Department of Health Care Policy and Financing
Line Item Description
FY 2010-11 Budget Request

November 6, 2009

(1) EXECUTIVE DIRECTOR'S OFFICE

(A) GENERAL ADMINISTRATION

PERSONAL SERVICES

This line item funds the Department's expenditures for FTE, temporary staff, and some of its contractors. All allocated POTS for Salary Survey, Performance Achievement Pay, Health, Life, Dental, Short Term Disability, and Amortization Equalization Disbursement are paid through this line item. Supplemental Amortization Equalization Disbursement, however, is not included in this total as it is already included as part of the Salary Survey amount.

For FY 2007-08 the Department received an appropriation of $16,305,976 and 238.0 FTE for this line item through the Long Bill, SB 07-239. This amount was impacted by the special bills listed below.

- HB 07-1021, to implement the Prescription Drug Consumer Information and Technical Assistance Act, increased the appropriation by $58,616 and added 1.0 FTE.
- SB 07-001, for the Colorado Cares Rx program, increased the appropriation by $140,495 and added 2.5 FTE to develop rules for the Medical Services Board, contract with participating pharmacies, answer stakeholder questions, maintain files, and perform accounting functions.
- SB 07-004, for Early Intervention Services for Children, increased the appropriation by $58,616 and added 1.0 FTE to implement and administer the bill.
- SB 07-130, Medical Homes for Children, increased the appropriation by $57,773 and added 1.0 FTE to develop standards and a measurement system.
- SB 07-196, for Health Information Technology, increased the appropriation by $29,308 and added 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, increased the appropriation by $64,806 and added 1.3 FTE; 0.5 FTE to produce reports for the General Assembly, and 0.8 FTE to develop standards and methods for collecting, analyzing, and disclosing health information.

Additionally, the Department requested additional adjustments to its spending authority as a result of a 1331 Supplemental request, "Office of Colorado Benefits Management System Staff Reallocation," submitted on June 20, 2007. The Department received $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 was to fund a Medical Director Consortium at $80,000 (S-6, "Health Care and Financing Medical Director Consortium," FY 2007-08 Supplemental Requests, January 2, 2008); the second was for $10,500 in Personal Services associated with acquiring additional space for staff to work (S-7, "Funding for Additional Leased Space," FY 2007-08 Supplemental Requests, January 2, 2008); and the third was for

$125,000 to hire a contractor to collect data and create a cost study of current mental health rates (S-14, "Implement Mental Health Audit Findings," FY 2007-08 Supplemental Requests, January 2, 2008). These adjustments brought 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 Department received an appropriation of $19,015,961 and 273.2 FTE through the Long Bill, HB 08-1375. The following special bills also impacted the Department's appropriation bringing it to a total of $19,059,462 and 269.2 FTE:

- SB 08-155 established the Governor's Office of Information Technology and reduced the Department's appropriation by 1.5 FTE.
- HB 08-1114 created the Nursing Facility Provider fee and provided $246,824 and 1.3 FTE to implement the program.
- SB 09-132 eliminated the Colorado Cares Rx program and reduced the appropriation for this line item by $203,323 and 3.8 FTE.
- SB 09-187 transferred funding for a Program Administrator to the Breast and Cervical Cancer Prevention and Treatment program.

The Department was appropriated $19,679,334 and 275.0 FTE per SB 09-259, the FY 2009-10 Long Bill. Additionally, HB 09-1047 provided funding of $47,538 and 0.8 FTE for a General Professional IV position to provide Alternative Therapies for Persons with Disabilities under Medicaid. Funding for HB 09-1047 will also be used to draft and submit a federal waiver request, and to convene an advisory committee that will draft program rules, complete reporting requirements, and provide general administration of the program. HB 09-1293, "Colorado Health Care Affordability Act," allows the Department to charge a provider fee to hospitals in order to fund public program enhancements. HB 09-1293 provided $1,174,862 and 12.0 FTE for implementation. Finally, SB 09-262 converted $11,659 General Fund to cash funds from the Breast and Cervical Cancer Treatment and Prevention Fund for the Program Administrator for the Breast and Cervical Cancer Prevention and Treatment program. As a result, the FY 2009-10 appropriation for Personal Services was $20,901,734 and 287.8 FTE.

Additionally due to the economic downturn the Department submitted two FY 2009-10 Early Supplemental Requests that impact its Personal Services appropriation: ES-3, "Department Administrative Reductions," which reduced the FY 2009-10 Appropriation by $6,093 total funds and ES-4, "Safety Net Grant Reductions," which reduced administrative funding for those programs by $8,205 and 0.2 FTE. These Early Supplementals were submitted to the Joint Budget Committee on August 24, 2009. These adjustments reduce the FY 2009-10 appropriation to $20,887,436 and 287.6 FTE.

The Department's FY 2010-11 base request includes annualizations of the FY 2009-10 Long Bill, special bills, and other adjustments. As such, the total request is based on the FY 2009-10 appropriation of $20,887,436 and 287.6 FTE with the following adjustments:

- less $2,031 for ES-3, "Department Administrative Reductions"
- less $6,382 for ES-4, "Safety Net Grant Reductions"
- plus $15,846 and 0.2 FTE for HB 09-1047, "Alternative Therapies for Persons with Disabilities"

- plus $6,117 and 0.1 FTE for BRI-2, "Medicaid Program Efficiencies;" (November 3, 2008 FY 2009-10 Budget Request)
- plus $11,596 for DI-6 "Medicaid Value-Based Care Coordination Initiative," and BA-38, "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative" (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18 2009, page 66)
- plus $5,284 and 0.1 FTE for DI-12, "Enhance Medicaid Management Information System" (November 3, 2008 FY 2009-10 Budget Request)
- plus $1,331,150 and 29.0 FTE for continued implementation of HB 09-1293, "Colorado Health Care Affordability Act"
- plus $359,596 in restored funds associated with the Joint Budget Committee's 1.82% reduction to Personal Services that was made to the appropriation as part of the budget balancing of SB 09-259, the FY 2009-10 Long Bill.

The Department's FY 2010-11 base request also includes the statewide indirect cost allocation. The statewide indirect adjustment is a departmental allocation developed by the State Controller's Office, and distributed to the State departments with the Common Policies. This appropriation 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. As a result of this adjustment, there was a decrease of $849,287 General Fund; therefore, the Department's FY 2010-11 base request is $22,608,612 and 317.0 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. For FY 2009-10 these percentages stayed at 90%. For FY 2010-11, due to the economic downturn, the reimbursement rate for the Health portion stayed at 90% of the market average, however the Dental benefit was reduced to 85% of market average.

The FY 2007-08 appropriation of $929,293 reflected 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. For FY 2009-10, the Department's base appropriation of $1,414,691 was based on Common Policy instructions issued by the Department of Personnel and Administration in October 2008.

In FY 2009-10, this appropriation was increased by $82,152 to cover the increased costs of this benefit due to the implementation of HB 09-1293, "Colorado Health Care Affordability Act," for a total appropriation of $1,496,843. However, due to the economic downturn, the Department submitted ES-4, "Reduce Funding for Indigent Care Programs" on August 24, 2009, which eliminated funding for the Comprehensive Primary and Preventive Care Grants Program. As a result, there was a reduction of $465 to this line

item for FY 2009-10, with an annualization of $361 in FY 2010-11. The Department's FY 2010-11 request for Health, Life, and Dental includes these annualizations as well as a common policy adjustment of $81,959 and an annualization of HB 09-1293 which increases the FY 2010-11 request by $198,534. Finally, the transfer of the Department's information technology personnel reduces this appropriation by $111,403 for a total FY 2010-11 Department request of $1,776,975.

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 yearly 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 submits 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.

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% but also included an additional $1,170 to account for the Department's FY 2007-08 FTE requests. HB 08-1375, the FY 2008-09 Long Bill, appropriated $22,871 and reflects the Common Policies issued by the Department of Personnel and Administration, again using a rate of 0.13%. This appropriation was further adjusted to reflect SB 09-132 "Repeal Colorado Cares Prescription Drug Program," which reduced the appropriation by $250. The FY 2009-10 appropriation of $23,588 was calculated using a rate of 0.155% and was set during Figure Setting by the Joint Budget Committee. (FY 2009-10 Figure Setting, March 18, 2009, page 66). This appropriation was reduced by ES-4, "Reduce Funding for Indigent Care Programs" by $10 for FY 2009-10 and annualized for another $8 in FY 2010-11. Additionally, a common policy adjustment of $3,998 issued by the Department of Personnel and Administration in September 2009 increased this appropriation. The Department's FY 2010-11 base request is for $27,568.

SB 04-257 AMORTIZATION EQUALIZATION DISBURSEMENT

The Amortization Equalization Disbursement increased the employer contribution to the PERA Trust Fund to amortize the unfunded liability in the Trust Fund beginning in January 2006. The annual 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% between 2006 and

2013. Due to mid-year increases for FY 2006-07, the Amortization Equalization Disbursement was calculated using an effective rate of 0.75%. Fiscal Year 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 through December 2007, and 1.4% for January through June 2008. The FY 2008-09 appropriation of $279,035 used a rate of 1.4% for July through December 2008, and a rate of 1.8% for January to June 2009, which is effectively 1.6% for the entire fiscal year. This was reduced by $3,074 when the Colorado Cares Rx Program was eliminated by SB 09-132, for a final appropriation of $275,961. The FY 2009-10 appropriation of $332,946 was calculated in the same manner as prior years using a rate of 1.8% for July through December 2009 and a rate of 2.2% for January through June, and is based on the Joint Budget Committee's Common Policies set during Figure Setting (FY 2009-10 Figure Setting, March 18, 2009 page 59). The total includes adjustments associated with the elimination of the State's Salary Survey and Performance Based Pay for FY 2009-10, and funding to cover the additional costs of $45,977 for implementing HB 09-1293, "Colorado Health Care Affordability Act." Funding for this line was reduced through ES-4, "Reduce Funding for Indigent Care Programs" by $135 for FY 2009-10 with an annualization of $105 in FY 2010-11(FY 2009-10 Budget Reductions, August 24, 2009). Finally, a common policy adjustment of $109,242 increased the Department's FY 2010-11 base request to $487,925.

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 appropriation of $204,850 is based on the Joint Budget Committee's Common Policies set during Figure Setting (FY 2009-10 Figure Setting, March 18, 2009 page 59). In calculating the appropriation amount, an effective rate of 1.25% (1.0% from July to December 2009, and 1.5% from January to June 2010) is used. This amount also reflects adjustments due to the elimination of Salary Survey and Performance Based Pay, and implementation of HB 09-1293, "Colorado Health Care Affordability Act." Funding for this line item was reduced by $85 for FY 2009-10 with an annualization of $65 in FY 2010-11 as a result of ES-4, "Reduce Funding for Indigent Care Programs," submitted on August 24, 2009. Finally, a common policy adjustment of $114,135 brings the Department's FY 2010-11 request to $341,823 and includes funding for the additional staff associated with the implementation of HB 09-1293, "Colorado Health Care Affordability Act," in FY 2010-11.

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.

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 line item. 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 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. Due to the economic downturn, for FY 2009-10 there was no funding appropriated for Salary Survey. The Department is not requesting funding in FY 2010-11 for this line item.

PERFORMANCE ACHIEVEMENT PAY

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. Effective July 2001, the Department of Personnel and Administration implemented a performance management plan under authority of SB 00-211. This legislation required the State Personnel Director to submit a plan to the Joint Budget Committee for payouts to occur on July 1,

2001. Due to the State's fiscal situation, the payout date was delayed to July 1, 2002. The performance management component of the new system began without associated payouts on July 1, 2001.

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, applying the method used for FY 2007-08, which allowed for a 1% base building award for all satisfactory performers and a 2% non-base building award for the Department's Peak Performers. Application of this method resulted in an appropriation of $251,236. Due to the economic downturn, for FY 2009-10 no funding was provided for Performance Achievement Pay. The Department is not requesting funding for FY 2010-11 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.

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 a 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 final appropriation of $34,252 is based on the Common Policy approved by the Joint Budget Committee on March 18, 2009 of $36,279 and two Early Common Policy Supplementals from the Department of Personnel and Administration that reduce the Department's appropriation by $2,032 (NP-ES-10, "Risk Management Contract Review and Reduction," for $515, and NP-ES-11, "Risk Management Reduction of Liability, Property and Worker's Compensation Volatility," for $1,512). A Common Policy adjustment issued by the Department of Personnel and Administration on September 4, 2009 increased this appropriation by $3,621. This brings the FY 2010-11 base request to $37,873.

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 to 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.

Per SB 07-239, the FY 2007-08 Long Bill, the Department received $1,003,515 for this line item. However the Department's Supplemental Bill (HB 08-1285) included an annualization of prior year appropriations that reduced the FY 2007-08 appropriation by $32,496 total funds. The Colorado General Assembly also passed several special bills, listed below, that increased the Department's spending authority:

- HB 07-1021, 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 Rx Act," appropriated $14,395 for Department staff to develop rules for the Medical Services Board, contract with participating pharmacies, answer stakeholder questions, maintain files, and perform 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 for Children appropriated $3,955 for Department personnel to implement the provisions of the bill.
- 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 to collect and analyze objective clinical standards to maximize dollars available for medical care.

These special bills increased the final FY 2007-08 appropriation to $1,006,969. The Department received approval to roll forward $1,862 for purchased furniture and reverted its under-expenditure of $24,642, which resulted in a total expenditure 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 to furnish new leased space at 225 E. 16th Avenue, replace deteriorating cubicles, and address poor air circulation within its building at 1570 Grant Street. 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 Department was also appropriated $43,548 to provide for employee training to increase the collective skill level of the Department.

In addition, the Department received $250,000 in Operating Expenses to perform background checks when re-enrolling Medicaid providers. The Department anticipates it reenrolls one-tenth of its providers each year. The Department was also appropriated $71,096 for operating expenses associated with FTE hired by the Department's Program Integrity Section to increase provider recoveries. Further, the Department was appropriated $79,286 for the Operating Expenses associated with the Department's approved FTE request, DI-7, "Additional FTE to Restore Department Efficiency and Functionality," submitted in the Department's November 1, 2007 FY 2008-09 Budget Request. The Department received an additional $6,486 for expenses of an FTE hired to assist in the implementation of the Preferred Drug List. Another $6,486 was appropriated for 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 SB 07-239, the FY 2007-08 Long Bill, 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 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 line items to other long bill groups, the passage of HB 08-1375 resulted in the consolidation of 46 line items into 31 line items in Long Bill group (1) Executive Director's Office beginning in FY 2008-09. In addition, during FY 2008-09 Figure Setting the Joint Budget Committee consolidated the line item for the Single Entry Point Administration into the Operating Expenses line item. This action increased the appropriation for Operating Expenses by $53,000. Annualization of one-time costs associated with FY 2007-08 Operating Expenses reduced FY 2008-09 funding by a total of $26,925. The FY 2008-09 Long Bill appropriation for Operating Expenses was $1,803,990.

The following 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.
- HB 08-1046 appropriated $2,000 for training webcasts.
- HB 08-1114 supplied $8,098 for the Operating Expenses of the FTE charged with revising the reimbursement methodology for Nursing Facilities under the Medicaid program.
- SB 09-209 repealed the Inmate Assistance Program which reduced the appropriation for the line item by $2,000.
- SB 09-132 eliminated the Colorado Cares Prescription Drug Program and saved $3,800.

Due to the economic downturn in FY 2008-09, the Department submitted Supplemental Request, S-27 "Reduction in Operating Expenses," to reduce funding for this line by $225,256 in the Department's January 15, 2009 FY 2008-09 Budget Reduction Proposals. As a result, the FY 2008-09 appropriation was $1,606,114.

The FY 2009-10 Long Bill, SB 09-259, appropriated $1,511,489 for this line item. In addition, there were impacts to this line from annualizations and special bills. Adjustments are based on the FY 2009-10 Long Bill appropriation of $1,511,489:

- less $3,456 for the annualization of HB 08-1046, Reimbursement of Nursing Facilities under Medicaid
- less $2,000 above the FY 2008-09 annualization for SB 09-209, which repealed the Inmate Assistance Program
- plus $5,942 for HB 09-1047, "Alternative Therapies for Persons with Disabilities"
- plus $498,136 for implementation of HB 09-1293, "Colorado Health Care Affordability Act"
- less $34,000 for ES-3, "Department Administrative Reductions," (FY 2009-10 Budget Reductions, August 24, 2009).

These annualizations, special bills, and Early Supplementals, when added to the FY 2009-10 Long Bill appropriation result in a final FY 2009-10 appropriation of $1,976,111.

The Department's FY 2010-11 base request is $1,661,541, which is based on the final FY 2009-10 appropriation of $1,976,040 which incorporates the following adjustments:

- less $4,992 for HB 09-1047 "Alternative Therapies for Persons with Disabilities"
- less $273,574 for HB 09-1293 "Colorado Health Care Affordability Act"
- less $5,228 for DI-6 and BA-38 "Medicaid Value-Based Care Coordination Initiative" and BA-38 "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative" (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 66)
- less $5,228 for DI-12 "Enhance Medicaid Management Information System Effectiveness" (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 67)
- less $25,228 for BRI-2 "Medicaid Program Efficiencies" (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 67)
- less $320 for ES-3 "Department Administrative Reductions" (FY 2009-10 Budget Reductions, August 24, 2009)
- less $54 for ES-4 "Reduce Funding for Indigent Care Programs" (FY 2009-10 Budget Reductions, August 24, 2009).

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 hourly rate charged is based on a blended attorney/paralegal rate developed by the Department of Law.

For FY 2007-08 the Department was appropriated 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 reflected 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 was comprised of 13,089 hours at the blended rate of $75.10.

For FY 2009-10 the Department was again provided funding for 13,089 hours, however the hourly blended attorney/paralegal rate increased to $75.38 through a Common Policy adjustment for a total appropriation of $986,650 per SB 09-259, the FY 2009-10 Long Bill.

For FY 2010-11, the Department's base request $896,514. This request amount is based on the FY 2009-10 appropriation less $150,000 due to ES-3, "Department Administrative Reductions," plus $59,864 as an annualization of HB 09-1293, "Colorado Health Care Affordability Act."

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.

The FY 2007-08 Long Bill appropriation of $407,509 as authorized by SB 07-239, reflected amounts calculated by the Department of Personnel and Administration through Common Policies, however this amount 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 as authorized by HB 08-1375, 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 appropriation of $456,922 was approved by the Joint Budget Committee on March 17, 2009, and reflects a Common Policy reduction of $12,867 for staffing and Operating Expense reductions at the Office of Administrative Courts and was included in the Long Bill.

For FY 2010-11, a Common Policy adjustment reduced this appropriation by $37,206. A $28,610 adjustment was also added for annualization of HB 09-1293, "Colorado Health Care Affordability Act" for a total request of $448,326. The Department's FY 2010-11 base request is $448,326.

PURCHASES OF SERVICES FROM COMPUTER CENTER

This line item 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 calculated by multiplying 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, although each department is responsible for determining the appropriate financial participation rates across federal, cash, and reappropriated funding sources.

In the past, a portion of computer center costs were billed directly to the Department. The balance was paid on behalf of the Department by the Department of Human Services through an Interagency Agreement for the Client Oriented Information Network. The Department stopped using the Client Oriented Information Network in FY 2005-06 because it was replaced by the Colorado Benefits Management System.

In FY 2007-08 the appropriation for this line was reduced significantly because the appropriated amount for FY 2007-08 was based on actual usage from FY 2005-06, when the Department stopped using the Client Oriented Information Network. During the Joint Budget Committee's Common Policy Figure Setting process for FY 2007-08, the Department was appropriated $18,516, (FY 2007-08 JBC Common Policy Figure Setting, March 15, 2007 page 5).

Due to the significant reduction in the need for allocated central computer services beginning in FY 2007-08, the Department also revised its request for reappropriated funds from the Old Age Pension Fund. The amount allocated from the FY 2007-08 Old Age Pension Fund 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. As a result, the Department required $3,337 from the Old Age Pension Fund. Additionally, the Department adjusted the federal financial participation for this appropriation in its base request. Since a portion of this money is to support centralized 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. As such, there was a 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 departments. Prior to this time, the State Controller's Office recovered these costs through its statewide 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 Long Bill appropriation of $135,103 was reduced

through NP-ES-2, OIT - GGCC FY 2009-10 by $5,940 for a final appropriation of $129,163. The FY 2010-11 Request of $150,518 reflects a Common Policy adjustment of $25,110 issued by the Department of Personnel and Administration on September 4, 2009.

MANAGEMENT AND ADMINISTRATION OF OIT

SB 08-155 created the Governor's Office of Information Technology's (OIT). The OIT was created in an effort to enhance the effectiveness of Information Technology (IT) services available within State government and to provide value-driven outcomes in changing times. The objectives developed to support this mission included securing and protecting State IT assets, optimizing expenditures for IT programs, projects and technology, and to effectively manage IT project costs and improve service delivery through collaboration and innovation. By focusing on these key objectives, OIT staff can effectively support the mission in the execution of the strategic initiatives and in driving enterprise technology solutions. SB 08-155 also created the mechanism for billing associated executive agencies beginning in FY 2008-09 in order to fund the OIT.

The OIT recommended that a central Common Policy line item be created. As such, this line item was created during FY 2008-09 and funds the OIT's "back-office" expenses. For FY 2008-09 the Department was billed $459,984 for OIT expenses.

For FY 2009-10 a Common Policy adjustment established during the Department's Figure Setting increased funding by $22,772 total funds to continue the transition and consolidation of functions with the OIT (FY 2009-10 Figure Setting, March 18, 2009, page 60).

However, due to the economic downturn, the Department submitted an Early Supplemental for a one-time reduction of $68,435 to bring the appropriation to $414,321 for FY 2009-10 (NP-ES-13, "FY 2009-10 OIT Management and Administration One-time Adjustment," FY 2009-10 Budget Reductions, August 24, 2009). The Department's FY 2010-11 base request of $482,491 reflects a Common Policy reduction of $265 and restoration of the one-time reduction.

PAYMENT 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 its policy and began billing the Department for the Property Program portion.

The FY 2007-08 appropriation was reduced during Common Policy Figure Setting (FY 2007-08 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 HB 08-1375, the FY 2008-09 Long Bill appropriation. For FY 2008-09 the Property Program portion of this appropriation totaled $1,016.

For the FY 2009-10 appropriation a Common Policy adjustment of $11,193 increased the request to $83,182, but was reduced through NP-ES-11 "Risk Management Reduction of Liability, Property and Workers' Compensation Volatility," by $4,695 for a final appropriation of $78,487 (FY 2009-10 Budget Reductions, August 24, 2009). For FY 2010-11, a Common Policy adjustment reduced this appropriation by $39,287, bringing the Department's FY 2010-11 base request to $39,200.

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 and staff from the Department of Public Health and Environment to the Department via the Long Bill, SB 03-258.

The FY 2007-08 appropriation of $272,318 was increased due to the annualization of the prior year's request for funding for Commercial Leased Space. However, due to timing issues associated with the submission and approval of DI-5, "Increase Funding for Commercial Leased Space," (November 1, 2006 FY 2007-08 Budget Request) and the subsequent submission and approval of S-8, "Increase Funding for Commercial Leased Space," (FY 2006-07 Supplemental Request, January 4, 2007), $53,369 was inadvertently left in the Department's Leased Space appropriation beginning in FY 2007-08 and going forward. As a result, the Department submitted S-7-BA-2, "Funding for Additional Leased Space," 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. The requests were DI-10, "Funding for Additional Leased Space," and S-7, BA-2, "Funding for Additional Leased Space," (November 1, 2007 FY 2008-09 Budget Request: 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 8,347 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 appropriation reflected continued funding for the Department's leases. This line item was increased due to the passage of HB 09-1293,"Colorado Health Care Affordability Act." HB 09-1293 included an appropriation for an additional $302,328 for additional space to house 57.0 FTE staff working on the implementation of the program. As a result, the final FY 2009-10 appropriation was $696,564. The Department is requesting continuation funding for FY 2010-11.

CAPITOL COMPLEX LEASED SPACE

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

The 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 usable 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 square foot. The FY 2009-10 appropriation reflects a Common Policy adjustment of $5,660 that increased the Department's total appropriation to $400,868 and a rate of $12.72 per square foot. However this appropriation was decreased by $5,408 through an early Supplemental (NP-ES-12, "Building Maintenance Reductions," FY 2009-10 Budget Reductions, August 24, 2009) for a final FY 2009-10 appropriation of $395,460. For FY 2010-11 a Common Policy adjustment reduced this appropriation by $7,233 to bring the Department's base request to $388,227.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This was a new line item created for FY 2008-09 that contains any special or temporary projects 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 (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. Further, the General Assembly appropriated additional funds to support several Department and Governor's initiatives for an FY 2008-09 appropriation of $2,443,584. This amount includes $55,000 for HB 08-1072, "Medicaid Buy-in for Disabled Adults," and $382,400 to implement SB 08-217, "Centennial Care Choices Program." However, due to the economic downturn, the Department submitted several supplemental actions to reduce funding in this line item (S-26, "Hiring Freeze Reduction" January 15, 2009 FY 2008-09 Budget Reduction Proposals) that reduced the appropriation by $361,498 total funds. Additionally, it delayed the actuarial study provided through HB 08-1072, saving $55,000 and reduced funding for the Actuarial study contained in SB 08-217 by $299,900 in FY 2008-09. These actions resulted in a final FY 2008-09 appropriation of $1,727,186.

During the 2009 legislative session several Department initiatives were approved, among them were two Budget Reduction Items requested in the Department's November 3, 2008 Budget Request. The first, BRI-1, "Pharmacy Technical and Pricing Efficiencies," provided $750,000 for a contractor to create and Automated Prior Authorization system for Medicaid providers, and $225,000 for a contractor to develop a costing model to be used in determining the maximum amount the State will reimburse providers for specific prescription drugs. The other Budget Reduction Item, "BRI-2, Medicaid Program Efficiencies," provided $300,000 for the first year

of a three-year evaluation of the current fee-for-service Medicaid benefit package. Called Benefits Collaborative, the intent of the evaluation is to establish a streamlined process for determining medically necessary care based on scope, amount, and duration. The intent of this project is to reduce the need for Prior Authorization Reviews before treatment can commence. It also provided $141,964 to perform reviews of the outcomes of services provided and health of Medicaid clients. The Department also received funding of $300,000 to assist in the establishment the Council for Affordable Health Insurance that will implement the requirements of SB 06-128, a program for services for people with disabilities under Medicaid. These actions, along with annualizations and other smaller proposals, resulted in an FY 2009-10 Long Bill appropriation of $3,384,105. Two special bills were also passed that impacted this line: HB 09-1073 provided $52,500 for a contractor to perform a feasibility study on the use of electronic prescriptions for Medicaid clients, and $275,000 for various consultants to assist in the implementation of HB 09-1293, "Colorado Health Care Affordability Act." Finally, Early Supplemental ES-2, "Medicaid Program Reductions," increased this appropriation by $20,000 for a contracted actuary to review and certify rates paid to health maintenance organizations (FY 2009-10 Budget Reductions, August 24, 2009). These actions resulted in a final FY 2009-10 appropriation of $3,731,605.

For FY 2010-11 annualizations of approved legislation, change requests, and supplemental requests associated with the economic downturn bring the Department's FY 2010-11 base request to $3,910,800. This number is based on the FY 2009-10 appropriation with the following adjustments:

- less $100,000 through the annualization of DI-5 and BA-35, "Improved Eligibility and Enrollment Processing," (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 77)
- plus $75,000 for BRI-1 "Pharmacy Technical and Pricing Efficiencies; (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Figure Setting, March 18, 2009, page 77)
- plus $26,695 due to the Joint Budget Committee's one-time1.82% personal services cut for FY 2009-10 (Budget balancing of SB 09-259, the FY 2009-10 Long Bill)
- plus $250,000 for HB 09-1293, "Colorado Health Care Affordability Act"
- less $52,500 for HB 09-1073, "Electronic Prescriptions"
- less $20,000 for ES-2, "Medicaid Program Reductions" (FY 2009-10 Budget Reductions, August 24, 2009).

These adjustments bring the Departments' FY 2010-11 base request to $3,910,800.

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

TRANSFER TO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT FOR FACILITY SURVEY AND CERTIFICATION

The Department of Public Health and Environment is authorized to establish and enforce standards of operation for health facilities per 25-1.5-103, C.R.S. (2009). Federal statute at 42 C.F.R. §488, authorizes and sets requirements for both Medicare and Medicaid

surveys and certification of health facilities. This line item helps to fund the survey and certification of nursing facilities, hospices, home health agencies, and home and community-based services agencies (including alternative care facilities personal care/homemaking agencies, and adult day services), by paying the Medicaid share. The Department also pays the Department of Public Health and Environment to maintain and operate the Minimum Data Set resident assessment instrument, which is used for nursing facility case mix reimbursement methodology. However, the Minimum Data Set resident assessment instrument is not Medicaid funded. The Department contracts with the Department of Public Health and Environment through an interagency agreement for these functions. Federal financial participation is broken into two categories: expenditures qualifying for a 75% enhanced federal financial participation rate for skilled professionals and expenditures related to long-term care facilities, and expenditures qualifying for a 50% federal financial participation rate to cover POTS and other Common Policies for the FTE that perform these services.

The federal 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 compliance for these Medicare requirements are also performed by the Department of Public Health and Environment; however, they are Medicare funded rather than Medicaid funded.

The Health Facilities and Emergency Medical Services subdivision of the Department of Public Health and Environment receives funding from the Department to survey a variety of facilities that serve Medicaid patients. Based on the survey, the Department of Public Health and Environment makes a recommendation to the Department as to whether or not a facility or provider is in compliance with applicable regulations and should be Medicaid certified.

The FY 2007-08 Long Bill (SB 07-239) appropriated $4,539,038 to this line. This amount reflected the removal of $4,780 in one-time funding, which was authorized in HB 06S-1023, "Concerning the Immediate Implementation of Restrictions on Public Benefits as Defined in Article 8 of the United State Code for Persons Eighteen Years of Age or Older Effective August 1, 2006." Further, the total FY 2007-08 appropriation included the addition of $135 in base funding, as requested in NP-9, "DPHE – Implementation of HB 06S-1023," submitted in the Department's November 1, 2006 FY 2007-08 Budget Request. This funding was requested in order to cover the cost of implementing the additional immigration checks required for providers. Finally, SB 07-239 included an increase of $233,978 in base-building funds in FY 2007-08 for Common Policy adjustments described in the first paragraph above.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $4,932,027 for this line item, an increase of $392,989 over FY 2007-08. Included in this total is the FY 2007-08 appropriation of $4,539,038:

- plus $37,700 from the annualization of SB 07-196, "Health Information Technology"
- plus $264,889 in Common Policy adjustments
- plus $90,400 for ongoing costs to cover the additional surveys needed to ensure compliance with Medicaid regulations for the Intermediate Care Facilities that have been established by the Department of Human Services for clients who are developmentally

disabled as requested in NP-4, "Department of Human Services Regional Center ICF/MR Conversion and Year 2 of Staffing Study," submitted in the Department's November 1, 2007 FY 2008-09 Budget Request.

Due to the economic downturn in FY 2008-09, the Department submitted two supplementals to reduce funding for this line. To reconcile the funding splits with adjustments to the total federal financial participation blended rate, the Department requested a net zero total funds change, which increased General Fund by $58,116 and reduced federal funds by a corresponding $58,116 in Supplemental Request NP-S-1, "DPHE – Adjustment to Medicaid Funds for CDPHE Survey and Certification," FY 2008-09 Supplemental Request, January 2, 2009. In addition, the Department submitted NP-S-19, "DPHE – Hiring Freeze Savings," in the Department's January 15, 2009 FY 2008-09 Budget Reduction Proposals. The request was for a reduction of $6,361 in total funds for FY 2008-09. These requests were authorized by the Department's FY 2008-09 Supplemental Bill (SB 09-187).

During FY 2008-09, it was discovered that some federal funds related to this line item had been inadvertently overdrawn so that additional General Fund would be needed to repay the overdrawn federal funds. On June 22, 2009, the Department submitted the 1331 Supplemental Request "Federal Funds Replacement for Transfer to Department of Public Health and Environment for Facility Survey and Certification" for $313,036 additional General Fund to come from an underexpenditure in the Medicare Modernization Act of 2003 State Contribution Payment line item. The Joint Budget Committee of the General Assembly approved this request, and the federal funds have been repaid.

The FY 2009-10 Long Bill (SB 09-259) appropriated $5,001,243 total funds with $1,502,513 General Fund and $3,498,730 federal funds to this line item. This Long Bill included $145,018 in Common Policy adjustments with an increase of $169,309 General Fund and a decrease of $24,291 in federal funds as a continuing effort to align correctly the blended federal financial participation rates. The final appropriation also includes a reduction of 1.82%, or $69,441, for Personal Services that was made to the appropriation as part of the budget balancing of SB 09-259, the FY 2009-10 Long Bill.

The Department is requesting $5,070,684 in total funds for FY 2010-11. This request includes a request for the restoration of the 1.82% reduction in Personal Services, or $69,441 in total funds for FY 2009-10, that was made during budget balancing of SB 09-259, the FY 2009-10 Long Bill.

TRANSFER TO THE DEPARTMENT OF REGULATORY AGENCIES FOR NURSE AIDE CERTIFICATION

Federal statute located at 42 C.F.R. §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 Nurse Aide Certification program under a three-way interagency agreement with the Department and the Department of Public Health and Environment. The Department provides Medicaid funding for the program and Medicare funding for the program is provided through the Department of Public Health and Environment. Pursuant to Section 12-38-101, C.R.S. (2009), 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, taught by nurses from

the Department of Public Health and Environment, followed by testing and application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered by the Division of Registrations located in the Department of Regulatory Agencies and is directly overseen by a five-member Nurse Aide Advisory Committee.

The Department of Regulatory Agencies is required to administer the Nurse Aide Certification program using established standards for the training curriculum to ensure that nurse aides receive federally required training, and that nurse aides are tested regularly 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 comprised of General Fund and fees collected directly from nurse aides. These fees are assessed as part of the required criminal background check. Federal regulations prohibit requiring nurse aides to pay for certification, but requiring non-certified nurse aides to pay the cost of the background check is a permissible exception to these regulations. Many nursing facilities reimburse the nurse aides for any fees paid as part of the pre-hiring requirements.
The State funds, consisting of General Fund and reappropriated funds from the Department of Regulatory Agencies (background checks), are used to draw down federal funds. Specifically, Section 12-38.1-103 (6), C.R.S. (2009) 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.

Per the FY 2008-09 Long Bill, HB 08-1375, total funding of $325,343 was provided for this line item. Of this total, $148,020 is General Fund, $14,652 is reappropriated funds from the Department of Regulatory Agencies, and $162,671 is federal funds. The Department was appropriated the same amount in the FY 2009-10, Long Bill, SB 09-259. The Department is requesting continuation funding of $325,343 for FY 2010-11.

TRANSFER TO DEPARTMENT OF REGULATORY AGENCIES FOR REVIEWS

The Office of Policy, Research and Regulatory Reform in the Department of Regulatory Agencies conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The Departments affected by the legislation reimburse the Department of Regulatory Agencies for performance of such sunset reviews. Previously, whenever the Department had a particular law requiring a sunset review, a specific line item was established in the Department's Long Bill with a line item name that referred to the short name of the legislation, and in subsequent fiscal years, the line item became obsolete. This new line item was established as a result of Add-ons to the FY 2009-10 Long Bill, SB 09-259 beginning with FY 2008-09. The new line item name is generic to accommodate the potential for multiple sunset reviews required by various laws across multiple Department programs and functions. Sunset reviews are a special form of audits that are performed to provide information to the General Assembly on the effectiveness and efficiencies of particular programs. This information is used by the General Assembly to provide guidance on future legislation or modifications to current legislation.

The Department was appropriated a total of $9,000 for FY 2008-09 for the review of two Department functions: the Obesity Treatment pilot program and the Telemedicine pilot program. The cost of each review is standard hourly rate used by the Office of Policy, Research and Regulatory Reform of $49.42 per hour multiplied by the number of hours required to complete the review. The Obesity Treatment pilot program required 10.5 hours of review and the Telemedicine pilot program required 120.5 hours of review for a total cost of $6,474. However, no state funding was needed to pay for the reviews in FY 2008-09 as private grant funding was available. The Department cannot depend on grant funding being consistently available, so the Department will continue to request state funding to ensure that there is adequate funding to pay for reviews on an as-needed basis.

Occasionally, the sunset review work is spread over two fiscal years. For FY 2009-10, $14,000 was appropriated for sunset reviews on the Telemedicine pilot program, the Teen Pregnancy and Dropout Prevention program, and the In-Home Support Services program. A small amount of follow-up review on the Obesity Treatment pilot program may also occur, but that follow-up is expected to be minimal as it was not possible for the Department to implement that particular program.

Future requests to adjust the funding will depend on letters that might be received from the Director of the Office of Policy, Research, and Regulatory Reform in the Department of Regulatory Agencies. Those letters substitute for formal Decision Items or Supplemental Requests. The base request for FY 2010-11 is $14,000 for the performance of sunset reviews on the Teen Pregnancy and Dropout Prevention program and the In-Home Support Services program. If additional letters are received, the amount needed for FY 2010-11 may change.

TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

This line item funds a portion of the administrative expenses of the Public School Health Services Program created in SB 97-101. Specifically, the line funds the administrative expenses of the Colorado Department of Education, which receives and reviews all local plans, conducts on-site reviews, submits annual reports, and provides technical assistance to medical staff at participating school districts. In addition, prior to FY 2009-10, the cost of a contractor responsible for developing a new reimbursement methodology and performing time studies to support the rate-setting methodology was funded from this line.

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. This annual reconciliation ensures 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, Inc. (PCG) to assist with developing an updated Public School Health Services rate-setting methodology. The focus was on developing district-specific rates and a cost settlement process to compare actual costs to interim payments made to participating Public School Health Services providers. PCG's

scope of work also included planning and administering time studies to support the rate-setting methodology, assisting the Department in drafting a State Plan Amendment that included all proposed changes to the Public School Health Services rate-setting methodology, and training school staff. Further contract responsibilities included defining allowable cost, providing assistance in the certification of public expenditures process, and developing a transition plan from the current to the new rate-setting methodology.

During FY 2007-08 Figure Setting for the Department of Education, the Joint Budget Committee recommended an increase of $7,176 to this line item for a POTS adjustment from the FY 2006-07 appropriation (FY 2007-08 Department of Education Figure Setting, March 8, 2007, page 114). The final FY 2007-08 appropriation for this line item was $391,696 in federal funds.

For FY 2008-09, the Department requested $407,747 for this line item. The request reflected an increase of $16,051 for additional POTS funding and indirect cost assessments from the Department of Education (FY 2007-08 Department of Education Figure Setting, March 8, 2007). The contract funding for Public Consulting Group remained at $200,000. The final FY 2008-09 appropriation was $407,747 in federal funds.

The Department submitted DI-17 "School Health Services Program Auditor" in its November 3, 2008, FY 2009-10 Budget Request. This request contained a reorganization of the (1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services line item. The $200,000 in funding for the contract with Public Consulting Group was moved into the (1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts. Joint Budget Committee Staff recommended an increase of $3,564 to the line item to account for an Indirect Cost Assessment performed by the Department of Education (FY 2009-10 Figure Setting, March 18, 2009, page 85). These actions brought the FY 2009-10 appropriation for this line item to $211,312 in federal funds.

The Department is requesting continuation funding for this line item in FY 2010-11 in the amount of $211,312 federal funds.

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 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 services, 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.

To qualify as an In-Home Support Services agency, an entity must offer independent living core services, provide 24-hour back-up services, and contract with or have on staff a health professional that will be responsible for oversight of training of attendants. Each In-Home Support Services agency must submit a provider enrollment application and participate in an on-site survey conducted by the Colorado Department of Public Health and Environment.

Because these agencies served a new function for the Department, the Department of Regulatory Agencies was required to conduct a study of In-Home Support Services agencies, pursuant to Section 24-34-104.1, C.R.S. (2009). As a result, the Department of Regulatory Agencies commissioned a review of the In-Home Support Services agencies beginning in FY 2006-07. The study was performed 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 a 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. Work continued in FY 2007-08, and the sunset report was completed and presented to the General Assembly in October 2007. The report recommended that the program be continued and contained recommendations to implement a better tracking program; require periodic training seminars for case managers; and enhance educational outreach. HB 08-1210 extended the In-Home Support Services Program until July 2011.

The FY 2007-08 appropriation in the FY 2007-08 Long Bill, SB 07-239, was for $4,000 to complete the review. This amount was 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). Because the review was completed by October 2007, no additional funding was required beyond FY 2007-08.

(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 $27,451,189 in total funds for FY 2009-10, which is comprised of $6,006,676 General Fund, $1,176,844 cash funds, $100,328 reappropriated funds, and $20,167,341 federal funds. Of this total amount, $26,787,775 was for the Medicaid Management Information System Contract budget item, and $663,414 was for the HIPAA Web Portal Maintenance budget item.

The Department's FY 2010-11 base request for the Information Technology Contracts line item is funding in the amount of $36,883,007 for the budget 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 financial participation rate for design, development, or installation of an MMIS and a 75% federal financial participation 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.

The Department has contracted with Affiliated Computer Systems (ACS) to perform as the fiscal agent for the operation of its MMIS since December 1, 1998. The MMIS processes 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 MMIS Contract budget item covers costs for running claims through the processing system and for certain administrative functions contracted to the fiscal agent.

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. During FY 2006-07, reprocurement of the MMIS operational responsibilities was completed, and ACS was reselected as the fiscal agent. On July 1, 2007 a new MMIS contract began and will remain in effect until June 30, 2010. For FY 2010-11 the Department seeks to exercise the first of five one-year contract extensions.

Beginning March 1, 2004, the MMIS contract was converted to a fixed price contract that covers all claims processing, provider enrollment and notification, and prior authorization reviews. Under the MMIS contract, the Drug Rebate Analysis and Management System is also covered under the fixed price portion of the contract. Items that are not included in the fixed price portion include: postage, development costs associated with systems changes, preferred drug list maintenance, and Payment Error Rate Measurement (PERM) maintenance costs.

The MMIS Contract budget item was appropriated funding from the Tobacco Tax Bill, HB 05-1262 beginning in FY 2005-06. Funding supported one-time development costs and other one-time purchases including additional centralized processing unit disk space for the Decision Support System. The continuation funding in the amount of $284,899 cash funds authorized by HB 05-1262

funds operational support for the processing unit disk space for the Decision Support System and pharmacy prior authorization reviews.

The Preferred Drug List was established by Executive Order D 004 07 on January 4, 2007. The Department was appropriated $170,370 in total one-time funding for systems development costs for the implementation of the Preferred Drug List in FY 2006-07 as requested by Executive Order and authorized by SB 07-239 Long Bill Add-ons (FY 2007-08 Figure Setting February 14, 2007, page 49). The requested funding for development costs was annualized as maintenance costs for the Preferred Drug List and an anticipated increase in the number of prior authorization requests in the amount of $170,510 in SB 07-239, the FY 2007-08 Long Bill. The Department has received continuation funding in this amount since FY 2007-08. The Department requests continuation funding of $340, 880 in 2010-11.

Funding for the PERM Project was requested in S-5, BA-1, "Revised Federal Rule for Payment Error Rate Measurement Program," submitted in the Department's FY 2006-07 Supplemental and FY 2007-08 Budget Request Amendment on January 4, 2007,. The request was approved in the Department's Supplemental Bill, SB 07-163, and annualized in SB 07-239, the Department's FY 2007-08 Long Bill to $10,080.

In FY 2007-08, the budget 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 the fixed price portion of the contract that resulted from lower costs negotiated during reprocurement was removed. New development costs in the amount of $180,558 was appropriated as part of SB 07-239 for the Children's Basic Health Plan Premiums Assistance Program, known as CHP+ at Work, to allow employers of parents who have children enrolled in the program to transmit enrollment fees deducted from the parent or parents' paychecks. As part of S-1A, "Building Blocks to Health Care Reform," submitted on February 15, 2008, the Department requested 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 FY 2008-09 Long Bill, HB 08-1375 as an add-on appropriation. With this late supplemental, the FY 2007-08 appropriation increased to $21,774,116.

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 pursuant to SB 07-001, and transfer funding from the Breast and Cervical Cancer Treatment Program to the General Fund pursuant to 25.5-5-308 C.R.S. (2009). The Department submitted DI-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 Request Amendment (BA-9) on January 23, 2008 which requested one-time funding in the amount of $50,400. The development funding modified the MMIS in order 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 was $23,663,414 total funds.

As part of the Department's FY 2008-09 budget reduction proposals, the Department submitted S-22, "Postpone Implementation of SB 08-006," on January 15, 2009 to postpone the implementation of SB 08-006, "Suspension of Medicaid Benefits for Confined Persons." Included in this proposal was a savings resulting from MMIS system development costs.

The Department also submitted S-14, BA-13 "Eliminate Colorado Cares Fund," in its FY 2008-09 Supplemental and FY 2009-10 Budget Request Amendments, submitted on January 2, 2009. Taken together, S-22, "Postpone Implementation of SB 08-006," and S-14, BA-13 "Eliminate Colorado Cares Fund," removed $1,602,244 total funds from FY 2008-09 and were authorized in the Department's Supplemental Bill, SB 09-187. The final FY 2008-09 appropriation was $22,061,170.

For FY 2009-10, adjustments were made to remove $306,203 total funds in one-time funding for development projects from the prior fiscal year. Additional funding was provided by the following requests submitted in the Department's November 3, 2008 FY 2009-10 Budget Request: 1) DI-6, "Medicaid Value-Based Care Coordination Initiative;" 2) DI-10, "Annual MMIS Cost Adjustment;" 3) DI-12, "Enhance MMIS Effectiveness;" and 4) BRI-1, and "Pharmacy Technical and Pricing Efficiencies." Reductions were also made as a result of BA-16, "MMIS Funding for HIPAA and v5010/D.0 Transactions" (FY 2009-10 Stand Alone Budget Amendment, January 23, 2009); and BA-33, "Provider Volume and Rate Reductions" (FY 2009-10 Budget Reductions, January 23, 2009). As part of the FY 2009-10 budget reductions, the Department submitted two Early Supplementals (ES-2 and ES-3) on August 24, 2009 to reduce the MMIS contract. ES-2, "Medicaid Program Reductions" added $126,900 total funds to expand the Preferred Drug List and ES-3, "Department Administrative Reductions" reduced the fixed price portion of the MMIS contract by $510,000 total funds. The final FY 2009-10 appropriation, including the effects from early supplementals and HB 09-1293, "Colorado Health Care Affordability Act" is $27,451,189

For FY 2010-11, adjustments to the requested amount included adjustments for the effects of two special bills, HB 09-1047, "Alternative Therapies for Persons with Disabilities" and HB 09-1293, "Health Care Affordability Act of 2009", $75,600 and $4,899,586 total funds, respectively. The total base request for FY 2010-11 is $36,883,007 in total funds.

HIPAA WEB PORTAL MAINTENANCE

The Health Insurance Portability and Accountability 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, Congress added to title XI of the Social Security Act a new Part C, titled Administrative Simplification. The purpose of this new part 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 C.F.R. 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 in the amount of $312,900 was requested for the web portal through BA-2, "Correct Methodology for Computer Systems Costs Funding Splits" submitted 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, the Department submitted S-4, "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005," FY 2006-07 Supplemental Request, on January 4, 2007. In this supplemental, the Department 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 (MMIS) and the Colorado Benefits Management System (CBMS) through the Department's Web site. The supplemental request was approved through SB 07-163, the Department's supplemental bill, bringing the FY 2007-08 appropriation for this budget item to $314,800.

As part of the Department's November 1, 2007 FY 2008-09 Budget Request, it submitted DI-13, "Web Portal Contract Adjustments and Enhancements" to request one-time funding in the amount of $117,833 total funds. The funding was requested in order 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. The request was approved during Figure Setting (FY 2008-09 Figure Setting, March 11, 2008, pages 60-61) and subsequently appropriated in HB 08-1375, the FY 2008-09 Long Bill. As a result of this request, and the removal of the one-time funding associated with S-4, "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005," the FY 2008-09 appropriation for this budget item was $430,733.

In FY 2009-10, adjustments were made to remove one-time funding provided by DI-13, "Web Portal Contract Adjustments and Enhancements," in the amount of $117,833 total funds and increased funding by $350,514 total funds for Web portal provider reprocurement activities (DI-15, "Provider Web Portal Reprocurement," November 3, 2008 FY 2009-10 Budget Request). Authorization for this request was provided by SB 09-259, the FY 2009-10 Long Bill. In FY 2010-11, the Department requests continuation funding of $663,414 total funds.

FRAUD DETECTION SOFTWARE CONTRACT

On January 23, 2008 the Department submitted BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries" requesting $1,250,000 in total funding to increase efficiencies in Medicaid cost avoidances and provider recoveries. The budget amendment allowed the Department to purchase fraud detection software and also allowed the Department to implement improvements to the Medicaid provider re-enrollment process.

The fraud detection software utilizes neural network and learning technology to detect fraud, abuse, or waste in the Medicaid program. It also supports such functions as compliance monitoring, provider referrals, and utilization review. Moreover, it provides 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; looking for known abusive or fraudulent practices using target queries on procedure or diagnosis codes; and tracking the progress of individual cases, including case hours, investigative cost and travel expenses related to the Medicaid program.

In FY 2008-09, the Department's fiscal agent determined the one-time cost for the fraud detection software at $774,000 total funds. However, the Centers for Medicare and Medicaid approved a 90% federal financial participation rate for 57% of the total cost with the remainder funded at 75% federal financial participation. As a result of the blended federal financial participation, the Department requested additional General Fund in the amount of $27,764 to purchase the software. The additional funding request was approved by JBC staff and appropriated through the Long Bill Add-Ons, SB 09-259. The final appropriation for FY 2008-09 was $778,403 total funds which included $127,764 General Fund. In FY 2009-10 the Department was appropriated $250,000 total funds in the Long Bill, SB 09-259 which included an annualization of $528,403 from BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries" (FY 2008-09 Stand Alone Budget Amendment, January 23, 2008).

In FY 2010-11, the Department requests continuation funding in the amount of $250,000 for annual technology maintenance and updates for the fraud detection software contract. The Department would receive 75% federal financial participation for annual maintenance costs per 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.

COLORADO BENEFITS MANAGEMENT SYSTEM MEDICAL ASSISTANCE PROJECT

This project was initially requested by S-1A, BA-A1A, "Building Blocks to Health Care Reform," FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, submitted February 15, 2008. Funding of $5,300,000 was provided in the FY 2008-09 Long Bill, HB 08-1375, for the purpose of working toward a realignment of the Colorado Benefits Management System (CBMS) so that Medicaid and the Children's Basic Health Plan eligibility determinations could be streamlined. The goal of this project was to realize administrative efficiencies in order to:

- decrease application processing time;
- reduce future system change costs;
- 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
- streamline the application processes for programs administered by the Department of Human Services.

CBMS is the system that determines eligibility for Medicaid and the Children's Basic Health Plan and the financial assistance programs administered by the Department of Human Services. As such, it is in the best interests of both state departments to create an environment that simplifies client correspondence specific to the financial and medical assistance programs within CBMS and an environment that streamlines the re-determination notices and processes. By ensuring that client correspondence is timely and accurate, the departments can assure that there is not a break in a client's eligibility that results in a loss of continuity of care.

Initial changes to CBMS include the development of a Web-based portal and a redesign of the front end data entry screens and screen flow which will provide improved customer service to CBMS users. The Department anticipates these changes will be implemented by February 2010 for phase one, and phase two will continue through June 2010. The Intelligent Data Entry enhancement to CBMS involves a redesign of data entry screens and screen flow used in the application process for the entry of client data. The Web-based portal will allow individuals to apply for programs or submit redetermination information from any location with internet access. In addition, clients will be able to report changes in information through the Web-based portal and check benefit and application status. The realignment of the user interface and data entry screens into a more user-friendly, work-flow oriented format is expected to reduce application processing time, eliminate redundancies and reduce data entry errors. Making the application process more efficient will result in increased access to benefits and improved workloads for county workers.

The FY 2008-09 Long Bill, HB 08-1375, appropriated $5,300,000 for this project. However, JBC Staff Supplemental Recommendation #1, made after consultation with the Department's management, recommended a decrease of $3,739,000 total funds ($1,789,242 in General Fund and $1,949,757 in federal funds) in FY 2008-09 (The Department's Supplemental Requests figure setting document for FY 2008-09, January 29, 2009, pages 73-74) for a final appropriation of $1,561,000. The reduction was effective with the FY 2008-09 Supplemental Bill, SB 09-187. Of this total, the Department paid $98,825 in consulting fees to Solutions Consulting Group Inc., also known as Public Knowledge, to identify and make recommendations for improvements to client services.

Both the Department and the Department of Human Services submitted a 1331 Supplemental Request called "Refinance Colorado Benefits Management System Improvements" to the Joint Budget Committee of the General Assembly on June 22, 2009. The request was approved by the Joint Budget Committee. This request combined the remaining $1,462,175 in the Department's appropriation to with program funding from the Department of Human Services, resulting in a combined total of $1,623,982 total funding that would be shared by both Departments according to the Random Moment Sampling methodology used by the regular CBMS project. The funding was placed into a separate line item, (6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services – Medicaid Funding, Colorado Benefits Management Information System Client Services Improvement Project. The improvement project will add a Web portal to be used specifically for CBMS. Intelligent Data Entry software will also allow clients to enter much of their own information into CBMS, thus reducing the need to travel several times to local social services offices.

The FY 2009-10 Long Bill, SB 09-259, appropriated $2,995,100 to the Department for continuation of the original project. The Department's base request for FY 2010-11 is continuation funding of $2,995,100 for the original project as the Client Services Improvement Project is expected to have continuing needs for an additional fiscal year.

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. The Blue Ribbon Commission for Health Care Reform (the "208 Commission") was created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal (as released on November 4, 2007) suggested creating a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility. This entity would streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, create expedited eligibility, and improve outreach and enrollment in both programs. These changes would ensure easier, more reliable and timely eligibility and enrollment processes. Such changes would make the program more efficient and effective in delivering important benefits to clients, providers, and enrollment staff. This entity would enhance and complement the current multiple county-level process.

The FY 2008-09 Long Bill, HB 08-1375, provided $460,800 in total funds in FY 2007-08 and $153,000 in FY 2008-09 for the purpose of hiring a vendor to gather the requirements and draft the request for proposals for an Eligibility Modernization Vendor (single state-level entity to determine eligibility). Funding for this initiative was requested in the Department's FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, S-1A, BA-A1A, "Building Blocks to Health Care Reform," February 15, 2008, page S.1A-1. Funding was used for a contractor, Public Knowledge, to conduct a comprehensive business process analysis, with accompanying cost benefit and return on investment analysis, for the purpose of improving the efficiency and quality of the eligibility and enrollment operations for the Department's health care programs.

Public Knowledge provided a report of its findings to the Department in December 2008. The Public Knowledge report contained lessons learned from other states as well as best practices for eligibility and enrollment models. The Department and Public Knowledge drafted a request for proposals based on the findings in the report as well as information obtained through the request for information.

In its November 3, 2008 FY 2009-10 Budget Request, the Department submitted DI-5 "Improved Eligibility and Enrollment Processing" which requested $7,741,136 total funds in this line item to implement and administer an Eligibility Modernization Vendor model. However, the Department later submitted and received approval for BA-35 "Revised Implementation of DI-5 Improved Eligibility and Enrollment Processing" reducing the request to $100,000 total funds in this line item (FY 2009-10 Figure Setting, March 18, 2009, page 95). The total funds of $100,000 in FY 2009-10 allows the Department to continue working towards improvements that are a necessary building block to allow for coverage of more eligible but not enrolled Coloradoans in public health programs. The Department released a request for proposals for an eligibility and enrollment vendor in September 2009 and anticipates

awarding a contract in January 2010. The Department anticipates the eligibility and enrollment vendor will initially implement modernization strategies for Children's Basic Health Plan clients.

For FY 2010-11, the Department's base request includes an appropriation of $760,000 total funds from HB 09-1293 "Colorado Health Care Affordability Act". This total includes $366,320 from the Hospital Provider Fee Cash Fund and $393,680 federal funds. These funds will be used for a vendor to process eligibility and enrollment for the expansion of the Children's Basic Health Plan up to 250% FPL.

(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 service providers. If clients could not show proof of Medicaid eligibility, providers could, at times, refuse to provide services.

The Department submitted BRI-2 "New Medical Identification Card Process" in its November 1, 2002 FY 2003-04 Budget Request. The BRI requested funding in order to implement a process for issuing a plastic card to all eligible clients, a process which was put into place in September 2003. 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.

Under this system, clients are issued plastic Medicaid authorization cards upon a determination of their eligibility for Medicaid. Prior to rendering Medicaid services, providers must verify Medicaid eligibility electronically after viewing the client's plastic card. In the event plastic cards are lost, replacement cards are issued when necessary. The plastic authorization 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.

Old Age Pension State Medical Program clients have always received Medicaid authorization cards, but prior to FY 2003-04 there were no specific funds to pay for the production of these cards. Therefore, beginning in FY 2003-04, funding for authorization cards for the Old Age Pension State Medical Program's clients was added to the appropriation. The amount of 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.

For FY 2007-08, the Department requested $190,892 total funds, but during the Department's Figure Setting on February 14, 2007 through Joint Budget Committee action, funding for the Medical Identification Cards line item was reduced by $70,892 due to decreased caseload forecasts, resulting in total funding for FY 2007-08 of $120,000. Funding in the amount of $120,000 was requested for FY 2008-09 and FY 2009-10. For FY 2010-11, the Department requests continuation funding of $120,000 total funds.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item provides funding for four Department functions: Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review, School District Eligibility Determinations, and Hospital Outstationing.

Prior to FY 2008-09, Disability Determination Services, Nursing Home Preadmission and Resident Assessments, and School District Eligibility Determinations were funded through their own separate line items within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, 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, HB 08-1375, the FY 2008-09 Long Bill consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The three budget items for Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review, 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. Hospital Outstationing has been added as a result of the passage of HB 09-1293, "Colorado Health Care Affordability Act."

This line item received an appropriation of $2,418,712 in total funds for FY 2009-10, which is comprised of $918,770 General Fund, $34,576 cash funds, and $1,465,366 federal funds. Of this total amount, $1,173,662 was for Disability Determination Services, $985,040 was for Nursing Facility Preadmission Screening and Resident Review, and $260,010 was for School District Eligibility Determinations. Hospital Outstationing did not receive an appropriation for FY 2009-10.

The Department's FY 2010-11 Base Request for (D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations is for funding of $5,233,102 in total funds for all four functions 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.

Since FY 2005-06, the Department has received $1,173,662 per fiscal year for disability determination services. Of this total amount, $581,831 is General fund, $5,000 is cash funds from the Colorado Autism Treatment Fund, and $586,831 is federal funds. The Department was appropriated continuation funding of $1,173,662 in FY 2009-10 and requests the same amount for FY 2010-11.

NURSING HOME PREADMISSION AND RESIDENT ASSESSMENTS

This budget item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing facility 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, regardless of individual payer source, are subject to preadmission screening and all current residents, regardless of individual payer source, are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care, remain in the nursing facility for the appropriate amount of time, 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. For Medicaid clients, these questions are a part of the Uniform Long-Term Care 100.2 Form, an assessment completed by the Single Entry Point agencies 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 or the Division for Developmental Disabilities (DDD) for a Level II Enhanced Evaluation. These Level I screenings are funded out the Long Term Care Utilization Review budget item, which is in Long Bill group (1) Executive Director's Office; (E) Utilization and Quality Review Contracts.

The purpose of the Level II enhanced evaluation is to confirm a diagnosis of a major mental illness (MMI) and/or mental retardation/developmental disability or related condition (MR/DD/RC) and to establish need for nursing facility-based specialized services. Upon diagnosis of a Level II MMI or MR/DD/RC, the Level II enhanced evaluation is sent to the State Mental Health Authority or the State Mental Retardation Authority at the Department of Human Services for review and to determine placement. These extensive evaluations also provide recommendations to assist the nursing facility in developing an appropriate plan of care for necessary services. They are coordinated by the nursing facility with a mental health and developmental disabilities service provider. A resident review must be conducted for residents of Medicaid-certified nursing facilities that have a MMI and/or MR/DD/RC diagnosis whenever there is a significant change in their medical and/or psychiatric condition. Level II enhanced evaluations, resident reviews, and depression diversion screenings by mental health centers are funded through the Preadmission Screening and Resident Review (PASRR) budget item.

In 2007, it was determined that training is needed to ensure that community-based PASRR providers understand and follow correct screening and review procedures and comply with all State and federal PASRR program requirements. The program administrator conducts trainings throughout the year using this funding. These trainings cover the entire PASRR process, preadmission screenings,

Level II screenings, and resident reviews. The training is available to all PASRR providers which includes mental health centers, nursing facilities, Community Centered Boards, Single Entry Point agencies, and hospital and hospice discharge planners.

The appropriation for this function remained constant at $1,010,040 from FY 2003-04 through FY 2008-09, as utilization forecasts indicated this total budget amount to be adequate. During the 2009 legislative session, a one-time reduction of $100,000 in total funds for FY 2008-09 was made as a result of the passage of the Department's Supplemental bill, SB 09-187. Further, a permanent reduction of $25,000 in total funds for training purposes was made beginning in FY 2009-10 as a result of BA-40, "Reduce Funding for Nursing Home Preadmission and Resident Assessments Training Program" (FY 2009-10 Figure Setting, March 18, 2009, page 98). As a result, the Department requests continuation funding of $985,040 for Nursing Facility Preadmission Screening and Resident Review in FY 2010-11. Of this amount, $246,260 is General Fund and $738,780 is federal funds.

SCHOOL DISTRICT ELIGIBILITY DETERMINATIONS

This budget item funds school district eligibility determinations authorized under HB 06-1270 at 25.5-4-205 (1) (a.5), C.R.S. (2009) to increase enrollment of eligible children into Medicaid or the Children's Basic Health Plan. House Bill 06-1270 established a demonstration project for school-based medical assistance sites which is being conducted in three school districts: 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 Committees of the General Assembly for review before January 15, 2010.

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 from the Health Care Expansion Fund, 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.

The Department requested an additional $32,718 in total funds for this budget item beginning in FY 2009-10 in DI#16, "School Based Medical Assistance Site Pilot Expansion" in its November 3, 2008 FY 2009-10 Budget Request. During FY 2009-10 Figure Setting, Joint Budget Committee staff recommended that the Department's request for funding be granted and the Joint Budget Committee concurred with staff recommendation. (FY 2009-10 Figure Setting, March 18, 2009, page 99.)

As a result, with the passage of SB 09-259, the FY 2009-10 Long Bill, the final appropriation for this budget item in FY 2009-10 was $260,010 in total funds. The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary

in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-3 "Department Administrative Reductions," the Department proposed eliminating the School District Eligibility Determinations budget item effective September 1, 2009. This resulted in a total fund reduction of $216,675 in FY 2009-10, with a General Fund reduction of $75,566, a cash fund reduction of $24,647 from the Health Care Expansion Fund, and a federal fund reduction of $116,462. The Department's FY 2010-11 base request includes an annualized total fund reduction of $260,010, with a General Fund reduction of $90,679, a cash fund reduction of $29,576 from the Health Care Expansion Fund, and a federal fund reduction of $139,755.

HOSPITAL OUTSTATIONING

This budget item funds outstationing activities at hospitals in order for hospitals to process applications for the Medicaid program. This item was created as a result of the passage of HB 09-1293, "Health Care Affordability Act" to assist with the anticipated increase in caseload due to the bill. Outstationing activities include providing certain on-site services to inform, educate, and assist qualifying clients in gaining enrollment into the Medicaid program. Due to the implementation plan for this bill, hospitals will begin outstationing activities in FY 2010-11. Not every hospital is anticipated to participate in outstationing activities, but costs for these activities were based on 1.0 FTE at each hospital. The Department's FY 2010-11 base request is for a total of $3,074,400 as calculated in the fiscal note for HB 09-1293. Of the total amount, 50% is cash funds from the Hospital Provider Fee Cash Fund and 50% is federal funds.

COUNTY ADMINISTRATION

This line item 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 the Department of Human Services. 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.

As part of the Department's fiscal note for SB 06-219, 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 federally-approved 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 of 50% federal funds, 30% State funds and 20% local funds; 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 between the Department and Department of Human Services pursuant to 24-75-106, C.R.S. (2009) in order to maximize Medicaid reimbursement to the counties, thereby maximizing reimbursement of county expenditures.

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, $20.5 million above the $64.7 million appropriated to both departments in FY 2007-08. In addition, the study found that the total expenditures related to medical assistance programs administered by the Department, was equal to $34,753,075, which was $10,996,866 above the $23,756,209 FY 2007-08 appropriation.

In FY 2007-08, the Department's appropriation was $23,756,209 which was $2,641,076 above the final FY 2006-07 appropriation. The increase resulted from Governor's Budget Amendment #2 which provided an additional $2,209,022 to the counties as a bridge until the workload study could be completed, $317,344 was provided to the counties from the 1.5% provider rate increase, and $41,184 was for the annualization of SB 07-163 related to the Deficit Reduction Act and HB 06S-1023 (Figure Setting, March 8, 2007, pages 108-110). In addition, with the passage of the Colorado Cares Rx Program (SB 07-001), an additional $73,526 in cash funds was provided to County Administration to process 15,160 clients for six months at a cost of $4.85 per county referral. However, this program was not implemented as anticipated, and the cash funds were not expended (for more information regarding this program, please refer to the line item description for Colorado Cares Rx Program Contract Costs).

In order to maximize federal funds and county reimbursement, a General Fund transfer was made from the Department of Human Services to the Department for FY 2007-08 in the amount of $2,226,323. This transfer allowed the Department to draw an additional $3,923,342 in federal funds and a local share of $1,616,753 for a final total expenditure of $31,449,101.

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. With the passage of SB 09-132, Modify Colorado Cares Rx Program, the total of $120,450 cash funds was removed from the appropriation. In addition, HB 08-1250 appropriated $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. During 2009 Figure Setting, an additional $3,335,848 of one-time total funds were added due to General Fund made available from additional federal funds provided by the American Recovery and Reinvestment Act of 2009. This one-time funding does not include a local share. The total appropriation for FY 2008-09 was $30,418,531.

