
# Department of Health Care Policy and Financing
# Line Item Description
# FY 2011-12 Budget Request

**November 1, 2010**

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

The final FY 2008-09 appropriation consisted of $7,863,390 General Fund, $658,159 cash funds, $1,557,401 reappropriated funds, and $8,980,512 federal funds.

In the FY 2009-10 Long Bill (SB 09-259), the Department was appropriated $19,679,334 and 275.0 FTE. This included continuation funding plus the following prior-year adjustments:

- a reduction of $141,122 and an increase of 0.7 FTE for the annualization of HB 08-1114;
- a reduction of $27,500 for the annualization of FY 2008-09 DI-9 "Information Technology Replacement Plan";
- an increase of $91,782 and 1.6 FTE for the annualization of FY 2008-09 DI-7 "Additional FTE to Restore Department Efficiency and Functionality";
- an increase of $9,893 and 0.2 FTE for the annualization of FY 2008-09 BA-12 "Efficiencies in Pharmaceuticals through the Expansion of 340B Pricing";
- a reduction of $125,000 for the annualization of FY 2008-09 BA-5 "Implement Mental Health Audit Findings";
- an increase of $41,194 and 0.5 FTE for the annualization of FY 2008-09 BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries"; and,
- an increase of $877,477 for the annualization of the prior-year Salary Survey and Performance-based Pay.

In addition, the following FY 2009-10 Department requests were approved during the FY 2009-10 Figure Setting:

- FY 2009-10 BRI-2 "Medicaid Program Efficiencies," an increase of $86,785 and 0.9 FTE;
- FY 2009-10 DI-6 and BA-38 "Medicaid Value-Based Care Coordination Initiative," an increase of $144,644 and 1.0 FTE;
- FY 2009-10 DI-12 "Enhance Medicaid Management Information System Effectiveness," an increase of $58,101 and 0.9 FTE; and,
- FY 2009-10 BA-20 "Technical Adjustment for SB 07-196 FY 2009-10 Fiscal Impact," a reduction of $36,785

Additionally, due to an economic downturn, a 1.82% personal services cut was approved during the First Conference Committee, resulting in a reduction of $359,597 to this line item in the Long Bill. Due to the continued economic downturn, the Department issued three Early Supplemental requests to reduce its FY 2009-10 Personal Services appropriation, which were submitted to the Joint Budget Committee (JBC) on August 24, 2009. The first reduction reduced the Personal Services appropriation $247,918 to account for the impact of the mandated eight furlough days; the second, a reduction of $6,093, was due to refinancing the implementation of HB 09-1293; and, the third reduction named "Safety Net Grant Reductions" reduced administrative funding for those programs by $8,205 and 0.2 FTE and was included in HB 10-1323 "Use of Tobacco Litigation Moneys."

The Department subsequently received appropriation from several Special Bills from the 2009 Legislative Session. These include an increase of $1,302,788 and 12.0 FTE for HB 09-1293 "Colorado Health Care Affordability Act"; in increase of $47,538 and 0.8 FTE for HB 09-1047 "Alternative Therapies for Persons with Disabilities under Medicaid"; and 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. These adjustments reduced the final FY 2009-10 total appropriation to $20,767,444 and 287.6 FTE. This appropriation consisted of $7,943,237 General Fund, $1,247,075 cash funds, $1,585,892 reappropriated funds, and $9,991,240 federal funds.

The Department's FY 2010-11 Long Bill appropriation of $20,016,423 and 287.8 FTE 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 $20,767,444 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";
- less $47,538 and 0.8 FTE for HB 09-1047 "Alternative Therapies for Persons with Disabilities" due to lack of sufficient gifts, grants, or donations;
- plus $6,117 and 0.1 FTE for BRI-2 "Medicaid Program Efficiencies";
- 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";
- plus $5,284 and 0.1 FTE for DI-12 "Enhance Medicaid Management Information System";
- plus $880,890 and 23.3 FTE for continued implementation of HB 09-1293 "Colorado Health Care Affordability Act";
- plus $359,596 in restored funds associated with JBC's 1.82% reduction to Personal Services that was made to the appropriation as part of the budget balancing of the FY 2009-10 Long Bill (SB 09-259);
- plus $247,918 annualization of the FY 2009-10 Statewide Furloughs;

- plus $48,699 and 0.9 FTE to implement the Coordinated Payment and Payment Reform Act;
- less $1,737,029 and 25.0 FTE to account for the consolidations and transfer of Department personnel to the Governor's Office of Information Technology;
- plus $3,300 due to the delay in implementing the Department's Accountable Care Collaborative program; and,
- less $521,441 for the Statewide PERA adjustment reducing the State portion of the contribution for employee retirement benefits.

The Medicaid Efficiency and False Claims Act (SB 10-167) appropriated $447,118 and 7.0 FTE to implement and manage the program. In response to continuing budget balancing, the Department's appropriation is reduced by $80,422 pursuant to NP ES-1 "1% Across the Board Personal Services Reduction." This brings the Department's FY 2010-11 appropriation to $20,383,119 and 294.8 FTE. Of this amount, $7,538,461 General Fund, $1,652,353 cash funds, $520,127 reappropriated funds, and $10,672,178 federal funds.

The Department's FY 2011-12 base request includes continuation funding and annualizations of FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform" for $4,427 and 0.1 FTE, BA-5 "Accountable Care Collaborative" for $39,900, NP ES-1 "1% Across the Board Personal Services Reduction" for $80,422, and NP BA-2 "Statewide PERA Adjustment" associated with the reduction of the State portion of the contribution for employee retirement benefits is annualized back into the base for $521,441. Furthermore, HB 09-1293 "Colorado Health Care Affordability Act" annualizes for $985,912 and 16.0 FTE. Other Special Bill annualizations include: HB 10-1323 "Use of Tobacco Tax Master Settlement," which increases the appropriation by $14,587 and 0.2 FTE; SB 10-061 annualization, which adds $31,693 and 0.5 FTE; and, the Medicaid Efficiency and False Claims Act (SB 10-167) provides an additional $10,246.

The Department's FY 2011-12 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 is 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 $87,948 General Fund.

All these adjustments bring the Department's FY 2011-12 request to $22,071,747 and 311.6 FTE. The base request includes $7,749,954 General Fund, $2,254,578 cash funds, $456,838 reappropriated funds, and $11,610,377 federal funds.

**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 (DPA). 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 and FY 2011-12, due to an 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 2008-09 appropriation of $1,278,471 was based on Common Policy instructions issued by DPA. This amount included $578,598 General Fund, $28,315 cash funds, $35,213 reappropriated funds, and $636,345 federal funds.

For FY 2009-10, the Department's base appropriation of $1,414,691 was based on Common Policy instructions issued by DPA in October 2008. For FY 2009-10, this appropriation was increased by $65,736 to cover the increased costs of this benefit due to the implementation of HB 09-1293 "Colorado Health Care Affordability Act." However, due to an economic downturn, the Department submitted ES-4 "Reduce Funding for Indigent Care Programs," which temporarily reduced 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, reducing the final appropriation to $1,479,962. This amount included $640,247 General Fund, $63,735 cash funds, $ 8,965 reappropriated funds, and $737,015 federal funds.

The Department's FY 2010-11 appropriation for Health, Life, and Dental includes annualizations as well as a Common Policy adjustments. Annualization of HB 09-1293 increased the FY 2010-11 appropriation by $297,102. ES-4 "Reduce Funding for Indigent Care Programs" annualizes the $465 removed in FY 2009-10 back into the base. A Common Policy adjustment and the transfer of the Department's information technology personnel reduces this appropriation by $130,711. Finally the Joint Budget Committee reinstated $59,239 to the Department's FY 2010-11 appropriation that DPA had requested be reduced, for a total FY 2010-11 Department request of $1,706,057. The appropriation includes $611,752 General Fund, $205,744 cash funds, $15,219 reappropriated funds, and $873,342 federal funds.

For FY 2011-12, the Department's request of $2,024,577 is for continuation funding from the FY 2010-11 appropriation plus annualization of HB 09-1293 for $27,384 and FY 2011-12 Common Policy Adjustment for $291,136. The base request consists of $619,632 General Fund, $263,281 cash funds, and $1,141,664 federal funds.

**SHORT-TERM DISABILITY**

This component of POTS expenditure 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 (DPA). If the actual rate for the fiscal year differs substantially from the estimated rate, DPA submits a statewide supplemental request to adjust the appropriation.

The budget request for this line is based on the Office of State Planning and Budgeting's budget instructions. A given rate by DPA is used against the sum of base salaries, Salary Survey, range adjustments, and Performance Achievement Pay.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $22,871 and reflects the Common Policies issued by DPA 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 final FY 2008-09 appropriation was $22,621, comprised of $9,538 General Fund, $568 cash funds, $1,795 reappropriated funds, and $10,720 federal funds.

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. The appropriation was further reduced by $844 due to the effects of the statewide furloughs. Finally, HB 09-1293 "Colorado Health Care Affordability Act" increased the appropriation by $1,722 to cover the additional FTE authorized in that legislation for a final FY 2009-10 appropriation of $24,456. Of this amount, $9,267 was General Fund, $1,540 was cash funds, $1,885 was reappropriated funds, and $11,764 was federal funds.

The Department's FY 2010-11 Long Bill (HB 10-1376) appropriation was $26,138 and was set during Figure Setting by the Joint Budget Committee (FY 2009-10 Figure Setting, March 16, 2010, page 33), of which $9,539 is General Fund, $2,174 is cash funds, $737 is reappropriated funds, and $13,688 is federal funds.

For FY 2011-12, the Department is requesting funding of $35,899, which reflects continuation funding and a restoration of $10 removed in ES-4 "Reduce Funding for Indigent Care Programs" for FY 2009-10 as well as FY 2011-12 Common Policy Adjustment for $9,751. This base request includes $11,715 General Fund, $3,973 cash funds, and $20,211 federal funds.

**SB 04-257 AMORTIZATION EQUALIZATION DISBURSEMENT**

The Amortization Equalization Disbursement increased the employer contribution to the Public Employees' Retirement Association (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%. FY 2006-07 was the first full year this program was in effect. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation, and includes all employees eligible for State retirement benefits.

For FY 2008-09, the 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, leaving a final appropriation of $275,961. The appropriation consisted of $114,941 General Fund, $6,983 cash funds, $22,096 reappropriated funds, and $131,941 federal funds.

The FY 2009-10 Long Bill appropriation of $317,902 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. 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 $23,432 for implementing HB 09-1293 "Colorado Health Care Affordability Act" was included. The appropriation was reduced by $10,888 to account for the Statewide Furlough impact. Funding for this line was also reduced through ES-4 "Reduce Funding for Indigent Care Programs" by $135. The final FY 2009-10 appropriation was $330,311, consisting of $123,846 General Fund, $20,931 cash funds, $25,615 reappropriated funds, and $159,919 federal funds.

The FY 2010-11 appropriation of $402,667 was set during Figure Setting by the Joint Budget Committee (FY 2009-10 Figure Setting, March 16, 2010, page 34), based on assumptions of the rate for CY 2010 being set at 2.2% and the rate for CY 2011 being set for 2.6%. The FY 2010-11 appropriation is comprised of $145,650 General Fund, $33,664 cash funds, $11,411 reappropriated funds, and $211,942 federal funds.

The FY 2011-12 request of $567,904 reflects continuation funding plus annualizations for HB 09-1293 "Colorado Health Care Affordability Act" in the amount of $41,629 and $135, which restores funding that was removed FY 2009-10 through ES-4 "Reduce Funding for Indigent Care Programs," as well as FY 2011-12 Common Policy Adjustment for $123,473. Of the base request, $185,323 is General Fund, $62,851 is cash funds, and $319,730 is federal funds.

**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. This appropriation included $127,446 total funds, $51,968 General Fund, $3,273 cash funds, $10,358 reappropriated funds, and $61,847 federal funds.

The FY 2009-10 Long Bill appropriation of $197,328 is based on the Joint Budget Committee's Common Policies set during Figure Setting. 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) was used. This amount also reflects adjustments due to the elimination of Salary Survey, Performance Based Pay, and the impact of the statewide furloughs. Implementation of HB 09-1293 "Colorado Health Care Affordability Act" increased funding for this line by $15,216. Additionally, funding for this line item was reduced by $85 for FY 2009-10 as a result of ES-4 "Reduce Funding for Indigent Care Programs," submitted on August 24, 2009. The final FY 2009-10 appropriation of $205,654 consisted of $76,042 General Fund, $13,368 cash funds, $16,009 reappropriated funds, and $100,235 federal funds.

The Department's FY 2010-11 appropriation of $292,544 was set during Figure Setting by the Joint Budget Committee (FY 2009-10 Figure Setting, March 16, 2010, page 36). The appropriation includes funding for the additional staff associated with the implementation of HB 09-1293 "Colorado Health Care Affordability Act" in FY 2010-11. The FY 2010-11 appropriation includes $105,135 General Fund, $24,547 cash funds, $8,321 reappropriated funds, and $154,541 federal funds.

The Department's FY 2011-12 request is again for continuation funding of $292,544, plus the final annualization associated with HB 09-1293 "Colorado Health Care Affordability Act" of $20,816 and $142,907 for FY 2011-12 Common Policy Adjustment, for a total FY 2011-12 request of $456,352. This results in a base request consisting of $148,921 General Fund, $50,505 cash funds, and $256,926 federal funds.

**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. Applicable PERA and Medicare amounts are added into the Salary Survey calculations.

The FY 2008-09 appropriation was computed according to the Office of State Planning and Budgeting's budget instructions, 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 an economic downturn, for FY 2009-10 there

was no funding appropriated for Salary Survey. Additionally, the Department was not appropriated any funds in FY 2010-11 and is not requesting funding for this line item in FY 2011-12.

**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 depressed 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 2008-09, the appropriation was developed according to the Office of State Planning and Budgeting's budget instructions, 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 an economic downturn, for FY 2009-10, no funding was provided for Performance Achievement Pay. Additionally, the Department was not appropriated any funds in FY 2010-11 and is not requesting funding for this line item in FY 2011-12.

**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 (DPA) 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. DPA's actuaries determine departmental allocations.

The FY 2008-09 appropriation of $32,346 reflects a Common Policy adjustment of $6,983, and included $16,173 General Fund and $16,173 federal funds. This amount was developed by DPA 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 DPA that reduce the Department's appropriation by $2,027. The FY 2009-10 appropriation consisted of $17,126 General Fund and $17,126 federal funds.

For FY 2010-11 the Department was appropriated $34,748 in the Long Bill (HB 10-1376) and reflects a Common Policy adjustment of $496. This amount includes $17,374 General Fund and $17,374 federal funds.

The FY 2011-12 request of $35,997 is based on DPA calculations issued on August 27, 2010, and reflects a Common Policy adjustment of $1,249. Of this base request, $17,999 is General Fund and $17,998 is federal funds.

**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.

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 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. 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.

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 funding to furnish new leased space at 225 East 16th Avenue, replace deteriorating cubicles, and address poor air circulation within its building at 1570 Grant Street. Additionally, it received funding to implement an Information Technology replacement plan that would allow the Department to replace its employees' computer workstations using a four-year life cycle. The Department was also appropriated funds to provide for employee training to increase the collective skill level of the Department.

In addition, the Department received funding in Operating Expenses to perform background checks when re-enrolling Medicaid providers, which is anticipated to support reenrolling one-tenth of the Department's providers each year. The Department was also appropriated operating expenses associated with FTE hired by the Department's Program Integrity Section to increase provider recoveries, expenses of an FTE hired to assist in the implementation of the Preferred Drug List the FTE charged with expanding the 340B pharmaceutical pricing program, and costs associated with the Department's approved FTE request, DI-7 "Additional FTE to Restore Department Efficiency and Functionality," submitted in the Department's FY 2008-09 Budget Request.

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; and,
- SB 09-132 eliminated the Colorado Cares Rx Program and saved $3,800.

Due to an 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, comprised of $766,781 General Fund, $23,889 cash funds, $13,377 reappropriated funds, and $802,067 federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriated $1,511,489 for this line item. This included continuation funding plus the following annualizations:

- a decrease of $13,528 for the annualization of SB 08-161;
- a reduction of $2,742 for the annualization of HB 08-1114;
- a decrease of $35,562 for the annualization of the Department's FY 2008-09 DI-7 "Additional FTE to Restore Department Efficiency and Functionality";
- a decrease of $60,000 for the annualization of the Department's FY 2008-09 DI-10 "Additional Leased Space";
- a reduction of $5,536 for the annualization of FY 2008-09 BA-3 "Implement Preferred Drug List";
- a decrease of $32,596 for the annualization of FY 2008-09 BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries"; and,
- a reduction of $5,536 for the annualization of FY 2008-09 BA-12 "Efficiencies in Pharmaceuticals through the Expansion of 340B Pricing."

During the Department's FY 2009-10 Figure Setting, a number of requests were approved that impacted this line item, including:

- FY 2009-10 BRI-2 "Medicaid Program Efficiencies," which added $26,178'
- FY 2009-10 DI-6 and BA-38 "Medicaid Value-Based Care Coordination Initiative", which added $6,178;
- FY 2009-10 DI-12 "Enhance Medicaid Management Information System Effectiveness", which added $6,178;
- FY 2009-10 NP-9 "DPA - Mail Equipment Upgrade", which added $15,640;
- FY 2009-10 NP-12 "DPA - Postage Increase", which added $4,703 and
- SB 09-209 adjustment, which added $2,000.

In addition, there were impacts to this line from annualizations and special bills:

- less $71 associated with FY 2009-10 ES-4 "Reduce Funding for Indigent Care Programs";
- less $15,442 for the delay in implementing NP S-5 "Mail Equipment Upgrade Supplemental and Budget Amendment";
- plus $5,942 for HB 09-1047 "Alternative Therapies for Persons with Disabilities";
- plus $494,136 for implementation of HB 09-1293 "Colorado Health Care Affordability Act"; and,

- less $34,000 for ES-3 “Department Administrative Reductions.”

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 $1,962,054. This appropriation included $702,685 General Fund, $265,839 cash funds, $13,461 reappropriated funds, and $980,069 federal funds.

The Department’s FY 2010-11 Long Bill appropriation was $1,587,445 which is based on the final FY 2009-10 appropriation of $1,962,054, and incorporates the following adjustments:

- less $5,942 for HB 09-1047 “Alternative Therapies for Persons with Disabilities”;
- less $285,284 for the annualization of HB 09-1293 “Colorado Health Care Affordability Act”;
- less $5,228 for the annualization of FY 2009-10 DI-6 BA-38 “Medicaid Value-Based Care Coordination Initiative” and BA-38 “Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative”;
- less $5,228 for the annualization of FY 2009-10 DI-12 “Enhance Medicaid Management Information System Effectiveness”;
- less $25,228 for the annualization of FY 2009-10 BRI-2 “Medicaid Program Efficiencies”;
- plus $71 annualization for ES-4 “Reduce Funding for Indigent Care Programs”;
- plus $15,750 annualization for FY 2009-10 NP S-5 "Mail Equipment Upgrade Supplemental and Budget Amendment";
- plus $5,620 for FY 2010-11 BRI-2 “Coordinated Payment and Payment Reform”; and,
- less $69,140 for FY 2010-11 BA-17 “General Operating Expenses Reduction,” which delayed or reduced the scope and quantity of planned operating expenses.

SB 10-167 “Medicaid Efficiency and False Claims” increased the appropriation by $39,340, bringing the total FY 2010-11 appropriation to $1,626,785. This appropriation is composed of $680,628 General Fund, $120,297 cash funds, $13,461 reappropriated funds, and $812,399 federal funds.

For FY 2011-12, the Department request is based on the final FY 2010-11 appropriation of $1,626,785 and incorporates the following adjustments:

- less $76,469 annualization of HB 09-1293 “Colorado Health Care Affordability Act”;
- less $32,690 annualization of SB 10-167 “Medicaid Efficiency and False Claims”;
- less $4,670 annualization of FY 2010-11 BRI-2 “Coordinated Payment and Payment Reform”; and,
- plus $475 annualization of SB 10-061 “Medicaid Hospice room and Board Charges.”

These adjustments bring the total FY 2011-12 request to $1,513,431, comprised of $662,186 General Fund, $82,063 cash funds, $13,461 reappropriated funds, and $755,721 federal funds.

**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.

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. The appropriation included $399,044 General Fund, $87,378 cash funds, and $496,562 federal funds.

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 the FY 2009-10 Long Bill (SB 09-259). The FY 2009-10 appropriation was reduced by $150,000 due to ES-3 "Department Administrative Reductions," for a final appropriation of $836,650, comprised of $346,629 General Fund, $69,189 cash funds, and $420,832 federal funds.

For FY 2010-11, the Department's Long Bill appropriation was $872,590, reflecting funding for 11,893 hours at a blended attorney/paralegal rate of $73.37. This appropriation includes $337,174 General Fund, $99,121 cash funds, and $436,295 federal funds.

The FY 2011-12 request of $927,244 is based on the FY 2010-11 appropriation plus $54,654 for annualization of HB 09-1293 "Colorado Health Care Affordability Act." Of this base request, $337,174 is General Fund, $126,448 is cash funds, and $463,622 is federal funds.

**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 and 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 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. This included $234,895 General Fund and $234,894 federal funds. 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. This appropriation included $228,461 General Fund and $228,461 federal funds.

For FY 2010-11, the Long Bill (HB 10-1376) appropriated $442,378 reflecting a Common Policy adjustment reducing the appropriation by $14,544 and an increase of $28,610 for the annualization of HB 09-1293 "Colorado Health Care Affordability Act." This appropriation consists of $206,884 General Fund, $14,305 cash funds, and $221,189 federal funds.

The Department's FY 2011-12 request is $512,543 and is based on the Department of Personnel and Administrations calculations issued on August 27, 2010. This total reflects a continuation funding of $442,378, a Common Policy adjustment of $44,045, and $26,120 for an annualization of HB 09-1293. This base request includes $228,907 General Fund, $27,365 cash funds, and $256,271 federal funds.

**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 (DPA) 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. DPA 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.

The FY 2008-09 Long Bill (HB 08-1375) appropriation was increased to $135,103 pursuant to a DPA 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 resulted in an appropriation consisting of $65,883 General Fund, $3,337 cash funds, and $65,913 federal funds.

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. Of this amount, $62,913 was General Fund, $3,337 was cash funds, and $62,913 was federal funds.

The FY 2010-11 appropriation of $298,386 reflects a Common Policy adjustment of $169,223 associated with the creation and consolidation of Department Information Technology personnel into the Governor's Office of Information Technology. The increase in this line was offset by a corresponding reduction to the Department's Personal Service appropriation and FTE count. The appropriation consists of $145,856 General Fund, $3,337 cash funds, and $149,193 federal funds.

The FY 2011-12 request is $577,783, reflecting a Common Policy adjustment of $279,397 and is based on the Governor's Office of Information Technology calculations issued on September 1, 2010. This base request includes $285,555 General Fund, $3,337 cash funds, and $288,891 federal funds.

**MULTIUSE NETWORK PAYMENTS**

This line was created for FY 2010-11 due to the establishment of the Governor's Office of Information Technology and subsequent consolidation of Department Information Technology personnel into that organization. These payments are to cover the cost of managing the statewide multiuse network.

The FY 2010-11 appropriation of $199,438 was offset by a corresponding reduction to the Department's FY 2010-11 Personal Service appropriation and FTE count, and includes $99,719 General Fund and $99,719 federal funds.

The FY 2011-12 request of $227,138 reflects a Common Policy adjustment of $27,700, issued by the Governor's Office of Information Technology on September 1, 2010, and includes $113,569 General Fund and $113,569 federal funds.

**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, which included $229,992 General Fund and $229,992 federal funds.

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. However, due to an 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, consisting of $207,161 General Fund and $207,160 federal funds.

The Department's FY 2010-11 appropriation of $624,180 reflects an additional transfer of Department employees to the Governor's Office of Information Technology. This appropriation includes $312,090 General Fund and $312,090 and federal funds.

The FY 2011-12 request of $637,261 reflects a Common Policy adjustment of $13,081 that was issued by the Governor's Office of Information Technology on September 1, 2010, resulting in a base request of $318,631 General Fund and $318,630 federal funds.

**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 2008-09 appropriation of $71,989 included $35,995 General Fund and $35,994 federal funds. 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 appropriation 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. This included $39,244 General Fund and $39,243 federal funds.

For FY 2010-11, a Common Policy adjustment reduced this appropriation by $54,069, bringing the Department's FY 2010-11 appropriation to $24,418, consisting of $12,209 General Fund and $12,209 federal funds.

The FY 2011-12 request is for $96,112 and is based on the Department of Personnel and Administrations calculations issued on August 27, 2010, and reflects a FY 2011-12 Common Policy adjustment of $71,694. This base request includes $48,056 General Fund and $48,056 federal funds.

**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 (EPSDT) program and staff from the Department of Public Health and Environment to the Department via the Long Bill (SB 03-258).

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." 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, consisting of $191,619 General Fund, $5,500 cash funds, and $197,117 federal funds.

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," which included an appropriation for an additional $151,164 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 $545,400, including $191,619 General Fund, $81,082 cash funds, and $272,699 federal funds.

The Department's appropriation for FY 2010-11 is $696,564 and reflects an annualization of $151,164 for additional space associated with HB 09-1293, and consists of $191,619 General Fund, $156,664 cash funds, and $348,281 federal funds.

The FY 2011-12 request is for continuation funding in the amount of $696,564, comprised of $191,619 General Fund, $156,664 cash funds, and $348,281 federal funds.

**CAPITOL COMPLEX LEASED SPACE**

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

The FY 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. This appropriation was $395,208 total funds, consisting of $197,604 General Fund and $197,604 federal funds.

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 early Supplemental NP-ES-12 "Building Maintenance Reductions" for a final FY 2009-10 appropriation of $395,460, including $197,730 General Fund and $197,730 federal funds.

For FY 2010-11, a Common Policy adjustment reduced this appropriation by $7,232 to bring the Department's base appropriation to $388,228, including $194,144 General Fund and $194,144 federal funds.

