Department of Health Care Policy and Financing
Line Item Descriptions
FY 2009-10 Budget Request

November 3, 2008

(1) EXECUTIVE DIRECTOR'S OFFICE

(A) GENERAL ADMINISTRATION

PERSONAL SERVICES
Prior to FY 2003-04, 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,
- Colorado 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 2003-04 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 consolidated into one appropriation (FY 2003-04 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.

For FY 2006-07 the Department was appropriated $15,154,208 and 222.7 FTE through the Long Bill, HB 06-1385.

SB 07-163, the FY 2006-07 Supplemental Bill, appropriated an additional $159,939, and 4.3 FTE, and is 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 $14,752 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 07-239, FY 2007-08 Long Bill Add-ons, adjusted FY 2006-07 funding by $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 2007-08 Long Bill, as an Add-on, the annualization is already included in the FY 2007-08 appropriation.

A number of special bills also impacted the Department's appropriation, such as 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 2006-07 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 06-219, 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. These appropriations bring the Department's final appropriation for FY 2006-07 to $15,571,350 with 231.8 FTE.

For FY 2007-08 the Department received a Long Bill appropriation of $16,305,976 and 238.0 FTE. Special Bills consisting of the following also impacted the Department's appropriation: 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 to develop rules for the Medical Services Board, and contract with participating pharmacies, answer stakeholder questions, maintain files, and perform accounting functions. SB 07-004, for Early Intervention Services for Children appropriated $58,616 and 1.0 FTE to implement and administer the Act. SB 07-130, Medical Homes for Children, appropriated $57,773 and 1.0 FTE 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 to produce reports for the General Assembly, 0.8 FTE to develop standards and methods for collecting, analyzing, and disclosing health information.

Additionally, the Department received additional adjustments to its spending authority through 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 dissolution and re-allocation of personnel to the Department. The Department also submitted three Supplemental requests, the first, to fund a Medical Director Consortium at $80,000 (S-6, Health Care and Financing Medical Director Consortium, January 2, 2008), the second, $10,500 for Personal Services associated with acquiring additional space for staff to work (S-7, Funding for Additional Leased Space, January 2, 2008) and the third request was for $125,000 to hire a contractor to accumulate data and create a cost study of current mental health rates (S-14, Implement Mental Health Audit Findings, January 2, 2008). All allocated POTS for Salary Survey, Performance Achievement Pay, Health, Life, Dental, Short Term Disability, and Amortization Equalization Disbursement are included, however Supplemental Amortization Equalization Disbursement is not included in this total as it is already shown in the Salary Survey amount and was "carved" out of that appropriation. These adjustments bring the total of the FY 2007-08 Long Bill, adjustments to spending authority, Supplemental requests, POTS allocations, and Special Bill appropriations to $18,244,031 and 257.3 FTE.

For FY 2008-09, the appropriation column on the Schedule 3 shows the Department's Long Bill (HB 08-1375) appropriation of $19,251,491 and 272.7 FTE. Special Bills are also included in this total, including $235,530 and 1.0 FTE for an Accountant I position for HB 08-1114, for Reimbursement of Nursing Facilities under Medicaid. This funding is for contractors to establish a pay for performance reimbursement for nursing facilities and to establish an effective financing methodology relating to collection of fees used to draw federal match. Additionally, SB 08-155 Centralize Information Technology Management in the Office of Information Technology, while not having a fiscal impact to the Department, removes 1.5 FTE from the Department.

The FY 2009-10 Request is essentially the same as the FY 2008-09 estimate column on the Schedule 3. However, the FY 2009-10 figure includes the Office of State Planning and Budget mandated 1.0% reduction and State-wide Indirect cost allocation. 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 Reappropriated Funds. The purpose is to allocate the unbilled costs of central service agencies to individual programs. The incremental difference between the FY 2008-09 allocation and the FY 2009-10 allocation is shown, including fund splits. The incremental difference between the two years' General Fund is a decrease of $145,277. The FY 2009-10 base request also includes annualization of the FY 2008-09 Long Bill and Special Bills, as well as HB 08-1114, Reimbursement of Nursing Facilities under Medicaid which removes funding for the contractor in the amount of $129,828 and adding 1.0 FTE.

Additionally, several Department requests that were included in the FY 2008-09 Long Bill also require annualization. Decision Item #7, “Additional FTE to Restore Department Efficiency and Functionality”, submitted November 1, 2007, increases the appropriation by 1.6 FTE and $91,782. Decision Item #9, “Information Technology Replacement Plan”, submitted November 1, 2007, removes one time funding of $27,500 for a contractor to work on upgrades to the Department's website. Budget Request Amendment #3, “Implement Preferred Drug List” annualizes with an additional 0.1 FTE and $3,827, Budget Request Amendment #5, Implement Mental Health Audit Findings which reduces the Departments FY 2009-10 appropriation by $125,000, Budget Request Amendment #9 “Efficiencies in Medicaid Cost Avoidances” which appropriates 0.5 FTE and $41,194, and Budget Request Amendment #12 “Efficiencies in Pharmaceuticals through the Expansion of 340B Pricing” increasing the appropriation by 0.1 FTE and $6,066 are also included. These totals are added to the proposed FY 2008-09 Salary Survey of $676,435 and the base building portion of the proposed Performance Achievement Pay $200,989, to arrive at the total FY 2009-10 base request of $19,989,456 and 276.0 FTE.

HEALTH, LIFE, AND DENTAL

This insurance benefit is part of the POTS component paid jointly by the State and State employees on a predetermined ratio, based on the type of package that each employee selects (e.g., Employee, Employee + 1, Employee + Spouse, etc). Since FY 2005-06 the State has been increasing its proportionate percentage of the costs for this benefit. For FY 2006-07 the reimbursement was 75% of the market average, as determined by the Department of Personnel and Administration, in FY 2007-08 the State increased the reimbursement to 85% of the market average and for FY 2008-09 the reimbursement was increased to 90% of the market average.

The FY 2006-07 appropriation of $629,640 used different rates for each plan provided in the Supplement to FY 2006-07 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 2007-08 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 2008-09 final appropriation of $1,278,471 was based on mid-year Common Policy instructions, but also includes an additional $64,110 for Health Life and Dental coverage for the Department's FY 2008-09 FTE request. For FY 2009-10, the Department's base request of $1,414,691 is based on Common Policy instructions issued by the Department of Personnel and Administration in October 2008.

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.

For FY 2006-07, 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, the requested amount was adjusted during Figure Setting by the Joint Budget Committee and was ultimately appropriated in the FY 2006-07 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 13, 2006.

The FY 2007-08 appropriation of $19,548 was 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 2008-09 Long Bill (HB 08-1375) appropriation of $22,871 reflects the Common Policies issued by the Department of Personnel and Administration again using a rate of 0.13% but also includes an additional $1,062 to account for the Department's FY 2008-09 FTE request. The FY 2009-10 base request of $22,360 is based on the Common Policy instructions issued by the Department of Personnel and Administration in September 2008.

SB 04-257 AMORTIZATION EQUALIZATION DISBURSEMENT

The Amortization Equalization Disbursement increases the employer contribution to the PERA Trust Fund to amortize the unfunded liability in the Trust Fund beginning in January 2006. The Budget Request for this line is computed per the Office of State Planning and Budgeting's budget instructions. The rate is provided by the Department of Personnel and Administration and is calculated using the sum of base salaries, Salary Survey and range adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses.

The Amortization Equalization Disbursement was established using 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 2006-07, the Amortization Equalization Disbursement was calculated using an effective rate of 0.75%. FY 2006-07 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 2007-08, 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 appropriation were 1.0% for July to December 2007, and 1.4% for the January to June 2008. The FY 2008-09 appropriation used 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. The FY 2009-10 base request of $344,000 is based on the Common Policy instructions issued by the Department of Personnel and Administration in September 2008.

SB 06-235 SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. It is similar to the Amortization Equalization Disbursement discussed above. However, this item is 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 2007-08 using 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 2007-08 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 2008-09 the calculation was based on the average contribution rate of 0.75% (0.5 % from July to December 2008, and 1.0% from January to June 2009), and was

developed using the Office of State Planning and Budgeting's budget instructions. The FY 2009-10 base request of $215,000 is based on the Common Policy instructions issued by the Department of Personnel and Administration in September 2008.

SALARY SURVEY AND SENIOR EXECUTIVE SERVICE

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.

In the Common Policy instructions for FY 2006-07, 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 2006-07 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 2006-07 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 2006-07. Applicable PERA and Medicare amounts are added into the Salary Survey calculations.

The FY 2007-08 appropriation was $508,676, which included an additional appropriation of $27,753 associated with the dissolution of the Offices of Colorado Benefits Management System, but did not include $34,950 that was "carved" out and allocated to the Supplemental Amortization Equalization Disbursement mentioned in the narrative above. The FY 2008-09 appropriation 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 reflected a Common Policy increase of $167,759 bringing this appropriation to $676,435. The FY 2009-10 base request of $394,749 is based on the Common Policy instructions issued by the Department of Personnel and Administration in September 2008.

PERFORMANCE ACHIEVEMENT PAY

This line item replaced the Anniversary Increases budget line item in FY 2002-03. 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 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.

For FY 2006-07, 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 2006-07.

For FY 2007-08 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. For FY 2008-09 the appropriation was developed according to the Office of State Planning and Budgeting's budget instructions following the method used for FY 2007-08, of a 1% base building for all satisfactory performers and a 2% non-base building award for the Department's Peak Performers. This method resulted in an appropriation of $251,236. The Department is not requesting funding for FY 2009-10 pursuant to instructions provided by the Office of State Planning and Budgeting.

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.

For FY 2006-07, the Long Bill appropriation of $42,834 reflected a Common Policy increase of $3,430 over FY 2005-06. However, this appropriation was reduced by $17,074 through SB 07-163 for a final appropriation $25,760. The FY 2007-08 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. However this amount was increased through a Supplemental appropriation contained in HB 08-1285, the FY 2007-08 Supplemental bill of $1,116 for a final appropriation of $25,363. The FY 2008-09 appropriation of $32,346 reflects the Common Policy adjustment of $6,983 this amount was developed by the Department of Personnel and Administration and allocated to

the Department. The FY 2009-10 base request of $32,395 is based on the Common Policy instructions issued by the Department of Personnel and Administration in September 2008.

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, telephones 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 2003-04, 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.

For FY 2006-07, the Department's Long Bill (HB 06-1385) appropriation provided $1,002,013 in funding for Department programs, this funding was augmented with the Supplemental Bill (SB 07-163) which provided an additional $236,562 and Long Bill Add-ons (SB 07-239) which provided another $10,000. Several Specials Bills were also passed that provided additional funding totaling $18,596 (HB 06-1270, SB 06-128, SB 06-165, and SB 06-219). These appropriations result in the Department's final appropriation of $1,267,171. Total expenditures for FY 2006-07 were $1,196 014. The Department requested a roll-forward in the amount of $14,004 and under expended the remaining FY 2006-07 spending authority by $57,153.

For FY 2007-08 the Department received a Long bill appropriation of $1,003,515. However the Department's Supplemental Bill (HB 08-1285) included annualization of prior year appropriations that reduced the FY 2007-08 appropriation by $32,496 Total Funds. The legislature did pass several Special Bills that increased the Department's spending authority, such as HB 07-1021 which provided $3,956 of funding for an FTE to implement the Prescription Drug, Consumer Information and Technical Assistance Act. SB 07-001, the Colorado Cares Prescription Drug program appropriated $14,395 for Department staff to develop rule recommendations for the Medical Services Board to consider, contract with participating pharmacies, answer stakeholder questions, maintaining files, and to develop and implement financial accounting functions. SB 07-004 provided $4,230 to execute a coordinated system of payment for early intervention services for children eligible for benefits under the federal "individuals with disabilities education act". SB 07-130, Medical Homes of children appropriated $3,955 for Department personnel to implement the provisions of the act. SB 07-196 appropriated $3,480 for staff to develop a long-range plan for health care information technology, including the use of electronic medical records, computerized clinical support systems, computerized physician order entry, regional data sharing interchanges for health care information, data privacy and security measures, and other methods of incorporating information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care. SB 07-211, Improve Health Care for Children, provided $5,934 in order to collect and analyze objective clinical standards to maximize dollars available for medical care. This resulted in a final FY

2007-08 appropriation of $1,006,969. The Department received approval to roll-forward $1,862 for purchased furniture and reverted its under-expenditure of $24,642, resulting in total expenditures for FY 2007-08 of $980,465.

For FY 2008-09, the Department received an appropriation of $1,803,990, a significant increase over its final 2007-08 appropriation. The reasons for the increase were primarily to address staff comfort, productivity, and professional development issues. The Department received $247,208 for furnishing new Leased Space at 225 E. 16th Avenue, and to replace deteriorating cubicles and address poor air circulation within the building at its 1570 Grant St. location. Additionally, it received funding of $66,836 to implement an Information Technology replacement plan that would allow the Department to replace its employees' workstations using a four year life cycle. The amount of $43,548 was also appropriated to provide for employee training that will be used to increase the collective skill level of the Department.

The Department also received $250,000 to perform background checks when re-enrolling Medicaid providers. The Department anticipates it will re-enroll one-tenth of its providers each year.

The amount of $71,096 was also appropriated for FTE that are to increase provider recoveries in the Department's Program Integrity section. The amount of $79,286 was supplied to the Department for the Operating Expenses associated with the Department's approved FTE request, DI - 7, Additional FTE to Restore Department Efficiency and Functionality, an additional $6,486 was provided for the expenses of an FTE that will assist in the implementation of the Department's Preferred Drug List. Another $6,486 was appropriated for the Operating Expenses of the FTE charged with expanding the 340B pharmaceutical pricing program (FY 2008-09 Figure Setting, March 11, 2008 pgs. 33, 45 and 48).

Footnote #22 of the FY 2007-08 Long Bill SB 07-239 instructed the Department to submit a plan for restructuring its Executive Director’s Office long bill group appropriations into a more programmatic format. As a result, the Department submitted a proposal to the Joint Budget Committee on November 9, 2007 that placed 46 line items into groups based on similarity in functions. As a result of conversations during Figure Setting about the consolidation of these line items and the transfer of some to other long bill groups, the passage of HB 08-1375 resulted in 31 line items in long bill group (1) Executive Director’s Office for FY 2008-09. During FY 2008-09 Figure Setting, The Joint Budget Committee combined the Department's appropriation for its Single Entry Point Administration program with the Operating Expenses appropriation. This action increased the appropriation by $53,000. Annualization of one time operating costs associated with FY 2007-08 Operating Expenses appropriation, reduced the available funding by a total of $26,925. All of the above items were ultimately included in the FY 2008-09 Long Bill appropriation of $1,803,990.

Finally, a number of Special Bills also impacted this line item. SB 08-007 provided $2,000 to broaden the scope of existing training to assist jail inmates with applying for the Department’s programs, including the Colorado Indigent Care Program. SB 08-161 provided $21,082 to purchase software allowing for the self-declaration of income for applicants of the Medicaid program and the Children’s Basic Health Plan applications. HB 08-1046 appropriated $2,000 for training webcasts. HB 08-1114 supplied $4,406 for the

Operating Expenses of the FTE charged with revising the reimbursement methodology for Nursing Facilities under the Medicaid program. This results in a total FY 2008-09 appropriation of $1,833,478.

The FY 2009-10 Base Request of $1,681,669 reflects the FY 2008-09 final appropriation with annualization of bills that remove one-time funding. SB 08-161 removes $13,528 in one time funding for office equipment and computers for the appropriated FTE. Additionally, FY 2008-09 Decision Items that were included in the Department's Long Bill also had one-time funding removed totaling $139,230. HB 08-1114, provides an additional $949 to pay for phone and office supplies of a second FTE that is to start in FY 2009-10.

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 2005-06, 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 was requested and approved for FY 2006-07 and FY 2007-08. However, for FY 2008-09, the Joint Budget Committee staff recommended that funding for this line be combined in the Operating expenses appropriation for the Department. The Recommendation was approved and this line item was eliminated for FY 2008-09, (Figure Setting, March 11, 2008, page 77) and all funding was moved to the Department's Operating Expenses appropriation.

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 rate charged is based on a blended Attorney/Paralegal rate developed by the Department of Law.

The FY 2006-07 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 2006-07 appropriation was based on 12,684 hours of usage for a total appropriation of $859,595. The FY 2007-08 appropriation continued funding for 12,684 hours at a blended rate of $72.03, for total funding of $913,629. This amount reflected a common policy adjustment increase of $54,034. This effectively raised the blended attorney/paralegal rate to $72.03. The Department's FY 2008-09 appropriation reflects a Common Policy adjustment of $49,940 and $19,415 for the Department to defend itself against provider re-enrollment appeals associated with the Department's provider re-enrollment program. The appropriation amount is now comprised of 13,089 hours at the blended rate of $75.10. For FY 2009-10, the Department is requesting continuation funding.

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 2001-02, 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 these Requests are made.

For FY 2006-07, 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. The FY 2007-08 Long Bill appropriation of $407,509 reflects amounts calculated by the Department of Personnel and Administration through Common Policies, however this was increased by a Supplemental Request from the Department of Personnel and Administration for $31,466 for a final FY 2007-08 appropriation of $438,975.

The FY 2008-09 Long Bill appropriation of $469,789 reflects an increase of $21,183 through Common Policies due to additional utilization, and $9,631 for the Department to defend itself against provider appeals associated with the Department's provider re-enrollment program. The FY 2009-10 base request is based on the Common Policy instructions and reflects a Common Policy adjustment of $18,152 issued by the Department of Personnel and Administration on September 10, 2008 for staffing increases at the Office of Administrative Courts.

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 2006-07, 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 2006-07 Supplemental Bill.

For FY 2007-08, the Department's appropriation reflected a significant reduction to this line. The reason for this reduction is that the amount of billing for FY 2007-08 is based on actual usage from FY 2005-06, 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 2007-08. However, during the Joint Budget Committee's Common Policy Figure Setting process for FY 2007-08, the Department was appropriated $18,516 for FY 2007-08, (JBC Common Policy Figure Setting, March 15, 2007 Page 5). Therefore, the FY 2007-08 appropriation is for this line was only $18,516.

Please note that because of the significant reduction in allocated central computer services beginning in FY 2007-08, the Department has revised its need for Reappropriated Funds from the Old Age Pension Fund. The FY 2007-08 Old Age Pension Fund amount was reduced using a two-year average of the ratio between Cash Funds Exempt to total funds for FY 2005-06 and FY 2006-07 ($3,337 = $16,235/(($93,436+$94,815)/2)). Therefore, the Department required $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 2007-08 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 2008-09 Long Bill appropriation of $15,973 reflects a further decrease in usage and is reflected in the Common Policy decrease of $2,543. However, the Department of Personnel and Administration submitted a Supplemental Request to begin billing for the Technology Management Unit directly to State Department's directly. Prior to this time the State Controller's Office recovered these costs through its state-wide indirect cost allocation. This Common Policy adjustment increased the appropriation to the Department by $119,130 for a final FY 2008-09 appropriation of $135,103. The FY 2009-10 base request is for continuation funding.

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 2007-08, the Department did not participate in the Property Program. However, for FY 2007-08, the Department of Personnel and Administration adjusted it policy and began billing the Department for the Property portion of this program.

For FY 2006-07, the appropriation of $58,143 was increased by $43,668 through a Common Policy adjustment set by the Department of Personnel and Administration. The Department of Personnel and Administration re-allocated costs for administration of the workers comp, risk management and property funds. In addition to revising the methodology for determination of reserve levels, the

property fund reserve was increased from 5% to 16.5% (January 23, 2007 JBC FY 2006-07 Supplemental Hearing Document, Page 64). The FY 2007-08 appropriation was reduced during Common Policy Figure Setting (JBC Figure Setting, March 15, 2007, page 15) to $91,727. This appropriation was subsequently reduced by $31,243 due to a common policy adjustment for a final FY 2007-08 appropriation of $60,484. The increase to the FY 2007-08 appropriation for participating in the Property Program was insignificant.

The FY 2008-09 appropriation of $71,989 reflects Common Policy adjustments of $11,505 issued by the Department of Personnel and Administration on August 15, 2007 and subsequently included in the FY 2008-09 Long Bill (HB 08-1375) appropriation. For FY 2008-09 the Property Program portion of this appropriation totaled $1,016. The FY 2009-10 base request is for continuation funding.

LEASED SPACE

Previously called Commercial Leased Space, this line item was established in FY 2003-04, 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 2006-07, 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 2006-07 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 2006-07 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 2006-07 Supplemental Bill).

The FY 2007-08 appropriation increased funding to $272,318 due to annualization of the increased Funding for Commercial Leased Space Request. However, due to timing issues associated with the Department's FY 2007-08 Decision Item (DI-5) submitted on November 1, 2006 and the Department's FY 2006-07 Supplemental (S-8) submitted on January 4, 2007 for Leased Space, $53,369 was inadvertently left in the Department's Leased Space appropriation for FY 2007-08 and beyond. Therefore, for the Department submitted S-7 to revert $9,547 of its FY 2007-08 Leased Space appropriation. (FY 2007-08 Supplemental Request and FY 2008-09 Budget Request Amendments, January 2, 2008)

For FY 2008-09 the Department submitted requests for additional Leased Space to house additional appropriations of FTE contained in DI-10 and S-7/BA-2, (FY 2008-09 Budget Request, November 1, 2007, FY 2007-08 Supplemental Request and FY 2008-09 Budget Request Amendments January 2, 2008). These requests were for total additional funding of $131,465, to lease an additional 8347 square feet of space to provide the Department with additional needed conference rooms and staff offices for 35 FTE. This funding brought the Department's total FY 2008-09 Leased Space appropriation to $394,236.

The FY 2009-10 Base Request reflects continuation funding.

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.

For FY 2006-07, 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 2005-06 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 2006-07 Long Bill appropriation to the Department equal to $344,022.

The Department’s FY 2007-08 Long Bill appropriation of $391,079 was 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 2006-07; however, the cost per square foot charged by the Department of Personnel and Administration increased to $12.41 per useable square foot. This amount was further modified through a Supplemental Request submitted by the Department of Personnel and Administration that increased the appropriation by $6,159 for a final FY 2007-08 appropriation of $397,238

The FY 2008-09 Long Bill appropriation was based on Common Policies issued by the Department of Personnel and Administration and reflects a rate of $12.54 per useable square foot. The FY 2009-10 base request is based on the Common Policy instructions issued by the Department of Personnel and Administration in September 2008 for a total FY 2009-10 Base Request of $395,208.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS
This is a new line item created for FY 2008-09 and contains any special or temporary projects that the General Assembly chooses to fund each year. Several ongoing Personal Services line item appropriations were also transferred to this appropriation for FY 2008-09 (Figure Setting, March 11, 2008, page 52). The Department initially transferred $493,742 in ongoing personal services contracts to this appropriation for FY 2008-09. Additionally, the General Assembly appropriated additional funds to support several Department and Governor's initiatives. These actions resulted in a final FY 2008-09 appropriation of $2,443,584. For FY 2009-10, the Department is requesting continuation funding.

(***B) TRANSFERS TO OTHER DEPARTMENTS***

TRANSFER TO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT FOR FACILITY SURVEY AND CERTIFICATION
This line item funds the survey and certification of nursing facilities, hospices, home health agencies, and Home and Community Based Services agencies (including Alternative Care Facilities), 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 2006-07 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 13 in support of this request in its FY 2006-07 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 2006-07 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 2006-07.

The FY 2007-08 Long Bill (SB 07-239) appropriated $4,539,038 to this 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 2007-08 for Common Policy items.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $4,932,027 for this line item. Included in the year over year increase were $37,700 additional funds from the annualization of SB 07-196 Health Information Technology, $264,889 as Common Policy Adjustments, and $90,400 for Non-prioritized Request, 4, "Department of Human Services Regional Center ICF/MR Conversion and Year 2 of Staffing Study", submitted November 1, 2007. The purpose of the $90,400 is to cover the additional surveys needed to ensure compliance with Medicaid regulations for the new Intermediate Care Facilities that are being established by the Department of Human Services.

The Department's base request for FY 2009-10 is $5,132,264 which includes a Common Policy Adjustment of $200,237.

TRANSFER TO THE DEPARTMENT OF REGULATORY AGENCIES FOR 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 a three-way 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. (2008), 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 a nurse aide training program followed by testing and 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. However, many nursing facilities reimburse the nurse aides for any fees paid as part of the pre-hiring requirements. These State funds are then used to draw down federal matching funds. Specifically, Section 12-38.1-103 (6), C.R.S. (2008) 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 Nurse Aide Certification appropriation for FY 2006-07 per the Long Bill HB, 06-1385 was $308,766. This appropriation included an increase of $15,143 for Common Policy items. The amount appropriated for FY 2007-08, per the Long Bill, SB 07-239, 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 2006-07 appropriation for Common Policy items.

Continuation funding of $325,343 was provided for FY 2008-09 per the Long Bill, HB 08-1375, and the Department is requesting the same amount for FY 2009-10.

TRANSFER TO DEPARTMENT OF EDUCATION FOR 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 intended to "monitor Colorado's compliance with federal statute, regulations, and policy". 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 2006-07, Supplemental Requests, January 4, 2007). Additionally, within the Supplemental, the Department requested a technical adjustment to properly document the $184,520 transferred as Reappropriated Funds[1] for the Department of Education's administrative costs. The Joint Budget Committee approved the Department's request, and with the passage of SB 07-163, the Department received $384,520 in its Executive Director's Office Long Bill group. The supplemental bill also created a new line item that removed the Public School Health Services Administration funding from Personal Services and moved it into "Public School Health Services Administration".

During FY 2007-08 Figure Setting for the Department of Education, the Joint Budget Committee recommended a $7,176 POTS adjustment, which increased funding for this line item by $7,176 (Department of Education Figure Setting, March 8, 2007, page 114).

For FY 2008-09, the Department requested $396,561 for this appropriation. The Department's request was adjusted during its March 11, 2008 Figure Setting (page 85 of the Figure Setting Document) to add $16,051 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 2008-09 appropriation was $407,747 in federal funds. The Department is requesting continuation funding for this line item for FY 2009-10.

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

[1] The terminology "Cash Funds Exempt" was eliminated upon passage of HB 08-1320. All moneys that were previously so designated have been renamed either "cash funds" or "Reappropriated Funds" in order to more accurately reflect the nature of the funding source.

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. (2008). 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 2006-07. This estimate was based on previous reviews of similar programs. The hourly rate used to estimate FY 2006-07 totals was $40.08, which was the billable rate used by the Department of Regulatory Agencies in FY 2005-06. Work continued in FY 2007-08, and the sunset report was completed and presented to the General Assembly in October 2007.

The FY 2006-07 Long Bill, HB 06-1385, appropriated $6,000 to the Department which will be transferred to the Department of Regulatory Agencies. The FY 2007-08 appropriation in Long Bill SB 07-239 was 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 was requested for FY 2008-09 and no funding is requested for FY 2009-10.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

INFORMATION TECHNOLOGY CONTRACTS

Footnote 22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The two line items for Medicaid Management Information System Contract and HIPAA Web Portal Maintenance were combined into one line item titled "(C) Information Technology Contracts and Projects: Information Technology Contracts" within Long Bill group (1) Executive Director's Office. This line item received an appropriation of $24,094,147 in total funds for FY 2008-09, which is comprised of $5,499,078 General Fund, $1,881,903 cash funds, $100,328 Reappropriated Funds and $16,612,838 federal funds. Of this total amount, $23,663,414 was for Medicaid Management Information System Contract and $430,733 was for HIPAA Web Portal Maintenance.

The Department's FY 2009-10 Base Request for the Information Technology Contracts line item is for the amount of $23,489,449 in total funds for the two items described below.

MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT

Section 1903(r)(1) of the Social Security Act states that, to receive federal funding for use of automated data systems in administration of the Medicaid program, the State must have a mechanized claims processing and information retrieval system. The Centers for Medicare and Medicaid Services' State Medicaid Manual states that for Medicaid purposes, the mechanized system is called the Medicaid Management Information System (MMIS). The MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The system may be operated by either a state agency or a fiscal agent, which is a private contractor hired by the state.

Section 1903(a) of the Social Security Act authorizes a 90% federal reimbursement rate for design, development, or installation of an MMIS and a 75% reimbursement rate for operation of an MMIS. The Centers for Medicare and Medicaid Services' State Medicaid Manual identifies the specific types of MMIS costs that are allowable for federal reimbursement. For such costs to be allowable at the enhanced rate of 75%, they must be related to the operations of the MMIS for ongoing automated processing of claims, payments, and reports.

In Colorado, the MMIS processes or adjudicates claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from the MMIS.

The State must competitively bid the role of the fiscal agent for the operation of the MMIS 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 to perform as the fiscal agent since December 1, 1998. During FY 2006-07, reprocurement of the MMIS operational responsibilities was completed, and Affiliated Computer Services was reselected as the fiscal agent. Effective July 1, 2007, a new contract began which will remain in effect for the next three fiscal years with the two additional years for contract extensions.

The MMIS Contract line item covers costs for running claims through the processing system and for certain administrative functions contracted to the fiscal agent. Funding for claims processing include:

- General Fund for regular Medicaid claims;
- Reappropriated Funds from the Department of Human Services for Old Age Pension State Medical Program claims;
- General Fund for Breast and Cervical Cancer Prevention and Treatment claims;
- Nurse Home Visitor Program claims (as Reappropriated Fund 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 to assist in support of the fixed price contract;
- Cash funds from the Colorado Autism Treatment Fund;
- Cash funds from the Health Care Expansion Fund authorized by HB 05-1262; and,
- Matching federal funds.

Claims processing expenditures for School Based Health claims are funded with 100% federal funds that are matched with certified 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 for the expansion programs funded by the Health Care Expansion Fund. Development projects are funded at either 75% 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 2006-07 with 50% General Fund and 50% federal funds. Ongoing maintenance costs for the Preferred Drug List are funded at 25% General Fund and 75% federal funds. Payment Error Rate Measurement (PERM) Project maintenance costs are split between Medicaid and the Children's Basic Health Plan. The Colorado Cares RX program ongoing costs are funded with cash funds from the Colorado Cares RX Program Fund.

Beginning March 1, 2004, the MMIS contract was converted to a fixed price contract that covers all claims processing, provider enrollment and notification, as well as most prior authorization reviews. Under the new MMIS contract effective July 1, 2007, DRAMS is also covered under fixed price portion of the contract. Items that are not included in fixed price include: postage costs, development costs, Preferred Drug List maintenance costs, the PERM maintenance costs, and the Colorado Cares RX ongoing costs.

The Tobacco Tax Bill, HB 05-1262, contributed funding to the MMIS Contract line item. A portion of this funding in FY 2005-06 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 2006-07 and is ongoing.

Changes during FY 2006-07 added components to the MMIS 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 PERM 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 2007-08 Long Bill (SB 07-239). The Colorado Cares Rx program began with SB 07-001.

For FY 2007-08, the line item underwent adjustments to remove funding that applied to the prior year only, primarily for one-time development costs resulting from special bills and for one-time funding supplied by the Supplemental Bill, SB 07-163. 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 CHP+ 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. As

part of the Health Care Reform Building Blocks, the Department submitted Supplemental #1A on February 15, 2008 to request one-time funding in the amount of $79,758 for MMIS development costs associated with Medical Homes for Children. The amount was approved in the Department's Long Bill, HB 08-1375 as an add-on.

For FY 2008-09, adjustments were made to remove one-time funding for development projects from the prior fiscal year, increase funding for the Colorado Cares Rx program, and transfer funding from the Breast and Cervical Cancer Treatment Program to the General Fund. The Department submitted Decision Item 5, "MMIS Fixed Price Increase" on November 1, 2007 as part of its FY 2008-09 Budget Request, which requested $313,010 for adjustments to the MMIS contract. Additionally for FY 2008-09, the Department submitted Stand Alone Budget Amendment 9 on January 23, 2008 which requested one-time funding in the amount of $50,400. The development funding will modify the MMIS to allow it to store the results of medical personnel background checks in the existing provider database. Both budget requests were funded by the passage of the Department's Long Bill, HB 08-1375. The final FY 2008-09 appropriation is $23,663,414.

Similarly, for FY 2009-10, adjustments to the requested amount included adjustments for effects of special bills for a total Base Request of $23,176,549.

HIPAA WEB PORTAL MAINTENANCE

The Health Insurance Portability and Accounting Act of 1996 (HIPAA), which became law on August 21, 1996, included provisions to address the need for developing a consistent framework for electronic transactions and other administrative issues. Through subtitle F of title II of Public Law 104-191, the Congress added to title XI of the Social Security Act a new Part C, titled Administrative Simplification. The purpose of which is to improve the efficiency and effectiveness of the Medicare and Medicaid programs by encouraging the development of standards and requirements to enable the electronic exchange of certain health information.

Under part C of title XI, section 1172 makes any standard adopted applicable to: 1) health plans; 2) health care clearinghouses; and 3) health care providers who transmit any health information in electronic form in connection with a transaction covered by 45 CFR Part 162. Based on this section of the Social Security Act, Colorado's Medicaid program is considered a covered health plan.

To comply with the provisions under HIPAA, the Department issued a request for proposals to design, develop, implement, monitor and maintain a web portal application. The web portal became operational in 2003 and provides a web application front-end for providers to submit HIPAA-compliant electronic transactions to and from the Medicaid Management Information System, Colorado Benefits Management System, and Benefits Utilization System. In addition to these services, the Department's medical assistance site workers also use the web portal for access to other Departmental computer 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 2005-06 and each fiscal year thereafter, base funding for this line item has continued at

$312,900 total funds. During FY 2006-07, a Supplemental Request, S-4, submitted January 4, 2007, requested $1,900 in one-time funding for implementation of the Systematic Alien Verification of Entitlement Program. This enhancement 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.

As part of the Department's FY 2008-09 Budget Request, it submitted Decision Item #13, "Web Portal Contract Adjustments and Enhancements" to request one-time funding in the amount of $117,833 total funds to increase the number of pooled hours for change management and additional hardware and transmission capacity to increase the number of concurrent users from 500 to 700 (FY 2008-09, Budget Request, November 1, 2007, Volume 1, DI-13). The request was approved during the Department's FY 2008-09 Figure Setting (Figure Setting, Joint Budget Committee Working Document, March 11, 2008, Pages 60-61) and subsequently appropriated in the Long Bill, HB 08-1375.

The Department's web portal contract with CGI Technology and Solutions, Inc. is set to expire on June 30, 2009. During FY 2008-09, the Department will issue a request for proposals and secure a new contractor to begin July 1, 2009. For FY 2009-10, the Department's Base Request is for continuation funding in the amount of $312,900.

FRAUD DETECTION SOFTWARE CONTRACT

On January 23, 2008 the Department submitted BA-9 as a Stand Alone Budget Amendment requesting $1,250,000 in funding to increase efficiencies in Medicaid cost avoidances and provider recoveries. Within the budget amendment, the Department requested an additional 5.5 FTE (annualized to 6.0 FTE) to implement improvements to the Medicaid provider re-enrollment process as well as purchase enhanced fraud detection technology.

The fraud detection software would utilize neural network and learning technology to detect fraud, abuse or waste in the Medicaid program. It would also support such functions as compliance monitoring, provider referrals, and utilization review. Moreover, it would provide support to the Department's Program Integrity Section by providing additional research on potential fraud and abuse; receiving and accessing licensing board data to compare with provider data; look for known abusive or fraudulent practices using target queries on procedure or diagnosis codes; and track the progress of individual cases, including case hours, investigative cost and travel expenses related to the Medicaid program.

The one-time cost for the fraud detection software was estimated at $1,000,000 in FY 2008-09. Thereafter, the Department would require $250,000 for annual technology maintenance and updates. The Department would receive 90% federal financial participation for the one-time software costs (42 CFR §433.15 (3)) and 75% federal financial participation for annual maintenance costs (42 CFR §433.15 (4)). These costs would be offset by anticipated savings in the Medical Service Premiums line item from increased recoupment and recovery efforts.

During the Department's FY 2008-09 Figure Setting on March 11, 2008, Joint Budget Committee staff recommended that the $1,000,000 for the fraud detection software be added to a new line item called "Fraud Detection Software Contract" under (1) Executive Director's Office; (C) Information Technology Contracts and Projects. The remaining amount of $250,000 for provider background checks and other operating costs associated with re-enrolling Medicaid providers would be added to the Department's Operating Expenses line item under (1) Executive Director's Office; (A) General Administration.

For FY 2009-10, the Department requests continuation funding in the amount of $250,000 for annual technology maintenance and updates for the fraud detection software contract.

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 May 21, 2004 1331 Supplemental Request. An official appropriation for this FY 2004-05 spending authority was achieved by the Department's Supplemental Bill, SB 05-112. The out-year of this request was appropriated in the FY 2005-06 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 2006-07. Given that the same fiscal agent was selected, the necessary consulting hours were substantially reduced. Therefore, the funding for FY 2006-07 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 2007-08. 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 2007-08. Therefore, FY 2007-08 funding was removed by Joint Budget Committee recommendation during Figure Setting, February 14, 2007, page 50. No funding was requested for FY 2008-09 and no funding is requested for FY 2009-10.

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 2006-07 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 2005-06. Therefore, the Department submitted a Supplemental Request and Budget Amendment to reallocate $109,100 of FY 2006-07 funding to FY 2005-06 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 2006-07 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 a regular operations procedure.

COLORADO BENEFITS MANAGEMENT SYSTEM MEDICAL ASSISTANCE PROJECT

This project was initially requested by Budget Amendment BA#A1A, "Building Blocks to Health Care Reform," submitted February 15, 2008. Funding of $5,300,000 was provided by the FY 2008-09 Long Bill, HB 08-1375 for the purpose of working towards a

realignment of the Colorado Benefits Management System (CBMS) so that Medicaid and the Children's Basic Health Plan eligibility determinations can be streamlined. The goal of this project is to realize of administrative efficiencies that will 1) decrease application processing time, 2) reduce future system change costs, 3) better enable the Department to respond to expansions in eligibility for medical assistance programs and other public health insurance programs that may not have oversight by the federal government, and 4) streamline the application processes for programs administered by the Department of Human Services.

While CBMS will remain the system that determines eligibility Medicaid and the Children's Basic Health Plan within the Department and the financial assistance programs administered by the Department of Human Services, it is in the best interests of both state departments to create an environment that generates simplified client correspondence specific to the financial and medical assistance programs within CBMS and an environment that streamlines the re-determination notices and processes so that there is not a break in a client's eligibility that results in a loss of continuity of care.

The initial goal of the CBMS enhancement process is to understand the options that are available to the Department and Department of Human Services. Further, once both departments make policy decisions on what alternatives are acceptable, a detailed design assessment must be created to provide a final price and budget information. Options need to include the ability to create alternative venues to submitting applications, changes in circumstance information, and re-determinations. Potential options could include the ability for clients to request an application and information online, while the final eligibility determination is made by CBMS.

The FY 2008-09 Long Bill, HB 08-1375, provided $5,300,000 in total funds in FY 2008-09 for CBMS realignment activities. $250,000 is appropriated to conduct a study to determine whether the realignment of CBMS is feasible; $100,000 was funded to review and validate the cost and system assumptions and conclusions of the vendor performing the feasibility study; and $4,950,000 represents funding to make actual changes to the system in the event it is determined that the realignment of CBMS is feasible. The Department's FY 2009-10 request is for a total of $5,050,000 which includes an annualization of the original appropriation that removes the $250,000 for the study.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill, HB 08-1375 for the implementation and administration of a centralized eligibility vendor model. As a part of its Building Blocks Request (BA#A1A: "Building Blocks to Health Care Reform" submitted February 15, 2008) the Department proposed a centralized eligibility vendor model for determining eligibility for its programs. The Long Bill Add-ons for FY 2007-08 (07-239), appropriated $460,800 to the Department in order to hire a contractor to study the various models available to transition to a centralized eligibility vendor model. For FY 2008-09 the Long Bill (HB 08-1375) appropriated $153,000 to the Department for this function.

The contractor will provide the Department with best practices in other states and at the county level for administering eligibility and enrollment functions, including, existing programmatic delivery models, client enrollment access points, application intake, ongoing

case maintenance, and fraud and abuse monitoring. In addition, the contractor is expected to conduct a comprehensive business process analysis, with accompanying cost benefit and return on investment analyses, to improve the efficiency and quality for determining eligibility and enrollment operations for the Department's programs.

Based on the contractor's comprehensive business process analysis, the contractor and the Department will develop a request for proposals for a single state-administered contractor to manage the business processes for eligibility and enrollment for the Department's programs. The contractor began work in August 2008 and will provide a report of its findings to the Department by November 2008.

The Department is not requesting funding for FY 2009-10 as the contractor is expected to complete work by the end of FY 2008-09.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

The purpose of Medicaid authorization cards is to show proof of a client's Medicaid eligibility to medical providers. If clients could not show proof of Medicaid eligibility, providers would, at times, refuse to provide services. Plastic identification cards were first used in September 2003; however prior to that time, paper identification cards were used. Due to the non-durability of paper identification cards, many were reissued each month causing high annual expenditures.

In FY 2003-04, Base Reduction Item BRI-2 submitted November 1, 2002 implemented the process of issuing a plastic card to all eligible clients. Replacement cards are issued when necessary or when new clients become eligible. Prior to rendering medical services, 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 cards also allow clients to move on and off covered programs without receiving a new card each time. The conversion from paper to plastic cards has reduced printing costs.

Old Age Pension State Medical Program clients have always received Medicaid authorization cards but prior to FY 2003-04, no specific funds were provided to pay for the production of these cards. Beginning in FY 2003-04, Cash Funds Exempt for the Old Age Pension State Medical Program's clients were reflected in the appropriation. The amount of Cash Funds Exempt or Reappropriated Funds 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 2005-06, 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 2005-06 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 fund to cash fund 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 FY 2005-06 final appropriation for FY 2005-06 was $382,697.

For FY 2006-07 funding, Base Reduction Item BRI-1 was submitted November 15, 2005 to remove General Government Computer Center funding of $113,077 and $79,154 for production and mailing of the cards since fewer replacement cards were needed. The total reduction requested was $192,231 which 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 2006-07 funding to $190,892.

Continuation funding of $190,892 was requested for FY 2007-08, but during the Department's Figure Setting on 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 2007-08 of $120,000. Continuation funding of $120,000 was requested for FY 2008-09 and the Department is requesting continuation funding of $120,000 for FY 2009-10.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item funds services provided through three Department programs: Disability Determination Services, Nursing Home Preadmission and Resident Assessments, and School District Eligibility Determinations. Prior to FY 2008-09, each of these programs was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote 22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The three line items for Disability Determination Services, Nursing Home Preadmission and Resident Assessments, and School District Eligibility Determinations were combined into one line item titled "(D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations" within Long Bill group (1) Executive Director's Office. This line item received an appropriation of $2,410,994 in total funds for FY 2008-09, which is comprised of $913,610 General Fund, $30,854 cash funds, and $1,466,530 federal funds. Of this total amount, $1,173,662 was for Disability Determination Services, $1,010,040 was for Nursing Home Preadmission and Resident Assessments, and $227,292 was for School District Eligibility Determinations.

The Department's FY 2009-10 Base Request for (D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations is for continuation funding of $2,410,994 in total funds for all three programs described below.

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 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 2005-06, 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, was matched with federal funds for disability determinations of autism clients. For FY 2006-07 and FY 2007-08, the Department was appropriated continuation funding of $1,173,662.

NURSING HOME PREADMISSION AND RESIDENT ASSESSMENTS

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

Upon diagnosis of a Level II developmental disability, the client is referred to the Department of Human Services and community centered boards. Each Level II client is sent to either 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.

Periodically, a forecast of utilization is developed 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. The program administrator conducts trainings throughout the year and these trainings are funded in the Preadmission Screening and Resident Review line item.

The appropriation for this line has remained constant at $1,010,040 since FY 2003-04, as utilization forecasts have indicated this total budget amount to be adequate. Of this amount, $252,510 is General Fund and $757,530 is federal funds. Continuation funding of $1,010,040 for the line Nursing Home Preadmission and Resident Assessments in FY 2009-10 is requested.

SCHOOL DISTRICT ELIGIBILITY DETERMINATIONS

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 either 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 either Medicaid or the Children's Basic Health Plan.

In an effort to increase enrollment of eligible children into either Medicaid or the Children's Basic Health Plan, HB 06-1270 established a demonstration project for school-based medical assistance sites and 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 (1) (a.5), C.R.S. (2008), the Department secured contracts with the following three school districts 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 either Medicaid or Children's Basic Health Plan eligibility determinations. If the State receives sufficient gifts, grants, or donations, the Department will contract for an independent evaluation of the project, the results of which will be given to the Health and Human Services Committee for review before January 15, 2010.

Funding for School District Eligibility Determinations was $59,532 in FY 2006-07 but was appropriated under Personal Services and Operating Expenses. The Department hired 1.0 FTE in FY 2006-07 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 2006-07 appropriations. No additional FY 2006-07 appropriations were made as the school districts were in the process of being chosen.

In FY 2007-08, the Department was appropriated $227,292 in total funds, of which $79,269 was General Fund, $25,854 was Cash Funds Exempt, and $122,169 was federal funds. The bids received for the contracts for the operation of the program across the three school districts in FY 2007-08 totaled $223,821, which was $3,471 less than the total appropriation of $227,292. 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.

In FY 2008-09, the Department was provided continuation funding of $227,292 and adjusted contract amounts to equal the full appropriation. The Department requests continuation funding in its Base Request for FY 2009-10.

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 2006-07, 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 as 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 2006-07, 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 2006-07, 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 2006-07. In addition, the study found that the total expenditures related to medical assistance programs administered by the Department, including the proportional funding for opening doors, was equal to $35,004,134, which was $11,247,925 above the $23,756,209 FY 2007-08 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 2006-07, 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 2006-07 Supplemental document, Pages 28-31). The final FY 2006-07 appropriation was $21,115,133.

In FY 2007-08, the Department's appropriation was increased to $23,756,209 which is $2,641,076 above the final FY 2006-07 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. In FY 2007-08, the Department began implementing the Colorado Cares Rx Program, but during the planning process a similar program was implemented by the Denver Metro Chamber. As a result, the Department worked with a vendor to implement an alternative program. For more information regarding this program, please refer to the line item description for Colorado Cares Rx Program Contract Costs. Any budgetary impact will be addressed through the regular budget process.

Through the FY 2008-09 Long Bill (HB 08-1375), the Department was appropriated $23,803,133, an increase of $46,924 over the FY 2007-08 appropriation due to the annualization of funding for the Colorado Cares Rx Program. In addition to the Long Bill, HB 08-1250 appropriated an additional $3,400,000 for County Administration through shifting funding from the County Tax Base Relief Fund (previously known as the County Contingency Fund). HB 08-1250 revised the methodology for determining which counties receive payments from the County Tax Base Relief Fund so that fewer counties receive a payment, leaving additional funding available for transfer to the County Administration line item. HB 08-1250 brings the Department's total appropriation for County Administration in FY 2008-09 to $27,203,133. The Department is requesting continuation funding for FY 2009-10.

ADMINISTRATIVE CASE MANAGEMENT

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 2005-06, 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 2006-07, 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 if necessary, 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 2006-07. However, pursuant to 24-75-106 (1) C.R.S. (2008), 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 2006-07 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 2007-08, the Department was provided continuation funding of $1,593,624 and again, this amount was not sufficient and the Department received a transfer from the Department of Human Services in the amount of $1,048,341.

For FY 2008-09, the Department submitted Decision Item #15, "Accuracy in Budgeting – Administrative Case Management" on November 1, 2007, requesting an increase of $1,300,000 which was offset by a corresponding decrease to the Department of Human Services budget. The decision item was approved and the Department's FY 2008-09 Long Bill appropriation is $2,917,528. The Department is requesting continuation funding for FY 2009-10.

CUSTOMER OUTREACH

This line item funds customer outreach services provided through two Department programs: the Early and Periodic Screening, Diagnosis, and Treatment Program and the SB 97-05 Enrollment Broker Program. Prior to FY 2008-09, each of these programs was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office long bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. Two of the consolidated line items were the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker, which were combined into one line item titled "(D) Eligibility Determinations and Client Services: Customer Outreach" within Long Bill group "(1) Executive Director's Office." This line item received an appropriation of $3,790,283 in total funds for FY 2008-09, of which $1,861,628 is General Fund, $33,514 is cash funds, and $1,895,141 is federal funds. Of the total amount for the line, $2,468,383 was for the Early and Periodic Screening, Diagnosis, and Treatment Program and $1,321,900 was for the Enrollment Broker Program.

The Department's FY 2009-10 Base Request for (D) Eligibility Determinations and Client Services: Customer Outreach is $3,573,001 in total funds. This total includes continuation funding of $3,790,283, of which $2,468,383 is for the Early and Periodic Screening, Diagnosis, and Treatment Program and $1,321,900 is for the Enrollment Broker Program. The Department's FY 2009-10 Base Request also includes a reduction of $217,282 in total funds for the annualization of FY 2008-09 BA#A1A: "Building Blocks to Health Care Reform" submitted February 15, 2008.

A description of the appropriation history for the Early and Periodic Screening, Diagnosis, and Treatment Program as well as the Enrollment Broker Program is provided below.

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 for children. The services include, but are not 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 2003-04, 5.0 FTE at the Department of Public Health and Environment managed the Early and Periodic Screening, Diagnosis and Treatment Program with a final appropriation of $2,721,758 in FY 2002-03.

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 (1) Executive Director's Office, (A) General Administration: Personal Services Long Bill line.

In the FY 2003-04 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 2003-04, adjusted by an add-on section of HB 04-1422, was $2,468,383. The appropriation has remained at this level since FY 2003-04. Funding for this program includes 50% federal financial participation.

Only 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. The funding for medical services provided through the Early and Periodic Screening, Diagnosis, and Treatment Program remain in the Department's Long Bill group (2) Medical Services Premiums.

The Department's FY 2009-10 Base Request for "(D) Eligibility Determinations and Client Services: Customer Outreach" includes continuation funding of $2,468,383 for the Early and Periodic Screening, Diagnosis, and Treatment Program.

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 all 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 in accordance with Medicaid rules. MAXIMUS does this work under the name of Health*Colorado*.

In FY 2005-06, the Base Request was $875,756, the same as FY 2004-05. 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 for an additional 23,524 clients. However, a technical correction for FY 2005-06 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 June 2, 2005 1331 Supplemental Request for this correction.) Only $875,756 was actually expended for this line item in FY 2005-06 because implementation of the caseload expansion was delayed until July 2006.

For FY 2006-07, the assumptions in the Department's fiscal note for HB 05-1262 forecasted a caseload increase of 12,825 clients above the FY 2005-06 forecast, resulting in an annualization of the costs for the Enrollment Broker Program of an additional $23,650. This resulted in a final FY 2006-07 appropriation of $942,784.

During FY 2007-08 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). The Joint Budget Committee reduced funding for the enrollment broker contract to $700,000 for FY 2007-08. As a result of a drop in caseload for managed care, the Department was able to work with MAXIMUS to revise the scope of work from $942,784 to $700,000 for a proposed contract for FY 2007-08. This new contract drastically cut the amount of information provided to clients through mailings and relied on internet resources as a means of information provision.

Although this proposed contract was able to manage to the $700,000 appropriation for FY 2007-08, direction from the Centers for Medicare and Medicaid Services stated that this contract would not be in compliance with federal regulation. The Centers for Medicare and Medicaid Services stated that the State may maintain a website so that clients may access additional resources, but required that the State provide hard copy mailings of the information materials listed in 42 CFR 438.10. The Department was required to change the FY 2007-08 contract back to the former scope of work to ensure compliance, which resulted in a 10-month contract running from July 1, 2007 to April 30, 2008.

As a result of the reduction to the appropriation for FY 2007-08 and the resulting 10-month contract with MAXIMUS, the Department submitted a supplemental, S-11, "Restore Enrollment Broker Contract Funding" (January 2, 2008 FY 2007-08 Supplemental Requests). The total amount of the supplemental request was $159,570. This included an identified total funding need of $257,418 with an offset of $97,848 from (1) Executive Director's Office, Operating Expenses line item into the Enrollment Broker line item for costs associated with printing and mailing a managed care report card. This request also sought funding to restore the full 12-month contract as well as fulfill the directive from the Centers for Medicare and Medicaid Services to ensure all Medicaid clients make informed decisions when choosing among available medical assistance programs. The Department's supplemental request S-11 "Restore Enrollment Broker Contract Funding" was approved in the FY 2007-08 Supplemental Bill (HB 08-1285), resulting in a total appropriation for the Enrollment Broker line of $957,418. Also, a late supplemental requesting a one-time add-on of $2,200 for Medical Home material updates for FY 2007-08 (February 15, 2008 Budget Request Amendments Page S.1A-D9) was requested in S-1A, BA-A1A "Building Blocks to Health Care Reform," and appropriated in HB 08-1285.