In order to maximize federal funds and county reimbursement, a General Fund transfer was made from the Department of Human Services in the amount of $1,259,529. This transfer allowed the Department to draw an additional $2,099,215 in federal funds and a local share of $839,686 for a final total expenditure of $34,616,961.

The FY 2009-10 Long Bill, SB 09-259 appropriated $30,986,377. This appropriation includes the removal of the one-time funding of $3,335,848, but adds $3,091,214 total funds that were also made available due to excess federal funds provided by the American Recovery and Reinvestment Act of 2009. In addition, during the Department's March 18, 2009 Figure Setting, $812,480 was added from the Health Care Expansion Fund (Figure Setting, March 18, 2009, page 100). The total increase in funding of $3,903,694 does not include a local share. HB 09-1293, "Colorado Health Care Affordability Act" appropriated an additional $1,871,830 for this line item which does include a 20% local share. The Department's total base request for FY 2010-11 is $32,858,207.

ADMINISTRATIVE CASE MANAGEMENT

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services. Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management 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 Public Consulting Group, Inc.

Similar to the County Administration appropriation narrated above, State appropriated funding for these services is allocated across all 64 counties. The Department and the Department of Human Services agreed that the best allocation for this 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 this funding.

In FY 2007-08, the Department was appropriated$1,617,528 total funds in the Long Bill, SB 07-239. In order to maximize federal funds and county reimbursement, the Department received a General Fund transfer from the Department of Human Services in the amount of $1,048,341. This transfer allowed the Department to draw matching federal funds for a total FY 2007-08 expenditure of $3,714,209.

For FY 2008-09, the Department submitted DI-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 was $2,917,528.

The Centers for Medicare and Medicaid Services proposed Medicaid regulations affecting financing and federal funding that could severely restrict the ability of state Medicaid operations to continue to administer services at the current level. One of the proposed rules had a potential impact to Administrative Case Management. Due to the heavy costs imposed by these regulations, not only to Colorado, but to every state Medicaid program, Congress imposed a moratorium on the federal rules. The Centers for Medicare and Medicaid Services released guidance in July 2008 relating to the proposed rules and the moratorium regarding case management services. The guidance states that any guidance released prior to December 2007 through State Medicaid Director Letters and other issuances is still in effect. State Medicaid Director Letter #01-013 released January 2001 clarified policy regarding targeted case management offered through the Medicaid program as it relates to an individual's participation in other social, educational, or other programs. The letter states that Medicaid case management services do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual is referred. The letter then uses the example of the foster care program and states that activities performed as a component of the overall foster care program do not qualify as Medicaid case management services.

Administrative Case Management includes the following activities:

- completing or assisting in the Medicaid eligibility process for a child and/or their family; and
- collecting information or updating health needs of a child (Child's Health Passport) which includes gathering information to complete the Colorado Assessment Continuum (CAC) for the child and family. This process includes documenting medical/mental health needs and history of treatment of the child and parent(s) including medications, hospitalizations, immunizations and current functioning and other health information.

The Department will continue to pay for the first activity as it is still eligible for Medicaid reimbursement. However, the second activity is related to the direct delivery of Child Welfare services because it involves collecting information required for the Child Welfare program and not the Medicaid program. Therefore, pursuant to guidance from the federal Centers for Medicare and Medicaid Services, the Department can no longer draw down federal funds for this activity. The Department submitted S-15, "Reduce Funding for Administrative Case Management" on January 2, 2009 requesting to reduce funding by a total of $2,337,785. The General Fund amount of the reduction, $1,188,892 was transferred to the Department of Human Services. The final FY 2008-09 appropriation was $539,743. At the end of FY 2008-09, a greater proportion of Administrative Case Management activities were eligible for Medicaid reimbursement than anticipated in the Department's supplemental request. In order to maximize federal funds and county reimbursement, a General Fund transfer was made from the Department of Human Services in the amount of $165,005. This transfer allowed the Department to draw an additional $165,006 in federal funds for a final total expenditure of $869,755.

The FY 2009-10 Long Bill, SB 09-257, has a total appropriation of $539,744 and the Department requests continuation funding for FY 2010-11.

CUSTOMER OUTREACH

This line item funds customer outreach services provided through two Department functions: the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker. Prior to FY 2008-09, each of these functions was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote #22 of SB 07-239, the FY 2007-08 Long Bill, 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 of HB 08-1375, the FY 2008-09 Long Bill, 46 line items were consolidated into 31 line items within Long Bill group (1) Executive Director's Office. Two of the consolidated budget 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." As a result of SB 09-259, the FY 2009-10 Long Bill, this line item was appropriated $3,573,001 in total funds for FY 2009-10, of which $1,752,987 is General Fund, $33,514 is cash funds, and $1,786,500 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 $1,104,618 was for Enrollment Broker functions.

The Department's FY 2010-11 Base Request for (D) Eligibility Determinations and Client Services: Customer Outreach is $4,192,321 in total funds. Of this total, $2,468,383 is for the Early and Periodic Screening, Diagnosis, and Treatment Program and $1,723,938 is for Enrollment Broker functions.

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

<u>EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM</u>

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 within 60 days of eligibility being established;
- 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;
- 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;
- assisting clients with the program and managed care information process; and
- referring applicants to the enrollment broker at the time of Medicaid application.

Only administrative and outreach services are funded by this budget item. Services funded by this budget item are contracted primarily by county health department staff, but may include other local outreach providers such as hospitals and community-based organizations. 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 2010-11 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 them of Medicaid plan choices. If a client chooses the Primary Care Physician Program or a health maintenance organization, MAXIMUS, Inc. will enroll the client in the plan. MAXIMUS, Inc. also enrolls and disenrolls clients from the managed care plans in accordance with Medicaid rules. MAXIMUS, Inc. does this work under the name of Health*Colorado*.

In FY 2008-09, MAXIMUS, Inc. enrolled 92,801 clients across the Department's physical health plans and the medical home program. This total includes new enrollments, re-enrollments, continuous and open enrollments, and transfers between plans. MAXIMUS, Inc. also handled 14,066 disenrollments, which does not include clients disenrolling due to loss of eligibility, change in eligibility, or health plan closure. In addition, 57,209 calls were received in FY 2008-09, with an average wait time of 49 seconds.

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 (FY 2008-09 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. The Department was able to work with MAXIMUS, Inc. to revise the scope of work from $942,784 to $700,000 for the FY 2007-08 contract. This revised contract

drastically cut the amount of information provided to clients through mailings and relied on internet resources as a means of information provision.

The Department received direction from the Centers for Medicare and Medicaid Services, however, 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 requires the State to provide hard copy mailings of the information materials listed in 42 CFR §438.10. As a result, the Department changed the FY 2007-08 contract back to the former scope of work to ensure compliance, and reduced the duration from 12 months to 10 months, 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, Inc., the Department submitted a supplemental, S-11, "Restore Enrollment Broker Contract Funding" (FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments, January 2, 2008). 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 for FY 2007-08. Also, a late supplemental requesting a one-time add-on of $2,200 for medical home material updates for FY 2007-08 was requested in S-1A, BA-A1A "Building Blocks to Health Care Reform," FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008 , and appropriated in HB 08-1285.

For FY 2008-09, the Department received $1,321,900 in total funds for this budget item. This funding included:

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

In FY 2009-10, the Department's appropriation for this budget item was $1,104,618. 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 costs associated with implementation of the SB 07-130 Medical Home program (S-1A, BA-A1A "Building Blocks to Health Care Reform," FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008, and FY 2009-10 Figure Setting, March 18, 2009, page 103).

The Department's FY 2010-11 base request for (D) Eligibility Determinations and Client Services: Customer Outreach is $4,192,321 in total funds, of which $1,723,938 is for the Enrollment Broker line item. This request is based on:

- The FY 2009-10 appropriation of $1,104,618;
- less $2,200 as a technical adjustment in order to account for a miscalculated annualization of costs associated with the implementation of SB 07-130 Medical Home program in the Department's November, 3, 2008 FY 2008-09 Request (S-1A, BA-A1A "Building Blocks to Health Care Reform," FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008);
- plus $80,504 in funding for implementation of HB 09-1293 "Colorado Health Care Affordability Act," which was signed into law on April 21, 2009;
- plus $541,016 for implementation of DI-6, "Medicaid Value-Based Care Coordination Initiative" and BA-38, "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative." (November 3, 2008 FY 2009-10 Budget Request and January 23, 2009 FY 2009-10 Budget Reduction Proposals).

Of the total $80,504 appropriated as a result of HB 09-1293, $40,252 is cash funds from the Hospital Provider Fee Cash Fund and $40,252 is federal funds. In FY 2010-11, funding would be used to provide information on health plan choices and Medicaid benefits for the expansion population of low-income parents to 100% of the federal poverty level.

The FY 2010-11 total request for the Enrollment Broker budget item includes continuation funding of $957,418 in total funds for traditional enrollment broker activities, which is defined as the provision of information on basic Medicaid benefits offered through all managed care health plans. The federal financial participation rate for traditional enrollment broker activities 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. Additionally, the total request includes $145,000 in continuation funding for costs associated with the SB 07-130 Medical Home program as initially requested in S-1A, BA-A1A "Building Blocks to Health Care Reform" (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008). The federal financial participation rate for this portion of the requested funding is 50%.

As described in the bullet list above, the Department's FY 2010-11 base request includes an increase of $541,016 in total funds for enrollment broker activities as requested in DI-6, "Medicaid Value-Based Care Coordination Initiative" in the Department's November 3, 2008 FY 2009-10 Budget Request. The initial request was for $354,092 in total funds in FY 2009-10 and $567,170 in total funds in FY 2010-11 for enrollment broker activities. However, in BA-38, "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative" (January 23, 2009 FY 2009-10 Budget Reduction Proposals and FY 2009-10 Figure Setting,

March 18, 2009, page 103) the Department requested a reduction to the request of $146,666 in FY 2009-10 and $146,666 in FY 2010-11. This resulted in an adjusted request for total funding for 2009-10 of $207,426 and an adjusted FY 2010-11 request of $420,504.

During conference committee for final balancing of SB 09-259, the FY 2009-10 Long Bill, funding totaling $207,426 was removed from the (1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach line item delaying the Enrollment Broker activities requested in DI-6 "Medicaid Value-Based Care Coordination Initiative" and BA-38 "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative" until July 2010. As a result, the Department shifted the originally requested three months of funding for Enrollment Broker activities in FY 2009-10 into the first three months of FY 2010-11. This shift resulted in an annualized amount of $541,016 total funds in FY 2010-11, which is greater than the amount requested in DI-6 and BA-38 because the passive enrollment costs for 45,000 clients during the first three months of implementation were shifted into FY 2010-11. For the remainder of FY 2010-11, enrollment costs are anticipated to be consistent with those outlined in DI-6, "Medicaid Value-Based Care Coordination Initiative."

The Department is requesting $1,723,938 in total funds for enrollment broker activities for FY 2010-11.

(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 budget 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 $4,576,355 in total funds for FY 2009-10, which is comprised of $1,359,148 General Fund, $54,949 cash funds and $3,162,258 federal funds. Of this total amount, $1,375,906 was for Acute Care Utilization Review, $1,824,966 was for Long-term Care Utilization Review, $812,193 for External Quality Review, $210,483 for Drug Utilization Review and $352,807 for Mental Health External Quality Review.

The Department's FY 2010-11 base request for the Professional Services Contracts line item is for the amount of $5,204,383 total funds for the budget items described below.

ACUTE CARE UTILIZATION REVIEW

Acute Care Utilization Review includes the performance of 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 the care paid for was medically necessary, required an acute level of care, and was coded and billed correctly.

The Department contracts with an independent contractor to perform prospective and retrospective reviews. 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 C.F.R. §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 as defined 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. As a result, the FY 2006-07 appropriation was $1,375,906, as authorized by HB 06-1385, the FY 2006-07 Long Bill. The additional tobacco tax funding is documented in Table 4 of the Department's 1331 Supplemental Request, "Technical Correction to Adjust Appropriations for HB 05-1262," (June 2, 2005, page 12). In addition to this change, $2,174 was shifted from cash funds exempt to 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 SB 07-239, the FY 2007-09 Long Bill.

Although continuation funding was requested for FY 2008-09, $725 was shifted from cash funds exempt to General Fund for the Breast and Cervical Cancer Program as required by section 25.5-5-308 C.R.S. (2009). In FY 2009-10 the Department was appropriated $1,375,906 in total funds. The Department is requesting $1,406,356 for FY 2010-11 in total funding, which includes an annualization of $30,450 total funds from HB 09-1293, "Colorado Health Care Affordability Act."

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 agencies (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 budget 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

Ascend Management Innovations, LLC 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. Ascend Management Innovations also conducts reviews for the Level II Pre-Admission Screening and Resident Review Program.

Under Section 1903 (a)(2)(C) of the Social Security Act and 42 C.F.R. §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.

In FY 2007-08 and FY 2008-09, the Department's appropriation for this budget item was $1,744,966 total funds. During FY 2008-09 Figure Setting on March 11, 2008, Joint Budget Committee staff recommended a technical correction to the cash funding source for this budget item, changing it from the Autism Treatment Fund to the Health Care Expansion Fund. This change was appropriated in the FY 2008-09 Long Bill, HB 08-1375.

In FY 2009-10, the Department was appropriated one-time funding in the amount of $80,000 total funds under BRI-2 "Medicaid Program Efficiencies" as requested in the Department's November 3, 2008 FY 2009-10 Budget Request, which was authorized in SB 09-259, the FY 2009-10 Long Bill. Funding was requested to implement the Patient Electronic Data System which was a component of the Hospital Back-Up program enhancements portion of the request. The new system is a web-based system application that the Department anticipates will reduce the application and admission process for the Hospital Back-Up program from the current average of 58 days to no more than five days. The additional funding also provides for the development of training materials and the presentation of statewide trainings on the new Hospital Back-Up admission process for hospital discharge planners, nursing facilities, and Single Entry Point agencies. This increase in funding resulted in a final appropriation of $1,824,966 total funds for FY 2009-10.

For FY 2010-11 the Department requests $1,744,966 total funds which includes an annualization of $80,000 for BRI-2 "Medicaid Program Efficiencies."

EXTERNAL QUALITY REVIEW

This budget item provides funding for the Department's contractor, Health Services Advisory Group, Inc., to validate performance improvement projects and Healthcare Effectiveness Data and Information Set (HEDIS) measures for managed care organizations, the Primary Care Physician Program, and fee-for-service providers. Health Services Advisory Group, Inc. also provides an annual report of activities and recommendations. The contractor is responsible for the day-to-day administration and management of a credentialing program for Medicaid providers. The process includes, but is not limited to:

- collection and verification of the status of licensure;
- validation of Drug Enforcement Agency or Controlled Dangerous Substances certification;
- verification of relevant training, experience, and board certification;
- maintenance of records on any past liability claims;
- tracking of United States Department of Health and Human Services, Medicare and Medicaid sanctions; and
- verification of work history.

Through the credentialing process, the contractor verifies the credentials of approximately 33% of the primary care providers enrolled in the Primary Care Physician 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 helps the Department identify 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 C.F.R. §438.320 and 42 CFR §433.15 (b)(10).

In FY 2007-08, SB 07-211 "Health Care for Children" provided one-time funding in the amount of $70,000 total funds to consult with clinical advisors and develop clinical standards and methods of collecting, analyzing, and disclosing clinical performance information to assess children's health outcomes. In FY 2008-09 the Department's appropriation was reduced by $70,000 to annualize the one-time funding from SB 07-211. As a result, the final appropriation for FY 2008-09 for this budget item was $812,193 total funds. In FY 2009-10 the Department received continuation funding in the amount of $812,193 total funds.

The Department is requesting funding in the amount of $1,466,436 total funds for FY 2010-11 which includes an annualization of $49,463 total funds from HB 09-1293 "Health Care Affordability Act" and $604,780 total funds from DI-6, Medicaid Value-Based Care Coordination Initiative.

DRUG UTILIZATION REVIEW

This budget item funds the Department's drug utilization review program established pursuant to 42 C.F.R. §456.703. 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. Pursuant to 25.5-5-506 (3) (b), C.R.S. (2009), the Department submits an annual report to the Health and Human Services Committees of 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 quality of care; and
- an estimate of the cost savings generated as a result of the drug use review program.

The Department's drug utilization review program was implemented in six phases:

- Phase I, effective December 15, 2003, developed prior authorization reviews for certain sleeping agents, a non-steroid, anti-inflammatory, short-term pain medication, certain anti-migraine products, and certain anti-nausea products.
- Phase II, effective March 4, 2004, included certain atypical antipsychotics, two narcotic pain medications and COX-2 pain inhibitors.
- Phase III, effective February 2005, included two asthma treatment drugs and three skin infection treatment drugs for which less expensive alternative prescriptions existed.
- Phase IV, effective March 1, 2007, implemented prior authorizations for stimulant medications, Zantac liquid, Tramadol, narcotic analgesics containing acetaminophen, certain injectable medications, Methadone, Provigil, and Fentora.
- Phase V, effective February 1, 2008, implemented the Preferred Drug List (PDL) authorized by Executive Order D 004 07. The program provides needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. It also formed a Pharmacy and Therapeutics Committee which evaluates clinical data and evidence on all drugs under consideration for inclusion in the PDL. The Department also evaluated and pursued supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.
- Phase VI, effective FY 2008-09, continued the addition of drug classes to the PDL. The Department added 12 more drug classes by the end of FY 2008-09.

The Department submitted BRI-2, "Decrease Drug Utilization Review Funding" in its November 1, 2006 FY 2007-08 Budget Request. This BRI requested a reduction in funding in the amount of $84,832 for vendor contracts beginning in FY 2007-08. The request also included a technical adjustment that restored the federal financial participation for the budget item to 75%, which was inadvertently changed as a result of SA-6, BA-1, "Revisions to the Medicare Modernization Act Implementation," submitted in the Department's FY 2005-06 Supplemental and FY 2006-07 Budget Request Amendment on January 3, 2006. The reduction in the amount of $84,832 was approved in the FY 2007-08 Long Bill, SB 07-239. HB 07-1021 created the Prescription Drug Information and Technical Assistance Program to provide advice about prescription drugs to Medicaid clients, adding $16,950 total funds to the appropriation.

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 (S-9, B-3, "Implement Preferred Drug List," FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, January 2, 2008). The net result was a reduction of $61,000 total funds for FY 2007-08, leaving a final appropriation of $243,143. As part of the Department's January 2, 2008 submission, it requested under BA-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.

In FY 2009-10 the Department was appropriated $210,483 total funds per the FY 2009-10 Long Bill, SB 09-259. This total amount included an annualization of $172,680 from BA-3 "Implement Preferred Drug List."

The Department is requesting $233,818 total funds for FY 2010-11 which includes an annualization of $23,335 total funds from HB 09-1293 "Health Care Affordability Act."

MENTAL HEALTH EXTERNAL QUALITY REVIEW

This budget item funds federally-required external quality review activities that receive 75% federal financial participation when the activities are conducted by an external quality review organization as defined in 42 C.F.R. §438.320 and 42 C.F.R. §433.15 (b)(10). Federal statute at 42 C.F.R. §456.1 requires a statewide utilization control program of all Medicaid services. Federal statute located at 42 C.F.R. §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 budget item is specific to mental health services.

The Department's contractor, Health Services Advisory Group, Inc., is responsible for six 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 reviews 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 organization's 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 behavioral health organizations must meet the Department's Quality Strategy in order to promote safe and effective health care. The contractor uses 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 no more than two performance improvement projects conducted by each behavioral health organization each year. 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 (the Department's Supplemental Bill) established an appropriation of $352,807 for Mental Health External Quality Review in FY 2004-05 and the appropriation has remained at this level.

The Department is requesting continuation funding of $352,807 for FY 2010-11.

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item funds various audit contracts managed by the Department. 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 budget 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. The budget item School Health Services Program Auditor was added as a result of DI-17, "School Health Services Program Auditor" (November 3, 2008 FY 2009-10 Budget Request) and the budget item Colorado Indigent Care Program Auditor was added as a result of HB 09-1293, "Health Care Affordability Act." This line item received an appropriation of $2,272,266 in total funds for FY 2009-10, which is comprised of $919,283 General Fund and $1,352,983 federal funds. Of this total amount, $1,227,366 was for Nursing Facility Audits, $499,200 was for Hospital and Federally Qualified Health Clinics Audits, $112,000 was for Single Entry Point Audits, and $433,700 was for School Health Services Auditor. No funding was appropriated for FY 2009-10 for the Payment Error Rate Measurement Contract, Nursing Facility Appraisals or Colorado Indigent Care Program Auditor.

The Department's FY 2010-11 base request for the Professional Services Contracts line item is for funding in the amount of $3,640,513 for the budget items described below.

NURSING FACILITY AUDITS

This budget item funds statutorily required audits of 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 procurement period expired June 30, 2009; however, a new competitive procurement was not conducted. The Department extended the current period through FY 2009-10 and the Department anticipates a new competitive procurement will be completed by the start of FY 2010-11.

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 the appropriated amount due to increased technical audit requirements and costs on the part of the contractor. As a result, the Department requested $233,350 in additional funding (S-6, "Nursing Facility Audits Reconciliation to Recent Bid," FY 2004-05 Supplemental Requests, January 3, 2005). The request was authorized by SB 05-112, the Department's supplemental bill. As a result, the FY 2004-05 appropriation for this budget item was increased to $1,097,500. The appropriation remained at this level through FY 2008-09. Due to the passage of HB 08-1114, "Reimbursement of Nursing Facilities Under Medicaid," the Department requested a total of $144,600 additional one-time funding for audits to be done in order to implement the new reimbursement structure required by the bill (S-11, "Nursing Facility Audits to Implement HB 08-1114" FY 2008-09 Supplemental Request, January 2, 2009). These audits were funded with 50% cash funds from the Nursing Facility Cash Fund and 50% federal funds to bring the FY 2008-09 total appropriation to $1,242,100.

The FY 2009-10 Long Bill, SB 09-259, appropriated $1,227,366 for this budget item, which includes a $129,866 increase to cover the overall increase in costs associated with conducting audits of nursing facilities (DI-14, "Nursing Facility Audit Reprocurement," November 3, 2008 FY 2009-10 Budget Request). The Department requests continuation funding for FY 2010-11.

HOSPITAL AND FEDERALLY QUALIFIED HEALTH CENTERS AUDITS

This budget item funds a Department contract 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 participates in 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.

In FY 2007-08, the Long Bill (SB 07-239) appropriated a total of $499,200 for these audits. The Department's contractor conducted 106 audits which resulted in $17,530,973 in total costs avoided. The appropriation has remained at this level through FY 2009-10 and the Department requests continuation funding for FY 2010-11.

SINGLE ENTRY POINT AUDITS

This budget 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 budget item in DI-5, "Increased Funding for Single Entry Point Audits," in its November 15, 2005 FY 2006-07 Budget Request 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, 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 appropriation has remained at this level through FY 2009-10 and the Department requests continuation funding for FY 2010-11.

PAYMENT ERROR RATE MEASUREMENT PROJECT CONTRACT

This budget item funds the Payment Error Rate Measurement Project, which 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 FY 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.

On August 28, 2006, the Centers for Medicare and Medicaid Services issued an interim final rule stating 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. The last time Colorado was required to conduct eligibility and payment error reviews for Medicaid and the Children's Basic Health Plan was 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 funds were requested so that a contractor could create and populate a database to review and verify the accuracy of provided documentation (S-5 and BA-1, "Revised Federal Rule for Payment Error Rate Measurement Program, submitted 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 (FY 2007-08 Figure Setting, February 14, 2007, page 85). As a result, the Department received total funds of $147,126 for FY 2006-07 (FY 2006-07 Supplemental Bill, SB 07-163) and $441,375 for FY 2007-08 (FY 2007-08 Long Bill, SB 07-239). The FY 2007-08 appropriation was $294,249 higher than the FY 2006-07 appropriation because the FY 2007-08 Payment Error Rate Measurement contract encompasses a full year of services (FY 2007-08 Figure Setting, February 14, 2007, page 84).

Under the Payment Error Rate Measurement project, reviews are conducted in three areas: fee-for-service, managed care, and eligibility for both Medicaid and Children's Basic Health Plan. For FY 2006-07 and FY 2007-08, the claims review was conducted by federal contractors, whereas the eligibility review was conducted by the states. The results of these reviews are used to produce national program error rates as well as state-specific program error rates. According to a Centers for Medicare and Medicaid Services press release on November 18, 2008, national error rates were 10.5%, or $32.7 billion for Medicaid and 14.7%, or $1.2 billion for the State Children's Health Insurance Program (Children's Basic Health Plan in Colorado).

Colorado specific error rates were as follows:

Components	Medicaid Sample Size	Medicaid Error Rate	CBHP Sample Size	CBHP Error Rate
Overall	**1,296**	**6.02%**	**776**	**6.12%**
Fee-For-Service	520	5.42%	-	-
Managed Care	272	0.11%	272	0.12%
Eligibility Payment Error Rate	504	1.20%	504	6.01%

The majority of Medicaid and Children's Basic Health Plan claim errors were due to inadequate documentation, as providers either did not submit medical records when requested or did not submit additional records when requested. For Medicaid and Children's Basic Health Plan eligibility errors, the majority of them were because: 1) reviewers were unable to obtain case files, 2) reviewers were unable to verify Deficit Reduction Act of 2005 documents, or 3) eligibility files contained inaccurate income calculations.

For FY 2010-11, the Department's base request is $588,501 with $147,125 General Fund, 102,988 cash funds (from the Children's Basic Health Plan Trust) and $338,388 in federal funds.

NURSING FACILITY APPRAISALS

This budget item funds nursing facility appraisals which 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 25.5-6-201, C.R.S. (2009). The per diem rate paid to nursing facilities is based in part on the fair rental value of the facility. For the appraisals conducted in FY 2006-07, the Department requested 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 requested for this line item in FY 2008-09 or FY 2009-10. Nursing facility appraisals are due to be conducted in FY 2010-11 and the Department requests continuation funding of $279,746.

SCHOOL HEALTH SERVICES PROGRAM AUDITOR

This new budget item funds audit services related to the School Health Services Program (for more information about the program, please refer to the Public School Health Services line item description). In 2004, the Centers for Medicare and Medicaid Services performed an audit on the certification of public expenditures and a review of Colorado's Public School Health Services program. The Centers for Medicare and Medicaid Services' report requested that the State complete an annual reconciliation of interim payments reported on the certifications of public expenditures to actual incurred expenditures at the individual school level to ensure that the state is only reimbursing providers for actual incurred costs according to the federal requirements outlined in Colorado's Medicaid State Plan.

As a result of the audit findings, the Department contracted with Public Consulting Group, Inc. to assist with developing an updated Public School Health Services rate-setting methodology. As the funding for this contract used to be in the (1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration, please see that line item description for additional information about the scope of the contract.

The Department submitted DI-17, "School Health Services Program Auditor" (FY 2009-10 November 3, 2008 Budget Request) to transfer $200,000 from the Transfers to Department of Education line item to the Professional Audit Contracts line item in order to better reflect utilization of the funding. In addition, DI-17 "School Health Services Program Auditor" transferred $233,700 in total funds from the (5) Other Medical Services; Public School Health Services line item for a contractor to assist the State in ensuring school district compliance with federal mandates and accurate cost certification. Beginning in FY 2009-10, the scope of the contract with Public Consulting Group, Inc. (PCG) includes the administration a quarterly random moment time study for the School Health Services program for three cost pools to include direct services, targeted case management, and administrative claiming. The time study administration includes collecting staff pool lists from the providers, updating the software with current provider information, calculating a statewide cost allocation percentage, monitoring time study response rates, preparing weekly reports for the compliance response rates, and assisting the Department with quarterly time study summary reports for the Centers for Medicare and Medicaid Services. In addition, PCG trains the providers, develops associated training materials, and updates templates to ensure compliance with changes in federal mandates.

The total appropriation for this budget item in FY 2009-10 was $433,700 (Long Bill, SB 09-257) and the Department requests continuation funding for FY 2010-11. This budget item is 100% federally funded.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, authorized in 25.5-4-302, C.R.S. (2009) and established by HB 91S2-1030, is operated by a contractor under supervision of the Department. The contractor pursues recoveries on a contingency fee basis and recovers funds from estates and places liens on real property held by Medicaid clients in nursing facilities or clients who are over the age of 55. Since FY 2003-04, the contractor has charged a contingency fee of 10.9%, with the remainder of the recoveries acting as an offset to the Medical Services Premiums line.

In FY 2008-09 and FY 2009-10, the Department's base appropriation for estate recovery was $700,000 total funds. In FY 2008-09, the Department recovered $3,168,375 in net estate recoveries and liens, which was slightly higher by an amount of $184,384 as compared to estate recoveries and liens collected in FY 2007-08. The Department primarily recovers residential real estate and sells the property, but it has been difficult to sell these properties and convert them into cash recoveries due to the value of the state's residential real estate market. The challenges in selling these properties is anticipated to 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 requests continuation funding of $700,000 for FY 2010-11.

(H) NURSING FACILITY PENALTY CASH FUND, NURSING FACILITY CULTURE CHANGE

This new line item was created due to the passage of HB 09-1196, "Nursing Facility Penalty Cash Fund." Funding from this line item is to be used to promote culture change in nursing facilities through training; consumer education; newsletter production; Web site development and maintenance; and other measures.

For FY 2009-10, $200,000 in cash funds was appropriated to this line item. HB 09-1196 created a Nursing Facility Culture Change Accountability Board within the Department to make recommendations to the Department and the Department of Public Health and Environment regarding the distribution of funds. In addition, HB 09-1196 requires a new annual report to be submitted jointly by the Department and the Department of Public Health and Environment to the Governor and the Health and Human Services Committee beginning in October 2010. The report will detail information regarding the amount of moneys expended for culture change, the recipients of the funds, and the effectiveness of the funds.

Beginning in FY 2010-11 and each fiscal year thereafter, 25% of the total deposits in the fund during the prior fiscal year shall be distributed for this purpose. HB 09-1196 requires that the fund balance not fall below one million dollars due to these distributions. Total estimated deposits for FY 2009-10 are $379,348 for a total estimated fund balance of $1,948,505; therefore, Department requests $94,837 in total cash funds for FY 2010-11.

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

During the FY 2009-10 Figure Setting process, the General Assembly did not adjust appropriations to reflect the enhanced Federal Medicaid Assistance Percentage (FMAP) that the State receives for Medicaid medical assistance expenditures due to the American Recovery and Reinvestment Act of 2009 (ARRA). There was a concern that a reduction to the appropriation would have made the State unable to fully fund statewide General Fund obligations when the enhanced federal medical assistance percentage FMAP expires in FY 2010-11. The State may not have been able to fund these obligations due to the requirement that General Fund appropriations growth not exceed 6% over the prior year, pursuant to Section 24-75-201.1 (1) (a) (II), C.R.S. (2009). Rather, the estimated savings due to the enhanced FMAP was reflected in the budget balancing process by the General Assembly at an aggregate overview level. With the passage of SB 09-228, "Concerning an Increase in the Flexibility of the General Assembly to Determine the Appropriate Use of State Revenues," the 6% limitation was repealed and replaced with a new spending limit based on personal income growth. This allows the state to include the enhanced FMAP in its appropriations without causing adverse consequences to the State General Fund operating budget. By including the enhanced FMAP and reducing the total General Fund appropriations, the calculation of the State's statutorily required 2.0% General Fund reserve is lowered by approximately $7 million General Fund.

In response to the Governor's June 25, 2009 directive for all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%, the Department submitted ES-5 "Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage." This request adjusts the Department's General Fund appropriations to account for the enhanced FMAP. As opposed to adjusting the appropriation for every line item in the Department's budget that is impacted by the enhanced FMAP, the request assumes the creation of a new line item for each Long Bill group which has a net zero total funds impact but accounts for the adjusted fund splits from the enhanced FMAP. This adjustment does not apply to Long Bill group (1) Executive Director's Office since there is no enhanced funding available through ARRA for administrative functions.

In order to prevent double-counting, the calculations for this proposal explicitly exclude any changes to the following line items in Long Bill group (4) Indigent Care Program: Colorado Health Care Services Fund; The Children's Hospital, Clinic Based Indigent Care; Health Care Services Fund Programs, and; Pediatric Specialty Hospital. These line items were previously adjusted for the expected additional federal funds as part of SB 09-264, section 9. Adjustments for these line-items are contained in the Department's Early Supplemental request ES-4, "Reduce Funding for Indigent Care Programs," submitted August 24, 2009.

(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. Because of the recent financial crisis, the Department has submitted a large number of Supplemental Requests and Budget Amendments which, if approved, will cause reductions to the Medical Services Premiums line item. Except where noted, those Supplemental Requests and Budget Amendments are not considered in this request. In some cases, however, overlap is unavoidable. In places where the Department's Request for Medical Services Premiums supersedes other budget actions, it will be noted in the narrative and/or the Exhibits.

2. Adjustments have been made to caseload and per capita costs for estimated impacts due to HB 05-1262, the Tobacco Tax Bill and HB 09-1293, the Health Care Affordability Act of 2009. The costs are calculated in various ways. Expenditure for the programs included in these two bills are from Cash Funds sources other than the General Fund. Adjustments to ensure that funding is requested from the Health Care Expansion Fund, for the Tobacco Tax funded programs, and from the Hospital Provider Fee Cash Fund are incorporated into Exhibit A, pages EJ-1 and EJ-2. Pages EJ-3 through EJ-8 provide detail on the components of the fund splits. Additional information is available in Exhibit J.

3. 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.

4. The Department is currently contracting with several managed care plans as managed care organizations 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.

5. 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.

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

7. Presumptive eligibility for Medicaid pregnant women was eliminated on September 1, 2004, and was reinstated by HB 05-1262, effective July 1, 2005. During the initial phase of the program, services were billed through a single contractor, which resulted in a "Presumptive Eligibility" service category in the Acute Care group. This arrangement ended January 1, 2008; therefore, expenditure in that service category has dropped to zero. Clients who are presumptively eligible receive services through fee-for-service, and expenditure is recorded in service-appropriate categories.

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. Minor differences are noted in the description of each exhibit in section IV.

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. 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. Because of the differences between the methodologies used in the original and new caseload reports, the Department restated historical Medicaid caseload through FY 2002-03. 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 of historical caseload by eligibility type.

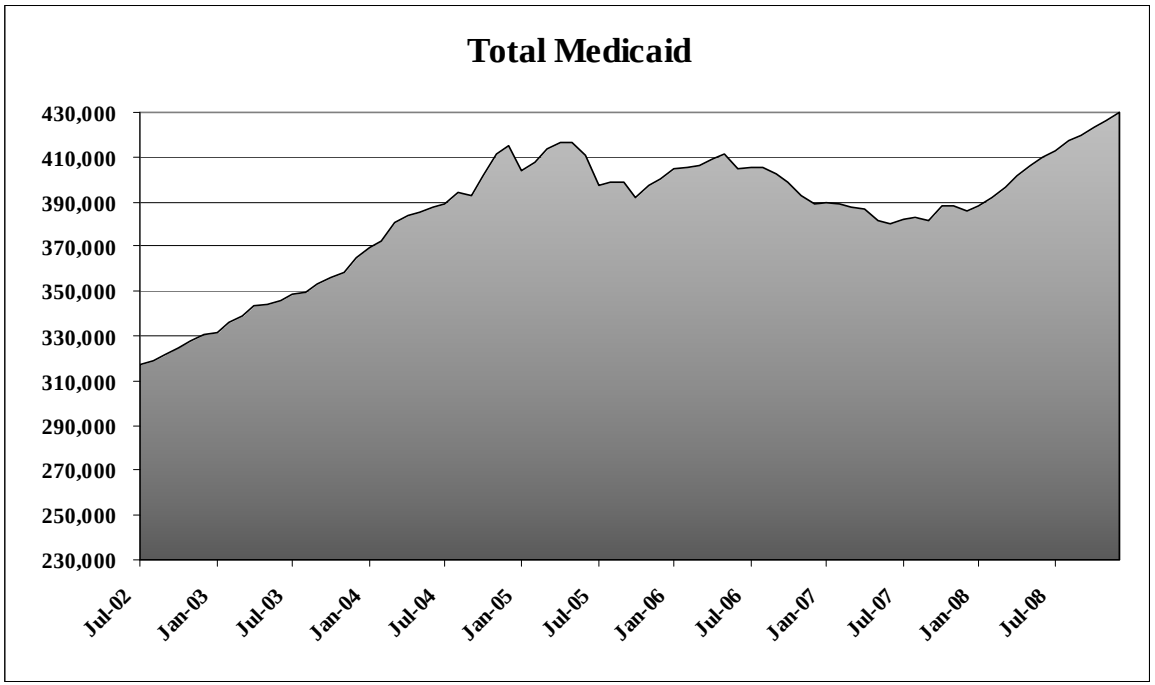
In addition to estimating the funding need for the Medical Services Premiums line item, Medicaid caseload is used to determine the funding need for the Medicaid Mental Health Community Programs. Comprehensive mental health services are available to eligible Medicaid clients. Thus, the Medicaid Mental 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	406,074	(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
FY 2008-09	436,812	(19,062)	417,750

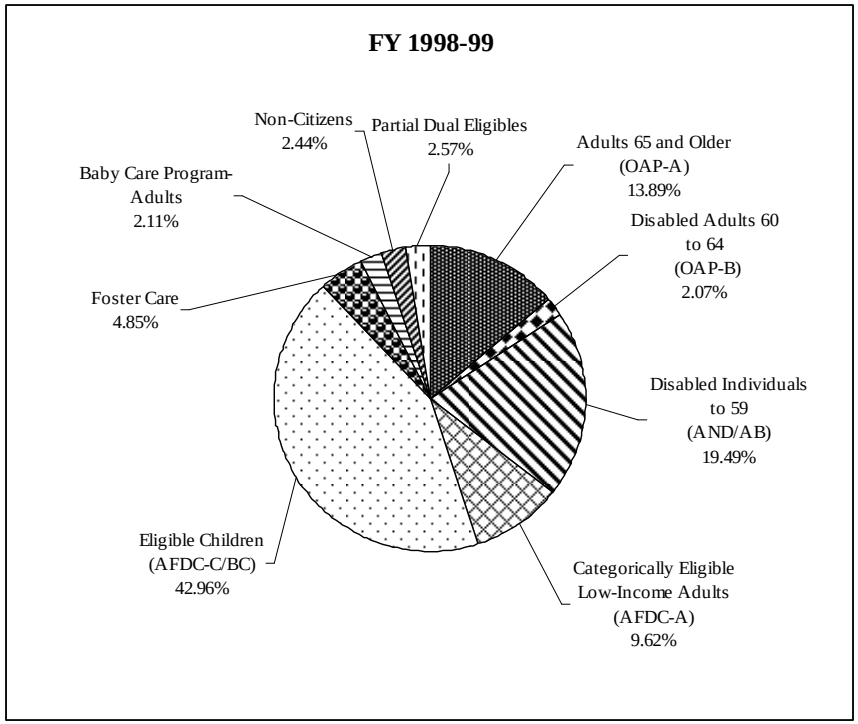
Recent Caseload History

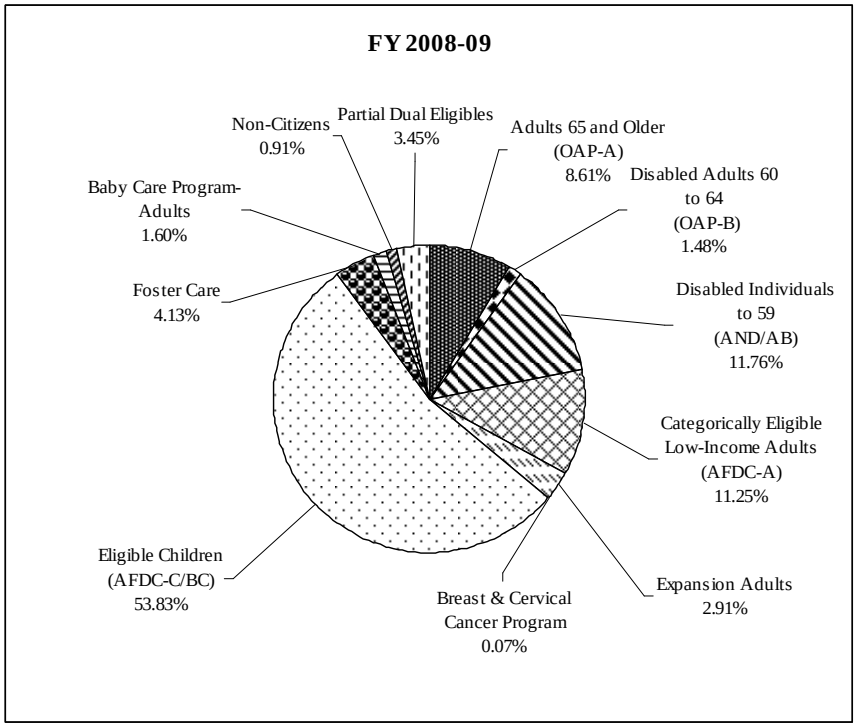
Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 1995-96 to FY 2008-09. Projections for FY 2009-10 to FY 2011-12 are also presented in the table and will be discussed in the Categorical Projections section of this document. A graphical representation of aggregate Medicaid caseload history from FY 2002-03 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. With the weakening economy, caseload continued to grow at an increasing rate in FY 2008-09, resulting in annual growth of 11.44%.



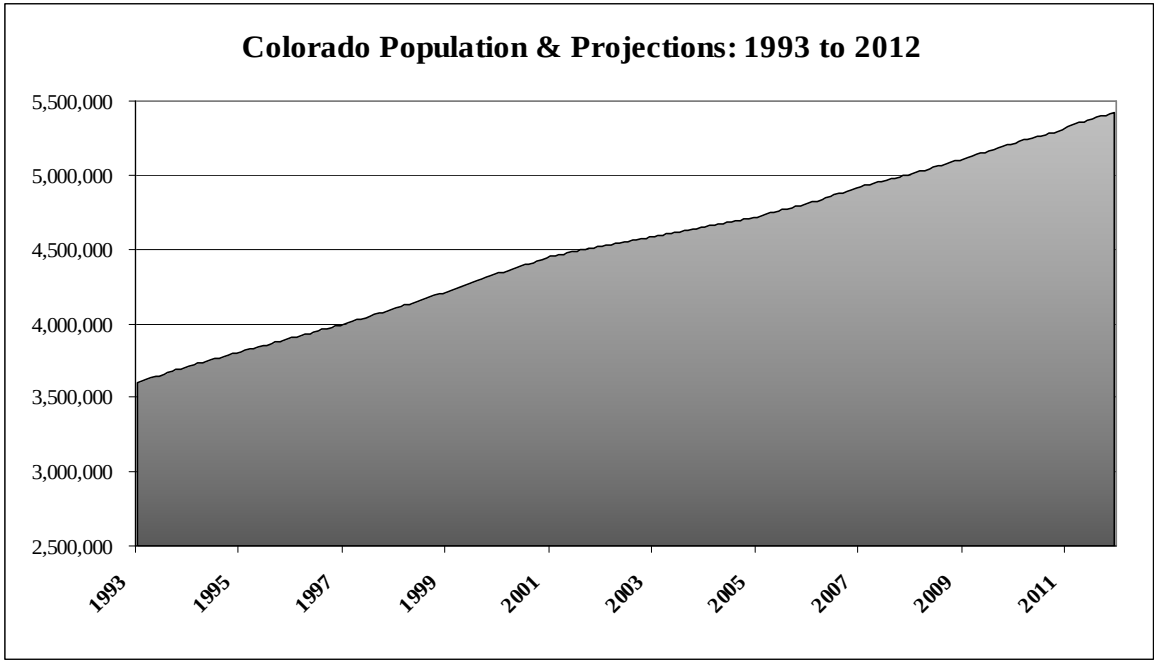
The charts below show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 1998-99 and FY 2008-09. As a percentage of the entire Medicaid caseload, Eligible Children have increased by nearly eleven percentage points, the largest gain when compared with all other categories. The percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined by approximately eight 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 21.2% from July of 1999 to July of 2009. The Department of Local Affairs forecasts that Colorado's population will increase a further 6.4% from July of 2009 to July of 2011. 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.



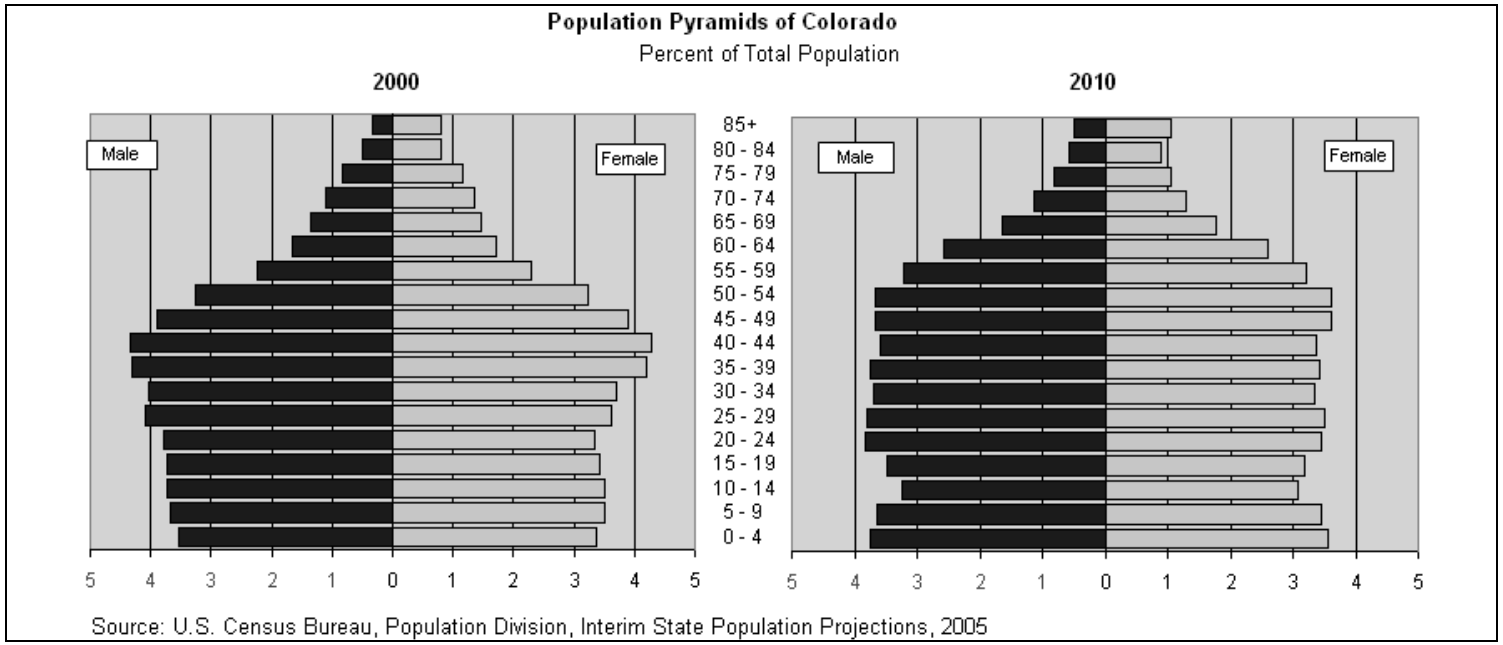
When using population data to project caseload, the Department marries population subgroups to their appropriate Medicaid category. For example, when projecting caseload for Eligible Children, the Department uses population statistics for Colorado residents aged 0 to 18. By using subgroups instead of 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[1]. 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 positive throughout the forecast period, buoyed by rates of unemployment and housing value deflation that are lower than the national average.

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

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

to seek health care. From 1999 to 2009, Colorado's median age increased by 1.8 years.[2] 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. According to 2008 data from the United States Census Bureau, Colorado had the 11th lowest median age and the 3rd lowest old-age dependency ratio (defined as the population 65 and older as a percent of population 18 to 64) in the nation.[3] While the population over 60 in Colorado is projected to increase by 36.8% between 2000 and 2010, which is expected to cause an increase in the State's median age. Additionally, Colorado's old-age dependency ratio is projected to increase from 15.6 in 2000 to 17.3 in 2010, a 10.9% increase.[4] This growth is significantly higher than the nation average, which is projected to increase by 2.8% over the same timeframe. This suggests that Colorado will be aging faster than the average state over the forecast period. In 2008, 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

[2] Source: Department of Local Affairs, Demography Division
[3] Source: 2008 American Community Survey http://www.census.gov/acs/www/
[4] Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005 http://www.census.gov/population/www/projections/index.html

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 and FY 2007-08, the average length of stay also declined. Preliminary data for FY 2008-09 indicate that the average length of stay for both low-income adults and children increased, which is consistent with economic conditions.

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
FY 2007-08	7.62	8.42
FY 2008-09	7.77	8.61

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. Employment began to soften in October 2008, when 7,200 jobs were shed over-the-year. As of September 2009, the over-the-year loss was estimated to be 120,000, or 4.8%. The employment declines have been accelerating since the downturn; for example, the over-the-year contraction in January 2009 was 43,000, or 1.8%. Current economic forecasts project declines in employment through the beginning of 2010, followed by a very moderate trend.

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
2004	$92.1	2,179,600	1.2%	5.6%
2005	$97.4	2,226,000	2.1%	5.1%
2006	$104.1	2,279,100	2.4%	4.4%
2007	$110.9	2,330,300	2.3%	3.9%
2008	$115.7	2,350,000	0.8%	4.9%
2009	$112.0	2,265,400	-3.6%	7.8%
2010	$113.3	2,272,200	0.3%	8.6%
2011	$116.0	2,294,900	1.0%	8.2%

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. 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, though states may elect to reduce this requirement to fewer than three months. Clients may receive Transitional Medicaid as long as their income is below 185% of the federal poverty level. Another small group of clients are eligible for Transitional Medicaid services that would otherwise lose their Medicaid benefits due to child or spousal support payments. Families in this group receive a four-month extension. Although this program has been set to expire many times, it has been renewed regularly, most recently through December 31, 2010. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2011-12. 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 declined between December 2005 and June 2008, but caseload increased throughout FY 2008-09. The Department expects that the Transitional Medicaid caseload will remain stable given projected economic conditions, as job growth is projected to be low in the forecast period.

[5] Source: Office of State Planning and Budgeting, September 2009 Revenue Forecast
[6] Projecting elderly and disabled client populations does not prioritize economic variables

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	16,065	9,968
FY 2007-08	13,000	7,778
FY 2008-09	13,489	7,905

Policy Changes - State and federal policy decisions can alter the Medicaid caseload. The following list briefly describes major State and 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.
- SB 07-211: Established presumptive eligibility for Medicaid children.

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 Expansion Adults and Eligible

Children forecasts to account for the approval of HB 09-1293, Colorado Health Care Affordability Act. This legislation increases eligibility for parents and caretakers of children eligible for either Medicaid or the Children's Basic Health Plan from 60% to 100% of the federal poverty level effective April 1, 2010. Additionally, the legislation allows the Department to guarantee all children in Medicaid 12 months of continuous enrollment, regardless of changes in income or family situation. All caseload estimates are taken from the fiscal note for HB 09-1293. 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 reversed as of the second half of FY 2007-08, when the Eligible Children caseload started to show significant monthly increases. Strong increases continued in FY 2008-09, with average monthly growth increasing at an increasing rate throughout the year, resulting in annual growth of 11.4%. Given the recent trends and projected economic conditions, the Department is forecasting Medicaid caseload to increase by 17.1% in FY 2009-10 to 511,411. Of the projected caseload increase of 74,599 in FY 2009-10, some 12,900 are anticipated to be the result of the Expansion Adults eligibility increase to 100% of the federal poverty level. Caseload is anticipated to continue growing at a decreasing rate through the forecast period. In FY 2010-11, the positive trend is projected to moderate to 11.0%, and caseload is forecasted to reach 567,483. As in FY 2009-10, the Expansion Adults expansion is a large factor in this projected growth rate, accounting for 30,100 of the projected 56,072 caseload increase in FY 2010-11. The following table shows actual and projected aggregate Medicaid caseload from FY 2003-04 through FY 2011-12.

Fiscal Year	Medicaid Caseload	Growth Rate	Level Growth
FY 2003-04	367,559	10.8%	35,759
FY 2004-05	406,074	10.5%	38,465
FY 2005-06	402,218	-0.9%	(3,806)
FY 2006-07	392,228	-2.5%	(9,990)
FY 2007-08	391,962	-0.1%	(266)
FY 2008-09	436,812	11.4%	44,850
FY 2009-10 projection	511,411	17.1%	74,599
FY 2010-11 projection	567,483	11.0%	56,072
FY 2011-12 projection	608,918	7.3%	41,435

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 2009 and historical and forecasted economic and demographic data

that were revised in June 2009 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 2009, the Office of State Planning and Budgeting and the Colorado Department of Local Affairs' Demography Division supplied actual and forecasted values of the following independent variables, which were used in the regression models:

- Employment - level of employment, this variable is measured in thousands;
- Unemployment Rate - the number of unemployed divided by the number in the labor force, this variable is measured as a percent;
- Total Wages - level of total wages, 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.

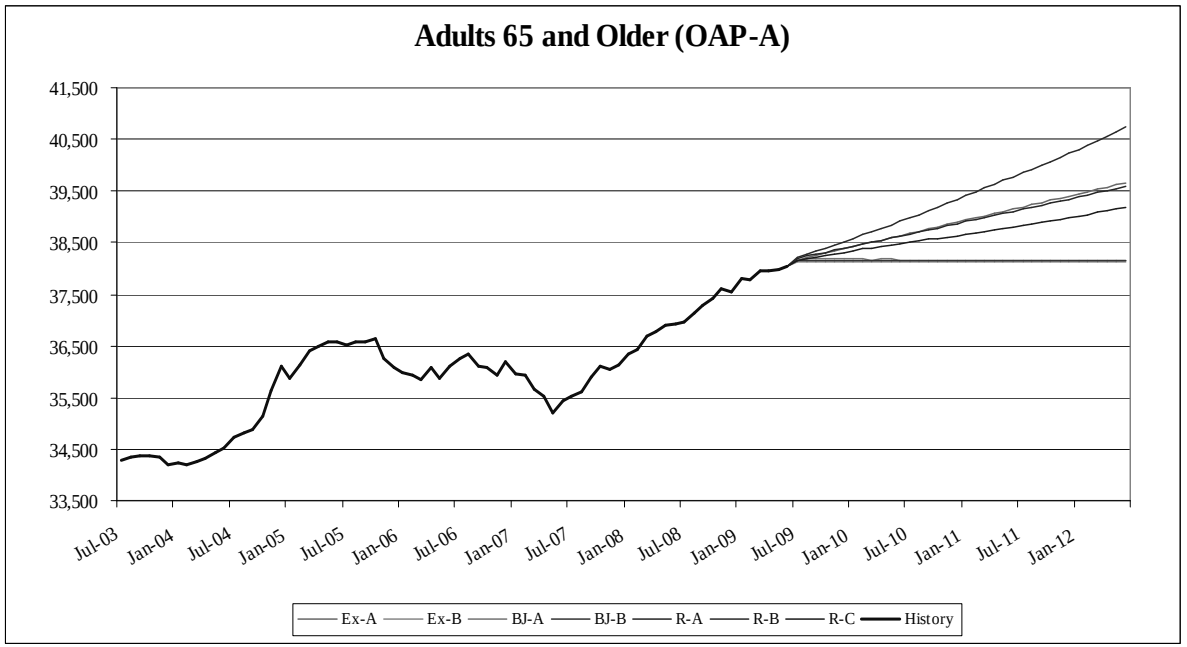
CATEGORICAL PROJECTIONS

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 2011-12 projections are included for informational purposes. Graphical representations of caseload history to FY 2003-04 are included in each categorical section.

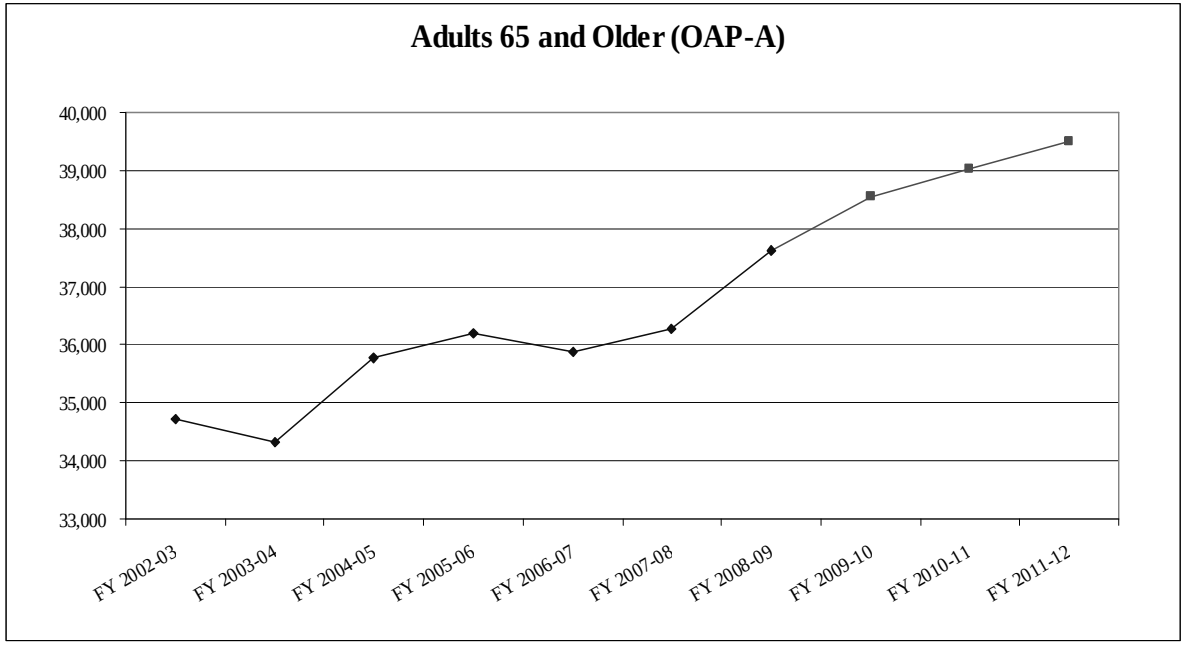
Adults 65 and Older

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 more 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*	0.9954	
Exponential Smoothing B	0.9807	
Box-Jenkins A	0.9956	
Box-Jenkins B*	0.9824	
Regression A	0.9958	OAP-A [-1], OAP-A [-2], CBMS Dummy, Auto [-1]
Regression B	0.9969	OAP-A [-1], Population 65+, CBMS Dummy, CBMS Dummy [-1], Auto [-1]
Regression C	0.9947	OAP-A [-1], Total Population, CBMS Dummy, Trend, Auto [-11]



Adults 65 and Older: Model Results						
FY 2009-10	FY 2007-08	FY 2008-09	Projected Growth Rate	Projected FY 2009-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	36,284	37,619	2.09%	38,405	786	50
Exponential Smoothing B	36,284	37,619	1.36%	38,131	512	7
Box Jenkins A	36,284	37,619	1.48%	38,176	557	11
Box Jenkins B*	36,284	37,619	1.46%	38,168	549	10
Regression A	36,284	37,619	2.11%	38,413	794	49
Regression B	**36,284**	**37,619**	**2.49%**	**38,556**	**937**	**72**
Regression C	36,284	37,619	1.87%	38,322	703	36

* Denotes Expert Selection, Bold denotes Trend Selection

Adults 65 and Older: Model Results						
FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	37,619	38,556	1.33%	39,069	513	42
Exponential Smoothing B	37,619	38,556	0.00%	38,556	0	0
Box Jenkins A	37,619	38,556	-0.01%	38,552	(4)	0
Box Jenkins B*	37,619	38,556	0.00%	38,556	0	0
Regression A	**37,619**	**38,556**	**1.23%**	**39,030**	**474**	**39**
Regression B	37,619	38,556	2.12%	39,373	817	72
Regression C	37,619	38,556	0.86%	38,888	332	27

FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	38,556	39,030	1.31%	39,541	511	42
Exponential Smoothing B	38,556	39,030	0.00%	39,030	0	0
Box Jenkins A	38,556	39,030	0.00%	39,030	0	0
Box Jenkins B*	38,556	39,030	0.00%	39,030	0	0
Regression A	**38,556**	**39,030**	**1.23%**	**39,510**	**480**	**40**
Regression B	38,556	39,030	2.31%	39,932	902	81
Regression C	38,556	39,030	0.91%	39,385	355	32

[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 2009-10: 2.49%
FY 2010-11: 1.23%
FY 2011-12: 1.23%

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 or economic conditions. Data for FY 2008-09 indicate that approximately 31.6% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (Source: MARS 474701 report).
- 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). This 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 has been strong since FY 2007-08. Between FY 2002-03 and FY 2006-07, the caseload increased by an average of 19 clients per month,

compared with 108 in FY 2007-08 and FY 2008-09. 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 Department has seen strong growth in the Home- and Community-based Services for the Elderly, Blind, and Disabled waiver over the last two years. There has also been a large increase in the number of clients in this eligibility type who are not eligible for Supplemental Security Income (SSI) or on a waiver. The Department believes this is related to caseload declines in the State-only Old Age Pension Health and Medical Care program, which were caused by the implementation of new requirements around Systematic Alien Verification for Entitlements (SAVE) to comply with HB 06S-1023 and Department regulations.