The FY 2011-12 request is for $415,505 and is based on the Department of Personnel and Administrations calculations issued on August 27, 2010 and reflects an effective rate of $13.19 per square foot. The base request includes $207,753 General Fund and $207,752 federal funds

**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. The Department was appropriated $2,006,184 for FY 2008-09 through the Long Bill (HB 08-1375). 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 an economic downturn, the Department submitted several supplemental actions to reduce funding in this line item (S-26 "Hiring Freeze Reduction") 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, including $787,343 General Fund, $41,250 cash funds, and $898,593 federal funds.

During the 2009 legislative session, several Department initiatives were approved, among them were two Budget Reduction Items requested in the Department's FY 2009-10 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 cost 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. 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. The approval of FY 2009-10 DI-5 and BA-35 "Improved Eligibility and Enrollment Processing" increased the appropriation by $100,000 to conduct a study to assess the impact that the Department's Eligibility Modernization Project would have on other state departments and county social service benefits, and FY 2009-10 DI-6 and BA-38 "Medicaid Value-Based Care Coordination Initiative" resulted in an increase of $125,000 for actuary services associated with developing the pay-for-performance calculations for the Colorado Accountable Care Collaborative. These actions, combined with a decrease of $26,695 from the FY 2009-10 First Conference Committee and the following annualizations resulted in an FY 2009-10 Long Bill appropriation of $3,384,105:

- FY 2008-09 S-26 "Hiring Freeze Reduction", resulting in an increase of $55,000;
- SB 08-217 "Centennial Care Choices Program," for a decrease of $82,500;
- FY 2008-09 DI-9 "Information Technology Replacement Plan," a decrease of $27,500;
- FY 2008-09 BA-A1A "Building Blocks to Health Care Reform," an increase of $46,650; and,
- FY 2008-09 BA-5 "Implement Mental Health Audit Findings," a decrease of $250,000.

In connection with an economic downturn, the Department submitted three FY 2009-10 Supplemental Requests, reducing this appropriation by a net $78,305. The first, FY 2009-10 ES-2 "Medicaid Programs Reductions," increased the appropriation by $20,000 for a contracted actuary to review and certify rates paid to health maintenance organizations. FY 2009-10 S-6 "Accountable Care Collaborative" reduced the appropriation by $125,000 by eliminating the funding for an actuary to develop a pay for performance mechanism for the Administrative Services Organization. FY 2009-10 NP S-2 "Statewide Furlough Impact" increased the appropriation by $26,695 due to a change in the method for implementing the 1.82% reduction the Joint Budget Committee (JBC) mandated for Personal Services reductions. During the Department's Figure Setting, the JBC approved a transfer of $150,000 for Nursing Facility Pay for Performance evaluations to this line from the Medical Services Premiums line. Other 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, HB 09-1047 "Alternative Therapies for Persons with Disabilities" appropriated $53,480 to implement a new program for Medicaid clients with disabilities, and $421,850 for various consultants to assist in the implementation of HB 09-1293 "Colorado Health Care Affordability Act."

These actions resulted in a final FY 2009-10 appropriation of $3,983,630, including $1,304,994 General Fund, $612,175 cash funds, and $2,066,461 federal funds.

For FY 2010-11, annualization of approved legislation, change requests, and supplemental requests associated with the economic downturn bring the Department's FY 2010-11 Long Bill appropriation to $4,316,995. This number is based on the FY 2009-10 appropriation with the following adjustments:

- less $100,000 through the annualization of FY 2009-10 DI-5 and BA-35 "Improved Eligibility and Enrollment Processing";
- plus $75,000 for FY 2009-10 BRI-1 "Pharmacy Technical and Pricing Efficiencies";
- less $20,000 for FY 2009-10 ES-2 "Medicaid Program Reductions";
- plus $26,695 due to the JBC one-time 1.82% personal services cut for FY 2009-10;
- less $53,480 for HB 09-1047 "Alternative Therapies for Persons with Disabilities";
- less $52,500 for HB 09-1073 "Electronic Prescriptions";
- plus $85,000 through the annualization HB 09-1196 "Nursing Facility Penalty Cash Fund." Funding for this bill was appropriated to its own line item in FY 2009-10. See Executive Director's Office, (H) Nursing Facility Penalty Cash Fund, Nursing Facility Culture Change;
- plus $103,150 for HB 09-1293 "Colorado Health Care Affordability Act";
- plus $419,500 for FY 2010-11 BRI-2 BA-13 "Coordinated Payment and Payment Reform"; and,
- less $150,000 through the annualization of the Council for Affordable Health Insurance that assists with the implementation requirements of SB 06-128, a program for services for people with disabilities under Medicaid.

These adjustments bring the Departments' FY 2010-11 Long Bill appropriation to $4,316,995. Special bills also impacted the FY 2010-11 appropriation:

- plus $25,000 for HB 10-1027 "Prognosis for Hospice Care";
- plus $75,000 for HB 10-1053 "Conduct Study for Community Long-Term Care Savings"; and,
- plus $102,570 for SB10-061 "Room & Board in a Hospice Inpatient Facility."

These Special bills when added to the Long Bill appropriation result in a FY 2010-11 total appropriation of $4,519,565, consisting of $1,480,361 General Fund, $673,785 cash funds, and $2,365,419 federal funds.

For FY 2011-12, the Department's request is $4,501,995. This number is based on the FY 2010-11 total appropriation with the following adjustments:

- plus $150,000 through the annualization of HB 09-1293 "Colorado Health Care Affordability Act";
- less $75,000 through the annualization of HB 10-1053 "Conduct Study for Community Long-Term Care Savings"; and,
- less $92,570 through the annualization of SB 10-061 "Room & Board in a Hospice Inpatient Facility."

The base request consists of $1,480,361 General Fund, $665,000 cash funds, and $2,356,634 federal funds.

## ***(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 (DPHE) is authorized to establish and enforce standards of operation for health facilities per 25-1.5-103, C.R.S. (2010). Federal statute 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 DPHE 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, from which the data is obtained, is not Medicaid funded. The Department contracts with DPHE through an interagency agreement for these functions. Federal financial participation is broken into two categories: 1) expenditures qualifying for a 75% enhanced federal financial participation rate for skilled professionals expenditures related to long-term care facilities, and 2) 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 (CMS) 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 DPHE; however, they are Medicare funded rather than Medicaid funded.

The Health Facilities and Emergency Medical Services subdivision of DPHE receives funding from the Department to survey a variety of facilities that serve Medicaid patients. Based on the survey, DPHE 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 2008-09 Long Bill (HB 08-1375) appropriated $4,932,027 for this line item. Due to the economic downturn in FY 2008-09, the Department submitted NP S-19 "DPHE – Hiring Freeze Savings," which resulted in a reduction of $8,268 in total funds for FY 2008-09. 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." These

requests were authorized by the Department's FY 2008-09 Supplemental Bill (SB 09-187). The final FY 2008-09 appropriation to this line was $4,923,759, including $1,356,814 General Fund and $3,566,945 federal funds.

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 under-expenditure in the Medicare Modernization Act (MMA) of 2003 State Contribution Payment line item. The Joint Budget Committee (JBC) 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 $146,925 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 appropriation also includes a reduction of 1.82%, or $69,441, for Personal Services that was part of the budget balancing of SB 09-259, the FY 2009-10 Long Bill. Supplemental Request NP S-4 "DPHE – Statewide Furlough Impact" added $9,970 total funds as approved by Joint Budget Committee and included in the FY 2009-10 Supplemental Bill (HB 10-1300) for a revised total funding of $5,011,213 for this line item. This appropriation consisted of $1,505,903 General Fund and $3,505,310 federal funds.

For the FY 2010-11 Long Bill (HB 10-1376) appropriation for this line item was $4,917,090, comprised of $1,475,127 General Fund and $$3,441,963 federal funds. This funding is allocated as $3,847,994 for program costs, $356,314 POTS costs, $15,475 Vehicle Lease costs, $15,475 General Government Computer Center costs, and $552,760 federal indirect costs. This included the following adjustments:

- an increase of $69,441 from annualization of the FY 2009-10 Conference Committee action for "1.82% Personal Services Cut";
- a decrease of $9,970 from annualization of FY 2009-10 NP S-4 "DPHE – Statewide Furlough Impact";
- a decrease of $722 from removal of funding in FY 2010-11 NP-8 "DPHE-Statewide Information Technology Staff Consolidation";
- a decrease of $76,394 from FY 2010-11 NP BA-3 "DPHE-Statewide PERA Adjustment";
- a decrease of $2,768 from one-time-only FY 2010-11 Common Policy GGCC adjustment by JBC;
- a decrease of $96,563 from FY 2010-11 NP BA-11 "DPHE-Total Compensation Update";
- an increase of $17,715 from FY 2010-11 JBC recommendation to restore some Health, Life, and Dental insurance funding; and,
- an increase of $5,138 from a continuing JBC effort to reconcile fund splits between General Fund and federal funds by adding $6,550 General Fund while reducing $1,412 federal funds for total funds to agree with appropriated funding at DPHE associated with this line item.

As a result of the continuation of budget balancing, this appropriation was reduced by $36,092 pursuant to NP ES-2 "CDPHE- 1% Across the Board Personal Services Reduction." The resulting FY 2010-11 appropriation is $4,880,998, consisting of $1,462,495 General Fund and $3,418,503 federal funds.

For FY 2011-12, the Department is requesting $4,993,484, which includes continuation funding plus $36,092 pursuant to NP ES-2 "CDPHE- 1% Across the Board Personal Services Reduction" and $76,394 due to annualization of NP BA-3 "DPHE – Statewide PERA Adjustment." This amount includes $1,501,865 General Fund and $3,491,619 federal funds.

**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 (below 200% of the federal poverty level), first-time mothers with a baby less than one month old. The nurses offer services during the mother's pregnancy and up to the child's second birthday. According to statute, the overall goal of the program is to serve all low-income, first-time mothers who want to participate by the year 2010 (25-31-102, C.R.S. (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. 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. The goals of the program are improvements in pregnancy outcomes and the health and development of their children, as well as long-term economic self-sufficiency of their families.

Between FY 2005-06 and FY 2008-09, the program grew from serving 2,162 to 2,405 families, all of which were enrolled in Medicaid. Information is not yet available for FY 2009-10, pending release of the annual report near the end of the 2010 calendar year. Families who do not qualify for Medicaid are served entirely by funding from the Nurse Home Visitor Program Fund, managed by the Department of Public Health and Environment (DPHE), which does not have federal financial participation.

Nineteen grantee organizations have been contracted by DPHE to provide Nurse Home Visitor Program services in 52 counties in Colorado. Most providers serve Medicaid eligible clients, and often serve multiple counties. DPHE 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 that 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 (CMS), 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. CMS recommended that the Department use the United States Bureau of Labor Statistics (BLS) State Occupational Employment and Wage Estimates, which the Department used to set a revised rate structure. On June 8, 2009, CMS notified the Department that this revised rate structure was approved, retroactive to July 16, 2008.

It was necessary, however, to repay federal funds for whatever rate amounts were not approved previously. DPHE agreed to use funding from the Nurse Home Visitor Program Cash Fund to repay CMS. A 1331 Supplemental Request for $889,708 cash funds from the Nurse Home Visitor Program Cash Fund was approved by the Joint Budget Committee (JBC) on June 22, 2009, to repay 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. CMS notified the Department that repayment of any over-claimed federal funds during FY 2004-05 through FY 2007-08 would not be required, and that CMS would regard the repayment for FY 2008-09 as fully meeting the State's obligation.

The Colorado General Assembly passed SB 10-073 "Concerning the Nurse Home Visitor Program Duties of the Health Sciences Facility at the University of Colorado," which transferred the administration of the program from DPHE to the Health Sciences Center (Medical School). The Health Sciences Center looks for ways to expand and enhance the program to reach more needy clients in more counties. However, the financial management of the program remains with DPHE. The Department will continue to have an Interagency Agreement with DPHE to pay Medicaid claims for clients that are eligible through Medicaid.

Since FY 2007-08, the Department has been annually appropriated $3,010,000 this line item, consisting of $1,505,000 reappropriated funds and $1,505,000 federal funds. The FY 2009-10 appropriation was adjusted to account for the enhanced Federal Medical Assistance Percentage (FMAP) provided under the American Recovery and Reinvestment Act of 2009 (ARRA), which resulted in a decrease of $348,859 reappropriated funds and a corresponding increase in federal funds.

In the Department's 2010 Figure Setting, the JBC staff recommended that this line item be moved from the Department's (5) Other Medical Services Long Bill Group to the (1) Executive Director's Office, (B) Transfers to Other Departments subdivision in order to accurately reflect the nature of this appropriation (Figure Setting document dated March 16, 2010, page 185). The Committee approved this recommendation, and the line item was transferred in the FY 2010-11 Long Bill (HB 10-1376).

The FY 2010-11 Long Bill (HB 10-1376) made appropriations to the line in the amount of $3,010,000. This amount includes the annualization of ARRA from the previous year and the reinstatement of ARRA for FY 2010-11. During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010;

however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the reappropriated fund appropriation of $56,655 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was reduced by $46,456 pursuant to ES-2 "Fee-For-Service Delay." The FY 2010-11 appropriation is $2,963,544, consisting of $1,191,086 reappropriated funds and $1,772,458 federal funds.

For FY 2011-12, the Department's base request for this line item is $3,010,000, which includes the annualizations of FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" and ES-2 "Fee-For-Service Delay. The base request consists of $1,505,000 reappropriated funds and, due to the expiration of ARRA, $1,505,000 federal funds.

**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. Regular medical services for Prenatal Plus clients are paid under the Department's line item for Medical Services Premiums.

The program provides care to slightly fewer than 2,000 women each year. Data from the Medicaid Management Information System indicates the number of clients served in FY 2009-10 was 1,874. Enhanced prenatal services are provided at county health departments, county nursing services, community health centers, and private non-profit agencies. The sites are visited by the Department of Public Health and Environment (DPHE) 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 the Nurse Home Visitor Program, in which the nurses visit the pregnant women and new mothers at the family home.

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 – which has been in effect since the federal Centers for Medicare and Medicaid Services (CMS) 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 based on the number of visits by the pregnant woman: one to four visits; five to nine visits; ten visits; and, eleven or more visits. The more visits that occur, the more likely behavioral changes will occur to improve the outcome of the pregnancy. Total visits of 10 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 in order to determine the total number of visits. Payments for the visits are paid through the Department's Medical Services Premiums line item.

This program is managed by DPHE, within which 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.

The Department's FY 2008-09 Long Bill (HB 08-1375) appropriation was $117,411, including $58,706 General Fund and $58,705 federal funds. The FY 2009-10 Long Bill (SB 09-259) appropriated $119,006 to this line item, which included a POTS increase of $1,595, and decreases of $342 and $28 for FY 2009-10 NP BA-37 "DPHE – SAED and AED Adjustments Due to the Reduction of Salary Survey" and FY 2009-10 NP BA-40 "DPHE – Fund Splits for Life Insurance Reduction," respectively. The FY 2009-10 Long Bill appropriation included $58,752 General Fund and $60,254 federal funds.

In the Department's 2010 Figure Setting, the JBC staff recommended that this line item be moved from the Department's (5) Other Medical Services Long Bill Group to the (1) Executive Director's Office, (B) Transfers to Other Departments subdivision in order to accurately reflect the nature of this appropriation (Figure Setting document dated March 16, 2010, page 185). The Committee approved this recommendation, and the line item was transferred in the FY 2010-11 Long Bill (HB 10-1376). As a result of the continuation of budget balancing, this appropriation was reduced by $779 pursuant to NP ES-2 "CDPHE- 1% Across the Board Personal Services Reduction." The FY 2010-11 appropriation is $118,227, consisting of $58,362 General Fund and $59,865 federal funds.

For FY 2011-12, the Department is requesting funding of $119,006, which includes continuation funding plus the annualization of NP ES-2 "CDPHE- 1% Across the Board Personal Services Reduction." This request includes $58,752 General Fund and $60,254 federal funds.

**TRANSFER TO THE DEPARTMENT OF REGULATORY AGENCIES FOR NURSE AIDE CERTIFICATION**

Federal law requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients (42 C.F.R. §483.150 (b)). The Department of Regulatory Agencies (DORA) administers the Nurse Aide Certification program under an interagency agreement with the Department and the Department of Public Health and Environment (DPHE). The Department provides Medicaid funding for the program and DPHE provides Medicare funding for the program. Pursuant to Section 12-38-101, C.R.S. (2010), the Colorado State Board of Nursing in DORA 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 DPHE, 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 DORA and is directly overseen by the five-member Nurse Aide Advisory Committee.

DORA 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. DORA 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 DORA are used to draw down federal funds.

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 DORA, and $162,671 is federal funds. The Department was appropriated the same amount in the FY 2009-10 Long Bill (SB 09-259) as well as the FY 2010-11 Long Bill (HB 10-1376).

For FY 2011-12, the Department requests continuation funding of $325,343, including $148,020 General Fund, $14,652 reappropriated funds from DORA, and $162,671 federal funds.

**TRANSFER TO DEPARTMENT OF REGULATORY AGENCIES FOR REVIEWS**

The Office of Policy, Research, and Regulatory Reform in the Department of Regulatory Agencies (DORA) conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The Departments affected by the legislation reimburse DORA for performance of such sunset reviews. Previously, when the Department had a law requiring a sunset review, a specific line item was established in the Long Bill with a line item name that referred to the short name of the legislation, which was subsequently eliminated upon completion of the review.

This line item was established in the FY 2009-10 Long Bill Add-Ons (SB 09-259), beginning with FY 2008-09. The line item name was created to accommodate the potential for multiple sunset reviews required by various laws across multiple Department programs and functions. Sunset reviews are a type of audit 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. Statutory authority authorizing DORA to conduct these reviews comes from 24-34-104 (8) (a), C.R.S. (2010).

The Department was appropriated a total of $9,000 for FY 2008-09 for the review of two Department functions: 1) the Obesity Treatment pilot program, and 2) the Telemedicine pilot program. The cost of each review is at a 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.

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. This appropriation consisted of $6,500 General Fund, $500 local funds, and $7,000 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation is $14,000 for the performance of sunset reviews on the Teen Pregnancy and Dropout Prevention program and the In-Home Support Services program. The funding is a combination of $6,500 General Fund, $500 local funds, and $7,000 federal funds.

For FY 2011-12, the Department requests continuation funding in the amount of $14,000. 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 DORA, which substitute for formal Decision Items or Supplemental Requests.

**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. Prior to FY 2009-10, the line also included the cost of a contractor responsible for developing a new reimbursement methodology and performing time studies to support the rate-setting methodology.

In 2004, the Centers for Medicare and Medicaid Services (CMS) 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 CMS 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 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.

For FY 2008-09, the Department was appropriated $407,747 for this line item. 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" line. Joint Budget Committee staff recommended an increase of $3,565 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 Long Bill (SB 09-259) appropriation for this line item to $211,312 in federal funds.

The Department's FY 2009-10 Supplemental Request S-9 "Public School Health Services Administrative Claiming" reduced this line item by $61,312 to consolidate external Public School Health Services administration into one line item in the Department's (5) Other Medical Services Long Bill Group, resulting in a revised appropriation of $150,000 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $150,388 federal funds to this line, which includes an addition of $388 for a PERA Common Policy adjustment.

For FY 2011-12, the Department requests an appropriation of $149,999, which includes annualization of the Common Policy adjustment.

## ***(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 (MMIS) 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. In FY 2010-11, this line item received an appropriation of $34,553,769 in total funds, which is comprised of $6,134,303 General Fund, $2,433,429 cash funds, $100,328 reappropriated funds, and $25,885,709 federal funds. Of this total amount,

$33,890,355 was for the Medicaid Management Information System Contract budget item, and $663,414 was for the HIPAA Web Portal Maintenance budget item.

For FY 2011-12, the Department is requesting $31,825,489 for this line item: $31,162,075 for MMIS Contract and $663,414 for Provider Web Portal. Of the $31,825,489 total request amount, $6,147,923 is General Fund, $1,766,770 is cash funds, $100,328 is reappropriated funds, and $23,810,465 is federal funds.

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' (CMS) 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.

CMS's State Medicaid Manual identifies the specific types of MMIS costs that are allowable for federal reimbursement. For activities related to the design, development, or installation of an MMIS, the Department may receive, with proper approval, 90% federal financial participation per 42 C.F.R. §433.15 (b)(3). Any costs related to the operations of MMIS for ongoing automated processing of claims, payments, and reports, the Department may receive 75% federal financial participation per 42 C.F.R. §433.15 (b)(4).

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

The State must competitively bid the role of the fiscal agent for the operation of MMIS once every eight years. During FY 2006-07, reprocurement of MMIS operational responsibilities was completed, and ACS was reselected as the fiscal agent. On July 1, 2007 a new MMIS contract began and remained in effect until June 30, 2010. Prior to the expiration of the current contract, the Department entered into negotiations with ACS for the extension of the MMIS contract. In June 2010 the Department completed negotiations with ACS and extended the MMIS contract until June 30, 2015. Later on July 14, 2010, CMS approved the Department's five-year contract extension in accordance with federal statute at 45 C.F.R. §95.611.

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. 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.

For FY 2008-09, the Long Bill (HB 08-1375) appropriated $23,180,959 to this line. During the 2008 Legislative Session, the Department was appropriated $298,495 for systems changes to implement SB 08-006, "Suspension of Medicaid Benefits for Confined Persons" and $183,960 for modifications required by SB 08-160 "Improvements to Medicaid and Children's Basic Health Plan for Children." As part of the Department's FY 2008-09 budget reduction proposals, the Department submitted S-22 "Postpone Implementation of SB 08-006" to postpone the implementation of this bill. 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, these requests removed $1,602,244 total funds from FY 2008-09 and were authorized in the Supplemental Bill (SB 09-187). The final FY 2008-09 appropriation was $22,061,170.

For FY 2009-10, adjustments were made to remove $188,370 total funds in one-time funding for development projects from the prior fiscal year. Additional funding of $1,695,647 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." Increases totaling $1,050,022 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). The FY 2009-10 Long Bill (SB 09-259) appropriation was $24,618,469.

As part of the FY 2009-10 budget reductions, the Department submitted two Early Supplementals that affected 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 Department submitted FY 2009-10 S-6 "Accountable Care Collaborative" to postpone the implementation of the Accountable Care Collaborative in MMIS, resulting in a decrease of $552,636 total funds. The Department was appropriated $3,664,436 through the passage of HB 09-1293 to implement system development changes associated with the HB 09-1293 expansion populations. The final FY 2009-10 appropriation was $27,347,169.

The Long Bill (HB 10-1376) appropriation was $33,248,452, and included numerous funding changes from the FY 2009-10 final appropriation. Adjustments were made during Figure Setting on March 16, 2010 to remove one-time development costs for three projects: 1) decrease of $347,760 total funds for the Accountable Care Collaborative; 2) decrease of $504,000 total funds for provider rate reductions, which was requested as part of the Department's budget reduction proposals on January 23, 2009, BA-33 "Provider Rate Reductions"; and, 3) decrease of $16,380 total funds for "Pharmacy Technical and Pricing Efficiencies," requested under BRI-1. The prior-year adjustments also included a net increase of $2,200,838 total funds for system costs associated with two federal mandates to implement HIPAA Version 5010 and ICD-10.

The Long Bill also included adjustments for the following:

- additional funding provided by HB 09-1293 in the amount of $3,787,556 total funds to implement system development changes associated with the HB 09-1293 expansion populations and annual maintenance costs for Medicaid Parents to 100% FPL and Children's Basic Health Plan expansion to 250% FPL;
- funding in the amount of $96,768 to implement changes to the State Maximum Allowable Cost methodology as requested in BRI-3 "Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology";
- an increase of $45,864 for system changes associated to payment coordination for federally qualified health centers and behavioral health organizations via BRI-2 "Coordinated Payment and Payment Reform";
- funding of $269,528 for an annual MMIS cost adjustment via DI-5 "Medicaid Management Information System Cost Adjustment";
- an increase of $439,153 total funds to secure consultant services to assist the Department in identifying areas of the MMIS system that must be upgraded prior to the reprocurement in June 2015 via BA-15 "MMIS Adjustments"; and,,
- a net reduction in the amount of $70,284 total funds which includes consolidating prior authorization reviews with a Quality Improvement Organization and development costs to implement prospective utilization reviews of hospital claims and web-based prior authorization review system via BA-12 "Evidence Guided Utilization Review (EGUR)."

For FY 2010-11, additional funding was appropriated from SB 10-167 "Medicaid Efficiencies Act" in the amount of $641,903. As a result of the continuation of budget balancing, this appropriation was increased by $126,000 pursuant to ES-3 "Delay Managed Care Payments." Including the effects from Department approved budget requests, annualization of prior requests, and funding from special bills, the appropriation for this line item in FY 2010-11 is $34,016,355 total funds.

For FY 2011-12, the Department removed one-time funding for FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform," FY 2010-11 BRI-3 "State Maximum Allowable Cost," FY 2010-11 BA-5 "Accountable Care Collaborative," and annualized the effects of FY 2010-11 BA-12 "Evidence-Guided Utilization Reform," BA-15 "MMIS Adjustments," ES-3 "Delay Managed Care Payments," HB 09-1293 "Hospital Provider Fee," and SB 10-167 "Medicaid Efficiencies Act." The cumulative effect is a net reduction of $2,854,280 total funds. The Department's base request is for $31,162,075 total funds.

PROVIDER WEB PORTAL

The Health Insurance Portability and Accountability Act (HIPAA) of 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 (MMIS), Colorado Benefits Management System (CBMS), and Benefits Utilization System.

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" in FY 2004-05. As part of the Department's FY 2008-09 Budget Request, DI-13 "Web Portal Contract Adjustments and Enhancements" requested one-time funding in the amount of $117,833 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 and subsequently appropriated in the FY 2008-09 Long Bill (HB 08-1375). 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 total funds.

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 and increased funding by $350,514 total funds for Provider Web Portal reprocurement activities via DI-15 "Provider Web Portal Reprocurement." Authorization for this request was permitted through the FY 2009-10 Long Bill (SB 09-259). The final appropriation for FY 2009-10 was $663,414 total funds.

In FY 2010-11, the Department received continuation funding of $663,414 total funds. For FY 2011-12, the Department requests continuation funding in the amount 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 Services (CMS) 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 Joint Budget committee 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 the removal of $528,403 for the annualization of BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries."

In FY 2010-11, the Department requested continuation funding in the amount of $250,000 for annual technology maintenance and updates for the fraud-detection software contract. The Department receives 75% federal financial participation for annual maintenance costs per 42 C.F.R. §433.15 (b)(4). During FY 2010-11 Figure Setting, the JBC approved the request and appropriated $250,000 total funds for this line item in the Long Bill (HB 10-1376).

