extensive Support Waiver Program. The Department received approval for the additional expansions from the Centers for Medicare and

Medicaid Services in December 2006. All new Children's Home and Community Based Service expansion slots were filled by July 2007, and all new Children's Extensive Support expansion slots are projected to be filled in FY 07-08.

- As this category is disabled, economic conditions have a small impact on this group. Only a small segment of the population has the ability to shift on-and-off Medicaid, which leads to a relatively stable population.
- Although the last 24 months have shown an upward trend, this is largely due to Tobacco Tax expansion, and history indicates that this effect is temporary and will likely be mitigated in the future.
- Growth in FY 06-07 was in line with the February 2007 forecast, in which the caseload was projected to be approximately 48,516. The selected trend for FY 07-08 is slightly higher than that from the February 2007 forecast, and would yield average growth of 35 clients per month in FY 07-08. This higher forecasted growth rate reflects the increasingly strong monthly growth experienced at the end of FY 06-07, which also leaves caseload at a higher starting point for FY 07-08.
- Out-year growth is projected to return to long-term trend as all expansion clients have been in the caseload for at least a full year.

25.5-5-101 (1), C.R.S. (2007)
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;
(h) Institutionalized individuals who were eligible for medical assistance in December 1973;
(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 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. (2007)
(b) Individuals who would be eligible for cash assistance except for their institutionalized status;
(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;
(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

Disabled Individuals to 59: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	47,519	-	-
Jul-05	47,214	(305)	-0.64%
Aug-05	47,358	144	0.30%
Sep-05	47,467	109	0.23%
Oct-05	47,365	(102)	-0.21%
Nov-05	47,783	418	0.88%
Dec-05	47,429	(354)	-0.74%
Jan-06	47,373	(56)	-0.12%
Feb-06	47,541	168	0.35%
Mar-06	47,579	38	0.08%
Apr-06	47,705	126	0.26%
May-06	48,055	350	0.73%
Jun-06	47,912	(143)	-0.30%
Jul-06	47,946	34	0.07%
Aug-06	48,192	246	0.51%
Sep-06	48,320	128	0.27%
Oct-06	48,611	291	0.60%
Nov-06	48,503	(108)	-0.22%
Dec-06	48,363	(140)	-0.29%
Jan-07	48,576	213	0.44%
Feb-07	48,714	138	0.28%
Mar-07	48,785	71	0.15%
Apr-07	48,766	(19)	-0.04%
May-07	48,975	209	0.43%
Jun-07	49,057	82	0.17%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			1.01%

	Caseload	% Change	Level Change
FY 93-94	38,140	-	-
FY 94-95	41,773	9.53%	3,633
FY 95-96	44,736	7.09%	2,963
FY 96-97	46,090	3.03%	1,354
FY 97-98	46,003	-0.19%	(87)
FY 98-99	46,310	0.67%	307
FY 99-00	46,386	0.16%	76
FY 00-01	46,046	-0.73%	(340)
FY 01-02	46,349	0.66%	303
FY 02-03	46,378	0.06%	29
FY 03-04	46,565	0.40%	187
FY 04-05	47,626	2.28%	1,061
FY 05-06	47,565	-0.13%	(61)
FY 06-07	48,567	2.11%	1,002
FY 07-08	49,354	1.62%	787
FY 08-09	49,556	0.41%	202
FY 09-10	49,606	0.10%	50

February 2007 Trend Selections			
FY 07-08	49,156	1.32%	589
FY 08-09	49,210	0.11%	54

Actuals		
	Monthly Change	% Change
6-month average	116	0.24%
12-month average	95	0.20%
18-month average	90	0.19%
24-month average	64	0.13%

Categorically Eligible Low-Income Adults

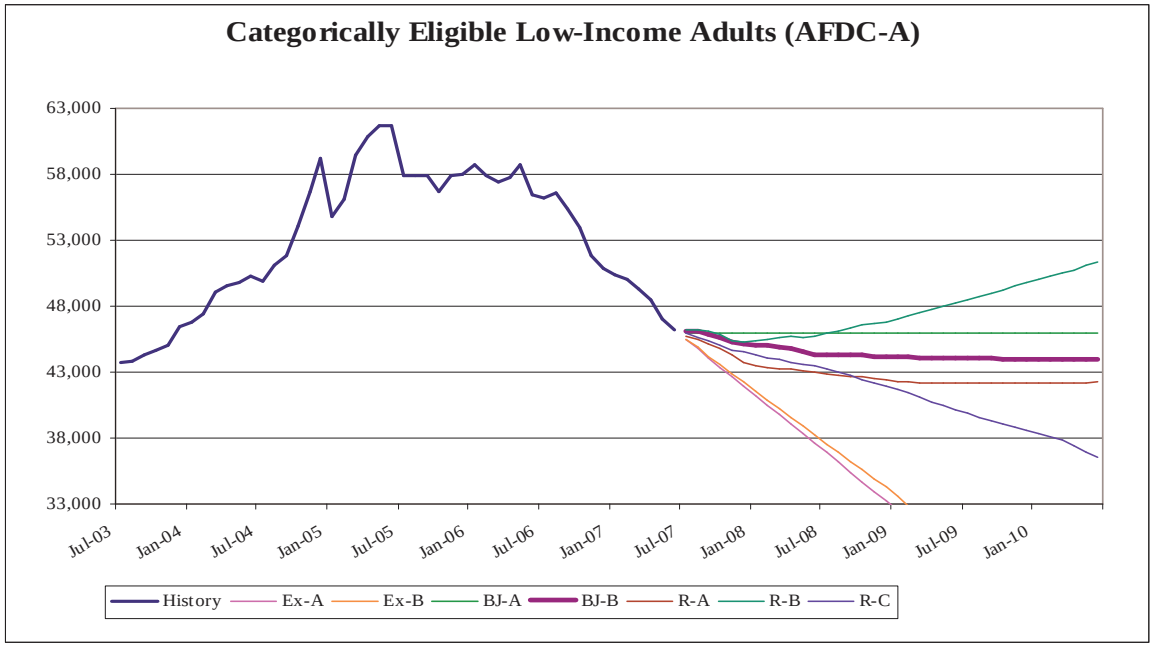
One of the primary ways that adults qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 06-07, there were an average of 9,968 adults in this program. Transitional Medicaid benefits have been extended through September 30, 2007, and the Department's forecast assumes that the program will continue through FY 08-09.

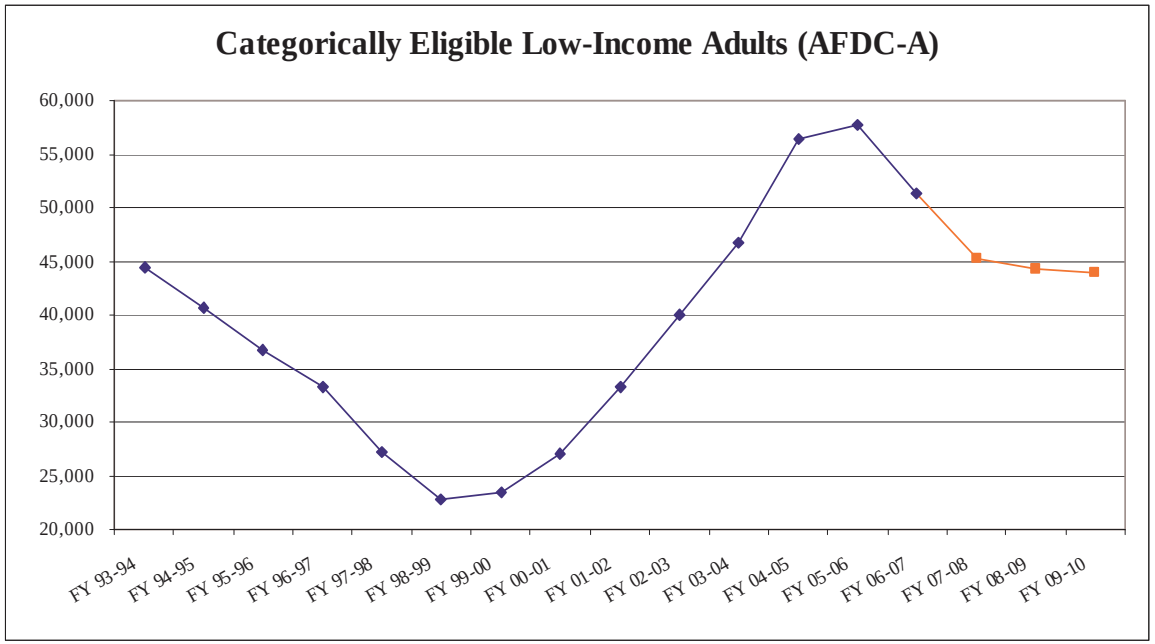
The graph in Exhibit Q, page EQ-6, shows that before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted 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[26] 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. For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Budget Request, pages A-37 to A-38.

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

Categorically Eligible Low-Income Adults: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9941	
Exponential Smoothing A	0.9893	
Box-Jenkins A	0.9889	
Box-Jenkins B	0.9957	
Regression A	0.9952	AFDC-A [-1], CBMS Dummy, Systems Dummy, Unemployment Rate, Auto [-7]
Regression B	0.9954	AFDC-A [-1], CBMS Dummy, Systems Dummy, Total Wages, Auto [-6]
Regression C	0.9958	AFDC-A [-1], CBMS Dummy, Systems Dummy, Population 19-59, Labor Force



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	57,754	51,361	-19.11%	41,546	(9,815)	(719)
Exponential Smoothing B	57,754	51,361	-18.43%	41,895	(9,466)	(665)
Box Jenkins A*	57,754	51,361	-10.54%	45,948	(5,413)	(23)
Box Jenkins B*	**57,754**	**51,361**	**-11.94%**	**45,228**	**(6,133)**	**(155)**
Regression A	57,754	51,361	-14.26%	44,037	(7,324)	(268)
Regression B	57,754	51,361	-11.00%	45,711	(5,650)	(40)
Regression C	57,754	51,361	-13.30%	44,530	(6,831)	(231)

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	51,361	45,228	-20.76%	35,839	(9,389)	(719)
Exponential Smoothing B	51,361	45,228	-19.04%	36,617	(8,611)	(665)
Box Jenkins A*	51,361	45,228	-0.02%	45,219	(9)	0
Box Jenkins B*	**51,361**	**45,228**	**-2.31%**	**44,183**	**(1,045)**	**(28)**
Regression A	51,361	45,228	-3.65%	43,577	(1,651)	(66)
Regression B	51,361	45,228	2.89%	46,535	1,307	207
Regression C	51,361	45,228	-6.23%	42,410	(2,818)	(274)

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	45,228	44,183	-26.19%	32,611	(11,572)	(719)
Exponential Smoothing B	45,228	44,183	-23.52%	33,791	(10,392)	(665)
Box Jenkins A*	45,228	44,183	0.00%	44,183	0	0
Box Jenkins B*	**45,228**	**44,183**	**-0.43%**	**43,993**	**(190)**	**(5)**
Regression A	45,228	44,183	-0.55%	43,940	(243)	2
Regression B	45,228	44,183	6.07%	46,865	2,682	258
Regression C	45,228	44,183	-8.07%	40,617	(3,566)	(301)

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Categorically Eligible Low-Income Adults: Trend Selections

FY 07-08: -11.94%
FY 08-09: -2.31%
FY 09-10: -0.43%

Categorically Eligible Low-Income Adults: Justifications

- Growth rates in this category were unprecedented between FY 00-01 and FY 04-05. During this time, 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 to 2.3% 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 19 to 59 population dropped from approximately 2.6% per year from FY 95-96 to FY 01-02 to 1.4% per year from FY 02-03 to FY 06-07. The growth in this population is projected to rebound to an average of

1.5% over the forecast period[27]. Projections from the Office of State Planning and Budgeting indicate that the economy will continue to improve, though at a moderating pace, throughout the forecast period, with nonagricultural employment to grow by approximately 1.8% per year. Similarly, unemployment is expected to remain steady, and wage and salary income is projected to grow by an average of 6.3% per year.

- There have been a number of large declines in the last year, which the Department believes indicates that the improving economy is having the expected effect on caseload, however it is not known at this time. There is evidence that some of the clients that are leaving this eligibility category are going to the Expansion Adults, from both 1931 and Transitional Medicaid, due to increased income.
- The caseload declines in FY 06-07 were larger than the Department's February 2007 forecast in which caseload was projected to be 51,684. The selected trend for FY 07-08 is lower than that from the February 2007 forecast, and would yield average declines of 155 clients per month in FY 07-08. This lower forecast is reflective of the large monthly declines in the last half of FY 06-07, which leaves caseload at a lower starting point for the year. The Department believes that the economy is the most important factor in this change, however it is not known at this time. Because of this, the Department sees no compelling evidence that caseload declines will not continue.
- Out-year trend selections are expected to moderate, reflecting the positive but moderating growth in the economy.

25.5-5-101 (1), C.R.S. (2007)
(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;

25.5-5-201 (1), C.R.S. (2007)
(a) Individuals who would be eligible for but are not receiving cash assistance;
(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;

[27] Source: Department of Local Affairs, Demography Division.

Categorically Eligible Low-Income Adults: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	61,684	-	-
Jul-05	57,905	(3,779)	-6.13%
Aug-05	57,827	(78)	-0.13%
Sep-05	57,922	95	0.16%
Oct-05	56,684	(1,238)	-2.14%
Nov-05	57,923	1,239	2.19%
Dec-05	57,944	21	0.04%
Jan-06	58,721	777	1.34%
Feb-06	57,872	(849)	-1.45%
Mar-06	57,354	(518)	-0.90%
Apr-06	57,730	376	0.66%
May-06	58,748	1,018	1.76%
Jun-06	56,416	(2,332)	-3.97%
Jul-06	56,253	(163)	-0.29%
Aug-06	56,565	312	0.55%
Sep-06	55,341	(1,224)	-2.16%
Oct-06	53,950	(1,391)	-2.51%
Nov-06	51,838	(2,112)	-3.91%
Dec-06	50,857	(981)	-1.89%
Jan-07	50,395	(462)	-0.91%
Feb-07	50,058	(337)	-0.67%
Mar-07	49,325	(733)	-1.46%
Apr-07	48,513	(812)	-1.65%
May-07	47,016	(1,497)	-3.09%
Jun-07	46,219	(797)	-1.70%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			-10.01%

	Caseload	% Change	Level Change
FY 93-94	44,394	-	-
FY 94-95	40,602	-8.54%	(3,792)
FY 95-96	36,690	-9.63%	(3,912)
FY 96-97	33,250	-9.38%	(3,440)
FY 97-98	27,179	-18.26%	(6,071)
FY 98-99	22,852	-15.92%	(4,327)
FY 99-00	23,515	2.90%	663
FY 00-01	27,081	15.16%	3,566
FY 01-02	33,347	23.14%	6,266
FY 02-03	40,021	20.01%	6,674
FY 03-04	46,756	16.83%	6,735
FY 04-05	56,453	20.74%	9,697
FY 05-06	57,754	2.30%	1,301
FY 06-07	51,361	-11.07%	(6,393)
FY 07-08	45,228	-11.94%	(6,133)
FY 08-09	44,183	-2.31%	(1,045)
FY 09-10	43,993	-0.43%	(190)

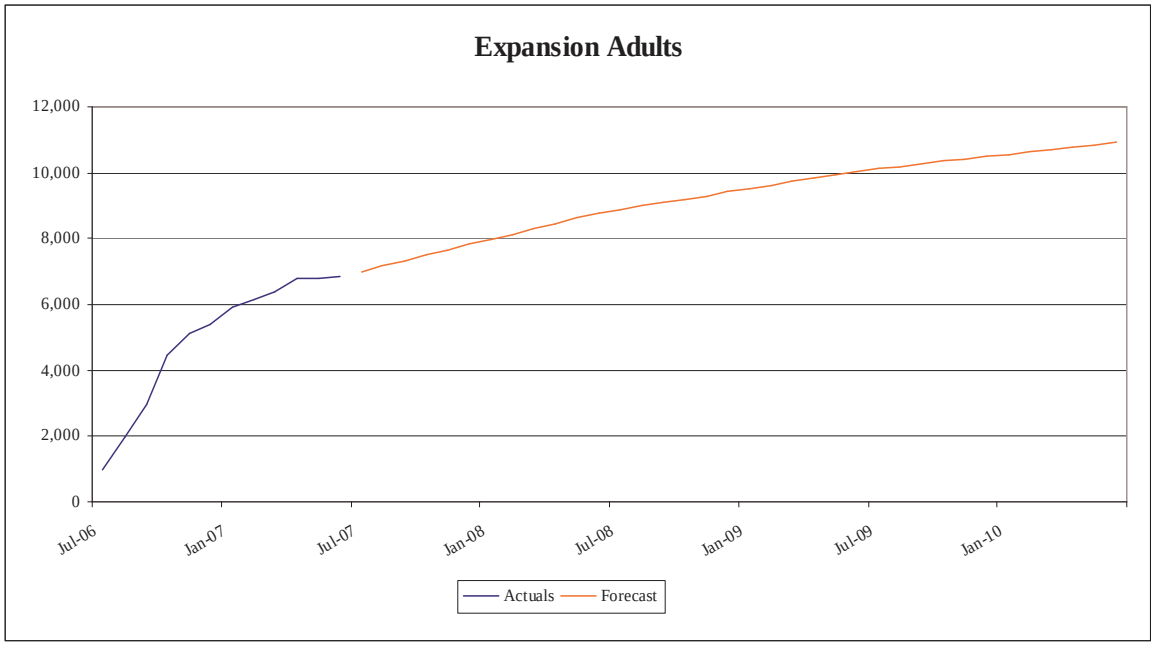
February 2007 Trend Selections			
FY 07-08	46,579	-9.53%	(4,782)
FY 08-09	45,267	-3.19%	(1,312)

Actuals		
	Monthly Change	% Change
6-month average	(773)	-1.58%
12-month average	(850)	-1.64%
18-month average	(651)	-1.24%
24-month average	(644)	-1.18%

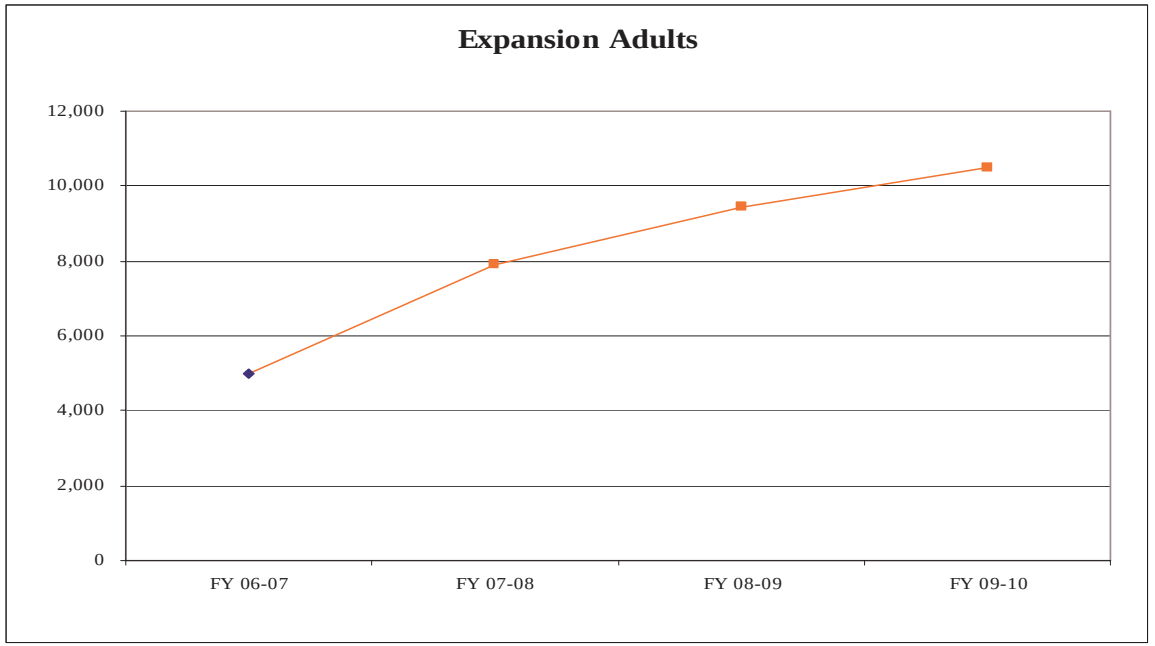
Expansion Adults

HB 05-1262 (Tobacco Tax bill) allows for expanding Medicaid eligibility to parents of children enrolled in either Medicaid or the Children's Basic Health Plan up to 60% of the federal poverty level. The increase in the percentage of allowable federal poverty level was implemented on July 1, 2006. The Department has created a new category to track these clients, known as the Expansion Adults.

Expansion Adults: Model Results



	Projected Level	Growth Rate
FY 06-07	4,974	-
FY 07-08	7,886	58.54%
FY 08-09	9,462	19.98%
FY 09-10	10,518	11.16%



The caseload forecast is based on the average monthly change experienced between March and June 2007. During this time, caseload increased by an average of 160 clients per month. This timeframe is used for comparison because the caseload increases at the beginning of the year are reflective of a new population, and are assumed to not be representative of future caseload growth. In addition, monthly growth appears to have declined over the last six months of FY 06-07, as the graph in Exhibit Q, page EQ-7 shows. The Department's forecast is for caseload to increase by an average of 160 clients per month in FY 07-08, in line with the recent growth trend. The FY 08-09 forecast assumes that this growth will decrease by one-third to 107 clients per month. Similarly, the FY 09-10 forecast assumes that growth will decrease by one-third from that in FY 08-09 to 72 clients per month.

Expansion Adults FY 06-07 Actuals			
	Actuals	Monthly Change	% Change
Jul-06	971	-	-
Aug-06	1,976	1,005	103.50%
Sep-06	2,940	964	48.79%
Oct-06	4,452	1,512	51.43%
Nov-06	5,131	679	15.25%
Dec-06	5,388	257	5.01%

Expansion Adults FY 06-07 Actuals			
Jan-07	5,901	513	9.52%
Feb-07	6,162	261	4.42%
Mar-07	6,366	204	3.31%
Apr-07	6,774	408	6.41%
May-07	6,786	12	0.18%
Jun-07	6,846	60	0.88%
Average	**4,974**	**534**	**22.61%**

As seen in the table below, the Year 1 growth rate, calculated as the growth from July to June, is in line with the similar growth rate experienced in other expansion populations in Medicaid and the Children's Basic Health Plan. However, the previous expansion populations did not display the lessening growth that Expansion Adults has seen over the course of the first year. These other populations continued to display strong monthly growth rates through their first years, into the second years. The Department believes that the strengthening economy is weakening the pattern of strong growth at the beginning of an expansion, which occurred with prior expansion populations.

	Year 1*	Year 2	Year 3
Breast & Cervical Cancer Program	1800.00%	123.91%	48.54%
Children's Basic Health Plan Children	209.92%	118.00%	54.10%
Children's Basic Health Plan Prenatal	560.71%	168.33%	40.92%
Average	**856.88%**	**136.75%**	**47.85%**

* Growth in Year 1 is calculated as that experienced from July to June's caseload in the first year.

Expansion Adults: Justification and Monthly Projections

- This population would be expected to have a high penetration rate, as these are parents of children eligible for either Medicaid or the Children's Basic Health Plan, which have relatively high penetration rates.
- This population would be expected to be effected by the economy in similar ways as the Categorically Eligible Low-Income Adults and Eligible Children populations, although the effects are mitigated given that these clients are up to 60% of the federal poverty level. This would support relatively slower growth rates than previous expansions.
- The Department is in the process of implementing Centers for Medicare and Medicaid Services eligibility policy decisions that will affect this eligibility type, which will be incorporated into subsequent forecasts.

25.5-5-201 (1), C.R.S. (2007)
(m) (I) Parents of children who are eligible for the medical assistance program or the children's basic health plan, article 8 of this title, whose family income does not exceed a specified percent of the federal poverty level, adjusted for family size, as set by the state board by rule, which percentage shall be not less than sixty percent;

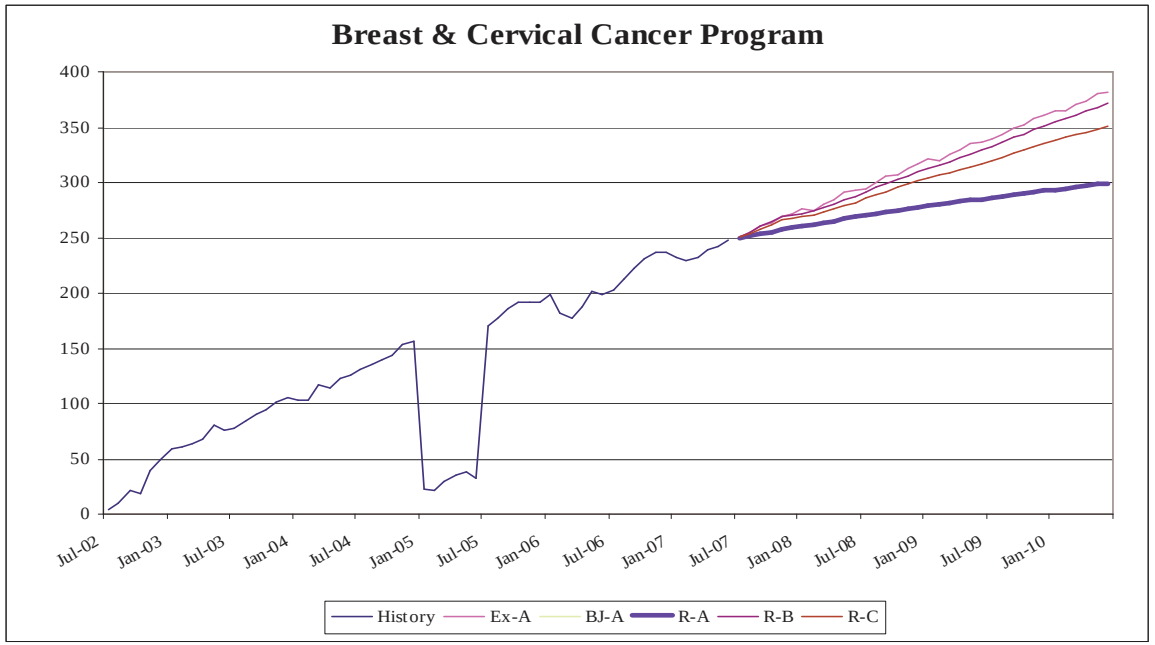
	FY 06-07	FY 07-08	FY 08-09	FY 09-10
July	**971**	7,006	8,873	10,122
August	**1,976**	7,166	8,980	10,194
September	**2,940**	7,326	9,087	10,266
October	**4,452**	7,486	9,194	10,338
November	**5,131**	7,646	9,301	10,410
December	**5,388**	7,806	9,408	10,482
January	**5,901**	7,966	9,515	10,554
February	**6,162**	8,126	9,622	10,626
March	**6,366**	8,286	9,729	10,698
April	**6,774**	8,446	9,836	10,770
May	**6,786**	8,606	9,943	10,842
June	**6,846**	8,766	10,050	10,914
Annual Average	**4,974**	**7,886**	**9,462**	**10,518**
Annual Growth Rate*	**605.05%**	**58.54%**	**19.98%**	**11.16%**
Average Monthly Growth	**534**	**160**	**107**	**72**

* Growth in Year 1 is calculated as that experienced from July to June's caseload in the first year.

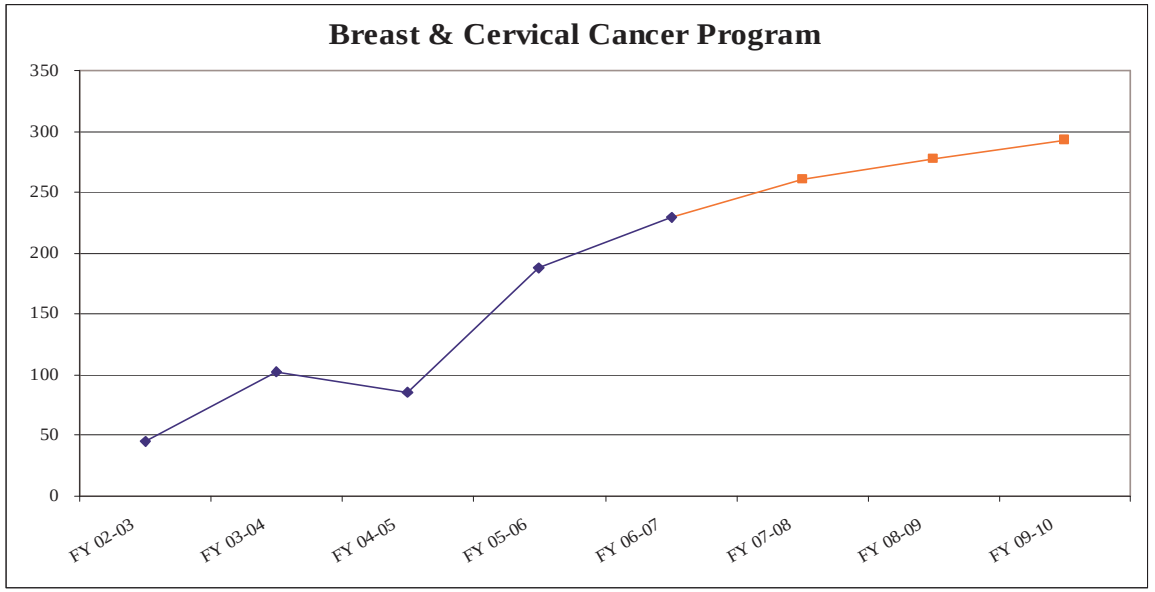
Breast and Cervical Cancer Program

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.

Breast and Cervical Cancer Program: Model Results



	Adjusted R^2	Notes
Exponential Smoothing	0.9935	
Box-Jenkins	0.9925	
Regression A	0.9927	BCCP [-1], Female Population 19-59
Regression B	0.9907	BCCP [-1], BCCP [-11], Female Population 19-59, Trend
Regression C	0.9903	BCCP [-1], BCCP [-11], Total Wages



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing*	188	230	18.26%	272	42	2
Box Jenkins	188	230	13.04%	260	30	1
Regression A	**188**	**230**	**13.04%**	**260**	**30**	**1**
Regression B	188	230	17.83%	271	41	2
Regression C	188	230	16.09%	267	37	1

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing*	230	260	16.54%	303	43	4
Box Jenkins	230	260	6.92%	278	18	1
Regression A	**230**	**260**	**6.92%**	**278**	**18**	**1**
Regression B	230	260	14.76%	298	38	3
Regression C	230	260	13.11%	294	34	3

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing*	260	278	16.67%	324	46	4
Box Jenkins	260	278	5.40%	293	15	1
Regression A	**260**	**278**	**5.40%**	**293**	**15**	**1**
Regression B	260	278	13.18%	315	37	4
Regression C	260	278	11.26%	309	31	3

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Breast and Cervical Cancer Program: Trend Selections

FY 06-07: 13.04%
FY 07-08: 6.92%
FY 08-09: 5.40%

Breast and Cervical Cancer Program: Justifications

- Clients in this eligibility type exceed Medicaid income guidelines, so it is reasonable to expect that the caseload will continue to grow, as they are not affected by the economy as much as low-income adults and children, and they do not have alternative insurance to utilize.
- This program receives ongoing Tobacco Tax funding to subcontract with clinics that provide screenings. The Department knows of no new clinics coming into the program in FY 07-08, and believes that the leveling off in the number of new clinics providing screenings is reflected in the decreasing monthly growth in caseload.
- The graph in Exhibit Q, page EQ-8 shows caseload steadily increasing from July of 2002 to December of 2004. At that time, 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 Q, page EQ-8.
- Growth in FY 06-07 was lower than the Department's February 2007 forecast in which caseload was projected to be 243. The selected trend for FY 07-08 is lower than that from the February 2007 forecast, and would yield average growth of 1 client per month in FY 07-08. This lower forecasted growth rate reflects the moderating growth experienced over the course of FY 06-07,

which also leaves caseload at a lower staring point for FY 07-08, as well as the fact that no new clinics are expected to be added in FY 07-08.

- Out-year growth rates are projected to continue to moderate. As a program matures, growth is expected to slow. The Department believes that the Breast and Cervical Cancer program has reached a level of maturity where, barring unforeseen circumstances, growth of more than 10% per year is no longer expected.

25.5-5-201 (1), C.R.S. (2007)
(i) Persons who are eligible for the breast and cervical cancer prevention and treatment program pursuant to section 25.5-5-308;

Breast and Cervical Cancer Program: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	32	-	-
Jul-05	171	139	434.38%
Aug-05	178	7	4.09%
Sep-05	186	8	4.49%
Oct-05	192	6	3.23%
Nov-05	191	(1)	-0.52%
Dec-05	191	0	0.00%
Jan-06	198	7	3.66%
Feb-06	181	(17)	-8.59%
Mar-06	178	(3)	-1.66%
Apr-06	188	10	5.62%
May-06	201	13	6.91%
Jun-06	198	(3)	-1.49%
Jul-06	203	5	2.53%
Aug-06	213	10	4.93%
Sep-06	222	9	4.23%
Oct-06	231	9	4.05%
Nov-06	236	5	2.16%
Dec-06	237	1	0.42%
Jan-07	232	(5)	-2.11%
Feb-07	229	(3)	-1.29%
Mar-07	233	4	1.75%
Apr-07	239	6	2.58%
May-07	242	3	1.26%
Jun-07	248	6	2.48%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			7.83%

	Caseload	% Change	Level Change
FY 02-03	46	-	-
FY 03-04	103	123.91%	57
FY 04-05	86	-16.50%	(17)
FY 05-06	188	118.60%	102
FY 06-07	230	22.34%	42
FY 07-08	260	13.04%	30
FY 08-09	278	6.92%	18
FY 09-10	293	5.40%	15

February 2007 Trend Selections			
FY 07-08	294	20.99%	64
FY 08-09	343	16.67%	49

Actuals		
	Monthly Change	% Change
6-month average	2	0.78%
12-month average	4	1.91%
23-month average	211	1.40%

Eligible Children

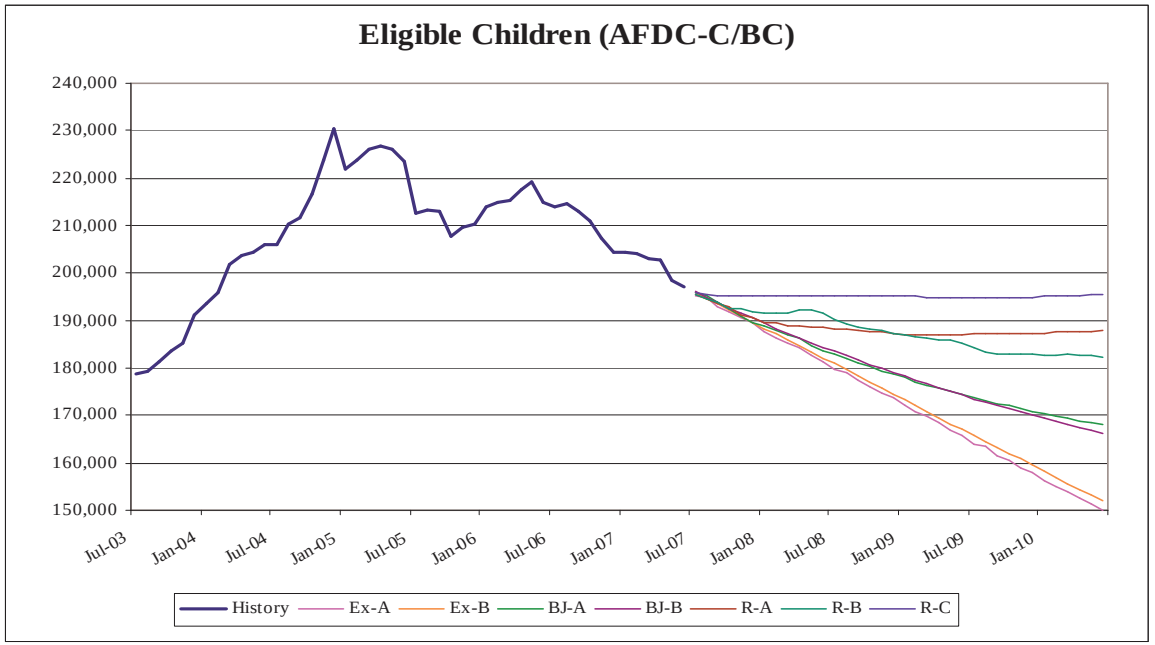
One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 06-07, there were an average of 16,065 children on Transitional Medicaid. Authorization for Transitional Medicaid benefits was extended through September 30, 2007, and the Department's forecast assumes that the program will continue in FY 07-08.

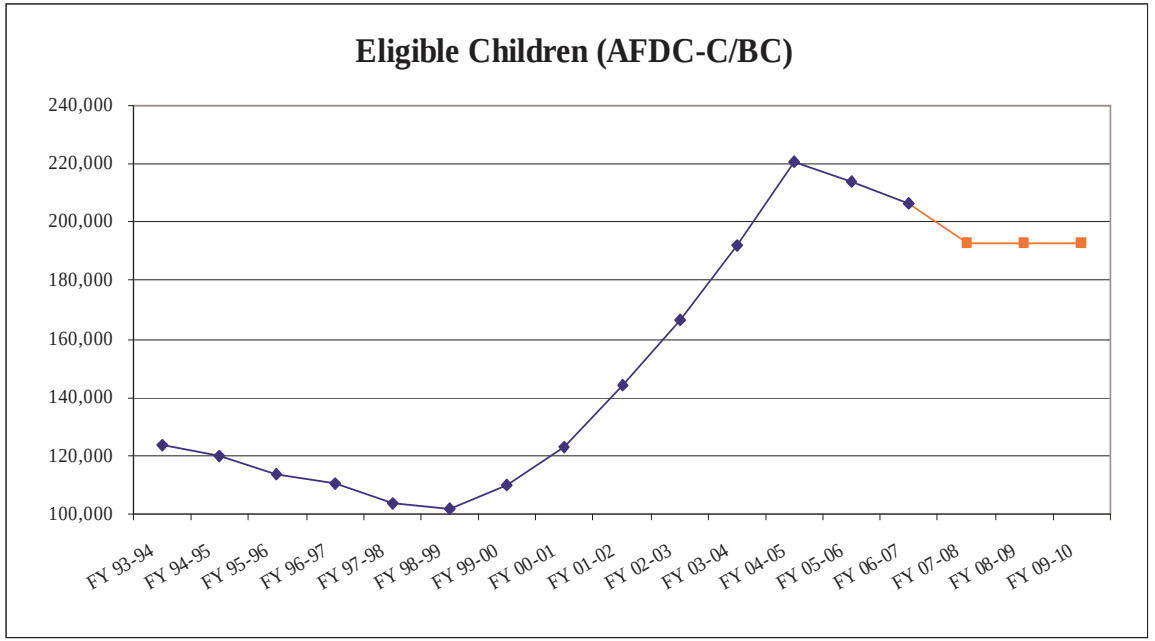
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic 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 and 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 and Kid 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.