- Growth in FY 2008-09 was higher than the Department's February 2009 forecast, in which the annual caseload was projected to be 37,558. The selected trend for FY 2009-10 is in line with that from the Department's February 2009 forecast, and would result in average growth of **72 per month**. This is reflective of the monthly increases experienced over the past three years.
- 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. (2009)
(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. (2009)
(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**
Jun-07	35,448	-	-
Jul-07	35,532	84	0.24%
Aug-07	35,624	92	0.26%
Sep-07	35,916	292	0.82%
Oct-07	36,104	188	0.52%
Nov-07	36,059	(45)	-0.12%
Dec-07	36,126	67	0.19%
Jan-08	36,329	203	0.56%
Feb-08	36,418	89	0.24%
Mar-08	36,702	284	0.78%
Apr-08	36,771	69	0.19%
May-08	36,897	126	0.34%
Jun-08	36,932	35	0.09%
Jul-08	36,961	29	0.08%
Aug-08	37,127	166	0.45%
Sep-08	37,273	146	0.39%
Oct-08	37,441	168	0.45%
Nov-08	37,591	150	0.40%
Dec-08	37,530	(61)	-0.16%
Jan-09	37,814	284	0.76%
Feb-09	37,769	(45)	-0.12%
Mar-09	37,942	173	0.46%
Apr-09	37,947	5	0.01%
May-09	37,989	42	0.11%
Jun-09	38,044	55	0.14%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	31,321	-	-
FY 1996-97	32,080	2.42%	759
FY 1997-98	32,664	1.82%	584
FY 1998-99	33,007	1.05%	343
FY 1999-00	33,135	0.39%	128
FY 2000-01	33,649	1.55%	514
FY 2001-02	33,916	0.79%	267
FY 2002-03	34,704	2.32%	788
FY 2003-04	34,329	-1.08%	(375)
FY 2004-05	35,780	4.23%	1,451
FY 2005-06	36,207	1.19%	427
FY 2006-07	35,888	-0.88%	(319)
FY 2007-08	36,284	1.10%	396
FY 2008-09	37,619	3.68%	1,335
FY 2009-10	38,556	2.49%	937
FY 2010-11	39,030	1.23%	474
FY 2011-12	39,510	1.23%	480

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2008-09	37,558	3.51%	1,274
FY 2009-10	38,332	2.06%	774
FY 2010-11	39,122	2.06%	790

Actuals		
	Monthly Change	**% Change**
6-month average	86	0.23%
12-month average	93	0.25%
18-month average	107	0.29%
24-month average	108	0.28%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	38,044	1.13%	425

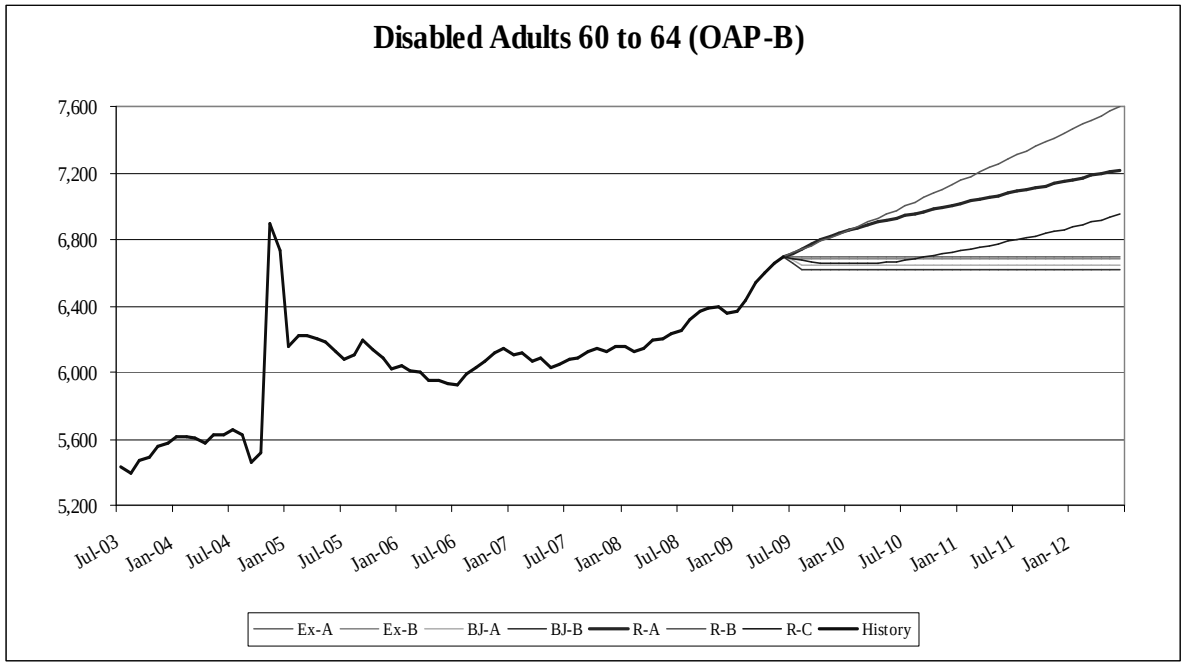
Disabled Adults 60 to 64

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

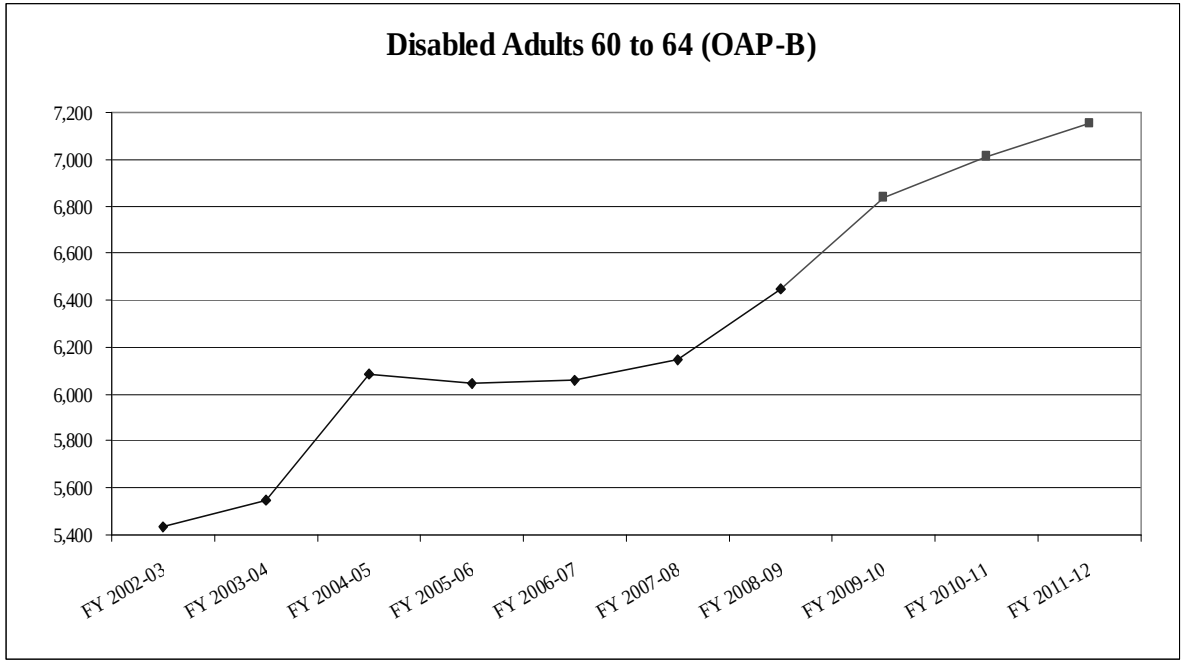
limit and limited resources. Disabled adults aged 60 to 64 who are eligible for Supplemental Security Income are included in this category. In addition, states may extend coverage to individuals with incomes above the Supplemental Security Income limit, and who meet the nursing home level of care. Referred 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*	0.9770	
Exponential Smoothing B*	0.8834	
Box-Jenkins A	0.9800	
Box-Jenkins B	0.9012	
Regression A	0.9958	OAP-B [-1], OAP-B [-3], CBMS Dummy, Auto [-4], Auto [-6]
Regression B	0.9976	OAP-B [-1], OAP-B [-3], Population 60-64, CBMS Dummy, CBMS Dummy [-2], Trend
Regression C	0.9970	OAP-B [-1], OAP-B [-2], Total Population, CBMS Dummy, CBMS Dummy [-2], Constant



Disabled Adults 60 to 64: Model Results						
FY 2009-10	FY 2007-08	FY 2008-09	Projected Growth Rate	Projected FY 2009-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	6,146	6,447	3.88%	6,697	250	1
Exponential Smoothing B*	6,146	6,447	3.68%	6,684	237	(1)
Box Jenkins A	6,146	6,447	3.07%	6,645	198	(4)
Box Jenkins B	6,146	6,447	2.64%	6,617	170	(6)
Regression A	**6,146**	**6,447**	**6.05%**	**6,837**	**390**	**20**
Regression B	6,146	6,447	6.17%	6,845	398	24
Regression C	6,146	6,447	3.33%	6,662	215	(2)

* Denotes Expert Selection, Bold denotes Trend Selection

Disabled Adults 60 to 64: Model Results						
FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	6,447	6,837	0.00%	6,837	0	0
Exponential Smoothing B*	6,447	6,837	0.00%	6,837	0	0
Box Jenkins A	6,447	6,837	-0.05%	6,834	(3)	0
Box Jenkins B	6,447	6,837	-0.05%	6,834	(3)	0
Regression A	**6,447**	**6,837**	**2.52%**	**7,009**	**172**	**12**
Regression B	6,447	6,837	4.34%	7,134	297	26
Regression C	6,447	6,837	0.98%	6,904	67	10

FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	6,837	7,009	0.00%	7,009	0	0
Exponential Smoothing B*	6,837	7,009	0.00%	7,009	0	0
Box Jenkins A	6,837	7,009	0.00%	7,009	0	0
Box Jenkins B	6,837	7,009	0.00%	7,009	0	0
Regression A	**6,837**	**7,009**	**2.04%**	**7,152**	**143**	**12**
Regression B	6,837	7,009	4.33%	7,312	303	26
Regression C	6,837	7,009	2.13%	7,158	149	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 2009-10: 6.05%
FY 2010-11: 2.52%
FY 2011-12: 2.04%

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. The Department has seen strong growth in the Home- and Community-based Services for the Elderly, Blind, and Disabled waiver over the last two years. There has also been a large increase in the number of clients in this

eligibility type who are not eligible for Supplemental Security Income (SSI) or on a waiver. The Department believes this is related to caseload declines in the State-only Old Age Pension Health and Medical Care program, which were caused by the implementation of new requirements around Systematic Alien Verification for Entitlements (SAVE) to comply with HB 06S-1023 and Department regulations.

- 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 55.1% of this population received Supplemental Security Income and are therefore automatically Medicaid eligible in FY 2008-09 (Source: MARS 474701 report). 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 2008-09 was higher than the Department's February 2009 forecast, in which annual caseload was projected to be 6,384. The selected trend for FY 2009-10 is higher than that from the February 2009 forecast, and would yield average growth of **20 per month**. The high forecasted annual growth rate for FY 2009-10 is partially due to the strong increases experienced at the end of FY 2008-09, which leaves caseload at a high starting point for FY 2009-10. It is also reflective of the increasing trend in monthly growth seen over the last two years.
- 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 increases of an average of approximately 6.8% per year over the forecast period.

25.5-5-101 (1), C.R.S. (2009)
(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. (2009)
(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**
Jun-07	6,048	-	-
Jul-07	6,073	25	0.41%
Aug-07	6,091	18	0.30%
Sep-07	6,124	33	0.54%
Oct-07	6,141	17	0.28%
Nov-07	6,127	(14)	-0.23%
Dec-07	6,150	23	0.38%
Jan-08	6,158	8	0.13%
Feb-08	6,128	(30)	-0.49%
Mar-08	6,145	17	0.28%
Apr-08	6,188	43	0.70%
May-08	6,203	15	0.24%
Jun-08	6,227	24	0.39%
Jul-08	6,249	22	0.35%
Aug-08	6,317	68	1.09%
Sep-08	6,369	52	0.82%
Oct-08	6,386	17	0.27%
Nov-08	6,399	13	0.20%
Dec-08	6,361	(38)	-0.59%
Jan-09	6,367	6	0.09%
Feb-09	6,438	71	1.12%
Mar-09	6,539	101	1.57%
Apr-09	6,597	58	0.89%
May-09	6,654	57	0.86%
Jun-09	6,691	37	0.56%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	4,261	-	-
FY 1996-97	4,429	3.94%	168
FY 1997-98	4,496	1.51%	67
FY 1998-99	4,909	9.19%	413
FY 1999-00	5,092	3.73%	183
FY 2000-01	5,157	1.28%	65
FY 2001-02	5,184	0.52%	27
FY 2002-03	5,431	4.76%	247
FY 2003-04	5,548	2.15%	117
FY 2004-05	6,082	9.63%	534
FY 2005-06	6,042	-0.66%	(40)
FY 2006-07	6,059	0.28%	17
FY 2007-08	6,146	1.44%	87
FY 2008-09	6,447	4.90%	301
FY 2009-10	6,837	6.05%	390
FY 2010-11	7,009	2.52%	172
FY 2011-12	7,152	2.04%	143

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2008-09	6,384	3.87%	238
FY 2009-10	6,544	2.51%	160
FY 2010-11	6,708	2.51%	164

Actuals		
	Monthly Change	**% Change**
6-month average	55	0.85%
12-month average	39	0.60%
18-month average	30	0.47%
24-month average	27	0.47%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	6,691	3.78%	244

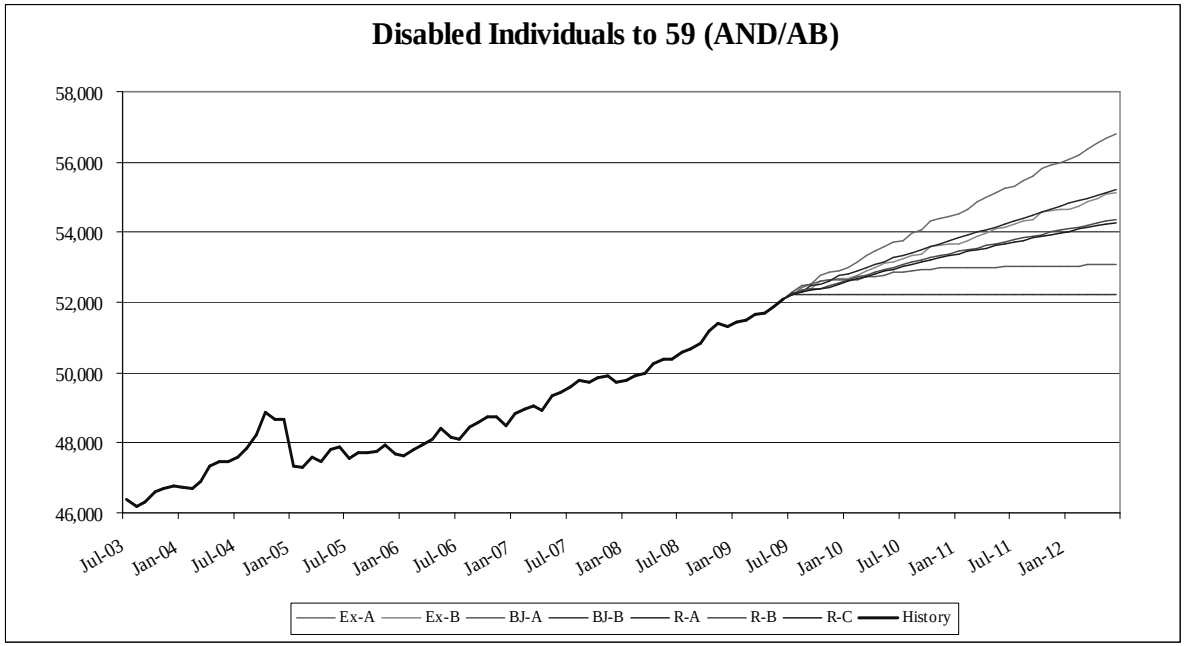
Disabled Individuals to 59

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.

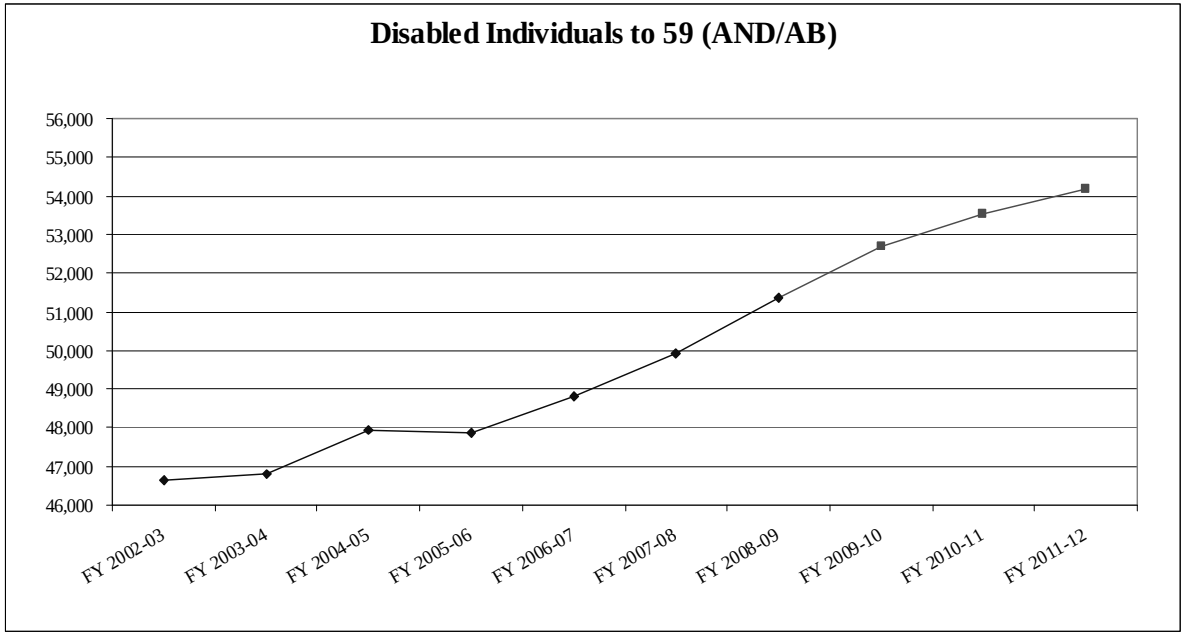
The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults. Zebley required that children's disability be measured using child appropriate activities. As a result, the number of children determined to be disabled significantly 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*	0.9945	
Exponential Smoothing B	0.9819	
Box-Jenkins A	0.9940	
Box-Jenkins B*	0.9799	
Regression A	0.9914	AND/AB [-1], Auto [-6]
Regression B	0.9834	AND/AB [-1], AND/AB [-24], Migration, Auto [-4]
Regression C	0.9834	AND/AB [-1], AND/AB [-24], Auto [-4]



Disabled Individuals to 59: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	49,933	51,355	3.18%	52,988	1,633	133
Exponential Smoothing B	**49,933**	**51,355**	**2.64%**	**52,711**	**1,356**	**88**
Box Jenkins A	49,933	51,355	2.48%	52,629	1,274	62
Box Jenkins B*	49,933	51,355	1.64%	52,197	842	8
Regression A	49,933	51,355	2.74%	52,762	1,407	96
Regression B	49,933	51,355	2.43%	52,603	1,248	75
Regression C	49,933	51,355	2.37%	52,572	1,217	70

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	51,355	52,711	2.90%	54,240	1,529	128
Exponential Smoothing B	51,355	52,711	1.87%	53,697	986	82
Box Jenkins A	51,355	52,711	0.63%	53,043	332	14
Box Jenkins B*	51,355	52,711	0.00%	52,711	0	0
Regression A	51,355	52,711	1.95%	53,739	1,028	81
Regression B	**51,355**	**52,711**	**1.53%**	**53,517**	**806**	**61**
Regression C	51,355	52,711	1.48%	53,491	780	60

Disabled Individuals to 59: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	52,711	53,517	2.82%	55,026	1,509	128
Exponential Smoothing B	52,711	53,517	1.84%	54,502	985	82
Box Jenkins A	52,711	53,517	0.16%	53,603	86	3
Box Jenkins B*	52,711	53,517	0.00%	53,517	0	0
Regression A	52,711	53,517	1.83%	54,496	979	82
Regression B	**52,711**	**53,517**	**1.24%**	**54,181**	**664**	**52**
Regression C	52,711	53,517	1.23%	54,175	658	52

[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 2009-10: 2.64%
FY 2010-11: 1.53%
FY 2011-12: 1.24%

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.
- This population has historically been stable, having increased by approximately 5,000 clients between FY 1998-99 and FY 2008-09, or an average of 1.0% per year. However, growth rates in this population have increased significantly in the last three fiscal years, with caseload in Home- and Community-Based Services waivers showing particularly strong growth.
- 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 67.9% of this population received Supplemental Security Income and are therefore automatically Medicaid eligible (Source: MARS 474701 report).

- Growth in FY 2008-09 was in line with the Department's February 2009 forecast, in which annual caseload was projected to be 51,411. The selected trend for FY 2009-10 is higher than the February 2009 forecast, and would yield average growth of 88 per month. This higher forecasted growth rate reflects the continuation of strong monthly growth experienced over the last two years.
- Out-year growth is projected to moderate and maintain a long-term trend.

25.5-5-101 (1), C.R.S. (2009)
(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. (2009)
(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**
Jun-07	49,449	-	-
Jul-07	49,590	141	0.29%
Aug-07	49,768	178	0.36%
Sep-07	49,743	(25)	-0.05%
Oct-07	49,853	110	0.22%
Nov-07	49,889	36	0.07%
Dec-07	49,741	(148)	-0.30%
Jan-08	49,785	44	0.09%
Feb-08	49,891	106	0.21%
Mar-08	49,989	98	0.20%
Apr-08	50,237	248	0.50%
May-08	50,358	121	0.24%
Jun-08	50,351	(7)	-0.01%
Jul-08	50,565	214	0.43%
Aug-08	50,671	106	0.21%
Sep-08	50,864	193	0.38%
Oct-08	51,201	337	0.66%
Nov-08	51,406	205	0.40%
Dec-08	51,298	(108)	-0.21%
Jan-09	51,452	154	0.30%
Feb-09	51,494	42	0.08%
Mar-09	51,640	146	0.28%
Apr-09	51,695	55	0.11%
May-09	51,862	167	0.32%
Jun-09	52,107	245	0.47%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	44,736	-	-
FY 1996-97	46,090	3.03%	1,354
FY 1997-98	46,003	-0.19%	(87)
FY 1998-99	46,310	0.67%	307
FY 1999-00	46,386	0.16%	76
FY 2000-01	46,046	-0.73%	(340)
FY 2001-02	46,349	0.66%	303
FY 2002-03	46,647	0.64%	298
FY 2003-04	46,789	0.30%	142
FY 2004-05	47,929	2.44%	1,140
FY 2005-06	47,855	-0.15%	(74)
FY 2006-07	48,799	1.97%	944
FY 2007-08	49,933	2.32%	1,134
FY 2008-09	51,355	2.85%	1,422
FY 2009-10	52,711	2.64%	1,356
FY 2010-11	53,517	1.53%	806
FY 2011-12	54,181	1.24%	664

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2008-09	51,411	2.96%	1,478
FY 2009-10	52,629	2.37%	1,218
FY 2010-11	53,592	1.83%	963

Actuals		
	Monthly Change	**% Change**
6-month average	135	0.26%
12-month average	146	0.29%
18-month average	131	0.26%
24-month average	111	0.23%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	52,107	1.46%	752

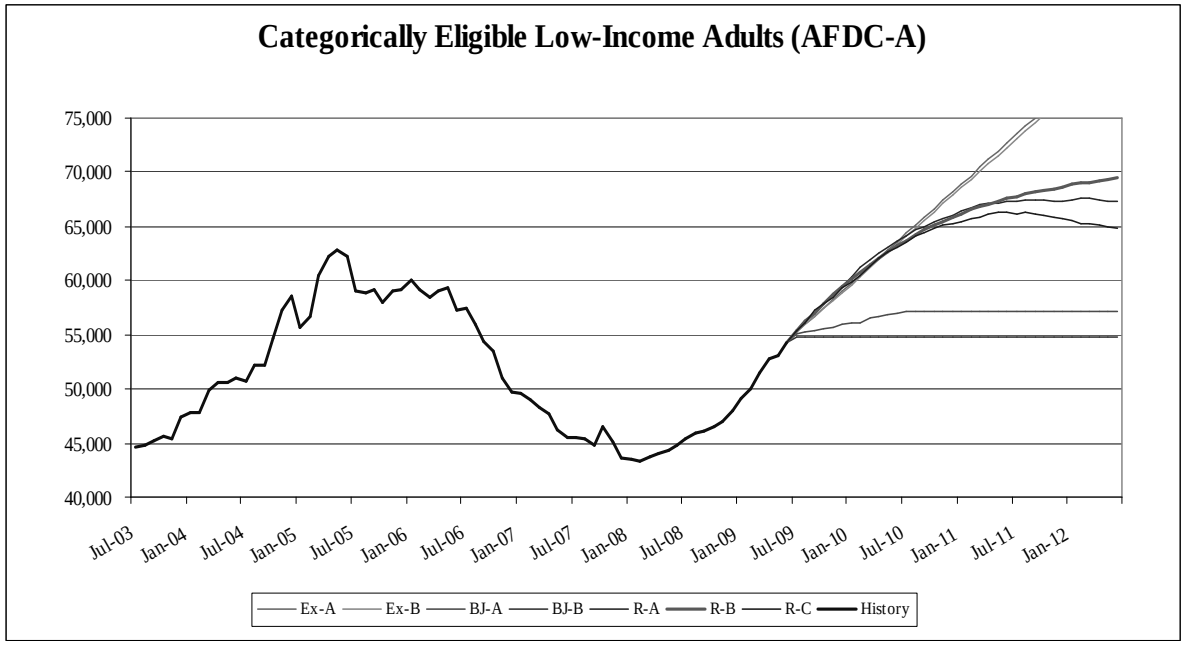
Categorically Eligible Low-Income Adults

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 2008-09, there were an average of 7,905 adults in this program. Transitional Medicaid benefits have been extended through December 31, 2010, and the Department's forecast assumes that the program will continue through FY 2011-12.

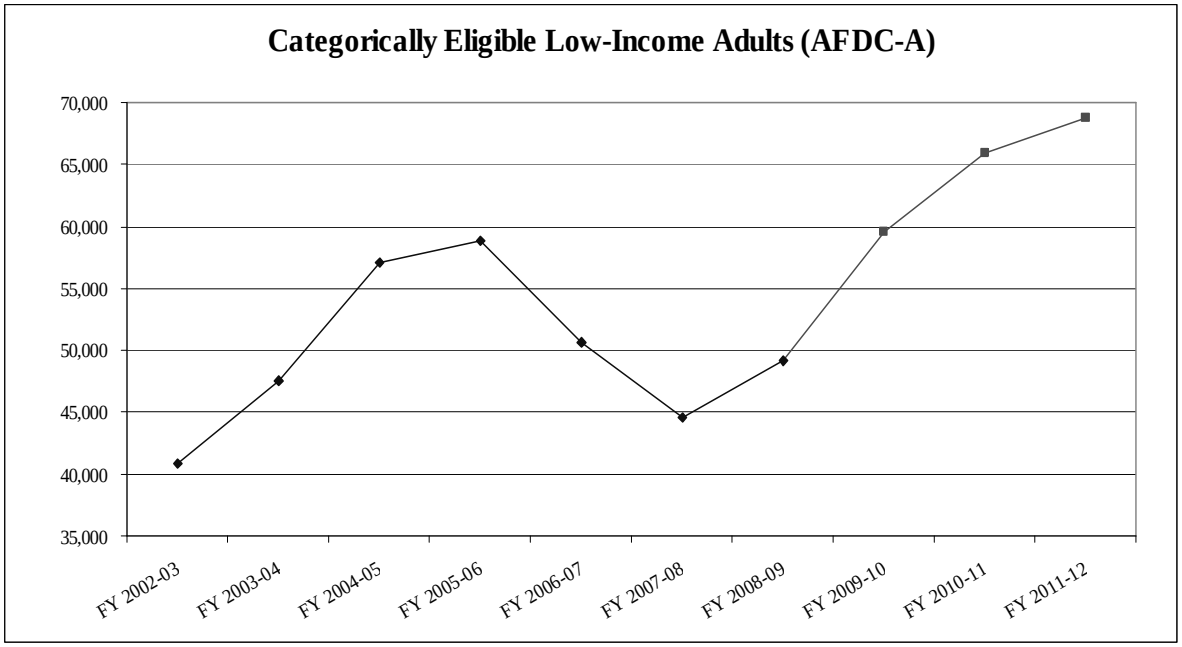
Before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash 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	0.9939	
Exponential Smoothing B	0.9882	
Box-Jenkins A*	0.9956	
Box-Jenkins B*	0.9878	
Regression A	0.9955	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, Unemployment Rate [-2], Total Wages, CBMS Dummy, Systems Dummy
Regression B	0.9955	AFDC-A [-1], AFDC-A [-9], Total Wages, CBMS Dummy, Systems Dummy
Regression C	0.9960	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, Total Wages, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Auto [-6]



Categorically Eligible Low-Income Adults: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	44,555	49,147	20.86%	59,399	10,252	785
Exponential Smoothing B	44,555	49,147	20.63%	59,286	10,139	768
Box Jenkins A*	44,555	49,147	14.01%	56,032	6,885	239
Box Jenkins B*	44,555	49,147	11.50%	54,799	5,652	53
Regression A	44,555	49,147	21.63%	59,777	10,630	787
Regression B	**44,555**	**49,147**	**21.23%**	**59,581**	**10,434**	**754**
Regression C	44,555	49,147	21.06%	59,497	10,350	747

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	49,147	59,581	15.38%	68,745	9,164	761
Exponential Smoothing B	49,147	59,581	15.06%	68,554	8,973	744
Box Jenkins A*	49,147	59,581	1.99%	60,767	1,186	9
Box Jenkins B*	49,147	59,581	0.00%	59,581	0	0
Regression A	49,147	59,581	10.49%	65,831	6,250	305
Regression B	**49,147**	**59,581**	**10.57%**	**65,879**	**6,298**	**363**
Regression C	49,147	59,581	9.64%	65,325	5,744	259

Categorically Eligible Low-Income Adults: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	59,581	65,879	13.33%	74,661	8,782	761
Exponential Smoothing B	59,581	65,879	13.09%	74,503	8,624	744
Box Jenkins A*	59,581	65,879	0.01%	65,886	7	0
Box Jenkins B*	59,581	65,879	0.00%	65,879	0	0
Regression A	59,581	65,879	2.09%	67,256	1,377	0
Regression B	**59,581**	**65,879**	**4.31%**	**68,718**	**2,839**	**161**
Regression C	59,581	65,879	0.56%	66,248	369	(123)

[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 2009-10: 21.23%
FY 2010-11: 10.57%
FY 2011-12: 4.31%

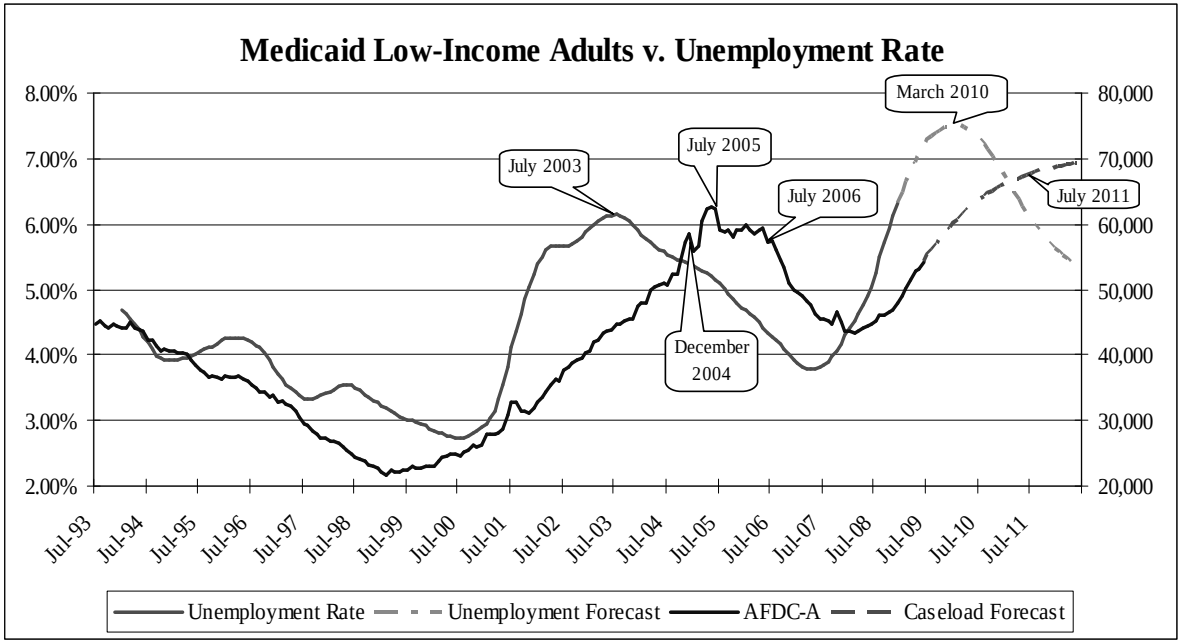
Categorically Eligible Low-Income Adults: Justifications

- Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of adults aged 19 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 2008-09. The growth in this population is projected to remain at an average of 1.4% over the forecast period[8]. The economy is projected remain weak over the forecast period, with the unemployment rate to increase from 4.9% in 2008 to 7.8% in 2009 and 8.6% in 2010. Personal income is projected to decline by 0.9% in 2009, with moderate growth of 1.6% in 2010, increasing to 4.1% in 2010.[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. Similarly, large and consistent increases since July 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.
- Growth in FY 2008-09 was much higher than the Department's February 2009 forecast, in which average caseload was projected to be 48,266. The Department believes that economic conditions are largely responsible for this, as the seasonally adjusted unemployment rate has increased from 4.8% in June 2008 to 7.6% in June 2009.[10] The last period during which the unemployment rate was increasing at a similar pace was April 2001 through April 2002. During this time, the AFDC adults caseload was increasing by approximately 1.9% per month. The selected trend for FY 2009-10 is higher than that from the February 2009 forecast, and would yield average increases of **754 per month**. This higher forecast is reflective of the consistent and accelerating

[8] Source: Department of Local Affairs, Demography Division
[9] Source: Office of State Planning and Budgeting, September 2009 Revenue Forecast
[10] Source: Bureau of Labor Statistics

increases since the second half of FY 2007-08. Because the economy is believed to be largely responsible this change, the Department believes that projected economic conditions give no indication that the trend will not continue to be large and positive through FY 2009-10.

- Current forecasts indicate that the economic conditions should begin to improve in 2010. The selected out-year trend reflects this, and the monthly increases are forecasted to moderate over the forecast period.



25.5-5-101 (1), C.R.S. (2009)
(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. (2009)
(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;

Categorically Eligible Low-Income Adults: Historical Caseload and Forecasts

Categorically Eligible Low-Income Adults: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-07	45,470	-	-
Jul-07	45,453	(17)	-0.04%
Aug-07	45,363	(90)	-0.20%
Sep-07	44,739	(624)	-1.38%
Oct-07	46,590	1,851	4.14%
Nov-07	45,100	(1,490)	-3.20%
Dec-07	43,665	(1,435)	-3.18%
Jan-08	43,491	(174)	-0.40%
Feb-08	43,344	(147)	-0.34%
Mar-08	43,723	379	0.87%
Apr-08	44,037	314	0.72%
May-08	44,349	312	0.71%
Jun-08	44,802	453	1.02%
Jul-08	45,318	516	1.15%
Aug-08	45,954	636	1.40%
Sep-08	46,099	145	0.32%
Oct-08	46,589	490	1.06%
Nov-08	47,013	424	0.91%
Dec-08	48,042	1,029	2.19%
Jan-09	49,155	1,113	2.32%
Feb-09	50,023	868	1.77%
Mar-09	51,530	1,507	3.01%
Apr-09	52,740	1,210	2.35%
May-09	53,134	394	0.75%
Jun-09	54,170	1,036	1.95%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	36,690	-	-
FY 1996-97	33,250	-9.38%	(3,440)
FY 1997-98	27,179	-18.26%	(6,071)
FY 1998-99	22,852	-15.92%	(4,327)
FY 1999-00	23,515	2.90%	663
FY 2000-01	27,081	15.16%	3,566
FY 2001-02	33,347	23.14%	6,266
FY 2002-03	40,798	22.34%	7,451
FY 2003-04	47,562	16.58%	6,764
FY 2004-05	57,140	20.14%	9,578
FY 2005-06	58,885	3.05%	1,745
FY 2006-07	50,687	-13.92%	(8,198)
FY 2007-08	44,555	-12.10%	(6,132)
FY 2008-09	49,147	10.31%	4,592
FY 2009-10	59,581	21.23%	10,434
FY 2010-11	65,879	10.57%	6,298
FY 2011-12	68,718	4.31%	2,839

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2008-09	48,266	8.33%	3,711
FY 2009-10	54,116	12.12%	5,850
FY 2010-11	57,542	6.33%	3,426

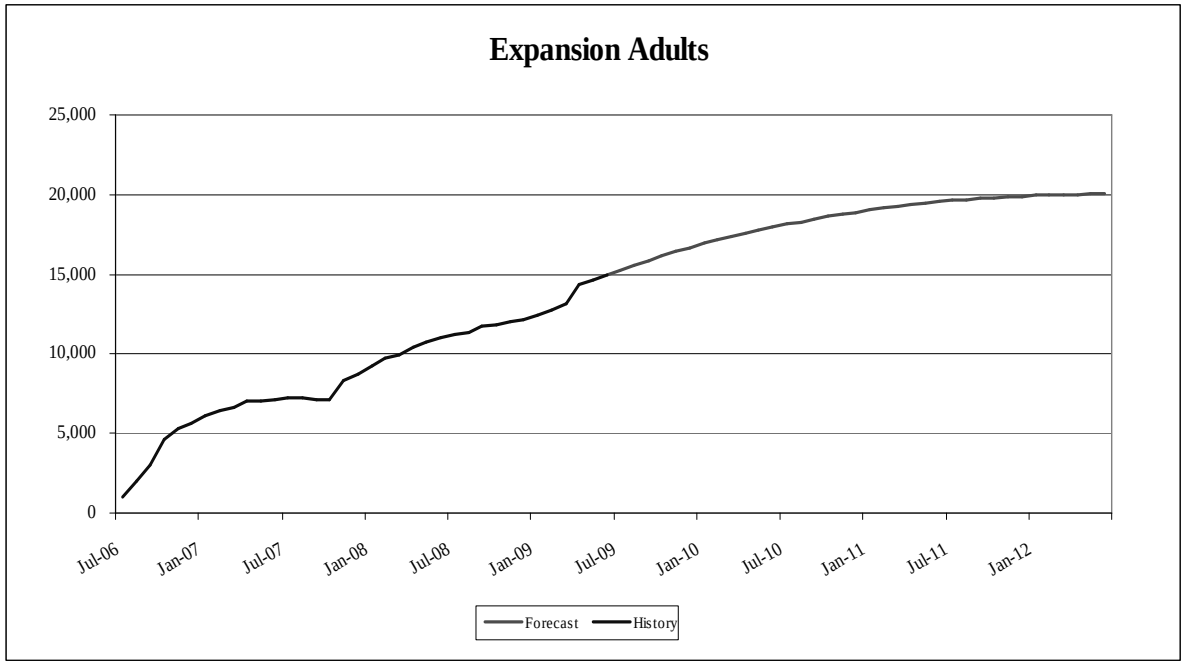
Actuals		
	Monthly Change	**% Change**
6-month average	1,021	2.02%
12-month average	781	1.60%
18-month average	584	1.21%
24-month average	363	0.98%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	54,170	10.22%	5,023

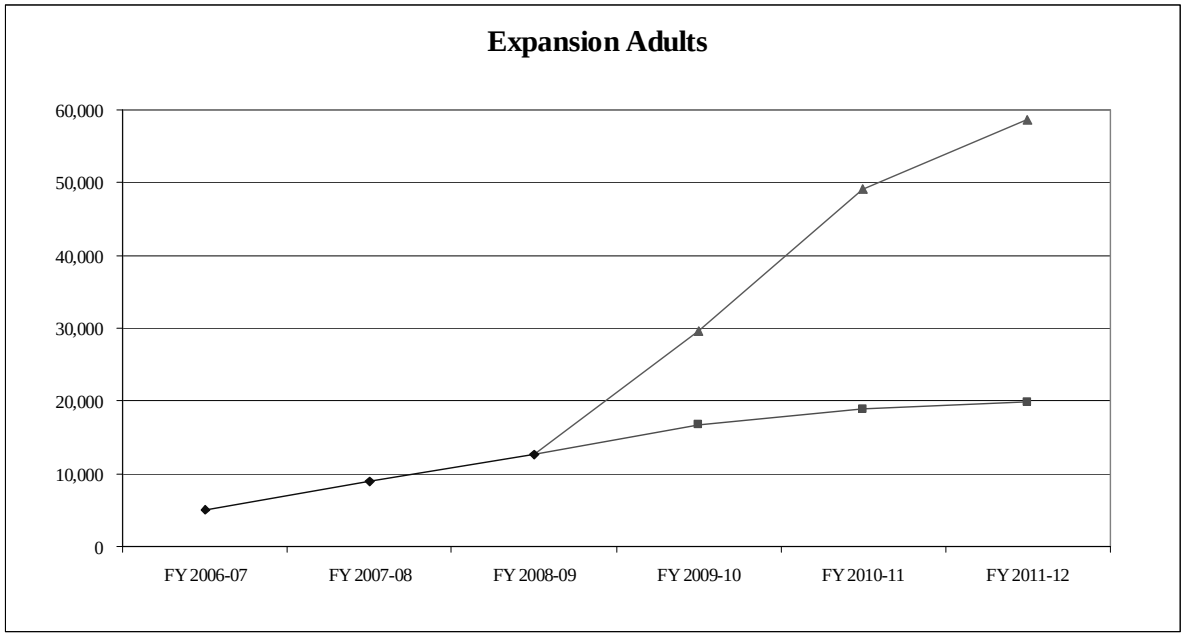
Expansion Adults

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. Pursuant to HB 09-1293, Colorado Health Care Affordability Act, eligibility in this population is to be increased to 100% of the federal poverty level effective April 1, 2010.

Expansion Adults: Model Results



Actuals		
	Monthly Change	**% Change**
6-month average	476	3.61%
7-month average	427	3.25%
8-month average	395	3.03%
9-month average	356	2.73%
12-month average	333	2.64%
18-month average	345	3.04%



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.
- Growth in FY 2008-09 was higher than the Department's February 2009 forecast, in which annual caseload was projected to be 12,316. The selected trend for FY 2009-10 is higher than that from the February 2009 forecast, and would yield average growth of **246 per month**. This forecast is based on the average monthly change experienced between June 2008 and June 2009. During this time, caseload increased by an average of 2.08% per month (excluding April 2009, which the Department believes is an anomaly). 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 future caseload growth. The FY 2009-10 forecast assumes that this growth will decrease over the course of the year, to average 1.51% per month.
- The Department assumes that growth will continue to decrease throughout the forecast period, to an average of 0.73% per month in FY 2010-11 and FY 0.21% per month in FY 2011-12. Though economic conditions may be partially responsible for the increased caseload in this group, monthly growth is expected to moderate as the eligibility category becomes established.
- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which expands eligibility for parents of children in Medicaid or the Children's Basic Health Plan from 60% to 100% of the federal poverty level effective April 2010.

25.5-5-201 (1), C.R.S. (2009)
(m) (I)(A) 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 one hundred percent;

Expansion Adults: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-07	6,846	-	-
Jul-07	7,009	163	2.38%
Aug-07	6,926	(83)	-1.18%
Sep-07	6,900	(26)	-0.38%
Oct-07	7,021	121	1.75%
Nov-07	7,975	954	13.59%
Dec-07	8,482	507	6.36%
Jan-08	8,921	439	5.18%
Feb-08	9,300	379	4.25%
Mar-08	9,608	308	3.31%
Apr-08	10,142	534	5.56%
May-08	10,447	305	3.01%
Jun-08	10,594	147	1.41%
Jul-08	10,874	280	2.64%
Aug-08	11,026	152	1.40%
Sep-08	11,570	544	4.93%
Oct-08	11,492	(78)	-0.67%
Nov-08	11,719	227	1.98%
Dec-08	11,910	191	1.63%
Jan-09	11,381	(529)	-4.44%
Feb-09	12,297	916	8.05%
Mar-09	12,912	615	5.00%
Apr-09	13,918	1,006	7.79%
May-09	14,260	342	2.46%
Jun-09	14,730	470	3.30%

	Caseload	**% Change**	**Level Change**
FY 2006-07	5,162	-	-
FY 2007-08	8,918	72.76%	3,756
FY 2008-09	12,727	42.71%	3,809
FY 2009-10	16,736	31.50%	4,009
FY 2010-11	18,937	13.15%	2,200
FY 2011-12	19,905	5.11%	968

Adjustments (HB 09-1293)	
FY 2009-10	12,900
FY 2010-11	30,100
FY 2011-12	38,700

Projections After Adjustments			
FY 2009-10	29,636	132.86%	16,909
FY 2010-11	49,037	65.46%	19,400
FY 2011-12	58,605	19.51%	9,568

February 2009 Trends			
	Caseload	**% Change**	**Level Change**
FY 2008-09	12,316	38.10%	3,398
FY 2009-10	14,430	17.16%	2,114
FY 2010-11	15,809	9.56%	1,379

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	14,730	15.74%	2,003

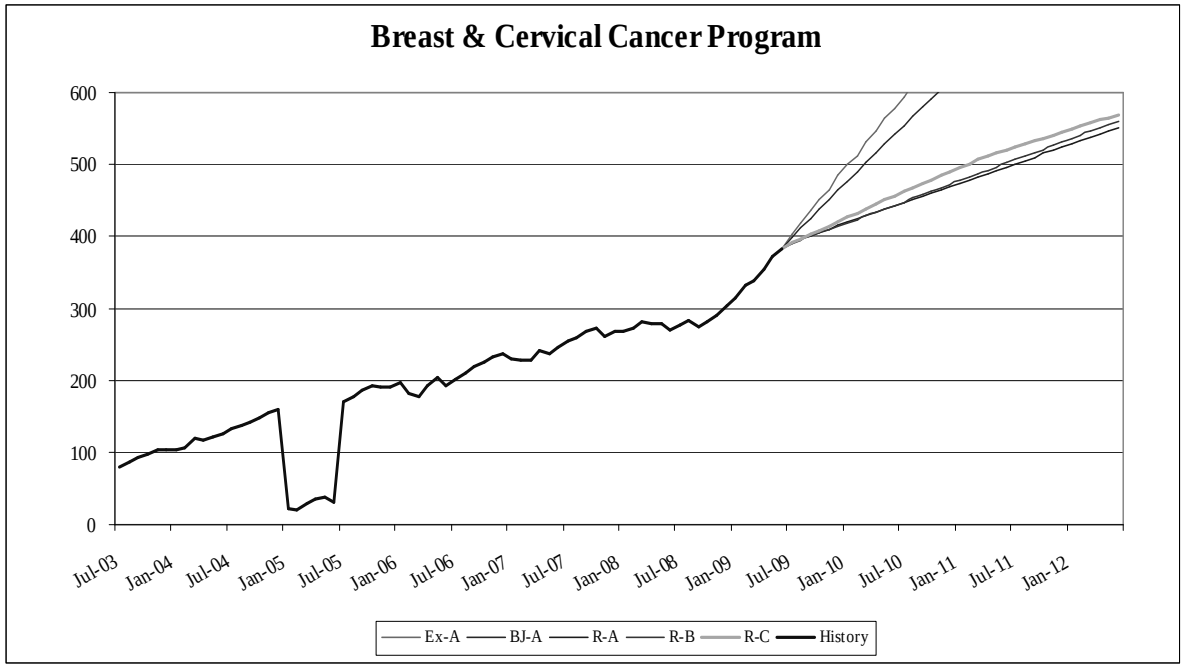
Actuals		
	Monthly Change	**% Change**
6-month average	470	3.69%
12-month average	345	2.84%
18-month average	347	3.15%
24-month average	329	3.32%

Forecasted Monthly Growth		
	Monthly Change	**% Change**
FY 2009-10	246	1.51%
FY 2010-11	136	0.73%
FY 2011-12	41	0.21%

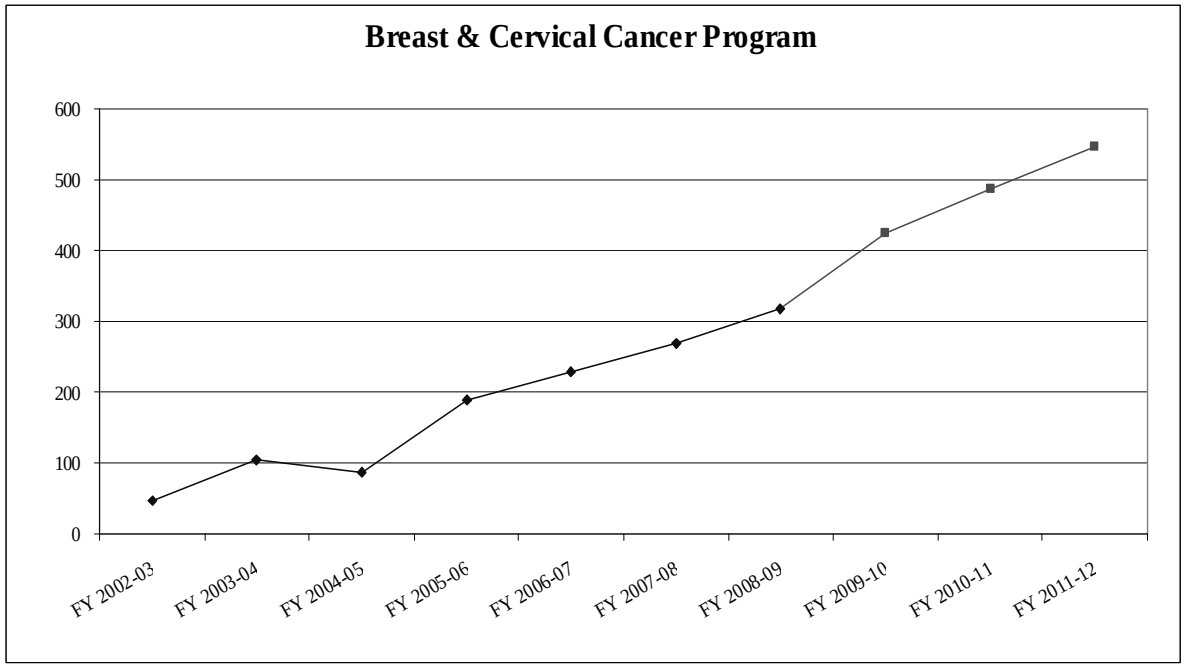
Breast and Cervical Cancer Program

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*	0.9940	
Box-Jenkins A	0.9936	
Regression A	0.9931	BCCP [-1], Female Population 19-59, Auto [-1]
Regression B	0.9931	BCCP [-1], Trend
Regression C	0.9934	BCCP [-1], Unemployment Rate, Migration



Breast and Cervical Cancer Program: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing*	270	317	54.89%	491	174	16
Box Jenkins	270	317	48.26%	470	153	13
Regression A	270	317	31.55%	417	100	5
Regression B	270	317	31.55%	417	100	5
Regression C	**270**	**317**	**33.75%**	**424**	**107**	**6**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing*	317	424	35.85%	576	152	16
Box Jenkins	317	424	30.00%	551	127	13
Regression A	317	424	11.99%	475	51	5
Regression B	317	424	12.71%	478	54	5
Regression C	**317**	**424**	**14.86%**	**487**	**63**	**5**

Breast and Cervical Cancer Program: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing*	424	487	31.18%	639	152	16
Box Jenkins	424	487	26.19%	615	128	12
Regression A	424	487	12.63%	549	62	5
Regression B	424	487	13.62%	553	66	5
Regression C	**424**	**487**	**12.32%**	**547**	**60**	**4**

[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 2009-10: 33.75%
FY 2010-11: 14.86%
FY 2011-12: 12.32%

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. These clients may be affected by economic conditions, though it may be mitigated by the specificity of the diagnoses required for eligibility.
- 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.
- 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 2008-09 was significantly higher than the Department's February 2009 forecast, in which annual caseload was projected to be 299. The selected trend for FY 2009-10 is higher than that from the February 2009 forecast, and would yield average growth of **6 per month**. The high projected annual growth rate in FY 2009-10 is partially due to strong increases at the end of FY 2008-09, which leaves caseload at a high starting point for FY 2009-10. The projected monthly growth is reflective of a return to longer term trends.
- Out-year growth is projected to continue at historic levels. As a program matures, growth is expected to slow and stabilize. The

Department believes that the Breast and Cervical Cancer program is approaching a level of maturity where, barring unforeseen circumstances, average growth of more than 2% per month should no longer expected.

25.5-5-201 (1), C.R.S. (2009)
(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 and Cervical Cancer Program: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-07	246	-	-
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%
Jul-08	277	7	2.59%
Aug-08	283	6	2.17%
Sep-08	275	(8)	-2.83%
Oct-08	282	7	2.55%
Nov-08	290	8	2.84%
Dec-08	304	14	4.83%
Jan-09	314	10	3.29%
Feb-09	331	17	5.41%
Mar-09	339	8	2.42%
Apr-09	355	16	4.72%
May-09	373	18	5.07%
Jun-09	383	10	2.68%

	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	317	17.41%	47
FY 2009-10	424	33.75%	107
FY 2010-11	487	14.86%	63
FY 2011-12	547	12.32%	60

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2007-08	299	10.74%	29
FY 2008-09	321	7.36%	22
FY 2009-10	343	6.85%	22

Actuals		
	Monthly Change	**% Change**
6-month average	13	3.93%
12-month average	9	2.98%
18-month average	6	2.03%
24-month average	6	2.15%

Base trend if caseload were to stay at the June 2009 level			
FY 2008-09	383	20.82%	66

Eligible Children

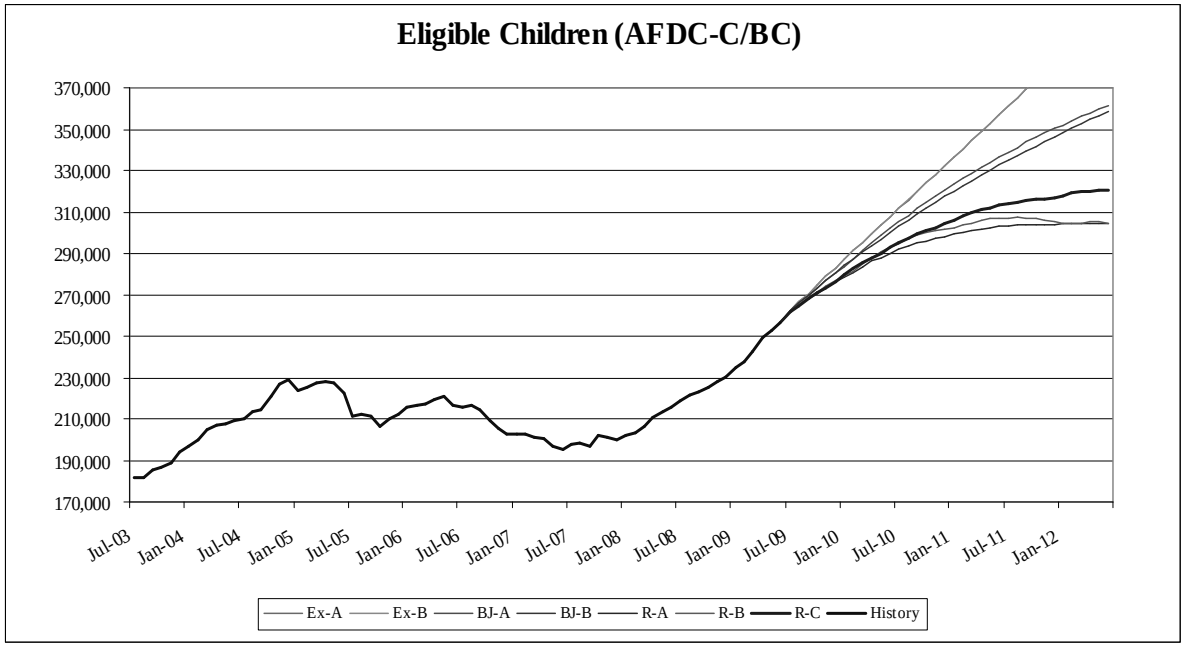
One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 2008-09, there were an average of 13,489 children on Transitional Medicaid. Authorization for Transitional Medicaid benefits was extended through December 31, 2010, and the Department's forecast assumes that the program will continue through FY 2011-12.

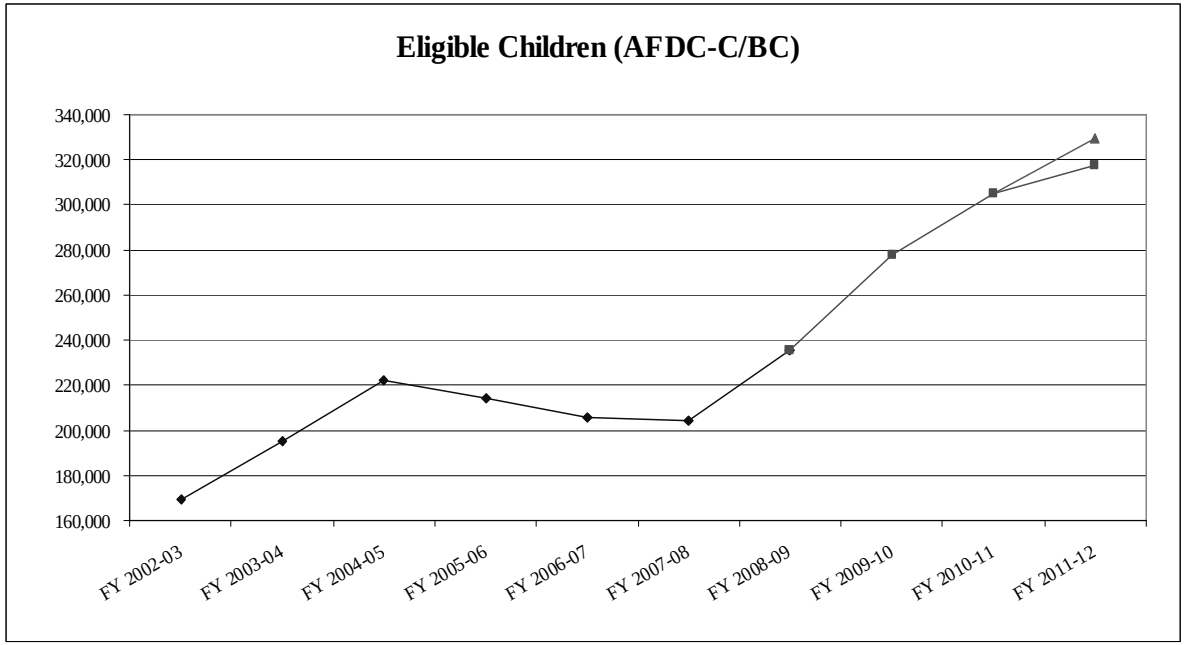
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic 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	0.9984	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, Systems Dummy, Auto [-12]
Regression B	0.9987	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Trend, Auto [-10]
Regression C	0.9985	KIDS [-1], KIDS [-7], Unemployment Rate, Population Under 19, Trend, CBMS Dummy, Systems Dummy



Eligible Children: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	204,022	235,129	21.22%	285,023	49,894	4,247
Exponential Smoothing B*	204,022	235,129	21.23%	285,047	49,918	4,250
Box Jenkins A*	204,022	235,129	20.02%	282,202	47,073	3,790
Box Jenkins B	204,022	235,129	19.81%	281,708	46,579	3,610
Regression A	204,022	235,129	17.76%	276,888	41,759	2,810
Regression B	204,022	235,129	18.18%	277,875	42,746	3,006
Regression C	**204,022**	**235,129**	**18.15%**	**277,805**	**42,676**	**3,024**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	235,129	277,805	17.28%	325,810	48,005	4,104
Exponential Smoothing B*	235,129	277,805	17.28%	325,810	48,005	4,105
Box Jenkins A*	235,129	277,805	13.92%	316,475	38,670	2,857
Box Jenkins B	235,129	277,805	13.00%	313,920	36,115	2,728
Regression A	235,129	277,805	7.73%	299,279	21,474	1,049
Regression B	235,129	277,805	8.68%	301,918	24,113	1,185
Regression C	**235,129**	**277,805**	**9.75%**	**304,891**	**27,086**	**1,681**

Eligible Children: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	277,805	304,891	14.73%	349,801	44,910	4,104
Exponential Smoothing B*	277,805	304,891	14.73%	349,801	44,910	4,105
Box Jenkins A*	277,805	304,891	9.09%	332,606	27,715	2,101
Box Jenkins B	277,805	304,891	9.06%	332,514	27,623	2,148
Regression A	277,805	304,891	1.92%	310,745	5,854	116
Regression B	277,805	304,891	1.22%	308,611	3,720	(186)
Regression C	**277,805**	**304,891**	**4.16%**	**317,574**	**12,683**	**645**

[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

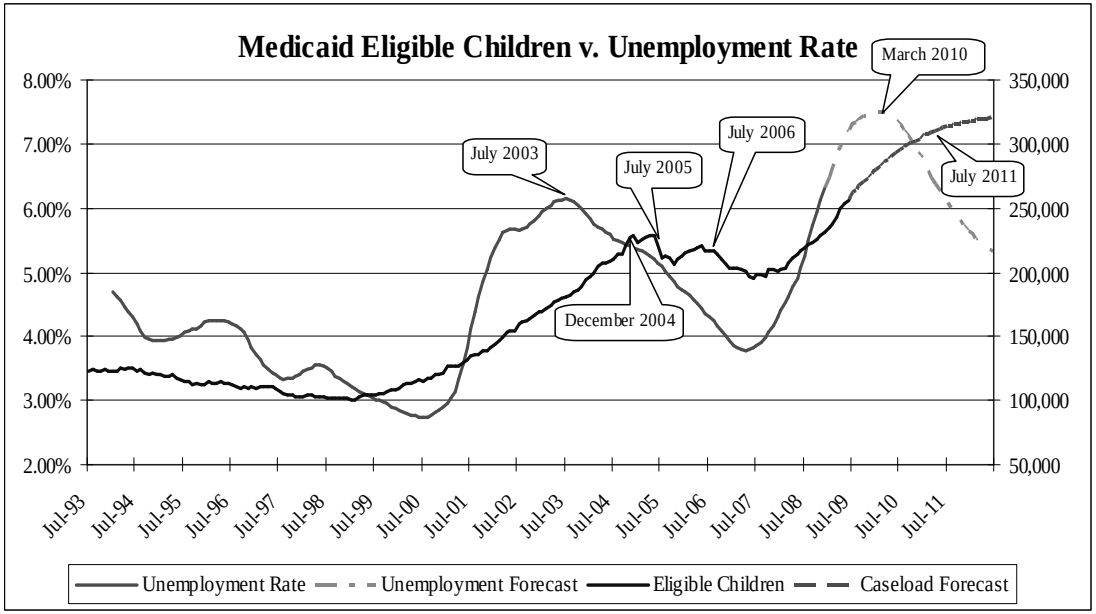
FY 2009-10: 18.15%
FY 2010-11: 9.75%
FY 2011-12: 4.16%

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 1.3% per year from FY 2002-03 to FY 2008-09. The expansion in this age group is projected to average 1.7% throughout the forecast period.[11] The economy is projected remain weak over the forecast period, with the unemployment rate to increase from 4.9% in 2008 to 7.8% in 2009 and 8.6% in 2010. Personal income is projected to decline by 0.9% in 2009, with moderate growth of 1.6% in 2010, increasing to 4.1% in 2010.[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. Similarly, large and consistent increases since January 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.

[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 do not provide proper proof of citizenship will no longer be automatically eligible for the Children's Basic Health Plan. This may increase growth in Medicaid as families find documents to ensure coverage of children.
- Growth in FY 2008-09 was much higher than the Department's February 2009 forecast, in which annual caseload was projected to be 232,585. The Department believes that softening economic conditions is partially responsible for this, as the seasonally adjusted unemployment rate has increased from 4.5% in May 2008 to 7.4% in May 2009 (source: Bureau of Labor Statistics). The last period during which the unemployment rate was increasing at a similar pace was April 2001 through April 2002. During this time, the Eligible Children caseload was increasing by 1.5% per month. The selected trend for FY 2009-10 is higher than that from the February 2009 forecast, and would yield average increases of **3,024 per month**. This high forecast is reflective of the large and consistent monthly increases since the second half of FY 2007-08. Because the economy is assumed to be at least partially responsible this change, the Department believes that projected economic conditions give no indication that the trend will not continue to be large and positive through FY 2009-10.
- Similar to the pattern seen in AFDC adults, the out-year trend is expected to temper with moderating monthly growth, reflective of projected moderating economic conditions beginning in 2010. Growth in children is expected to be higher than that in the 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.
- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which extends 12-month guaranteed eligibility to children in Medicaid beginning in January 2012. This is anticipated to increase the length of stay in the Medicaid, which will result in a caseload increase.



25.5-5-101 (1), C.R.S. (2009)
(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. (2009)
(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. (2009)
(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-07	195,549	-	-
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%
Jul-08	218,619	2,465	1.14%
Aug-08	221,736	3,117	1.43%
Sep-08	223,167	1,431	0.65%
Oct-08	225,486	2,319	1.04%
Nov-08	228,186	2,700	1.20%
Dec-08	230,447	2,261	0.99%
Jan-09	234,744	4,297	1.86%
Feb-09	237,345	2,601	1.11%
Mar-09	242,805	5,460	2.30%
Apr-09	249,444	6,639	2.73%
May-09	252,943	3,499	1.40%
Jun-09	256,630	3,687	1.46%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	113,439	-	-
FY 1996-97	110,586	-2.52%	(2,853)
FY 1997-98	103,912	-6.04%	(6,674)
FY 1998-99	102,074	-1.77%	(1,838)
FY 1999-00	109,816	7.58%	7,742
FY 2000-01	123,221	12.21%	13,405
FY 2001-02	143,909	16.79%	20,688
FY 2002-03	169,311	17.65%	25,402
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	235,129	15.25%	31,107
FY 2009-10	277,805	18.15%	42,676
FY 2010-11	304,891	9.75%	27,086
FY 2011-12	317,574	4.16%	12,683

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

Adjustments (HB 09-1293)	
FY 2009-10	0
FY 2010-11	0
FY 2011-12	12,125

Actuals		
	Monthly Change	**% Change**
6-month average	4,364	1.81%
12-month average	3,373	1.44%
18-month average	3,139	1.39%
24-month average	2,545	1.29%

Projections After Adjustments			
FY 2009-10	277,805	-12.52%	(39,769)
FY 2010-11	304,891	9.75%	27,086
FY 2011-12	329,699	8.14%	24,808

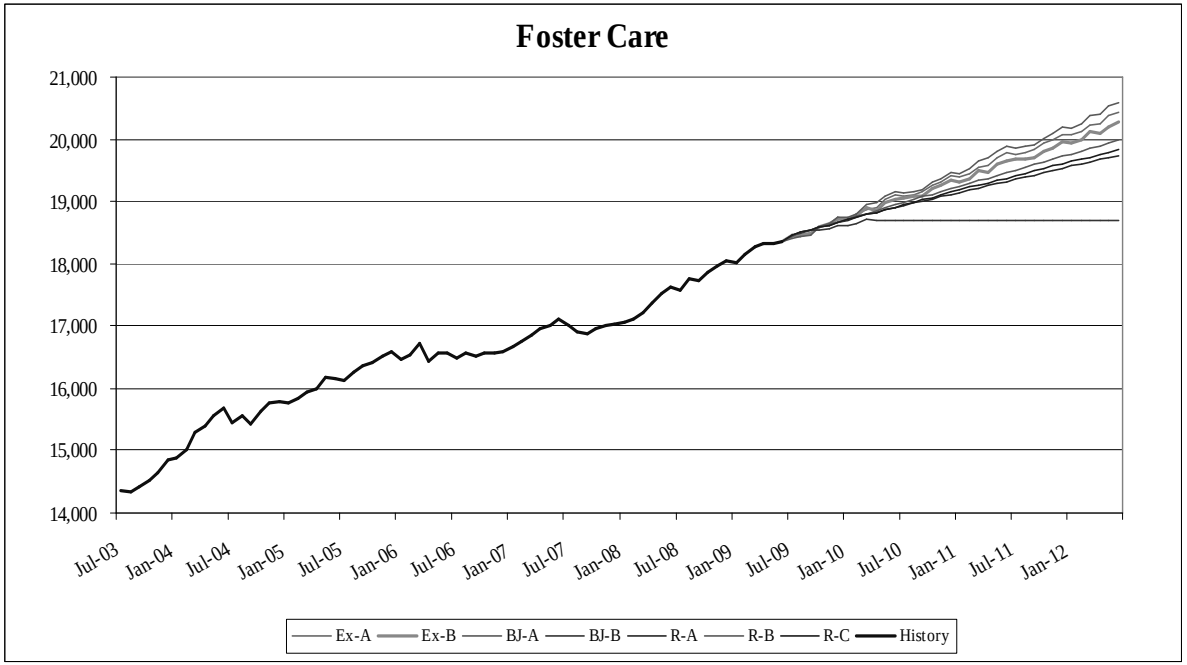
Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	256,630	9.14%	21,501

February 2009 Trends			
FY 2008-09	232,585	14.00%	28,563
FY 2009-10	257,356	10.65%	24,771
FY 2010-11	274,290	6.58%	16,934

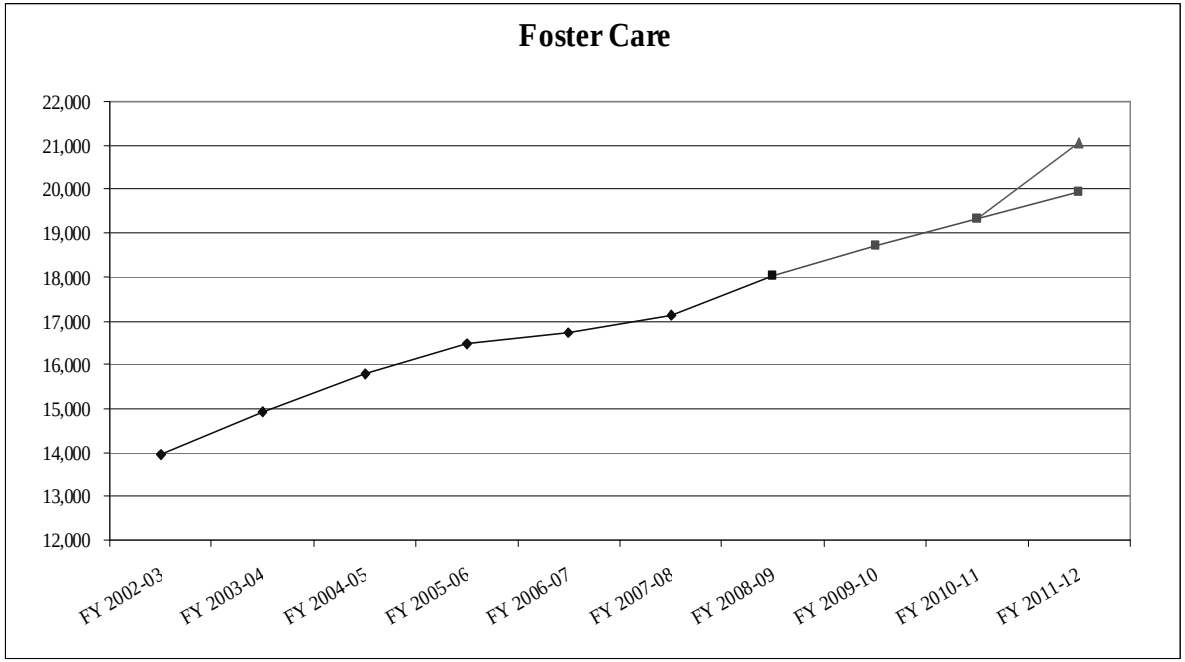
Foster Care

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 through 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	0.9982	FOSTER [-1], Population Under 19, Auto [-12]
Regression B	0.9986	FOSTER [-1], Total Population, Auto [-1]
Regression C	0.9986	FOSTER [-1], Trend, Auto [-1]



Foster Care: Model Results						
FY 2009-10	FY 2007-08	FY 2008-09	Projected Growth Rate	Projected FY 2009-10 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	17,141	18,033	3.86%	18,729	696	63
Exponential Smoothing B*	**17,141**	**18,033**	**3.78%**	**18,715**	**682**	**57**
Box Jenkins A	17,141	18,033	3.96%	18,747	714	67
Box Jenkins B	17,141	18,033	3.15%	18,601	568	29
Regression A	17,141	18,033	3.61%	18,684	651	46
Regression B	17,141	18,033	3.69%	18,698	665	49
Regression C	17,141	18,033	3.62%	18,686	653	47

* Denotes Expert Selection, Bold denotes Trend Selection

Foster Care: Model Results						
FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	18,033	18,715	3.58%	19,385	670	56
Exponential Smoothing B*	**18,033**	**18,715**	**3.28%**	**19,329**	**614**	**51**
Box Jenkins A	18,033	18,715	3.85%	19,436	721	60
Box Jenkins B	18,033	18,715	0.52%	18,812	97	0
Regression A	18,033	18,715	2.39%	19,162	447	35
Regression B	18,033	18,715	2.81%	19,241	526	44
Regression C	18,033	18,715	2.57%	19,196	481	39

FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	18,715	19,329	3.46%	19,998	669	56
Exponential Smoothing B*	**18,715**	**19,329**	**3.18%**	**19,944**	**615**	**51**
Box Jenkins A	18,715	19,329	3.70%	20,044	715	60
Box Jenkins B	18,715	19,329	0.00%	19,329	0	0
Regression A	18,715	19,329	2.17%	19,748	419	34
Regression B	18,715	19,329	2.70%	19,851	522	43
Regression C	18,715	19,329	2.38%	19,789	460	37

[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 2009-10: 3.78%
FY 2010-11: 3.28%
FY 2011-12: 3.18%

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 began to increase, which is partially due to the implementation of SB 07-002 and SB 08-099, which expanded eligibility for Foster Care through age 20.