For the FY 2011-12 Base Request, the Department requests continuation funding in the amount of $250,000 for annual technology maintenance and updates to the fraud-detection software, including $62,500 General Fund and $187,500 federal funds. These costs would be offset by anticipated savings in the Medical Service Premiums line item from increased recoupment and recovery efforts.

<u>CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT</u>

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 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." Funding was used for 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 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 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 for this line item. 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 yet enrolled, Coloradoans in public health programs. The Department released a request for proposals for an eligibility and enrollment vendor in September 2009 and the contract was awarded July 2010. The eligibility and enrollment vendor will initially implement modernization strategies for Children's Basic Health Plan clients with other populations to be added later.

For FY 2010-11, the Department was appropriated $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 (88% of the total funds receive a 50% federal match, and 12% of the totals funds receive a 65% federal match). 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.

The Department's base request for FY 2011-12 is $2,221,482 total funds, with $964,169 from the Hospital Provider Fee Cash Fund and $1,257,313 federal funds. The Department's base request includes additional funding for increased caseload from the expansion of the Children's Basic Health Plan. In addition, the base request includes additional funding for the buy-in program for individuals with disabilities (anticipated to be implemented July 2011) and the program for adults without dependent children (anticipated to be implemented January 2012).

## ***(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.

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.

In FY 2008-09, the Department was appropriated funding of $120,000 for this line. Of this amount, $48,444 was General Fund, $10,759 was cash funds, $1,593 was reappropriated funds, and $59,204 was federal funds.

In FY 2009-10, $124,000 was appropriated for this line item, including continuation funding and an increase of $4,000, for expansion populations funded through HB 09-1293 "Health Care Affordability Act." This appropriation consisted of $48,444 General Fund, $12,759 cash funds, $10,759 reappropriated funds, and $61,204 federal funds.

In FY 2010-11, the Department was appropriated $120,000 total funds, which includes a decrease of $4,000 from the FY 2009-10 appropriation for the annualization of HB 09-1293. Of this amount, $48,444 is General Fund, $10,759 is cash funds, $1,593 is reappropriated funds, and $59,204 is federal funds.

For FY 2011-12, the Department requests continuation funding of $120,000 total funds. This base request consists of $48,444 General Fund, $10,759 cash funds, $1,593 reappropriated funds, and $59,204 federal 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. The School District Eligibility Determinations line item was eliminated in FY 2009-10.

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 $5,233,102 in total funds through the FY 2010-11 Long Bill (SB 10-1376), which was comprised of $828,091 General Fund, $1,542,200 cash funds, and $2,862,811 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 $3,074,400 was for Hospital Outstationing. School District Eligibility Determinations did not receive an appropriation for FY 2010-11.

The Department's FY 2011-12 Base Request for (D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations is for funding of $7,454,318 in total funds for all four functions described below. Of this total amount, $3,394,878 is for Disability Determination Services, $985,040 is for Nursing Facility Preadmission Screening and Resident Review, and $3,074,400 is for Hospital Outstationing.

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 (DHS) 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 DHS to the Department of Health Care Policy and Financing.

From FY 2005-06 to FY 2010-11, the Department was appropriated $1,173,662 per fiscal year for disability determination services. Of the total amount, $581,831 was General fund, $5,000 was cash funds from the Colorado Autism Treatment Fund, and $586,831 was federal funds.

With the implementation of HB 09-1293 "Health Care Affordability Act," the Department will experience an expansion of the Medicaid-eligible disabled population up to age 59. Consequently, the Department's FY 2011-12 request includes an increase of $2,221,216 this line item. The Department's total fund base request for FY 2011-12 is $3,394,878; of this amount, $581,831 is General Fund, $5,000 is cash funds from Colorado Autism Treatment Fund, $1,110,608 is cash fund from the Hospital Provider Fee Cash Fund, and $1,697,439 is federal funds.

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. The final FY 2008-09 appropriation was $910,040, of which $227,510 was General Fund and $682,530 was federal funds.

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). With the annualization of SB 09-187, the final FY 2009-10 appropriation was $985,040, consisting of $246,260 General Fund and $738,780 federal funds. PASRR was appropriated continuation funding for FY 2010-11, including $246,260 General Fund and $738,780 federal funds.

For FY 2011-12, the Department requests continuation funding of $985,040 for this line item. 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. (2010) 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 2008-09, the Department was appropriated funding of $227,292, of which $79,269 was General Fund, $25,854 was cash funds from the Health Care Expansion Fund, and $122,169 was federal funds.

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 the FY 2009-10 Long Bill (SB 09-259), the 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 final FY 2009-10 appropriation to this line item was $173,340 total funds, consisting of $60,453 General Fund, $19,717 cash funds, and $93,170 federal funds. This line item was eliminated in the Department's FY 2010-11 budget.

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 year-to-date appropriation is $3,074,400, as calculated in the fiscal note for HB 09-1293. Of the total amount, $1,537,200 is cash funds from the Hospital Provider Fee Cash Fund and $1,537,200 is federal funds.

For FY 2011-12, the Department requests continuation funding in the amount of $3,074,400.

**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 (DHS) 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 DHS. However, with the passage of SB 06-219 beginning in FY 2006-07, oversight and funding for the Medicaid portion of county administration was transferred to the Department, 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 DHS 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 DHS to determine the allocation of expenditures between programs administered by the Department and those administered by DHS; 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 DHS pursuant to 24-75-106, C.R.S. (2010) 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 DHS 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, which was $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.

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," a 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 the Department's 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 (ARRA) of 2009. This one-time funding does not include a local share. The total appropriation for FY 2008-09 was $30,418,531, consisting of $9,916,867 General Fund, $5,332,531 cash funds, and $15,169,133 federal funds.

In order to maximize federal funds and county reimbursement for FY 2008-09, a General Fund transfer was made from DHS 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 in FY 2008-09.

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 ARRA. In addition, during the Department's March 18, 2009, Figure Setting, $812,480 was added from the Health Care Expansion Fund. 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 $730,864 for this line item which does include a 20% local share, putting the Department's final FY 2009-10 appropriation at $31,717,241. This appropriation included $9,794,550 General Fund, $6,104,203 cash funds, and $15,818,488 federal funds.

In order to maximize county reimbursement for FY 2009-10, a General Fund transfer was made from the Department to DHS in the amount of $166,706. The Department did not fully expend its appropriation and this transfer allowed DHS to cover more of the county expenditures related to their programs. The Department's final expenditure for FY 2009-10 was $31,153,171.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $32,858,207 for this line item. This appropriation includes an annualization of $1,140,966 from HB 09-1293 to fund increased caseload. In the 2010 Legislative Session, SB 10-167 "Colorado False Claims Act" added $200,000 to this line item to expand the use of the Public Assistance Reporting Information System (PARIS). PARIS is a federal data-matching initiative that includes of three different types of matches which consists of participating States submitting demographic information on public assistance clients for the purposes identifying dual Medicaid participation across states. Expanded use of PARIS for data matching allows the State to identify clients enrolled in Medicaid in other states and close their cases where appropriate. The final County Administration appropriation for FY 2010-11 is $33,058,207, consisting of $9,894,550 General Fund, $6,674,686 cash funds, and $16,488,971 federal funds.

The Department's base request for FY 2011-12 is $33,547,878, which includes an annualization of $489,671 from HB 09-1293 to fund increased caseload. This base request includes $9,894,550 General Fund, $6,919,522 cash funds, and $16,733,806 federal funds.

**ADMINISTRATIVE CASE MANAGEMENT**

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services (DHS). Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services (CMS) for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management was transferred from DHS, beginning July 1, 2006. Prior to FY 2006-07, Medicaid funding for these programs was transferred through interagency transfers, originating in the Department's Long Bill group (6) DHS – 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 DHS 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 DHS. Also similar to the County Administration appropriation, DHS 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.

For FY 2008-09, the Department submitted DI-15 "Accuracy in Budgeting – Administrative Case Management," requesting an increase of $1,300,000, which was offset by a corresponding decrease to the DHS budget. This request was initiated in order to minimize end-of-year transfers. The decision item was approved, and the Department's FY 2008-09 Long Bill appropriation was $2,917,528.

In FY 2007-08, CMS 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. CMS 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 CMS, the Department can no longer draw down federal funds for this activity. The Department submitted FY 2008-09 S-15 "Reduce Funding for Administrative Case Management," requesting to reduce funding by a total of $2,337,785. The $1,188,892 General Fund amount of the reduction was transferred to DHS, and the Department's 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 DHS 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) had a total appropriation of $539,744; however, during Figure Setting, the Joint Budget Committee (JBC) appropriated an additional $330,000 to this line item for a final appropriation of $869,744. This appropriation included $434,872 General Fund and $434,872 federal funds.

At the end of FY 2009-10, in order to maximize federal funds and county reimbursement, a General Fund transfer was made from DHS in the amount of $14,264. This amount allowed the Department to receive corresponding federal matching funds for a total expenditure of $898,270.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $869,744 for this line item, which was based on the final appropriation in FY 2009-10. This appropriation includes $434,872 General Fund and $434,872 federal funds.

For FY 2011-12, the Department requests continuation funding of $869,744, consisting of $434,872 General Fund and $434,872 federal funds.

**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 the FY 2010-11 Long Bill (HB 10-1376), this line item was appropriated $3,947,598 in total funds, of which $1,900,033 was General Fund, $73,766 was cash funds, and $1,973,799 was federal funds. Of the total amount for the line, $2,476,544 was for the Early and Periodic Screening, Diagnosis, and Treatment Program and $1,471,054 was for Enrollment Broker functions.

The Department's FY 2011-12 Base Request for (D) Eligibility Determinations and Client Services: Customer Outreach is $4,390,159 in total funds. Of this total, $2,479,343 is for the Early and Periodic Screening, Diagnosis, and Treatment Program and $1,910,816 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.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

The Department is required to ensure Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 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 EPSDT 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 EPSDT Program remain in the Department's Long Bill group (2) Medical Services Premiums.

The FY 2008-09 and FY 2009-10 appropriation for EPSDT was $2,468,383 total fund, comprised of $1,234,192 General Fund and $1,234,191 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation for EPSDT includes continuation funding of $2,468,383 for the EPSDT Program, plus $8,161 from FY 2010-11 S-6, BA-5 "Accountable Care Collaborative," for a total appropriation of $2,476,544. This appropriation consists of $1,238,272 General Fund and $1,238,272 federal funds

The Department's FY 2011-12 base request for EPSDT is $2,478,504, which includes continuation funding of $2,476,544 from the prior year plus $10,960 for the annualization of HB 09-1293 "Colorado Health Care Affordability Act." The base request includes $1,238,272 General Fund, $5,480 cash funds from the Hospital Provider Fee Cash Fund, and $1,243,752 federal funds.

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 2009-10, MAXIMUS, Inc. enrolled 112,282 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 15,940 disenrollments, which does not include clients disenrolling due to loss of eligibility, change in eligibility, or health plan closure. In addition, 67,506 calls were received in FY 2009-10, with an average wait time of 58 seconds.

In FY 2008-09, the Department received $1,321,900 in total funds for this budget item. Of this amount, $627,436 was General Fund, $33,514 was cash funds from the Health Care Expansion Fund, and $660,950 was federal funds.

In FY 2009-10, the Department's appropriation for this budget item was $1,104,618. This funding included continuation funding of $1,321,900 from FY 2008-09 and a reduction of $217,282 in total funds for annualization of costs associated with implementation of the SB 07-130 Medical Home program. The appropriation was further increased by $36,352 for the implementation of HB 09-1293 "Colorado Health Care Affordability Act," which was signed into law on April 21, 2009. Of the $1,140,970 appropriated for Enrollment Broker in FY 2009-10, $518,795 was General Fund, $33,514 was cash funds from the Health Care Expansion Fund, $18,176 was cash funds from the Hospital Provider Fee Cash Fund, and $570,485 was federal funds.

In FY 2010-11, the Department was appropriated $1,471,054 for the Enrollment Broker line item. This appropriation includes continuation funding of $1,140,970 from FY 2009-10, a reduction of $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 FY 2008-09 Budget Request, an increase of $44,152 for the annualization of HB 09-1293, and an increase of $288,132 for implementation of FY 2010-11 S-6 BA-5 "Accountable Care Collaborative." The Department requested $568,343 for the Accountable Care Collaborative, but Joint Budget Committee staff did not recommend the Department's request in figure setting (March 16, 2010, page 72); the Committee partially approved the Department's comeback on March 22, 2010, by reducing its funding for this request due to delayed implementation. Of the $1,471,054 appropriated for Enrollment Broker in FY 2010-11, $661,761 is General Fund, $40,252 is cash funds from the Hospital Provider Fee Cash Fund, $33,514 is cash funds from the Health Care Expansion Fund, and $735,527 is federal funds.

For FY 2011-12, the Department's base request for the Enrollment Broker line item is $1,902,655, which includes continuation funding of $1,471,054 from the FY 2010-11 appropriation, an increase of $20,754 from annualization of HB 09-1293, and an increase of $410,847 from annualization of FY 2010-11 S-6 BA-5 "Accountable Care Collaborative." Of the $1,902,655 requested for FY 2011-12, $867,185 is General Fund, $50,629 is cash funds from the Hospital Provider Fee Cash Fund, $33,514 is cash funds from the Health Care Expansion Fund, and $951,327 is federal funds.

## ***(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 $6,462,871 in total funds through the FY 2010-11 Long Bill (HB 10-1376), which is comprised of $1,766,994 General Fund, $86,596 cash funds and $4,609,281 federal funds. Of this total amount, $3,092,124 was for Acute Care Utilization Review, $1,744,966 was for Long-Term Care Utilization Review, $1,039,156 for External Quality Review, $233,818 for Drug Utilization Review and $352,807 for Mental Health External Quality Review.

The Department's FY 2011-12 base request for the Professional Services Contracts line item is for the amount of $7,270,839 total funds for the budget items described below. Of this total, $3,656,132 is for Acute Care Utilization Review, $1,744,966 is for Long-term Care Utilization Review, $255,121 for Drug Utilization Review, $1,261,813 for External Quality Review, and $352,807 for Mental Health External Quality Review.

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.

The Department was appropriated $1,375,906 in FY 2008-09, of which $345,428 was General Fund, $16,520 was cash funds, and $1,013,958 was federal funds.

In FY 2009-10, the Department was appropriated $1,461,306 in total funds for this line item. In addition to continuation funding of $1,375,906, the Department was appropriated $85,400 in the Department's Supplemental bill (HB 10-1300) pursuant to approval of the Department's S-10 "Acute Care Utilization Review Adjustments". This request was in response to the increase in Medicaid caseload, which has resulted in an increase in the number of prior authorizations that must be performed, and also corrected the fund split to the Acute Care Utilization Review line item to reflect a 75% federal match on all activities funded through this line item. In addition, the appropriation was increased by $13,750 total funds pursuant to HB 09-1293 "Colorado Health Care Affordability Act." The FY 2009-10 appropriation was $1,475,056 and consisted of $348,807 General Fund, $19,958 cash funds, and $1,106,291 federal funds.

In FY 2010-11, $3,092,124 was appropriated for this line item through the Long Bill (HB 10-1376). This figure is based on continuation funding of $1,475,056 as well as:

- an increase of $16,700 from annualization of HB 09-1293
- an increase of $1,536,208 from FY 2010-11 BA-12 "Evidence Guided Utilization Review" (EGUR) and FY 2010-11 BRI-1 "Prevention and Benefits for Enhanced Value" (P-BEV); and,
- an increase of $64,160 total funds for FY 2010-11 BA-8 "Acute Care Utilization Review Adjustments."

The FY 2010-11 appropriation consists of $748,899 General Fund, $24,133 cash funds, and $2,319,092 federal funds.

For FY 2011-12, the Department is requesting $3,656,132 in total funding including continuation of $3,092,124 plus $27,800 and $536,208 from annualization of HB 09-1293 and FY 2010-11 BA-12 "Evidence Guided Utilization Review" (EGUR), respectively. This base request includes $882,951 General Fund, $31,083 cash funds, and $2,742,098 federal funds.

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; and,,
- 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 2008-09, the Department's appropriation for this budget item was $1,744,966 total funds, consisting of $598,813 General Fund, $38,429 cash funds, and $1,107,724 federal funds.

In FY 2009-10, the Department was appropriated continuation funding plus one-time funding in the amount of $80,000 total funds through the FY 2009-10 Long Bill (SB 09-259) pursuant to the Department's BRI-2 "Medicaid Program Efficiencies.". This 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. Of this amount, $638,813 was General Fund, $38,429 was cash funds, and $1,147,724 was federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $1,744,966 total funds for this line. This amount includes the prior year's appropriation of $1,824,966 minus $80,000 due to annualization of BRI-2 "Medicaid Program Efficiencies." The FY 2010-11 appropriation includes $598,813 General Fund, $38,429 cash funds, and $1,107,724 federal funds.

For FY 2011-12, the Department requests continuation funding of $1,744,966 total funds for this line item. The base request includes $598,813 General Fund, $38,429 cash funds, and $1,107,724 federal funds.

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 U.S. 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 2008-09, the Department's appropriation for this line item was $812,193 total funds. Of this amount, $203,048 was General Fund and $609,145 was federal funds.

In FY 2009-10, the Department received continuation funding in the amount of $812,193 total funds plus $22,335 total funds for the implementation of HB 09-1293 "Colorado Health Care Affordability Act." The final FY 2009-10 appropriation was $834,528 consisting of $203,048 General Fund, $5,584 cash funds, and $625,896 federal funds.

The Department was appropriated $1,039,156 total funds for this budget item for FY 2010-11. This amount includes continuation funding of $834,528 from the prior year's appropriation, an increase of $27,128 from annualization of HB 09-1293, and $177,500 for implementation of S-6 BA-5 "Accountable Care Collaborative." The Department had originally requested $355,000 for the Accountable Care Collaborative, but Joint Budget Committee staff did not recommend the Department's request in during the Department's Figure Setting (March 16, 2010, page 72); however, the Committee partially approved the Department's comeback on March 22, 2010, by reducing funding for this request due to a delay in implementation. The FY 2010-11 appropriation of $1,039,156 consists of $247,423 General Fund, $12,366 cash funds, and $779,367 federal funds.

For FY 2011-12, the Department is requesting funding in the amount of $1,261,813 total funds, which includes continuation of the appropriation from FY 2010-11, an increase of $45,157 total funds from annualization of HB 09-1293, and an increase of $177,500 from annualization of FY 2010-11 S-6 BA-5 "Accountable Care Collaborative." Of this base request, $291,798 is General Fund, $23,655 is cash funds, and $946,360 is federal funds.

MENTAL HEALTH EXTERNAL QUALITY REVIEW

This budget line 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 five activities related to behavioral health, which include the following:

- 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.
- 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 fewer 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.
- 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.
- 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.
- 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 since remained at this level.

The Department is requesting continuation funding of $352,807 for FY 2011-12. Of this base request, $88,202 is General Fund and $264,605 is federal funds.

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. (2010), 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.

The appropriation for FY 2008-09 was $383,163, which included $126,827 General Fund and $256,336 federal funds.

In FY 2009-10, the Department was appropriated $210,483 total funds per the FY 2009-10 Long Bill (SB 09-259). This amount included continuation funding less an annualization of $172,680 from BA-3 "Implement Preferred Drug List." The appropriation was increased by $10,537 total funds pursuant to HB 09-1293 "Colorado Health Care Affordability Act." The final FY 2009-10 appropriation was $221,020, comprised of $83,657 General Fund, $5,269 cash funds, and $132,094 federal funds.

In FY 2010-11, the Department was appropriated $233,818 total funds, which included continuation funding plus $12,798 total funds for annualization of HB 09-1293 "Colorado Health Care Affordability Act." This appropriation includes $83,657 General Fund, $11,668 cash funds, and $138,493 federal funds.

For FY 2011-12, the Department is requesting $255,121, which is comprised of continuation funding of the prior year's appropriation with an increase of $21,303 from annualization of HB 09-1293. This base request includes $83,657 General Fund, $22,319 cash funds, and $149,145 federal funds.

## ***(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 Colorado Indigent Care Program Auditor was later added as a result of HB 09-1293 "Health Care Affordability Act," and the budget item Disproportionate Share Hospital (DSH) Audits was added as a result of DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures." A discussion of the appropriations history for each of the components of this line item is discussed below.

This line item received an appropriation of $3,306,813 through the FY 2010-11 Long Bill (HB 10-1376), which is comprised of $1,256,281 General Fund, $352,988 cash funds, and $1,697,544 federal funds. Of this total amount, $1,227,366 is for Nursing Facility Audits, $499,200 is for Hospital and Federally Qualified Health Clinics Audits, $112,000 is for Single Entry Point Audits, $588,501 is for the Payment Error Rate Measurement Contract, $279,746, $500,000 is for the Colorado Indigent Care Auditor, and $100,000 for the DSH Audits.

The Department's FY 2011-12 base request for the Professional Services Contracts line item is for funding in the amount of $2,438,566 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 contract period through FY 2009-10, and the Department completed a new competitive procurement for 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"). 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"). These audits were funded with 50% cash funds from the Nursing Facility Cash Fund and 50% federal funds, bringing 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"). The Department was appropriated $1,227,366 for FY 2010-11, and the Department requests continuation funding of the same amount for FY 2011-12.

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 participation 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 appropriation has remained at this level through FY 2010-11, and the Department requests continuation funding of this amount for FY 2011-12.

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. For 2006-07, the Department requested additional funding of $76,660 for this budget item in DI-5 "Increased Funding for Single Entry Point Audits." The appropriation was increased to $112,000 in FY 2006-07 in order to increase the accuracy of Single Entry Point agency billing and potentially increase recovery of improper payments. The

appropriation has remained at this level through FY 2010-11, and the Department requests continuation funding of $112,000 for FY 2011-12.

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; estimate the amount of improper payments made; and, 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 (CMS) 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.

In August 2006, CMS 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 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 completed eligibility and payment error reviews for Medicaid and the Children's Basic Health Plan was FY 2007-08. Due to the three-year cycle, Colorado will complete the eligibility and payment error reviews in FY 2010-11.

In response to the August 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"). JBC 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. As a result, the Department received total funds of $147,126 for FY 2006-07 and $441,375 for FY 2007-08. 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. The total amount for both years was $588,501 total funds, the same amount which the Department requested and was appropriated for FY 2010-11.

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 CMS press release dated 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 (known as the 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.

Through the FY 2010-11 Long Bill (HB 10-1376), the Department was appropriated $588,501 for this line item, comprised of $147,125 General Fund, $102,988 cash funds (from the Children's Basic Health Plan Trust), and $338,388 in federal funds. A contract was awarded in September 2010 in order to complete the reviews as required by June 2011.

No funding is requested for FY 2011-12 as the reviews are to be completed by the end of FY 2010-11.

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. (2010). 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. The Department requested and was appropriated this same level of funding for FY

2010-11. The Department anticipates that a contract will be awarded in late 2010 for the appraisal of approximately 189 facilities in FY 2010-11. No funding is requested for FY 2011-12.

COLORADO INDIGENT CARE PROGRAM AUDITOR

This new budget item funds an auditor for the Colorado Indigent Care Program due to the passage of HB 09-1293 "Heath Care Affordability Act." Prior to this passage of this bill, the providers were paid using certification of public expenditures in order to draw federal matching funds. The Department currently contracts with a certified public accounting firm to perform federally mandated cost and rate data audits for hospitals, federally qualified health clinics, and rural health centers that participate in Medicaid. The certified public accounting firm establishes reimbursement rates, reviews contracts, calculates final cost settlements, rebases calculations, consults and assists on cost report interpretations, and meets with providers to resolve discrepancies. Prior to the passage of HB 09-1293, the Department did not perform such audits for providers participating in the Colorado Indigent Care Program. However, due to HB 09-1293, reimbursements for providers participating in the program are to be increased to 100% of cost, requiring similar audits to be conducted for the Colorado Indigent Care Program providers.

Through this budget item, the Department will utilize two types of audits to ensure proper payment of hospital fee funds to Colorado Indigent Care Program providers. The first are desk audits to: analyze cost reports to determine the accuracy and reasonableness of financial data reported by providers; identify problem areas that warrant additional review; and, obtain information for use in planning a site audit if deemed necessary. Second are on-site audits that will focus on specific payment issues that are potentially material in nature and a more detailed verification of data than the desk audit. Based on hospital audits currently conducted, costs for this function are $500,000 total funds annually. Due to the implementation plan for HB 09-1293, the Department was appropriated $250,000 total funds for this activity in FY 2009-10; however, those funds were not expended. For 2010-11, the Department was appropriated $500,000 total funds, with 50% cash funds from the Hospital Provider Fee Cash Fund and 50% from federal funds. The Department requests continuation funding of $500,000 for FY 2011-12.

DISPROPORTIONATE SHARE HOSPITAL AUDITS

This new budget item provides funding for Disproportionate Share Hospital (DSH) audits as a result of DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures" (November 2, 2009 FY 2010-11 Budget Request). This funding is for a contractor that is responsible for auditing the Department's DSH expenditures on an annual basis, pursuant to reporting requirements mandated by the federal Centers for Medicare and Medicaid Services (CMS) in rule (CMS-2198-F). This rule, which went into effect on January 19, 2009, institutes new auditing requirements that will clarify allowable expenditures under the DSH program and help the Department prevent improper expenditure of DSH funds. The rule also requires states to submit an independent certified audit of their DSH expenditures on an annual basis to CMS, while specifying the data elements that need to be included in each submission.

DSH payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients. These payments assist in securing the hospitals' financial viability and preserving access to care for Medicaid and low-income clients,

while reducing the shift in costs to private payers. Within Colorado's DSH allotment, three payments are currently authorized: low income, bad debt, and Medicaid shortfall payments. For more information regarding these types of payments, please see the Safety Net Provider Payments section of this document.

The CMS regulations require that the Department submit an independent certified audit of DSH expenditures by December 2011 for FY 2004-05 and FY 2005-06. The Department will hire a contractor and anticipates it will submit the required information to CMS by the deadline.

The FY 2010-11 Long Bill, HB 10-1376, appropriated $100,000 total funds to this budget item, and the Department requests continuation funding of the same amount for FY 2011-12.