Eligible Children: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9978	
Exponential Smoothing A	0.9942	
Box-Jenkins A	0.9982	
Box-Jenkins B	0.9942	
Regression A	0.9982	KIDS [-1], CBMS Dummy, Systems Dummy, Unemployment Rate, Auto [-6]
Regression B	0.9985	KIDS [-1], CBMS Dummy, Systems Dummy, Services Employment, Female Population 19-59, Trend, Auto [-11]
Regression C	0.9983	KIDS [-1], CBMS Dummy, Systems Dummy, Migration, Auto [-2]



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	213,600	206,170	-8.55%	188,542	(17,628)	(1,308)
Exponential Smoothing B	213,600	206,170	-8.33%	188,996	(17,174)	(1,257)
Box Jenkins A	213,600	206,170	-8.00%	189,676	(16,494)	(1,121)
Box Jenkins B*	213,600	206,170	-7.83%	190,027	(16,143)	(1,060)
Regression A	213,600	206,170	-7.34%	191,037	(15,133)	(718)
FY 07-08	**FY 05-06**	**FY 06-07**	**Projected Growth Rate**	**Projected FY 07-08 Caseload**	**Level Change**	**Average Monthly Change [1]**
Regression B	**213,600**	**206,170**	**-6.58%**	**192,604**	**(13,566)**	**(468)**
Regression C	213,600	206,170	-5.29%	195,264	(10,906)	(166)

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	206,170	192,604	-8.32%	176,579	(16,025)	(1,308)
Exponential Smoothing B	206,170	192,604	-7.98%	177,234	(15,370)	(1,257)
Box Jenkins A	206,170	192,604	-5.94%	181,163	(11,441)	(777)
Box Jenkins B*	206,170	192,604	-5.93%	181,183	(11,421)	(844)
Regression A	206,170	192,604	-1.90%	188,945	(3,659)	(122)
Regression B	206,170	192,604	-2.73%	187,346	(5,258)	(528)
Regression C	**206,170**	**192,604**	**-0.10%**	**192,411**	**(193)**	**(19)**

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	192,604	192,411	-9.07%	174,959	(17,452)	(1,308)
Exponential Smoothing B	192,604	192,411	-8.67%	175,729	(16,682)	(1,257)
Box Jenkins A	192,604	192,411	-4.31%	184,118	(8,293)	(535)
Box Jenkins B*	192,604	192,411	-5.02%	182,752	(9,659)	(673)
Regression A	192,604	192,411	0.01%	192,430	19	62
Regression B	192,604	192,411	-2.36%	187,870	(4,541)	(249)
Regression C	**192,604**	**192,411**	**0.02%**	**192,449**	**38**	**53**

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Eligible Children: Trend Selections

FY 07-08: -6.58%
FY 08-09: -0.10%
FY 09-10: 0.02%

Eligible Children: Justifications

- This population is affected by economic conditions in similar ways as the Categorically Eligible Low-Income Adults and Baby Care Adults, as children on Medicaid have eligibility granted as a function of a parent or guardian in most cases. 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 2.3% per year from FY 95-96 to FY 01-02 to about 1.2% per year from FY 02-03 to FY 06-07. The expansion in this age group is projected to rebound to an average of 1.7% throughout the

forecast period.[28] 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 1.8% per year. Similarly, unemployment is expected to remain steady, and wage and salary income is projected to grow by an average of 6.3% per year.

- The graph in Exhibit Q, page EQ-9, 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 before conferring Children's Basic Health Plan eligibility. As more children applied, many were found to be Medicaid eligible and were enrolled in Medicaid. From FY 00-01 to FY 04-05, 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%.
- The declines continued through FY 06-07, which the Department believes indicates that the improving economy is having the expected effect on caseload.
- Under current rules, children who do not provide proper proof of citizenship may not gain Medicaid eligibility, but would still be eligible for the Children's Basic Health Plan, which is not subject to the Deficit Reduction Act. By early FY 07-08, all Medicaid cases should have undergone an annual redetermination under the citizenship requirements of the Deficit Reduction Act. This may reduce the number of children that are moving from Medicaid to the Children's Basic Health Plan. In addition, the number of children moving from the Children's Basic Health Plan to Medicaid due to the removal of the Medicaid asset test should decline at the beginning of FY 07-08, as all Children's Basic Health Plan children will have undergone an annual redetermination.
- The monthly declines in FY 06-07 were smaller than the Department's February 2007 forecast, in which the caseload was projected to be 205,804. The selected trend for FY 07-08 is slightly lower than that from the February 2007 forecast, and would yield average declines of 468 clients per month in FY 07-08. The Department believes that the economy is the most important factor in this change, however it is not known at this time. Because of this, the Department sees no compelling evidence that caseload will not continue to decline. It is possible that caseload declines may be higher in FY 07-08, as the removal of the asset test will be completed by the end of FY 06-07, which may decrease the number of children moving from the Children's Basic Health Plan to Medicaid.
- Similar to the pattern seen in Categorically Eligible Low-Income Adults, out-year trend selections are expected to moderate, reflecting the positive but moderating growth in the economy.
- There is a bottom-line adjustment for HB 06-1270, which establishes medical assistance sites in public schools to allow qualified personnel to make Medicaid eligibility determinations.

[28] Department of Local Affairs, Demography Division.

25.5-5-101 (1), C.R.S. (2007)
(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, 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;

25.5-5-201 (1), C.R.S. (2007)
(a) Individuals who would be eligible for but are not receiving cash assistance;
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
(e) Individuals under the age of twenty-one who would be eligible for aid to families with dependent children but do not qualify as dependent children;
(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.;

25.5-5-205 (3), C.R.S. (2007)
(a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program… (b) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent…;
(c) (I) On and after July 1, 1991, children born after September 30, 1983, who have attained age six but have not attained age nineteen shall be eligible for benefits under the baby and kid care program… (II) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this paragraph (c) shall be one hundred percent;

Eligible Children: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	223,659	-	-
Jul-05	212,576	(11,083)	-4.96%
Aug-05	213,413	837	0.39%
Sep-05	212,975	(438)	-0.21%

	Caseload	% Change	Level Change
FY 93-94	123,653	-	-
FY 94-95	120,034	-2.93%	(3,619)
FY 95-96	113,439	-5.49%	(6,595)
FY 96-97	110,586	-2.52%	(2,853)

	Actuals	Monthly Change	% Change
Oct-05	207,644	(5,331)	-2.50%
Nov-05	209,732	2,088	1.01%
Dec-05	210,394	662	0.32%
Jan-06	213,996	3,602	1.71%
Feb-06	215,042	1,046	0.49%
Mar-06	215,429	387	0.18%
Apr-06	217,685	2,256	1.05%
May-06	219,252	1,567	0.72%
Jun-06	215,060	(4,192)	-1.91%
Jul-06	214,085	(975)	-0.45%
Aug-06	214,766	681	0.32%
Sep-06	212,808	(1,958)	-0.91%
Oct-06	211,000	(1,808)	-0.85%
Nov-06	207,366	(3,634)	-1.72%
Dec-06	204,273	(3,093)	-1.49%
Jan-07	204,363	90	0.04%
Feb-07	204,054	(309)	-0.15%
Mar-07	202,939	(1,115)	-0.55%
Apr-07	202,831	(108)	-0.05%
May-07	198,384	(4,447)	-2.19%
Jun-07	197,166	(1,218)	-0.61%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			-4.37%

February 2007 Trend Selections			
FY 07-08	199,380	-3.12%	(6,790)
FY 08-09	195,711	-1.84%	(3,669)

	Caseload	% Change	Level Change
FY 97-98	103,912	-6.04%	(6,674)
FY 98-99	102,074	-1.77%	(1,838)
FY 99-00	109,816	7.58%	7,742
FY 00-01	123,221	12.21%	13,405
FY 01-02	143,909	16.79%	20,688
FY 02-03	166,537	15.72%	22,628
FY 03-04	192,048	15.32%	25,511
FY 04-05	220,592	14.86%	28,544
FY 05-06	213,600	-3.17%	(6,992)
FY 06-07	206,170	-3.48%	(7,430)
FY 07-08	192,604	-6.58%	(13,566)
FY 08-09	192,411	-0.10%	(193)
FY 09-10	192,449	0.02%	38

HB 06-1270 Adjustments	
FY 07-08	230
FY 08-09	306
FY 09-10	306

Projections After HB 06-1270 Adjustments			
FY 07-08	192,834	-6.47%	(13,336)
FY 08-09	192,717	-0.06%	(117)
FY 09-10	192,755	0.02%	38

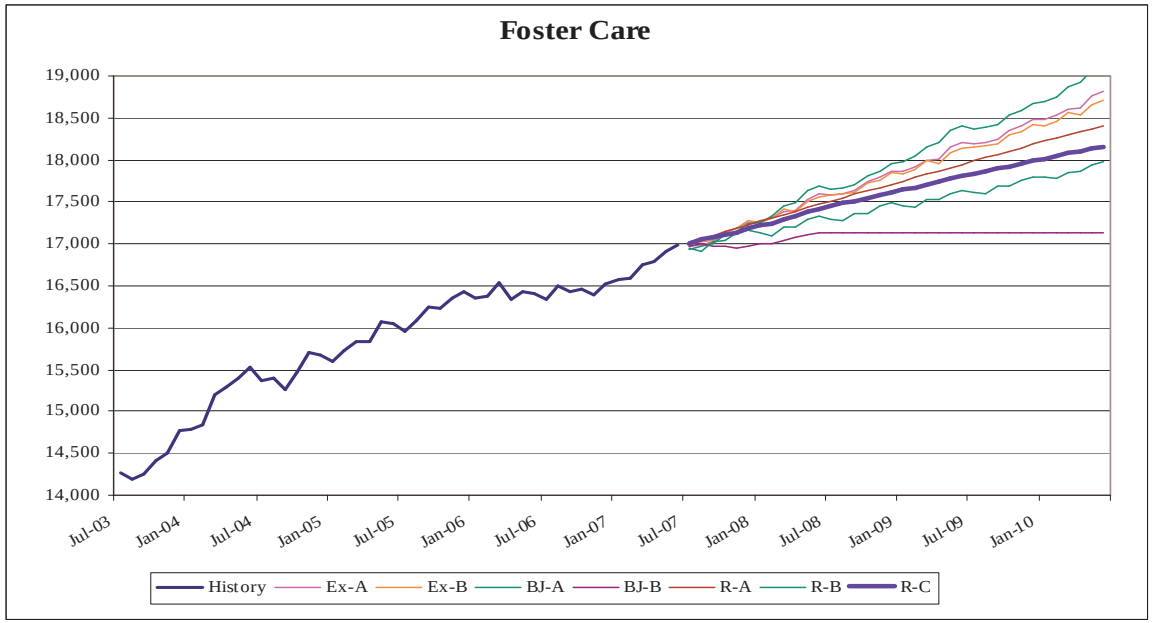
Actuals		
	Monthly Change	% Change
6-month average	(1,185)	-0.59%
12-month average	(1,491)	-0.72%
18-month average	(735)	-0.35%
24-month average	(1,104)	-0.51%

Foster Care

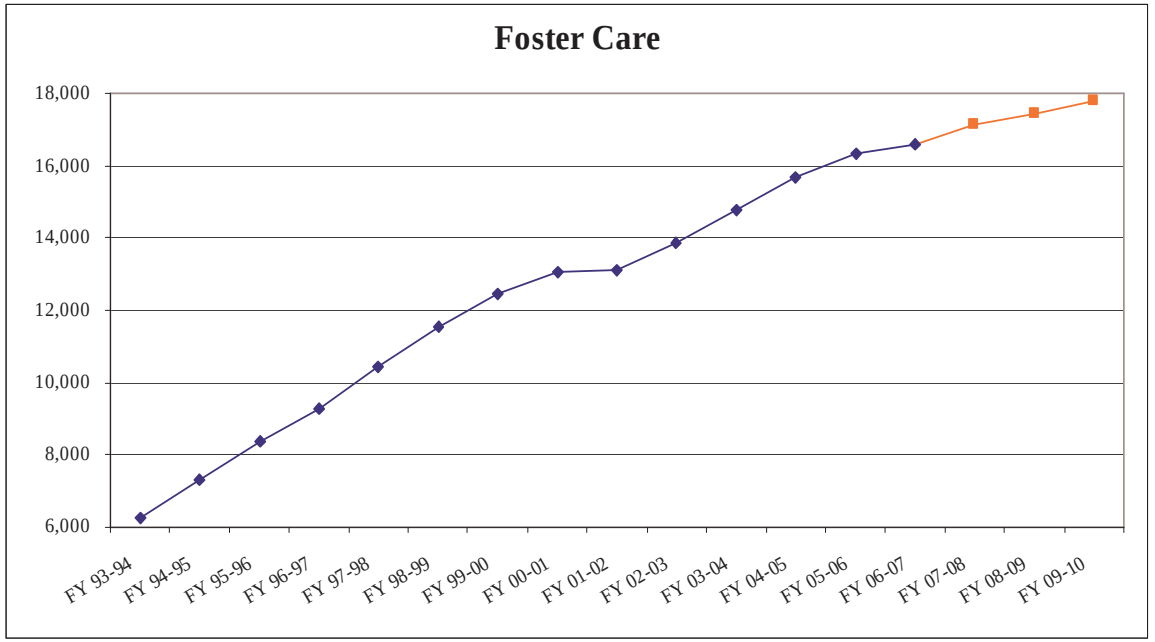
Federal law mandates that states provide Medicaid to individuals under Title IV-E of the Social Security Act (42 U.S.C. 470-479A) for adoption assistance and foster care. Title IV-E is a subpart of Title IV, Child Welfare, of the federal Social Security Act. Title IV-E provides federal reimbursement 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. During the 2007 legislative session, SB 07-002 was passed extending Medicaid eligibility through age 20 for children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act.

Foster Care: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9985	
Exponential Smoothing A	0.9895	
Box-Jenkins A	0.9985	
Box-Jenkins B	0.9878	
Regression A	0.9983	FOSTER [-1], Population Under 19, Auto [-1]
Regression B	0.9971	FOSTER [-6], Total Population, Auto [-1]
Regression C	0.9978	FOSTER [-1], Trend, Auto [-12]



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	16,311	16,601	3.91%	17,250	649	51
Exponential Smoothing B*	16,311	16,601	3.95%	17,257	656	48
Box Jenkins A	16,311	16,601	4.03%	17,270	669	59
Box Jenkins B	16,311	16,601	2.49%	17,014	413	13
Regression A	16,311	16,601	3.88%	17,245	644	41
Regression B	16,311	16,601	3.15%	17,124	523	29
Regression C	**16,311**	**16,601**	**3.62%**	**17,202**	**601**	**36**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	16,601	17,202	3.55%	17,813	611	51
Exponential Smoothing B*	16,601	17,202	3.34%	17,777	575	48
Box Jenkins A	16,601	17,202	4.14%	17,914	712	60
Box Jenkins B	16,601	17,202	0.69%	17,321	119	0

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Regression A	16,601	17,202	2.81%	17,685	483	40
Regression B	16,601	17,202	1.90%	17,529	327	26
Regression C	**16,601**	**17,202**	**2.47%**	**17,627**	**425**	**32**

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	17,202	17,627	3.43%	18,232	605	51
Exponential Smoothing B*	17,202	17,627	3.23%	18,196	569	48
Box Jenkins A	17,202	17,627	3.98%	18,329	702	59
Box Jenkins B	17,202	17,627	0.00%	17,627	0	0
Regression A	17,202	17,627	2.66%	18,096	469	39
Regression B	17,202	17,627	1.89%	17,960	333	27
Regression C	**17,202**	**17,627**	**2.12%**	**18,001**	**374**	**30**

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Foster Care: Trend Selections

FY 06-07: 3.62%
FY 07-08: 2.47 %
FY 08-09: 2.12%

Foster Care: Justifications

- 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 Q, page EQ-10, shows that growth rates in this category since FY 02-03 have been positive and declining over the last three years.
- Given improving economic conditions, there is no evidence to expect that the moderation of the growth rate in this category will not continue.

- Growth in FY 06-07 was in line with the Department's February 2007 forecast, in which caseload was projected to be 16,508. The selected trend for FY 07-08 is slightly higher than that from the February 2007 forecast, and would yield average growth of 29 clients per month in FY 07-08. This higher forecasted growth rate reflects the increasingly strong monthly growth experienced at the end of FY 06-07, which also leaves caseload at a higher starting point in FY 07-08.
- Out-year growth reflects a continuation of positive growth, and a return to more moderate growth in line with historical trend.
- There is a bottom-line adjustment for SB 07-002, which extends Medicaid eligibility through age 20 for children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act.

25.5-5-101 (1), C.R.S. (2007)
(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 (2007)
(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;
(n) Individuals under the age of twenty-one years eligible for medical assistance pursuant to section 25.5-5-101 (1) (e) immediately prior to attaining the age of eighteen years or otherwise becoming emancipated;

Foster Care: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	16,049	-	-
Jul-05	15,958	(91)	-0.57%
Aug-05	16,078	120	0.75%
Sep-05	16,249	171	1.06%
Oct-05	16,237	(12)	-0.07%
Nov-05	16,351	114	0.70%
Dec-05	16,427	76	0.46%
Jan-06	16,348	(79)	-0.48%
Feb-06	16,366	18	0.11%
Mar-06	16,539	173	1.06%
Apr-06	16,334	(205)	-1.24%
May-06	16,437	103	0.63%
Jun-06	16,410	(27)	-0.16%
Jul-06	16,332	(78)	-0.48%
Aug-06	16,492	160	0.98%

	Caseload	% Change	Level Change
FY 93-94	6,243	-	-
FY 94-95	7,300	16.93%	1,057
FY 95-96	8,376	14.74%	1,076
FY 96-97	9,261	10.57%	885
FY 97-98	10,453	12.87%	1,192
FY 98-99	11,526	10.26%	1,073
FY 99-00	12,474	8.22%	948
FY 00-01	13,076	4.83%	602
FY 01-02	13,121	0.34%	45
FY 02-03	13,843	5.50%	722
FY 03-04	14,790	6.84%	947
FY 04-05	15,669	5.94%	879
FY 05-06	16,311	4.10%	642
FY 06-07	16,601	1.78%	290
FY 07-08	17,202	3.62%	601

	Actuals	Monthly Change	% Change
Sep-06	16,430	(62)	-0.38%
Oct-06	16,461	31	0.19%
Nov-06	16,387	(74)	-0.45%
Dec-06	16,512	125	0.76%
Jan-07	16,565	53	0.32%
Feb-07	16,587	22	0.13%
Mar-07	16,754	167	1.01%
Apr-07	16,791	37	0.22%
May-07	16,922	131	0.78%
Jun-07	16,981	59	0.35%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			2.29%

February 2007 Trend Selections			
FY 07-08	16,813	1.85%	212
FY 08-09	17,102	1.72%	289

	Caseload	% Change	Level Change
FY 08-09	17,627	2.47%	425
FY 09-10	18,001	2.12%	374
SB 07-002 Adjustments			
FY 07-08		1,226	
FY 08-09		1,678	
FY 09-10		1,714	

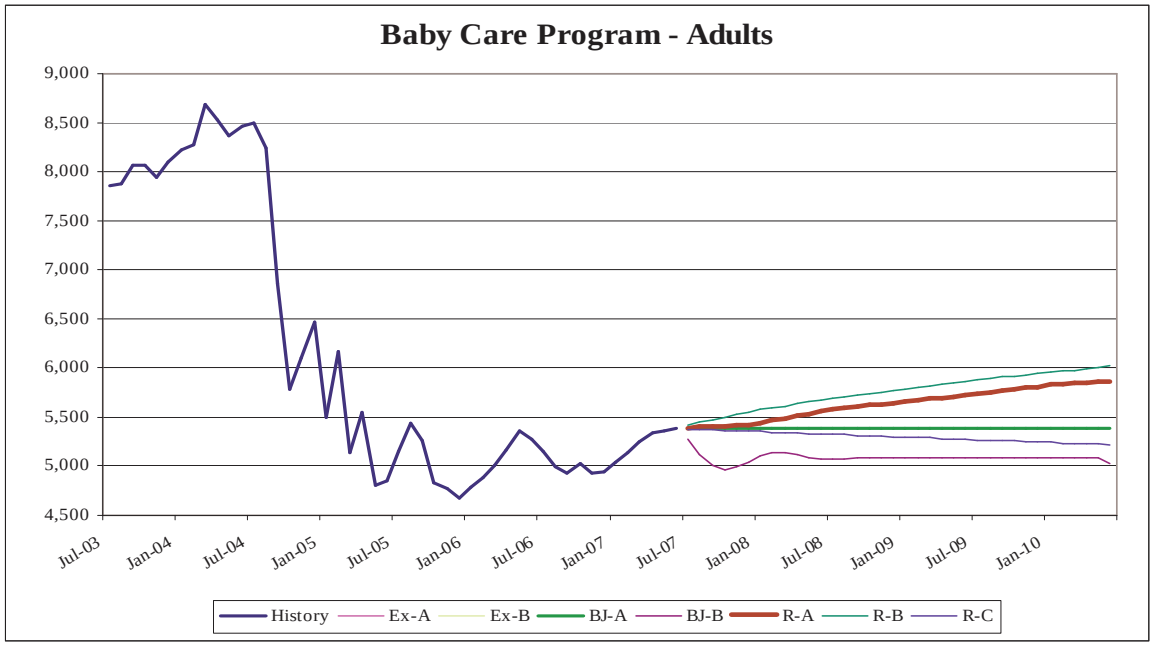
Projections After SB 07-002 Adjustments			
FY 07-08	18,428	11.01%	1,827
FY 08-09	19,305	4.76%	877
FY 09-10	19,715	2.12%	410

Actuals		
	Monthly Change	% Change
6-month average	78	0.47%
12-month average	48	0.29%
18-month average	31	0.19%
24-month average	39	0.24%

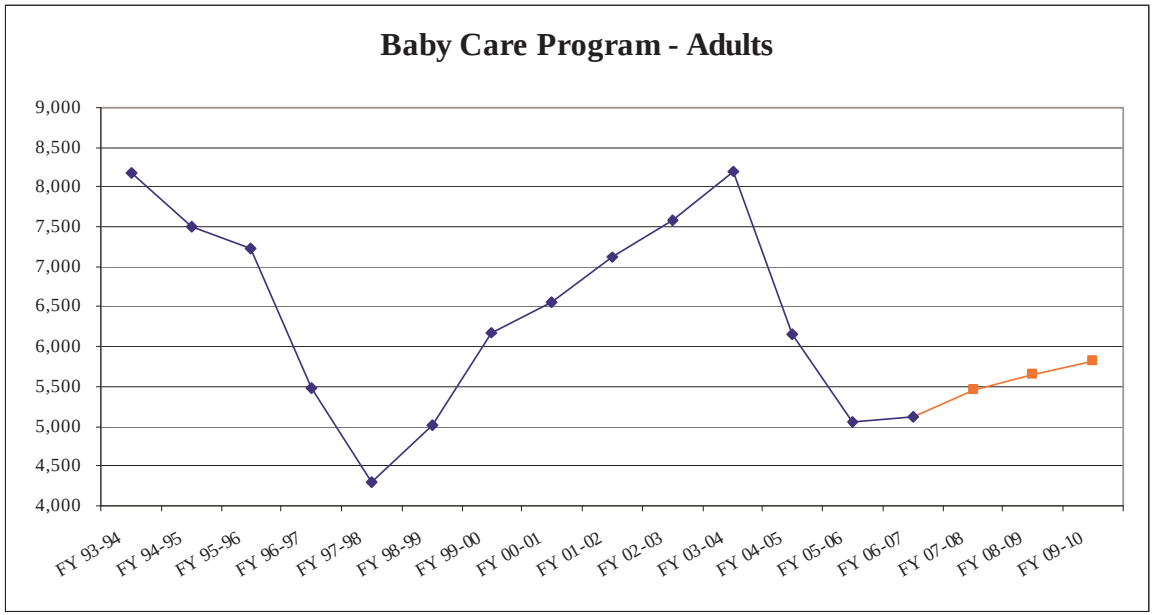
Baby Care Adults

Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, the program was authorized through 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 and Kid Care Program serves a much higher income level than the 1931 families program, and pregnant mothers were never subject to resource/asset limitations to qualify for the program. Moreover, the Baby and Kid Care Program has never had a cash-assistance component and was unaffected by welfare reform.

Baby Care Program- Adults: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9454	
Exponential Smoothing A	0.5246	After July 2005
Box-Jenkins A	0.9457	
Box-Jenkins B	0.7060	After July 2005
Regression A	0.9559	BCA [-1], Total Employment, Female Population 19-59, BCA Dummy
Regression B	0.9556	BCA [-1], Births, Female Population 19-59, BCA Dummy, Auto [-1]
Regression C	0.9553	BCA [-1], BCA Dummy



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	5,050	5,123	5.02%	5,380	257	0
Exponential Smoothing B*	5,050	5,123	5.04%	5,381	258	0
Box Jenkins A*	5,050	5,123	5.04%	5,381	258	0
Box Jenkins B	5,050	5,123	-0.70%	5,087	(36)	(26)
Regression A	**5,050**	**5,123**	**6.44%**	**5,453**	**330**	**15**
Regression B	5,050	5,123	8.39%	5,553	430	24
Regression C	5,050	5,123	4.45%	5,351	228	(5)

Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	5,123	5,453	0.00%	5,453	0	0
Exponential Smoothing B*	5,123	5,453	0.00%	5,453	0	0
Box Jenkins A*	5,123	5,453	0.00%	5,453	0	0
Box Jenkins B	5,123	5,453	-0.06%	5,450	(3)	1

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Regression A	**5,123**	**5,453**	**3.59%**	**5,649**	**196**	**13**
Regression B	5,123	5,453	4.09%	5,676	223	16
Regression C	5,123	5,453	-1.03%	5,397	(56)	(5)
FY 09-10	**FY 07-08 Projected Caseload**	**FY 08-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 09-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	5,453	5,649	0.00%	5,649	0	0
Exponential Smoothing B*	5,453	5,649	0.00%	5,649	0	0
Box Jenkins A*	5,453	5,649	0.00%	5,649	0	0
Box Jenkins B	5,453	5,649	-0.04%	5,647	(2)	(5)
Regression A	**5,453**	**5,649**	**2.81%**	**5,808**	**159**	**12**
Regression B	5,453	5,649	2.92%	5,814	165	14
Regression C	5,453	5,649	-1.02%	5,591	(58)	(5)

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Baby Care Program- Adults: Trend Selections

FY 06-07: 6.44%
FY 07-08: 3.59%
FY 08-09: 2.81%

Baby Care Program- Adults: Justifications

- This population is affected by the economy in similar ways as the Low-Income Adults and Children populations, although the effects are mitigated given that these clients have incomes up to 133% of the federal poverty level.
- Caseload trends for this category shown in Exhibit Q, page EQ-11, 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%.[29] However, from 1991 to 2002 teen pregnancy rates in Colorado fell 19%.[30] 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 (Tobacco Tax bill) effective July 1, 2005.
- Models in this aid category are heavily influenced by the caseload decline due to the end of the presumptive eligibility program in 2004. The exponential smoothing and Box-Jenkins models do not reflect the reimplementation of presumptive eligibility. The volatility in this population forces many forecasts to be flat, even after accounting for presumptive eligibility.
- Growth in FY 06-07 was higher than the Department's February 2007 forecast in which caseload was projected to be 4,949. The selected trend for FY 07-08 is much higher than that from the February 2007 forecast, and would yield average growth of 15 clients per month in FY 07-08. This higher forecasted growth rate reflects the strong monthly growth experienced at the end of FY 06-07, which also leaves caseload at a higher starting point in FY 07-08. The Department does not know the cause of the volatility experienced at the beginning of FY 06-07, but such volatility and consecutive months of declines are not unprecedented.
- Out-year trends moderate slightly assuming a stable economy. The growth rates reflect monthly growth in line with the long-term trend.

25.5-5-101 (1), C.R.S. (2007)
(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;

25.5-5-205 (3), C.R.S. (2007)
(a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program… (b) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent…;

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

Baby Care Program- Adults: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	4,846	-	-
Jul-05	5,151	305	6.29%
Aug-05	5,434	283	5.49%
Sep-05	5,259	(175)	-3.22%
Oct-05	4,834	(425)	-8.08%
Nov-05	4,775	(59)	-1.22%
Dec-05	4,682	(93)	-1.95%
Jan-06	4,778	96	2.05%
Feb-06	4,887	109	2.28%
Mar-06	5,009	122	2.50%
Apr-06	5,161	152	3.03%
May-06	5,354	193	3.74%
Jun-06	5,273	(81)	-1.51%
Jul-06	5,152	(121)	-2.29%
Aug-06	4,990	(162)	-3.14%
Sep-06	4,926	(64)	-1.28%
Oct-06	5,026	100	2.03%
Nov-06	4,927	(99)	-1.97%
Dec-06	4,948	21	0.43%
Jan-07	5,042	94	1.90%
Feb-07	5,133	91	1.80%
Mar-07	5,252	119	2.32%
Apr-07	5,347	95	1.81%
May-07	5,356	9	0.17%
Jun-07	5,381	25	0.47%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			5.04%

	Caseload	% Change	Level Change
FY 93-94	8,183	-	-
FY 94-95	7,510	-8.22%	(673)
FY 95-96	7,223	-3.82%	(287)
FY 96-97	5,476	-24.19%	(1,747)
FY 97-98	4,295	-21.57%	(1,181)
FY 98-99	5,017	16.81%	722
FY 99-00	6,174	23.06%	1,157
FY 00-01	6,561	6.27%	387
FY 01-02	7,131	8.69%	570
FY 02-03	7,579	6.28%	448
FY 03-04	8,203	8.23%	624
FY 04-05	6,162	-24.88%	(2,041)
FY 05-06	5,050	-18.05%	(1,112)
FY 06-07	5,123	1.45%	73
FY 07-08	5,453	6.44%	330
FY 08-09	5,649	3.59%	196
FY 09-10	5,808	2.81%	159

February 2007 Trend Selections			
FY 07-08	4,926	-0.46%	(197)
FY 08-09	4,948	0.45%	22

Actuals		
	Monthly Change	% Change
6-month average	72	1.41%
12-month average	9	0.19%
18-month average	39	0.80%
24-month average	22	0.48%

Non-Citizens

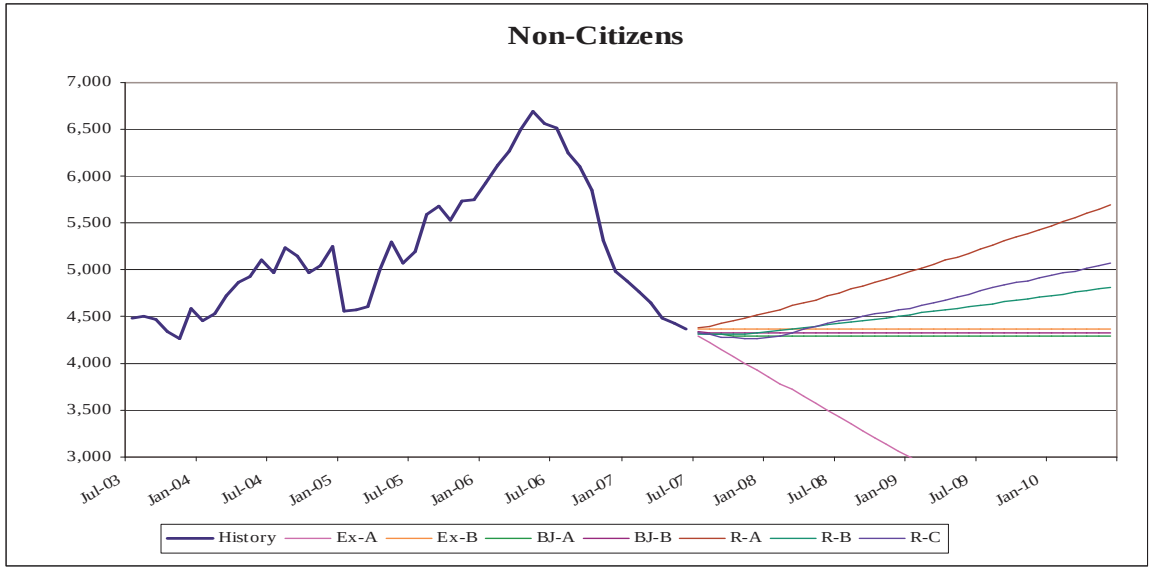
Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived 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 quarters of Social Security coverage;
- Cuban or Haitian entrants; and,
- Immigrants who are honorably discharged veterans of the United States military.

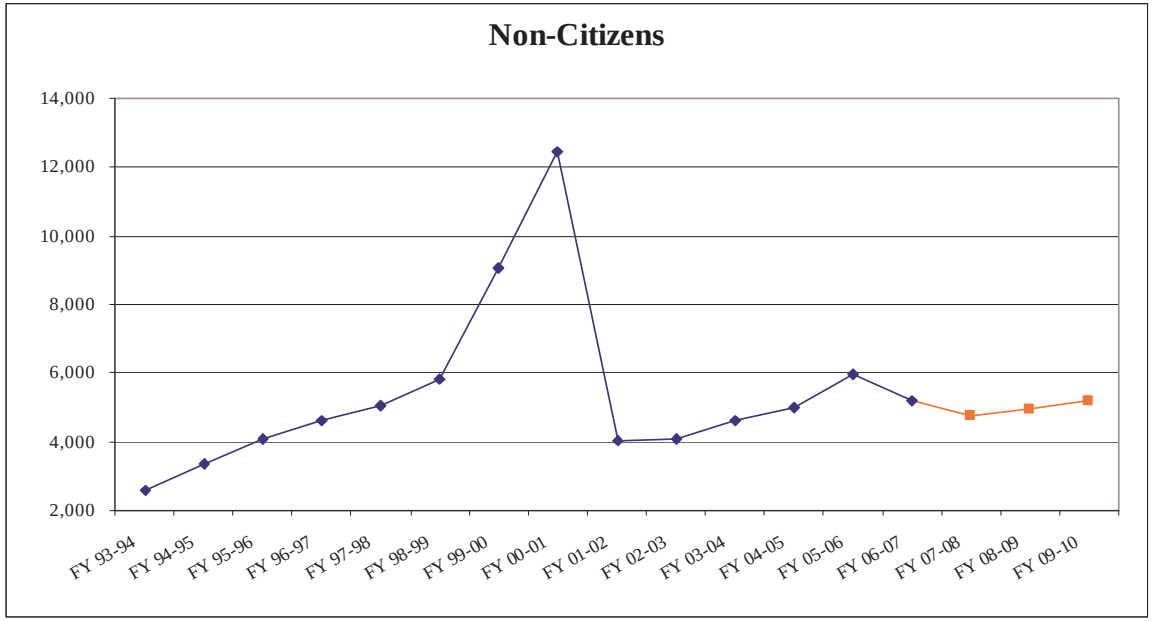
Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. citizenship.

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 Q, page EQ-12.

Non-Citizens: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9624	
Exponential Smoothing A	0.8809	After June 2001
Box-Jenkins A	0.9767	
Box-Jenkins B	0.8985	After June 2001
Regression A	0.9846	ALIEN [-1], Alien Dummy, Female Population 19-59, Migration
Regression B	0.9882	ALIEN [-1], ALIEN [-2], Alien Dummy, Auto [-3]
Regression C	0.9877	ALIEN [-1], Alien Dummy, Unemployment Rate, Auto [-1], Auto [-2]



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	5,959	5,214	-25.34%	3,893	(1,321)	(72)
Exponential Smoothing B	5,959	5,214	-16.36%	4,361	(853)	0
Box Jenkins A	5,959	5,214	-17.53%	4,300	(914)	(6)
Box Jenkins B*	5,959	5,214	-17.09%	4,323	(891)	(3)
Regression A	5,959	5,214	-12.98%	4,537	(677)	30
Regression B	5,959	5,214	-16.76%	4,340	(874)	4
Regression C	5,959	5,214	-17.22%	4,316	(898)	5

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	5,214	4,762	-22.17%	3,706	(1,056)	(72)
Exponential Smoothing B	5,214	4,762	0.00%	4,762	0	0
Box Jenkins A	5,214	4,762	-0.14%	4,755	(7)	0
Box Jenkins B*	5,214	4,762	-0.05%	4,760	(2)	0
Regression A	5,214	4,762	9.35%	5,207	445	39
Regression B	**5,214**	**4,762**	**4.01%**	**4,953**	**191**	**16**
Regression C	5,214	4,762	6.35%	5,064	302	27

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	4,762	4,953	-28.51%	3,541	(1,412)	(72)
Exponential Smoothing B	4,762	4,953	0.00%	4,953	0	0
Box Jenkins A	4,762	4,953	0.00%	4,953	0	0
Box Jenkins B*	4,762	4,953	0.00%	4,953	0	0
Regression A	4,762	4,953	9.92%	5,444	491	42
Regression B	**4,762**	**4,953**	**4.46%**	**5,174**	**221**	**17**
Regression C	4,762	4,953	7.32%	5,316	363	28

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Non-Citizens: Trend Selections

FY 06-07: -8.67%
FY 07-08: 4.01%
FY 08-09: 4.46%

Non-Citizens: Justifications

- The graph in Exhibit Q, page EQ-12 also illustrates that the caseload in this category has had a positive trend between FY 02-03 and FY 05-06. 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.[31]

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

- Expenditures in this category did not decline along with caseload in FY 06-07. Until October 2006, the eligibility spans for pregnant clients who delivered in Non-citizens were left open for 60 days post partum in case of an emergency. These clients, however, rarely utilized any services. The caseload declines in FY 06-07 may indicate that eligibility spans for the Non-citizens clients are now being ended sooner. In addition, it is possible that some undocumented citizens are not applying for Medicaid emergency services out of fear due to the Deficit Reduction Act and HB 06S-1023 identification requirements, even though the Medicaid application clearly states that emergency services are exempt. Although the effects of these state and federal legislations, as well as the 60 day post partum policy change, are unquantifiable, the Department believes that the declines experienced in FY 06-07 are likely to abate.
- Growth in FY 06-07 was lower than the Department's February 2007 forecast, in which the caseload was projected to be 5,406. The selected trend for FY 07-08 is much lower than that from the February 2007 forecast, and would yield average growth of 62 clients per month in FY 07-08. Though caseload is forecasted to increase over the course of FY 07-08, the annual decline reflects the strong monthly decreases experienced in FY 06-07, which leaves caseload at a lower starting point in FY 07-08. Despite the recent monthly declines, this caseload has historically shown resistance to approaching 4,000. This eligibility type should have a lower limit, as it is comprised largely of pregnant women and there will always be a certain number of pregnant women in the State. The Department believes that it is reasonable to expect that over the course of FY 07-08, caseload will increase by approximately as much as it declined during the second half of FY 06-07.
- The out-year trends assume moderate growth for the reasons noted above.

25.5-5-103 (3), C.R.S. (2007)
(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.