- Growth in FY 2008-09 was in line with the Department's February 2009 forecast, in which annual caseload was projected to be 18,031. The selected trend for FY 2009-10 is in line with that from the February 2009 forecast, and would yield average growth of **57 per month**.
- Out-year growth reflects a continuation of positive growth, and a return to more moderate growth in line with historical trend.
- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which extends 12-month guaranteed eligibility to children in Medicaid beginning in January 2012. This is anticipated to increase the length of stay in the Medicaid, which will result in a caseload increase.

25.5-5-101 (1), C.R.S. (2009)
(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 (2009)
(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-07	17,100	-	-
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%
Jul-08	17,588	(32)	-0.18%
Aug-08	17,761	173	0.98%
Sep-08	17,736	(25)	-0.14%
Oct-08	17,864	128	0.72%
Nov-08	17,977	113	0.63%
Dec-08	18,033	56	0.31%
Jan-09	18,022	(11)	-0.06%
Feb-09	18,144	122	0.68%
Mar-09	18,265	121	0.67%
Apr-09	18,328	63	0.34%
May-09	18,327	(1)	-0.01%
Jun-09	18,348	21	0.11%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	8,376	-	-
FY 1996-97	9,261	10.57%	885
FY 1997-98	10,453	12.87%	1,192
FY 1998-99	11,526	10.26%	1,073
FY 1999-00	12,474	8.22%	948
FY 2000-01	13,076	4.83%	602
FY 2001-02	13,121	0.34%	45
FY 2002-03	13,967	6.45%	846
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	18,033	5.20%	892
FY 2009-10	18,715	3.78%	682
FY 2010-11	19,329	3.28%	614
FY 2011-12	19,944	3.18%	615

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

Adjustments (HB 09-1293)	
FY 2009-10	0
FY 2010-11	0
FY 2011-12	1,125

Actuals		
	Monthly Change	**% Change**
6-month average	53	0.29%
12-month average	61	0.34%
18-month average	73	0.41%
24-month average	52	0.40%

Projections After Adjustments			
FY 2009-10	18,715	3.78%	682
FY 2010-11	19,329	3.28%	614
FY 2011-12	21,069	9.00%	1,740

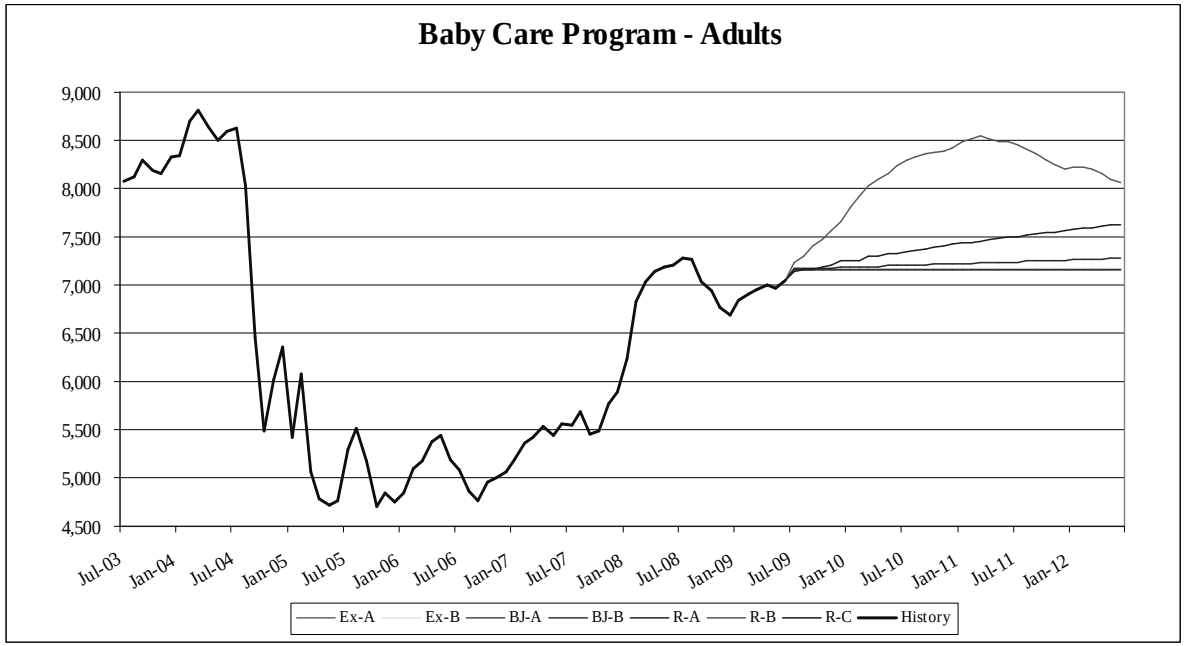
Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	18,348	1.75%	315

February 2009 Trends			
FY 2008-09	18,031	5.19%	890
FY 2009-10	18,686	3.63%	655
FY 2010-11	19,293	3.25%	607

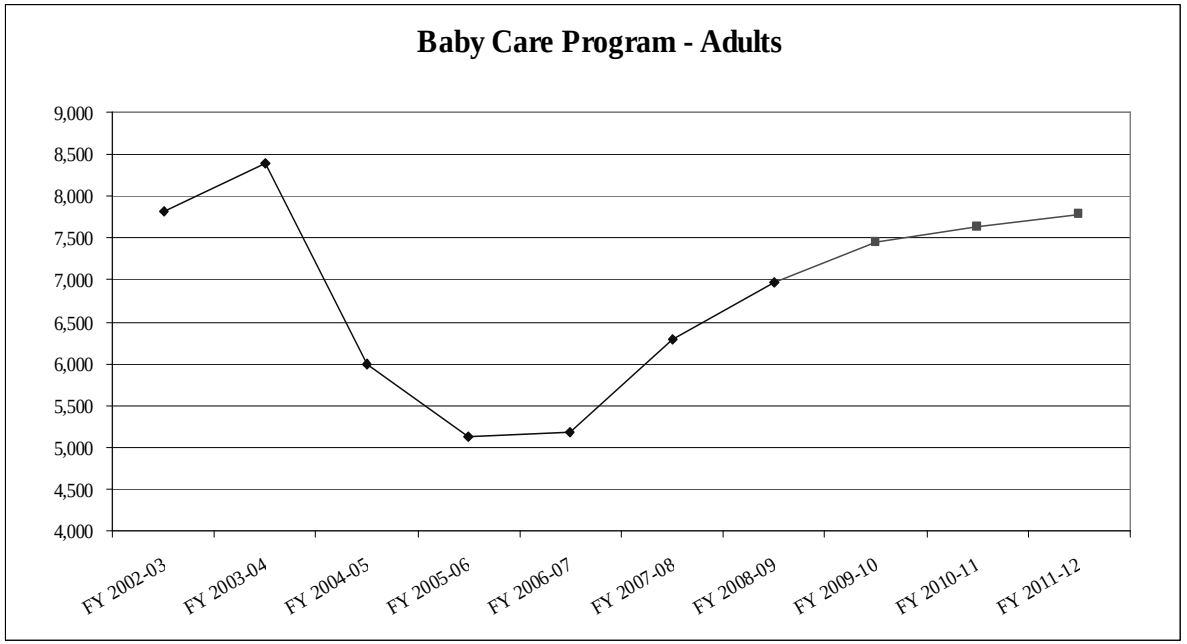
Baby Care Adults

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*	0.9466	
Exponential Smoothing B*	0.9318	
Box-Jenkins A	0.9469	
Box-Jenkins	0.9324	
Regression A	0.9563	BCA [-1], BCA Dummy
Regression B	0.9478	BCA [-1], Migration, Unemployment Rate, Auto [-3]
Regression C	0.9539	BCA [-1], Female Population 19-59, BCA Dummy, Auto [-2], Auto [-9]



Baby Care Program-Adults: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	6,288	6,976	2.67%	7,162	186	10
Exponential Smoothing B*	6,288	6,976	2.67%	7,162	186	10
Box Jenkins A	6,288	6,976	2.67%	7,162	186	10
Box Jenkins B	6,288	6,976	2.67%	7,162	186	10
Regression A	6,288	6,976	2.97%	7,183	207	13
Regression B	6,288	6,976	10.94%	7,739	763	100
Regression C	6,288	6,976	3.74%	7,237	261	24

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	6,976	7,448	0.00%	7,448	0	0
Exponential Smoothing B*	6,976	7,448	0.00%	7,448	0	0
Box Jenkins A	6,976	7,448	0.00%	7,448	0	0
Box Jenkins B	6,976	7,448	0.00%	7,448	0	0
Regression A	6,976	7,448	0.53%	7,487	39	3
Regression B	6,976	7,448	8.98%	8,117	669	21
Regression C	**6,976**	**7,448**	**2.57%**	**7,639**	**191**	**13**

Baby Care Program-Adults: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	7,448	7,639	0.00%	7,639	0	0
Exponential Smoothing B*	7,448	7,639	0.00%	7,639	0	0
Box Jenkins A	7,448	7,639	0.00%	7,639	0	0
Box Jenkins B	7,448	7,639	0.00%	7,639	0	0
Regression A	7,448	7,639	0.53%	7,679	40	3
Regression B	7,448	7,639	-2.23%	7,469	(170)	(36)
Regression C	**7,448**	**7,639**	**1.99%**	**7,791**	**152**	**11**

[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 2009-10: 6.77%
FY 2010-11: 2.57%
FY 2011-12: 1.99%

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 2008-09 was higher than the Department's February 2009 forecast, in which annual caseload was projected to be 6,861. 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 2009-10 is significantly higher than that from the February 2009 forecast, and would yield average growth of **62 per month**. Caseload in this eligibility type was volatile in FY 2008-09, with average monthly decreases of 85 clients in the first half of the year and average increases of 59 in the second half. While the cause of the volatility is unknown at this time, the Department does not

anticipate that either large decreases or increases will continue. The Department believes the volatility in the historical data is resulting in models that are not producing accurate trends for FY 2009-10. The Department has chosen to forecast FY 2009-10 using the two-year average monthly growth of 62, which results in a 6.77% annual trend.

- 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).

25.5-5-101 (1), C.R.S. (2009)
(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. (2009)
(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**
Jun-07	5,561	-	-
Jul-07	5,551	(10)	-0.18%
Aug-07	5,691	140	2.52%
Sep-07	5,448	(243)	-4.27%
Oct-07	5,479	31	0.57%
Nov-07	5,759	280	5.11%
Dec-07	5,896	137	2.38%
Jan-08	6,233	337	5.72%
Feb-08	6,827	594	9.53%
Mar-08	7,035	208	3.05%
Apr-08	7,142	107	1.52%
May-08	7,191	49	0.69%
Jun-08	7,200	9	0.13%
Jul-08	7,286	86	1.19%
Aug-08	7,270	(16)	-0.22%
Sep-08	7,027	(243)	-3.34%
Oct-08	6,932	(95)	-1.35%
Nov-08	6,773	(159)	-2.29%
Dec-08	6,689	(84)	-1.24%
Jan-09	6,847	158	2.36%
Feb-09	6,910	63	0.92%
Mar-09	6,959	49	0.71%
Apr-09	6,995	36	0.52%
May-09	6,973	(22)	-0.31%
Jun-09	7,045	72	1.03%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	7,223	-	-
FY 1996-97	5,476	-24.19%	(1,747)
FY 1997-98	4,295	-21.57%	(1,181)
FY 1998-99	5,017	16.81%	722
FY 1999-00	6,174	23.06%	1,157
FY 2000-01	6,561	6.27%	387
FY 2001-02	7,131	8.69%	570
FY 2002-03	7,823	9.70%	692
FY 2003-04	8,398	7.35%	575
FY 2004-05	5,984	-28.74%	(2,414)
FY 2005-06	5,119	-14.46%	(865)
FY 2006-07	5,182	1.23%	63
FY 2007-08	6,288	21.34%	1,106
FY 2008-09	6,976	10.94%	688
FY 2009-10	7,448	6.77%	472
FY 2010-11	7,639	2.57%	191
FY 2011-12	7,791	1.99%	152

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2008-09	6,861	9.11%	573
FY 2009-10	6,750	-1.62%	(111)
FY 2010-11	6,915	2.44%	165

Actuals		
	Monthly Change	**% Change**
6-month average	59	0.87%
12-month average	(13)	-0.17%
18-month average	64	1.03%
24-month average	62	1.10%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	7,045	0.99%	69

Non-Citizens

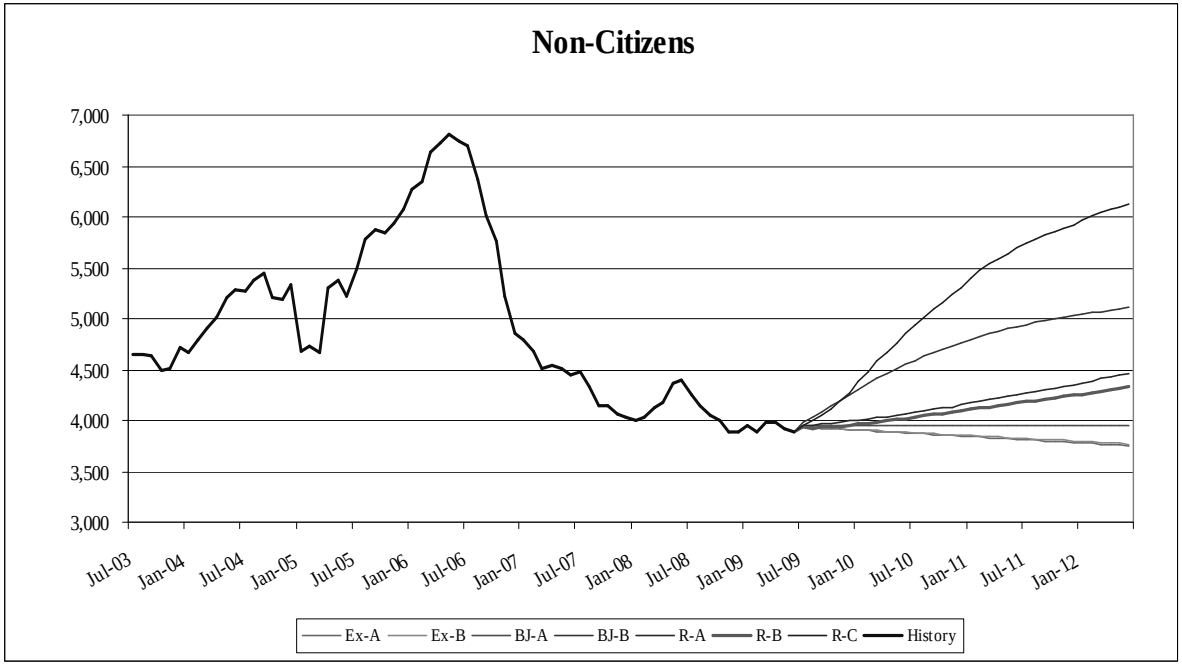
Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived 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.

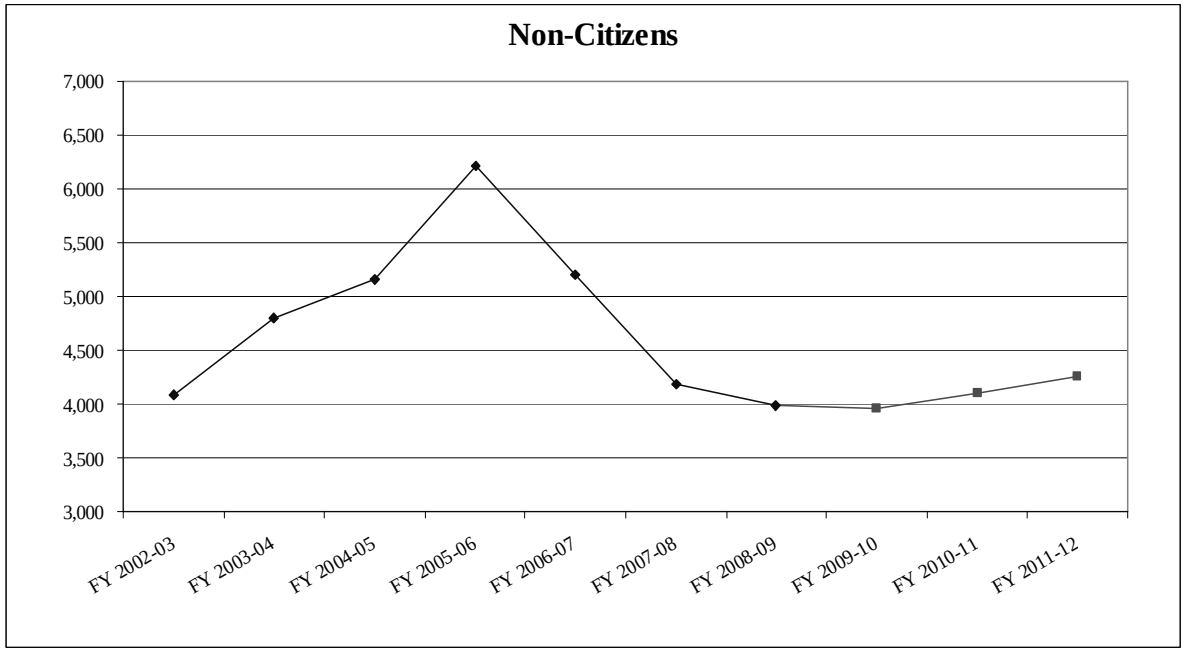
Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. citizenship.

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	0.9638	
Exponential Smoothing B*	0.9486	
Box-Jenkins A*	0.9775	
Box-Jenkins B	0.9649	
Regression A	0.9850	ALIEN [-1], Female Population 19-59, Migration, Alien Dummy
Regression B	0.9886	ALIEN [-1], ALIEN [-2], Alien Dummy, Auto [-3]
Regression C	0.9981	ALIEN [-1], Unemployment Rate, Alien Dummy, Auto [-1], Auto [-2]



Non-Citizens: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	4,191	3,987	-2.01%	3,907	(80)	(1)
Exponential Smoothing B*	4,191	3,987	-1.93%	3,910	(77)	(1)
Box Jenkins A*	4,191	3,987	-0.83%	3,954	(33)	5
Box Jenkins B	4,191	3,987	7.15%	4,272	285	55
Regression A	4,191	3,987	0.35%	4,001	14	14
Regression B	**4,191**	**3,987**	**-0.60%**	**3,963**	**(24)**	**11**
Regression C	4,191	3,987	9.28%	4,357	370	80

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	3,987	3,963	-1.59%	3,900	(63)	(5)
Exponential Smoothing B*	3,987	3,963	-1.48%	3,904	(59)	(5)
Box Jenkins A*	3,987	3,963	0.03%	3,964	1	0
Box Jenkins B	3,987	3,963	11.73%	4,428	465	31
Regression A	3,987	3,963	4.00%	4,122	159	16
Regression B	**3,987**	**3,963**	**3.51%**	**4,102**	**139**	**12**
Regression C	3,987	3,963	22.58%	4,858	895	70

Non-Citizens: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	3,963	4,102	-1.64%	4,035	(67)	(5)
Exponential Smoothing B*	3,963	4,102	-1.48%	4,041	(61)	(5)
Box Jenkins A*	3,963	4,102	0.00%	4,102	0	0
Box Jenkins B	3,963	4,102	5.43%	4,325	223	15
Regression A	3,963	4,102	4.83%	4,300	198	17
Regression B	**3,963**	**4,102**	**3.73%**	**4,255**	**153**	**13**
Regression C	3,963	4,102	11.27%	4,564	462	36

[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 2009-10: -0.60%
FY 2010-11: 3.51%
FY 2011-12: 3.73%

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. Research shows that Mexican immigrants tend to have longer life expectancies than natives of the United States or of other Hispanic origins, and that the mortality advantage is higher for lower income immigrants.[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 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 beginning in October 2007 and has been relatively flat since.

[13] Source: Turra, CM and Goldman, N. *Socioeconomic differences in mortality among U.S. adults: insights into the Hispanic paradox.* The Journals of Gerontology, Series B, Psychological sciences and social sciences, Volume 62 Issue 3, pages 184-192.

- The Department believes that the caseload decreases in this eligibility type in FY 2008-09 are somewhat related to those experienced in the Baby Care-Adults caseload, as a large portion of the Non-citizens caseload are pregnant women. Though the cause of these declines is unknown at this time, the Department does not anticipate that the decreases will continue.
- Growth in FY 2008-09 was slightly higher than the Department's February 2009 forecast, in which annual caseload was projected to be 3,953. The selected trend for FY 2009-10 is in line with that from the February 2009 forecast, and would yield average increases of **11 per month**.
- The out-year trends assume moderate monthly growth. As discussed in the Baby Care-Adults section, a number of Family Planning initiatives will be implemented during the forecast period, which may be expected to decrease the number of pregnancies.

25.5-5-103 (3), C.R.S. (2009)
(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**
Jun-07	4,437	-	-
Jul-07	4,475	38	0.86%
Aug-07	4,330	(145)	-3.24%
Sep-07	4,148	(182)	-4.20%
Oct-07	4,136	(12)	-0.29%
Nov-07	4,069	(67)	-1.62%
Dec-07	4,032	(37)	-0.91%
Jan-08	4,007	(25)	-0.62%
Feb-08	4,026	19	0.47%
Mar-08	4,130	104	2.58%
Apr-08	4,178	48	1.16%
May-08	4,371	193	4.62%
Jun-08	4,389	18	0.41%
Jul-08	4,258	(131)	-2.98%
Aug-08	4,136	(122)	-2.87%
Sep-08	4,052	(84)	-2.03%
Oct-08	4,005	(47)	-1.16%
Nov-08	3,889	(116)	-2.90%
Dec-08	3,884	(5)	-0.13%
Jan-09	3,954	70	1.80%
Feb-09	3,885	(69)	-1.75%
Mar-09	3,988	103	2.65%
Apr-09	3,984	(4)	-0.10%
May-09	3,919	(65)	-1.63%
Jun-09	3,892	(27)	-0.69%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	4,100	-	-
FY 1996-97	4,610	12.44%	510
FY 1997-98	5,032	9.15%	422
FY 1998-99	5,799	15.24%	767
FY 1999-00	9,065	56.32%	3,266
FY 2000-01	12,451	37.35%	3,386
FY 2001-02	4,028	-67.65%	(8,423)
FY 2002-03	4,084	1.39%	56
FY 2003-04	4,793	17.36%	709
FY 2004-05	5,150	7.45%	357
FY 2005-06	6,212	20.62%	1,062
FY 2006-07	5,201	-16.27%	(1,011)
FY 2007-08	4,191	-19.42%	(1,010)
FY 2008-09	3,987	-4.87%	(204)
FY 2009-10	3,963	-0.60%	(24)
FY 2010-11	4,102	3.51%	139
FY 2011-12	4,255	3.73%	153

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

February 2009 Trends			
FY 2008-09	3,953	-5.68%	(238)
FY 2009-10	3,957	0.10%	4
FY 2010-11	4,104	3.71%	147

Actuals		
	Monthly Change	**% Change**
6-month average	1	0.05%
12-month average	(41)	-0.98%
18-month average	(8)	-0.17%
24-month average	(23)	-0.21%

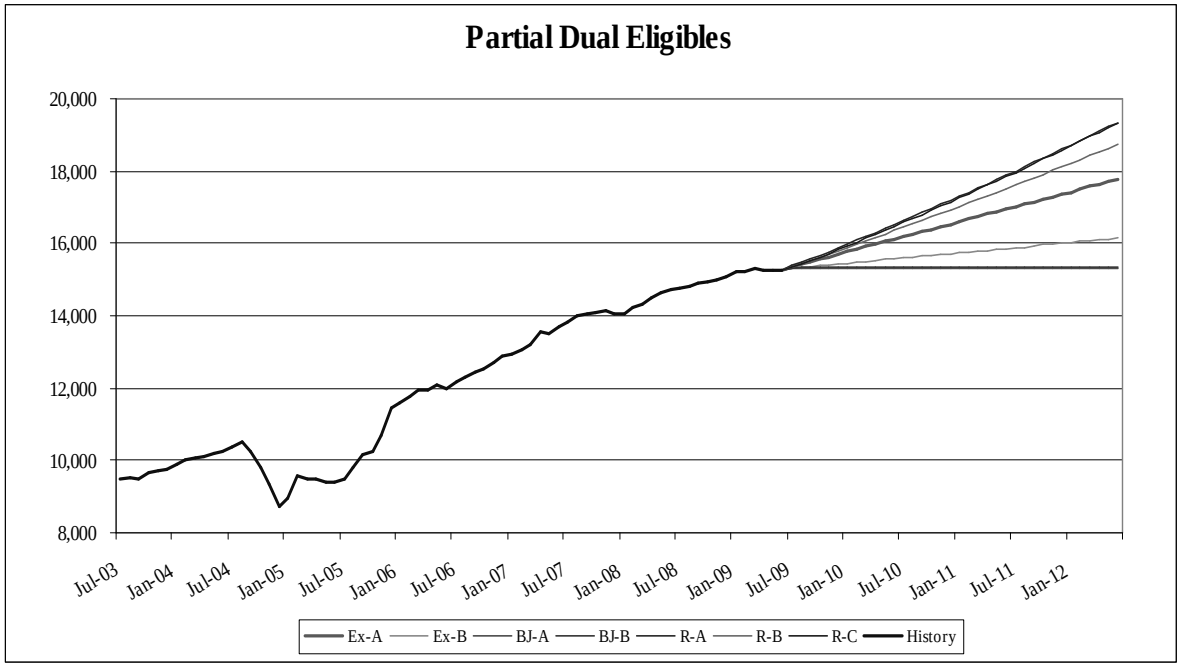
Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	3,892	-2.38%	(95)

Partial Dual Eligibles

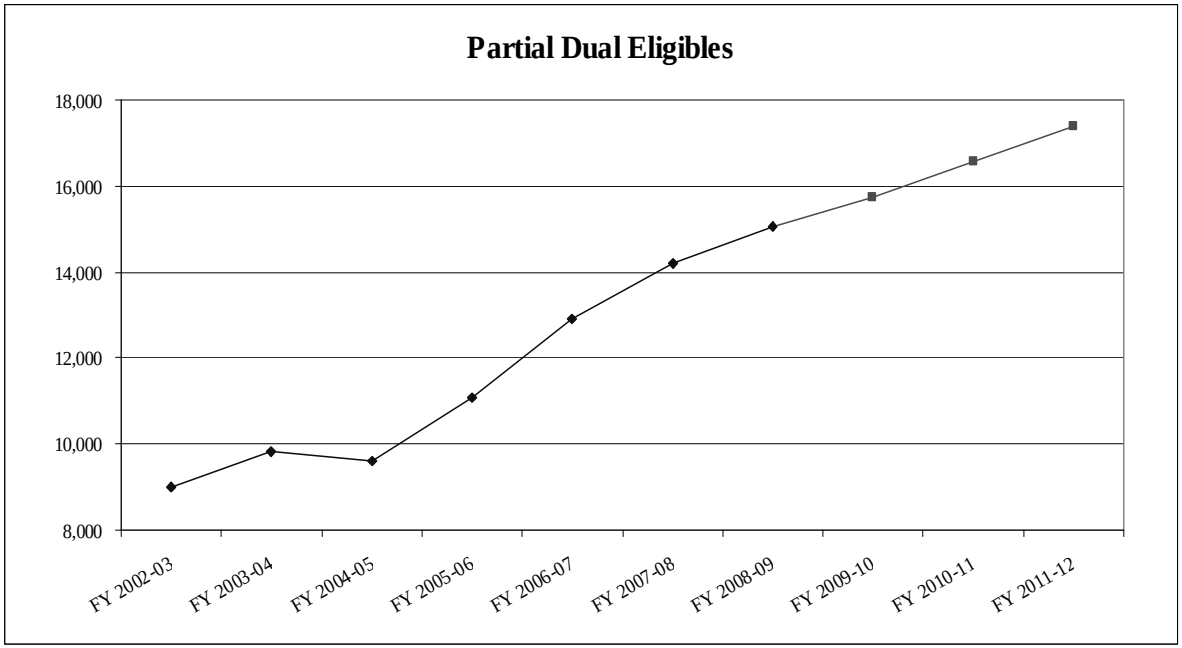
Medicare eligible beneficiaries who have incomes at a certain federal poverty level and limited resources may qualify to have Medicaid cover some of their out-of-pocket expenses, such as their Medicare Part B premiums and other coinsurance and deductibles.

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*	0.9974	
Exponential Smoothing B	0.9958	
Box-Jenkins A	0.9973	
Box-Jenkins B*	0.9965	
Regression A	0.9992	PDE [-1], PDE Dummy, CBMS Dummy, Auto [-1]
Regression B	0.9992	PDE [-1], Population 65+, PDE Dummy, CBMS Dummy, Auto [-1]
Regression C	0.9992	PDE [-1], PDE [-2], PDE Dummy, CBMS Dummy, Auto [-3]



Partial Dual Eligibles: Model Results						
FY 2009-10	**FY 2007-08**	**FY 2008-09**	**Projected Growth Rate**	**Projected FY 2009-10 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	**14,214**	**15,075**	**4.38%**	**15,735**	**660**	**72**
Exponential Smoothing B	14,214	15,075	2.43%	15,441	366	27
Box Jenkins A	14,214	15,075	1.57%	15,312	237	6
Box Jenkins B*	14,214	15,075	1.74%	15,337	262	8
Regression A	14,214	15,075	5.67%	15,930	855	105
Regression B	14,214	15,075	5.14%	15,850	775	92
Regression C	14,214	15,075	5.37%	15,885	810	101

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2010-11	**FY 2008-09**	**Projected FY 2009-10 Caseload**	**Projected Growth Rate**	**Projected FY 2010-11 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	**15,075**	**15,735**	**5.26%**	**16,563**	**828**	**69**
Exponential Smoothing B	15,075	15,735	1.83%	16,023	288	24
Box Jenkins A	15,075	15,735	0.03%	15,740	5	0
Box Jenkins B*	15,075	15,735	0.04%	15,741	6	0
Regression A	15,075	15,735	8.24%	17,032	1,297	113
Regression B	15,075	15,735	7.10%	16,852	1,117	96
Regression C	15,075	15,735	8.29%	17,039	1,304	115

Partial Dual Eligibles: Model Results						
FY 2011-12	**Projected FY 2009-10 Caseload**	**Projected FY 2010-11 Caseload**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	**15,735**	**16,563**	**5.00%**	**17,391**	**828**	**69**
Exponential Smoothing B	15,735	16,563	1.81%	16,863	300	24
Box Jenkins A	15,735	16,563	0.00%	16,563	0	0
Box Jenkins B*	15,735	16,563	0.00%	16,563	0	0
Regression A	15,735	16,563	8.24%	17,928	1,365	123
Regression B	15,735	16,563	7.02%	17,726	1,163	102
Regression C	15,735	16,563	8.37%	17,949	1,386	124

[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 2009-10: 4.38%
FY 2010-11: 5.26%
FY 2011-12: 5.00%

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 2008-09 was slightly lower than the Department's February 2009 forecast, in which annual caseload was projected to be 15,129. The selected trend for FY 2009-10 is similar to that from the February 2009 forecast, and would yield average growth of **72 per month**.
- 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. (2009)
(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. (2009)
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. (2009)
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**
Jun-07	13,669	-	-
Jul-07	13,821	152	1.11%
Aug-07	13,988	167	1.21%
Sep-07	14,064	76	0.54%
Oct-07	14,105	41	0.29%
Nov-07	14,144	39	0.28%
Dec-07	14,028	(116)	-0.82%
Jan-08	14,066	38	0.27%
Feb-08	14,212	146	1.04%
Mar-08	14,333	121	0.85%
Apr-08	14,479	146	1.02%
May-08	14,628	149	1.03%
Jun-08	14,700	72	0.49%
Jul-08	14,768	68	0.46%
Aug-08	14,821	53	0.36%
Sep-08	14,898	77	0.52%
Oct-08	14,933	35	0.23%
Nov-08	14,980	47	0.31%
Dec-08	15,053	73	0.49%
Jan-09	15,194	141	0.94%
Feb-09	15,205	11	0.07%
Mar-09	15,293	88	0.58%
Apr-09	15,268	(25)	-0.16%
May-09	15,240	(28)	-0.18%
Jun-09	15,249	9	0.06%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	3,937	-	-
FY 1996-97	4,316	9.63%	379
FY 1997-98	4,560	5.65%	244
FY 1998-99	6,104	33.86%	1,544
FY 1999-00	7,597	24.46%	1,493
FY 2000-01	8,157	7.37%	560
FY 2001-02	8,428	3.32%	271
FY 2002-03	8,988	6.64%	560
FY 2003-04	9,842	9.50%	854
FY 2004-05	9,605	-2.41%	(237)
FY 2005-06	11,092	15.48%	1,487
FY 2006-07	12,908	16.37%	1,816
FY 2007-08	14,214	10.12%	1,306
FY 2008-09	15,075	6.06%	861
FY 2009-10	15,735	4.38%	660
FY 2010-11	16,563	5.26%	828
FY 2011-12	17,391	5.00%	828

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

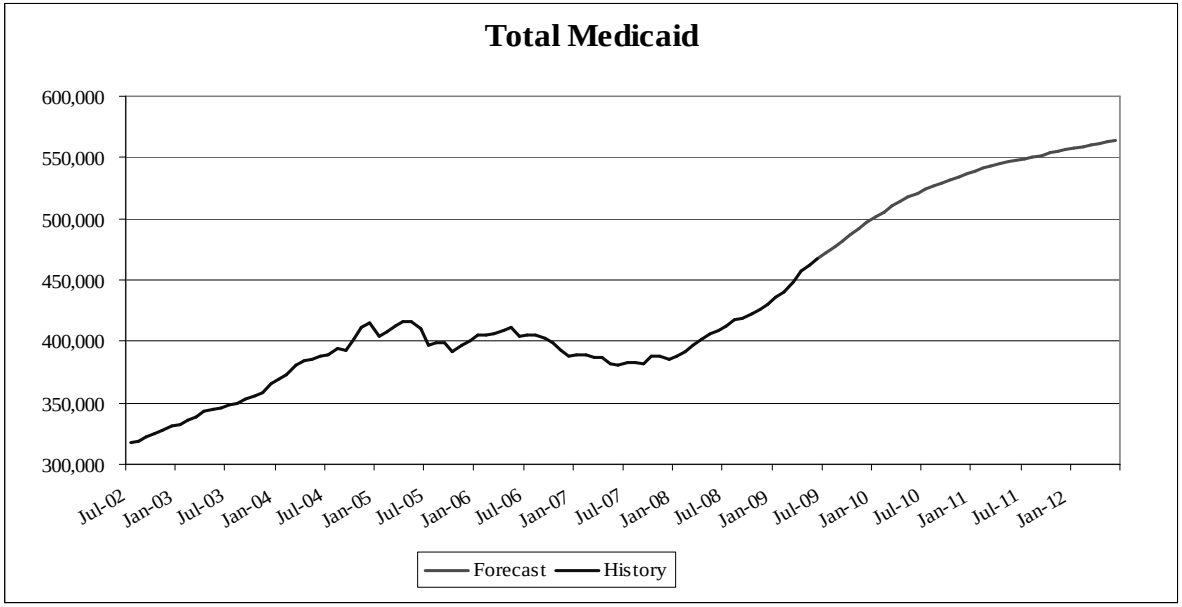
February 2009 Trends			
FY 2008-09	15,129	6.44%	915
FY 2009-10	16,016	5.86%	887
FY 2010-11	16,905	5.55%	889

Actuals		
	Monthly Change	**% Change**
6-month average	33	0.22%
12-month average	46	0.31%
18-month average	68	0.47%
24-month average	66	0.40%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	15,249	1.15%	174

Summary

The Department is forecasting a FY 2009-10 total Medicaid caseload of 498,511, a 14.12% increase from FY 2008-09. The trend is projected to moderate in FY 2010-11, and caseload is expected to increase by 7.80% to 537,383.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500,000
450,000
400,000
350,000
300,000
Jul-02
Jan-03
Jul-03
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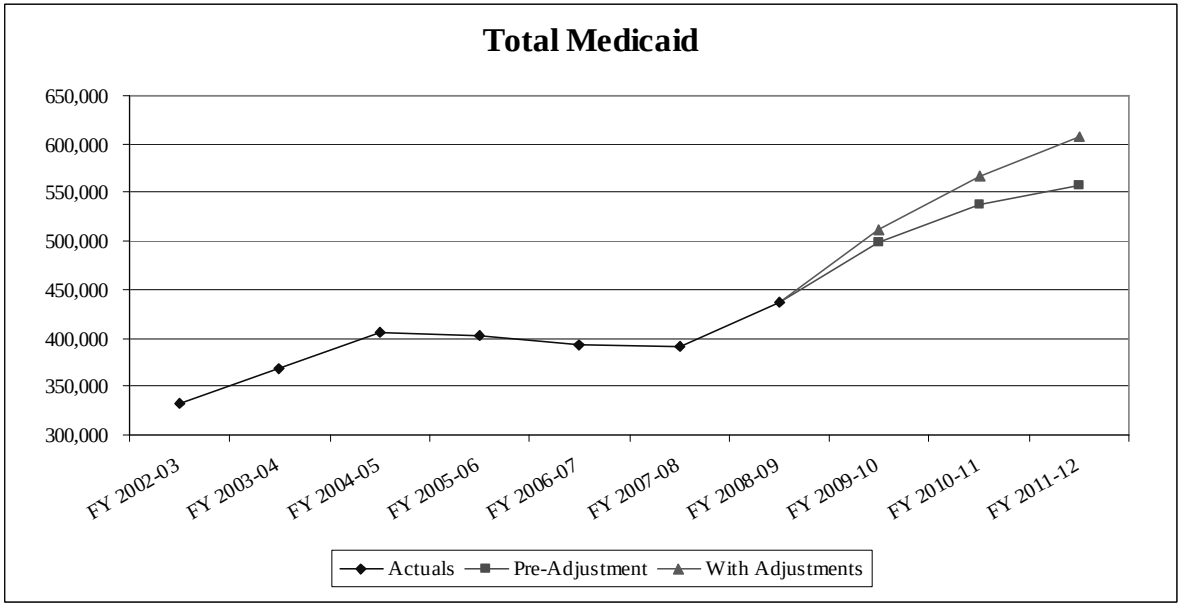
Jan-12
Forecast
History


Total Medicaid
650,000
600,000
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500,000
450,000
400,000
350,000
300,000
FY 2002-03
FY 2003-04
FY 2004-05
FY 2005-06
FY 2006-07
FY 2007-08
FY 2008-09
FY 2009-10
FY 2010-11
FY 2011-12
Actuals
Pre-Adjustment
With Adjustments

Total Medicaid: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-07	380,081	-	-
Jul-07	382,446	2,365	0.62%
Aug-07	383,218	772	0.20%
Sep-07	381,620	(1,598)	-0.42%
Oct-07	388,469	6,849	1.79%
Nov-07	388,145	(324)	-0.08%
Dec-07	385,852	(2,293)	-0.59%
Jan-08	388,471	2,619	0.68%
Feb-08	391,647	3,176	0.82%
Mar-08	396,191	4,544	1.16%
Apr-08	401,685	5,494	1.39%
May-08	406,143	4,458	1.11%
Jun-08	409,640	3,497	0.86%
Jul-08	413,125	3,485	0.85%
Aug-08	417,411	4,286	1.04%
Sep-08	419,554	2,143	0.51%
Oct-08	422,955	3,401	0.81%
Nov-08	426,512	3,557	0.84%
Dec-08	429,783	3,271	0.77%
Jan-09	436,349	6,566	1.53%
Feb-09	440,274	3,925	0.90%
Mar-09	448,490	8,216	1.87%
Apr-09	457,699	9,209	2.05%
May-09	462,033	4,334	0.95%
Jun-09	467,556	5,523	1.20%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	254,083	-	-
FY 1996-97	250,098	-1.57%	(3,985)
FY 1997-98	238,594	-4.60%	(11,504)
FY 1998-99	237,598	-0.42%	(996)
FY 1999-00	253,254	6.59%	15,656
FY 2000-01	275,399	8.74%	22,145
FY 2001-02	295,413	7.27%	20,014
FY 2002-03	331,800	12.32%	36,387
FY 2003-04	367,559	10.78%	35,759
FY 2004-05	406,074	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	436,812	11.44%	44,850
FY 2009-10	498,511	14.12%	61,699
FY 2010-11	537,383	7.80%	38,872
FY 2011-12	556,968	3.64%	19,585

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

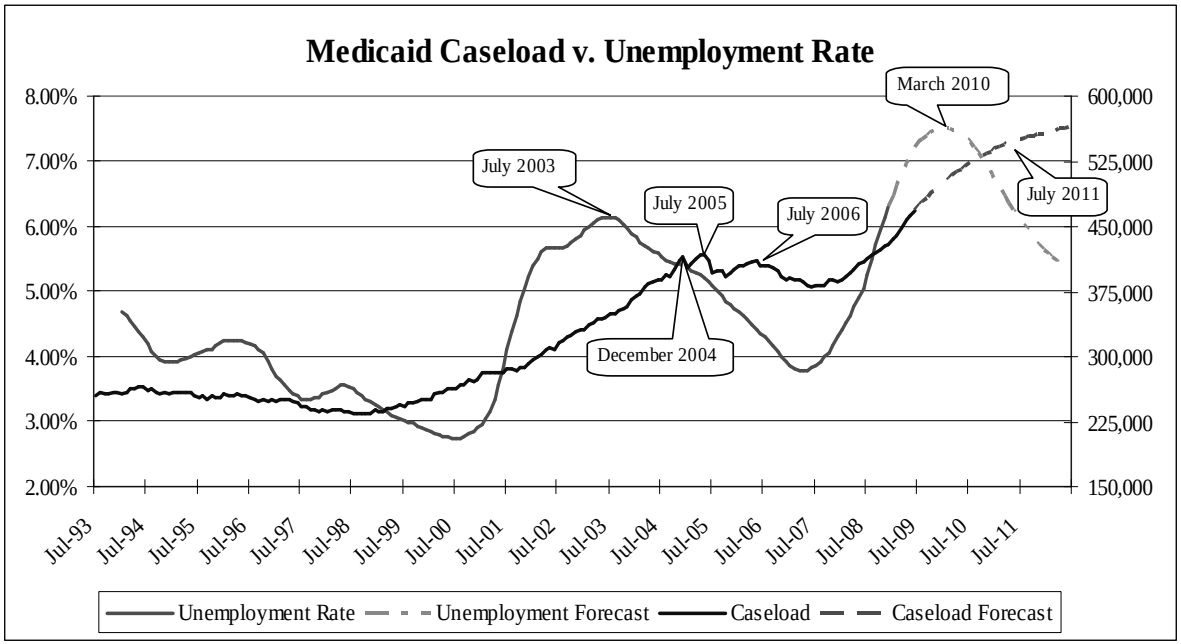
Actuals		
	Monthly Change	**% Change**
6-month average	6,296	1.41%
12-month average	4,826	1.11%
18-month average	4,539	1.07%
24-month average	3,645	0.99%

Base trend if caseload were to stay at the June 2009 level			
FY 2009-10	467,556	7.04%	30,744

Adjustments (HB 09-1293)	
FY 2009-10	12,900
FY 2010-11	30,100
FY 2011-12	50,825

Projections After Adjustments			
FY 2009-10	511,411	17.08%	74,599
FY 2010-11	567,483	10.96%	56,072
FY 2011-12	607,793	7.10%	40,310

February 2009 Trends (AFTER Adjustments)			
FY 2008-09	432,793	10.42%	40,831
FY 2009-10	469,137	8.40%	36,344
FY 2010-11	494,623	5.43%	25,486



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, pre-existing 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:

- Physician 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
- Home and Community Based Services: Mental Illness
- Home and Community Based Services: Disabled Children
- Home and Community Based Services: Persons Living with AIDS
- Home and Community Based Services: Brain Injury
- Home and Community Based Services: Children with Autism
- Home and Community Based Services: Pediatric Hospice
- Private Duty Nursing
- Hospice

Long Term Care:
- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-inclusive Care for the Elderly

Insurance:
- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:
- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

Note that for services in the Long Term Care, Insurance, and Service Management categories, separate forecasts are performed. Only Acute Care and Community Based Long Term Care are forecast as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

Exhibit A - Calculation of Total Request and Fund Splits

Summary of Request (Pages EA-1 and EA-2)
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-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year, excluding the impact of the American Recovery and Reinvestment Act (ARRA). Both the total spending authority and total projected estimated current year expenditures are adjusted for the impact of ARRA. The incremental impact of ARRA on FY 2009-10 expenditures is from page EA-4. The difference between the two adjusted figures is the Department's request for the Medical Services Premiums Long Bill Group total adjustment.

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-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year, excluding the impact of ARRA. Both the total Base Amount and total projected estimated request year expenditure are adjusted for the impact of ARRA. The incremental impact of ARRA on FY 2010-11 expenditures is from page EA-6. The difference between the two adjusted figures is the Department's request for the Medical Services Premiums Long Bill Group total adjustment.

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

Calculation of Fund Splits (pages EA-3 through EA-6)
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 FFP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services, as reported through the Federal Register, or as specified in federal law and/or regulation. The FFP 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.

The FFP rate is impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA is an enhanced federal medical assistance percentage (FMAP) for specified Medicaid programs; the effective period of this enhanced rate is October 1, 2008 through December 31, 2010. All states which meet general qualifying criteria receive a 6.2% increase in the FFP for eligible programs. Additional relief is available for states which experience increased unemployment; there are three defined tiers of the rate

of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA includes a 'hold harmless period'; if the FFP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 would be less than the FFP for the preceding quarter, the higher percent shall continue in effect for each subsequent calendar year ending before July 1, 2010. Below is a table detailing the Department's FFP, as reported by federal Centers for Medicare and Medicaid Services, for FY 2008-09 through FY 2010-11.

FFP Rate		**Effective Period**	**Fiscal Year Quarters**
50.00%	Pre-ARRA	Through September 2008	Through first quarter of FY 2008-09
58.78%	Enhanced rate per ARRA	October 2008 through March 2009	Second and third quarters of FY 2008-09
61.59%	Enhanced rate per ARRA	April 2009 through December 2010	FY 2009-10, First and second quarters of FY 2010-11
50.00%	Post-ARRA	January 2011 forward	Third quarter of FY 2010-11 forward

The Department first calculates the appropriate fund splits, excluding the impact of ARRA. The pre-ARRA fund splits for FY 2009-10 are on page EA-3, and for FY 2010-11 are on page EA-5. In separate tables, the Department then calculates the incremental impact of the enhanced federal matching rate, per ARRA, on the fund splits. These incremental figures for FY 2009-10 are on page EA-4, and for FY 2010-11 are on page EA-6.

In order to calculate appropriate pre-ARRA 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 for calculations.
- 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. (2009). For FY 2009-10 and FY 2010-11, 100% of state funding comes 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. Through FY 2008-09, prenatal services were provided as a state-only option and therefore required to be funded through 100% General Fund with the exception that delivery costs qualify for the standard 50% federal financial participation rate. However, as part of ES-2, Medicaid Program

Reductions, the Department granted full eligibility, subject to federal approval, to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status retroactive back to July 2009; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Please see Exhibit F for calculations.

- 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 J for calculation of the fund splits for programs funded through the Health Care Expansion Fund.

- Nursing Facility Provider Fee and General Fund Cap: HB 08-1114 directs the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate and authorized the Department to collect a provider fee from nursing facilities statewide. SB 09-263 amends the new methodology. Any growth in the portion of the per diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all Supplemental Payments. Please refer to Exhibit H for calculations and additional details.

- 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.

- Tobacco Tax Funded Disease Management: The Department annually receives funding from the Department of Public Health and Environment for the operation of disease management programs that address cancer, heart disease, lung disease and the risk factors associated therewith. The funding for these programs is a constant $2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by the Department of Public Health and Environment. The Department receives the standard 50% federal match on disease management expenditures, however the American Recovery and Reinvestment Act of 2009 has increased the federal matching percentage.

- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated certified expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The state share of funding is through certification of public expenditure. In FY 2009-10, and FY 2010-11, SB 09-264 requires that the Department retain any ARRA enhanced federal contribution and transfer that to the State's General Fund, effectively moving the ARRA driven federal dollars from the cash fund into General Fund.

- Hospital Provider Fee Programs: HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medial assistance; and 3)

pay the administrative costs to the Department in implementing and administering the program. The expansion populations will be funded through revenue generating from federal funds and two State cash funds: the Hospital Provider Fee Fund and the Medicaid Buy-in Fund. Because these populations were not provided benefits prior to the passage of ARRA, they are not eligible to receive the enhanced federal match.

- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to a limited number of children living with Autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to $1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Typically eligible for a FFP rate of 50%, the program is eligible for enhanced federal financial participation during the ARRA period.
- 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.
- Coordinated Care for People with Disabilities Program: The Joint Budget Committee recommended and approved $500,000 in additional appropriated total funds for the 2009 Long Bill to implement the coordinated care for people with disabilities pilot program as directed by SB 06-128, which authorizes the Department to pay per member per month administration fees to the Colorado Alliance for Health and Independence (CAHI).
- 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 2009-10 and FY 2010-11 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2008-09.
- Cash Funds Financing: This item includes the impact of legislation, SB 09-261 and SB 09-271, and five initiatives from Executive Order D 017 09, which reduce General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information. In addition, the item includes a $2.0 million transfer of reappropriated funds, for FY 2009-10 only, from the Prevention, Early Detection and Treatment fund. These funds are transferred from the Department of Public Health and Environment for the Disease Management program, although the Department has statutory flexibility to use the funding for the treatment of the specified conditions. This program is detailed in the Exhibit I section.

Exhibit B - Medicaid Caseload Projection
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 2008-09) and projections are included for historical reference and comparison, and are calculated on a cash-accounting basis.

Exhibit D - Cash Funds Report
Effective with the November 2009 Budget Request, this exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented on Exhibit A.

The information presented on the "Summary of Request by Eligibility Category" has been replaced with information shown in Exhibit E, page E-1, in the rows for "Total Per Capita."

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-10 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 18, 2009 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

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 are made for legislation and other impacts not included in historical trends. 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 budget 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 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 became 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 2003-04 through FY 2008-09. 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 2006-07, FY 2007-08, and FY 2008-09. 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 table below describes the trend selections for FY 2009-10 and FY 2010-11. In some 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."

As described in the Department's caseload narrative, populations which are sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth leads to per capita declines, due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting, where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance, and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2009-10 and FY 2010-11 with the rationale for selection, are as follows:

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Adults 65 and Older (OAP-A)	7.27% Half of the percent increase in FY 2004-05 (without Rx)	3.64% Half of estimated FY 2009-10 growth rate	The FY 2009-10 trend selection is consistent with recent strong growth in per capita trends over the last two years and uses trends without pharmacy expenditure due to Medicare Part D. Increasing population growth due to economic factors and demographics should reduce the per capita trend in the out-year.
Disabled Adults 60 to 64 (OAP-B)	4.07% Average of FY 2003-04 through FY 2007-08 (without RX)	4.07% Average of FY 2003-04 through FY 2007-08 (without RX)	The FY 2009-10 trend utilizes non-pharmacy expenditure due to the Medicaid Part D benefit and is selected as the highest magnitude long term trend to capture both the long-term growth and highly volatile nature of expenditure within this eligibility category. The out-year trend is held constant.
Disabled Individuals to 59 (AND/AB)	7.30% Average of FY 2006-07 through FY 2008-09 (without Rx)	3.65% Half of estimated FY 2009-10 growth rate	The FY 2009-10 trend utilizes non-pharmacy expenditure, this time to account for the irregular impact of pharmacy rebate revenues to this eligibility category, and is selected to capture both the long-term robust growth and highly volatile nature of expenditure within this eligibility category, similar to the other disabled category. The out-year trend is half of the 2009-10 trend, as the Department anticipates a return to more historic growth levels.
Categorically Eligible Low-Income Adults (AFDC-A)	-4.52% Percent increase in FY 2001-02	-2.26% Half of estimated FY 2009-10 growth rate	The FY 2009-10 trend is selected as a moderately decreasing per capita to account for the extremely robust caseload growth this eligibility category is experiencing. The Department anticipates that the per capita will continue to decline in FY 2009-10, although at a slower rate, as the rate of caseload increase begins to slow.
Expansion Adults	8.39% Half the percent increase in FY 2008-09	4.20% Half of estimated FY 2009-10 growth rate	The Expansion Adult population has experienced dynamic growth in recent years. This population will witness further growth due to the passage of HB 09-1293, making the most recent year the most predictive of future years. However, ever increasing rate of caseload growth should mitigate per capita rate growth both in FY 2009-10 and further into the out-year.

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Breast & Cervical Cancer Program	0.79% See page EF-6.	0.79%	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)	-2.09% Percent increase in FY 2001-02	-2.09% Percent increase in FY 2001-02	Historically, this population has experienced large per capita declines in periods of rapid caseload growth; this economic downturn; recent policy changes, including large rate increases to preventive-care services and the passage of HB 09-1293 will encourage additional caseload growth and drive per capita declines. Therefore, for both years, the Department believes that a conservative downward trend factor is warranted.
Foster Care	6.62% Average of FY 2005-06 through FY 2008-09	3.31% Half of estimated FY 2009-10 growth rate	The FY 2009-10 trend reflects that in recent years, overall, this aid category has seen steady per capita growth while year-to-year per capita changes have been moderately volatile. The out-year takes a conservative view of this volatility, moving away from the stronger 2009-10 trend.
Baby Care Program - Adults (BCKC-A)	3.74% Average of FY 2004-05 through FY 2008-09	3.74% Average of FY 2004-05 through FY 2008-09	The FY 2009-10 trend reflects that historical trends are limited in their predictive power for the future, as policy changes regarding presumptive eligibility have made the per capita unstable. These policy changes have now had time to find equilibrium, and the Department has selected a conservative long-term trend factor typical of Medicaid programs when caseload populations are stable. For the out-year, that trend is carried forward.
Non-Citizens	6.77% Average of FY 2004-05 through FY 2008-09	3.39% Half of estimated FY 2009-10 growth rate	The FY 2009-10 trend reflects that the last three years of expenditure for this eligibility category has seen proportional expenditure increase by service category along with stable and large per capita increases; for the out-year, the Department has selected a conservative long-term trend factor typical of Medicaid programs when caseload populations are stable

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Partial Dual Eligibles	10.04% Average of FY 2007-08 through FY 2008-09	10.04% Average of FY 2007-08 through FY 2008-09	The last three years have witnessed steady, double-digit per capita growth. The Department has selected an average of the last two fiscal years for the FY 2009-10 and out-year trend factors.

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:

- BRI-1, Pharmacy Efficiencies, reduces expenditure as a result of implementing an automated prior authorization system in February 2010 and changing the reimbursement rates of drugs using a state maximum allowable cost structure in December 2009. Automating prior authorizations increases efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process makes it easier for providers to submit requests, in turn making it easier and faster for clients to obtain drugs with prior authorization restrictions.
- BRI-2, Medicaid Program Efficiencies: Fluoride Varnish, allows trained medical and dental professional to administer fluoride varnish treatments to children up to age 6, beginning in July 2009. Studies demonstrate that fluoride varnish is the safest and most effective form of topical fluoride for young children and helps reduce the need for more expensive dental care in the future.
- S-8, Physician Supplemental Payment to Denver Health, provided the Department with spending authority to draw a federal financial match on uncompensated certified expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. Every year Denver Health Medical Center incurs uncompensated costs related to directly employing or contracting for physicians and non-physician practitioners who provide services to patients in inpatient and outpatient hospital settings. The costs for these physicians and practitioners are not included in inpatient or outpatient hospital costs.
- BA-24, Adjust Outpatient Hospital Cost to Charge Ratio, annualizes the Department's received authority to update its "cost-to-charge" ratios for outpatient hospitals, implemented in January 2009. Outpatient hospitals are paid at percentage of costs; however, actual costs are not known for several years, until the hospital is audited. To ensure that hospitals receive accurate and timely payments, claims paid are adjusted using a cost-to-charge ratio that adjusts billed charges to approximate costs using historical data. BA-24 adjusts and updates these cost-to-charge ratios to ensure that the Department is not overpaying hospitals only to recoup those funds several years later. In most cases, the updated cost-to-charge ratio for each hospital is lower than that which was currently in place. By resetting the ratio, the Department reduces its current year expenditure, but decreases the amount of recoupments it makes when final costs are audited, typically between 3 and 5 years after the fiscal year ends.

- BA-33, Promote Use of VA for Veterans, increases efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system beginning in July 2009.
- BA-33, Prior Authorization of Anti-convulsant Drugs, adds anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses of anti-convulsants in coordination with the BRI-1, Pharmacy Efficiencies (see above).
- BA-33, Correct Home Health Billing for Dual Eligibles, requires the Department, through more targeted enforcement beginning in July 2009, to avoid costs by ensuring providers have appropriately billed Medicaid for dual eligible clients only after receiving a Medicare denial for home health claims.
- BA-33, Restrict Inpatient Hospital Claims for Readmission with in 24 Hours, requires the Department, beginning in July 2009, to have its claims system to automatically deny a separate bill for clients readmitted to the same hospital for the same condition less than 24 hours after the initial discharge. Until system changes are complete, the Department, through its existing utilization review contracts, manually denies these claims. Exceptions are granted on an as-needed basis.
- BA-33, Reduce Selected Physician Codes to 100% of Medicare, annualizes the reduction of physician reimbursement for selected codes.
- BA-33, Rate Reductions, requires the Department to solicit ideas from provider groups on how to reduce unnecessary volume and create efficiencies in order to generate a 2.0% reduction in provider expenditure (excluding pharmacy) in FY 2009-10, effective July 1, 2009. The Department is required to reduce pharmacy expenditure by reducing pharmacy reimbursements to the average wholesale price (AWP) minus 14.0% for brand-name drugs, and AWP minus 40% for generic medications. The Department has taken steps to generate the 2.0% reduction for provider expenditures; those steps are described in Section V of this narrative.
- BA-37, HIBI Increase, is estimated to increase enrollment in the Department's Health Insurance Buy-In (HIBI) program by 100 clients. The Health Insurance Buy-In Program (HIBI) is a service in which the Department pays the health insurance premiums, deductibles, coinsurance, and/or co-pays for those Medicaid clients who have access to private health insurance or COBRA, when it is found to be cost effective for the State to do so. The estimated savings of this initiative is included in this section; the administrative cost is included in the HIBI section of this request.
- SB 09-259, Refinance Pediatric Specialty Hospital, shifting funding from Medical Services Premiums to the Pediatric Specialty Hospital line item, which exists to fund the Children's Hospital to offset the cost of providing care to large numbers of Medicaid and indigent care clients.
- ES-2, Provider Rate Reductions, included a permanent 1.5% reduction, effective September 1, 2009, in the reimbursement rate paid for most Acute Care services for FY 2009-10. The effective date for managed care provider payments is October 1, 2009, to allow time to actuarially certify rates.

- ES-2, FQHC Payment Methodology, requires the Department to reduce rates paid to federally qualified health centers (FQHC) by 50% of the difference between each provider's current rate and the minimum rate required under the Benefits Improvement and Protection Act of 2000 (BIPA), or an average of approximately 106% of the BIPA rate, beginning September 2009. Currently, the Department pays FQHCs above the minimum rate required under federal law, set in the BIPA. The Department estimates that the statewide average reimbursement for FQHCs was approximately 113% of BIPA at the beginning of FY 2009-10.
- ES-2, Prenatal State Only Benefits, grants full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status beginning July 2009; this allows the Department to receive federal financial participation for these clients without enrolling any new populations.
- ES-2, Pharmacy Reimbursements, directs the Department to reduce rates paid to pharmacies to average wholesale price (AWP) minus 14.5% for brand-name medications and AWP minus 45% for generic medication, beginning September 2009.
- ES-2, Expand PDL, the Department is expanding its preferred drug list (PDL) by subjecting approximately $40,000,000 of gross pharmacy expenditure to new or additional restrictions under its PDL beginning March 2010, allowing the Department to receive an additional supplemental rebates back from manufacturers.
- The Average Wholesale Pricing Reduction line accounts for a reduction in the average wholesale price (AWP) of certain drugs due to a lawsuit involving First DataBank, which provider the Department with AWP information used in the pricing of Medicaid pharmacy claims. See section V for more detail.
- The Reduction to Synagis Recommended Dosage line accounts for the impact of the change in recommended dosage protocol for administering Synagis by the American Academy of Pediatrics. Previously, recipients were to receive a six dose course of treatment; the new protocol recommends 3 to 4 doses per client.
- The Estimated Impact of PACE Enrollment line accounts for the Department's initiative to increase enrollment of new PACE providers. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community Based Long Term Care service groups to the PACE service category. The Department's calculations are contained in Section V of this part of the narrative.
- SB 09-265 requires the Department to delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This is a one-time shift which will be reversed with a corresponding increase in expenditure in FY 2010-11.
- SB 09-265 also requires the Department to begin paying its managed care payments in the month following service deliver, rather than during the month in which services are delivered, as is current practice. This action creates a permanent savings in the final month of the fiscal year, as those payments that were normally to be made in June 2010 will now be paid in July 2011, or the start of the next fiscal year.

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-6)

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program in the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. The Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's 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, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the effected caseload is very small and changes to total expenditure, therefore, have a large impact on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as -32.73%.

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 2009 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 adjusted the factor to obtain a full-year trend factor. The Department holds the per capita constant in the out-year; new caseload, which typically has higher costs within this eligibility category, should balance out any declines from longer-term caseload with lower treatment costs. These trend factors are applied to the base per capita on page EF-4.

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. (2009), 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. According to the original legislation, beginning in FY 2009-10 and into the future, state funding would be split: 50% from General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 09-262 revised the statute, requiring that in FY 2009-10 and FY 2010-11, 100% of state funding for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2009), 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. Using the allocation methodology described above, 70% of clients are funded through the Breast and Cervical Cancer Prevention and Treatment Fund, while the remaining 30% of clients are funded through the Prevention, Early Detection, and Treatment Fund.

All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

Antipsychotic Drugs (Page EF-7)

Antipsychotic drugs were moved from the Department's premiums 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-7 through EF-8, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The rebate calculation excludes supplemental rebates, as antipsychotic drugs are not including on the Department's preferred drug list. 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-9)

Pursuant to 25.5-5-103 (3), C.R.S. (2009), 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.