## ***(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS***

### ESTATE RECOVERY

The estate recovery program, authorized in 25.5-4-302, C.R.S. (2010) 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 through FY 2010-11, the Department's appropriation for estate recovery was $700,000 total funds. In FY 2009-10, the Department recovered $3,682,865 in estate recoveries and liens of which $401,432 was paid in contingency fee; net recoveries totaled $3,281,433. This amount represents only a marginal increase over the previous fiscal year; the Department saw growth in estate recoveries and liens to the amount of $184,384 over FY 2008-09. 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.

For FY 2011-12, the Department requests continuation funding of $700,000 for this line item.

## *(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. In June 2010, the Department was directed, by the Governor's Office of State Planning and Budgeting and the State Controller, to withhold payments to Medicaid providers for the final two weeks of FY 2009-10. The Department subsequently released payments in the first week of July 2010. As a result of the payment delay, actuals for FY 2009-10 are understated when compared to prior fiscal years. Further, this creates difficulties from a forecasting perspective, as cash-based actuals do not reflect similar periods.

   To account for the delayed payments, the Department has taken the following steps:
   - Additional pages showing the effect of the delay are included in Exhibit C, Exhibit M, and Exhibit N.
   - In all cases, the Department's forecasts are based on the delay-adjusted cash-based actuals. As a result, the Department consistently forecasts a 52-week period in Exhibits F, G, H, and I.

   This request does not account for the FY 2010-11 payment of the delayed claims. The Department has used separate change requests to account for the impact of the delay.

2. As a result of recent federal legislation, the Department has submitted an early supplemental request on August 23, 2010 to account for the extension of the American Recovery and Reinvestment Act (ARRA) and the phase down in the federal medical assistance percentage over the second half of FY 2010-11. The Department anticipates that FMAP will be, on average, 59.71% for FY 2010-11. The Department incorporates this FMAP figure throughout all exhibits where appropriate.

   To prevent double counting with the Department's early supplemental request, the Department has calculated its official request net of the early supplemental request. In effect, the Department treats the early supplemental request as if it was included in its

spending authority. This methodology prevents double counting of the early supplemental request and this request. The totals shown in Exhibit A, page EA-1, reflect the correct incremental request when the early supplemental is taken into account.

3. At the direction of the Office of State Planning and Budgeting, the Department is requesting to draw additional Hospital Provider fee for budget balancing purposes in the Medical Services Premiums base. In FY 2011-12, the Department would collect an additional $50,000,000 in provider fee, which would leave the aggregate net benefit to all hospitals at approximately the same level as FY 2010-11. In FY 2012-13 forward, the Department would collect an additional $25,000,000 increased by an inflationary factor to be determined based on growth in hospital revenue, which will allow the net benefit to all hospitals to increase from the FY 2011-12 level. This financing mechanism will require legislation.

4. The Department's request includes a number of references to various budget reduction items and early supplemental budget reductions. Effective July 1, 2009, September 1, 2009, December 1, 2009, and again on July 1, 2010, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding.

5. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom line impacts. Bottom line impacts can be found by service category (e.g. Acute Care, Community Based Long Term Care, Long Term Care, Insurance, etc.) in the respective sections of this request. Those bottom line impacts include the identification number of the originally submitted request, so that the bottom line impact in the current year may be traced to that originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom line impacts.

6. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information, and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J.

7. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations which gain eligibility as a result of HB 09-1293. This includes continuous eligibility for eligible children and foster care clients, and the implementation of the Disabled Buy-In program in FY 2011-12. These expansions increase Medicaid caseload, and are discussed further in Sections II and III of this narrative.

8. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for

administration and case management are included in Exhibit I. For further information, see the Department's FY 2009-10 request S-6, "Accountable Care Collaborative".

9. The Department's request includes revisions to SB 10-169, which allowed the Department to use certain funds from the Hospital Provider Fee Cash fund to pay for Medicaid services in FY 2009-10 and FY 2010-11.

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 ("the Department") 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, the 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 together clients with similar characteristics and costs. 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 (OSPB). The Department then meets with OSPB, 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 OSPB.

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 (MMIS) 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 10 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 MMIS 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.

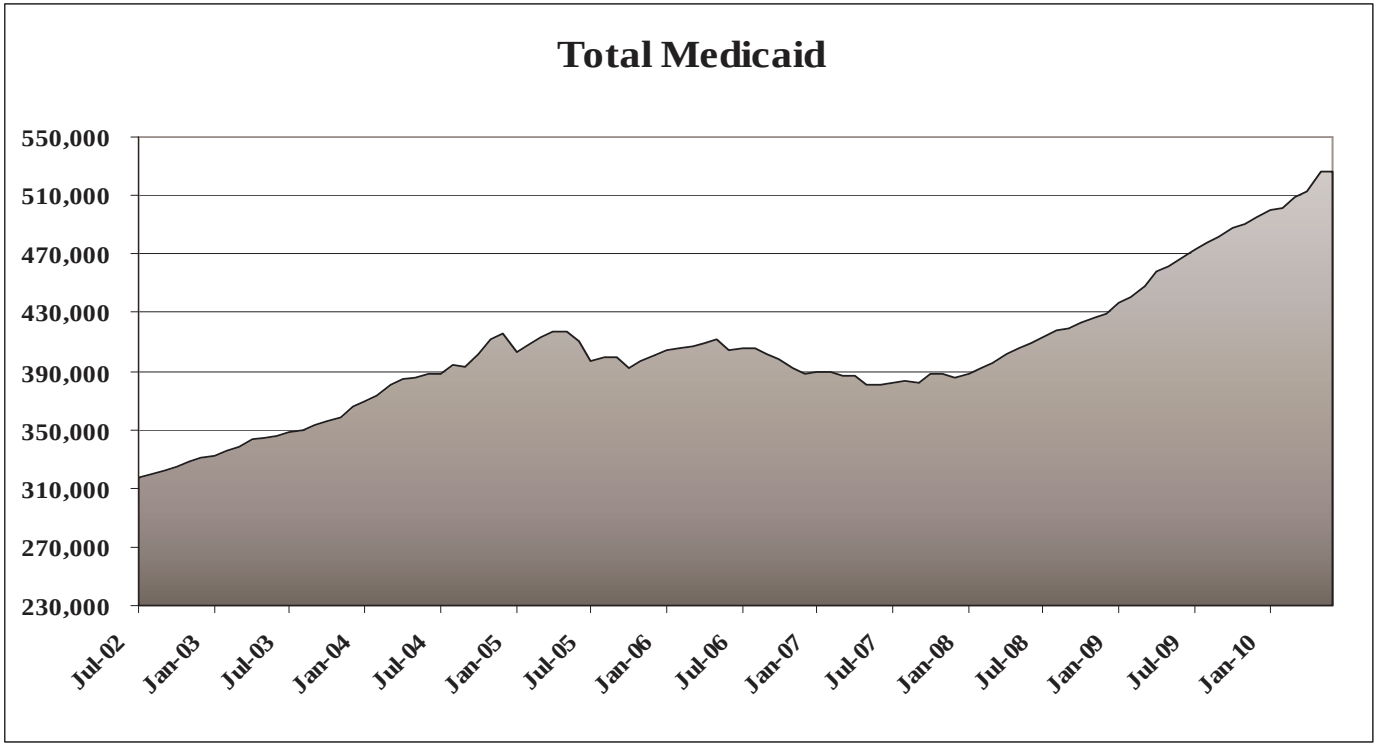
The Department has developed a new caseload report that it believes measures caseload more accurately: the REX01/COLD (MARS) R-474701. This report captures eligibility movements for the entire month in question and also stores the data table that underlies the report. As a result, the Department is able 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.

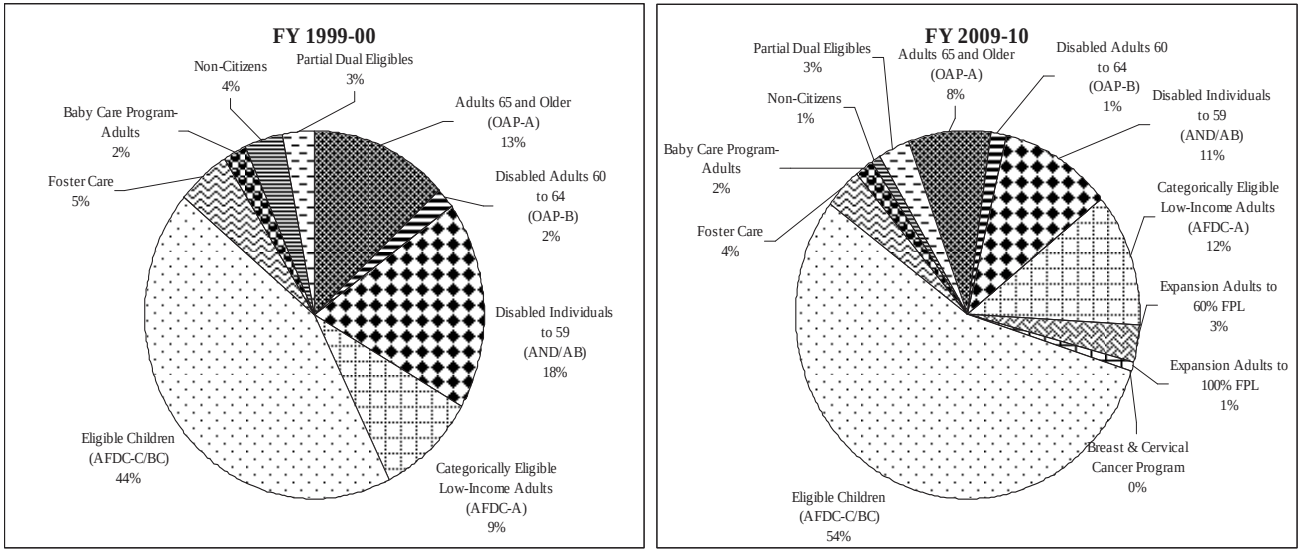
| Fiscal Year | Medical Services Premiums Caseload | Less: Mental Health Ineligible Categories | Mental Health Caseload |
|---|---|---|---|
| FY 2002-03 | 331,800 | (13,072) | 318,728 |
| FY 2003-04 | 367,559 | (14,635) | 352,924 |
| FY 2004-05 | 406,024 | (14,755) | 391,269 |
| FY 2005-06 | 402,218 | (17,304) | 384,914 |
| FY 2006-07 | 392,228 | (18,109) | 374,119 |
| FY 2007-08 | 391,962 | (18,405) | 373,557 |
| FY 2008-09 | 436,812 | (19,062) | 417,750 |
| FY 2009-10 | 498,797 | (19,612) | 479,185 |

**Recent Caseload History**

Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 1995-96 to FY 2009-10. Projections for FY 2010-11 to FY 2012-13 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 weak economy, caseload continued to grow at an increasing rate, resulting in annual growth of 11.44% in FY 2008-09 and 14.19% in FY 2009-10. Reasons for these recent growth rates will be discussed below.

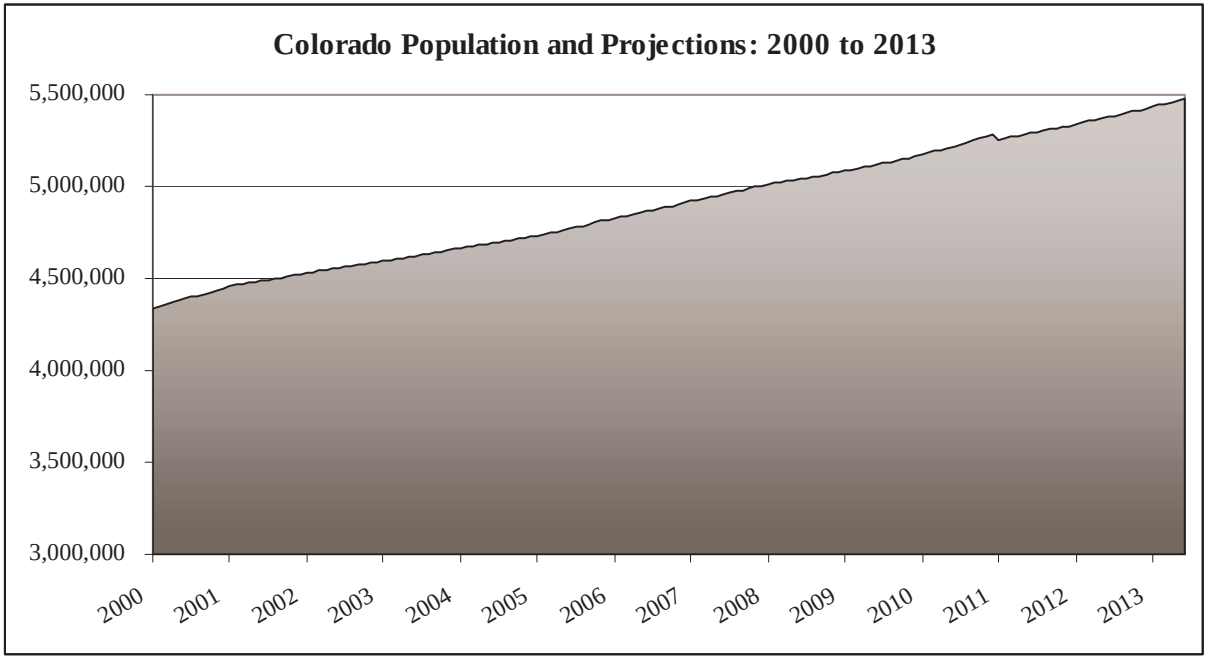



The charts below show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 1999-00 and FY 2009-10. As a percentage of the entire Medicaid caseload, Eligible Children have increased by 10 percentage points, the largest gain when compared with all other categories. The percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined by approximately seven 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 10 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 19.20% from July of 2000 to July of 2010. The Department of Local Affairs forecasts that Colorado's population will increase a further 5.05% from July of 2010 to July of 2013. 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.

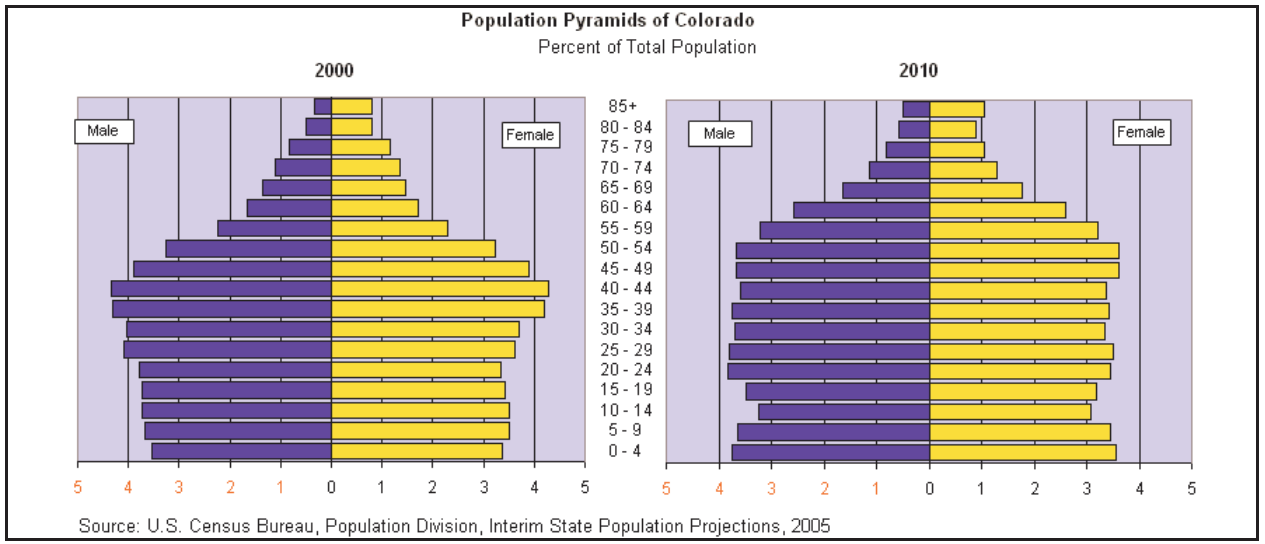



When using population data to project caseload, the Department marries population subgroups to their appropriate Medicaid category. For example, when projecting caseload for Eligible Children, the Department uses population statistics for Colorado residents aged 0 to 18. By using subgroups instead of 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, overtaking 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.

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

*Age* - The age of the population can provide some insight as to why Medicaid caseloads have been increasing. As the population ages, so too does the demand for medical care. Generally, as individuals age, their health becomes more fragile and the more likely they are to seek health care. From 2000 to 2010, Colorado's median age increased by 1.7 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] 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 2009, 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 some of 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 2009-10 indicate that the average length of stay for low-income children increased for the second year in a row, which is consistent with economic conditions and enrollment and retention initiatives under the Ritter administration. While the average length of stay for low-income adults declined in FY 2009-10, this is solely due to the implementation of the expansion to 100% of the federal poverty level in May 2009, which artificially reduced the average number of months of enrollment as these clients were eligible for only two months. Excluding these clients, the Department estimates that the average length of stay for low-income adults was approximately 7.91 months.

| **Average Number of Months on Medicaid** | | |
|---|---|---|
| **Fiscal Year** | **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 |
| FY 2009-10 | 7.63 | 9.01 |

*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 30 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 December 2009, the over-the-year loss was estimated to be 86,600, or 3.7%. The employment declines accelerated through the downturn; for example, the over-the-year contraction in January 2009 was 43,000, or 1.8%. The annual contractions appear to have peaked in September

2009, when job losses numbered 113,800 (4.8%) over the year. Current economic forecasts project declines in employment through 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 |
|---|---|---|---|---|
| 2003 | $88.0 | 2,152,800 | -1.4% | 6.1% |
| 2004 | $92.1 | 2,179,600 | 1.2% | 5.6% |
| 2005 | $98.9 | 2,226,000 | 2.1% | 5.1% |
| 2006 | $105.8 | 2,279,100 | 2.4% | 4.4% |
| 2007 | $112.6 | 2,331,300 | 2.3% | 3.9% |
| 2008 | $116.6 | 2,350,300 | 0.8% | 4.9% |
| 2009 | $112.6 | 2,244,200 | -4.5% | 7.3% |
| 2010 | $113.0 | 2,207,000 | -1.7% | 7.9% |
| 2011 | $118.3 | 2,235,000 | 1.3% | 7.7% |

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, provided that the proper income reporting requirements are followed. 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

[5] Source: Office of State Planning and Budgeting, September 2010 Revenue Forecast
[6] Projecting elderly and disabled client populations does not prioritize economic variables

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 and FY 2009-10.

The Department implemented two changes that affected Transitional Medicaid in FY 2009-10. First, section 5004 of the American Recovery and Reinvestment Act of 2009 (ARRA) extended Transitional Medicaid through December 31, 2010. Also included in ARRA were options for states to modify eligibility for Transitional Medicaid, including waiving the requirement that the family was eligible for Medicaid in at least three of the preceding six months and extending families' eligibility to 12 months, rather than six months followed by a second six-month period that is dependant upon reporting, income, and technical eligibility requirements. Colorado elected the option to provide 12 months of Transitional Medicaid coverage, which is anticipated to be effective October 1, 2010. Finding #58a of the State of Colorado Statewide Single Audit for the Fiscal Year ending June 30, 2009 stated that the Department should address an issue in the Colorado Benefits Management System that prevented the prompt termination of Transitional Medicaid benefits if the proper reporting, income, and technical eligibility requirements were not met. The Department's response indicated that it was researching whether it would be more efficient for both county eligibility staff and clients, as well as from a fiscal standpoint, to grant 12 months of Transitional Medicaid eligibility with no reporting requirements. The Department determined that this was indeed the case and decided in May 2010 to go forward with this option. Second, when the Department implemented the eligibility expansion for Medicaid Parents to 100% of the federal poverty level, the Department made modifications to the Colorado Benefits Management System to increase eligibility for all Family Medicaid clients to 100% of the federal poverty level. Previously, the Expansion Adults to 60% of the federal poverty level (FPL) group had its own eligibility requirements within Family Medicaid, which the Centers for Medicare and Medicaid Services indicated to the Department was incorrect. This change leads to income eligibility for Transitional Medicaid spanning 101-185% FPL, rather than the Aid to Families with Dependant Children (AFDC) level, which currently approximates 29% FPL, through 185% of the federal poverty level. This change will result in a lower Transitional Medicaid caseload beginning in May 2010.

| 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 |
| FY 2009-10 | 13,582 | 8,099 |

*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 Disabled Individuals to 59, Eligible Children, and Foster Care forecasts to account for the approval of HB 09-1293, Colorado Health Care Affordability Act. This legislation establishes the Medicaid Buy-In Program for Individuals with Disabilities in July 2011. 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 effective February 2012. 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 Medicaid in FY 2008-09, with average monthly growth increasing at an increasing rate throughout the year, resulting in annual growth

of 11.4%. Similarly, strong monthly increases continued in FY 2009-10, though the magnitude of the growth moderated over the course of the year, resulting on annual growth of 14.2%. Given the recent trends and projected economic conditions, the Department is forecasting Medicaid caseload to increase by 10.6% in FY 2010-11 to 551,570. Base caseload is anticipated to continue growing at a decreasing rate through the forecast period, but large caseload increases are anticipated due to expansions from the Colorado Health Care Affordability Act. In FY 2011-12, the trend is projected to be 10.6%, and caseload is forecasted to reach 610,025. The Colorado Health Care Affordability Act expansions are a large factor in this projected growth rate, accounting for 25,422 of the projected 58,455 caseload increase in FY 2011-12. The following table shows actual and projected aggregate Medicaid caseload from FY 2003-04 through FY 2012-13.

| Fiscal Year | Medicaid Caseload | Growth Rate | Level Growth |
|---|---|---|---|
| FY 2003-04 | 367,559 | 10.78% | 35,759 |
| FY 2004-05 | 406,024 | 10.46% | 38,465 |
| FY 2005-06 | 402,218 | -0.94% | -3,806 |
| FY 2006-07 | 392,228 | -2.48% | -9,990 |
| FY 2007-08 | 391,962 | -0.07% | -266 |
| FY 2008-09 | 436,812 | 11.44% | 44,850 |
| FY 2009-10 | 498,797 | 14.19% | 61,985 |
| FY 2010-11 Projection | 551,570 | 10.58% | 52,773 |
| FY 2011-12 Projection | 610,025 | 10.60% | 58,455 |
| FY 2012-13 Projection | 675,938 | 10.80% | 65,913 |

**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 December 2009 and historical and forecasted economic and demographic data that were revised in December 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 30 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 2010, 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.

The Department uses the June forecasts for variables because caseload estimates must be completed before September in order to calculate the November 1 request.

**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, statistical models can not be applied and the estimate is based on the growth experienced since FY 2006-07.

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

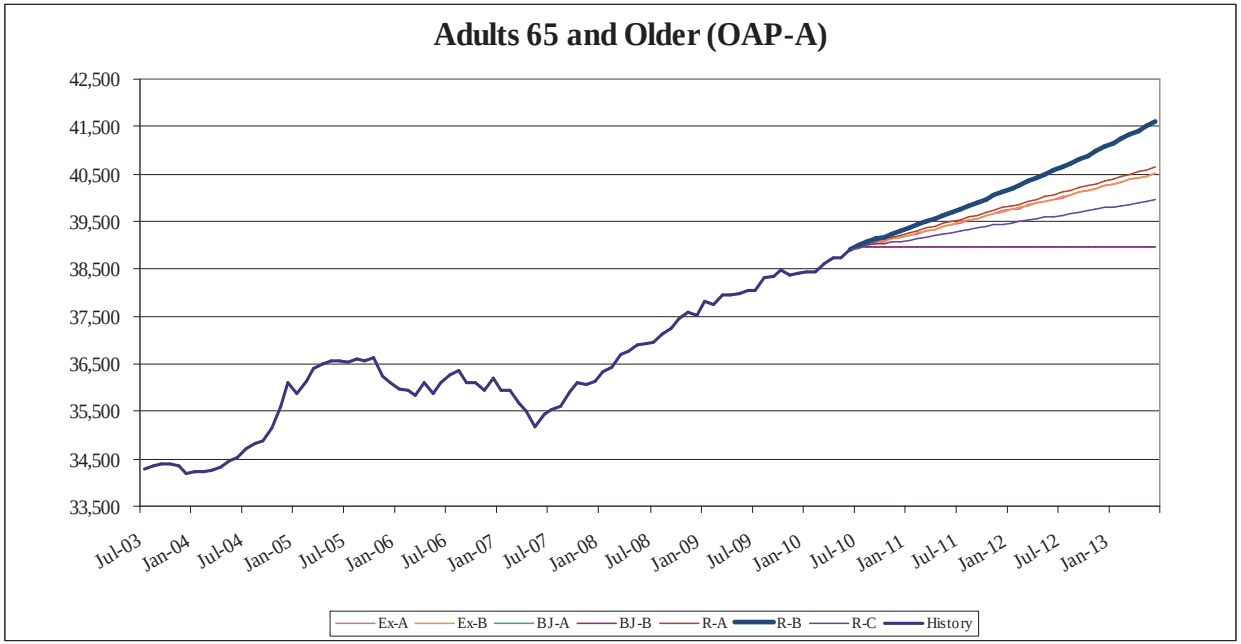
## CATEGORICAL PROJECTIONS

This section details the caseload projections by eligibility category. For each category, the following are presented: a discussion of the category, model results, rationale for the forecast, statutory authority, and historical caseload and forecasts. FY 2012-13 projections are included for informational purposes. Graphical representations of caseload history to FY 2003-04 are included in each categorical section.