Non-Citizens: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	5,074	-	-
Jul-05	5,187	113	2.23%
Aug-05	5,588	401	7.73%
Sep-05	5,670	82	1.47%
Oct-05	5,523	(147)	-2.59%
Nov-05	5,732	209	3.78%
Dec-05	5,744	12	0.21%
Jan-06	5,930	186	3.24%

	Caseload	% Change	Level Change
FY 93-94	2,597	-	-
FY 94-95	3,360	29.38%	763
FY 95-96	4,100	22.02%	740
FY 96-97	4,610	12.44%	510
FY 97-98	5,032	9.15%	422
FY 98-99	5,799	15.24%	767
FY 99-00	9,065	56.32%	3,266
FY 00-01	12,451	37.35%	3,386

	Actuals	Monthly Change	% Change
Feb-06	6,120	190	3.20%
Mar-06	6,265	145	2.37%
Apr-06	6,496	231	3.69%
May-06	6,689	193	2.97%
Jun-06	6,563	(126)	-1.88%
Jul-06	6,514	(49)	-0.75%
Aug-06	6,248	(266)	-4.08%
Sep-06	6,103	(145)	-2.32%
Oct-06	5,849	(254)	-4.16%
Nov-06	5,306	(543)	-9.28%
Dec-06	4,978	(328)	-6.18%
Jan-07	4,888	(90)	-1.81%
Feb-07	4,762	(126)	-2.58%
Mar-07	4,649	(113)	-2.37%
Apr-07	4,480	(169)	-3.64%
May-07	4,424	(56)	-1.25%
Jun-07	4,361	(63)	-1.42%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			-16.36%

	Caseload	% Change	Level Change
FY 01-02	4,028	-67.65%	(8,423)
FY 02-03	4,101	1.81%	73
FY 03-04	4,604	12.27%	503
FY 04-05	4,976	8.08%	372
FY 05-06	5,959	19.75%	983
FY 06-07	5,214	-12.50%	(745)
FY 07-08	4,762	-8.67%	(452)
FY 08-09	4,953	4.01%	191
FY 09-10	5,174	4.46%	221

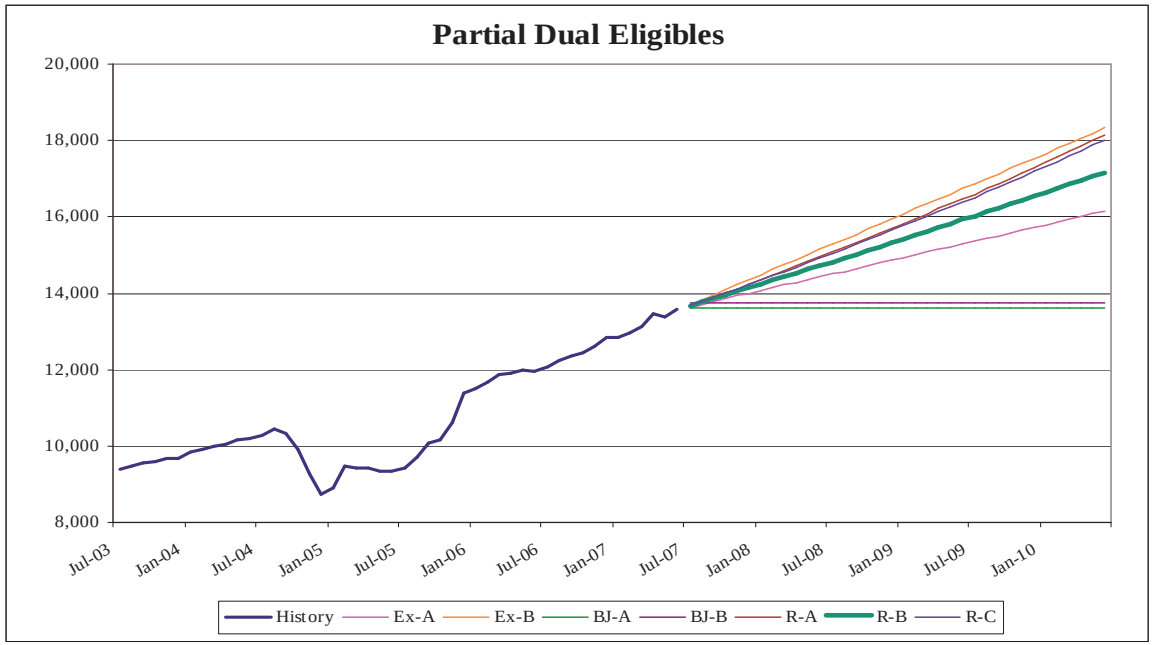
February 2007 Trend Selections			
FY 07-08	5,406	0.00%	192
FY 08-09	5,843	8.08%	437

Actuals		
	Monthly Change	% Change
6-month average	(103)	-2.18%
12-month average	(184)	-3.32%
18-month average	(77)	-1.46%
24-month average	(30)	-0.56%

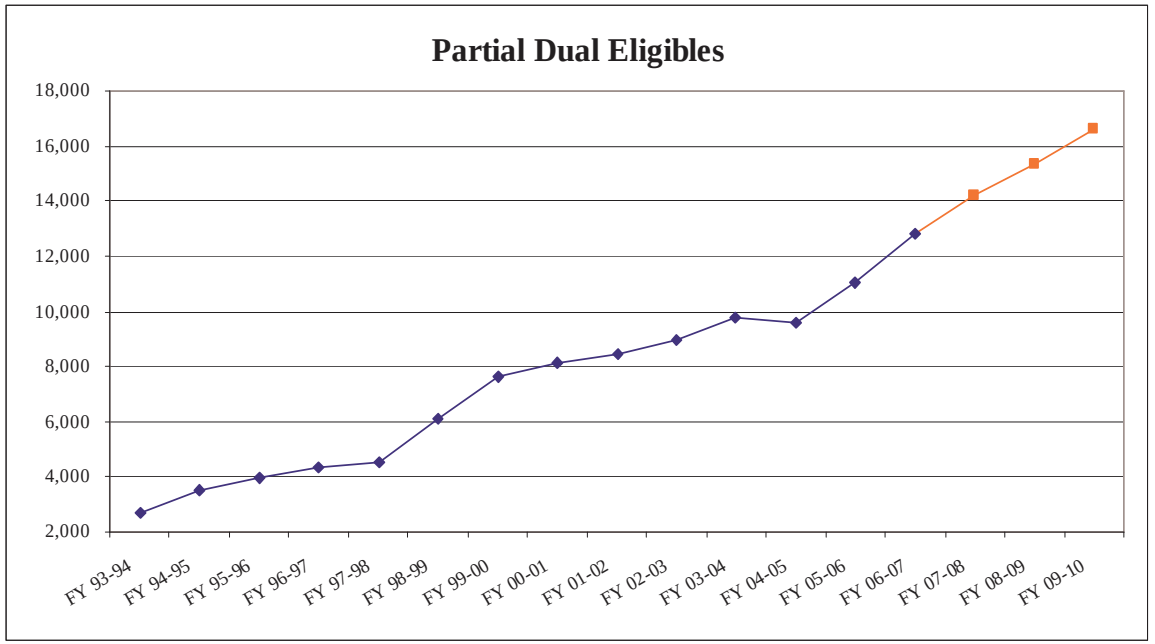
Partial Dual Eligibles

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. This group, formerly known as Qualified Medicare Beneficiaries/ Special Low Income Medicare Beneficiaries, is now collectively known as Partial Dual Eligibles. 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.

Partial Dual Eligibles: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9955	
Exponential Smoothing A	0.9878	
Box-Jenkins A	0.9955	
Box-Jenkins B	0.9895	
Regression A	0.9986	PDE[-1], PDE Dummy, CBMS Dummy
Regression B	0.9958	PDE [-1], PDE [-2],CBMS Dummy, Population 65+
Regression C	0.9986	PDE [-1], PDE [-2], PDE Dummy, CBMS Dummy



FY 07-08	FY 05-06	FY 06-07	Projected Growth Rate	Projected FY 07-08 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	11,012	12,818	9.45%	14,029	1,211	72
Exponential Smoothing B	11,012	12,818	12.51%	14,422	1,604	132
Box Jenkins A	11,012	12,818	6.29%	13,624	806	5
Box Jenkins B*	11,012	12,818	7.29%	13,752	934	16
Regression A	11,012	12,818	11.55%	14,298	1,480	115
Regression B	**11,012**	**12,818**	**10.69%**	**14,188**	**1,370**	**96**
Regression C	11,012	12,818	11.48%	14,290	1,472	113

Denotes Expert Selection, Bold denotes Trend Selection

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	12,818	14,188	6.14%	15,059	871	72
Exponential Smoothing B	12,818	14,188	11.00%	15,749	1,561	132
Box Jenkins A	12,818	14,188	0.01%	14,189	1	0
Box Jenkins B*	12,818	14,188	0.00%	14,188	0	0

FY 08-09	FY 06-07	FY 07-08 Projected Caseload	Projected Growth Rate	Projected FY 08-09 Caseload	Level Change	Average Monthly Change [1]
Regression A	12,818	14,188	10.18%	15,632	1,444	127
Regression B	**12,818**	**14,188**	**8.26%**	**15,360**	**1,172**	**100**
Regression C	12,818	14,188	9.90%	15,593	1,405	123

FY 09-10	FY 07-08 Projected Caseload	FY 08-09 Projected Caseload	Projected Growth Rate	Projected FY 09-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	14,188	15,360	5.79%	16,249	889	72
Exponential Smoothing B	14,188	15,360	9.91%	16,882	1,522	132
Box Jenkins A	14,188	15,360	0.00%	15,360	0	0
Box Jenkins B*	14,188	15,360	0.00%	15,360	0	0
Regression A	14,188	15,360	10.18%	16,924	1,564	140
Regression B	**14,188**	**15,360**	**8.01%**	**16,590**	**1,230**	**105**
Regression C	14,188	15,360	9.90%	16,881	1,521	135

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Partial Dual Eligibles: Trend Selections

FY 06-07: 10.69%
FY 07-08: 8.26%
FY 08-09: 8.01%

Partial Dual Eligibles: Justification

- These clients have higher income than Adults 65 and Older or Disabled Adults 60 to 64, and are relatively healthy. Given the increased life expectancy, more people are living healthier longer, which would support strong growth rates in this population. In addition, this population may start to be affected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in CY 2006.
- 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 graph in Exhibit Q, page EQ-13, 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 as a result of the court order regarding the Colorado Benefits Management System.
- The relatively strong growth since the beginning of FY 05-06 may be due to a wood work effect from Medicare Modernization Act, under which Medicare Part D clients are screened for Medicaid as they apply for the low-income subsidy.

- Growth in FY 06-07 was in line with the Department's February 2007 forecast, in which caseload was projected to be 12,810. The selected trend for FY 07-08 is similar to that from the February 2007 forecast, and would yield average growth of 96 clients per month in FY 07-08.
- Out-year trend selections moderate to growth in line with historic rates, reflecting the stable economy and the complete incorporation of baby boomers and any clients affected by the Medicare Modernization Act.

25.5-5-101 (1), C.R.S. (2007)
(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".

25.5-5-104, C.R.S. (2007)
Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation.

25.5-5-105, C.R.S. (2007)
Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus Budget Reconciliation Act of 1989", or subsequent amending federal legislation. The state department is hereby designated as the single state agency to administer benefits available to qualified disabled and working individuals. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government.

Partial Dual Eligibles: Historical Caseload and Forecasts

	Actuals	Monthly Change	% Change
Jun-05	9,336	-	-
Jul-05	9,416	80	0.86%
Aug-05	9,710	294	3.12%
Sep-05	10,063	353	3.64%
Oct-05	10,162	99	0.98%
Nov-05	10,584	422	4.15%
Dec-05	11,378	794	7.50%
Jan-06	11,491	113	0.99%
Feb-06	11,673	182	1.58%
Mar-06	11,850	177	1.52%
Apr-06	11,891	41	0.35%

	Caseload	% Change	Level Change
FY 93-94	2,727	-	-
FY 94-95	3,490	27.98%	763
FY 95-96	3,937	12.81%	447
FY 96-97	4,316	9.63%	379
FY 97-98	4,560	5.65%	244
FY 98-99	6,104	33.86%	1,544
FY 99-00	7,597	24.46%	1,493
FY 00-01	8,157	7.37%	560
FY 01-02	8,428	3.32%	271
FY 02-03	8,949	6.18%	521
FY 03-04	9,787	9.36%	838

	Actuals	Monthly Change	% Change
May-06	11,994	103	0.87%
Jun-06	11,934	(60)	-0.50%
Jul-06	12,050	116	0.97%
Aug-06	12,250	200	1.66%
Sep-06	12,349	99	0.81%
Oct-06	12,438	89	0.72%
Nov-06	12,594	156	1.25%
Dec-06	12,837	243	1.93%
Jan-07	12,833	(4)	-0.03%
Feb-07	12,958	125	0.97%
Mar-07	13,109	151	1.17%
Apr-07	13,453	344	2.62%
May-07	13,387	(66)	-0.49%
Jun-07	13,562	175	1.31%
Base trend if caseload were to stay at the June 2007 level in FY 07-08			5.80%

	Caseload	% Change	Level Change
FY 04-05	9,572	-2.20%	(215)
FY 05-06	11,012	15.04%	1,440
FY 06-07	12,818	16.40%	1,806
FY 07-08	14,188	10.69%	1,370
FY 08-09	15,360	8.26%	1,172
FY 09-10	16,590	8.01%	1,230

February 2007 Trend Selections			
FY 07-08	14,185	10.73%	1,367
FY 08-09	15,355	8.25%	1,170

Actuals		
	Monthly Change	% Change
6-month average	121	0.92%
12-month average	136	1.07%
18-month average	121	0.98%
24-month average	176	1.58%

Summary

The Department is forecasting a FY 07-08 total Medicaid caseload of 379,715, a 3.40% decrease from FY 05-06. The trend is projected to moderate in FY 08-09, and caseload is expected to increase by 0.88% to 383,067.

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.

Rationale For Grouping Services For Projection Purposes

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

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

Acute Care:

- Physicians Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health

- Presumptive Eligibility

Community Based Long Term Care:
- Home and Community Based Services: Elderly, Blind and Disabled waiver
- Home and Community Based Services: Mental Illness waiver
- Home and Community Based Services: Disabled Children waiver
- Home and Community Based Services: Persons Living with AIDS waiver
- Home and Community Based Services: Consumer Directed Attendant Support waiver
- Home and Community Based Services: Brain Injury waiver
- Home and Community Based Services: Children with Autism waiver
- Private Duty Nursing
- Hospice

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

Insurance *(a summary of the totals of individual service calculations, not a grouped calculation):*
- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management *(a summary of the totals of individual calculations, not a grouped calculation):*
- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request (Page EA-1)

This page is new to the November 1, 2007 Budget Request, although the information presented on this page was previously contained in other pages in Exhibit A. For the current year, the Department sums total spending authority by fund source, including the Long

Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from page EA-2. The difference between the two figures is the Department's Estimate of Need in the November Budget Request, and the Department's Supplemental Request in the February Supplemental Budget Request.

For the request year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-3. The difference between the two figures is the Department's Decision/Base Reduction Item for FY 08-09 in the November Budget Request, and the Department's Budget Amendment in the February Supplemental Budget Request.

Totals on this page correspond with Columns 3, 5, and 8 on the Schedule 13, as appropriate.

Calculation of Fund Splits (pages EA-2 and EA-3)

These pages have been reformatted for the November 1, 2007 Budget Request; some information has been relocated to page EA-1, as described above. These pages take the total estimated expenditure by service group and calculate the required source of funding for each. For each service category, the federal financial participation rate (FFP, also known as the federal match rate) is listed on the right-hand side of the table. The federal financial participation calculations reflect the participation rate 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 law.

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g. Acute Care) by programs which are funded with either a different state source or a different federal financial participation rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

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

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate. To determine state funding, the population is separated into two groups: traditional clients, and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308 (9), C.R.S. (2007). For FY 07-08, 75% of total state funding comes from the General Fund, and 25% of state funding comes from the Breast and Cervical Cancer

Prevention and Treatment Fund. For FY 08-09, 100% of the state funding comes from the General Fund. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive state funding through the Prevention, Early Detection, and Treatment fund. Please see Exhibit F, page 6 for calculations.

- Prenatal Costs: A portion of Acute Care expenditure is for prenatal care for Non-Citizens. Prenatal services are provided as a state-only option and therefore must be funded through 100% General Fund. Delivery costs qualify for the standard 50% federal financial participation rate. For further information, 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-4 through EA-7 for calculation of the fund split for the Health Care Expansion Fund.

- Indian Health Services: The federal financial participation rate 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: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 80% of the total will receive federal financial participation, while 20% will be provided as a state-only option.

- Single Entry Point: A portion of this line item is for clients who do not receive Medicaid coverage (4%) and does not receive federal financial participation. Instead this portion must be funded through 100% General Fund.

- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom line adjustment to total expenditures.

- Denver Health Outstationing: 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. The FY 07-08 and FY 08-09 totals are based on the total amount Denver Health Medical Center was able to certify in FY 06-07.

- HB 03-1292 ICR-MR Fee: This bill permitted the Department of Human Services to collect a service fee for the purposes of maintaining the quality and continuity of services provided by intermediate care facilities for the mentally retarded (ICF-MR). Fees assessed to public ICFs-MR are transferred to the Department of Health Care Policy and Financing in order to receive a federal match. However, the Department of Human Services has never collected a fee from the Department's only public ICF-MR, and in conversations with Department of Human Services staff, it does not appear that the Department of Human Services will collect this fee in the foreseeable future. Therefore, the Department has removed the fund split adjustment for this fee.

Additionally, all bill annualizations have been relocated from page EA-3 to page EA-1.

Health Care Expansion Fund (pages EA-4 through EA-7)

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 divided out in the Federal Match Calculation, Exhibit A, pages EA-2 and EA-3 splitting the request by General Fund, Cash Funds Exempt, and federal funds accordingly. To isolate certain expenditures, the Department performs bottom line adjustments to allocate expenditure to the Health Care Expansion Fund. For simplicity, pages EA-4 through EA-7 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-2 and EA-3). The following programs are funded via the Health Care Expansion Fund:

a. Expansion Adults
b. Expansion Foster Care (SB 07-002)
c. Presumptive eligibility
d. Legal Immigrants
e. Removal of Medicaid asset test (children expansion)
f. Removal of Medicaid asset test (adult expansion)
g. Children's Home and Community Based Services – State Plan and waiver services
h. Children's Extensive Support – State Plan services

The Department's projections for Expansion Adults and Expansion Foster Care are part of the regular projection methodology for Medical Services Premiums, contained in Exhibits F, G, H, and I.

The Department's projections for presumptive eligibility, Legal Immigrants, the removal of the Medicaid asset test (adult and children expansion), Children's Home and Community Based Services, and Children's Extensive Support are described in detail in the Tobacco Tax Update, Section Q of this Budget Request.

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.

EXHIBIT B - MEDICAID CASELOAD PROJECTION AND REQUEST WITHOUT RETROACTIVITY

This exhibit is described in the Medicaid Caseload Budget Narrative section.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

Medical Services Premiums per capita costs history (through FY 06-07) and projections are included for historical reference and comparison, and are calculated on a cash-accounting basis.

EXHIBIT D - SUMMARY OF REQUEST BY ELIGIBILITY CATEGORY

The exhibit displays the Medical Services Premiums caseload, per capita costs and expenditure projections for the current year and the request year by eligibility category. Projections include Upper Payment Limit Financing and other financing. Caseload does not include retroactivity.

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Page EE-1 of this exhibit is a summary of the requests by service group and by eligibility category for the current year and the request year.

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 8, 2007 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 13.

EXHIBIT F - ACUTE CARE CALCULATIONS

Calculation of Acute Care Expenditure (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 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 the current year. To calculate the request year, the same methodology is applied to the projected request year 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 and FY 06-07 per capita costs for eligibility categories with significant amounts of dual-eligibles are skewed by the new Part D benefit. In Adults 65 and Older (OAP-A), Disabled Adults 60 to 64 (OAP-B), and Disabled Individuals to 59 (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, FY 05-06, and FY 06-07. 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 08-09 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. The half-year per capita costs and expenditures at the end of Exhibit F were used to assist in the trend selection.

The table below describes the trend selections for FY 07-08 and FY 08-09. 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 07-08 and FY 08-09, with the rationale for selection, are as follows:

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	4-Year Average of FY 03-04 through FY 06-07 (Without RX) 1.67%	4-Year Average of FY 03-04 through FY 06-07 (Without RX) 1.67%	Despite per capita declines in FY 05-06 and FY 06-07 (without RX), the Department anticipates that per capita costs will grow in FY 07-08 and FY 08-09. A comparison of expenditure between the first and second half of FY 06-07 shows a sharp increase in total expenditure along with most fee-for-service categories. Strong per capita growth by aid category is mitigated by a sharp decline in managed care. However, because overall expenditure has increased, at a faster rate than caseload, per capita costs are also rising. Therefore, the Department has selected a moderate long-term trend which does not incorporate recent policy changes.
Disabled Adults 60 to 64 (OAP-B)	5-Year Average of FY 02-03 through FY 06-07 (Without RX) 1.56%	5-Year Average of FY 02-03 through FY 06-07 (Without RX) 1.56%	Without prescription drugs, the last four years for this aid category have oscillated between positive and negative trends. In FY 06-07, expenditure and per capita costs (without RX) were virtually flat. Recent history - namely FY 05-06 and FY 06-07 - has shown moderate changes in the per capita cost, and therefore the years immediately prior - FY 03-04 and FY 04-05 - are not included in the trend. The Department anticipates that in the absence of large policy changes, the per capita growth will continue to be moderate.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	3-Year Average of FY 02-03 through FY 04-05 3.72%	3-Year Average of FY 02-03 through FY 04-05 3.72%	Without prescription drugs, per capita growth has oscillated between positive and negative trends. Negative years have served to keep long- and short-term trend factors low. The overall percent change in per capita from FY 02-03 to FY 06-07 was less than 0.5%. However, prescription drugs are still a part of this category and still show significant growth. Although total expenditure between the first and second half of the year declined, a more granular analysis reveals that expenditure has been increasing steadily in calendar year 2007. Further, a comparison of expenditure between the first and second halves of FY 06-07 shows that expenditure has increased in most fee-for-service categories. Therefore, the Department anticipates this trend will continue and that per capita costs will rise in FY 07-08 and FY 08-09.
Categorically Eligible Low-Income Adults (AFDC-A)	5-Year Average of FY 02-03 through FY 06-07 5.02%	5-Year Average of FY 02-03 through FY 06-07 5.02%	Recent history in this aid category is erratic, including a very large per capita increase in FY 06-07, a small increase in FY 05-06 after a large per capita decline, and two other large per capita increases. Of note is that although caseload has experienced a sharp decline in FY 06-07, expenditure did not decrease. This is partially responsible for the large per capita growth in FY 06-07. The Department anticipates that as caseload levels off, per capita growth will also settle to a growth rate more in line with historical trends. Therefore, the Department has selected a long-term trend incorporating the most recent history.
Expansion Adults	AFDC-A 5-Year Average of FY 02-03 through FY 06-07 5.02%	AFDC-A 5-Year Average of FY 02-03 through FY 06-07 5.02%	Because of a lack of history in this category, the Department applies the same per capita growth rate as the Categorically Eligible Low-Income Adults.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Breast & Cervical Cancer Program	0.04%	0.04%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/BCKC-C)	4-Year Average of FY 03-04 through FY 06-07 4.28%	4-Year Average of FY 03-04 through FY 06-07 4.28%	The last three years have demonstrated strong positive growth in per capita. However, the Department believes that per capita growth in the most recent year is more influenced by sharply declining caseload than by actual increases in utilization (although utilization is still a factor). Further, this eligibility category has not demonstrated the propensity for sustained long term growth more than a few years. Therefore, the Department has selected a more moderate trend for FY 07-08 and anticipates that with caseload stabilizing, the trend will continue in FY 08-09.
Foster Care	2-Year Average of FY 05-06 through FY 06-07 5.24%	2-Year Average of FY 05-06 through FY 06-07 5.24%	Per capita costs increased significantly in FY 06-07, which differs from recent history in this category. A comparison of expenditure between the first and second halves of FY 06-07 indicates that growth may be slowing from the FY 06-07 level. Therefore, the Department has selected a short-term growth factor below the FY 06-07 level.
Baby Care Program – Adults (BCKC-A)	5-Year Average of FY 00-01 through FY 04-05 4.93%	Half of FY 07-08 Trend Factor 2.47%	Because of the reimplementation of presumptive eligibility and the nature of the program (where caseload is not counted until the client becomes fully Medicaid eligible), per capita cost has increased at virtually the same rate as expenditure. The Department anticipates that as caseload associated with clients who are presumptively eligible becomes fully realized, per capita increases will moderate. Therefore, the Department has selected a long term trend which does not include the current implementation of presumptive eligibility. For FY 08-09, the Department has halved the trend factor to reflect a more moderate base growth rate.

Aid Category	FY 07-08 Acute Care Trend Selection	FY 08-09 Acute Care Trend Selection	Justification
Non-Citizens	8.00%	Per capita change from FY 04-05 to FY 05-06 3.33%	This aid category receives emergency services and prenatal care only. Long term trends in this aid category are affected by policy changes, and may not be indicative of future trends. During the previous fiscal year, caseload has seen a dramatic decrease, while expenditure and the number of utilizers has remained relatively flat. It appears that this is a one-time correction to the caseload in this category. The trend factors for this category are varied, and are not expected to provide a good indicator for FY 06-07. Therefore, a fixed trend of 8.00% was chosen, based on an approximately constant expenditure. For FY 08-09, a return to more recent stable growth periods is predicted.
Partial Dual Eligibles	2-Year Average of FY 05-06 through FY 06-07 6.57%	2-Year Average of FY 05-06 through FY 06-07 6.57%	Expenditure in this category is primarily for Medicare co-insurance. Prior to FY 06-07, caseload increased sharply without a corresponding increase in expenditure, causing a per capita increase. In FY 06-07, expenditure increased significantly, possibly as a result of clients becoming more familiar with available benefits as a dual-eligible. Therefore, the Department anticipates that this growth with moderate in FY 07-08 and FY 08-09.

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 Request for Acute Care:

- HB 05-1015 added an outpatient substance abuse benefit, which began July 1, 2006. The bottom-line impact in FY 07-08 reflects the annualization of the expected savings from the program.
- HB 06-1385 provided rate increases to home health providers effective April 1, 2007. The bottom-line impact in FY 07-08 reflects the annualization amount funded in SB 07-239.

- SB 06-165 authorized the Department to implement treatment via telemedicine. Telemedicine services began in October 2007. The bottom-line impact in FY 07-08 reflects only the transmission costs of the program.
- SB 06-165 also added funding for a telemedicine disease management program. The disease management programs began in July 2007. The bottom-line impact in FY 07-08 reflects the savings to Acute Care as a result of the disease management program. Costs for the disease management program are included in Exhibit I. The bottom-line impact in FY 08-09 reflects the annualization amount.
- HB 07-1021 authorized the Department to implement a medication management program. The program is scheduled to start January 1, 2008. The bottom-line impact in FY 07-08 reflects the estimated savings of the program. The bottom-line impact in FY 08-09 reflects the annualization amount.
- SB 07-239 appropriated rate increases to certain provider types, including inpatient hospitals, and select physician and other medical services. The bottom-line impact in FY 07-08 reflects the estimated cost of those rate increases.
- The estimated costs of adjusting of claims paid to certain rural health centers which occurred in FY 06-07. The bottom-line impact for FY 07-08 reflects the annualization of the impact.
- The estimated savings from performing additional audits on hospitals and FQHCs (FY 07-08 Base Reduction Item 1), funded in SB 07-239 and starting July 1, 2007. The bottom-line impact for FY 07-08 reflects the savings from the additional audits.
- The estimated managed care incentive payment funded in SB 07-239. The bottom-line impact for FY 07-08 reflects the estimated payment amount.
- The estimated savings from the implementation of a preferred drug list, established pursuant to Executive Order 004 07 and funded in SB 07-239. The bottom-line impact for FY 07-08 reflects the estimated savings that were assumed during Figure Setting. The bottom-line impact in FY 08-09 reflects the annualization amount.[32]
- The estimated costs associated with administration of the human papillomavirus vaccine. The bottom-line impact in FY 07-08 reflects only the costs of physician visits required to receive the vaccine, as the vaccine is assumed to be covered under the federal Vaccines for Children program.
- The estimated costs of raising health maintenance organization rates to 100% of fee-for-service costs.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits (Page EF-6)

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program in the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. 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

[32] As described in Section V, this total does *not* reflect the actual savings for the program. See Section V for further details.

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" clients.

Per Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed that the expenditure and per capita costs in FY 05-06 grew at an unexpected rate. The Department has investigated the issues involved, and determined that the total expenditure in FY 05-06 contained a large amount of retroactive transactions, causing the expenditure for FY 05-06 to appear overstated. Further research revealed that these retroactive transactions ceased in June 2006. Additionally, the Department implemented additional system changes to properly record expenditure for clients enrolled in the program in March 2006.

As such, the Department uses only the most recent expenditure history to forecast the per capita for this program. The Department has used monthly program costs from April 2006 through June 2007 to estimate the per capita costs for eligible clients. All monthly costs are as reported in the Department's monthly report to the Joint Budget Committee on the Health Care Policy and Financing Medical Services Premiums Expenditures and Medicaid Caseload (footnote 20 of HB 06-1385), with the exception of June 2006. Because of the last retroactive payment, June 2006 is calculated from data in the Medicaid Management Information System. The Department used the monthly caseload for the program (presented in Exhibit B) to calculate a monthly per capita, and calculated a trend factor by using the average percent change between the rolling 3-month averages. Because this factor is the average increase for each 3-month period, the Department multiplied the factor by 4 to obtain a full-year trend factor. This trend factor is applied to the base per capita on page EF-3. Only the final per capita costs for each year are listed on page EF-6.

Fund Splits

The second half of 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.

Per 25.5-5-308 (9) (b) and (c), C.R.S. (2007), some state funding for "traditional" Medicaid Breast and Cervical Program clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. In FY 07-08, 25% of state funding (8.75% of total funding) comes from the Breast and Cervical Cancer Prevention and Treatment Fund. In FY 08-09, no explicit requirement exists for funding from the Breast and Cervical Cancer Prevention and Treatment Fund; therefore, the Department assumes that all state funding

will come from the General Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2007), 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.

Antipsychotic Drugs Projection (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 the current year and the request year. 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 this exhibit, as trending on service category has proven 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.

Sharp declines in expenditure were experienced as a result of the implementation of the Medicare Modernization Act of 2003, as antipsychotic drugs are covered under the Medicare Part D benefit. For aid categories affected by the Part D benefit, trend factors in FY 05-06 and FY 06-07 are skewed by the large drop in expenditure. Therefore, for OAP-A, OAP-B, and AND/AB, FY 07-08 Pre-Rebate Expenditures are calculated utilizing FY 06-07 pre-rebate actuals, increased by the average percentage change in pre-rebate expenditures between FY 03-04 and FY 04-05. For other aid categories, FY 06-07 pre-rebate actuals are inflated by the average percentage change in pre-rebate expenditures between FY 05-06 and FY 06-07. The percentage increases are held constant in FY 08-09.

State-Only Prenatal Care Costs for Non-Citizens (Page EF-9)

Pursuant to 25.5-5-103 (3), C.R.S. (2007), Colorado opted to provide prenatal care at its sole expense for certain non-citizens (legal immigrants not eligible for full Medicaid). SB 03-176 eliminated this service for legal immigrants, however due to legal challenges, there was no interruption in services. HB 05-1086 officially reinstated the services. The Department receives a 50% federal match for any emergency services provided for these clients, in particular, labor and delivery. Effective with the November 1, 2006 Budget Request, the Department has revised its reporting of expenditure. In Budget Requests prior to FY 06-07, the Department's exhibit incorrectly listed the state-only portion of expenditure as the total amount spent on the program.

The FY 07-08 and FY 08-09 estimated expenditures are calculated by trending the FY 06-07 total expenditure by 4.26%. Although the Department experienced sharp declines in expenditure in FY 05-06 and FY 06-07, an analysis of monthly expenditure reveals that total expenditure has been increasing since a low point in April 2006. In order to calculate a trend factor, the Department applied a rolling 6-month average to monthly expenditures and selected a trend factor based on the average percent change in the rolling average over the most recent 9 periods. This incorporates the most recent 15 months of data.

Family Planning - Calculation of Enhanced Federal Match (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 07-08 and FY 08-09 is based on the average yearly percentage change from FY 04-05 to FY 06-07, 2.00%.

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.

Expenditure by Half-Year (Page EF-11)

This exhibit replaces the Department's Year-to-Date exhibit from the February 15, 2007 Budget Request. Because the Department only has limited experience in FY 07-08, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 06-07 actual expenditure into half-year increments to analyze the changing rates of expenditure over time.

EXHIBIT G - COMMUNITY BASED LONG TERM CARE

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 1.2% 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 Community Based Long Term Care Expenditure (Page EG-1 through EG-4)

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 00-01 through FY 06-07. 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 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, FY 05-06, and FY 06-07. 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 08-09 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. The half-year per capita costs and expenditures at the end of Exhibit G were used to assist in the trend selection.

The table below describes the trend selections for FY 07-08 and FY 08-09. 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.

The selected trend factors for FY 07-08 and FY 08-09, with the rationale for selection, are as follows:

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	3-Year Average of FY 03-04 through FY 05-06 5.02%	3-Year Average of FY 03-04 through FY 05-06 5.02%	FY 06-07 experienced a very large per capita growth rate; however, this growth is largely due to the rate increases appropriated by the General Assembly in April and July 2006, and April 2007. The Department has selected a period of relative stability to use as a trend factor in order to avoid double-counting the impact of the recent rate increases. Because enrollment in the Department's Elderly, Blind, and Disabled waiver is increasing, the Department anticipates that base growth in this category will remain strong for the request years.
Disabled Adults 60 to 64 (OAP-B)	2-Year Average of FY 03-04 through FY 04-05 1.68%	2-Year Average of FY 03-04 through FY 04-05 1.68%	FY 06-07 experienced a very large per capita growth rate; however, this growth is largely due to the rate increases appropriated by the General Assembly in April and July 2006, and April 2007. FY 05-06 is excluded from the trend because of large per capita growth which appears to be a one-time shift in expenditure patterns. The Department anticipates that this category will return to a more stable trend for the request years.

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	2-Year Average of FY 04-05 through FY 05-06 7.15%	3-Year Average of FY 03-04 through FY 04-05 2.60%	FY 06-07 experienced a very large per capita growth rate; however, this growth is largely due to the rate increases appropriated by the General Assembly in April and July 2006, and April 2007. After rate increases, this category in particular experienced sustained monthly expenditure growth, as opposed to a one-time expenditure shift. This will translate into large per capita growth in FY 07-08, even if the growth abates. Therefore, the Department has selected a larger trend factor to account for a new level of expenditure. The Department estimates that base growth to level off in FY 08-09.
Categorically Eligible Low-Income Adults (AFDC-A)	0.00%	0.00%	Clients in this aid 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 aid category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. At present, the Department anticipates expenditure to hold constant in this Budget Request.
Expansion Adults	0.00%	0.00%	Clients in this aid 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 aid category changes to AND/AB. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. At present, the Department anticipates expenditure to hold constant in this Budget Request.
Breast &	0.00%	0.00%	Clients in this eligibility category are not eligible for

Aid Category	FY 07-08 Community Based Long Term Care Trend Selection	FY 08-09 Community Based Long Term Care Trend Selection	Justification
Cervical Cancer Program			community based long term care benefits.
Eligible Children (AFDC-C/ BCKC-C)	AND/AB 2-Year Average of FY 04-05 through FY 05-06 7.15%	AND/AB 3-Year Average of FY 03-04 through FY 04-05 2.60%	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	2-Year Average of FY 05-06 through FY 06-07 1.57%	2-Year Average of FY 05-06 through FY 06-07 1.57%	Foster care children only receive private duty nursing and hospice care. Only a very small number of clients receive services. However, expenditure in this aid category has been relatively constant since FY 05-06. Therefore, the Department has selected a trend factor based on the most recent two years of actuals.
Baby Care Program – Adults (BCKC-A)	0.00%	0.00%	Clients in this aid category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this aid category are not eligible for community based long term care benefits.
Partial Dual Eligibles	OAP-A 3-Year Average of FY 03-04 through FY 05-06 5.02%	OAP-A 3-Year Average of FY 03-04 through FY 05-06 5.02%	Clients in this aid category are not eligible for community based long term care benefits. However, there tends to be some expenditure in waiver services. This is due to clients incurring costs before their aid category changes to OAP-A. Because of the uncertain nature of expenditure in this aid category, per capita trends are unreliable. At present, the Department anticipates any growth in expenditure to be consistent with OAP-A trends.

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 Request for Community Based Long Term Care:

- SB 04-177 added a waiver benefit for children with autism. Services started in April 2007. The bottom-line impact in FY 07-08 reflects the estimated cost of the waiver benefit.
- HB 05-1243 directed the Department to add consumer directed care as a benefit to its Home and Community Based Waiver programs. This option is expected to begin January 1, 2008. The bottom-line impact in FY 07-08 is the estimated savings expected to be generated by the program. The bottom-line impact for FY 08-09 is the annualization amount.
- HB 06-1369 provided rate increases for certain home and community based services. Rate increases for the HCBS – Consumer Directed Attendant Support waiver program was applied in February 2007. The bottom-line impact in FY 07-08 is the annualization amount funded in SB 07-239.
- HB 06-1385 provided rate increases for certain home and community based services. Rate increases were effective April 1, 2007. The bottom-line impact in FY 07-08 is the annualization amount funded in SB 07-239.
- SB 07-239 provided a 1.5% cost of living increase to home and community based services. Rate increases were effective July 1, 2007. The bottom-line impact in FY 07-08 is the amount funded in SB 07-239.

Expenditure by Half Year (Page EG-4)

This exhibit replaces the Department's Year-to-Date exhibit from the February 15, 2007 Budget Request. Because the Department only has limited experience in FY 07-08, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 06-07 actual expenditure into half-year increments to analyze the changing rates of expenditure over time.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

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
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request (Page EH-1)
This exhibit summarizes the total requests from the worksheets within Exhibit H.

Class I Nursing Facilities (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 7.2% (through the estimated FY 07-08 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.

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[33]:

- The Department received information from its nursing facility cost-report auditor, Myers and Stauffer, to estimate the FY 07-08 per diem allowable Medicaid rate. This rate is based on a weighted average of nursing facility rates, before the impact of HB 07-1183 is considered. The estimated per diem allowable Medicaid rate is $171.39.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment of $30.29 for claims that will be incurred in FY 07-08. The difference between the estimated per diem rate and the estimated patient payment, $141.10, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 07-08.

[33] For clarity, FY 07-08 figures are used as an example. The estimate for FY 08-09 is based on the estimate for FY 07-08, and follows the same methodology.

- Using the same data from above, the Department calculates the estimated number of patient days for FY 07-08, a total of 3,533,475 days.
- 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 07-08, $495,684,624.
- Of the estimated total reimbursement for claims incurred in FY 07-08, only a portion of those claims will be paid in FY 07-08. The remainder is assumed to be paid in FY 08-09. The Department estimates that 91.78% of claims incurred in FY 07-08 will also be paid during FY 07-08. Footnote 5 of Exhibit H, page EH-4, details the calculation of the percentage of claims that will be incurred and paid in FY 07-08. The total amount estimated to be paid in FY 07-08 for claims incurred in FY 07-08 ("current year claims") is $457,614,001.
- During FY 07-08, the Department will also pay for some claims incurred during FY 06-07 ("prior year claims"). In Footnote 6 of Exhibit H, page EH-4, the Department applies the percentages calculated in Footnote 5 to claims incurred during FY 06-07 to calculate an estimate of outstanding claims of $40,191,606 to be paid in FY 07-08.
- The sum of the current year claims and the prior year claims, $497,805,607, is the estimated expenditures in FY 07-08 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, and recoveries from Department overpayment reviews. Information and calculations regarding these adjustments are contained in the footnotes for the Class I Nursing Facilities request, on pages EH-3 through EH-5.
- Legislative impacts are added as bottom line adjustments. For FY 07-08, this includes HB 07-1183, which established the Nursing Facility Grant Rate Program. For a detailed discussion of bottom-line impacts, see the narrative for the Department's reasonableness projection for Class I Nursing Facilities, located below.
- Once the "non-rate" factors are estimated, the sum of the gross budget estimate and the non-rate adjustments yields the total estimated FY 07-08 expenditure, $495,684,624.

For FY 08-09, the same methodology is applied, taking into account the estimate for 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 Class I Nursing Facilities request:

- HB 07-1183 established the Nursing Facility Grant Rate Program, which increases the rates of providers whose rates decreased as a result of the end of the rate floor provision established in SB 06-131. The total amount appropriated for the Nursing Facility Grant Rate Program is $397,000. No funding exists for FY 08-09.