For FY 2008-09, the Department received a total appropriation of $3,790,283 in total funds, of which $1,321,900 was for the Enrollment Broker Program. This funding is based on:

- The total appropriation for FY 2007-08 of $959,618;
- Less $2,200 for removal of one-time funding from S-1A, BA-A1A "Building Blocks to Health Care Reform" (February 15, 2008 Budget Request Amendments Page S.1A-D9);
- Plus $364,482 for costs associated with implementation of the SB 07-130 Medical Home program in FY 2008-09 (FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments, February 15, 2008 and FY 2008-09 Figure Setting, March 11, 2008, page 79).

The Department's FY 2009-10 Base Request for (D) Eligibility Determinations and Client Services: Customer Outreach is $3,573,001 in total funds, of which $1,104,618 is for the Enrollment Broker Program. This funding is based on:

- The total appropriation for FY 2008-09 of $1,321,900;
- Less $217,282 in total funds for annualization of FY 2008-09 BA#A1A: "Building Blocks to Health Care Reform".

The federal financial participation rate for the Enrollment Broker Program is 50%. Of the State's 50% share, $33,514 is cash funds from the Health Care Expansion Fund and the remainder is General Fund.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five line items for Acute Care Utilization Review, Long-term Care Utilization Review, External Quality Review, Drug Utilization Review and Mental Health External Quality Review were combined into one line item titled "(E) Utilization and Quality Review Contracts: Professional Services Contracts" within Long Bill group (1) Executive Director's Office. This line item received an appropriation of $4,669,035 in total funds for FY 2008-09, which is comprised of $1,362,318 General Fund, $54,949 cash funds and $3,251,768 federal funds. Of this total amount, $1,375,906 was for Acute Care Utilization Review, $1,744,966 was for Long-term Care Utilization Review, $812,193 for External Quality Review, $383,163 for Drug Utilization Review and $352,807 for Mental Health External Quality Review.

The Department's FY 2009-10 Base Request for the Professional Services Contracts line item is for the amount of $4,496,355 which includes an annualization for Budget Request Amendment #3 "Implement Preferred Drug List", submitted January 2, 2008.

ACUTE CARE UTILIZATION REVIEW

Acute Care Utilization Review includes performing both prospective and retrospective reviews for specified services to ensure that requests for benefits are a covered benefit and that the service is medically necessary and appropriate. Prospective reviews are conducted prior to the delivery of services and include the following service categories: transplants; select procedures; out-of-state elective admissions; inpatient mental health services; inpatient substance abuse rehabilitation; durable medical equipment; select non-emergent medical transportation; Early and Periodic Screening, Diagnosis and Treatment home health service reviews; and outpatient physical and occupational therapy requests. Retrospective reviews are conducted on inpatient stays after the hospital claims have been paid. By examining the paid claims against the medical records, the contractor ensures that the care paid for was medically necessary, required acute level of care and was coded and billed correctly.

The Department contracts with an independent contractor to perform prospective and retrospective reviews. By contract, the contractor is responsible for conducting a minimum of 9,500 prospective and 4,000 retrospective reviews per fiscal year. These reviews result in cost avoidance and recovery of provider payments should the provider or facility fail to provide the required documentation.

Under Section 1903 (a)(3)(C)(i) of the Social Security Act and 42 CFR §433.15 (6)(i), the Department is allowed to request enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a qualified improvement organization. The Department's acute care utilization review contractor qualifies as a quality improvement organization under Section 1152 of the Social Security Act.

In FY 2006-07, tobacco tax funding was annualized for anticipated caseload growth of expansion populations, adding $7,840 to the Department's FY 2006-07 base appropriation of $1,368,066 and resulted in a Long Bill (HB 06-1385) appropriation of $1,375,906. The additional tobacco tax funding was discussed in Table 4 of the Department's June 3, 2005 1331 Supplemental Request. In addition to this change, the appropriation underwent a shift of $2,174 between Cash Funds Exempt and General Fund for the Breast and Cervical Cancer Treatment Program as required by the original statute for the program. The Department requested continuation funding of $1,375,906 for FY 2007-08 and was subsequently approved by the Long Bill (SB 07-239).

Although continuation funding was requested for FY 2008-09, $725 will shift between Cash Funds Exempt and General Fund for the Breast and Cervical Cancer Program as required by section 25.5-5-308 C.R.S. (2008). This will complete the transition so that the program is only using General Fund for the State portion of the funding beginning in FY 2008-09.

The Department is requesting continuation funding of $1,375,906 for FY 2009-10.

LONG-TERM CARE UTILIZATION REVIEW

Long-term care utilization reviews include performing prior authorization reviews for certain services to determine medical necessity, level of care, and target population determinations as well as periodic reevaluation of services. 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. The Single Entry Point agencies and other contractors perform the following functions with funding from this line item:

- Uniform Long-Term Care 100.2 Form (ULTC 100.2) assessments for needed level of care;
- Pre-Admission Screening and Resident Review (Level I) to identify clients who need Level II screening;
- Hospital Back-Up Program provides cost-effective alternatives for clients who have extended acute hospitalizations, by permitting transfer to nursing facilities capable of providing care;
- Assessments for the Children's Extensive Support waiver which provides Medicaid benefits, services and support for children with developmental disabilities or delays and require special services and provide an alternative to institutional placement;
- Assessments for Private Duty Nursing which provides eligible clients with skilled nursing services in a home setting;
- Data management;
- Training for case managers.

DDM Ascend 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. DDM Ascend also conducts reviews for the Level II Pre-Admission Screening and Resident Review Program (PASRR).

Under Section 1903 (a)(2)(C) of the Social Security Act and 42 CFR §433.15 (9), the Department is allowed to request enhanced federal financial participation of 75% for funds expended to conduct preadmission screening and resident review activities. If a contractor qualifies as a qualified improvement organization under Section 1152 of the Social Security Act, then the Department may seek enhanced federal financial participation of 75% for the performance of medical and utilization review activities other than preadmission screening and resident review activity. The Department's contractor, DDM Ascend, is not recognized as a qualified improvement organization in Colorado. As a result, the medical and utilization review activities performed by DDM Ascend which are not related to preadmission screening and resident review activity qualify for federal financial participation of 50% (42 CFR §433.15 (b)(6)(ii) and §433.15 (b)(7)).

In FY 2006-07 and FY 2007-08, the Department's appropriation was $1,744,966. During FY 2008-09 Figure Setting on March 11, 2008, the Department requested continuation funding of $1,744,966 but the Joint Budget Committee staff recommended a technical correction to the cash funding source. Rather than receiving cash funding in the amount of $38,429 from the Autism Treatment Fund, the line item receives $38,429 from the Health Care Expansion Fund.

The Department is requesting continuation funding of $1,744,966 for FY 2009-10.

EXTERNAL QUALITY REVIEW

The Department's contractor, Health Services Advisory Group, Inc., validates performance improvement projects and Health Effectiveness Data and Information Set (HEDIS) measures for managed care organizations, the primary care physician program, and fee-for-service providers and provides an annual report of activities and recommendations. The contractor is responsible for the day-to-day administration and management of a credentialing program. The process includes, but is not limited to, collection and verification of the status of licensure; validity of Drug Enforcement Agency or Controlled Dangerous Substances certification; relevant training and experience; board certification; any past liability claims; and United States Department of Health and Human Services, Medicare and Medicaid sanctions and work history. Through the credentialing process, the contractor verifies the credentials of approximately 33% of the primary care providers enrolled in the Primary Care Provider Program each year (up to 380 annually) and 20 primary care providers enrolled in the Self-Insured Network, plus new monthly enrollments. The credentialing process is important and helps the Department to identify any quality of care issues, fraudulent representation, loss of privileges, and licensure revocation or illegal practices which require further investigation. If such actions from physician regulatory boards have been recommended, the Department staff suggests further actions that may include termination of Medicaid participation.

The Department is permitted to receive an enhanced federal financial participation rate of 75% for funds expended for performance of external quality review or related activities when they are conducted by an external quality review organization as defined in 42 CFR §438.320 (42 CFR §433.15 (b)(10)).

In FY 2006-07, the Department's appropriation was $812,193. For FY 2007-08, SB 07-211 provided one-time funding in the amount of $70,000 to consult with clinical advisors, develop clinical standards and methods of collecting, analyzing, and disclosing clinical performance information to assess children's health outcomes. During Figure Setting on March 11, 2008, the appropriation was reduced by $70,000 to annualize one-time funding from SB 07-211 and resulted in the final appropriation of $812,193 in FY 2008-09 (Figure Setting, March 11, 2008, Joint Budget Committee Working Document, Page 66).

The Department is requesting continuation funding of $812,193 for FY 2009-10.

DRUG UTILIZATION REVIEW

Pursuant to 42 CFR §456.703 the State must have in operation, by January 1, 1993, a drug use review program. The purpose of the program is to ensure appropriate drug therapy while permitting sufficient professional prerogatives to allow for individualized drug therapy. The program consists of both prospective and retrospective reviews, the application of explicit predetermined standards, and an educational program. The Department submits an annual report to the Health and Human Services Committee in the General Assembly that contains information on the prospective and retrospective drug review program, the steps taken by the Department and Drug Use Review Board to ensure compliance with the requirements for predetermined standards, a summary of the educational interventions used and an assessment of the effect of these educational efforts on the quality of care, and an estimate of the cost savings generated as a result of the drug use review program.

The Department's drug use review program was implemented in three phases:

1. 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.
2. Phase II, effective March 4, 2004, included certain atypical antipsychotics, two narcotic pain medications and COX-2 pain inhibitors.
3. Phase III, effective February 2005, included two asthma treatment drugs and three skin infection drugs for which less expensive alternative prescriptions existed.

In FY 2005-06, 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, the appropriation for FY 2005-06 was over-estimated based upon implementation of the Medicare Modernization Act of 2003 implemented on January 1, 2006 which transferred nearly one half of all Medicaid prescription drug costs to the federal government's

Medicare program. Based on the reduced expenditures for prescription drugs, 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 (Supplemental #6, "Revision to the Medicare Modernization Act Implementation", submitted January 3, 2006). The total reduction requested by the Department for the drug prior authorization review was $276,000 and was authorized by the Department's FY 2005-06 Supplemental Bill (HB 06-1217). In FY 2006-07, the Department received continuation funding in the amount of $372,025 through the Long Bill, HB 06-1385.

For FY 2007-08, the Department submitted change request, Base Reduction Item #2, "Decrease Drug Utilization Review Funding" on November 1, 2006 which requested a reduction in funding to the amount for which there were actual vendor contracts at the time. The reduction in the amount 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 added $16,950 to the total appropriation. The net result of these change requests decreased the appropriation for FY 2007-08 to $304,143.

On January 2, 2008, the Department submitted a supplemental request to replace the Preferred Drug List contract with the Drug Effectiveness Review Project (DERP) and correct the federal financial participation rate for all drug utilization review activities (FY 2007-08 Supplemental Requests, January 2, 2008, Supplemental #9, Budget Request Amendment #3, "Implement Preferred Drug List"). The net result was a reduction in the amount of $61,000 for FY 2007-08 leaving a final appropriation of $243,143.

As part of the Department's January 2, 2008 submission, it requested under Budget Request Amendment #3 an increase of $79,020 to the base appropriation of $304,143 for FY 2008-09. The purpose of the request allowed the Department to purchase clinical data from the Drug Effectiveness Review Project and correct fund splits for all contracts under the line item for FY 2008-09. The requested appropriation for FY 2008-09 was $383,163 which was an increase of $140,020 over the final appropriation for FY 2007-08.

For FY 2009-10, the Department requests an appropriation of $210,483 (FY 2008-09 Budget Request Amendments, January 2, 2008, BA-3, Page S.9-20).

MENTAL HEALTH EXTERNAL QUALITY REVIEW

The Department conducts federally-required external quality review activities that receive 75% federal financial participation for when the activities are conducted by an external quality review organization as defined in 42 CFR §438.320 (42 CFR §433.15 (b)(10)). 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 contractor, Health Services Advisory Group, Inc., is responsible for five activities related to behavioral health which include the following:

1. Validate performance measures using the Centers for Medicare and Medicaid Services' protocol as a resource for validation methodology. The contractor will review the validity of designated performance measures, which may include clinical outcomes from the Colorado Client Assessment Record, and satisfaction survey results from the Mental Health Statistics Improvement Program and Youth Services Survey for Families or other internally developed performance measures. Performance measure validation for behavioral health organizations requires review of each behavioral health organizations' Information Systems Capabilities Assessment Tool and site visits.
2. Conduct compliance monitoring which includes standards for access to services, structure and operations, and quality measurement and improvement. The standards for behavioral health organizations must meet the Department's Quality Strategy in order to promote safe and effective health care. The contractor will use no less than five main sources of information to determine compliance, which include: document review; record review; secret shopper surveys; interviews with health plan personnel; and stakeholder/provider input.
3. Validate, on an annual basis, no more than two performance improvement projects conducted by each behavioral health organization. In order for such projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the performance improvement projects must be designed, conducted, and reported in a methodologically sound manner as outlined in the Centers for Medicare and Medicaid Services' protocol.
4. Conduct quality of care reviews that investigate individual potential quality concerns and assist the Department in addressing concerns or discovering issues that may require focused study. Medical records are the primary review source for individual case reviews.
5. Deliver an annual report on each behavioral health organization.

The Department's responsibility for the Mental Health External Quality Review program began in FY 2004-05 with the passage of HB 04-1265. Prior to this time, the Department of Human Services managed Medicaid mental health programs, including the external quality review organization for mental health. Based on historical costs, SB 05-112 established an appropriation of $352,807 for Mental Health External Quality Review in FY 2004-05.

In FY 2006-07, FY 2007-08, and FY 2008-09 the Department's appropriation was $352,807. The Department is requesting continuation funding of $352,807 for FY 2009-10.

(F) PROVIDER AUDITS AND SERVICES:

PROFESSIONAL AUDIT CONTRACTS

Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375)

consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five line items for Nursing Facility Audits, Hospital and Federally Qualified Health Clinics Audits, Single Entry Point Audits, Payment Error Rate Measurement Contract and Nursing Facility Appraisals were combined into one line item titled "(F) Provider Audits and Services: Professional Audit Contracts" within Long Bill group (1) Executive Director's Office. This line item received an appropriation of $1,708,700 in total funds for FY 2008-09, which is comprised of $854,350 General Fund, and $854,350 federal funds. Of this total amount, $1,097,500 was for Nursing Facility Audits $499,200 for Hospital and Federally Qualified Health Clinics Audits, $112,000 for Single Entry Point Audits and no funding for the Payment Error Rate Measurement Contract or Nursing Facility Appraisals.

The Department's FY 2009-10 Base Request for the Professional Services Contracts line item is for continuation funding in the amount of $1,708,700 for the items described below.

NURSING FACILITY AUDITS

The Department is statutorily required to audit costs reported by Medicaid nursing facilities for rate setting purposes. The Department conducts a competitive procurement once every five years to obtain professional audit services needed to perform this function. The current procurement period will expire on June 30, 2009. A new procurement will be conducted in FY 2008-09 to continue audit services for the five-year period beginning July 1, 2009.

The Department contracts with an independent accounting firm to perform audits of nursing facility cost reports. The Medicaid "Financial and Statistical Report of Nursing Homes" (MED-13) determines which costs are reasonable, necessary, and patient related to subsequently set rates based on those costs. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care for Medicaid clients, in accordance with State and federal statutes.

During FY 2003-04, the Department solicited bids for a new five-year contract to begin in FY 2004-05. The FY 2004-05 appropriation was based on the FY 1999-00 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 (Supplemental #6, submitted January 3, 2005). This appropriation has remained at this level since FY 2004-05. The FY 2008-09 appropriation is $1,097,500 and the Department is requesting continuation funding for FY 2009-10.

HOSPITAL AND FEDERALLY QUALIFIED HEALTH CENTERS 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 2005-06, an appropriation of $250,000 for desk audits of over 200 hospitals and federally qualified health clinics produced over $5 million in costs avoided in Medical Services Premiums. This funding was increased to $350,000 in FY 2005-06 through the Long Bill (SB 05-209) with approval of the Department's Decision Item Decision Item #11 submitted November 1, 2004 to include site audits as part of the program to provide greater accuracy in identifying actual costs. With the additional funding appropriated in FY 2005-06, the Department's contractor recovered $13,938,704 from hospitals and $2,498,982 from federally qualified health clinics for a total of $16,437,686 in cost avoided from site audits. An additional $17,850 was added to this appropriation in FY 2006-07 through the Long Bill (HB 06-1385) to include a cost of living adjustment for the contractor.

In FY 2007-08, 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 FY 2008-09 appropriation is $499,200 and the Department is requesting continuation funding for FY 2009-10.

SINGLE ENTRY POINT AUDITS

This item funds annual audits of Single Entry Point agencies provided through a contractor. From FY 2003-04 through FY 2005-06, the total appropriation was $35,340. Since this amount was insufficient to conduct on-site reviews of the 23 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 2006-07 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 23 Single Entry Point agencies, not conducting the audits 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 billing, and potentially increase recovery of improper payments, the appropriation was increased to $112,000 in FY 2006-07. The same amount was appropriated for this line item in FY 2007-08 and FY 2008-09. The Department requests continuation funding in FY 2009-10.

PAYMENT ERROR RATE MEASUREMENT PROJECT CONTRACT

The Payment Error Rate Measurement Project was established in response to the federal Improper Payments Information 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 FY 2003-04 and 2004-05, 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 2005-06. 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 2005-06 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 2005-06 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 2005-06 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 was required to conduct eligibility and payment error reviews for Medicaid and the Children's Basic Health Plan starting in FY 2006-07.

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 2006-07 and $1,178,820 in FY 2007-08. The contractor created and populated 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 (Figure Setting, February 14, 2007, page 85). As a result, the Department received total funds of $147,126 for FY 2006-07 (Supplemental Bill, SB 07-163) and $441,375 for FY 2007-08 (Long Bill, SB 07-239). The FY 2007-08 appropriated funds are $294,249 higher than the FY 2006-07 appropriated funds because the FY 2007-08 Payment Error Rate Measurement contract

encompasses a full year of services (Figure Setting, February 14, 2007, page 84). No money was requested for FY 2008-09 due to the three-year review cycle and no money is requested for FY 2009-10.

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 25.5-6-202, C.R.S. (2008). The per diem rate paid to nursing facilities is based in part on the fair rental value of the facility. In FY 2002-03, there were 194 nursing facilities appraised at a cost of $266,171. For the appraisals conducted in FY 2006-07, the Department requested continuation funding of $266,171. However, $279,746 was appropriated in FY 2006-07, due to a Joint Budget Committee action to account for a 5.1% inflation factor. In FY 2006-07, 191 nursing facilities were appraised with actual expenses to the Department of $279,746. Continuation funding was not be requested for this line item in FY 2008-09 and no funding is requested for FY 2009-10, as nursing facility appraisals will not be conducted again until FY 2010-11.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, authorized in 25.5-4-302, C.R.S. (2008) 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 recoveries on a contingency fee basis. Since FY 2003-04, the contingency fee rate has been 10.9% with the remainder of recoveries acting as an offset to the Medical Services Premiums line.

In FY 2006-07 and FY 2007-08, the Department's base appropriation for estate recovery was $700,000. In FY 2007-08, the Department recovered $2,983,991 in net estate recoveries from activities in FY 2006-07. In FY 2007-08 estate recoveries were lower than anticipated due to economic hardship in the real estate market. The Department primarily recovers residential real estate and sells the property. The Department has a large portfolio of properties, but it has been difficult to sell these properties to convert them into cash recoveries. This difficulty will continue until the real estate market recovers, especially the secondary investment real estate market which includes those who buy and repair homes and resell them, which represents the typical buyer of Department properties involved in Department estate recoveries.

Using the current contingency fee rate of 10.9%, the maximum allowable amount of estate recoveries is $6,422,018 per fiscal year. The Department is requesting continuation funding of $700,000 for FY 2009-10.

(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, the 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 2005-06 and FY 2006-07 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 1998-99 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.

8. 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 2006-07. 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. 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 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 2003-04 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 2003-04 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.

Through June 2008, the Department utilized the REX01/COLD (MARS) R-464600 report for caseload levels, which is a standard report from the Medicaid Management Information System. Eligibility information included in the Medicaid Management Information System is fluid, and is updated from the Colorado Benefits Management System on a daily basis. This report is run on the Friday before the last Tuesday of every month, and does not incorporate eligibility changes that occurred between the run date and the last day of the given month. In addition, the report is a one-time snapshot and cannot be replicated in the future because of the fluid nature of eligibility. The limitations of this report prevent the Department from analyzing caseload by characteristics other than eligibility types, such as gender, county of residence, or age.

The Department has developed a new caseload report that it believes measures caseload more accurately, the REX01/COLD (MARS) R-474701. This report captures eligibility movements for the entire month in question, and also stores the data table that underlies the report. As a result, the Department is able to analyze caseload by many other demographic and geographic characteristics while still balancing to the official Medicaid caseload. The Department began to use this new caseload report with the July 2008 caseload report to the Joint Budget Committee.

The Department has been tracking this report since October 2007 and has noted differences between the original Medicaid caseload and caseload from the new report. These disparities are a result of any eligibility activity that occurred during the days not included in the original R-464600 report. Consider for example a hypothetical May 2008 caseload of 1,000, and 100 new clients become eligible in the last week of May 2008 and 50 existing clients become ineligible. Under the original R-464600 report, the reported May 2008 caseload would be 1,000 and the June 2008 caseload would start at a level of 1,050 (1,000 + 100 – 50). Under the new R-474701 report, the May 2008 caseload would be 1,050, which would also be the starting point for June 2008 caseload. This difference is due to the new report utilizing the entire month of eligibility changes. See Table for Scenario #1 below.

Scenario #1			
	May 2008 Caseload	June 2008 Caseload	Growth
R-464600 Caseload (original)	1,000	1,050	5.00%
R-474701 Caseload (new)	1,050	1,000	-4.76%
Difference	5.00%	-4.76%	
* For May 2008, assumes 100 new clients become eligible and 50 existing clients become ineligible during the last week of the month. June 2008 assumes 50 new clients become eligible and 100 existing clients become ineligible during the last week of that month.			

The differences between the reports are eligibility-type specific and tend to vary based on the magnitude and direction of the caseload change in the following month. If caseload is changing in one direction for an extended period of time, it is likely that this same trend is occurring during the days of eligibility not included in the original report. As a result, the original report tends to understate the large trends (either positive or negative), which amplifies the difference between the two reports during protracted increases or declines. This phenomenon also mitigates the disparity in the reports at inflection points or during times of moderate and consistent caseload changes. In the hypothetical Scenario #1 above, the difference between the two reports for May 2008 would be 5% (50 clients out of 1,000). Further, consider if no other eligibility activity occurs in June 2008 and that in the last week of the month 50 new clients become eligible and 100 existing clients lose eligibility (a change in trend). Because these changes occur in the last week of the month, the R-464600 caseload stays constant from the beginning of the month at 1,050, growth of 5% over May 2008. The R-474701 report reflects these changes and shows a caseload of 1,000 for June 2008, a decline of 4.76% from May 2008.

Consider Scenario #2 below. These caseload changes are similar in direction to those in Scenario #1, but smaller in magnitude. The difference between the reports is smaller at only 1% in May 2008, and the disparity between the growth rates from May and June 2008 is smaller.

Scenario #2			
	May 2008 Caseload	June 2008 Caseload	Growth
R-464600 Caseload (original)	1,000	1,010	1.00%
R-474701 Caseload (new)	1,010	1,000	-0.99%
Difference	1.00%	-0.99%	
* For May 2008, assumes 20 new clients become eligible and 10 existing clients become ineligible during the last week of the month. June 2008 assumes 20 new clients become eligible and 10 existing clients become ineligible during the last week of that month.			

Because of the differences between the methodologies used in the original and new caseload reports, the Department is restating historical Medicaid caseload through FY 2002-03. In order to restate in a methodology consistent with the new report, the Department analyzed the trends by eligibility type. In general, monthly caseload is restated based on the growth trend from the following month for the reasons discussed above. The magnitude of historical monthly growth is compared to the monthly growth rates from the tracking period (October 2007 through June 2008), and the original caseload level is adjusted by a similar percent difference that occurred between the reports.

Below is an example of how the caseload is restated. In July 2005, the next month's growth rate is -0.13%. This rate is closest in magnitude to the growth rate experienced in February 2008, which would correspond to the January 2008 percent difference between the reports. In this instance, the caseload decline appears to be a one-time decrease, and is not part of a long-term negative trend. Because this appears to be a one-time decrease, the original caseload is adjusted up rather than down, as it is unlikely that the drop would have been larger under the methodology of the new report. Thus, the restated caseload is 57,905 * (1+1.90%) = 59,005.

Categorically Eligible Low-Income Adults (AFDC-A)

	Original Caseload	Original Monthly Growth	Restated Caseload	Restated Monthly Growth	Percent Difference Between Reports (used to adjust the original caseload)	Original Following Month Growth Rate
Jul-05	57,905	-6.13%	59,005	-5.23%	1.90%	-0.13%
Aug-05	57,827	-0.13%	58,926	-0.13%	1.90%	0.16%
Sep-05	57,922	0.16%	59,202	0.47%	2.21%	-2.14%
Oct-05	56,684	-2.14%	57,937	-2.14%	2.21%	2.19%
Nov-05	57,923	2.19%	59,024	1.88%	1.90%	0.04%
Dec-05	57,944	0.04%	59,225	0.34%	2.21%	1.34%
Jan-06	58,721	1.34%	60,019	1.34%	2.21%	-1.45%
Feb-06	57,872	-1.45%	59,151	-1.45%	2.21%	-0.90%
Mar-06	57,354	-0.90%	58,495	-1.11%	1.99%	0.66%
Apr-06	57,730	0.66%	59,006	0.87%	2.21%	1.76%
May-06	58,748	1.76%	59,300	0.50%	0.94%	-3.97%
Jun-06	56,416	-3.97%	57,330	-3.32%	1.62%	-0.29%
Jul-06	56,253	-0.29%	57,372	0.07%	1.99%	0.55%
Aug-06	56,565	0.55%	56,033	-2.33%	-0.94%	-2.16%
Sep-06	55,341	-2.16%	54,433	-2.86%	-1.64%	-2.51%
Oct-06	53,950	-2.51%	53,443	-1.82%	-0.94%	-3.91%
Nov-06	51,838	-3.91%	50,988	-4.59%	-1.64%	-1.89%
Dec-06	50,857	-1.89%	49,733	-2.46%	-2.21%	-0.91%
Jan-07	50,395	-0.91%	49,624	-0.22%	-1.53%	-0.67%
Feb-07	50,058	-0.67%	48,952	-1.35%	-2.21%	-1.46%
Mar-07	49,325	-1.46%	48,235	-1.46%	-2.21%	-1.65%
Apr-07	48,513	-1.65%	47,717	-1.07%	-1.64%	-3.09%
May-07	47,016	-3.09%	46,245	-3.08%	-1.64%	-1.70%
Jun-07	46,219	-1.70%	45,470	-1.68%	-1.62%	0.34%

Reference Table from Comparison Period		
	Original Following Month Growth Rate	Percent Adjustment
Oct-07	-2.52%	1.64%
Nov-07	-3.74%	0.94%
Dec-07	-0.77%	1.53%
Jan-08	-0.09%	1.90%
Feb-08	0.33%	1.65%
Mar-08	1.30%	2.21%
Apr-08	0.34%	1.62%
May-08	0.54%	1.99%

In December 2006, however, caseload was in a long-term negative trend. The next month's growth rate is -0.91%, which is similar in magnitude to that from March 2008. Because caseload was experiencing consistent declines, it is likely that the new reporting

methodology would have been lower than the original caseload, as more clients would have become ineligible during the period omitted from the current report. Thus, the original caseload is restated down by the percent difference from the March 2008 reports. The December 2006 restated caseload is 50,857 * (1-2.21%) = 49,733.

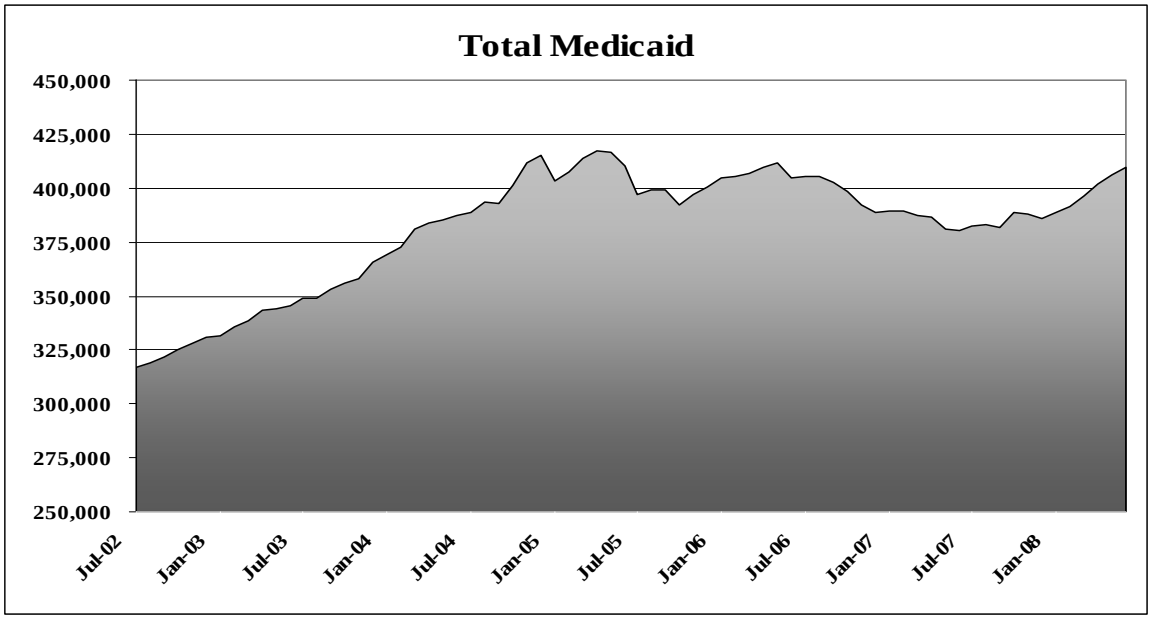
All caseload history and forecasts included in the following narrative, as well as the Medical Services Premiums and Medicaid Mental Health projections, are the official restated caseload. Exhibit Q includes graphs and tables by eligibility type comparing the originally reported caseload from the R-464600 report to the restated caseload.

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.

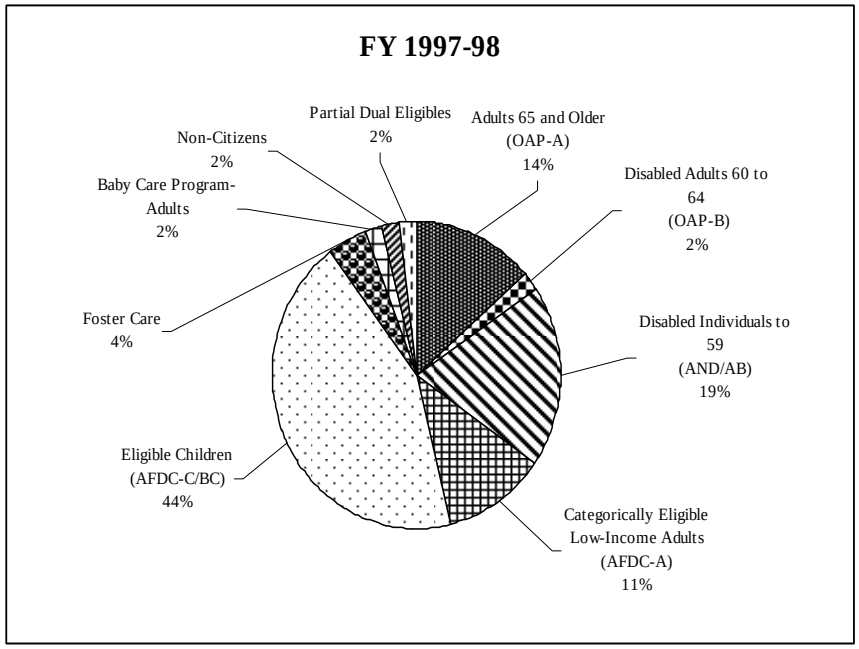
Fiscal Year	Medical Services Premiums Caseload	Less: Mental Health Ineligible Categories	Mental Health Caseload
FY 2002-03	331,800	(13,072)	318,728
FY 2003-04	367,559	(14,635)	352,924
FY 2004-05	406,024	(14,755)	391,269
FY 2005-06	402,218	(17,304)	384,914
FY 2006-07	392,228	(18,109)	374,119
FY 2007-08	391,962	(18,405)	373,557

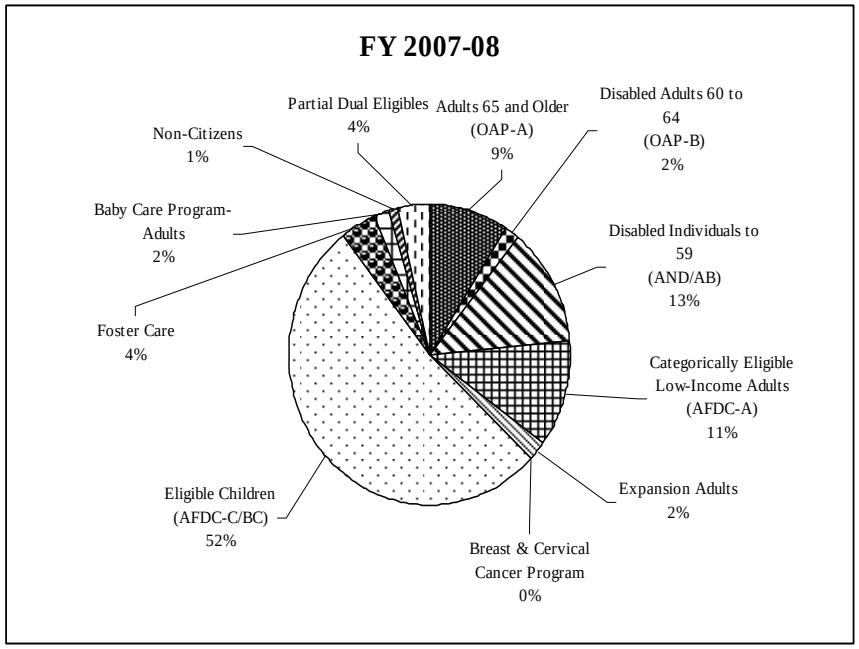
Recent Caseload History

Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 2002-03 to FY 2006-07. Projections for FY 2007-08 and FY 2008-09 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 is shown below. Medicaid in Colorado had double-digit growth rates in FY 2003-04 and FY 2004-05 of 10.78% and 10.48%, respectively. These high rates of growth ceased in FY 2005-06, and caseload declined by 0.95% in FY 2005-06 and by a further 2.48% in FY 2006-07. Monthly declines continued in the first half of FY 2007-08 but ceased in the second half, resulting in a nearly flat decline of 0.07% for the fiscal year. Reasons for these recent growth rates will be discussed below.



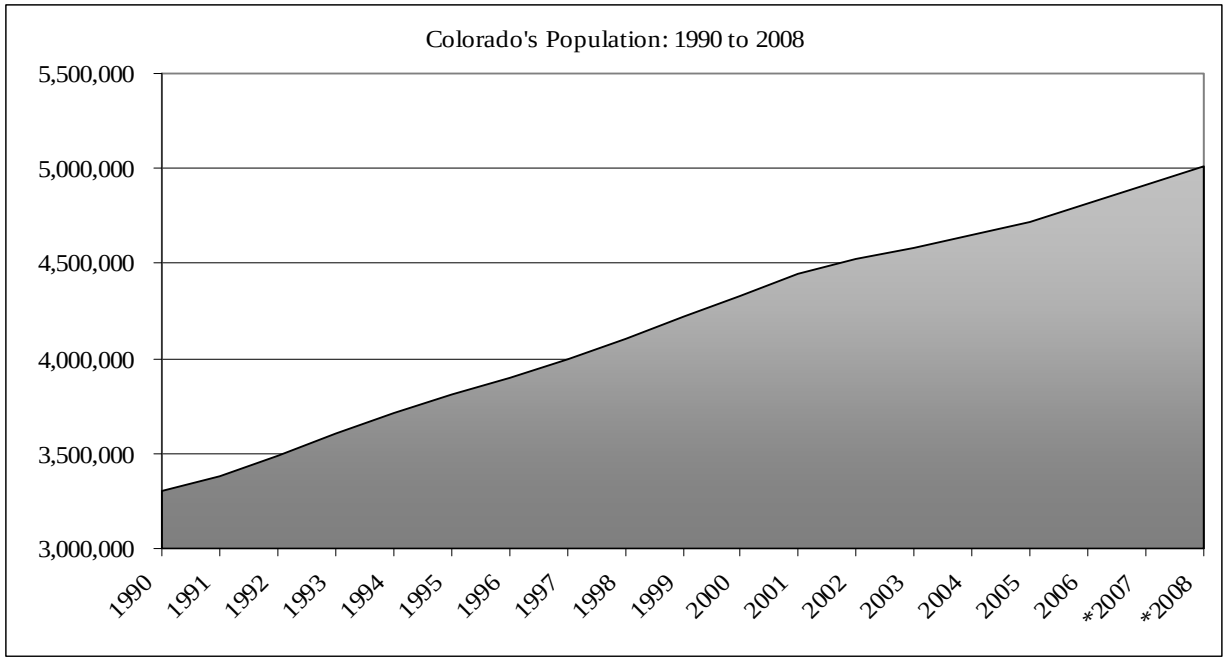
The charts below show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 1997-98 and FY 2007-08. As a percentage of the entire Medicaid caseload, Eligible Children have increased by eight percentage points, the largest gain when compared with all other categories. The percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined six percentage points, and Adults 65 and Older (OAP-A) has decreased by five percentage points. 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) Adults 65 and Older (OAP-A)) 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 22.1% from July of 1998 to July of 2008. The Department of Local Affairs forecasts that Colorado's population will increase a further 4.0% from July of 2008 to July of 2010. 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.

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 24,893[2]. An increase of 24,893 persons in a population of over 4.5 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 52,346 in 2006, to overtake natural increase (births minus deaths) as the major component of population growth. In-state migration is projected to remain high throughout the forecast period.

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

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 1998 to 2008, Colorado's median age increased by 2.0 years.[3] This may be the result of retirees moving to the State, increased longevity, or fewer births. Regardless of the reason, an aging population has a direct effect on the demand for medical services, 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.[4] This suggests that Colorado will have more elderly adults per one working adult in 2025 than any other state. In 2007, Colorado did experience increases in the eligibility categories that include older individuals, though the growth was not as high as population growth in the general population aged 60 and over. This may be the result of a healthier aging population and demographic factors, such as the elderly population working longer and the baby-boom generation not yet reaching retirement age.

Length of Stay- Medicaid caseload is not only affected by the number of individuals served, but also the length of time they remain in the program. 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 on Medicaid dropped by 10.6% for adults and 8.5% for children between FY 2003-04 FY 2004-05, and in FY 2005-06 increased to levels near those for FY 2003-04. As caseload declined in FY 2006-07, the average length of stay has also dropped from FY 2005-06. This data will be updated to include the FY 2007-08 length of stay information in its February 15, 2009 Budget Request.

Average Number of Months on Medicaid

Fiscal Year	Categorically Eligible Low-Income Adults	Eligible Children
FY 1999-00	6.78	8.29
FY 2000-01	6.87	8.29
FY 2001-02	7.20	8.51
FY 2002-03	7.66	8.71
FY 2003-04	7.84	8.99
FY 2004-05	7.01	8.23
FY 2005-06	7.85	8.72
FY 2006-07	7.73	8.57

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

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 2008, the over the year gain was estimated to be 30,800, or 1.3%. This is a decline from July 2007, when over the year growth was 56,700, or 2.5%. Job growth is projected to be average approximately 1.7% throughout the forecast period.

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

Year	Wage and Salary Income (billions)	Non-Agricultural Employment	Employment Growth	Unemployment Rate
2003	$88.00	2,152,800	-1.40%	6.10%
2004	$92.10	2,179,600	1.20%	5.60%
2005	$97.40	2,226,000	2.10%	5.20%
2006	$104.40	2,279,100	2.40%	4.30%
2007	$110.60	2,330,200	2.20%	3.80%
2008	$116.80	2,362,600	1.40%	4.70%
2009	$123.50	2,400,200	1.60%	4.50%
2010	$130.90	2,446,700	1.90%	4.30%
2011	$138.80	2,497,300	2.10%	4.20%

While the economic outlook remains relatively promising for the State as a whole, it is less encouraging for Medicaid for several reasons. First, the timing of an economic cycle is important in estimating the impact on the Medicaid caseload. As the economy recovers from a downturn, workers need to find jobs in order to withdraw from the Medicaid rolls. Jobs that primarily affect family and children Medicaid populations[6] are hourly and concentrated in the service industry. These employment types are often the last to benefit from improving economic conditions. Therefore, any economic impact on the Medicaid caseload will have a lagged effect.

[5] Source: Office of State Planning and Budgeting, June 2008 Revenue Forecast
[6] Projecting elderly and disabled client populations does not prioritize economic variables

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 for 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 June 30, 2009. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2009-10. As illustrated in the following table, the average number of adults and children on Transitional Medicaid increased dramatically in FY 2004-05. The Department suspects that the high growth in FY 2004-05 and FY 2005-06 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 Transitional Medicaid caseload will remain stable given projected economic conditions.

Fiscal Year	Average Number of Eligible Children on Transitional Medicaid	Average Number of Adults on Transitional Medicaid
FY 2002-03	7,645	4,689
FY 2003-04	7,349	4,709
FY 2004-05	10,776	6,586
FY 2005-06	16,749	10,745
FY 2006-07	16,222	10,106
FY 2007-08	13,222	8,027

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.

- 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 discontinued 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 are made to the Eligible Children forecasts to account for the approval of two FY 2008-09 Department Budget Requests. In the November 1, 2008 Decision Item #3A "Additional Children's Basic Health Plan Outreach", the Department requested funding to expand current Children's Basic Health Plan outreach efforts to find eligible but not enrolled children. Because Children's Basic Health Plan children must first be determined ineligible for Medicaid, such outreach is also expected to result in additional Medicaid caseload. Per the Department's request, estimates for Eligible Children are increased by 4,000 in FY 2008-09 and 4,104 in FY 2009-10. In the February 15, 2008 Budget Amendment #A1A "Building Blocks to Health Care Reform", the Department requested funding to implement a medical home program for children in Medicaid. This request includes caseload increases of 1,967 in FY 2008-09 and 4,014 in FY 2009-10 due to an anticipated increase in the length of stay arising from higher levels and quality of care.

Off-line adjustments are also made to the FY 2008-09 and FY 2009-10 Foster Care forecasts to account for the passage of SB 08-099 *(Extend Medicaid Foster Care)*. This bill expands Medicaid eligibility through age 20 for children whom state subsidized adoption assistance or foster care maintenance payments are made. This bill supplements SB 07-002, which expanded eligibility through age 20 for children receiving Title IV-E foster care or adoption assistance payments. Based on the fiscal note for SB 08-099, estimates for the Foster Care category are increased by 201 clients in FY 2008-09 and 494 in FY 2009-10. 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 2002-03 and FY 2004-05. During this time, Medicaid caseload increased by 74,274 clients, growth of 22.4%. Caseload decreased in the subsequent years, resulting in a decline of 14,112, or 3.5%, between FY 2004-05 and FY 2007-08. The Department believes that the improving economic conditions are the driving factor in this decrease, as consistent monthly declines occurred in Categorically Eligible Low-Income Adults and Eligible Children, which are expected to be most affected by the economy. This trend appears to have reversed as of the second half of FY 2007-08, with significant monthly increases in the Eligible Children caseload. Given the recent trends, the Department is forecasting Medicaid caseload to increase by 7.57% in FY 2008-09 to 421,651. There are two factors that are driving a strong forecasted growth rate. First, large monthly increases experienced in the second half of FY 2007-08 are leaving the caseload at

a higher point at the beginning of FY 2008-09. Second, of the projected caseload increase of 29,689 in FY 2008-09, some 6,168 are anticipated to be the result of an eligibility expansion and Department requests and initiatives. In FY 2009-10, the trend is projected to moderate, and caseload is forecasted to increase by 3.17% and reach 435,038. The following table shows actual and projected aggregate Medicaid caseload from FY 2002-03 through FY 2010-11. As in FY 2008-09, Department expansions and initiatives are a large factor in this projected growth rate, accounting for 8,612 of the projected 13,387 caseload increase in FY 2009-10.

Fiscal Year	Medicaid Caseload	Growth Rate	Level Growth
FY 2002-03	331,800	-	-
FY 2003-04	367,559	10.78%	35,759
FY 2004-05	406,024	10.46%	38,465
FY 2005-06	402,218	-0.94%	(3,806)
FY 2006-07	392,228	-2.48%	(9,990)
FY 2007-08	391,962	-0.07%	(266)
FY 2008-09 projection	421,651	7.57%	29,689
FY 2009-10 projection	435,038	3.17%	13,387

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 2008 and historical and forecasted economic and demographic data that were revised in June 2008 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 2008, 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 2006-07 and FY 2007-08.

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.

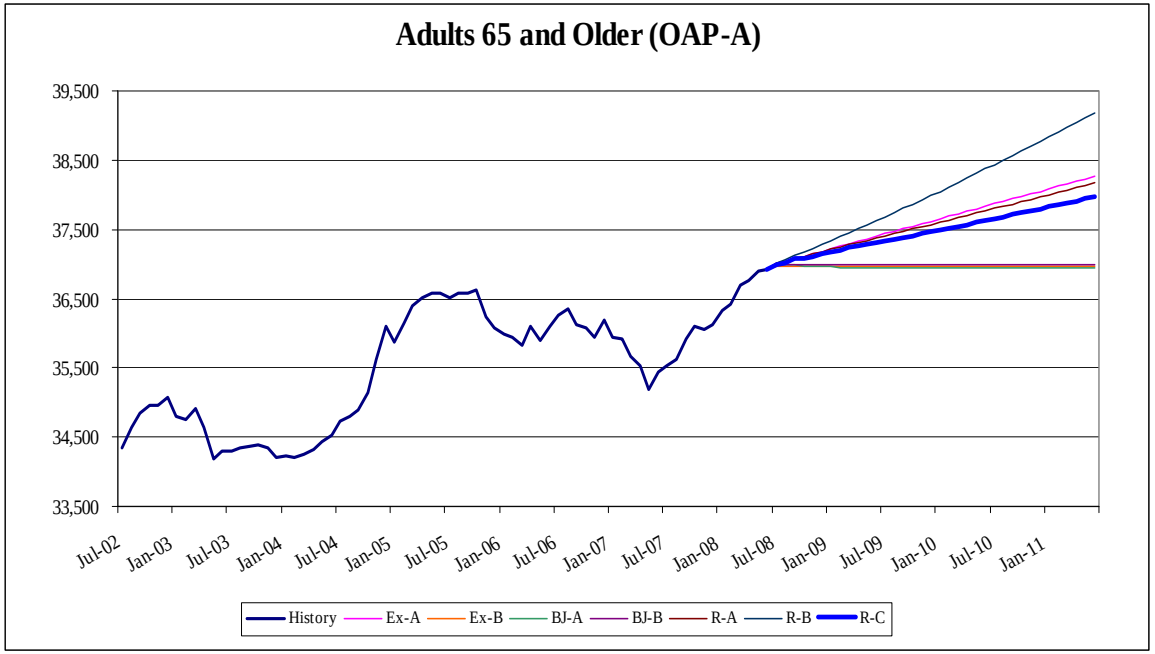
CATEGORICAL PROJECTIONS

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 2010-11 projections are included for informational purposes. Graphical representations of caseload history to FY 2002-03 are included in each categorical section.

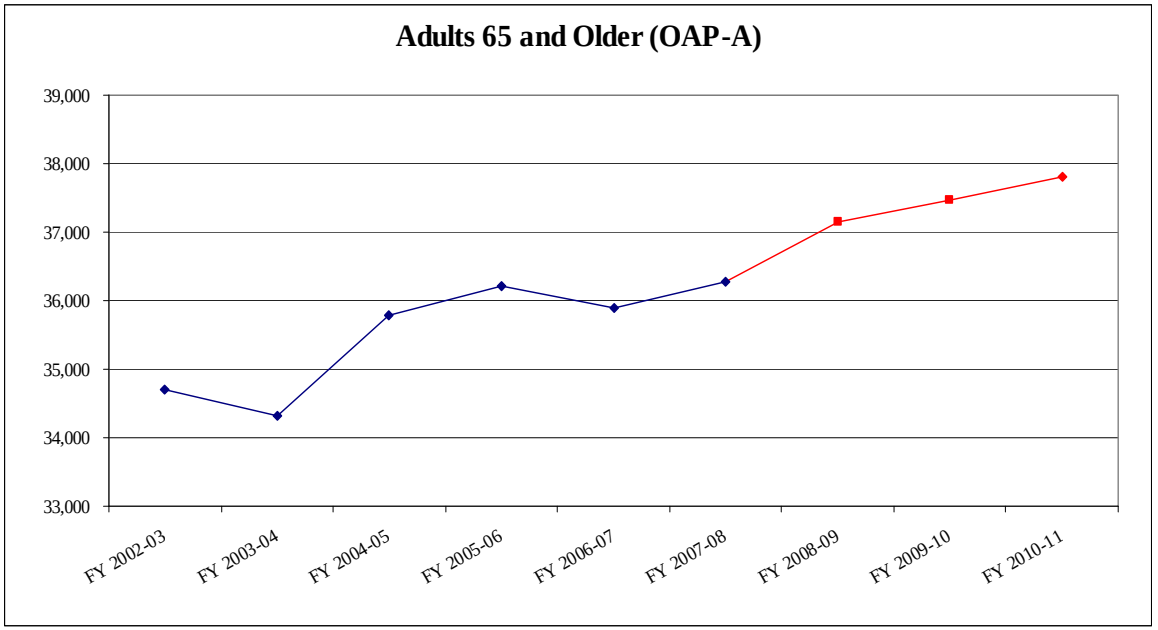
Adults 65 and Older

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



Adults 65 and Older: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9943	
Exponential Smoothing B	0.9707	
Box-Jenkins A*	0.9948	
Box-Jenkins B*	0.9737	
Regression A	0.9949	OAP-A [-1], OAP-A [-2], CBMS Dummy, Auto [-1]
Regression B	0.9947	OAP-A [-1], Population 65+, CBMS Dummy, Trend
Regression C	0.9934	OAP-A [-1], Total Population, CBMS Dummy, Trend, Auto [-11]



Adults 65 and Older: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	35,888	36,284	2.53%	37,202	918	36
Exponential Smoothing B	35,888	36,284	1.88%	36,966	682	0
Box Jenkins A	35,888	36,284	1.86%	36,959	675	(3)
Box Jenkins B*	35,888	36,284	1.96%	36,995	711	2
Regression A	35,888	36,284	2.51%	37,195	911	34
Regression B	35,888	36,284	2.84%	37,314	1,030	54
Regression C	**35,888**	**36,284**	**2.40%**	**37,155**	**871**	**29**
* Denotes Expert Selection, Bold denotes Trend Selection						
FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	36,284	37,155	1.17%	37,590	435	36
Exponential Smoothing B	36,284	37,155	0.00%	37,155	0	0
Box Jenkins A	36,284	37,155	-0.07%	37,129	(26)	0
Box Jenkins B*	36,284	37,155	0.00%	37,155	0	0
Regression A	36,284	37,155	1.06%	37,549	394	33
Regression B	36,284	37,155	1.90%	37,861	706	62
Regression C	**36,284**	37,155	**0.87%**	**37,478**	**323**	**26**

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	37,155	37,478	1.15%	37,909	431	36
Exponential Smoothing B	37,155	37,478	0.00%	37,478	0	0
Box Jenkins A	37,155	37,478	0.00%	37,478	0	0
Box Jenkins B*	37,155	37,478	0.00%	37,478	0	0
Regression A	37,155	37,478	1.05%	37,872	394	33
Regression B	37,155	37,478	2.05%	38,246	768	66
Regression C	**37,155**	**37,478**	**0.88%**	**37,808**	**330**	**29**

[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 2008-09: 2.40%
FY 2009-10: 0.87%
FY 2010-11: 0.88%

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 calendar year 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 2007-08, approximately 32.9% of this eligibility type received Supplemental Security Income and were automatically eligible for Medicaid (source: Medicaid Management Information System query).
- This population may be affected 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 above shows that historically, this population has had relatively flat growth, though monthly growth was strong in FY 2007-08. Between FY 2002-03 and FY 2006-07, the caseload increased by an average of 19 clients per month, compared with 122 in FY 2007-08. Historical growth rates are stable and tend to fluctuate between 1% and 2%. The Department suspects that the high growth rate in FY 2004-05 is due to the court order regarding the Colorado Benefits Management System. The Department speculates that the decline in FY 2006-07 may be indicative that the effects of the asset and annuities provisions in the Deficit Reduction Act may be stronger than expected. The reasons for the large increases in FY 2007-08 are not known at this time, and the Department believes that growth substantially above historical levels is unlikely to continue.
- Growth in FY 2007-08 was higher than the Department's February 2008 forecast, in which the caseload was projected to be 35,858. The low annual growth in FY 2007-08 relative to the monthly increases reflects the large declines at the end of FY 2006-07, which left caseload at a lower starting point for FY 2007-08. The selected trend for FY 2008-09 is higher than that from the

February 2008 forecast, and would yield average growth of 29 clients per month for FY 2008-09. This higher forecasted growth rate reflects the growth experienced during FY 2007-08, and a return to longer-term monthly growth trends.