Upon federal approval in FY 2009-10, as per the Department's request ES-2, these clients will begin to receive full Medicaid benefits and therefore will receive a federal match on all Medicaid provided services. The total expenditure estimate remains part of the Department's request; however, the General Fund and federal fund estimates are presented for comparison purposes, only. The fund

splits in Exhibit A of this request uses the estimated total expenditure from this exhibit on page EF-9, but accounts for receiving federal funds for all the expenditure. In the event that federal approval is not received, the Department's calculations on Exhibit A would be replaced by the ones on this exhibit.

Prior to FY 2009-10, expenditure for clients in the state-only prenatal care program was included in the Non-Citizens aid category. Upon receipt of federal approval, expenditure will be recorded in the Baby Care Adults column.

An analysis of monthly expenditure reveals that total expenditure for this population has relatively stable in recent months. The selected trend factor is the one month rolling average from the last three months of FY 2008-09, and results in a conservative estimate of changes in expenditure when compared to annual expenditure change in the last two fiscal years, based on the average percent change in expenditure over the most recent 6 months. The estimated state-only and federally matched portions are based on the FY 2008-09 experience but are not used, as described above, in Exhibit A.

Family Planning - Calculation of Enhanced Federal Match (Page EF-10)

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided both 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-10 are taken directly from the Department's requests from the Centers for Medicare and Medicaid Services for enhanced federal funds.

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. Additionally, historically, 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 were combined beginning in FY 2008-09, and a single combined estimate is now produced.

The total estimate for FY 2009-10 and the out-year is based on the average yearly percentage change from FY 2005-06 to FY 2006-07, 2.00%. More recent family planning expenditure has increased as a result of the Departments considered effort to educate providers as to what services are billable as family planning services. Research by the Department had indicated that only a fraction of allowable services were being appropriately billed. The Department believes that the recent double-digit percentage increases in family planning expenditure are due to this education effort, and anticipates growth to now return to historical levels.

Prior Year Expenditure (Page EF-11)
As an additional reasonableness check, this section presents last fiscal year's actual and per capita expenditure by six month intervals. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The change in per capita by six month period can be quickly compared, and the prior year's per capitas may be referenced with page EF-1 and 2 of this request.

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 (HCBS) 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 15% 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 need for that 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.

HB 05-1243 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. The Department has incorporated the estimated costs and savings of this program in the base trends for Community-Based Long Term Care.

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 2008-09. 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 2006-07, FY 2007-08, and FY 2008-09.

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 table below describes the trend selections for FY 2009-10 and FY 2010-11. On Exhibit G, the selected trend factors have been bolded for clarification.

The selected per capita trend factors for FY 2009-10 and FY 2010-11, with the rationale for selection, are as follows:

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Adults 65 and Older (OAP-A)	7.07% Average of FY 2007-08 through FY 2008-09	3.54% Half of FY 2009-10 Trend Selection	The FY 2009-10 trend is based on the current expenditure and prior-year cash flow. The primary driver in this eligibility category is expenditure for Elderly, Blind and Disabled waiver clients with over 70% of expenditure; this growth rate of expenditure for these waiver services has dampened in FY 2008-09. Hospice services account for nearly a quarter of expenditure for this aid category, and expenditure growth stabilized from the first half to second half of FY 2008-09. The Department anticipates relatively stable expenditures overall through the end of the fiscal year, moderating in the next fiscal year. The FY 2010-11 trend factor is half of the FY 2009-10 selection.

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Disabled Adults 60 to 64 (OAP-B)	8.93% Average of AND/AB trend from FY 2003-04 through FY 2006-07	4.47% Half of FY 2009-10 Trend Selection	The Department anticipates that expenditure in this category will follow a pattern similar to the Disabled Individuals to 59 (AND/AB) aid category since individuals in the Disabled Adults 60 to 64 (OAP-B) category generally age in from the AND/AB category. Both FY 2009-10 and FY 2010-11 trend selections match those for the AND/AB category.
Disabled Individuals to 59 (AND/AB)	8.93% Average of FY 2003-04 through FY 2006-07	4.47% Half of FY 2009-10 Trend Selection	The FY 2009-10 trend is based on the current expenditure, prior-year cash flow and historical growth rates. Expenditure for Elderly, Blind and Disabled waiver clients is over half of the expenditure for this aid category; the growth rate for expenditure for these waiver services dampened in FY 2008-09, but expenditure growth for disabled clients is still higher than for the Adults 65 and Older Category. Two other significant drivers of expenditure are the Mental Illness waiver client and Private Duty Nursing service categories; growth in FY 2008-09 was relatively stable for the Mental Illness clients and decreased for clients who received Private Duty Nursing services. The Department anticipates some overall moderating of recent trends. The FY 2009-10 trend is a long-term historical average which allows for growth, yet which dampens the recent trends. The Department halves the trend factor in FY 2010-11.
Categorically Eligible Low-Income Adults (AFDC-A)	-53.33% FY 2008-09 Growth Rate of Expenditures	-26.67% Half of FY 2009-10 Trend Selection	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. The Department expects the FY 2008-09 growth rate of expenditures to continue into FY 2009-10 as clients are moved to the correct aid category, and a FY 2010-11 trend at half of the FY 2009-10 rate to allow for a relatively slower rate of movement out of this aid category as the expenditure level decreases.

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Expansion Adults	-50.00%	-25.00% Half of FY 2009-10 Trend Selection	Similar to the low-income adults category, clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to a relatively small level of 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. The Department anticipates that the current level of expenditure will drop by one half in FY 2009-10 as clients are moved to the correct aid category, and a FY 2010-11 trend at half of the FY 2009-10 rate to allow for a relatively slower rate of movement out of this aid category as the expenditure level decreases.
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)	-9.43% Average of FY 2006-07 through FY 2008-09	-9.43% Average of FY 2006-07 through FY 2008-09	The FY 2009-10 trend is based on the current expenditure, prior-year cash flow and historical growth rates. 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. Most of the expenditure is driven by private duty nursing services, which has declined. The FY 2009-10 selected trend is a two-year average growth rate which is a moderate declining trend. The Department holds the trend selection constant in FY 2010-11.

Aid Category	FY 2009-10 Trend Selection	FY 2010-11 Trend Selection	Justification
Foster Care	8.86% Average of FY 2004-05 through FY 2008-09	8.86% Average of FY 2004-05 through FY 2008-09	The FY 2009-10 trend is based on the current expenditure, prior-year cash flow and historical growth rates. Expenditure for Foster Care children is limited to private duty nursing services, which has dampened in FY 2008-09. The FY 2009-10 selected growth rate is a historical trend which allows moderate growth yet which moderates the most recent trends. The Department holds the trend selection constant in FY 2010-11.
Baby Care Program - Adults (BCKC-A)	-100.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Partial Dual Eligibles	-15.00%	-30.00%	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. The Department anticipates a relatively slower decrease of expenditure in this aid category in FY 2009-10 as compared to FY 2008-09, returning to a faster decline in FY 2010-11.

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:

- BA-15 Community Transitions Services for Mental Illness Waiver Clients, included a reduction of FY 2009-10 expenditure, and an annualized reduction in FY 2010-11 expenditure, due to clients utilizing the relatively less costly waiver services rather than residing in a facility.

- BA-33 Provider Volume and Rate Reductions, included a reduction of FY 2009-10 expenditure due to a permanent 2% rate reduction in Community Based Long Term Care services, effective July 1, 2009. In addition, the proposal estimates two initiatives with FY 2009-10 implementation: a reduction in expenditure by increasing efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system, and an additional reduction by implementing cost-sharing requirements for Home and Community Based Services programs for clients/families with incomes over $250,000.
- ES-2, Medicaid Program Reductions, included a permanent 1.5% reduction in the reimbursement rate paid for Community Based Long Term Care for FY 2009-10, effective September 1, 2009.
- ES-2, Medicaid Program Reductions, included, a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients would be limited to 2 roundtrips per week. Trips to adult day programs will not be subject to the cap included limitations on the HCBS waiver transportation benefit.
- ES-2, Medicaid Program Reductions, included a cap on the amount of personal care and homemaker services a client enrolled in a home and community based services waiver program can receive each day. The Department would limit personal care expenditure to $72.05 per day, which is 150% of the daily rate for a client living in an alternative care facility. The Department is currently seeking alternative options to achieve the cost savings from this initiative.
- Impact of Retroactive Increase of HB 08-1114 on FY 2008-09 Hospice Rates: Since hospice rates are a function of the reimbursement rate for Class I Nursing Facilities, the reimbursement methodology changes directed by HB 08-1114 have a fiscal impact on hospice expenditure. This impact was not anticipated and is included as a retroactive adjustment in FY 2009-10, annualized as a corresponding reduction in FY 2010-11.
- 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.
- SB 09-265 required the Department to delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This is a one-time shift which will reduce the total funds expended for CBLTC services in FY 2009-10 and which will be reversed with a corresponding increase in expenditure in FY 2010-11.

Prior Year Expenditure (Page EG-4)

As an additional reasonableness check, the Department has split FY 2008-09 actual expenditure into two 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 (Pages EH-2 and EH-3)
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 12.8% (through the FY 2008-09 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.

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized 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. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

The new reimbursement methodology is further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for

administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments.

For complete information regarding specific calculations, the footnotes in pages EH-4 through EH-7 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[14]:

- Based on calculations provided by Myers and Stauffer, the Department's rate contractor, the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2009-10 is $185.36. The estimated rate for add-on payments is $4.05.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment of $31.39 for claims that will be incurred in FY 2009-10. The difference between the estimated per diem rate for core components and the estimated patient payment, $153.97, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2009-10 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2009-10, a total of 3,385,605 days.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2009-10, $521,281,589. Similarly, the estimated total reimbursement for add-on payments in FY 2009-10 is $13,711,700, the product of the estimated Medicaid reimbursement per day for add-on payments and the estimated number of patient days.
- Of the estimated total reimbursement for claims incurred in FY 2009-10, only a portion of those claims will be paid in FY 2009-10. The remainder is assumed to be paid in FY 2010-11. The Department estimates that 92.27% of claims incurred in FY 2009-10 will also be paid during FY 2009-10. Footnote 5 of Exhibit H, page EH-4, details the calculation of the percentage of claims that will be incurred and paid in FY 2009-10. The total amount estimated to be paid in FY 2009-10 for claims incurred in FY 2009-10 ("current year claims") is $494,698,222.
- During FY 2009-10, the Department will also pay for some claims incurred during FY 2008-09 ("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 2008-09 to calculate an estimate of outstanding claims to be paid in FY 2009-10. The estimate is calculated separately for expenditures for core components and add-on payments. Note that, beginning in FY 2010-11, the calculation is only necessary for core components since the "add-on" payments become "Supplemental Payments" which are paid once annually and which are not subject to retroactive adjustments.

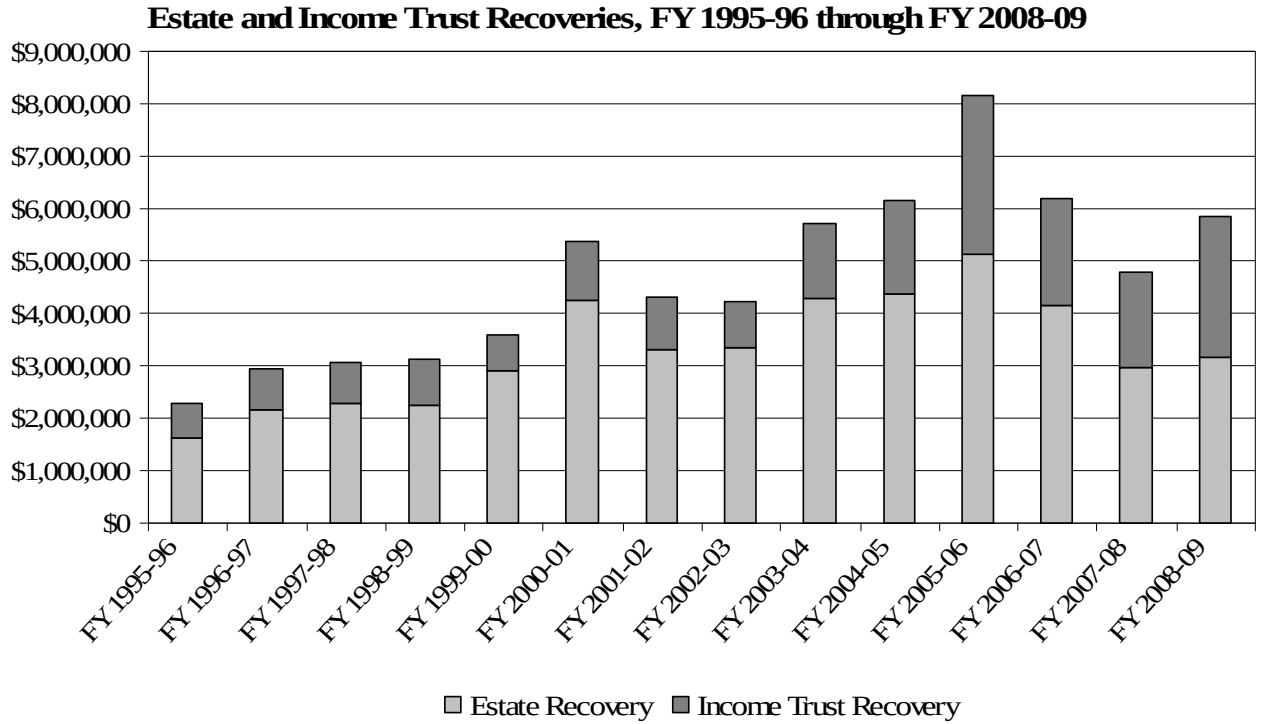
[14] For clarity, FY 2009-10 figures are used as an example. The estimate for FY 2010-11 is based on the estimate for FY 2009-10, and follows the same methodology.

- The sum of the current year claims and the prior year claims, $536,312,500, is the estimated expenditures in FY 2009-10 prior to adjustments ("gross budget estimate").
- Other non-rate factors are then added or subtracted from the gross budget estimate. These include the hospital backup program and out of state placements, estimated estate and income trust recoveries, recoveries from Department overpayment reviews, and program reductions. 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 2009-10, this includes SB 09-265, which shifts the MMIS payment from the last week in FY 2009-10 into the first week of FY 2010-11.
- Once the "non-rate" factors are estimated, the sum of the gross budget estimate and the non-rate adjustments yields the total estimated FY 2009-10 expenditure, $523,401,823.

For FY 2010-11, the same methodology is applied, taking into account the estimate for 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 impacts have been included in the FY 2009-10 and FY 2010-11 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2009-10 and FY 2010-11. Please refer to footnote (7) on page EH-6 for more detail.
- The Department reduces the request by the expected amount to be received in estate and income trust recoveries in FY 2009-10 and FY 2010-11. The following chart illustrates the history of estate and income trust recoveries from FY 1995-96 through FY 2008-09. As described in footnote (8) on page EH-6, 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 level of estate recoveries remained relatively flat from FY 2007-08 to FY 2008-09.



- The Budget Reduction Proposal, BA-36 Enhanced Estate and Income Trust Recoveries, estimated an additional reduction of expenditure due to estate and income trust recoveries in FY 2009-10 which would be the direct result of the enhanced recovery efforts. The Department is in process of amending the contract with HMS, a contractor, to explicitly enhance estate and income trust recovery efforts.
- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.5% reduction in the reimbursement rate paid to Class I Nursing Facilities for FY 2009-10. This rate reduction has a delayed implementation date of March 1, 2010, due to the need for a statute change. In the event the statutory requirements are not changed, the Department cannot implement this rate reduction, and the including savings would not be achieved.
- In addition to the estate and income trust recoveries, the Department receives recovery dollars from in-house audits of nursing facilities, and the estimated amount of recoveries is included as a bottom line impact for FY 2009-10 and FY 2010-11. Footnote (9) on page EH-7 contains additional detail about these recoveries.

- The Department has not implemented the expansion of the Hospital Back Up Program, as directed by BRI-2, Medicaid Program Efficiencies, due to program uncertainty. The Department continues to work with stakeholders to determine an appropriate methodology to implement this initiative.
- SB 09-265 allows the Department to delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This delay will reduce the total funds expended for Class I Nursing Facilities in FY 2009-10, a one-time shift which will require a corresponding increase in expenditure in FY 2010-11. Footnote (11) on page EH-7 contains additional detail about this shift.

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 2008-09 which will be paid in FY 2009-10, and the percentage of claims incurred in FY 2009-10 which will be paid in FY 2010-11.

The Department uses the IBNR adjustment calculation from the February 16, 2009 Budget Request, using paid claims data through December 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%
February/November 2009	92.27%

Patient Payment and Patient Days Forecasts Models

To forecast both patient days and patient payment rates, the Department selected a seasonal, auto-regressive model on time with a linear trend. This model was selected because both sets of data exhibit monthly seasonality and follow a trend over time. In addition, the value in a given month is partially a function of the value in the previous month; this is represented by an auto-regressive term in the forecasting model.

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. Second, the stationarity of the model needs to be tested to determine the validity of the forecasts. The Department tested stationarity by performing a Dickey-Fuller unit root test. In this test, the first difference of the values predicted by the forecast model are a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the lagged term is the calculated d-statistic. This is compared again the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation, and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Testing the Overall Predictive Ability of the Model

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. This test indicates how well the components of the model together generate valid forecasts. With a p-value of 0.0000, the model is statistically significant at the 99% confidence level.

Testing the Stationarity of the Model

The second set of statistics test the stationarity of the models. This is important, because if a model is not stationary, it cannot be used to predict values for time periods outside of the period represented by the actual data. The Department tested stationarity by performing a Dickey-Fuller unit root test. Theoretically, this test checks to see if the predictive components defined in the forecasting

model are actually generating random predictions even though the overall model is statistically significant. With any model, a portion of the predicted value will be random. So, having a random element in the model is not in itself a problem; stationarity issues result from a model in which the components assumed to be generating defined results are actually generating random results.

Technically, the test is performed by creating a model where the first difference (the current month minus the previous month's value) of each value predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the auto-regressive term is the calculated "d-statistic." This is compared again the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation (a unit root), and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Ex Post/In-sample Forecasts
As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts and compared the results to actual data reported for July 2008 through June 2009.

Forecasting Patient Payment Rates

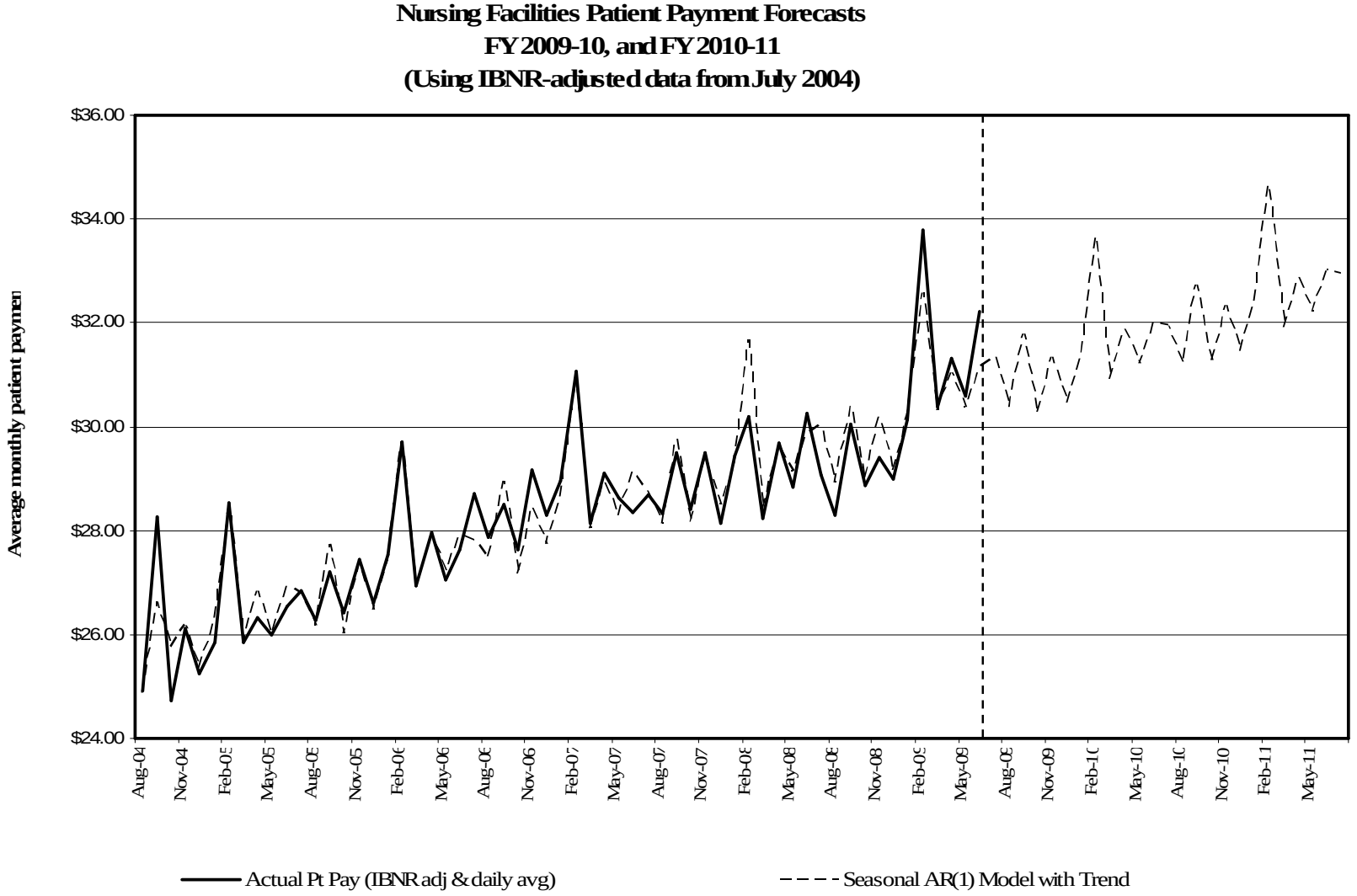
The table below includes the forecasted average annual patient payment rates for FY 2009-10 and FY 2010-11 resulting from the method defined in the previous section. The table also includes a base trend calculated as the expected increase if the patient payment rate was held at the June 2009 level.

The FY 2008-09 patient payment data was adjusted for use in calculating projections; mass adjustments to all claims caused a number of claims which were originally 100% patient paid to have a portion of the payment paid by the Department. Claims for which the Department does not make a Medicaid payment are not included in the calculation of the effective per diem rate. When the mass-adjusted claims which were originally excluded from the calculation became part of the data set, the effective per diem rates were skewed by claims for individuals who would have been responsible for 100% of the claim before the mass adjustment. However, these claims could not be retroactively billed to the client, so the Department paid a small share of the claim; this share was covered by the nursing facility provider fee. In order to obtain an appropriate patient payment per diem rate for FY 2008-09, the Department backed out any claims which were originally 100% patient paid.

The forecasted 3.73% growth rate from FY 2008-09 to FY 2009-10 is relatively consistent with long term growth rates; the average annual growth rate from FY 2005-06 to FY 2008-09 is 3.99%, and from FY 2000-01 to FY 2008-09 3.85%. The Department projects a lower growth rate, 3.15%, for FY 2010-11.

	Forecasted Annual Average Patient Payment Rate	Percent change from prior FY
FY 2009-10	$31.39	3.73%
FY 2010-11	$32.38	3.15%
Base trend at flat June 2009 level		
FY 2008-09	$30.26	--
June 2009	$32.22	6.50%

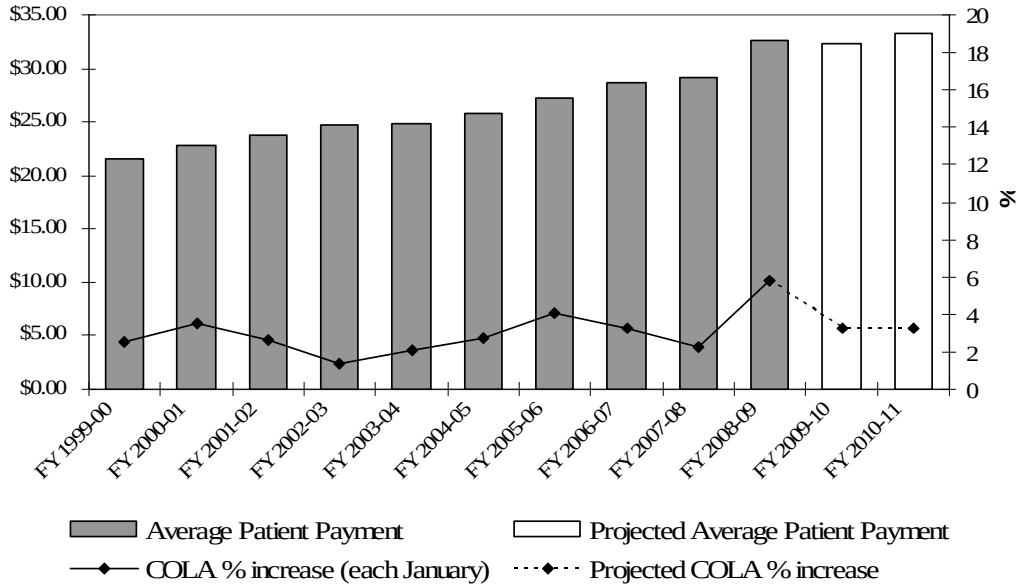
TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend.					
F-statistic:	36.23	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:			1.441	Confidence level:	99%
Durbin-Watson d-statistic, upper bound:			1.541	Calculated d-statistic:	-13.054
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					



The patient payment rate is a function of patient income. The spikes in each January are due to the annual SSI Cost of Living Adjustment; Social Security Income is a major component of patient income, so patient payment rates are influenced by this adjustment. As shown in the graph below, the average monthly patient 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 of 2.3%. The COLA calculations are based on Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) figures. The 2008 COLA rate was significantly higher at 5.8% than the increases in previous years; the COLA rate was not increased in January 2009.[15]

Average Patient Payment and Annual Social Security Income Cost of Living Adjustment (SSI COLA), FY 1999-00 through FY 2010-11



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 2009-10 and FY 2010-11 is again utilized, however in this step, the forecasts are made for July 2008 through June 2009 and compared to the actual data for this period. The forecasted average patient payment rate is 0.4% more than the actual average rate. Note that the actual data did not have the significant spike in January

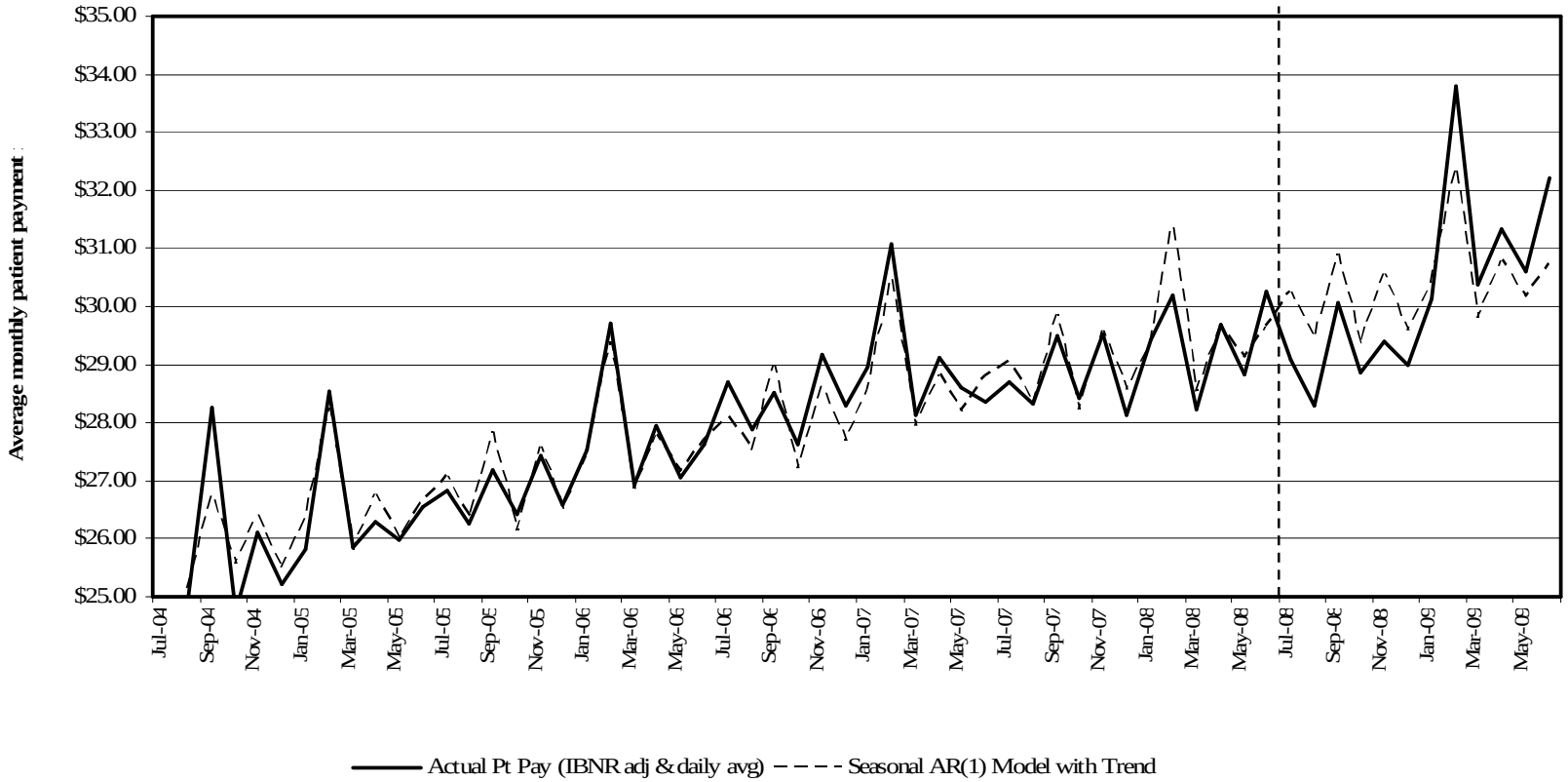
[15] Source for COLA data: Social Security Administration, http://www.ssa.gov/OACT/COLA/colaseries.html
FY 2009-10 and FY 2010-11 patient payment rates are estimated. Note that the annual COLA increase takes effect with the January SSI payments, changing at the mid-way point of the Department's fiscal year.

2008 which is pronounced and recurring in previous fiscal years. This is likely due to a low COLA increase in 2007 (see discussion above).

Actual average (using IBNR-adjusted data)	Forecasted average	Percentage Difference
$30.26	$30.37	0.4%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend.					
F-statistic:	24.34	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:			1.350	Confidence level:	99%
Durbin-Watson d-statistic, upper bound:			1.484	Calculated d-statistic:	-12.423
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

Patient Payment Forecast Compared with Actual, FY 2008-09
(Using IBNR adjusted data from July 2004)



Forecasting Patient Days

Similar to the table for patient payment rates, the table below includes the estimated monthly patient days and FTEs for FY 2009-10 and FY 2010-11 resulting from the method defined in the previous section. The table also includes a base trend calculated as the expected increase if the number of patient days were held at the June 2009 level.

	Forecasted Annual Patient Days	Percent change from prior FY
FY 2009-10	3,379,426	-0.81%
FY 2010-11	3,362,117	-0.51%
Base trend if flat at June 2008 level		
FY 2008-09	3,407,051	--
June 2009	3,304,208	-3.02%

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.

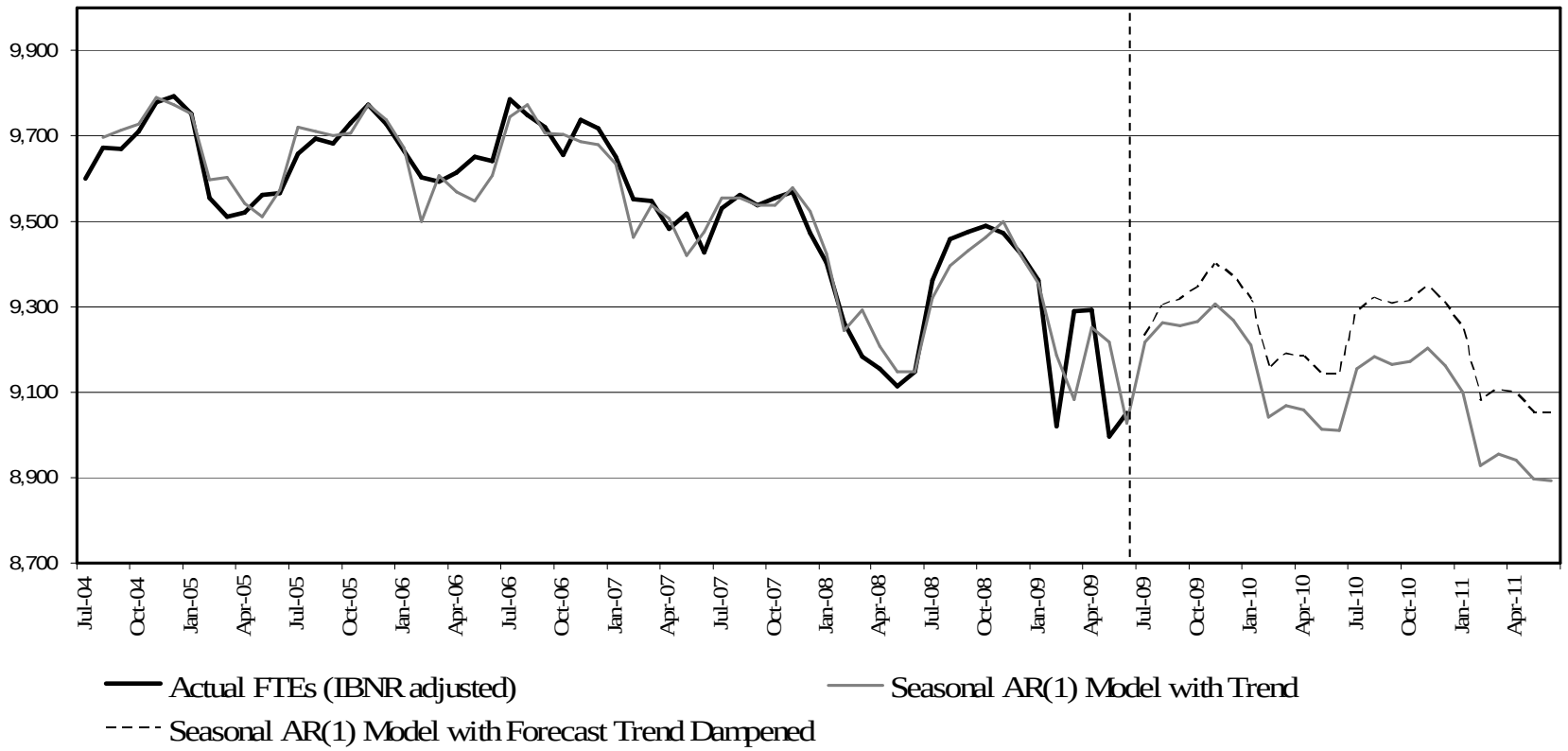
The declining trend in patient days is consistent with Department program policies; clients are enrolled in home care or alternative care facilities rather than nursing facilities, if appropriate. From FY 2005-06 to FY 2008-09, the average annual patient days decreased by 3.5%. From FY 2005-06 to FY 2008-09, home and community-based services average monthly paid enrollment was up approximately 22% (from 14,640). The number of clients in Alternative Care Facilities increased 5.4% from FY 2005-06 to FY 2007-08 (from 3,800).

The Department believes that the pronounced negative trend observed in recent data will carry forward into FY 2009-10 and FY 2010-11, but at a dampened rate. Therefore, the Department utilizes the seasonal and autoregressive components of the forecast model, but dampens the trend component by 20%.

	Forecasted FTEs	Percent change from prior FY
FY 2009-10	9,258	-0.53%
FY 2010-11	9,210	-0.52%
Base trend if flat at June 2009 level		
FY 2008-09	9,307	--
June 2009	9,053	-2.74%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend dampened by 20%.					
F-statistic:	33.95	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:			1.441	Confidence level:	99%
Durbin-Watson d-statistic, upper bound:			1.541	Calculated d-statistic:	-3.562
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

Nursing Facilities FTE Forecasts
FY 2009-10 and FY 2010-11
(Using IBNR-adjusted data from July 2004)



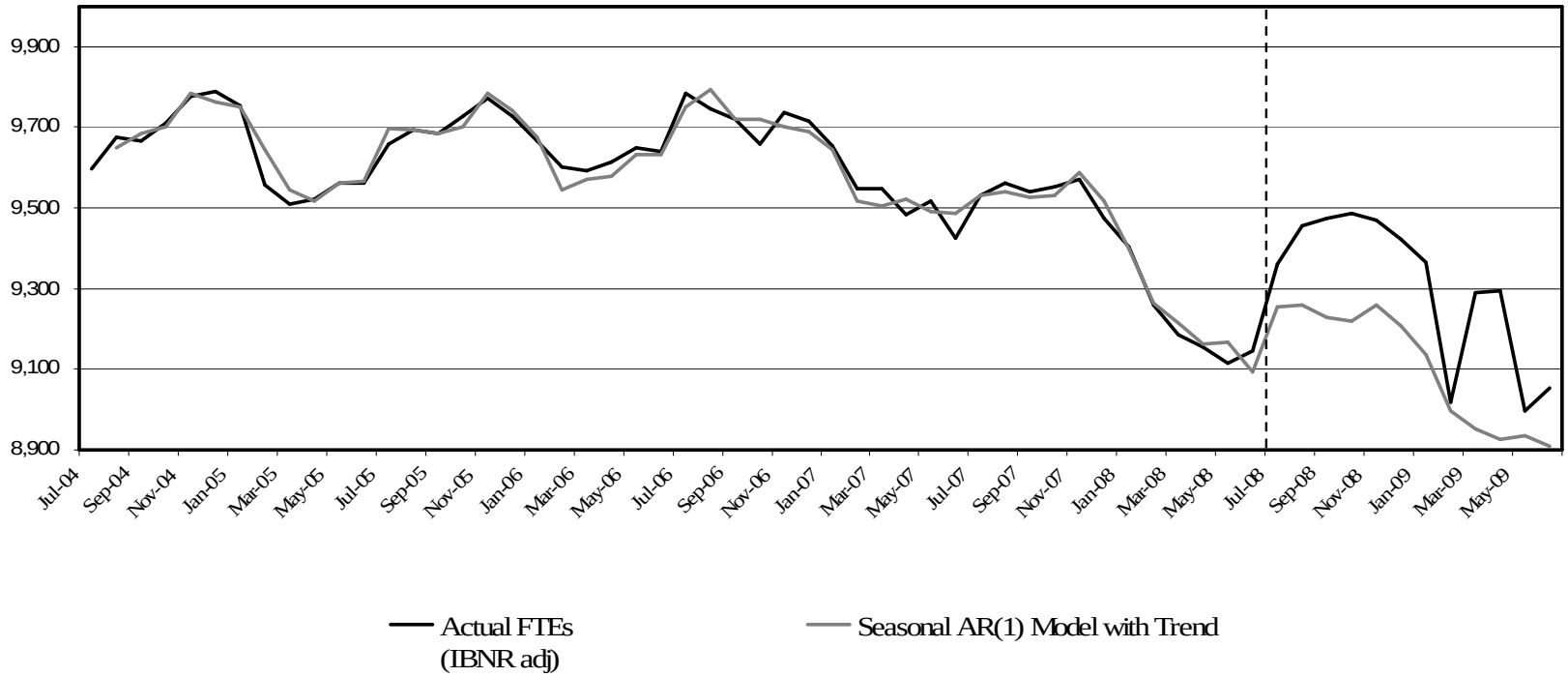
Ex Post (In-Sample) Forecasts of Patient Days

As described above for forecasting patient payment rates, the Department takes an additional step to compare data smoothing methods by calculating ex post (in-sample) 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. The forecasted average FTEs for FY 2008-09 are 2.2% lower than the actual average FTEs. Visually analyzing the graph on the following page, the forecasting model was not able to predict the trend in FY 2008-09, which differs substantially from previous fiscal years. In FY 2007-08, the patient days fell sharply for the first half of the fiscal year and rose sharply in the second half of the fiscal year, though not reaching the July 2007 level. The Department does not expect the pronounced negative trend to continue past FY 2008-09.

Actual FTEs (using IBNR-adjusted data)	Forecasted FTEs	Percentage Difference
9,307	9,107	-2.2%

TESTING THE OVERALL GOODNESS OF FIT OF THE MODEL					
The predicted values are a function of seasonal indicators, one autoregressive AR(1) term, and a linear trend.					
F-statistic:	70.82	p-value:	0.0000	Confidence level:	99%
DICKEY-FULLER TEST OF STATIONARITY OF THE MODEL					
The first difference of the predicted values are a function of one autoregressive AR(1) term and a linear trend.					
Durbin-Watson d-statistic, lower bound:			1.350	Confidence level:	99%
Durbin-Watson d-statistic, upper bound:			1.484	Calculated d-statistic:	-1.724
Since the absolute value of the calculated d-statistic is greater than the upper bound, there is no evidence of serial autocorrelation in the model; it is assumed that the model is stationary.					

Nursing Facilities FTE Forecast Compared with Actual, FY 2008-09
(Using IBNR-adjusted data from July 2004)



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.

FY 2009-10 The new methodology established in HB 08-1114 was further amended by SB 09-263 which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments.

Class I Nursing Facilities – Calculation of Nursing Facilities General Fund Cap (Page EH-9 and EH-10)
This exhibit calculates the cash funds needed from the Nursing Facility Cash Fund as directed by HB 08-1114 and SB 09-263 for 1) General Fund growth over the allowable per diem cap, and 2) Add-on or Supplemental Payments. Per SB 09-263, the state share of all growth in the General Fund portion of the per diem rate for core components is required to be funded by the cash fund. The state share of growth over 5% in this rate from FY 2009-10 to FY 2010-11 is funded by the cash fund. The state share of all Add-on or Supplemental Payments are funded by the cash fund. The exhibit incorporates the impact of the American Recovery and Reinvestment Act (ARRA).

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category (Page EH-11)
For comparison purposes to other service categories, this exhibit lists prior year expenditure along with the projected expenditure from page EH-2. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year.
Totals for each aid category are used to calculated total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities (Page EH-13)
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. The estimated growth rates for FY 2009-10 and FY 2010-11 are the average of overall growth in expenditures from FY 2007-08 to FY 2008-09. 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.

Program of All-Inclusive Care for the Elderly (PACE) (Page EH-14)
The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older

(OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

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.

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.

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: 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 2009-10 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 2008-09 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 2008-09 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2009-10 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 2009-10 total expenditure. FY 2010-11 is calculated in the same fashion.

To estimate the increase in enrollment in FY 2009-10, the Department selected half of the FY 2006-07 growth rate for Adults 65 and Older and Disabled Adults 60 to 64 categories, 4.08% and 3.91%, respectively. The trend for the Disabled Adults 60 to 64 category is applied to the Disabled Individuals to age 59 aid category. To estimate the increase in enrollment in FY 2010-11, the Department selected one half of these estimated FY 2009-10 trends.

To estimate the average increase in cost per enrollee in FY 2009-10, the Department selected the average percent increase in cost per enrollee between FY 2005-06 and FY 2008-09 for all three aid categories. For FY 2010-11, the Department held the FY 2009-10 trend selections constant.

The Department has received applications for additional PACE providers. Senior CommUnity Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally

planned to open a third facility in Grand Junction in Spring 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. The Department anticipates that Total Longterm Care, the Department's oldest PACE organization, will open a facility in late 2009 to serve clients in Pueblo as well as facilities in Loveland and Englewood in Spring 2011. The organization also plans to expand the current facility in the Brighton area; this is planned for Spring 2011.

The Department anticipates that by the end of FY 2009-10, approximately 306 clients will be enrolled in the new programs. For calculation purposes, this reflects an average monthly caseload of 247 clients. In FY 2010-11, the Department anticipates that approximately 436 clients will be added to PACE enrollment, with a incremental PACE caseload impact of 118 clients in FY 2010-11. As expansion information becomes known, the Department will adjust its Budget Requests accordingly.

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 FY 2009-10 and FY 2010-11 calculations for the Program of All-Inclusive Care for the Elderly (PACE):

- HB 08-1114 directed the Department to change the method of reimbursement for Class I Nursing Facilities. Since the PACE reimbursement rate is a function of the nursing facility rate, this change in methodology will impact PACE expenditure. The fiscal note for HB 08-1114 included $893,455 for increased PACE expenditures in FY 2009-10. The FY 2010-11 impact is assumed to be annualized into the base amount.
- To meet budget balancing goals, the ES-2: Medicaid Program Reductions budget request included a reduction in fee-for-service reimbursement rates. This indirectly reduced the reimbursement rate paid for PACE for FY 2009-10, as PACE rates are based on the Department's fee-for-service rates. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of October 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.
- SB 09-265 provides that managed care capitation payments shall not be made before the first day of the month following the enrollment of the recipients. This impacts payments for Program of All-Inclusive Care for the Elderly (PACE) by effectively shifting the last monthly payment in FY 2009-10 to FY 2010-11. This is a permanent shift with one-time savings in FY 2009-10.

Supplemental Medicare Insurance Benefit (SMIB) (Page EH-18)
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.[16] 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.

Supplemental Medicare Insurance Benefit (SMIB) expenditure 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:[17]

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%
2009	$443.00	4.73%	$96.40	0.00%

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.

[16] 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.

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

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 2009-10, the Department first inflates the actual expenditure from the first half of FY 2009-10 by the estimated caseload trend for the first to second half of FY 2009-10 from Exhibit B, page EB-1. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium, which is zero percent in 2009. The total estimated expenditure for FY 2009-10 is the sum of the first half actual expenditures and the second half estimated expenditures.
To forecast FY 2010-11, the Department first inflates the estimated expenditure from the first half of FY 2010-11 by the estimated caseload trend for FY 2010-11 from Exhibit B, page EB-1. This figure represents the approximate expenditure for the first half of FY 2010-11. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2010-11 is the sum of the first half and second half estimates.

Health Insurance Buy-In (HIBI) (Page EH-20)
The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2009). 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 exceptions, 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 long term per capita trends are a good indicator for FY 2009-10 expenditure. Total growth in FY 2006-07 was 41.62%; growth in FY 2007-08 was

21.90%, yet growth in FY 2008-09 was only 4.11%. The Department selected the FY 2008-09 growth rate of expenditures for all categories to trend expenditure to FY 2009-10 and FY 2010-11 for the Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB) aid categories. The Department selected the FY 2008-09 growth rate for the Eligible Children category, and this trend was applied to Categorically Eligible Low-Income Adults (AFDC-A). The Department selected a 10% growth rate for Baby Care Program Adults. All FY 2009-10 trend selections were held constant for FY 2010-11.

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 2009-10 and FY 2010-11 calculations for the Health Insurance Buy-In (HIBI) program:

- The Budget Reduction Proposal, BA-37 Increased Enrollment in Health Insurance Buy-In Program, estimates an increase in enrollment of 100 new HIBI clients for FY 2009-10 by repurposing existing resources to process a current backlog of HIBI applications. The administrative cost of this initiative is included in this section; the savings amount is included in the Acute Care section of this request.

Exhibit I – Service Management
This service group includes 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.

Single Entry Points (Page EI-2)
Single Entry Point (SEP) 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. (2009)). 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. (2009)).

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. (2009)).

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. (2009)). 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.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. 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.

Also fully annualized in the budget request is the impact of HB 05-1243, which 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 began to provide these services effective January 1, 2008.

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, nor do they reflect actual single entry point caseload; 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. The Department believes that growth in paid enrollment is a good proxy for growth in single entry point caseload.

For FY 2009-10, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2009-10 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds two legislative impacts (see below). For FY 2010-11, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2005-06 through FY 2008-09 for each aid category. The estimated FY 2009-10 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2010-11 expenditure.

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 FY 2009-10 and FY 2010-11 calculations for Single Entry Points:

- The Budget Reduction Proposal, BA-33 Provider Volume and Rate Reductions, decreases the amount paid to Single Entry Point providers by 2%, effective July 1, 2009.
- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.5% reduction in the reimbursement rate paid for Single Entry Points for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of September 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.

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. (2009)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs 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.

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma; congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD); high risk obstetrics; and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was 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. (2009), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated 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 was reflected as a bottom-line impact.

The Department's disease management contractors operated on a fixed budget (specified in the contract), and client enrollment could not exceed a fixed number of clients that the Department has determined shall be managed on that budget. Contractors accepted new clients only up to the enrollee limit as specified in the contract.

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in HB 02-1003. The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered amount of $63,488 is included in the FY 2009-10 request. The Department does not plan to renew the telemedicine contract when it expires on September 30, 2009. The amount included in FY 2010-11 is the total amount of funds from the Prevention Early Detection and Treatment Fund which is reappropriated from the Department of Public Health and Environment.

Prepaid Inpatient Health Plan Administration (Page EI-5)

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 2009-10 and FY 2010-11, the Department has used actual enrollment in its current administrative service organization to forecast expenditure in FY 2009-10 and FY 2010-11.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans for cost avoidance in FY 2005-06 through FY 2008-09. 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. At that time, the Department anticipated that it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09, with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. The FY 2009-10 figure was estimated based on the percentage enrollment increase of 1.37% in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS) system.

Concurrent with the project to include all encounter data in the MMIS system, the Department has adopted a new payment methodology effective FY 2009-10. This change is directed by HB 07-1346. Under the new methodology, the annual cost avoidance payments will no longer be made, and there will likely be an acceleration of payments due to cash accounting. The impact is

indeterminate at the time of preparing this budget request, and the Department will adjust for any fiscal impact through the normal budget process.

The Department holds the estimated amount of cost avoidance for the contract years FY 2005-06 and FY 2006-07 constant from the February 16, 2009 Budget Request. This bottom line adjustment of $943,802 is projected to impact FY 2009-10. The estimated amount of cost avoidance for the contract years FY 2007-08 and FY 2008-09 is estimated as the amount originally estimated for FY 2007-08 in the February Request. Since there may or may not be cost avoidance savings realized for these years, the Department holds the FY 2007-08 figure constant at $956,606, though now as an estimate of the cost avoidance amount both years, and projects a FY 2010-11 impact.

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.

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 FY 2009-10 and FY 2010-11 calculations for Prepaid Inpatient Health Plan Administration:

- In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.
- The Joint Budget Committee recommended and approved $500,000 in additional appropriated total funds for the 2009 Long Bill to implement the coordinated care for people with disabilities pilot program as directed by SB 06-128.
- SB 09-265 provides that managed care capitation payments shall not be made before the first day of the month following the enrollment of the recipients. This impacts payments for Prepaid Inpatient Health Plan Administration by effectively shifting the last monthly payment in FY 2009-10 to FY 2010-11. This is a permanent shift with one-time savings in FY 2009-10.
- The FY 2010-11 request includes funding for the Department's Medicaid Value-Based Care Coordination Initiative, and for the administrative cost of a Colorado Regional Integrated Care Collaborative study related to the initiative.
- To meet budget balancing goals, the Department proposed a series of initiatives to reduce Medicaid expenditure through the ES-2: Medicaid Program Reductions budget request. The Executive Order included a 1.5% reduction in the reimbursement rate paid for Prepaid Inpatient Health Plan Administration for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, with an implementation date of September 1, 2009, and the annualized impact is a bottom line adjustment for FY 2010-11.

Exhibit J - Cash Funded Expansion Populations

Summary of Cash Funded Expansion Populations (Pages EJ-1 and EJ-2)
These exhibits summarize the source of funding for Health Care Affordability Act of 2009 and Tobacco Tax cash funded expansion populations.

Health Care Expansion Fund Populations (Pages EJ-3 through EJ-6)
The caseload impacts of the Health Care Expansion Fund from HB 05-1262 are already included in the Medicaid caseload projections. The Medical Services Premiums request is based on these caseload projections and per capita costs. 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-3 through EA-6 splitting the request by General Fund, Cash Funds, 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 EJ-3 through EJ-6 show the fund split adjustments that need to be made to the General Fund amounts shown in each section of the Calculation of Federal Match exhibits (page EA-3 through EA-6).

The Health Care Expansion 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, 5) providing presumptive eligibility to pregnant women in Medicaid, 6) parents of children enrolled in Medicaid or the Children's Basic Health Plan from 36% to least 60% of the federal poverty level, and 7) additional foster care clients between 18 and 21 years of age eligible for Medicaid immediately prior to their 18th birthday. 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.

	FY 2009-10		**FY 2010-11**	
Health Care Expansion Fund Programs	**Total Funds**	**Health Care Expansion Fund**	**Total Funds**	**Health Care Expansion Fund**
Expansion Adults	$43,657,998	$21,829,000	$52,100,258	$26,050,129
Expansion Foster Care	$2,518,688	$1,259,334	$2,966,315	$1,483,158
Presumptive Eligibility	$3,584,127	$1,792,064	$3,764,395	$1,882,198
Legal Immigrants	$34,199,974	$17,099,987	$38,563,356	$19,281,678
Removal of Medicaid Asset Test	$69,816,155	$34,908,078	$77,788,553	$38,894,277
Children's Home and Community Based Services	$21,180,205	$10,590,103	$22,574,363	$11,287,182
Children's Extensive Support	$3,266,878	$1,633,439	$3,481,916	$1,740,958
Total*	**$178,224,025**	**$89,112,015**	**$201,239,156**	**$100,619,580**

* Figures presented are not adjusted for the impact of the American Recovery and Reinvestment Act (ARRA).

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 typically described in detail in the Tobacco Tax Update included with of this Budget Request. However, due to the impact of state mandated furlough days, the narrative for the Tobacco Tax Update has been omitted from this budget request. Please refer to the Department's February 2009 Supplemental Request for Medical Services Premiums and Tobacco Tax Update for a description of the Department's forecast methodologies, where appropriate.

Expansion Adults

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 who are 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.

Expansion Foster Care

Foster care eligibility for some clients was extended to children up to age 21 via SB 07-002. The Department began forecasting costs for these clients separately from the traditional Foster Care population as of this Budget Request due to substantial differences in the service utilization patterns between the two populations. In forecasting caseload and per capita costs for this population using historical expenditure data and enrollment levels, the Department assumes that this population is still in the ramp-up phase of program implementation. Therefore, per capita cost and caseload growth rates are expected to exceed those projected for the traditional Foster

Care population until FY 2010-11. However, per capita cost growth for this population has stabilized over the past year, and is expected to grow by 3.14% in FY 2010-11.

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 was handled through the Anthem network through December 2007. 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 2009-10 and FY 2010-11 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.

Optional 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. 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 identified system changes that can be made within the Colorado Benefits Management System that has enabled the Department to track this expansion population. Effective August 2007, the Department implemented system changes enabling it to track actual expenditures and monthly enrollment levels for the Optional Legal Immigrants population.

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). The Department's projections have been revised to include the actual projected expenditure for this population beginning with FY 2008-09.

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 methodology used to forecast costs for these clients assumes that similar patterns of caseload and per capita cost growth exist within eligibility types. The Department uses the executive forecasts of caseload and per capita growth rates amongst the eligibility types potentially affected by the removal of the asset test, weighted by the relative size of those populations, to project total expenditures for the removal of the asset test into future budget years.

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.

Hospital Provider Fee Funded Populations (Pages EJ-7 and EJ-8)

HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs and using the combined funds to: (I) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; (II) increase the number of persons covered by public medial assistance; and (III) pay the administrative costs to the Department in implementing and administering the program. This bill has a FY 2010-11 impact on the Medical Services Premiums budget request and would similarly have an impact on FY 2009-10 should the program receive federal approval in time for current year implementation. The Department is presenting the updated figures for FY 2009-10 (page EJ-7) for informational purposes. Because the Department's appropriations are conditional upon federal approval, the estimated impact on FY 2009-10 is removed from the Department's official request in Exhibit A.

The Department anticipates enrolling new clients into the Medicaid system beginning in April 2010. The populations, described, below, will be funded through revenue generating from federal funds and two State cash funds: the Hospital Provider Fee Fund and the Medicaid Buy-in Fund.

Hospital Provider Fee Fund

HB 09-1293 establishes this fund provides for costs of administering Medicaid programs to three of the four HB 09-1293 expansion populations that impact the Medical Services Premiums budget (a fifth expansion population impacts the CHP+ program):

Expansion Adults to 100%

While the Health Care Expansion Fund provides funding for parents of children enrolled in Medicaid or the Children's Basic Health Plan from 36% to least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund covers expenditures for parents from over 60% to 100% of the federal poverty level. Subject to federal approval, this expansion population would receive the same benefits as parents currently eligible under Medicaid. The Department estimated that rules and a state plan amendment would be approved by March 2010, with an effective date of April 1, 2010.

The Department's estimated caseload for this expansion are based on data provided by The Lewin Group. This data is described in the Department's February 16, 2008 Budget Request, S-3, "Children's Basic Health Plan Medical Premium and Dental Benefit Costs." For this expansion, the Department has assumed phase-in rates of 30% in FY 2009-10, 70% in FY 2010-11, and 90% in FY 2011-12. The Department will update these caseload estimates through the normal budget process when more recent data become available.

The Department assumes that the medical and mental health per capita costs for this expansion group will be the same as those for the Medicaid Expansion Adults population. The Department will update these per capita estimates through the normal budget process when more recent data become available.

Continuously Eligible Children: Family Medical Program and Foster Care
The Department anticipates providing 12 months of guaranteed eligibility to children in Medicaid beginning in February 2012. The Department assumes that it would be necessary to revise its State Medical Services Board rules as well as submit a state plan amendment.

The Department assumes that with 12-month guaranteed eligibility in Medicaid as described above, the average length of stay in Medicaid and the Children's Basic Health Plan would equalize at a lower level than experienced by children currently in Children's Basic Health Plan. This is due to children being able to move between the programs within the same 12-month guaranteed period, which would result in a slightly lower average length of stay in both programs.

The Department assumes that fee-for-service costs for these additional months of service would be lower than the current Medical Services Premiums per capitas. The current per capitas do not assume 12-months of guaranteed eligibility. Low-income clients are assumed to have a pent up demand for services, which drives higher per capita costs. For the additional months created by 12-month guaranteed eligibility, these higher cost services are assumed to be resolved, and the per capita should decline.

Adults Without Dependant Children to 100% FPL
The Department assumes that it would be necessary to revise its State Medical Services Board rules, submit a state plan amendment, as well as receive a federal waiver to establish the proposed Adults Without Dependant Children (AWDC) program (previously known as Childless Adults), effective January 2012. The Department assumes that the new AWDC program would require an 1115 demonstration waiver from CMS. Section 1115 of the Social Security Act provides CMS broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Some states expand eligibility with 1115 waivers to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

The number of uninsured individuals assumed to participate in the program is based on data provided by income date and analysis supplied by The Lewin Group.

The assumed medical per capita for the AWDC program is based on the actuarially developed rate for the basic benefit package outlined in the 'Better Health Care For Colorado' proposal from the Blue Ribbon Commission for Healthcare Reform, trended forward by projected medical inflation. The Department assumes that these individuals would also be eligible for mental health benefits and has assumed the per capita cost for Medicaid low-income adults.

Medicaid Buy-in Fund
This fund is administered by the Department to support expenditure for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities
Disabled individuals with income up to 450% of the federal poverty level would become eligible for Medicaid benefits beginning in July 2011. The Department assumes that it would be necessary to revise its State Medical Services Board rules, and seek appropriate federal approval in order to establish the proposed Medicaid Disabled Buy-in program.

The Department's estimated caseload for this expansion are based on data provided by The Lewin Group. This data is described in the Department's February 16, 2009 Budget Request, S-3, "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," and will be updated with more recent data as it becomes available.

The Department assumes that the Medical Services Premiums and Medicaid Mental Health per capita costs for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department assumes that the Mental Health per capita for the Buy-In program would be equivalent to that for Medicaid Disabled Individuals to 59, and the Medical Services Premiums per capita is adjusted based on the following assumptions:

- The Department assumes that there would be proportionally fewer children in the Buy-In program than in the current Medicaid Disabled Individuals to 59 (AND/AB) population. Parental income is not included in the determination of eligibility for children's waivers, so there should be few high income children that would not already be eligible. On average, children exhibit higher costs than adults, so the per capita is decreased based on the costs of adults in Disabled Individuals to 59 compared to the total per capita.
- The Department assumes that most clients in the Buy-In program will have little utilization of many Home and Community Based Services waivers and other Long Term Care services. The Department assumes that few individuals with the ability to work would meet the level of care for either a waiver or nursing facility, decreasing the per capita costs.

	FY 2009-10		**FY 2010-11**	
Hospital Provider Fee Programs	**Total Funds**	**Cash Fund**	**Total Funds**	**Cash Fund**
Expansion Adults to 100%	$33,600,277	$16,800,139	$82,459,819	$41,229,910
Continuously Eligible Children: Family Medical Program	$0	$0	$0	$0
Continuously Eligible Children: Foster Care	$0	$0	$0	$0
Buy-in for Individuals with Disabilities	$0	$0	$0	$0
Adults without Dependant Children to 100% FPL	$0	$0	$0	$0
Total	$33,600,277	$16,800,139	$82,459,819	41,229,910

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 (CMS) that it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process as long as it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

Projections for all provider types are provided in Exhibit K.

Exhibit L - Appropriations and Expenditures
This exhibit displays the FY 2008-09 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2008-09 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 Group	Old Title	New Title
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 (MMIS) 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 2008-09 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 2007-08, FY 2008-09, and FY 2009-10 in the chronological order of the events. Shaded areas indicate that the Request or appropriation has not yet taken place.

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, November 3, 2008, and February 16, 2009 Budget Requests to the FY 2008-09 appropriation including special bills, and the placeholder used by the Joint Budget Committee during the Department's Supplemental briefing.

For FY 2009-10, this exhibit compares the Department's November 3, 2008, February 16, 2009, and November 6, 2009 Budget Requests.

Exhibit P – Global Reasonableness

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. In addition, on page EP-3, this exhibit displays the FY 2009-10 year-to-date expenditures through September 2009 and the cash flow pattern of actual expenditures for the first quarter of FY 2008-09 to determine a rough estimate of FY 2009-10 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 EP-3.

Exhibit Q – Caseload Graphs

This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during the 2008 and 2009 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.

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. This bill was amended by SB 09-262, which is described below.

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. The Department assumes that these annualized amounts are reflected in overall trend selections for the Acute Care base expenditure.

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. The Department assumes that these annualized amounts are reflected in overall trend selections for the Acute Care base expenditure.

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 09-259 – FY 2009-10 Long Bill

The FY 2009-10 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2009 Legislative Session which impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- *Pharmacy Technical and Pricing Efficiencies (BRI-1):* This Budget Reduction Item reduces FY 2009-10 expenditure by an estimated $1,022,887, with an additional $1,110,999 reduction in FY 2010-11, as the result of an automated prior authorization system for pharmacy claims as well as through changing the reimbursement rates for drugs using a state maximum allowable cost structure.
- *Medicaid Program Efficiencies (BRI-2):* This Budget Reduction Item increases FY 2009-10 expenditure by an estimated $141,964, with an additional $464,864 increase in FY 2010-11. The Department will begin allowing trained medical and dental professional to administer fluoride varnish treatments to children up to age 6.
- *Community Transitions Services for Mental Illness Waiver Clients (BA-15):* This Budget Reduction Proposal estimates a reduction of $373,390 in FY 2009-10 expenditure due to clients utilizing the relatively less costly waiver services rather than residing in a facility. The savings annualizes to $388,324 in FY 2010-11.
- *Additional Certification for Outpatient Charges (BA-24):* This Budget Amendment annualizes the Department's updating of its "cost-to-charge" ratios for outpatient hospitals. The Department estimates a reduction of $4,897,557 in FY 2009-10.
- *Provider Volume and Rate Reductions (BA-33):* This Budget Reduction Proposal includes several initiatives to reduce Medicaid expenditure. The proposal includes some direct rate reductions, however, where possible, the Department presented ideas on how to reduce avoidable, inappropriate, duplicative or unnecessary volume and create efficiencies. Together, the following initiatives reduced the Medical Services Premiums budget request by $54,027,098 total funds:
    - Enroll Eligible Veterans in VA Health Care System: The Department estimates a reduction of $10,826,952 by increasing efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system. Of the total fund savings, $9,129,991 is a reduction of expenditure for Acute Care services, and $1,696,961 is a reduction to Community Based Long Term Care services expenditure.
    - Prior Authorization of Anti-convulsant Drugs: The Department estimates a reduction of $960,000 in expenditures for Acute Care services by adding anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses of anti-convulsants, excluding treatment for seizures.
    - Correct Home Health billing for Dual Eligibles: The Department estimates a reduction of $500,000 in Acute Care expenditure for home health services by implementing enhanced requirements to ensure that clients are fully exhausting their Medicare home health benefit or have Medicare determine the care is not a covered benefit before receiving the full Medicaid benefit. The savings is achieved by reducing the total claims which are inappropriately billed by providers and paid by Medicaid.