Summary of FY 07-08 and FY 08-09 Request

FY 07-08 Estimate	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$457,614,001
Estimated Expenditures for FY 06-07 Dates of Service	$40,191,606
Estimated Expenditures in FY 07-08 Prior to Adjustments	**$497,805,607**
Adjustments	($2,120,983)
Total Estimated FY 07-08 Expenditures	**$495,684,624**
FY 08-09 Request	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$476,513,317
Estimated Expenditures for FY 07-08 Dates of Service	$40,959,322
Estimated Expenditures in FY 08-09 Prior to Adjustments	**$517,472,639**
Adjustments	($2,475,177)
Total Estimated FY 08-09 Expenditures	**$514,997,462**

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 an "Incurred But Not Reported" (IBNR) adjustment. The IBNR 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 IBNR 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 6 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 06-07 which will pay in FY 07-08, and the percentage of claims incurred in FY 07-08 which will be paid in FY 08-09.

The Department has updated its IBNR adjustment calculation from the February 15, 2007 Budget Request, using paid claims data through July 2007.

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). Provisions from SB 06-131 are applicable for FY 06-07 only.
FY 07-08	Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.

Class I Nursing Facilities – Cash Based Actuals and Totals by Aid Category (Pages EH-6 and EH-7)

This exhibit has changed since the Department's February 15, 2007 Budget Request. Previously, the Department performed a separate projection of Class I Nursing Facilities expenditure using a per capita-based methodology. However, because that projection was not utilized in the final request, the Department no longer includes it in the official Budget Request. For comparison purposes to other service categories, this exhibit lists prior year expenditure along with the projected expenditure from page EH-2. Estimated

totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year.

Totals for each aid category are used to calculated total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities (Page EH-8 through EH-10)

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. There are no plans to eliminate this facility as it essentially functions more like a group home than an institutional facility.

At the end of FY 05-06, Good Shepherd Lutheran increased its enrollment from 16 clients to 20 clients. During FY 06-07, the census at this facility has remained constant, and there is no expectation that there will be a further change in enrollment at this facility. Additionally, this facility received an annual cost-based rate adjustment, similar to class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. Therefore, in order to project expenditure for this category, the Department calculated the projected expenditure for FY 07-08 as the total expenditure in each aid category multiplied by the percent change in total expenditure from FY 04-05 to FY 05-06. Because all clients are paid the same rate regardless of aid category, it is anticipated that change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant. The Department holds this estimated percent increase constant for FY 08-09.

Program Of All-Inclusive Care For The Elderly (PACE) (Page EH-11 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). PACE rates are adjusted once per year, generally on January 1 of each year.

For the November 1, 2007 Budget Request, the Department has substantially revised the methodology used to calculate the projections for PACE expenditure. In prior years, the Department performed a per capita-based estimate, similar to the Acute Care and

Community Based Long Term Care projections. However, enrollment trends in PACE are different from the overall Medicaid population. Therefore, the standard per capita measure is unreliable, in that it does not reflect the true cost of serving a client enrolled in PACE.

To better forecast expenditure, the Department has provided two new metrics on page EH-12: average monthly enrollment, and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System. The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

The FY 07-08 projection for PACE is computed in several parts: First, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 06-07 average cost per enrollee. Second, the Department estimates the growth in the average enrollment, and applies the selected trend factor to the FY 07-08 average enrollment. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 07-08 base expenditure. Then, the Department adjusts for any bottom line impacts not incorporated in the trend (described below). The sum of the base expenditure and the bottom line adjustments is the estimated FY 07-08 total expenditure. FY 08-09 is calculated in the same fashion.

To estimate the increase in enrollment, the Department selected the average percent increase in enrollment between FY 04-05 through FY 05-06 for Adults 65 and Older, 3.13%, and the percent increase in total Disabled Adults 60 to 64 and Disabled Individuals combined enrollment from FY 03-04 through FY 05-06, 4.81%. The Department selected a combined factor for these groups because of the similarities between the populations.

To estimate the average increase in cost per enrollee, the Department selected the average percent increase in cost per enrollee between FY 03-04 and FY 05-06 for Adults 65 and Older, 6.15%, and the combined average percent increase in cost per enrollee between FY 03-04 and FY 05-06 for Disabled Adults 60 to 64 and Disabled Individuals, 6.57%. There are several factors influencing the decision to use a more historical period rather than recent periods. First, in FY 05-06, PACE rates were decreased to reflect implementation of the Medicaid Modernization Act. Second, in FY 06-07, due to concerns raised by the Centers for Medicare and Medicaid Services (CMS) late in the PACE rate setting process, PACE rates were not implemented until July 1, 2007, rather than January 1, 2007. Therefore, the Department feels that percent changes from FY 06-07 will not appropriately reflect future changes in cost per enrollee.

The Department has received applications for additional PACE sites, and program staff indicates that a maximum of approximately 114 clients may enroll. As reported in the Department's Joint Budget Committee hearing on December 19 and 20, 2006, the Department received two applications for the same service area. The review process is lengthy, and the Department does not anticipate that any new facility will be operational in FY 07-08. However, the Department does currently believe that at least one new

facility will be operational in FY 08-09; although the Department believes that no clients will be served until January 1, 2009 at the earliest. In the Request Year projection, the Department increases estimated enrollment by 57 clients, which reflects the estimated 114 clients enrolled for a half year.

Legislative Impacts and Bottom Line Adjustments
Adjustments to FY 07-08 and FY 08-09 include the following:

- In FY 05-06, the Department reached a settlement agreement with its PACE provider to correct for instances where the incorrect rate was paid for clients. During FY 05-06, the Department recouped $1,462,091. In FY 06-07, the Department recouped the outstanding amount of $350,902. Because of the nature of this recoupment, these are one-time payments to the Department. The Department has adjusted the FY 07-08 estimates as bottom-line adjustments by adding a bottom line adjustment reversing the impact of the estimated FY 06-07 collection.

- In FY 07-08, the PACE rates will be adjusted to include the rate increases provided to Acute Care and Community Based Long Term Care services in HB 06-1369 and HB 06-1385. These rate increases would have been applied on January 1, 2007, however the delay imposed by the Centers for Medicare and Medicaid Services in setting new rates has pushed this impact back to July 1, 2007, effective with new PACE rates. The original estimates for HB 06-1369 and HB 06-1385 did not include an impact for PACE. This is a bottom-line impact for $629,975.

The sum of the bottom line impacts to PACE increases the estimated FY 07-08 projection by $980,877. The revised estimated FY 07-08 PACE total is $49,325,276.

No bottom line impacts have been included for FY 08-09. The estimated FY 08-09 PACE total is $58,001,837.

Supplemental Medicare Insurance Benefit (Page EH-15 through EH-17)

The Supplemental Medicare Insurance Benefit (SMIB) 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 in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B, and in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare

Beneficiary eligibility group only.[34] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types, 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.

Expenditure in this service category is related to two primary factors: the number of dual-eligible clients, and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[35]

[34] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.
[35] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

Medicare Premiums				
Calendar Year	**Part A**	% Change	**Part B**	% Change
2003	$316.00		$58.70	
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%

These premiums reflect the standard Medicare premiums paid by most Medicare recipients, or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium. Additionally, some clients pay higher Part B premiums based on higher adjusted gross income, but it is assumed that clients meeting those requirements do not qualify for Medicaid.

The Department has adjusted the methodology to forecast this benefit from prior years. To forecast FY 07-08, the Department first divides FY 06-07 expenditure into 6-month increments; the first half and the second half of the fiscal year. The Department then inflates the second half by the estimated caseload trend for FY 07-08 from Exhibit B, page EB-1. This figure represents the approximate expenditure for the first half of FY 07-08.[36] Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium. No further adjustment for caseload is made, as it is already incorporated in the first half estimate. The total estimated expenditure for FY 07-08 is the sum of the first half and second half estimates, $90,788,446. The Department applies the same methodology to FY 08-09, and estimates that total expenditure will be $101,187,718

Health Insurance Buy-In (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. (2007). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, 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 significant decrease in HIBI expenditure and enrollment in FY 05-06. Additionally, the Department found that, with rare exception, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB), for clients who do not qualify for the Medicare Part D benefit.

[36] It should be noted that the Department does not apply an adjustment for the estimated increase in the Medicare premium for the first half of the year; this is because the increase in the premium is effective each January 1.

In FY 06-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency has referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 06-07, the Department examined and upgraded the existing process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Because of the dramatic changes in the expenditure patterns in recent years, the Department does not believe that per capita trends are a good indicator for FY 07-08 expenditure. At the same time, the Department believes the most recent growth in expenditure is not likely to continue in the future. Total growth in FY 06-07 was 41.62%; the Department selected 20.81% to trend expenditure to FY 07-08, and 10.41% to trend expenditure to FY 08-09. The Department selected these percentages by reducing the FY 06-07 growth rate by 50% in FY 07-08, and by 50% again in FY 08-09. The Department anticipates that the growth rate will begin to moderate in the absence of additional policy changes.

EXHIBIT I – SERVICE MANAGEMENT

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 prepaid inpatient health plans.

Summary Of Service Management (Page EI-1)
This exhibit summarizes the total requests from the worksheets within Exhibit I on pages EI-2 through EI-8.

Single Entry Points (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. (2007)). 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. (2007)).

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 (Section 25.5-6-106 (2) (b), C.R.S. (2007)).

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 (2) (c), C.R.S. (2007)). 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.

For the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in Home and Community Based Services (HCBS) utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the Cash Accounting basis of Medical Services Premiums.

For FY 07-08, the Department's projection uses the current amount allocated to Single Entry Points in the FY 07-08 Long Bill, and adds two legislative impacts (see below). The Department's estimate does not include any increase for service utilization for this Budget Request; however, the Department may include an additional request in its February 15, 2008 Budget Request.

For FY 08-09, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 03-04 through FY 06-07 for each aid category. The estimated FY 07-08 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 08-09 expenditure.

FY 07-08 and FY 08-09 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 07-08 and FY 08-09 calculations for Single Entry Points:

- 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. The Department received approval from the Centers for Medicare and Medicaid Services to add consumer directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007; the Department expects services to begin January 1, 2008. This is an increase of $504,187 to FY 07-08 and an increase of $504,188 to FY 08-09 (Legislative Council fiscal note for HB 05-1243, March 15, 2005).
- SB 07-239 contained rate increases for Single Entry Points. The Department was appropriated an additional $3,852,887 to the Department for the purpose of increasing the amounts paid to Single Entry Points, effective July 1, 2007 (Figure Setting, March 8, 2007, page 43).

The sum of the bottom line impacts for Single Entry Points in FY 06-07 is an increase of $4,357,074. The revised estimated FY 07-08 Single Entry Points total expenditure is $22,198,784.

The sum of the bottom line impacts for Single Entry Points in FY 08-09 is an increase of $504,188. The revised estimated FY 08-09 Single Entry Points total expenditure is $23,738,130.

Disease Management (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. (2007)). 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 07-08, the Department replaced its diabetes management program with a congestive heart failure program. FY 07-08 disease management contracts are for a total of $627,778. The Department anticipates that these contracts will continue into FY 08-09.

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 07-08 and FY 08-09 calculations for Disease Management:

- 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 increase to Disease Management of $380,928 (Legislative Council fiscal note for SB 06-165, April 24, 2006), effective July 1, 2007. The total is included in the base contracts in FY 08-09.
- 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. (2007). Statutory authority for this funding was set to expire at the end of FY 06-07; however, the Department was granted roll-forward authority for these funding in SB 07-239. This is an estimated increase to Disease Management of $3,940,776 in FY 07-08 (Legislative Council fiscal note for HB 05-1262, April 25, 2005, SB 07-239).

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. The revised estimated FY 07-08 Disease Management total expenditure is $4,949,482.

Because the bottom line impact for SB 06-165 is incorporated in the base for FY 08-09, there are no bottom line impacts for FY 08-09. The estimated FY 08-09 Disease Management total expenditure is $1,008,706.

Prepaid Inpatient Health Plan Administration (Page EI-7)

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an 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 prepaid inpatient health plan, Rocky Mountain Health Plans. In FY 05-06, the Department ended its contract with Management Team Solutions. Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts only the administrative 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 07-08, the Department has used actual enrollment in its current administrative service organization to forecast expenditure in FY 07-08 and FY 08-09.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payment to Rocky Mountain Health Plans for cost avoidance in both FY 05-06 and FY 06-07. In January 2007, the Department made a contracted payment to Rocky Mountain Health Plans for services rendered in FY 04-05, for $1,058,219. 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 4.74%. The final 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 04-05 level.

The FY 07-08 estimate for the prepaid inpatient health plan including cost avoidance payments is $4,599,057. The FY 08-09 estimate is $4,600,667.

EXHIBIT J - ESTIMATE OF FY 07-08 EXPENDITURE USING FY 06-07 CASH FLOW PATTERNS

This exhibit displays the FY 07-08 year-to-date expenditures through September 2007 and the cash flow pattern of actual expenditures for the first quarter of FY 06-07 to determine a rough estimate of FY 07-08 expenditures, 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.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends. Exceptions to the cash flow pattern are noted in footnotes on page EJ-1.

Notably, an exception to the cash flow pattern has not been made for health maintenance organizations. During FY 05-06 and FY 06-07, the Department implemented passive enrollment, which caused a large number of clients to move from fee-for-service to managed care. In October 2006, one of the Departments health maintenance organizations left the program, causing a large number of clients to move from managed care to fee-for-service. Therefore, cash flow pattern for health maintenance organizations is likely skewed. Additionally, because expenditures for fee-for-service categories, such as physician services, are also affected by managed care enrollment, cash flow patterns for fee-for-service categories are also likely skewed. Rather than perform a complex adjustment, for the purpose of this exhibit the Department assumes that the overall cash flow pattern for acute care services will remain the same.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit financing methodology accomplishes the following:

- 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.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

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. 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 07-08 estimate equals $12,755,823. The FY 08-09 estimate equals $13,265,580.

EXHIBIT L - APPROPRIATIONS AND EXPENDITURES

This exhibit displays the FY 06-07 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 06-07 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.

EXHIBIT M – CASH BASED ACTUALS

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 labeling changes to this exhibit:

Service Group	Old Title	New Title
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community Based Long Term Care	Home and Community Based Services-Case Management	HCBS - Elderly, Blind, and Disabled
Community Based Long Term Care	Home and Community Based Services-Mentally Ill	HCBS - Mental Illness
Community Based Long Term Care	Home and Community Based Services-Children	HCBS - Disabled Children
Community Based Long Term Care	Home and Community Based Services-People Living with AIDS	HCBS - Persons Living with AIDS
Community Based Long Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community Based Long Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

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 report) and the Colorado Financial Reporting System (COFRS).

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 95-96 through FY 06-07 final actual expenditures are included in this Budget Request for historical purpose and comparison. This exhibit has been revised to list more recent years first.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

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.

For FY 06-07, this exhibit compares the Department's November 15, 2005; February 15, 2006; November 1, 2006; and February 15, 2007 Budget Requests to the final FY 06-07 appropriation.

For FY 07-08, this exhibit lists the Department's November 1, 2006, February 15, 2007, and November 1, 2007 Budget Requests to the FY 07-08 appropriation.

EXHIBIT P – GLOBAL REASONABLENESS

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

EXHIBIT Q – CASELOAD GRAPHS

This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during the 2004, 2005, 2006, and 2007 legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for 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 Intermediate Care Facility for the Mentally Retarded (ICF-MR and not receiving services from any of the alternatives to long-term care waiver programs. The Department was required to seek a federal waiver that meets budget neutrality requirements. Services under this waiver are outlined and limited to $25,000 annually per participant. Community Centered Boards for persons with developmental disabilities are the single entry point agencies for case management services. Administrative costs for the Community Centered Boards are capped at 15%.

The autism waiver application was first submitted on April 19, 2005. Through a series of correspondence, the Department began working with the Centers for Medicare and Medicaid Services in July 2005, and submitted the additional information on October 14, 2005. The Centers for Medicare and Medicaid Services approved the waiver application for Home and Community Based Services for Children with Autism on December 23, 2005. The next steps to implement the waiver were contingent upon receipt of that federal approval.

Upon approval of the waiver application, the Department promulgated rules, including the provider certification process; made necessary systems changes; and developed the contracts with the Community Centered Boards to provide case management services for the Children with Autism waiver clients. All of these processes were interrelated and any delay in one process affected a delay in the others.

The rules were developed with substantial input from stakeholders, including parents of children with autism and medical professionals with expertise treating children with autism. The rules were presented to the Medical Services Board in April 2006 and became effective on July 1, 2006. Provider rates were also developed and finalized at this time.

As a part of the provider certification process, the Department has an agreement with the Department of Public Health and Environment to conduct a review to determine if a provider meets the waiver requirements. Execution of the agreement was delayed, but the Department has been working with the Department of Public Health and Environment to expedite the certification process for providers of the waiver for Children with Autism. The Department expects that surveys will begin in mid-January 2008. In the

interim, the Department has established a provisional certification process for providers to ensure that eligible clients are able to receive services. The Department began to enroll clients in March 2007.

Because of the stringent requirements for certification as a provider in the program, enrollment in the program has been slower than originally anticipated in the fiscal note for SB 04-177. Therefore, the Department's estimates remain based on the original fiscal note, and have not been adjusted for the limited enrollment since April 2007. The Department believes that the estimate from the fiscal note remains relevant, as clients are subject to a cap of $25,000 of service.

SB 04-177	Total Funds	Cash Funds Exempt*	Federal Funds
FY 07-08 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**

*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.

Based on assumptions from the fiscal note for HB 05-1015, the Department assumed that 4,668 clients would utilize substance abuse benefits in the first year of the program at an average cost $1,512.87 per client (November 1, 2006 Budget Request, page M-161). However, caseload for the program to date has been significantly lower than previously estimated. Based on claims reported in the Medicaid Management Information System, average monthly utilization for the program was 203 clients, with total program expenditure of $390,565. However, July and August 2006 saw limited and enrollment and expenditure because of the lag between when claims are incurred and when claims are paid. Therefore, the Department annualizes the total as if the program had only been in effect for 10 months instead of 12.

Based on the revised estimated full year expenditure, the Department recalculated the estimated savings for HB 05-1015. As with prior Budget Requests, the Department assumes that savings will be proportional to the original fiscal note. Because the program is

relatively new, the Department does not yet have enough data to accurately determine the actual reduction in costs due to the program.[37] Under the revised assumptions, the Department estimates the impact as follows:

HB 05-1015	Fiscal Note Estimate	Revised Estimate
Estimated Medicaid Caseload Eligible for Outpatient Substance Abuse Treatment	4,668	243
Annual estimated cost per client	$1,512.87	$1,928.72
Estimated Expenditure (Annual)	$7,062,073	$468,678
Anticipated savings in Medical Services Premiums (6 Months)	($1,218,371)	**($80,858)**

The FY 07-08 impact is the annualization of anticipated savings, $80,858. Program costs are fully annualized in the FY 07-08 base. The Department will continue to monitor the program, and if caseload or program cost significantly increase, the Department will include an additional bottom line impact in Medical Services Premiums in its February 2008 Budget Request.

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. Approval by the Centers for Medicare and Medicaid Services for the implementation of Consumer Directed Care for the Elderly, Blind, and Disabled waiver and the Mental Illness waiver was granted in mid-2007. Services are expected to start in January 2008. 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.

[37] In the fiscal note from HB 05-1015, the savings estimate was based on a 1997 report by the Washington State Department of Social Services, projected forward. This estimate was applied on a per client basis, and therefore it is appropriate to reduce savings proportionally to program caseload.

Description	FY 07-08	FY 08-09 Annualization Amounts
Service Management (Single Entry Point) (Exhibit I)	$1,008,375	$0
Community Based Long Term Care savings (Exhibit G)	($2,012,790)	($2,415,348)
Fiscal Year Impact	**($1,004,415)**	**($2,415,348)**

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 Department's Request for Medical Services Premiums.

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-2 and EA-3 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-2 and EA-3.

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. 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 171 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	78	$1,955,260	$684,341	$1,270,919
Estimated FY 07-08 Health Care Expansion Breast and Cervical Cancer Program	83	$2,081,754	$728,614	$1,353,140

Disease Management

In HB 05-1262, the Department was given authority to pursue disease management programs 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. Under HB 05-1262, 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.

Statutory authority for the funding expired at the end of FY 06-07. However, in SB 07-239, the Department was granted roll-forward authority to implement programs in FY 07-08 (Figure Setting, March 8, 2007, page 32). The Department has included the roll-forward, $3,940,777, in its Budget Request in Exhibit I. The Department receives this funding as a transfer from the Department of Public Health and Environment, and not from the Prevention, Early Detection, and Treatment Fund directly.

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 total for each program is listed in the table below. Following the tables are short descriptions for each of the programs. For a complete description of the projections, see Section Q (Tobacco Tax Update) of this Budget Request.

	FY 07-08		**FY 08-09**	
Health Care Expansion Fund Programs	Total Funds	Health Care Expansion Fund	Total Funds	Health Care Expansion Fund
Expansion Adults	$12,355,556	$6,177,778	$15,559,439	$7,779,720
Expansion Foster Care (SB 07-002)	$4,227,510	$2,113,756	$6,039,926	$3,019,964
Presumptive Eligibility	$6,263,496	$3,131,748	$6,971,916	$3,485,958
Legal Immigrants	$11,596,517	$6,216,752	$11,596,517	$6,216,752
Removal of Medicaid Asset Test	$52,845,822	$26,422,911	$54,535,239	$27,267,620
Children's Home and Community Based Services	$11,044,213	$5,522,107	$11,779,755	$5,889,878
Children's Extensive Support	$1,028,237	$514,119	$1,074,610	$537,305
Total	**$99,361,351**	**$50,099,171**	**$107,557,402**	**$54,197,197**

Expansion Adults and Expansion Foster Care

Eligibility for low-income adults was expanded via HB 05-1262. Clients who do not qualify as Categorically Eligible Low Income Adults (AFDC-A), have income less than 60% of the federal poverty level, and have children became Medicaid eligible. Foster care eligibility was extended to children up to age 21 via SB 07-002. These populations receive the full family-Medicaid benefits package, and are forecast as part of the standard per capita development in Exhibits F, G, H, and I.

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. To be eligible for presumptive eligibility, a woman shall have a verified pregnancy, declare that her household's income shall not exceed 133% of federal poverty level and declare that she is a United States citizen or a documented immigrant. Eligibility for Medicaid must be determined by the county within 45 days of application. 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 Department reconciles with Anthem to ensure that the provider has been paid appropriately for services rendered.

Using the normalized data, the Department has projected caseload for FY 06-07 using the average monthly enrollment in the first half of FY 06-07. Expenditure is projected using the current monthly payment rate of $285.58, plus the amount due to Anthem during the cost settlement, $30.85, multiplied by the monthly caseload. The Department has forecast expenditure based on historical monthly expenditure and caseload. Forecasting methodology is described in Section P of this Budget Request.

Medicaid Legal Immigrants

SB 03-176 eliminated Medicaid coverage to legal immigrants. However, 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.

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 a mandatory Medicaid population and receive full benefits, provided they meet the eligibility requirements other than citizenship status. Optional Medicaid legal immigrants (those who have 5 years of residency but less than 40 work quarters) also receive 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.

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. In FY 07-08, the Department was appropriated $11,596,517 for legal immigrants; the amount funded by the Health Care Expansion Fund was $6,216,752 (Figure Setting, March 8, 2007, Appendix B, page 11).

Removal of the Medicaid Asset Test

Effective July 1, 2006, the asset test no longer applies to children and adults. As a result, clients who were previously ineligible for Medicaid became Medicaid eligible. Additionally, clients who were eligible for only the Children's Basic Health Plan now qualify for Medicaid. During FY 06-07, the Department began to receive data on clients who are affected by the removal of the asset test. Currently, however, the Department's reporting only identifies total expenditure and not expenditure by eligibility category. The Department has forecast expenditure based on historical monthly expenditure and known caseload. Forecasting methodology is described in Section Q of this Budget Request.

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, he/she 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 the Medicaid Caseload Assumptions and Calculations, the Department anticipates only 485 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.

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 Q of this Budget Request (Tobacco Tax Update), the Department anticipates that only 59 of these slots will be filled for FY 07-08 and FY 08-

09. This figure does not reflect only 59 clients being served; rather, it reflects the fact that some expansion slots are vacated when a traditional waiver slot becomes available and there may be some lag before the expansion slot is filled again.

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 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's revised caseload estimate, based on current caseload trends, is 230 clients in FY 07-08 and 300 clients in FY 08-09. The Department's forecasting methodology is described in Section II of this section of the Budget Narrative. 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.

HB 06-1270	FY 07-08	FY 08-09
Estimated Caseload	230	300
Estimated Per Capita	$1,706.32	$1,771.66
Estimated Expenditure	**$392,454**	**$531,498**

HB 06-1385 – Provider Rate Increases

In the FY 06-07 Long Bill, HB 06-1385, footnotes 26, 27, and 28 also provided rate increases for providers. For this Budget Request, rate increases applied effective July 1, 2006 are considered annualized in the base and not expressly considered as bottom line adjustments in this Budget Request.

Footnote 28 of HB 06-1385 was effective April 1, 2007. This footnote provided rate increases for home health and community-based long term care providers. The Department's FY 07-08 Long Bill appropriation in SB 07-239 includes the annualization of these rate increases. The Long Bill includes $4,097,363 for Home Health rate increases, and $8,318,888 for community-based long term care rate increases (Figure Setting, March 8, 2007, pages 38 and 38a). The Department has incorporated the Long Bill amounts as bottom-line impacts in Exhibit F (Home Health) and Exhibit G (Community Based Long Term Care).

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 was estimated at $600,060.[38] The program was assumed to start January 1, 2007. 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 group. Therefore, an adjustment was made to Medical Services Premiums in the Long Bill for non-emergency transportation services. The line-item for non-emergency transportation services is adjusted to reflect the estimated savings.

Currently, the Department anticipates that telemedicine services will start October 1, 2007. The Department's estimate for telemedicine services in FY 07-08 reflects the Legislative Council Fiscal Note adjusted for 8-month implementation in FY 07-08, $800,078. FY 08-09 reflects the annualization amount of $266,692.

Beginning July 1, 2007, the Department entered 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.

[38] The legislative council fiscal note contains a slight rounding error, and lists the total expenditure as $600,058.

HB 07-1021 - Concerning the Prescription Drug Consumer Information and Technical Assistance Program, and Making an Appropriation Therefor.

HB 07-1021 established the Prescription Drug Consumer Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients. The Department of Health Care Policy and Financing is required to administer the program and provide incentive payments to pharmacists and physicians who consult with Medicaid clients about how to avoid dangerous drug interactions and improve outcomes. Pharmacists and physicians participating in the program will receive $75 for each consultation provided to selected Medicaid clients. Each year, 226 clients with high dollar pharmaceutical expense are expected to receive consultations. Payments to pharmacists are included in the Department's Executive Director's Office Long Bill Group.

Based on a similar program in Wyoming, total drug costs for participating clients are expected to be reduced by 33 percent. For FY 07-08, drug expenditures for the 226 clients prior to receiving consultations are anticipated to be $3,786,685. Assuming implementation in January 2008, the savings for the 6 months after the consultations totals $624,803. For FY 08-09, drug expenditures for the 226 clients receiving consultations are currently anticipated to be $4,166,490, and HB 07-1021 is expected to result in full-year savings of $1,374,942. The Department's FY 08-09 calculations reflect the annualizations amount of $750,139.

HB 07-1183 - Concerning Reimbursement of Nursing Facilities under the "Colorado Medical Assistance Act", and Making an Appropriation Therefor.

HB 07-1183 established the Nursing Facility Grant Rate Program to provide assistance to certain nursing facilities. Facilities that received a Medicaid rate increase in FY 06-07 as a result of the minimum rate established by SB 06-131, but whose rate for FY 07-08 decreases are eligible for the program. The program is repealed July 1, 2008. HB 07-1183 appropriated a total of $397,000 for the grant program. Per diem rates for affected providers have been adjusted so that total expenditure for the program does not exceed the appropriated amount. This amount is included as a bottom line impact to the Class I Nursing Facilities budget, in Exhibit H, page EH-2.

HB 07-1346 - Concerning Managed Care in the Medical Assistance Program, and Making an Appropriation Therefor.

HB 07-1346, specifies that the Department may enter into prepaid inpatient health plan (PIHP) agreements, which are a type of managed care. These agreements would be with entities that provide medical services on the basis of per capita payments and have responsibility for inpatient hospital services for enrollees. PIHP agreements may include quality incentive payments of up to 5 percent, so long as incentive payments do not exceed total cost savings. PIHP agreements may also include payment for the costs of collecting and maintaining electronic medical records.

The Department was appropriated funding to initiate a feasibility study for increasing the number of prepaid inpatient health plans participating in the Department's managed care program. When the feasibility study is completed, the Department may submit an additional budget action to change the scope of its current managed care program; however, no such decision has yet been made.

In addition, the bill removes the requirement that managed care capitation rates be no more than 95 % of fee-for-service rates for an equivalent group. However, managed care organizations may submit capitation rate proposals of up to 100% of direct health care costs, but the state is not obligated to increase General Fund expenditures. In June 2007, the Department was informed by its only remaining risk-based managed care organization that it would no longer participate in the managed care program unless rates were raised to the 100% level. The Department submitted an Emergency Supplemental request to the Joint Budget Committee on June 20, 2007, requesting funding to raise capitation rates. The Joint Budget Committee denied the request, as it did not sufficiently meet criteria for an emergency supplemental. However, the Joint Budget Committee gave a favorable review to the Department's request and correspondingly, the Department raised capitation rates to the 100% level.

The Department's FY 07-08 calculation of Acute Care expenditure (Exhibit F) includes a bottom line impact of $4,178,940 to raise capitation rates to 100%. This figure is based on the Department's June 20, 2007 Emergency Supplemental. The Department will revise the estimated impact of this figure in its February 15, 2008 Budget Request, when more accurate caseload figures are available.

SB 07-002 - Concerning Extending Medicaid Eligibility for Persons who are in the Foster Care System Immediately Prior to Emancipation, and Making an Appropriation Therefor.

SB 07-002 expands Medicaid eligibility to young adults, who are under 21 years of age and who were in the foster care system immediately prior to their 18th birthday or emancipation. Currently, most foster children lose Medicaid eligibility on their 18th birthday or when they graduate from high school. Funding for clients who have regaining eligibility as a result of this expansion comes from the Health Care Expansion Fund. The Department's revised caseload estimate, based on current caseload trends, is 1,226 clients in FY 07-08 and 1,678 clients in FY 08-09. The Department's forecasting methodology is described in Section II of this section of the Budget Narrative. 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.

SB 07-002	FY 07-08	FY 08-09
Estimated Caseload	1,226	1,678
Estimated Per Capita	$3,448.21	$3,599.48
Estimated Expenditure	**$4,227,510**	**$6,039,926**

Executive Order 004 07 - Establishing a Preferred Drug List

In January 2007, Governor Ritter signed Executive Order D 004 07 establishing a preferred drug list for Colorado's Medicaid program. The purpose of this program is to provide needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This Executive Order gives the Department the authority to implement a preferred drug list after evaluating various methods of implementation and determining the best option for Colorado. In addition, the Department will be responsible for forming a Pharmacy and Therapeutics Committee responsible for evaluating clinical data and evidence on all drugs under consideration for inclusion in the preferred drug list. The Department will also evaluate and pursue supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.

During Figure Setting in March 2007, the Joint Budget Committee reduced the Medical Services Premiums appropriation by $670,376 in FY 07-08 to reflect expected savings from the implementation of a preferred drug list (Figure Setting, March 8, 2007, page 52). This figure was based on the Legislative Council fiscal note for SB 05-022, despite significant differences in the proposed legislation and the Executive Order.

In this Budget Request, the Department has submitted a separate budget action (Base Reduction Item 2, Implement Preferred Drug List) to reconcile the differences between the appropriation and the costs and savings associated with implementing the Executive Order. Therefore, to prevent double-counting of the Request, the Request for Medical Services Premiums holds the reduction that was included in the Long Bill constant at $670,376 in both FY 07-08 and FY 08-09 (see Exhibit F, pages EF-3 and EF-4).

Human Papillomavirus (HPV) Vaccines for Children Under 20

During Figure Setting in March 2007, the Joint Budget Committee increased the Medical Services Premiums appropriation by $1,010,084 in FY 07-08 for the costs of dispensing the human papillomavirus (HPV) vaccines to children between the ages of twelve to twenty years old. The Centers for Disease Control has approved the HPV vaccine as a recommend childhood vaccination. The estimate assumed that the cost of the vaccine will be paid by the federal Vaccines for Children program; therefore, the increased costs are for the office visits that are required in order to receive the vaccine. The Department includes the increased costs as a bottom line adjustment in Acute Care.

Adjustment of Claims Paid to Certain Rural Health Centers

For FY 02-03 and FY 03-04, the Department submitted two Change Requests (Decision Item 7, November 1, 2002, and Supplemental Request 9, January 2, 2003; both titled "Conform to Federal Mandate in Reimbursement Methodology for Rural Health Centers") requesting authorization and funding to implement the per visit methodology. These Change Requests were subsequently approved (Figure Setting, March 13, 2003, page 109), and the Department implemented the new regulations. With the approval of the Centers

for Medicare and Medicaid Services, the Department chose to reimburse rural health clinics a per visit rate equal to the higher of the Prospective Payment System rate or their corresponding Medicare rate. Implementing the per visit rate methodology took several years, since these rates could not be set until the Department had the clinics' 1999 and 2000 audited Medicare cost reports. Once the cost reports were available, rates were established retroactive to January 1, 2001 and the Department paid the rural health clinics the difference between what had been reimbursed previously and what was required under the Benefits Improvement and Protection Act.

During FY 06-07, the Department discovered that for three rural health centers the per visit rate methodology was never implemented. Although encounter rates had been calculated for these providers, claims for these providers were paid under the old methodology, wherein the provider was reimbursed a percentage of billed charges. Upon investigation, it was determined that the classification for these providers in the Department's Medicaid Management Information System were not updated to reflect the new methodology; thus, the providers continued to be reimbursed under the old payment system. The Department believes that, by continuing to reimburse these providers under the old methodology, it is out of compliance with both state regulation and the Benefits Improvement and Protection Act of 2000.

In its February 15, 2007 Budget Request, the Department requested a total of $200,318 to adjust claims paid to rural health centers and implement the correct payment methodology going forward. The Joint Budget Committee approved the Department's request, and the annualization amount of $16,982 was included in the Department's Long Bill appropriation (Figure Setting, March 8, 2007, page 38). Accordingly, the Department includes the annualization amount as a bottom line impact to Acute Care (Exhibit F, page EF-3).

(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

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated 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 medically necessary mental health services 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 those 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 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. 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 has been responsible for oversight 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. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in FY 04-05 Long Bill (HB 04-1422). 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 in 2001 it was discovered that the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. 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 into 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, in November 2004, the Department received an order from the Centers for Medicare and Medicaid Services to cease making Child Placement Agency payments since 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, HB 06-1385 (FY 06-07 Long Bill) and FY 05-06 Add-ons removed the line from the Department budget until approval is received.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by 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, are included in both the FY 07-08 Estimate and the FY 08-09 Budget Request 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 with a prescription drug benefit. Additional information is also available in the Medical Services Premiums Exhibit Q and Medical Services Premiums narrative section of this FY 08-09 Budget Request.

- 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. The FY 03-04 Supplemental Bill (HB 04-1320) 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 that an actuarially certified payment would become part of the Mental Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 06-07 capitations.

- SB 07-002 expanded Medicaid eligibility for certain foster care children up to age 21.

Program Administration

In FY 05-06, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration expenditures 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 Estimate and the FY 08-09 Budget Request for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

As part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals are appropriated to this Long Bill group as Cash Funds Exempt. This is an informational-only line item: the costs for these drugs are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer takes place. Because there is no corresponding decrease to the Medical Services Premiums Long Bill group, this double counts the funding for these drugs. In previous Budget Requests, the Department has recommended the removal of this informational line item. However, no action has been taken.

In this Budget Request, the Department is officially requesting the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This will not impact the Department's ability to pay for these drugs, as they are still part of the Medicaid physical health benefit (as are all other pharmaceuticals related to the treatment of mental health conditions, such as anti-depressants). The Department will

continue to report expenditure for anti-psychotics in its Budget Request in future years (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan), and so no information will be lost from the Budget Request.

By removing the double-count, the Department's Budget will more accurately reflect the total funds appropriated to the Department, and the actual expenditure for Medicaid services.

(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, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for 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 were separate payments prior to FY 05-06, and incorporated into the Mental Health Capitation Payments line item in FY 05-06.

The behavioral health organizations are responsible for providing or arranging all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility 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 rates are combined into six categories, as indicated in the table below. Partial Dual Eligibles 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 (AFDC-A), Expansion Adults, and Baby Care Program – Adults
Eligible Children (AFDC-C/BC)
Foster Care
Breast and Cervical Cancer

Analysis of Historical Expenditure Allocations across Eligibility Categories:

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System. Monthly payments were paid based on eligibility categories. The Medicaid Management Information System provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System. The drawback was the Colorado Financial Reporting System provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the Colorado Financial Reporting System. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was 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 for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the Colorado Financial Reporting System. This calculation estimated actual Colorado Financial Reporting System expenditures across each eligibility category. Variance between the two systems was less than 0.3%.

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 from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) 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 average 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%, based on various forecast factors, including the Department's trended cost analysis, the Medicare Economic Index from the Centers for Medicare and Medicaid Services, and the U.S. Department of Labor's Bureau of Labor Statistics consumer price index for local medical costs, 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 Budget Request was 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 was 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 was due to rate increases that were implemented July 1, 2006. This was necessary because the Centers for Medicare and Medicaid Services denied 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% actuarially certified increase, was then used to develop the FY 07-08 Budget Request using the FY 06-07 Estimate as the base. The FY 08-09 Budget Request was calculated using the same methodology.

The following narrative describes in greater detail the assumptions and calculations used in developing the FY 08-09 Budget Request for Medicaid Mental Health Community Programs. It should be noted that the data and values in many of the exhibits are 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, 2007 Budget Request, Volume 1, Section F.

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

Exhibit AA demonstrates the changes 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 07-08 Estimate and the FY 08-09 Base Budget Request. All of the years prior to FY 06-07 have been adjusted to include Goebel enhanced service costs for each particular year (see page DD-5 for the calculations) and therefore vary from previous submissions. 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 Partial Dual Eligibles and Non-Citizens.

The mental health caseload excludes the caseload for Partial Dual Eligibles and Non-Citizens and ties to the Medicaid Medical Services Premiums Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid Caseload projections. The chart in Exhibit AA illustrates a comparison in the change of the mental health caseload compared to the change in capitated expenditures.

General Fund, Cash Funds Exempt, and Federal Funds Match Calculations, FY 08-09 (Exhibit BB):

Exhibit BB details funds splits for all Mental Health Community Programs budget lines for the FY 07-08 Estimate and the FY 08-09 Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% state funds and 50% federal funds. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately below. Capitation expenditures have been split between traditional clients and expansion clients funded from Tobacco Tax Funds.