- Out-year trends are moderately positive to reflect the aging population, and are slightly lower than long-term trends to reflect the Deficit Reduction provisions, which may negatively affect caseload.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
(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

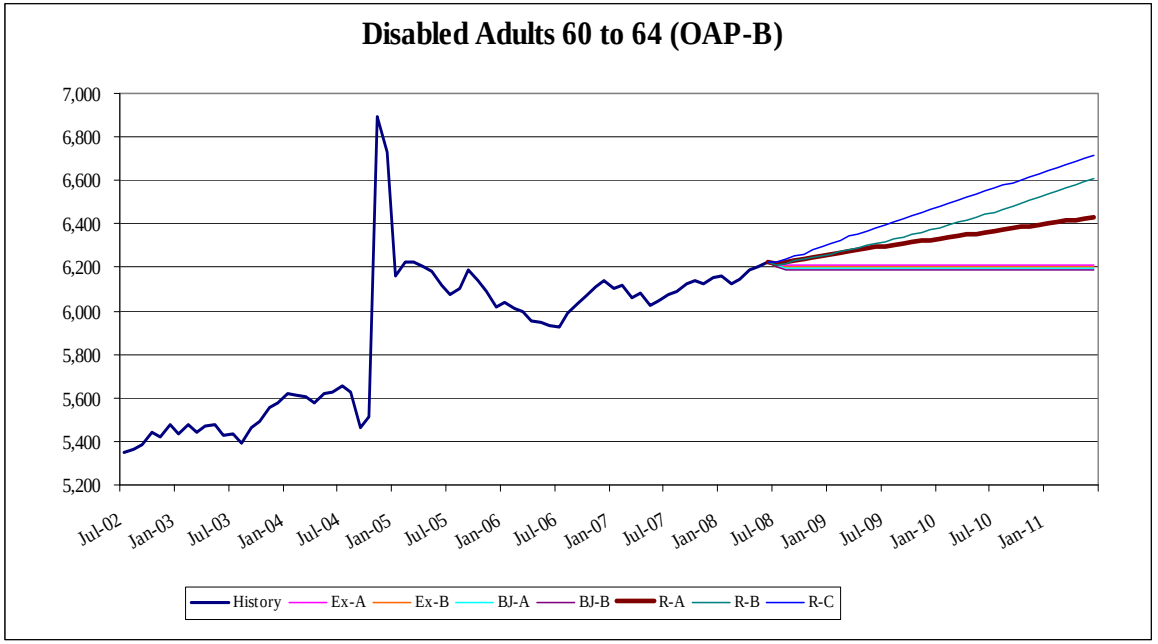
Adults 65 and Older: Historical Caseload and Projections								
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	36,103	-	-		FY 2002-03	34,704	-	-
Jul-06	36,264	161	0.45%		FY 2003-04	34,329	-1.08%	(375)
Aug-06	36,356	92	0.25%		FY 2004-05	35,780	4.23%	1,451
Sep-06	36,113	(243)	-0.67%		FY 2005-06	36,207	1.19%	427
Oct-06	36,088	(25)	-0.07%		FY 2006-07	35,888	-0.88%	(319)
Nov-06	35,939	(149)	-0.41%		FY 2007-08	36,284	1.10%	396
Dec-06	36,195	256	0.71%		FY 2008-09	37,155	2.40%	871
Jan-07	35,947	(248)	-0.69%		FY 2009-10	37,478	0.87%	323
Feb-07	35,929	(18)	-0.05%		FY 2010-11	37,808	0.88%	330
Mar-07	35,664	(265)	-0.74%					
Apr-07	35,526	(138)	-0.39%		**February 2008 Trends**			
May-07	35,186	(340)	-0.96%		FY 2007-08	35,858	-0.08%	(30)
Jun-07	35,448	262	0.74%		FY 2008-09	36,278	1.17%	420
Jul-07	35,532	84	0.24%		FY 2009-10	36,601	0.89%	323
Aug-07	35,624	92	0.26%					
Sep-07	35,916	292	0.82%					
Oct-07	36,104	188	0.52%		**Actuals**			
Nov-07	36,059	(45)	-0.12%				**Monthly Change**	**% Change**
Dec-07	36,126	67	0.19%		6-month average		134	0.37%
Jan-08	36,329	203	0.56%		12-month average		124	0.34%
Feb-08	36,418	89	0.24%		18-month average		41	0.11%
Mar-08	36,702	284	0.78%		24-month average		35	0.14%
Apr-08	36,771	69	0.19%					
May-08	36,897	126	0.34%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	36,932	35	0.09%		FY 2008-09	36,932	1.79%	648

Disabled Adults 60 to 64

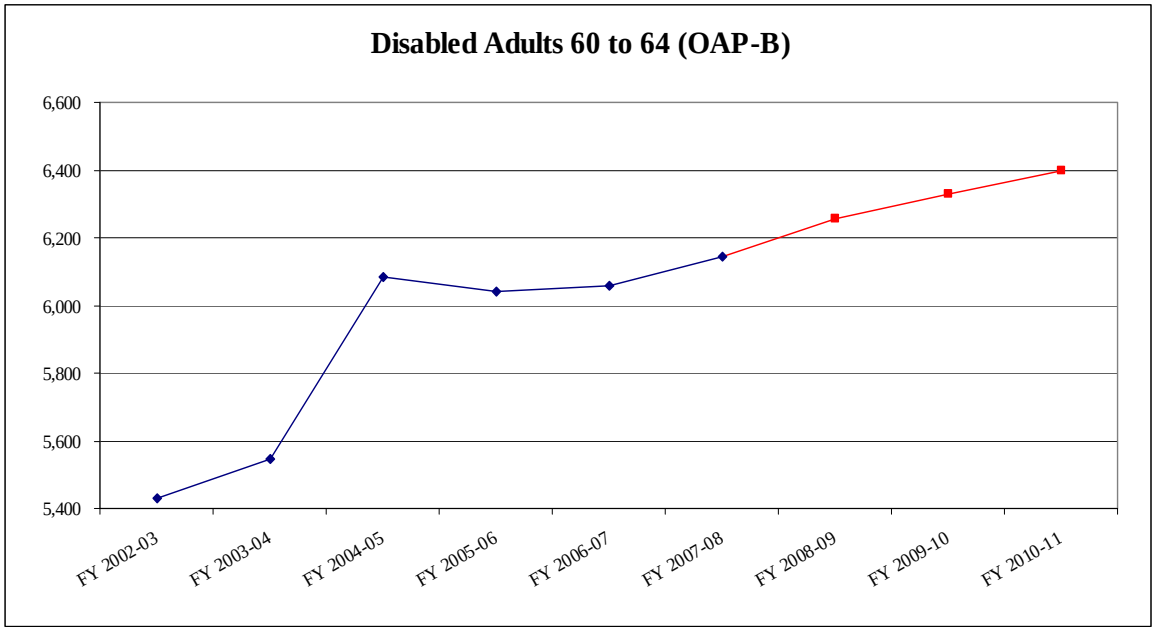
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual 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



Disabled Adults 60 to 64: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9733	
Exponential Smoothing B	0.8496	
Box-Jenkins A*	0.9770	
Box-Jenkins B*	0.8738	
Regression A	0.9955	OAP-B [-1], OAP-B [-3], CBMS Dummy, Auto [-2], Auto [-6]
Regression B	0.9958	OAP-B [-1], OAP-B [-3], Population 60-64, CBMS Dummy, Constant, Auto [-5]
Regression C	0.9950	OAP-B [-1], Total Population, CBMS Dummy, Constant, Auto [-12]



Disabled Adults 60 to 64: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	6,059	6,146	1.06%	6,211	65	0
Exponential Smoothing B*	6,059	6,146	0.96%	6,205	59	(1)
Box Jenkins A	6,059	6,146	0.83%	6,197	51	(1)
Box Jenkins B	6,059	6,146	0.67%	6,187	41	(2)
Regression A	**6,059**	**6,146**	**1.81%**	**6,257**	**111**	**7**
Regression B	6,059	6,146	1.85%	6,260	114	8
Regression C	6,059	6,146	2.54%	6,302	156	14

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	6,146	6,257	0.00%	6,257	0	0
Exponential Smoothing B*	6,146	6,257	0.00%	6,257	0	0
Box Jenkins A	6,146	6,257	-0.02%	6,256	(1)	0
Box Jenkins B	6,146	6,257	-0.03%	6,255	(2)	0
Regression A	**6,146**	6,257	**1.17%**	**6,330**	**73**	**6**
Regression B	6,146	6,257	1.90%	6,376	119	11
Regression C	6,146	6,257	2.70%	6,426	169	14

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	6,257	6,330	0.00%	6,330	0	0
Exponential Smoothing B*	6,257	6,330	0.00%	6,330	0	0
Box Jenkins A	6,257	6,330	0.00%	6,330	0	0
Box Jenkins B	6,257	6,330	0.02%	6,331	1	0
Regression A	**6,257**	**6,330**	**1.11%**	**6,400**	**70**	**6**
Regression B	6,257	6,330	2.37%	6,480	150	14
Regression C	6,257	6,330	2.58%	6,493	163	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 2008-09: 1.81%
FY 2009-10: 1.17%
FY 2010-11: 1.11%

Disabled Adults 60 to 64: Justifications

- 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 to 59 (AND/AB) population, while the remaining 449 clients came from the Adults 65 and Older (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 4 clients per month since FY 2002-03, excluding the level shift that occurred from the court order regarding the Colorado Benefits Management System. 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 calendar year 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, approximately 57.3% of this population received Supplemental Security Income and are therefore automatically Medicaid eligible in FY 2007-08 (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 32.9% of the population received Supplemental Security Income in FY 2007-08.
- Growth in FY 2007-08 was slightly lower than the Department's February 2008 forecast, in which caseload was projected to be 6,127. The selected trend for FY 2008-09 is slightly higher than that from the February 2008 forecast, and would yield average growth of 7 clients per month for FY 2008-09. This forecasted growth rate reflects a return to longer-term monthly growth trends.

- Out-year trends are moderate, as this population may become affected by a larger portion of the baby boom generation over the next 5 years. This age group is forecasted to be the fastest growing population in Colorado, with projected growth of an average of approximately 8.2% per year over the forecast period.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
(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

Disabled Adults 60 to 64: Historical Caseload and Projections								
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	5,933	-	-		FY 2002-03	5,431	-	-
Jul-06	5,927	(6)	-0.10%		FY 2003-04	5,548	2.15%	117
Aug-06	5,989	62	1.05%		FY 2004-05	6,082	9.63%	534
Sep-06	6,032	43	0.72%		FY 2005-06	6,042	-0.66%	(40)
Oct-06	6,067	35	0.58%		FY 2006-07	6,059	0.28%	17
Nov-06	6,113	46	0.76%		FY 2007-08	6,146	1.44%	87
Dec-06	6,141	28	0.46%		FY 2008-09	6,257	1.81%	111
Jan-07	6,102	(39)	-0.64%		FY 2009-10	6,330	1.17%	73
Feb-07	6,116	14	0.23%		FY 2010-11	6,400	1.11%	70
Mar-07	6,064	(52)	-0.85%					
Apr-07	6,083	19	0.31%		**February 2008 Trends**			
May-07	6,028	(55)	-0.90%		FY 2007-08	6,127	1.12%	68
Jun-07	6,048	20	0.33%		FY 2008-09	6,216	1.45%	89
Jul-07	6,073	25	0.41%		FY 2009-10	6,283	1.08%	67
Aug-07	6,091	18	0.30%					
Sep-07	6,124	33	0.54%					
Oct-07	6,141	17	0.28%		**Actuals**			
Nov-07	6,127	(14)	-0.23%				**Monthly Change**	**% Change**
Dec-07	6,150	23	0.38%		6-month average		13	0.21%
Jan-08	6,158	8	0.13%		12-month average		15	0.24%
Feb-08	6,128	(30)	-0.49%		18-month average		5	0.08%
Mar-08	6,145	17	0.28%		24-month average		12	0.10%
Apr-08	6,188	43	0.70%					
May-08	6,203	15	0.24%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	6,227	24	0.39%		FY 2008-09	6,227	1.32%	81

Disabled Individuals to 59

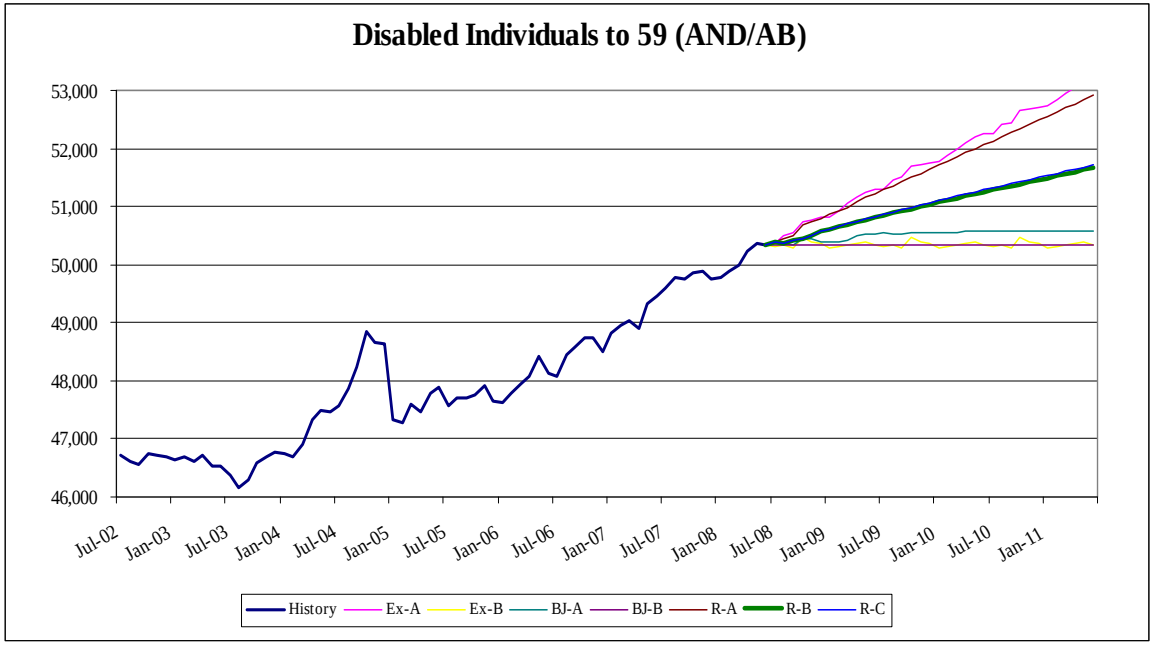
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual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

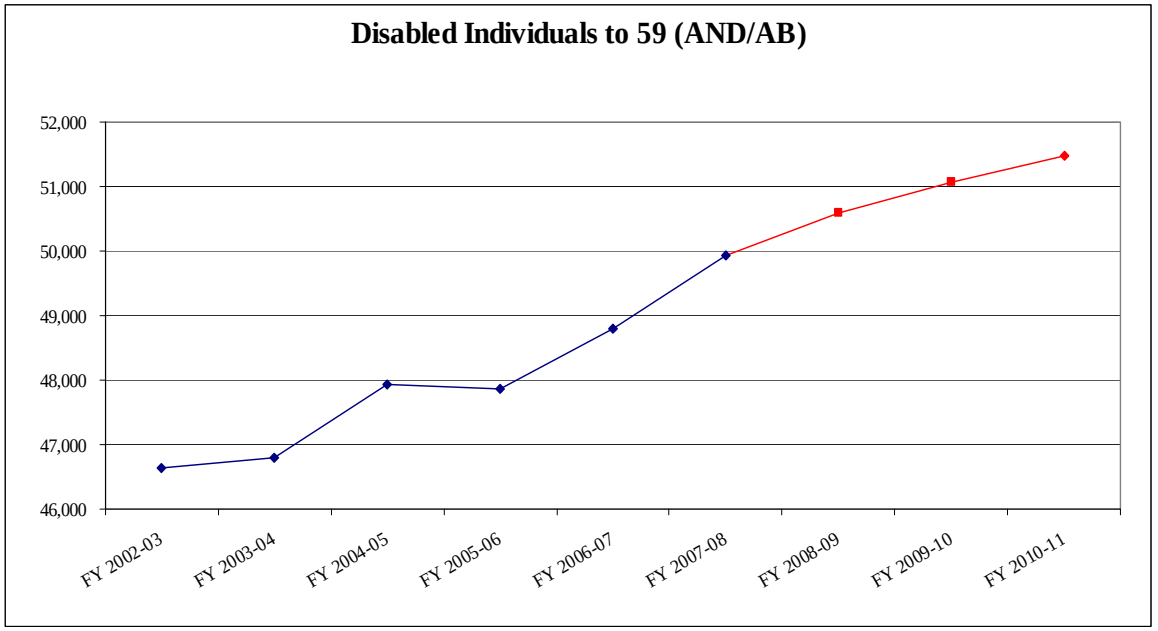
The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults. Zebley required that children's disability be measured using child appropriate activities. As a result, the number of children determined to be disabled significantly 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.

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.

Disabled Individuals to 59: Model Results



Disabled Individuals to 59: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9935	
Exponential Smoothing B*	0.9643	
Box-Jenkins A	0.9930	
Box-Jenkins B	0.9623	
Regression A	0.9888	AND/AB [-1], Auto [-6]
Regression B	0.9691	AND/AB [-1], AND/AB [-24], Migration, Auto [-4]
Regression C	0.9692	AND/AB [-1], AND/AB [-24], Auto [-4]



Disabled Individuals to 59: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	48,799	49,933	1.84%	50,852	919	79
Exponential Smoothing B*	48,799	49,933	0.83%	50,347	414	0
Box Jenkins A	48,799	49,933	0.99%	50,427	494	15
Box Jenkins B	48,799	49,933	0.82%	50,342	409	0
Regression A	48,799	49,933	1.77%	50,817	884	73
Regression B	**48,799**	**49,933**	**1.30%**	**50,582**	**649**	**39**
Regression C	48,799	49,933	1.31%	50,587	654	40

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	49,933	50,582	1.87%	51,528	946	79
Exponential Smoothing B*	49,933	50,582	0.00%	50,582	0	0
Box Jenkins A	49,933	50,582	0.24%	50,703	121	4
Box Jenkins B	49,933	50,582	0.00%	50,582	0	0
Regression A	49,933	50,582	1.69%	51,437	855	70
Regression B	**49,933**	50,582	**0.94%**	**51,057**	**475**	**36**
Regression C	49,933	50,582	0.98%	51,078	496	38

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	50,582	51,057	1.83%	51,991	934	79
Exponential Smoothing B*	50,582	51,057	0.00%	51,057	0	0
Box Jenkins A	50,582	51,057	0.06%	51,088	31	1
Box Jenkins B	50,582	51,057	0.00%	51,057	0	0
Regression A	50,582	51,057	1.64%	51,894	837	71
Regression B	**50,582**	**51,057**	**0.83%**	**51,481**	**424**	**35**
Regression C	50,582	51,057	0.86%	51,496	439	35

[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 2008-09: 1.30%
FY 2009-10: 0.94%
FY 2010-11: 0.83%

Disabled Individuals to 59: Justifications

- As the graph above shows, caseload growth through FY 2003-04 remained relatively constant, with average monthly growth of 32 clients in FY 2002-03 and FY 2003-04. The elimination of the Med-9 disability determination has also contributed to slower growth.
- 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 2005-06. 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 FY 2007-08.
- 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; economic conditions play a smaller role in the size of this population. In FY 2007-08, approximately 68.8% of this population received Supplemental Security Income and are therefore automatically Medicaid eligible (source: Medicaid Management Information System query).
- Growth in FY 2007-08 was in line with the February 2008 forecast, in which caseload was projected to be 49,626. The selected trend for FY 2008-09 is lower than that from the February 2008 forecast, and would yield average growth of 39 clients per month for FY 2008-09. This lower forecasted growth rate reflects the moderating monthly growth experienced in FY 2007-08, and reflects a return to a longer-term trend.
- Out-year growth is projected to maintain a long-term trend.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
(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

Disabled Individuals to 59: Historical Caseload and Projections								
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	48,142	-	-		FY 2002-03	46,647	-	-
Jul-06	48,080	(62)	-0.13%		FY 2003-04	46,789	0.30%	142
Aug-06	48,443	363	0.75%		FY 2004-05	47,929	2.44%	1,140
Sep-06	48,576	133	0.27%		FY 2005-06	47,855	-0.15%	(74)
Oct-06	48,747	171	0.35%		FY 2006-07	48,799	1.97%	944
Nov-06	48,736	(11)	-0.02%		FY 2007-08	49,933	2.32%	1,134
Dec-06	48,498	(238)	-0.49%		FY 2008-09	50,582	1.30%	649
Jan-07	48,829	331	0.68%		FY 2009-10	51,057	0.94%	475
Feb-07	48,948	119	0.24%		FY 2010-11	51,481	0.83%	424
Mar-07	49,044	96	0.20%					
Apr-07	48,903	(141)	-0.29%		**February 2008 Trends**			
May-07	49,337	434	0.89%		FY 2007-08	49,626	1.69%	827
Jun-07	49,449	112	0.23%		FY 2008-09	50,058	0.87%	432
Jul-07	49,590	141	0.29%		FY 2009-10	50,108	0.10%	50
Aug-07	49,768	178	0.36%					
Sep-07	49,743	(25)	-0.05%					
Oct-07	49,853	110	0.22%		**Actuals**			
Nov-07	49,889	36	0.07%				**Monthly Change**	**% Change**
Dec-07	49,741	(148)	-0.30%		6-month average		102	0.20%
Jan-08	49,785	44	0.09%		12-month average		75	0.15%
Feb-08	49,891	106	0.21%		18-month average		103	0.21%
Mar-08	49,989	98	0.20%		24-month average		92	0.17%
Apr-08	50,237	248	0.50%					
May-08	50,358	121	0.24%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	50,351	(7)	-0.01%		FY 2008-09	50,351	0.84%	418

Categorically Eligible Low-Income Adults

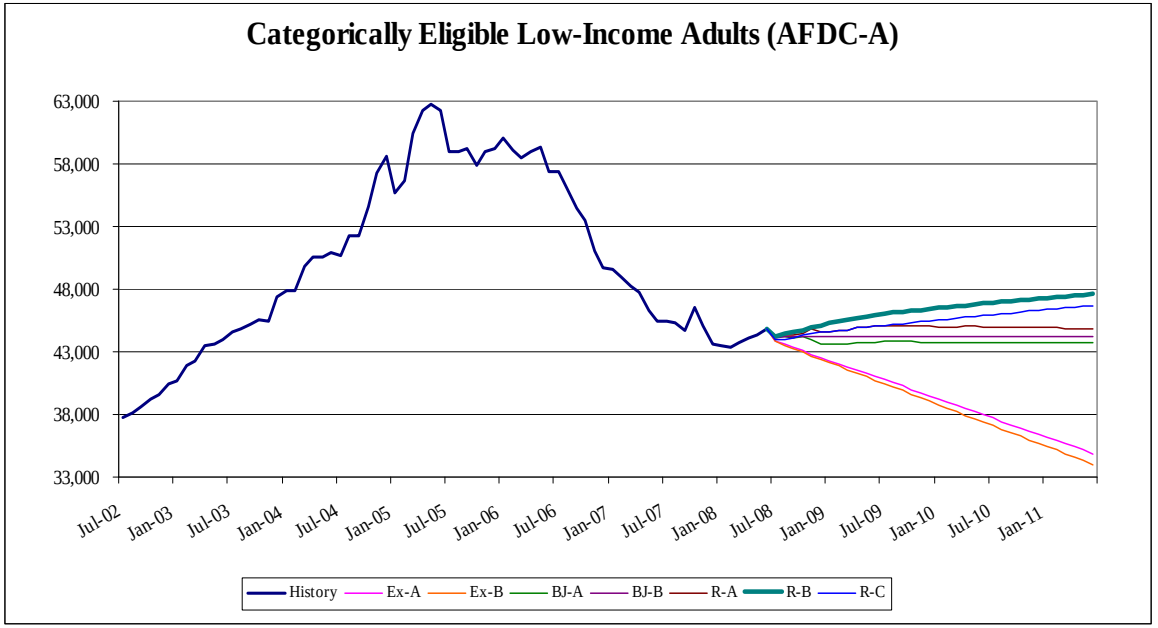
One of the primary ways that adults qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 2007-08, there were an average of 8,027 adults in this program. Transitional Medicaid benefits have been extended through July 30, 2009, and the Department's forecast assumes that the program will continue through FY 2009-10.

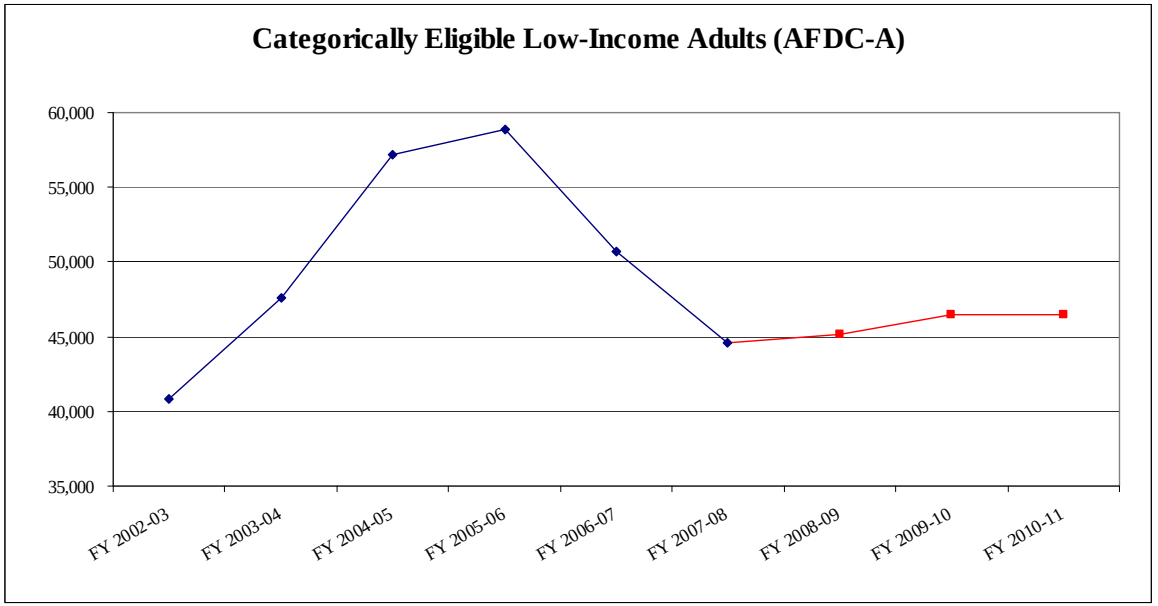
Before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash 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[7] 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 2001-02. For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Budget Request, pages A-37 to A-38.

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

Categorically Eligible Low-Income Adults: Model Results



Categorically Eligible Low-Income Adults: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9940	
Exponential Smoothing B*	0.9888	
Box-Jenkins A	0.9957	
Box-Jenkins B	0.9885	
Regression A	0.9951	AFDC-A [-1], Unemployment Rate, CBMS Dummy, Systems Dummy, Auto [-12]
Regression B	0.9948	AFDC-A [-1], Unemployment Rate, Services Wages, CBMS Dummy, Systems Dummy
Regression C	0.9952	AFDC-A [-1], Population 19-59, CBMS Dummy, Systems Dummy, Auto [-6]



Categorically Eligible Low-Income Adults: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	50,687	44,555	-4.76%	42,434	(2,121)	(254)
Exponential Smoothing B*	50,687	44,555	-5.12%	42,274	(2,281)	(278)
Box Jenkins A*	50,687	44,555	-1.54%	43,869	(686)	(25)
Box Jenkins B	50,687	44,555	-0.85%	44,176	(379)	7
Regression A	50,687	44,555	0.20%	44,644	89	77
Regression B	**50,687**	**44,555**	**1.36%**	**45,161**	**606**	**152**
Regression C	50,687	44,555	0.00%	44,555	0	80

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	44,555	45,161	-7.23%	41,896	(3,265)	(254)
Exponential Smoothing B*	44,555	45,161	-7.95%	41,571	(3,590)	(278)
Box Jenkins A*	44,555	45,161	-0.28%	45,035	(126)	(5)
Box Jenkins B	44,555	45,161	0.00%	45,161	0	0
Regression A	44,555	45,161	0.87%	45,554	393	(1)
Regression B	**44,555**	**45,161**	**2.84%**	**46,444**	**1,283**	**75**
Regression C	44,555	45,161	2.14%	46,127	966	69

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	45,161	46,444	-7.80%	42,821	(3,623)	(254)
Exponential Smoothing B*	45,161	46,444	-8.63%	42,436	(4,008)	(278)
Box Jenkins A*	45,161	46,444	-0.05%	46,421	(23)	(1)
Box Jenkins B	45,161	46,444	0.00%	46,444	0	0
Regression A	45,161	46,444	-0.27%	46,319	(125)	(17)
Regression B	45,161	46,444	1.79%	47,275	831	64
Regression C	45,161	46,444	1.82%	47,289	845	67

[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 2008-09: 1.36%
FY 2009-10: 2.84%
FY 2010-11: 0.09%

Categorically Eligible Low-Income Adults: Justifications

- Growth between FY 2002-03 and FY 2004-05 in this category was very high. During this time, annual caseload grew by an approximately 40.0%, which the Department believes is largely due to the state of the economy. The rate of growth fell to 3.05% in FY 2005-06.
- 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 1995-96 to FY 2001-02 to 1.4% per year from FY 2002-03 to FY 2007-08. The growth in this population is projected to remain at an average of 1.4% over the forecast period[8]. The economy is projected to soften over the forecast period, with the unemployment rate to increase from 3.8% in 2007 to 4.7% in 2008 and 4.5% in 2009. Personal income growth is projected to be 4.0% in 2007, 4.0% in 2008, and 4.1% in 2009[9].
- There were large and consistent declines between July 2006 and December 2007, which seems to indicate that the improved economy was having the expected effect on caseload. There is evidence that a number of clients that left this eligibility category went to the Expansion Adults, from both 1931 and Transitional Medicaid, due to increased income.
- The caseload declines in FY 2007-08 were smaller than the Department's February 2008 forecast, in which caseload was projected to be 43,878. This is largely due to an average increase of 270 in the last four months of the year. The Department believes that softening economic conditions is partially responsible for this, as the unemployment rate has increased from 4.0% in December

[8] Source: Department of Local Affairs, Demography Division
[9] Source: Office of State Planning and Budgeting, June 2008 Revenue Forecast

2007 to 5.2% in July 2008[10]. The last period during which the unemployment rate was at approximately this same level and was increasing at a similar pace was June 2001 through January 2002. During this time, the AFDC-adults caseload was increasing by approximately 1.0% per month. The selected trend for FY 2008-09 is higher than that from the February 2008 forecast, and would yield average increases of 152 clients per month for FY 2008-09. This higher forecast is reflective of the monthly increases in the second half of FY 2007-08, which marked a change in trend from the first half of the year. Because the economy is believed to be at least partially responsible this change, the Department believes that the flat and moderate economic conditions throughout the forecast period give no indication that the trend will not be slightly positive in FY 2008-09.

- Out-year trend selections are expected to be temper, reflecting the moderating economy. FY 2010-11 trend assumes zero growth from the June 2010 level.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
(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;

[10] Source: Bureau of Labor Statistics

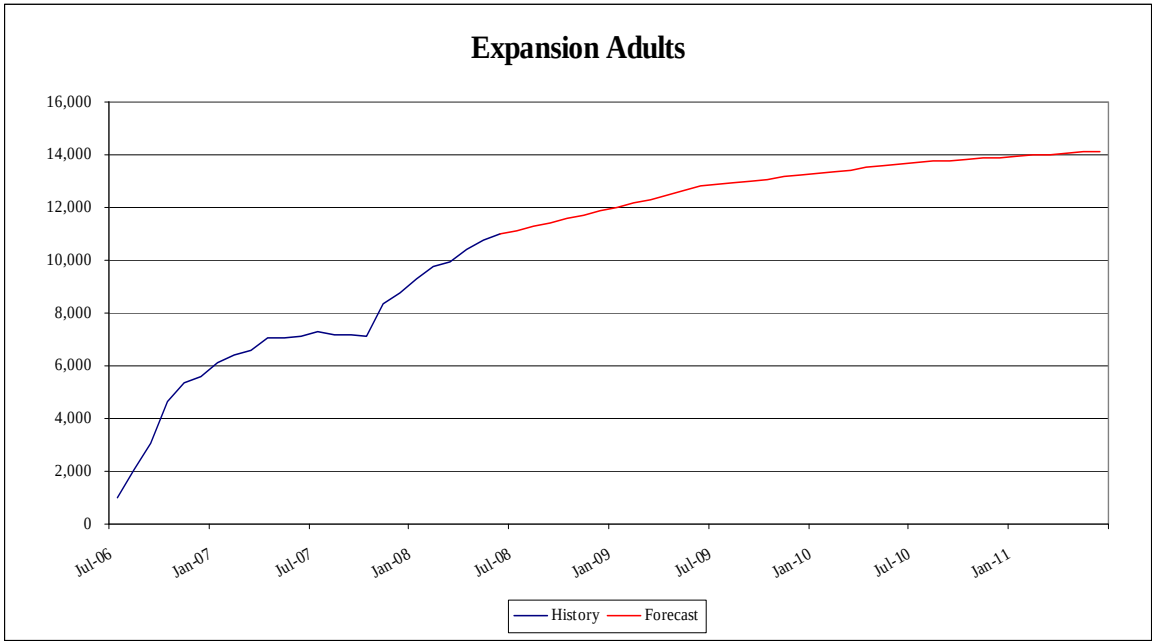
Categorically Eligible Low-Income Adults: Historical Caseload and Forecasts

Categorically Eligible Low-Income Adults: Historical Caseload and Projections							
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	57,330	-	-		FY 2002-03	40,798	-	-
Jul-06	57,372	42	0.07%		FY 2003-04	47,562	16.58%	6,764
Aug-06	56,033	(1,339)	-2.33%		FY 2004-05	57,140	20.14%	9,578
Sep-06	54,433	(1,600)	-2.86%		FY 2005-06	58,885	3.05%	1,745
Oct-06	53,443	(990)	-1.82%		FY 2006-07	50,687	-13.92%	(8,198)
Nov-06	50,988	(2,455)	-4.59%		FY 2007-08	44,555	-12.10%	(6,132)
Dec-06	49,733	(1,255)	-2.46%		FY 2008-09	45,161	1.36%	606
Jan-07	49,624	(109)	-0.22%		FY 2009-10	46,444	2.84%	1,283
Feb-07	48,952	(672)	-1.35%		FY 2010-11	46,486	0.09%	42
Mar-07	48,235	(717)	-1.46%					
Apr-07	47,717	(518)	-1.07%		**February 2008 Trends**			
May-07	46,245	(1,472)	-3.08%		FY 2007-08	43,878	-13.43%	(6,809)
Jun-07	45,470	(775)	-1.68%		FY 2008-09	41,667	-5.04%	(2,211)
Jul-07	45,453	(17)	-0.04%		FY 2009-10	41,638	-0.07%	(29)
Aug-07	45,363	(90)	-0.20%					
Sep-07	44,739	(624)	-1.38%					
Oct-07	46,590	1,851	4.14%		**Actuals**			
Nov-07	45,100	(1,490)	-3.20%				**Monthly Change**	**% Change**
Dec-07	43,665	(1,435)	-3.18%		6-month average		190	0.43%
Jan-08	43,491	(174)	-0.40%		12-month average		(56)	-0.11%
Feb-08	43,344	(147)	-0.34%		18-month average		(274)	-0.56%
Mar-08	43,723	379	0.87%		24-month average		(522)	-0.66%
Apr-08	44,037	314	0.72%					
May-08	44,349	312	0.71%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	44,802	453	1.02%		FY 2008-09	44,802	0.55%	247

Expansion Adults

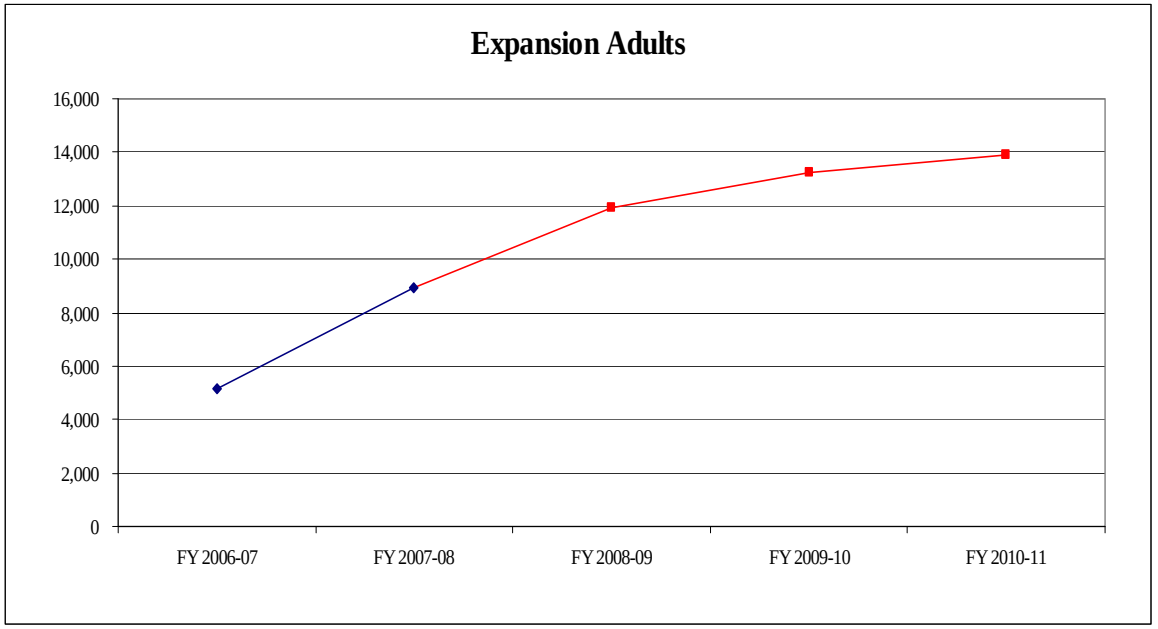
HB 05-1262 (Tobacco Tax bill) allows for expanding Medicaid eligibility to parents of children enrolled in either Medicaid or the Children's Basic Health Plan up to 60% of the federal poverty level. The increase in the percentage of allowable federal poverty level was implemented on July 1, 2006. The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

Expansion Adults: Model Results



Expansion Adults: Historical Caseload and Projections			
	Actual/ Projected Level	**Growth Rate**	**Level Change**
FY 2006-07	5,162	-	-
FY 2007-08	8,918	72.76%	3,756
FY 2008-09	11,950	34.00%	3,032
FY 2009-10	13,260	10.96%	1,310
FY 2010-11	13,913	4.92%	653

Base trend if caseload were to stay at the June 2008 level			
FY 2008-09	10,594	18.79%	1,676
February 2008 Trends			
FY 2007-08	8,151	57.90%	2,989
FY 2008-09	9,629	18.13%	1,478
FY 2009-10	10,172	5.64%	543



Growth in FY 2007-08 was much higher than the February 2008 forecast, in which the caseload was projected to be 8,151. The selected trend for FY 2008-09 is higher than that from the February 2008 forecast, and would yield average growth of 150 clients per month for FY 2008-09. This forecast is based on the average monthly change experienced between January 2007 and June 2008. During this time, caseload increased by an average of 300 clients per month. This timeframe is used for comparison because the caseload increases at the beginning of FY 2006-07 are reflective of a new population, and are assumed to not be representative of short-term future caseload growth. In addition, the Department speculates that a Colorado Benefits Management System update caused the increases between November 2007 and January 2008. The FY 2008-09 forecast assumes that this growth will decrease by one-half to 150 clients per month. The FY 2009-10 forecast assumes that growth will decrease by approximately one-half from that in FY 2008-09 to 72 clients per month, and FY 2010-11 assumes a further approximately 50% decline to average growth of 39 clients per month.

Expansion Adults Actuals			
	Actuals	**Monthly Change**	**% Change**
Jul-06	1,008	-	-
Aug-06	2,051	1,043	103.47%
Sep-06	3,051	1,000	48.76%
Oct-06	4,620	1,569	51.43%
Nov-06	5,325	705	15.26%
Dec-06	5,592	267	5.01%
Jan-07	6,124	532	9.51%
Feb-07	6,395	271	4.43%
Mar-07	6,607	212	3.32%
Apr-07	7,030	423	6.40%
May-07	7,042	12	0.17%
Jun-07	7,104	62	0.88%
FY 2006-07 Average	**5,162**	**554**	**22.60%**
Jul-07	7,273	169	2.38%
Aug-07	7,187	(86)	-1.18%
Sep-07	7,160	(27)	-0.38%
Oct-07	7,110	(50)	-0.70%
Nov-07	8,364	1,254	17.64%
Dec-07	8,783	419	5.01%
Jan-08	9,268	485	5.52%
Feb-08	9,755	487	5.25%
Mar-08	9,949	194	1.99%
Apr-08	10,395	446	4.48%
May-08	10,775	380	3.66%
Jun-08	10,995	220	2.04%
FY 2007-08 Average	**8,918**	**324**	**3.81%**

	Monthly Change	**% Change**
6-month average	369	3.82%
7-month average	376	3.99%
8-month average	486	5.70%
9-month average	426	4.99%
12-month average	324	3.81%
18-month average	300	3.91%

Expansion Adults: Justification and Monthly Projections

- This population would be expected to have a high penetration rate, as these are parents of children in either the Children's Basic Health Plan or Medicaid, which have high penetration rates.
- This population would be expected to be affected by the economy in similar ways as the AFDC-adult and children populations, although the effects are likely increased given that these clients are up to 60% of the federal poverty level, which would support higher growth rates.
- Over the last eighteen months, the Department has implemented three Centers for Medicare and Medicaid Services policy decisions affecting this eligibility type. These changes are expected to increase caseload growth, and are as follows:
    - Eligibility may be granted for children in any Medicaid program, rather than only to parents of children in a Family Medical program;
    - Eligibility may be granted to responsible relatives of children in Medicaid, rather than only custodial parents, and;
    - Children's income is excluded from the family income used to determine the eligibility of parents or responsible relatives.
- The Department expects that once this expansion has been in place for three or four years, this group will be able to be combined with the Categorically Eligible Low-Income Adults for caseload forecasting purposes. These groups are currently displaying different growth rates due to the newness of the expansion population. The groups will continue to be reported separately due to differing per capita costs.

25.5-5-201 (1), C.R.S. (2008)
(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;

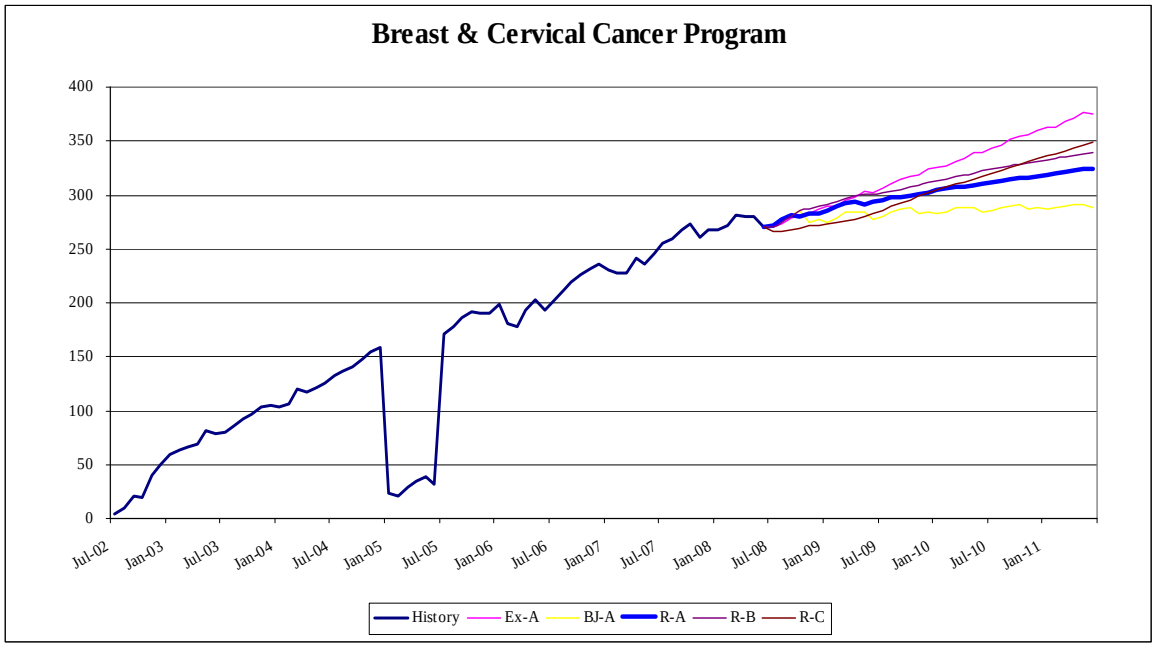
	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
July	**1,008**	**7,273**	11,135	12,869	13,698
August	**2,051**	**7,187**	11,277	12,939	13,737
September	**3,051**	**7,160**	11,421	13,009	13,776
October	**4,620**	**7,110**	11,567	13,080	13,815
November	**5,325**	**8,364**	11,714	13,151	13,854
December	**5,592**	**8,783**	11,863	13,222	13,893
January	**6,124**	**9,268**	12,014	13,294	13,932
February	**6,395**	**9,755**	12,167	13,366	13,971
March	**6,607**	**9,949**	12,322	13,439	14,010
April	**7,030**	**10,395**	12,479	13,512	14,050
May	**7,042**	**10,775**	12,638	13,585	14,090
June	**7,104**	**10,995**	12,799	13,659	14,130
Annual Average	**5,162**	**8,918**	**11,950**	**13,260**	**13,913**
Annual Growth Rate*	**604.76%**	**72.76%**	**34.00%**	**10.96%**	**4.92%**
Average Monthly Growth	**534**	**312**	**150**	**72**	**39**

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

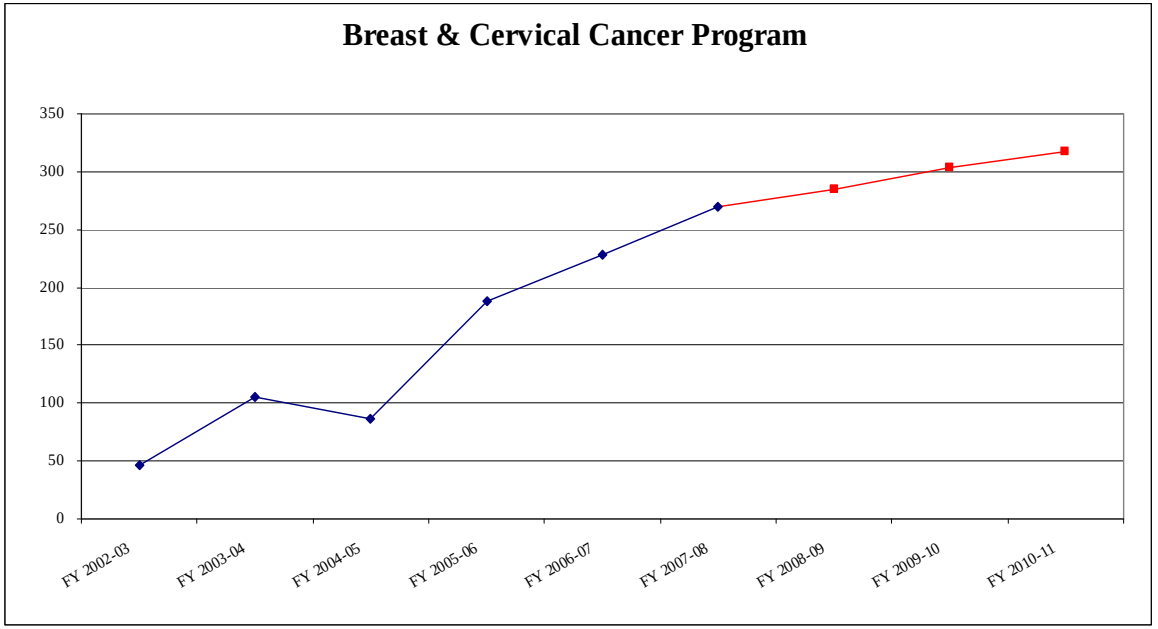
Breast and Cervical Cancer Program

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 Department of Public Health and Environment administers the screening program as a grantee of the Centers of Disease Control. Regulations for the nationwide screening program indicate that the program is for low-income women, which the Department of Public Health and Environment has interpreted to be less than 250% of the federal poverty level. To date, all 50 states have approved the option of covering these women under Medicaid.

Breast and Cervical Cancer Program: Model Results



Breast & Cervical Cancer Program: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9938	
Box-Jenkins A*	0.9933	
Regression A	0.9834	BCCP [-1], BCCP [-12], Female Population 19-59, Auto [-11]
Regression B	0.9902	BCCP [-1], BCCP [-12], Trend
Regression C	0.9932	BCCP [-1], Total Wages, Unemployment Rate, Auto [-5]



Breast & Cervical Cancer Program: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	228	270	6.67%	288	18	3
Box Jenkins *	228	270	3.33%	279	9	1
Regression A	**228**	**270**	**5.56%**	**285**	**15**	**2**
Regression B	228	270	7.04%	289	19	3
Regression C	228	270	1.11%	273	3	1

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	270	285	12.50%	321	36	3
Box Jenkins *	270	285	2.15%	291	6	1
Regression A	**270**	**285**	**6.32%**	**303**	**18**	**1**
Regression B	270	285	7.96%	308	23	2
Regression C	270	285	10.99%	316	31	3

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing	285	303	16.67%	354	51	3
Box Jenkins *	285	303	1.40%	307	4	0
Regression A	**285**	**303**	**4.95%**	**318**	**15**	**1**
Regression B	285	303	6.41%	322	19	1
Regression C	285	303	10.56%	335	32	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 2008-09: 5.56%
FY 2009-10: 6.32%
FY 2010-11: 4.95%

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 during the forecast period, 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 above 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.
- Growth in FY 2007-08 was lower than the Department's February 2008 forecast, in which caseload was projected to be 274. The selected trend for FY 2008-09 is lower than that from the February 2008 forecast, and would yield average growth of 2 clients per month for FY 2008-09.

- Out-year growth rates are projected to continue to be moderate. As a program matures, growth is expected to slow. The Department believes that the Breast and Cervical Cancer program is approaching a level of maturity where, barring unforeseen circumstances, growth of more than 15% per year should no longer expected.