- Restrict Inpatient Hospital Claims for Readmission with in 24 Hours: The Department estimates a $1,400,000 reduction in Acute Care expenditure by altering its claims system to automatically deny a separate bill for clients who are readmitted to the same hospital for the same condition less than 24 hours after the initial discharge. Until system changes are complete, the Department, through its existing utilization review contracts, manually denies these claims.
- HCBS Cost Sharing for High Income Families: The Department estimates a reduction of $22,383 in Community Based Long Term Care services by implementing cost-sharing requirements for Home and Community Based Services programs for clients/families with incomes over $250,000.
- Reduce Pharmacy Reimbursement: The Department estimates a reduction of $3,489,218 in FY 2009-10 by reducing the reimbursement rates paid for pharmacies to the average wholesale price (AWP) minus 14.5% for brand-name drugs, and AWP minus 45% for generic medications.
- Reduce Selected Physician Codes to 100% of Medicare: The Department estimates a $5,432,902 reduction to Acute Care expenditure by reducing selected physician codes below 100% of the Medicare rate.
- Rate and Volume Reductions: The Department estimates a reduction of $30,833,418, in total Medical Services Premiums expenditure, equivalent to approximately 2% of Acute Care expenditure, is due to provider rate and volume reductions. An estimated reduction of over $20,300,000 is due to rate reductions effective July 1, 2009; these include fee-for-service Acute Care reductions as well as a reduction of $1,107,125 for HMO payments, $4,660,232 in Community Based Long Term Care services, and $505,223 for payments to Single Entry Points. The balance of savings is produced through volume reductions for programs, including:
  - Dental services
  - Durable Medical Equipment (DME)
  - Practitioner Services including Imaging, Physician Services (E&M), NEMT, and others
  - Home Health and HCBS Elderly Blind & Disabled Waiver, Persons with Mental Illness Waiver, and Persons Living with AIDS Waiver
  - Hospital Services

- *Enhanced Estate and Income Trust Recoveries (BA-36):* This Budget Reduction Proposal estimates that an additional $1,116,721 in estate and income trust recoveries in FY 2009-10 would be the direct result of the enhanced recovery efforts. The Department is in process of amending the contract with HMS, a contractor, to explicitly enhance estate and income trust recovery efforts. The Department estimates a reduction of $1,116,721 in FY 2009-10.
- *Increased Enrollment in Health Insurance Buy-In Program (BA-37):* This Budget Reduction Proposal estimates an increase in enrollment of 100 new HIBI clients for FY 2009-10 by repurposing existing resources to process a current backlog of HIBI applications. The administrative cost of this initiative is $336,538 in FY 2009-10, and the estimated savings in Acute Care

services in the same fiscal year is $961,538. The Department estimates that the initiative will result in an estimated overall savings of $625,000 in FY 2009-10.

- *Administrative costs for Colorado Alliance for Health and Independence (CAHI) Prepaid Inpatient Health Plan:* The Joint Budget Committee recommended and approved $500,000 in additional appropriated total funds for the 2009 Long Bill to implement the coordinated care for people with disabilities pilot program as directed by SB 06-128, which authorizes the Department to pay a per member per month administration fee.
- Transfer of Funds to Pediatric Specialty Hospital Line Item (Joint Budget Conference Committee Amendment): The Joint Budget Committee recommended and approved a transfer of $2,211,994 from the Pediatric Specialty Hospital Fund for use for general state expenditure.

SB 09-261 – Concerning the Use of Moneys in the Supplemental Old Age Pension Health and Medical Care Fund to Pay for Services Received by Certain Persons in the State Medicaid Program

This bill authorizes the use of the Supplemental Old Age Pension Health and Medical Care Fund for persons age 65 or older who are served through the state Medicaid program; the fund is used to cover Medicaid costs associated with clients age 65 and older who would have otherwise been eligible for the OAP Medical program. Moneys in the fund can be applied toward Medicaid expenditures for FY 2008-09 and FY 2009-10 only. General Fund expenditures for FY 2008-09 were reduced by a $3.0 million offset from the fund, and FY 2009-10 expenditures were reduced by a $6.0 million offset from the same fund.

SB 09-262 – Concerning the Funding Source for State Costs of the Breast and Cervical Cancer Prevention and Treatment Program

This bill amends HB 08-1373. The state cost for the Medicaid Breast and Cervical Cancer Prevention and Treatment Program was fully funded through the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Fund for FY 2008-09, and the state funding sources was due to change in FY 2009-10 to 50 percent from the General Fund and 50 percent from the BCCPT Fund. SB 09-262 specifies that 100 percent of the state funding for the program is from the BCCPT Fund for FY 2009-10 through 2011-12. Then, for FY 2012-13 and FY 2013-14, the formula returns to 50 percent General Fund and 50 percent BCCPT Fund. After FY 2013-14, the state cost for the program is paid 100 percent from the General Fund. This change impacted Medical Services Premiums expenditures in FY 2009-10 by reducing the needed General Fund expenditure by $874,603, with a corresponding increase from the BCCPT Fund.

SB 09-263 – Concerning Payments to Medicaid Nursing Facility Providers

SB 09-263 makes changes in the calculation of Medicaid nursing facility reimbursement rates. The bill specifies the method to calculate the General Fund share of payments to Medicaid nursing facilities during the federal American Recovery and Reinvestment Act (ARRA) time period; reduces the growth rate for the General Fund share from 3 to 0 percent in FY 2009-10, allows for 5 percent growth in FY 2010-11, and reinstates the current 3 percent cap in future fiscal years; specifies that payments made to nursing facilities as a result of provider fees and matching federal funds are supplemental payments instead of an additional per diem rate, and allows payments to be reduced by the Department of Health Care Policy and Financing based on available funding; limits the nursing facility

provider fee to $7.50 per non-Medicare-resident day in FY 2009-10, and allows the fee to increase by inflation in future years; limits the increase in the reimbursement of direct and indirect health care services and raw food to 8 percent per year, determined and indexed from the health care portion of rates effective on July 1, 2009; includes a hold-harmless provision for administration and general services under certain circumstances; and makes certain changes to the pay-for-performance payments for nursing facilities. The effect of SB 09-263 is discussed in detail in the section for Exhibit H in this narrative.

SB 09-265 – Concerning the Timing of Payments Made Under Public Medical Assistance Programs

SB 09-265 provides that, 1) the Medicare Modernization Act State Contribution Payment does not have to be paid before the date it is due, 2) managed care capitation payments shall not be made before the first day of the month following the enrollment of the recipients, and 3) the Department of Health Care Policy and Financing has the authority to delay the last weekly provider payment cycles in FY 2009-10 to after July 1, 2010. These provisions impact the Medical Services Premiums budget request as follows:

- The Department will delay the last weekly provider payment cycle in FY 2009-10 to after July 1, 2010. This delay will reduce the total funds expended for Medical Services Premiums in FY 2009-10, including: a $29,127,184 reduction in Acute Care expenditures, a $5,793,280 reduction in Community Based Long Term Care services, and the reimbursement for Class I Nursing Facilities will be reduced by $10,129,504. This is a one-time shift which will require corresponding increases in expenditure for each respective service category in FY 2010-11
- The Department will not make managed care capitation payments before the first day of the month following the enrollment of the recipients. This impacts the total funds expended for Medical Services Premiums in FY 2009-10 by effectively shifting the last monthly payment in FY 2009-10 to FY 2010-11 for the following service categories: payments for Acute Care services will be reduced by $11,850,594, Program of All-Inclusive Care for the Elderly (PACE) will be reduced by $6,427,375, and payments for Prepaid Inpatient Health Plans will be reduced by $380,781.

The Department's estimates in this request replace the estimates from the original fiscal note for SB 09-265.

SB 09-271 – Concerning the Use of Tobacco Revenues Generated Under Section 21 of Article X of the State Constitution in a State Fiscal Emergency

Pursuant to declaration of a state fiscal emergency in SJR09-35, for FY 2009-10 only, the bill expands the purposes for use of tobacco tax revenue (Amendment 35 moneys) in the Tobacco Education Programs Fund and the Prevention, Early Detection, and Treatment Fund. Specifically, moneys in these funds may be used for any health-related purpose and to serve persons enrolled in both the Children's Basic Health Plan and Medicaid. This change impacted Medical Services Premiums expenditures in FY 2009-10 by reducing the needed General Fund expenditure by $27,400,000, with corresponding offsets from the following funds: $8.0 million from the Tobacco Education Programs Fund, $12.0 million from the Prevention, Early Detection, and Treatment Fund, and $ 7.4 million from the Primary Care Fund.

Executive Order D 017 09 – Declaring Insufficient Revenues Available for Expenditures and Ordering Suspension of Certain State Programs and Services in order to Meet a Revenue Shortfall in Fiscal Year 2009-10

Executive Order D 017 09 included a series of initiatives presented by the Department to meet budget balancing goals. The budget request and/or spending authority for Medical Services Premiums was impacted by the following initiatives:

- ES-1, Enhanced Federal Funding Adjustments, is a net zero total funds request which reduces the General Fund by using the incremental savings to the Hospital Provider Fee Cash Fund due to the enhanced federal funds per the American Recovery and Reinvestment Act (ARRA) to offset General Fund expenditure. The savings is annualized in FY 2010-11.
- ES-2, Medicaid Program Reductions, reduces expenditure through combination of rate reductions, service restrictions, elimination of certain programs, increased cost-sharing, and financial efficiencies. Included in the request are seven initiatives which impact the Medical Services Premiums request:
    - Provider Rate Reductions: A 1.5% reduction in the reimbursement rate paid for providers of Acute Care and Community Based Long Term Care services as well as payments to Single Entry Points for FY 2009-10. The effective date is September 1, 2009. Rates paid to managed care organizations, including PACE, will have corresponding decreases totaling approximately 1.2%; effective date October 1, 2009, with the extra month to allow for actuarial rate certification. In addition, the reimbursement rate for Class I nursing facilities is reduced by 1.5%; the effective date is March 1, 2010, since a statute changes is necessary. These reductions are bottom line adjustments for FY 2009-10, and the respective annualized impacts are bottom line adjustments for FY 2010-11.
    - FQHC Payment Methodology: the Department reduced rates paid to federally qualified health centers (FQHC) by 50% of the difference between each provider's current rate and the minimum rate required under the Benefits Improvement and Protection Act of 2000 (BIPA), or an average of approximately 106% of BIPA, beginning September 2009. Currently, the Department pays FQHCs above the minimum rate required under federal law, set in the Benefits Improvement and Protection Act of 2000 (BIPA). The Department estimates that the statewide average reimbursement for FQHCs is currently 113% of BIPA.
    - Prenatal State Only Benefits: the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status retroactive back to July 2009; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).
    - Pharmacy Reimbursements: the Department reduced rates paid to pharmacies to average wholesale price (AWP) minus 14.5% for brand-name medications and AWP minus 45% for generic medication, beginning September 2009.

- Expand PDL: the Department is expanding its preferred drug list (PDL) by subjecting approximately $40,000,000 of gross pharmacy expenditure to new or additional restrictions under its PDL beginning March 2010, allowing the Department to receive an additional supplemental rebates back from manufacturers.
- Non-Medical Transportation Cap: the Department imposed a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients would be limited to two roundtrips per week. Trips to adult day programs are not be subject to the cap included limitations on the HCBS waiver transportation benefit.
- Personal Care Cap: the Department intended to impose a cap on the amount of personal care and homemaker services a client enrolled in a home and community based services waiver program can receive each day, effective January 1, 2010. Under the proposal, the Department would limit personal care expenditure to $72.05 per day, which is 150% of the daily rate for a client living in an alternative care facility. The Department is currently seeking alternative options to achieve the cost savings from this initiative.

- ES-4, Safety Net Grant Reductions, eliminates certain supplemental payments made to providers participating in the Colorado Indigent Care Program (CICP) and the associated administrative expenses These reductions to supplemental payments would be cash fund reductions to CICP line items that would be used to offset General Fund in the Medical Services Premiums line item.
- NP-ES#5, a Department of Human Services budget reduction initiative, closes 59 beds at the Colorado Mental Health Institute at Fort Logan. This impacts Medicaid as former residents of the Fort Logan institute relocate to an appropriate nursing facility.
- NP-ES#8, a Department of Human Services budget reduction initiative, closes a 32-bed Nursing Facility at Grand Junction Regional Center. This impacts Medicaid as former residents at the Regional Center relocate to and appropriate nursing facility.
- NP-ES#16 is a Department of Public Health and Environment budget reduction initiative which utilizes cash funds from the Tobacco Education Program Fund 18M to offset General Fund expenditure.
- NP-ES#17 is a Department of Public Health and Environment budget reduction initiative which utilizes cash funds from the Health Disparities Grant Program Fund 19F 18M to offset General Fund expenditure.
- NP-ES#18 is a Department of Public Health and Environment budget reduction initiative which utilizes cash funds from the Prevention, Detection and Treatment Fund 18N to offset General Fund expenditure.

S-8 Physician Supplemental Payment to Denver Health

S-8, Physician Supplemental Payment to Denver Health, provided the Department with spending authority to draw a federal financial match on uncompensated certified expenditures by Denver Health Medical Center on physician and other non-physician practitioner

professional services. The Department estimates an expenditure reduction of $6,420,530 in FY 2009-10, with an annualized impact of a $4,040,949 in FY 2010-11.

Average Wholesale Pricing Reduction

The Average Wholesale Pricing Reduction results from the impact of the settlement of providers with First Databank, which effectively reduces the average wholesale price (AWP) of certain drugs. First DataBank has agreed to a settlement with plaintiffs in a lawsuit that alleges the company colluded with prescription drug wholesaler McKesson to raise the average wholesale prices of prescription drugs. Effective in late September 2009, First DataBank agreed to reduce the AWPs for many drugs by five percentage points. Further, First DataBank will cease to publish the AWPs two years after the settlement is final. The estimated expenditure reduction is $5,058,978 in FY 2009-10, annualizing to and $6,812,036 in FY 2010-11.

Reduction to Synagis Recommended Dosage

The American Academy of Pediatrics altered its recommendation for the appropriate use of Synagis for client care. Synagis is the only Food and Drug Administration (FDA) approved medication to mitigate the risk of newborns and infants contracting respiratory syncytial virus (RSV). Previously, recommended courses of treatment required 6 doses of the medication. The new recommendations call for 3-4 doses given approximately a month apart. The Department estimates a decrease in expenditure of $1,259,131 in FY 2009-10.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and 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 in the long-term; 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 1/12th of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

Estimated Savings due to PACE Enrollments				
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	($616,960)	($120,683)	($59,561)	($797,204)
CBLTC	($1,066,798)	($157,755)	($77,857)	($1,302,410)
Total	**($1,683,758)**	**($278,438)**	**($137,418)**	**($2,099,614)**
FY 2010-11	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($333,506)	($60,648)	($32,239)	($426,393)
CBLTC	($576,670)	($79,279)	($42,141)	($698,090)
Total	**($910,176)**	**($139,927)**	**($74,380)**	**($1,124,483)**

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. As these changes were made and as the Department began tracking rebate revenue, rebate impact has been built into the Department's base budget. Throughout the budget process, as new information becomes available, new estimates are wrapped into the Departments standard budget requests. Currently, the Department estimates almost $2,000,000 in additional rebate from hospital administered drugs.

Estimated Drug Savings for 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
E	FY 2007-08 Hospital Administered Drug Expenditures	$12,444,033	Based on FY 2007-08 claims data
F	Estimated Annual Increase in Expenditure	7.75%	FY 2007-08 percent increase in pharmacy expenditure (Exhibit N)
G	Estimated FY 2010-11 Expenditure	$16,773,754	Row E * (1 + Row F)^3
H	Estimated FY 2010-11 Single Source Expenditure Receiving Additional Rebate	$10,902,940	Row G * (1 - Row C)
I	Estimated FY 2010-11 Multiple Source Expenditure Receiving Additional Rebate	$226,026	(Row G - Row H) * Row B The Department only anticipates receiving a rebate for the top 20 multiple source drugs
J	Estimated FY 2010-11 Total Expenditure Receiving Additional Rebate	$11,128,966	Row H + Row I
K	Estimated FY 2010-11 Additional Drug Rebate	($1,992,753)	Row J * Row A * Row D * -1

(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. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

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.

- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund.

- SB 09-265 delayed various Medicaid payments. The payments for the final week of FY 2009-10 for mental health fee-for-service was delayed until the beginning of FY 2010-11, thus reducing the FY 2009-10 expenditure and increasing the FY 2010-11 expenditure by the same amount. The bill also altered the timing of payments for the capitated mental health program. Beginning in the final month of FY 2009-10, capitation payments are paid in the month following rather than prospectively in the beginning of the month. This will produce a one-time savings as FY 2009-10 expenditure will only include eleven months of capitation payments.

- The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department's mental health programs in the following ways:

  1. As a part of ES-2 "Medicaid Program Reductions" the Department reduced the reimbursement rate for the mental health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years' mental health capitation payments. This was estimated to result in a total fund reduction of $8,520,268 and a General Fund reduction of $4,259,696 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund increase of $1,660,475 and a General Fund increase of $890,761 in FY 2010-11 (note, the incremental increase estimated for FY 2010-11 is due to the nature of the one time recoupment being built back into the out-year base budget).

  2. As a part of NP-ES-5 "Close Beds at the Mental Health Institutes" the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients of the capitated mental health program. While treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the "payer of last resort." Displacing these clients would allow them to be eligible to receive Medicaid funded benefits. This resulted in an estimated total fund increase of $582,420 and a General Fund reduction of $291,210 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund increase of $582,419 and a General Fund increase of $291,210 in FY 2010-11.

- HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans. Implementation of the bill for FY 2009-10 is contingent upon Centers for Medicare and Medicaid Services (CMS) approval. For FY 2010-11, the law results in a total fund increase of $8,062,050 and a Hospital Provider Fee Cash Fund increase of $4,031,025.

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 2009-10 Estimate and the FY 2010-11 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. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

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 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 methodology may 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 2009-10 Estimate and the FY 2010-11 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 2, 2009 Budget Request, Section F.

Calculation of Current Total Long Bill Group Impact (Exhibit AA):

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the 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 Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Medicaid Mental Health Programs. In previous budget requests, the Department has presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

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 Exhibit BB. The difference between the two figures is the Department's Decision/Base Reduction Item in the November Budget Request, and the Department's Budget Amendment in the February Supplemental Budget Request.

Of particular note is that the Department's ES-2 budget action of July 2009, which requires the Department to pay its Behavioral Healthcare Organizations at a rate -2.5% from the actuarially set rate midpoint (see above), is replaced by this Request. This request accounts for the impact of ES-2 as that impact changes due to changing caseload and actuarially set capitation rates.

For this budget cycle, the Department has also presented in this exhibit the incremental impact created by the American Recovery and Reinvestment Act (ARRA). See the description of ARRA impacts at the opening of "(2) Medical Services Premiums," in this document.

Calculation of Fund Splits (Exhibit BB):

Exhibit BB details fund splits for all Mental Health Community Programs budget lines for the current fiscal year Supplemental and the out-year 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 (prior to ARRA impacts, see the description of Exhibit AA, above). 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 or from Hospital Provider Fee funds. For FY 2009-10, implementation of the Hospital Provider Fee is contingent upon CMS approval. The numbers are presented for informational purposes and then removed from the build to the total estimated capitation expenditure (see exhibit JJ for tax and fee impacts on mental health expenditure). Finally, the recoupments for mental health capitation overpayments in prior years are also presented (see Exhibit II for recoupment calculations).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Health Care Expansion Fund clients are paid for with 50% cash funds from the Health Care Expansion Fund and 50% federal funds. Clients enrolled in the Breast and Cervical Cancer Prevention and Treatment Program (BCCP) are paid for with 35% state funds and 65% federal funds. State funding for 70% of the BCCP program comes from the Breast and Cervical Cancer Prevention and Treatment fund, and the remaining 30% of state funding comes from the Prevention, Early Detection, and Treatment fund (as reappropriated funds from the Department of Public Health and Environment). Expansion clients funded through HB 09-1293 receive state share funding from either the Hospital Provider Fee Cash Fund or (in future years) the Medicaid Buy-in Fund, and are discussed in more detail, below. These clients also receive a 50% federal match.

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.

An additional page has been added to Exhibit BB for the purpose of presenting ARRA impacts to funding. For FY 2009-10, those populations of clients not already receiving an enhanced federal match (e.g. Breast and Cervical Cancer Clients) received an increased federal match of 61.59% (from the established 50% match). For FY 2010-11, the increase in match is assumed to be the same, but is in place for only the first six months of that fiscal year. Therefore, the effective increase in match is half of the incremental increase of 11.59%, or 5.795%. ARRA has the effect of decreasing state-share responsibility for the entirety of the Medicaid Mental Health Programs, shifting expenditure from General Fund or various cash funds to federal funds.

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. (2009). 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.

Mental Health Services for Hospital Provider Fee Expansion Clients:

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients to be funded is parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients will be funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other adult expansion clients, and expenditure for these clients are therefore calculated using the same per capita rate as other adult clients (see exhibit JJ). In future years, additional expansion populations will receive funding through the Hospital Provider Fee Cash Fund as well as through the Medicaid Buy-in Fund. Currently, the Medicaid Buy-in Fund line is provided as a place-holder to ensure continuity of exhibits in future years.

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 do not include one-time events, such as the impact of a prior year overexpenditure restriction, but do include the impacts of actions with perpetual effect, such as the decrease in payment rates by 2.5%. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

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 include the Goebel lawsuit expenditures as incorporated into the expenditure history 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. The first table shows total caseload for the combined disabled categories as well as the combined Adult categories. The second table displays caseload by all Mental Health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. 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 caseload numbers and 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. The first table sets forth total per capita for the combined disabled categories as well as the combined Adult categories. The second table displays per capita by all Mental Health eligibility categories. However, since the actual per capita from the first table 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 fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures includes 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.

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. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the Colorado Financial Reporting System as fiscal periods close. Because the variance is minor, 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 current fiscal year and the request year.

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 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 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 (excepting Partial Dual Eligibles and Non-Citizens, as discussed, above).

The Department has broken down the current fiscal year and the request year in a two ways: first and second quarter estimate (Q1 and Q2), and a third and fourth quarter estimate (Q3 and Q4); The Department typically makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the actuarial midpoint of the rate from the previous two quarters (the first two

quarters of the calendar year). 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.

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.

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 percentage of claims paid in a six month period that come from that same period and those which come from pervious periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, 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 has taken approximately three 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. Hence, a larger percentage of claims from previous periods exists for this category of clients.

SB 09-265 also impacts the IBNR calculations (see the History and Background Information section of this narrative, above). Beginning in June 2010 and carrying forward into the future of the program, no claims will be paid in the month in which expenses were incurred. By switching managed care payments from the month in which services are delivered to the month following delivery of services, the IBNR factor changes drastically beginning in the second half of FY 2009-10.

On pages F.EE-4 through F.EE-6, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages EE-1 and 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 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 five 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 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 three 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 from eight, 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 comparisons to claims paid.

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 the average relationship percentage, from 100%.

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..

Beginning in January of 2009, the Department switched its rate setting cycle form a state fiscal year cycle to a calendar year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents it forecasted rates in six month blocks to account for the rate change occurring in the middle of a state fiscal year.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

Based on the Department's calculations and rate setting process, and input from the behavioral health organizations, the Department's actuaries certify a capitation rate range for each BHO and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "midpoint rate"), and add or subtract 5% from that rate to develop the upper and lower bounds for actuarial soundness. Exhibit GG presents the weighted midpoint rates, and the trend of those rates is used for forecasting. From January 1, 2009 to June 30, 2009, the Department paid rates 3% above the actuarial midpoint; however, these rates are not presented, here, in order to allow for comparison across years and so as to not artificially inflate the rate trend and therefore overestimate the rate in future years.

It is important to note that the overall weighted rate presented in the exhibit is weighted across two factors. 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 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 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 that are used as the source of the expenditure calculations provided in Exhibit EE. Page F.HH-2 presents the final rate estimates in their 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 or from historical changes, a point estimate is selected as an input into page F.HH-1. Based on the point estimates, the adjustments presented in Exhibit FF 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 on page F.HH-2 (see below). For Decision Items, the first rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year, due to the calendar year rate setting cycle. Finally, the rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

For Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described, below.

The projected rate is then adjusted by any policy impacts. In accordance with budget action ES-2, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. For the first six months forecast, this equates to two-thirds of that period being paid at a reduced rate. This is an effective cut of two-thirds of -2.5%, or -1.67%. For the remaining forecast periods, the full 2.5% reduction is presented. (This request replaces the ES-2 submission, with that action's provider rate decreases accounted for, here, and with ES-2's recoupment of overexpenditure accounted for in Exhibit II.)

The forecasted rate is also adjusted by the claims-based adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims are impacted by payments made for partial months of eligibility as well as payments made for clients determined to be eligible, retroactively; neither of these types of payments will be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the adjusted claims-based rate is adjusted a third time, 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.

Capitation Trend Models:
The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-2 and historical rates are presented in Exhibit GG.

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.

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.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. FY 2008-09 was a unique period for the mental health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes that the previous year's experience is the most predictive of the likely current year and future year experiences.

For 1) Adults 65 and Older, 2) Categorically Eligible Low Income Adults, and 3) Eligible Children, the change in rate from FY 2007-08 to FY 2008-09 was carried forward to the next change in the rate setting cycle, beginning January 1, 2010.

For Disabled Adults 60 to 64, a linear trend was selected. The rate for the disabled population has seen a steady year-to-year increase, from 6.39% to 7.79% annually, but for the Goebel settlement year (see the "History and Background" section of this narrative). The Department anticipates this linear growth to continue.

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 but at a reduced rate of change. The Department has selected the smallest magnitude historical rate change (the change from FY 2005-06 to 2006-07).

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. The Department's ES-2 budget action of July 2009, presented these recoupments for budget savings purposes. This portion of this Request replaces that component of ES-2. 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. SB 09-265 requires that, beginning with FY 2010-11, payments for a monthly capitation will be made in the month immediately following the incurred month. Because the Department will have an additional month to determine eligibility before processing payment, eligibility determination may be more accurately adjudicated prior to payments being made; this, in turn, may reduce the total amount of recoupments required at the end of each fiscal year.

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. This process has proven to be complicated by the various reporting practices of the community mental health centers that provide services to clients. The Department is currently working with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department anticipates implementing in FY 2009-10. Therefore, recoupment collection is anticipated to resume during FY 2009-10, and to be accelerated in its processing. Recoupments from FY 2004-05 through FY 2007-08 should be processed in the later half of FY 2009-10. FY 2010-11 recoupment collections should still cover FY 2008-09. The recoupments in FY 2010-11 from incurred expenses in FY 2008-09 will be altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved.

Cash Funded Expansion Populations (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 as well as the Colorado Health Care Affordability Act (HB 09-1293) to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note that the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Tobacco Tax Bill:

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, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, Optional Legal Immigrants eligible for services as a result of HB 05-1086, and Foster Care clients eligible for services up to the age of 21 as a result of beginning SB 07-002. 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 is 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 were paid for through the Health Care Expansion Fund due to the other 20 clients not being Medicaid eligible at the time these slots were approved. Based on the consistently increasing number of individuals on the waitlist for the Children's Extensive Support waiver, the Department requested that the remaining 20 slots approved for FY 2006-07 be paid out of the Health Care Expansion Fund as well. In total, the Department expects to pay for 79 Children's Extensive Support expansion slots. Exhibit JJ provides additional detail regarding the Department's 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 were taken from the Department's caseload projections provided in this 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's caseload projections are provided in this Budget Request (see Exhibit B in Medical Services Premiums). As with Expansion Adults, the rate of per capita growth for this expanded Foster Care population is assumed to be the same as for the traditional Foster Care population. However, unlike the Expansion Adults, the individually identified costs of the expansion foster care clients are used as the base upon which the per capita cost growth rates in the larger Foster Care population are applied.

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. Based on a review of the asset test population in FY 2008-09, it was concluded that approximately 70.1% 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 built its estimated caseload and per capita growth rates from the last completed fiscal year by applying the last known changes to the current year as well as the growth rates from the estimated current year to the request year.

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. See the Tobacco Tax Report in this Budget Request for the Department's caseload projections for this group.

Colorado Health Care Affordability Act:
HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans in FY 2009-10 and beyond. Implementation of the bill for FY 2009-10 is contingent upon Centers for Medicare and Medicaid Services (CMS) approval

The first expansion population to be affected by HB 09-1293 is the expansion adult population described, above, but now with income limits up to 100% of the federal poverty level. The Department has presented caseload calculations in this Request (see Exhibit B in Medical Services Premiums) for this population. The Department also anticipates that the costs for this population will 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.

(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 current fiscal year's estimated expenditure is based on last fiscal year's actual expenditures, trended forward based upon the expected change in caseload. Similarly, the request year estimate is the result of a forward trend of the current year estimate by the factor of the anticipated change in caseload.

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.

For 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 2009-10 appropriation is 4.83% lower than FY 2008-09 actual expenditures, primarily due to the various expenditure cutting initiatives implemented in light of the state budget shortfall. The FY 2009-10 estimate incorporates increased caseload projections and results in a 3.08% decrease from FY 2008-09 actual expenditures but a 1.84% increase from the current appropriation. The FY 2010-11 Budget Request is built on the FY 2009-10 estimate, and presents a 21.51% expenditure increase. This increase is primarily due to 1) increased caseload projections for traditional clients, 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations, and 3) adjustments to the base budget to replace one-time savings measures from FY 2009-10 (such as the MMIS delay from SB 09-265). The FY 2010-11 Request represents a 23.75% increase over the current appropriation.

(4) INDIGENT CARE PROGRAM

The Indigent Care Program Long Bill group consists of the Colorado Indigent Care Program, Colorado Health Care Services payments, the Children's Basic Health Plan, the Primary Care Fund Program, and the Comprehensive Primary and Preventive Care Grants Program. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. A description of each program, the budget history, and the FY 2010-11 budget request amounts are presented below.

COLORADO INDIGENT CARE PROGRAM

The Colorado Indigent Care Program provides direct or indirect funding to hospitals and clinics that have uncompensated costs from treating underinsured or uninsured Coloradans. It is neither an insurance program nor an entitlement program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. In FY 2007-08, total payments to indigent care providers through the Colorado Indigent Care Program equaled $174,079,470 and 195,000 clients were served by the program. As of FY 2009-10, the program consists of the following five line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; Health Care Services Fund Programs; Pediatric Specialty Hospital; and Comprehensive Primary and Preventive Care Rural and Public Hospital Grant Program. 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 (DSH) and Medicare Upper Payment Limit (UPL). 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 DSH Allotment and the Medicare UPL. 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. Included in this federal legislation was further fiscal relief for Disproportionate Share Hospitals beginning in FFY 2004. From FFY 2004 to FFY 2008, the State DSH annual limit is set to be $87,127,600 (or 16% growth over the FFY 2003 DSH limit). For FFY 2009 the DSH allotment was increased to $90,612,704, which translated to an allotment of $89,741,428 for the State FY 2008-09. In addition, on February 17, 2009, the President signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). Among other things, this legislation authorized an increase in the DSH allotment of 2.5% each federal fiscal year through FFY 2010, after which the determination of each state's DSH allotment will proceed without regard to the increased DSH allotments received during the relevant ARRA period.

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, pages EK-6-7 in the Department's November 3, 2008 FY 2009-10 Budget Request, Volume I. For calendar year 2007 data, this information can be found in Exhibit K, pages EK-6-7 in the Department's November 6, 2009 FY 2010-11 Budget Request, Volume I.

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," which 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 a provider have taxing authority in order to be defined as such. 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 rules published by the Centers for Medicare and Medicaid Services, specifically 42 CFR §433.50, would make Colorado's public hospitals ineligible for federal financial participation under the Upper Payment Limit and Disproportionate Share Hospital payments as they do not have taxing authority. 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 imposed a two-year moratorium on implementing the Centers for Medicare and Medicaid Services proposed rule. Congress determined that, due to the extensive impact of the Centers for Medicare and Medicaid Services 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. While the moratorium was initially set to expire in April of 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) imposed further restrictions on the proposed regulations. Modifications to one of these regulations are relevant to the Colorado Indigent Care Program: Public Provider Cost Limit Regulation (CMS 2258-FC). This regulation would change public provider payments and financing arrangements with Medicaid programs. As a result of this regulation, Colorado would experience negative fiscal and programmatic impacts as the Department's ability to reimburse publicly owned hospitals for serving low-income individuals would be greatly reduced. Due to ARRA, the Centers for Medicare and Medicaid Services was instructed to cancel this regulation. However, as of June 2009 the Centers for Medicare and Medicaid Services had taken no further action on this rule.

Prior to the State's knowledge of the cancelling of this regulation and 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.

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, the FY 2003-04 Long Bill. Decision Item #6, "Change Methodology for Financing the Indigent Care Program and Disproprtionate Share Hospital Through Proposed Safety Net Funding Allocation," from the Department's November 1, 2002 FY 2003-04 Budget Request, requested the consolidation of the following line items into the new Safety Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. The primary goal in combining the line items was to create a more simplified system that could more easily be understood by Department staff, 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, this request 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 rules related to the reimbursement of Safety Net providers is given in the following matrix.

Payment Type	Public Hospitals	Private Hospitals
Low-Income Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Disproportionate Share Hospital federal funds limit imposed by federal law. Prior to ARRA, for FY 2009-10 this cap is expected to equal $90,612,704. 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 the 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 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 qualified providers for 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 $90,612,704 prior to ARRA, which increased the DSH allotment by 2.5%. 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 financial participation is limited to different amounts among 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.

For FY 2007-08, the Department received continuation funding of $296,188,630 through SB 07-239. Several pieces of legislation

were passed during the 2009 session affecting the FY 2008-09 appropriation to this line item. During the Department's FY 2009-10 Figure Setting dated March 18, 2009, Joint Budget Committee staff recommended several changes that were subsequently included in the add-ons to the FY 2009-10 Long Bill, SB 09-259. Among these was an increase to the line item pursuant to ARRA in the amount of $4,312,816 cash funds, equal to the difference between the prior and updated DSH allotments of $87,127,600 and $91,440,416. In addition, a total funds reduction in the amount of $456,978 was recommended to account for actual expenditures being historically lower than total appropriations, resulting in a final FY 2008-09 total fund appropriation to the line item of $304,357,286.

Per ARRA, the FY 2009-10 DSH allotment was again increased by 2.5% from the adjusted SFY 2008-09 DSH allotment of $91,440,416 to $94,619,485. This represents a total funds increase of $6,358,138 from the FY 2008-09 appropriation, and, per SB 09-259, the FY 2009-10 Long Bill, resulted in a FY 2009-10 appropriation of $310,715,422.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-4 "Reduce Funding for Indigent Care Programs," the Department proposed a reduction to the General Fund appropriated to the Safety Net Provider Payments line item. This resulted in a total fund reduction of $15,634,320 and a General Fund reduction of $7,817,760 to this line in FY 2009-10.

The Department's FY 2010-11 base request includes an annualized total fund decrease of $10,547,244 and a General Fund reduction of $5,273,622 pursuant to the Department's FY 2009-10 ES-4, which will eliminate the remaining General Fund appropriations to the line item. In addition to this reduction, an increase in the amount of $59,211,588 is being requested in FY 2010-11 pursuant to HB 09-1293, the "Colorado Health Care Affordability Act." This legislation will increase reimbursement to up to 100% of cost and refinance the line item using a fee assessed on hospitals in place of certified public expenditures as the state share necessary to draw federal funding for the reimbursement of providers. The FY 2010-11 base request for this line item is $343,745,446, consisting of $171,872,723 in cash funds and an equal amount in federal funds.

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 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. Pursuant to Section 25.5-3-112 (2) (b) (III), C.R.S. (2009), the Health Care Services Fund was appropriated $15,000,000 in FY 2007-08.

During the 2009 legislative session, the General Assembly passed SB 09-264, "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009." This bill directed the Department to retain federal funding received above 50% of total expenditures in some lines, and reduced cash funds appropriations in other line items for the duration of ARRA. The purpose of this directive was to offset General Fund shortfalls in the State's budget. In circumstances where line items contained statutorily-defined appropriations, statute was adjusted in the bill to allow a reduction in cash fund appropriations to maintain the same total fund appropriations while achieving state General Fund relief. The Colorado Health Care Services Fund is among the line items with defined appropriations. The FY 2008-09 appropriation was reduced by $2,081,250 pursuant to SB 09-264, resulting in a final appropriation to the Colorado Health Care Services Fund of $12,918,750 General Fund in FY 2008-09 (25.5-3-112 (1) (b) (II), C.R.S. (2009)).

SB 09-259, the FY 2009-10 Long Bill appropriation was set at $15,000,000 prior to the passage of SB 09-264, which in turn resulted in a total fund decrease to the line of $3,057,000 due to the enhanced federal financial participation. The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-4 "Reduce Funding for Indigent Care Programs," the Department included the early elimination of the Colorado Health Care Services Fund. This resulted in a total fund reduction of $11,943,000 and a General Fund reduction of $11,943,000 in FY 2009-10, eliminating the line item.

The Department is not requesting funding for the line item in FY 2010-11, as the statutorily-defined appropriations to the Fund expire at the end of FY 2009-10, pursuant to 25.5-3-112 (1) (b), C.R.S. (2009).

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 constant at the FY 2002-03 appropriation of $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 (FY 2006-07 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, the FY 2006-07 Long Bill. 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.

During the 2007 legislative session, the General Assembly passed HB 07-1258 which allows funding from the Health Care Services Fund to be used for any individual eligible for the Colorado Indigent Care Program (as opposed to only adults as intended by SB 06-044). In addition, HB 07-1258 requires that, to the extent possible, the Department pursue opportunities to maximize federal funds for the community health centers. While HB 07-1258 did not have an appropriation clause, passage of this bill resulted in the FY 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 for federal financial participation in the Health Care Services Fund, the Department submitted a supplemental request and stand alone budget request amendment, S-16-BA-10, "Federal Funds Appropriation for Health Care Services Fund Line Items," (FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments) to draw down $10,086,000 in federal funds. During FY 2007-08 Figure Setting, Joint Budget Committee staff recommended that this state funding be moved from the Health Care Services Fund Programs line item into the Children's Hospital, Clinic-Based Indigent Care line item. This appropriation was subsequently incorporated into the budget through the FY 2007-08 Supplemental Bill, HB 08-1285, bringing the final FY 2007-08 appropriation to $26,291,760.

In the FY 2008-09 Long Bill, HB 08-1375, the Department received continuation funding of $26,291,760. In order to comply with requirements at 25.5-3-112 (2) (b) (III) stating that the allocation of the Health Care Services Fund is to be based on prior utilization of services in FY 2008-09 and FY 2009-10, the Department submitted a supplemental request and stand alone budget request amendment, "Reallocation of the Health Care Services Fund," (S-12-BA-11, January 2, 2009 FY 2008-09 Supplemental Requests and FY 2009-10 Budget Request Amendments) to change the distribution of the fund based on prior utilization, which would result in Community Health Clinics administered by Children's Hospital receiving more of the fund relative to primary care clinics. The request was recommended by Joint Budget Committee Staff during Figure Setting and later approved by the Joint Budget Committee and incorporated into the FY 2008-09 Supplemental Bill, SB 09-187, resulting in an increase to the FY 2008-09 appropriation of $738,000.

During the 2009 legislative session, the General Assembly passed SB 09-264, "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009.'" This bill directed the Department to retain federal funding received above 50% of total expenditures in some lines, and reduced cash funds appropriations in other line items for the duration of ARRA to

offset General Fund shortfalls in the State's budget. In circumstances where line items contained statutorily-defined appropriations, statute was adjusted in the bill to allow a reduction in cash fund appropriations to maintain the same total fund appropriations while achieving state General Fund relief. Distributions from the Colorado Health Care Services Fund to the Children's Hospital, Clinic-Based Indigent Care and Health Care Services Fund Programs line items are among the line items with defined appropriations. The FY 2008-09 reappropriated funds appropriation to the Children's Hospital, Clinic-Based Indigent Care line item was reduced by $1,450,631 with a corresponding increase in the federal funds appropriation. The final total funds appropriation to the Children's Hospital, Clinic-Based Indigent Care line item was $27,029,760 in FY 2008-09, consisting of $3,059,880 General Fund, $9,004,369 reappropriated funds, and $14,965,511 federal funds.

Per SB 09-259, the FY 2009-10 Long Bill, this line item was appropriated $27,767,760. This appropriation included an increase of $738,000 total funds as a result of S-12-BA-11, "Reallocation of the Health Care Services Fund" (January 2, 2009 FY 2008-09 Supplemental Requests and FY 2009-10 Budget Request Amendments). The Long Bill appropriation was set prior to the passage of SB 09-264, which in turn resulted in a decrease to the line of $2,205,931 reappropriated funds and corresponding increase in federal funds. Finally, the request eliminating the Health Care Services Fund as included in the Department's ES-4 "Reduce Funding for Indigent Care Programs" removed all reappropriated funds appropriations from this line item and associated federal funds. The year-to-date FY 2009-10 appropriation to the line item is $6,119,760 total funds, consisting of $3,059,880 in General Fund with an (M) Headnote, indicating that federal funds received above 50% during the ARRA period must be used to offset General Fund reductions authorized by the Headnote, and that the General Fund saved in this way must be transferred to the General Fund.

The Department is requesting continuation funding for FY 2010-11 in the amount of $6,119,760 total funds.

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 Hospital Authority (Denver Health) and the remaining 82% to clinics. Of the 82% to be distributed to clinics, 18% must be distributed to clinics operated by licensed or certified health care facilities (hospitals) and the remaining 82% must be distributed to federally qualified health centers. This new line item contains only the funding for both Denver Health and the clinics that are operated by licensed or certified health care facilities.

In FY 2007-08 the line item received a $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 a supplemental request (S-16) submitted on January 2, 2008 allowed the Department to draw down federal funding for this line item. The final appropriation for FY 2007-08 was $11,053,421, which included retroactive and current federal funding totaling $6,139,421 and $4,914,000 reappropriated funds.

In the FY 2008-09 Long Bill (HB 08-1375), the Department received an appropriation of $9,828,000, which included continuation funding less the annualization of federal funding received retroactively for FY 2007-08. In order to comply with requirements at 25.5-

3-112 (2) (b) (III) C.R.S. (2009) stating that the allocation of the Health Care Services Fund is to be based on prior utilization of services in FY 2008-09 and FY 2009-10, the Department submitted a supplemental request and budget request amendment, S-12-BA-11, "Reallocation of the Health Care Services Fund," (January 2, 2009, FY 2008-09 Supplemental Requests and FY 2009-10 Budget Request Amendments). This request would provide authority for the Department to change the distribution of the fund based on prior utilization, which would result in Community Health Clinics administered by Children's Hospital receiving more of the fund relative to primary care clinics. The request was approved by the Joint Budget Committee, and later incorporated into that year's Supplemental Bill, SB 09-187, resulting in a decrease to the FY 2008-09 appropriation of $738,000.

During the 2009 legislative session, the General Assembly passed SB 09-264, "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009.'" This bill directed the Department to retain federal funding received above 50% of total expenditures in some lines, and reduced cash funds appropriations in other line items for the duration of ARRA to offset General Fund shortfalls in the State's budget. In circumstances where line items contained statutorily-defined appropriations, statute was adjusted in the bill to allow a reduction in cash fund appropriations to maintain the same total fund appropriations while achieving state General Fund relief. Distributions from the Colorado Health Care Services Fund to the Children's Hospital, Clinic-Based Indigent Care and Health Care Services Fund Programs line items are among the line items with defined appropriations. The FY 2008-09 reappropriated funds appropriation to the Health Care Services Fund Programs line item was reduced by $630,619 with a corresponding increase in federal funds. The final total funds appropriation to the Health Care Services Fund Programs line item was $9,090,000 in FY 2008-09, consisting of $3,914,381 reappropriated funds and $5,175,619 federal funds.

The FY 2009-10 Long Bill, SB 09-259, appropriated $8,352,000 total funds, which included a decrease of $738,000 total funds from S-12-BA-11, "Reallocation of the Health Care Services Fund," (January 2, 2009, FY 2008-09 Supplemental Requests and FY 2009-10 Budget Request Amendments) to complete the reallocation from the Health Care Services Fund. The Long Bill appropriation was set prior to the passage of SB 09-264, which in turn resulted in a decrease to the line of $851,069 reappropriated funds and a corresponding increase in federal funds. Finally, the request eliminating the Health Care Services Fund as included in the Department's ES-4 "Reduce Funding for Indigent Care Programs" (FY 2009-10 Budget Reductions, August 24, 2009) removed all reappropriated funds appropriations to this line item and associated federal funds appropriations, thus eliminating this line item.

The Department is not requesting funding for the line item in FY 2010-11, as the statutorily-defined appropriations to the fund expire at the end of FY 2009-10, pursuant to 25.5-3-112 (1) (b), C.R.S. (2009).

PEDIATRIC SPECIALITY HOSPITAL

The creation of this line item 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 Specialty Hospital line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing.

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 a lower Tobacco Tax revenue projection provided by Legislative Council Staff in June 2006 (FY 2007-08 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 had received an additional $200,000 in federal funding to match the state funds that were to be appropriated by HB 07-1359. Though 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 SB 07-239, 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 cash funds exempt for FY 2007-08, was included during the Department's FY 2008-09 Figure Setting on March 11, 2008 (page 155). 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 08-1375 (Long Bill Add-ons) increased the funding for this line item by $4,824. Of this total, 50% is cash funds exempt and 50% is federal funds. The resulting final FY 2007-08 appropriation was $8,447,802, consisting of $3,551,000 General Fund, $672,901 cash funds exempt, and $4,223,901 federal funds.

During the Department's Figure Setting for FY 2008-09, several adjustments were made to the revised FY 2007-08 appropriation. Annualization of the impacts of SB 07-097 (Allocation of Master Settlement Supplemental Account) increased the total funds appropriation by $425,810. Subsequently, a revised Tobacco Tax revenue forecast reduced the total funds appropriation by $8,400. The cash funds exempt appropriation to the line was reclassified as cash funds pursuant to HB 08-1320, "Eliminate Cash Fund Exempt Designation," which changed all cash funds exempt appropriations in the State budget to cash funds or reappropriated funds. Finally, the Joint Budget Committee recommended a total funds increase of $4,000,000 for The Children's Hospital because it is the State's only pediatric hospital. The FY 2008-09 Long Bill (HB 08-1375) appropriation was $12,865,212.During the supplemental process for FY 2008-09, Joint Budget Committee staff recommended and the Committee approved a reduction to the line due to revised estimates of revenue that would be received pursuant to the Tobacco Master Settlement Agreement. This common adjustment was subsequently incorporated into the FY 2008-09 Supplemental Bill, SB 09-187.

During the 2009 legislative session, the General Assembly passed SB 09-264, "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009.'" This bill directed the Department to retain federal funding received above 50% of total expenditures in some lines, and reduced cash funds appropriations in other line items for the duration of ARRA to offset General Fund shortfalls in the State's budget. In circumstances where line items contained statutorily-defined appropriations, statute was adjusted in the bill to allow a reduction in cash fund appropriations to maintain the same total fund appropriations while achieving state General Fund relief. Distributions of Tobacco Tax and Tobacco Master Settlement Funds to the Pediatric Specialty

Hospital Fund and the Supplemental Tobacco Litigation Settlement Moneys Account of the Pediatric Specialty Hospital Fund are among the line items with defined appropriations. Consequently, the cash fund and reappropriated funds appropriations to the line item were reduced by $51,292 and $68,000, respectively, while the federal funds spending authority was increased by $120,429, for a total funds increase to the line of $1,137. Also contained in SB 09-264 was a reclassification of a portion of the General Fund appropriations to the line item as General Fund Exempt, which had no net impact to the line's funding. The final FY 2008-09 appropriation to the line item was $12,829,721, consisting of $5,483,000 General Fund, $68,000 General Fund Exempt, $317,000 cash funds, $427,000 reappropriated funds, and $6,534,721 federal funds.

Several changes were made to the line item as a result of the passage of SB 09-259, the FY 2009-10 Long Bill. These changes were the result of Joint Budget Committee staff recommendations made during the Department's FY 2009-10 Figure Setting on March 12, 2009. Changes in the Amendment 35 (Tobacco Tax) revenue forecast resulted in a total fund increase to the line of $18,000, and revisions to the Tobacco Master Settlement revenue forecast resulted in a total fund decrease of $25,866. During Conference Committee for SB 09-259, the Joint Budget Committee recommended a transfer of spending authority in the amount of $2,211,994 total funds from the Department's Medical Services Premiums line item to the Pediatric Specialty Hospital. This was recommended because the Children's Hospital Kid's Street and Medical Day Treatment Programs did not qualify for fee-for-service reimbursement under Medicaid, but would qualify for a supplemental payment to Children's Hospital through the Colorado Indigent Care Program.

The FY 2009-10 Long Bill appropriation was $15,032,712. This appropriation was set prior to the passage of SB 09-264, which resulted in a decrease to the line of $557 total funds. SB 09-269, "Tobacco Litigation Settlement Adjustments" led to a decrease in the appropriation of $5,359 total funds due to the reallocation of funds as required in the bill.

As a part of ES-4, "Reduce Funding for Indigent Care Programs," (FY 2009-10 Budget Reductions, August 24, 2009) the Department requested that a technical adjustment be made in order to adjust the financial participation rates established in SB 09-264, which assumed a lower enhanced federal financial participation rate than the State is receiving. This resulted in a total funds increase to the FY 2009-10 appropriation of $557, and a year-to-date FY 2009-10 appropriation of $15,027,353 total funds. Of this total, $6,540,170 is General Fund, $116,827 is General Fund Exempt, $267,628 is cash funds, $387,173 is reappropriated funds, and $7,715,555 is federal funds.

The annualizations of SB 09-264, SB 09-269, and ES-4 in FY 2010-11 result in a net increase of $4,802 total funds from the FY 2009-10 appropriation. An adjustment to the projected Tobacco Master Settlement revenue forecast reduces the cash funds appropriation by $13,456, and an updated Amendment 35 Revenue Forecast reduced the Reappropriated Funds appropriation by $9,414, resulting in a base request of $15,009,285 total funds for the line item in FY 2010-11. Of this total, $6,612,411 is General Fund, $44,586 is General Fund Exempt, $310,730 is cash funds, $450,000 is reappropriated funds, and $7,591,558 is federal funds.

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. Further, the revenues fund tobacco use prevention services administered by the Department of Public Health and Environment as well as 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., (2009) 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. (2009), 50% of these above mentioned revenues are to be appropriated by the General Assembly to the Pediatric Specialty Hospital Fund as General Fund Exempt.

The FY 2007-08 Long Bill (SB 07-239) appropriated $513,000 total funds to the line. A revision to the projected Amendment 35 revenue led to a decrease in the line's funding equal to $13,800, for a final FY 2007-08 appropriation of $499,200 General Fund Exempt.

During the FY 2008-09 legislative session, the General Assembly passed SB 09-264, which reduced total funding to the line by $68,000 (see Pediatric Specialty Hospital). In addition, updates to the Amendment 35 revenue forecast reduced appropriations to the line by $4,200 for a final FY 2008-09 appropriation of $427,000 General Fund Exempt.

The FY 2009-10 Long Bill (SB 09-259) appropriation for this line was set at $504,000, which included an increase of $9,000 total funds from updates to the Amendment 35 revenue forecast. The Long Bill appropriation was set prior to the passage of SB 09-264, which in turn resulted in a decrease to the line of $103,000. To align the funding available for the line item with the Department's ES-4, the General Fund appropriation to the line item was reduced by $13,827, resulting in a year to date FY 2009-10 appropriation of $387,173. For FY 2010-11, the annualizations of SB 09-264 and ES-4 resulted in a net increase to the line of $72,241. In addition, the September 2009 amendment 35 Revenue Forecast reduced the appropriation to the line by $9,414, resulting in a year to date FY 2010-11 appropriation of $450,000, consisting entirely of General Fund Exempt dollars.

The Department's base request for this line item is $453,000 General Fund Exempt in FY 2010-11, which includes continuation funding plus $52,000 for the annualization of SB 09-264.

HB 05-1262 APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In 2005, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1) (c) (I) (A), C.R.S. (2009) 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.

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 Specialty Hospital Fund. However, since the Department did not receive authority to transfer the funds to the Department of Public Health and Environment in a Letternote or otherwise, there was some concern that the Department of Public Health and Environment would not receive the intended funds. To clarify the appropriation, the Joint Budget Committee appropriated the Department of Public Health and Environment's portion directly, effectively cutting the Department's appropriation by 50%. This amount only reflects the double-count of the funds transferred to the Pediatric Specialty Hospital Fund. In addition, a revision to the Amendment 35 revenue forecast reduced the appropriation by $13,800 for a final FY 2007-08 appropriation of $499,200 Cash Funds Exempt.

The FY 2008-09 Long Bill, HB 08-1375, appropriation was $495,000 which included a reduction of $4,200 based on revised Tobacco Tax revenue estimated by the Colorado Legislative Council. The cash funds exempt appropriation to the line was reclassified as cash funds pursuant to HB 08-1320, "Eliminate Cash Fund Exempt Designation," which changed all cash funds exempt appropriations in the State budget to cash funds or reappropriated funds. The final FY 2008-09 appropriation was $495,000 cash funds.

The FY 2009-10 Long Bill, SB 09-259, incorporated updates to the Amendment 35 revenue forecast, which led to an increase in the appropriation of $9,000. The year-to-date FY 2009-10 appropriation is $504,000 cash funds.

For FY 2010-11 the Department is requesting continuation funding of $504,000 for this line item.

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 (2) (b), C.R.S. (2009) and distributes funds generated from Amendment 35 (Tobacco Tax) to the providers based on the portion of medically indigent or uninsured patients they served relative to the total number of medically indigent or uninsured clients served by all qualified providers. For more information on Amendment 35 and the programs funded with tobacco taxes, please see the Tobacco Tax Update in Volume 2 of the November 6, 2009 FY 2010-11 Budget Request. To be a qualified provider, an entity must:

- accept all patients regardless of their ability to pay, using either a sliding fee schedule or providing benefits at no charge;
- serve a population that lacks adequate health care services;
- provide cost-effective care;
- provide comprehensive primary care for all ages;
- screen and report eligibility for the Medical Assistance Program, Children's Basic Health Plan, and the Indigent Care Program; and
- be a federally qualified health center per Section 330 of the federal Public Health Services Act **or** have a patient base that is at least 50% uninsured, medically indigent, a participant in Children's Basic Health Plan, a participant in the Medical Assistance Program, or any combination thereof.

The FY 2007-08 Long Bill, SB 07-239, reduced the appropriation for the Primary Care Fund by $499,460 from the FY 2006-07 appropriation of $32,939,958 based on the anticipated drop in Tobacco Tax revenues addressed during FY 2007-08 Department Figure Setting on March 8, 2007. In addition, the Joint Budget Committee approved DI-12, Internal Audit of Primary Care Fund," (November 1, 2006 FY 2007-08 Budget request and March 8, 2007 Figure Setting, page 68), which moved $75,200 out of the Primary Care Fund appropriation into the (1) Executive Director's Office; (A) General Administration, Personal Services line item 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 cash funds exempt.

During the Department's FY 2008-09 Figure Setting on March 11, 2008, funding for this line item was decreased by $1,090,498 to reflect an updated Tobacco Tax revenue forecast. In addition, the funding used to audit the program in FY 2007-08 was restored for FY 2008-09 with 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 transferred from this line item into the Executive Director's Office, reducing the appropriation by $55,343. Finally, the cash funds exempt appropriation to the line was reclassified as cash funds pursuant to HB 08-1320, "Eliminate Cash Fund Exempt Designation," which changed all cash funds exempt appropriations in the State budget to cash funds or reappropriated funds. The final FY 2008-09 appropriation for this line was $31,294,657 cash funds.

Per SB 09-259, the FY 2009-10 Long Bill appropriation of $24,520,000 included an increase of $625,343 to account for anticipated growth in Amendment 35 revenues during FY 2009-10. SB 09-271, which concerns the emergency use of tobacco tax revenues during a state fiscal emergency, later reduced funding to this line item by $7,400,000 in order to offset General Fund of equal amount in (2) Medical Services Premiums Long Bill group, bringing year-to-date FY 2009-10 appropriations to the line item to $24,520,000.

The base request for this line item is for $31,920,000 cash funds, which includes continuation funding and the annualized impact of SB 09-271.

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 counter some of the adverse effects resulting from low reimbursement rates to hospitals combined with increases in unreimbursed costs to these providers. Most notable amongst these effects is a shifting of costs from providers to the general population in the form of higher prices charged for medical services as hospitals attempt to recover some portion of these losses. 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 State Plan Amendments (TN 06-13 for Inpatient Hospital Services and TN 06-014 for Outpatient Hospital Services) on September 29, 2006 to the Centers for Medicare and Medicaid Services. Pursuant to 29-28-103 (2) C.R.S. (2009), local governments electing to participate in the fee collection program are required 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 S-17, BA-11, "Federal Funds Match for Local Government Provider Fees," FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, January 2, 2008, the Department's FY 2007-08 Supplemental Requests, 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 S-17, BA-11, "Federal Funds Match for Local Government Provider Fees," on January 2, 2008 (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment) in order to receive equal federal financial participation for fees collected by local governments as authorized by the passage of SB 06-145. The initial appropriation for ongoing and retroactive funding requested through S-17 was included in the FY 2007-08 Supplemental Bill, HB 08-1285, while the removal of retroactive federal funding for the line's operation prior to FY 2007-08 was requested through BA-11, which was incorporated into the FY 2008-09 Long Bill, HB 08-1375. As of November 3, 2008, only the City of Brighton had elected to participate in the collection of inpatient provider fees. Estimates produced by the Department for the purposes of the associated request found that $2,112,929 in collected fees would be eligible for federal financial participation in FY 2006-07 and FY 2007-08, 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 submitted S-16, "Revised Implementation of SB 06-145" on January 2, 2009, (FY 2008-09 Supplemental Requests) eliminating the FY 2008-09 appropriation and delaying indefinitely implementation of the Local Government Provider Fee and appropriations to the SB 06-145 Inpatient Hospital Payments line item.

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 The Department submitted S-17, BA-11, "Federal Funds Match for Local Government Provider Fees," on January 2, 2008 (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment)) in order to receive equal federal financial participation for fees collected by local governments as authorized by the passage of SB 06-145. The initial appropriation for ongoing and retroactive funding requested through S-17 was included in the FY 2007-08 Supplemental Bill, HB 08-1285, while the removal of retroactive federal funding for the line's operation prior to FY 2007-08 was requested through BA-11, which was incorporated into the FY 2008-09 Long Bill, HB 08-1375. As of November 3, 2008, the City of Brighton had elected to participate in the collection of outpatient provider fees. Estimates produced by the

Department for the purposes of the associated request found that $2,992,746 in collected fees would be eligible for federal financial participation in FY 2006-07 and FY 2007-08, which with the inclusion of the federal match resulted in a final appropriation for FY 2007-08 of $5,985,492. This amount 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 submitted S-16 "Revised Implementation of SB 06-145" on January 2, 2009 (FY 2008-09 Supplemental Requests), eliminating the FY 2008-09 appropriation and delaying indefinitely implementation of the Local Government Provider Fee and appropriations to the SB 06-145 Outpatient Hospital Payments line item.

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, per 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. This eligibility expansion was suspended in SB 09-211 due to budget constraints.

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.

The Department has historically requested a cash funds appropriation for annual enrollment fees in its Change Request for the Children's Basic Health Plan Premium Costs line. Beginning with the FY 2008-09 Supplemental bill, the cash funds appropriation to this line item was eliminated, as statute allows for these fees to be collected in the Trust Fund without an appropriation. Thus, this line item will reflect only any appropriations to the Trust required to support program costs in excess of the Fund balance.

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 S-3, see FY 2007-08 Figure Setting, March 8, 2007, pages 79-80). This funding increase was a result of the Department's FY 2007-08 DI-3 and BA-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. These requests can be found in the Department's November 1, 2006 FY 2007-08 Budget Request and the Department's February 15, 2008 FY 2007-08 Budget Request Amendment for the Children's Basic Health Plan. The 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 S-3, "Updates to Children's Basic Health Plan Medical Premium and Dental Benefit Costs" 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, HB 08-1375, removed one-time funding of $5,576,155 and increased the cash funds appropriation by $85,263 from the FY 2007-08 appropriation (FY 2008-09 Figure Setting, March 11, 2008, page 179). The increase in the cash funds appropriation was a result of the annualization of SB 07-097 and caseload increases included in the following FY 2008-09 Department requests:

- DI-3 and BA-A3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs;" (November 1, 2007 FY 2008-09 Budget Request and FY 2008-09 Budget Request Amendment for the Children's Basic Health Plan, February 15, 2008);
- DI-3A "Additional Children's Basic Health Plan Outreach," (November 1, 2007 FY 2008-09 Budget Request); and
- BA-A1A "Building Blocks to Health Care Reform," (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15 2008).

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. During the Department's January 29, 2009 Supplemental Hearing, Joint Budget Committee Staff recommended and the Committee approved the elimination of the cash funds appropriation to this line item. As a result, the cash funds appropriation was reduced by $375,717 in the Department's Supplemental Bill (SB 09-187). Accompanying the Department's submission of S-23, "Delay CHP+ Expansion to 225% FPL in the Department's January 15, 2009 FY 2008-09 Budget Reduction Proposals, SB 09-211 was passed during the 2009 legislative session to eliminate this expansion, resulting in a reduction in the cash funds appropriation of $30,328. The FY 2008-09 final appropriation was $0.

FY 2009-10 Appropriation for the Trust

The FY 2009-10 Long Bill (SB 09-259) included a General Fund appropriation of $2,500,000 to the Trust Fund for anticipated funding needs in FY 2009-10 pursuant to DI-3 and BA-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs." (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Budget Request Amendment for the Children's Basic Health Plan,

February 16, 2009) SB 09-269 appropriated $1,000,000 General Fund to the Trust as a partial replacement of reduced Tobacco Master Settlement revenue anticipated in FY 2009-10 due to the reallocation of funds as required in the bill. The FY 2009-10 appropriation is $3,500,000 General Fund.

FY 2010-11 Base Request for the Trust
The base request is to remove one-time funding of $3,500,000 General Fund to the Trust, resulting in a request of $0.

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION
This line item funds private contracts for administrative services associated with the operation of the Children's Basic Health Plan. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to clients enrolled in 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 financial participation for the Medicaid program is 50%. The federal financial participation for 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 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 DI-4 "Implementation of HB 06S-1023 and Deficit Reduction Act of 2005," submitted in the Department's November 1, 2006 FY 2007-08 Budget Request.

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 (HB 08-1375) 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, DI-3A, "Additional Children's Basic Health Plan Outreach" (November 1, 2007 FY 2008-09 Budget Request) was approved and resulted in a $1,400,000 increase to the total appropriation. The Department's February 15, 2008 FY 2008-09 BA-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, "Eliminate Cash Fund Exempt Designation" 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. Pursuant to the Department's S-18 "Suspend Outreach Efforts," submitted in the Department's January 15, 2009 FY 2008-09 Budget Reduction Proposals, the appropriation for administration was reduced by $600,000. The FY 2008-09 appropriation was $6,352,590 total funds, including $2,785,791 cash funds and $3,566,799 federal funds.

FY 2009-10 Appropriation for Administration

The FY 2009-10 Long Bill (SB 09-259) appropriation for administrative costs include the removal of one-time funding totaling $16,000 from BA-A1A "Building Blocks to Health Care Reform" (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008) and SB 08-160. The appropriation also included the annualization of SB 09-187, which removed the appropriation for $1,400,000 in additional outreach funding approved pursuant to DI-3A, "Additional Children's Basic Health Plan Outreach" which was initially requested in the Department's November 1, 2007 FY 2008-09 Budget Request. This resulted in a reduction of $816,000 from the FY 2008-09 appropriation. The FY 2009-10 appropriation is $5,536,590, including $2,472,951 cash funds and $3,063,639 federal funds.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-3, "Department Administrative Reductions," the Department proposed the elimination of currently uncommitted outreach funding from the Children's Basic Health Plan Administration line item. This results in an on-going reduction of $250,000 total funds to this line beginning in FY 2009-10.

FY 2010-11Base Request for Administration
The FY 2010-11 base request is for $5,306,513, which includes continuation funding of $5,287,590, the removal of $1,000 of one-time funding from SB 08-160 "Health Care for Children," and an increase of $19,926 for the annualization of HB 09-1293, "Colorado Health Care Affordability Act." This bill increases eligibility in the Plan to 250% of the federal poverty level and results in increased external quality review costs. The base request consists of $2,383,912 cash funds and $2,922,604 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). The federal share of funding is from Title XXI (State Children's Health Insurance Program). Title XXI provides a 65% federal financial participation rate 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. Beginning in FY 2008-09, enrollment fees were spent in the Premiums Costs line as cash funds. However, there is no federal financial participation 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 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 S-3, see FY 2007-08 Figure Setting March 8, 2007, pages 79-80). This funding increase was as a result of the Department's FY 2007-08 DI-3 and BA-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 (November 1, 2006 FY 2007-08 Budget Request and FY 2007-08 Budget Request Amendment for the Children's Basic Health Plan, February 15, 2007).

The Long Bill appropriation was later increased for four special bills, including SB 07-004, which 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 was $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 S-3 "Updates to Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (FY 2007-08 Supplemental Request, February 15, 2008 and Figure Setting, 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 DI-3 and S-3-BA-A3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (November 1, 2007 FY 2008-09 Budget Request and FY 2008-09 Budget Request Amendment for The Children's Basic Health Plan, February 15, 2008), 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 DI-3A "Additional Children's Basic Health Plan Outreach," requested in the Department's November 1, 2007 FY 2008-09 Budget Request, which included a forecasted increase in the children's caseload. As a result of the Department's February 15, 2008 BA-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 (FY 2008-09 Figure Setting, March 11, 2008, page 168). This line item was also impacted by the passage of HB 08-1320, "Eliminate Cash Fund Exempt Designation" 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 FY 2008-09 appropriation for base caseload and per capita costs was decreased by $23,374,872 in the Department's Supplemental bill (SB 09-187) based on estimates from the Department's November 3, 2008 FY 2009-10 Budget Request as contained in DI-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (Supplemental document dated January 29, 2009, page 43). This appropriation included the impact of eliminating the cash funds appropriation to the Trust Fund, which in turn eliminated the reappropriated funds in the Premiums Costs line item. Pursuant to updated estimates included in the Department's S-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (FY 2008-09 Supplemental Request for the Children's Basic Health Plan, February 16, 2009 and FY 2009-10 Figure Setting, March 12, 2009, page 153), the appropriation was further decreased by $7,600,324 in SB 09-259 (FY 2009-10 Long Bill Add-ons).

The appropriation was also increased for two special bills from the 2008 legislative session. 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.

Accompanying the Department's submission of S-23, "Delay CHP+ Expansion to 225% FPL in the Department's January 15, 2009 FY 2008-09 Budget Reduction Proposals, FY SB 09-211 was passed during the 2009 legislative session to eliminate the eligibility expansion to 225% of the federal poverty level, resulting in a reduction to the appropriation of $2,883,046. The FY 2008-09 appropriation was $120,880,965 total funds, consisting of $42,505,174 cash funds and $78,375,791 federal funds.