In both the FY 07-08 Estimate and the FY 08-09 Budget Request capitation base, traditional clients receive 50% General Fund and 50% federal funds, while capitation base expansion clients receive 50% Cash Funds Exempt from the Health Care Expansion Fund, created by the Tobacco Tax Bill, and 50% federal funds, except for the Breast and Cervical Cancer Prevention and Treatment Program which receives 35% State funds and 65% federal funds. In the FY 07-08 Estimate, funding for Breast and Cervical Cancer Program traditional clients is 8.75% Cash Funds Exempt from the Breast and Cervical Cancer Prevention and Treatment Fund (administered by the Department), 26.25% General Fund and 65% federal funds. Funding for expansion clients is 35% Cash Funds Exempt from the Prevention, Early Detection and Treatment Fund (administered by the Department of Public Health and Environment) and 65% federal funds. In the FY 08-09 Budget Request, Breast and Cervical Cancer Program funding for traditional clients is 35% General Fund and 65% federal funds. Funding for expansion clients is 35% Cash Funds Exempt from the Prevention, Early Detection and Treatment Fund and 65% federal funds. A separate exhibit was not necessary for the Breast and Cervical Cancer Program. Hence, a description of the Breast and Cervical Cancer Program immediately follows this section.

Medicaid Mental Health Fee-for-Service Payments also receive 50% General Fund and 50% federal funds. The sum of the capitations and the fee-for-service payments comprise the Department's Request.

Anti-Psychotic Pharmaceuticals are reported for information purposes only as Cash Funds Exempt to avoid double counting an appropriation that is included in the Department's Medical Services Premiums line item. As described above, the Department is officially recommending 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 Fee-For-Service Payments (Exhibit HH) section.

The Department's current year estimate (FY 07-08) is no longer inflated due to the over-expenditure restriction imposed as a result of the Department's FY 06-07 over-expenditure. This differs from prior year Budget Requests. This line item has over-expenditure authority pursuant to Section 24-75-109 (1) (a), C.R.S. (2007). The Department will require a supplemental appropriation for the total restriction pursuant to Section 24-75-109 (4) (a), C.R.S. (2007), but this is not reflected in the Department's Request. The total supplemental appropriation required to lift the restriction is described in Exhibit FF.

Mental Health Services for Breast and Cervical Cancer Program Adults:

SB 01S2-12 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 Medicaid Mental Health Community Programs 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 that includes the Breast and Cervical Cancer Program Adults eligibility category. In addition to different fund splits, a separate per capita is paid for Breast and Cervical Cancer Treatment Program Adults than the one paid for Eligible 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 in Section 25.5-5-308 (9) (b) and (c), C.R.S. (2007). Exhibit BB details funds splits for Mental Health Community Programs Capitations lines. In addition to clients already enrolled in the program, also called "traditional 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, Early Detection and Treatment Fund administered by the Department of Public Health and Environment and 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. For traditional clients, the source for Cash Funds Exempt is the Breast and Cervical Cancer Prevention and Treatment Fund; for expansion clients, the Department receives a transfer from the Department of Public Health and Environment from the Prevention, Early Detection and Treatment Fund.

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 change in capitation expenditures from $184,640,568 during FY 06-07 to an estimated $207,720,078 for the FY 08-09 Budget Request. At the same time, total Medicaid Mental Health Community Programs expenditures increased from $220,303,363 (including the $1.5 million overexpenditure) in FY 06-07 to an estimated $252,783,778 for FY 08-09. During that time frame, capitation expenditures decreased from 83.8% to 82.2% of total Medicaid Mental Health Community Program expenditures. These calculations include an increase of $9,445,931 in Medicaid Anti-Psychotic Pharmaceuticals.

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 EE.

Mental Health Caseload and Per Capita History and Projections, Expenditure History, and Calculations for Goebel Adjustments, for FY 08-09 Request (Exhibit DD):

Exhibit DD has been completely revised for the FY 08-09 Budget Request. Per capita history and projections, formerly in Exhibit EE, have been significantly expanded to provide information on each of the nine eligibility categories. The same is true for per capita projections and historical expenditures. The calculations, including the Goebel lawsuit expenditures into the expenditure history, are included for FY 03-04 through FY 05-06. Each of the tables that comprise Exhibit DD is described below.

Medicaid Mental Health Community Programs Caseload for FY 08-09 Request

Medicaid Mental Health Community Programs caseload is displayed in two tables. Table 1 is the same format as previous years showing total caseload for the combined disabled categories as well as the combined Adult categories. Table 2 displays caseload by all Mental Health eligibility categories. Figures for FY 03-04 through FY 06-07 are actual caseloads, while FY 07-08 and FY 08-09 caseloads are trended current estimates. The caseload numbers and percentage changes are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and narrative.

Medicaid Mental Health Community Programs Per Capita Historical Summary

As with caseload, Medicaid Mental Health Community Programs per capita is displayed in two tables. Table 1 sets forth total per capita for the combined disabled categories as well as the combined Adult categories. Table 2 displays per capita by all Mental Health eligibility categories. However, since the actual per capita from Table 1 is the same for both disabled categories, and the three Adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing

each individual category expenditure by the caseload. Figures for FY 03-04 through FY 06-07 are actual caseloads, while FY 07-08 and FY 08-09 caseloads are trended current estimates. The per capita numbers are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and Narrative.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures covers FY 04-05 through FY 06-07, includes combined category and expanded category tables, as well as total expenditures for both capitations and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately. Expanded service category information for fee-for-service expenditure is not available prior to FY 04-05.

As described briefly in "Analysis of Historical Expenditure Allocations across Eligibility Categories" above, actual expenditures are only available from the Colorado Financial Reporting System. Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the Colorado Financial Reporting System. The Medicaid Management Information System does provide expenditures by eligibility category, but does not include offline transactions and accounting adjustments. Since the two systems are within 0.3% of each other, 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 to be estimated. 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.DD-2 as FY 06-07.

Adjustments to Medicaid Mental Health Community Programs Expenditures for Inclusion of Goebel Expenditures

For comparative purposes, expenditures for all years must contain the same primary components. However, expenditures for Goebel enhanced services were not included in the capitation payments for the years shown prior to FY 06-07. Therefore, an adjustment was made for those years. The table sets forth actual expenditures including the Goebel expenditures. Actual expenditures were distributed by an average percentage from available years since actual percentages were not available for every year. These are the capitation expenditures used in the previous sections of this exhibit.

Medicaid Mental Health Community Programs FY 07-08 Estimate and FY 08-09 Budget Request (Exhibit EE):

Exhibit EE provides calculations for exhibits that use FY 06-07 Actuals, FY 07-08 Estimate year, and/or FY 08-09 data. The calculations for eligibility category expenses and per capita in the FY 06-07 base year, as well as development of the FY 07-08 Estimate year and the FY 08-09 Budget Request 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 using combined disabled categories as well as combined Adult categories. Per capita methodology has been used to calculate the FY 07-08 Estimate and to develop the FY 08-09 Budget Request. 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 DD began in FY 03-04 because the transfer of Medicaid Mental Health Services to the Department began in the last quarter of that year. Prior data not only had a different accounting basis, but reflected different rates, services, and provider groupings.

The per capita budget methodology is straightforward. In FY 06-07, the base year, per capita costs were calculated 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 07-08 Estimate and FY 08-09 Budget Request per capita were developed.

To develop the FY 07-08 estimate, the Department starts with total expenditure and per capita cost from the prior year. The Department then adjusts actual expenditure by adding in the total amount of recoupments performed in the prior year. The revised capitation base now reflects the actual amount of capitations paid by the Department in the prior year[39]. Using the adjusted actuals (the FY 06-07 Capitation Base), the Department recalculates the FY 06-07 per capita cost. This adjusted per capita cost is trended forward using the percentage increase in the actuarially certified rates for FY 07-08. This per capita is then multiplied by the FY 07-08 projected caseload to determine the expenditures before adjustments (the "Base Expenditure"). The Department then subtracts the estimated value of recoupments expected to be performed during FY 07-08. This is the estimated FY 07-08 total expenditure.

To develop the FY 08-09 estimate, the Department beings with the FY 07-08 Base Per Capita Cost. This figure does not include expected recoupments in FY 07-08. The base per capita is trended forward using the average percentage increase in the actuarially

[39] Recoupments performed in a year are for service dates in a previous year. For example, recoupments performed in FY 06-07 are for dates of service for FY 05-06 or prior. Because this reduction to FY 06-07 expenditure is unrelated to the amount of capitations paid in FY 06-07, it would be inappropriate to include the total amount of recoupments in the base. Recoupments are further discussed in this Budget Narrative in the discussion for Exhibit FF.

certified rates between FY 05-06 and FY 07-08. The Department's rationale for this trend factor is described below. This per capita is then multiplied by the FY 08-09 projected caseload to determine the expenditures before adjustments (the "Base Expenditure"). The Department then subtracts the estimated value of recoupments expected to be performed during FY 08-09. This is the estimated FY 08-09 total expenditure.

Beginning in January 2009, the Department will implement calendar year rates instead of fiscal year rates. Since the actuarially certified percentage increase is accepted as the most reliable predictor of mental health capitation expenditure growth, the Department used an average of the certified rates for the past three years, which is 3.62%, as the change rate for FY 08-09. It is anticipated this will result in a more accurate projection than previous methods.

It is important to note that the Department does not adjust projected expenditure for either estimated costs due to the Goebel lawsuit, or SB 07-002 (Expansion of Foster Care). Goebel payments were included in the FY 06-07 capitation base and are included as part of the total estimate. The Department accounts for SB 07-002 by increasing total caseload by the estimated number of clients. This adjustment is described in detail in the Medicaid Caseload portion of this Budget Narrative. Because these clients are paid at the same capitation rate as other foster care children, no additional adjustment needs to be made.

Actuarially Certified Rates

The determination of capitated rates with the behavioral health organizations needs to be actuarially certified and approved by the Centers for Medicare and Medicaid Services, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. The trended cost analysis by the Department's contracted actuary began by reviewing encounter data and financial reports from each behavioral health organization and regions, and 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 07-08 and an average trend for each was calculated. A weight was applied to each average change rate, and a weighted average change of 3.76% for FY 07-08 was developed. Since these certified rates are considered the most accurate predictors of future activity, Percentage Change for FY 08-09 was calculated using the average of three most recent actuarial certification letters which were 3.25% for FY 05-06, 3.85% for FY 06-07, and 3.76% for FY 07-08 for a 3.62% three year average.

Reconciliation of Spending Authority 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, an adjustment was made to FY 04-05 capitation expenditures to reverse a one-time recoupment for institute payment disallowance totaling $448,858. Adjustments for overexpenditure restrictions and underexpenditures are also shown in this table when they occur.

Explanation of FY 06-07 Overexpenditure:

In FY 06-07, there was a total funds overexpenditure of $1,499,555. While the actual caseload was 0.05% under the appropriation, a change in mix between high and low cost eligibility categories, and a change in the mix of various behavioral health organizations' rates, contributed to the overexpenditure. The overexpenditure was the net of: greater than anticipated caseload in Children/Foster Care and Adults, with capitation payments $2.1 million and $0.1 million over the projected amounts, respectively, and lower than anticipated caseload in the disabled category, which had capitation payments $0.7 million under the appropriated amount.

Of the Department's overexpenditure, $1,474,141 was General Fund and $750,906 was federal funds. Total overexpenditure was partially offset by an underexpenditure of $725,492 in Cash Funds Exempt. Underexpenditure, however, does not cause any restrictions to the Department's appropriation. Pursuant to Section 24-75-109 (4) (a), C.R.S. (2007), the Department will require a supplemental appropriation to lift the restriction.

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

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is 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. FY 04-05 was the first full year for monthly capitation payments on a concurrent basis.

Prior to FY 05-06, the recoupment process was done once a year, with a two-year lag. 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 was completely implemented in early 2007. The estimated FY 07-08 and FY 08-09 recoupments have been decreased as a result of more timely eligibility processing due to the implementation of the Colorado Benefits Management System and a systems change made in FY 06-07 to pop-up a warning message to Colorado Benefits Management System users when the potential for cancellations or retroactive terminations arises. The warning is intended to minimize the number of retroactive terminations or benefits cancellations. Since payments should be minimized during months where a client was terminated, no recoupments will be necessary for them. As the implementation was begun before any recoupments were made, the Department chose not to process any recoupments in FY 05-06. There was time for only one year's recoupments to be made for FY 03-04 ineligibles in FY 06-07. It is planned that recoupments for FY 04-05 and FY 05-06 ineligibles will be made in FY 07-08 which will bring the Department to a one year lag beginning in FY 08-09. 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 funds the Department recoups is expected to drop significantly from the past.

Tobacco Tax Impacts on General Fund, Cash Funds Exempt, and Federal Funds Match Calculations (Exhibit GG):

Exhibit GG is a stand-alone exhibit designed to show the effect of the Tobacco Tax Bill (HB 05-1262) to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the FY 07-08 Estimate and the FY 08-09 Budget Request. Note that the caseloads shown are the average monthly number over each year and will fluctuate monthly through the year.

HB 05-1262 established a number of funds, two of which provide funding to the Medicaid Mental Health Community Programs line: 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. The Health Care Expansion Fund provides capitated mental health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, as well as the Children's Extensive Support and Children's Home and Community Based Services waiver programs. The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program. 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.

With the passage of HB 05-1262, the Department received funding to provide services to the 478 individuals on the Children's Home and Community Based Services waiver program waiting list. In addition, the Joint Budget Committee decided to add an additional 200 expansion slots during FY 06-07 Figure Setting (see the March 13, 2006 Figure Setting Document, page 145). In total, there are 678 expansion slots in the Children's Home and Community Based Services waiver program that will be served in FY 07-08 and subsequent fiscal years. Please see Exhibit GG for the Department's projected Health Care Expansion Fund expenditures for the Children's Home and Community Based Services.

HB 05-1262 also provided additional funding to pay for 148 individuals on the Children's Extensive Support wait list. However, since 99 of these clients were already Medicaid eligible, expenditures associated with these clients cannot be billed to the Health Care Expansion Fund. Therefore, only 49 of the original 148 expansion slots are funded with Health Care Expansion Fund money. During FY 06-07 figure setting, the Joint Budget Committee approved an additional 30 expansion slots (March 13, 2006 Figure Setting Document, page 145), of which 10 will be paid for through the Health Care Expansion Fund. In total, the Department expects to pay for 59 Children's Extensive Support expansion slots in FY 07-08 and subsequent fiscal years. Exhibit GG provides additional detail

regarding the Department's FY 07-08 and FY 08-09 estimate of expenditures for the Children's Extensive Support expansion population.

The Health Care Expansion Fund also provides capitated mental health services to expansion adults. This population consists of individuals that meet the following requirements: 1) they are parents of children that are eligible for either Medicaid or the Children's Basic Health Plan, 2) their income is less than 60% of the federal poverty level, and 3) they are not otherwise eligible for Medicaid. The estimated caseloads of 7,886 in FY 07-08 and 9,462 in FY 08-09 were taken from the Department's caseload projections provided in this November 1, 2007 Budget Request (see Exhibit EB – 1). Per capita costs for each expansion population are assumed to be the same as for the traditional populations. This is because the vast majority of mental health services payments are made via the capitation, and do not change based on client utilization.

Finally, the Health Care Expansion Fund pays for individuals that are eligible for Medicaid as a result of the removal of the asset test, as required by HB 05-1262. Due to the fact that many Medicaid recipients are no longer required to submit information for the asset test, the Department has found it difficult to track expenditures for this population. Currently, approximately 50% of the total asset test removal population has an asset test flag that allows the Department to discern whether or not they are eligible as a result of the removal of the asset test. To project expenditures in the Medicaid Mental Health Community Programs line for the asset test removal population from FY 07-08 and forward, the Department has applied its estimated caseload and per capita growth rates from FY 06-07 to FY 07-08 to actual FY 06-07 expenditures. As a result, the Department estimates that the asset test removal population will require $7,199,882 and $7, 420,520 in total funds for FY 07-08 and FY 08-09, respectively.

(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS

All Medicaid Mental Health Community Programs payments which are not part of the capitation payments are under this Long Bill group. Of the two appropriations in this group, only Mental Health Fee-For-Service Payments are actual expenditures while Mental Health Anti-Psychotic Pharmaceuticals, which are paid from Medical Services Premiums, are included for information only.

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. Expenditures for this line shown in Exhibit HH. The data from Exhibit HH also appears in Exhibits AA, BB, and CC as well as the Schedule 13.

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services 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 the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are

included in the fee-for-service category. These are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and mental health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

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 which was 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 Centers for Medicare and Medicaid Services, 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 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 Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The FY 07-08 Estimate is based on FY 06-07 actual expenditures, decreased by 3.81% due to decreased caseload, to $1,315,785 which is $173,218 under the FY 07-08 appropriation. FY 06-07 Actuals of $1,367,867 were $121,136 under the final FY 06-07 appropriation.

The FY 07-08 Estimate is trended forward by the 0.55% mental health caseload change rate to the FY 08-09 Budget Request. The requested amount is $7,255 over the FY 07-08 Estimate. The Department's request incrementally decreases $165,963 from the FY 07-08 appropriation of $1,489,003 to $1,323,040 in the FY 08-09 Budget Request due to a lower caseload change percentage. No rate or utilization increases are forecast. Please see the Medicaid Mental Health Fee-for-Service Payments table that reconciles to the Department's FY 07-08 Estimate and FY 08-09 Budget Request.

Mental Health Anti-Psychotic Pharmaceuticals:

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 costs to the State for providing prescription drugs, including anti-psychotic medications, were expected to decline. However, the rate of increase for anti-psychotic medications has been approximately the same, and is projected to continue.

In this Budget Request, the Department is officially requesting the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This will not impact the Department's ability to pay for these drugs, as they are still part of the Medicaid physical health benefit (as are all other pharmaceuticals related to the treatment of mental health conditions, such as anti-depressants). The Department will continue to report expenditure for anti-psychotics in its Budget Request in future years (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan), and so no information will be lost from the Budget Request.

By removing the double-count, the Department's Budget will more accurately reflect the total funds appropriated to the Department, and the actual expenditure for Medicaid services.

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 DD. The FY 07-08 appropriation is 6.32% higher than FY 06-07 actual expenditures. The FY 07-08 Estimate incorporates reduced caseload projections (and includes Goebel enhanced services in the FY 04-05 and FY 05-06 Actuals for comparison) which results in an 8.64% increase over FY 06-07 actual expenditures. The FY 08-09 Budget Request is built on the FY 07-08 Estimate, increased by a 3.57% per capita change percentage and increased caseload projections of 1,989. The result is a 9.11% increase over the FY 07-08 appropriation and 6.78% over the FY 07-08 Estimate. Since the costs of Goebel clients were not included in previous actual years until FY 06-07, they were added to the FY 04-05 and FY 05-06 Actual Expenditures so the data was not skewed. Thus, the data being evaluated are comparable. The $1,841,421 adjustment for the annualization of SB 07-002 also contributes to the increases.

(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, the budget history, and the FY 08-09 Budget Request amounts are presented below.

COLORADO INDIGENT CARE PROGRAM

The Colorado Indigent Care Program provides direct or indirect funding to hospitals and clinics that have uncompensated costs from treating underinsured or uninsured Coloradans. It is neither an insurance program nor an entitlement program. As of FY 07-08, the program consists of the following three line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; and Pediatric Specialty Hospital. These line items allow providers to receive partial compensation for uncompensated costs associated with services rendered to uninsured or underinsured low-income Colorado residents who are not eligible for Medicaid or the Children's Basic Health Plan (effective July 1, 2002). Clients can have third-party insurance, but this resource must be exhausted prior to the providers receiving any reimbursement from the program.

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 increased from 185% to 200% of the federal poverty level effective February 1, 2006 due to the expansion populations created under HB 05-1262 (Health Care Expansion Fund). On July 1, 2006, the financial eligibility requirement was further increased to 250% of the federal poverty level per SB 06-044 (Colorado Health Care Services Fund). The program contracts directly with hospitals and community health clinics. By statute, providers are 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 co-payment determinations. To determine eligibility, providers assign a "rate" to applicants based on their total income and assets. Nearly all clients are required to pay a minimal annual co-payment, which varies according to services received and client rating. For all clients ratings except the N-rating (0-40% of the federal poverty level), annual co-payments cannot exceed 10% of the family's total income and equity in assets. The annual co-payment for clients with an N-rating cannot exceed $120.

The majority of the program is supported by two sources of federal funds: Disproportionate Share Hospital and Medicare Upper Payment Limit. 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 matching federal funds. Therefore, public entities receive cash payments from the State consisting entirely of federal funds. Private entities cannot certify expenditures, so the State must appropriate General Fund to these providers to draw down 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 "Safety-Net Provider Payments" line item for more detail about funding mechanisms.

The introduction of the 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 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 limit of $75,110,000.

In late 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act. 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 limit).

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 06-07 data, this information can be found in Exhibit K, page EK-8 in the Department's FY 08-09 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 following the passage of SB 03-258. 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 more easily be understood by Department staff, 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 providing increased overall payments to qualified providers.

Additionally, Decision Item DI-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 payments: Low-Income, Bad Debt, High-Volume, and Medicaid 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 08-09 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 payment 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 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 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 federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is General Fund. The federal share is from the federal Medicaid matching rate for Colorado.
Medicaid Shortfall Payment: Payable to medical facilities that provide services to a large number of Medicaid and low-income, underinsured patients, but 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 federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is General Fund. The federal share is from the federal Medicaid matching rate for Colorado.

Under the distribution model, four separate payment calculations (Low-Income payments, Bad Debt payments, High-Volume payments, and Medicaid Shortfall payments) are used to determine funding available for reimbursement of uncompensated costs associated with treating indigent clients. 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 08-09 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 Medicaid Shortfall, with any additional federal funds available at fiscal year end to be distributed as Bad Debt payments.

The Upper Payment Limit for inpatient hospital services 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 05-06, the Department received a Long Bill appropriation of $255,282,024, equal to the final FY 04-05 appropriation of $264,013,206 less 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 total funding of $25,725,726 (FY 05-06, Supplemental Requests, 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 subsequently 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 to finance private hospitals under the Upper Payment Limit and 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 was therefore $296,188,630.

For FY 07-08, the Department received continuation funding of $296,188,630 and is requesting continuation funding of $296,188,630 for FY 08-09.

Line Item: Safety-Net Provider Payments	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$264,013,206**	**$287,296,074**	**$296,188,630**	**$296,188,630**
Removal of FY 04-05 Joint Budget Committee recommended increase for FY 03-04 funding related to Upper Payment Limit	($8,731,182)	$0	$0	$0
Joint Budget Committee action recommending an increase to Upper Payment Limit funding	$0	$8,892,556	$0	$0
Long Bill Appropriation / Request	**$255,282,024**	**$296,188,630**	**$296,188,630**	**$296,188,630**
HB 05-1349 involving the transfer of interest from the Controlled Maintenance Trust Fund (with matching federal funds)	$6,288,324	$0	$0	$0
HB 06-1217 increase to Upper Payment Limit financing to allow for greater certification of local match (S-9, January 3, 2006)	$25,725,726	$0	$0	$0
Final Appropriation / Request	**$287,296,074**	**$296,188,630**	**$296,188,630**	**$296,188,630**
General Fund	$12,576,646	$13,090,782	$13,090,782	$13,090,782
Cash Funds Exempt	$131,071,391	$135,003,533	$135,003,533	$135,003,533
Federal Funds	$143,648,037	$148,094,315	$148,094,315	$148,094,315

HEALTH CARE SERVICES FUND

In FY 05-06, SB 06-044 created the Health Care Services Fund to provide funding for indigent adult primary care to decrease the number of emergency room visits and their associated costs. SB 06-044 appropriated $14,962,408 to the Health Care Services Fund. The appropriation was intended to reimburse 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 beginning in FY 06-07.

Pursuant to Section 25.5-3-112 (1) (b), C.R.S. (2007), the Health Care Services Fund is appropriated $15,000,000 for FY 07-08 and each of the two fiscal years thereafter. The Department's FY 08-09 Base Request includes $15,000,000 in Cash Funds Exempt.

Line Item: Health Care Services Fund	FY 05-06	FY 06-07[40]	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$0**	**$14,962,408**	**$0**	**$15,000,000**
Annualization of SB 06-044	$0	($14,962,408)	$15,000,000	$0
Long Bill Appropriation / Request	**$0**	**$0**	**$15,000,000**	**$15,000,000**
SB 06-044 (Health Care Services to Low Income Adults)	$14,962,408	$0	$0	$0
Final Appropriation / Request	**$14,962,408**	**$0**	**$15,000,000**	**$15,000,000**
General Fund	$14,962,408	$0	$15,000,000	$15,000,000

THE CHILDREN'S HOSPITAL, CLINIC BASED INDIGENT CARE

The Children's Hospital, Clinic Based Indigent Care line item was created in FY 02-03 with a Long Bill appropriation of $6,119,760. Funding was comprised of General Fund and federal funds, which utilized the Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies for this payment because the hospital is privately-owned. Being privately-owned, the certification of public expenditures for uncompensated Medicaid costs is not allowed. Instead, 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 participating clinics. The $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to participating clinics 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.

[40] There was no appropriation in FY 06-07 because the unused appropriation from FY 05-06 was carried forward.

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 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 with the passage of HB 06-1385. Later in the 2006 legislative session, however, SB 06-208 was passed to deduct $200,000 of these funds, with $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 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.

In FY 06-07, the Department received continuation funding of $6,119,760. During the 2007 legislative session, the General Assembly passed HB 07-1258 which allows funding from the Health Care Services Fund to be used for any individual eligible for the Colorado Indigent Care Program (as opposed to only adults as intended by SB 06-044). In addition, HB 07-1258 requires that to the extent possible, the Department pursue opportunities to maximize federal funds for the community health centers. While HB 07-1258 did not have an appropriation clause, passage of this bill resulted in the FY 07-08 Long Bill (SB 07-239(having an additional $10,086,000 in Cash Funds Exempt for this purpose (FY 07-08, Figure Setting, March 8, 2007, page 62). The Department's FY 08-09 Base Request is for continuation funding of $16,205,760. Once the Department can finalize the process for distributing these Health Care Services Fund monies to the clinics, and federal financial participation is confirmed, the Department will submit a budget action to increase federal funds.

Line Item: The Children's Hospital, Clinic Based Indigent Care	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$6,119,760**	**$6,119,760**	**$6,119,760**	**$16,205,760**
HB 07-1258 (Joint Budget Committee Action, Figure Setting March 8, 2007, page 62).	$0	$0	$10,086,000	$0
Long Bill Appropriation / Request	**$6,119,760**	**$6,119,760**	**$16,205,760**	**$16,205,760**
HB 06-1385 (Long Bill Add-ons)	$30,124,816	$0	$0	$0
SB 06-208 (Health Care Reform)	($200,000)	$0	$0	$0
SB 06-044 (Health Care Services For Adults)	($29,924,816)	$0	$0	$0
Final Appropriation / Request	**$6,119,760**	**$6,119,760**	**$16,205,760**	**$16,205,760**
General Fund	$3,059,880	$3,059,880	$3,059,880	$3,059,880

Line Item: The Children's Hospital, Clinic Based Indigent Care	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Cash Funds Exempt	$0	$0	$10,086,000	$10,086,000
Federal Funds	$3,059,880	$3,059,880	$3,059,880	$3,059,880

HEALTH CARE SERVICES FUND PROGRAMS

In 2006, SB 06-044 appropriated $15,000,000 General Fund to the Colorado Health Care Services Fund in FY 07-08, FY 08-09 and FY 09-10. SB 06-044 required that 18% of the available funding be distributed to Denver Health and the remaining 82% to clinics. Of the 82% to be distributed to clinics, 18% must be distributed to clinics operated by licensed or certified health care facilities (hospitals) and the remaining 82% must be distributed to federally qualified health centers. This new line item contains the funding for both Denver Health and the clinics that are operated by licensed or certified health care facilities.

In FY 07-08 through FY 09-10, the line item will contain the $2,700,000 appropriation for Denver Health and another $2,214,000 for health clinics associated with licensed or certified health care facilities. The total FY 07-08 appropriation is $4,914,000. The remaining $10,086,000 from SB 06-044 was moved to the Children's Hospital line through a Joint Budget Committee Action (Figure Setting, March 8, 2007, page 62).

For FY 08-09, the Department is requesting continuation funding of $4,914,000.

Line Item: Health Care Services Fund Programs	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$N/A**	**$4,914,000**
SB 06-044 Denver Health	$2,700,000	$0
SB 06-044 Licensed or Certified Health Care Facilities	$2,214,000	$0
Long Bill Appropriation / Request	**$4,914,000**	**$4,914,000**
Cash Funds Exempt	$4,914,000	$4,914,000

COLORADO HEALTH CARE SERVICES FUND - DENVER HEALTH

One of three payments made from the Colorado Health Care Services Fund is to Denver Health. At the time the SB 06-044 fiscal note was priced, 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. Pursuant to SB 06-044, Denver Health's portion of the allocation is 18% of the total Colorado Health Care Services Fund. For FY 06-07, this amount was equal to $2,693,233.

As a result of Joint Budget Committee action during FY 07-08 Figure Setting, the Committee recommended this appropriation be combined with the Colorado Health Care Services Fund – Primary Care Clinics under the Health Care Services Fund Programs Long Bill line item (FY 07-08, Figure Setting, March 8, 2007, pages 63-64). Therefore, there is no appropriation for FY 07-08 or request for FY 08-09.

Line Item: Colorado Health Care Services Fund - Denver Health	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**N/A**	**$2,693,233**	**$0**
Annualization of SB 06-044	$0	$6,767	$0
Joint Budget Committee action to move line item under Health Care Services Fund Program (FY 07-08, Figure Setting, March 8, 2007, page 62).		($2,700,000)	$0
Long Bill Appropriation / Request	**$0**	**$0**	**$0**
SB 06-044 (Health Care Services to Low Income Adults)	$2,693,233	$0	$0
Final Appropriation / Request	**$2,693,233**	**$0**	**$0**

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 funding 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 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. The higher projected revenue increased funding in FY 07-08 for community health clinics equal to $10,086,000. However, as a result of Joint Budget Committee action during FY 07-08 Figure Setting, the Committee recommended this funding be moved under The Children's Hospital, Clinic Based Indigent Care line item to fund community health centers. Therefore, the FY 07-08 appropriation and FY 08-09 request do not reflect any funding.

Line Item: Colorado Health Care Services Fund – Certified Health Care Providers	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**N/A**	**$10,060,723**	**$0**
Annualization of SB 06-044	$0	$25,277	$0
Joint Budget Committee action moved funding for community health centers to The Children's Hospital, Clinic Based Indigent Care line item per SB 06-044 (Joint Budget Committee Figure Setting, March 8, 2007, page 62).		($10,086,000)	$0
Long Bill Appropriation / Request	**$0**	**$0**	**$0**
SB 06-044 (Health Care Services to Low Income Adults)	$10,060,723	$0	$0
Final Appropriation / Request	**$10,060,723**	**$0**	**$0**

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 anticipated FY 07-08 need includes $5,548 for the annualization of SB 06-044. However, as a result of Joint Budget Committee action during FY 07-08 Figure Setting, the Committee recommended this appropriation be combined with the Colorado Health Care Services Fund – Denver Health under the Health Care Services Fund Programs Long Bill line item (FY 07-08, Figure Setting, March 8, 2007, pages 63-64). Therefore, no funding is appropriated or requested in this line item for FY 07-08 or FY 08-09.

Line Item: Colorado Health Care Providers – Private Primary Care Clinics	FY 06-07	FY 07-08	FY 08-09
Prior Year Appropriation	N/A	$2,208,452	$0
Annualization of SB 06-044	$0	$5,548	$0
Joint Budget Committee action to move funding to Health Care Services Fund Program line item (FY 07-08, Figure Setting, March 8, 2007, page 62).	$0	($2,214,000)	$0

Line Item: Colorado Health Care Providers – Private Primary Care Clinics	FY 06-07	FY 07-08	FY 08-09
Long Bill Appropriation / Request	**$0**	**$0**	**$0**
SB 06-044 (Health Care Services to Low Income Adults)	$2,208,452	$0	$0
Final Appropriation / Request	**$2,208,452**	**$0**	**$0**

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, the Joint Budget Committee made recommendations during the Department's Figure Setting session on March 13, 2006 to increase 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 $516,036 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 originally requested continuation funding of $7,732,072, but received several adjustments before the Long Bill was passed. The first adjustment reduced the appropriation by $6,072 as a technical adjustment for the lower tobacco tax revenue projection provided by the Office of State Planning and Budgeting in June 2006 (Figure Setting, March 8, 2007, page 65). During Figure Setting, the Joint Budget Committee recommended a 6% General Fund increase for The Children's Hospital because it was the State's only pediatric hospital. This recommendation increased the appropriation by $402,000 in total funds. When the Department's Long Bill appropriation was finalized, the line item received additional Cash Fund Exempt funding of $200,000 from SB 07-097 with matching federal funds of $200,000. However, HB 07-1359 reduced the $200,000 appropriation from SB 07-097 by $28,711 for FY 07-08. The culmination of these changes resulted in a final appropriation of $8,499,289 for FY 07-08.

For FY 08-09, the Department is requesting continuation funding with increases from the annualization of special bills (HB 07-1359 and SB 07-097). The annualization amounts to $228,711 in Cash Funds Exempt for FY 08-09 and increases the final appropriation to $8,728,000.

Line Item: Pediatric Specialty Hospital	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$0**	**$5,452,134**	**$7,732,072**	**$8,499,289**
SB 05-209 (FY 05-06 Long Bill)	$5,452,134	$0	$0	$0
Joint Budget Committee recommendation to increase the General Fund in this appropriation (Figure Setting, March 13, 2006)	$0	$1,247,866	$0	$0
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	$0
Tobacco Tax forecast revision	$0	$0	($6,072)	$0
Joint Budget Committee action recommended 6% General Fund increase	$0	$0	$402,000	$0
SB 07-097 Reallocation of Tobacco Settlement Funds	$0	$0	$200,000	$0
Annualization of Special Bills: HB 07-1359 and SB 07-097	$0	$0	$0	$228,711
Long Bill Appropriation / Request	**$5,452,134**	**$7,732,072**	**$8,328,000**	**$8,728,000**
SB 07-097 Reallocation of Tobacco Settlement Funds	$0	$0	$200,000	$0
HB 07-1359 Allocation of Tobacco Litigation Settlement Moneys	$0	$0	($28,711)	$0
Final appropriation / Request	**$5,452,134**	**$7,732,072**	**$8,499,289**	**$8,728,000**
General Fund	$2,726,067	$3,350,000	$3,551,000	$3,551,000
Cash Funds Exempt	$0	$516,036	$684,289	$913,000
Federal Funds	$2,726,067	$3,866,036	$4,264,000	$4,264,000

HB 05-1262 APPROPRIATION FROM THE GENERAL FUND TO PEDIATRIC SPECIAL 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. Section 24-22-117 (1) (c) (I) (A), C.R.S., (2007) 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. Pursuant to Section 24-22-117 (1) (c) (I) (B), C.R.S. (2007), 50% of these above mentioned revenues are to be appropriated by the General Assembly to the Pediatric Specialty Hospital Fund.

In FY 06-07, the amount transferred in four quarterly payments totaled $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, SB 07-239 has appropriated $513,000 for this line that will be transferred quarterly.

The Department's FY 08-09 Base Request is $486,600 which includes a reduction of $26,400 based on revised Tobacco Tax revenue estimated by the Office of Legislative Counsel.

Line Item: HB 05-1262 Appropriation from General Fund to the Pediatric Special Hospital Fund	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$0**	**$516,036**	**$513,000**
Adjustment for Forecasted Tobacco Tax Revenue	$516,036	($3,036)	($26,400)
Final appropriation / Request	**$516,036**	**$513,000**	**$486,600**
General Fund Exempt	$516,036	$513,000	$486,600

HB 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. Section 24-22-117 (1) (c) (I) (A), C.R.S. (2007) states that of the 3% of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund, 20% 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 Joint Budget Committee streamlined the appropriation from the Tobacco Tax Fund to the General Fund. Originally, the appropriation contained the Department of Public Health and Environment's portion as required by HB 05-1262, as well as a double-count of the funds transferred to the Pediatric Specialty Hospital Fund. However, since the Department did not receive an authorization to transfer the funds to the Department of Public Health and Environment in a letternote or otherwise, there was some concern that the Department of Public Health and Environment would not receive the intended funds. To clarify the appropriation, the Joint Budget Committee appropriated the Department of Public Health and Environment's portion directly, effectively cutting the Department's appropriation by 50%. This amount only reflects the double-count of the funds transferred to the Pediatric Specialty Hospital Fund. For FY 07-08, the amount appropriated for this line totaled $513,000. The Department's FY 08-09 Base Request is $486,600 which includes a reduction of $26,400 based on revised Tobacco Tax revenue estimated by the Office of Legislative Counsel.

Line Item: HB 05-1262 Appropriation from Tobacco Tax Cash Fund to the General Fund	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$0**	**$1,032,072**	**$513,000**
Adjustment for Forecasted Tobacco Tax Revenue	$1,032,072	$0	($26,400)
Joint Budget Committee Action to Clarify Appropriation	$0	($519,072)	$0
Final appropriation / Request	**$1,032,072**	**$513,000**	**$486,600**
Cash Funds Exempt	$1,032,072	$513,000	$486,600

PRIMARY CARE FUND PROGRAM

The Primary Care Fund supports payments to providers serving indigent clients. Each provider seeking assistance from the Primary Care Fund must submit an application and meet other Department criteria. The Fund was authorized under Section 24-22-117, C.R.S. (2007) and distributes money to the providers based on the portion of medically indigent or uninsured patients they served relative to the total amount of medically indigent or uninsured clients served by all qualified providers. 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,
- Screen and report 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 Section 25.5-3-102 C.R.S. (2007), 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 were removed from this

line and appropriated in (1) Executive Director's Office Personal Services and Operating Expenses line items. Therefore, the final appropriation for FY 06-07 was $32,939,958 (Figure Setting, March 13, 2006, pages 182-183).

The FY 07-08 Long Bill (SB 07-239) has reduced the appropriation for the Primary Care Fund by $499,460 based on the anticipated drop in tobacco tax revenues. In addition, the Department's DI -12 that was approved by the Joint Budget Committee (March 8, 2007 Figure Setting document, page 68) moved $75,200 out of the Primary Care Fund appropriation into a separate line item to pay for an internal audit of the program for FY 07-08. The Department has assumed continuation funding for the Primary Care Fund Program in FY 08-09, except to reflect reduced tobacco tax revenues as estimated by the Office of Legislative Counsel.

Line Item: Primary Care Fund	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$0**	**$44,099,000**	**$32,939,958**	**$32,365,298**
Revision of estimated tobacco tax revenues	$0	($11,159,042)	($499,460)	($1,622,498)
DI - 12 Internal Audit of Primary Care Fund Program	$0	$0	($75,200)	$75,200
Long Bill Appropriation / Request	**$0**	**$32,939,958**	**$32,365,298**	**$30,818,000**
HB 05-1262 (Tobacco Tax Bill)	$44,099,000	$0	$0	$0
Final Appropriation / Request	**$44,099,000**	**$32,939,958**	**$32,365,298**	**$30,818,000**
Cash Funds Exempt	$44,099,000	$32,939,958	$32,365,298	$30,818,000

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. HB 98-1325 authorized Colorado to participate in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes below 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 under 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 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.

In 2007, the Colorado Legislature passed SB 07-097, which expanded eligibility in the Children's Basic Health Plan to children and pregnant women with family incomes up to 205% of the federal poverty level.

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 a portion of 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.

FY 05-06 Appropriation for the Trust

On March 15, 2005, the Joint Budget Committee staff (Figure Setting dated March 15, 2005, page 160) recommended a FY 05-06 appropriation of $2,255,000 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. On June 30, 2006, pursuant to SB 05-211, $8,100,000 was transferred from the Children's Basic Health Plan Trust Fund to General Fund.