25.5-5-201 (1), C.R.S. (2008)
(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

Breast & Cervical Cancer Program: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-06	193	-	-
Jul-06	202	9	4.66%
Aug-06	211	9	4.46%
Sep-06	220	9	4.27%
Oct-06	226	6	2.73%
Nov-06	232	6	2.65%
Dec-06	236	4	1.72%
Jan-07	231	(5)	-2.12%
Feb-07	228	(3)	-1.30%
Mar-07	228	0	0.00%
Apr-07	241	13	5.70%
May-07	236	(5)	-2.07%
Jun-07	246	10	4.24%
Jul-07	255	9	3.66%
Aug-07	260	5	1.96%
Sep-07	267	7	2.69%
Oct-07	273	6	2.25%
Nov-07	261	(12)	-4.40%
Dec-07	268	7	2.68%
Jan-08	268	0	0.00%
Feb-08	272	4	1.49%
Mar-08	282	10	3.68%
Apr-08	280	(2)	-0.71%
May-08	280	0	0.00%
Jun-08	270	(10)	-3.57%

	Caseload	% Change	Level Change
FY 2002-03	47	-	-
FY 2003-04	105	123.40%	58
FY 2004-05	87	-17.14%	(18)
FY 2005-06	188	116.09%	101
FY 2006-07	228	21.28%	40
FY 2007-08	270	18.42%	42
FY 2008-09	285	5.56%	15
FY 2009-10	303	6.32%	18
FY 2010-11	318	4.95%	15

February 2008 Trends

FY 2007-08	274	20.18%	46
FY 2008-09	301	9.85%	27
FY 2009-10	319	5.98%	18

Actuals

	Monthly Change	% Change
6-month average	0	0.15%
12-month average	2	0.81%
18-month average	2	0.79%
24-month average	3	0.96%

Base trend if caseload were to stay at the June 2008 level

FY 2008-09	270	0.00%	0

Eligible Children

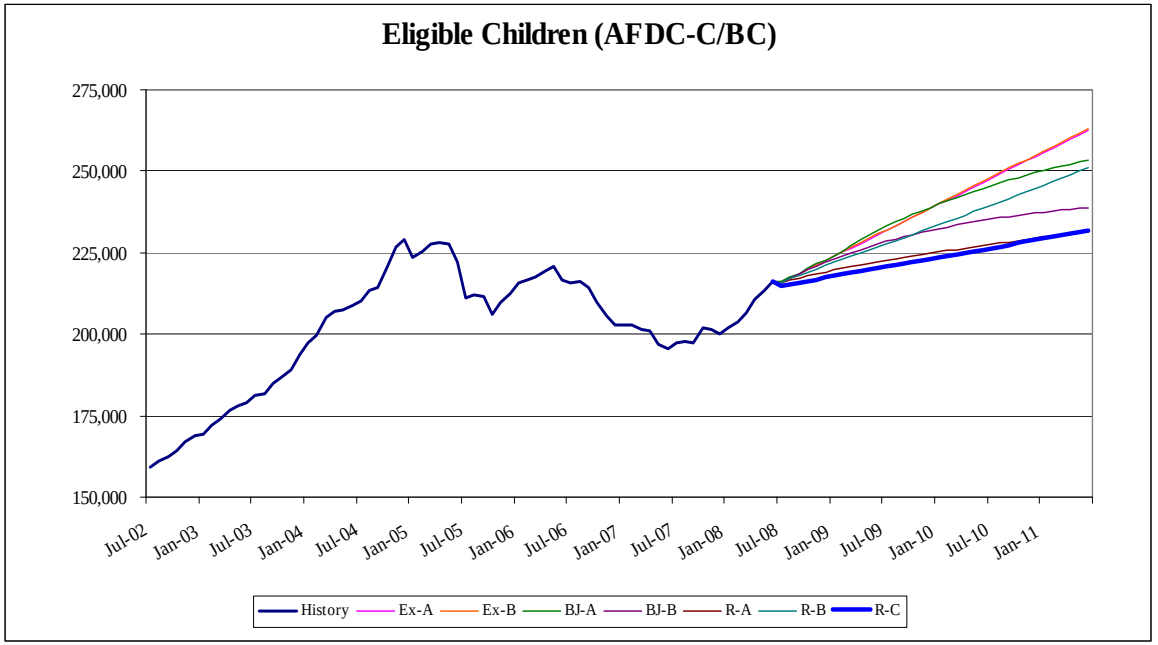
One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 2007-08, there were an average of 13,222 children on Transitional Medicaid. Authorization for Transitional Medicaid benefits was extended through June 30, 2009, and the Department's forecast assumes that the program will continue in FY 2009-10.

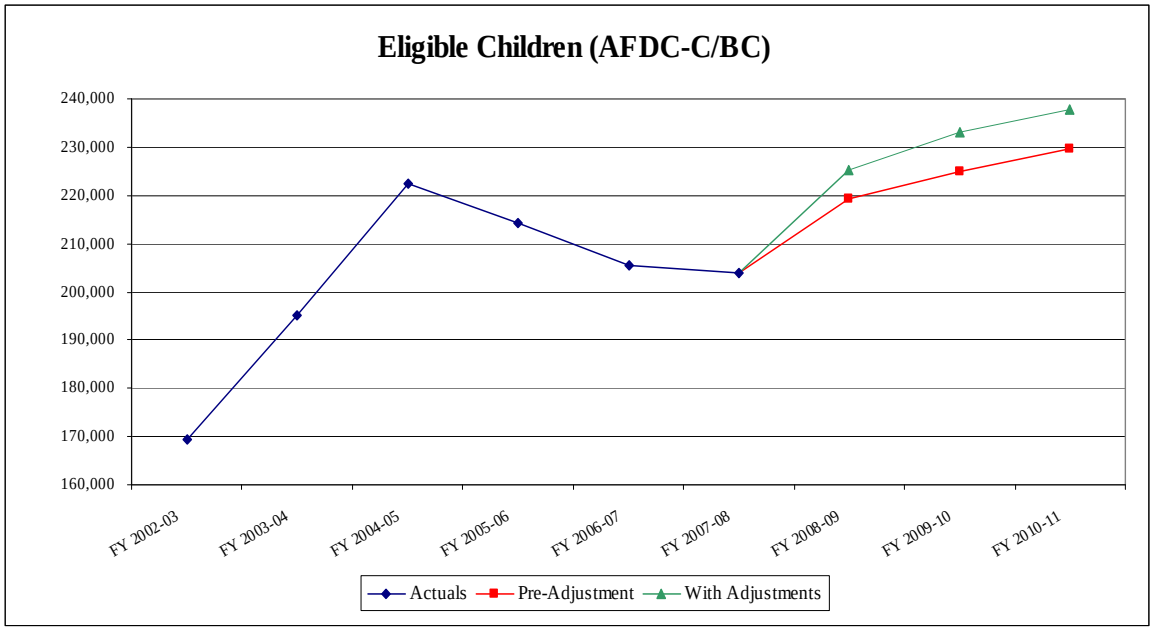
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic 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 2002-03, 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



Eligible Children: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9977	
Exponential Smoothing B	0.9937	
Box-Jenkins A	0.9983	
Box-Jenkins B	0.9938	
Regression A	0.9982	KIDS [-1], Unemployment Rate, CBMS Dummy, Systems Dummy, Auto [-2]
Regression B	0.9981	KIDS [-1], Services Employment, CBMS Dummy, Systems Dummy, Trend, Auto [-2]
Regression C	0.9975	KIDS [-1], Female Population 19-59, CBMS Dummy



Eligible Children: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	205,390	204,022	9.38%	223,159	19,137	1,320
Exponential Smoothing B	205,390	204,022	9.42%	223,241	19,219	1,333
Box Jenkins A*	205,390	204,022	9.65%	223,710	19,688	1,442
Box Jenkins B*	205,390	204,022	8.93%	222,241	18,219	1,084
Regression A	**205,390**	**204,022**	**7.46%**	**219,242**	**15,220**	**642**
Regression B	205,390	204,022	8.53%	221,425	17,403	1,012
Regression C	205,390	204,022	6.65%	217,589	13,567	473

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	204,022	219,242	7.18%	234,984	15,742	1,320
Exponential Smoothing B	204,022	219,242	7.25%	235,137	15,895	1,333
Box Jenkins A*	204,022	219,242	6.95%	234,479	15,237	1,061
Box Jenkins B*	204,022	219,242	4.36%	228,801	9,559	598
Regression A	**204,022**	**219,242**	**2.61%**	**224,964**	**5,722**	**403**
Regression B	204,022	219,242	5.28%	230,818	11,576	976
Regression C	204,022	219,242	2.65%	225,052	5,810	475

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	219,242	224,964	6.70%	240,037	15,073	1,320
Exponential Smoothing B	219,242	224,964	6.76%	240,172	15,208	1,333
Box Jenkins A*	219,242	224,964	4.38%	234,817	9,853	697
Box Jenkins B*	219,242	224,964	2.30%	230,138	5,174	330
Regression A	**219,242**	**224,964**	**2.04%**	**229,553**	**4,589**	**357**
Regression B	219,242	224,964	5.22%	236,707	11,743	1,024
Regression C	219,242	224,964	2.58%	230,768	5,804	475

[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 2008-09: 7.46%
FY 2009-10: 2.61%
FY 2010-11: 2.04%

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 1995-96 to FY 2001-02 to about 1.4% per year from FY 2002-03 to FY 2007-08. The expansion in this age group is projected to average 1.6% throughout the forecast period.[11] The economy is projected to soften over the forecast period, with the unemployment rate to increase from 3.8% in 2007 to 4.7% in 2008 and 4.5% in 2009. Personal income growth is projected to be 4.0% in 2007, 4.0% in 2008, and 4.1% in 2009[12].
- Caseload declines occurred from 1993 to 1999 due 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. Between FY 2002-03 and FY 2004-05, caseload in this category grew by 31.4%, which the Department believes is largely due to the state of the economy. The rate of growth fell drastically in FY 2005-06, and the caseload actually contracted by 3.74%.
- There were large and consistent declines between July 2006 and December 2007, which seems to indicate that the improved economy was having the expected effect on caseload.

[11] Department of Local Affairs, Demography Division
[12] Source: Office of State Planning and Budgeting, June 2008 Revenue Forecast

- Recent changes to the rules regarding the citizenship requirements of the Deficit Reduction Act of 2005 may effect this population and result in higher growth. Children who can not provide proper proof of citizenship will no longer be automatically eligible for the Children's Basic Health Plan. This may increase the growth in Medicaid as families find such documents to ensure coverage of children.
- The monthly declines in FY 2007-08 were smaller than the Department's February 2008 forecast, in which the caseload was projected to be 197,305. This is largely due to average increases of 2,500 in the last six months of the year. The Department believes that softening economic conditions is partially responsible for this, as the unemployment rate has increased from 4.0% in December 2007 to 5.2% in July 2008 (source: Colorado Department of Labor & Employment). The last period during which the unemployment rate was at approximately this same level and was increasing at a similar pace was June 2001 through January 2002. During this time, the Eligible Children caseload was increasing by approximately 1.3% per month. The selected trend for FY 2008-09 is higher than that from the February 2008 forecast, and would yield average increases of 642 clients per month for FY 2008-09. This higher forecast is reflective of the monthly increases in the second half of FY 2007-08, which marked a change in trend from the first half of the year. Because the economy is assumed to be at least partially responsible this change, the Department believes that flat and moderate economic conditions throughout the forecast period give no indication that the trend will not be positive in FY 2008-09.
- Similar to the pattern seen in AFDC adults, out-year trend selections are expected to temper, reflecting the positive but moderating growth in the economy. Growth in this eligibility type is expected to be higher than that in the low-income adult populations due to current marketing in the Children's Basic Health Plan and a number of community initiatives to enroll eligibles, most of which target children.

Bottom-line Adjustments

The bottom-line adjustment for HB 06-1270, Public School Eligibility Determinations, is no longer being included as the expansion was implemented in FY 2007-08 and is assumed to be included in the base. Bottom-line adjustments are made for the Department's November 1, 2007 Decision Item #3A"Additional CHP+ Outreach" and the Department's February 15, 2008 Budget Amendment #A1A "Building Blocks to Health Care Reform".

Additional CHP+ Outreach

FY 2008-09: 4,000

- From the Department's November 1, 2007 Decision Item #3A.

FY 2009-10: 4,104

- Applied forecasted FY 2009-10 Eligible Children growth rate to FY 2008-09 estimate.

FY 2010-11: 4,188

- Applied forecasted FY 2010-11 Eligible Children growth rate to FY 2009-10 estimate.

Building Blocks to Health Care Reform

FY 2008-09: 1,967

- From the Department's February 15, 2008 Budget Amendment #A1A. The original estimate is halved because the Department was appropriated approximately half of its request related to medical home, which will cause the final caseload to be phased in.

FY 2009-10: 4,014

- From the Department's February 15, 2008 Budget Amendment #A1A. This is the full FY 2009-10 estimate from the Department's request related to medical home.

FY 2010-11: 4,096

- Applied forecasted FY 2010-11 Eligible Children growth rate to FY 2009-10 estimate.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
(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. (2008)
(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

Eligible Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-06	216,522	-	-
Jul-06	215,937	(585)	-0.27%
Aug-06	216,226	289	0.13%
Sep-06	214,255	(1,971)	-0.91%
Oct-06	209,565	(4,690)	-2.19%
Nov-06	205,572	(3,993)	-1.91%
Dec-06	202,812	(2,760)	-1.34%
Jan-07	202,963	151	0.07%
Feb-07	202,656	(307)	-0.15%
Mar-07	201,549	(1,107)	-0.55%
Apr-07	200,833	(716)	-0.36%
May-07	196,757	(4,076)	-2.03%
Jun-07	195,549	(1,208)	-0.61%
Jul-07	197,420	1,871	0.96%
Aug-07	198,001	581	0.29%
Sep-07	197,134	(867)	-0.44%
Oct-07	201,710	4,576	2.32%
Nov-07	201,378	(332)	-0.16%
Dec-07	200,121	(1,257)	-0.62%
Jan-08	201,816	1,695	0.85%
Feb-08	203,657	1,841	0.91%
Mar-08	206,695	3,038	1.49%
Apr-08	210,620	3,925	1.90%
May-08	213,554	2,934	1.39%
Jun-08	216,154	2,600	1.22%

Base trend if caseload were to stay at the June 2008 level			
FY 2008-09	216,154	5.95%	12,132

	Caseload	% Change	Level Change
FY 2002-03	169,311	-	-
FY 2003-04	195,279	15.34%	25,968
FY 2004-05	222,472	13.93%	27,193
FY 2005-06	214,158	-3.74%	(8,314)
FY 2006-07	205,390	-4.09%	(8,768)
FY 2007-08	204,022	-0.67%	(1,368)
FY 2008-09	219,242	7.46%	15,220
FY 2009-10	224,964	2.61%	5,722
FY 2010-11	229,553	2.04%	4,589

Adjustments (FY 2008-09 DI-3A and BA-A1A)	
FY 2008-09	5,967
FY 2009-10	8,118
FY 2010-11	8,284

Projections After Adjustments			
FY 2008-09	225,209	10.38%	21,187
FY 2009-10	233,082	3.50%	7,873
FY 2010-11	237,837	2.04%	4,755

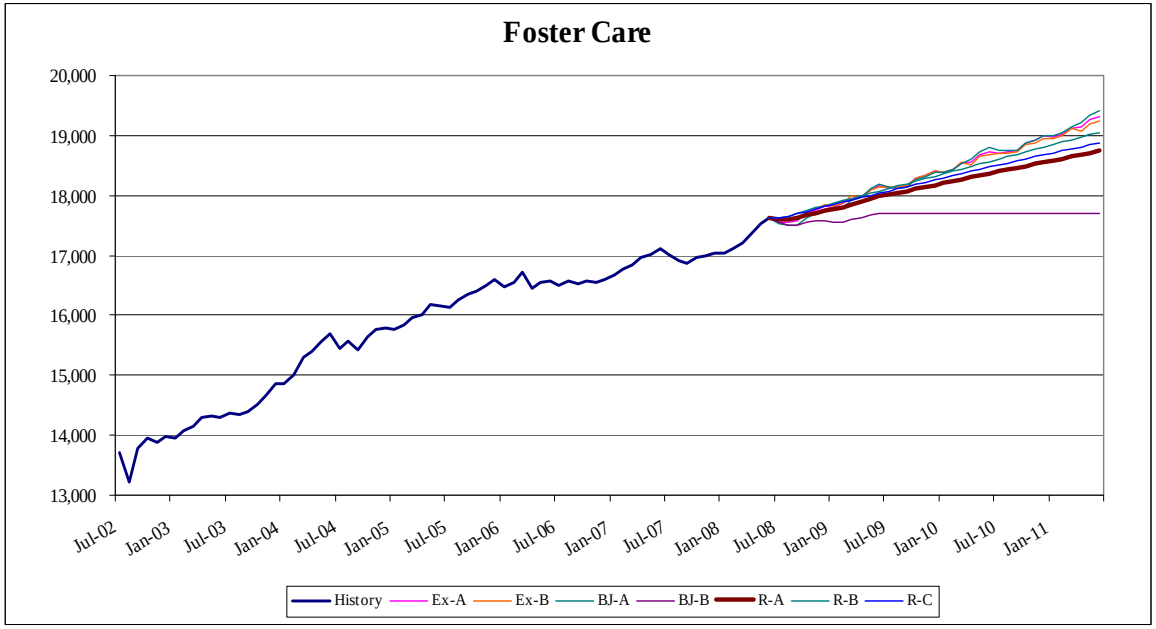
February 2008 Trends (AFTER Adjustments)			
FY 2007-08	197,535	-3.82%	(7,855)
FY 2008-09	192,948	-2.32%	(4,587)
FY 2009-10	189,764	-1.65%	(3,184)

Actuals		
	Monthly Change	% Change
6-month average	2,672	1.29%
12-month average	1,717	0.84%
18-month average	741	0.36%
24-month average	(15)	0.00%

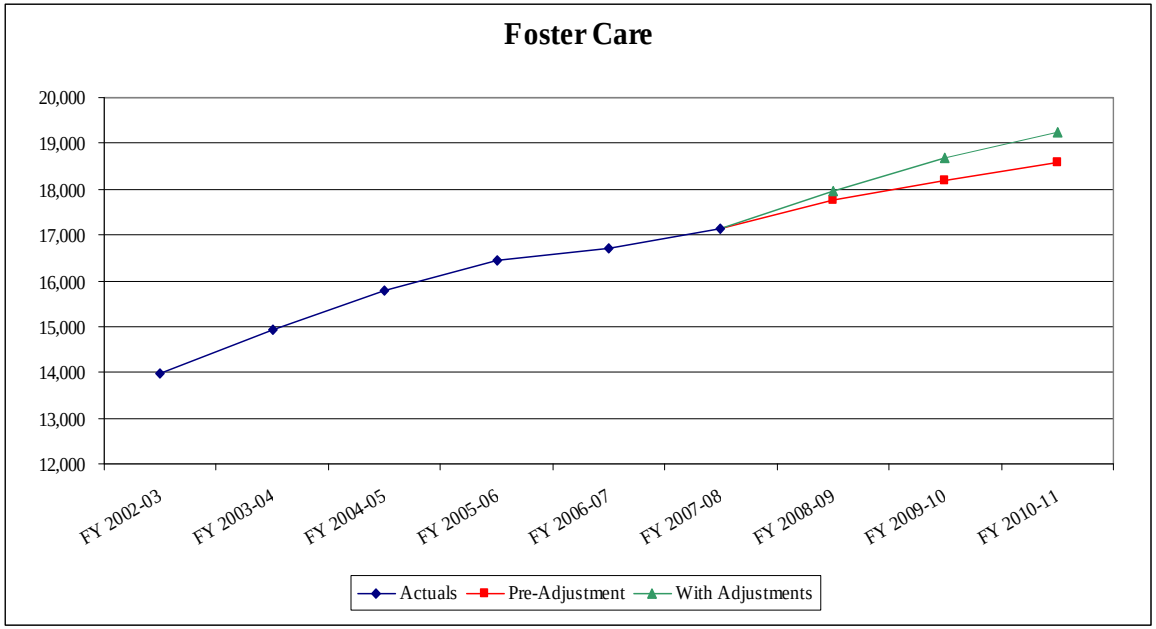
Foster Care

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. Eligibility for children receiving state subsidized adoption or foster care payments (non Title IV-E) was extended through age 20 in the 2008 Legislative Session through SB 08-099.

Foster Care: Model Results



Foster Care: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9987	
Exponential Smoothing B*	0.9917	
Box-Jenkins A	0.9986	
Box-Jenkins B	0.9904	
Regression A	0.9980	FOSTER [-1], Population Under 19, Auto [-12]
Regression B	0.9985	FOSTER [-1], Total Population, Auto [-1]
Regression C	0.9985	FOSTER [-1], Trend, Auto [-1]



Foster Care: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	16,724	17,141	3.93%	17,815	674	47
Exponential Smoothing B*	16,724	17,141	4.04%	17,833	692	45
Box Jenkins A	16,724	17,141	3.75%	17,784	643	50
Box Jenkins B	16,724	17,141	2.57%	17,582	441	9
Regression A	**16,724**	**17,141**	**3.65%**	**17,767**	**626**	**33**
Regression B	16,724	17,141	4.12%	17,847	706	41
Regression C	16,724	17,141	4.01%	17,828	687	37

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	FY 2007-08	FY 2008-09 Projected Caseload	Projected Growth Rate	Projected FY 2009-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	17,141	17,767	3.28%	18,350	583	48
Exponential Smoothing B*	17,141	17,767	3.13%	18,323	556	46
Box Jenkins A	17,141	17,767	3.48%	18,385	618	51
Box Jenkins B	17,141	17,767	0.64%	17,881	114	0
Regression A	**17,141**	**17,767**	**2.37%**	**18,188**	**421**	**32**
Regression B	17,141	17,767	2.77%	18,259	492	41
Regression C	17,141	17,767	2.50%	18,211	444	36

FY 2010-11	FY 2007-08	FY 2008-09 Projected Caseload	Projected Growth Rate	Projected FY 2009-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	17,767	18,188	3.17%	18,765	577	48
Exponential Smoothing B*	17,767	18,188	3.03%	18,739	551	46
Box Jenkins A	17,767	18,188	3.32%	18,792	604	50
Box Jenkins B	17,767	18,188	0.00%	18,188	0	0
Regression A	**17,767**	**18,188**	**2.11%**	**18,572**	**384**	**31**
Regression B	17,767	18,188	2.65%	18,670	482	40
Regression C	17,767	18,188	2.29%	18,605	417	34

[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 2008-09: 3.65%
FY 2009-10: 2.37 %
FY 2010-11: 2.11%

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 unusually slow growth experienced in this category in FY 2001-02. 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 above shows that growth in this category since FY 2002-03 have been positive and stable over the last four years. Growth at the end of FY 2007-08 increased, which is partially due to the implementation of SB 07-002, which expanded eligibility for children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act.

- Growth in FY 2007-08 was slightly lower than the Department's February 2008 forecast, in which caseload was projected to be 17,333. This was largely due to the delayed implementation of SB 07-002, which expanded eligibility to age 21 for some Foster Care clients. These expansion clients did not start being counted in caseload until January 2008, and the FY 2007-08 expansion caseload was well below the adjustment included in the February 2008 forecast. Unexpected declines of nearly 300 between June and September 2007 held the annual growth rate down, and the Department believes that caseload growth has returned to longer-term trends. The selected trend for FY 2008-09 is higher than that from the February forecast, and would yield average growth of 33 clients per month for FY 2008-09. This relatively strong forecasted growth rate reflects the monthly declines experienced at the beginning of FY 2007-08, which leaves caseload at a lower starting point in FY 2007-08.
- Out-year growth reflects a continuation of positive growth, and a return to more moderate growth in line with historical trend.

Bottom-line Adjustments

The bottom-line adjustment for SB 07-002, which expanded Foster Care eligibility to age 21 for some clients, is no longer being included as the expansion was implemented in FY 2007-08 and is assumed to be included in the base. A bottom-line adjustment is made for SB 08-099, Foster Care Expansion, as these clients are going to start to be added in FY 2008-09. This expansion is effective July 1, 2008, and all adjustments are from the fiscal note for SB 08-099. These adjustments are: 201 in FY 2008-09; 494 in FY 2009-10, and; 681 in FY 2010-11.

25.5-5-101 (1), C.R.S. (2008)
(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 (2008)
(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 paragraph (l) of this subsection (1) or 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

Foster Care: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-06	16,571	-	-
Jul-06	16,499	(72)	-0.43%
Aug-06	16,574	75	0.45%
Sep-06	16,524	(50)	-0.30%
Oct-06	16,576	52	0.31%
Nov-06	16,554	(22)	-0.13%
Dec-06	16,595	41	0.25%
Jan-07	16,683	88	0.53%
Feb-07	16,761	78	0.47%
Mar-07	16,849	88	0.53%
Apr-07	16,962	113	0.67%
May-07	17,007	45	0.27%
Jun-07	17,100	93	0.55%
Jul-07	17,003	(97)	-0.57%
Aug-07	16,915	(88)	-0.52%
Sep-07	16,877	(38)	-0.22%
Oct-07	16,968	91	0.54%
Nov-07	16,995	27	0.16%
Dec-07	17,042	47	0.28%
Jan-08	17,050	8	0.05%
Feb-08	17,117	67	0.39%
Mar-08	17,208	91	0.53%
Apr-08	17,358	150	0.87%
May-08	17,537	179	1.03%
Jun-08	17,620	83	0.47%

Base trend if caseload were to stay at the June 2008 level			
FY 2008-09	17,620	2.79%	479

	Caseload	**% Change**	**Level Change**
FY 2002-03	13,967	-	-
FY 2003-04	14,914	6.78%	947
FY 2004-05	15,795	5.91%	881
FY 2005-06	16,460	4.21%	665
FY 2006-07	16,724	1.60%	264
FY 2007-08	17,141	2.49%	417
FY 2008-09	17,767	3.65%	626
FY 2009-10	18,188	2.37%	421
FY 2010-11	18,572	2.11%	384

Adjustments (SB 08-099)	
FY 2008-09	201
FY 2009-10	494
FY 2010-11	681

Projections After Adjustments			
FY 2008-09	17,968	4.82%	827
FY 2009-10	18,682	3.97%	714
FY 2010-11	19,253	3.06%	571

February 2008 Trends (AFTER Adjustments)			
FY 2007-08	17,333	3.64%	609
FY 2008-09	18,657	7.64%	1,324
FY 2009-10	19,517	4.61%	860

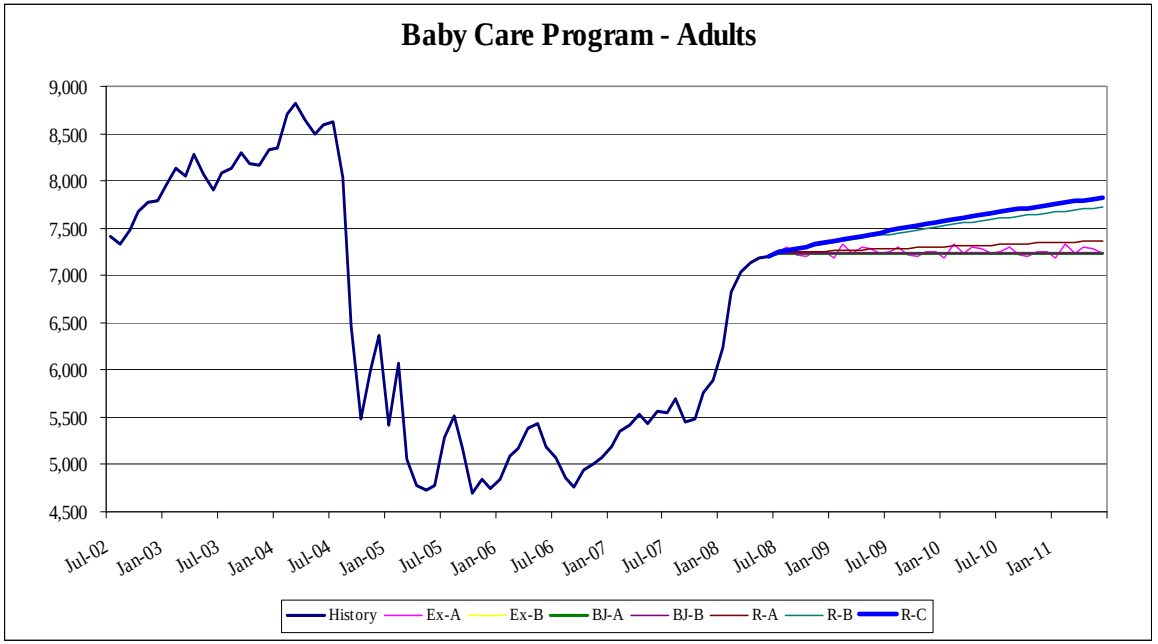
Actuals		
	Monthly Change	**% Change**
6-month average	96	0.56%
12-month average	43	0.25%
18-month average	57	0.33%
24-month average	44	0.33%

Baby Care Adults

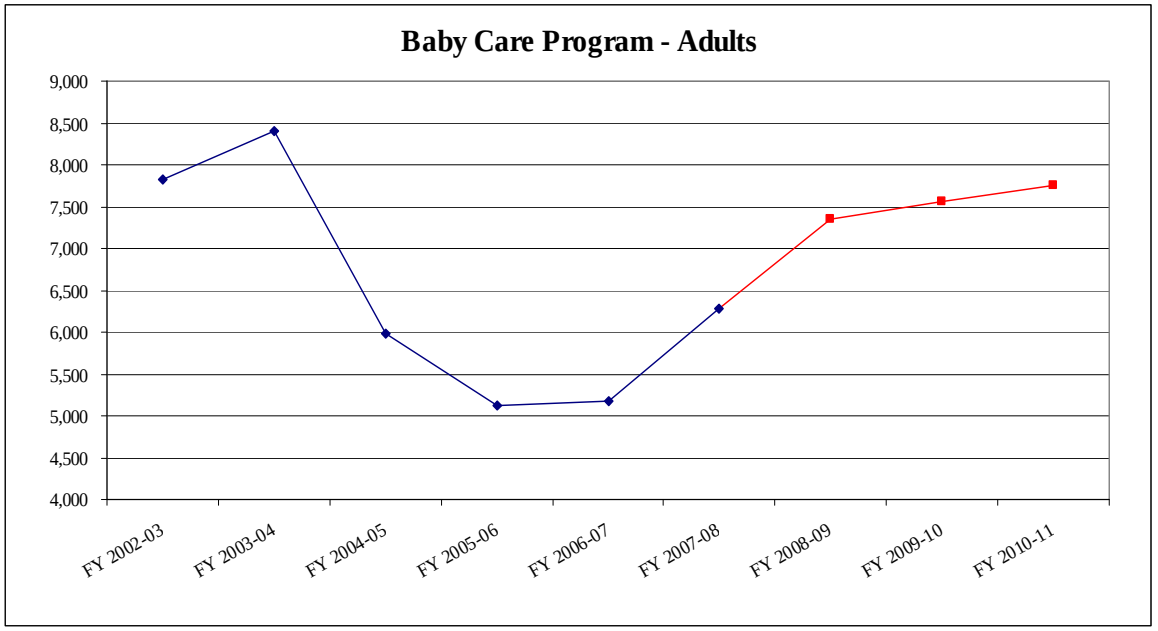
Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, the program was authorized through the Medicare Catastrophic Coverage Act of 1988. The program enrolls Baby

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



Baby Care Program Adults: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9460	
Exponential Smoothing B	0.9269	
Box-Jenkins A*	0.9447	
Box-Jenkins B	0.9274	
Regression A	0.9541	BCA [-1], Total Employment, Female Population 19-59, BCA Dummy, Auto [-2], Auto [-12]
Regression B	0.9544	BCA [-1], Female Population 19-59, BCA Dummy, Auto [-2]
Regression C	0.9545	BCA [-1], Total Population, Migration, BCA Dummy



Baby Care Program Adults: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	5,182	6,288	15.31%	7,251	963	0
Exponential Smoothing B	5,182	6,288	15.03%	7,233	945	0
Box Jenkins A*	5,182	6,288	15.04%	7,234	946	0
Box Jenkins B*	5,182	6,288	15.04%	7,234	946	0
Regression A	5,182	6,288	15.43%	7,258	970	4
Regression B	5,182	6,288	16.60%	7,332	1,044	15
Regression C	**5,182**	**6,288**	**16.94%**	**7,353**	**1,065**	**18**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	6,288	7,353	0.00%	7,353	0	0
Exponential Smoothing B	6,288	7,353	0.00%	7,353	0	0
Box Jenkins A*	6,288	7,353	0.00%	7,353	0	0
Box Jenkins B*	6,288	7,353	0.00%	7,353	0	0
Regression A	6,288	7,353	0.59%	7,396	43	4
Regression B	6,288	7,353	2.54%	7,540	187	14
Regression C	**6,288**	**7,353**	**2.90%**	**7,566**	**213**	**16**

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	7,353	7,566	0.00%	7,566	0	0
Exponential Smoothing B	7,353	7,566	0.00%	7,566	0	0
Box Jenkins A*	7,353	7,566	0.00%	7,566	0	0
Box Jenkins B*	7,353	7,566	0.00%	7,566	0	0
Regression A	7,353	7,566	0.60%	7,611	45	4
Regression B	7,353	7,566	1.93%	7,712	146	10
Regression C	**7,353**	**7,566**	**2.41%**	**7,748**	**182**	**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.

Baby Care Program- Adults: Trend Selections

FY 2008-09: 16.94%
FY 2009-10: 2.90%
FY 2010-11: 2.41%

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 may be increased given that these clients have incomes up to 133% of the federal poverty level.
- 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. Discounting these policy changes, caseload for this category is erratic and tends to be mired with spikes, as displayed in the graph above.
- 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 2007-08 was much higher than the Department's February 2008 forecast, in which caseload was projected to be 5,678. Prior to January 2008, all functions for presumptive eligibility for pregnant women in Medicaid were performed by an external contractor. The Department now completes eligibility determinations in the Colorado Benefits Management System, which caused a one-time increase in caseload and resulted in the strong growth in February 2008. The selected trend for FY 2008-09 is much higher than that from the February 2008 forecast, and would yield average growth of 18 clients per month for FY 2008-09. The strong forecasted growth rate is reflective of the large monthly increases in FY 2007-08, which has left caseload at a higher starting point for FY 2008-09.

- The Colorado Department of Public Health & Environment Family Planning Initiative was recently awarded a grant for approximately $3.5 million to address the issue of unintended pregnancy in Colorado. This funding will provide local Title X Family Planning clinics with money to purchase long acting methods of contraception, funding for sterilizations and funding to expand clinic capacity to see more Title X clients. The vast majority of Title X clients are under 200% of the federal poverty level. Out-year trends moderate slightly due to this Family Planning initiative (as well as the Family Planning waiver that will be submitted by the Department in accordance with SB 08-003) and assuming a stable economy.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
(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…;

Baby Care Program- Adults: Historical Caseload and Forecasts

Baby Care Program Adults: Historical Caseload and Projections								
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	5,193	-	-		FY 2002-03	7,823	-	-
Jul-06	5,074	(119)	-2.29%		FY 2003-04	8,398	7.35%	575
Aug-06	4,852	(222)	-4.38%		FY 2004-05	5,984	-28.74%	(2,414)
Sep-06	4,761	(91)	-1.88%		FY 2005-06	5,119	-14.46%	(865)
Oct-06	4,950	189	3.97%		FY 2006-07	5,182	1.23%	63
Nov-06	5,002	52	1.05%		FY 2007-08	6,288	21.34%	1,106
Dec-06	5,070	68	1.36%		FY 2008-09	7,353	16.94%	1,065
Jan-07	5,181	111	2.19%		FY 2009-10	7,566	2.90%	213
Feb-07	5,353	172	3.32%		FY 2010-11	7,748	2.41%	182
Mar-07	5,422	69	1.29%					
Apr-07	5,526	104	1.92%		**February 2008 Trends**			
May-07	5,437	(89)	-1.61%		FY 2007-08	5,678	9.57%	496
Jun-07	5,561	124	2.28%		FY 2008-09	6,028	6.16%	350
Jul-07	5,551	(10)	-0.18%		FY 2009-10	6,160	2.19%	132
Aug-07	5,691	140	2.52%					
Sep-07	5,448	(243)	-4.27%					
Oct-07	5,479	31	0.57%		**Actuals**			
Nov-07	5,759	280	5.11%				**Monthly Change**	**% Change**
Dec-07	5,896	137	2.38%		6-month average		217	3.44%
Jan-08	6,233	337	5.72%		12-month average		137	2.23%
Feb-08	6,827	594	9.53%		18-month average		118	2.01%
Mar-08	7,035	208	3.05%		24-month average		84	1.97%
Apr-08	7,142	107	1.52%					
May-08	7,191	49	0.69%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	7,200	9	0.13%		FY 2008-09	7,200	14.50%	912

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:

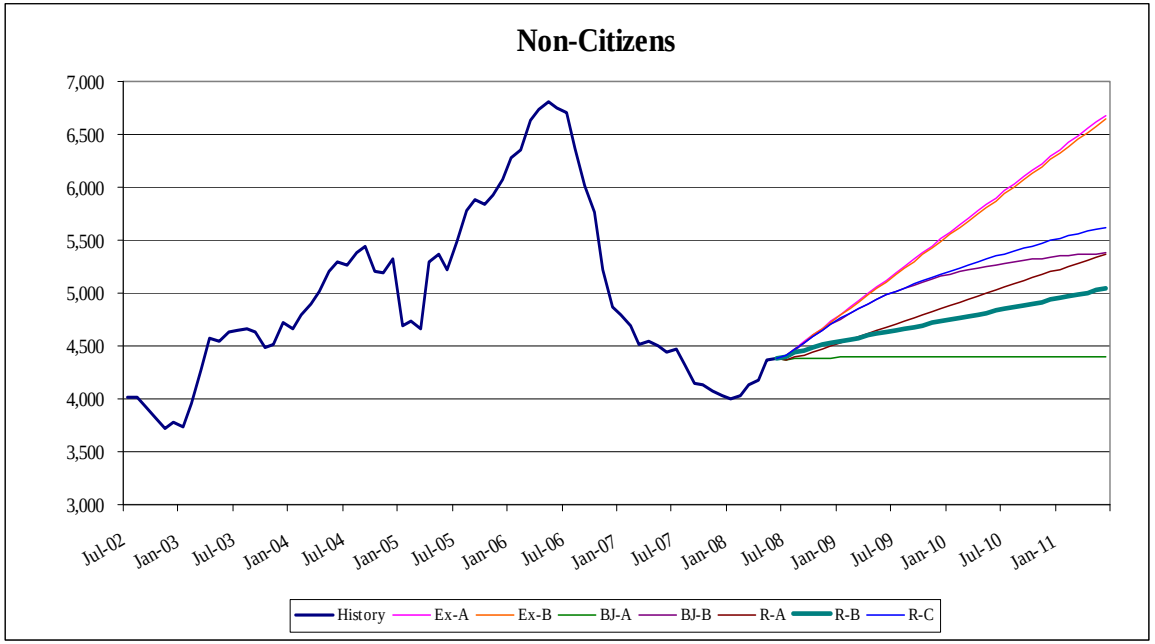
- Refugees for the first seven years after entry into the United States;
- Asylees for the first seven years after asylum is granted;
- Individuals whose deportation is being withheld for the first seven years after the initial withhold;

- 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.

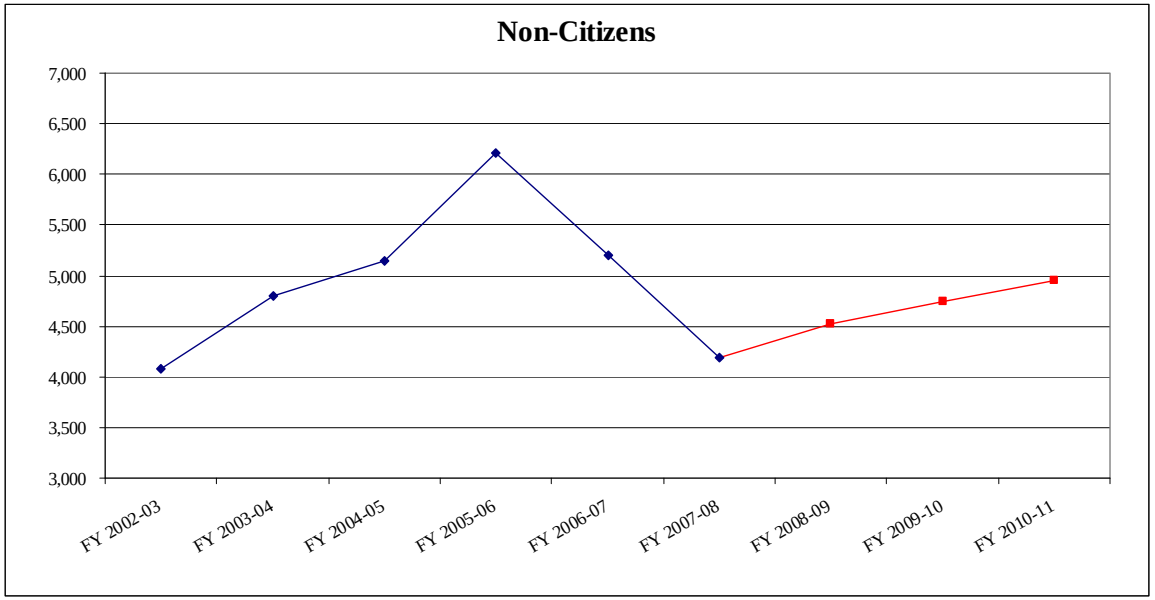
Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. citizenship.

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.

Non-Citizens: Model Results



Non-Citizens: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9631	
Exponential Smoothing B	0.9462	
Box-Jenkins A*	0.9770	
Box-Jenkins B*	0.9626	
Regression A	0.9848	ALIEN [-1], Female Population 19-59, Migration, Alien Dummy
Regression B	0.9884	ALIEN [-1], ALIEN [-2], Alien Dummy, Auto [-3]
Regression C	0.9879	ALIEN [-1], Unemployment Rate, Alien Dummy, Auto [-1], Auto [-2]



Non-Citizens: Model Results						
FY 2008-09	FY 2006-07	FY 2007-08	Projected Growth Rate	Projected FY 2008-09 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	5,201	4,191	13.72%	4,766	575	63
Exponential Smoothing B	5,201	4,191	13.53%	4,758	567	61
Box Jenkins A*	5,201	4,191	4.68%	4,387	196	4
Box Jenkins B*	5,201	4,191	12.46%	4,713	522	51
Regression A	5,201	4,191	7.68%	4,513	322	26
Regression B	**5,201**	**4,191**	**8.06%**	**4,529**	**338**	**23**
Regression C	5,201	4,191	12.55%	4,717	526	51

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	FY 2007-08	FY 2008-09 Projected Caseload	Projected Growth Rate	Projected FY 2009-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	4,191	4,529	16.37%	5,270	741	63
Exponential Smoothing B	4,191	4,529	16.10%	5,258	729	61
Box Jenkins A*	4,191	4,529	0.09%	4,533	4	0
Box Jenkins B*	4,191	4,529	9.48%	4,958	429	23
Regression A	4,191	4,529	7.78%	4,881	352	29
Regression B	**4,191**	**4,529**	**4.64%**	**4,739**	**210**	**16**
Regression C	4,191	4,529	10.01%	4,982	453	30

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	4,529	4,739	14.05%	5,405	666	63
Exponential Smoothing B	4,529	4,739	13.85%	5,395	656	61
Box Jenkins A*	4,529	4,739	0.00%	4,739	0	0
Box Jenkins B*	4,529	4,739	3.45%	4,902	163	9
Regression A	4,529	4,739	7.15%	5,078	339	27
Regression B	**4,529**	**4,739**	**4.35%**	**4,945**	**206**	**17**
Regression C	4,529	4,739	6.05%	5,026	287	22

[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 2008-09: 8.06%
FY 2009-10: 4.64%
FY 2010-11: 4.35%

Non-Citizens: Justifications

- The graph above illustrates that the caseload in this category had a positive trend between FY 2002-03 and FY 2005-06. 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 tend to have longer life expectancies than natives of the United States.[13]
- Expenditures in this category did not decrease along with caseload in FY 2006-07 and FY 2007-08, indicating that the caseload decline was not occurring in clients that were utilizing services. 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 2006-07 and FY 2007-08 may indicate that eligibility spans for the Non-Citizens clients

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

are now being ended sooner, caused by eligibility technicians actively working more cases because they are required to collect citizenship information. 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 2006-07 and FY 2007-08 are unlikely to continue. In fact, the declines in this category moderated in October 2007 and caseload began to increase in February 2008.

- The caseload declines in FY 2007-08 were in line with the Department's February 2008 forecast, in which the caseload was projected to be 4,017. The large annual decline in FY 2007-08 reflects the strong monthly decreases experienced in FY 2006-07, which left caseload at a lower starting point in FY 2007-08. The selected trend for FY 2008-09 is much higher than that from the February 2008 forecast, and would yield average increases of 23 clients per month for FY 2008-09. The strong annual growth reflect the large monthly increases experienced in FY 2007-08, which leaves caseload at a higher staring point for FY 2008-09. The Department believes that the apparent shift in trend beginning in March 2008 implies that all cases have undergone an annual redetermination, and that large monthly increases due to this phenomenon are no longer expected. The Department assumes that monthly growth should be lower than historical trends due to the Deficit Reduction Act and the removal of the 60 days of post-partum benefits, which should decrease the number of cases that have erroneously long eligibility spans.
- The out-year trends assume moderate monthly growth for the reasons noted above.

25.5-5-103 (3), C.R.S. (2008)
(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

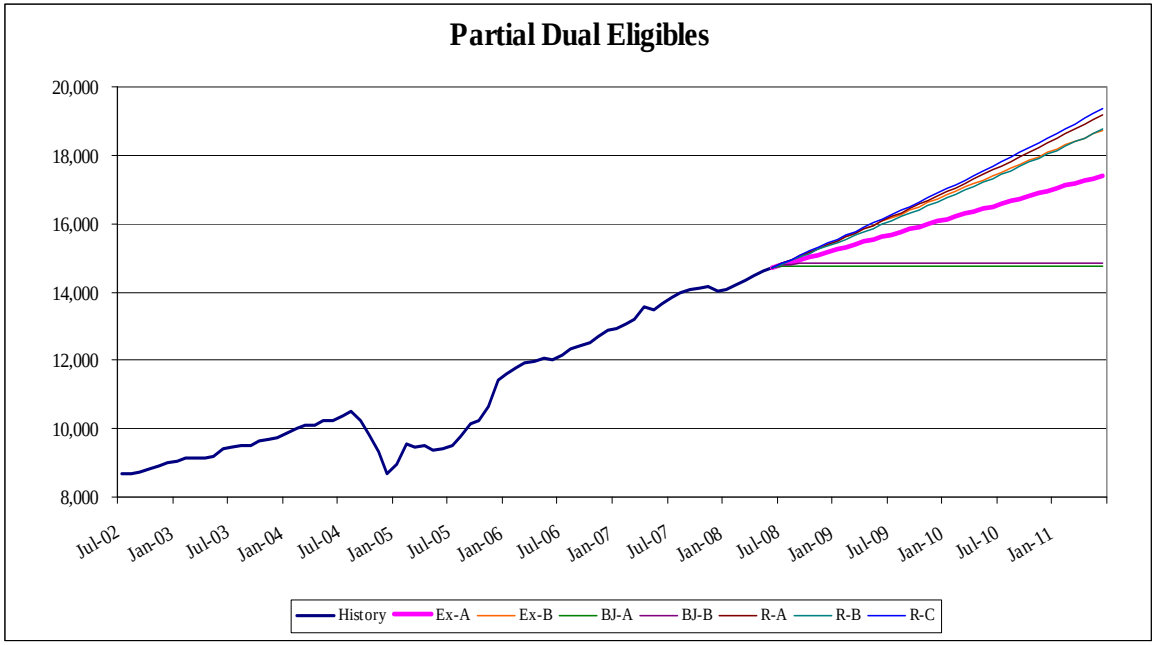
Non-Citizens: Historical Caseload and Projections								
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	6,746	-	-		FY 2002-03	4,084	-	-
Jul-06	6,703	(43)	-0.64%		FY 2003-04	4,793	17.36%	709
Aug-06	6,364	(339)	-5.06%		FY 2004-05	5,150	7.45%	357
Sep-06	6,011	(353)	-5.55%		FY 2005-06	6,212	20.62%	1,062
Oct-06	5,761	(250)	-4.16%		FY 2006-07	5,201	-16.27%	(1,011)
Nov-06	5,226	(535)	-9.29%		FY 2007-08	4,191	-19.42%	(1,010)
Dec-06	4,864	(362)	-6.93%		FY 2008-09	4,529	8.06%	338
Jan-07	4,798	(66)	-1.36%		FY 2009-10	4,739	4.64%	210
Feb-07	4,690	(108)	-2.25%		FY 2010-11	4,945	4.35%	206
Mar-07	4,514	(176)	-3.75%					
Apr-07	4,547	33	0.73%		**February 2008 Trends**			
May-07	4,501	(46)	-1.01%		FY 2007-08	3,842	-26.13%	(1,359)
Jun-07	4,437	(64)	-1.42%		FY 2008-09	3,738	-2.71%	(104)
Jul-07	4,475	38	0.86%		FY 2009-10	3,738	0.00%	0
Aug-07	4,330	(145)	-3.24%					
Sep-07	4,148	(182)	-4.20%					
Oct-07	4,136	(12)	-0.29%		**Actuals**			
Nov-07	4,069	(67)	-1.62%				**Monthly Change**	**% Change**
Dec-07	4,032	(37)	-0.91%		6-month average		60	1.44%
Jan-08	4,007	(25)	-0.62%		12-month average		(4)	-0.06%
Feb-08	4,026	19	0.47%		18-month average		(26)	-0.55%
Mar-08	4,130	104	2.58%		24-month average		(98)	-0.88%
Apr-08	4,178	48	1.16%					
May-08	4,371	193	4.62%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	4,389	18	0.41%		FY 2008-09	4,389	4.72%	198

Partial Dual Eligibles

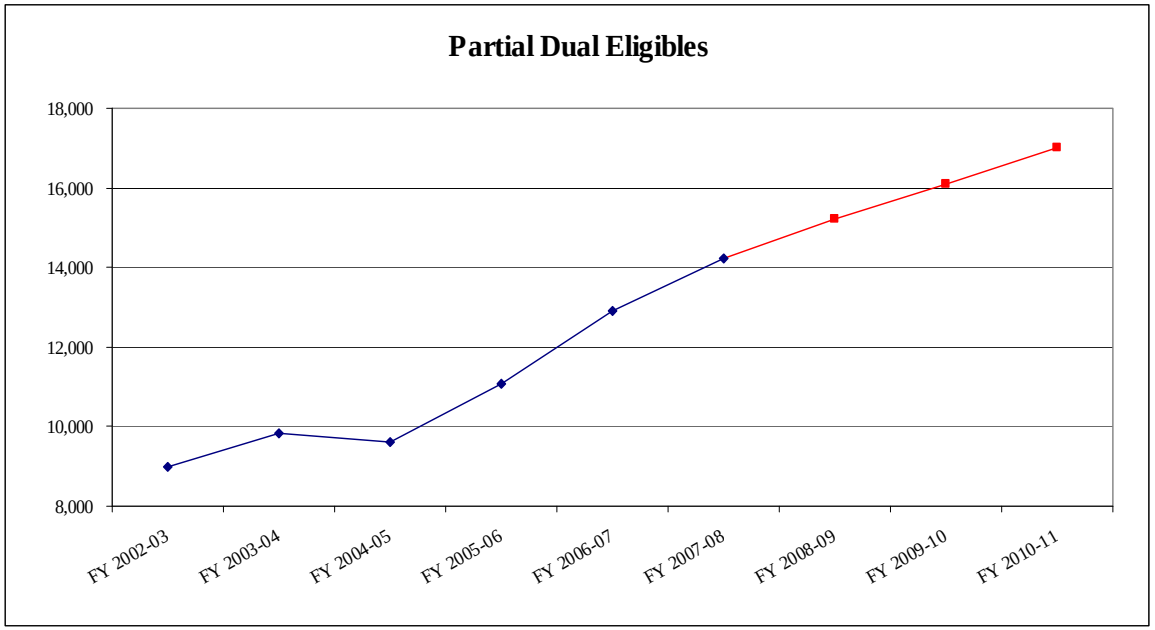
Medicare eligible beneficiaries who have incomes at a certain federal poverty level and limited resources may qualify to have Medicaid cover some of their out-of-pocket expenses, such as their Medicare Part B premiums and other coinsurance and deductibles. The two groups of clients that qualify for this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



Partial Dual Eligibles: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9966	
Exponential Smoothing B*	0.9935	
Box-Jenkins A	0.9960	
Box-Jenkins B	0.9938	
Regression A	0.9990	PDE [-1], PDE Dummy, CBMS Dummy, Auto [-1]
Regression B	0.9990	PDE [-1], Population 65+, PDE Dummy, CBMS Dummy, Auto [-1]
Regression C	0.9989	PDE [-1], PDE [-2], PDE Dummy, CBMS Dummy, Auto [-3]



Partial Dual Eligibles: Model Results						
FY 2008-09	**FY 2006-07**	**FY 2007-08**	**Projected Growth Rate**	**Projected FY 2008-09 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	**12,908**	**14,214**	**6.95%**	**15,202**	**988**	**74**
Exponential Smoothing B	12,908	14,214	8.64%	15,442	1,228	111
Box Jenkins A	12,908	14,214	3.83%	14,758	544	4
Box Jenkins B*	12,908	14,214	4.37%	14,835	621	11
Regression A	12,908	14,214	8.66%	15,445	1,231	113
Regression B	12,908	14,214	8.29%	15,392	1,178	104
Regression C	12,908	14,214	8.93%	15,483	1,269	118

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2009-10	**FY 2007-08**	**FY 2008-09 Projected Caseload**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	**14,214**	**15,202**	**5.89%**	**16,097**	**895**	**74**
Exponential Smoothing B	14,214	15,202	8.68%	16,522	1,320	111
Box Jenkins A	14,214	15,202	0.01%	15,204	2	0
Box Jenkins B*	14,214	15,202	0.08%	15,214	12	0
Regression A	14,214	15,202	9.24%	16,607	1,405	123
Regression B	14,214	15,202	8.45%	16,487	1,285	111
Regression C	14,214	15,202	9.53%	16,651	1,449	127

FY 2010-11	FY 2008-09 Projected Caseload	FY 2009-10 Projected Caseload	Projected Growth Rate	Projected FY 2010-11 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	**15,202**	**16,097**	**5.57%**	**16,994**	**897**	**74**
Exponential Smoothing B	15,202	16,097	7.98%	17,382	1,285	111
Box Jenkins A	15,202	16,097	0.00%	16,097	0	0
Box Jenkins B*	15,202	16,097	0.00%	16,097	0	0
Regression A	15,202	16,097	9.24%	17,584	1,487	134
Regression B	15,202	16,097	8.38%	17,446	1,349	120
Regression C	15,202	16,097	9.53%	17,631	1,534	139

[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 2008-09: 6.95%
FY 2009-10: 5.89%
FY 2010-11: 5.57%

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 calendar year 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.
- Caseload growth in this category was positive and steady between FY 1999-00 and FY 2003-04. Caseload experienced an unprecedented contraction on FY 2004-05, 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 2005-06 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 2007-08 was in line with the Department's February 2008 forecast, in which caseload was projected to be 14,131. The selected trend for FY 2008-09 is similar to that from the February 2008 forecast, and would yield average growth of 74 clients per month for FY 2008-09.
- Out-year trend selections moderate to growth in line with historic rates, reflecting the complete incorporation of baby boomers and any clients affected by the Medicare Modernization Act.