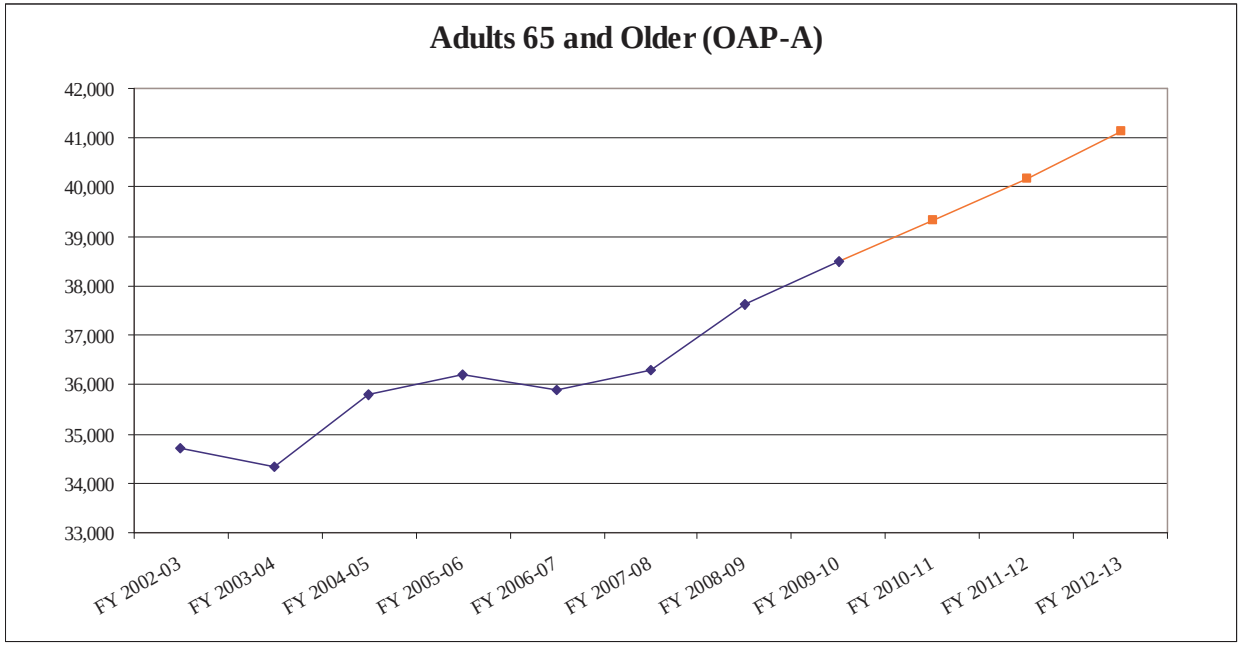
**Adults 65 and Older**

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 greater than half of the enrollees in the Home and Community Based Services, Elderly, Blind, and Disabled waiver program.

***Adults 65 and Older: Model Results***




| **Adults 65 and Older: Model Statistics** | Adjusted $R^2$ | Notes |
|---|---|---|
| Exponential Smoothing A* | 0.9958 | |
| Exponential Smoothing B | 0.9849 | |
| Box-Jenkins A | 0.9960 | |
| Box-Jenkins B* | 0.9855 | |
| Regression A | 0.9965 | OAP-A [-1], OAP-A [-2], CBMS Dummy |
| Regression B | 0.9971 | OAP-A [-1], Population 65+, CBMS Dummy, CBMS Dummy [-1], Auto [-1], Auto [-9] |
| Regression C | 0.9958 | OAP-A [-1], Total Population, CBMS Dummy, Trend, Auto [-11] |




| Adults 65 and Older: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 37,619 | 38,487 | 1.84% | 39,195 | 708 | 45 |
| Exponential Smoothing B | 37,619 | 38,487 | 1.84% | 39,195 | 708 | 45 |
| Box Jenkins A* | 37,619 | 38,487 | 1.27% | 38,976 | 489 | 7 |
| Box Jenkins B* | 37,619 | 38,487 | 1.25% | 38,968 | 481 | 6 |
| Regression A | 37,619 | 38,487 | 1.96% | 39,241 | 754 | 50 |
| **Regression B** | **37,619** | **38,487** | **2.23%** | **39,345** | **858** | **67** |
| Regression C | 37,619 | 38,487 | 1.61% | 39,107 | 620 | 31 |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A | 38,487 | 39,345 | 1.37% | 39,884 | 539 | 45 |
| Exponential Smoothing B | 38,487 | 39,345 | 1.37% | 39,884 | 539 | 45 |
| Box Jenkins A* | 38,487 | 39,345 | 0.01% | 39,349 | 4 | 0 |
| Box Jenkins B* | 38,487 | 39,345 | 0.00% | 39,345 | 0 | 0 |
| Regression A | 38,487 | 39,345 | 1.44% | 39,912 | 567 | 47 |
| **Regression B** | **38,487** | **39,345** | **2.08%** | **40,163** | **818** | **73** |
| Regression C | 38,487 | 39,345 | 0.91% | 39,703 | 358 | 28 |

| Adults 65 and Older: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 39,345 | 40,163 | 1.35% | 40,705 | 542 | 45 |
| Exponential Smoothing B | 39,345 | 40,163 | 1.35% | 40,705 | 542 | 45 |
| Box Jenkins A* | 39,345 | 40,163 | 0.00% | 40,163 | 0 | 0 |
| Box Jenkins B* | 39,345 | 40,163 | 0.00% | 40,163 | 0 | 0 |
| Regression A | 39,345 | 40,163 | 1.44% | 40,741 | 578 | 48 |
| **Regression B** | **39,345** | **40,163** | **2.38%** | **41,119** | **956** | **86** |
| Regression C | 39,345 | 40,163 | 0.85% | 40,504 | 341 | 29 |

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

***Adults 65 and Older: Trend Selections***

FY 2010-11: 2.23%
FY 2011-12: 2.08%
FY 2012-13: 2.38%

***Adults 65 and Older: Justifications***

- This population will be affected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in 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 2009-10 indicate that approximately 30.7% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (Source: MARS 474701 report). Additionally, 85.7% of this population were eligible for both Medicaid and Medicare (dual eligible) in FY 2009-10.
- This population may be affected by provisions in the Deficit Reduction Act of 2005, notably sections 6011 (lengthening of look-back period), 6012 (treatment of annuities), 6014 (disqualification of individuals with substantial home equity), 6015 (reform of asset test rules). These provisions may decrease the long-term growth rates as fewer people may now be eligible due to these provisions.
- The graph above shows that historically, this population has had relatively flat growth, though monthly growth 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 96 between FY 2007-08 and FY 2009-10. 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 three 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 2009-10 was in line with the Department's February 2010 forecast, in which the annual caseload was projected to be 38,496 and average monthly growth was projected to be 62. The selected trend for FY 2010-11 is slightly higher than that from the Department's February 2010 forecast, and would result in average growth of **67 per month**.
- 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. Population growth in this age group is projected to overtake that of the 60-64 group in 2012 to become the fastest growing age group.

*25.5-5-101 (1), C.R.S. (2010)*
*(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. (2010)*
*(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-08 | 36,932 | - | - |
| 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% |
| Jul-09 | 38,058 | 14 | 0.04% |
| Aug-09 | 38,306 | 248 | 0.65% |
| Sep-09 | 38,346 | 40 | 0.10% |
| Oct-09 | 38,480 | 134 | 0.35% |
| Nov-09 | 38,387 | (93) | -0.24% |
| Dec-09 | 38,410 | 23 | 0.06% |
| Jan-10 | 38,452 | 42 | 0.11% |
| Feb-10 | 38,432 | (20) | -0.05% |
| Mar-10 | 38,597 | 165 | 0.43% |
| Apr-10 | 38,727 | 130 | 0.34% |
| May-10 | 38,754 | 27 | 0.07% |
| Jun-10 | 38,900 | 146 | 0.38% |

| | **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 | 38,487 | 2.31% | 868 |
| FY 2010-11 | 39,345 | 2.23% | 858 |
| FY 2011-12 | 40,163 | 2.08% | 818 |
| FY 2012-13 | 41,119 | 2.38% | 956 |

* 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 | 82 | 0.21% |
| 12-month average | 71 | 0.19% |
| 18-month average | 76 | 0.20% |
| 24-month average | 82 | 0.22% |

| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 38,900 | 1.07% | 413 |

| February 2010 Trends | | | |
|---|---|---|---|
| FY 2009-10 | 38,496 | 2.33% | 877 |
| FY 2010-11 | 39,162 | 1.73% | 666 |
| FY 2011-12 | 39,914 | 1.92% | 752 |

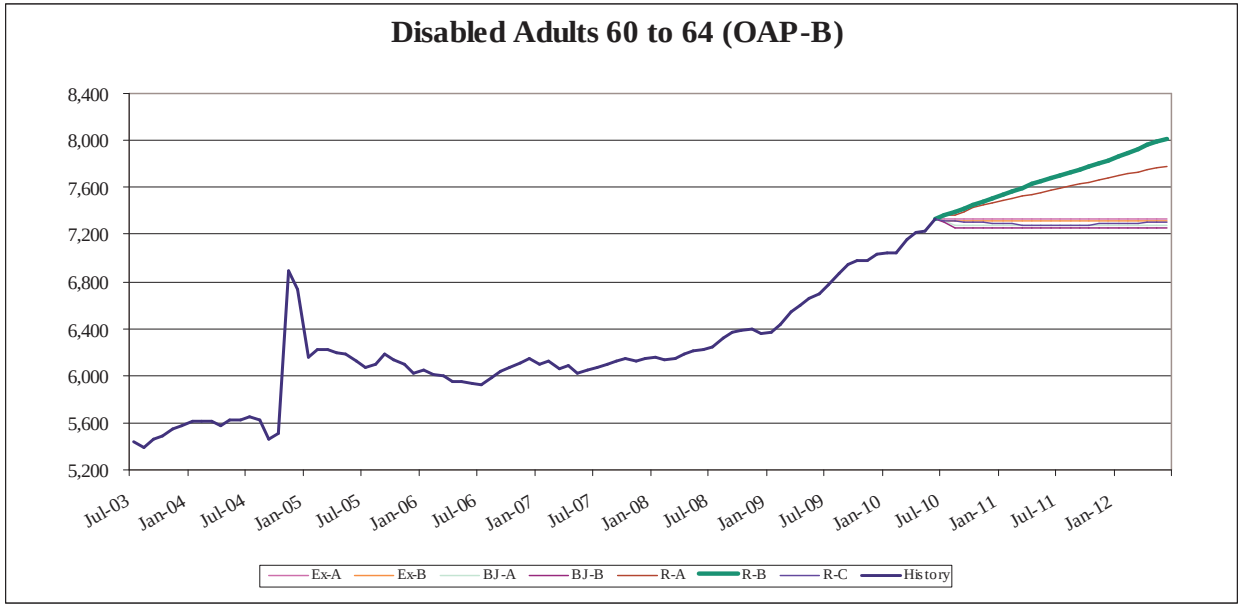
| Monthly Average Growth Comparisons | | |
|---|---|---|
| FY 2009-10 1st Half | 61 | 0.16% |
| FY 2009-10 2nd Half | 82 | 0.21% |
| February 2010 Forecast | 62 | 0.16% |
| FY 2010-11 Forecast | 67 | 0.17% |
| February 2010 Forecast | 59 | 0.15% |
| FY 2011-12 Forecast | 73 | 0.18% |
| February 2010 Forecast | 66 | 0.17% |

**Disabled Adults 60 to 64**

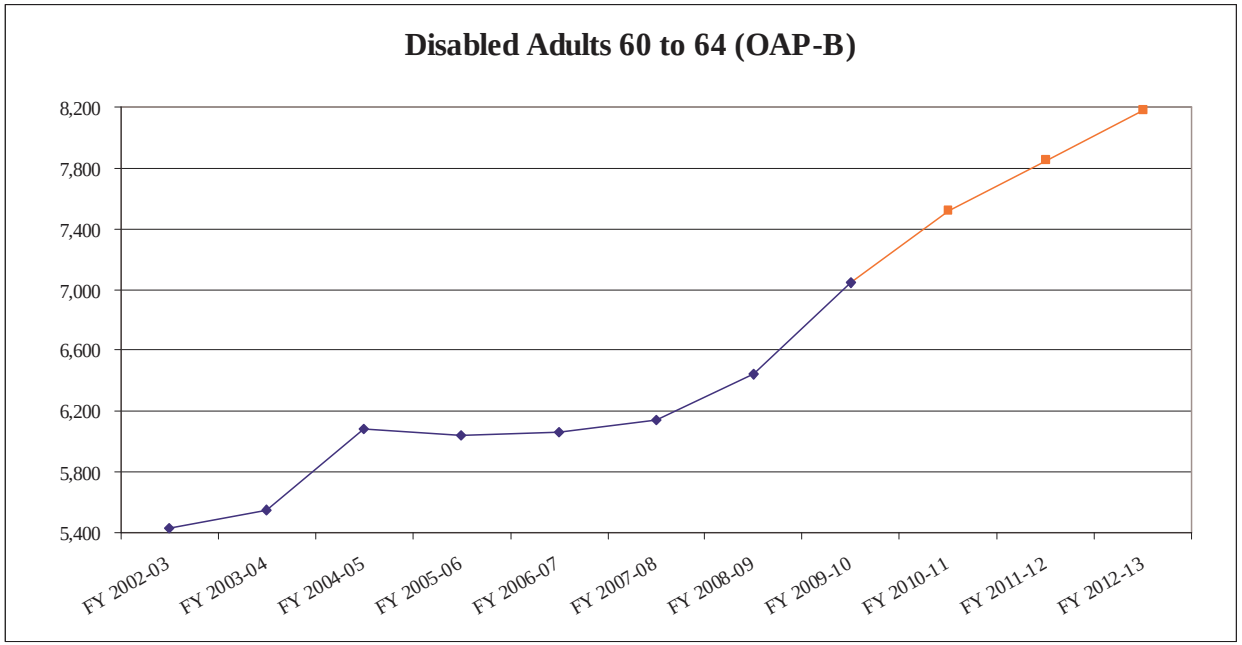
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual 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* | 0.9795 | |
| Exponential Smoothing B* | 0.9094 | |
| Box-Jenkins A | 0.9821 | |
| Box-Jenkins B | 0.9295 | |
| Regression A | 0.9966 | OAP-B [-1], OAP-B [-3], CBMS Dummy, Auto [-4] |
| Regression B | 0.9960 | OAP-B [-1], Population 60-64, CBMS Dummy, CBMS Dummy [-1], Trend |
| Regression C | 0.9972 | OAP-B [-1], OAP-B [-2], Total Population, CBMS Dummy, CBMS Dummy [-2], Constant |




| **Disabled Adults 60 to 64: Model Results** | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 6,447 | 7,049 | 4.04% | 7,334 | 285 | 1 |
| Exponential Smoothing B* | 6,447 | 7,049 | 3.77% | 7,315 | 266 | (1) |
| Box Jenkins A | 6,447 | 7,049 | 3.29% | 7,281 | 232 | (4) |
| Box Jenkins B | 6,447 | 7,049 | 2.98% | 7,259 | 210 | (6) |
| Regression A | 6,447 | 7,049 | 6.02% | 7,473 | 424 | 21 |
| **Regression B** | **6,447** | **7,049** | **6.70%** | **7,521** | **472** | **29** |
| Regression C | 6,447 | 7,049 | 3.50% | 7,296 | 247 | (4) |

* Denotes Expert Selection, Bold denotes Trend Selection

| Disabled Adults 60 to 64: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 7,049 | 7,521 | 0.00% | 7,521 | 0 | 0 |
| Exponential Smoothing B* | 7,049 | 7,521 | 0.00% | 7,521 | 0 | 0 |
| Box Jenkins A | 7,049 | 7,521 | -0.05% | 7,517 | (4) | 0 |
| Box Jenkins B | 7,049 | 7,521 | -0.06% | 7,516 | (5) | 0 |
| Regression A | 7,049 | 7,521 | 2.88% | 7,738 | 217 | 17 |
| **Regression B** | **7,049** | **7,521** | **4.41%** | **7,853** | **332** | **29** |
| Regression C | 7,049 | 7,521 | -0.05% | 7,517 | (4) | 2 |

| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A* | 7,521 | 7,853 | 0.00% | 7,853 | 0 | 0 |
| Exponential Smoothing B* | 7,521 | 7,853 | 0.00% | 7,853 | 0 | 0 |
| Box Jenkins A | 7,521 | 7,853 | 0.00% | 7,853 | 0 | 0 |
| Box Jenkins B | 7,521 | 7,853 | 0.00% | 7,853 | 0 | 0 |
| Regression A | 7,521 | 7,853 | 2.71% | 8,066 | 213 | 18 |
| **Regression B** | **7,521** | **7,853** | **4.13%** | **8,177** | **324** | **23** |
| Regression C | 7,521 | 7,853 | 0.58% | 7,899 | 46 | 5 |

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

### *Disabled Adults 60 to 64: Trend Selections*

FY 2010-11: 6.70%
FY 2011-12: 4.41%
FY 2012-13: 4.13%

### *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 began to be affected by the baby-boom generation, defined by the U.S. Census Bureau as the generation born between 1946 and 1964, 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 three 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. Data for FY 2009-10 indicate that approximately 53.4% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (Source: MARS 474701 report), compared with 30.7% of OAP-A. Additionally, 43.9% of this population were dual eligibles in FY 2009-10.
- Growth in FY 2009-10 was higher than the Department's February 2010 forecast, in which the annual caseload was projected to be 7,036 and average monthly growth was projected to be 44. The selected trend for FY 2010-11 is higher than that from the February 2010 forecast, and would yield average growth of **31 per month**. The high forecasted annual growth rate for FY 2010-11 is partially due to the strong increases at the end of FY 2009-10, which leaves caseload at a high starting point for FY 2010-11, and is also reflective of the high trend in monthly growth from the last three 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 5.6% per year over the forecast period.

*25.5-5-101 (1), C.R.S. (2010)*
*(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. (2010)*
*(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-08 | 6,227 | - | - |
| 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% |
| Jul-09 | 6,774 | 83 | 1.24% |
| Aug-09 | 6,863 | 89 | 1.31% |
| Sep-09 | 6,945 | 82 | 1.19% |
| Oct-09 | 6,985 | 40 | 0.58% |
| Nov-09 | 6,986 | 1 | 0.01% |
| Dec-09 | 7,025 | 39 | 0.56% |
| Jan-10 | 7,047 | 22 | 0.31% |
| Feb-10 | 7,049 | 2 | 0.03% |
| Mar-10 | 7,152 | 103 | 1.46% |
| Apr-10 | 7,212 | 60 | 0.84% |
| May-10 | 7,228 | 16 | 0.22% |
| Jun-10 | 7,326 | 98 | 1.36% |

| | **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 | 7,049 | 9.34% | 602 |
| FY 2010-11 | 7,521 | 6.70% | 472 |
| FY 2011-12 | 7,853 | 4.41% | 332 |
| FY 2012-13 | 8,177 | 4.13% | 324 |

* 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 2010 Trends** | | | |
|---|---|---|---|
| FY 2009-10 | 7,036 | 9.14% | 589 |
| FY 2010-11 | 7,424 | 5.51% | 388 |
| FY 2011-12 | 7,771 | 4.67% | 347 |

| **Actuals** | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 50 | 0.70% |
| 12-month average | 53 | 0.76% |
| 18-month average | 54 | 0.79% |
| 24-month average | 46 | 0.68% |

| **Monthly Average Growth Comparisons** | | |
|---|---|---|
| FY 2009-10 1st Half | 56 | 0.82% |
| FY 2009-10 2nd Half | 50 | 0.70% |
| February 2010 Forecast | 44 | 0.66% |
| FY 2010-11 Forecast | 29 | 0.40% |
| February 2010 Forecast | 31 | 0.43% |
| FY 2011-12 Forecast | 29 | 0.38% |
| February 2010 Forecast | 29 | 0.40% |

| **Base trend from June 2010 level** | | | |
|---|---|---|---|
| FY 2010-11 | 7,326 | 3.93% | 277 |

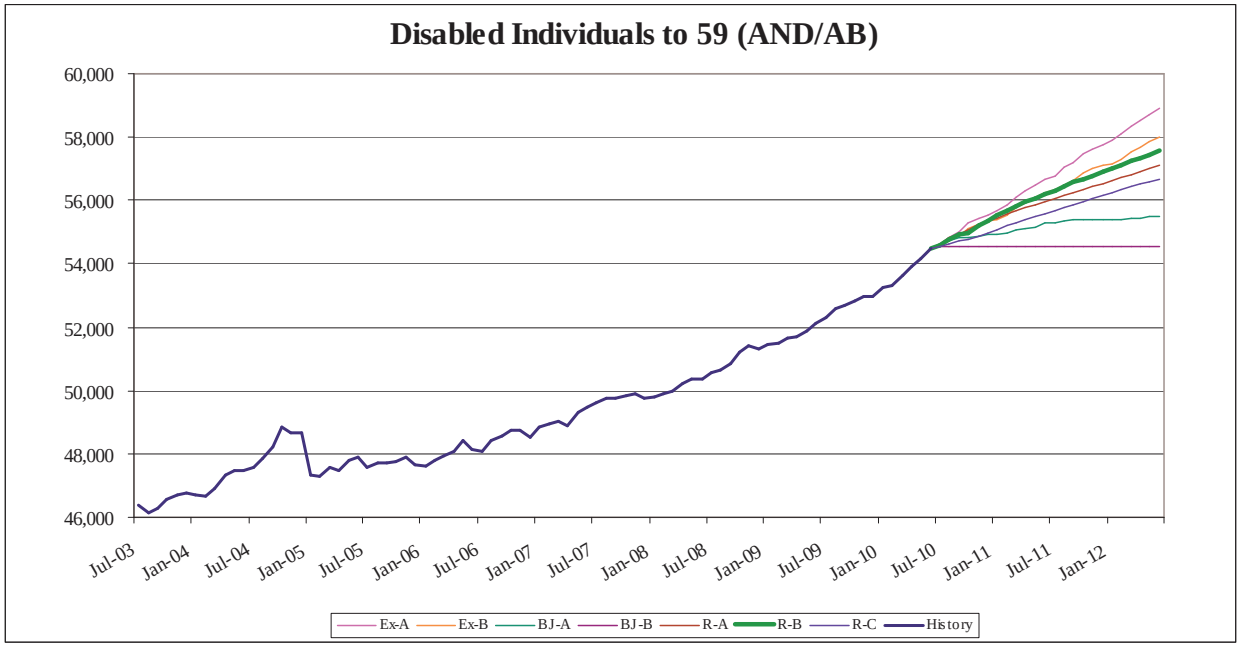
**Disabled Individuals to 59**

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.

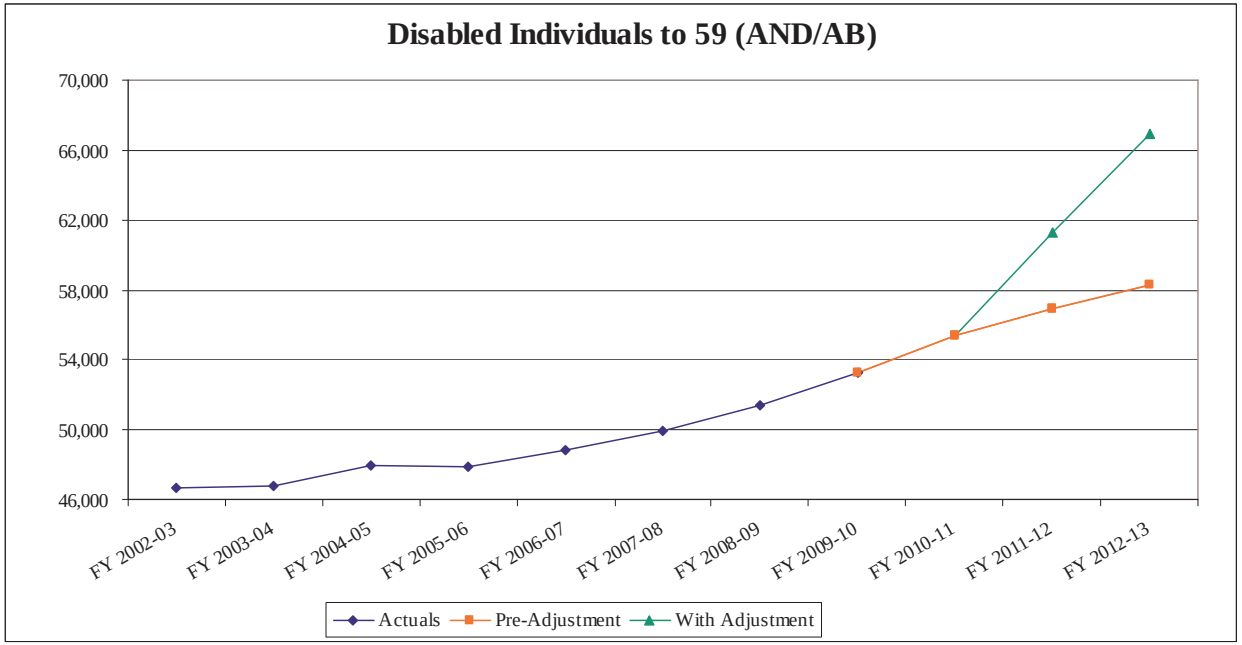
The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults. Zebley required that children's disability be measured using child-appropriate activities. As a result, the number of children determined to be disabled significantly 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* | 0.9951 | |
| Exponential Smoothing B | 0.9870 | |
| Box-Jenkins A | 0.9947 | |
| Box-Jenkins B* | 0.9853 | |
| Regression A | 0.9935 | AND/AB [-1], AND/AB [-3], Auto [-5] |
| Regression B | 0.9931 | AND/AB [-1], AND/AB [-9], Migration, Auto [-4] |
| Regression C | 0.9909 | AND/AB [-1], AND/AB [-24], Auto [-4] |




| Disabled Individuals to 59: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 51,355 | 53,264 | 4.49% | 55,656 | 2,392 | 183 |
| Exponential Smoothing B* | 51,355 | 53,264 | 4.02% | 55,405 | 2,141 | 146 |
| Box Jenkins A | 51,355 | 53,264 | 3.15% | 54,942 | 1,678 | 67 |
| Box Jenkins B | 51,355 | 53,264 | 2.40% | 54,542 | 1,278 | 4 |
| Regression A | 51,355 | 53,264 | 3.95% | 55,368 | 2,104 | 123 |
| **Regression B** | **51,355** | **53,264** | **4.04%** | **55,416** | **2,152** | **141** |
| Regression C | 51,355 | 53,264 | 3.36% | 55,054 | 1,790 | 92 |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A* | 53,264 | 55,416 | 3.97% | 57,616 | 2,200 | 184 |
| Exponential Smoothing B* | 53,264 | 55,416 | 3.17% | 57,173 | 1,757 | 146 |
| Box Jenkins A | 53,264 | 55,416 | 0.86% | 55,893 | 477 | 18 |
| Box Jenkins B | 53,264 | 55,416 | 0.00% | 55,416 | 0 | 0 |
| Regression A | 53,264 | 55,416 | 2.22% | 56,646 | 1,230 | 96 |
| **Regression B** | **53,264** | **55,416** | **2.77%** | **56,951** | **1,535** | **115** |
| Regression C | 53,264 | 55,416 | 2.10% | 56,580 | 1,164 | 90 |

| Disabled Individuals to 59: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 55,416 | 56,951 | 3.82% | 59,127 | 2,176 | 184 |
| Exponential Smoothing B* | 55,416 | 56,951 | 3.07% | 58,699 | 1,748 | 146 |
| Box Jenkins A | 55,416 | 56,951 | 0.23% | 57,082 | 131 | 5 |
| Box Jenkins B | 55,416 | 56,951 | 0.00% | 56,951 | 0 | 0 |
| Regression A | 55,416 | 56,951 | 2.04% | 58,113 | 1,162 | 97 |
| **Regression B** | **55,416** | **56,951** | **2.32%** | **58,272** | **1,321** | **108** |
| Regression C | 55,416 | 56,951 | 1.72% | 57,931 | 980 | 75 |

[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 2010-11: 4.04%
FY 2011-12: 2.77%
FY 2012-13: 2.32%

***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 2009-10, approximately 67.6% of this population received Supplemental Security Income and are therefore automatically Medicaid eligible (Source: MARS 474701 report). Additionally, 33.7% of this population were dual eligibles in FY 2009-10.