FY 06-07 Appropriation for the Trust

The FY 06-07 Long Bill (HB 06-1385) appropriation was for $21,165,996. This appropriation was the result of the Department's November 15, 2005 Change Request (DI-3) which requested a reduction of Cash Funds from annual enrollment fees by $53,670 due to caseload adjustments and, an increase to the Cash Funds Exempt appropriation by $46,395 due to an increase to the Tobacco Master Settlement Revenue projection.

The appropriation was further reduced by HB 06-1310 which eliminated the need to appropriate the funds from the Tobacco Master Settlement Agreement by setting up an automatic transfer to the appropriate agencies. This bill removed an appropriation of these funds in this year and subsequent years, resulting in a reduction to the Children's Basic Health Plan Trust of $20,973,924 in Cash Funds Exempt.

Finally, the Department submitted a late Supplemental to the Joint Budget Committee on January 19, 2007 for $2,500,000 General Fund, which was approved and appropriated in SB 07-163 (Supplemental Bill). SB 07-163 also included General Fund appropriations to the Children's Basic Health Plan Trust Fund in the amount of $9,117 for Supplemental #4 regarding the implementation of HB 06S-1023 and the Deficit Reduction Act of 2005, and $34,098 for Supplemental #5 regarding the Payment Error Rate Measurement Program. Supplemental #3 (appropriated for in SB 07-239) in the Department's February 15, 2007 Budget Request requested in an increase of $31,777 to the Cash Funds appropriation and a General Fund appropriation of $8,700,000 for caseload and rate changes. The final FY 06-07 appropriation of $11,467,064, consisted of $223,849 in Cash Funds and $11,243,215 in General Fund.

In addition to the final appropriated amount, an emergency Supplemental was submitted and approved by the Joint Budget Committee on June 20, 2007, which resulted in an increase in the spending authority of $10,567 Cash Funds due to increased caseload and greater collection of enrollment fees.

FY 07-08 Appropriation for the Trust

The FY 07-08 Long Bill removed one-time funding of $11,274,992 and increased the Cash Funds appropriation by $53,392 from the FY 06-07 appropriation (prior to Supplemental #3, see Figure Setting dated March 7, 2008, pages 79-80). The FY 07-08 Long Bill appropriation was $245,464 Cash Funds. During the 2007 legislative session, three special bills were adopted which revised funding for this appropriation.

SB 07-036, Mandatory Coverage of Mental Disorders, requires health insurance coverage of certain disorders, including through the Children's Basic Health Plan. Based on the fiscal note for SB 07-036, the State fund cost to the Children's Basic Health Plan is $11,011 in FY 07-08. SB 07-097 increases eligibility in the Children's Basic Health Plan and reallocates Tobacco Master Settlement Agreement funds that are currently not allocated to existing tobacco settlement programs, resulting in an appropriation of $1,300,000 to the Children's Basic Health Plan Trust Fund. Lastly, HB 07-1359 accelerates the strategic contribution fund payment in the Master Settlement Agreement, and reverses the appropriation of $1,300,000 included in SB 07-097. The FY 07-08 appropriation is $256,475 total funds, consisting of $11,011 General Fund and $245,464 Cash Funds.

FY 08-09 Base Request for the Children's Trust

The Base Request for FY 08-09 is based on assumptions in current law. The total Base Request is for $271,456, which includes $14,981 for the annualizations of SB 07-036 and SB 07-097. The Base Request consists of $22,762 General Fund and $248,964 Cash Funds from annual enrollment fees. The Department requests increased General Fund and adjustments to the Cash Funds from annual enrollment fees through a FY 08-09 Decision Item.

Line Item: H.B. 97-1304 Children's Basic Health Plan Trust	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$24,136,294**	**$23,173,271**	**$11,467,064**	**$256,475**
FY 05-06 DI-5 (November 1, 2004) Children's Basic Health Plan caseload and rate changes	($376,770)	$0	$0	$0
FY 06-07 DI-3 (November 15, 2005) Reduction to anticipated enrollment fees and rate and caseload adjustment	$0	($7,275)	$0	$0
FY 06-07 BA-10 (February 15, 2006) Appropriation to balance Trust Fund due to increased caseload	$0	$152,570	$0	$0

Line Item: H.B. 97-1304 Children's Basic Health Plan Trust	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Removal of Prior Year General Fund appropriation as part of Base Request	$0	($2,152,570)	$0	$0
Removal of one-time funding (SB 07-163, SB 07-239, and FY 06-07 Emergency Supplemental #1)	$0	$0	($11,274,992)	$0
BA-A3 (February 15, 2007) Caseload and rate updates	$0	$0	$53,392	$0
Annualization of SB 07-036 Mandatory Coverage of Mental Disorders	$0	$0	$0	$11,751
Annualization of SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$0	$3,230
Long Bill Appropriation / Request	**$23,759,524**	**$21,165,996**	**$245,464**	**$271,456**
HB 05-1262 Reduction of General Fund need based on removal of Medicaid Asset Test plus additional client enrollment fees	($2,169,514)	$0	$0	$0
HB 06-1217 Tobacco Master Settlement Agreement revenue estimates	($416,739)	$0	$0	$0
HB 06-1369 Due to delay in removal of Medicaid asset test	$2,000,000	$0	$0	$0
HB 06-1310 Revisions to Tobacco Master Settlement Agreement revenues and removal of budgetary double counting of funds	$0	($20,973,924)	$0	$0
SB 07-163 S-4 and S-5 (January 4, 2007) and Late Supplemental Request (January 19, 2007)	$0	$2,543,215	$0	$0
SB 07-239 Add-ons Caseload and Rates Update	$0	$8,731,777	$0	$0
SB 07-036 Mandatory Coverage of Mental Disorders	$0	$0	$11,011	$0
SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$1,300,000	$0
HB 07-1359 Strategic Reallocation of Tobacco Master Settlement Agreement Funds	$0	$0	($1,300,000)	$0
FY 06-07 Emergency Supplemental #1 (June 20, 2007)	$0	$10,567	$0	$0
Final Appropriation / Request	**$23,173,271**	**$11,477,631**	**$256,475**	**$271,456**
General Fund	$2,000,000	$11,243,215	$11,011	$22,762
Cash Funds	$245,742	$234,416	$245,464	$248,694
Cash Funds Exempt	$20,927,529	$0	$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. 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, claims 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 collect 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 of the Social Security Act, and which are reimbursed by the State's Child Health Insurance Program, Title XXI of the Social Security Act. The federal match under the Medicaid program is 50%. The federal match under Title XXI is 65%. Note that while total federal funds are referenced in legislative appropriation clauses, 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 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 also provided $1,300,000 for cost-effective marketing, and $95,000 for application redesign and reprinting associated with removing the Medicaid asset test. The following table shows the allocation 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 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. Therefore, 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 Cash Funds Exempt and $3,055,573 federal funds.

SB 07-163, the Department's Supplemental Bill, appropriated an additional $13,501 to the Children's Basic Health Plan Administration line item. This funding was requested by the Department in its January 4, 2007 S-4, "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005," for increased application processing costs to the contracted eligibility determination and enrollment vendor. The sum of these two bills resulted in the final FY 06-07 appropriation of $5,534,708, consisting of $2,472,141 Cash Funds Exempt and $3,062,567 federal funds.

FY 07-08 Appropriation for Administration

The FY 07-08 Long Bill provided $5,535,590 for administrative costs to the Children's Basic Health Plan, which included continuation funding, plus $882 for the annualization of the Department's FY 07-08 DI-4, "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005."

In additional to the Long Bill, two Special Bills were adopted by the 2007 General Assembly which provided additional resources for program administration. SB 07-007, which establishes a comprehensive system of early intervention services to be provided by private insurers, including those participating in the Children's Basic Health Plan, resulted in a total funds appropriation of $4,000 for network changes and actuarial costs. SB 07-097, which expanded Children's Basic Health Plan eligibility to 205% of the federal poverty level, also increased the appropriation to this line item by $1,000 for actuarial services. Therefore, the FY 07-08 appropriation is $5,541,590, consisting of $2,474,735 Cash Funds Exempt and $3,066,855 federal funds.

FY 08-09 Base Request for Administration

The FY 08-09 Base Request is for $5,536,590, which includes continuation funding of $5,541,590 less the one-time funding for SB 07-004 and SB 07-097, totaling $5,000. The Base Request consists of $2,472,951 Cash Funds Exempt and $3,063,639 federal funds.

Line Item: Children's Basic Health Plan Administration	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$4,325,385**	**$5,577,207**	**$5,534,708**	**$5,541,590**
Remove FY 04-05 one-time funding for prenatal program implementation costs	($144,178)	$0	$0	$0
Remove HB 05-1262 one-time funding for application redesign and actuarial costs	$0	($56,000)	$0	$0
Annualization of FY 07-08 DI-4 Implementation of HB 06S-1023 and Deficit Reduction Act	$0	$0	$882	$0
Annualization of SB 07-004 Early Intervention	$0	$0	$0	($4,000)
Annualization of SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$0	($1,000)
Long Bill Appropriation / Request	**$4,181,207**	**$5,521,207**	**$5,535,590**	**$5,536,590**
HB 05-1262 Tobacco Tax Implementation	$1,396,000	$0	$0	$0
SB 07-163 Implementation of HB 06S-1023 and Deficit Reduction Act	$0	$13,501	$0	$0
SB 07-004 Early Intervention	$0	$0	$4,000	$0
SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$2,000	$0
Final Appropriation / Request	**$5,577,207**	**$5,534,708**	**$5,541,590**	**$5,536,590**
Cash Funds Exempt from Children's Basic Health Plan Trust Fund	$1,947,089	$1,953,596	$1,954,022	$1,954,022
Cash Funds Exempt from Health Care Expansion Fund	$545,405	$518,545	$518,545	$518,545
Title XXI Federal Funds	$1,283,135	$1,279,249	$1,283,537	$1,280,321
Title XIX Federal Funds	$1,801,578	$1,783,318	$1,783,318	$1,783,318

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 (Tobacco Tax). Beginning in FY 07-08, the State share of funding also includes the Supplemental Tobacco Litigation Settlement Account within the Children's Basic Health Plan Trust Fund which was created to fund the program expansion to 205% of the federal poverty level created in SB 07-097. 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 and to fund enrollment above the FY 03-04 level. The bill also removed the Medicaid asset test, effective July 1, 2006. This change caused children previously enrolled in the Children's Basic Health Plan to become Medicaid eligible. These children moved from the Children's Basic Health Plan to Medicaid over the course of FY 06-07 based on their annual eligibility redeterminations.

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 dated 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**

Calculations for Children's Premiums Costs	FY 05-06 Long Bill (SB 05-209) Appropriation for Children's Program
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 up to 185% of the federal poverty level) was increased. The net change from the delays in the Medicaid asset test removal was a reduction of $1,590,000 for the "stabilization fund." In addition, the mix of expansion versus traditional clients changed in both children and prenatal clients, compounded with even more growth in traditional clients, resulting in a net decrease in funding of $5,547,883.

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 Cash Funds Exempt and $42,519,862 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

dated March 13, 2006, pages 187 and 190-197). These two budgetary actions requested a decrease in the traditional children's caseload and an increase of the caseload of the expansion populations (children and pregnant women up to 200% of the federal poverty level) and for changes to the per member per month rates (the children's capitation increased from $101.44 to $104.14 and the adult prenatal program medical costs were increased from $806.97 to $905.54.)

Lastly, the Department received federal approval for expanding the prenatal program up to 200% of the federal poverty level effective February 1, 2006. As such, 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.

The FY 06-07 Long Bill appropriation was increased by $11,112,793 per SB 07-239 (Long Bill Add-ons) pursuant to the Department's February 15, 2007 Supplemental #3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload Updates" (see Figure Setting dated March 7, 2008, page 71). The final appropriation for FY 06-07 was $81,483,970, consisting of $28,664,893 in Cash Funds Exempt and $52,819,077 in federal funds.

An Emergency Supplemental was submitted to the Joint Budget Committee on June 20, 2007, which resulted in an increase of $8,236,467 to the spending authority. This increase was due to greater than anticipated caseload growth, as well as the reversal of a FY 05-06 accounts receivable, which had to be accounted for as expenditures in FY 06-07 (see the Department's June 20, 2007 Emergency Supplemental #1, "Adjustments to the FY 06-07 Children's Basic Health Plan Caseload and Costs").

FY 07-08 Appropriation for Premiums Costs

The FY 07-08 Long Bill (SB 07-239) increased the total funds appropriation by $8,341,843 from the FY 06-07 appropriation (prior to Supplemental #3, see Figure Setting dated March 7, 2008, pages 79-80). The Long Bill appropriation was later increased for four special bills, including: SB 07-004 requires the Children's Basic Health Plan program to provide Early Intervention Services in line with those provided under Medicaid. The appropriation to this line item was increased by $59,734 to provide such services. SB 07-036, Mandatory Coverage of Mental Disorders, requires health insurance coverage of certain disorders under Medicaid and the Children's Basic Health Plan. Based on the fiscal note for SB 07-036, the cost to the Children's Basic Health Plan is $31,459 in FY 07-08. SB 07-097 increases eligibility in the Children's Basic Health Plan to 205% of the federal poverty level, resulting in an appropriation of $76,811 to this line item. HB 07-1301 establishes the Cervical Cancer Immunization program to provide women and girls with cervical cancer vaccines, resulting in an appropriation of $298,177 to provide the vaccine through the Children's Basic Health Plan. Lastly, the FY 07-08 appropriation was reduced per SB 07-133 which moved the Children's Basic Health Plan Premiums Costs line item to a cash system of accounting, resulting in one-time savings of $3,865,396. Therefore, the FY 07-08 appropriation is $86,426,598 total funds, consisting of $1,479 Cash Funds, $30,408,342 Cash Funds Exempt, and $56,016,777 federal funds.

FY 08-09 Base Request for Premiums Costs

The FY 08-09 Base Request is for $91,098,718, which includes continuation funding of $86,426,598 plus $4,672,120 for the annualizations of the five previously discussed bills. The one-time savings resulting from SB 07-113 is removed. In addition, SB 07-097 results in a caseload increase due in expanded eligibility, and SB 07-004, SB 07-036, and HB 07-1301 all result in changes to the per member per month rates for children (see the November 1, 2007 Decision Item #3, Children's Basic Health Plan Medical Premium and Dental Benefit Costs", for detailed information about the per capita and caseload adjustments associated with these bills). The Base Request includes $32,045,063 Cash Funds Exempt and $59,053,655 federal funds.

Line Item: Children's Basic Health Plan Premiums Costs	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation	**$58,569,692**	**$65,932,159**	**$81,483,970**	**$86,426,598**
FY 05-06 DI-3 (November 1, 2004) Children's Basic Health Plan caseload and rate changes	$18,436,431	$0	$0	$0
DI-3 (November 15, 2005) and BA-10 (February 15, 2006) Adjust caseload and rates	$0	$4,792,180	$0	$0
Remove SB 06-135 one-time funding for State Only Prenatal and Delivery	$0	($353,162)	$0	$0
DI-3 (November 1, 2006) and BA-A3 (February 15, 2007) Caseload and Rates Update	$0	$0	$8,341,843	$0
Annualization of SB 07-004 Early Intervention for Children	$0	$0	$0	$24,596
Annualization of SB 07-036 Mandatory Coverage of Mental Disorders	$0	$0	$0	$33,576
Annualization of SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$0	$484,328
Annualization of SB 07-113 HCPF Cash Accounting	$0	$0	$0	$3,865,396
Annualization of HB 07-1301 Cervical Cancer Immunization	$0	$0	$0	$264,224
Long Bill Appropriation / Request	**$77,006,123**	**$70,371,177**	**$89,825,813**	**$91,098,718**
HB 05-1262 (Tobacco Tax Implementation)	($4,289,242)	$0	$0	$0
HB 06-1385 Add-ons Delay in Removal of Asset Test	($7,137,883)	$0	$0	$0
HB 06-135 (State Only Prenatal and Delivery)	$353,161	$0	$0	$0
SB 07-239 Add-ons Caseload and Rates Update	$0	$11,112,793	$0	$0
SB 07-004 Early Intervention for Children	$0	$0	$59,734	$0
SB 07-036 Mandatory Coverage of Mental Disorders	$0	$0	$31,459	$0
SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$76,811	$0

Line Item: Children's Basic Health Plan Premiums Costs	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
SB 07-113 HCPF Cash Accounting	$0	$0	($3,865,396)	$0
HB 07-1301 Cervical Cancer Immunization	$0	$0	$298,177	$0
Final Appropriation / Request	**$65,932,159**	**$81,483,970**	**$86,426,598**	**$91,098,718**
Cash Funds	$0	$0	$1,479	$0
Cash Funds Exempt from Children's Basic Health Plan Trust Fund	$18,652,016	$21,438,540	$21,372,565	$22,740,435
Cash Funds Exempt from Health Care Expansion Fund	$4,760,281	$7,226,353	$8,897,709	$8,909,731
Cash Funds Exempt from Supplemental Tobacco Litigation Settlement Account	$0	$0	$47,273	$223,645
Cash Funds Exempt from Colorado Immunization Fund	$0	$0	$90,795	$171,251
Federal Funds	$42,519,862	$52,819,077	$56,016,777	$59,053,656

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), and selected the vendor who offered the most complete dental benefit package. The Department established a $500 yearly maximum benefit per client, and a statewide network with several hundred participating dentists and contracts with Essential Community Providers. 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, 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 (Tobacco Tax). Beginning in FY 07-08, the State share of the funding also includes the Supplemental Tobacco Litigation Settlement Account within the Children's Basic Health Plan Trust Fund which was created to fund the program expansion to 205% of the federal poverty level pursuant to SB 07-097.

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 dated 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 the FY 05-06 Long Bill (SB 05-209), 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 up 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 up 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 $462,135 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 dated 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.

The FY 06-07 total funds appropriation was later increased by $388,983 in SB 07-239 (Long Bill Add-ons) pursuant to the Department's February 15, 2007 Supplemental #3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload Updates" (see Figure Setting dated March 7, 2008, page 71). The final appropriation for FY 06-07 was $6,302,642, consisting of $2,205,925 Cash Funds Exempt and $4,096,717 federal funds. In addition, an Emergency Supplemental was submitted to and approved by the Joint Budget Committee on June 20, 2007, which resulted in an increase of $572,326 to the spending authority due to greater than anticipated caseload growth.

FY 07-08 Appropriation for Dental Benefit Costs

The FY 07-08 Long Bill (SB 07-239) increased the total funds appropriation by $802,198 from the final FY 06-07 appropriation (prior to Supplemental #3, see Figure Setting dated March 7, 2008, pages 79-80). In additional, this appropriation was changed to reflect two Special Bills that passed during the 2007 legislative session, including: SB 07-097 increases eligibility in the Children's Basic Health Plan up to 205% of the federal poverty level, resulting in an appropriation of $4,806 to this line item. SB 07-133 moves the

Children's Basic Health Dental Benefit Costs line item to a cash system of accounting, resulting in one-time savings of $222,847. The FY 07-08 appropriation is $6,886,799 total funds, consisting of $2,410,380 Cash Funds Exempt and $4,476,419 federal funds.

FY 08-09 Base Request for Dental Benefit Costs

The FY 08-09 Base Request is for $7,137,597, which includes continuation funding of $6,886,799 plus $250,798 for the annualizations of the two previously discussed bills. The one-time savings resulting from SB 07-113 is removed, and SB 07-097 results in a caseload increase due in expanded eligibility (see the November 1, 2007 Decision Item #3, Children's Basic Health Plan Medical Premium and Dental Benefit Costs", for detailed information about the caseload adjustments associated with this bill). The Base Request includes $2,498,159 Cash Funds Exempt and $4,639,438 federal funds.

Line Item: Children's Basic Health Plan Dental Benefit Costs	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$5,606,150**	**$5,451,524**	**$6,302,642**	**$6,886,799**
FY 05-06 DI-4 (November 1, 2004) Children's Basic Health Plan caseload and rate changes	$612,633	$0	$0	0
DI-3 (November 15, 2005) and BA-10 (February 15, 2006) Adjust caseload and rates	$0	$462,135	$0	0
DI-3 (November 1, 2006) and BA-A3 (February 15, 2007) Caseload and Rates Update	$0	$0	$802,198	$0
Annualization of SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$0	$27,951
Annualization of SB 07-113 HCPF Cash Accounting	$0	$0	$0	$222,847
Long Bill Appropriation / Request	**$6,218,783**	**$5,913,659**	**$7,104,840**	**$7,137,597**
HB 05-1262 (Tobacco Tax Implementation)	($700,968)	$0	$0	0
HB 06-1385 Add-ons Delay in Removal of Asset Test	($66,291)	$0	$0	0
SB 07-239 Add-ons Caseload and Rates Update	$0	$388,983	$0	$0
SB 07-097 Tobacco Master Settlement Agreement Reallocation	$0	$0	$4,806	$0
SB 07-113 HCPF Cash Accounting	$0	$0	($222,847)	$0
Final Appropriation / Request	**$5,451,524**	**$6,302,642**	**$6,886,799**	**$7,137,597**
Cash Funds Exempt from Children's Basic Health Plan Trust Fund	$1,837,633	$2,048,935	$2,083,646	$2,161,642
Cash Funds Exempt from Health Care Expansion Fund	$70,400	$156,990	$325,052	$325,052
Cash Funds Exempt from Supplemental Tobacco Litigation Settlement	$0	$0	$1,682	$11,465

Line Item: Children's Basic Health Plan Dental Benefit Costs	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Account				
Federal Funds	$3,543,491	$4,096,717	$4,476,419	$4,639,438

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE FUND

The Comprehensive Primary and Preventive Care Fund was created within SB 00-071. Pursuant to Section 25.5-3-207, C.R.S. (2007), 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 came 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. Statutory authority now contained in Section 25.5-3-207, C.R.S. (2007), was previously part of Section 26-4-1007, C.R.S. (2005) which was amended by HB 04-1421. 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.

In FY 05-06, the Long Bill (SB 05-209) appropriated $2,668,034 to the Comprehensive Primary and Preventive Care Fund. 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, initially resulting in a $2,621,740 allocation 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 from FY 06-07 forward. 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 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation	**$2,578,694**	**$2,615,941**	**$0**	**$0**
Adjustment to Prior Year Forecast	$89,340	$5,799	$0	$0
Long Bill Appropriation / Request	**$2,668,034**	**$2,621,740**	**$0**	**$0**
HB 06-1217, Supplemental Bill	($52,093)	$0	$0	$0
HB 06-1310, Simplifying Procedures for Distributing	$0	($2,621,740)	$0	$0

Line Item: Comprehensive Primary and Preventive Care Fund	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Tobacco Settlement Moneys Among the Programs Currently Receiving the Moneys				
Final Appropriation / Request	**$2,615,941**	**$0**	**$0**	**$0**
Cash Funds Exempt	$2,615,941	$0	$0	$0

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANTS PROGRAM

The Comprehensive Primary and Preventive Care Grants Program is authorized by Section 25.5-3-201 through 207, C.R.S. (2007), 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 Colorado families who are at or below 200% of the federal poverty level. 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 expanding clinics or hiring additional staff and purchasing 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. 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.

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 initial FY 05-06 appropriation of $2,668,034 was adjusted downward to correct for updated Tobacco Master Settlement Agreement revenue forecasts by the State's Supplemental Bill (HB 06-1217). The final appropriation in FY 05-06 was $2,615,941.

The increase of $5,799 from the final FY 05-06 to the FY 06-07 Long Bill (HB 06-1385) appropriation of $2,621,740, was due to another updated forecast to the State's Tobacco Master Settlement Agreement revenue forecasts. Similarly, pursuant to HB 06-1310, this appropriation was reduced by $89 due to the projection that the State was going to receive a reduced amount from the Master

Settlement Agreement. The FY 06-07 appropriation was adjusted one more time during the course of the year. This was in large part due to the dynamic nature of the Comprehensive Primary and Preventive Care Grants Program's funding source. Revenues into the Tobacco Master Settlement Agreement were less than expected in FY 06-07 because some of the signatories on the settlement agreement contested their portions of the settlement agreement. The companies argued that non-signatories, also known as non-participating manufacturers, gained market share relative to the larger producers, and were therefore liable to pay a larger portion of the settlement amount. Therefore, the Joint Budget Committee approved a one-time decrease to the FY 06-07 appropriation of $220,525 with the passage of the Department's Supplemental Bill, SB 07-163. The final appropriation for FY 06-07 was $2,401,426.

After the Joint Budget Committee approved the $220,525 decrease to the Comprehensive Primary and Preventive Care Grants Program, one of the major withholding tobacco manufacturers transferred its portion of the settlement agreement funds to the States, causing a larger than expected payment. The difference between the final FY 06-07 appropriation and the FY 07-08 Long Bill (SB 07-239) appropriation was an increase of $65,526 due to the updated revenue forecast.

During the 2007 legislative session, two bills were passed that affected the Comprehensive Primary and Preventive Grants Program line that were not incorporated into the Long Bill (SB 07-239). SB 07-097 appropriated an additional $2,000,000 from the Supplemental Tobacco Litigation Settlement Moneys Account, which SB 07-097 created within the Comprehensive Primary and Preventive Care Fund, to the Comprehensive Primary and Preventive Care Grants Program. SB 07-097 stipulates that this additional money is to be used to supplement rural hospitals of 60 beds or less and all public hospitals that provide health care to indigent individuals.

HB 07-1359 changed the statute created in SB 07-097 to adjust the additional funds appropriated to the Comprehensive Primary and Preventive Care Grants Program. The revised appropriations language decreased the amount of money available to fund rural hospitals of 60 beds or less and public hospitals that serve Colorado's indigent population by $544,046 but increased the amount of funding available for grants made through the Comprehensive Primary and Preventive Care Grants Program by $215,464. The net change to this appropriation was a reduction of $328,582 for the Comprehensive Primary and Preventive Care Grants Program.

The Department's FY 08-09 Base Request is for $2,668,034, to reflect Legislative Council Staff's most recent June 2006 Tobacco Master Settlement Agreement revenue predictions.

Line Item: Comprehensive Primary and Preventive Care Grants Program	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Appropriation	$2,578,694	$2,615,941	$2,401,126	$4,138,070
Adjustment to Prior Year Tobacco Forecast	$89,340	$5,799	($154,999)	$530,348
Reversal of SB 07-163, Supplemental Bill	$0	$0	$220,525	$0
Annualization of SB 07-097, Allocation of Tobacco Litigation Settlement Moneys that Are Not Currently Required to Be Allocated to Existing Tobacco Settlement Programs	$0	$0	$0	$1,000,000
Annualization of HB 06-1359, Allocation of a Portion of The Tobacco Litigation Settlement Moneys Received by The State from the Strategic Contribution Fund in the State Fiscal Year in Which They Are Received Rather Than in the Next State Fiscal	$0	$0	$0	$325,582
Long Bill Appropriation / Request	**$2,668,034**	**$2,621,740**	**$2,466,652**	**$5,997,000**
HB 06-1217, Supplemental Bills	($52,093)	$0	$0	$0
HB 06-1310, Simplifying Procedures for Distributing Tobacco Settlement Moneys Among the Programs Currently Receiving the Moneys	$0	($89)	$0	$0
SB 07-163, Supplemental Bill	$0	($220,525)	$0	$0
SB 07-097, Allocation of Tobacco Litigation Settlement Moneys that Are Not Currently Required to Be Allocated to Existing Tobacco Settlement Programs	$0	$0	$2,000,000	$0
HB 06-1359, Allocation of a Portion of The Tobacco Litigation Settlement Moneys Received by The State from the Strategic Contribution Fund in the State Fiscal Year in Which They Are Received Rather Than in the Next State Fiscal	$0	$0	($328,582)	$0
Final Appropriation / Request	**$2,615,941**	**$2,401,126**	**$4,138,070**	**$5,997,000**
Cash Funds Exempt	$2,615,941	$2,401,126	$4,138,070	$5,997,000

History of Grants Awarded through the Comprehensive and Preventive Care Grant Program		
	FY 05-06	**FY 06-07**
Total Number of Active Grants	13	15
Total Number of Providers	9	9
Total Amount of Awarded Active Grants	$2,604,927	$2,550,814
Total Amount Awarded: Future Years		
FY 05-06	N/A	
FY 06-07	$827,808	
FY 07-08	$195,152	$1,077,449
FY 08-09	N/A	$496,725
Patients Receiving Medical Services	3,724	
Number of Medical Visits	10,848	
Patients Receiving Dental Services	60	
Number of Dental Visits	96	
Patients Receiving Mental Services	125	
Number of Mental Visits	1,043	
Average Visits per Patient	3.06	

(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. (2007).

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. 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 with current statute. Effective January 4, 2002, programmatic authority (including responsibility for managing, monitoring, and forecasting) for this appropriation was transferred to the Department of Human Services. Via General Assembly action effective July 1, 2002, all Old Age Pension funds were consolidated in an appropriation to the Department of Human Services. However, both the amounts for administration and for services were still "transferred" as Cash Funds Exempt to the Department. 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'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 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's 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. (2007) was transferred from the Department of Human Services to the Department 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 05-06 to contain costs, and in a handful of occasions increase reimbursements, for the Old Age Pension State Medical Program:

- 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.
- Effective September 1, 2006, the reimbursement rate was decreased from 100% of the Medicaid rate to 40% of the Medicaid rate for the following expenditure categories: practitioner/physician services, dental, medical supplies, home health care services, supplies and transportation, and independent laboratory claims. Finally, outpatient claims reimbursement was decreased from 62% to 40% of the Medicaid rate.
- Effective November 1, 2006, the reimbursement rate was decreased from 100% of the Medicaid rate to 70% of the Medicaid rate for pharmacist claims.
- Effective May 1, 2007, the reimbursement rate was increased from 40% of the Medicaid rate to 70% of the Medicaid rate for the following expenditure categories: practitioner/physician services, outpatient claims, dental, medical supplies, home health care services, supplies and transportation, and independent laboratory claims. Finally, reimbursement was increased from 10% to 50% of the Medicaid rate for inpatient services.
- Effective July 1, 2007, the reimbursement rate was decreased from 70% of the Medicaid rate to 60% of the Medicaid rate for the following expenditure categories: practitioner/physician services, outpatient claims, dental, medical supplies, home health care services, supplies and transportation, and independent laboratory claims. Finally, reimbursement was decreased from 50% to 10% of the Medicaid rate for inpatient services.

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 07-08 and FY 08-09 using the average annual growth from FY 05-06 to FY 06-07.

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 Actual	5,103	0.53%	
FY 07-08 Projection	5,283	3.52%	Average annual growth from FY 05-06 to FY 06-07 3.52% = (6.50%+0.53%)/2
FY 08-09 Projection	5,469	3.52%	

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 found 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. During FY 06-07, the Department conducted a feasibility study regarding the implementation of an Old Age Pension Health and Medical Drug Rebate Program. The Department, using a cost-benefit analysis, determined that a Drug Rebate Program would not be financially feasible for the Old Age Pension State Medical Program. Therefore, the Department does not anticipate any savings from the Old Age Pension State Medical Program Drug Rebate Program.

Expenditure History and Request

Pursuant to Article XXIV of the Colorado Constitution, the Department receives $10,000,000 from the Old Age Pension Health and Medical Care Fund annually. In addition, 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,[41] 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 $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 officially appropriated in SB 07-163, bringing the final FY 05-06 appropriation to $14,426,967.

In addition to the ongoing funding from tobacco tax revenue, the Joint Budget Committee[42] 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,

[41] Page 139 Figure Setting March 9, 2004
[42] March 13, 2006 Figure Setting, page 209

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 appropriation is for $13,293,672, which is a reduction of $968,891 from FY 06-07. This reduction includes a removal of the $976,180 of one-time funding in FY 06-07, a decrease of $37,500 in estimated revenue from the Tobacco Tax Cash Fund based on Legislative Council's June 2006 Revenue Forecast, and a decrease of $680,779 due the passage of SB 07-133, Department of Health Care Policy and Financing Cash Accounting, which shifted the program from accrual to cash accounting.

The FY 08-09 Base Request is for $12,959,483, which is a reduction of $334,189 from the FY 07-08 appropriations. The decrease is due to the removal of one time funding of $725,468 from the Supplemental Old Age Pension Fund balance, a reduction of $289,500 in estimated revenue from the Tobacco Tax Cash Fund based on Legislative Council's December 2006 Revenue Forecast, and an increase of $680,779 for the reversal of one-time savings due to SB 07-133, Department of Health Care Policy and Financing Cash Accounting.

The following table delineates historical expenditures.

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
FY 06-07 Actual	$12,589,332	($410,670)	$12,578,662	5,103	$2,464.95

The FY 08-09 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 08-09 Base Request estimates that the Supplemental Old Age Pension Medical Care Fund will receive $2,433,000 from the Tobacco Tax Cash Fund as projected by the Office of Legislative Council.

Line Item: Old Age Pension State Medical Program	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Previous Fiscal Year Final Appropriation	**$10,748,483**	**$13,286,483**	**$14,262,663**	**$13,293,672**
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	$976,180	$0	$0
Removal of one-time funding from the OAP Supplemental Fund Balance	$0	$0	($976,180)	($725,468)
Revised estimate of revenue from the Tobacco Tax Cash Fund	$0	$0	($37,500)	($67,500)
HB 05-1262 Transfer of Tobacco Tax Cash Fund into Supplemental Old Age Pension State Medical Fund	$0	$0	$725,468	$0
Annualization of SB 07-133	$0	$0	$0	$680,779
Long Bill Appropriation / Request	**$10,748,483**	**$14,262,663**	**$13,974,451**	**$13,181,483**
HB 06-1217 (Supplemental Bill)	$2,538,000	$0	$0	$0
SB 07-133 (Department of Health Care Policy and Financing Cash Accounting)	$0	$0	($680,779)	$0
Final Appropriation / Request	**$13,286,483**	**$14,262,663**	**$13,293,672**	**$13,181,483**
Cash Funds	$0	$0	$0	$0
Cash Funds Exempt	$13,286,483	$14,262,663	$13,293,672	$13,181,483

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). In FY 07-08, a Joint Budget Committee action included an appropriation of $2,500,500 from the Tobacco Tax Cash Fund through the Long Bill (SB 07-239). The Department's FY 08-09 Base Request estimates that the Supplemental Old Age Pension Health and Medical Care Fund will receive $2,433,000 from the Tobacco Tax Cash Fund as projected by the Office of Legislative Council.

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**	**FY 08-09**
Previous Fiscal Year Final Appropriation	**N/A**	**$2,580,180**	**$2,500,500**
Revised estimate of Tobacco Tax Revenue	$0	($76,680)	($67,500)
Long Bill Appropriation / Request	**$2,580,180**	**$2,500,500**	**$2,433,000**
Final Appropriation / Request	**$2,580,180**	**$2,500,500**	**$2,433,000**
Cash Funds Exempt	$2,580,180	$2,500,000	$2,433,000

HOME CARE ALLOWANCE

First authorized in 1979 by Section 26-2-122.3, C.R.S. (2007), 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.

To determine eligibility, a 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 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. Approved payments are sent out by the county offices through the Department of Human Services.

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. (2007).

For FY 05-06, this line was appropriated $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 because administrative responsibilities have been transferred to the Department of Human Services.

Line Item: Home Care Allowance	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$10,880,411**	**$10,880,411**	**$0**	**$0**
Long Bill Appropriation / Request	**$10,880,411**	**$10,880,411**	**$0**	**$0**
Reorganization of programs administered by the Department per SB 06-219	$0	($10,880,411)	$0	$0
Final Appropriation / Request	**$10,880,411**	**$0**	**$0**	**$0**
General Fund	$10,336,390	$0	$0	$0
Cash Funds Exempt	$544,021	$0	$0	$0

ADULT FOSTER CARE

Adult Foster Care was first authorized in 1977 by Section 26-2-122.3 C.R.S. (2007). 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. Generally, clients receiving Adult Foster Care also receive either Supplemental Security Income or Old Age Pension.

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. (2007) 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.

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 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Final Appropriation / Request	**$157,469**	**$157,469**	**$0**	**$0**
Long Bill Appropriation / Request	**$157,469**	**$157,469**	**$0**	**$0**
Reorganization of programs administered by the Department per SB 06-219	$0	($157,469)	$0	$0
Final Appropriation / Request	**$157,469**	**$0**	**$0**	**$0**
General Fund	$149,596	$0	$0	$0
Cash Funds Exempt	$7,873	$0	$0	$0

UNIVERSITY OF COLORADO FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The University of Colorado Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The Advisory Commission on Family Medicine in 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. Beginning in FY 94-95, the majority of the program's funding was financed with a funding 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.

For FY 05-06, the Joint Budget Committee recommended and the General Assembly approved an increase in funding of $127,058 over the final FY 04-05 appropriation. 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 was therefore $1,703,558.

In FY 07-08, the Department submitted Non-Prioritized Decision Item, NP-15 entitled "Leveraging Federal Matching Funds" which requested $100,000 in General Fund and matching federal funds of $100,000 (FY 07-08, Commission on Family Medicine Figure Setting, February 14, 2007, page 4). For FY 08-09, the Department submitted Non-Prioritized Decision Item, NP-2 entitled "Leveraging Additional Federal Funds" which requested $142,992 in General Fund and matching federal funds of $142,992. The request increased the Department's Base Request by $285,984 for FY 08-09 to $2,189,542.

Line Item: University of Colorado Family Medicine Residency Training Programs	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Previous Fiscal Year Final Appropriation	**$1,449,444**	**$1,576,502**	**$1,703,558**	**$1,903,558**
FY 05-06 Joint Budget Committee Recommendation	$127,058	$0	$0	$0
FY 06-07 Non Prioritized Decision Item #1 "Leveraging Additional Federal Matching Funds"	$0	$127,056	$0	$0
FY 07-08 Non Prioritized Decision Item #15 "Leveraging Federal Matching Funds"	$0	$0	$200,000	$0
FY 08-09 Non Prioritized Decision Item #2 "Leveraging Additional Federal Funds"	$0	$0	$0	$285,984

Line Item: University of Colorado Family Medicine Residency Training Programs	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Long Bill Appropriation / Request	**$1,576,502**	**$1,703,558**	**$1,703,558**	**$2,189,542**
Final Appropriation / Request	**$1,576,502**	**$1,703,558**	**$1,903,558**	**$2,189,542**
General Fund	$788,251	$851,779	$951,779	$1,094,771
Federal Fund	$788,251	$851,779	$951,779	$1,094,771

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[43]. 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. All funds transferred from the Department to the Department of Public Health and Environment are in the form of Cash Funds Exempt.

Within the Department of Public Health and Environment, the transferred funds are spread across a number of different lines, including Health Statistics and Vital Records, Information Technology Services, Prevention Services Division, and Women's Health. For FY 05-06 and FY 06-07, the Enhanced Prenatal Care Training Program was appropriated continuation funding to provide these services. During the FY 07-08 Figure Setting (March 8, 2007, pages 96-07), the amount of money requested for this line item was

[43] Prenatal Plus Program, 2004 Annual Report, page 3

changed. Joint Budget Committee staff recommended that the Enhanced Prenatal Care Training and Assistance line receive an adjustment for POTS related costs, which was approved. The additional funding brought the FY 07-08 appropriation up to $108,999. The Department's FY 08-09 Base Request of $117,411 includes an adjustment for POTS in the amount of $8,412.