25.5-5-101 (1), C.R.S. (2008)
(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. (2008)
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.

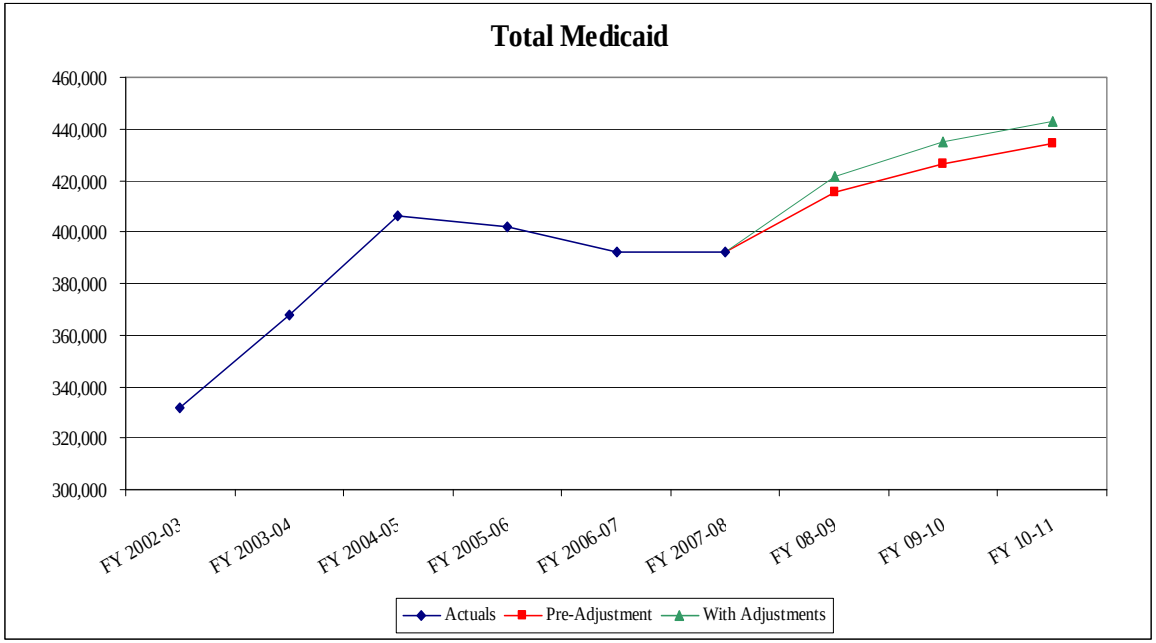
25.5-5-105, C.R.S. (2008)
Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus 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

Partial Dual Eligibles: Historical Caseload and Projections								
	Actuals	**Monthly Change**	**% Change**			**Caseload**	**% Change**	**Level Change**
Jun-06	12,001	-	-		FY 2002-03	8,988	-	-
Jul-06	12,145	144	1.20%		FY 2003-04	9,842	9.50%	854
Aug-06	12,316	171	1.41%		FY 2004-05	9,605	-2.41%	(237)
Sep-06	12,443	127	1.03%		FY 2005-06	11,092	15.48%	1,487
Oct-06	12,536	93	0.75%		FY 2006-07	12,908	16.37%	1,816
Nov-06	12,693	157	1.25%		FY 2007-08	14,214	10.12%	1,306
Dec-06	12,879	186	1.47%		FY 2008-09	15,202	6.95%	988
Jan-07	12,905	26	0.20%		FY 2009-10	16,097	5.89%	895
Feb-07	13,060	155	1.20%		FY 2010-11	16,994	5.57%	897
Mar-07	13,213	153	1.17%					
Apr-07	13,547	334	2.53%		**February 2008 Trends**			
May-07	13,493	(54)	-0.40%		FY 2007-08	14,131	9.47%	1,223
Jun-07	13,669	176	1.30%		FY 2008-09	15,068	6.63%	937
Jul-07	13,821	152	1.11%		FY 2009-10	16,022	6.33%	954
Aug-07	13,988	167	1.21%					
Sep-07	14,064	76	0.54%					
Oct-07	14,105	41	0.29%		**Actuals**			
Nov-07	14,144	39	0.28%				**Monthly Change**	**% Change**
Dec-07	14,028	(116)	-0.82%		6-month average		112	0.78%
Jan-08	14,066	38	0.27%		12-month average		86	0.61%
Feb-08	14,212	146	1.04%		18-month average		101	0.74%
Mar-08	14,333	121	0.85%		24-month average		112	0.78%
Apr-08	14,479	146	1.02%					
May-08	14,628	149	1.03%		**Base trend if caseload were to stay at the June 2008 level**			
Jun-08	14,700	72	0.49%		FY 2008-09	14,700	3.42%	486

Summary

The Department is forecasting a FY 2008-09 total Medicaid caseload of 421,651, a 7.57% increase from FY 2007-08. The trend is projected to moderate in FY 2009-10, and caseload is expected to increase by 3.17% to 435,038.



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 2007-08 and FY 2008-09, 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)

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 2008-09 in the November Budget Request, and the Department's Budget Amendment in the February Supplemental Budget Request.

For the purpose of this calculation, the Department includes the conditional appropriation for HB 08-1114 in FY 2008-09. This appropriation is not included in the Department's schedules or reconciliation document; however, because the Department includes the anticipated impact of this legislation in its calculation, it is also included here to correctly calculate the amount estimated funding net in FY 2008-09. Because of this, the total spending authority for FY 2008-09 shown on this exhibit does not match the Schedule 13, column 2.

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 effective with 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-9.

- 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. (2008). For FY 2008-09, 100% of state funding comes from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 2009-10, 50% of the

state funding comes from the General Fund, and 50% of the state funds come from the Breast and Cervical Cancer Prevention and Treatment 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 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.

- 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 Denver Health 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 2008-09 and FY 2009-10 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2007-08.

Health Care Expansion Fund (page EA-4)

The caseload impacts of the Health Care Expansion Fund from HB 05-1262 are already included in the Medicaid caseload projections. See Exhibit B 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
c. Presumptive Eligibility
d. Legal Immigrants
e. Removal of Medicaid Asset Test (Adult and Children Expansion)
f. Children's Home and Community Based Services – State Plan and Waiver services
g. 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 2007-08) 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 11, 2008 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)

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical per capita costs and the annual percent changes are also 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 expenditure after bottom-line adjustments is divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year expenditure, 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 2005-06 and FY 2006-07 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 claims. Selecting trends that incorporate FY 2005-06 would incorporate the shift in expenditure and may not be appropriate. This portion of the exhibit enables the Department to analyze and select trends without the net cost of pharmaceuticals, 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 1999-00 through FY 2005-06. 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 2004-05, FY 2005-06, FY 2006-07, and FY 2007-08. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs, although the Department makes adjustments to the selected trend where necessary.

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 2008-09 and FY 2009-10. 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 2007-08 and FY 2008-09, with the rationale for selection, are as follows:

Aid Category	FY 2008-09 Acute Care Trend Selection	FY 2009-10 Acute Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	Average of FY 2003-04 through FY 2007-08 (without RX) 3.16%	Average of FY 2003-04 through FY 2007-08 (without RX) 3.16%	The explanations for OAP-A, OAP-B, and AND/AB are combined: Although FY 2007-08 was a period of high per capita growth, the Department anticipates that base growth will settle a more stable level in the future. The Department estimates that the majority of base growth was due to policy changes: moving non-emergency medical transportation to Medical Services Premiums, and delayed payments under cash accounting due to the shift of clients from managed care to fee-for-service. Collectively, these aid categories saw the largest enrollments shifts due to the implementation of passive enrollment, and the loss of the Department's largest managed care provider. Due to cash accounting, this shift caused lower growth rates in FY 2006-07 and higher growth in FY 2007-08 -- as clients transitioned back to fee-for-service, it took several months for payments for services to reach prior levels. The high growth rates seen in FY 2007-08 are a direct result of that shift. The Department anticipates that this trend is now fully incorporated in the data and this category will return to a more stable base growth rates. In each instance, the Department has selected long-term trend factors which incorporate all of the recent policy changes.
Disabled Adults 60 to 64 (OAP-B)	Average of FY 2003-04 through FY 2006-07 (without RX) 2.31%	Average of FY 2003-04 through FY 2006-07 (without RX) 2.31%	
Disabled Individuals to 59 (AND/AB)	Average of FY 2003-04 through FY 2007-08 2.06%	Average of FY 2005-06 through FY 2007-08 3.12%	
Categorically Eligible Low-Income Adults (AFDC-A)	Average of FY 2004-05 through FY 2006-07 1.62%	Average of FY 2004-05 through FY 2007-08 3.32%	In FY 2007-08, per capita cost increased while total expenditure and caseload decreased. Part of the per capita increase is directly attributable to the decline in caseload; under cash accounting, the reduced expenditure is not fully realized in the per capita trend immediately. Per capita costs did fall slightly in the second half of FY 2007-08. Therefore, the Department anticipates a low positive trend in FY 2008-09, increases to a more long-term trend in FY 2009-10 as caseload stabilizes.

Aid Category	FY 2008-09 Acute Care Trend Selection	FY 2009-10 Acute Care Trend Selection	Justification
Expansion Adults	One-third of FY 2007-08 growth rate. 14.95%	Half of estimated FY 2008-09 growth rate. 7.48%	At present, the dominating factor in the per capita trend is the increase in caseload. Large increases in caseload in the second half of FY 2007-08 will cause high expenditure growth in FY 2008-09. As caseload growth abates, the Department anticipates that the per capita growth will also slow, eventually reaching a more consistent level.
Breast & Cervical Cancer Program	See page EF-5.	See page EF-5.	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)	0.00%	Average of FY 2002-03 through FY 2006-07 1.46%	Historically, in periods of high caseload growth, this per capita declines. Under cash accounting, new caseload does not immediately result in new expenditure. Because caseload grows very rapidly during slow economic periods, the Department anticipates that the per capita trend will be more reflective of similar periods, rather than recent periods. Increases for primary care services, including medical homes, will likely prevent this per capita from declining. As caseload stabilizes, the per capita will begin to grow again.
Foster Care	Average of FY 2005-06 through FY 2007-08 8.99%	Average of FY 2005-06 through FY 2007-08 8.99%	Over the last two years, experience has increases despite a relatively flat caseload, causing large per capita increases. The Department anticipates, as SB 07-002 and SB 08-099 add new clients, that per capita growth will begin to slow; however, this will still result in high per capita trends for the foreseeable future.

Aid Category	FY 2008-09 Acute Care Trend Selection	FY 2009-10 Acute Care Trend Selection	Justification
Baby Care Program - Adults (BCKC-A)	-12.50%	Average of FY 2004-05 through FY 2007-08 4.33%	Despite large increases in caseload (partially as a result of the incorporation of presumptive eligibility in the MMIS), the per capita cost for this aid category has remained virtually flat for the better part of three fiscal years. However, because caseload is estimated to increase sharply, the Department anticipates that, the per capita will generally decline as newer, generally healthier clients become enrolled. Once caseload stabilized, this aid category should return to a more stable growth rate.
Non-Citizens	Percent change from FY 2002-03 to FY 2003-04 -3.59%	Percent change from FY 2002-03 to FY 2003-04 -3.59%	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. This per capita declined sharply towards the end of the fiscal year, and with an estimated increase in caseload, the Department anticipates that overall per capita will continue to fall.
Partial Dual Eligibles	Average of FY 2005-06 through FY 2007-08 6.27%	Average of FY 2005-06 through FY 2007-08 6.27%	Expenditure in this category is primarily for Medicare co-insurance. Prior to FY 2006-07, caseload increased sharply without a corresponding increase in expenditure, causing a per capita increase. In FY 2006-07, expenditure increased significantly, possibly as a result of clients becoming more familiar with available benefits as a dual-eligible. Caseload is projected to continue to increase. The Department anticipates that this new caseload will mitigate continued per capita growth.

Legislative Impacts and Bottom-line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita 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:

- SB 04-206 directed the Department to implement a pediatric hospice program. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008. The bottom-line impact in FY 2008-09 reflects the estimated acute care savings of the waiver benefit.
- HB 07-1021 authorized the Department to implement a medication management program. The program started in FY 2007-08. The bottom-line impact in FY 2008-09 reflects the annualization of the estimated savings of the program.
- HB 08-1375 appropriated the Department funding for several different reasons, including: provider rate increases, including funding for medical homes; increasing managed care rates; funding to enroll additional clients in managed care organizations; savings from the implementation of the preferred drug list; savings from converting certain regional centers to ICF/MR facilities; savings from certain cost avoidance initiatives; and, savings from certain pharmacy initiatives. Impacts in FY 2009-10 are annualization values.
- HB 08-1407 reduced the Department's appropriation for the estimated savings associated with the prohibition of unreasonable delay or denial of payment by insurance companies.
- HB 08-1409 reduced the Department's appropriation for the estimated savings associated with enhanced requirements of third party insurers to accept the state's right of recovery of Medicaid payments.
- SB 08-090 reduced the Department's appropriation for the estimated savings associated with clients' increased access to mail-order pharmacies.
- SB 08-230 reduced the Department's appropriation for the transfer of funding for payments related to graduate medical education to a separate line item.
- Estimated Impact of PACE Enrollment: The Department has reduced its Acute Care projection under the assumption that increased enrollment in new PACE providers will cause a shift in expenditure from the Acute Care group to the PACE service category. The Department's calculations are contained in Section V of this part of the narrative.
- Drug Rebates for Physician and Hospital-Administered Drugs: The Department has reduced its Acute Care projection because of the estimated increase in drug rebates it will receive due to changes in federal law. The Department's calculations are contained in Section V of this part of the narrative.

Special bills which have caseload impacts are included as part of the Department's caseload projections, and no bottom-line expenditure adjustment is made. A bottom-line expenditure adjustment would double-count the impact of such a bill.

BREAST AND CERVICAL CANCER PROGRAM PER CAPITA DETAIL AND FUND SPLITS (PAGE EF-5)

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 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 2005-06 grew at an unexpected rate. The Department has investigated the issues involved, and determined that the total expenditure in FY 2005-06 contained a large amount of retroactive transactions, causing the expenditure for FY 2005-06 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 2007 through June 2008 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. 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-5.

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) (d) and (e), C.R.S. (2008), enacted in HB 08-1373, state funding for "traditional" Medicaid Breast and Cervical Program clients comes, in part, from the Breast and Cervical Cancer Prevention and Treatment Fund. In FY 2008-09, 100% of state funding comes from the Breast and Cervical Cancer Prevention and Treatment Fund. In FY 2009-10, state funding is split evenly between the Breast and Cervical Cancer Prevention and Treatment Fund and the General Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2008), 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 (PAGES EF-6 THROUGH EF-7)

Antipsychotic drugs were moved from the Department's premium line to the Department of Human Services for FY 2001-02. For FY 2003-04, 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, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational only line-item in Long Bill group (3), effective with HB 08-1375.

STATE-ONLY PRENATAL CARE COSTS FOR NON-CITIZENS (PAGE EF-8)

Pursuant to 25.5-5-103 (3), C.R.S. (2008), 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 2006-07, the Department's exhibit incorrectly listed the state-only portion of expenditure as the total amount spent on the program.

The FY 2008-09 and FY 2009-10 estimated expenditures are calculated by trending the FY 2007-08 total expenditure by 3.48%. Although the Department experienced sharp declines in expenditure in FY 2005-06 and FY 2006-07, and a large increase in FY 2007-08, an analysis of monthly expenditure reveals that total expenditure has relatively stable in recent months. 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 12 periods. This incorporates the most recent 18 months of data.

FAMILY PLANNING - CALCULATION OF ENHANCED FEDERAL MATCH (PAGE EF-9)

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided through fee-for-service and beginning in late FY 2001-02, 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 2004-05. Totals listed on page EF-9 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 2008-09 and FY 2009-10 is based on the average yearly percentage change from FY 2005-06 to FY 2007-08, 7.56%.

As of FY 2005-06, 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.

Half-Year Expenditure (Page EF-10)
This exhibit replaces the Department's Year-to-Date exhibit from the February 15, 2008 Budget Request. Because the Department only has limited experience in FY 2008-09, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 2007-08 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 1981-82, 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 a 10% increase in Medicaid caseload for Adults 65 and Older since FY 1997-98. In response to budget balancing in FY 2002-03, 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 (Pages EG-1 through EG-3)

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 2001-02 through FY 2007-08. 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 2004-05, FY 2005-06, FY 2006-07, and FY 2007-08. 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 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 2008-09 and FY 2009-10. 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 2008-09, with the rationale for selection, are as follows:

Aid Category	FY 2008-09 Community Based Long Term Care Trend Selection	FY 2009-10 Community Based Long Term Care Trend Selection	Justification
Adults 65 and Older (OAP-A)	Average of FY 2004-05 through FY 2005-06 2.84%	Average of FY 2004-05 through FY 2005-06 2.84%	High growth in prior years is primarily due to large rate increases at various points between FY 2005-06 and FY 2007-08. 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. The Department anticipates that, with moderate enrollment growth in waiver programs for this category, coupled with the increase in the number of clients enrolled in consumer-directed care options, that base growth will moderate in the near future.

Aid Category	FY 2008-09 Community Based Long Term Care Trend Selection	FY 2009-10 Community Based Long Term Care Trend Selection	Justification
Disabled Adults 60 to 64 (OAP-B)	Average of FY 2002-03 through FY 2006-07 (Total) 4.10%	Half of FY 2008-09 trend factor. 2.05%	High growth in prior years is primarily due to large rate increases at various points between FY 2005-06 and FY 2007-08. This has led to large trends in prior years which are not expected to continue. Therefore, the Department uses an overall trend factor from a relatively stable period to predict growth. The Department anticipates that growth will continue to moderate, particularly due to the influence of consumer-directed care options.
Disabled Individuals to 59 (AND/AB)	Percent change from FY 2002-03 to FY 2003-04 7.54%	Average of FY 2002-03 through FY 2006-07 (Total) 4.10%	High growth in prior years is primarily due to large rate increases at various points between FY 2005-06 and FY 2007-08. This has led to large trends in prior years which are expected to moderate in the future. After the rate increases, this category in particular experienced sustained monthly expenditure growth, as opposed to a one-time expenditure shift. This translated into large per capita growth in FY 2007-08, and the change in the annual per capita will reflect that continued growth. The Department anticipates that the growth will moderate over time.
Categorically Eligible Low-Income Adults (AFDC-A)	0.00%	0.00%	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their 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.

Aid Category	FY 2008-09 Community Based Long Term Care Trend Selection	FY 2009-10 Community Based Long Term Care Trend Selection	Justification
Expansion Adults	0.00%	0.00%	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their 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 & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Eligible Children (AFDC-C/ BCKC-C)	Percent change from FY 2006-07 to FY 2007-08 -15.45%	Half of FY 2008-09 trend -7.73%	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. Caseload increases will cause this per capita to fall drastically, although total expenditure will remain relatively constant. As caseload increases abate, so to will the decline in the per capita.
Foster Care	Average of FY 2003-04 through FY 2007-08 7.10%	Average of FY 2003-04 through FY 2007-08 7.10%	Foster care children only receive private duty nursing and hospice care. Only a very small number of clients receive services. Therefore, the Department has selected a trend factor based on a long term growth.
Baby Care Program - Adults (BCKC-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

Aid Category	FY 2008-09 Community Based Long Term Care Trend Selection	FY 2009-10 Community Based Long Term Care Trend Selection	Justification
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Partial Dual Eligibles	-50.00%	-25.00%	Clients in this eligibility category are not eligible for community based long term care benefits. In some cases, however, clients who are eligible for these services are incorrectly being assigned to this aid category. This began in January 2007, and appears to be abating. Clients receiving these services are generally eligible for OAP-A. Therefore, the Department anticipates that the per capita in this category will return to previous levels over time.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita 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 04-206 directed the Department to implement a pediatric hospice program. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008. The bottom-line impact in FY 2008-09 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 began with the Elderly, Blind and Disabled and Mental Illness waiver programs on January 1, 2008. The bottom-line impact for FY 2008-09 is the annualization amount.
- HB 08-1375 provided a 1.5% cost of living increase to home and community based services. Rate increases were effective July 1, 2008. The bottom-line impact in FY 2008-09 is the amount funded in HB 08-1375.
- Estimated Impact of PACE Enrollment: The Department has reduced its projection under the assumption that increased enrollment in new PACE providers will cause a shift in expenditure from the CBLTC group to the PACE service category. The Department's calculations are contained in Section V of this part of the narrative.

Half-Year Expenditure (Page EG-3)
This exhibit replaces the Department's Year-to-Date exhibit from the February 15, 2008 Budget Request. Because the Department only has limited experience in FY 2008-09, a year-to-date exhibit is not yet a good reasonableness check on the Department's request. Instead, the Department has split FY 2007-08 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)
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 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, 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 10.4% (through the FY 2007-08 total) since FY 1999-00. 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).

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

For complete information regarding specific calculations, the footnotes in pages EH-3 through EH-6 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[14]:

- Using historic claims data from the Medicaid Management Information System (MMIS) and information from the rate auditor, Myers and Stauffer, the Department calculates the estimated per diem allowable Medicaid rate of $179.18 for claims that will be incurred in FY 2008-09.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment of $30.82 for claims that will be incurred in FY 2008-09. The difference between the estimated per diem rate and the estimated patient payment, $148.36, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2008-09.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2008-09, a total of 3,355,212 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 2008-09, $497,779,252.
- Of the estimated total reimbursement for claims incurred in FY 2008-09, only a portion of those claims will be paid in FY 2008-09. The remainder is assumed to be paid in FY 2009-10. The Department estimates that 92.75% of claims incurred in FY 2008-09 will also be paid during FY 2008-09. Footnote 5 of Exhibit H, page EH-4, details the calculation of the percentage of claims that will be incurred and paid in FY 2008-09. The total amount estimated to be paid in FY 2008-09 for claims incurred in FY 2008-09 ("current year claims") is $461,690,256.
- During FY 2008-09, the Department will also pay for some claims incurred during FY 2007-08 ("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 2007-08 to calculate an estimate of outstanding claims of $33,870,607 to be paid in FY 2008-09.
- The sum of the current year claims and the prior year claims, $495,560,863, is the estimated expenditures in FY 2008-09 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-5 and EH-6.
- Legislative impacts are added as bottom-line adjustments. For FY 2008-09, this includes HB 08-1114, which established a new methodology for calculating nursing facility reimbursement rates as well as authorizing a provider fee to be collected by the Department.
- Once the "non-rate" factors are estimated, the sum of the gross budget estimate and the non-rate adjustments yields the total estimated FY 2008-09 expenditure, $505,162,843.

[14] For clarity, FY 08-09 figures are used as an example. The estimate for FY 09-10 is based on the estimate for FY 08-09, and follows the same methodology.

For FY 2009-10, the same methodology is applied, taking into account the estimate for FY 2008-09.

Legislative Impacts and Bottom-Line Adjustments

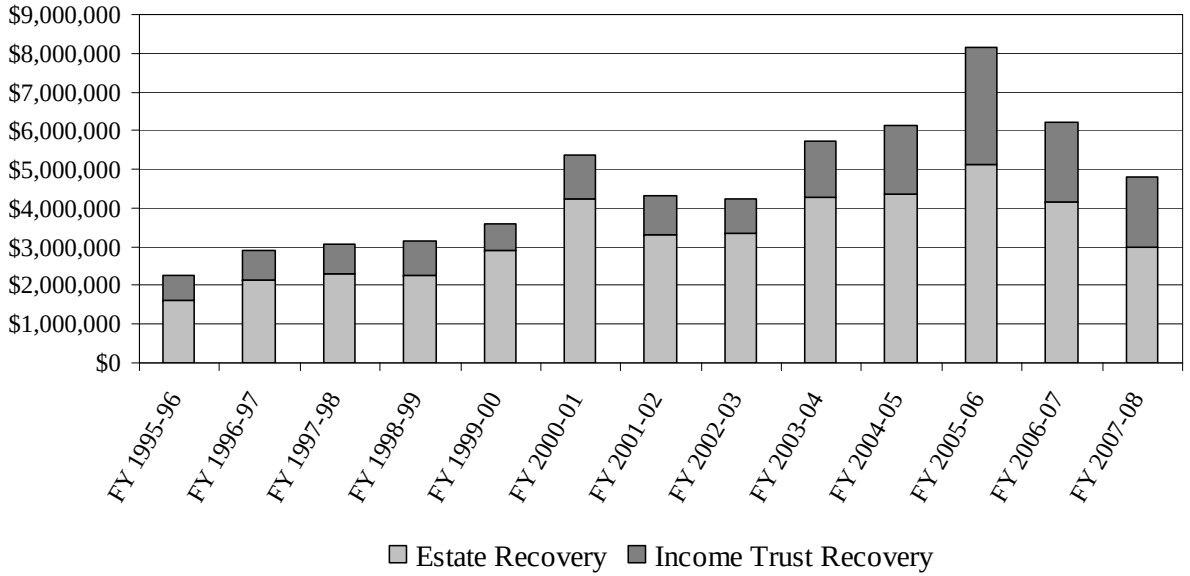
To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following legislative impact has been included in the Class I Nursing Facilities request:

- HB 08-1114 changes the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorizes a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities which do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. According to the Colorado Legislative Council Staff fiscal note dated April 12, 2008, the legislation is expected to increase nursing facility reimbursement rates by $11,854,320 in FY 2008-09 and by $15,397,478 in FY 2010-11. These amounts are conditional upon federal approval of both the nursing facility fee and the new rate reimbursement method.

In addition, the following bottom-line adjustments were included:

- The following expected Hospital Backup Program expenditures are included: $5,484,836 in FY 2008-09 and $5,759,078 in FY 2009-10. Refer to footnote (7) on page EH-5 for more detail.
- The Department expects to receive $5,810,275 in estate and income trust recoveries in FY 2008-09 and $7,054,668 in FY 2009-10. The following chart illustrates the history of estate and income trust recoveries from FY 1995-96 through FY 2007-08. As described in footnote (8) on page EH-5, the Department had an unusual number of high dollar recoveries in FY 2005-06. The decline from FY 2005-06 represented a return to a normal level of dollars recovered. The further decline from FY 2006-07 to FY 2007-08 was primarily due to a weak housing market. The Department does not expect the negative trend to continue, and the future trend is based on the average annual percent change from the three-year period of FY 2002-03 through FY 2004-05.

Estate and Income Trust Recoveries, FY 1995-96 through FY 2007-08



- In addition to the estate and income trust recoveries, the Department receives recovery dollars from in-house audits of nursing facilities. The Department anticipates receiving $1,926,901 in FY 2008-09 and $1,540,000 in FY 2009-10. Footnote (9) on page EH-6 contains additional detail about these recoveries.

Summary of FY 2008-09 and FY 2009-10 Request

FY 2008-09 Estimate	Amount
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$461,690,256
Estimated Expenditures for FY 2007-08 Dates of Service	$33,870,607
Estimated Expenditures in FY 2008-09 Prior to Adjustments	**$495,560,863**
Adjustments	$9,601,980
Total Estimated FY 2008-09 Expenditures	**$505,162,843**
FY 2009-10 Request	**Amount**
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$478,931,763
Estimated Expenditures for FY 2008-09 Dates of Service	$36,088,996
Estimated Expenditures in FY 2009-10 Prior to Adjustments	**$515,020,759**
Adjustments	$12,561,888
Total Estimated FY 2009-10 Expenditures	**$527,582,647**

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 four 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 2007-08 which will be paid in FY 2008-09, and the percentage of claims incurred in FY 2008-09 which will be paid in FY 2009-10.

The Department has updated its IBNR adjustment calculation from the February 15, 2008 Budget Request, using paid claims data through July 2008. For reference, the following table lists IBNR factors calculated over the previous four Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting that there is a decreasing lag time between the date of service and the payment of a typical claim.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%

Data Smoothing Adjustments

Before forecasting the estimates for patient payments and patient days, the historical data is adjusted to correct for seasonality and other data patterns which might affect the accuracy of trend forecasts. In calculating both the estimated patient payments and patient days, the exponential smoothing method is selected. The Department's rationale for these selections is described below.

Five methods of adjustment are utilized and compared:
Description of Data Smoothing Methods

2 x 12 moving average	Calculate a moving average using twelve monthly data points. Then, calculate the month to month average of each data point.
24-month average of moving averages	Calculate the 24-month average of the percent change from month to month of a twelve-month moving average series.
Seasonal indices	Use the 2 x 12 moving average data series to create a set of seasonal indices: divide each actual data point by the 2 x 12 moving average calculated for the same period. For each month, calculate the average of the seasonal indices. Divide each actual data point by the averaged seasonal index for the appropriate month.
Exponential smoothing	Create a smoothed data series where each data point is the current month's actual value multiplied by a smoothing coefficient plus the previous month's forecasted value multiplied by one less the same smoothing coefficient. This method gives more recent data more weight than older observations.
Holt's exponential smoothing algorithm	Create a smoothed data series where each data point is the current month's actual value multiplied by a smoothing coefficient plus the previous month's forecasted value multiplied by the difference between the forecasts in the two previous periods and the multiplied by one less the same smoothing coefficient. This method is a variation of exponential smoothing which also incorporates information about the previously forecasted trend.

Forecasting Patient Payment Rates

The table below includes the estimated average annual patient payment rates for FY 2008-09 and FY 2009-10 resulting from the five smoothing methods defined above. The table also includes a base trend calculated as the expected increase if the patient payment rate was held at the June 2008 level. A graph following the table below illustrates forecasted trends obtained by using the five methods of data smoothing.

For four of the methods, excluding the 24-month average of the moving averages, the trend is forecasted by performing a linear regression on the adjusted data series. The slope of the resulting trend line is then applied to the actual data, beginning with the data

point from June 2008. For the 24-month average of the moving averages, the slope of the trend line is the calculated average of 12-month moving averages over the most recent 24 months of data.

Since there is little difference between the forecasts obtained using data series adjusted using the exponential, Holt or 2 x 12 moving average methods, the widely accepted exponential method is selected. In analyzing the data, the Department believes that the exponential smoothing model provides the overall best fit for prior year data and will provide the most accurate predictions for future results. Appropriately, the rate of change in the out year is lower, reflecting an expected dampening of the positive trend.

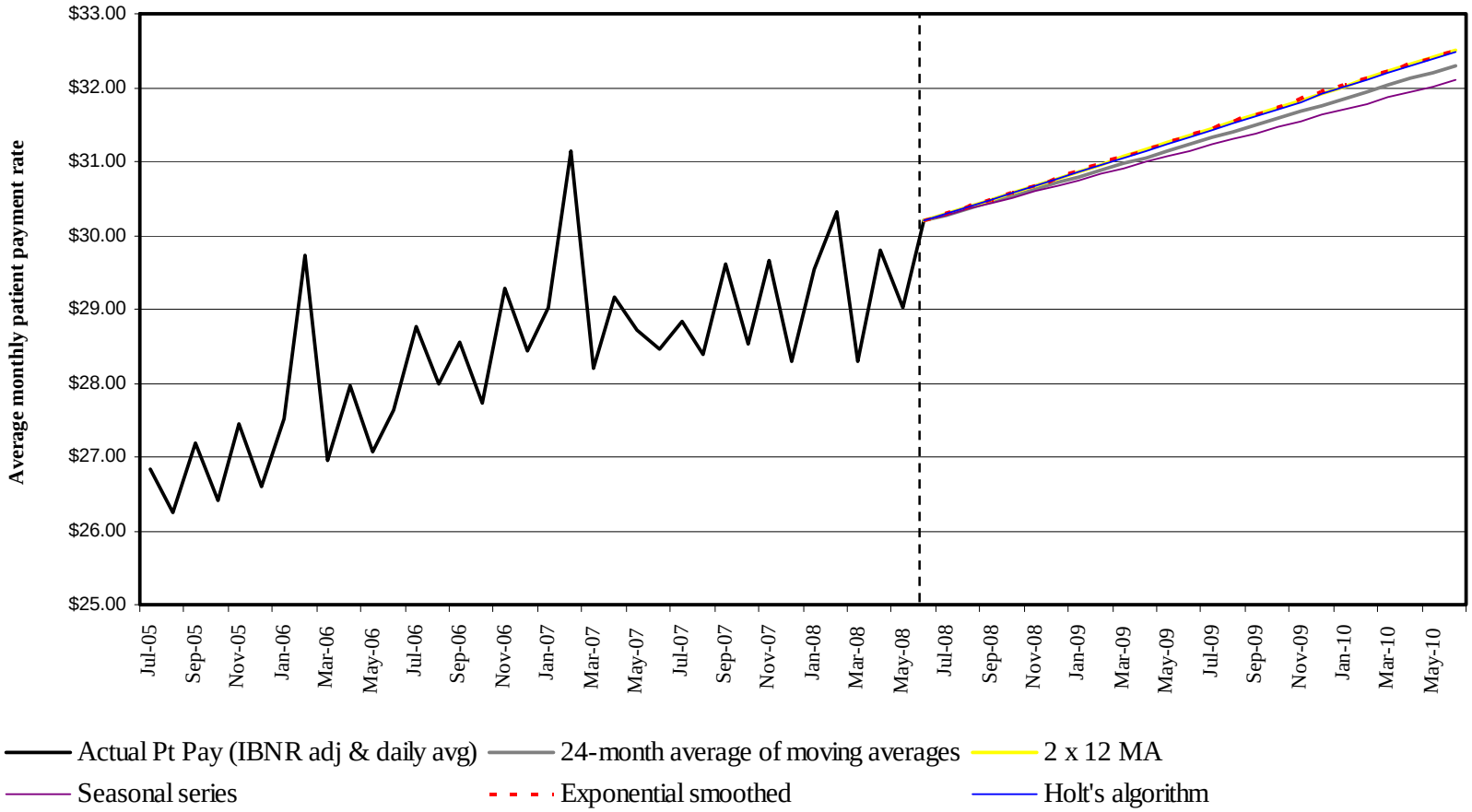
Patient Payment Rate Trend Forecasts – Reported as Annual Average Rates by Fiscal Year

	2x12 Moving average	Percent change from prior FY	**Exponential smoothed**	Percent change from prior FY	Seasonal indices method	Percent change from prior FY
FY 2008-09	$30.82	5.51%	**$30.82**	5.51%	$30.71	5.14%
FY 2009-10	$31.97	3.73%	**$31.98**	3.76%	$31.66	3.09%

	24-month average of moving averages	Percent change from prior FY	Holt's algorithm	Percent change from prior FY
FY 2008-09	$30.75	5.27%	$30.81	5.48%
FY 2009-10	$31.81	3.45%	$31.95	3.70%

Base trend if held at June 2008 level		
FY 2007-08	$29.21	--
June 2008	$30.20	3.39%

Patient Payment Forecasts for FY 2008-09 & FY 2009-10 using four years of IBNR adjusted data (seasonally adjusted and smoothed series with a 24-month forecast using a linear regression)

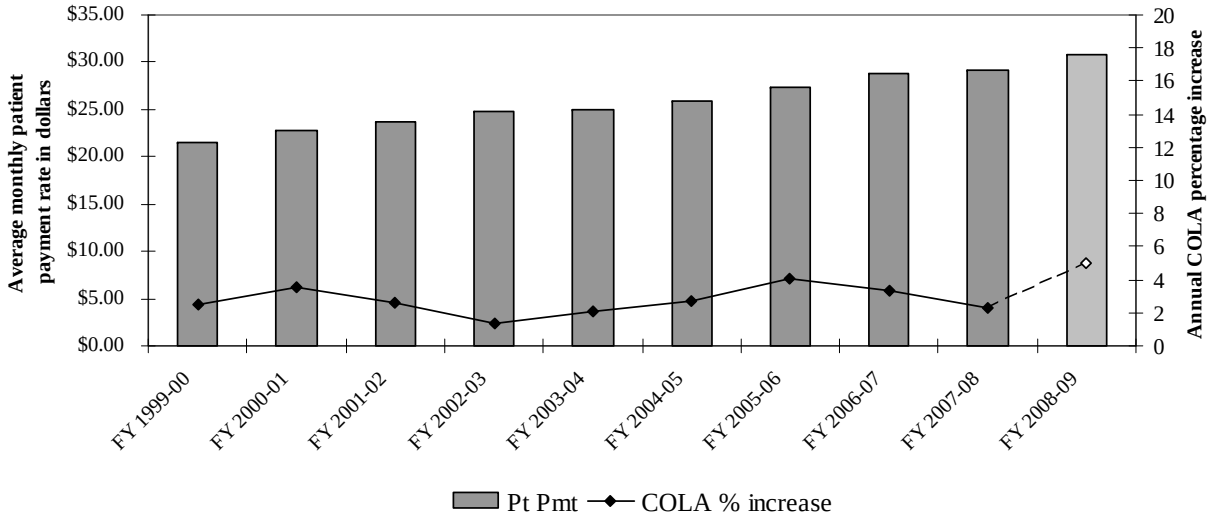


Note that the trend line for the 24-month average of moving averages is not created with a regression model.

The Department selected one of the higher trend forecasts. This choice is made since three of the forecasting methods indicate a similar trend, and because of the expectation of a higher Social Security Income Cost of Living Adjustment increase in FY 2008-09 than in previous years.

The patient payment rate is a function of patient income. Social Security Income (SSI) is a major component of patient income, so patient payment rates are influenced by the annual SSI Cost of Living Adjustments (COLA). As shown in the graph below, the average monthly payment rate does not exactly mirror the changes in the annual COLA rate. However, the flat patient payment rates from FY 2006-07 to FY 2007-08 corresponded to a relatively low COLA increase. The COLA calculations are based on Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) figures, and the latest figures indicate that the COLA should be significantly higher for 2008, around five percent. Thus, a higher rate of change in patient payments is appropriate.

Average Patient Payment and Annual Social Security Income Cost of Living Adjustment (SSI COLA), FY 1999-00 through FY 2008-09*



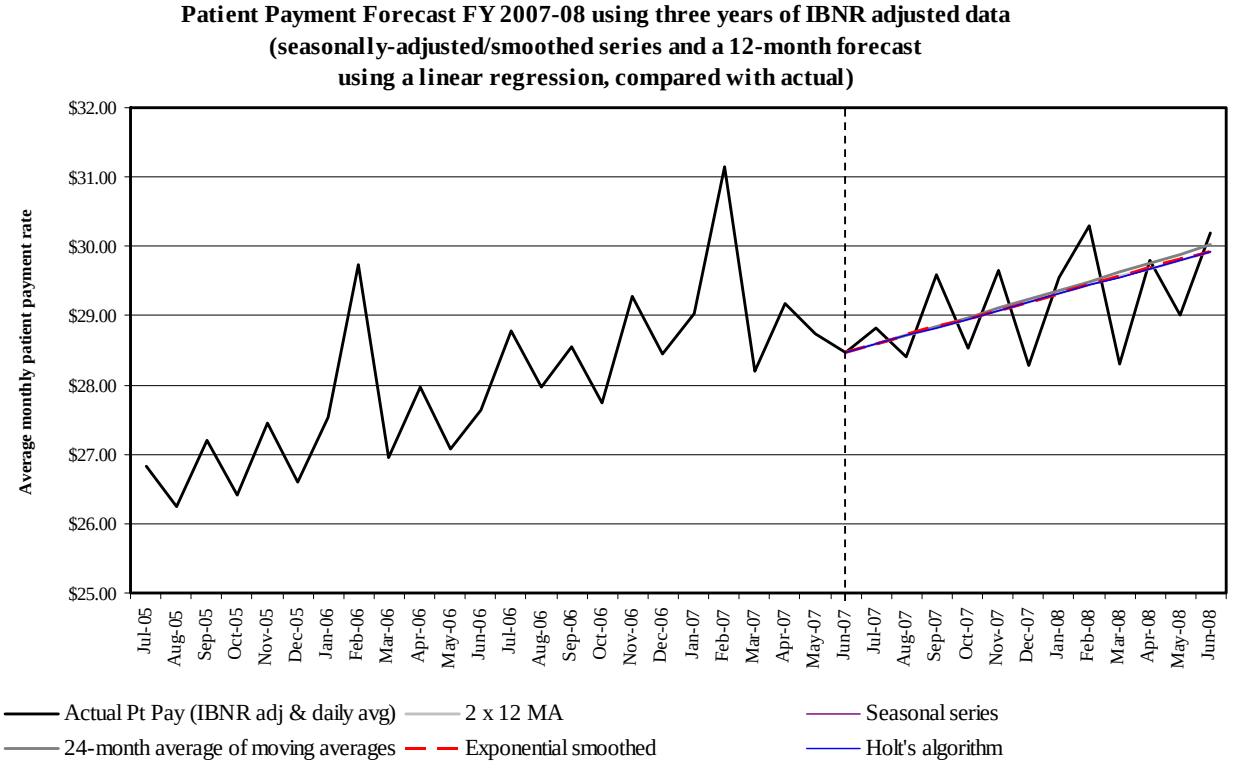
Source for COLA data: Social Security Administration, http://www.ssa.gov/OACT/COLA/colaseries.html

*FY 2008-09 figures are estimated. Note that the annual COLA increase takes effect with the January SSI payments, changing at the mid-way point of the Department's fiscal year.

Ex Post Forecasts of Patient Payment Rates – Reported as Annual Average Rates by Fiscal Year

An additional step to compare data smoothing methods is to calculate ex post forecasts for each method and compare the results with actual data. This step should not be considered an absolute test, as the data smoothing method which produces the most accurate ex post forecast will not necessarily produce the best forecast using current data. However, this is a useful test of reasonableness and robustness. The data set used to forecast the patient payment rates for FY 2008-09 and FY 2009-10 is again utilized, however in this step, the forecasts are made for FY 2007-08 and compared to the actual data for this period. With the exception of the 24-month average of moving averages method, there is little difference between the calculated average rates

	Actual average	2x12 Moving Average	Seasonal indices method	Exponential smoothed	Holt's algorithm	24-month average of moving averages
FY 2007-08	$29.21	$29.26	$29.25	$29.26	$29.25	$29.30



Forecasting Patient Days

Similar to the table for patient payment rates, the tables below include the estimated monthly patient days and FTEs for FY 2008-09 and FY 2009-10 resulting from the five smoothing methods defined above. The tables also include a base trend calculated as the expected increase if the number of patient days were held at the June 2008 level.

Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the number of FTEs, full time equivalent days. Trending is done using the FTEs, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month. A graph following the tables below illustrates forecasted trends of FTEs obtained by using the five methods of data smoothing.

As with the patient payments forecasts, for four of the methods (excluding the 24-month average of the moving averages), the trend is forecasted by performing a linear regression on the adjusted data series. The slope of the resulting trend line is then applied to the actual data, beginning with the data point from June 2008. For the 24-month average of the moving averages, the slope of the trend line is the calculated average of 12-month moving averages over the most recent 24 months of data.

Patient Days (FTEs) Trend Forecasts – Reported as Monthly Average FTEs by Fiscal Year

	2x12 Moving Average	Percent change from prior FY	**Exponential smoothed**	Percent change from prior FY	Seasonal indices method	Percent change from prior FY
FY 2008-09	9,205	-2.13%	**9,192**	-2.26%	9,170	-2.50%
FY 2009-10	9,141	-0.69%	**9,106**	-0.94%	9,042	-1.39%

	24-month average of moving averages	Percent change from prior FY	Holt's algorithm	Percent change from prior FY
FY 2008-09	9,170	-2.50%	9,191	-2.27%
FY 2009-10	9,044	-1.38%	9,103	-0.96%

Base trend if hold at June 2008 level		
FY 2007-08	9,405	--
June 2008	9,239	-1.77%

The exponential and Holt-Winters methods produce similar results. Both are relatively conservative forecasts which predict a continued negative trend which is flatter than the trend in the most recent year of actual data. As in the patient payment forecast, the exponential smoothing method is selected.

The declining trend in patient days is consistent with Department program policies; clients are enrolled in home care or alternative care facilities rather than nursing facilities if appropriate. From FY 2005-06 to FY 2007-08, the average annual patient days decreased by approximately 2%. In the same period, home and community-based services enrollment was up approximately 4% (from 18,461). The number of clients in Alternative Care Facilities increased approximately 4% from FY 2005-06 to FY 2006-07 (from 3,800).

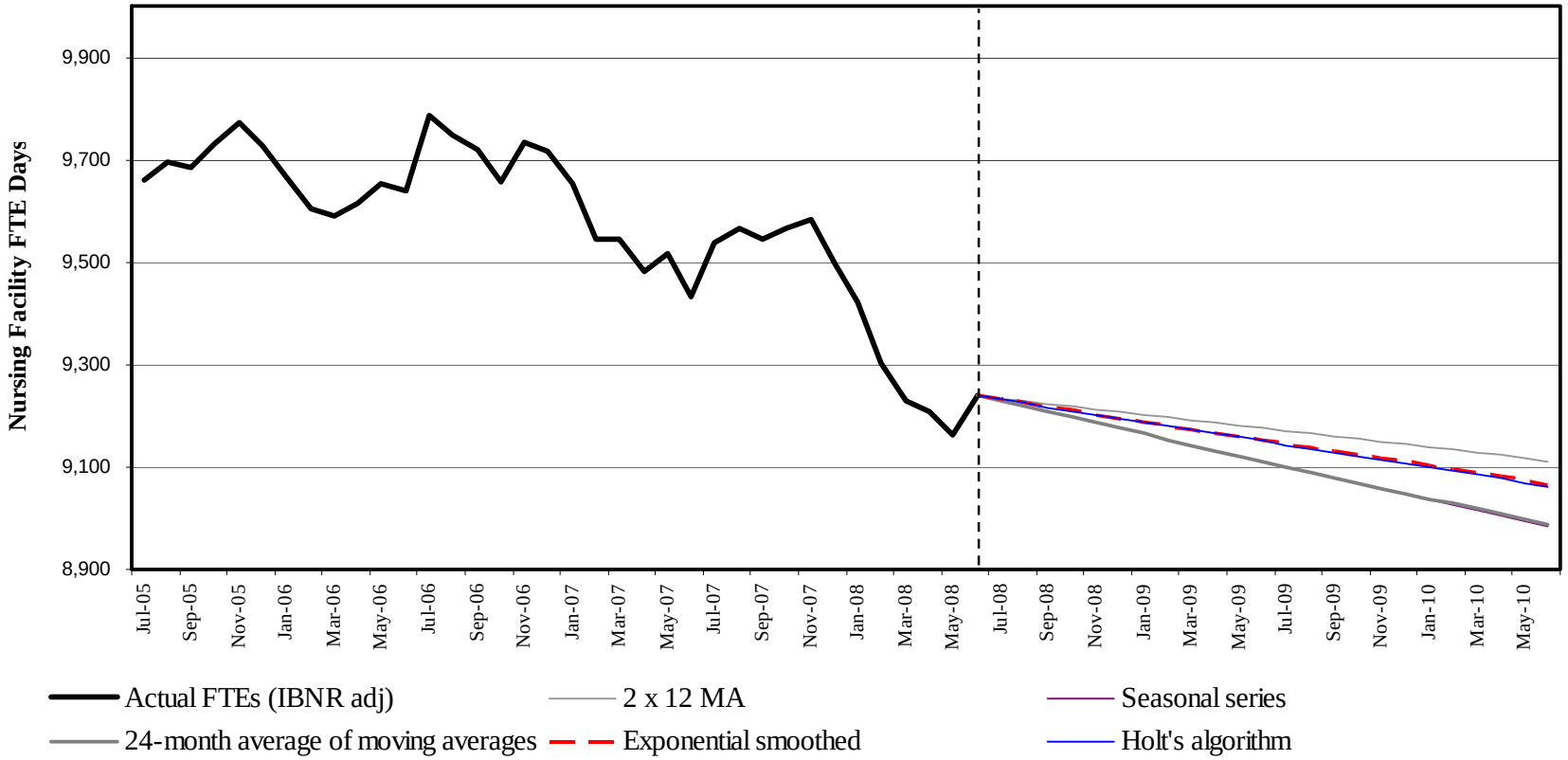
Patient Days Forecasts

	2x12 Moving Average	Percent change from prior FY	**Exponential smoothed**	Percent change from prior FY	Seasonal indices method	Percent change from prior FY
FY 2008-09	3,359,709	-2.41%	**3,355,212**	-2.54%	3,347,081	-2.77%
FY 2009-10	3,336,519	-0.69%	**3,323,690**	-0.94%	3,300,493	-1.39%

	24-month average of moving averages	Percent change from prior FY	Holt's algorithm	Percent change from prior FY
FY 2008-09	3,347,106	-2.77%	3,354,839	-2.55%
FY 2009-10	3,301,008	-1.38%	3,322,627	-0.96%

Base trend if hold at June 2008 level		
FY 2007-08	3,442,519	--
June 2008	3,372,235	-2.04%

Nursing Facilities FTE Forecasts FY 08-09 and FY 09-10 using four years of IBNR-adjusted data (seasonally-adjusted/smoothed series and a 24-month forecast using a linear regression)



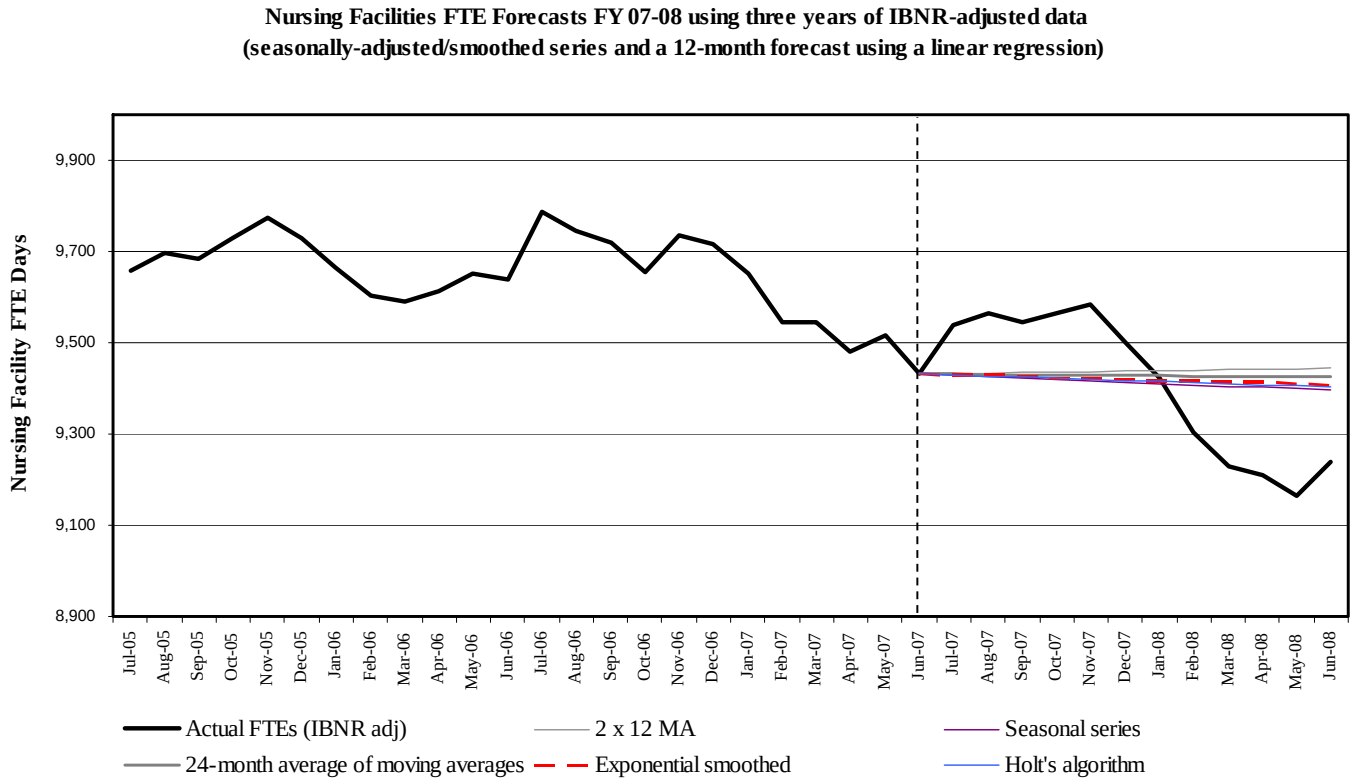
Note that the trend line for the 24-month average of moving averages is not created with a regression model.