- Growth in FY 2009-10 was higher than the Department's February 2010 forecast, in which the annual caseload was projected to be 53,096 and average monthly growth was projected to be 136. The selected trend for FY 2010-11 is higher than the February 2010 forecast, and would yield average growth of **141 per month**. This higher forecasted growth rate reflects the continuation of strong monthly growth experienced over the last three years.
- Out-year growth is projected to moderate and maintain a long-term trend.
- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which establishes the Buy-In Program for Individuals with Disabilities Program beginning in July 2012. This program will allow individuals to pay a premium to purchase Medicaid coverage if they are over income or are otherwise ineligible for Medicaid.

*25.5-5-101 (1), C.R.S. (2010)*
*(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. (2010)*
*(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-08 | 50,351 | - | - |
| 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% |
| Jul-09 | 52,315 | 208 | 0.40% |
| Aug-09 | 52,573 | 258 | 0.49% |
| Sep-09 | 52,710 | 137 | 0.26% |
| Oct-09 | 52,847 | 137 | 0.26% |
| Nov-09 | 52,982 | 135 | 0.26% |
| Dec-09 | 53,000 | 18 | 0.03% |
| Jan-10 | 53,255 | 255 | 0.48% |
| Feb-10 | 53,298 | 43 | 0.08% |
| Mar-10 | 53,629 | 331 | 0.62% |
| Apr-10 | 53,904 | 275 | 0.51% |
| May-10 | 54,164 | 260 | 0.48% |
| Jun-10 | 54,493 | 329 | 0.61% |

| | **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 | 53,264 | 3.72% | 1,909 |
| FY 2010-11 | 55,416 | 4.04% | 2,152 |
| FY 2011-12 | 56,951 | 2.77% | 1,535 |
| FY 2012-13 | 58,272 | 2.32% | 1,321 |

* 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 2010-11 | 0 |
| FY 2011-12 | 4,329 |
| FY 2012-13 | 8,658 |

| **Actuals** | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 249 | 0.46% |
| 12-month average | 199 | 0.37% |
| 18-month average | 178 | 0.34% |
| 24-month average | 173 | 0.33% |

| **Projections After Adjustments** | | | |
|---|---|---|---|
| FY 2010-11 | 55,416 | 7.91% | 4,061 |
| FY 2011-12 | 61,280 | 10.58% | 5,864 |
| FY 2012-13 | 66,930 | 9.22% | 5,650 |

| **Monthly Average Growth Comparisons** | | |
|---|---|---|
| FY 2009-10 1st Half | 149 | 0.28% |
| FY 2009-10 2nd Half | 249 | 0.46% |
| February 2010 Forecast | 136 | 0.26% |
| FY 2010-11 Forecast | 141 | 0.26% |
| February 2010 Forecast | 90 | 0.17% |
| FY 2011-12 Forecast | 96 | 0.20% |
| February 2010 Forecast | 78 | 0.14% |

| **February 2010 Trends (BEFORE ADJUSTMENTS)** | | | |
|---|---|---|---|
| FY 2009-10 | 53,096 | 3.39% | 1,741 |
| FY 2010-11 | 54,344 | 2.35% | 1,248 |
| FY 2011-12 | 55,328 | 1.81% | 984 |

| **Base trend from June 2010 level** | | | |
|---|---|---|---|
| FY 2010-11 | 54,493 | 2.31% | 1,229 |

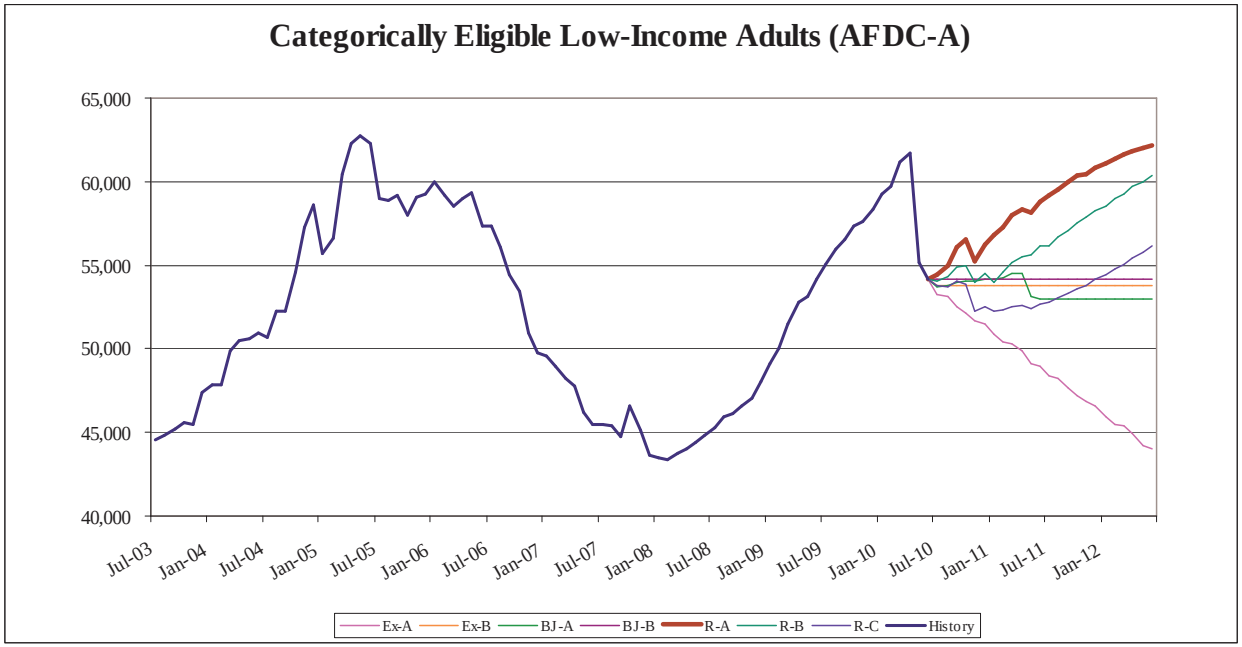
**Categorically Eligible Low-Income Adults**

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 one year. In FY 2009-10, there were an average of 8,099 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.

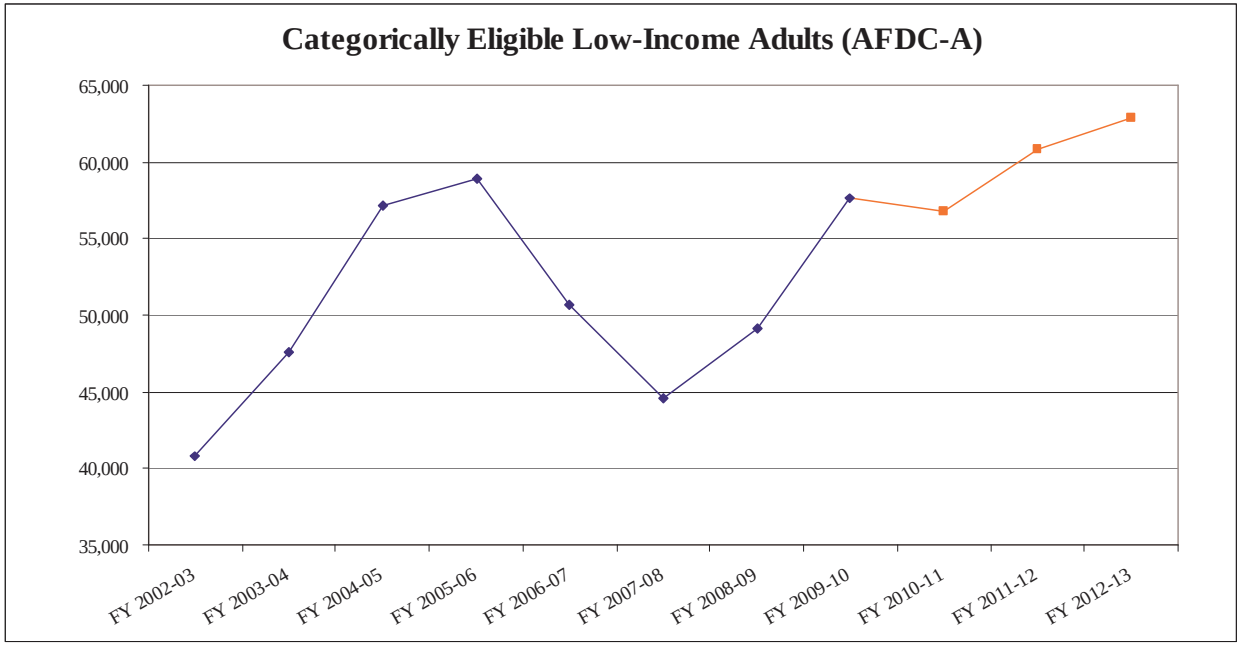
Before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash 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 | 0.9942 | |
| Exponential Smoothing B | 0.9888 | |
| Box-Jenkins A* | 0.9961 | |
| Box-Jenkins B* | 0.9882 | |
| Regression A | 0.9946 | AFDC-A [-1], AFDC-A [-3], Unemployment Rate, CBMS Dummy, Systems Dummy, Auto [-6] |
| Regression B | 0.9949 | AFDC-A [-1], AFDC-A [-9], Unemployment Rate, Total Wages, CBMS Dummy, Systems Dummy, Auto [-6], Auto [-8] |
| Regression C | 0.9951 | AFDC-A [-1], AFDC-A [-9], Total Wages, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Auto [-6] |




| Categorically Eligible Low-Income Adults: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 49,147 | 57,661 | -11.31% | 51,140 | (6,521) | (439) |
| Exponential Smoothing B* | 49,147 | 57,661 | -6.67% | 53,815 | (3,846) | (30) |
| Box Jenkins A | 49,147 | 57,661 | -6.47% | 53,930 | (3,731) | (99) |
| Box Jenkins B | 49,147 | 57,661 | -6.12% | 54,132 | (3,529) | (3) |
| **Regression A** | **49,147** | **57,661** | **-1.62%** | **56,727** | **(934)** | **383** |
| Regression B | 49,147 | 57,661 | -4.95% | 54,807 | (2,854) | 162 |
| Regression C | 49,147 | 57,661 | -8.26% | 52,898 | (4,763) | (125) |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A* | 57,661 | 56,727 | -9.59% | 51,287 | (5,440) | (409) |
| Exponential Smoothing B* | 57,661 | 56,727 | 0.00% | 56,727 | 0 | 0 |
| Box Jenkins A | 57,661 | 56,727 | -1.83% | 55,689 | (1,038) | (4) |
| Box Jenkins B | 57,661 | 56,727 | 0.00% | 56,727 | 0 | 0 |
| **Regression A** | **57,661** | **56,727** | **7.27%** | **60,851** | **4,124** | **284** |
| Regression B | 57,661 | 56,727 | 6.50% | 60,414 | 3,687 | 351 |
| Regression C | 57,661 | 56,727 | 2.77% | 58,298 | 1,571 | 289 |

| Categorically Eligible Low-Income Adults: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 56,727 | 60,851 | -10.61% | 54,395 | (6,456) | (409) |
| Exponential Smoothing B* | 56,727 | 60,851 | 0.00% | 60,851 | 0 | 0 |
| Box Jenkins A | 56,727 | 60,851 | 0.00% | 60,851 | 0 | 0 |
| Box Jenkins B | 56,727 | 60,851 | 0.00% | 60,851 | 0 | 0 |
| **Regression A** | **56,727** | **60,851** | **3.32%** | **62,871** | **2,020** | **83** |
| Regression B | 56,727 | 60,851 | 6.25% | 64,654 | 3,803 | 241 |
| Regression C | 56,727 | 60,851 | 7.65% | 65,506 | 4,655 | 370 |

[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 2010-11: -1.62%
FY 2011-12: 7.27%
FY 2012-13: 3.32%

***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 1.3% per year from FY 2002-03 to FY 2009-10. The growth in this population is projected to remain at an average of 0.8% over the forecast period[8]. The economy is projected remain relatively weak over the forecast period, with the unemployment rate to increase from 7.3% in 2009 to 7.8% in 2010, 7.7% in 2011, and 7.0% in 2012. Personal income is projected to increase by 2.0% in 2010, with moderate growth of 3.7% in 2011, increasing to 5.2% in 2012.[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 2009-10 was lower than the Department's February 2010 forecast, in which the annual caseload was projected to be 58,981 and average monthly growth was projected to be 725. The sole reason for this was the implementation of the expansion for Medicaid Parents to 100% FPL in May 2010. When Family Medical cases were re-run with the implementation, a large number of clients were moved within Medicaid, as seen in the table on the next page. The Department believes that economic conditions are largely responsible for the growth over the last three years, as the seasonally adjusted unemployment rate increased from a low of 3.6% in March 2007 to 8.3% in July 2009 (source: Bureau of Labor Statistics). The last period during which the unemployment

[8] Source: Department of Local Affairs, Demography Division
[9] Source: Office of State Planning and Budgeting, June 2010 Revenue Forecast

rate was increasing as quickly was April 2001 through April 2002. During this time, the AFDC adults caseload was increasing by approximately 1.9% per month. Since the unemployment rate peaked in June 2009, there has been little decline, with the May 2010 rate being 8.0%. The selected trend for FY 2010-11 is lower than that from the February 2010 forecast, and would yield average increases of **383 per month**. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which have been moderating over the last year. Because the economy is believed to be largely responsible this change, projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2010-11. The negative forecasted trend for FY 2010-11 is due to the level shift experienced at the end of FY 2009-10 with the implementation of the expansion to 100% FPL.

- Current forecasts indicate that the economic conditions should begin to improve in FY 2010-11. 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. (2010)*
*(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. (2010)*
*(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***

| AFDC Adults Churn | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | New to Medicaid | From Other Medicaid Category | From Parents to 60% FPL | From Parents to 100% FPL | To Other Medicaid Category | To Parents to 60% FPL | To Parents to 100% FPL | Lost Eligibility | Net Change | Net Without Movement Within Adults |
| May-10 | 4,171 | 561 | 1,424 | 0 | (120) | (5,219) | (4,383) | (3,025) | (6,591) | 1,587 |
| Jun-10 | 3,026 | 531 | 876 | 739 | (130) | (1,344) | (1,492) | (3,143) | (937) | 284 |

| Categorically Eligible Low-Income Adults: Historical Caseload and Projections | | | |
|---|---|---|---|
| | **Actuals** | **Monthly Change** | **% Change** |
| Jun-08 | 44,802 | - | - |
| 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% |
| Jul-09 | 55,087 | 917 | 1.69% |
| Aug-09 | 55,937 | 850 | 1.54% |
| Sep-09 | 56,489 | 552 | 0.99% |
| Oct-09 | 57,359 | 870 | 1.54% |
| Nov-09 | 57,595 | 236 | 0.41% |
| Dec-09 | 58,381 | 786 | 1.36% |
| Jan-10 | 59,210 | 829 | 1.42% |
| Feb-10 | 59,700 | 490 | 0.83% |
| Mar-10 | 61,190 | 1,490 | 2.50% |
| Apr-10 | 61,702 | 512 | 0.84% |
| May-10 | 55,110 | (6,592) | -10.68% |
| Jun-10 | 54,173 | (937) | -1.70% |

| | **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 | 57,661 | 17.32% | 8,514 |
| FY 2010-11 | 56,727 | -1.62% | (934) |
| FY 2011-12 | 60,851 | 7.27% | 4,124 |
| FY 2012-13 | 62,871 | 3.32% | 2,020 |

* 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.

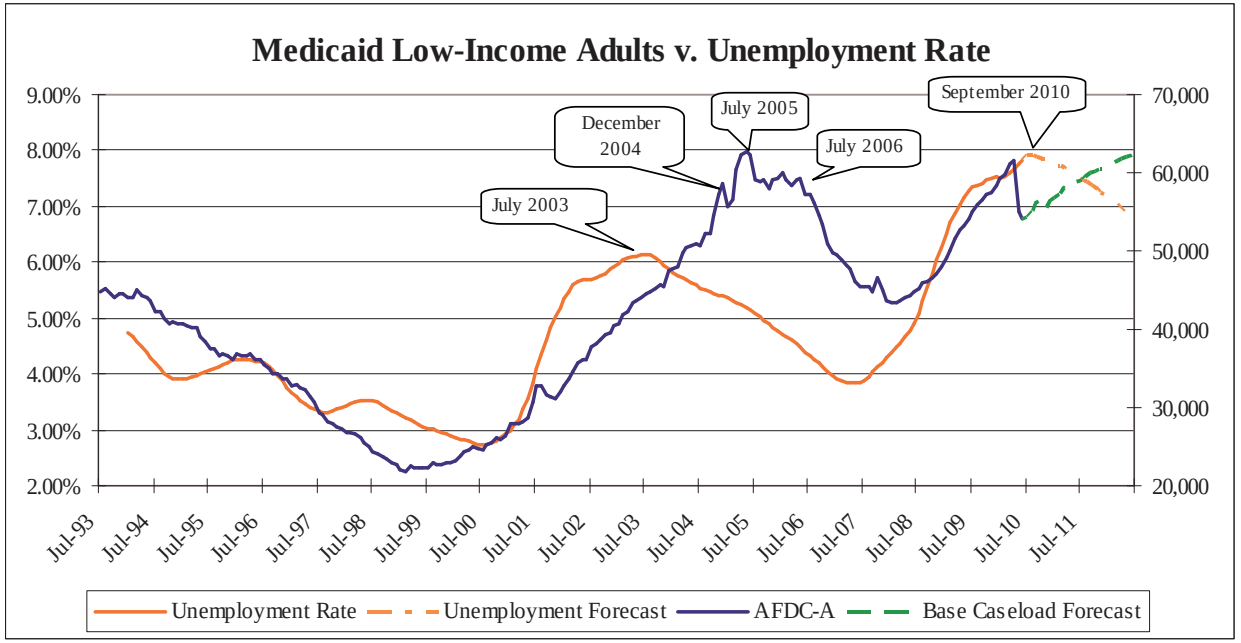
| February 2010 Trends | | | |
|---|---|---|---|
| FY 2009-10 | 58,981 | 20.01% | 9,834 |
| FY 2010-11 | 66,076 | 12.03% | 7,095 |
| FY 2011-12 | 69,624 | 5.37% | 3,548 |

| Actuals | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | (701) | -1.13% |
| 12-month average | 0 | 0.06% |
| 18-month average | 341 | 0.72% |
| 24-month average | 390 | 0.83% |

| Monthly Average Growth Comparisons | | |
|---|---|---|
| FY 2009-10 1st Half | 702 | 1.26% |
| FY 2009-10 2nd Half | (701) | -1.13% |
| February 2010 Forecast | 725 | 1.34% |
| FY 2010-11 Forecast | 383 | 0.71% |
| February 2010 Forecast | 470 | 0.75% |
| FY 2011-12 Forecast | 284 | 0.54% |
| February 2010 Forecast | 147 | 0.22% |

| Actuals Without May and June 2010 | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 830 | 1.40% |
| 12-month average | 753 | 1.31% |
| 18-month average | 854 | 1.58% |
| 24-month average | 768 | 1.47% |

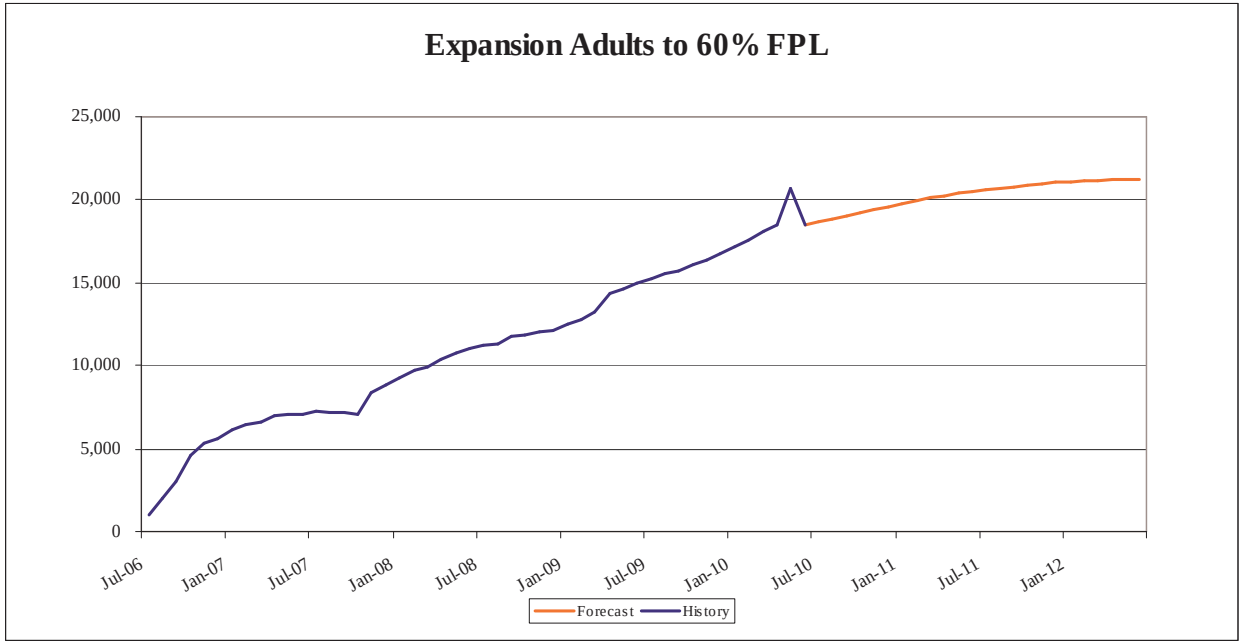
| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 54,173 | -6.05% | (3,488) |




**Expansion Adults to 60% FPL**

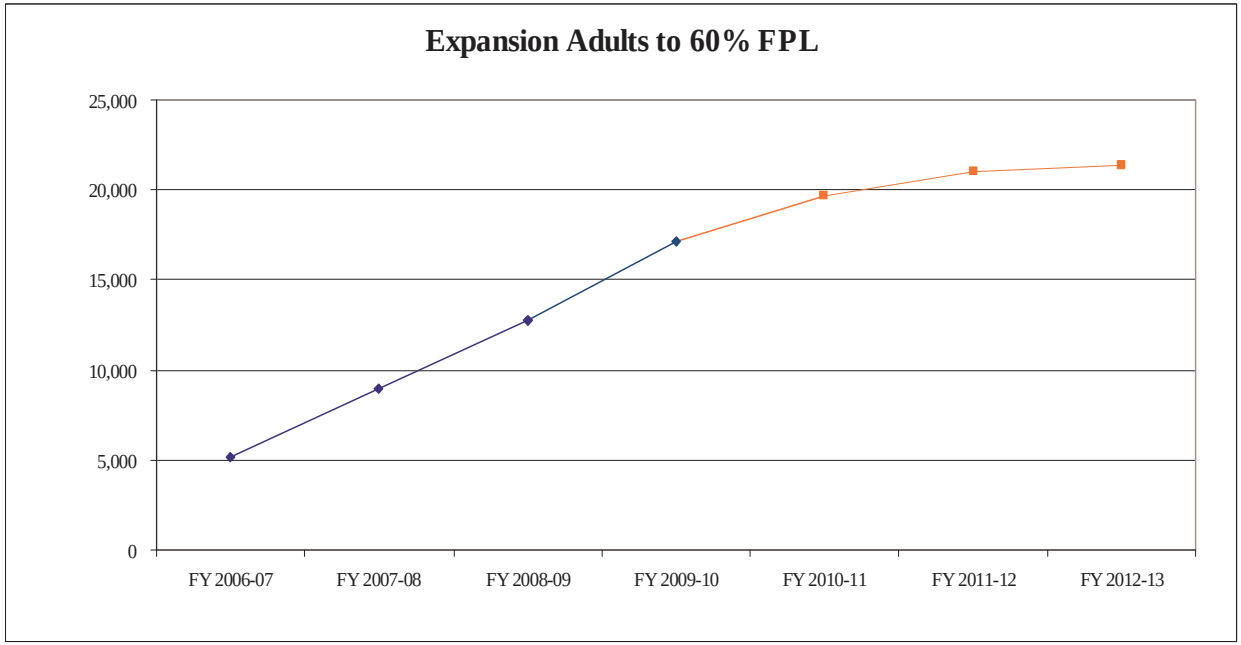
HB 05-1262 (Tobacco Tax bill) allows for expanding Medicaid eligibility to parents of children enrolled in either Medicaid or the Children's Basic Health Plan up to 60% of the federal poverty level. The increase in the percentage of allowable federal poverty level was implemented on July 1, 2006. The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

***Expansion Adults: Model Results***




| Actuals | | |
|---|---|---|
| | Monthly Change | % Change |
| 6-month average | 476 | 3.61% |
| 9-month average | 356 | 2.73% |
| 12-month average | 333 | 2.64% |
| 18-month average | 345 | 3.04% |
| 24-month average | 310 | 2.25% |

| Actuals Without May and June 2010 | | |
|---|---|---|
| | Monthly Change | % Change |
| 6-month average | 551 | 4.29% |
| 9-month average | 365 | 2.87% |
| 12-month average | 335 | 2.72% |
| 18-month average | 348 | 3.13% |
| 24-month average | 341 | 2.40% |




***Expansion Adults to 60% FPL: 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 2009-10 was higher than the Department's February 2010 forecast, in which the annual base caseload was projected to be 16,806 and average monthly growth was projected to be 271. The fluctuations in May and June 2010 are due to the implementation of the eligibility expansion for Medicaid Parents to 100% FPL in May 2010. When Family Medical cases were re-run with the implementation, a large number of clients were moved within Medicaid, as seen in the table below. The selected trend for FY 2010-11 is higher than that from the February 2010 forecast, and would yield average growth of **171 per month**. This forecast is based on the average monthly change experienced between June 2008 and April 20109. During this time, caseload increased by an average of 2.10% 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 2010-11 forecast assumes that this monthly growth will decrease over the course of the year, to average 0.88%.