The following table presents the changes in the funding from FY 05-06 to the FY 08-09 Base Request:

Line Item: Enhanced Prenatal Care Training Program	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation from Previous Fiscal Year	**$102,346**	**$102,346**	**$102,346**	**$108,999**
POTS Adjustments	$0	$0	$6,653	$8,412
Long Bill Appropriation / Request	**$102,346**	**$102,346**	**$108,999**	**$117,411**
General Fund	$51,173	$51,173	$54,500	$58,706
Federal Funds	$51,173	$51,173	$54,499	$58,705

NURSE HOME VISITOR PROGRAM

With the passage of SB 00-71, the General Assembly created the Colorado Nurse Home Visitor Program which is 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 her 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, 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 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.

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%.

In FY 05-06, the accounting and budgeting for the Nurse Home Visitor Program line was changed to a cash basis with the passage of SB 06-129, 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 Long Bill appropriation was returned to $3,010,000 in HB 06-1385. Continuation funding was requested and appropriated for FY 07-08 in SB 07-239, and is again being requested for FY 08-09.

Line Item: Nurse Home Visitor Program	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Budget Request
Previous Fiscal Year Final Appropriation	**$3,010,000**	**$2,778,972**	**$3,010,000**	$3,010,000
Reversal of SB 06-129 (Cash Accounting Bill)	$0	$231,028	$0	$0
Long Bill Appropriation / Request	**$3,010,000**	**$3,010,000**	**$3,010,000**	**$3,010,000**
SB 06-129 (Cash Accounting Bill)	($231,028)	$0	$0	$0
Final Appropriation / Request	**$2,778,972**	**$3,010,000**	**$3,010,000**	**$3,010,000**
Cash Funds Exempt	$1,389,486	$1,505,000	$1,505,000	$1,505,000
Federal Funds	$1,389,486	$1,505,000	$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 program was never implemented due to legal action and a court ordered stay. There were no requests for FY 06-07 and FY 07-08. This is no request for FY 08-09.

Line Item: Nursing Facility Service Program	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Previous Fiscal Year Final Appropriation	**$0**	**$0**	**$0**	**$0**
Long Bill Appropriation / Request	**$0**	**$0**	**$0**	**$0**
HB 04-1415 Reimbursement of Nursing Facilities	$1,157,225	$0	$0	$0
HB 05-1086 Legal Immigrants Bill	($1,157,225)	$0	$0	$0
Total Appropriation / Request	**$0**	**$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 came from the Tobacco Master Settlement Agreement in the form of Cash Funds Exempt. Per 25.5-6-805, C.R.S., (2007) 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 was not spent at the end of the fiscal year was to be invested by the State Treasurer as provided by law, so long as all interest and income derived from those investments were credited back to the fund. The Colorado Autism Treatment Fund allocated its money among several Executive Director's Office line items as well as the Medical Services Premiums line.

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.

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. However, beginning in FY 06-07, there was no 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 (March 13, 2006, page 223) this double counting of funds was eliminated. 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.

Line Item: Colorado Autism Treatment Fund Appropriation History	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Previous Fiscal Year Final Appropriation	**$0**	**$395,143**	**$0**	**$0**
Joint Budget Committee Action to remove appropriation	$0	($395,143)	$0	$0
Long Bill Appropriation / Request	**$395,143**	**$0**	**$0**	**$0**
Total Appropriation/Request	**$395,143**	**$0**	**$0**	**$0**
Cash Funds Exempt	$395,143	$0	$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; but rather the State uses certification of public expenditures that can be matched by the federal government through Title XIX of the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

The 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 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 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 matching funds.

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 in FY 05-06 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). With the tobacco tax monies included, the appropriation for FY 05-06 was $31,188,052. This amount was further adjusted by a one time charge of $5,412,313 under SB 06-129, decreasing the appropriation to $25,775,739 in order to switch to a cash-based accounting system. Lastly, HB 06-1217 decreased the appropriation another $4,698 to reconcile the Long Bill appropriations between the Department of Education and the Department. After all adjustments, the final appropriation for FY 05-06 was $25,771,041.

The Long Bill (HB 06-1385) appropriation for FY 06-07 was $31,535,961. The funding splits are $16,007,021 Cash Funds Exempt and $15,528,940 federal funds. The administrative costs for the Department and the Department of Education remained the same. After the Department's November 1, 2006 Budget Request submission, the Department submitted Supplemental S-11 (FY 06-07, Supplemental Requests, January 4, 2007, S-11) to fund the contract with Public Consulting Group (see the budget narrative for the Public School Health Services Administration line item for information concerning the contract). The line item was reduced by $200,000 in federal funds and the amount was transferred to the newly created line item entitled "Public School Health Services Administration."

In FY 07-08, the Department adjusted the appropriation based on Joint Budget Committee action during Figure Setting on March 1, 2007 for the Department of Education. During Figure Setting, the Joint Budget Committee increased the Department's administration cost by $972 and the Department of Education's administrative costs by $7,176. The adjustments for these administrative cost increases will come from federal funds. The final appropriation is $31,327,813, comprised of $16,007,021 Cash Funds Exempt and $15,320,792 in federal matching funds.

For FY 08-09, the Department received Common Policy adjustments to Personal Services and indirect cost assessments from the Department of Education in the amount of $4,865. This adjustment will increase the transfer to the Department of Education by $4,865 and correspondingly decrease the federal funds available for school providers. The amount transferred to the Department of Education for FY 08-09 will be $196,561. The Department requests a FY 08-09 appropriation of $31,322,948 which is comprised of $16,007,021 Cash Funds Exempt and $15,315,927 federal funds.

Line Item: Public School Health Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year Appropriation (includes removal of Administration)	**$29,805,501**	**$25,771,041**	**$31,335,961**	**$31,327,813**
Remove Reduction for Prior Year Administration	$545,410	$459,746	$478,080	$479,052
Removal of Administration Appropriated in Prior Year Supplemental Bill	($88,301)	$4,698	$0	$0
Reverse SB 06-129 Cash Accounting Bill Impact (one-time only)	$0	$5,412,313	$0	$0
Anticipated Certified Public Expenditures and Federal Match	$30,262,610	$31,647,798	$32,014,041	$32,014,041
Reductions for Administration				
Personal Services	($85,776)	($99,060)	($99,060)	($99,060)
Operating	($1,478)	($1,478)	($1,478)	($1,478)
Medicaid Management Information System	($193,022)	($193,022)	($193,022)	($193,022)
Transfer to Department of Education	($179,470)	($184,520)	($184,520)	($184,520)
Adjustment to Operating Expenditures	$0	$0	($972)	($972)
Total Reduction of Federal Funds for Administration	*($459,746)*	*($478,080)*	*($479,052)*	*($479,052)*
Joint Budget Committee 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	$164,535	$0	$0
HB 05-1262 Children's Extensive Support Waiting List Buy-Down (and out-year)	$0	$27,516	$0	$0
HB 05-1262 Home and Community Based Services Waiting List Buy-Down (and out-year)	$0	$174,192	$0	$0

Line Item: Public School Health Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Joint Budget Committee action reduced POTS allocation, Figure Setting, March 8, 2007, pages 98-100	$0	$0	($972)	$0
Joint Budget Committee action reduced Department of Education administrative costs, Figure Setting, March 8, 2007, pages 98-100	$0	$0	($7,176)	$0
Estimated adjustments for Personal services and indirect cost assessment, Department of Education	$0	$0	$0	($4,865)
Long Bill Appropriation / Request	**$29,802,864**	**$31,535,961**	**$31,327,813**	**$31,322,948**
Supplemental Bill (HB 06-1217) for true-up of Long Bill between Department of Education and the Department	($4,698)	$0	$0	$0
HB 05-1262 Children's Extensive Support Waiting List Buy-Down (and out-year)	$134,942	$0	$0	$0
HB 05-1262 Home and Community Based Services Waiting List Buy-Down (and out-year)	$1,250,246	$0	$0	$0
SB 06-129 Cash Accounting Bill	($5,412,313)	$0	$0	$0
SB 07-163 (Supplemental Bill), Supplemental #11	40	($200,000)	$0	$0
Final Appropriation/Request	**$25,771,041**	**$31,335,961**	**$31,327,813**	**$31,322,948**
Cash Funds Exempt	$13,117,743	$16,007,021	$16,007,021	$16,007,021
Federal Funds	$12,653,298	$15,528,940	$15,320,792	$15,315,927

MEDICARE MODERNIZATION ACT OF 2003 STATE CONTRIBUTION PAYMENT

On January 1, 2006, the Centers for Medicare and Medicaid Services 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 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.

During the Department's March 13, 2006 Figure Setting, the Joint Budget Committee reduced the Clawback payment based on a March 2006 update from the Centers for Medicare and Medicaid Services informing 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 payment was reduced by $3,057,082, to $28,442,918. However, in May 2006, the State Controller's Office notified the Department that based on generally acceptable accounting principles, this appropriation had to be processed under accrual accounting and that all months attributable to FY 05-06 caseload figures must be booked against FY 05-06 appropriations, regardless of when the invoice was received. As a result, the Department submitted 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, and an official appropriation was passed in the Add-on section of the Department's FY 06-07 Supplemental Bill (SB 07-163).

The FY 06-07 Long Bill (HB 06-1385) appropriation reflects the Department's November 15, 2005 Base Reduction Item, BRI-3. This appropriation of $73,493,542 was calculated based on 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).

For FY 07-08, the Department has been appropriated $69,546,453, a decrease of $3,947,089 from the final FY 06-07 appropriation. During the Department's March 8, 2007 Figure Setting, the Joint Budget Committee increased the appropriation by $3,226,279, based on an estimated increase in the average monthly enrollment for dual eligibles, an increase in the per capita costs, and a decrease in the phase down percentage. This increase over the final FY 06-07 appropriation brought the FY 07-08 Long Bill appropriation to $76,719,821. However, with the passage of SB 07-133, the Department's Cash Accounting Bill, $7,173,368 was removed from the

appropriation due to a shift from accrual to cash accounting which shifted the payment for June 2008 from FY 07-08 to FY 08-09. This Act results in a one-time savings during FY 07-08.

The Department's FY 08-09 Base Request is for $76,719,821, an increase of $7,173,368 above the FY 07-08 appropriation, due to the annualization of SB 07-133.

Line Item: Medicare Modernization Act of 2003 State Contribution Payment	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 07-08 Base Request**
Prior Year Final Appropriation	**N/A**	**$28,442,918**	**$73,493,542**	**$69,546,453**
Adjustments to incorporate first full year (in FY 06-07 only), caseload growth, reduction in State phase down percentage, and National Health Expenditure inflation	$0	$45,050,624	$0	$0
Adjustment for Caseload and Inflation (Joint Budget Committee, Figure Setting, March 8, 2007, Pages 100-102)	$0	$0	$3,226,279	$0
Annualization of SB 07-133 (Department of Health Care Policy and Financing Cash Accounting)	$0	$0	$0	$7,173,368
Long Bill Appropriation / Request	**$0**	**$73,493,542**	**$76,719,821**	**$76,719,821**
HB 06-1217 – Transfers funding from (2) Medical Services Premiums Long Bill group to (5) Other Medical Services	$31,500,000	$0	$0	$0
HB 06-1385 Add-ons	($3,057,082)	$0	$0	$0
SB 07-133 (Department of Health Care Policy and Financing Cash Accounting)	$0	$0	($7,173,368)	$0
Final Appropriation / Request	**$28,442,918**	**$73,493,542**	**$69,546,453**	**$76,719,821**
General Fund	$28,442,918	$73,493,542	$69,546,453	$76,719,821

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID – FUNDED PROGRAMS

This section of the Department's FY 08-09 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's share of the costs to support the Colorado Benefits Management System and other information technology support. Medicaid funds for these programs are sent as Cash Funds Exempt transfers from the Department 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. 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 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 08-09 Request should be directed to that department. This Department is a financing agency for these appropriations, meaning that the Department must validate that the Department of Human Services' funding request is for a Medicaid allowable purpose as outlined by the 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 (Department of Human Services FY 07-08 Figure Setting, February 22, 2007, page 15).

General Administration includes the Department of Human Services' Executive Director and any associated administrative staff, the Department's budgeting office, Public Information Officer, County Liaison, and Field Administration staff (Department of Human Services FY 07-08 Figure Setting, February 22, 2007, page 15). 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. For FY 07-08, the Department of Human Services requested continuation funding for its 22.4 FTE. 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 was 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 (Department of Human Services FY 07-08 Figure Setting, February 22, 2007, page 34). 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. The FTE also conduct periodic evaluations of all systems where technical, environmental, or operational changes have occurred. Operating expenses for this system include 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.

The FY 05-06 Long Bill appropriation of $9,318,892 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 pay date 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.

The initial FY 06-07 Long Bill appropriation was 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).

There were a number of common policy adjustments initiated by the Department of Personnel and Administration during FY 06-07 that affected the Medicaid portion of the Department of Human Services' Executive Director's Office line item. These common policy adjustments, which decreased the overall appropriation by $401,567[47], were due to risk management, pay date shift differential, salary survey, and worker's compensation. The final FY 06-07 appropriation was $9,727,721.

[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.

[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] ($401,567) is comprised of the following amounts: Risk Management and Property Funds = $48,525, Pay Date Shift Differential = ($292,933), Salary Survey Adjustment = ($355,444), and Worker's Compensation = $198,285.

The FY 07-08 appropriation of $12,509,047 includes $2,781,326[48] in Common Policy adjustments for the Department of Human Services. This reflects an increase of $1,308,285[49] 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 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$9,318,892**	**$8,900,473**	**$9,727,721**	**$12,509,047**
Common Policy Adjustments	$791,034	$1,207,623	$2,750,232	$1,244,011
Risk Management Adjustment	$0	$0	($23,048)	$728
Pay date Shift	($26,862)	$0	($6,638)	$0
Personal Services Adjustments (Reorganization, Salary Survey, and Vacancy Savings)	$71,153	$3,453	$5,033	$0
Adjustment to Office of Performance Improvement Funding	$25,654	$16,270	$11,004	$26,889
HIPAA Remediation Funding	($475,720)	$1,469	$44,743	$1,658
Long Bill Appropriation / Base Request	**$9,704,151**	**$10,129,288**	**$12,509,047**	**$13,782,333**
Supplemental Bill Common Policy adjustments	($803,678)	($401,567)	$0	$0
Final Appropriation / Final Request	**$8,900,473**	**$9,727,721**	**$12,509,047**	**$13,782,333**
General Fund	$4,450,237	$4,861,552	$6,253,141	$6,880,397
Federal Funds	$4,450,236	$4,866,169	$6,255,906	$6,901,936

[48] $2,781,326 is comprised of the following: Salary Survey from FY 06-07 = $5,033, Health, Life, and Dental = $974,258, Short-Term Disability = $4,858, Amortization Equalization Disbursement = $182,265, Supplemental Amortization Equalization Disbursement = $81,454, Salary Survey = $335,882, Performance Based Pay = $645,095, Pay Date Shift Differential = ($6,638), Worker's Compensation = $526,420, Risk Management = ($23,048), Office of Performance Improvement – Salary Survey and Annualization of SB 06-045 = $11,004, HIPAA Remediation – Salary Survey and Vacancy Savings = $44,743,

[49] $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.

The FY 08-09 Budget Request for the Department of Human Services Executive Director's Office appropriation is $13,782,333. The $1,273,286 difference between the FY 07-08 appropriation and the FY 08-09 Base Request is due to an increase of $1,244,011[50] in common policy items, $26,889 increase for the Office of Improvement, and a $1,658 adjustment for HIPAA remediation funding.

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES

1. OFFICE OF INFORMATION TECHNOLOGY SERVICES – COLORADO BENEFITS MANAGEMENT SYSTEM

The Colorado Benefits Management System tracks client data, determines eligibility, and calculates benefits for medical, food, and financial assistance programs in the State of Colorado. Prior to February 15, 2007, the development and operational phases of the Colorado Benefits Management System were overseen by three State agencies: 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. Because the Colorado Benefits Management System handles clients that receive a number of different federal participation rates from various programs, the Colorado Benefits Management System calculator was developed to allocate costs among the various programs. The Department's appropriation reflects a fraction, roughly 34.71%, of total costs. Therefore, the following discussion reflects only the Department's portion of Colorado Benefits Management System costs. Please refer to the Department of Human Services for the narrative concerning their portion of total expenditures.

The FY 05-06 Long Bill (SB 05-209) appropriation was $5,370,182. With the passage of HB 05-1262 (Tobacco Tax Bill), 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 $977,147 in response to the Deloitte audit report. On September 20, 2005, two Emergency 1331 Supplementals were passed to cover additional FTE to implement 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 on 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.

[50] $474,1731731,244,011 is comprised of the following amounts: $14,358358526 in Personal Services, ($466,203))$931,343 in Health, Life, and Dental, $18,413413489 in Short-term Disability, $322,616616323,555 in Amortization Equalization Disbursement, $167,280280166,723 in Supplemental Amortization Equalization Disbursement, $283,530($344,981) in Salary Survey and Senior Executive Services, $83,16016084,065 in Pay for Performance, ($159,039) in Pay-date Shift funds, and $209,330 for Worker's Compensation, and $728 in payments to Risk Management and Property Funds.

The initial FY 06-07 Long Bill (HB 06-1385) appropriation to the Colorado Benefits Management System was $7,599,713. The decrease in funding from the prior fiscal year was comprised of the removal of $178,778 for Health Care Expansion Fund (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 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 related to the Colorado Benefits Management System court order and lawsuit expenses. Originally, Joint Budget Committee staff recommended funding for these purposes; however, due to State budget balancing requirement to submit a balanced budget, the Joint Budget Committee removed all funding for these purposes on March 22, 2006. There was also a net increase to continuation funding for the Office of Colorado Benefits Management System and the Department of Human Services, equal to $167,876.

During FY 06-07, the Department of Human Services and the Department submitted a number of supplemental requests that had a significant impact on the final FY 06-07 appropriation for the Colorado Benefits Management System. The changes, as reflected in SB 07-163, were as follows: an increase of $61,217 to pay for updates to the Bendex interface to comply with federal mandates that required the Colorado Benefits Management System to accept data from the Social Security Administration (NP – S7); an increase of $35,404 to pay for additional requirements for Long Term Care eligibility processing, as required by the federal Deficit Reduction Act of 2005 (S – 10); an increase of $29,017 to pay for system changes required as a result of updated federal rules for the Payment Error Rate Measurement Program (S – 5); an increase of $61,229 for changes required by HB 06S-1023 and the Deficit Reduction Act of 2005 (S – 4). Finally, the FY 07-08 Long Bill (SB 07-239) included $142,953 in funding to pay for a reprocurement contractor to write the request for proposal to reprocure the Colorado Benefits Management System contract when it expires on July 15, 2008. The final FY 06-07 appropriation for the Colorado Benefits Management System was $7,929,533.

The FY 07-08 Budget Request for the Colorado Benefits Management System was $8,689,095 per the Long Bill (SB 07-239). The difference between the FY 07-08 appropriated amount and the FY 06-07 year-end appropriation is due to a number of decision items that were requested and approved during the FY 07-08 Figure Setting process and the removal of one-time costs. The one time costs totaling $679,697 that were removed from the appropriation are as follows:

One-time Costs Removed from Colorado Benefits Management System for FY 07-08		
Description	**Priority Number**	**Amount**
Update to the Bendex Interface	NP - S7	($61,217)
Deficit Reduction Act of 2005 - Long Term Care	S – 10	($35,404)
Payment Error Rate Measurement Program	S – 5	($29,017)
HB 06S-1023 and Deficit Reduction Act of 2005	S – 4	($61,229)

One-time Costs Removed from Colorado Benefits Management System for FY 07-08		
Description	**Priority Number**	**Amount**
Request for Proposal (RFP) Vendor	NP - S20	($142,953)
Additional Maintenance Pool Funds	DI – 3	($349,877)
Total		**($679,697)**

In addition to the removal of one-time costs, the Colorado Benefits Management System appropriation was adjusted in the following ways: an increase of $24,477 for Salary Survey; an increase of $195,215 for disaster recovery hardware; an increase of $1,086,197 in total funding to address top county concerns; an increase of $63,519 for premiums assistance; an increase of $142,403 for Electronic Data Systems contract increases; a decrease of $66,386 due to the elimination of the Governor's Office of the Colorado Benefits Management System director and assistant; and a decrease of $6,168 for vacancy savings.

The FY 07-08 Colorado Benefits Management System appropriation was further adjusted per two legislative actions and an emergency supplemental. The legislature passed SB 07-097 that reallocated tobacco settlement funds and required $6,248 in Colorado Benefits Management System programming changes to accommodate a new Children's Basic Health Plan eligibility category. SB 07-211 was designed to provide additional health care to low-income children in the State of Colorado. The Department's cost for Colorado Benefits Management System changes was estimated to be $20,687.

On February 15, 2007, Governor Ritter signed EO D 005 07 which dissolved the Governor's Office of the Colorado Benefits Management System. The Governor's Office of the Colorado Benefits Management System provided oversight for the entire program and facilitated the changes necessary to keep the program in compliance. Governor Ritter determined that maintaining a separate Office of Colorado Benefits Management System within the Governor's Office was no longer necessary or efficient. One of the mandates in the Executive Order was for the Department and the Department of Human Services to allocate the Governor's Office of the Colorado Benefits Management staff and responsibilities between the two departments. The reallocation was required to be General Fund neutral. The Department took advantage of the resulting emergency supplemental submitted to the Joint Budget Committee, approved on June 20, 2007, and refinanced 3.0 FTE that work on the Colorado Benefits Management System using the Colorado Benefits Management System calculator. Refinancing the 3.0 FTE saved $77,483 in General Fund.

To build to the FY 08-09 base, the Department has removed the following amounts due to one-time funding in FY 07-08: $122,326 for disaster recovery, $550,474 for the top county concerns, $63,519 for premiums assistance, and $16,357 due to the dissolution of the Governor's Office of the Colorado Benefits Management System. Finally, the Department has included $39,049[51] in funding for

[51] The $39,049 is comprised of the following: $26,347 for Salary Survey, $12,076 for performance based pay, $3,130 in additional Supplemental Amortization Equalization Disbursement funding, and ($2,504) for a 0.2% base reduction.

POTS adjustments. The following table shows the movement in the Colorado Benefits Management System appropriation from FY 05-06 through the FY 08-09 Base Request.

Line Item: (B) Office of Information Technology Services, Colorado Benefits Management System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year Final Appropriation	**$8,207,884**	**$8,953,830**	**$7,929,533**	**$8,716,030**
Removal of one-time funding from HB 05-1315	($2,908,449)	$0	$0	$0
POTS Adjustments	$6,772	$66,442	$24,477	$39,049
Colorado Benefits Management System Contract Increase (non-prioritized DI-4, November 1, 2004)	$63,975	$0	$0	$0
Removal of one-time funding from HB 05-1262	$0	($178,778)	$0	$0
Adjustment for revised programming hours (non-prioritized DI-3, November 15, 2005)	$0	($41,930)	$0	$0
Adjustment for net increase in contractor costs (non-prioritized DI-7, November 15, 2005)	$0	$53,393	$0	$0
Adjustment for change in FTE from CBMS to Food Stamps (non-prioritized DI-14, November 15, 2005)	$0	($23,958)	$0	$0
Joint Budget Committee action to increase funding for client correspondence over FY 05-06 levels	$0	$15,067	$0	$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	($1,412,229)	$0	$0

Line Item: (B) Office of Information Technology Services, Colorado Benefits Management System	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Adjustments to Office of CBMS funding and Department of Human Services base funding	$0	$167,876	$0	$0
Bendex Modernization (NP - S7, January 24, 2007)	$0	$61,217	($61,217)	$0
Deficit Reduction Act of 2005 - Long Term Care System Changes (S - 10, January 23, 2007 Supplemental Hearing)	$0	$35,404	($35,404)	$0
Payment Error Rate Measurement (S - 5, January 23, 2007 Supplemental Hearing)	$0	$29,017	($29,017)	$0
HB 06S-1023 and the Deficit Reduction Act of 2005 (S - 4, January 23, 2007 Supplemental Hearing)	$0	$61,229	($61,229)	$0
Colorado Benefits Management System RFP Vendor (non-prioritized S - 20)	$0	$142,953	($142,953)	$0
Governor's Office of the Colorado Benefits Management System , Elimination of Director and Assistant (Memo from Joint Budget Committee)	$0	$0	($66,386)	$0
Disaster Recovery Hardware (DI - 15, March 5, 2007 DHS-OIT Figure Setting, page 22).	$0	$0	$195,215	($122,326)
Top County Concerns - One Time Funding (GBA - 1, March 5, 2007 DHS-OIT Figure Setting, page 22)	$0	$0	$550,474	($550,474)
Top County Concerns - Base Funding (March 5, 2007 DHS-OIT Figure Setting, page 22)	$0	$0	$535,723	$0
Premiums Assistance (NP - 1, March 5, 2007 DHS-OIT Figure Setting, page 22)	$0	$0	$63,519	($63,519)

Line Item: (B) Office of Information Technology Services, Colorado Benefits Management System	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
EDS Contract Increase (DI - 5, March 5, 2007 DHS-OIT Figure Setting, page 22)	$0	$0	$142,403	$0
Maintenance Pool Funds (FY 07 DI - 3, March 5, 2007 DHS-OIT Figure Setting, page 22)	$0	$0	($349,877)	$0
Vacancy Savings	$0	$0	($6,168)	$0
Long Bill Adjustment	$0	$0	$2	$0
Removal of One-time SB 07-211 Funding	$0	$0	$0	($20,687)
Removal of One-time SB 07-097 Funding	$0	$0	$0	($6,248)
1331 Supplemental: Dissolution of OCBMS	$0	$0	$0	($16,357)
Long Bill Appropriation / Request	**$5,370,182**	**$7,929,533**	**$8,689,095**	**$7,975,468**
HB 05-1262 Tobacco Tax Bill	$304,508	$0	$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	$3,279,140	$0	$0	$0
SB 07-211 System Changes	$0	$0	$20,687	$0
SB 07-097 System Changes	$0	$0	$6,248	$0
Final Appropriation / Request	**$8,953,830**	**$7,929,533**	**$8,716,030**	**$7,975,468**
General Fund	$4,400,782	$3,501,300	$4,021,332	$3,677,330
Cash Funds Exempt	$322,302	$572,931	$580,621	$532,547
Federal Funds	$4,230,746	$3,525,482	$4,114,077	$3,765,591

2. 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 Colorado Benefits Management 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 received an appropriation of $51,718 for the Colorado Benefits Management System SAS – 70 line for FY 07-08, per the Long Bill (SB 07-239). The Department is requesting continuation funding for this line item in FY 08-09.

Line Item: Colorado Benefits Management System, SAS - 70	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Final Appropriation from Previous Fiscal Year	**$0**	**$54,305**	**$51,719**	**$51,718**
FY 06 S - 2	$54,305	$0	$0	$0
Joint Budget Committee Adjustment (March 8, 2006 Figure Setting, page 74)	$0	($2,586)	($1)	$0
Long Bill Appropriation / Request	**$54,305**	**$51,719**	**$51,718**	**$51,718**
General Fund	$0	$24,228	$24,228	$24,228
Cash Funds Exempt	$28,689	$3,095	$3,094	$3,094
Federal Funds	$25,616	$24,396	$24,396	$24,396

3. 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 Department of Human Services' major centralized computer systems, 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.

The Office of Information Technology has a staff of 76.2 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 institutional and community functions, disability determinations, and Department of Human Services' administrative services; children, youth and families and child support services; and 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.

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 04-05 final appropriation for the Other Office of Information Technology Services line was $540,458. The change from the FY 04-05 final appropriation to the FY 05-06 Long Bill was a decrease of $121,644. This net change included removal of $13,503 for the Legacy Systems shutdown that occurred in FY 04-05, an increase of $6,250 for Personal Services, 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 appropriation of $401,742 incorporated a $443 decrease in Personal Services, 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. In FY 06-07, two non-prioritized supplemental requests made one-time changes to the appropriation for the Other Office of Information Technology Services line. NP – S18 decreased the appropriation by $575 to account for Purchases of Services from Computer Center Common Policy adjustments made by the Department of Personnel and Administration, while NP – S19 decreased the appropriation by $13,398 to account for Multi-Use Network Common Policy adjustments. The final appropriation for the Other Office of Information Technology Services line in FY 06-07 was $387,769.

The Department has been appropriated $402,909 for the Other Office of Information Technology Services line in FY 07-08 which includes a $355 increase for Purchases of Services from Computer Center, a $10,767 increase for Multi-Use Network services, additional salary survey funds in the amount of $5,148 and a decrease of 0.5% ($1,130), base reduction (Department of Human Services Figure Setting, March 5, 2007, page 15). For FY 08-09, the Base Request reflects a common policy adjustment of $9,446 (which includes a 0.2% base reduction of $450) for personal services, and a decrease of $329 for purchases of services from the computer center.

Line Item: DHS Medicaid Funded Programs, (B) Office of Information Technology, Other Office of Information Technology Services	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$540,458**	**$419,886**	**$387,769**	**$402,909**
Common Policy Adjustments	($114,391)	($23,758)	$0	$0
Changes to Personal Services	$6,250	$5,614	$4,018	$9,446
Removal of One-time Funding for Legacy Systems Shutdown	($13,503)	$0	$0	$0
Purchases of Services from the Computer Center	$0	$0	$355	($329)
Common Policy Adjustments - NP - S19 Multi-use Network Payments - Annualization	$0	$0	$10,767	$0
Long Bill Appropriation / Request	**$418,814**	**$401,742**	**$402,909**	**$412,026**
Common Policy Adjustments	$1,072	$0	$0	$0
Common Policy Adjustments - NP - S18 Purchases of Services from the Computer Center	$0	($575)	$0	$0
Common Policy Adjustments - NP - S19 Multi-use Network Payments	$0	($13,398)	$0	$0
Final Appropriation / Request	**$419,886**	**$387,769**	**$402,909**	**$412,026**
General Fund	$209,943	$193,885	$201,455	$206,013
Federal Funds	$209,943	$193,885	$201,455	$206,013

(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 68% 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 Division of Facilities Management manages over 299 buildings that contain over 3,233,524 square feet of space (Department of Human Services Figure Setting, February 14, 2007, page 13). 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 the 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 14, 2007, page 13).

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 $35 million per year (Department of Human Services Figure Setting, February 14, 2007, page 13).

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 14, 2007, page 13).

Appropriation History

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 (SB 05-209). 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 for the net change in FTE, $26,976, originated from this appropriation.

Finally, the FY 06-07 appropriation was decreased by $43,993, per the Department of Personnel and Administrations supplemental request that adjusted each State department's funding for State vehicle leases. The request, which has been made for each of the past six years, is adjusted for each department's need (see Department of Personnel and Administration Supplemental document, January 23, 2007, page 35). The final FY 06-07 appropriation for the Office of Operations was $5,904,851.

To build to the FY 07-08 appropriation of $6,002,337, the Joint Budget Committee made a number of changes, including: reinstating the $43,993 of funding removed in FY 06-07 that adjusted for vehicle leases; added $34,573 in funding for personal services, which was partially offset by an $18,963 base reduction, as well as a decrease in operating funds of $25,645.

The Department of Human Services submitted DI – 4, which requested additional funding for general maintenance equipment, including compressors, pumps, water heaters, and floor buffers among other things. The Joint Budget Committee approved the funding request for a total of $63,526 in Medicaid funding, which, when included with the changes noted above, formed the FY 07-08 appropriated amount of $6,002,337.

The FY 08-09 Base Request of $6,151,223 represents an increase of $148,886 over the previous year's final appropriation due to a common policy adjustment for personal services. The following table provides the appropriation history for the Department of Human Services - Office of Operations line item.

Line Item: DHS Medicaid Funded Programs, (C) Office of Operations	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year's Final Appropriation	**$5,336,287**	**$5,812,424**	**$5,904,851**	**$6,002,337**
Vehicle Lease Payments	($9,528)	$74,551	$43,993	$0
0.2% Vacancy Savings Adjustment	$0	($7,585)	($18,963)	$0
Salary Survey	$0	$96,430	$34,573	$0
Personal Services	$93,350	$0	$0	$148,886
Operating Expenses	$3,564	$0	($25,645)	$0
Utilities	($20,800)	$0	$0	$0
DI - 4: General Maintenance Equipment	$0	$0	$63,526	$0
Adjustment to Long Bill	$0	$0	$2	$0
Long Bill Appropriation / Request	**$5,402,873**	**$5,975,820**	**$6,002,337**	**$6,151,223**
HB 06-1217 - Fuel Adjustment	$4,850	$0	$0	$0
HB 06-1217 - Utilities	$405,890	$0	$0	$0
HB 06-1217 - Vehicle Lease Payments	($1,189)	$0	$0	$0
SB 06-219 – Transfer to Health Care Policy and Financing for FTE	$0	($26,976)	$0	$0
One-time Vehicle Lease Payments Reduction	$0	($43,993)	$0	$0
Final Appropriation / Request	**$5,812,424**	**$5,904,851**	**$6,002,337**	**$6,151,223**
General Fund	$2,906,212	$2,952,426	$3,001,169	$3,078,114
Federal Funds	$2,906,212	$2,952,425	$3,001,168	$3,073,109

(D) COUNTY ADMINISTRATION

1. COUNTY ADMINISTRATION – MEDICAID FUNDING

This line item provided Medicaid funding for county departments of social/human services to administer Medicaid eligibility determinations (Department of Human Services Figure Setting, March 5, 2007, page 24). The allocation of Medicaid and non-Medicaid funding in the Department of Human Services' budget has always been dynamic, as the Department of Human Services was allowed to incorporate General Fund transfers between these funding streams pursuant to Section 24-75-106, C.R.S. (2007). 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 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 for eligibility determinations 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 was no FY 07-08 appropriation and there is no FY 08-09 Base Request for this appropriation.

Appropriation History

The final FY 04-05 appropriated amount for County Administration was $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 performance bonus, 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 in the amount of $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 Services' 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 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$8,624,879**	**$11,522,832**	**$0**	**$0**
2.0% Provider Rate Increase (DHS Figure Setting, March 8, 2005, page 58)	$172,498	$0	$0	$0
Removal of one-time funding for federal cash performance bonus for low payment error rate in food stamps	$0	($277,838)	$0	$0
Removal of one-time federal funding for administrative case management costs in FY 04-05	$0	($2,434,864)	$0	$0
Reallocation of Medicaid and non-Medicaid funding for County Administration	$0	$3,202,623	$0	$0
Increase for County Administration due to concerns of insufficient funds	$0	$2,569,864	$0	$0
3.25% provider rate increase	$0	$491,826	$0	$0
Eliminate funding for 8 Front Range counties for administration related to non-emergency medical transportation	$0	($485,733)	$0	$0
Long Bill Appropriation / Request	**$8,797,377**	**$14,588,710**	**$0**	**$0**
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	$2,725,455	$0	$0	$0
SB 06-219 - Transfer Entire Medicaid Amount to Health Care Policy and Financing	$0	($14,588,710)	$0	$0
Final Appropriation / Request	**$11,522,832**	**$0**	**$0**	**$0**
General Fund	$3,467,256	$0	$0	$0
Federal Funds	$8,055,576	$0	$0	$0

2. 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 and 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 has been requested since FY 06-07.

Line Item: DHS Medicaid Funded Programs, (D) County Administration, Administration Related to CBMS Implementation	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$1,527,318**	**$1,396,773**	**$0**	**$0**
Removal of one-time funding from prior year	($1,527,318)	($1,396,773)	$0	$0
Long Bill Appropriation / Request	**$0**	**$0**	**$0**	**$0**
HB 05-1315 - Supplemental Bill for Colorado Benefits Management System	$0	$0	$0	$0
HB 06-1217 - Official appropriation of approved 1331 Emergency Supplemental on June 21, 2005	$1,396,773	$0	$0	$0
Final Appropriation / Request	**$1,396,773**	**$0**	**$0**	**$0**
General Fund	$698,387	$0	$0	$0
Federal Funds	$698,386	$0	$0	$0

(E) DIVISION OF CHILD WELFARE

1. 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 is a Home and Community Based Services waiver and is designed to promote community placements and prevent institutional placements 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 oversight of programs. On-going federal approval of this waiver is 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 for 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. Through 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 when the Department was first under the child welfare settlement agreement.

During the Department of Human Services' Figure Setting session on February 9, 2005, (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/human 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 Performance-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 appropriation for FY 07-08 in the Long Bill (SB 07-239) is $127,485. Common policy adjustments account for the difference between the FY 06-07 final appropriation of $126,939 and FY 07-08's appropriation. The net increase of $546 represents the

combined effect of a $607 decrease for Base Reduction and a $1,153 increase for salary survey. The Department's FY 08-09 request of $132,025 reflects an additional $3,378 for salary survey, $1,404 for achievement based pay, and a 0.2% base reduction of $242.

Line Item: Child Welfare Administration	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Budget Request
Previous Fiscal Year Final Appropriation	**N/A**	**$60,506**	**$126,939**	**$127,485**
NP - 12: Personal Services and Operating for New GP V	$0	$64,799	$0	$0
Salary Survey	$0	$1,634	$1,153	$3,378
Achievement Based Pay	$0	$0	$0	$1,404
Leap Year Adjustment	$0	$0	$0	$0
Vacancy Savings Adjustments	$0	$0	$0	$0
0.5% Base Reduction	$0	$0	($607)	$0
0.2% Base Reduction	$0	$0	$0	($242)
Long Bill Appropriation / Request	**$60,506**	**$126,939**	**$127,485**	**$132,025**
Cash Funds Exempt	$30,253	$63,470	$63,743	$66,013
Federal Funds	$30,253	$63,469	$63,742	$66,012

2. DIVISION OF CHILD WELFARE - CHILD WELFARE SERVICES

The Child Welfare Services line item receives funding to provide the primary source of funding for counties to administer child welfare programs and deliver associated services for children and families. The line item provides funding for: (1) County Administration for Child Welfare related services; (2) out-of-home residential care; (3) subsidized adoptions; and (4) other necessary and appropriate services for children and families (Department of Human Services Figure Setting, February 22, 2007, page 39).

Only 80% of all child welfare services are funded by the State pursuant to Section 26-1-122, C.R.S. (2007). The remaining 20% is funded by the individual counties. Counties receive capped funding allocations for the administration and provision of child welfare services. At the end of any fiscal year, unexpended funds can be allocated to counties whose expenditures have exceeded their capped amounts. However, counties may only receive additional funds if the overexpenditures have been authorized, are the result of unanticipated caseload increases, and are not attributable to administrative or support functions. 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. Should the Department of Human Services and the Child Welfare Allocations Committee fail to agree to an allocation methodology, the two entities present alternative methodologies to the Joint Budget Committee for selection (Department of Human Services Figure Setting, February 22, 2007, page 39).

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 from 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 worked together to overhaul the Child Welfare program. Based on that collaboration, the Department filed a state plan amendment with the Centers for Medicare and Medicaid Services. The amendment sets forth the methodology for unbundling the rates. The amendment has not been approved as of October 1, 2007.

With the passage of HB 06-1395, the Child Welfare program was redesigned to include three new provider types, each provider offering a different level of care. These three provider types include: psychiatric residential treatment facilities (PRTF); therapeutic 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).

Therapeutic 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' level of care 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 05-06 Long Bill (SB 05-209) was greater than the previous year's final appropriation of $71,978,806 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 changes 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. The psychiatric residential treatment facilities (PRTFs) are considered one step below an inpatient care center. These types of facilities, according to the Centers for Medicare and Medicaid Services, are not eligible to bill a per diem rate, as they are not an inpatient care center, and must therefore charge on a fee-for-service basis. This bill also required that the Medical Services Board promulgate rules to administer the newly restructured program, and that the county share of this program be 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.