FY 2009-10 Appropriation for Premiums Costs

The FY 2009-10 Long Bill appropriation included annualizations totaling $8,925,037 for the previously discussed items listed below:

- SB 08-057, Insurance Coverage for Hearing Aids for Minors;
- SB 08-160, Health Care for Children;
- SB 09-211, Delay CBHP Eligibility Expansion;
- DI-3A "Additional Children's Basic Health Plan Outreach," (November 1, 2007 FY 2008-09 Budget Request); and
- BA-A1A, "Building Blocks to Health Care Reform," (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008).

In addition, the total funds appropriation was increased by $18,758,210 as a result of the Department's DI-3 and BA-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10

Budget Request Amendment for The Children's Basic Health Plan, February 16, 2009) which requested an increase to the caseload forecasts and estimated per client costs. The appropriation was decreased by $2,900,000 pursuant to BA-33, "Provider Volume and Rate Reductions," (FY 2009-10 Budget Reduction Proposals, January 23, 2009) as a result of additional reinsurance recoupments and participation in the Vaccines for Children program. The FY 2009-10 Long Bill appropriation was $145,664,212, consisting of $48,696,353 cash funds, $2,500,000 reappropriated funds, and $94,467,859 federal funds.

The FY 2009-10 appropriation was decreased by $12,225,344 due to the adoption of SB 09-265, Timing of Medicaid and CHP+ Payments, which shifts the date of payment for managed care capitations from the concurrent month to the beginning of the month following enrollment. The FY 2009-10 appropriation is $133,438,868 total funds, consisting of $44,417,482 cash funds, $2,500,000 reappropriated funds, and $86,521,386 federal funds.

FY 2010-11 Base Request for Premiums Costs

The FY 2010-11 base request is for $195,047,718, which includes continuation funding of $133,438,868 plus $12,225,344 for the annualization of SB 09-265, which included one-time savings. An additional annualization of $49,383,506 is included for HB 09-1293, "Colorado Health Care Affordability Act," which expands eligibility in the Plan to 250% of the federal poverty level. The base request includes $68,646,168 cash funds and $126,401,550 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).

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 S-3, see FY 2007-08 Figure Setting, 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 S-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (FY 2007-08 Supplemental Request, February 15, 2008 and Figure Setting,

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 DI-3 and BA-A3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," (November 1, 2007 FY 2008-09 Budget Request and FY 2008-09 Budget Request Amendment for The Children's Basic Health Plan, February 16, 2008) 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, 2007 DI-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 BA-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, "Eliminate Cash Fund Exempt Designation," 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.

The FY 2008-09 appropriation for base caseload and per capita costs was decreased by $1,763,681 in the Department's Supplemental bill (SB 09-187) based on estimates from DI-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," submitted in the Department's November 3, 2008 FY 2009-10 Budget Request, (Supplemental document dated January 29, 2009, page 43). Pursuant to updated estimates included in S-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs" (FY 2008-09 Supplemental Request for The Children's Basic Health Plan, February 16, 2009 and FY 2009-10 Figure Setting March 12, 2009, page 153), the appropriation was further decreased by $328,678 in SB 09-259 (FY 2009-10 Long Bill Add-ons).

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. Accompanying the Department's submission of S-23, "Delay CHP+ Expansion to 225% FPL in the Department's January 15, 2009 FY 2008-09 Budget Reduction Proposals, SB 09-211 was passed during the 2009 legislative session to eliminate the eligibility expansion to 225% of the federal poverty level, thus reversing the appropriation of $282,415. The FY 2008-09 appropriation is $10,078,035 total funds, including $3,526,612 cash funds and $6,549,423 federal funds.

FY 2009-10 Appropriation for Dental Benefit Costs

The FY 2009-10 Long Bill appropriation included annualizations totaling $812,800 for the previously discussed items listed below:

- SB 08-160, Health Care for Children;
- SB 09-211, Delay CBHP Eligibility Expansion;
- DI-3A "Additional Children's Basic Health Plan Outreach," (November 1, 2007 FY 2008-09 Budget Request); and

- BA-A1A, "Building Blocks to Health Care Reform," (FY 2007-08 Supplemental and FY 2008-09 Budget Request Amendment, February 15, 2008).

In addition, the total funds appropriation was increased by $59,627 as a result of DI-3 and BA-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," (November 3, 2008 FY 2009-10 Budget Request and FY 2009-10 Budget Request Amendment for The Children's Basic Health Plan, February 16, 2009) which requested an increase to the caseload forecasts and estimated per client costs. The FY 2009-10 Long Bill appropriation was $10,948,462, consisting of $3,831,962 cash funds and $7,116,500 federal funds.

The FY 2009-10 appropriation was decreased by $886,113 due to the adoption of SB 09-265, Timing of Medicaid and CHP+ Payments, which shifts the date of payment for managed care capitations from the concurrent month to the beginning of the month following enrollment. The FY 2009-10 appropriation is $10,062,349 total funds, consisting of $3,521,822 cash funds and $6,540,527 federal funds.

FY 2010-11Base Request for Dental Benefit Costs
The FY 2010-11 base request is for $13,422,178, which includes continuation funding of $10,062,349 plus $886,113 for the annualization of SB 09-265, which included one-time savings. An additional annualization of $2,473,716 is included for HB 09-1293, "Colorado Health Care Affordability Act," which expands eligibility in the Plan to 250% of the federal poverty level. The base request includes $4,697,763 cash funds and $8,724,415 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. (2009), and provides funds in the form of grants to providers that expand primary and preventive health care services to low income, uninsured residents of Colorado. More specifically, the Comprehensive Primary and Preventive Care Grants Program aims to provide services to Colorado families who are at or below 200% of the federal poverty level. The program and the services it provides do not replace or substitute for State Medicaid, the Colorado Indigent Care Program, or the Children's Basic Health Plan.

Funds from the Comprehensive Primary and Preventive Care Grants Program can be awarded to qualified providers that demonstrate the intended use of funds to expand services to indigent Colorado residents. Because of this, grant money issued through the program can be used in many ways, though its primary applications are expanding clinics or hiring additional staff and purchasing equipment. Grants are available for one to three years on a gradually declining basis, depending on the type of project being funded.

Since FY 2000-01, the Comprehensive Primary and Preventive Care Grants Program received its funding from the Comprehensive Primary and Preventive Care Fund line item. 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 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.

The FY 2007-08 Long Bill (SB 07-239) appropriation was increased by a total of $65,526 from the FY 2006-07 appropriation of $2,401,126 due to a larger than anticipated Tobacco Master Settlement Agreement payment in FY 2006-07 and a reduction in the Tobacco Master Settlement projection.

During the 2007 legislative session, two special bills were passed that affected the Comprehensive Primary and Preventive Grants Program line. SB 07-097 appropriated an additional $2,000,000 from the Supplemental Tobacco Litigation Settlement Moneys Account, which was created within the Comprehensive Primary and Preventive Care Fund through the bill, 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. Statute at 24-75-1104.5 (1.5) (a) (III), C.R.S. (2009) requires an appropriation 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 this purpose. 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 line item. The final appropriation for FY 2007-08 was $4,138,070 cash funds exempt.

The FY 2008-09 Long Bill (HB 08-1359) was $6,459,236, which included the annualizations of SB 07-097 and HB 07-1359, in addition to a revision to the Tobacco Settlement Forecast. The FY 2008-09 appropriation had a technical change during the Department's FY 2008-09 Figure Setting to transfer the portion of 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. Finally, the cash funds exempt appropriation to the line was reclassified as cash funds pursuant to HB 08-1320, "Eliminate Cash Fund Exempt Designation" which changed all cash funds exempt appropriations in the State budget to cash funds or reappropriated funds. On January 2, 2009, the Department submitted S-13, "Federal Funding for the Rural and Public Hospitals Payment and Reorganization of the Indigent Care Program" to separate the funding received for the reimbursement of rural and public hospitals from the moneys used to fund the Comprehensive Primary and Preventive Care Grants Program. The request was approved, reducing the FY 2008-09 appropriation to this line by $3,286,155. In addition, a decrease in projected revenues into the Tobacco Master Settlement Cash Fund reduced the appropriation to this line item by an additional $90,401, bringing the final FY 2008-09 appropriation to $3,082,680 cash funds.

The FY 2009-10 Long Bill (SB 09-259) appropriation for this line was $866,075 cash funds, which included the impacts of several items from the 2009 legislative session. During the Department's FY 2009-10 Figure Setting on March 13, 2009, Joint Budget

Committee staff recommended an increase of $10,895 to this appropriation to account for an increase in projected Tobacco Master Settlement Revenues in FY 2009-10. Due to the economic downturn and the related General Fund shortfall, several budget balancing bills were introduced by the Joint Budget Committee near the end of the 2009 legislative session. Among these bills was SB 09-210, the objective of which was to backfill General Fund shortfalls with reserves from various Cash Funds. This bill reduced the appropriation to the Comprehensive Primary and Preventive Care Grants Program by $2,400,000. In order to partially mitigate the impact of this reduction, Joint Budget Committee staff recommended a transfer of fund balance from the Comprehensive Primary and Preventive Care Fund to this line item in the amount of $172,500.

Additional budget balancing bills further reduced the appropriation to this program. SB 09-269, which limited in aggregate the distributions from the Tobacco Master Settlement Cash Fund to $100,000,000 for FY 2009-10, reduced the appropriation to the Comprehensive Primary and Preventive Care Grants program by $99,177. The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-4 "Reduce Funding for Indigent Care Programs," the Department proposed a reduction to the line item of $639,082, equal to approximately 83% of the original FY 2009-10 appropriation. The year-to-date FY 2009-10 appropriation to the line item is $127,816 cash funds.

The base request for this line includes continuation funding and annualizations of SB 09-210 and SB 09-269, which will restore a total of $2,499,177 to the line item, while the annualizations of ES-4 and the Joint Budget Committee recommendation to transfer the fund balance to the line in FY 2008-09 will reduce funding to the line by $300,316. The FY 2010-11 base request of $2,326,677 cash funds.

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE RURAL AND PUBLIC HOSPITAL GRANT PROGRAM

Created by the passage of SB 07-097, the funding for this line item is an allocation (equal to 8.5%) of Tier II Tobacco Master Settlement Funds previously included in the Comprehensive Primary and Preventive Care Grants Program line item. Intended to help further offset the cost of providing care to large numbers of indigent clients, two distributions were written into statute. Up to 50% of the Tier II Settlement funding transferred to the Comprehensive Primary and Preventive Care Fund must be distributed to small rural hospitals (60 beds or less) serving a disproportionate number of medically indigent, uninsured, and Medicaid clients. At least 50% of the money transferred to the Supplemental Tobacco Master Settlement Account of the Comprehensive Primary and Preventive Care Fund (plus the remainder of funding not distributed to small rural hospitals) must be distributed to "all public hospitals." The Department distributes this pool of funding based on the volume of uncompensated care costs incurred by a given provider.

A separate line item containing the funding for these purposes was created as a result of the Department's January 2, 2009 Supplemental and Budget Request Amendment, S-13-BA-12, "Federal Funding for the Rural and Public Hospitals Payment and Reorganization of the Indigent Care Program." The FY 2008-09 appropriation was based upon the estimated Tier II funding to the Comprehensive Primary and Preventive Care Fund, equal to $3,286,155 in cash funds and $3,286,155 in matching federal funds for a

total appropriation of $6,572,310. During Figure Setting on March 13, 2009, Joint Budget Committee staff recommended a reduction in the appropriation to this line item of $311,348 total funds to account for a declining estimate of Tobacco Master Settlement Funds to be received by the State in FY 2008-09. In addition, SB 09-210, a budget balancing bill, reduced the appropriation for this line item by $1,260,962 total funds and simultaneously rebalanced the line item fund splits to account for the enhanced match to be received by the line under the American Recovery and Reinvestment Act of 2009 (ARRA). As with other line items affected by SB 09-264, rather than retaining the federal funds earned above 50% on the total appropriation, the cash fund appropriation was reduced and the federal funds increased to keep the appropriation at the intended total funds level while still achieving a General Fund savings. The final FY 2008-09 appropriation to the line item was $5,000,000, of which $2,153,125 was cash funds and $2,846,875 was federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriation was $6,041,096, which included the annualization of SB 09-210 and a reduction of $219,866 due to a revised Tobacco Master Settlement revenue forecast. SB 09-264 annualized the impact of SB 09-210 into FY 2009-10, increasing the FY 2009-10 year to date appropriation by $1,260,962 and rebalancing the fund splits in the line at the enhanced ARRA percentages applicable in FY 2009-10. The June 22, 2009 General Revenue forecast indicated that additional General Fund reductions would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-4 "Reduce Funding for Indigent Care Programs," the Department proposed an elimination of the line item. Due to a combination of the effects of SB 09-264 and the Department's ES-5, "Adjust Department Appropriations to Reflect Enhanced Federal Medicaid Assistance Percentage," the reduction included in ES-4 resulted in a year-to-date FY 2009-10 appropriation of $1,019,000 in federal funds only. Similarly, the annualizations of SB 09-264 and ES-4 result in a positive appropriation of $738,752 for this line item. The Department is including a technical adjustment to this line to remove all funding, which has been included in the FY 2010-11 Reconciliation Table submitted with the November 6, 2009 FY 2010-11 budget request. In addition, the Department will be working with the Office of State Planning and Budgeting and the Joint Budget Committee staff to correct the line.

(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. 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 the Supplemental Old Age Pension Health and Medical Care Fund established in 25.5-2-101, C.R.S. (2009).

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. Through 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 the FY 2002-03 Long Bill (HB 02-1420).

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 both the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S. (2009) was transferred from the Department of Human Services to the Department of Health Care Policy and Financing 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 overexpenditure authority; and, 3) the program was not affected by the cash accounting changes authorized in SB 03-196 (however, the program moved to cash accounting on July 1, 2007). 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.

Reimbursement Rate History

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 six 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 pharmacy 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. 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 "Funding Increase for Old Age Pension State Medical Program" (FY 2008-09 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.
- On January 9, 2009 the reimbursement rate was increased from 60% of the Medicaid rate to 65% of the Medicaid rate for the following expenditure categories: practitioner/physician services, outpatient claims, dental, medical supplies, home health care services, transportation, and independent laboratory claims. Reimbursement was increased from 70% to 75% of the Medicaid rate for pharmacy claims.
- Due to budget reductions in FY 2008-09, on February 1, 2009 the reimbursement rate increase of January 9, 2009 was reversed and the reimbursement rates were decreased to their level prior to January 9, 2009. The reduction in the reimbursement rates left funds available in the Supplemental Old Age Pension Health and Medical Care Fund to be used to balance the state budget for FY 2008-09.
- After additional analysis of the caseload for the program, the Department determined that under prevailing caseload trends, a reimbursement rate increase was possible, while still leaving the additional funds available in the Supplemental Old Age Pension Health and Medical Care Fund for budget balancing. As a result, on April 15, 2009, the reimbursement rate was increased from 60% of the Medicaid rate to 65% of the Medicaid rate for the following expenditure categories: practitioner/physician services, outpatient claims, dental, medical supplies, home health care services, transportation, and independent laboratory claims. Reimbursement was increased from 70% to 75% of the Medicaid rate for pharmacy claims.

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 federal 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 into the United States 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). The

Department believes 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.

During FY 2008-09, caseload remained steady, showing only a 0.5% decrease from the previous year. All of the system fixes were implemented to correct the problems identified above with the implementation of HB 06S-1023. Evidence in caseload data suggests that with the transition of eligible clients to Medicaid OAP-A, the caseload for this program has been reset to a new base from which normal caseload growth is expected. Based on monthly caseload data early indications are that the program is beginning to show a more normal expected caseload growth from the new base. The Department continues to monitor the monthly caseload data for the program.

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%	
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%	
FY 2008-09 Actual	4,271	-0.5%	

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 S-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 request included a request for an FTE in order to implement this program. This supplemental request 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 will not be implemented. For FY 2008-09, the Department submitted DI-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 through SB 03-299. During the Department's FY 2004-05 Figure Setting session,[18] 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 FY 2007-08 appropriation was 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.

[18] Page 139 Figure Setting March 9, 2004

As a result of DI-11 "Technical Adjustments to Old Age Pension State Medical Program" in the Department's FY 2007-08 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 was $15,311,715 which was 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 $25,500 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, 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 FY 2009-10 Long Bill (SB 09-259) appropriated $15,368,483 for this line. The increase is due to two Joint Budget Committee actions. While the Department had requested the $2,088,232 increase for a single year, the Joint Budget Committee increased funding by an additional $11,786 to allow the Department to maintain the reimbursement increases of July 1, 2007[20]. The Joint Budget Committee also increased the appropriation by $45,000 to reflect the most recent tobacco tax revenue updates.

The following table shows historical expenditures for the program.

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
FY 2008-09 Actual	$10,788,114	($0)	$10,788,114	4,271	$2,525.90

[19] Budget Amendment 8, "FY 2008-09 Funding Increase for Old Age Pension State Medical Program", submitted January 23, 2008
[20] FY 2009-10 Figure Setting, March 18, 2009, page 170-173.

In FY 2008-09 as a result of SB 09-261, $3,000,000 was transferred out of the Supplemental Old Age Pension Health and Medical Care Fund into the Department's Medical Services Premiums line to offset General Fund expenditure for clients who are 65 years of age or older. The bill also authorizes a transfer of $6,000,000 out of the Supplemental Old Age Pension Health and Medical Care Fund into the Department's Medical Services Premiums line in FY 2009-10. While these actions are not directly reflected in this line, they affect the balance of the fund and the funding that will be available to this program in future years.

The Department's FY 2010-11 base request continues to be $15,368,483, the maximum allowed under current law. The base request assumes that the appropriation will be increased by the amount of tobacco tax revenue annually allocated to the Supplemental Old Age Pension Health and Medical Care Fund from the Cash Fund for Health Related Purposes and that sufficient funding will be available in the Old Age Pension Health and Medical Care Fund. The Department's FY 2010-11 base request estimates that the Supplemental Old Age Pension Medical Care Fund will receive $2,520,000 from the Tobacco Tax Cash Fund as projected by Colorado 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 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 FY 2007-08 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 FY 2008-09 Long Bill (SB 07-239) add ons.

In FY 2008-09 as a result of SB 09-261, $3,000,000 was transferred out of the Supplemental Old Age Pension Health and Medical Care Fund into the Department's Medical Services Premiums line to offset General Fund expenditure for clients who are 65 years of age or older. The bill also authorizes a transfer of $6,000,000 out of the Supplemental Old Age Pension Health and Medical Care Fund into the Department's Medical Services Premiums line in FY 2009-10. While these actions are not directly reflected in this line, they affect the balance of the fund.

The Department's FY 2010-11 base request estimates that the Supplemental Old Age Pension Health and Medical Care Fund will receive $2,520,000 from the Tobacco Tax Cash Fund as projected by Colorado Legislative Council.

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", which 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 a provider have taxing authority in order to be defined as such. 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 rules published by the Centers for Medicare and Medicaid Services, specifically 42 CFR 433.50, would make Colorado's public hospitals ineligible for federal financial participation under the Upper Payment Limit and Disproportionate Share Hospital payments as they do not have taxing authority. 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 imposed a two-year moratorium on implementing the Centers for Medicare and Medicaid Services proposed rule. Congress determined that, due to the extensive impact of the Centers for Medicare and Medicaid Services 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. While the moratorium was initially set to expire in April of 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) imposed further restrictions on the proposed regulations. Modifications to one of these regulations are relevant to the Colorado Indigent Care Program: Public Provider Cost Limit Regulation (CMS 2258-FC). This regulation would change public provider payments and financing arrangements with Medicaid programs. As a result of this regulation, Colorado would experience negative fiscal and programmatic impacts as the Department's ability to reimburse publicly owned hospitals for serving low-income individuals would be greatly reduced. Due to ARRA, the Centers for Medicare and Medicaid Services was instructed to cancel this regulation. However, as of June 2009 the Centers for Medicare and Medicaid Services had taken no further action on this rule.

Prior to the State's knowledge of the cancelling of this regulation and 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.

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. Before 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 federal financial participation rate of 50%. These new financial participation rates were 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.

In FY 2007-08, the Department submitted and the Joint Budget Committee approved Non-Prioritized DI-15 "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[21]. 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. Both Hospitals 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 included 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

[21] 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.

FY 2007-08 appropriation to this line item of $35,251. The final FY 2007-08 appropriation to this line item was $1,868,307, including $934,153 General Fund and $934,154 federal funds.

For FY 2008-09, the Department submitted Non-Prioritized DI-2 "Leveraging Additional Federal Funds" which requested $135,000 in General Fund and matching federal funds of $135,000. This request was subsequently approved by the Joint Budget Committee, increasing the funding to this line item by $270,000 to a total of $2,173,558 (Figure Setting document dated March 11, 2008, page 189). The FY 2008-09 impact of SB 08-230 (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 final FY 2008-09 appropriation to $1,932,052, including $966,026 General Fund and $966,026 federal funds.

The Department requested and was appropriated continuation funding for this line item for FY 2009-10 in the amount of $1,932,052, including $966,026 General Fund and $966,026 federal funds.

The Department is requesting continuation funding in the amount of $1,932,052 for FY 2010-11.

STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY

This line item was created through SB 08-230 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 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 Denver Health and Hospital Authority for Graduate Medical Education in two ways. First, 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 with FY 2007-08, funding for this purpose was directly appropriated to the (5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority line item. However, the appropriated amount of $410,000 in FY 2007-08 reflected only a partial year of expected implementation costs. For FY 2008-09, the Department was appropriated $1,829,008 for this line item, including $914,504 General Fund and $914,504 federal funds. Since the appropriations to this line item are offset by corresponding funding reductions in (2) Medical Services Premiums, the creation of this line item has had a net zero fiscal impact.

The annualization of SB 08-230 "Hospitals to Levy Sales Tax" increased the FY 2009-10 appropriation by $2,706, bringing the total FY 2009-10 appropriation to this line item to $1,831,714. This funding is split evenly with $915,857 General Fund and federal funds.

The Department is requesting continuation funding of $1,831,714 for FY 2010-11.

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. First, 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. Lump sum payments are also received when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Lastly, 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 with FY 2007-08, funding for this purpose was directly appropriated to the (5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority line item. However, the appropriated amount of $95,251 in FY 2007-08 reflected only a partial year of implementation. The final FY 2008-09 appropriation to this line item was $697,838, including $348,919 General Fund and $348,919 federal funds. Since the appropriations to this line item are offset by corresponding funding reductions in (2) Medical Services Premiums, the creation of this line item has had a net zero fiscal impact.

The annualization of SB 08-230 "Hospitals to Levy Sales Tax" increased the FY 2009-10 appropriation by $3,097, bringing the total FY 2009-10 appropriation to this line item to $700,935. This funding includes $350,468 General Fund and $350,467 federal funds.

The Department is requesting continuation funding of $700,935 for FY 2010-11.

ENHANCED PRENATAL CARE TRAINING AND TECHNICAL ASSISTANCE

The Enhanced Prenatal Care Training and Technical Assistance program provides funding for administrative activities for 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 aspects of a woman's life likely to affect her pregnancy. The Enhanced Prenatal Care program, also known as Prenatal Plus, has been effective at increasing the number of women who stop smoking, gain an adequate amount of weight, resolve psychosocial problems, and has decreased the number of infants who are born at low birth weight. Other regular Prenatal Plus medical services are paid under the Department's line item for Medical Services Premiums.

The program provides care to slightly less than 2,000 women each year. Per data from the Medicaid Management Information System, the number of clients served each year is as follows: 1,954 in FY 2005-06, 1,948 in FY 2006-07, 1,670 in FY 2007-08, and 1,713 in FY 2008-09. 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. This program is conducted by having the pregnant women visit the office sites for the services in contrast to another program called the Nurse Home Visitor Program in which the nurses visit the pregnant women and new mothers at the women's homes.

The Department last implemented a rate change in Medicaid reimbursement for the Enhanced Prenatal Care Training and Technical Assistance services effective July 1, 2004. The Medicaid reimbursement structure, that has been in effect since the federal Centers for Medicare and Medicaid Services approved the State Plan in 1996, pays more for model care, services that result in the best health outcomes for pregnant women and their infants. The reimbursement structure also encourages early enrollment of women to reduce pregnancy risk factors. There are four tiers in the reimbursement structure. Those tiers are: one to four visits by the pregnant woman, five to nine visits, ten visits, and eleven to twelve visits or more. The more visits that occur, the more likely behavioral changes will occur to improve the outcome of the pregnancy. Total visits of ten or more are considered to be model care. Payment to the providers is made only after delivery of the baby or after the woman leaves the program for other reasons, so the total number of visits can be determined.

This program is managed by the Department of Public Health and Environment. 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. During the FY 2007-08 Figure Setting (March 8, 2007, pages 96-97), Joint Budget Committee staff recommended that the Enhanced Prenatal Care Training and Assistance line receive an adjustment of $6,653 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.

The Department's FY 2008-09 Long Bill appropriation 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 FY 2009-10 Long Bill, SB 09-259, appropriated $119,006 that included a POTS adjustment of $1,595. The Department's Base Request for FY 2010-11 is continuation funding of $119,006.

This line item provides funding for administrative activities and therefore does not qualify for enhanced federal financial participation from the American Recovery and Reinvestment Act of 2009.

NURSE HOME VISITOR PROGRAM

The Nurse Home Visitor Program was created by SB 00-071 with funding from the Tobacco Master Settlement Agreement. The program uses regular in-home, visiting nurse services for low-income, first-time mothers, with the mother's consent. The nurses offer services during the mother's pregnancy and 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. According to statute, 25-31-102, C.R.S. (2009), the overall goal of the program is to serve all low-income, first-time mothers who want to participate by the year 2010.

The trained visiting nurses educate mothers on the importance of nutrition and avoiding alcohol and drugs, including nicotine, and to assist and educate mothers on providing general care for their children and to improve health outcomes for their children. In addition, visiting nurses may help mothers to locate assistance with educational achievement and employment. Any assistance provided through the program is done only with the consent of the mother who may refuse services at any time. The results are improvements in pregnancy outcomes, the health and development of their children, and the long-term economic self-sufficiency of their families.

This type of service is sometimes referred to as targeted case management involving a coordinated, ongoing, and personalized strategy for clients with a variety of needs, both medical and non-medical. Each unit of service provided equals 15 minutes and is rated and billed based on that timeframe.

Over the past few fiscal years, the program has grown from serving 2,162 families in FY 2005-06, to 2,187 in FY 2006-07, and to 2,358 families in FY 2007-08. Of the total number of families reported here, all were enrolled in Medicaid. Families who did not qualify for Medicaid were served entirely by funding from the Nurse Home Visitor Program Fund, managed by the Department of Public Health and Environment, which does not have federal financial participation.

Nineteen grantee organizations have been contracted by the Department of Public Health and Environment to provide Nurse Home Visitor Program services in 52 counties in Colorado. Eighteen providers use Medicaid funding for Medicaid eligible clients. Often the providers serve multiple counties. The Department of Public Health and Environment continues to explore ways to serve the other 12 counties in Colorado that are not yet participating in this program. The nurses providing these services work for various eligible grantees who are non-profit organizations, for-profit corporations, religious or charitable organizations, institutions of higher education, visiting nurse associations, other existing visiting nurse programs, local health departments, county departments of social services, or other governmental agencies.

In FY 2007-08, the federal Centers for Medicare and Medicaid Services notified the Department that the rate structure had not been approved for the Nurse Home Visitor Program. The rate plan, as developed by Public Consulting Group in 2003, was resubmitted to the Centers for Medicare and Medicaid Services, but the rate structure was not approved due to large variability in the rates. Increased scrutiny by the federal government on targeted case management services also contributed to the denial of the rate structure. The Centers for Medicare and Medicaid Services recommended that the Department use the United States Bureau of Labor Statistics State Occupational Employment and Wage Estimates, which the Department used to set a revised rate structure. On June 8, 2009 the Centers for Medicare and Medicaid Services notified the Department that this revised rate structure was approved retroactive to July 16, 2008.

However, it was necessary to repay federal funds for whatever rate amounts were not approved previously. The Department of Public Health and Environment agreed to use funding from the Nurse Home Visitor Program Cash Fund managed by that department to repay the federal Centers for Medicare and Medicaid Services. A 1331 Supplemental Request for $889,708 supplied by the Nurse

Home Visitor Program Cash Fund was approved by the Joint Budget Committee of the General Assembly on June 22, 2009 for the purpose of repaying the non-approved federal funding for FY 2008-09. An audit of the providers was completed by the Colorado Foundation for Medical Care to determine potential overpayment of federal funds in prior years. Negotiations are continuing with the federal Centers for Medicare and Medicaid Services about the need for repayment of non-approved federal funding for the years FY 2004-05 through FY 2007-08.

Since FY 2007-08 through FY 2009-10, the Department was appropriated $3,010,000 total funds for this line item.

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 obligation of states 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. This is known as the "Clawback" payment. 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, or "phased-down," by 1.67% each year, until it reaches 75% in 2015, where it will remain on a go-forward basis.

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 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, S-4 "Adjust State Contribution Payment for Caseload and Rates" submitted on January 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. On June 23, 2008 the Department submitted a 1331 Supplemental Request, "Transfer Excess State Contribution Payment Funding," to move $554,908 in excess General Fund resulting from lower than expected caseload, transferred to the Controlled Maintenance Trust Fund. As a result of the approval of this request, the final FY 2007-08 appropriation for this line item was $71,540,102.

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", submitted February 15, 2008. The FY 2008-09 appropriation in the FY 2008-09 Long Bill (HB 08-1375) for this line was $81,155,195.

As a part of the Department's January 15, 2009 Budget Reduction Proposals, the Department recommended that the May payment for each year be paid in the next fiscal year beginning with May 2009. Federal payment rules allow the Department to make the May Clawback payment as late as July 25 of the same year without incurring any penalty. On January 29, 2009 the Joint Budget Committee approved the Department's proposal to delay the May payment into the following fiscal year beginning starting in May 2009. This authority was further clarified by SB 09-265 "Medicaid CHP+ Payment Timing" which made clear that the Department must make the state contribution payment in compliance with Federal rules and regulations, but that the Department is not required to make the state contribution payment before they are required by Federal rules and regulations. As a result of this action, the Department's appropriation was reduced one-time by $6,827,682. The FY 2008-09 appropriation was further reduced by $118,679 to reflect updated estimates of caseload and the new per-client per-month rate established by the Centers for Medicare and Medicaid Services. The Department's final appropriation for FY 2008-09 was $74,208,834.

As part of HB 09-1222 "Administration of Appropriated Moneys" the State Controller is authorized to allow overexpenditures by the Department for the state contribution payment pursuant to the Medicare Modernization Act of 2003. This authority will expire after FY 2013-14.

The Department's expenditures for the state contribution payment in FY 2008-09 totaled $73,720,837. This included payment of the June 2008 through April 2009 invoices. On June 22, 2009, the Joint Budget Committee approved the Department's 1331 Emergency Supplemental request (Federal Funds Replacement for Transfer to Department of Public Health and Environment for Facility Survey and Certification) to transfer $313,036 to the (1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Public Health and Environment Facility for Survey and Certification line item to cover an overdraw of federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriated $88,808,586 to this line. This included restoration of $7,285,736 representing the annualized one-time savings removed in FY 2008-09 resulting from delaying the May invoice payment into the following fiscal year. This also included an increase of $8,189,674 based on BA-4 "Medicaid Modernization Act State Contribution Payment". This Budget Amendment was submitted to cover increases in the estimated dual eligible caseload and increases in the per-client per-month rate. On March 18, 2009, the Joint Budget Committee approved the Department's Budget Amendment. This figure was later reduced by $875,658 as a part of the budget balancing process to reflect the Department's most recent estimates based on updated caseload data for a total FY 2009-10 appropriation of $88,808.586.

For FY 2010-11, the Department is requesting continuation funding.

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 to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike other programs, the Public School Health Services program does not use General Fund dollars. Rather, the State uses certification of public expenditures that can be matched by the federal government through Title XIX of the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing and the Department of Education through an Interagency Agreement. The Department pays for claims processing through the Medicaid Management Information System and incurs costs in the (1) Executive Director's Office; (A) General Administration, Personal Services and Operating line items. 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. (2009), the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

For FY 2007-08, the Joint Budget Committee increased the Department's administration cost by $972 and the Department of Education's administrative costs by $7,176 (Department of Education Figure Setting dated March 1, 2007). 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 through its FY 2007-08 S-15, "General Fund to Request for CMS Disallowances" (FY 2007-08, Supplemental Requests, January 2, 2008). The final appropriation for FY 2007-08 was $41,808,014, 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 increased the transfer to the Department of Education by $16,051 and with a corresponding decrease in federal funds available for school providers through this line. The amount transferred to the Department of Education for FY 2008-09 was $207,747. The annualization of the FY 2007-08 supplemental request for funds to cover Centers for Medicare and Medicaid Services disallowances reduced the FY 2008-09 appropriation by $10,480,201 General Fund. During the Department's FY 2008-09 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. During the Department's FY 2009-10 Figure Setting on March 18, 2009, further adjustments were made to FY 2008-09 appropriations. Among those adjustments was a recommendation by Joint

Budget Committee staff to reduce the appropriation to the program by $7,259,414 in order to bring the appropriation into line with historical actual expenditures. This adjustment brought the final FY 2008-09 appropriation to the program to $20,242,120, which is comprised of $10,472,200 Cash Funds and $9,769,920 federal funds.

An adjustment was made to the FY 2008-09 appropriation for indirect cost assessments from the Department of Education, which reduced the appropriation to this line item by $3,564 federal funds (Figure Setting document dated March 18, 2009, page 21). The Department submitted FY 2009-10 DI-17 in its November 3, 2008, FY 2009-10 Budget Request, which requested to increase the amount of federal funds retained by the Department for the administration of the program. In order to bring the Department into compliance with federal mandates related to proper cost certification, the Department requested $233,700 in federal funds to be transferred from (5) Other Medical Services, Public School Health Services Program to the (1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts line item. This change request was approved, bringing the year to date FY 2009-10 appropriation to $20,004,856. This appropriation includes $10,472,200 cash funds and $9,532,656 federal funds.

For FY 2010-11, the Department is requesting continuation funding of $20,004,856.

COLORADO CARES RX PROGRAM CONTRACT COSTS

This line item was created in the Department's Figure Setting on March 11, 2008 as a consolidation of 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 FY 2008-09 Long Bill (HB 08-1375) appropriation was $2,278,378 cash funds from the Colorado Cares Rx Program Cash Fund.

The Department experienced barriers to implementing the program as enacted, including discovery of an alternate discount drug program already available to Coloradans at no charge and security/privacy concerns raised by the Department of Human Services related to the use of the Colorado Benefits Management System for non-Medicaid clients. The Department's pharmacy staff worked in consultation with the primary bill sponsor of SB 07-001 to develop an alternate approach of using a mail-order pharmacy for the implementation of the Colorado Cares Rx Program. The Department has contracted with a mail-order prescription program to address the basic intent of the directives contained in SB 07-001. The program, as revised, does not require the collection of fees from participants and the contractor does not receive payment from the Department. The Department submitted FY 2008-09 S-14 "Eliminate Colorado Cares Fund" to change the Department's responsibilities and eliminate the cash fund. During the 2009 Legislative Session, SB 09-132 eliminated this line item beginning FY 2009-10.

The mail-order based Colorado Cares Rx Program was implemented on January 1, 2008. Information about the program is available through the Department's Web site, and the Department has promoted the program through press releases in news media, and through outreach to counties, rural health centers, school-based health centers and through various newsletters and bulletins.

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 nor 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.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department's FY 2010-11 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, certain youth who are in the juvenile justice system, other child welfare clients, and community services for the elderly. 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 as well as operations costs separately accounted for but related to the other groups of clients mentioned above. Medicaid funds for these programs are sent as reappropriated funds transfers from the Department to the Department of Human Services. Although the funds are considered reappropriated from the perspective of the Department of Human Services, the funding sources for these transfers from the Department are General Fund, federal funds, and some cash funds.

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 follows.

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.

For FY 2009-10, one line item called Federally-matched Local Program Costs was removed because changes in federal regulations prohibit local contributions that are from non-governmental agencies and make contributions voluntary from local governmental agencies. No local governments voluntarily submitted contributions, so the line item ceased to be used. Also for FY 2009-10, a new line item called Federal Indirect Cost Reimbursement for Department of Human Services Programs was added. The new line item covers certain costs related to the Developmentally Disabled Program.

All funding requests in this Long Bill group originate with the Department of Human Services. Inquiries related to the FY 2010-11 Budget Request should be directed to that department. The Department of Health Care Policy and Financing 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. This Department also performs general oversight of the Medicaid-funded programs to ensure adherence to federal regulations for use of the Medicaid funds.

(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. Because the Executive Director's Office includes a wide range of elements, the authorizations in the Colorado Revised Statutes are also varied. The main authorization is 24-1-120, C.R.S (2009).

General Administration includes the Department of Human Services' Executive Director and associated administrative staff, including the Department's budget staff, the Public Information Officer, the Legislative Liaison, and the Division of Field Administration that includes the County Commissioner Liaison. These staff members are FTE at the Department of Human Services, but several of them also perform services related to Medicaid, so part of their salaries and related expenses are reimbursed by the Department.

General Administration is comprised of the following elements:

- Personal Services – salaries and wages for staff associated with the Executive Director's Office, some of whom have Medicaid-related responsibilities;
- Health, Life, and Dental Insurance – often called a POTS line and is a Common Policy, a centralized appropriation for the whole Department of Human Services from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Short Term Disability Insurance – often called a POTS line and is a Common Policy, a centralized appropriation for the whole Department of Human Services from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Amortization Equalization Disbursement – often called a POTS line and is a Common Policy, payments for portion of PERA paid by state government – a centralized appropriation for the whole Department of Human Services from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Supplemental Amortization Equalization Disbursement – often called a POTS line and is a Common Policy, additional payments for portion of PERA paid by state government – a centralized appropriation for the whole Department of Human Services from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Salary Survey and Senior Executive Service – is a Common Policy, appropriations to cover the costs of salary increases based on a job and wage classification survey conducted by the Department of Personnel and Administration, but due to the economic downturn is not anticipated to be included for FY 2010-11, partly funded by Medicaid;

- Performance Based Pay – is a Common Policy, achievement pay added to Personal Services according to guidelines established by the Department of Personnel and Administration for quality and quantity of each employee's work, but due to the economic downturn is not anticipated to be included for FY 2010-11, partly funded by Medicaid;
- Shift Differential – is a Common Policy, additional salary and wages paid to staff who work other than the day time shift in state residential facilities that must be staffed 24/7 and primarily used by the Mental Health Program and the Developmentally Disabled Program, partly funded by Medicaid;
- Workers Compensation – is a Common Policy, estimated share for inclusion in the state workers compensation plan as administered by the Department of Personnel and Administration and allocated based on the total number of employees, also designated as an indirect cost, partly funded by Medicaid;
- Operating Expenses – is a Common Policy, funding for consumable supplies and materials as well as capital outlay for purchase or replacement of medical equipment, furniture and other major items if the appropriation balance allows, partly funded by Medicaid;
- Payment to Risk Management and Property Funds – is a Common Policy, funding for a share of statewide costs for two programs operated by the Department of Personnel and Administration: (1) liability insurance for liability claims, and (2) property insurance for state buildings and their contents, and this line item is designated as an indirect cost with an allocation based on the number of employees, partly funded by Medicaid; and
- Injury Prevention Program – 100% Medicaid funded and primarily used by the Mental Health Program and the Developmental Disabilities Program because clients in those programs sometimes have violent tendencies or have serious physical needs that require much physical assistance from health care staff.

Also included in General Administration are line items for Legal Services, Administrative Law Judges, and Staff Training, but these three line items do not have a Medicaid component.

Special Purpose funding within the Executive Director's Office includes staff in the Office of Performance Improvement to oversee and to provide support for audits, human resources, and performance management. The Audits Section verifies, through internal and external audits, that State and federal financial assistance has been distributed in accordance with applicable regulations and laws. The Human Resources Section performs all personnel related activities, and the Performance Management Team ensures programmatic accountability for the Department of Human Services. The above mentioned staff members are FTE in the Department of Human Services, but their work overlaps Medicaid responsibilities, so the positions are partly funded by Medicaid.

The Health Insurance Portability and Accountability Act of 1996

Security Remediation in the context of The Health Insurance Portability and Accountability Act of 1996 comprises part of the Special Purpose funding. The Department of Human Services provides many health-related services to Medicaid eligible clients and non-Medicaid eligible clients. Therefore, it is legally required to comply with Health Insurance Portability and Accountability Act regulations. Expenditures for the services and programs associated with Medicaid clients are paid with Medicaid funds. Medicaid funding pays for Personal Services and associated Operating Expenses for staff members who perform the following tasks or monitor and audit other staff members who perform the following tasks:

- Risk assessment and risk management of health information;
- Preparation and enforcement of sanction policies for failures in health information risk management;
- Review of health information system activity;
- Workforce clearance procedures;
- Isolation of health care clearinghouse functions;
- Authorization of data access;
- Establishment and modifications of data access procedures;
- Provision of security reminders and training;
- Protection against malicious software;
- Monitoring of log-in reports;
- Management of password use ;
- Establishment of security incident procedures and contingency planning;
- Preparation of planning and follow procedures for data back-up;
- Preparation of disaster recovery plan and auditing use of the plan if need arises;
- Preparation of plans for an emergency mode of operations;
- Assurance that business associate contracts are used for vendors and health providers;
- Supervising facility access controls;
- Monitoring procedures for computer workstation use including security as well as supplemental devices and media used;
- Provision of automatic logoff procedures;
- Arranging for encryption and decryption;
- Supervising emergency data access procedures; and
- Monitoring transmission authentication of health information and integrity controls.

The Health Insurance Portability and Accountability Act of 1996 staff members report to the Deputy Executive Director of Operations and Financial Services, but the funding for these functions is included in the Executive Director's Office line item in the budget.

Special Purpose funding also includes administrative review for food stamp quality assurance to perform the federally mandated food stamp quality control, including monthly reviews to ensure accurate eligibility determinations and food stamp allotments to clients, as well as funding for several boards, councils, and commissions under the Department of Human Services auspices, but these components are not Medicaid funded.

The enhanced federal financial participation authorized by the American Recovery and Reinvestment Act of 2009 affects the payments made by the Department for Medicaid clients residing at the Regional Centers for the developmentally disabled. The Department pays Medicaid rates to cover various costs associated with providing services to these clients. Some of the service costs

are transferred to the following line items within Long Bill Group (6) Department of Human Services Medicaid-Funded Programs for better tracking of expenditures: (A) Executive Director's Office – Medicaid Funding; (B) Office of Information Technology Services – Medicaid Funding; and (C) Office of Operations – Medicaid Funding. During the time that the American Recovery and Reinvestment Act of 2009 is effective, these transfers receive enhanced federal financial participation.

Appropriation History

Medicaid funding for all of the above described services are funded into one line item for the Executive Director's Office. A large contributor for changes in appropriated funding from one year to the next is Common Policy adjustments requested by the Department of Personnel and Administration.

The FY 2007-08 appropriation of $12,509,047 included $2,781,326[22] in Common Policy adjustments for the Department of Human Services. This reflects an increase of $1,308,285[23] 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 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-S-17, "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 was $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 due to vacancy, 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 November 1, 2007 FY 2008-09 Budget Request, 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.

[22] $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

[23] $1,308,285 is comprised of the following amounts: Risk Management and Property Funds = $38,490, Workers' Compensation = $22,460, Shift Differential = ($26,925), Salary Survey = $48,542, Short-term Disability = $12,653, Health, Life and Dental = $580,696, Performance-based Pay = $389,490 and Amortization Equalization Disbursement = $242,879.

The Supplemental Bill, SB 09-187, included adjustments to reduce $46,762 from NP-S-15, "DHS-Hiring Freeze Savings," and to reduce $46,918 as a technical adjustment by the JBC to adjust the Department's funding so that it is in line with the reappropriated amount in the corresponding appropriations in the Department of Human Services. The final appropriation for FY 2008-09 was $14,351,038.

The FY 2009-10 Long Bill, SB 09-259, appropriated $13,011,981 total funding. This amount was derived by starting with the final appropriation from FY 2008-09 and making the following adjustments: remove the prior year Salary Survey for a reduction of $7,771,491; remove the prior year Performance Based Pay for a reduction of $777,184; annualize FY 2008-09 NP-3, DHS – Human Resources Staff" for an increase of $316; include FY 2009-10 Common Policy adjustments for an increase of $2,621,515; add FY 2009-10 NP-6, "DHS – Regional Centers – High Needs Clients," for an increase of $120,284; add FY 2009-10 NP-15, "DHS – Ombuds Program Increase – Workers Compensation," for an increase of $3,888; reverse FY 2008-09 NP-S-15, "DHS – Hiring Freeze Savings," for an increase of $28,762; add a JBC Common Policy adjustment for Payment to Risk Management and Property Funds for an increase of $10,044; add a JBC Common Policy adjustment for Short Term Disability for an increase of $7,346; remove funding based on JBC action to make a Medicaid Indirect Costs adjustment related to Regional Center costs for a decrease of $160,000 (See other description for new line item called Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs); reduce funding for a JBC Common Policy adjustment for Amortization Equalization Disbursement for a decrease of $28,746; reduce funding for a JBC Common Policy adjustment for Supplemental Amortization Equalization Disbursement for a decrease of $23,483; reduce funding for a JBC Common Policy adjustment for Shift Differential for a decrease of $279,586; reduce funding for FY 2009-10 BA-22, "DHS – Salary Survey," for a decrease of $1,429,321; and reduce funding for the General Assembly conference committee action to achieve budget balancing by decreasing 1.82%, or $18,847 in Personal Services.

The base request for FY 2010-11 is $13,061,348. This amount is based on the FY 2009-10 appropriation of $13,011,981:

- plus $18,847 for annualization of the one-time FY 2009-10 1.82% reduction to Personal Services;
- plus $30,520 for annualization of FY 2009-10 NP-6, "DHS – Regional Centers – High Risk Clients," (FY 2009-10 Budget Reductions, August 24, 2009).

(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. There is no specific authorization in Colorado Revised Statutes that specifically mentions the Colorado Benefits Management System. However, authorization can be inferred from 26-1-112, C.R.S. (2009).

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 enrolled in programs that receive varying levels of federal participation rates, the Colorado Benefits Management System calculator was developed to allocate costs among the various programs. Previously, during the development phase of the system and the early years after implementation of the system, the Department's appropriation reflected a fraction, roughly 34.71%, of total costs. 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 the calculator. The calculator has been revised to reflect the division of work resulting from polling of the county departments of social services according to the Random Moment Sampling methodology that has become accepted by both the Department and the Department of Human Services. The appropriation since FY 2008-09 reflects 38.31% of the total costs of the system to be paid by the Department as indicated by the last major change in percentages reflected in the Random Moment Sampling results. The remaining percentage of the expenditures is paid from the appropriation to the Department of Human Services. (Please refer to the Department of Human Services for a description of their portion of total expenditures.) Whenever the Random Moment Sampling results reflect another major change in percentages in the future, both departments anticipate that a change in funding will be requested through the normal budget request processes.

A private vendor has been contracted to perform the major operations for the system from the very beginning of the project. Previously, Electronic Data Systems was the contractor. In August 2008, management and operation of the system was reprocured, and Deloitte Consulting LLP was awarded the new contract. Both Electronic Data Systems and Deloitte Consulting LLP worked together during a transition phase. Deloitte Consulting LLP took over full responsibility for operation of the system on April 1, 2009.

A broad range of components are paid from the appropriation for the Colorado Benefits Management System. Besides contracted payments to the vendor, the following items are also paid from the appropriation: Personal Services and associated Common Policy expenditures for state employees who work on the project, computer hardware maintenance and repairs, computer software maintenance and upgrades, none-computer equipment rental, building rental, parking fee reimbursement for staff at a different work location, rental of computer network equipment, rental of personal computers used in the office of the project (avoids purchase of the personal computers), in-state travel for providing training to county departments, other travel expenditures, telecommunication services, printing and reproduction of paper documents, legal services, freight and shipping charges, data processing supplies, office supplies, postage, copy supplies, noncapitalized equipment purchases, dues and memberships, registration fees, capital lease principal payments, and capital lease interest payments. The operations vendor contracted payments mentioned above may include both the

base contracted amounts and any additional amounts from contract amendments that are necessary to request computer programming changes to implement requirements from special bills passed by the Colorado General Assembly.

The enhanced federal financial participation authorized by the American Recovery and Reinvestment Act of 2009 affects the payments made by the Department for Medicaid clients residing at the Regional Centers for the developmentally disabled. The Department pays Medicaid rates to cover various costs associated with providing services to these clients. Some of the service costs are transferred to this line item for better tracking of expenditures. During the time that the American Recovery and Reinvestment Act of 2009 is effective, these transfers receive enhanced federal financial participation.

Appropriation History

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.

Other budget actions occurred in FY 2008-09 that were formally appropriated in the Supplemental Bill, SB 09-187. Those budget actions included an increase of $911,590 for FY 2008-09 NP S-9, "Colorado Benefits Management System (CBMS) Refinancing" that updated the basic appropriation for the conversion from 34.71% of the CBMS project funding as used during the development phase

to 38.31% of the total project funding based on the most recent Random Moment Sampling results. Another one year only increase was $867,750 resulting from a 1331 Supplemental Request, "Colorado Benefits Management System (CBMS) New Vendor Transition," submitted to the Joint Budget Committee on September 22, 2008 and so approved. A Joint Budget Committee technical correction removed $37,475 that had been included in the Department's appropriation but was not included in the Department of Human Services appropriation. A Supplemental Bill Add-on for FY 2008-09, S-22, "Postpone Implementation of SB 08-006," reduced the funding by $94,092. The final appropriation for FY 2008-09 was $9,776,895.

To arrive at the funding for FY 2009-10, begin with the FY 2008-09 appropriation of $9,776,895 and:

- remove one-time funding for the 1331 Supplemental Request, "Colorado Benefits Management System (CBMS) New Vendor Transition," equaling: $867,750;
- 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;
- remove one-time funding for HB 08-1046 Offenders Apply for Public Benefits: $26,408;
- add prior year Salary Survey funding: $68,109;
- add prior year Performance Based Pay funding: $14,054;
- annualize by adding back funding for FY 2008-09 S-22, "Postpone Implementation of SB 08-006": $94,092;
- add funding for FY 2009-10 NP-5, "Postage Increase and Mail Equipment Upgrade": $118,325;
- add funding for FY2009-10 NP-BA-17, "DHS – Colorado Benefits Management System (CBMS) FY 2009-10 Refinance," to establish the Department's share at 38.31% ongoing (until another change occurs in the Random Moment Sampling): $832,031;
- remove the prior year impact of the Random Moment Sampling methodology based on FY 2008-09 NP-S-9, "DHS – Colorado Benefits Management System (CBMS) Refinancing," for a decrease of $911,590;
- remove 1.82% from Personal Services resulting from the General Assembly First Conference Committee action to balance the budget: $26,166;

As a result of the actions described above, the FY 2009-10 appropriation per the Long Bill, SB 09-259, was $8,957,494. There is one special bill that adds funding, HB 09-1293, "Colorado Health Care Affordability Act," which added $123,228. The Long Bill plus the one special bill combined result in a FY 2009-10 appropriation of $9,080,722.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of ES-15, "DHS – Aid to the Needy Disabled – State Only Program Suspension," the Department of Human Services proposed that a state only program of aid to the needy disabled be suspended for an indeterminate time period, which requires

changes in the Colorado Benefits Management System and that both Departments share in the overall costs. This resulted in a Medicaid total fund increase of $11,683 and a General Fund increase of $5,779 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund reduction of $11,683 and a General Fund reduction of $5,779 in FY 2010-11.

The base request involves certain adjustments. The special bill, HB 09-1293, annualizes with $425,610 additional funding. Restoration of the 1.82% Personal Services budget reduction from the prior year adds back $26,166. Currently the base request for FY 2010-11 is $9,414,173.

This line item is not qualified for enhanced federal match from the American Recovery and Reinvestment Act of 2009 because the line item covers administrative costs.

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) and it was recommended by the Joint Budget Committee staff. There is no specific authorization for the line item in Colorado Revised Statutes. However, authorization can be inferred from 26-1-112, C.R.S. (2009).

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 Statement on Accounting Standards Number 70, also called SAS-70, and named "Reports on the Processing of Transactions by Service Organizations," was developed by the American Institute of Certified Public Accountants as an auditing opinion on the fairness of the presentation of the service organizations description of controls that have been placed in operation and the suitability of the design of the controls to achieve the specified control objectives. This audit assures both the user organization, in this case, the state of Colorado, and the service organization, in this case the contracted vendor of the Colorado Benefits Management System or Deloitte Consulting LLP, that the Colorado Benefits Management System has adequate controls in place to handle whatever usual or unusual situations arise in order to operate in both normal operating environments and as recovered from disaster environments. This is not a financial audit, but rather an audit of functional controls.

This type of audit is generally completed once a year so the annual appropriations are renewed each year. The annual appropriations are paid by the Department and the Department of Human Services to the Colorado Office of State Auditor, which in turn, contracts with an independent auditor to conduct an audit staffed by control oriented professionals who have experience in accounting, auditing and information security. Such an audit allows the service organization to have its control policies and procedures evaluated and

tested by an independent party. This audit also allows the user organization to be assured that the service organization is fulfilling its security requirements.

Although the standards for the SAS-70 audit and the requirements from the Health Insurance Portability and Accountability Act of 1996 were developed independently of each other, the standards of the SAS-70 audit are very similar to the requirements from the Health Insurance Portability and Accountability Act of 1996. Generally, one audit of a service organization can satisfy both needs at the same time per the opinion of accountants associated with the American Institute of Certified Public Accountants.

In prior years, the service organization audited was the prior vendor of Electronic Data Systems. Electronic Data Systems was audited in FY 2008-09 and the results were satisfactory. Since the back-office support provided by Electronic Data Systems was located in India, the findings were somewhat limited. In FY 2009-10, the new vendor, Deloitte Consulting LLP, will be audited for the first time in its role of operating the Colorado Benefits Management System. Therefore, no results of a Colorado audit for Deloitte Consulting LLP are known at this time.

Because the SAS-70 audit directly related to the Colorado Benefits Management System, both departments rely on the Random Moment Sampling methodology to determine the sharing of the funding to pay for the audit. The same percentages for funding splits between the departments are used and updated when necessary. The Department paid 34.71% in prior years, but the percentage is now at 38.31% as updated during FY 2008-09.

The Department received an appropriation of $51,718 for the Colorado Benefits Management System SAS–70 for FY 2007-08, per the Long Bill (SB 07-239). In FY 2008-09, the Long Bill (HB 08-1375) continued the appropriation at $51,718, but that amount was updated to $57,075 by the Supplemental Bill (SB 09-187) to reflect the increase in the Random Moment Sampling data. For FY 2009-10, the Long Bill (SB 09-259) continued the amount at $57,075. The Department is requesting continuation funding for FY 2010-11 at $57,075.

This lines doe not qualify for enhanced federal match from the American Recovery and Reinvestment Act of 2009 because the line covers expenditures that are administrative in nature.

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. Please see the Line Item Description for (1) Executive Director's Office; (C) Information Technology Contracts, Colorado Benefits Management System Medical Assistance Project for additional information on Random Moment Sampling.

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.

To continue the process of catching up on all fiscal years for the redistribution of the funding splits between the Department and the Department of Human Services, a Supplemental Request NP-S5, "DHS – Colorado Benefits Management System (CBMS) Federal Reallocation, submitted January 2, 2009, requested $974,393 to true up both FY 2006-07 and FY 2007-08 funding from the 34.71% for the Department to 38.31% for the Department's share of the CBMS costs. This amount was approved by the FY 2008-09 Supplemental Bill, SB 09-187. The Department's share came entirely from federal funds.

There was no funding provided for this line item in the FY 2009-10 Long Bill, SB 09-259, because there was no need for it. As long as the Random Moment Sampling results continue to show approximately 38.31% as the Department's share of the costs of CBMS, no request is needed for a true-up of funding between the departments.

The Department is not requesting funding for this line item for FY 2010-11.

OTHER OFFICE OF INFORMATION TECHNOLOGY SERVICES LINE ITEMS

The Other Office of Information Technology Services line item 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. Because the elements covered by this line item vary, there is no one specific source in the Colorado Revised States, but authorization can be inferred from 26-1-120, C.R.S (2009).

The staff members in the Office of Information Technology Services 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 office is a service organization because it provides computer support in various ways to the other offices and divisions within the Department of Human Services. Some of the staff members mentioned above perform work associated with Medicaid services and part of their salaries come from Medicaid funding.

The Office of Information Technology Services, sometimes called the Division of Information Technology, currently has a dual reporting structure. The Division reports to both the Deputy Executive Director of Operations and Financial Services in the Department of Human Services and to the Director of the Governor's Office of Information Technology Services. For FY 2009-10, there is a new component called Administration for OIT included in the funding for the Other Office of Information Technology Services line item.-

Some funding in this appropriation is used to support the salaries and operating expenses associated with the staff mentioned above that perform Medicaid related work, 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 part of the budget for Other Office of Information Technology Services is funding to support the Regional Centers.

Appropriation History

The Department was 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-BA-2, "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-BA-3, "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.

The FY 2008-09 Supplemental Request NP-S-18, "DHS – OIT Common Policy – Management and Administration of OIT," added $14,738 to the Supplemental Bill, SB 09-189, under a newly created component called Management and Administration of OIT. The name was simplified in the FY 2009-10 Long Bill, SB 09-259, to Administration of OIT. The total funding appropriated in SB 09-189 was $442,191 for Other Office of Information Technology Services Line Items.

For the FY 2009-10 Long Bill, SB 09-259, $399,192 was appropriated. This amount is derived by adjustments to the $442,191 total funding from the FY 2008-09 Supplemental Bill, SB 09-189. The adjustments are:

- add $7,261 for the annualization of FY 2008-09 NP-5, "DHS – IT Infrastructure Support;"
- add $9,405 for prior year Salary Survey;
- add $2,702 for prior year Performance Based Pay;
- remove $4,303 for the General Assembly First Conference Committee action to balance the budget by reducing Personal Services by 1.82%;
- add $1,749 for the annualization of a Common Policy adjustment for Management and Administration (per JBC Analyst Michael Caine);
- remove $2,738 to correct Management and Administration (per JBC Analyst Michael Caine); and
- remove $57,075 for a technical error resulting in a difference between the Department and the Department of Human Services (this amount is suspected to be a removal of the funding for the CBMS SAS-70 Audit in the amount of $57,075 that is actually funded in a completely different line item).

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES-1, "DHS-Information Technology Services – Personal Services FTE Reduction" the Department of Human Services proposed that there would be small vacancy savings. This resulted in a total fund Medicaid reduction of $18,000 and a General Fund reduction of $9,000 to this line in FY 2009-10. This would be a one-time reduction in FY 2009-10 and would not affect FY 2010-11.

Furthermore, as a part of NP-ES-21, "DHS – FY 2009-10 OIT Management and Administration One-Time Adjustment", the Department of Human Services proposed that unneeded expenses associated with a vacancy be reduced for one fiscal year only. This

resulted in a total fund reduction of $5,686 and a General Fund reduction of $2,843 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund increase of $5,686 and a General Fund increase of $2,843 in FY 2010-11.

The Department requests base funding for FY 2010-11 in the amount of $456,319. This amount is derived by starting with the funding of $399,192 from the FY 2009-10 Long Bill, adjusting down to $375,506 for budget reductions, and adding the following adjustments:

- restore $4,303 for the General Assembly First Conference Committee action to balance the budget by reducing Personal Services through a one-time FY 2009-10 reduction of 1.82%;
- add $13,749 for annualization of FY 2008-09 NP-S-18, "DHS – OIT Common Policy – Management and Administration of OIT;"
- restore $57,075 for a technical correction of the difference between the Department and the Department of Human Services funding, and
- restore $5,686 for the one-time FY 2009-10 adjustment submitted in -ES-21, "DHS – FY 2009-10 OIT Management and Administration One-Time Adjustment."

COLORADO BENEFITS MANAGEMENT SYSTEM CLIENT SERVICES IMPROVEMENT PROJECT

This line item was created by a 1331 Supplemental Request submitted by both the Department and the Department of Human Services to the Joint Budget Committee of the General Assembly. The 1331 Request was approved for FY 2008-09 on June 22, 2009 by the Joint Budget Committee. This request used the remaining $1,462,175 in the Department's appropriation from the line item of Colorado Benefits Management Medical Assistance Project to combine with program funding from the Department of Human Services with the result that the total funds were leveraged into $1,623,982 total funding that would be shared by both Departments according to the Random Moment Sampling methodology used by the regular Colorado Benefit Management System (CBMS) project. The leveraging was possible because the Department of Human Services has several other programs that also use CBMS, and extra funding from those other programs added to the total funds available by reallocating the costs among all of the programs that were affected. The funding was placed into this separate line item. The improvement project will add a Web portal to be used specifically for CBMS. Intelligent Data Entry software will also allow clients to enter much of their own information into CBMS, thus reducing the need to travel several times to local social services office. Although computer programming work is continuing on both the CBMS Web portal and the Intelligent Data Entry software, expenditures for FY 2009-10 have reverted to the original line item of Colorado Benefits Management System Medical Assistance Project.

The Department's share of the funding for the Client Services Improvement Project for FY 2008-09 was $621,098. No funding has been requested or approved for FY 2009-10. The Department is making no request for funding for this line item in FY 2010-11.

Enhanced funding from the American Recovery and Reinvestment Act of 2009 does not apply to this line item because the associated expenditures were for administrative purposes.

(C) OFFICE OF OPERATIONS – MEDICAID FUNDING

The Department of Human Services' Office of Operations appropriation contains funding for four divisions: Facilities Management, Accounting, Procurement, and Contract Management, of which some are partially funded with Medicaid funding. This appropriation is for the cost of salaries and operating expenses associated with some of the positions in this Office, as well as for utilities costs and Common Policy items such as Vehicle Lease Payments. POTS funding is centrally appropriated in the Executive Director's Office for these positions and is transferred into the Office of Operations as the fiscal year progresses. Because the elements included in this line item are varied, there is no one specific authorization in the Colorado Revised Statutes. However, authorization can be inferred from 24-1-120, C.R.S. (2009).

This line funds various support services for the Department of Human Services. The funding is appropriated into two groupings of administration and special purposes. Within administration are the Division of Accounting, Division of Contract Management, and Division of Procurement. The Health Insurance Portability and Accountability Act of 1996 Officer also reports to the Deputy Executive Director of Operation and Financial Services, but this officer is funded through the Executive Director's Office. Some components of administration receive partial Medicaid funding. Special purpose funding includes the Division of Facilities Management and the State Garage Fund, and no Medicaid funding is provided for the special purpose functions.

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 Division of Accounting has staff assigned with specific responsibilities to ensure compliance with Generally Accepted Accounting Principles, the Governmental Accounting Standards Board, federal regulations, state fiscal rules, and internal auditing controls.

The Procurement Division includes 6% of the total Office of Operations' staff. The purchasing staff 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 with extra concentration on purchasing supplies for mental health and developmental disabilities centers. The Procurement Division complies with both federal and state laws regarding procurement procedures.

The Contract Management Division is responsible for managing the contracting process including development, approval, and oversight of performance (Department of Human Services FY 2007-08 Figure Setting, February 14, 2007, page 13). The Contract Management Division ensures that all requirements for entering into contracts with outside contractors and Interagency Agreements with other departments in state government are met according to federal and state laws as well as observing state fiscal years.

A 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, although food purchases and linen services are considered to be room and board and are not medical services, so thus, they are not Medicaid paid.

However, Utilities and Vehicle Lease Payments from the Regional Centers are considered to be Medicaid related, although those expenditures originate in the Regional Centers line item, they 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.

Vehicle Leased Payments provides funding for payments to the Department of Personnel and Administration for the cost of administration, loan repayment, and lease-purchase payments for new and replacement motor vehicles. The vehicle lease payment provides for the fixed portion of the vehicle leases from fleet management. Although the number of vehicles leased does vary somewhat, the number is generally in the range of 400 to 500 vehicles each year. The variable portion of the motor vehicle costs are charged back to the Department of Human Services on the Operating Costs line. Because some of the vehicles are used by programs with Medicaid funding, the Department reimburses the Department of Human Services that, in turn, makes payments to the Department of Personnel and Administration.

Utilities expenditures include payments for natural gas, electricity, water, and waste water at the Department of Human Services' residential facilities such as the Division of Youth Corrections, Mental Health Institutes, and Regional Centers for Persons with Developmental Disabilities. Parts of the residential facilities for Mental Health Institutes and Regional Centers are used by Medicaid funded programs, so the Department uses Medicaid funding to reimburse a portion of the utilities costs to the Department of Human Services.

Administration in the Office of Operations also provides for payments for Leased Space and Capital Complex Leased Space but these components do not relate directly to the Medicaid programs, so no Medicaid funding is currently used for leased spaces.

The enhanced federal financial participation authorized by the American Recovery and Reinvestment Act of 2009 affects the payments made by the Department for Medicaid clients residing at the Regional Centers for the developmentally disabled. The Department pays Medicaid rates to cover various costs associated with providing services to these clients. Some of the service costs are transferred to this line item for better tracking of expenditures. During the time that the American Recovery and Reinvestment Act of 2009 is effective, these transfers receive enhanced federal financial participation.

Appropriation History

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. This type of request would be considered to be for Operating Expenses that are approved for Medicaid payments.

The Supplemental Bill for FY 2007-08 (HB 08-1285) reduced 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.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $6,054,395. The variance between FY 2007-08 and FY 2008-09 consisted of:

- an increase of $18,338 from NP-BA-13, "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.

In the FY 2008-09 Supplemental Bill, SB 09-187, the funding remained unchanged at $6,054,395.