- The Department assumes that growth will continue to decrease throughout the forecast period, to an average of 0.29% per month in FY 2011-12 and FY 0.10% per month in FY 2012-13. 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.

*25.5-5-201 (1), C.R.S. (2010)*
*(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 to 60% FPL: Historical Caseload and Forecasts***

| Parents to 60% FPL Churn | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | New Clients to Medicaid | From Other Medicaid Category | From AFDC Adults | From Parents to 100% FPL | To Other Medicaid Category | To AFDC Adults | To Parents to 100% FPL | Lost Eligibility | Net Change | Net Without Movement Within Adults |
| May-10 | 1,472 | 195 | 5,219 | 0 | (57) | (1,424) | (2,031) | (1,169) | 2,205 | 441 |
| Jun-10 | 914 | 145 | 1,344 | 212 | (67) | (876) | (483) | (3,448) | (2,259) | (2,456) |

| Expansion Adults to 60% FPL: Historical Caseload and Projections | | | |
|---|---|---|---|
| | **Actuals** | **Monthly Change** | **% Change** |
| Jun-08 | 10,995 | - | - |
| Jul-08 | 11,236 | 241 | 2.19% |
| Aug-08 | 11,335 | 99 | 0.88% |
| Sep-08 | 11,794 | 459 | 4.05% |
| Oct-08 | 11,836 | 42 | 0.36% |
| Nov-08 | 12,008 | 172 | 1.45% |
| Dec-08 | 12,142 | 134 | 1.12% |
| Jan-09 | 12,486 | 344 | 2.83% |
| Feb-09 | 12,730 | 244 | 1.95% |
| Mar-09 | 13,190 | 460 | 3.61% |
| Apr-09 | 14,346 | 1,156 | 8.76% |
| May-09 | 14,619 | 273 | 1.90% |
| Jun-09 | 14,996 | 377 | 2.58% |
| Jul-09 | 15,269 | 273 | 1.82% |
| Aug-09 | 15,530 | 261 | 1.71% |
| Sep-09 | 15,703 | 173 | 1.11% |
| Oct-09 | 16,115 | 412 | 2.62% |
| Nov-09 | 16,362 | 247 | 1.53% |
| Dec-09 | 16,739 | 377 | 2.30% |
| Jan-10 | 17,193 | 454 | 2.71% |
| Feb-10 | 17,514 | 321 | 1.87% |
| Mar-10 | 18,096 | 582 | 3.32% |
| Apr-10 | 18,490 | 394 | 2.18% |
| May-10 | 20,694 | 2,204 | 11.92% |
| Jun-10 | 18,435 | (2,259) | -10.92% |

| Actuals | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 283 | 1.85% |
| 12-month average | 287 | 1.85% |
| 18-month average | 350 | 2.44% |
| 24-month average | 310 | 2.25% |

| | **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 | 17,178 | 34.97% | 4,451 |
| FY 2010-11 | 19,641 | 14.34% | 2,463 |
| FY 2011-12 | 20,991 | 6.87% | 1,350 |
| FY 2012-13 | 21,397 | 1.93% | 406 |

| February 2010 Trends (BEFORE ADJUSTMENTS) | | | |
|---|---|---|---|
| | **Caseload** | **% Change** | **Level Change** |
| FY 2009-10 | 16,806 | 32.05% | 4,079 |
| FY 2010-11 | 19,382 | 15.33% | 2,576 |
| FY 2011-12 | 20,651 | 6.55% | 1,269 |

| Monthly Average Growth Comparisons | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| FY 2010-11 | 171 | 0.88% |
| FY 2011-12 | 64 | 0.31% |
| FY 2012-13 | 22 | 0.10% |

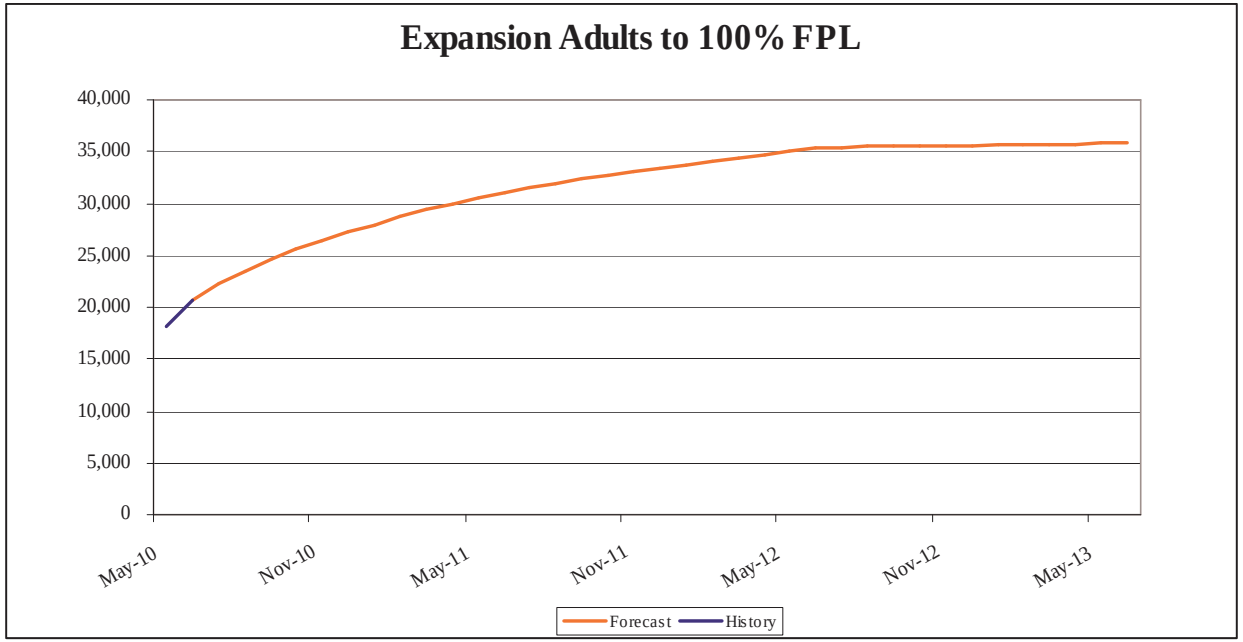
| Monthly Averages | | |
|---|---|---|
| FY 2009-10 1st Half | 291 | 1.85% |
| FY 2009-10 2nd Half | 283 | 1.85% |
| February 2010 Forecast | 271 | 1.65% |
| FY 2010-11 Forecast | 171 | 0.88% |
| February 2010 Forecast | 161 | 0.84% |
| FY 2011-12 Forecast | 64 | 0.31% |
| February 2010 Forecast | 60 | 0.29% |

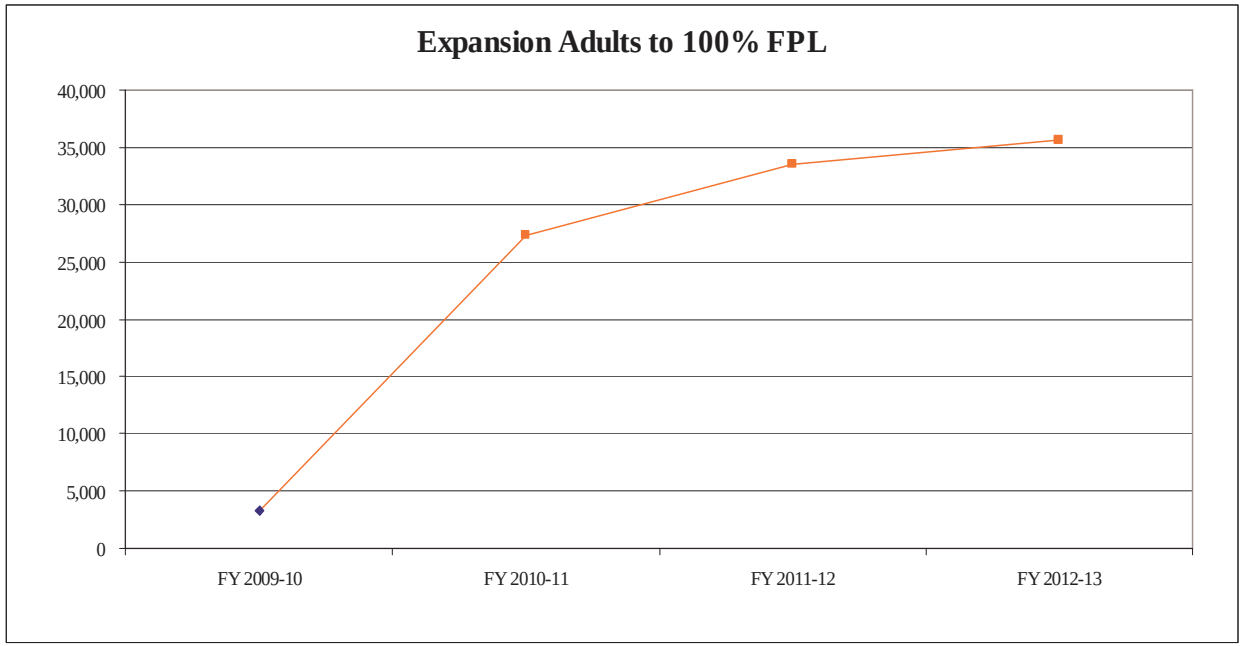
| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 18,435 | 7.32% | 1,257 |

## Expansion Adults to 100% FPL

HB 10-1293 (Colorado Health Care Affordability Act) allows for expanding Medicaid eligibility to parents of children enrolled in either Medicaid or the Children's Basic Health Plan up to 100% of the federal poverty level. The increase in the percentage of

allowable federal poverty level was implemented on May 1, 2010. The Department has created a new category to track these clients, known as the Expansion Adults to 100% FPL.






- This eligibility type was created from HB 09-1293, which expands eligibility for parents of children in Medicaid from 60% to 100% of the federal poverty level. This increase was effective May 1, 2010.
- The planned implementation for this group did not include redeterminations for current Family Medical cases. This population would have included only newly eligible individuals that had their applications processed on or after May 1, 2010. However, when the expansion was implemented, the Colorado Benefits Management System redetermined all existing Family Medical cases, as well as any cases that were denied in the previous three months. This resulted in a large number of individuals being immediately eligible for this population, and a May 2010 caseload of 18,253.
- The forecast for this population is based on uninsured data for 2009 trended forward. The Department's forecasts are much higher than those from the February 2010 forecast due entirely to the impacts from the implementation of the expansion. The forecasting methodology was retained, and assumes a phase-in of the remaining uninsured parents from 61% to 100% FPL over three years. The annual average caseload estimates are higher due to the level shift that occurred in May 2010.

| Parents to 100% FPL Churn | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | New Clients to Medicaid | From Other Medicaid Category | From AFDC Adults | From Parents to 60% | To Other Medicaid Category | To AFDC Adults | To Parents to 60% | Lost Eligibility | Net Change | Net Without Movement Within Adults |
| May-10 | 11,554 | 285 | 4,383 | 2,031 | 0 | 0 | 0 | 0 | 18,253 | 11,839 |
| Jun-10 | 1,871 | 206 | 1,492 | 483 | (26) | (739) | (212) | (721) | 2,354 | 1,330 |

| Expansion Adults to 100% FPL: Historical Caseload and Projections | | | |
|---|---|---|---|
| | **Actuals** | **Monthly Change** | **% Change** |
| May-10 | 18,325 | - | - |
| Jun-10 | 20,779 | 2,454 | 13.39% |

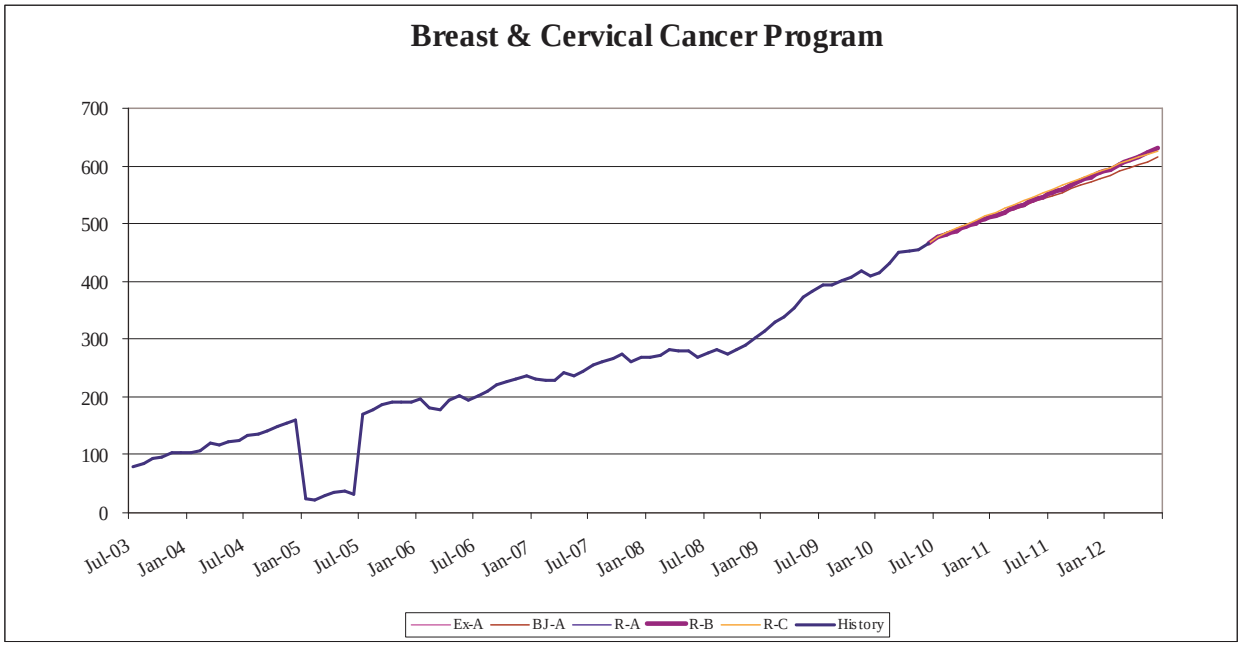
| | **Caseload** | **% Change** | **Level Change** |
|---|---|---|---|
| FY 2009-10 | 3,237 | - | - |
| FY 2010-11 | 27,270 | 742.45% | 24,033 |
| FY 2011-12 | 33,548 | 23.02% | 6,278 |
| FY 2012-13 | 35,626 | 6.19% | 2,078 |

| February 2010 Trends | | | |
|---|---|---|---|
| | **Caseload** | **% Change** | **Level Change** |
| FY 2009-10 | 750 | - | - |
| FY 2010-11 | 12,250 | 1533.33% | 11,500 |
| FY 2011-12 | 25,000 | 104.08% | 12,750 |

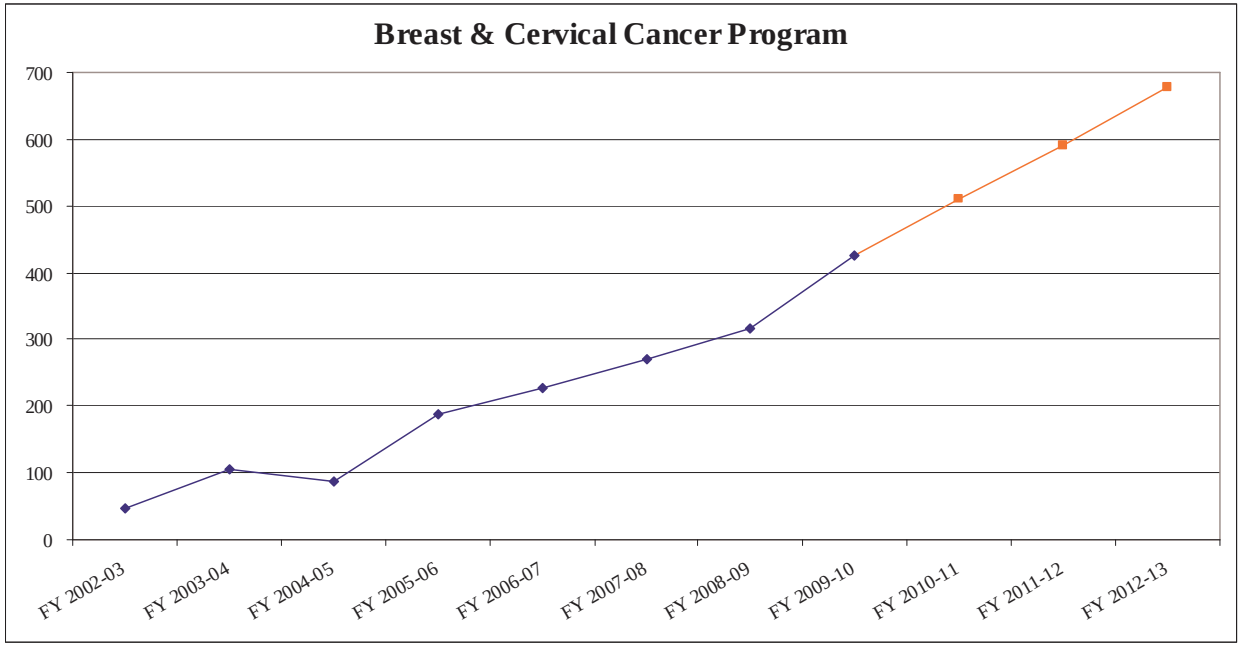
## Breast and Cervical Cancer Program

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 and Cervical Cancer Program: Model Statistics** | Adjusted $R^2$ | Notes |
|---|---|---|
| Exponential Smoothing A* | 0.9951 | |
| Box-Jenkins A | 0.9951 | |
| Regression A | 0.9956 | BCCP [-1], Female Population 19-59, Auto [-1] |
| Regression B | 0.9957 | BCCP [-1], Trend |
| Regression C | 0.9960 | BCCP [-1], Unemployment Rate, Migration |




| Breast and Cervical Cancer Program: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing | 317 | 425 | 20.47% | 512 | 87 | 7 |
| Box Jenkins * | 317 | 425 | 20.00% | 510 | 85 | 6 |
| Regression A | 317 | 425 | 20.71% | 513 | 88 | 7 |
| **Regression B** | **317** | **425** | **20.24%** | **511** | **86** | **7** |
| Regression C | 317 | 425 | 21.41% | 516 | 91 | 7 |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing | 425 | 511 | 15.63% | 591 | 80 | 7 |
| Box Jenkins * | 425 | 511 | 13.92% | 582 | 71 | 6 |
| Regression A | 425 | 511 | 15.59% | 591 | 80 | 7 |
| **Regression B** | **425** | **511** | **15.66%** | **591** | **80** | **7** |
| Regression C | 425 | 511 | 15.12% | 588 | 77 | 6 |

| Breast and Cervical Cancer Program: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing | 511 | 591 | 13.51% | 671 | 80 | 7 |
| Box Jenkins * | 511 | 591 | 12.22% | 663 | 72 | 6 |
| Regression A | 511 | 591 | 14.17% | 675 | 84 | 7 |
| **Regression B** | **511** | **591** | **14.55%** | **677** | **86** | **7** |
| Regression C | 511 | 591 | 11.28% | 658 | 67 | 5 |

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

***Breast and Cervical Cancer Program: Trend Selections***

FY 2010-11: 20.24%
FY 2011-12: 15.66%
FY 2012-13: 14.55%

***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 2009-10 was higher than the Department's February 2010 forecast, in which the annual caseload was projected to be 418 and average monthly growth was projected to be 5. The selected trend for FY 2010-11 is higher than that from the February 2010 forecast, and would yield average growth of **7 per month**.
- 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. (2010)*
*(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-08 | 270 | - | - |
| 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% |
| Jul-09 | 393 | 10 | 2.61% |
| Aug-09 | 395 | 2 | 0.51% |
| Sep-09 | 402 | 7 | 1.77% |
| Oct-09 | 406 | 4 | 1.00% |
| Nov-09 | 418 | 12 | 2.96% |
| Dec-09 | 411 | (7) | -1.67% |
| Jan-10 | 416 | 5 | 1.22% |
| Feb-10 | 431 | 15 | 3.61% |
| Mar-10 | 449 | 18 | 4.18% |
| Apr-10 | 452 | 3 | 0.67% |
| May-10 | 455 | 3 | 0.66% |
| Jun-10 | 466 | 11 | 2.42% |

| Actuals | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 9 | 2.12% |
| 12-month average | 7 | 1.66% |
| 18-month average | 9 | 2.42% |
| 24-month average | 8 | 2.37% |

| | **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 | 425 | 34.07% | 108 |
| FY 2010-11 | 511 | 20.24% | 86 |
| FY 2011-12 | 591 | 15.66% | 80 |
| FY 2012-13 | 677 | 14.55% | 86 |

* 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 2010 Trends | | | |
|---|---|---|---|
| FY 2009-10 | 418 | 31.86% | 101 |
| FY 2010-11 | 471 | 12.68% | 53 |
| FY 2011-12 | 535 | 13.59% | 64 |

| Monthly Average Growth Comparisons | | |
|---|---|---|
| FY 2009-10 1st Half | 5 | 1.19% |
| FY 2009-10 2nd Half | 9 | 2.12% |
| February 2010 Forecast | 5 | 1.31% |
| FY 2010-11 Forecast | 7 | 1.50% |
| February 2010 Forecast | 5 | 1.19% |
| FY 2011-12 Forecast | 7 | 1.28% |
| February 2010 Forecast | 5 | 1.10% |

| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 466 | 9.65% | 41 |

**Eligible Children**

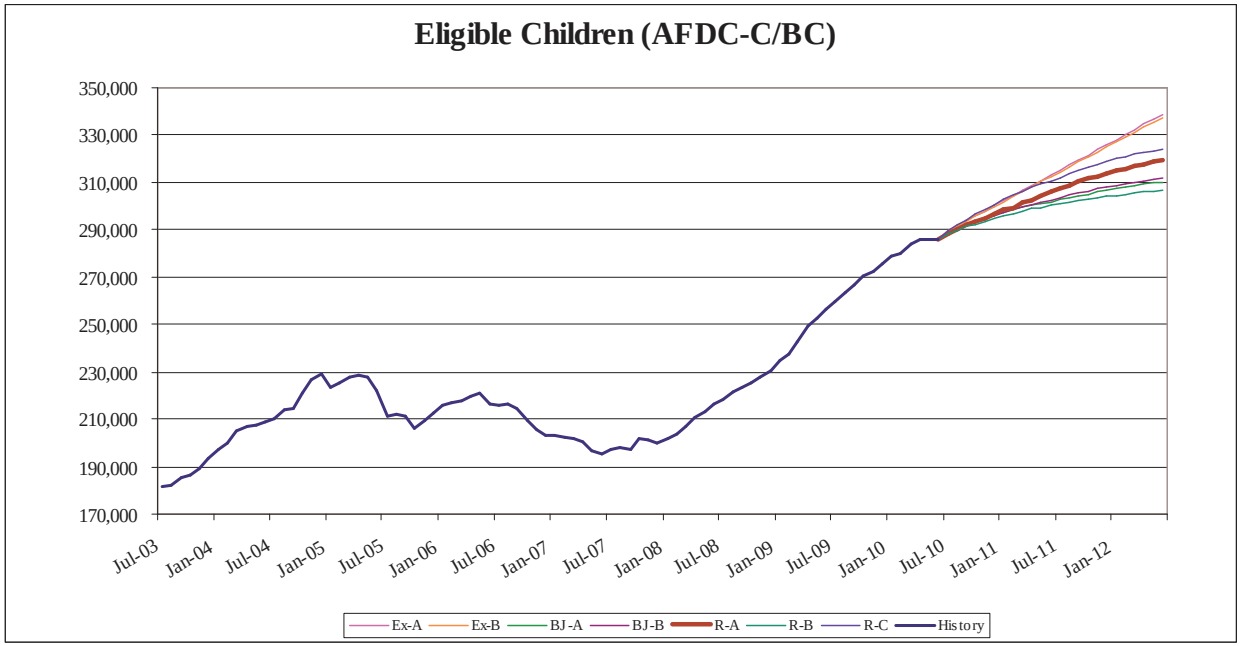
One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 receive Transitional Medicaid benefits for one year. In FY 2009-10, there were an average of 13,582 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.