SB 06-219 created greater clarity in the Department's statutes, transferred the administration of Home Care Allowance and Adult Foster Care to the Department of Human Services, and established two new line items in the Department's budget related to county administrative funding. One of these new appropriations was 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'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 was for continuation funding of $34,063,555. However, due to an increase in anticipated caseload, the appropriation for the Child Welfare Services FY 07-08 Base Request needed an increased appropriation. Pursuant to this request, made through the Department's DI #6, the Joint Budget Committee approved an additional $383,193 in funding for the Child Welfare Services appropriation. In addition, to this adjustment, the Joint Budget Committee also approved $389,545 for a 1.5% provider rate increase, and a leap year adjustment of $39,320. The leap year adjustment is necessary because the additional day of services in the fiscal year represents a substantial amount of funding. The Long Bill appropriation for FY 07-08 (SB 07-239) is $34,875,613, and the Department has requested $34,836,293 for FY 08-09, which is continuation funding with an adjustment for the removal of the leap year adjustment.

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare Services	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$71,978,806**	**$75,826,635**	**$34,063,555**	**$34,875,613**
FY 07-08 leap year adjustment	$0	$0	$39,320	($39,320)
Caseload growth	$1,847,566	$0	$383,193	$0
Transfer of Personal Services and Operating Expenses associated with CHRP FTE	($59,246)	$0	$0	$0
Provider Rate increase as part of a Joint Budget Committee action	$1,489,110	$0	$389,545	$0
Adjustment to match Long Bill	($6)	$0	$0	$0
3.25% cost-of-living adjustment as part of a Joint Budget Committee action	$0	$797,450	$0	$0
Caseload growth	$0	$831,948	$0	$0
Removal of nearly all residential treatment center Medicaid funding	$0	($51,486,475)	$0	$0

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare Services	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Transfer Personal Services and Operating for GP V overseeing Children's Habilitation Residential Program	$0	($64,799)	$0	$0
Long Bill Appropriation / Request	**$75,256,230**	**$25,904,759**	**$34,875,613**	**$34,836,293**
HB 06-1217 - Administrative case management funding as part of PCG initiative	$570,405	$0	$0	$0
HB 06-1395 - Psychiatric Residential Treatment Facilities Bill	$0	$8,747,740	$0	$0
SB 06-219 - Removal of administrative case management funding	$0	($588,944)	$0	$0
Final Appropriation / Request	**$75,826,635**	**$34,063,555**	**$34,875,613**	**$34,836,293**
General Fund	$37,913,318	$17,031,778	$17,437,807	$17,418,147
Federal Funds	$37,913,317	$17,031,777	$17,437,806	$17,418,146

3. 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 equal to $183,269, was appropriated as one-time funding in FY 05-06. There was no requested funding for this appropriation in FY 07-08 and is no funding request for FY 08-09.

Line Item: DHS Medicaid Funded Programs, Contingency Fee for Federal Funds Maximization	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Prior Year's Final Appropriation	**N/A**	**$183,629**	**$0**	**$0**
Removal of one-time funding from prior year	**$0**	($183,629)	$0	$0
Long Bill Appropriation	**$0**	**$0**	**$0**	**$0**
HB 06-1217 – Created new line item for contingency fee to contractor	$183,629	$0	$0	$0
Final Appropriation / Request	**$183,629**	**$0**	**$0**	**$0**
Federal Funds	$183,629	$0	$0	$0

4. 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 (2007). 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. (2007) must 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.

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 did not request funding for this line item in FY 07-08 and is not requesting funding for this line item in FY 08-09.

Line Item: DHS Medicaid Funded Programs, (E) Child Welfare - Family and Children's Programs	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**N/A**	**$973,056**	**$0**	**$0**
3.25% cost-of-living adjustment as part of a Joint Budget Committee action	$0	$31,624	$0	$0
Long Bill Appropriation	**$0**	**$1,004,680**	**$0**	**$0**
HB 06-1217 - Administrative case management funding as part of PCG initiative	$973,056	$0	$0	$0
SB 06-219 - Removal of administrative case management funding	$0	($1,004,680)	$0	$0
Final Appropriation / Request	**$973,056**	**$0**	**$0**	**$0**
General Fund	$486,528	$0	$0	$0
Federal Funds	$486,528	$0	$0	$0

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES

1. 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 Programs was transferred from the Department of Human Services to the Department.

Appropriation History

The change from the FY 04-05 final appropriation of $277,951 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 accounts for an increase in Salary Survey of $11,241 and a 0.5% Base Reduction of $1,537. The FY 08-09 Base Request of $328,584 assumes continuation funding plus $8,837 for salary survey, $3,548 for achievement based pay, and a 0.2% base reduction of $856.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services, Administration	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$277,951**	**$299,003**	**$307,351**	**$317,055**
Operating Expenses adjustment	$11,274	$0	$0	$0
Common Policy adjustment for Salary Survey, Pay-for-Performance, and 0.2% vacancy savings	$9,778	$8,348	$0	$0
Common Policy adjustment for Salary Survey	$0	$0	$11,241	$8,837
0.5% Base Reduction	$0	$0	($1,537)	$0
0.2% Base Reduction	$0	$0	$0	($856)
Achievement Based Pay	$0	$0	$0	$3,548
Long Bill Appropriation	**$299,003**	**$307,351**	**$317,055**	**$328,584**
Final Appropriation / Request	**$299,003**	**$307,351**	**$317,055**	**$328,584**
General Fund	$149,502	$153,676	$158,528	$164,292
Federal Funds	$149,501	$153,675	$158,527	$164,292

2. 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 persons with mental illness in northwest Denver. Persons with mental illness 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 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 Community Mental Health Community Services Program, mental health capitation payments line item. However, the Department's 1331 Emergency Supplemental, which was approved on September 20, 2006, transferred this funding 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, a transfer of the appropriation and administration of Goebel payments in FY 07-08 and onward to the Department's Medicaid Mental Health Program.

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'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.

There was no funding approved for this line item in the FY 07-08 Long Bill (SB 07-239) The Department is not requesting any funding for this line item in FY 08-09.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services - Goebel Lawsuit Settlement	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$11,655,586**	**$11,888,698**	**$0**	**$0**
2.0% provider rate increase	$233,112	$0	$0	$0
3.25% provider rate increase	$0	$386,383	$0	$0
Long Bill Appropriation	**$11,888,698**	**$12,275,081**	**$0**	**$0**
1331 Pay Goebel Lawsuit Settlement Costs through Mental Health Capitation appropriation	$0	($12,275,081)	$0	$0
Spending Authority / Request	**$11,888,698**	**$0**	**$0**	**$0**
General Fund	$5,944,349	$0	$0	$0
Federal Funds	$5,944,349	$0	$0	$0

3. 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 therapeutic residential child care facilities (TRCCFs), 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 or suitable for a placement based on "dependency and neglect" criteria (Department of Human

Services Figure Setting, March 14, 2007, page 56). SB 03-083, signed June 5, 2003 extended the repeal date to July 1, 2008. This line item provides funding for services not covered by private insurance, sliding-scale parent fees, Medicaid, and Supplemental Security Income (SSI).

Appropriation History

For FY 04-05, the General Assembly approved two pieces of legislation, SB 04-065 and HB 04-1421, which included appropriation clauses related to the Residential Treatment of Youth and the Tobacco Master Settlement Agreement monies that provide funding for it. However, the SB 04-065 appropriation clause included 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 $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 (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 appropriation was for $472,423, reflecting a reduction from the final amount of $482,630 appropriated in FY 04-05 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 the final appropriation for FY 05-06.

For FY 06-07, continuation funding from the previous year was increased by $15,354 to reflect the 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 appropriation 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 therapeutic residential child care facilities 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 Centers for Medicare and Medicaid Services indicated that Title XIX federal funds were not allowed for some of the functions provided at the therapeutic residential child care facilities, namely for room and board, 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 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. However, when the State Supplemental bill passed during the FY 06-07 Legislative session, the amount of funds removed from the base for FY 06-07 was only $261,206, but an additional $109,108 was removed to recognize Medicaid's decreased portion of total expenditures to build

to the FY 07-08 appropriated amount of $117,463. The Department has requested continuation funding for the FY 08-09 Base Request.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services - Residential Treatment of Youth	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$482,630**	**$472,423**	**$226,571**	**$117,463**
Revised Tobacco Master Settlement Agreement funding	($190)	$0	$0	$0
Reduction to General Fund need for caseload beyond Tobacco Master Settlement Agreement funding	($10,017)	$0	$0	$0
3.25% provider rate increase	$0	$15,354	$0	$0
Long Bill Appropriation	**$472,423**	**$487,777**	**$226,571**	**$117,463**
Adjustment for Allowable Expenditures	$0	($261,206)	($109,108)	$0
Final Appropriation / Request	**$472,423**	**$226,571**	**$117,463**	**$117,463**
General Fund	$27,183	$34,278	$34,975	$34,975
Cash Funds Exempt	$209,029	$79,008	$23,757	$23,757
Federal Funds	$236,211	$113,285	$58,731	$58,731

4. MENTAL HEALTH AND ALCOHOL AND DRUB ABUSE SERVICES - MENTAL HEALTH INSTITUTES

Mental Health Institutes provide inpatient hospitalization for persons with severe and persistent mental illness. 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 Department was appropriated continuation funding from FY 04-05, of $4,522,820 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.

In FY 06-07, the Department of Human Services submitted a request (NP – S10) to adjust funding at the regional treatment centers. The request reduced the appropriation by $677,770. However, because the request was intended to reduce the appropriation to the Mountain Star facility, which is funded out of the Child Welfare appropriation, the reduction to the Mental Health Facilities was made in error. To correct for this, the Long Bill Add-ons (SB 07-239) reinstated this funding and made two other adjustments: 1) a decrease of $1,601,705 to adjust for lower client utilization, and 2) an increase in funding in the amount of $2,117,551 as a one-time adjustment for the savings associated with moving to cash accounting. The sum of the three part adjustment to the appropriation was $1,193,616. The final FY 06-07 appropriation, taking these changes into account, was $ 5,461,954.

To build to the FY 07-08 appropriation, the Joint Budget Committee annualized the effects of the changes made in the Long Bill Add-ons (SB 07-239) by removing the $1,193,616 adjustment, and re-adjusted the appropriation for the initial $677,770 decrease. In total, the Joint Budget Committee decreased the final FY 06-07 appropriation by $2,117,551 to reverse the one-time savings for moving to cash accounting realized in FY 06-07 to reach the FY 07-08 Long Bill appropriation (SB 07-239). The Department is requesting continuation funding for FY 08-09.

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services – Mental Health Institutes	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$4,522,820**	**$4,946,108**	**$5,461,954**	**$3,344,403**
Reversal of SB 07-239 Long Bill Add-ons	$0	$0	($1,193,616)	$0
Annualization of Adjustments for Switch to Cash-based Accounting	$0	$0	($923,935)	$0
Long Bill Appropriation	**$4,522,820**	**$4,946,108**	**$3,344,403**	**$3,344,403**
Removal of Medicaid Funding for Mountain Star Facility (SB 07-163)	$0	($677,770)	$0	$0

Line Item: DHS Medicaid Funded Programs, (F) Mental Health and Alcohol and Drug Abuse Services – Mental Health Institutes	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Replacement of Medicaid Funding for Mountain Star Facility, Fee-for-service adjustment, One-time Savings for Cash Accounting	$0	$1,193,616	$0	$0
SB 05-209 Add-ons - Reduced patient revenue in fee-for-service clients	$0	$0	$0	$0
HB 06-1385 Add-ons - Revised estimate for patient revenue in fee-for-service clients	$423,288	$0	$0	$0
Final Appropriation / Request	**$4,946,108**	**$5,461,954**	**$3,344,403**	**$3,344,403**
General Fund	$2,473,054	$2,730,977	$1,672,202	$1,672,202
Federal Funds	$2,473,054	$2,730,977	$1,672,201	$1,672,201

5. 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 is funded in part by the Department and 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, page).

Appropriation History

FY 05-06 was the first fiscal year that this line item was separated into its own appropriation in the Department's budget. The FY 05-06 Long Bill (SB 05-209) included $17,213 for 0.3 FTE Personal Services and Operating Expenses. This amount annualized to $54,088 in the FY 06-07 Long Bill. The Department requested, and was granted, continuation funding for FY 07-08. The Department is requesting continuation funding for FY 08-09.

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**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**N/A**	**$17,213**	**$54,088**	**$54,088**
Annualization for remaining Personal Services for 0.7 FTE	$0	$35,923	$0	$0
Annualization of Operating Expenses	$0	$952	$0	$0
Long Bill Appropriation	**$17,213**	**$54,088**	**$54,088**	**$54,088**
General Fund	$8,607	$27,044	$27,044	$27,044
Federal Funds	$8,606	$27,044	$27,044	$27,044

6. 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 statewide voluntary alcohol and drug treatment program for pregnant women who are at risk of a poor birth outcome due to substance-related disorders. This program was developed with the following goals: 1) produce a healthy infant; 2) reduce or stop substance abusing behavior in pregnant woman during and after pregnancy; 3) promote and ensure 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 16 designated treatment facilities throughout the State. Services include an in-depth risk assessment, individual and group counseling, case management services, health education, and urinalysis screening and monitoring. Services are on an outpatient or residential basis depending upon client risk and placement criteria. This line provides Medicaid funding for prenatal and postpartum substance abuse treatment services for women at risk of a poor birth outcome due to alcohol or substance abuse. HB 04-1075 directed the Department 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. The approval letter for this waiver was received by the Department on December 27, 2006, with an effective date of January 1, 2007.

Appropriation History

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.

To build the FY 07-08 appropriation, the Joint Budget Committee included one adjustment for a 1.5% provider rate adjustment, which increased the FY 06-07 appropriation by $14,759. In FY 07-08, the High-Risk Pregnant Women Program received an appropriation of $998,717. The Department has requested continuation funding for FY 08-09.

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 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$1,133,667**	**$952,986**	**$983,958**	**$998,717**
Annualization of HB 05-1075 for post-partum benefits beyond 60 day limit	$31,935	$0	$0	$0
Provider rate increase recommended by Joint Budget Committee	$18,686	$0	$14,759	$0
Relief of overexpenditure restriction from FY 03-04	-$231,302	$0	$0	$0

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 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
3.25% provider rate increase recommended by Joint Budget Committee	$0	$30,972	$0	$0
Final Appropriation / Request	**$952,986**	**$983,958**	**$998,717**	**$998,717**
General Fund	$476,493	$491,979	$499,359	$499,359
Federal Funds	$476,493	$491,979	$499,358	$499,358

(G) SERVICES FOR PEOPLE WITH DISABILITIES

1. 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. These FTE are responsible for 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 changes in Common Policies for Salary Survey equal to $61,094 and the 0.2% vacancy savings reduction equal to $4,504, and 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 a Common Policy adjustment equal to an increase of $59,056 for Salary Survey. 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, an $11,749 decrease for a Joint Budget Committee recommended 0.5% base reduction, and a $96,236 increase due to the Department of Human Services' budget amendment for the Community and Contract Management System (CCMS) replacement. This system tracks developmental disability resource and contracts, as well as waiting list information

(Department of Human Services Figure Setting, March 14, 2007, page 30). The additional funds for the Community and Contract Management System replacement line item were requested to pay Medicaid's portion of updated software and hardware for this Information Technology System. The FY 07-08 appropriation per the Long Bill (SB 07-239), including all of the aforementioned changes, is equal to $2,582,358. To build to the FY 08-09 Base Request of $2,692,143, the Department has included an additional $84,361 for salary survey, $29,920 for achievement based pay, and a 0.2% base reduction of $4,496.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities – Community Services Administration	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**N/A**	**$2,337,168**	**$2,438,131**	**$2,582,358**
Add Personal Services associated with new quality assurance FTE	$0	$40,585	$0	$0
Add Operating Expenses associated with new quality assurance FTE	$0	$3,788	$0	$0
Common Policy adjustment for Salary Survey	$0	$61,094	$59,056	$84,361
Achievement Based Pay	$0	$0	$0	$29,920
Common Policy adjustment for 0.2% vacancy savings factor	$0	($4,504)	$0	$0
Annualization of Operating Expenses for Quality Control	$0	$0	($3,288)	$0
Annualization of Personal Services for Quality Control	$0	$0	$3,972	$0
0.5% Base Reduction	$0	$0	($11,749)	$0
0.2% Base Reduction	$0	$0	$0	($4,496)
Changes for CCMS Web Design	$0	$0	$96,236	$0
Long Bill Appropriation / Request	**$2,337,168**	**$2,438,131**	**$2,582,358**	**$2,692,143**
General Fund	$1,168,584	$1,219,066	$1,291,179	$1,346,072
Federal Funds	$1,168,584	$1,219,065	$1,291,179	$1,346,071

2. 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). Twenty community centered boards provide case management and utilization review, including Pre-Admission Screening and Annual Resident Reviews (PASARR), to clients 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, which included the mandatory "unbundling" of rates. 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 financial 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.

To implement the new rate setting methodology, the State hired a consultant to modify an existing behavioral assessment tool, the Supports Intensity Scale (SIS) Tool, in order to effectively gauge the level of care needed for every individual enrolled in the Home and Community Based Services - Developmental Disabilities waiver. Once the level of care has been established for each client, the State will be able to adjust its estimated expenditures accordingly. However, during the initial survey of a sample of developmentally disabled individuals, the State received guidance from the Supports Intensity Scale Tool contractor that individuals diagnosed with certain conditions, such as being a sexual predator, should automatically receive the maximum score, meaning they need the most assistance, on their surveys. After the completion of the initial round of surveys, the State was advised that the automatic maximization would not provide an accurate measure of the amount of care required for the targeted populations, and all work on the modification of the Supports Intensity Scale Tool stopped until the correct methodology could be put in place. Because of these delays, implementation of the new rate setting methodology has been pushed back.

In FY 06-07, the Department of Human Services wrote an emergency supplemental to remove a considerable amount of funding from the Community Services Adult Program Costs and CCMS Replacement line. The request cited underutilization of the Home and Community Based, Supported Living Services, and Children's Extensive Support waiver programs as justification for the under-expenditure. The emergency supplemental requested that a portion of the under-expenditure be used to pay for the purchase, modification, and user training for the aforementioned Supports Intensity Scale Tool, temporary assistance in processing Prior Authorization Reviews, and modifications to the Community Contract and Management System. These changes, according to the request, were necessary to keep the developmental disabilities programs running smoothly.

Appropriation History

The FY 05-06 Long Bill (SB 05-209) appropriation reflected an increase of $5,880,664 over the FY 04-05 final appropriation of $217,907,468. 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 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. The Joint Budget Committee's approval of this recommendation adjusted the spending authority for this program in FY 06-07 down to $240,711,455. The General Fund saved as a result of this request was used for the hold harmless clause and to pay for additional resources within the program itself.

In addition to the adjustment of the funding for the 3.25% cost of living adjustment, the Community Services Adult Program Costs and CCMS Replacement line was appropriated an additional $15,215,890 in total funds. This additional funding allowed the State to use General Fund in place of local match, which the Centers for Medicare and Medicaid Services disallowed on the basis that county specific expenditures cannot substitute for other counties' expenditures or community centered board catchments.

The Department of Human Services supplemental request to remove $8,391,630 in funding from the Community Services Adult Program Costs and CCMS Replacement (as discussed in the narrative above) was approved as requested. Finally, the FY 06-07 appropriation received a one-time adjustment that decreased the appropriation by $14,128,082 as a result of changing the yearly billing methodology from 304 days to 365 days. The final FY 06-07 appropriation was therefore $233,407,633.

There were a number of adjustments that were made to the FY 06-07 final appropriation to build to the FY 07-08 appropriation. The Joint Budget Committee replaced the $14,128,082 removed in the previous year for the billing adjustment, and replaced the $7,483,450 reduction that appropriated the 3.25% cost-of-living adjustment for FY 06-07 directly to the Department of Human Services to pay for additional resources, but also approved a separate 1.5% cost-of-living adjustment for FY 07-08 in the amount of $3,998,235.

Pursuant to the Department of Human Services' request to move Community and Contract Management System Replacement costs to a separate line, the Joint Budget Committee removed $103,880 from the Department's Community Services Adult Program Costs and CCMS Replacement line item and placed the majority of the funding into the Medicaid Funding Community Services Administration line.

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.

A number of additional resources for the Developmental Disability waiver program were requested during FY 06-07 and FY 07-08 that required adjustments to the FY 07-08 appropriation. The Department of Human Services' FY 06-07 Decision Item (FY 06-07 NP – 2) requested 79 additional comprehensive resources and 9 new adult supported living services, for which the Community Services Adult Program Costs and CCMS Replacement line received an additional $3,119,463. The Department of Human Services also submitted a FY 07-08 decision item request (see November 1, 2006 Budget Request, NP – 3) for additional resources in a number of other lines. The request was approved and the following appropriations were made to fund six months of services for the following groups: 1) $1,549,661 for 39 additional foster care resources; 2) $1,220,109 for 30 additional emergency resources; 3) $345,039 for 10 new waiting list resources; 4) $205,876 for 24 additional adult supported living services; 5) and $29,754 to pay for cost management for 104 additional early intervention resources. The final adjustment for resources is an annualization of a Children's

Extensive Support adjustment that refinanced $18,736 in State-only expenditures in the Department of Human Services to utilize Health Care Expansion Fund (Tobacco Tax) money, General Fund, and the corresponding federal match.

During the FY 07-08 Figure Setting process, the Joint Budget Committee decided that it would be more efficient to merge the Services for Children and Families appropriation with the Community Services Adult Program Costs and CCMS Replacement appropriation. As a result, an additional $7,291,981 was moved into this line, bringing the final FY 07-08 Long Bill appropriation (SB 07-239) to $281,791,710.

The FY 08-09 Base Request includes a number of annualizations for the additional resources that were added as a result of the Department's NP – 3 submitted in the November 1, 2006 Budget Request. Because the initial funding for these resources was approved for 6 months of FY 07-08, the Department has annualized these amounts to a full year for FY 08-09, which doubles the initial appropriation. Accordingly, the Department has requested the following: 1) $1,549,661 for 39 additional foster care resources; 2) $1,220,109 for 30 additional emergency resources; 3) $345,039 for 10 new waiting list resources; 4) $205,876 for 24 additional adult supported living services; 5) and $29,754 to pay for cost management for 104 additional early intervention resources. Finally, the Department has made an adjustment to remove $705,941 in leap-year funding included in the FY 07-08 appropriation. The following table shows the movement in the Community Services Adult Program Costs and CCMS Replacement line item from FY 05-06 through the FY 08-09 Base Request.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Community Services Adult Program Costs and CCMS Replacement	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$217,907,468**	**$224,704,570**	**$233,407,633**	**$281,791,710**
Removal of Previous Year's 1331 Supplemental Funds	$0	$0	$8,391,630	$0
Adjusted Prior Year's Final Appropriation	**$217,907,468**	**$224,704,570**	**$241,799,263**	**$281,791,710**
Annualization of removal of State Plan services funding from prior year	($376,950)	$0	$0	$0
Removal of all administrative funding from this appropriation, transferred to own line item	($2,186,355)	$0	$0	$0
2.0% provider rate increase per Joint Budget Committee action	$4,812,250	$0	$3,998,235	$0
Additional emergency and waiting list resources (half year only)	$2,366,195	$0	$0	$0

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Community Services Adult Program Costs and CCMS Replacement	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Emergency and waiting list resources	$1,265,524	$2,366,192	$0	$0
Reverse reduction to HB 05-1262 funding from prior fiscal year and annualize per fiscal note	$0	$63,060	$0	$0
Additional emergency and waiting list resources requested for current year (NP-2, November 15, 2005)	$0	$3,053,115	$0	$0
3.25% provider rate increase recommended by Joint Budget Committee	$0	$7,355,735	$0	$0
Addition of 60 new Support Living Services waiver slots	$0	$1,015,513	$0	$0
Addition of 90 new Comprehensive Services waiver slots	$0	$6,595,650	$0	$0
Base rate increase for Comprehensive Services waiver	$0	$2,426,919	$0	$0
Increase for targeted case management for 3,735 early intervention clients	$0	$541,365	$0	$0
Reduction to Post Eligibility Treatment of Income funding	$0	($12,298)	$0	$0
Technical adjustment for Children's Extensive Support resources and for targeted case management	$0	$18,736	$0	$0
Technical adjustment for base rate increase	$0	$66,348	$0	$0
Leap year adjustment	$0	$0	$705,941	($705,941)
General Fund to Supplant Local Match	$0	$15,215,890	$0	$0
Direct Appropriation of 3.25% Cost of Living Adjustment	$0	($7,483,450)	$7,483,450	$0
Adjust Billing Period from 304 Days to 365 Days	$0	($14,128,082)	$14,128,082	$0
Move Children and Families Funding to this Line	$0	$0	$7,291,981	$0
Removal of CCMS Costs	$0	$0	($103,880)	$0
Annualization of CES Slots	$0	$0	$18,736	$0

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Community Services Adult Program Costs and CCMS Replacement	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Annualization of FY 06-07 DI #1	$0	$0	$3,119,463	$0
New Foster Care Resources (NP - 3, November 1, 2006)	$0	$0	$1,549,661	$1,549,661
New Emergency Resources	$0	$0	$1,220,109	$1,220,109
New Wait List Resources	$0	$0	$345,039	$345,039
New Supported Living Services	$0	$0	$205,876	$205,876
Cost Management for New Early Intervention Resources	$0	$0	$29,754	$29,754
Long Bill Appropriation / Request	**$223,788,132**	**$241,799,263**	**$281,791,710**	**$284,436,208**
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	$161,320	$0	$0	$0
HB 06-1369 - Provider rate increase and elimination of early intervention waiting list	$803,514	$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	($48,396)	$0	$0	$0
Final Appropriation / Request	**$224,704,570**	**$241,799,263**	**$281,791,710**	**$284,436,208**
1331 Supplemental for Under-Expenditures	**$0**	**($8,391,630)**	**$0**	**$0**
Final Appropriation with 1331 Supplementals	**$224,704,570**	**$233,407,633**	**$281,791,710**	**$284,436,208**
General Fund	$112,321,761	$116,641,180	$140,288,917	$141,611,168
Cash Funds Exempt	$18,774	$32,364	$574,580	$574,580
Federal Funds	$112,364,035	$116,734,089	$140,928,213	$142,250,460

3. 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

The FY 05-06 Long Bill (SB 05-209) was for continuation funding of the final FY 04-05 appropriation 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 but due to the changes required by the Centers for Medicare and Medicaid Services, a large portion of expenditures previously incurred by the Federally Matched Local Program Costs were no longer eligible for federal reimbursement. To continue receiving the federal match, the State decided to pay for these expenses out of the Community Services Adult Program Costs and CCMS Replacement line item, as noted in the narrative above. In total, this action removed $11,957,531, and brought the final FY 06-07 appropriation to $12,324,307.

The Joint Budget Committee further reduced this appropriation for FY 07-08 because Joint Budget Committee Staff recommended the removal of $8,682,397 in funding from the FY 06-07 appropriation that was used to pay for services rendered in FY 05-06, but billed in FY 06-07. The Department is requesting continuation funding for FY 08-09.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Federally-matched Local Program Costs	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$19,807,076**	**$24,281,838**	**$12,324,307**	**$3,641,910**
Removal of FY 05-06 costs billed in FY 06-07	$0	$0	-$8,682,397	$0
Long Bill Appropriation	**$19,807,076**	**$24,281,838**	**$3,641,910**	**$3,641,910**
HB 06-1217 - Allowance for additional local certification of funds	$4,474,762	$0	$0	$0
Removal of Disallowed Local Match Funds	$0	-$11,957,531	$0	$0
Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Federally-matched Local Program Costs	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Final Appropriation / Request	**$24,281,838**	**$12,324,307**	**$3,641,910**	**$3,641,910**
Cash Funds Exempt	$12,140,919	$6,162,154	$1,820,955	$1,820,955
Federal Funds	$12,140,919	$6,162,153	$1,820,955	$1,820,955

4. 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 (ICFs/MR). 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 cannot adequately be 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 for this line 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 of $72,164 per Common Policies. 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. The Centers for Medicare and Medicaid Services required the Department 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. 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 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 appropriation was $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 to support County Administration. This transfer was for $29,024, resulting in the FY 06-07 appropriation of $40,359,904.

The FY 07-08 appropriation of $42,058,031 includes adjustments for many common policy items. The Regional Centers line was appropriated an additional $32,948 for operating expenses, which includes increases for standard operating expenses as well as medical and food inflation cost adjustments. An additional $630 was appropriated to pay for the cost of inflation for contractual services, such as laundry and security. The regional centers were also given a salary survey increase of $1,165,116 on top of an additional $342,541 to pay six months of salary for 16.5 FTE allocated to them as a result of their request to take care of staffing needs at the regional centers (NP – 1). Finally, the regional centers' appropriation was increased $157,342 to account for the increased amount of fees, and the associated federal match, that the regional centers will provide the State.

The Department is requesting $44,524,284 in funding for the Regional Centers line in FY 08-09. The difference between the FY 07-08 final appropriation and the FY 08-09 Base Request, of $2,569,244, is due to a $1,561,053 increase for salary survey, $530,805 for performance based pay, a decrease of $2,170 for operating expenses, and a $479,556 annualization of the Departments NP – 1 submitted in the November 1, 2006 Budget Request for Regional Center staffing.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Regional Centers	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Final Appropriation	**$38,613,115**	**$39,453,152**	**$40,359,904**	**$42,058,031**
0.2% vacancy savings reduction	$0	-$80,382	$0	$0
Annualization of transfer of Medicaid State Plan services funding from this appropriation	-$241,042	$0	$0	$0
Reduction to Medicaid funding due to annualization of Supplemental Security Income cost-of-living adjustment	-$26,407	-$43,463	$0	$0
Increase for Common Policies	$1,026,473	$0	$32,498	$0
Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Regional Centers	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Joint Budget Committee action to add medical inflationary increase	$5,037	$27,258	$0	$0
Reduction due to collection of service fees	-$13,280	$0	$0	$0
Client Cash Adjustment - Joint Budget Committee Actions	-$12,890	$159,131	$0	$0
Adjustment to Balance to Joint Budget Committee	$42	$0	$0	$0
Removal of one-time funding for overtime in prior fiscal year	$0	-$131,764	$0	$0
Increase for Salary Survey	$0	$1,047,750	$1,165,116	$1,561,053
Technical adjustment for a Supplemental Security Income cost-of-living adjustment of 4.1% per Joint Budget Committee memo dated March 15, 2006	$0	-$42,754	$0	$0
Additional Staff Request (November 1, 2007 NP - 1)	$0	$0	$342,541	$479,556
Purchase of Services - 2.0% Medical Inflation	$0	$0	$630	$0
Increase Due to Increased Regional Center Fees	$0	$0	$157,342	$0
Operating Expenses	$0	$0	$0	-$2,170
Performance Based Pay	$0	$0	$0	$530,805
Long Bill Appropriation / Request	**$39,351,048**	**$40,388,928**	**$42,058,031**	**$44,627,275**

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Regional Centers	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
HB 06-1217 Increase for fuel costs and reduction to Medicaid funding for incorporating 4.1% Supplemental Security Income cost-of-living increase	-$29,660	$0	$0	$0
HB 06-1385 Add-ons - One-time funding for overtime costs	$131,764	$0	$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	-$29,024	$0	$0
Final Appropriation / Request	**$39,453,152**	**$40,359,904**	**$42,058,031**	**$44,627,275**
General Fund	$18,983,376	$19,436,955	$20,207,348	$21,491,970
Cash Funds Exempt	$743,200	$742,997	$821,668	$821,668
Federal Funds	$19,726,576	$20,179,952	$21,029,015	$22,313,637

5. REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This appropriation was created to resolve a discrepancy in expenditure patterns between the Department 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 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.

The Department is requesting continuation funding for FY 08-09.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Depreciation and Annual Adjustments	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Appropriation	**$1,460,194**	**$1,498,251**	**$1,468,552**	**$1,267,579**
Joint Budget Committee action to increase appropriation	$38,057	$0	$0	$0
Joint Budget Committee action adjusting appropriation to reflect new straight-line projection	$0	($29,699)	($200,973)	$0
Long Bill Appropriation	**$1,498,251**	**$1,468,552**	**$1,267,579**	**$1,267,579**
Final Appropriation / Request	**$1,498,251**	**$1,468,552**	**$1,267,579**	**$1,267,579**
General Fund	$749,126	$734,276	$633,790	$633,790
Federal Funds	$749,125	$734,276	$633,789	$633,789

6. SERVICES FOR PEOPLE WITH DISABILITIES - SERVICES FOR FAMILIES AND CHILDREN – MEDICAID FUNDING
The Services for Children and Families line provides funding for the direct services portion of three State programs for children with developmental disabilities and their families: early intervention, family support services, and the Children's Extensive Support system. As detailed previously, the Joint Budget Committee decided to merge this line item with the Community Services Adult Programs Costs and CCMS Replacement line.

Appropriation History
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 final appropriation of $3,745,232. 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 reflected 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 of Human Services submitted a late supplemental in FY 06-07 to refinance this line item and the Community Services Adult Program Costs and CCMS Replacement line item. The supplemental, which estimated an underexpenditure of $1,567,391 in total funds, also gave the Department of Human Services the authority to roll forward any unspent funds in FY 06-07 to FY 07-08. The final FY 06-07 appropriation, including the late supplemental, was $5,346,247.

To build to the FY 07-08 appropriation, the Joint Budget Committee included $107,763 for a 2% cost-of-living adjustment for the providers in the Services for Families and Children line. The Joint Budget Committee also annualized the cost of adding 30 Children's Extensive Support waiver program slots, done during FY 06-07 Figure Setting, which added $270,560. The Joint Budget Committee also acted to restore the $1,567,391 in funding removed in the SB 07-239 Long Bill Add-ons.

Finally, as noted in the Community Services Adult Program Costs and CCMS Replacement line item, the Joint Budget Committee agreed with its staff recommendation to merge that line with the Services for Children and Families line. In effect, this transferred the amount of funding that would have been appropriated in FY 07-08, or $7,291,981, to the Community Services Adult Program Costs and CCMS Replacement line item.

The Department's FY 08-09 request does not include any funding for this line item.

Line Item: DHS Medicaid Funded Programs, (G) Services for People with Disabilities - Services for Families and Children	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Appropriation	**$3,745,232**	**$5,472,157**	**$5,346,267**	**$0**
Provider rate increase per Joint Budget Committee action	$35,337	$209,105	$0	$0
Increase for caseload growth	$32,508	$0	$0	$0
Annualization of HB 05-1262 (includes reversal of HB 06-1385 Add-ons in prior year)	$0	$926,499	$0	$0
Annualization of four new Children's Extended Support waiver slots	$0	$35,337	$0	$0
Joint Budget Committee action to add 30 additional Children's Extended Support waiver slots	$0	$270,560	$270,560	$0
2.0% Cost-of-living Adjustment	$0	$0	$107,763	$0
Reversal of Supplemental to Refinance Line Item	$0	$0	$1,567,391	$0
Merge Line Item with Community Services Adult Program Costs and CCMS Replacement Line Item	$0	$0	($7,291,981)	$0
Long Bill Appropriation	**$3,813,077**	**$6,913,658**	**$0**	**$0**
HB 05-1262 - Increase in traditional and expansion funding for 48 and 99 additional waiver slots, respectively	$2,370,114	$0	$0	$0
HB 06-1385 Add-ons - Revised impact from HB 05-1262 due to delays in implementation	($711,034)	$0	$0	$0
Late Supplemental to Refinance Line Item	$0	($1,567,391)	$0	$0
Final Appropriation / Request	**$5,472,157**	**$5,346,267**	**$0**	**$0**
General Fund	$2,461,514	$2,297,076	$0	$0
Cash Funds Exempt	$274,565	$375,985	$0	$0
Federal Funds	$2,736,078	$2,673,206	$0	$0

(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 08-09 Base Request is for continuation funding.

Line Item: DHS Medicaid Funded Programs, (H) Adult Assistance Programs - Community Services for the Elderly	FY 05-06	FY 06-07	FY 07-08	FY 08-09 Base Request
Long Bill Appropriation / Request	**$1,800**	**$1,800**	**$1,800**	**$1,800**
General Fund	$900	$900	$900	$900
Federal Funds	$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 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 Department of Human Services issued a late supplemental in FY 06-07 (S – 4) that reduced the number of youth corrections beds that the State funded in that year by 38.5. This reduction was partially offset by an increase in the Purchase of Contract Placements. The final impact to the Department was a one-time decrease of $1,156,181 in total funding. The final appropriation for FY 06-07 was therefore $2,720,046.

The Department's FY 07-08 appropriation of $2,852,877 reflects the following: 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 $12,958; 4) an increase of $41,443 for a provider rate increase; and 5) a decrease of $372 for the 0.5% base reduction per Common Policies. The Joint Budget Committee also replaced the funding removed from the Division of Youth Corrections appropriation removed to reduce the number of youth corrections beds funded in FY 06-07.

The Department of Human Services also submitted Recidivism Package BA #6 that reduced the appropriation by $2,128,582 and addressed the underutilization of case management and parole services. The reduction was based on a utilization projection issued by Legislative Council Staff in 2005. That projection was subsequently amended and, because utilization was not projected to be as low as initially projected, the Department of Human Services issued a decision item to amend the initial decrease and add $536,314 in total funds. The FY 07-08 appropriation in the Long Bill (SB 07-239) was $2,852,877.

For FY 08-09, the Department has requested an additional $2,375 for salary survey and $997 for performance based pay. In addition, the Department has removed $12,958 in leap-year funds that were appropriated in FY 07-08. The table below shows the Department's FY 08-09 Base Request.

Line Item: DHS Medicaid Funded Programs, (I) Division of Youth Corrections	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Prior Year's Appropriation	$13,632,224	$15,828,250	$2,720,046	$2,852,877
Common Policy adjustment for Personal Services	$39,757	$0	$0	$0
Increase for additional contract placements	$1,414,968	$0	$0	$0
Increase for managed care pilot project	$4,121	$0	$0	$0
Removal of nearly all residential treatment center Medicaid funding	$0	($13,746,108)	$0	$0
Reduction due to limitations of State capacity	$0	($90,876)	$0	$0
Provider rate increase recommended by Joint Budget Committee	$0	$74,873	$41,443	$0
Increase for additional contract placements	$0	$352,214	$0	$0
Leap year adjustment for services and managed care pilot program	$0	$0	$12,958	($12,958)
Common Policy adjustment for Salary Survey	$0	$0	$1,763	$2,375
Common Policy adjustment for 0.5% Base Reduction	$0	$0	($372)	$0
Annualization of HB 06-1395 for an additional 92 placements at $300 per day	$0	$0	$513,126	$0
Reverse Late Supplemental to Reduce Funding for 38.5 Contract Placement Beds	$0	$0	$1,156,181	$0
Recidivism Package BA #6	$0	$0	($2,128,582)	$0

Line Item: DHS Medicaid Funded Programs, (I) Division of Youth Corrections	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09 Base Request**
Case Management and Parole Services Increase	$0	$0	$536,314	$0
Performance Based Pay	$0	$0	$0	$997
Long Bill Appropriation / Base Request	**$15,091,070**	**$2,418,353**	**$2,852,877**	**$2,843,291**
HB 06-1217 - Revised Medicaid need due to changes in contract placement needs	$737,180	$0	$0	$0
HB 06-1395 - Funding to support 341 children at new psychiatric residential treatment facilities at $300 per day	$0	$1,457,874	$0	$0
Late Supplemental to Reduce Funding for 38.5 Contract Placement Beds	$0	($1,156,181)	$0	$0
Final Appropriation / Final Request	**$15,828,250**	**$2,720,046**	**$2,852,877**	**$2,843,291**
General Fund	$7,914,125	$1,360,023	$1,426,440	$1,421,647
Federal Funds	$7,914,125	$1,360,023	$1,426,437	$1,421,644