Ex Post Forecasts of Patient Days

As described above for forecasting patient payment rates, the Department takes an additional step to compare data smoothing methods by calculating ex post forecasts for each method and comparing the results with actual data. As previously noted, the data smoothing method which produces the most accurate ex post forecast will not necessarily produce the best forecast using current data. However, this is a useful test of reasonableness and robustness. The seasonal indices, Holt and exponential smoothing methods produce FTE estimates near the actual FY 2007-08 FTE figure.

Patient Days Reported as Monthly Average FTEs by Fiscal Year

	Actual	2x12 Moving Average	Seasonal indices method	Exponential smoothed	Holt's algorithm	24-month average of moving averages
FY 2007-08	9,405	9,439	9,412	9,418	9,416	9,428



Nursing Facility Rate Methodology Changes

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

FY 1997-98 8% Health Care Cap and 6% Administrative Cap Implemented
FY 1998-99 No change
FY 1999-00 8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 2000-01 No change
FY 2001-02 8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
FY 2002-03 Administrative Incentive Allowance removed for three months then reinstated
FY 2004-05 8% Health Care Cap reinstated
FY 2005-06 No change
FY 2006-07 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 2006-07 only.
FY 2007-08 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.
FY 2008-09 New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide. Until the required state plan amendments are approved by the Centers for Medicare and Medicaid Services, the methodology in FY 2007-08 remains in effect.

Class I Nursing Facilities – Cash Based Actuals and Projections by Aid Category (Page EH-7)

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 (Pages EH-8 through EH-9)

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 1997-98. Beginning in FY 1998-99, 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 2005-06, Good Shepherd Lutheran increased its enrollment from 16 clients to 20 clients. During FY 2006-07, 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 2008-09 as the total expenditure in each aid category multiplied by the average percent change in total expenditure from between FY 2005-06 and FY 2007-08, excluding FY 2006-07. 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 2009-10.

Program Of All-Inclusive Care For The Elderly (PACE) (Pages EH-10 through EH-12)

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.

Effective with 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-11: 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 2008-09 projection for PACE is computed in several parts: First, the Department estimates the growth in the average enrollment, and applies the selected trend factor to the FY 2007-08 average enrollment. Estimated enrollment at new PACE providers, which are not reflected in historical trends, is added as a bottom-line adjustment. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2007-08 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2008-09 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 2008-09 total expenditure. FY 2009-10 is calculated in the same fashion.

To estimate the increase in enrollment, the Department selected half of the average percent increase in enrollment between FY 2006-07 through FY 2007-08 for all aid categories, based in part on potential expansions for the current PACE program. This factor is held constant for FY 2009-10.

To estimate the average increase in cost per enrollee, the Department selected the average percent increase in cost per enrollee between FY 2003-04 and FY 2007-08 for Adults 65 and Older, and the average percent increase in cost per enrollee between FY 2003-04 and FY 2007-08 in the Disabled Adults 60 to 64 for both the Disabled Adults 60 to 64 and the Disabled Individuals to 59 aid category. The Disabled aid categories are anticipated to have like trends because PACE providers are paid the same rate for a disabled client regardless of age. Because of the volatile history in recent years, the Department anticipates that a long-term average will be the most reflective of future growth.

The Department has received applications for additional PACE providers, with a new provider serving clients in September 2008 in Montrose and Delta counties. The Department anticipates that another provider will begin to serve clients in January 2009, in El Paso county. The Department anticipates that by the end of FY 2008-09, approximately 93 clients will be enrolled in the new programs. For calculation purposes, this reflects an average monthly caseload of 34 clients. In FY 2009-10, the Department anticipates that approximately 357 clients will be added to PACE enrollment, with a PACE caseload impact of 241 clients. Further expansion is anticipated in FY 2010-11; as expansion information becomes known, the Department will adjust its Budget Requests accordingly.

Legislative Impacts and Bottom-Line Adjustments
Adjustments to FY 2008-09 and FY 2009-10 include the following:

- HB 08-1374 removed the requirement that the Department reimburse PACE providers at 95% of the equivalent fee-for-service cost, effective July 1, 2008. The Department now pays providers the lesser of the 100% rate or the federal upper payment limit.

Supplemental Medicare Insurance Benefit (SMIB) (Pages EH-13 and EH-14)
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.[15] 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. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal 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:[16]

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%
2008	$423.00	3.17%	$96.40	3.10%

[15] 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.

[16] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

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.

During FY 2007-08, the Department made its July 2007 payment for Medicare premiums several days late. As a result, Medicare automatically deducted the balance from the Department's Medicaid grant. As a result, from the perspective of Medicare, the Department effectively double-paid July, and the difference became a credit against the September total. As a result, the total expenditure for this line does not reflect payment for one month, because the federal funds Medicare received directly from the Medicaid grant did not pass through the state's accounting system. Therefore, in order to accurately project expenditure, the Department uses the actual Medicare invoice totals for FY 2007-08 instead of the actual expenditure for FY 2007-08. This ensures that the projection base is not understated, which would lead to a material under-projection in the forecast.

To forecast FY 2008-09, the Department first inflates the adjusted expenditure from the second half of FY 2007-08 by the estimated caseload trend for FY 2008-09 from Exhibit B, page EB-1. This figure represents the approximate expenditure for the first half of FY 2008-09. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium. The total estimated expenditure for FY 2008-09 is the sum of the first half and second half estimates. The Department repeats the methodology for FY 2009-10 using the estimated FY 2008-09 expenditure.

Health Insurance Buy-In (HIBI) (Pages EH-15 and EH-16)

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. (2008). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, 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 2005-06. 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.

In FY 2006-07, 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 2006-07, 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 2007-08 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 2006-07 was 41.62%; growth in FY 2007-08 was 21.90%. The Department selected 10.95% to trend expenditure to FY 2008-09, and 5.48% to trend expenditure to FY 2009-10. The Department selected these percentages by reducing the FY 2007-08 growth rate by 50% in FY 2008-09, and by 50% again in FY 2009-10. 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-6.

Single Entry Points (Page EI-2 and EI-3)
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. (2008)). 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. (2008)).

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. (2008)).

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. (2008)). 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.

Effective with 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 2008-09, the Department's projection uses the current amount allocated to Single Entry Points in the FY 2008-09 Long Bill, and adds two legislative impacts (see below). The Department's estimate does not include any increase for service utilization for this fiscal year, as current projections for single entry point services indicate that the current budget is sufficient.

For FY 2009-10, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2004-05 through FY 2007-08 for each aid category. The estimated FY 2008-09 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2009-10 expenditure.

FY 2008-09 and FY 2009-10 Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita 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 2007-08 and FY 2008-09 calculations for Single Entry Points:

- SB 04-206 directed the Department to implement a pediatric hospice program. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008. This is an increase of $79,013 in FY 2008-09. These figures are calculated based on the total estimated caseload (25 clients in FY 2007-08, and 75 additional clients in FY 2008-09) multiplied by the current per client rate. See section V of this narrative for additional details.
- 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 2007-08 and an increase of $504,188 to FY 2008-09 (Legislative Council fiscal note for HB 05-1243, March 15, 2005).

Disease Management (Page EI-4)

Beginning in July 2002 the Department implemented several targeted disease management pilot programs, as permitted by 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. (2008)). 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. In order to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits, the Department contracted with Alere Medical Incorporated for clients with asthma, and with McKesson Health Solutions for clients with diabetes. Over time, the Department has added and changed contracts as appropriate to ensure that Medicaid clients continue to receive quality care.
The Department currently has five disease management contracts covering specific conditions. Those conditions are: asthma; congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD); high risk obstetrics; and weight management. The Department also employs a contractor to do more general disease management via telemedicine. The Department's funding for these contracts is a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117 (2) (d) (IV.5), C.R.S. (2008), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separates the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation is reflected as a bottom-line impact (described below).

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.

Legislative Impacts and Bottom- Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita 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 2007-08 and FY 2008-09 calculations for Disease Management:

- SB 08-118 authorized a transfer from the Department of Public Health and Environment of $2,000,000 from the Prevention Early Detection and Treatment Fund for Medicaid disease management and treatment programs that address cancer, heart disease, and lung disease, or the risk factors associated with such diseases. This authorization replaces similar statutory language which was repealed at the end of FY 2006-07.

Prepaid Inpatient Health Plan Administration (Pages EI-5 and EI-6)

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 2003-04. The Department currently contracts with one prepaid inpatient health plan, Rocky Mountain Health Plans. In FY 2005-06, 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 2008-09 and FY 2009-10, the Department has used actual enrollment in its current administrative service organization to forecast expenditure in FY 2008-09 and FY 2009-10.

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 2005-06 and FY 2006-07. During FY 2007-08, the Department and Rocky Mountain Health Plans were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was paid. The Department anticipates that it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09, with existing funding. Similarly, in FY 2009-10, the Department anticipates making a single contracted payment for services rendered in FY 2007-08. This figure is an estimate based on the percentage enrollment increase of 1.37% in FY 2007-08. 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 estimated levels.

EXHIBIT J - ESTIMATE OF FY 2008-09 EXPENDITURE USING FY 2007-08 CASH FLOW PATTERNS

This exhibit displays the FY 2008-09 year-to-date expenditures through September 2008 and the cash flow pattern of actual expenditures for the first quarter of FY 2007-08 to determine a rough estimate of FY 2008-09 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.

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 2001-02. 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 related to changes in reimbursement rates.

In FY 2005-06, 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 2006-07 Base Reduction Item 2 (November 15, 2005) was approved; starting in FY 2006-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services that it would no longer be permitted to certify public expenditure for nursing facilities. Therefore, the Department does not include any totals for nursing facilities in its Request.

Projections for all provider types are provided in Exhibit K.

EXHIBIT L - APPROPRIATIONS AND EXPENDITURES

This exhibit displays the FY 2007-08 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2007-08 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, with 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.

Effective with the November 1, 2007 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

Effective with the February 15, 2008 Budget Request, the Department has restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2006-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

Effective with the November 3, 2008 Budget Request, the Department has restated actuals for Single Entry Points from, by using HCBS utilization rates as opposed to total expenditure in Community Based Long Term Care and Long Term Care service categories.

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 1995-96 through FY 2007-08 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 2006-07, FY 2007-08, and FY 2008-09 in the chronological order of the events. Shaded areas indicate that the Request or appropriation has not yet taken place.

For FY 2006-07, 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 2006-07 appropriation and actuals.

For FY 2007-08, this exhibit compares the Department's November 1, 2006, February 15, 2007, November 1, 2007, and February 15, 2008 Budget Requests to the final FY 2007-08 appropriation and actuals.

For FY 2008-09, this exhibit lists the Department's November 1, 2007, February 15, 2008, and November 3, 2008 Budget Requests to the FY 2008-09 appropriation including special bills.

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, 2007, and 2008 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 04-206 -- Concerning Hospice Care for Persons who are Eligible under the "Colorado Medical Assistance Act"

The bill required the Department to seek the appropriate federal authorization to prepare and submit a request for hospice care services for eligible children under the state's Medicaid program. The bill specifies that the hospice care services shall include but need not be limited to: respite care; expressive therapies; palliative care from the time of diagnosis of a potentially life-threatening illness; and continuum of care through the coordination of services, which may include skilled, intermittent, and around-the-clock nursing care. The Centers for Medicare and Medicaid Services granted the Department's waiver request, and services became available to clients effective January 1, 2008.

The fiscal note for SB 04-206 estimated a participation rate and savings based on a small sample of clients who would have qualified, based on diagnosis code, for a similar program for non-Medicaid clients, run by a Denver-area hospital. Because the program requirements have now been finalized, the Department has estimated the impact for the program in the table below. In particular, services are capped at $20,000 per client on the waiver. The Department assumes that, on average, each client will expend only 25% of that cap. Further, the Department estimates costs for Single Entry Points based on the standard rate of $1,053.50 per client, and estimates acute care savings as twice the waiver cost.

In its February 15, 2008 Budget Request, the Department assumed that program costs and associated savings would begin in approximately April 2008; however, due in part to cash accounting and the billing lag for services, the Department did not experience any costs (or savings) in FY 2007-08. Therefore, the Department has included the full impact for this program in FY 2008-09. For single entry points, however, the estimated impact remains the annualization value; single entry point contracts were increased for the estimated caseload in FY 2007-08, and the base contracts now only require the annualization value to be made whole. The Department believes that it was appropriate to increase single entry points in advance of receiving claims for this program, because, by the nature of their role, the single entry points assess the clients before claims can be submitted.

SB 04-206: Pediatric Hospice	**FY 2008-09**
Estimated Caseload	75
Average Cost Per Client Per Year	$5,000
Estimated Waiver Cost (Community Based Long Term Care)	375,000
Estimated Single Entry Point Cost (Annualization)	$79,013
Estimated Savings (Acute Care)	($1,000,000)
Total	**($545,987)**

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 became available to clients 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.

The remaining bottom-line impact of this program is the annualization of the estimated savings due to implementation of the program. Costs for services and single entry points are assumed to be fully incorporated into the base projection.

Description	FY 2007-08	FY 2008-09 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 in Exhibit F. For Disease Management, the fund-split is made directly in Exhibit A.

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 135 of this narrative.

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 2006-07. However, in SB 07-239, the Department was granted roll-forward authority to implement programs in FY 2007-08 (Figure Setting, March 8, 2007, page 32). In SB 08-118, the transfer was renewed, and set at a maximum of $2,000,000 (state funds) per year. The Department receives this funding as a transfer from the Department of Public Health and Environment, and not directly from the Prevention, Early Detection, and Treatment Fund.

Health Care Expansion Fund
This fund is administered by the Department. 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) Medicaid for legal immigrants, 4) increased Eligible Children due to the impact from marketing the Children's Basic Health, and 5) providing 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 2008-09		FY 2009-10	
Health Care Expansion Fund Program	Total Funds	Health Care Expansion Fund	Total Funds	Health Care Expansion Fund
Expansion Adults	**$29,615,436**	$14,807,719	$35,253,962	$17,626,981
Expansion Foster Care	$6,072,462	$3,036,232	$9,956,156	$4,978,079
Presumptive Eligibility	$3,788,294	$1,894,147	$4,084,808	$2,042,404
Legal Immigrants	$28,196,644	$14,098,322	$29,973,559	$14,098,322
Removal of Medicaid Asset Test	$64,810,164	$32,405,082	$68,128,983	$34,064,492
Children's Home and Community Based Services	$19,996,769	$9,998,385	$20,606,549	$10,303,275
Children's Extensive Support	$3,295,741	$1,647,871	$3,396,241	$1,698,121
Total	**$155,775,510**	**$77,887,758**	**$171,400,258**	**$84,811,674**

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 for some clients 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. Previously, the Department made payments to Anthem 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. Effective January 2008, clients who receive presumptive eligibility are being accounted for through the Medicaid Management Information System.

Using the normalized data, the Department has projected caseload for FY 2008-09 and FY 2009-10 using historical enrollment figures. Expenditure is projected using the current average monthly cost multiplied by the monthly caseload. The Department has forecasted expenditure based on historical monthly expenditure and caseload. Forecasting methodology is described in the Tobacco Tax Section 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 2004-05. In FY 2007-08, 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). In FY 2007-08, the Department implemented system changes allowing it to determine which clients were members of the optional legal immigrant population. As a result, the Department's projections have been revised to include the actual projected expenditure for this population. The Department's forecast methodology is described in the Tobacco Tax section of this Budget Request.

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 2006-07, 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 forecasted expenditure based on historical monthly expenditure and known caseload.

Because the Department is no longer able to request asset test information for individuals who are not applying for Medicaid and other financial assistance programs, the asset test removal population has been difficult to track. Changes to the Colorado Benefits Management System allow for all individuals applying for Medicaid benefits to be marked with a flag that reports the following: whether the client would have been eligible for Medicaid regardless of the asset test removal; if the client would not qualify for Medicaid if the asset test was still in place; or, if it is unknown whether the client's assets are a factor in determining eligibility. Circumstances where this information may not be known include: existing clients who have not gone through a yearly re-determination, or clients who are not required to provide asset information as a result of not applying for other public assistance programs.

For clients who have not provided asset test information, the Department transfers funds from the Health Care Expansion Fund under the assumption that a number of clients who have not reported asset information would not have qualified for Medicaid prior to the rule change. In previous years the Department assumed that of the clients who had not reported asset information, the proportion of these clients who would not have qualified prior to the change was the same as the proportion of clients who had reported asset information and would not have qualified. However, based on analysis performed in FY 2007-08, the number of clients who have reported asset information is well below the original levels anticipated. Therefore, starting in FY 2007-08, the Department has revised the methodology used to allocate expenditure for clients who have not reported asset information. The Department's preliminary research indicates that clients who gained eligibility because of the removal of the asset test have significantly higher income on average than clients who would have qualified regardless of the change. Further, clients who have not reported asset information have significantly higher income than those clients who have reported asset information. Based on this information, the Department believes that there is a significant under-reporting bias in the eligibility data, in that clients who have higher income are less likely to provide asset information.

Given the under-reporting bias, the Department does not believe that it is appropriate to use the strict ratio of clients who would not have qualified to the total population who have reported asset information. Rather, the Department has used that ratio as a base, and inflated it by 100%. This figure is a rough estimate, based on the average difference in incomes between clients who have reported asset information but would not have previously qualified for Medicaid and those that have not provided asset information. Because the results are preliminary, the Department has made a number of assumptions to ensure that the estimate is conservative and reasonable, and has rounded the figure because of the inherent uncertainty of this projection. The Department continues to research this issue, and anticipates that a more comprehensive and permanent framework will be available in a future Budget Request.
The Department's forecast methodology is described in the Tobacco Tax section 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. Once a child is on the waiver, he/she must receive at least one state-paid waiver service per month to remain on either of the Waiver programs.

In order to calculate the impact to the Health Care Expansion Fund, the Department calculates the estimated total cost per waiver slot for each program, and multiplies that cost by the total number of slots. The CHCBS waiver has 678 waiver slots, and the CES waiver has 79 slots which are funded via the Health Care Expansion Fund. For the CES waiver, waiver costs are not charged against the Medical Services Premiums Long Bill group; rather, those costs are borne by the Department of Human Services.

In FY 2007-08, the Department changed the methodology to account for the CHCBS waiver slots. In previous years, the Department considered each waiver slot as numbered sequentially; that is, the "last" 678 slots were considered expansion slots. This had the result of effectively reducing the total number of waiver slots eligible for Tobacco Tax funding, as there are delays in filling waiver slots when those slots become available. In its February 15, 2008 Budget Request, the Department requested to move to an "average slot" methodology, where the average per capita cost per slot was used to determine the total expenditure. The Joint Budget Committee approved the Department's methodology during Figure Setting in March 2008. Effective with FY 2008-09, the Department is requesting to apply this methodology to the CES waiver program as well. This has the effect of increasing the effective number of slots from 59 to 79, the total amount of expansion slots added.

HB 07-1021 - Concerning the Prescription Drug Consumer Information and Technical Assistance Program
HB 07-1021 established the Prescription Drug Consumer Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients. The Department 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 expenses are expected to receive consultations. Payments to pharmacists are included in the Department's Executive Director's Office Long Bill group. The program started in January 1, 2008; the Department's FY 2008-09 calculations reflect the annualization amount of $750,139, which includes the cost of the consultations and the estimated savings.

HB 08-1114 - Concerning the Reimbursement of Nursing Facilities Under the "Colorado Medical Assistance Act", and, in Connection Therewith, Amending the Reimbursement System for Class I Nursing Facilities and Authorizing the Department of Health Care Policy and Financing to Charge and Collect a Quality Assurance Fee from Certain Class I Nursing Facilities

HB 08-1114 provided a comprehensive revision to the statute which governs nursing facility rates. The methodologies for calculating the base components of the rate – specifically direct health care, indirect health care and food, administration and general, and fair rental allowance – were each modified. In addition, several new components were added to the rate, including: a pay-for-performance component; and additional payments for clients with severe mental conditions, severe cognitive dementia, or brain injuries. Funding for the new components is provided by a fee imposed on nursing facilities, with certain exceptions. Certain facilities which do not participate in Medicaid are still subject to the provider fee. Additionally, the statute specifies that the General Fund portion of the per diem rate cannot grow more than 3% in any fiscal year, and that any additional growth may be funded using the provider fee.

The provisions of HB 08-1114 do not go into effect until approval is granted for the new methodology is approved by the Centers for Medicare and Medicaid Services. Until such approval is granted, the nursing facility rates will continue to be calculated using the methodology in statute prior to the passage of HB 08-1114.

The Department received a conditional appropriation in FY 2008-09 of $11,854,320 to implement this bill; if the modifications are not approved, the appropriation does not take effect until FY 2009-10. The appropriation annualizes to $16,290,933 in FY 2009-10.

HB 08-1373 – Concerning the Breast and Cervical Cancer Prevention and Treatment Fund

HB 08-1373 altered the funding source for the Breast and Cervical Cancer Program for FY 2007-08 through FY 2013-14. For FY 2007-08 and FY 2008-09, 100% of the state funding is provided from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 2009-10 through FY 2013-14, 50% of the state funding is provided from the Breast and Cervical Cancer Prevention and Treatment Fund, and the remainder is provided from the General Fund. This bill did not impact the expansion clients who are funded through the Prevention, Early Detection, and Treatment Fund. The Department's General Fund appropriation was reduced by $1,800,529 in FY 2008-09, with a corresponding increase in cash funds. The annualization in FY 2009-10 increases General Fund by $865,485 in FY 2009-10, with a corresponding decrease in cash funds. The Department's estimates in Exhibit A differ from the appropriation levels, based on current caseload and costs estimated.

HB 08-1374 - Concerning Repeal of the Cap on the Capitated Rate under the Program of All-Inclusive Care for the Elderly

HB 08-1374 repealed the requirement that the Department pay a capitated rate based on 95% of the Medicaid fee-for-service costs of an actuarially similar population. Although not explicitly required, the Department was appropriated funding to raise rates to the 100% of fee-for-service level. Effective July 1, 2008, the Department has raised rates to the maximum amount allowable under federal law; in some cases, the federal upper payment limit may be lower than the 100% level. The Department received an

appropriation of $3,134,928 in FY 2008-09 to implement this bill; however, the Department has recalculated this amount in Exhibit H to reflect the current estimated program cost.

HB 08-1375 – FY 2008-09 Long Bill

The FY 2008-09 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests during the 2008 Legislative Session. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- *Provider Rate Increases (DI-6 and BA-1A):* In total, the Department received $39,057,940 in FY 2008-09 to increase rates to Medicaid providers in the Medical Services Premiums Long Bill group. The Department is increasing rates to providers in the following way: raising evaluation and management codes to 90% of the Medicare level; raising dental rates to 52% of the average commercial rate (as defined by the American Dental Association); increasing rates paid to substance abuse providers; increasing rates paid for radiology services; increasing rates paid for vision benefits; increasing rates paid to providers in the Prenatal Plus program; increasing rates paid to inpatient hospitals; and increasing rates paid to home health and HCBS providers. The bottom-line impact also includes the cost of incorporating the rate increases in managed care rates, which are based on fee-for-service rates.
- *Medical Homes (DI-6 and BA-1A):* The Department received $3,305,400 to increase rates to providers serving as medical homes for Medicaid children.
- *Increase Managed Care Rates (DI-12, S-12):* The Department received $843,162 to raise capitation rates paid to managed care organizations to 100% of fee-for-service costs.
- *Adjust Cash Flow for Managed Care Organizations (BA-1A*): The Department received $3,928,032 to account for the concurrent payment of fee-for-service claims and managed care capitations which are a result of enrolling existing clients in a prepaid managed care program. However, the Department has recently decided to revise its approach to managed care and does not anticipate that this funding will be necessary in FY 2008-09. The Department's bottom-line impact for this initiative has been zeroed-out. As part of this Budget Request, the Department's Decision Item 6 ("Medicaid Value Based Coordinated Care Initiative") details the Department's decision to suspend most new managed care enrollments and outlines the Department's future plans in this area.
- *Preferred Drug List (BA-3):* The Department's appropriation was reduced by $962,456 to account for estimated savings associated with the implementation and expansion of the Department's preferred drug list.
- *Regional Center Conversion (BA-7):* The Department's appropriation was reduced by $302,145 to account for decreased costs in the Medical Services Premiums Long Bill group due to the conversion of certain group homes which provide care to individuals with developmental disabilities to intermediate care facilities for the mentally retarded (ICF/MR). This initiative shifted funding to the Department of Human Services; only the reduction in costs is captured in the Medical Services Premiums Request.
- *Efficiencies in Medicaid Cost Avoidances and Provider Recoveries (BA-9):* The Department's appropriation was reduced by $3,875,000 for estimated savings due to improved efforts to reduce the amount of fraudulent and erroneous Medicaid payments.

- *Efficiencies in Pharmaceuticals through the Expansion of 340B Pricing (BA-12):* The Department's appropriation was reduced by $74,308 for estimated savings due to the implementation of a pilot program utilizing mail-order pharmacies which qualify for 340B pricing. The pilot program includes an increased dispensing fee for participating providers.

Where appropriate, the Department has included annualization values as bottom-line impacts for FY 2009-10.

HB 08-1407 - Concerning Strengthening Penalties for the Unreasonable Conduct of an Insurance Carrier

HB 08-1407 prohibits the unreasonable delay or denial of payment of a claim for benefits owed by an insurance company, and provides remedies for claimants. This bill is anticipated to reduce the amount of claims the Department pays for in fee-for-service for clients who are enrolled in the Health Insurance Buy-In (HIBI) program. The bill reduced the Department's appropriation by $277,780 in FY 2008-09.

HB 08-1409 - Concerning Recovery of Payments under Medicaid

HB 08-1409 authorizes the Department to take all reasonable measures to determine the legal liability of third parties to pay for services provided to Medicaid clients and to pursue claims against liable parties. As a condition of doing business in the state, third parties such as health insurance carriers and managed care organizations are required to do the following: provide monthly eligibility records identifying everyone to whom they provide benefits; accept the state's right of recovery of Medicaid payments; and respond to inquiries by the state regarding claims for payment that are within 3 years of the date of service. This bill also aligns Colorado law with federal requirements established in the Deficit Reduction Act of 2005. The bill reduced the Department's appropriation in FY 2008-09 by $300,000, annualizing to $400,000 in FY 2009-10.

SB 08-090 - Concerning Mail-Order Prescription Drugs under the State Medical Assistance Program

SB 08-090 makes the following two changes regarding mail-order prescription drugs under Medicaid: it allows Medicaid clients to use a mail-order pharmacy if they have third-party insurance and require maintenance medications, and it authorizes a mail-order pharmacy to bill Medicaid for the difference between the Medicaid co-payment and a third-party insurer's co-payment or deductible. Because Medicaid is the payer of last resort, when Medicaid clients also have third-party insurance, pharmacies are required to bill the insurer prior to billing Medicaid. However, when a local pharmacy bills a third-party insurer that requires the use of mail-order for maintenance medications, the insurance claim is denied. Because current law disallows mail-order pharmacies from billing Medicaid for the client's co-payment, either the client pays the co-payment required by the insurer, or Medicaid is billed for the entire claim. SB 08-090 allows Medicaid to pay the difference between the Medicaid co-payment (paid by the client) and the insurance co-payment.

The bill reduced the Department's appropriation in FY 2008-09 by $279,272 in FY 2008-09, annualizing to $478,752 in FY 2009-10.

SB 08-099 – Concerning Extending Medicaid Eligibility for Persons Who Are in the Foster Care System Immediately Prior to Emancipation

SB 08-099 expands Medicaid eligibility to young adults, under age 21, for whom the state made subsidized adoption or foster care payments immediately prior to the client turning age 18. These young adults were not eligible for Title IV-E federal funds while in foster care, but received state benefits. SB 07-002 expanded Medicaid eligibility to young adults, ages 18 to 21, who qualified for federal benefits through Title IV-E and aged-out of foster care or subsidized adoption programs. Anticipated caseload was based on the automatic enrollment of all young adults meeting the eligibility requirements. However, implementation of SB 07-002 has not progressed as anticipated.

Enrollment of these young adults has not approached the estimates provided. Only a small fraction of the estimated eligible clients have enrolled. Low enrollment is due to several factors, most notably the delay in computerized enrollment. Low enrollment can also be attributed to clients moving out of state, lack of knowledge about the expanded eligibility, lack of interest in receiving Medicaid benefits, and availability of employer-sponsored coverage. With the expansion in SB 08-099, the Department anticipates much stronger growth in the caseload for this population than occurred in FY 2007-08.

As with SB 07-002, clients who gain eligibility under the provisions of SB 08-099 are funded via the Health Care Expansion Fund. For FY 2008-09, the Department received an appropriation of $692,121, annualizing to $1,086,735 in FY 2009-10. The Department has updated the estimated cost of the program (including the effects of SB 07-002 and SB 08-099) in Exhibit A, starting on page EA-4. The Department's Request includes the most current estimates for caseload and per capita cost for these clients.

SB 08-118 – Concerning an Annual Transfer of Moneys to Pay for Medicaid Disease Management Programs

SB 08-118 directs an annual transfer of $2.0 million from the Prevention, Early Detection, and Treatment Fund (administered by the Department of Public Health and Environment) to the Department for Medicaid disease management and treatment programs. The transfer continues through FY 2012-13. This bill renews certain provisions of HB 05-1262 which expired in FY 2006-07, as described above. The funding may only be used for certain disease management programs, namely those that address cancer, heart disease, and lung disease, or the risk factors associated with such diseases.

The Department received an appropriation of $4,000,000 total funds in FY 2008-09.

SB 08-230 – Concerning the Authority of Certain Hospital Care Providers as Units of Government under Medicaid

SB 08-230 allows governmental hospitals to levy a sales tax throughout their specified taxing area, if approved by voters. Subject to available appropriations, the bill also requires the Department to make payments to state university teaching hospitals for providing care to Medicaid clients. The federal Centers for Medicare and Medicaid Services (CMS) published a rule that redefined "a unit of government" to those local governmental entities that: (1) have generally applicable taxing authority, (2) have direct access to tax revenue, or (3) are teaching hospitals with direct appropriations from the state. Under this proposed rule, the ability for public hospitals in Colorado to certify public expenditures will be eliminated. The proposed rules are current under a federal moratorium,

enacted by Congress. SB 08-230 addresses the requirements in the CMS rule that public hospitals have access to taxing authority, and therefore can continue to certify public expenditures as the state match for federal funds. The bill also addresses the requirement that state teaching hospitals receive direct appropriations from the state.

This bill reduced the Department's appropriation for Medical Services Premiums by $2,285,340 in FY 2008-09, annualizing to $2,291,143 in FY 2009-10. The funding which was removed was transferred to new line items for the hospitals which received taxing authority in the bill.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibit H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider – the in instance of a PACE provider, the payment covers acute care and long term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to acute care and CBLTC is not "dollar-for-dollar." The PACE program is designed to keep clients who have high community-based long term care needs out of nursing facilities. The clients who move into the PACE program typically are those clients whose needs are no longer met by an HCBS program. Thus, clients are moving from a lower-cost option (HCBS) to a higher-cost option (PACE). However, the Department still anticipates that the move is at least budget neutral; clients who do not move to a PACE program will typically require nursing facility coverage, which is more expensive than PACE coverage.

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost-per-enrollee attributable to those services (based on the actuarially-certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as $1/12^{th}$ of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

Estimated Savings due to PACE Enrollments				
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($91,280)	($10,354)	($5,162)	($106,796)
CBLTC	($143,126)	($8,703)	($4,339)	($156,168)
Total	**($234,406)**	**($19,057)**	**($9,501)**	**($262,964)**
FY 2009-10	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($676,947)	($85,879)	($37,458)	($800,284)
CBLTC	($1,061,444)	($72,185)	($31,486)	($1,165,115)
Total	**($1,738,391)**	**($158,064)**	**($68,944)**	**($1,965,399)**

Physician and Hospital Drug Rebates

In the Deficit Reduction Act of 2005, the federal government required that all provider claims provide information sufficient for states to obtain rebates by January 1, 2006 for single source physician administered drugs. For multiple source drugs, the federal government would publish the list of the top 20 physician administered drugs based on the highest dollar volume no later than January 1, 2007. All physicians and hospitals must provide information sufficient to obtain rebates for only these drugs by January 1, 2008. The top 20 list would be modified annually to reflect changes in highest dollar volume.

The Department already had a system in place to collect rebates from single source physician administered drugs prior to January 1, 2006. Beginning in September 2003 the Department contracted with Health Watch Technologies to identify single source drugs in the physician claims data and invoice pharmaceutical companies. This contract ended in June 2007 and was not renewed. The Department began performing these services in-house. The contract and in-house services only include physician administered drugs outside a hospital.

The Department did not collect rebates for single source hospital drug claims through Health Watch Technologies or through the in-house system. Hospitals use revenue codes rather than procedure codes to bill claims. This billing method does not provide the level of detail necessary to meet rebate requirements.

Uncertainty existed as to whether hospitals were required to meet the federal requirements identified in the Deficit Reduction Act of 2005. The Centers for Medicare and Medicaid Services clarified that hospitals are required to be in compliance with this law. This ruling required major systems changes to capture national drug code (NDC) information. Colorado, along with many other states, requested an extension to implement the top 20 physician administered drugs within hospitals. As a result, the Department was given until July 1, 2008 to collect refunds for claims linked to the top 20 multiple source drugs within hospitals. Due to the required systems changes and clarification of requirements, the Department is now able to seek rebates on claims for single source hospital administered drugs in addition to the claims for the top 20 multiple source drugs. The Department was able to begin submitting rebate invoices for the claims for top 20 multiple source drugs administered by physicians on the January 1, 2008 deadline.

Impacts of Physician and Hospital Drug Rebates

Changes in physician and hospital drug rebates require no additional appropriations. All changes in claims processing and reporting were absorbed within the Department using funding previously paid for the contractor to collect single source drug rebates from physician claims, Health Watch Technologies.

Physician and Hospital Drug Rebate Estimates

As a result of the Deficit Reduction Act of 2005, the Department is now able to collect drug rebates on drugs administered directly by physicians and hospitals. Previously, the Department was unable to invoice for these rebates due to the lack of information provided in the billing of these claims. The new regulations in place require physicians and hospitals to provide national drug code information for all single source drugs and the top 20 multiple source drugs.

The Department was able to make systems changes necessary to be in compliance with federal requirements resulting from the Deficit Reduction Act related to drug rebates in physician and hospital claims. The Department anticipates increases in rebate invoicing as a result of having the necessary information. The impact of these new requirements is an expected increase in drug rebates of $142,820 in FY 2008-09 and $2,092,551 in FY 2009-10. These amounts reduce the Department’s projection for Acute Care services.

Estimated Drug Savings for Physician and Hospital Administered Drugs			
Row	**Item**	**Total**	**Description**
A	FY 2007-08 Drug Rebate Percentage	25.58%	Derived from Exhibit N
B	Percentage of Expenditures Identified as Top 20 Drugs	3.85%	Based on FY 2007-08 claims data.
C	FY 2007-08 Estimated Percentage of Multiple Source Drugs in Physician Claims	35.00%	Based on FY 2007-08 claims data, and estimated based on the availability of generic drugs in the pharmacy drug claims.
D	Estimated Percentage of Invoiced Rebates Collected	70.00%	The Department currently receives 98% of invoiced rebates. Due to the changes in federal regulation, the Department assumes that pharmaceutical companies will challenge a larger number of invoiced rebates.
Physician Administered Drugs			
Row	**Item**	**Total**	**Description**
E	FY 2007-08 Physician Administered Drug Expenditures Identified as Top 20 Drugs	$698,189	Based on FY 2007-08 claims data.
F	Estimated Annual Increase in Expenditure	14.24%	FY 2007-08 percent increase in pharmacy expenditure. (Exhibit N)
G	Estimated FY 2008-09 Expenditure	$797,611	Row E * (1 + Row F)
H	**FY 2008-09 Estimated Additional Drug Rebates**	**($142,820)**	Row A * Row D * Row G * -1
I	Estimated FY 2009-10 Expenditure	$911,191	Row G * (1 + Row F)
J	**FY 2009-10 Estimated Additional Drug Rebates**	**($163,158)**	**Row A * Row D * Row H * -1**

Hospital Administered Drugs			
Row	**Item**	**Total**	**Description**
K	FY 2007-08 Hospital Administered Drug Expenditures	$12,444,033	Based on FY 2007-08 claims data.
L	Estimated Annual Increase in Expenditure	14.24%	FY 2007-08 percent increase in pharmacy expenditure. (Exhibit N)
M	Estimated FY 2009-10 Expenditure	$16,240,431	Row K * $(1 + \text{Row L})^2$
N	Estimated FY 2009-10 Single Source Expenditure Receiving Additional Rebate	$10,556,280	Row M * (1 - Row C)
O	Estimated FY 2009-10 Multiple Source Expenditure Receiving Additional Rebate	$218,840	(Row M - Row N) * Row B The Department only anticipates receiving a rebate for the top 20 multiple source drugs.
P	Estimated FY 2009-10 Total Expenditure Receiving Additional Rebate	$10,775,120	Row N + Row O
Q	**Estimated FY 2009-10 Additional Drug Rebate**	**($1,929,393)**	**Row P * Row A * Row D * -1**

Summary of Bottom Line Impacts			
Row	**Item**	**Total**	**Description**
AA	FY 2008-09 Reduction to Acute Care	($142,820)	Row H
BB	FY 2009-10 Reduction to Acute Care	($2,092,551)	Row J + Row P

(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 the FY 2004-05 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.

The recent history 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 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 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 2005-06.

- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. 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 2002-03 and the entire FY 2003-04 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 2004-05.

- 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 2002-03. 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 prospective per capita budget methodology did not require the use of historical data prior to FY 2002-03.

- 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 2003-04, 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 2004-05 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 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 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 2005-06.

- 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 2005-06.

  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 and the line item has been removed from the Department budget.

- 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 2008-09 Estimate and the FY 2009-10 Budget Request and are elaborated below.

- The Joint Budget Committee approved the Department's September 20, 2006 1331 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 2003-04 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 2003-04 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 2006-07 capitations.

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.

- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds, and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designates funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; b) for FY 2009-10 through FY 2013-14, 50% of State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.

Program Administration

In FY 2005-06, 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 2008-09 Estimate and the FY 2009-10 Budget Request for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item: the costs for these drugs were and are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

(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 2005-06, and incorporated into the Mental Health Capitation Payments line item in FY 2005-06.

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.

From February 2005 until the present Request, the Department had been transitioning towards a per capita methodology. Previous year actual amounts were trended forward by eligibility category, generating an estimated per capita. Prior to this Request, the Joint Budget Committee had asked the Department to explore the possibility of projecting budgets by behavioral health organization as well as by eligibility category. The Department has determined that such a projection is not yet possible due to the following: a) the recent (FY 2005-06) consolidation of eight mental health assessment and service agencies into five behavioral health organizations, b) the disproportionate impact of Goebel driven expenditures into one behavioral health organization's capitation rate, and c) the volatile nature of specific capitation rates as compared to the overall trend of capitation rate increases within respective eligibility categories. However, the Department will continue to explore this methodology as new data becomes available.

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per capita rates, the Department moved to a capitation trend forecast model for the FY 2008-09 Estimate and FY 2009-10 Request. In short, the new methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed upon capitation rate and caseload. By tying forecasts directly to capitation rates, the new methodology should provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g. Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some mental health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the FY 2008-09 Estimate and the FY 2009-10 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 3, 2008 Budget Request, 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 2008-09 Estimate and the FY 2009-10 Request. All of the years prior to FY 2006-07 have been adjusted to include Goebel enhanced service costs for each particular year (see Exhibit DD, page DD-5 for the calculations) and therefore vary from previous submissions. Certain Medicaid Medical Services Premiums eligibility categories, shown in Section 1, 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 caseload presented in the Request for Medical Services Premiums, Section E, 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.

Calculation of Fund Splits (Exhibit BB):

Exhibit BB details funds splits for all Mental Health Community Programs budget lines for the FY 2008-09 Estimate and the FY 2009-10 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 2008-09 Estimate and the FY 2009-10 Budget Request capitation base, traditional clients receive 50% General Fund and 50% federal funds, while capitation base expansion clients receive 50% cash funds from the Health Care Expansion Fund, created by the Tobacco Tax Bill, and 50% federal funds. The Breast and Cervical Cancer Prevention and Treatment Program is an exception, receiving 35% State funds and 65% federal funds. In the FY 2008-09 Estimate, funding for Breast and Cervical Cancer Program traditional clients is 35% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund (administered by the Department) and 65% federal funds. Funding for Breast and Cervical Cancer Program expansion clients is 35% Reappropriated Funds from the Prevention, Early Detection and Treatment Fund (administered by the Department of Public Health and Environment) and 65% federal funds. In the FY 2009-10 Budget Request, Breast and Cervical Cancer Program funding for traditional clients is 17.5% General Fund, 17.5% cash funds through the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds. Funding for expansion clients remains the same as FY 2008-09. Finally, clients enrolled in the Home and Community Based Services – Children with Autism Waiver are also an exception to the traditional clients' funds splits; for these clients, in both the FY 2008-09 Estimate and the FY 2009-10 Request, 50% of funds are received through cash funds, the Colorado Autism Treatment Fund, and 50% are received though matching federal funds.

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.

Mental Health Services for Breast and Cervical Cancer Program Adults:

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer Patients into the appropriation for Medicaid Mental Health Community Programs Capitation Payments effective with the FY 2005-06 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. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in Section 25.5-5-308 (8), (9), and (10) C.R.S. (2008). 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 JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients is 35% cash funds and 65% federal funds. For traditional clients, the source for cash funds 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 net capitation payments include recurring events, such as net recoupment of payment for clients later deemed ineligible for Medicaid (explained in detail on exhibit F.II-1), 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, (Exhibit DD):
Exhibit DD contains per capita history and projections 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 2003-04 through FY 2005-06. Each of the tables that comprise Exhibit DD is described below.

Medicaid Mental Health Community Programs Caseload

Medicaid Mental Health Community Programs caseload is displayed in two tables. Table 1 shows 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 2003-04 through FY 2007-08 are actual caseloads, while FY 2008-09 and FY 2009-10 caseloads are the current trended estimates. The caseload numbers and percent 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 2003-04 through FY 2007-08 are actual caseloads, while FY 2008-09 and FY 2009-10 caseloads are trended, current estimates.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures covers FY 2003-04 through FY 2007-08, including combined category and expanded category tables as well as total expenditures for both capitation 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 2004-05.

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.

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 2006-07. 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.

Estimate and Request by Eligibility Category (Exhibit EE):
Exhibit EE provides capitation expenditure calculations for the FY 2008-09 Estimate, and the FY 2009-10 Request.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the respective Estimate or Request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from subsequent exhibits (FF through HH), and will be presented in more detail, below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B.

For FY 2008-09, the Department has broken down the year in a two ways: first and second quarter estimate (Q1 and Q2), and a third and fourth quarter estimate (Q3 and Q4); unique for this fiscal year, the behavioral health organizations are operating under an actuarial agreement that sees a Q1 and Q2 capitation rate that is a 3.70% increase off of the FY 2007-08 capitation rate. The 3.70% increase has been applied uniformly across each behavioral health organization's capitation rate for each eligibility category. As such, the Department has presented a Q1 and Q2 expenditure estimate based on the known capitation rates for Q1 and Q2 and another expenditure estimate based upon the forecasted capitation rates for Q3 and Q4. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect. For the FY 2008-09 Estimate, each rate will be in effect for six months. For the FY 2009-10 Request, each rate will be in effect for twelve months.
In order to adjust the calculations to cash-accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below, and is shown starting on page EE-3.

Finally, an adjustment is made to each eligibility category's expenditure line for recoupments as some Medicaid payments will be made on behalf of individuals later determined to be ineligible. Exhibit II presents the recoupment calculations in more detail. For the purposes of estimating total expenditure, the anticipated amount of recoupment is distributed across the eligibility categories according to the proportion of capitation payments made on behalf of an eligibility category relative to the total number of capitation payments made for all eligibility categories.

Incurred but not Reported Estimates (Exhibit EE, pages EE-3 through EE-6)

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred but not reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have eleven more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years, and determined that the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Page F.EE-3 presents the historical data (and future estimate) of claims to be incurred but not paid in the same fiscal year. The Q1 and Q2 average for each eligibility category was applied to the Q1 and Q2 expenditure estimates and the Q3 and Q4 averages were applied to the Q3 and Q4 expenditure estimates for FY 2008-09. For the FY 2009-10 Request, the year-long average was used.

For each eligibility category except Disabled Adults 60 to 64 and Disabled Individuals to 59, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the Disabled Adults and Individuals, it takes two years for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting disability as opposed to criteria such as age or income.

On pages F.EE-4 through F.EE-6, the Department calculates the estimated outstanding claims for each month by applying the monthly IBNR factors to the monthly expenditure total by aid categories. The sums are then carried forward to the calculations on pages F.EE-1 and F.EE-2.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required 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. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

Medicaid Mental Health Claims to Caseload Adjustment and Claims-Based Adjustment Multiplier (Exhibit FF):

Capitations are paid for clients from the date that client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental Estimates and Requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations as compared to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Mental Health Capitation program. This difference is captured through a claims-based adjustment multiplier.

Claims to Caseload Adjustment:

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last four years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest that the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. Therefore, the simple average of the four years worth of percentages across each eligibility category was used as the percentage to be applied to the forecasted capitation rates.

Claims-Based Adjustment Multiplier:

To derive the claims-based adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last two years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future condition or trend comparisons.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation

rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated providing a simple comparison of any trend in claims-based rates as compared to capitation rates. As the percentage is similar across years, it is a good indicator the claims-based trends are matching capitation trends. In order to capture any potential variance between the trends, the forecasted capitation rate was multiplied by the difference of: a) the average relationship percentage, from b) the previous year's actual relationship percentage.

Medicaid Mental Health Capitation Rate Trends and Forecasts (Exhibit GG):

As presented, above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e. the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates for Q3 and Q4 of FY 2008-09 and for all quarters in FY 2009-10. The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

The Weighted Mental Health Total is a twice-weighted capitation rate. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that weighted rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Mental Health Total rate may or may not be a clear indicator of the rate trends across all eligibility categories.

Forecast Model Comparisons (Exhibit HH):

Exhibit HH produces the final capitation rate estimates by eligibility category used as the source of the expenditure calculations provided in Exhibit EE. Page F.HH-2 presents the final rate estimates for FY 2008-09 Q1 and Q2, FY 2008-09 Q3 and Q4, and FY 2009-10 in its entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page F.HH-2, a series of differing forecast models are presented for each eligibility category. From the differing models, a point estimate is selected as an input into page F.HH-1. Based on the point estimates, the adjustments are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts:

Page F.HH-1 begins by presenting the rate from the previous fiscal period and the point estimate of each eligibility category's rate as selected from the various models presented on page F.HH-2 (see below). However, for FY 2008-09 Q1 and Q2, the "point estimate"

is actually the known rate that is a 3.70% increase on the previous rate. This rate has been agreed upon by the behavioral health organizations and the Department as governed by the current actuarial agreement.

For FY 2008-09 Q3 and Q4, the prior year's capitation rate is compared to the forecasted capitation rate (as derived from page F.HH-2). The percentage change between those two figures represents the projected trend on the capitation rate. That trend is then applied to the previous year's per-claim rate to derive a projected per-claim rate.

The projected claims-based rate is then adjusted by the claims-based adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the capitation trend will not exactly mirror any trend on the claims-based rate.

Finally the adjusted claims-based rate is again adjusted, this time by the claims-to-caseload adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep mental health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE.

A similar methodology is applied to the rates in each eligibility category, and for each fiscal period: a) FY 2008-09 Q1 and Q2 (beginning with the known capitation rate that is a 3.70% increase on the previous year's rate), b) FY 2008-09 Q3 and Q4, and c) FY 2009-10 (the later two periods beginning with a forecasted capitation rate).

Capitation Trend Models:

The forecasted capitation rates used on page F.HH-1 for FY 2008-09 Q3 and Q4 as well as FY 2009-10 are the result of a point estimate selection from among several forecast trend models. These models are presented on page F.HH-2.

For each eligibility category, four different trend model forecasts were performed: an average growth model; a two-period moving average model; an exponential growth model; and, a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects that the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes that the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is an autoregression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

Based upon the four models, a forecasted point estimate was selected for each fiscal period. For FY 2008-09 Q1 and Q2, no forecast was performed, as the capitation rate is known to be a 3.70% increase on last fiscal year's capitation rate. The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

For FY 2008-09 Q3 and Q4, for a) Adults 65 and Older, and b) Eligible Children, that model was selected (providing the point estimate) which predicted modest growth for Q3 and Q4 on the known Q1 and Q2 rates. In recent years, the capitation rate for Adults 65 and Older and Eligible Children has largely experienced steady growth. However, the rate of growth has been slowing (and in fact the rate for Adults 65 and Older decreased in the last fiscal year). The Department anticipates that the growth rate will continue to level off, but given the rising costs to health providers, does not anticipate negative growth. As such, the Department has selected models which demonstrate an increase in the rate, but increases that are lower than historical increases (see Exhibit GG for historical rates). This same logic was applied to the selection of model of FY 2009-10.

In the eligibility categories of Disabled Adults 60 to 64, Disabled Individuals to 59, Categorically Eligible Low Income Adults, Expansion Adults, and Baby Care Program-Adults, rates have been experiencing accelerated growth rates. Both the linear growth model and the exponential growth model capture this robust growth. However, it is likely that the linear growth model underestimates the speed of growth as it does not capture the sometimes sharp increases the rates for these eligibility categories have experienced. The exponential growth model, on the other hand, likely overestimates the rate of growth as it assumes that the rates of growth will perpetually accelerate. The Department, therefore, has taken the average between the exponential and linear growth models was selected as the point estimate forecast for these groups for FY 2008-09 Q3 and Q4. Rates for these eligibility categories are expected to continue their current accelerated growth; therefore, the growth rates were held constant from the Q3 and Q4 rate increase and applied to FY 2009-10.

Foster care rates have been cyclically trending downwards. That is to say, the Foster care rates have witnessed a decrease then a slight increase followed by another decrease, over time. This is likely a result of the actuarial rate setting process. The Department works with providers to set future rates by examining both actual costs and historical rates. As providers become more efficient at providing services to these high-need clients, costs may continue to fall. The Department anticipates that as more recent data is incorporated into the rate setting process, the sharp declines seen in the rate from FY 2004-05 through FY 2006-07 will be mitigated, and approach a new equilibrium point and its natural trend. However, the Department does not believe that the rate has reached that point as of yet. As such, the Foster Care rate is expected to continue its trend of cyclically decreasing for the foreseeable future. The Department, based on the current state of actuarially sound rate setting estimates a slight increase in the Foster Care rate for FY 2008-09 Q3 and Q4 accompanied by a slight decrease in the rate for FY 2009-10.

The selected point estimates of the capitation rates are adjusted on page F.HH-1, as described above, for use in the expenditure calculations presented in Exhibit EE.

Recoupment of Payments Made for Clients Found to be Ineligible for Medicaid (Exhibit II):

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. Exhibit II 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 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. The Department anticipates that once this information is verified and the computer programming change is fully implemented, recoupments will continue to decrease as ineligibility is caught earlier in the process by the Colorado Benefits Management System. Recoupment collection is anticipated to resume during FY 2008-09, and to be accelerated in its processing. Recoupments from FY 2004-05 and FY 2005-06 should be processed in FY 2008-09. (Note that the total recoupment figure of $900,000 is split at $450,000 for a) the Q1 and Q2 estimate and b) the Q3 and Q4 estimate, as presented in Exhibit EE.) While FY 2009-10 recoupment collections should still cover two previous fiscal years, FY 2006-07 and FY 2007-08, the total amount collected from the two years should be significantly less than FY 2008-09 ($225,000 in total) due to the full implementation of the computer programming changes in the Colorado Benefits Management System.

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

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Tobacco Tax Bill (HB 05-1262) and related bills to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the FY 2008-09 Estimate and the FY 2009-10 Budget Request. Note that the caseloads shown are the average monthly number over each year and will fluctuate throughout 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. 30% of the Breast and Cervical Cancer Program caseload are paid for out of this Fund.

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 2006-07 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 FY 2008-09 and subsequent fiscal years. Please see Exhibit JJ 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 2006-07 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 2008-09 and subsequent fiscal years. Exhibit JJ provides additional detail regarding the Department's FY 2008-09 and FY 2009-10 projections of expenditures for the Children's Extensive Support expansion population.