The FY 2009-10 Long Bill, SB 09-259 appropriated $5,503,619 for this line item. The amount was derived by applying several adjustments to the amount from the prior year. Those adjustments included:

- add $121,320 for the prior year Salary Survey;
- add $45,600 for the prior year Performance Based Pay;
- remove $73,167 for the General Assembly First Conference Committee action to balance the budget by reducing Personal Services by 1.82%;
- remove $680,000 for Indirect Costs associated with the Regional Centers as recommended by the Joint Budget Committee of the General Assembly, but the federal match portion of $340,000 was moved into a new line item called Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs (see the narrative for the new line item description);
- add $791 for FY 2009-10 NP-5, "DHS – Postage Increase and Mail Equipment Upgrade," submitted November 3, 2008; and
- add $34,680 for Common Policy adjustments such as POTS.

The June 22, 2009 General Revenue forecast indicated that additional General Fund reductions would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the

agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES-4, "DHS – Office of Operations Personal Services and Operating Reduction," the Department of Human Services proposed that Personal Services and associated Operating Expenses be reduced on an ongoing basis. This resulted in a Medicaid total fund reduction of $39,922 and a General Fund reduction of $19,960 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund reduction of $17,119 and a General Fund reduction of $8,560.

Furthermore, as a part of NP-ES-22, "DHS – State Fleet Rebates – One-Time Refinance," the Department of Human Services proposed that the amount of state fleet funding paid back to the Department of Personnel and Administration be reduced. This resulted in a Medicaid total fund reduction of $8,422 and a General Fund reduction of $4,211 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund increase of $8,422 and a General Fund increase of $4,211 in FY 2010-11.

The base request for FY 2010-11 is $5,189,221, which includes $73,167 to restore the 1.82% Personal Services reduction made by the General Assembly during First Conference Committee budget balancing for SB 09-259, the FY 2009-10 Long Bill.

(D) DIVISION OF CHILD WELFARE-MEDICAID FUNDING

ADMINISTRATION

The Division of Child Welfare is located under the Deputy Executive Director of the Office of Children, Youth, and Families. The Administration of Child Welfare oversees a group of services intended to protect children from harm and to assist families in caring for and protecting their children. These services comprise Colorado's effort to meet the needs of children who must be placed or are at risk of placement outside of their homes for reasons of protection or community safety. 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. Many of the Child Welfare programs receive federal financial participation, and the Division of Child Welfare has a responsibility to show maintenance of effort for continuation of the federal funds.

Administrative functions for this line include providing supervision to the county departments of social/human services; responding 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. Authorization for this line item can be found at 26-1-201 (f), (g), (i) and (j), C.R.S. (2009).

Although the Division of Child Welfare Administration was created as a separate line item in the budget for the Department of Human Services in FY 2000-01, the separate line for the Department titled "(D) Division of Child Welfare: Administration" was added to the

Long Bill in the Department's appropriation in FY 2005-06. 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. The Child Welfare program receives Medicaid funding under federal Title XIX for the medical needs of children who are in the custody of the county departments of social services, but other types of services are provided under federal Title IV-E funding. The federal Centers for Medicare and Medicaid Services requires that Title XIX and Title IV-E funding not be co-mingled.

The 2007 Foster Care Performance Audit indicated that the State needed to improve performance in reviewing and monitoring count practice in regarding compliance with foster care requirements, indentifying successful foster parent recruitment and retention strategies for counties, improving oversight of safety in county homes that remain open following an abuse incident, ensuring county compliance with national safety, permanency and well-being standards, ensuring timely county completing with corrective action plan, and assuring county compliance with reporting critical incidents and appropriate follow-up. The Department of Human Services has taken action to complete those requirements. However, the action taken for the above corrections involved use of Title IV-E funding, not Medicaid funding.

The same staff members who oversee the Child Welfare program for Title IV-E funding are also responsible for oversight of the county work to enroll the children for Medicaid Services. The Medicaid funding in this administration line item pays for portion of the staff member salaries related to the Medicaid oversight work. Generally, the automated case management system used by the Department of Human Services for child welfare cases and known as Colorado Trails starts the enrollment process and passes information onto the Colorado Benefits Management System.

Appropriation History

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 the appropriation for FY 2007-08. The net increase of $546 represents the combined effect of a $607 decrease related to a POTS adjustment 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. However, the appropriation of $130,712 was reduced by $3,026 from the FY 2008-09 Request, NP-S-15, "DHS – Hiring Freeze Savings"(FY 2008-09 Budget Reduction Proposals, January 15, 2009). Authorization for this request was provided by the Supplemental Bill, SB 09-187.

The FY 2009-10 Long Bill, SB 09-259, appropriated $135,195 for this line item. That amount was derived including the following adjustments to the prior year amount of $127,686:

- add $5,341 for prior year Salary Survey;
- add $1,524 for prior year Performance Based Pay;

- add back $3,026 for the prior year reduction from NP-S-15, "DHS – Hiring Freeze Savings;" and
- reduce $2,382 for the 1.82% one-time reduction to Personal Services made by the General Assembly First Conference Committee to balance SB 09-259, the FY 2009-10 Long Bill.

The base request for FY 2010-11 is $137,577. In order to get to this number, $2,382 must be restored from the one-time Personal Services reduction of1.82% for FY 2009-10.

The line does not qualify for enhanced federal match through the American Recovery and Reinvestment Act of 2009 because the line covers administrative costs.

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. Authorization for this line item includes 26-5-101 and following subsections, C.R.S. (2009). The line item provides funding for: (1) County Administration for Child Welfare related services; (2) out-of-home placement, including foster care, (3) out of home placement in residential care facilities for children needing behavioral health treatment, (4) regular adoptions, (5) subsidized adoptions; (6) child welfare related child care and burials, (7) administration of the Interstate Compact on Placement of Children who are moving in or out of Colorado, including placement of children by Colorado in another state, and (8) other necessary and appropriate services for children and families.

Although Medicaid covers both physical health needs and mental health needs of the children in the child welfare system, most of the Medicaid 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. (2009). The remaining 20% is funded by 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 FY 2007-08 Figure Setting, February 22, 2007, page 39).

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 provider 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 FY 2006-07 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 FY 2006-07 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 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 FY 2006-07 Figure Setting, March 8, 2006, page 97-98).

The Colorado Children's Habilitation Residential program, sometimes abbreviated as CHRP, is a Home and Community-Based Services waiver and is designed to promote community placements and prevent institutional placements of children with developmental disabilities. Authorization for this waiver was provided by SB 96-178. On-going federal approval of this waiver is conditioned on having a State FTE administer the waiver. The Department of Human Services continues to meet this requirement under the child welfare system.

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.

The Department and the Department of Human Services have statutory authorization to transfer unlimited amounts of General Fund between the two department when required by changes from the levels in the amount of Medicaid Cash Funds (or reappropriated funds in the Department of Human Services budget) earned through programs or services provided under the supervision of the departments per 24-75-106, C.R.S. (2009). This provision is commonly used for the Child Welfare Services line item. If an unexpectedly large number of children receive services that are eligible for Medicaid reimbursement, the Department of Human Services may transfer extra General Fund to the Department so that it may receive federal financial participation for the services provided. Conversely, if child welfare Medicaid services are lower than the amounts reflected in the appropriation, the Department of Human Services can request that the Department transfer the General Fund portion of the associated Medicaid appropriation back to the Department of Human Services, so that the General Fund may be used to provide other child welfare services that are not eligible for federal financial participation for Medicaid. This approach has a net General Fund impact of $0.

Appropriation History

The Department's FY 2007-08 base request was for continuation funding of $34,063,555. However, due to an anticipated increase in caseload, the Department of Human Services submitted DI 6 (NP-6, "DHS-Child Welfare Services Block Increase" in the FY 2007-08 Budget Request submitted November 1, 2006). As a result of this request, he Joint Budget Committee approved an additional $383,193 in funding for the Child Welfare Services line item. 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 was 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:

- Restoration of Leap Year adjustment 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; and
- 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; Total funding was reduced by $18,000,000, resulting from NP-S7, NP-BA-4, "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.

During the budget reduction process to balance the budget for FY 2008-09, NP-S-10, "DHS – Child Welfare Block Correction from FY 2008-09 Figure Setting," submitted January 15, 2009, requested a reduction that was approved by the Supplemental Bill, SB 09-187. The reduction of $262,779 resulted in a revised appropriation of $18,508,228.

The FY 2009-10 Long Bill, SB 09-259, appropriated $18,746,950, which was based on the FY 2008-09 appropriation of $18,508,228 with an addition of $238,722 for NP-4, "DHS – Child Welfare Caseload," submitted on November 3, 2008 for FY 2009-10 and adjusted during Department of Human Services FY 2009-10 Figure Setting on February 18, 2009. See page 47 of the Figure Setting Document for more information.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES-9, "DHS – Reduction to the Child Welfare Services Block," the Department of Human Services proposed that overall funding for child welfare services be reduced. This resulted in a Medicaid total fund reduction of $4,238,722 and a General Fund reduction of $2,119,361 to this line in FY 2009-10. The Department's FY 2010-11 budget request stays reduced by the same amount as in FY 2009-10.

The Department's base request for FY 2010-11 is $14,508,228.

The line items does qualify for enhanced federal match through the American Recovery and Reinvestment Act of 2009 because the line pays for services provided to Medicaid clients.

(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 Personal Services and Operating Expenditures for oversight of the mental health services provided by the Department of Human Services. Colorado provides mental health care to a larger population than just Medicaid clients, but this line item is prorated from the total state expenditures for mental health care to represent only the Medicaid portion. There is no specific reference in Colorado Revised Statutes for Mental Health Administration, but a references may be inferred from 24-1-120, C.R.S. (2009).

The Executive Director of Behavioral Health and Housing oversees the Division of Behavioral Health, the Division of Community Mental Health (for non-Medicaid clients), the Division of Mental Health Institutes, and the Division of Supportive Housing and Homelessness. Not all of these divisions have a connection with Medicaid. Administration includes development of policies, standards, rules and regulations, planning, contracting, allocation of resources, program and contract monitoring, technical assistance, program evaluation and outcome measurement, end user work for development and maintenance of management information systems

(technical systems work done in the Office of Information Technology) related to mental health, and interfaces with budgeting and accounting functions in the Department of Human Services.

However, the administration at the Department of Human Services does not oversee the Medicaid portion of the mental health program for community services provided by the behavioral health organization to categorically eligible Medicaid clients, except occasionally when a client with severe mental health needs that would usually be served by a Medicaid community behavioral health organization is referred to a facility under the jurisdiction of the Department of Human Services. Since 2004 when HB 04-1265 was signed into law, the Medicaid community behavioral health organizations have been under oversight and funded through appropriations in the Department.

Personal Services for the staff in this administrative line item include salaries and associated expenditures. POTS items are centrally appropriated in the Executive Director's Office of the Department of Human Services and are transferred into this administrative line throughout the fiscal year as needed. Operating expenses include small items such as office waste disposal services, minor building maintenance and repairs, office equipment maintenance and repairs, information technology hardware and software maintenance and upgrades, vehicle and motor pool variable costs, travel costs, telecommunications costs, printing and reproduction services, data processing supplies, general office supplies, postage, noncapitalized equipment purchases, and conferences and training classes registration fees.

Appropriation History

The FY 2007-08 Long Bill (SB 07-239) funding was $317,055, which included 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 same amount of funding remained in the appropriation after the Supplemental Bill, SB 09-187, was approved.

The appropriation increased to $348,973 as authorized by the FY 2009-10 Long Bill, SB 09-259. This amount included additions of $18,155 for prior year Salary Survey and $5,620 for prior year Performance-Based Pay.

Continuation funding in the amount of $348,973 is the base request for FY 2010-11.

Funding in this line does not qualify for enhanced federal match from the American Recovery and Reinvestment Act of 2009 because the expenditures cover administrative functions.

RESIDENTIAL TREATMENT FOR YOUTH (HB 99-1116)

HB 99-1116 created the Child Mental Health Treatment Act that improved the probability of children with significant mental health needs to receive treatment. Children so served under this Act are often referred to as 1116 Kids. This act is codified in 27-10.3-101 and following subsections, C.R.S. (2009).This legislation was passed to help mitigate parents' frustrations in navigating the various governmental system including child welfare, mental health, law enforcement, juvenile justice, education, and youth corrections in seeking help for their children. Often these situations resulted in a court action of dependency and neglect that caused parents to give up custody of their children to the local departments of social services. The Child Mental Health Treatment Act set up a framework for getting mental health treatment for these children without resorting to the dependency and neglect action. However, during the evaluation process for admission to the residential treatment center, if it is determined that the child is a victim of child abuse, then the case is referred to child welfare services.

Mental health agencies are responsible for providing the full range of mental health treatment services, including residential care for these children who do not start out to be categorically eligible for Medicaid but who may be determined to be eligible for Supplemental Security Income (SSI), and by virtue of qualification for SSI, then become eligible for Medicaid also. These children are served under the Medicaid funding for this line item of Residential Treatment for Youth.

Some of the children who need this service do not qualify for either SSI or Medicaid are considered to be private pay clients at the Residential Treatment Centers, and the children's parents pay for the treatment if the parents do not have private insurance that would cover such treatment. If none of the aforementioned payment options are available, then the Department of Human Services pays for the treatment from the larger appropriation for Residential Treatment for Youth, of which the reappropriated funds in the larger appropriation are Medicaid funds to be use only for Medicaid clients.

Although there has been a therapeutic residential child care facility located at the Colorado Mental Health Institute at Fort Logan, other Residential Treatment Centers may be privately operated facilities that have contracted to provide this type of care. These treatment centers are referred to as a therapeutic residential child care facility (TRCCF) because they provide the highest, most intensive level of care for children. Often there may also be children who are in the custody of Child Welfare in the Department of Human Services or in the custody of the Division of Youth Corrections at the Department of Human Services who are also treated with mental health care in the same therapeutic residential child care facility. The difference for the 1116 Kids is that they remain in the custody of their parents even though the children are temporarily in an out of home placement situation, but not in the custody of a governmental organization.

Historically, there used to be much larger Medicaid appropriations for this line item because the treatment at these facilities included room and board as well as mental health medical care. The federal Centers for Medicare and Medicaid Services has indicated that Medicaid, Title XIX, would not cover room and board, so that only mental health medical care is now covered with the result that smaller Medicaid appropriation have been in effect going forward from FY 2006-07.

Appropriation History
Per the FY 2007-08 Long Bill, SB 07-239, the FY 2007-08 appropriation was $117,463.

The FY 2008-09 Long Bill, HB 08-1375, appropriated $119,225. This number is based on the prior year funding of $117,463 plus $1,762 for provider rate increases as requested in NP-9, "DHS Provider Rate Increases"(November 1, 2007 FY 2008-09 Budget Request) and approved by the Joint Budget Committee during Figure Setting.

Continuation funding was provided by the FY 2009-10 Long Bill, SB 09-259, for the same amount as provided in the prior year.

The Department requests continuation funding for FY 2010-11.

Enhanced federal match is available through the American Recovery and Reinvestment Act of 2009 because this line item provides services for Medicaid clients.

MENTAL HEALTH INSTITUTES
The State operates two hospitals for the severely mentally ill: the Colorado Mental Health Institute at Fort Logan, established in 1961 and located in Denver, and the Colorado Mental Health Institute, established in 1879, at Pueblo. These institutes are codified in 27-13-101 and following subsections, C.R.S. (2009) and 27-15-101 and following subsections, C.R.S. (2009). The institute at Pueblo generally serves clients from the southern and western regions of Colorado, while the institute at Fort Logan generally serves clients from the Denver Metropolitan area as well as the north central and northeastern regions of Colorado. The institutes provide inpatient psychiatric hospital services to citizens of Colorado 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; pastoral services; substance abuse education and treatment; and discharge and aftercare planning.

The Mental Health Institutes play an important role in the continuum of care in the mental health system in Colorado. Residential occupancy at both Fort Logan and at Pueblo has declined over a period of time as the institutes have moved away from simply housing mentally ill patients (sometimes for their entire lives) to providing active treatment in a secure setting with the goal of reintegrating the mentally ill individuals back into the community. The intention is that the institutes provide short-term secure stabilization services only to the State's most severely mentally ill citizens. The majority of the clients in the institutes are referred by Community Mental Health Centers, or the Behavioral Health Centers, if a client is too unstable for effective treatment in the community.

Over the years, the number of court-ordered and competency evaluations has increased significantly. To meet this need, the Colorado Mental Health Institute at Pueblo has a separate unit called the High Security Forensics Institute for clients who have been charged

with crimes but are believed to be mentally incompetent. These clients have been referred by court order for sanity and competency evaluations, and this unit serves an important function because, otherwise, the clients would have to wait in jail until other arrangements could be made. If a client is found to be mentally incompetent, the purpose of treatment at this high security location is to restore competency if at all possible. Clients in this situation sometimes have to remain at the High Security Forensics Institute for several years, depending on how long treatment is deemed necessary.

Funding for the institutes comes from a variety of sources such as disability payments, Medicare, Medicaid, third party insurers or insurance companies, counties, school districts, and other State Departments, for example, Department of Corrections and Department of Education. The institutes also transfer a portion of their revenues to other offices in the Department of Human Services that provide support for operations of the institutes. These supporting operations include facilities management and accounting functions in the Office of Operations and computer functions in the Office of Information Technology. The Department pays for the services provided to Medicaid clients at the institutes as well as the Medicaid portion of the functions in the Office of Operations and Office of Information Technology that relate to Medicaid services at the institutes. (See separate line item descriptions for the Office of Operations and the Office of Information Technology in the Department of Human Services Medicaid-Funded Programs.)

The institutes do not have a separate appropriation for capital outlay. All such purchases are included in the main appropriation. Capital outlay covers purchases of furniture, fixtures, and special equipment when the items cost over $5,000. A portion of those purchase costs are paid by Medicaid if the items are to be used by Medicaid clients. However, capital outlay purchases take a lower priority than the general costs of providing everyday services to all of the clients, including Medicaid clients.

Appropriation History

The appropriation for this line item in FY 2007-08 was $3,344,403 from the Long Bill, SB 07-239. This amount was increased by $360,335 through a late Supplemental Request, NP-S20, "Mental Health Institute Revenue Adjustment," submitted February 15, 2008, and approved by the Add-on sections of the FY 2008-09 Long Bill, HB 08-1375, resulting in a final appropriation of $3,704,738 for FY 2007-08.

Continuation funding of $3,704,738 was appropriated in the FY 2008-09 Long Bill, HB 08-1375. This amount was decreased by $250,505 through a late Supplemental Request, NP-S-23, "DHS – Mental Health Institutes Revenue Adjustment," submitted February 16, 2009, and approved by the Add-on sections of the FY 2009-10 Long Bill, SB 00-259, resulting in a final amount of $$3,454,233.

As a result of the Joint Budget Committee taking staff recommendation regarding funding the General Hospital section at the Colorado Mental Health Institute at Pueblo, a reduction of $2,415 was made to the FY 2009-10 appropriation. Thus, the FY 2009-10 Long Bill, SB 09-259, appropriated $3,451,518.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the

agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES-5, "DHS – Close 59 Beds at the Colorado Mental Health Institute at Fort Logan," the Department of Human Services proposed that 50 underutilized beds at Fort Logan be closed and that future potential clients for those beds be referred to psychiatric units at local general hospitals. This resulted in a Medicaid total fund reduction of $257,624 and a General Fund reduction of $128,812 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund reduction of $257,624 and a General Fund reduction of $128,812 in FY 2010-11.

The Department requests continuation funding of $2,936,570 for FY 2010-11.

Federal enhanced match is available for this line item from the federal American Recovery and Reinvestment Act of 2009 because the line item funds services for clients.

ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION

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.

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 approximately 42 treatment providers in approximately 200 treatment facilities throughout Colorado. Finally, staff oversees and provides technical assistance to 98 prevention program contracts No specific reference for Alcohol and Drug Abuse Administration is in the Colorado Revised Statutes, but authority can be inferred from 24-1-120, C.R.S. (2009).

Medicaid funding has been provided to the Alcohol and Drug Abuse Division (ADAD) to assure that substance abuse treatment programs meet distinct requirements of Alcohol and Drug Abuse Division 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.

The Medicaid funding actually covers the portion of the Personal Service and Operating Expenses prorated for Medicaid purposes. POTS are centrally appropriated in the Executive Director's Office and transferred throughout the fiscal year as needed to cover the benefits associated with Personal Services in the Alcohol and Drug Abuse Division, Administration line item.

Appropriation History

The Department requested, and was granted per the Long Bill, SB 07-239, $54,088 for FY 2007-08. Of this total, $53,136 was for Personal Services and $952 was for Operating Expenses. The Department was appropriated continuation funding in the FY 2008-09 Long Bill, HB 08-1375.

The Department requested continuation funding of $54,088 for FY 2009-10. However, a technical error occurred in FY 2009-10 Long Bill, SB 09-259 because only the Personal Services portion of $53,136 was appropriated, but the Operating Expenses portion of $952 was inadvertently left out. The Department is requesting a restoration of the $952 for FY 2010-11, for a total base request of $54,088. This requested adjustment has been included in the FY 2010-11 Reconciliation Table submitted with the November 2, 2009 FY 2010-11 Budget Request. In addition, the Department will be working with the Office of State Planning and Budgeting and the Joint Budget Committee staff to request a restoration of funding for the FY 2009-10 appropriation.

ALCOHOL AND DRUG ABUSE DIVISION, HIGH-RISK PREGNANT WOMEN PROGRAM

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. 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 poor birth outcomes due to substance abuse-related disorders. This program was developed with the following goals: 1) delivery of healthy infants; 2) reduce or stop substance abuse 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. 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. The program is an entitlement program fully funded by Medicaid but administered by the Alcohol and Drug Abuse Division in the Department of Human Services.

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. Under the current waiver, the maximum number of days that a woman may receive treatment is 524, allowing for participation during pregnancy and after delivery.

Approximately one third of the clients enter the program during the first trimester of pregnancy. A little less than half of the clients enter the program during the second trimester, and a little less than one third enter the program during the third trimester. Individual programs are developed for each woman. Prenatal care is also available for participating clients.

Authority for the program is provided at 25-1-212 through 25-1-213, C.R.S., (2009). The Medicaid Assistance portion of this program is also authorized by 25.5-5-310 through 312, C.R.S. (2009).

The outpatient program is available though the Addiction Research and Treatment Services in Denver; Arapahoe House locations in Denver, Aurora, and Thornton; Boulder County Health Department; Centennial Mental Health Center in Sterling; Cortez Addictions Recovery Services located in the four corners area of Colorado; Crossroad's Turning Point locations in Pueblo, Walsenburg, and Trinidad; Denver Area Youth Services (DAYS) in Denver, El Paso County Health Department in Colorado Springs; Jefferson County Health Department; and Outpatient Behavioral Health Services at Denver Health and Hospital Authority.

For residential treatment, a total of 74 beds are available: Of this total, 16 beds are in Littleton, 16 beds are in Westminster, 16 beds are in Pueblo, and 26 beds are in Denver. The services offered by the residential program are the same as those offered on an outpatient basis. Residential treatment is provided for pregnant women who can not maintain abstinence in an outpatient setting. However, Medicaid pays for only the medical treatment. Room and board can be provided to the women in the residential program through a federal Substance Abuse Block Grant managed by the Department of Human Services.

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. Stimulants restrict the blood flow from the mother to the newborn via the placenta, which can lead to lower birth weight, and these newborns require longer hospital stays. Future physical and mental health needs of the children of the mothers enrolled in the program can often be prevented as a result of the services provided. Cost savings accrue from this program by preventing higher costs required to pay for the children's physical and mental health problems if substance abuse treatment had not been provided to their mothers.

Appropriation History

To build the FY 2007-08 appropriation, the Joint Budget Committee included an adjustment for a 1.5% provider rate increase, which increased the FY 2006-07 appropriation by $14,759. As a result, in FY 2007-08, the High-Risk Pregnant Women Program line item received an appropriation of $998,717 per the Long Bill, SB 07-239.

The FY 2008-09 Long Bill (HB 08-1375) authorized $1,013,700 total funds for this line item. Of this amount, $14,983 was for a provider rate increase. This increase was requested in NP-9, "DHS – Provider Rate Increases," in the FY 2008-09 Budget Request submitted November 3, 2008 and approved by the Joint Budget Committee. As a result of increased caseload in addition to the extension of the program from 60 days postpartum to 12 months postpartum, an increase in funding was requested for FY 2008-09 in

NP-S-22, "DHS – High Risk Pregnant Women Program," submitted February 16, 2009 for $597,350. This request was approved in the Add-on section of the FY 2009-10 Long Bill, SB 09-259. Thus, the final appropriation for FY 2008-09 was $1,611,048.

For FY 2009-10, an increase in funding was requested in NP-13, "DHS – High Risk Pregnant Women Program," submitted November 3, 2008. This request was for $428,897 total funds and was approved in the FY 2009-10 Long Bill, SB 09-259 for a total appropriation of $2,039,945.

The Department is requesting continuation funding of $2,039,945 for FY 2010-11.

This line item qualifies for enhanced federal financial participation through the American Recovery and Reinvestment Act of 2009 because the expenditures covered are for services to clients.

(F) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ADMINISTRATION

This line item supports approximately 90% of the total costs associated with 34 Administrative FTE. 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 (FY 2009-10 Figure Setting for the Department of Human Services Medicaid Programs, March 4, 2009, page 54). This line also funds 70% of the costs for the Community and Contract Management System (CCMS). 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. The Community and Contract Management System also tracks disability resources and contracts, as well as waiting list information. This line also funds 100% of operating expenses, as well as Medicaid waiver transition costs.

Appropriation History

SB 07-239, the FY 2007-08 Long Bill, included a Common Policy adjustment increase of $59,056 for salary survey and an additional $3,972 for personal services for quality assurance FTE over the FY 2006-07 appropriation. The Joint Budget Committee approved a 0.5% salary base reduction of $11,749. Additional adjustments included an annualization decrease of $3,288 for operating expenses from FY 2006-07, and a $96,236 increase for a Community and Contract Management System web redesign (FY 2009-10 Figure Setting for the Department of Human Services Medicaid Programs, March 14, 2007, page 33). The additional funds were appropriated to pay Medicaid's portion of updated software and hardware for this information technology system. SB 07-239, the FY 2007-08 Long Bill, authorized an appropriation for the line item of $2,582,358.

The appropriation was adjusted by HB 08-1285, the FY 2007-08 Supplemental Bill, as a result of the Joint Budget Committee's approval of NP-S2, "DHS – Division for Developmental Disabilities Medicaid Waiver Reform Transition Costs." The supplemental request for $20,318 was submitted as the result of the Centers for Medicare and Medicaid Services audit requiring the Home and

Community-Based Services Waiver Program unbundling of services and costs. As a result, the final FY 2007-08 appropriation for this line item 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.

Governor Ritter implemented a statewide hiring freeze for state Government in October of 2008, a freeze which remained in place for the rest of the fiscal year. Consequently, NP-S15, "DHS-Hiring Freeze Savings" was approved by the Joint Budget Committee, and became part of SB 09-187, the FY 2008-09 Supplemental Bill, reducing the line item appropriation by $117,283 as a one-time reduction. The final FY 2008-09 line item appropriation was $2,659,043.

To build to SB 09-259, the FY 2009-10 Long Bill, SB 08-002, "Family Caregiver for Developmentally Disabled," was annualized, adding $72,582. The Hiring Freeze Savings from FY 2008-09 was annualized as a reversal, resulting in an increase of $117,283. NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study" from FY 2008-09 was also annualized, adding $10,848. Prior year Common Policy adjustments of $90,680 for salary survey and $28,970 for performance-based pay were also added to the line item appropriation. The Joint Budget Committee approved NP-5, "DHS Postage Increase and Mail Equipment Upgrade", which added $72. This request addressed increasing postage costs and equipment upgrade needs in the Department of Human Services as requested by the Department of Personnel and Administration. The Joint Budget Committee recommended, and the Legislature approved, an across-the-board Personal Services cut of 1.82% throughout the State budget and this became part of SB 09-259, the FY 2009-10 Long Bill. This reduced the appropriation by $47,913. The final line item appropriation for FY 2009-10 was $2,931,565.

To build to the FY 2010-11 base request, the $2,931,565 appropriated through the Long Bill, SB 09-259, served as the base. The request includes a reduction of $72 for the prior year's NP-5, "DHS Postage Increase and Mail Equipment Upgrade." One additional annualization of the prior year's Joint Budget Committee action adds $47,913 for the one-time 1.82% personal services reduction from the prior year.

The Department is requesting total funding of $2,979,406 for FY 2010-11.

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, PROGRAM COSTS

The Adult Program Costs and the Services for Children and Families, Program Funding line items in this section were consolidated into the Community Services for People with Developmental Disabilities, Program Costs starting in FY 2007-08. This line item currently appropriates funds for Medicaid eligible services for approximately 7,804 clients through three waivers (described below) supporting the Adult Comprehensive Services, Adult Supported Living Services, and Children's Extensive Support Services Programs. 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. Case Management services are currently appropriated for approximately 8,252 Medicaid clients under the new consolidated line item. This number has increased each of the past three years.

The Comprehensive Home and Community-Based Services Waiver for People with Developmental Disabilities under the former Adult Program Costs and Services for Children and Families, Program Funding line items was replaced by funding displaying all three waivers individually under the new line item. The three waivers are: Supported Living Services, Comprehensive Developmental Disabilities, and Children's Extensive Support.

The Supported Living Services waiver provides supported living in the home or community to persons with developmental disabilities. Services include the provision of specialized medical equipment and supplies, counseling and behavioral therapies, dental, vision, hearing, day habilitation, home modification, personal assistance, supported living consultation, and transportation. The Supported Living Services waiver also helps individuals with pre-vocational and supported employment. The Comprehensive Developmental Disabilities waiver provides services and support to persons with developmental disabilities, allowing them to continue to live in the community outside of the family home. Services provided under this waiver include day habilitation, residential habilitation, transportation, specialized medical equipment and supplies, supported employment, skilled nursing, counseling, dental, and vision. The Children's Extensive Support waiver provides various services for children who require nearly 24-hour supervision due to the severity of the child's developmental disability. Services include the provision of specialized medical equipment and supplies, community connection services, home modifications, personal assistance, and professional services.

From the late-1990s through FY 2005-06 the developmental disability system was managed pursuant to a systems change agreement between the Department of Human Services and the Joint Budget Committee. Systems change was pursued as an alternative to full-fledged managed care. The goal was to provide community centered boards with increased flexibility to manage developmental disability funding, programs, and services, resulting in lower service costs. The Department of Human Services used a bundled rate methodology to reimburse the community centered boards through the Community and Contract Management System (CCMS) for client services. The result was a quasi managed-care system, in which community centered boards received payment based on an average service rate for their region and number of persons served. They negotiated agreements with individual providers based on the specific needs of the individuals served.

The federal Centers for Medicare and Medicaid Services (CMS) conducted an audit of the Comprehensive Home- and Community-Based Services Waiver for People with Developmental Disabilities and the audit was completed on April 26, 2004. Because CMS indicated that the managed-care methodology in use at the time was no longer acceptable, its use was terminated beginning in FY 2006-07, and the overall developmental disability system was substantially restructured. The State was instructed to establish a method to ensure accountability for federal funds and to demonstrate the Single State Medicaid Agency, the Department of Health Care Policy and Financing, retained administrative oversight of the waivers in accordance with federal requirements. As a result, a new uniform rate setting methodology was developed for the Comprehensive Home- and Community-Based Services Waiver for People with Developmental Disabilities, which included the mandatory "unbundling" of rates. The agreement with CMS was that the State could phase in this new methodology starting with the Comprehensive Home- and Community-Based Services Waiver for People with Developmental Disabilities, so long as all three individual waivers were in compliance for their July 1, 2009 renewals.

The Centers for Medicare and Medicaid Services required that: (1) Colorado return to a fee-for-service billing structure through which costs for individuals could be tracked; (2) providers have the option of billing Medicaid services directly and that they not be required to bill through the community centered boards; (3) the State adopt a uniform rate structure; and (4) the Department provide further program oversight. Pursuant to a Plan of Correction submitted to CMS in May, 2006, Colorado agreed to the following:

- *Interim Solution:* By July 31, 2006, the State would establish and implement statewide interim uniform tiered rates for the Comprehensive Home- and Community-Based Services Waiver for People with Developmental Disabilities based on analysis of existing rates. Providers would be given the option to enroll as Medicaid providers and to bill directly in time for submission of July 2006 claims.
- *Long-term Solution:* The State committed to selecting an intensity tool for use in identifying a client's reimbursement tier based upon client need and would administer the selected intensity tool to a sample of clients for these purposes. This would be used for an actuarial study that would establish uniform tiered rates for residential services and day habilitation services.

The interim set of changes was implemented August 1, 2006. Implementation of the long-term solution was ultimately delayed to January 1, 2009 for the comprehensive program and July 1, 2009 for the Supported Living Services and Children's Extensive Support programs. (FY 2009-10 Figure Setting for the Department of Human Services Medicaid Programs, March 4, 2009, pages 52-53)

The State addressed the audit concerns in part by organizing 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. As a result of committee efforts, a new interim seven-tiered services matrix, based upon a fee-for-service reimbursement methodology, was developed and implemented beginning July 1, 2006. An interim rate structure would serve until the final rate methodology could be completed. Under the new methodology, clients are assigned to one of seven acuity levels according to his/her required service needs. 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 Department of Human Services 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 Comprehensive Home and Community-Based Services Waiver for People with Developmental Disabilities and Supported Living Services waiver. Once the level of care has been established for each client, the State will be able to adjust its estimated expenditures accordingly. Although the payment methodologies have been implemented, both departments continue to review the expenditures to determine if any adjustments might be needed. In FY 2006-07, the Department of Human Services submitted a 1331 emergency supplemental request to pay for the purchase, modification, and user training for the above-referenced Supports Intensity Scale tool, temporary assistance in processing Prior Authorization Reviews, and modifications to the Community Contract and Management System. These changes were necessary to keep the developmental disabilities programs running smoothly.

During FY 2007-08 the steering committee met monthly to develop the contents of an updated comprehensive developmental disabilities waiver to be submitted to CMS. The updated waiver amendment was submitted April 29, 2008. Also during FY 2007-08, a Rates Development Committee met frequently to develop the 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 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 in HB 05-1262, state funding for these new clients was appropriated from tobacco tax revenues and matching federal funds.

The FY 2007-08 Long Bill, SB 07-239, appropriated $281,791,710 total funds to this line item. During the fiscal year NP-S19, "DHS–Division of Developmental Disabilities Medicaid Appropriation Reduction" was submitted, requesting a funding reduction because Medicaid expenditures for developmental disabilities services and case management were less than originally anticipated. The Joint Budget Committee reduced the appropriation by $4,153,701 for under-expenditures and another $5,753,055 for the removal of roll-forward funds from FY 2006-07. Rounding differences added $1 to the Long Bill appropriation. These changes totaling $9,906,755 were reflected in the FY 2007-08 Long Bill Add-on Section, HB 08-1375, and total funding for FY 2007-08 was $271,884,955. Per footnote 79b in the FY 2008-09 Long Bill, HB 08-1375, the Department of Human Services was authorized to roll forward up to 3% of unspent Medicaid funds from FY 2007-08 in order to assist in and provide contingency funds for the transition from the bundled rate Medicaid system to the new fee for service system. Consequently, the Department rolled forward $5,057,748 into FY 2008-09. Final actual expenditures for FY 2007-08 were $262,895,206 and $3,932,001 total funds were reverted.

To build to the FY 2008-09 appropriation, the $271,884,955 appropriated through the FY 2007-08 Long Bill Add-on section, HB 08-1375, served as the base. In FY 2006-07, the Department submitted NP-3, "DHS – Provide Resources to Specific Populations", in

which it requested new developmental disability resources for FY 2007-08. The request was approved and an annualized appropriation of $3,320,685 was included in the FY 2008-09 Long Bill, HB 08-1375. The Department submitted NP-10, "DHS – Division for Developmental Disabilities New Resource Request" and NP-BA-17, "Governor's New Resources for Developmental Disabilities". These requests were approved and $12,658,599 was added as part of the FY 2008-09 Long Bill, HB 08-1375, to begin in mid-year FY 2008-09 and then annualize to a full year appropriation the following year. The Department submitted NP-9, "DHS Provider Rate Increases", requesting an increase of 1.35% for all client service providers. The Joint Budget Committee enacted a 1.5% increase and $4,266,097 was included as part of the FY 2008-09 Long Bill, HB 08-1375. Due to the one-time nature of the appropriations reductions from the FY 2007-08 NP-S19, "DHS–Division of Developmental Disabilities Medicaid Appropriation Reduction" totaling $9,906,755, these funds were restored to the line. Other funding actions that became part of the FY 2008-09 Long Bill, HB 08-1375, include two funding reductions: 1) a reversal of a leap year adjustment of $705,941, and 2) a Supported Living Services base adjustment of $427,540. Rounding differences reduced the Long Bill appropriation by $1. The final amount appropriated to the line through the FY 2008-09 Long Bill, HB 08-1375, was $300,903,609. One other action moved $583,199 from the line's cash funds exempt funding source to the cash funding source. These funds represent local match funds and were moved as part of "Eliminate Cash Fund Exempt Designation," HB 08-1320, eliminating the cash funds exempt funding source designation from the long bill.

During the winter of FY 2008-09, the deteriorating economic conditions required the Department to recommend areas where budget reductions could be made. The Joint Budget Committee took action on NP-S11, "DHS Fee for Service versus Bundled Billing," eliminating $5,300,000 in total funding (January 15, 2009 FY 2008-09 Budget Reduction Proposals). The Committee also took action on NP-S12, "DHS Vacancy Savings due to Systematic Client Turnover," removing another $1,668,362 total funds, and NP-S13, "DHS Developmental Disability Services 2007-08 Roll Forward," eliminating $5,057,748. Both proposals were also submitted on January 15, 2009. In total, the FY 2008-09 Supplemental Bill, SB 09-187, reduced the funding to the line by $12,026,110, bringing the final appropriation funding for FY 2008-09 down to $288,877,499.

Unlike previous years, the Department received no roll-forward authority to carry funds into the next fiscal year. Expenses for the year exceeded appropriations by less than 1% and the Department of Human Service transferred $227,697 total funds and another $2,281,772 from the Department's Regional Centers line item into this line item. FY 2008-09 final total expenditures were slightly less than initially estimated, totaling $291,337,532, and $49,436 General Fund was reverted.

The Department is the federally recognized Single State Agency responsible for administering the Medicaid program. Based upon the state's increased unemployment rate, the American Recovery and Reinvestment Act (ARRA) authorized an enhanced federal financial participation rate in FY 2008-09 that affects the fund splits for this line item. This enhanced rate did not affect the total funding to this line item, but it did provide more federal funds. This reduced the amount of General Fund required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item for the second half of FY 2008-09 and is scheduled to continue to impact financial participation rates through December 2010.

To build to the FY 2009-10 appropriation, the $288,877,499 appropriated through the Long Bill Add-on section, SB 09-259, served as the base. The above-referenced NP-S11, "DHS – Fee for Service versus Bundled Billing," and NP-S13, "DHS – Developmental Disability Services 2007-08 Roll Forward," were one-time reductions and were reversed, restoring $10,357,748 in funding to the line. The previous year's NP-10, "DHS – Division for Developmental Disabilities New Resource Request" and NP-BA-17, "Governor's New Resources for Developmental Disabilities," increased the FY 2009-10 appropriation by $12,658,599 total funds since it only funded one half of a fiscal year in FY 2008-09. Consistent with past practice, the Department submitted a request for funding as a result of the addition new developmentally disabled caseload, NP-3, "DHS – Community Funding for Individuals with Developmental Disabilities." This request was approved and $5,189,494 was appropriated. The Joint Budget Committee also appropriated $590,620 for Regional Center Transition Placements and Staff Adjustment for Case Management. The regional centers' transition involves the transfer of clients with less intensive needs to community center providers decreasing costs in the Regional Centers line and increasing costs into this line item.

General Revenue forecasts in early 2009 projected continued deterioration in the state economy and the Joint Budget Committee reviewed funding for the line due to state budget balancing requirements. The Committee reviewed past appropriations approved for the line item and enacted reductions to specific requests. Reductions totaling $3,406,407 were made to previously approved appropriations for new resources. The Joint Budget Committee made a technical reduction of $167,535 to reflect PASARR billing in FY 2007-08 that was less than the amount appropriated. As a result of these reductions the FY 2009-10 Long Bill, SB 09-259, appropriated $314,100,018 to this line item.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES7 "DHS – DDD Medicaid Waivers Provider Rate Reduction," the Department proposed to reduce provider rates/services by 2.5% effective October 1, 2009 for Adult Comprehensive Services, Adult Supported Living Services, and Children's Extensive Support. Some rates/services may be reduced by less than 2.5%, while others may experience a reduction greater than 2.5%. This resulted in a total fund reduction of $5,888,663, a General Fund reduction of $2,933,459, a cash fund reduction of $10,873, and a federal fund reduction of $2,944,331 to this line in FY 2009-10. This line is also affected by the enhanced federal financial participation authorized by the American Recovery and Reinvestment Act, which will reduce the General Fund portion of the appropriation while increasing the federal portion. The Department's FY 2010-11 base request includes an annualized total fund reduction of $7,851,550, a General Fund reduction of $3,911,278, a cash fund reduction of $14,497, and a federal fund reduction of $3,925,775 in FY 2010-11.

To build to the FY 2010-11 base request, the $314,100,018 appropriated through the Long Bill, SB 09-259, served as the base. The previous year's NP-3, "Community Funding for Individuals with Developmental Disabilities" required an annualization increase of $5,189,494 total funds since it only funded one half of a fiscal year in FY 2009-10. However, the related Joint Budget Committee prior reduction made to the Developmental Disabilities New Resources also required an annualized reduction totaling $3,243,265, and

the above-referenced NP-BA9, "DHS Reduce FY 2010 Decision Item for New Resources" required an annualized reduction totaling $163,142. NP-ES7, "DHS – DDD Medicaid Waivers Provider Rate Reduction," will annualize to a $7,851,550 reduction.

The Department is requesting total funding of $308,031,555 for FY 2010-11.

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 financial participation 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 federal Centers for Medicare and Medicaid Services (CMS) previously 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 was to enroll additional eligible individuals into the programs.

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.

HB 08-1220 enabled remittance of local funds to the state for the purchase of services for people with developmental disabilities. The passage of HB 08-1220 (Developmental Disabilities Statutory Cleanup) modified provisions concerning services for people with developmental disabilities to comply with federal requirements and practices of the Department of Human Services related to funding for and purchase of services from the community centered boards. Despite the legislation, the line item did not expend any funds throughout FY 2008-09. No counties or local governments have used the revised approach and federal financial participation for this program ceased in December 2008. As a result, this line was eliminated from the Long Bill for FY 2009-10. (FY 2009-10 Department of Human Services Figure Setting, March 4, 2009, pages 82-83).

Appropriation History

Continuation funding of $24,281,838 total funds was appropriated for FY 2006-07 but due to the changes required by CMS, 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 former Community Services Adult Program Costs and Community and Contract Management System Replacement line item (see line item description for Community Services for People with Developmental Disabilities, Program Costs). In total, this action removed $11,957,531 total funds, and brought the final FY 2006-07 appropriation to $12,324,307 total funds. Of these remaining funds, $8,682,397 was spent to pay for services rendered in FY 2005-06. Since the services paid were no longer eligible for federal reimbursement, they were considered non-recurring. The final FY 2007-08 appropriation was $3,641,910.

Funding for FY 2008-09 was further reduced as the result of a Joint Budget Committee action. This action was taken because of the elimination of the federal financial participation for the line item combined with the fact that clients were being absorbed into other programs. Staff determined that appropriations needed for this line item would decrease by $1.8 million in FY 2008-09 and, pending further information, recommended that the remaining line item appropriation be rounded to $2,000,000.

The Department requested continuation funding for FY 2009-10 of $2,000,000 total funds. Local level funding was needed in order to obtain federal financial participation. No local level financial remittances in accordance with HB 08-1220 materialized and federal financial participation for this program ended in December 2008. The line item did not expend any funds throughout FY 2008-09. As a result, the Joint Budget Committee decided to eliminate this line item from SB 09-259, the FY 2009-10 Long Bill, for FY 2009-10. (FY 2009-10 Department of Human Services Figure Setting, March 4, 2009, page 83).

The Department is not requesting funding for this line in FY 2010-11.

REGIONAL CENTERS

The state operates three regional centers that provide direct support for adults with developmental disabilities. These are individuals who have very significant needs and for whom adequate services and support are not available in the community centered board system to safely meet their needs. The regional centers are located in Grand Junction, Pueblo, and Wheat Ridge. Regional centers serve adults in community group homes that provide services for between four and eight people. The majority of regional center beds are operated under the same comprehensive Home and Community-Based waiver program that supports most community-based residential services. The regional center campuses also house Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR). In addition to group home and ICF/MR campus facilities, there are a limited number of nursing facility beds on the campus of the Grand Junction Regional Center.

Many persons served by regional centers have multiple disabling conditions, such as maladaptive behaviors or severe, chronic medical conditions that require specialized and intensive levels of services. Regional centers provide active treatment through a number of services including: 24-hour supervision, residential services, day programming, habilitation, medical, training and behavioral intervention, and short-term emergency/crisis support to the community system. Regional centers work closely with the community centered board system, which provides community-operated services for persons with developmental disabilities. Since April 2003, the regional centers have used the following admissions criteria: (1) individuals who have extremely high needs requiring very specialized professional medical support services; (2) individuals who have extremely high needs due to challenging behaviors; and/or (3) individuals who pose significant community safety risks to others and require a secure setting.

The Department provides funding for Personal Services, Operating Expenses, capital outlay for patient needs, leased space, residential incentive allowance, and the purchase of services. Funding has recently been allocated through the budget process to address staffing, wait-lists, and Medicaid waiver changes. Over the past four years, the regional centers have been serving clients with more severe disabilities largely due to admissions criteria implemented in 2003 and established to meet the high demand for regional center

services. These individuals may require high levels of staff attention for monitoring of safety and provision of necessary treatment. This requires a very low staff-to-patient ratio (approximately 2.5-to-1) as well as highly trained staff with very specialized professional skills. The Colorado Department of Public Health and Environment (CDPHE) identified the staffing pressures facilities serving clients with more severe disabilities face during requisite surveys of the facilities. All three centers were cited for inadequate staffing with plans of correction requiring additional staff. Continued certification by CDPHE and Medicaid funding for the programs were at risk if adequate staff was not obtained.

Pursuant to the above circumstances, the Department of Human Services undertook a comprehensive study of the staff of the regional centers. As a result of the study, the Joint Budget Committee approved a phased-in process designed to convert approximately 75% of the beds at the regional centers so that they have the designation of Intermediate Care Facility for the Mentally Retarded (ICF/MR). Funding was provided for direct care staff, therapists, doctors, and infrastructure that would enable all group homes at the Wheat Ridge Regional Center to be converted to an ICF/MR.

The plan proposes to eventually convert all Grand Junction and Pueblo Regional Center beds to ICFs/MR in future years. ICFs/MR are an entitlement component of the Medicaid State Plan. Intermediate Care Facilities for the Mentally Retarded are not overseen by community centered boards or other case-management entities and must comply with different regulatory guidelines than Home and Community-Based Services – Developmental Disability (HCBS-DD) placements. Intermediate Care Facilities for the Mentally Retarded must provide 24-hour access to physician services, as well as active treatment services, while the HCBS-DD regulations require that such services be accessed from community providers. Implementation of conversion will mitigate staffing concerns and will enable an enhanced federal financial participation rate.

The conversion of regional centers to ICFs/MR was initially proposed to take place from FY 2008-09 through FY 2010-11. The state fiscal budget crisis beginning in FY 2008-09 has caused the implementation of conversion to be extended due to associated up-front costs.

Another issue facing the regional centers has been wait-lists. Because the regional centers have operated at capacity, a community centered board with a patient who it believes is more appropriate for regional center placement must displace a client from a regional center in order to move a new client into placement. This results in the transfer of patients who may be adequately cared for in community centered board facilities and preserves the regional centers only for most severe cases.

The impact of federal Medicaid waiver changes is similar to the wait-list issue above. The regional center budgets are affected by the restructuring of developmental disability waiver programs being required by federal authorities, since the majority of beds are operated under the HCBS-DD Waiver program that supports most community based residential services. Due to federal requirements that waivers not cover services available through the Medicaid State Plan, the Department has been required to find outside providers for key services such as physician services, occupational, and physical therapy, and medical transportation. Unable to effectively access such services, the regional centers requested direct General Fund support for physician services costing the state more money.

Conversion to ICFs/MR will invoke the 24-hour physician access requirement and will also allow the state to tap federal matching funds. The Department anticipates this to result in reduced state costs.

Appropriation History

The FY 2007-08 Long Bill, SB 07-239, appropriation of $42,058,031 included adjustments for many Common Policy items. This line was appropriated an additional $32,948 for operating expenses, which included general operating, leased computers, printers, and software expenses and for 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 in addition to an additional $342,541 to pay six months of salary for 29 FTE appropriated as a result of Joint Budget Committee action addressing staffing needs for Health Care Services trainees and Health Care Techs at the regional centers (NP–1, "DHS- Regional Staffing Shortfall," FY 2007-08 Budget Request, November 1, 2006, page G.1) Additionally, this line item 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. NP-S17, "DHS – Regional Center High Needs Clients," FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments, February 15, 2008, page NP-S17.1, was approved by Joint Budget Committee action and 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," FY 2007-08 Budget Request, November 1, 2006, page G.1, for an increase of $477,386;
- Annualization of the prior year's NP-S17, "Regional Center High Needs Clients," FY 2007-08 Supplemental Requests and FY 2008-09 Budget Request Amendments, February 15, 2008, page NP-S17.1, for a decrease of $1,337,293;
- NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study," FY 2008-09 Budget Request, November 1, 2007, page G.1, for an increase of $1,589,444;
- 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 of Human Services submitted a late supplemental request (corresponding Department of Health Care Policy and Financing NP-S31, "DHS – Regional Centers Prior Year Accounting Issues") in late March of 2009. The Joint Budget Committee approved the request, but levied a penalty of $415,000 against the Department of Human Services for not having submitted the request in conformance with the Joint Budget Committee's calendar. The penalty only passes through the Department's budget and will be

removed from the FY 2009-10 appropriation. The request increased the FY 2008-09 appropriation for the line item by $2,205,696. This brought the final appropriation for FY 2008-09 as reflected in the Long Bill Add-on section for FY 2008-09, SB 09-259, to $48,343,626.

Expenditures from the Regional Centers line item were significantly higher than appropriated due to higher than projected per-client costs. The Department of Human Services transferred General Fund totaling $1,597,021 into the line (24-75-106.5 (1), C.R.S. (2009)). Funds totaling $3,069,574 were transferred within the Department into this line from other related lines (24-75-108 (1), C.R.S. (2009)). Another $6,249,539 was transferred from the Department's Department of Human Services Medicaid-Funded Programs – Executive Director's Office – Medicaid Funding appropriation for personal services expenses in the regional centers (24-75-108 (1), C.R.S. (2009)). This transfer of funds is standard practice for administering personnel expenses within the Regional Centers line. FY 2008-09 total expenditures were $57,662,739 and $739 General Fund was reverted.

To build to the FY 2009-10 Long Bill, SB 09-259, appropriation, the $48,343,626 appropriated through the Long Bill Add-on section, SB 09-259, served as the base. NP-4, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study," FY 2008-09 Budget Request, November 1, 2007, page G.1, was annualized as an increase of $1,605,055. The FY 2008-09 increase of $2,205,696 from NP-S31, "DHS – Regional Centers Prior Year Accounting Issues" was reversed due to the one-time nature of the request and the associated penalty of $415,000 was also applied as an appropriation reduction. The Joint Budget Committee reduced the funding for leased space by $127,389 but added $1,247,280 for provider fees. The Joint Budget Committee also recommended and approved a personal services reduction of 1.82% (budget balancing action) for $863,840. Common Policy adjustments $1,456,662 for salary survey and $520,295 performance based pay increased the appropriation as annualizations from the previous year. The Committee also approved appropriations for NP-5, "DHS – Postage Increase and Mail Equipment Upgrade" for $996, NP-6, "DHS – Regional Centers – High Need Clients" for $323,491, and NP-8, "DHS – Direct Care Capital Outlay" for $164,250. Two other technical matters affected funds splits – The Joint Budget Committee approved a fund split adjustment from FY 2008-09, a Joint Budget Committee appropriation for ICF/MR provider fees, moving $40,126 out of the General Fund and into reappropriated funds. The final amount appropriated to the line through SB 09-259, the FY 2009-10 Long Bill was $50,049,730.

The June 22, 2009 General Revenue forecast indicated that additional General Fund reductions would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES-8, "DHS – Closure of 32 bed Nursing Facility at Grand Junction Regional Center," the Department proposed a phased closure of the 32 bed facility, transitioning patients to lower cost community nursing facilities by the end of FY 2009-10. This resulted in a total fund reduction of $2,327,600, a General Fund reduction of $1,047,419, a cash fund reduction of $116,380, and a federal fund reduction of $1,163,801 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund reduction of $2,765,452, a General Fund reduction of $1,244,454, a cash fund reduction of $138,273, and a federal fund reduction of $1,382,725 in FY 2010-11.

To build to the FY 2010-11 base request, the $50,049,730 appropriated through the Long Bill, SB 09-259, served as the base. The request includes an addition for the annualization of the prior year's Joint Budget Committee-adjusted NP-6, "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study," adding $28,417. The request includes a reduction of $996 for the prior year's NP-5, "DHS Postage Increase and Mail Equipment Upgrade." The request also includes the annualization of the prior year's NP-8, "DHS – Direct Care Capital Outlay," a reduction of $164,250. Two additional annualizations of the prior year's Joint Budget Committee actions include the addition of $415,000 for a one-time penalty incurred by the Department of Human Services (which impacted Medicaid funding) and $863,840 for the one-time 1.82% personal services reduction from the prior year. NP-ES8, "DHS – Closure of 32 bed Nursing Facility at Grand Junction Regional Center," will annualize to a $5,093,051 reduction.

The Department is requesting total funding of $46,098,689 for FY 2010-11.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item enables the State to capture depreciation payments from federal authorities associated with the Department of Human Services' regional centers. The line item was added through a FY 2003-04 supplemental bill (HB 04-1320) to reflect historic department practice. The Department of Human Services is required to conduct annual depreciation calculations as part of its federal cost reporting. Depreciation amounts, allowed by federal authorities, have been included in the daily rates the Department of Human Services charges to the Department for regional center consumers (all of whom are Medicaid-eligible). However, because depreciation is associated with a past expenditure and is not an operating expense that is included in the Department of Human Services' operating budget, the Department of Human Services has never had the authority to spend these monies. Instead, the depreciation amounts paid by the Department (which are based on a standard 50% federal financial participation) may be reverted at the end of the year. In addition, provision of this line item assists the State in managing the discrepancy that may exist between the cash funds accounting method used in HCPF and the accrual accounting method used in the Department of Human Services (the "Annual Adjustments" component). A benefit of the depreciation appropriation is a 100% return on General Fund dollars per year through the addition of federal financial participation.

Appropriation History

For FY 2007-08, Joint Budget Committee action reduced this line item by $200,973 total funds based on the revised straight line depreciation calculations completed by the Department of Human Services required as part of its annual federal cost reporting. The SB 07-239, the FY 2007-08 Long Bill, final line item appropriation was $1,267,579. The Department spent no money from this line item in FY 2007-08 and the appropriated funds were reverted.

Joint Budget Committee action reduced funding for FY 2008-09 by removing $124,667 based on revised straight line depreciation calculations by the Department of Human Services. These calculations are required for federal cost reporting. HB 09-1375, the FY 2008-09 Long Bill, final line item appropriation was $1,142,912. The appropriation was fully expended in FY 2008-09.

For FY 2009-10, the Department requested continuation funding of $1,142,912. The Joint Budget Committee increased this appropriation by $115,172 to reflect revised depreciation figures based on the annual calculations completed by the Department of Human Services. SB 09-259, the FY 2009-10 Long Bill final line item appropriation was $1,258,084.

The Department is requesting continuation funding of $1,258,084 for FY 2010-11.

(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. The Department of Human Services manages the program through a contract with the Legal Center for Persons with Disabilities and Older Persons. 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 Ombudsman program is codified in 26-11.5-101 through 112, C.R.S. (2009)

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. Because Medicaid pays for services in long-term care facilities to clients who are categorically eligible for Medicaid, the possibility exists that clients in those facilities may need someone to intervene on their behalf when the need arises. Therefore, Medicaid pays a small contribution to the overall costs of the State Ombudsman Program.

Funding for this line item has remained at $1,800 since FY 2003-04. The Department's FY 2010-11 base request is for continuation funding.

The line item does not qualify for enhanced federal financial participation from the American Recovery and Reinvestment Act of 2009 because the covered expenditures are for administrative purposes.

(H) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING

The Division of Youth Corrections is one of the divisions under the direction of the Deputy Executive Director for Children, Youth and Families at the Department of Human Services. 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. In addition, juveniles may be sentenced as a condition of parole for up to 45 days to a detention facility. While not all services are eligible for Medicaid funding, services provided by the

Division of Youth Corrections includes: 24-hour supervision, meals, therapy, vocational, and educational assistance. Youth Corrections in the Colorado Revised Statutes can be found in 19-2-402 through 418, C.R.S. (2009).

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 portion of Personal Services, a portion of Purchase of Contract Placements (mental health services), and a portion for a Managed Care Pilot Project.

Personal Services for Community Programs cover case managers, support staff, and regional administrators who are responsible for overseeing contract placements and the overall operations of Division of Youth Corrections services. The role of case managers have been combined with parole officers so the same individual manager tracks a juvenile through the system from commitment to the end of parole. The POTS associated with the Personal Services are centrally appropriated in the Department of Human Services Executive Director's Office, General Administration section. The POTS funding is transferred to the Division of Youth Corrections on an as needed basis as the fiscal year progresses.

The Division of Youth Corrections has augmented its capacity through the Purchase of Contract Placements subprogram, and this subprogram is essential to the operations of the total Youth Corrections program. 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. This subprogram contracts with private vendors who provide a range of services depending on specific treatment and counseling needs. Although these services provide residential care, Medicaid pays for only the medical care expenditures. Basic room and board at the residential care centers are paid by the Department of Human Services from General Fund appropriated for that purpose.

The Managed Care Pilot Project is a managed care agreement between the Division of Youth Corrections and Boulder County for handling adolescent delinquent youth. The Integrated Managed Partnership for Adolescent Community Treatment, sometimes called IMPACT, is a community based effort to integrate care from the Boulder County Social Services, Boulder County Mental Health services, and the state Division of Youth Corrections. The Medicaid contribution is primarily through the Boulder County Mental Health services. The partnership arrangement performs gate keeping, assessment, concurrent utilization review, and quality assurance reviews for delinquent youth who are already in placement or at risk of placement. The Division of Youth Corrections would like to expand this project to other counties, but at the present time only Boulder County is participating.

Appropriation History

The Department's FY 2007-08 appropriation of $2,852,877 reflects the following:

- annualization of HB 06-1395 for an additional $513,126 to support 92 placements at a cost of $300 per day;
- an increase of $1,763 for Common Policy adjustments in Salary Survey;

- a leap year adjustment for services equal to $12,958;
- an increase of $41,443 for a provider rate increase; and
- a decrease of $372 for the 0.5% base reduction per Common Policies.

The Joint Budget Committee also restored 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-S-18, "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 Add-on section in the FY 2008-09 Long Bill (HB 08-1375), with a final appropriation of $1,880,915.

For FY 2008-09, the Long Bill (HB 08-1375) appropriated $2,885,273 total funding. This amount is based on the restoration of 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, an increase of $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 included a reduction of $12,958 for the one-time Leap Year Adjustment in FY 2007-09, and an adjustment of $104 for fund split alignment. Consequently, the FY 2008-09 Long Bill Medicaid Funding for Youth Corrections included $44,520 for Personal Services, $2,807,417 for Purchase of Contract Placements, and $33,336 for a managed care pilot project.

A Supplemental Request during FY 2008-09, NP-S21, "DHS – Purchase Contract Placement – Continuum of Care, " submitted on February 16, 2009 for a reduction of $1,247,600 was approved in the Add-on section of the FY 2009-10 Long Bill, SB 09-259, resulting in a final appropriation of $1,637,673 for FY 2008-09.

Several adjustments occurred in the calculation of the FY 2009-10 Long Bill, SB 09-259, appropriation. Those adjustments and the associated impacts were as follows:

- Prior year adjustment of $1,819 increase for Salary Survey;
- Prior year adjustment of $651 increase for Performance-based Pay;,
- Common Policy adjustment for a reduction of $130;

- Reduction of $852, or 1.82% of the Personal Services in FY 2009-10 as a result of budget balancing during First Conference Committee of the General Assembly action for SB 09-259, the FY 2009-10 Long Bill;
- Annualization of Supplemental Request, NP-S21, "DHS – Purchase Contract Placement – Continuum of Care," that first occurred during FY 2008-09 to further reduce the line item by $24,362.

After the above adjustments, the appropriation for FY 2009-10 was $1,614,799 per the FY 2009-10 Long Bill, SB 09-259. The Personal Services component was $46,860, while the Purchase of Contract Placement component was $1,535,455, and the Managed Care Pilot Project component was $33,336.

The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee on August 24, 2009. As a part of NP-ES-3, "DHS – Increase State Capacity to 120% at State Commitment Facilities", the Department of Human Services proposed that the number of youths committed to the youth facilities be increased without opening additional new facilities. This resulted in a total fund Medicaid reduction of $166,246 and a General Fund reduction of $83,123 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund increase of $166,246 and a General Fund increase of $83,123 in FY 2010-11.

Furthermore, as a part of NP-ES-6, "DHS – Reclassification of Licensing Category of Ridgeview Youth Services Center for Medicaid Billing", the Department of Human Service proposed that Ridgeview be re-classed as a residential treatment center. This resulted in a Medicaid total fund increase of $412,083 and a General Fund increase of $206,042 to this line in FY 2009-10. The Department's FY 2010-11 base request includes an annualized total fund increase of $576,917 and a General Fund increase of $288,459 in FY 2010-11.

As a base request for FY 2010-11, the First Conference Committee action from FY 2009-10 was annualized to add back $852 for Personal Services. The Department requests a base of $2,604,651 for FY 2010-11.

Two components of the line item, Purchase of Contract Placements and the Managed Care Pilot Project, qualify for the enhanced federal financial participation from the American Recovery and Reinvestment Act of 2009 because those components cover expenditures for services to clients. The Personal Services component of this line item does not qualify for the enhanced federal financial participation from the American Recovery and Reinvestment Act of 2009 because that component is for administrative purposes.

(I) OTHER CONTRACTUAL SERVICES

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DEPARTMENT OF HUMAN SERVICES PROGRAMS

This line item was created in the FY 2009-10 Long Bill, SB 09-259, at the recommendation of the Joint Budget Committee. An indirect cost is for a service that is provided for a total department but used jointly by several divisions within the department. As such, it is difficult to assign costs to a specific cost center such as a specific division. Indirect costs are usually constant for a wide range of services and are grouped under fixed costs because the cost is still occurring even if there is a change in work activities. Indirect costs go by other names as well, because they are sometimes called common costs, overhead costs, or joint costs. Colorado Revised Statutes do not specifically cover this line item. However, a general authorization for the Department as the singe state agency for Title XIX is found in 25.5-4-104, C.R.S. (2009).

Federal regulations describe the requirements for federal indirect costs as listed in Appendix E of 2 CFR Part 225, A.1 (2009): "Indirect costs are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the results achieved. After direct costs have been determined and assigned directly to Federal awards and other activities as appropriate, indirect costs are those remaining to be allocated to those benefitted cost objectives. A cost may not be allocated to a Federal award as an indirect cost if any other cost incurred for the same purpose, in like circumstances, has been assigned to a Federal award as a direct cost."

Similarly, in federal regulations related to the Medicaid program, 42 CFR §433.34 (2009) states that "A State plan under Title XIX of the Social Security Act must provide that the singe or appropriate Agency will have an approved cost allocation plan one file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95. Subpart E also sets forth the effect on FFP [federal financial participation] if the requirements contained in that subpart are not met."

Federal indirect costs offset General Fund costs for related Medicaid programs. This line item currently covers $160,000 for Payment to Risk Management and Property Funds in the Executive Director's Office at the Department of Human Services and $340,000 for Vehicle Lease Payments and Utilities in the Office of Operations at the Department of Human Services. However, the portion of these mentioned indirect costs that this line item covers is associated with the Regional Centers for People with Developmental Disabilities. Other programs in the Department of Human Services, some of which are Medicaid programs also have indirect costs allocated to them, but the other programs claim the federal indirect costs through a non-appropriated line item in the Department's budget.

Appropriation History

The FY 2009-10 Long Bill, SB 09-259, appropriated $500,000 in total federal funds. The Department requests continuation funding for FY 2010-11.

The line item does not qualify for the enhanced federal financial participation from the American Recovery and Reinvestment Act of 2009 because the expenditures associated with this line item are considered to be administrative costs.

TRANSFER TO THE DEPARTMENT OF HUMAN SERVICES FOR RELATED ADMINISTRATION

The Department has an Interagency Agreement with the Department of Human Services to support, or at least partially support, 1.0 FTE to staff the Information Technology Help Desk. Funding contains only basic Personal Services salary items. 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.

Although in prior years, this help desk position 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 the Colorado Benefits Management System. The help desk assists with the manual process of presumptive eligibility applications for the Breast and Cervical Cancer Treatment Program in the Colorado Benefits Management System if the eligibility application can not be processed from a location that is a regular Medical Assistance site. In addition, to the help desk provides 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 for the financial system.

Transfers to the Department of Human Services related to this line item typically occur quarterly based on Interagency Transfer Requests that are processed by both departments after both departments have signed an Interagency Agreement that must be renewed and resigned each fiscal year. Likewise, the Department of Human Services transfers the POTS funding to the Department on a quarterly basis, so that the Department can, in turn, transfer both the Personal Services payments along with the associated POTS payments back to the Department of Human Services.

Appropriation History

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 2010-11.

The line item does not qualify for enhanced federal financial participation from the American Recovery and Reinvestment Act of 2009 because the expenditures are considered to be administrative costs.