The Health Care Expansion Fund also provides funding for 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 11,537 in FY 2008-09 and 12,802 in FY 2009-10 were taken from the Department's caseload projections provided in this November 3, 2008 Budget Request (see Exhibit B in Medical Services Premiums). Costs for each expansion population are assumed to be the same as for the traditional populations as the vast majority of mental health services payments are made via the capitation, and do not change based on client utilization.

SB 07-002 and SB 08-099 provided for appropriations to support Medicaid clients from the Foster Care system who are between the ages of 18 and 21. The Department anticipates a caseload of 1,460 in FY 2008-09 and 2,211 in FY 2009-10 (based on caseload projections provided in this November 3, 2008 Budget Request; see Exhibit B in Medical Services Premiums). As with Expansion Adults, the cost for this expanded Foster Care population is assumed to be the same as for the traditional Foster Care population.

The Health Care Expansion Fund also 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, the Department has applied its estimated caseload and per capita growth rates from FY 2007-08 to FY 2008-09 and the growth rates from the estimated FY 2008-09 figures to FY 2009-10 to actual FY 2007-08 expenditures yielding the estimated costs for FY 2008-09 and FY 2009-10.

The Optional Legal Immigrants program is also funded out of the Health Care Expansion Fund. The caseload for this program is spread across all of the eligibility categories, and funds are matched by the federal government at 50% to the State's 50% contribution. The Department projects a caseload of 5,183 for FY 2008-09 and 5,346 for FY 2009-10 (see the Tobacco Tax Report in this November 3, 2008 Budget Request for the Department's caseload projections for this group).

Finally the state share for clients enrolled in the HCBS – Children with Autism waiver program (included in the Disabled Adults and Disabled Individuals eligibility category) are funded from the Colorado Autism Treatment Fund, per 25.5-6-805, C.R.S. (2008). The Department estimates that there will be 75 clients enrolled in the waiver program in FY 2008-09 and FY 2009-10.

(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 as Mental Health Fee-For-Service Payments.

Medicaid Mental Health Fee-for-Service Payments (Exhibit KK):

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in Medicaid Mental Health Community Programs. Expenditures for this line are shown in Exhibit KK. The data from Exhibit KK 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 2002-03, Fee-for-Service Payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 2003-04, 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 2004-05. Also during FY 2004-05, 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 2003-04. 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 2004-05 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 September 3, 2004 1331 Supplemental 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 2005-06 there was a one-time recoupment of $303,492 in the inpatient services area for disallowed payments going back to FY 2001-02. 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 KK 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 2008-09 Estimate is based on FY 2007-08 actual expenditures. The estimate is for an increase to $1,437,155 due to a 7.59% increased in caseload. The estimated change in caseload is taken from Exhibit DD. This estimate is $148,115 less than the FY 2008-

09 appropriation. The FY 2008-09 Estimate is trended forward by the 3.06% mental health caseload change rate to the FY 2009-10 Budget Request. The requested amount is $43,917 over the FY 2008-09 Estimate.

No rate or utilization increases are forecast, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments.

Mental Health Anti-Psychotic Pharmaceuticals:

This line was 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 FY 2008-09, the Department requested and received approval on the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item. This change did 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 so no information will be lost from the Budget Request.

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

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

The Global Reasonableness Test presented in Exhibit LL compares the percent change between mental health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2008-09 appropriation is 6.01% higher than FY 2007-08 actual expenditures. The FY 2008-09 Estimate incorporates increased caseload projections (and includes Goebel enhanced services in the FY 2004-05 and FY 2005-06 Actuals for comparison) which results in an 8.19% increase over FY 2007-08 actual expenditures. The FY 2009-10 Budget Request is built on the FY 2008-09 Estimate, increased by a 6.53% expenditure increase, which incorporates increased caseload projections. The FY 2008-09 Estimate and FY 2009-10 Request represent a 2.05% increase and a 8.71% increase over the current FY 2008-09 appropriation, respectively. Since the costs of Goebel clients were not included in previous actual years until FY 2006-07, they were added to the FY 2004-05 and FY 2005-06 Actual Expenditures so the data was not skewed. Thus, the data being evaluated are comparable.

(4) INDIGENT CARE PROGRAM

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, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. In FY 2006-07, total payments to indigent care providers equaled $174,079,470 and 172,510 clients were served by the program. As of FY 2008-09, 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 client 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 Reappropriated Funds to draw down these federal funds. The State utilizes certification of public expenditures for all publicly-owned facilities (seen as cash funds 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 1997-98: $93 million, FFY 1998-99: $85 million, FFY 1999-00: $79 million and FFY 2000-01 and beyond: $74 million, with limits adjusted by a cost of living factor each year after FFY 2001-02. However, federal legislation enacted in December 2000 maintained the FFY 1999-00 allotment of $79 million for FFY 2000-01 and FFY 2001-02, plus increases tied to the Consumer Price Index for all Urban Consumers for those years. The new allotments for FFY 2000-01 and FFY 2001-02 were $81,765,000 and $83,890,890, respectively. Beginning in FFY 2002-03, 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 2002-03, 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 2003-04. From FFY 2003-04 to approximately FFY 2009-10, 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 calendar year 2006 data, this information can be found in Exhibit K, page EK-7 in the Department's FY 2009-10 Budget Request, November 3, 2008, 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 more easily understood by Department staff, the General Assembly and providers. Another goal in combining the line items was to create a system that distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved 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 matrix below.

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 2009-10 this cap is expected to equal $87,127,600 (Department Figure Setting, March 11, 2008, pg. 143). 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 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.
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. The federal share of payments is from Disproportionate Share Hospital federal funds. The payment is only available to Denver Health and University of Colorado 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 of Colorado Hospital, who voluntarily distribute a portion of the funding to other qualified providers to maintain equality between providers.

Payment Type	Public Hospitals	Private Hospitals
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. 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 2009-10 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 2005-06, the Department received a Long Bill appropriation of $255,282,024, equal to the final FY 2004-05 appropriation of $264,013,206 less one-time funding of $8,731,182 that related to the Upper Payment Limit for FY 2003-04. 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 2004-05 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 2005-06, Supplemental Requests, S-9, January 3, 2006). The final appropriation for FY 2005-06 was $287,296,074.

In FY 2006-07, 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 2006-07 was therefore $296,188,630.

For FY 2007-08, the Department received continuation funding of $296,188,630 through SB 07-239. The Department received continuation funding of $296,188,630 for FY 2008-09, and is requesting continuation funding in the amount of $296,188,630 for FY 2009-10.

COLORADO HEALTH CARE SERVICES FUND

The Colorado Health Care Services Fund was created pursuant to SB 06-044 which went into effect on July 1, 2006. This legislation increased a client's financial eligibility for the Colorado Indigent Care Program from 200% to 250% of the Federal Poverty Level. In addition, this legislation established the Colorado Health Care Services Fund to make funding available to Denver Health Medical Center (as the Community Health Clinic provider for the city and county of Denver), Community Health Clinics and primary care clinics operated by Colorado Indigent Care Program Hospitals, for the provision of primary care services to low-income adults. House Bill 07-1258, which was signed by the Governor on April 16, 2007, removed the age restriction so that Denver Health Medical Center and other eligible community health clinics and primary care clinics would receive distributions from the Health Care Services Fund for primary care services provided to low-income clients of all ages, not just adults. SB 06-044 appropriated $14,962,408 to the Health Care Services Fund for these purposes in FY 2006-07. Pursuant to Section 25.5-3-112 (1) (b), C.R.S. (2008), the Health Care Services Fund was appropriated $15,000,000 for FY 2007-08.

The Department's FY 2008-09 Base Request included $15,000,000 General Fund. The Department is requesting continuation funding of $15,000,000 General Fund for FY 2009-10.

THE CHILDREN'S HOSPITAL, CLINIC BASED INDIGENT CARE

The Children's Hospital, Clinic Based Indigent Care line item was created in FY 2002-03 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.

Funding for FY 2003-04 and FY 2004-05 remained as continuation funding from FY 2002-03 equal to $6,119,760. However, in FY 2005-06, 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 2005-06 was returned to $6,119,760.

In FY 2006-07, 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, including children, 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 2007-08 Long Bill (SB 07-239) having an additional $10,086,000 in Reappropriated Funds from the Health Care Services Fund for this purpose (FY 2007-08, Figure Setting, March 8, 2007, page 62). On January 2, 2008, having received approval from the Centers for Medicare and Medicaid Services for the federal financial participation for the Health Care Services Fund payments, the Department submitted Supplemental 16, "Federal Funds for Health Care Services" on January 2, 2008, to obtain the spending authority for $10,086,000 in federal funds, bringing the final FY 2007-08 appropriation to $26,291,760. For FY 2008-09, the Department received continuation funding of $26,291,760 through Long Bill (HB 08-1375). Continuation funding in the amount of $26,291,760 is requested for FY 2009-10.

HEALTH CARE SERVICES FUND PROGRAMS

In 2006, SB 06-044 appropriated $15,000,000 General Fund to the Colorado Health Care Services Fund for fiscal years 2007-08, 2008-09, and 2009-10. 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 line item contains the funding for both Denver Health and the clinics that are operated by licensed or certified health care facilities.

For FY 2007-08 through FY 2009-10, 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. Approval of Supplemental 16, "Federal Funds for Health Care Services" submitted on January 2, 2008, allowed the Department to draw down federal funding for this line item; the final appropriation for FY 2007-08, which included retroactive and current federal funding totaling $6,139,421, was $11,053,421. The remaining $10,086,000 General Fund 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).

In FY 2008-09, the Department received continuation funding of $9,828,000 through the Long Bill (HB 08-1375), reduced from $11,053,421 by the annualization of federal funding received retroactively for FY 2007-08. For FY 2009-10, the Department is requesting continuation funding for this line item in the amount of $9,828,000.

PEDIATRIC SPECIALITY 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 2005-06 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 Speciality 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 2006-07, 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 Speciality 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 2006-07 (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 2007-08, 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 an additional $200,000 in federal funding to match the state funds that were to be appropriated pursuant to HB 07-1359. This HB 07-1359 provided for a Cash Funds Exempt appropriation increase of $171,289, (reduced from the SB 07-097 amount by $28,711) for FY 2007-08. This appropriation was not included in the line item's funding until after passage of the FY 2007-08 Long Bill. Therefore, the culmination of these changes resulted in an initial appropriation of $8,328,000 for FY 2007-08. The Cash Funds Exempt impact of SB 07-097 and HB 07-1359, which increased the line's funding by $171,289 for FY 2007-08, was addressed during the Department's Figure Setting for FY 2008-09. In addition, adjustments to the federal funds appropriation to match the reduction in state funds from $200,000 to $171,289 as provided for in HB 07-1359, reduced the federal funding to this line item by $28,711. A revised Tobacco Tax revenue forecast incorporating the December 2007 Legislative Council Forecast reduced the Cash Funds Exempt appropriation by $27,600. Finally, HB 08-1285 (the Department's Supplemental Bill) increased both the Cash Funds Exempt and Federal Fund appropriations to this line item by $2,412, resulting in a revised FY 2007-08 appropriation of $8,447,802.

During the Department's Figure Setting for FY 2008-09, several adjustments were made to the FY 2007-08 appropriation. Annualization of the impacts of SB 07-097 (Allocation of Master Settlement Supplemental Account) increased the appropriation by $425,810, while a revised Tobacco Tax revenue forecast reduced the appropriation by $8,400. Finally, the Joint Budget Committee recommended a General Fund increase of $2,000,000 for this line item and a corresponding increase in federal funds, bringing the year-to-date FY 2008-09 appropriation to the Pediatric Speciality Hospital to $12,865,212. For FY 2009-10, the Department is requesting continuation funding of $12,865,212.

HB 05-1262 APPROPRIATION FROM THE GENERAL FUND TO PEDIATRIC SPECIALITY 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 addition to funding tobacco use prevention services administered by the Department of Public Health and Environment and a revenue loss compensation program administered by the Department of Revenue. 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. (2008) 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. (2008), 50% of these above mentioned revenues are to be appropriated by the General Assembly to the Pediatric Speciality Hospital Fund.

In FY 2006-07, 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 2007-08, SB 07-239 appropriated $513,000 for this line that is transferred quarterly.

The Department's FY 2008-09 Base Request was $486,600 which included a reduction of $26,400 based on Tobacco Tax revenue estimates by the Legislative Council Staff. However, Joint Budget Committee staff recommended a net decrease of $18,000 based upon a more recent Legislative Council Tobacco Tax Revenue Forecast being available; this was subsequently approved by the Joint Budget Committee, resulting in a year–to-date FY 2008-09 General Fund Exempt appropriation to this line item of $495,000. For FY 2009-10, the Department is requesting continuation funding of $495,000.

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. (2008) 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 2006-07, 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 2007-08, 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 Speciality 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 Speciality Hospital Fund. For FY 2007-08, the amount appropriated for this line totaled $513,000. The Department's FY 2008-09 Base Request was $495,000 which included a reduction of $18,000 based on revised Tobacco Tax revenue estimated by Legislative Council Staff. For FY 2009-10 the Department is requesting continuation funding of $495,000.

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. (2008) 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.

Due to timing, once HB 05-1262 was passed, the FY 2005-06 appropriation to this line item reflected nearly 18 months of collected Tobacco Taxes. Therefore, the FY 2006-07 appropriation reflects a decrease in Cash Funds Exempt in the amount of $11,159,042 since there was no longer a backlog of funding as there was in FY 2005-06. This reduction also included transfers to the (1) Executive Director's Office for administrative costs associated with 0.5 FTE. Therefore, the final appropriation for FY 2006-07 was $32,939,958 (Figure Setting, March 13, 2006, pages 182-183).

The FY 2007-08 Long Bill (SB 07-239) 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 Decision Item 12 "Internal Audit of Primary Care Fund" submitted November 1, 2006, was approved by the Joint Budget Committee (March 8, 2007 Figure Setting document, page 68) and moved $75,200 out of the Primary Care Fund appropriation into the (1) Executive Director's Office; (A) General Administration: Personal Services line item to pay for an internal audit of the program for FY 2007-08. The final FY 2007-08 appropriation to the Primary Care Fund was $32,365,298.

During the Department's Figure Setting on March 11, 2008, funding for this line item was further adjusted to reflect an updated Tobacco Tax revenue forecast; $1,090,498 was subsequently subtracted from the appropriation for this purpose. In addition, the funding used to audit the program in FY 2007-08 was replaced for FY 2008-09 by a transfer of $75,200 from the (1) Executive Director's Office; (A) General Administration: Personal Services line item. Administrative costs associated with 0.5 FTE for FY 2008-09 were again transferred from this line item into the Executive Director's Office, reducing the appropriation by $55,343, resulting in a year-to-date FY 2008-09 appropriation to this line of $31,294,657. The Department is requesting continuation funding for this line item for FY 2009-10.

PROVIDER FEES

During the 2006 Legislative Session, the General Assembly passed SB 06-145, which allowed local governments to impose a fee on private hospital providers within their jurisdictions that provide inpatient and/or outpatient services for the purposes of obtaining federal financial participation for unreimbursed Medicaid costs. The legislation was designed to counteract some of the adverse effects resulting from low reimbursement rates to hospitals combined with increases in unreimbursed costs to these providers, including a shifting of costs within the health care system to the general population. By enabling the collection of fees by local

governments, the legislation gave the Department the legal authority to generate a body of revenue that could be considered public and was therefore eligible for federal financial participation.

Since the passage of SB 06-145, the Department has developed a reimbursement methodology and submitted two Medicaid State Plan Amendments (TN 06-013 for Inpatient Hospital Services and TN 06-014 for Outpatient Hospital Services) on September 29, 2006 to the Centers for Medicare and Medicaid Services. Local governments electing to participate in the fee collection program are required, pursuant to 29-28-103 (2) C.R.S. (2008), to distribute the full amount of funds collected from the imposition of the provider fee and federal financial participation received for eligible unreimbursed Medicaid costs. The amounts eligible for federal financial participation under this program are based on a provider assessment base (inpatient revenues adjusted for inflation) and an appropriate assessment rate, the result of which is adjusted by the provider's most recent available audited Medicare/Medicaid cost report (CMS 2552-96), (see the Department's January 2, 2008, FY 2007-08 Supplemental 17, "Federal Funds Match for Local Government Provider Fees" pages S.17-1 through S.17-14 for more detail). Federal financial participation for the local government inpatient/outpatient hospital reimbursement payment is limited by the Medicare Upper Payment Limit, which is a reasonable estimate of the amount that Medicare would have paid for the services provided under Medicaid payment principles.

SB 06-145 INPATIENT PROVIDER FEE

The purpose of this line item is to allow the Department to draw federal funds to match local government payments to inpatient hospitals made possible by the collection of a provider fee. The Department submitted Supplemental 17, "Federal Funds Match for Local Government Provider Fees" on January 2, 2008 for matching federal funds for fees collected by local governments as authorized by the passage of SB 06-145. As of November 3, 2008, only the City of Brighton had elected to participate in the collection of inpatient provider fees. In its supplemental request, the Department estimated that $2,112,929 in collected fees would be eligible for federal financial participation, resulting in a total FY 2007-08 appropriation of $4,225,858. This amount included $2,154,322 needed for FY 2007-08, as well as retroactive funding for FY 2006-07 in the amount of $2,071,536. In the annualization into FY 2008-09, the retroactive federal funding was removed, bringing the total request for this line item for FY 2008-09 to $2,154,322. The Department is requesting continuation funding for this line item in FY 2009-10 in the amount of $2,154,322 total funds.

SB 06-145 OUTPATIENT PROVIDER FEE

The purpose of this line item is to allow the Department to draw federal funds to match local government payments to outpatient hospitals made possible by the collection of a provider fee. The Department submitted Supplemental 17, "Federal Funds Match for Local Government Provider Fees" on January 2, 2008 for matching federal funds for fees collected by local governments as authorized by the passage of SB 06-145. As of November 3, 2008, only the City of Brighton had elected to participate in the collection of outpatient provider fees. In its supplemental request, the Department estimated that $2,992,746 in collected fees would be eligible for federal financial participation resulting in a final appropriation for FY 2007-08 of $5,985,492. This appropriation included $3,051,374 needed for FY 2007-08, as well as retroactive funding for FY 2006-07 in the amount of $2,934,118. In the

annualization into FY 2008-09, the retroactive federal funding was removed, bringing the total request for this line item for FY 2008-09 to $3,051,374. The Department is requesting continuation funding for this line item in FY 2009-10 in the amount of $3,051,374 total funds.

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 for children 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 2000-01 via Supplemental Bill SB 01-183, the line items and appropriations were moved from the (5) Other Medical Services Long Bill group to the (4) Indigent Care Program Long Bill group. In the Long Bill for FY 2003-04, 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.

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. Eligibility in the Children's Basic Health Plan was further expanded to 225% of the federal poverty level in 2008 with the passage of SB 08-160.

HB 97-1304 CHILDREN'S BASIC HEALTH PLAN TRUST

This line item is for contributions to the Children's Basic Health Plan Trust Fund. The Trust Fund balance funds the State's share of the other line items for the Plan. By statute, at the end of any given fiscal year, unspent appropriations remain in the Trust Fund rather than revert to the General Fund. Moreover, funds in the Trust that are not appropriated to other lines also earn interest each year. Common sources of funding for appropriations to the Trust are General Fund and cash funds from the collection of annual enrollment fees from families. The Trust also receives an annual transfer from the Tobacco Litigation Settlement Trust Fund. Thus, the appropriations discussed below do not reflect the balance of the 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 2006-07 Appropriation for the Trust

The FY 2006-07 Long Bill (HB 06-1385) appropriation was for $21,165,996. This appropriation was the result of the Department's November 15, 2005 Decision Item 3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes", 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 submitted January 2007, 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 2006-07 appropriation was $11,467,064, which consisted of $223,849 in cash funds and $11,243,215 in General Fund.

In addition to the final appropriated amount, the June 20, 2007 1331 Supplemental was submitted and approved by the Joint Budget Committee, 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 2007-08 Appropriation for the Trust

The FY 2007-08 Long Bill removed one-time funding of $11,274,992 and increased the cash funds appropriation by $53,392 from the FY 2006-07 appropriation (prior to Supplemental 3, see Figure Setting dated March 8, 2007, pages 79-80). This funding increase was as a result of the Department's FY 2007-08 Decision Item 3 and Budget Amendment A3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes", which increased the caseload forecasts and estimated per client costs. The FY 2007-08 Long Bill appropriation was $245,464 cash funds.

During the 2007 legislative session, three special bills were adopted which also 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 2007-08. 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 Department submitted Supplemental 3 to the Joint Budget Committee on February 15, 2008 due to increased caseload forecasts. As a result of this request, the cash funds appropriation was increased by $44,990 in HB 08-1375 (FY 2008-09 Long Bill Add-ons). HB 08-1375 also included a General Fund appropriation of $5,553,393 for anticipated future funding needs. The final FY 2007-08 appropriation was $5,854,858 total funds, consisting of $5,564,404 General Fund and $290,454 cash funds.

FY 2008-09 Appropriation for the Trust

The FY 2008-09 Long Bill removed one-time funding of $5,576,155 and increased the cash funds appropriation by $85,263 from the FY 2007-08 appropriation (see Figure Setting dated March 11, 2008, page 179). The increase in the Cash Fund appropriation was a result of the annualization of SB 07-097 and caseload increases included in the following FY 2008-09 Department requests: Decision Item 3 and Budget Amendment A3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs", Decision Item 3A "Additional Children's Basic Health Plan Outreach", and Budget Amendment #A1A "Building Blocks to Health Care Reform". The FY 2008-09 Long Bill appropriation was $375,717 cash funds.

During the 2008 legislative session, SB 08-160 was adopted which revised funding for this appropriation. SB 08-160 expanded eligibility in the Children's Basic Health Plan to 225% of the federal poverty level, resulting in an increase of $30,328 to the cash funds appropriation. The FY 2008-09 appropriation is $406,045 cash funds.

FY 2009-10 Base Request for the Trust

The total Base Request is for $488,936 cash funds, which includes continuation funding of $406,045 and $82,891 for the annualizations of SB 08-160 and the Department's FY 2008-09 Budget Amendment A1A and Decision Item 3A.

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 2006-07 Appropriation for Administration

The FY 2006-07 Long Bill provided continuation funding for administrative costs paid through the Children's Basic Health Plan Trust Fund, totaling $5,577,207 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 Decision Item 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 2006-07 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 Supplemental 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 2006-07 appropriation of $5,534,708, consisting of $2,472,141 Cash Funds Exempt and $3,062,567 federal funds.

FY 2007-08 Appropriation for Administration

The FY 2007-08 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 2007-08 Decision Item 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 07-004, 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 2007-08 appropriation was $5,541,590, consisting of $2,474,735 Cash Funds Exempt and $3,066,855 federal funds.

FY 2008-09 Appropriation for Administration

The FY 2008-09 Long Bill appropriation for administrative costs to the Children's Basic Health Plan included continuation funding and reversed one-time funding for actuarial services included in SB 07-004 and SB 07-097. In addition, the Department's FY 2008-09 Decision Item 3A "Additional Children's Basic Health Plan Outreach" was approved and resulted in a $1,400,000 increase to the total appropriation. The Department's FY 2008-09 Budget Amendment A1A "Building Blocks to Health Care Reform" was also approved, which resulted in an increase of $15,000 for network changes to implement a medical home initiative. This line item was also impacted by the passage of HB 08-1320, which changed the designation of the Cash Funds Exempt appropriations in the line item to cash funds. The FY 2008-09 Long Bill appropriation was $6,951,590, consisting of $3,015,871 cash funds and $3,935,719 federal funds.

During the 2007 legislative session, SB 08-160 was adopted which revised funding for this appropriation. SB 08-160 expanded eligibility in the Children's Basic Health Plan to 225% of the federal poverty level, resulting in an increase of $1,000 to the appropriation for actuarial services. The FY 2008-09 appropriation is $6,952,590 total funds, including $3,016,221 cash funds and $3,936,369 federal funds.

FY 2009-10 Base Request for Administration
The FY 2009-10 Base Request is for $6,937,590, which includes continuation funding of $6,952,590 less one-time funding of $15,000 for the Department's FY 2008-09 Budget Amendment A1A "Building Blocks to Health Care Reform". The Base Request consists of $3,010,971 cash funds and $3,926,619 federal funds.

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. This rate includes the expected costs of providing medical benefits to enrollees as well as medical management services such as claims management. The Department uses the rates to develop estimated per capita costs. For children in the Plan, the per capita is a "blended" cost 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.

The State share of funding for medical premiums is appropriated from the Children's Basic Health Plan Trust Fund as either cash funds or Reappropriated Funds. Beginning in FY 2005-06, 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 2007-08, 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 Reappropriated Funds. However, a federal match is not provided on the annual enrollment fees collected from families. Thus, these fees are subtracted from the calculations below when computing the line item funding split.

FY 2006-07 Appropriation for Premiums Costs
For FY 2006-07, the Long Bill (HB 06-1385) provided funding of $70,371,177. Funding for FY 2006-07 was increased by $4,792,180 from the final FY 2005-06 appropriation with the approval of Decision Item 3 "Adjust Children's Basic Health Plan

Medical Premium and Dental Costs for Caseload and Rate Changes", and Budget Amendment 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). In addition, 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 2006-07 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 8, 2007, page 71). The final appropriation for FY 2006-07 was $81,483,970, consisting of $28,664,893 Cash Funds Exempt and $52,819,077 federal funds.

A June 20, 2007 1331 Supplemental was submitted to the Joint Budget Committee, 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 2005-06 accounts receivable, which had to be accounted for as expenditures in FY 2006-07 (see the Department's June 20, 2007 1331 Supplemental "Adjustments to the FY 2006-07 Children's Basic Health Plan Caseload and Costs").

FY 2007-08 Appropriation for Premiums Costs

The FY 2007-08 Long Bill (SB 07-239) increased the total funds appropriation by $8,341,843 from the FY 2006-07 appropriation (prior to Supplemental 3, see Figure Setting dated March 8, 2007, pages 79-80). This funding increase was as a result of the Department's FY 2007-08 Decision Item 3 and Budget Amendment A3, "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes", which requested an increase to the caseload forecasts and estimated per client costs.

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 2007-08. 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 2007-08 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.

The FY 2007-08 appropriation was increased by $22,446,373 per HB 08-1375 (Long Bill Add-ons) pursuant to the Department's February 15, 2008 Supplemental 3 "Updates to Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (see Figure Setting dated March 11, 2008, page 168). This increase was due to higher caseload forecasts for both children and prenatal women in the Plan. Therefore, the final FY 2007-08 appropriation was $108,872,971 total funds, consisting of $1,479 cash funds, $38,292,856 Cash Funds Exempt, and $70,578,636 federal funds.

FY 2008-09 Appropriation for Premiums Costs

The FY 2008-09 Long Bill (HB 08-1375) included continuation funding of $108,872,971 and $4,673,599 for the annualizations of the Special Bills passed in the 2007 Legislative Session discussed above. In addition, the total funds appropriation was increased by $24,936,154 as a result of the Department's FY 2008-09 Decision Item 3 and Budget Amendment A3 "Updates to the Children's Basic Health Plan Medical Premium and Dental Benefit Costs", which requested an increase to the caseload forecasts and estimated per client costs. The appropriation was also increased by $8,712,483 pursuant to the approval of the Department's November 1, 2007 Decision Item 3A "Additional Children's Basic Health Plan Outreach", which included a forecasted increase in the children's caseload. As a result of the Department's February 15, 2008 Budget Amendment A1A "Building Blocks to Health Care Reform", the appropriation was further increased by $1,647,108 for the implementation of a medical home program and anticipated caseload increases due to the initiative (see Figure Setting dated March 11, 2008, page 168). This line item was also impacted by the passage of HB 08-1320, which changed the designation of the Cash Funds Exempt appropriations in the line item to cash funds, and designated the enrollment fees appropriated from the Children's Basic Health Plan Trust Fund as Reappropriated Funds. The FY 2008-09 Long Bill appropriation was $148,842,315, consisting of $52,336,927 cash funds and $96,505,388 federal funds.

The Long Bill appropriation was later increased for two special bills. SB 08-057, Insurance Coverage for Hearing Aids for Minors, requires health insurance coverage for medically appropriate hearing aids for minors in the Children's Basic Health Plan. Based on the fiscal note for SB 08-057, the cost to the Children's Basic Health Plan is $54,300 in FY 2008-09. SB 08-160 was also adopted, which increases eligibility in the Children's Basic Health Plan to 225% of the federal poverty level and requires the mental health benefits for children in the Children's Basic Health Plan to be as comprehensive as those for children in Medicaid. This bill resulted in an appropriation of $5,842,592 to this line item. The FY 2008-09 appropriation is $154,739,207 total funds, consisting of $54,390,220 cash funds, $30,328 Reappropriated Funds and $100,318,659 federal funds.

FY 2009-10 Base Request for Premiums Costs

The FY 2009-10 Base Request is for $177,141,049, which includes continuation funding of $154,739,207 plus $13,338,536 for the annualizations of the two previously discussed bills. In addition, the Base Request includes $8,061,239 for the annualizations of the previously discussed FY 2008-09 Decision Item 3A "Additional Children's Basic Health Plan Outreach" and FY 2008-09 Budget Amendment A1A "Building Blocks to Health Care Reform", which included ongoing increases to caseload and per client costs. An additional annualization of $1,002,067 is included in the Base Request to identify the increase in funding for the Children's Basic

Health Plan Premiums Costs required as a result of the changes in benefits and eligibility requirements for children in the Plan. This adjustment is a result of simultaneous bills from the 2008 legislative session and Department's Change Requests for FY 2008-09. The Base Request includes $62,222,676 cash funds, $92,421 Reappropriated Funds and $114,825,952 federal funds.

CHILDREN'S BASIC HEALTH PLAN DENTAL BENEFIT COSTS

In FY 2001-02, 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 currently excluded), and selected the vendor who offered the most complete dental benefit package. The Department currently has a $600 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 appropriated from the Children's Basic Health Plan Trust Fund. Beginning in FY 2005-06, 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 2007-08, 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 2006-07 Appropriation for Dental Benefit Costs

Funding for FY 2006-07 was increased by $462,135 from the FY 2005-06 final appropriation with the approval of Decision Item 3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes" and Budget Amendment 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 2006-07, 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 2006-07 Long Bill appropriation of $5,913,659 consists of $2,069,780 Cash Funds Exempt and $3,843,879 federal funds.

The FY 2006-07 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 8, 2007, page 71). The final appropriation for FY 2006-07 was $6,302,642, consisting of $2,205,925 Cash Funds Exempt and $4,096,717 federal funds. In addition, a June 20, 2007 1331 Supplemental was submitted to and approved by the Joint Budget Committee, which resulted in an increase of $572,326 to the spending authority due to greater than anticipated caseload growth.

FY 2007-08 Appropriation for Dental Benefit Costs

The FY 2007-08 Long Bill (SB 07-239) increased the total funds appropriation by $802,198 from the final FY 2006-07 appropriation (prior to Supplemental 3, see Figure Setting dated March 8, 2007, pages 79-80). In addition, this appropriation was changed to reflect

two Special Bills that passed during the 2007 legislative session. SB 07-097 increases eligibility in the Children's Basic Health Plan up to 205% of the federal poverty level, which resulted in an appropriation of $4,806 to this line item. SB 07-133 moved 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 2007-08 appropriation was increased by $2,089,586 per HB 08-1375 (Long Bill Add-ons) pursuant to the Department's February 15, 2008 Supplemental 3 "Updates to Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (see Figure Setting dated March 11, 2008, page 168). This increase was due to higher caseload forecasts for children in the Plan. Therefore, the final FY 2007-08 appropriation was $8,976,385 total funds, consisting of $3,141,735 Cash Funds Exempt and $5,834,650 federal funds.

FY 2008-09 Appropriation for Dental Benefit Costs

The FY 2008-09 Long Bill (HB 08-1375) included continuation funding of $8,976,385 and $250,798 for the annualizations of the two Special Bills passed in the 2007 Legislative Session discussed above. In addition, the total funds appropriation was increased by $1,964,539 as a result of the Department's FY 2008-09 Decision Item 3 and Budget Amendment A3 "Updates to the Children's Basic Health Plan Medical Premium and Dental Benefit Costs", which requested an increase to the caseload forecasts and estimated per client costs. The appropriation was also increased by $864,674 pursuant to the approval of the Department's November 1, 2008 Decision Item 3A "Additional Children's Basic Health Plan Outreach", which included a forecasted increase in the children's caseload. As a result of the Department's February 15, 2008 Budget Amendment A1A "Building Blocks to Health Care Reform", the appropriation was further increased by $111,998 for the anticipated caseload increases due to the medical home initiative in the Plan. This line item was also impacted by the passage of HB 08-1320, which changed the designation of the Cash Funds Exempt appropriations in the line item to cash funds. The FY 2008-09 Long Bill appropriation was $12,168,394, consisting of $4,258,938 cash funds and $7,909,456 federal funds.

During the 2008 legislative session, SB 08-160 was adopted which revised funding for this appropriation. SB 08-160 expanded eligibility in the Children's Basic Health Plan to 225% of the federal poverty level, resulting in an increase of $282,415 to this line item. The FY 2008-09 appropriation is $12,450,809 total funds, including $4,357,783 cash funds and $8,093,026 federal funds.

FY 2009-10 Base Request for Dental Benefit Costs

The FY 2009-10 Base Request is for $13,892,765, which includes continuation funding of $12,450,809 plus $629,155 for the annualization of SB 08-160 discussed above. In addition, the Base Request includes $812,801 for the annualizations of the previously discussed FY 2008-09 Decision Item 3A "Additional Children's Basic Health Plan Outreach" and FY 2008-09 Budget Amendment A1A "Building Blocks to Health Care Reform", which included on-going increases to caseload and per client costs. The Base Request includes $4,862,468 cash funds and $9,030,297 federal funds.

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. (2008), 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 services provided through the Medicaid program, 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 2000-01, the Comprehensive Primary and Preventive Care Grants Program has received its funding from the Comprehensive Primary and Preventive Care Fund. However, in FY 2006-07, 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 have dropped approximately 49% from their highest level in FY 2003-04, (equal to $5,064,339), down to FY 2005-06 expenditures of $2,604,927. The initial FY 2005-06 appropriation of $2,668,034 was adjusted downward to adjust for updated Tobacco Master Settlement Agreement revenue forecasts by the State's Supplemental Bill (HB 06-1217). The final appropriation in FY 2005-06 was $2,615,941.

The increase of $5,799 from the final FY 2005-06 appropriation to the FY 2006-07 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 2006-07 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 2006-07 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 2006-07 appropriation of $220,525 with the passage of the Department's Supplemental Bill, SB 07-163. The final appropriation for FY 2006-07 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 2006-07 appropriation and the FY 2007-08 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. Pursuant to 24-75-1104.5 (1.5) (III), C.R.S. (2008) an appropriation is to be made in an amount equal to 8.5% of settlement funding remaining after distribution to "Tier 1" programs to the Supplemental Tobacco Litigation Settlement Moneys Account for the supplemental payments to hospitals.

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 initial appropriation for FY 2007-08 was $2,138,070. A revised Tobacco Master Settlement Agreement revenue collection was published by Legislative Council Staff on February 14th, 2008, which was used to reallocate funds to programs funded by the Master Settlement Agreement. Consequently, The Comprehensive Primary and Preventive Care program received an additional $2,000,000 in Reappropriated Funds for use in FY 2007-08, bringing the final appropriation to $4,138,070. During the Department's 2008 Figure Setting, the annualization of SB 07-097 and HB 07-1359, in addition to a revision to the Tobacco Settlement Forecast further increased the funding for this line item by $2,343,191 (March 11, 2008 Figure Setting, page 182). The FY 2008-09 appropriation underwent a technical change after the March 11, 2008 Figure Setting to transfer the FTE responsible for administering the Comprehensive Primary and Preventive Care Grants program into the Department's Personal Services line item, reducing the appropriation by $22,025 and bringing the FY 2008-09 appropriation to $6,459,236. Pursuant to 24-75-1104.5, C.R.S. (2008), which defines the allocation of the Master Settlement Account, $3,286,155 of this amount will be available for Small Rural and Public Hospitals, and the remaining $3,173,081 will be available for the Comprehensive Primary and Preventive Care Grants Program. For FY 2009-10, the Department is requesting continuation funding of $6,459,236.

(5) OTHER MEDICAL SERVICES

SERVICES FOR OLD AGE PENSION STATE MEDICAL PROGRAM CLIENTS

The Services for Old Age Pension State Medical Program Clients line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical care for non-Medicaid eligible 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 XXIV of the constitution and 25.5-2-101, C.R.S. (2008).

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 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 2002-03, 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 (the Department) 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. Pursuant to 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 2002-03 Long Bill).

Under an Interagency Agreement in FY 2002-03, the Department's responsibilities for this appropriation were changed to include processing claims, producing Medicaid Authorization Cards and providing data that could assist the Department of Human Services in calculating 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. (2008) was transferred from the Department of Human Services to the Department effective July 1, 2003.

Beginning in FY 2003-04, this line item was placed 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 appropriation 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 2005-06 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.
- The Department requested additional funding for the program through BA-8 (FY 2008-09 "Funding Increase for Old Age Pension State Medical Program", Stand Alone Budget Request Amendments, January 23, 2007). With the approval of the additional funding the Department has been able to maintain the reimbursement rates at the rates effective July 1, 2007.

Caseload History

The table below presents the caseload history for this program since FY 1990-91. The program's caseload has fluctuated over the years, but has risen steadily since FY 2002-03 until FY 2007-08. Upon the passage of HB 06S-1023 (Restrictions On Defined Public Benefits) verification of alien status through the Systematic Alien Verification for Entitlements program was required. This change was implemented in the Colorado Benefits Management System in June 2007. Due to both the implementation of the alien status verification and the different verification processes between the Department and the Department of Human Services, new applicants for the program were denied eligibility since the Colorado Benefits Management System had no record that the client provided acceptable documentation of sufficient residency. Also in June 2007, the Date of Entry field in the Colorado Benefits Management System was no longer optional and was required for all non-citizen applicants. Required use of the applicant's date of entry may have impacted the state-only Old Age Pension Health and Medical Care Program client caseload. This potential impact may have occurred because non-citizens who have resided in the United States for five years may be eligible for Medicaid benefits under OAP-A (Old Age Pension - Supplemental Security Income for persons 65 years of age or older). It is possible that an unexpectedly large number of clients in the state-only program have transitioned into Medicaid as a result of these changes to the Colorado Benefits Management System. The Department continues to perform analyses to determine the extent and duration of the impacts resulting from these changes to the Colorado Benefits Management System.

Old Age Pension State Medical Program Caseload History and Projection			
Year	**Caseload**	**% Change**	**Source**
FY 1990-91 Actual	3,586		February 14, 2003 Budget Request, Exhibit B, "Caseload History and Projections with Rates of Change"
FY 1991-92 Actual	3,540	-1.28%	
FY 1992-93 Actual	3,446	-2.66%	
FY 1993-94 Actual	3,011	-12.62%	
FY 1994-95 Actual	3,056	1.49%	
FY 1995-96 Actual	3,150	3.08%	

Old Age Pension State Medical Program Caseload History and Projection			
Year	**Caseload**	**% Change**	**Source**
FY 1996-97 Actual	3,152	0.06%	
FY 1997-98 Actual	3,215	2.00%	
FY 1998-99 Actual	3,150	-2.02%	
FY 1999-00 Actual	3,066	-2.67%	Business Objects America Queries ran on 7/1/04
FY 2000-01 Actual	3,212	4.76%	
FY 2001-02 Actual	3,782	17.75%	
FY 2002-03 Actual	3,794	0.33%	Average of monthly figures gathered from COLD MARS R4600 Reports
FY 2003-04 Actual	4,261	12.31%	
FY 2004-05 Actual	4,766	11.85%	
FY 2005-06 Actual	5,076	6.50%	
FY 2006-07 Actual	5,103	0.53%	
FY 2007-08 Actual	4,291	-15.9%	

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 United States 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 of Supplemental Request 11, "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 included a request for an FTE in order to implement this 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 2006-07, 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 and this rebate program has not been

implemented. For FY 2008-09, the Department submitted Decision Item 7, "Additional FTE to Restore Department Efficiency and Functionality" on November 1, 2007, and that decision item abolished the FTE to implement this 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 2002-03, 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 2003-04 via SB 03-299. During the Department's FY 2004-05 Figure Setting session,[17] the Joint Budget Committee combined funding sources into a single line item for FY 2004-05 for a total of $10,750,000. The FY 2005-06 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 2005-06. 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 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 June 20, 2006 1331 Supplemental entitled "Prevent Old Age Pension State Medical Program Overexpenditure" which requested an additional $1,140,484 in FY 2005-06 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 2005-06 appropriation to $14,426,967.

In addition to the ongoing funding from tobacco tax revenue, the Joint Budget Committee[18] increased the spending authority for FY 2006-07 by $976,180. This additional funding is comprised of the $943,500 in tobacco tax revenue that can be attributed to FY 2004-05, plus $32,680 from the prior year tobacco tax revenue exceeding revenue projections provided by the Legislative Council. As a result of these changes, the final FY 2006-07 appropriation for the Old Age Pension State Medical Program was $14,262,663.

The FY 2007-08 appropriation is for $13,293,672, which is a reduction of $968,991 from FY 2006-07. This reduction includes a removal of the $976,180 of one-time funding in FY 2006-07, 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 one-time 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. As a result of Decision Item 11 "Technical Adjustments to Old Age Pension State Medical Program" in the Department's FY 2007-08

[17] Page 139 Figure Setting March 9, 2004

[18] March 13, 2006 Figure Setting, page 209

Budget Request, the Department was allowed to use the fund balance in the Supplemental Old Age Pension Fund to help offset the decrease of $1,013,680 resulting from the removal of one-time funding (Joint Budget Committee Figure Setting, March 8, 2007).

The FY 2008-09 appropriation is for $15,311,715 which is an increase of $2,018,043 from the FY 2007-08 appropriation. The increase is due to several actions. These actions include 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 2007 Revenue Forecast, an increase of $680,779 from the reversal of one-time savings due to SB 07-133, Department of Health Care Policy and Financing Cash Accounting, and an increase of $2,088,232[19] for a one-time increase in funding to allow the Department to maintain the current reimbursement rates and provide stability for the program.

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 1999-00 Actual	$9,681,696	($663,715)	$9,017,981	3,066	$2,941.29
FY 2000-01 Actual	$10,639,144	($803,201)	$9,835,943	3,212	$3,062.25
FY 2001-02 Actual	$10,468,408	($930,753)	$9,537,655	3,782	$2,521.85
FY 2002-03 Actual	$11,241,636	($495,571)	$10,746,065	3,794	$2,832.38
FY 2003-04 Actual	$11,447,158	($700,984)	$10,746,174	4,261	$2,521.98
FY 2004-05 Actual	$10,923,336	($924,015)	$9,999,321	4,766	$2,098.05
FY 2005-06 Actual	$15,182,038	($755,071)	$14,426,967	5,076	$2,842.19
FY 2006-07 Actual	$12,589,332	($410,670)	$12,578,662	5,103	$2,464.95
FY 2007-08 Actual	$9,956,951	($0)	$9,956,951	4,291	$2,320.43

Expenditures for FY 2007-08 are lower due to an unanticipated decrease in caseload. Due to both the implementation of the alien status verification and the different verification processes between the Department and the Department of Human Services, new applicants for the program were denied eligibility since the Colorado Benefits Management System had no record that the client provided acceptable documentation of sufficient residency.

The FY 2009-10 Base Request continues to be the maximum allowed under current law, minus the administrative costs of the Medical Identification Cards and the removal of the one-time funding to maintain rates and stabilize the program. The Base Request assumes

[19] Budget Amendment 8, "FY 2008-09 Funding Increase for Old Age Pension State Medical Program", submitted January 23, 2008

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 2009-10 Base Request estimates that the Supplemental Old Age Pension Medical Care Fund will receive $2,475,000 from the Tobacco Tax Cash Fund as projected by the Office of Legislative Council.

TRANSFER OF TOBACCO TAX CASH FUND INTO THE SUPPLEMENTAL OLD AGE PENSION STATE MEDICAL FUND

In 2002, the General Assembly passed HB 02-1276 that created the Supplemental Old Age Pension Health and Medical Care Fund to supplement the Old Age Pension program with an additional $1,000,000 annually since 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 2006-07, the Supplemental Old Age Pension State Health and Medical Fund had no direct appropriation. In FY 2006-07, 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 2007-08, 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 2009-10 Base Request estimates that the Supplemental Old Age Pension Health and Medical Care Fund will receive $2,475,000 from the Tobacco Tax Cash Fund as projected by the Office of Legislative Council.

COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The Commission on 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. Prior to FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education. Beginning in FY 1994-95, 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 payments to the hospitals enrolled in the program. Since federal Medicaid funds were involved, a line item appropriation to the Department was established.

For FY 2005-06, the Joint Budget Committee recommended and the General Assembly approved an increase in funding of $127,058 over the final FY 2004-05 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 2004-05, 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 2005-06

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 2005-06 was $1,576,502.

In FY 2006-07, 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 2005-06 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 2006-07 was therefore $1,703,558.

In FY 2007-08, 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 2007-08, Commission on Family Medicine Figure Setting, February 14, 2007, page 4).

During the 2008 Legislative Session, the General Assembly passed SB 08-230, which granted taxing authority to Denver Health and Hospital Authority and University of Colorado Hospital Authority in order to avoid the adverse effects of a rule passed by the Centers for Medicare and Medicaid Services that would have redefined "Public Hospital" and put at risk a substantial portion of the federal funding utilized by the Colorado Indigent Care Program[20]. The bill created two new line items, (5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority, and (5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority. The hospital had previously received funding indirectly through the Department's (2) Medical Services Premiums and (5) Other Medical Services; Commission on Family Medicine Residency Training Program line items, but due to the impact of SB 08-230 and the need to identify the hospital more explicitly as a unit of government, the new line item began receiving direct appropriations from the General Assembly during the last part of FY 2007-08. In order to offset the appropriation to this new line item, the funding previously embedded in the Commission on Family Medicine Residency Training Program for the University of Colorado Hospital, which operated one of the Commission's nine family medicine residency training programs, was removed. This resulted in a reduction to the FY 2007-08 appropriation to this line item of $35,251, which was annualized in FY 2008-09, resulting in a net zero impact to the line item.

For FY 2008-09, the Department submitted Non-Prioritized Decision Item, NP-2 entitled "Leveraging Additional Federal Funds" which requested $135,000 in General Fund and matching federal funds of $135,000, which was subsequently approved by the Joint

[20] See the descriptions of the State University Teaching Hospitals, and the section entitled "Centers for Medicare and Medicaid Services: Public Hospitals as Units of Government" for more detail.

Budget Committee, increasing the funding to this line item by $270,000 to $2,173,558. The impact of SB 08-230 in FY 2008-09, (the first full year of implementation), transferred $241,506 from the line item to (5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority, bringing the FY 2008-09 appropriation to $1,932,052. The Department is requesting continuation funding for this line item for FY 2009-10 in the amount of $1,932,052.

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, 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[21]. 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 last approved a change in Medicaid reimbursement for the Enhanced Prenatal Care Training and Technical Assistance services effective July 1, 2004. The Medicaid reimbursement structure pays more for model care, services that provide the best health outcomes for pregnant women and their infants. The reimbursement structure also encourages early enrollment of women to reduce pregnancy risk factors.

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 2006-07 through Long Bill HB 06-1385, the Enhanced Prenatal Care Training Program was appropriated continuation funding of $102,346 to provide these services. During the FY 2007-08 Figure Setting (March 8, 2007, pages 96-07), the amount of money requested for this line item was 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 2007-08 appropriation up to $108,999 as appropriated in the Long Bill SB 07-239.

[21] Prenatal Plus Program, 2004 Annual Report, page 3

The Department's FY 2008-09 Base Request of $117,411 included an adjustment for POTS in the amount of $8,412 which was approved and appropriated in Long Bill HB 08-1375. The Department requests continuation funding of $117,411 for FY 2009-10.

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 which continues to serve both non-Medicaid clients and Medicaid clients. Services for Medicaid clients are billed through the Department's Medicaid Management Information System. See the Department of Public Health and Environment Budget Request for justification and calculations regarding the final request. The federal financial participation for this line item is 50%.

The accounting and budgeting for the Nurse Home Visitor Program line was changed to a cash basis with the passage of SB 06-129. The FY 2006-07 Long Bill appropriation was $3,010,000 in HB 06-1385. Continuation funding was requested and appropriated for FY 2007-08 in SB 07-239, and again in FY 2008-09 through Long Bill HB 08-1375. The same amount of $3,010,000 is requested for FY 2009-10.

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 were 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% in 2015, where it will remain on a go-forward basis.

During the Department's FY 2005-06 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 2005-06. On January 20, 2006, as outlined on page 27 of the Department's FY 2005-06 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 2005-06 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 2005-06 caseload figures must be booked against FY 2005-06 appropriations, regardless of when the invoice was received. As a result, the Department submitted June 20, 2006 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 2006-07 Supplemental Bill (SB 07-163).

The FY 2006-07 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).

During the Department's March 8, 2007 Figure Setting, the Joint Budget Committee increased the FY 2007-08 appropriation by $3,226,279, based on an estimated increase in the average monthly enrollment for dual eligible clients, an increase in the per-client per-month costs, and a decrease in the phase down percentage. This increase over the final FY 2006-07 appropriation brought the FY 2007-08 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. This shifted the payment for June 2008 from FY 2007-08 to FY 2008-09. This Act resulted in a one-time savings during FY 2007-08.

During October 2007 as a result of technical systems change which changed the way that dual eligible clients are identified in the Colorado Benefits Management System, the retroactive dual eligible caseload increased unexpectedly. The Joint Budget Committee approved the Department's Supplemental Request 4 "Adjust State Contribution Payment" submitted on June 2, 2008, for an additional $1,743,731 to cover the one-time spike in the dual eligible caseload in October 2007 and $804,826 to cover anticipated increases in the dual eligible client caseload through the end of FY 2007-08. For FY 2007-08 total expenditures in this line were $71,350,801. The Department submitted June 23, 2008 1331 Supplemental Request, to have the excess funds transferred to the Controlled Maintenance Trust Fund.

Through a combination of the removal of the one-time savings resulting from SB 07-133 (the Department's Cash Accounting Bill) and the Department's supplemental request to increase funding due to expected increases in caseload and per-client per-month costs, the appropriation for FY 2008-09 was increased by $4,624,811. The FY 2008-09 appropriation was further increased by $4,435,374 through the approval of the Department's Budget Amendment BA-A4 (Adjust State Contribution Payment). The FY 2008-09 appropriation for this line is currently $81,155,195 and the Department is requesting continuation funding for FY 2009-10.

PUBLIC SCHOOL HEALTH SERVICES

The Public School Health Services program 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 for 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 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. Pursuant to 25.5-5-318 (8) (b) C.R.S. (2008), the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The FY 2005-06 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 2005-06 from HB 05-1262 (Tobacco Tax Bill) which expanded the slots available for the Children's Extensive Support waiver program by 59 and Children's Home and Community Based Services waiver program by 678. With the Tobacco Tax monies included, the appropriation for FY 2005-06 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 2005-06 was $25,771,041.

The Long Bill (HB 06-1385) appropriation for FY 2006-07 was $31,535,961, where $16,007,021 was Cash Funds Exempt and $15,528,940 was 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 2006-07, 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). This 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 2007-08, 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 came from federal funds. Additionally, the Department requested a General Fund appropriation to cover the Centers for Medicare and Medicaid Services disallowances in the amount of $10,480,201 (FY 2007-08, Supplemental Requests, January 2, 2008, S-15). The final appropriation for FY 2007-08 was $41,808,014, which was comprised of $16,007,021 Cash Funds Exempt, $15,320,792 in federal matching funds, and $10,480,201 in General Fund.

For FY 2008-09, the Department received Common Policy adjustments to Personal Services and indirect cost assessments from the Department of Education in the amount of $16,051 (Department of Education Figure Setting, March 4, 2008). This adjustment will increase the transfer to the Department of Education by $16,051 and correspondingly decrease the federal funds available for school providers through this line. The amount transferred to the Department of Education for FY 2008-09 will be $207,747. The annualization of the supplemental request for funds to cover the Centers for Medicare and Medicaid Services disallowances reduced the FY 2008-09 appropriation by $10,480,201 General Fund. Also, during Department Figure Setting, Joint Budget Committee staff recommended a decrease in total funds of $3,810,228 in order to more accurately reflect actual expenditure history of the program;

historically, the program has been appropriated more funding than was required to cover expenses in order to allow for the possibility of increased participation by school districts. The Department requested an FY 2008-09 appropriation of $27,501,534 which is comprised of $14,101,907 cash funds and $13,399,627 federal funds. The Department is requesting continuation funding for this line item for FY 2009-10 in the amount of $27,501,534.

COLORADO CARES RX PROGRAM CONTRACT COSTS

During the Department's Figure Setting on March 11, 2008, this new line item was created for the Colorado Cares Rx Program. This line item was added to (5) Other Medical Services and consolidated two line items previously located in (1) Executive Director's Office: Colorado Cares Rx Program – CBMS Appropriation and Colorado Cares Rx Program – Third Party Vendor. For FY 2008-09 the Department was appropriated $2,278,378 in the Long Bill, HB 08-1375. The source of funding is cash funds from Colorado Cares Rx Program Fund. The Department requests continuation funding for FY 2009-10. Please see the two items below for detail regarding the Colorado Cares Rx Program Contract Costs line item.

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 would have been determined through the Colorado Benefits Management System, which processes eligibility for 36 of Colorado's medical, food, and financial assistance programs. For FY 2006-07, the Department was 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. This funding was rolled forward into FY 2007-08. There is no federal match for these changes as the Colorado Cares Rx Program is a State-only program.

Beginning in FY 2008-09, the Department was appropriated $323,146 in cash funds that were expected to be generated from the fees collected from Colorado Care Rx Program participants. Originally this appropriation was included in the Long Bill group (1) Executive Director's Office. In HB 08-1385 Joint Budget Committee staff recommended that the Colorado Cares Rx Program – Colorado Benefits Management System line be moved to (5) Other Medical Services. In addition, this line was combined with the Colorado Cares Rx Program – Third Party Vendor. As a result, all Colorado Cares appropriations are now part of (5) Colorado Cares Rx Program Contract Costs. These funds would have been used to finalize Colorado Benefits Management System changes and pay for eligibility processing as the Colorado Cares Rx Program enters into its operational phase.

The Department began implementing SB 07-001 in FY 2007-08 but during the planning process the Denver Metro Chamber introduced the Colorado Drug Card. This is a separate entity that is not affiliated with the Department but provides the same services that would have been provided under the Colorado Cares Rx Program. This program was able to provide discount services to a larger population at a lower cost. Eligibility restrictions defined in the bill limited the availability of services to certain populations. As a

result, the Department worked with an alternative company, Express Scripts to create a modified discount drug program. The Department began advertising Express Scripts' Rx Outreach discount drug program as Colorado Cares Rx in February 2008. The Express Scripts' Rx Outreach discount drug program was an existing program providing discount medications to participating individuals. This alternative does not require any systems development; neither the state or program participants are paying enrollment fees. All services and administration are provided by Express Scripts. Monthly reports are submitted to Department staff to review participation rates. Any budgetary impacts from this alternative will be addressed through the regular budgetary process.

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 would provide a discount pharmacy card for uninsured Coloradans who qualify and pay a year application fee to participate. The application fees would have paid for a contractor who would accept and process applications, collect fees, determine eligibility and produce program identification cards.

The Department received $1,333,420 in total funds in FY 2007-08 through SB 07-001. All funding for this program comes from cash funds through the Colorado Cares Rx Program Fund. The Department's FY 2008-09 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. Originally this appropriation was included in the Long Bill group (1) Executive Director's Office. In HB 08-1385 Joint Budget Committee staff recommended that the Colorado Cares Rx Program – Third Party Vendor line be moved to (5) Other Medical Services. In addition, this line was combined with the Colorado Cares Rx Program – Colorado Benefits Management System line. As a result, all Colorado Cares appropriations are now part of (5) Colorado Cares Rx Program Contract Costs. Due to changes in the program resulting from the introduction of the Colorado Drug Card through the Denver Metro Chamber, the Department did not implement the Colorado Cares Rx program as a discount drug card. The Department advertises Express Scripts' Rx Outreach discount drug program as Colorado Cares Rx. This alternative does not require the state to pay for any services and all enrollment and management services are provided by Express Scripts. Any budgetary impacts from this alternative will be addressed through the regular budgetary process.

CENTERS FOR MEDICARE AND MEDICAID SERVICES: PUBLIC HOSPITALS AS UNITS OF GOVERNMENT

On January 18, 2007 the Centers for Medicare and Medicaid Services promulgated rules relating to "Cost Limits for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership", (these were subsequently published in the Federal Register of May 29, 2007). Among other things, these rules narrowed the definition of a "Unit of Government" by requiring that for a provider to be defined as such they must have taxing authority. The Department relies heavily on the use of public financing mechanisms such as Certification of Public Expenditures in order to draw federal funding available through the Federal Upper Payment Limit and the Disproportionate Share Hospital Payment. In order for federal funding to be obtained, however, the entity for which expenditures are being certified must be "Public", meaning, a unit of government. The proposed rules published by the Centers for Medicare and Medicaid Services, specifically found at 42 CFR 433.50, would therefore

make Colorado's public hospitals ineligible for federal financial participation under the Upper Payment Limit and Disproportionate Share Hospital payments. According to the Senate Joint Memorial 07-004, which urges Congress to enact legislation preventing the federal Centers for Medicare and Medicaid Services from promulgating rules interfering with states' definitions of units of government, the proposed Centers for Medicare and Medicaid Services rule would reduce federal funding to Colorado's Public Hospitals by approximately $128,000,000. Most adversely affected would be Denver Health and the University of Colorado Hospital, as those two entities have historically received the two largest state payments of federal funding through the Colorado Indigent Care Program.

The United States Congress introduced three bills (Senate Bill 787 and House Bills 1480 and 1741) that impose a two-year moratorium on implementing the proposed rule. Congress determined that, due to the extensive impact of the rule and the fundamental change in the federal-state financial partnership that it would entail, more time was needed to study the impact of these changes. The moratorium is currently set to expire on April 1, 2009. In order to maintain the state's access to federal financial participation for its two largest providers of indigent care, the General Assembly resolved to grant Denver Health and Hospital Authority and the University of Colorado Hospital Authority powers of taxation. To this end, SB 08-230 was introduced during the 2008 legislative session. This bill defined taxing areas and gave taxing authority to Denver Health and University of Colorado Hospital. In addition, the bill transferred funding directed to these entities and designated for Graduate Medical Education from (2) Medical Services Premiums and (5) Other Medical Services; Commission on Family Medicine Residency Training Programs in order to make direct appropriations to the hospitals through two new line items: (5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority; and (5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority. This action represents a budget-neutral transfer of funds between Department line items. This action will allow the state to continue to draw federal funding for these entities regardless of the implementation of the new rules. This change also allowed the Department to clarify the status of Denver Health and University of Colorado Hospital as units of government through their role as providers of State University certified Graduate Medical Education.

STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY

This line item was created in order to clarify the status of Denver Health and Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented through SB 08-230 allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses Denver Health and Hospital Authority for Graduate Medical Education in two ways: fee-for-service payments to Denver Health and Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Denver Health and Hospital Authority also receives lump sum payments when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education.

Costs incurred by Denver Health and Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's (2) Medical Services Premiums line item. Beginning in FY 2008-09 however,

funding for this purpose will be directly appropriated to the (5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority line item. The Department made the determination that this amount would be $410,000 in FY 2007-08; however this consisted of only a partial year of implementation. For FY 2008-09 the Department was appropriated $1,829,008 for this line item. The Department is requesting $1,831,714 for this line item in FY 2009-10. Since the appropriations to this line item are offset by corresponding funding reductions in (2) Medical Services Premiums, this line item will have a net zero fiscal impact.

STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

Due to the passage of SB 08-230, this line item was created in order to clarify the status of the University of Colorado Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the bill allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses the University of Colorado Hospital Authority for Graduate Medical Education in three ways: fee-for-service payments to University of Colorado Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education, and lump sum payments are received when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. In addition, the University of Colorado Hospital Authority receives funding for one of nine family medicine residency training programs administered by the Commission on Family Medicine.

Costs incurred by the University of Colorado Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's (2) Medical Services Premiums and (5) Other Medical Services; University of Colorado Family Medicine Residency Training Programs line items. Beginning in FY 2008-09 however, funding for this purpose will be directly appropriated to the (5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority line item. The Department determined that this amount would be $95,251 in FY 2007-08, though this consisted of only a partial year of implementation. The year-to-date FY 2008-09 appropriation to this line item was $697,838. The Department is requesting $700,935 for this line item in FY 2009-10. Since the appropriations to this line item are offset by corresponding funding reductions in (2) Medical Services Premiums and (5) Other Medical Services; University of Colorado Family Medicine Residency Training Programs, this line item will have a net zero fiscal impact.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department's FY 2009-10 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 Reappropriated Funds transfers from the Department to the Department of Human Services.

Until FY 2001-02, Medicaid funding for the Department of Human Services was appropriated in one line item. In FY 2001-02, 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 2005-06, 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.

In FY 2008-09, the Joint Budget Committee transferred another administrative line item, Transfer to the Department of Human Services for Related Administration, from the Department's Executive Director's Office Long Bill group (1) to the Department of Human Services Medicaid-Funded Long Bill group (6). Currently there are 20 line items in the Department's budget within the Department of Human Services Medicaid-Funded Long Bill group.

All funding requests in this Long Bill group originate with the Department of Human Services. Inquiries related to the FY 2009-10 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 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.

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 2007-08 Figure Setting, February 22, 2007, page 15). In FY 2006-07, 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 2007-08, the Department of Human Services requested continuation funding for its 22.4 FTE, and the same number of FTE was approved for FY 2008-09. The positions covered in this appropriation will remain the same through FY 2009-10. In addition to these staff, the Department of Human Services requests all Common Policy funding in this appropriation. This includes Salary Survey; Performance Based Pay Awards; Health, Life, and Dental; Workers' Compensation; Short-term Disability; Shift Differential; Payments to Risk Management and Property Funds; Amortization Equalization Disbursement; Supplemental Amortization Equalization Disbursement; and Injury Prevention Program. Operating Expenses specifically for the Executive Director's Office are also included in the line item. A portion of this funding, specifically POTS, is transferred throughout each fiscal year to support the FTE appropriated in other areas within the Department of Human Services' Long Bill. A significant portion of these items result from expenditures, especially POTS, Workman's Compensation, and Risk Management, for the Regional Centers for clients with developmental disabilities.

This line also helps fund the Office of Performance Improvement which was appropriated 68.1 FTE in FY 2006-07, and a team of 2.0 FTE to perform security remediation for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Department of Human Services FY 07-08 Figure Setting, February 22, 2007, page 34). The Office of Performance Improvement grew to 69.1 FTE in FY 2007-08 per Long Bill SB 07-239 and grew again in FY 2008-09 to 74.1 FTE per Long Bill HB 08-1375. 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). The FTE for the Health Insurance Portability and Accountability Act of 1996 Security Remediation has remained stable through FY 2007-08 and FY 2008-09 as appropriated in the Long Bills, SB 07-239 and HB 08-1375.

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 initial FY 2006-07 Long Bill appropriation was equal to $10,129,288. Changes from the final FY 2005-06 appropriation included a net decrease of $1,207,623[22] 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 2006-07 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[23], were due to risk management, pay date shift differential, salary survey, and worker's compensation. The final FY 2006-07 appropriation was $9,727,721.

The FY 2007-08 appropriation of $12,509,047 includes $2,781,326[24] in Common Policy adjustments for the Department of Human Services. This reflects an increase of $1,308,285[25] from the final FY 2006-07 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. The Department's Supplemental Bill, HB 08-1285, reduced funding by $367,082 as a Worker's Compensation Common Policy Adjustment and reduced $43,518 for Risk Management Common Policy Adjustment to arrive at $12,098,447 total funding. In addition, the Add-on sections of the FY 2008-09 Long Bill (HB 08-1375) corrected some items missing from the Supplemental Bill by adding $6,494 total funding for the closing of the Office of

[22] $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.

[23] ($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.

[24] $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

[25] $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.

Colorado Benefits Management System (1331 Supplemental Request heard by the Joint Budget Committee on June 20. 2007), and including $116,169 for the request of NP-S17, "Regional Center High Needs Clients," submitted February 15, 2008. The ending appropriation for FY 2007-08 was $12,221,110.

The FY 2008-09 Long Bill (HB 08-1375) appropriation is $14,426,718. The differences between the FY 2007-08 final appropriation and the FY 2008-09 appropriation include $11,023 for contracted professional services, a reduction of $7,021 for annualization of salary survey, an increase of $144,393 for annualization of Performance-Based Pay, a salary savings (vacancy savings) of $3,500, an increase of $1,722,378 for Common Policy Adjustments, an increase of $32,915 for Human Resources staffing resulting from NP-3, "DHS – Human Resources Staff," in the FY 2008-09 Budget Request submitted November 1, 2007, an increase of $279,904 for Regional Center associated expenses resulting from NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study" in the FY 2008-09 Budget Request submitted November 1, 2007, and an increase of $25,516 for C-SEAP services for employees resulting from NP-7 , "State-wide C-SEAP Program Staffing" in the FY 2008-09 Budget Request submitted November 1, 2007.

The Department's Base Request for FY 2009-10 is $14,499,873 based on the appropriation from FY 2008-09 with reductions for Prior Year Salary Survey of $1,771,491 and a reduction for Prior Year Performance-Based Pay of $777,184 and a Common Policy Adjustment adding $2,621,830.

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING

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. Expenditures are currently divided between the Department and the Department of Human Services based on a calculator that has been in place since the development phase of the system. Both Departments are moving toward a conversion to Random Moment Sampling methodology for dividing the expenditures. No definite date has been set for reliance on Random Moment Sampling as the sole source of devising the fund splits. Please refer to the Department of Human Services for the narrative concerning their portion of total expenditures.

The initial FY 2006-07 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 of the following Decision Items: a decrease of $41,930 to reflect an adjustment to programming hours from FY 2005-06 (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 the Colorado Benefits Management System 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 2005-06 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 for Personal Services and other Common Policy items.

During FY 2006-07, the Department of Human Services and the Department submitted a number of supplemental requests that had a significant impact on the final FY 2006-07 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, "DHS – Implement Bendex Modernization," submitted January 4, 2007); 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, "IT Changes Needed for Implementation of Deficit Reduction Act of 2005 – Long Term Care," submitted January 4, 2007); 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, "Revised Federal Rule for Payment Error Rate Measurement Program," submitted January 4, 2007); an increase of $61,229 for changes required by HB 06S-1023 and the Deficit Reduction Act of 2005 (S–4, "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005," submitted January 4, 2007). Finally, the FY 2007-08 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 (NP–S20, "Request for Proposal RFP Vendor," submitted January 4, 2007) when it expires on July 15, 2008. The final FY 2006-07 appropriation for the Colorado Benefits Management System was $7,929,533.

The FY 2007-08 Budget Request for the Colorado Benefits Management System was $8,689,095 per the Long Bill (SB 07-239). The difference between the FY 2007-08 appropriated amount and the FY 2006-07 year-end appropriation is due to a number of decision items that were requested and approved during the FY 2007-08 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:

- Remove one-time funding for the Bendex Interface: $61,217;
- Remove one-time funding for the federal Deficit Reduction Act of 2005 for Long Term Care: $35,404;

- Remove one-time funding for the Payment Error Rate Measurement Program: $29,017;
- Remove one-time funding for HB 06S-1023 Restriction of Public Benefits (related to illegal immigrants and the federal Deficit Reduction Act of 2005: $61,229;
- Remove one-time funding for Request for Proposal Vendor: $142,953; and,
- Remove one-time funding for Additional Maintenance Pool Funds (for contractor Electronic Data Systems): $349,877.

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 2007-08 Colorado Benefits Management System appropriation was further adjusted per two legislative actions and a June 20, 2007 1331 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, although additional funding was sought through Supplemental Request S-8, "Additional Funding to Implement SB 07-211", in the FY 2007-08 Supplemental Requests submitted January 2, 2008 for $84,902, and was approved by the Joint Budget Committee.

On February 15, 2007, Governor Ritter signed Executive Order 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 used the opportunity of the resulting June 20, 2007 1331 Supplemental submitted to the Joint Budget Committee to refinance 3.0 FTE working on the Colorado Benefits Management System using the Colorado Benefits Management System calculator. Refinancing the 3.0 FTE saved $77,483 in General Fund. The total addition to Colorado Benefits Management System funding in the Department for the close of the Governor's Office of Colorado Benefits Management System was $37,475. Final funding for Colorado Benefits Management System in FY 2007-08 was $8,838,407. The net change in funding at the Department of Human Services was zero.

To build to the FY 2008-09 base, the Department removed the following amounts due to one-time funding in FY 2007-08:

- Remove one-time funding for SB 07-097: $6,248;

- Remove one-time funding for SB 02-211 Improving Health Care for Children: both $20,687 initially appropriated and $84,902 as a supplemental appropriated;
- Remove part of the funding to Governor's Top Ten County and State Program Concerns: $550,475;
- Remove one-time funding for Hardware for Disaster Recovery: $195,215; and,
- Remove one-time funding for Information Technology Contract Monitoring: $63,520.

Furthermore, the following adjustments were also made: annualization of Salary Survey added $28,762; annualization of Performance-Based Pay added $9,661; vacancy savings reduced the amounts by $10,815; and the Joint Budget Committee staff recommended an increase of $26,234 to bring the Department's total appropriation into conformance with the 34.71% expected funding split compared to the total Colorado Benefits Management System appropriation at the Department of Human Services. The result was $7,971,202 as appropriated in the FY 2008-09 Long Bill, HB 08-1375.

The following Special Bills increased the appropriation for FY 2008-09: HB 08-1046 Offenders Apply for Public Benefits added $26,408; SB 08-006 Suspension of Medicaid Benefits added $94,092; SB 08-161 Medicaid and Children's Basic Health Plan added $5,554; and SB 08-160 Health Care for Children added $31,866. The resulting FY 2008-09 appropriation is $8,129,122.

The FY 2009-10 Base Request, required certain adjustments to remove some one-time funding:

- Remove one-time funding for SB 08-006 Suspension of Medicaid Benefits: $94,092;
- Remove one-time funding for SB 08-160 Health Care for Children: $14,452;
- Remove one-time funding for SB 08-161 Medicaid and Children's Basic Health Plan: $5,554; and,
- Remove one-time funding for HB 08-1046 Offenders Apply for Public Benefits: $26,408.

In addition, annualization of the prior year Salary Survey added $68,109, and annualization of prior year Performance-Based Pay added $14,054 and a Common Policy adjustment reduced funding by $17,414 for a total FY 2009-10 Base Request of $8,053,365.

CBMS SAS-70 AUDIT

Funding for this line item first began in FY 2005-06 for the State Auditor's Office to complete an audit based on the Statement on Auditing Standards 70 (SAS-70). Work on the audit funded by this appropriation 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.

The FY 2006-07 Long Bill (HB 06-1385) contained funding of $51,719 for this line item. The Department received an appropriation of $51,718, based on recalculation by the Joint Budget Committee Staff, for the Colorado Benefits Management System SAS–70 for FY 2007-08, per the Long Bill (SB 07-239). The Department requested and received continuation funding for this line item in FY 2008-09 per Long Bill (HB 08-1375). The same amount is requested for FY 2009-10.

CBMS FEDERAL REALLOCATION

When the Colorado Benefits Management System was implemented in September 2004, the federal Centers for Medicare and Medicaid Services required the State of Colorado to devise a different methodology for the sharing of costs between the Department and the Department of Human Services than had been used during the development phase. Both Departments agreed to use Random Moment Sampling methodology, and the federal Centers for Medicare and Medicaid Services approved the methodology. Data has been collected for each fiscal year since September 2004. However, due to the delays in implementing this methodology, both Departments were not able to use the data for realigning appropriations until FY 2007-08, when a Supplemental Request was approved by the Joint Budget Committee to address the changes in funding for FY 2004-05 and FY 2005-06. Because it is impossible to make accounting adjustments for prior years, it was necessary to appropriate the funding in FY 2007-08, as a "true up" for the prior years.

NP-S4, "DHS – Colorado Benefits Management System (CBMS) Refinancing FY 2004-05," in the FY 2007-08 Supplemental Requests submitted January 2, 2008, requested $359,018, all in federal funds, for the Department's share of the cost true up. In June 2008, a similar request, "DHS – Colorado Benefits Management System (CBMS) Refinancing FY 05-06" was made through a 1331 Supplemental Request in the amount of $659,296, all in federal funds. The Joint Budget Committee approved both requests.

At this time, no requests have been made to true up FY 2006-07 or FY 2007-08, although both Departments are working together to evaluate the need to complete a Supplemental Request to true up those cycles. The FY 2008-09 Long Bill (HB 08-1375) does not contain funding for reallocation of costs, and the Department is not requesting funding for this purpose for FY 2009-10.

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 not all 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 had a staff of 76.2 FTE in FY 2007-08, and the number increased to 78.6 FTE in FY 2008-09. The staff members are 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. A portion of the computer system expenses associated with the Regional Centers for clients with developmental disabilities are transferred to the Other Office of Information Technology Services line item; therefore much of the budget for Other Office of Information Technology Services is funding to support the Regional Centers.

Appropriation History

The FY 2006-07 Long Bill (HB 06-1385) 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 2006-07, 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 2006-07 was $387,769.

The Department has been appropriated $402,909 for the Other Office of Information Technology Services line in the FY 2007-08 Long Bill (SB 07-239) 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).

The FY 2007-08 Supplemental Bill (HB 07-1285) modified the funding by reducing funding for the Purchase of Services from the General Government Computer Center by $178. However, a further correction for FY 2007-08 occurred in the Add-on section to the FY 2008-09 Long Bill with a Common Policy adjustment to the Purchase of Services from the General Government Computer Center by increasing the amount with $529. The resulting FY 2007-08 funding totaled $411,630.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $427,453 which resulted from adjustments to the FY 2007-08 final funding. Adjustments included an increase of $6,552 from NP-5, "DHS – IT Infrastructure Support," in the FY 2008-09 Budget Request submitted November 1, 2007; an increase of $12,377 from NP-6, "DHS – Adjustment to Statewide Multiuse Network Payments," in the FY 2008-09 Budget Request submitted November 1, 2007, but was further adjusted by NP-BA2, "DHS – Adjustment to Statewide Multiuse Network Payments," in the FY 2007-08 Supplemental Requests submitted January 2, 2008 with a decrease of $1,650; and a decrease of $138 from NP-BA3, "GGCC Supplemental True-up, in the FY 2007-08 Supplemental Requests submitted January 2, 2008. The other adjustment was a slight decrease in Microcomputer Lease Payments as agreed to by the vendor, Hewlett Packard.

For the FY 2009-10 Base Request, the Department requests $446,821 beginning with $427,453 from FY 2008-09 and adding $7,261 for annualization of the prior year NP-5, "DHS – IT Infrastructure Support," plus $9,405 annualized for prior year salary survey, and $2,702 additional as annualization for prior year Performance-Based Pay.

(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 three million square feet of space (Department of Human Services Figure Setting, February 14, 2007, page 13). The Division of Facilities Management is also responsible for the 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. These functions continued through FY 2007-08 and will continue in FY 2008-09.

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.

The Contract Management 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).

A large portion of the budget and actual expenditures relate to needs of the Regional Centers for clients with developmental disabilities. The Office of Operations is responsible for the funding of food purchases and linen services for the Regional Centers. Utilities and Vehicle Lease Payments from the Regional Centers, although originating as expenditures for the Regional Centers line item are transferred to the Office of Operations as a financial transaction. Likewise, the Office of Operations performs similar functions for the Mental Health Institutes by concentrating on economies of scale to achieve financially favorable arrangements.

Appropriation History

In the FY 2006-07 Long Bill (HB 06-1385), the appropriation was increased from the prior fiscal year 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 2006-07 Long Bill appropriation of $5,975,820.

The FY 2006-07 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'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 to oversee the counties on work performed on behalf of the Department. A portion of this funding for the net change in FTE, $26,976, originated from the Office of Operations at the Department of Human Services.

The final FY 2006-07 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 2006-07 appropriation for the Office of Operations was $5,904,851.

To build to the FY 2007-08 appropriation of $6,002,337, the Joint Budget Committee made a number of changes, including: reinstating the $43,993 of funding removed in FY 2006-07 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 (non-prioritized with no number assigned by the Department), which requested additional funding for general maintenance equipment, including compressors, pumps, water heaters, and floor buffers among other items. 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 2007-08 appropriated amount of $6,002,337 per Long Bill SB 07-239.

The Supplemental Bill for FY 2007-08 (HB 08-1285) reduced the funding by $23,320 as requested in NP-S16, "DHS – Adjustment to Statewide Vehicle Lease Payments," in the FY 2007-08 Supplemental Requests submitted January 2, 2008 that was approved by the Joint Budget Committee, resulting in a revised total appropriation of $5,979,017.

For FY 2008-09, the Long Bill (HB 08-1375) appropriates $6,054,395. The variance between FY 2007-08 and FY 2008-09 consists of:

- An increase of $18,338 from NP-BA13, "Adjustment to Statewide Vehicle Lease Payments," submitted January 23, 2008 as a late Budget Amendment;
- A decrease of $22,550 from NP-BA14, "DHS – Mental Health Institute Menu Planning and Food Preparation and Office of Operations Consolidation of Food Purchases" in the FY 2007-08 and FY 2008-09 Budget Request Amendments submitted February 15 2008;
- An increase of $104,637 for Salary Survey increases as a Common Policy;
- An increase of $14,160 for Indirect Cost Allocation as a Common Policy; and,
- A decrease of $39,207 for Vacancy Savings for Salaries as a Common Policy.

The Department's Base Request for FY 2009-10 is $6,221,315. This amount builds from the FY 2008-09 appropriation of $6,054,395 with additions of $121,320 for prior year Salary Survey and $45,600 for prior year Performance-Based Pay.

(D) DIVISION OF CHILD WELFARE-MEDICAID FUNDING

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 in 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 responding to consumer requests for information (Department of Human Services Figure Setting, March 8, 2006, page 84).

The (D) Division of Child Welfare: Administration line item became a separate line item in the Department's appropriation in FY 2004-05. Prior to that fiscal year, both administration and services were in a blended appropriation titled "Division of Child Welfare – Medicaid Funding." The separation was created to facilitate better financial tracking.

Appropriation History

The FY 2006-07 Long Bill (HB 06-1385) added $64,799 to the final FY 2005-06 appropriation to include the salary and operating costs of a new FTE at the General Professional V level for the administration of the 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 2006-07 was appropriated at $126,939.

The appropriation for FY 2007-08 in the Long Bill (SB 07-239) was $127,485. Common Policy adjustments account for the difference between the FY 2006-07 final appropriation of $126,939 and FY 2007-08'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 FY 2008-09 Long Bill (HB 08-1375) appropriated $130,712 with additions from FY 2007-08 funding for Common Policy adjustments of $3,357 for annualization of prior year Salary Survey, annualization of Performance-Based Pay at $1,123, and Vacancy Savings for salaries with a reduction of $1,253.

For the FY 2009-10 Base Request, the Department requests the FY 2008-09 appropriation plus $5,341 for prior year Salary Survey and $1,524 for prior year Performance-Based Pay for a total request of $137,577.

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).

Much of the funding in the Child Welfare Services line item is reserved for children needing treatment for emotional or mental health reasons. Many of these children qualify for the Medicaid program due to extensive medical needs that include physical health, dental health, and/or mental health issues. The adopted children continue to qualify for Medicaid for as long as needed, which may range from a year or two or up to the age of 18 when the children age out of eligibility for Child Welfare Services. The time period may extend to age 21 if the adopted children have developmental disabilities and have continuing needs.

Only 80% of all child welfare services are funded by the State pursuant to Section 26-1-122, C.R.S. (2008). 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 2006-07, 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 to be eligible for per diem reimbursements. Thus, in FY 2006-07, 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 set forth the methodology for unbundling the rates.

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 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

Beginning in FY 2006-07, Medicaid funding for the Child Welfare program was significantly revised to incorporate changes to the provider structure for this program. After April 20, 2005, when 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, appropriation changes were necessary. This resulted in the Department's Budget Amendment (non-prioritized Budget Amendment BA-15 submitted as a late request 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 the Child Welfare Services Administration line item through non-prioritized Decision Item NP-12. The sum of changes resulted in a FY 2006-07 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 lower in the intensity of care than 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 2004-05 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 2006-07 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 in the Department's section of the Long Bill.

The Department's FY 2007-08 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 2007-08 Base Request needed an increased appropriation. Pursuant to this request, made through the Department of Human Services DI 6 (NP-6, "DHS-Child Welfare Services Block Increase" in the FY 2007-08 Budget Request submitted November 1, 2006), 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 2007-08 (SB 07-239) was $34,875,613,

For FY 2008-09, the Long Bill (HB 08-1375) reduced total funding by $18,000,000 for a total appropriation of $18,773,007. This amount was derived from the FY 2007-08 amount of $34,875,613 with the following adjustments:

- The Leap Year adjustment was rescinded for a reduction of $39,320;
- The Department of Human Services requested Decision Item, DI-3, "Child Welfare Services Block Increase," in the FY 2008-09 Budget Request submitted November 1, 2007, for an increase of $1,414,170;

- Provider rate increases of $522,544 were approved, resulting from NP-9, "DHS – Provider Rate Increase," in the FY 2008-09 Budget Request submitted November 1, 2007; and
- Total funding was reduced by $18,000,000, resulting from NP-S7, NP-BA4, "DHS – Funding Adjustment Related to Residential Child Health Care Program, in the FY 2007-08 Supplemental Requests submitted January 2, 2008. Although the request for reduction was for both FY 2007-08 and FY 2008-09, the Joint Budget Committee delayed the reduction until FY 2008-09. The reduction was based on children receiving more care from community mental health organizations and less care from out of home residential treatment centers.

The Department is requesting continuation funding in FY 2009-10.

(E) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES-MEDICAID FUNDING

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 of the Department of Human Services, 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 2006-07, 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 for community services provided by the behavioral health organizations to categorically eligible Medicaid clients. However, with the passage of HB 04-1265, "Medicaid Mental Health Services," both the administration and the program expenditures associated with Medicaid Community Mental Health Services Programs were transferred from the Department of Human Services to the Department. See the description provided in Long Bill group (3) Medicaid Mental Health Community Programs for additional information.

Appropriation History

The FY 2006-07 Long Bill (HB 06-1385) appropriation was for a net increase in POTS of $8,348 over the FY 2005-06 final appropriation. The FY 2006-07 Long Bill and final appropriation were $307,351. The FY 2007-08 Base Request accounts for an increase in Salary Survey of $11,241 and a 0.5% Base Reduction of $1,537. The FY 2008-09 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.

The FY 2007-08 Long Bill (SB 07-239) funding was $317,055 that resulted from adjustments including a reduction of $1,537 for vacancy savings and an increase of $11,241 for Salary Survey. The Supplemental Request process did not change the funding during that fiscal year.

For FY 2008-09, funding was increased in the Long Bill (HB 08-1375) to $325,197 because of adjustments annualizing the prior year Salary Survey for $8,477, an increase for Achievement Pay of $2,836, and a vacancy savings reduction of $3,171. The Department is requesting $348,972 for FY 2009-10. This amount includes additions of $18,155 for prior year Salary Survey and $5,620 for prior year Performance-Based Pay.

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). 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 2006-07, 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 2006-07 Long Bill appropriation was set at $487,777.

Note that a September 20, 2006 1331 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, "Residential Child Health Care." 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 September 20, 2006 1331 Supplemental approved spending authority changes in FY 2006-07 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 2006-07 Legislative session, the amount of funds removed from the base for FY 2006-07 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 2007-08 appropriated amount of $117,463.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $119,225 derived from the prior year funding of $117,463 plus $1,762 for provider rate increases as approved by the Joint Budget Committee. The Department requests continuation funding of $119,225 for FY 2009-10.

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 Colorado Mental Health Institute at Fort Logan located in Denver, and the Colorado Mental Health Institute at Pueblo. 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). Per Figure Setting for the Department of Human Services, Mental Health and Alcohol and Drug Abuse, March 6, 2008, pages 21 and 22, occupancy at both Fort Logan and at Pueblo has declined from earlier in this decade.

Appropriation History

The FY 2006-07 Long Bill (HB 06-1385) 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 2006-07 Long Bill total appropriation for this line item was $4,946,108.

In FY 2006-07, 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 associated with moving to cash accounting. The sum of the three part adjustment to the appropriation was $1,193,616. The final FY 2006-07 appropriation, taking these changes into account, was $5,461,954.

To build to the FY 2007-08 (Long Bill SB 07-239) 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 2006-07 appropriation by $2,117,551 to reverse the one-time savings resulting from moving to cash accounting realized in FY 2006-07 to reach the FY 2007-08 Long Bill appropriation (SB 07-239) of $3,344,403.

FY 2008-09 funding included an increase of $360,335 from NP-S20, "Mental Health Institute Revenue Adjustment, in the FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments submitted February 15, 2008 to arrive at total funding of $3,704,738 in the Long Bill, HB 08-1375. The Department requests the same amount in continuation funding for FY 2009-10.

ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION

During FY 2005-06 Figure Setting, the Joint Budget Committee separated the administration budget from the services budget for the High Risk Pregnant Women program. Some of the Department of Human Services' 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) contracting for a survey of 6^{th}, 8^{th}, 10^{th}, and 12^{th} graders to determine their use of alcohol and other drugs; 8) maintaining a prevention resource system that provides technical assistance, and training materials for school districts, community agencies, and the general public; and, 9) collecting, processing, analyzing and providing 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 contracts 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).

Medicaid funding has been provided to the Alcohol and Drug Abuse Division (ADAD) to assure that substance abuse treatment programs meet distinct requirements of ADAD licensure and to ensure that substance abuse clinicians meet certification or licensure requirements to abide by treatment standards. All client services are delivered according to the current versions of the American Society of Addiction Medicine patient placement criteria, which is the accepted national standard for substance abuse treatment services in both public and private sector programs.

Appropriation History

FY 2005-06 was the first fiscal year that this line item was separated into its own appropriation in the Department's budget. Prior to that time, funding for both Alcohol and Drug Abuse Administration and High Risk Pregnant Women Program were blended into the same appropriation. The appropriations were separated in order to facilitate better financial tracking.

The FY 2006-07 appropriation from the Long Bill (HB 06-1385) was $54,088. The Department requested, and was granted, continuation funding for FY 2007-08. The amount of $54,088 consists of $53,136 for Personal Services and $952 for Operating Expenses. The Department was appropriated the same amount in the FY 2008-09 Long Bill (HB 08-1375) and the Department is requesting continuation funding for FY 2009-10.

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 abuse-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 provided 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, "Extend Services for High-risk Pregnancies," 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.

In 1991, the General Assembly adopted SB 91-056, "Creation of a Health Care and Treatment Program for Women and Their Children Who Are at Risk of Poor Birth Outcomes Due to Substance Abuse," to create a health care and treatment program for women and their children who are at risk of poor birth outcomes due to maternal substance use disorders. See also 25-1-212 through 25-1-213, C.R.S., (2008). The program is an entitlement program fully funded by Medicaid but administered by the ADAD in the Department of Human Services. The initial program was for outpatient treatment only; however, in FY 2001-02 residential treatment was added to the program, and both outpatient and residential treatment services are currently available depending on the treatment needed by the individual. Under the current waiver, the maximum number of days that a woman may receive treatment is 524, allowing for the time both during pregnancy and after delivery. For residential treatment, a total of 74 beds are available: 16 beds in Littleton, 16 beds in Westminster, 16 beds in Pueblo, and 26 beds in Denver.

Fetal Alcohol Spectrum Disorders, resulting from alcohol use during pregnancy, is a preventable birth defect. Alcohol use during pregnancy causes brain damage to the unborn. Stimulant drugs restrict the blood flow from the mother to the newborn via the placenta, which can lead to lower birth weight among babies born to mothers using these drugs, and these newborns require longer hospital stays than children born without the influence of drugs in utero. During pregnancy, women are particularly open to changes in behavior and lifestyles for the sake of the unborn child as well as their existing children, and need access to treatment in order to help make these changes permanent in their lives and the lives of their families. Future mental health needs for the children can often be prevented by treatment provided to the mothers.

Appropriation History

The FY 2006-07 Long Bill (HB 06-1385) appropriation of $983,958 includes a 3.25% provider rate increase recommended by the Joint Budget Committee for most State providers. To build the FY 2007-08 appropriation, the Joint Budget Committee included an adjustment for a 1.5% provider rate increase, which raised the FY 2006-07 appropriation by $14,759. In FY 2007-08, the High-Risk Pregnant Women Program received an appropriation of $998,717.

The FY 2008-09 Long Bill (HB 08-1375) provided funding of $1,013,700 by adding a provider rate increase of $14,983. The Department has requested continuation funding for FY 2009-10.

(F) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, 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 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 the 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. This line item also includes the costs for the Community and Contract Management System (CCMS), a computerized data system used by the Division for Developmental Disabilities. The Community and Contract Management System is used to authorize services, collect individual data, bill for services, and collect demographic data for people with developmental disabilities.

Appropriation History

The FY 2006-07 Long Bill (HB 06-1385) amount was $2,438,131, with the appropriation including changes in Common Policies for a Salary Survey increase 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, "Program Quality Data Monitoring" in the FY 2006-07 Budget Request, submitted November 15, 2005).

The FY 2007-08 appropriation included 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 resources and contracts, as well as waiting list information (Department of Human Services Figure Setting, March 14, 2007, page 30). The additional funds for the CCMS replacement line item were requested to pay Medicaid's portion of updated software and hardware for this information technology system. The FY 2007-08 appropriation per the Long Bill (SB 07-239), including all of the aforementioned changes, was equal to $2,582,358.

The FY 2007-08 appropriation was further adjusted by the Supplemental Bill (HB 08-1285) to account for NP-S2, "DHS – Division for Developmental Disabilities Medicaid Waiver Reform Transition Costs," in the FY 2007-08 Supplemental Requests, submitted January 2, 2008. The final FY 2007-08 appropriation was $2,602,676.

To build to the FY 2008-09 Long Bill (HB 08-1375) appropriation, the $20,318 from the prior year Supplemental Bill was reversed and $79,028 was added from NB-BA1, "Division for Developmental Disabilities Medicaid Waiver Reform Transition Costs," in the FY 2007-08 Supplemental Requests, submitted January 2, 2008. Other adjustments included a reduction of $3,517 from NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study", in the FY 2008-09 Budget Request, submitted November 1, 2007; $84,725 added for Salary Survey, $23,935 added for Achievement Pay, and a reduction of $24,468 for vacancy savings. The total appropriation was $2,742,062 in the FY 2008-09 Long Bill. A special bill, SB 08-002, "Family Caregiver for Developmental Disabled," added $30,334 for Personal Services and $3,930 for Operating Expenses with a total of $34,264. The total FY 2008-09 appropriation was $2,776,326.

For the Base Request in FY 2009-10, the Department started with total FY 2008-09 funding and added the following adjustments:

- Annualization of SB 08-002, "Family Caregiver for Developmentally Disabled," for $72,582 additional (includes Personal Services and Operating Expenses);
- Annualization of FY 2008-09 NP-4, "DHS – Regional Center ICF/MR Conversion and Year 2 of Staffing Study" for $10,848;
- Prior year Salary Survey added $90,680; and,
- Prior year Performance Based Pay added $28,970.

The total request for FY 2009-10 is $2,979,406.

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, PROGRAM COSTS

This line item, formerly known as the Community Services Adult Program Costs and CCMS Replacement, appropriates funds for 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. In the FY 2008-09 Long Bill (HB 08-1375), the number of Medicaid clients was revised to approximately 7,533.

Waivers include 1) Home and Community Based Services – Comprehensive Developmental Disabilities Waiver 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 Waiver provides 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 Waiver 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 of and eligibility for 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.

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 representatives, Office of State Planning and Budgeting staff, and members from the community centered boards. Based on committee efforts, a new interim seven-tiered services matrix, based upon a fee-for-service reimbursement methodology, was developed and put into use beginning July 1, 2006. The interim rate structure would serve until the final rate methodology could be completed. 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. There continue to be delays in the implementation of the final reimbursement methodology.

In FY 2006-07, the Department of Human Services wrote a 1331 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 1331 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.

During FY 2007-08 a steering committee, composed of members from the Department, the Department of Human Services, representatives of the community centered boards, and representatives from the community, met approximately monthly to develop the contents of an updated waiver to be submitted to the federal Centers for Medicare and Medicaid Services. The updated waiver amendment was submitted April 29, 2008. Also during FY 2007-08, a Rates Development Committee met frequently to develop current rates on a fee for service basis to be implemented July 1, 2008. Implementation of the new rates was postponed until January 1, 2009 to allow time for further study of the new rates.

Appropriation History

Due to the passage of Referendum C, and subsequently HB 05-1262, "Tobacco Tax Implementation," 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. 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.

Changes in the appropriation for the FY 2006-07 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 Supported 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 recommendation of a 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 of 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 2006-07 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 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 2006-07 Long Bill appropriation was thus equal to $248,194,905.

The Department submitted a corresponding non-prioritized item for a Department of Human Services' June 20, 2006 1331 Supplemental requesting that the General Fund appropriation associated with the Joint Budget Committee's recommended 3.25% provider rate increase for FY 2006-07 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. This 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 2006-07 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, this line item 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 2006-07 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 2006-07 appropriation was, therefore, $233,407,633.

There were a number of adjustments that were made to the FY 2006-07 final appropriation to build to the FY 2007-08 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 2006-07 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 2007-08 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 2007-08 Base Request for this appropriation is $252,042,444. Changes from the current FY 2006-07 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, "DHS-Provide Resources to Specific Populations Including Waiting List" in the FY 2006-07 Budget Request submitted November 15, 2005), and an increase of $794,425 for a leap year adjustment.

A number of additional resources for Developmental Disability waivers programs were requested during FY 2006-07 and FY 2007-08 that required adjustments to the FY 2007-08 appropriation. The Department of Human Services' FY 2006-07 Decision Item (NP–2, "DHS-Provide Resources to Specific Populations Including Waiting Lists," submitted November 15, 2005) 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 2007-08 Decision Item request (see November 1, 2006 Budget Request, NP–3, "DHS-Provide Resources to Specific Populations,") 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; and 5) $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 2007-08 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 2007-08 Long Bill appropriation (SB 07-239) to $281,791,710. However, NP-S19, "DHS–Division of Developmental Disabilities Medicaid Appropriation Reduction," in the FY 2007-08 Supplemental Requests and FY 2008-09 Budget Requests Amendment submitted February 15, 2008, reduced the funding by $9,906,755 that was reflected in the HB 08-1375 Add-on section for an end of year total funding of $271,884,955.

The FY 2008-09 Long Bill (HB 08-1375) total funding was $300,903,609 which is the result of the following adjustments:

- Annualization of NP-S19, "DHS – Division of Developmental Disabilities Medicaid Reduction" in the FY 2008-08 Supplemental Requests and FY 2008-09 Budget Requests Amendments submitted February 15, 2008, (restored) for $9,906,755;

- Annualization of DI-3, "DHS – Child Welfare Services Block Increase" in the FY 2006-07 Budget Request submitted November 15, 2005 for $3,320,685;
- Reverse Leap Year Adjustment for a reduction of $705,941;
- Reverse Supported Living Services Base Adjustment for a reduction of $427,540
- NP-9, "DHS – Provider Rate Increases" in the FY 2008-09 Budget Request submitted November 1, 2007 for $4,266,097; and,
- NP-10/BA17, "DHS – Division of Developmental Disabilities New Resources Request," in the FY 2007-08 Supplemental Requests and FY 2008-09 Budget Requests Amendments submitted February 15, 2008 and approved by the Joint Budget Committee for $12,658,599.

The Department requests $313,562,408 as Base Request for FY 2009-10. This begins with the FY 2008-09 funding plus $12,658,799 for annualization of FY 2008-09 NP-10/BA-17, "DHS – Division of Developmental Disabilities New Resources Request."

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL 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).

The community centered boards use local tax revenues provided by their city or county to expand their services to clients with developmental disabilities. Federal regulations allow the use of public funds as the State share in claiming Federal Financial Participation if the public agency certifies that those funds represent expenditures eligible for Federal Financial Participation. Actual fund disbursement typically occurs on a quarterly basis.

Appropriation History

Continuation funding of $24,281,838 was appropriated for FY 2006-07 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 2006-07 appropriation to $12,324,307.

The Joint Budget Committee further reduced this appropriation to $3,641,910 for FY 2007-08 because Joint Budget Committee staff recommended the removal of $8,682,397 in funding from the FY 2006-07 appropriation that was used to pay for services rendered in FY 2005-06, but billed in FY 2006-07.

Funding for FY 2008-09 was further reduced by Joint Budget Committee action to $2,000,000 because the federal Centers for Medicare and Medicaid Services determined that only local governments, not independent agencies such as the community centered boards, could certify public expenditures. Therefore, less local funding was eligible for a federal match resulting in less funding than anticipated.

The Department is requesting continuation funding for FY 2009-10.

REGIONAL CENTERS

Funding in this line item is for support of Colorado's Regional Centers and intermediate care facilities for the mentally retarded (ICFs/MR). Generally, the 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 group homes are often located on the same grounds as the institutional settings. 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 change in Medicaid funding from the final FY 2005-06 appropriation to the FY 2006-07 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 2005-06 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 2006-07 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 2006-07 Long Bill contained an appropriation at $40,388,928.

The FY 2006-07 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 2006-07 appropriation of $40,359,904.

The FY 2007-08 appropriation of $42,058,031 included 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, "DHS- Regional Staffing Shortfall" in the FY 2007-08 Budget Request submitted November 1, 2006). 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 would provide the State. A Supplemental Request, NP-S17, "DHS – Regional Center High Needs Clients," in the FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments submitted February 15, 2008, was approved by Joint Budget Committee action and confirmed by the General Assembly in the Long Bill (HB 08-1375) Add-on section which increased funding by $1,337,293, resulting in a final appropriation in FY 2007-08 of $43,395,324.

The FY 2008-09 Long Bill (HB 08-1375) appropriated total funding of $46,137,930 that involved several adjustments to the amount from the prior fiscal year:

- Annualization of the prior year's NP-1, "Regional Centers Staffing Shortfalls," in the FY 2007-08 Budget Request submitted November 1, 2006 for an increase of $477,386;
- Annualization of the prior year's NP-S17, "Regional Center High Needs Clients," in the FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments submitted February 15, 2008 for a decrease of $1,337,293;
- NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study," in the FY 2008-09 Budget Request submitted November 1, 2007, for an increase of $1,599,444;
- Joint Budget Committee action added an increase of $79,472 for ICF/MR Provider Rate increases;
- Joint Budget Committee action to adjust fund splits resulted in a total decrease of $55,270;
- Annualization of the FY 2007-08 Salary Survey Common Policy added $1,564,223;
- Achievement Pay Common Policy added $424,644; and,
- Joint Budget Committee action reduced funding by $427,703 for Common Policies. However, doing the budget balancing process, the Joint Budget Committee restored the $427,703.

The Department requests $49,719,942 as a Base Request for FY 2009-10 which includes additions for the annualization of the prior year's NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study," in the FY 2008-09 Budget Request submitted

November 1, 2007, for $1,528,654; annualization of FY 2008-09 Joint Budget Committee action for "ICF/MR Provider Fees" in the amount of $76,401; prior year Salary Survey increase for $1,456,662; and prior year Performance-Based Pay for $520,295.

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 2003-04 Supplemental Bill (HB 04-1320).

The FY 2006-07 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 2006-07 Long Bill appropriation was therefore set at $1,468,552.

For FY 2007-08, Joint Budget Committee action further reduced this appropriation by $200,973 based on converting to a straight line projection. The FY 2007-08 Long Bill (SB 07-239) reflects the adjustment for total funding of $1,267,579. Joint Budget Committee action again reduced funding for FY 2008-09 by removing $124,667 since less funding has been needed the past fiscal year to arrive at total funding of $1,142,912 as reflected in the FY 2008-09 Long Bill (HB 08-1375).

The Department is requesting $1,412,912 continuation funding for FY 2009-10.

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 2006-07 Long Bill (HB 06-1385) appropriated $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 2006-07 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 2006-07 to FY 2007-08. The final FY 2006-07 appropriation, including the late supplemental, was $5,346,247.

To build to the FY 2007-08 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 2006-07 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 2007-08, or $7,291,981, to the Community Services Adult Program Costs and CCMS Replacement line item.

The Department's FY 2008-09 request did not include any funding for this line item, and the Department is not requesting funding for FY 2009-10.

(G) 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 programs provided for the elderly are administered through the county departments of social/human services or through regional Area Agencies on Aging. This program also provides statewide advocacy for residents in long term care facilities. The advocate can investigate complaints made by or on behalf of residents in the long term care facilities.

The types of services provided under this program include a nutrition program, a caregiver program, a senior employment program, the long-term care ombudsman program mentioned above, and other supportive services.

The FY 2003-04 Long Bill (SB 03-258) appropriation was $1,800, and funding has remained at this same level since that time. The Department's FY 2009-10 Base Request is for continuation funding.

(H) 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 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 the administration costs for the 15.4 FTE in the Division are Medicaid eligible. Of the 15.4 FTE indicated above, 3 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 2006-07 (Department of Human Services' Figure Setting, March 8, 2006, page 158).

The Division is currently organized into Administration, Institutional Programs, and Community Programs. Medicaid funding is provided only within the Community Programs section. Within the Community Programs section, the Medicaid funding covers a small amount for Personal Services, a substantial amount for Purchase of Contract Placements (mental health services), and a small amount for a Managed Care Pilot Project. The Purchase of Contract Placements provides mental health services to youth in custody of Youth Corrections. The mental health services involve placement in a Therapeutic Residential Child Care Facility or in a Psychiatric Residential Treatment Facility, depending on level of acuity of mental health needs.

Appropriation History

The FY 2005-06 final appropriation was $15,828,250 and the FY 2006-07 Long Bill appropriation 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 as a late request, which reduced the Medicaid funding for this program and 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 2006-07 appropriation was increased by $1,457,874 later in the 2006 Legislative Session with the passage of HB 06-1395, "Residential Child Health Care," which completed the redesign of the old residential treatment centers and created the new psychiatric residential treatment facilities. The anticipated number of children going through the new psychiatric residential treatment facilities would be 341 children per year for an average of 14.25 days per child.

The Department of Human Services issued a late supplemental in FY 2006-07 (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 2006-07 was therefore $2,720,046.

The Department's FY 2007-08 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 that reduced the number of youth corrections beds funded in FY 2006-07. 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 forecast, the Department of Human Services issued a Decision Item to amend the initial decrease and add $536,314 in total funds. The FY 2007-08 appropriation in the Long Bill (SB 07-239) was $2,852,877.

There was a reduction in FY 2007-08 as a result of NP-S18, "DHS – Purchase of Contract Placement," in the FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments submitted February 15, 2008, that reduced funding for Contract Placements by $971,962 because there was less need for the services at that time. The General Assembly confirmed this reduction in the FY 2008-09 Long Bill (HB 08-1375) in the Add-on section with a new amount of $1,880,915.

For FY 2008-09, the Long Bill (HB 08-1375) appropriated $2,885,273 total funding. This amount resulted from restoring the reduction of $971,962 from the prior year, plus annualization of the prior year Salary Survey for $2,470, annualization of Performance-Based Pay for $798, adding $41,982 for NP-9, "DHS – Provider Rate Increases," in the FY 2008-09 Budget Request submitted November 1, 2008 and approved by the Joint Budget Committee. It also includes a subtraction of $12,958 for reversing the Leap Year Adjustment, and a small adjustment of $104 for fund split alignment. Consequently, the FY 2008-09 Long Bill Medicaid

Funding for Youth Corrections includes $44,520 for Personal Services, $2,807,417 for Purchase of Contract Placements, and $33,336 for a managed care pilot project.

The Department requests an FY 2009-10 Base of $2,887,613 which includes $1,819 for prior year Salary Survey and $651 for prior year Performance-Based Pay and a reduction of $130 as a Common Policy adjustment.

(I) OTHER CONTRACTUAL SERVICES

TRANSFER TO THE DEPARTMENT OF HUMAN SERVICES FOR RELATED ADMINISTRATION

The Department has an Interagency Agreement with the Department of Human Services to support 1.0 FTE to staff the Information Technology Help Desk. Although in prior years, this help desk assisted with the manual process of presumptive eligibility applications in the Colorado Benefits Management System for the Medicaid Baby Care/Kids Care Program, the presumptive eligibility applications for Baby Care/Kids Care are now automated in Colorado Benefits Management System. However, the help desk continues to assist with the manual process of presumptive eligibility applications for the Breast and Cervical Cancer Treatment Program in the Colorado Benefits Management System. In addition, this help desk continues to provide computer support for end users of the Colorado Financial Reporting System because the Department does not yet have full supervision of all end user functions. The funding for this line item contains only basic Personal Services salary. The Department of Human Services, through the Common Policy funding of benefits in the Executive Director's Office for General Administration, provides the associated POTS for the FTE. The corresponding appropriation for the Transfer to the Department of Human Services for Related Administration line item in the Department of Human Services' budget can be found under Office of Information Technology Services, Personal Services.

This line item has had the same appropriation of $74,564 since FY 2006-07. The Department is requesting continuation funding of $74,564 for FY 2009-10.