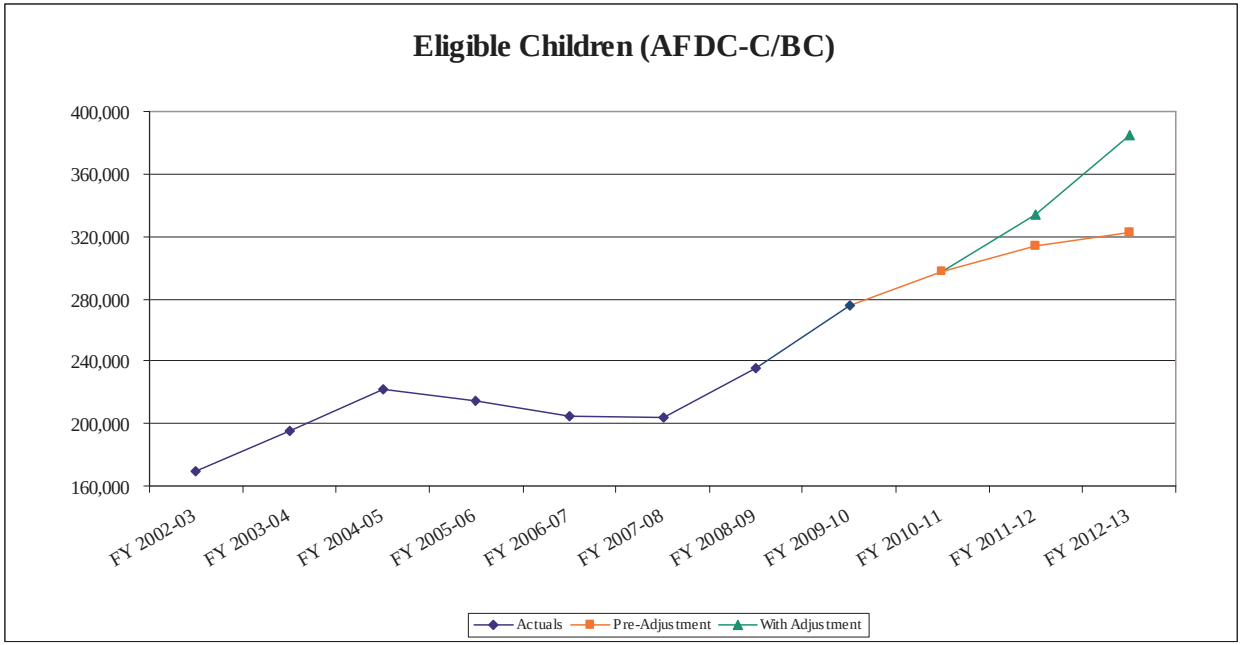
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic 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 | 0.9988 | KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, Systems Dummy, Auto [-12] |
| Regression B | 0.9988 | KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Auto [-12] |
| Regression C | 0.9889 | KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, Population Under 19, Trend, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Auto [-12], Auto [-18] |




| Eligible Children: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 235,129 | 275,672 | 9.27% | 301,227 | 25,555 | 2,271 |
| Exponential Smoothing B | 235,129 | 275,672 | 9.13% | 300,841 | 25,169 | 2,214 |
| Box Jenkins A* | 235,129 | 275,672 | 7.40% | 296,072 | 20,400 | 1,332 |
| Box Jenkins B* | 235,129 | 275,672 | 7.44% | 296,182 | 20,510 | 1,403 |
| **Regression A** | **235,129** | **275,672** | **7.86%** | **297,340** | **21,668** | **1,717** |
| Regression B | 235,129 | 275,672 | 6.97% | 294,886 | 19,214 | 1,196 |
| Regression C | 235,129 | 275,672 | 9.21% | 301,061 | 25,389 | 2,062 |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A | 275,672 | 297,340 | 8.55% | 322,763 | 25,423 | 2,145 |
| Exponential Smoothing B | 275,672 | 297,340 | 8.34% | 322,138 | 24,798 | 2,090 |
| Box Jenkins A* | 275,672 | 297,340 | 3.58% | 307,985 | 10,645 | 706 |
| Box Jenkins B* | 275,672 | 297,340 | 4.03% | 309,323 | 11,983 | 789 |
| **Regression A** | **275,672** | **297,340** | **5.61%** | **314,021** | **16,681** | **1,085** |
| Regression B | 275,672 | 297,340 | 3.09% | 306,528 | 9,188 | 531 |
| Regression C | 275,672 | 297,340 | 5.90% | 314,883 | 17,543 | 1,115 |

| Eligible Children: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 297,340 | 314,021 | 7.87% | 338,734 | 24,713 | 2,145 |
| Exponential Smoothing B | 297,340 | 314,021 | 7.70% | 338,201 | 24,180 | 2,090 |
| Box Jenkins A* | 297,340 | 314,021 | 2.15% | 320,772 | 6,751 | 434 |
| Box Jenkins B* | 297,340 | 314,021 | 2.39% | 321,526 | 7,505 | 487 |
| **Regression A** | **297,340** | **314,021** | **2.77%** | **322,719** | **8,698** | **432** |
| Regression B | 297,340 | 314,021 | 1.26% | 317,978 | 3,957 | 168 |
| Regression C | 297,340 | 314,021 | 2.44% | 321,683 | 7,662 | 346 |

[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 2010-11: 7.86%
FY 2011-12: 5.61%
FY 2012-13: 2.77%

***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 1.2% per year from FY 2002-03 to FY 2009-10. The expansion in this age group is projected to average 1.4% throughout the forecast period.[10] The economy is projected remain relatively weak over the forecast period, with the unemployment rate to increase from 7.3% in 2009 to 7.8% in 2010, 7.7% in 2011, and 7.0% in 2012. Personal income is projected to increase by 2.0% in 2010, with moderate growth of 3.7% in 2011, increasing to 5.2% in 2012.[11]
- 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

[10] Department of Local Affairs, Demography Division
[11] Source: Office of State Planning and Budgeting, June 2010 Revenue Forecast

effect on caseload. Similarly, large and consistent increases since January 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.

- Recent changes to the rules regarding the citizenship requirements of the Deficit Reduction Act of 2005 may effect this population and result in higher growth. Children who can not provide proper proof of citizenship will no longer be automatically eligible for the Children's Basic Health Plan. This may increase growth in Medicaid as families find documents to ensure coverage of children.
- Growth in FY 2009-10 was lower than the Department's February forecast, in which the annual caseload was projected to be 277,828 and average monthly growth was projected to be 3,154. The Department believes that the sole reason for this was the implementation of the expansion for Medicaid Parents to 100% FPL in May 2010. The Department believes that economic conditions are largely responsible for the growth over the last three years, as the seasonally adjusted unemployment rate increased from a low of 3.6% in March 2007 to 8.3% in July 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 which the Eligible Children caseload was increasing by 1.5% per month. The selected trend for FY 2010-11 is lower than that from the February 2010 forecast, and would yield average increases of **1,717 per month**. Because the economy is believed to be largely responsible for the growth during the last 3 years, projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2010-11.
- Similar to the pattern seen in AFDC adults, the out-year trend is expected to slow with declining monthly growth, reflective of projected moderating economic conditions beginning in FY 2010-11. Growth in children is expected to be higher than that in the adult populations due to current outreach activities funded by the Department and a number of community initiatives to enroll eligibles, most of which target children.
- Additionally, the U.S. Department of Health and Human Services (HHS) is launching the "Get Covered. Get in the Game." initiative in seven pilot states across the country, including Colorado. The initiative is part of the *Connecting Kids to Coverage* effort, led by HHS Secretary Kathleen Sebelius, which calls on government and business leaders, health and human services providers, schools, the faith community, and those working with children in any setting to find and enroll roughly five million uninsured children in the U.S. who are currently eligible for Medicaid and the Children's Health Insurance Program (CHIP). This initiative will provide coaches with information about CHIP and Medicaid and how families can get their eligible children enrolled. Coaches and others in the school community can serve as a resource to families to help ensure that children are linked to vital health benefits. CMS will support events launching this initiative, outreach to news outlets across the pilot states, coaches' trainings, and the placement of promotional materials at select youth sports events to help direct families to enrollment assistance.
- 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 February 2012. This is anticipated to increase the length of stay in the Medicaid, which will result in increased caseload.

*25.5-5-101 (1), C.R.S. (2010)*
*(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. (2010)*
*(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. (2010)*
*(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***

| Medicaid Eligible Children Churn | | | | | | | |
|---|---|---|---|---|---|---|---|
| | New Clients to Medicaid | From Other Medicaid Category | From CHP+ | To Other Medicaid Category | To CHP+ | Lost Eligibility | Net Change |
| May-10 | 10,404 | 121 | 2,382 | (523) | (2,615) | (9,736) | 33 |
| Jun-10 | 10,898 | 183 | 2,583 | (525) | (2,796) | (10,344) | (1) |

**Eligible Children: Historical Caseload and Projections**

| | Actuals | Monthly Change | % Change |
|---|---|---|---|
| Jun-08 | 216,154 | - | - |
| 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% |
| Jul-09 | 259,609 | 2,979 | 1.16% |
| Aug-09 | 263,415 | 3,806 | 1.47% |
| Sep-09 | 266,381 | 2,966 | 1.13% |
| Oct-09 | 270,514 | 4,133 | 1.55% |
| Nov-09 | 272,453 | 1,939 | 0.72% |
| Dec-09 | 275,867 | 3,414 | 1.25% |
| Jan-10 | 279,000 | 3,133 | 1.14% |
| Feb-10 | 279,898 | 898 | 0.32% |
| Mar-10 | 283,625 | 3,727 | 1.33% |
| Apr-10 | 285,746 | 2,121 | 0.75% |
| May-10 | 285,779 | 33 | 0.01% |
| Jun-10 | 285,778 | (1) | 0.00% |

| | 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 | 275,672 | 17.24% | 40,543 |
| FY 2010-11 | 297,340 | 7.86% | 21,668 |
| FY 2011-12 | 314,021 | 5.61% | 16,681 |
| FY 2012-13 | 322,719 | 2.77% | 8,698 |

* 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 2010-11 | 0 |
| FY 2011-12 | 19,970 |
| FY 2012-13 | 61,569 |

| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 285,778 | 3.67% | 10,106 |

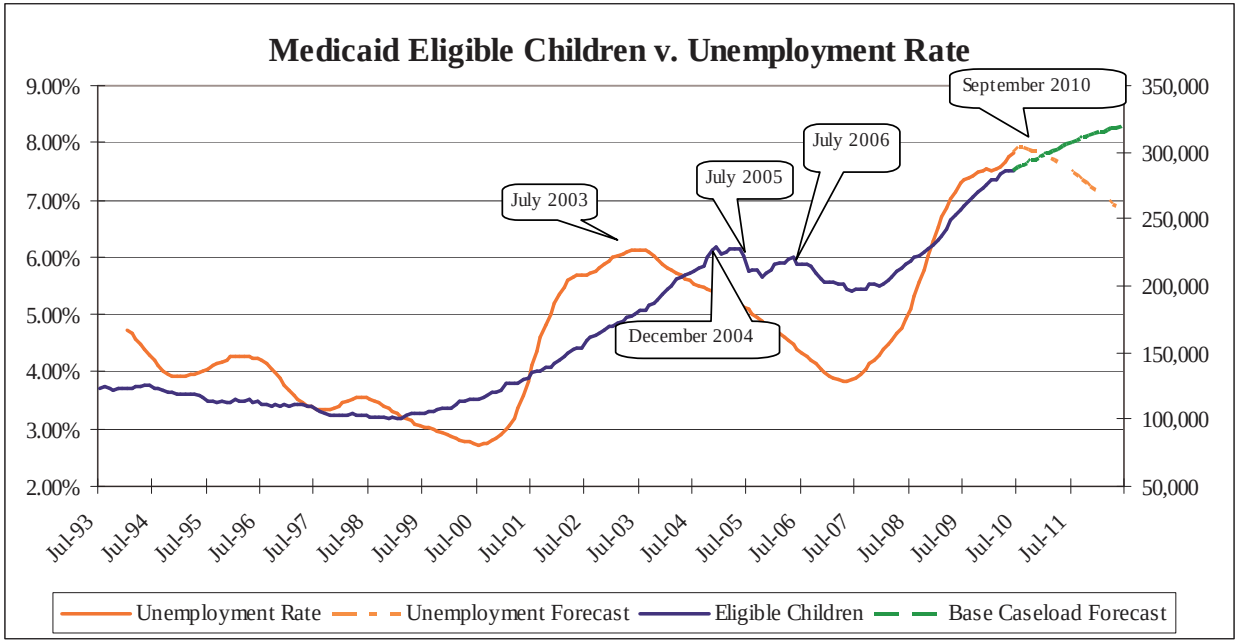
| Projections After Adjustments | | | |
|---|---|---|---|
| FY 2010-11 | 297,340 | 26.46% | 62,211 |
| FY 2011-12 | 333,991 | 12.33% | 36,651 |
| FY 2012-13 | 384,288 | 15.06% | 50,297 |

| Actuals | | |
|---|---|---|
| | Monthly Change | % Change |
| 6-month average | 1,652 | 0.59% |
| 12-month average | 2,429 | 0.90% |
| 18-month average | 3,074 | 1.21% |
| 24-month average | 2,901 | 1.17% |

| February 2010 Trends (BEFORE ADJUSTMENTS) | | | |
|---|---|---|---|
| FY 2009-10 | 277,828 | 18.16% | 42,699 |
| FY 2010-11 | 307,278 | 10.60% | 29,450 |
| FY 2011-12 | 322,796 | 5.05% | 15,518 |

| Actuals Without May and June 2010 | | |
|---|---|---|
| | Monthly Change | % Change |
| 6-month average | 2,470 | 0.88% |
| 12-month average | 2,912 | 1.08% |
| 18-month average | 3,456 | 1.35% |
| 24-month average | 3,213 | 1.28% |

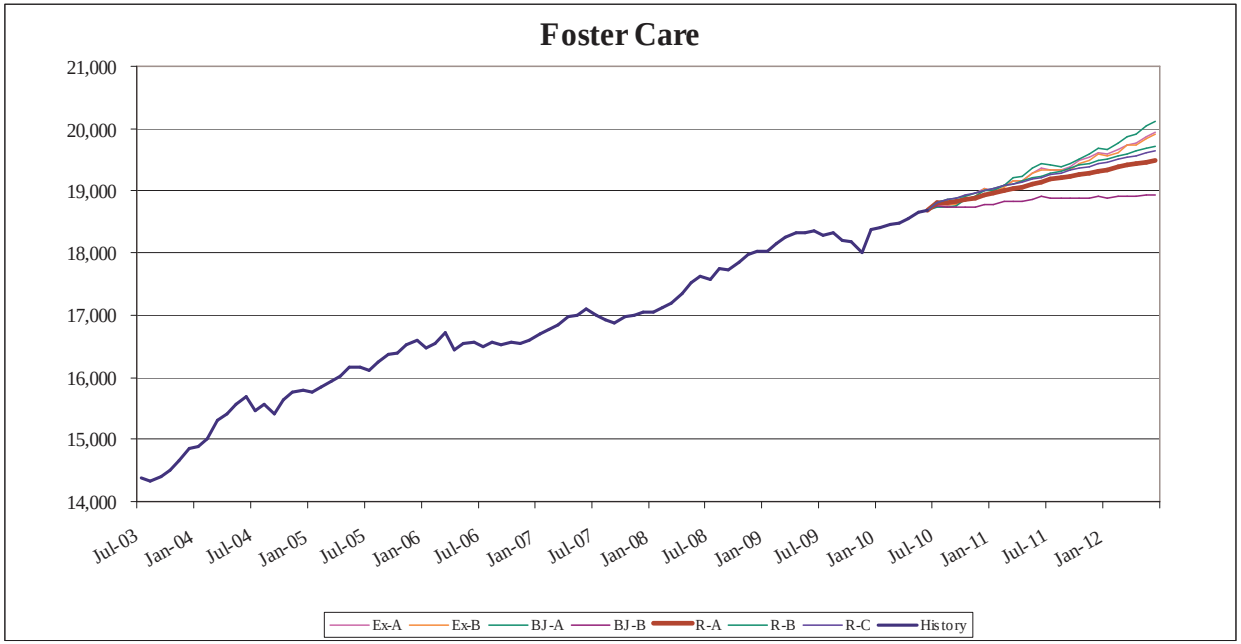
| Monthly Average Growth Comparisons | | |
|---|---|---|
| FY 2009-10 1st Half | 3,206 | 1.21% |
| FY 2009-10 2nd Half | 1,652 | 0.59% |
| February 2010 Forecast | 3,154 | 1.26% |
| FY 2010-11 Forecast | 1,717 | 0.60% |
| February 2010 Forecast | 1,869 | 0.63% |
| FY 2011-12 Forecast | 1,085 | 0.35% |
| February 2010 Forecast | 885 | 0.28% |



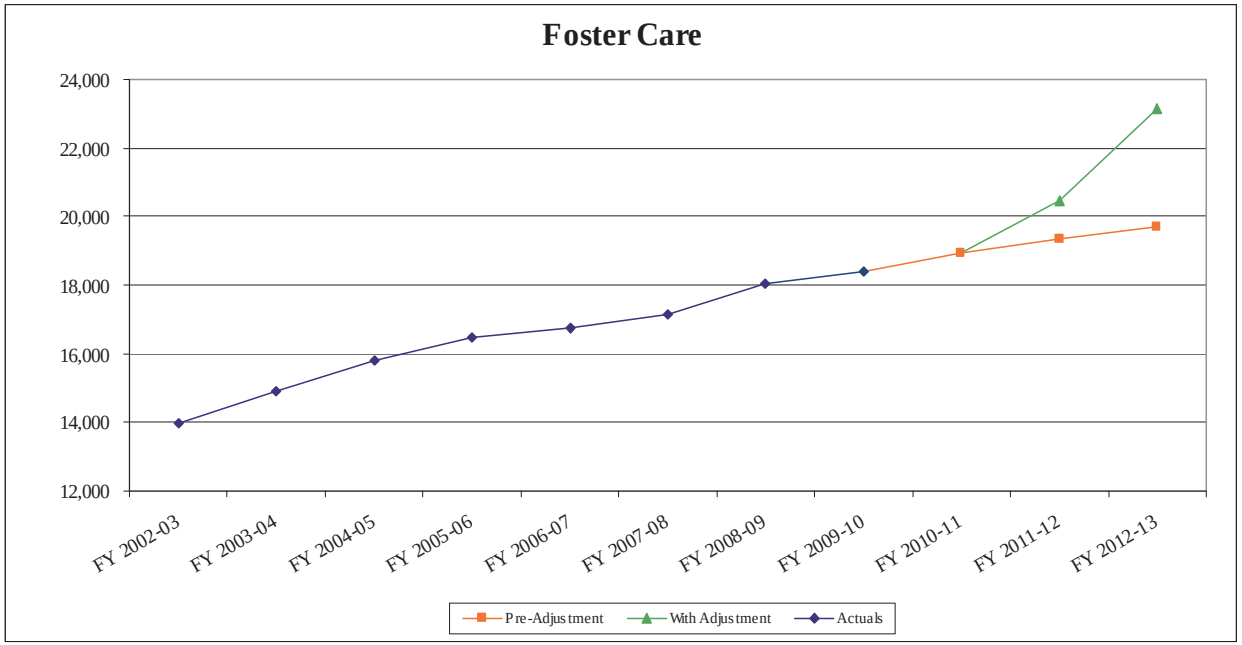

**Foster Care**

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* | 0.9989 | |
| Exponential Smoothing B* | 0.9946 | |
| Box-Jenkins A | 0.9989 | |
| Box-Jenkins B | 0.9937 | |
| Regression A | 0.9985 | FOSTER [-1], Population Under 19, Auto [-12] |
| Regression B | 0.9987 | FOSTER [-1], FOSTER [-5], Total Population |
| Regression C | 0.9988 | FOSTER [-1], Trend, Auto [-1] |




| Foster Care: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 18,033 | 18,381 | 3.50% | 19,024 | 643 | 57 |
| Exponential Smoothing B | 18,033 | 18,381 | 3.44% | 19,013 | 632 | 56 |
| Box Jenkins A* | 18,033 | 18,381 | 3.53% | 19,030 | 649 | 63 |
| Box Jenkins B* | 18,033 | 18,381 | 2.25% | 18,795 | 414 | 18 |
| **Regression A** | **18,033** | **18,381** | **3.13%** | **18,956** | **575** | **39** |
| Regression B | 18,033 | 18,381 | 3.50% | 19,024 | 643 | 47 |
| Regression C | 18,033 | 18,381 | 3.47% | 19,019 | 638 | 45 |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A | 18,381 | 18,956 | 3.06% | 19,536 | 580 | 49 |
| Exponential Smoothing B | 18,381 | 18,956 | 2.98% | 19,521 | 565 | 47 |
| Box Jenkins A* | 18,381 | 18,956 | 3.53% | 19,625 | 669 | 56 |
| Box Jenkins B* | 18,381 | 18,956 | 0.57% | 19,064 | 108 | 3 |
| **Regression A** | **18,381** | **18,956** | **2.00%** | **19,335** | **379** | **30** |
| Regression B | 18,381 | 18,956 | 2.52% | 19,434 | 478 | 39 |
| Regression C | 18,381 | 18,956 | 2.28% | 19,388 | 432 | 35 |

| Foster Care: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 18,956 | 19,335 | 2.97% | 19,909 | 574 | 49 |
| Exponential Smoothing B | 18,956 | 19,335 | 2.89% | 19,894 | 559 | 47 |
| Box Jenkins A* | 18,956 | 19,335 | 3.44% | 20,000 | 665 | 56 |
| Box Jenkins B* | 18,956 | 19,335 | 0.19% | 19,372 | 37 | 1 |
| **Regression A** | **18,956** | **19,335** | **1.83%** | **19,689** | **354** | **29** |
| Regression B | 18,956 | 19,335 | 2.37% | 19,793 | 458 | 38 |
| Regression C | 18,956 | 19,335 | 2.10% | 19,741 | 406 | 33 |

[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 2010-11: 3.13%
FY 2011-12: 2.00%
FY 2012-13: 1.83%

***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 2010-11 was slightly higher than the Department's February 2010 forecast, in which the annual caseload was projected to be 18,365 and average monthly growth was projected to be 20. The selected trend for FY 2010-11 is slightly higher than that from the February 2010 forecast, and would yield average growth of **39 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 February 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. (2010)*
*(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 (2010)*
*(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-08 | 17,620 | - | - |
| 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% |
| Jul-09 | 18,285 | (63) | -0.34% |
| Aug-09 | 18,325 | 40 | 0.22% |
| Sep-09 | 18,200 | (125) | -0.68% |
| Oct-09 | 18,169 | (31) | -0.17% |
| Nov-09 | 17,992 | (177) | -0.97% |
| Dec-09 | 18,371 | 379 | 2.11% |
| Jan-10 | 18,400 | 29 | 0.16% |
| Feb-10 | 18,467 | 67 | 0.36% |
| Mar-10 | 18,486 | 19 | 0.10% |
| Apr-10 | 18,552 | 66 | 0.36% |
| May-10 | 18,651 | 99 | 0.53% |
| Jun-10 | 18,678 | 27 | 0.14% |

| | **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 | 18,381 | 1.93% | 348 |
| FY 2010-11 | 18,956 | 3.13% | 575 |
| FY 2011-12 | 19,335 | 2.00% | 379 |
| FY 2012-13 | 19,689 | 1.83% | 354 |

* 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 2010-11 | 0 |
| FY 2011-12 | 1,123 |
| FY 2012-13 | 3,438 |

| Actuals | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 51 | 0.28% |
| 12-month average | 28 | 0.15% |
| 18-month average | 36 | 0.20% |
| 24-month average | 44 | 0.24% |

| Projections After Adjustments | | | |
|---|---|---|---|
| FY 2010-11 | 18,956 | 3.13% | 575 |
| FY 2011-12 | 20,458 | 7.92% | 1,502 |
| FY 2012-13 | 23,127 | 13.05% | 2,669 |

| Monthly Average Growth Comparisons | | |
|---|---|---|
| FY 2009-10 1st Half | 4 | 0.03% |
| FY 2009-10 2nd Half | 51 | 0.28% |
| February 2010 Forecast | 20 | 0.11% |
| FY 2010-11 Forecast | 39 | 0.21% |
| February 2010 Forecast | 27 | 0.15% |
| FY 2011-12 Forecast | 30 | 0.16% |
| February 2010 Forecast | 28 | 0.15% |

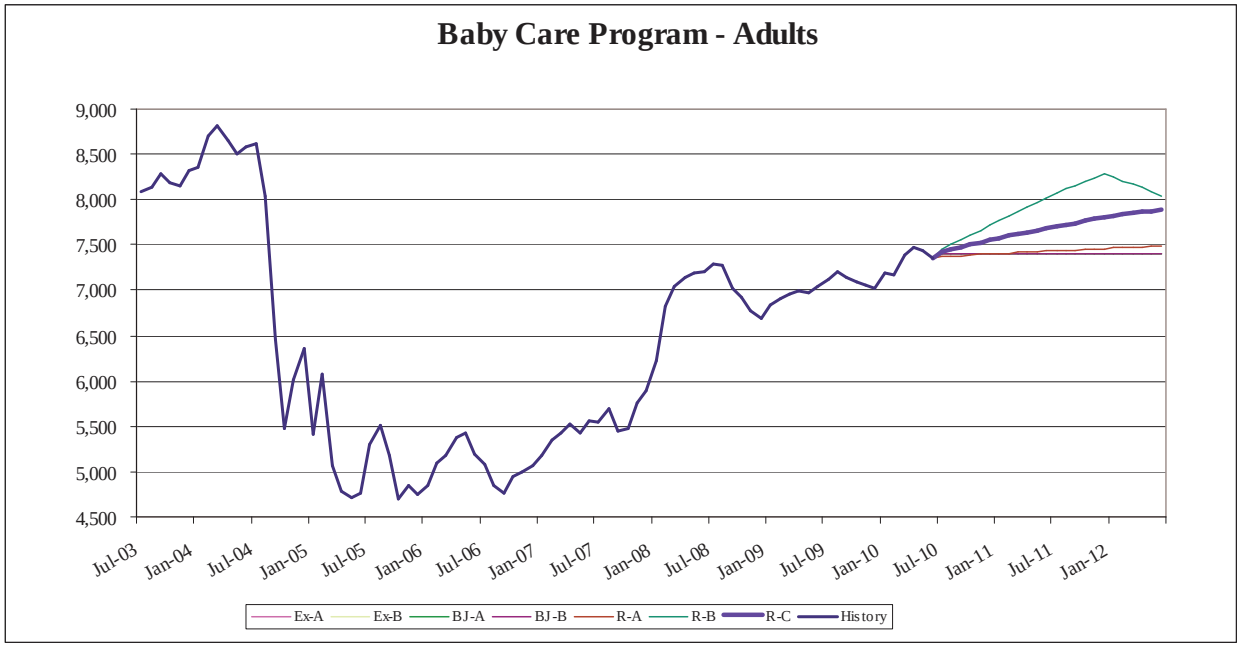
| February 2010 Trends (BEFORE ADJUSTMENTS) | | | |
|---|---|---|---|
| FY 2009-10 | 18,365 | 1.84% | 332 |
| FY 2010-11 | 18,753 | 2.11% | 388 |
| FY 2011-12 | 19,102 | 1.86% | 349 |

| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 18,678 | 1.62% | 297 |

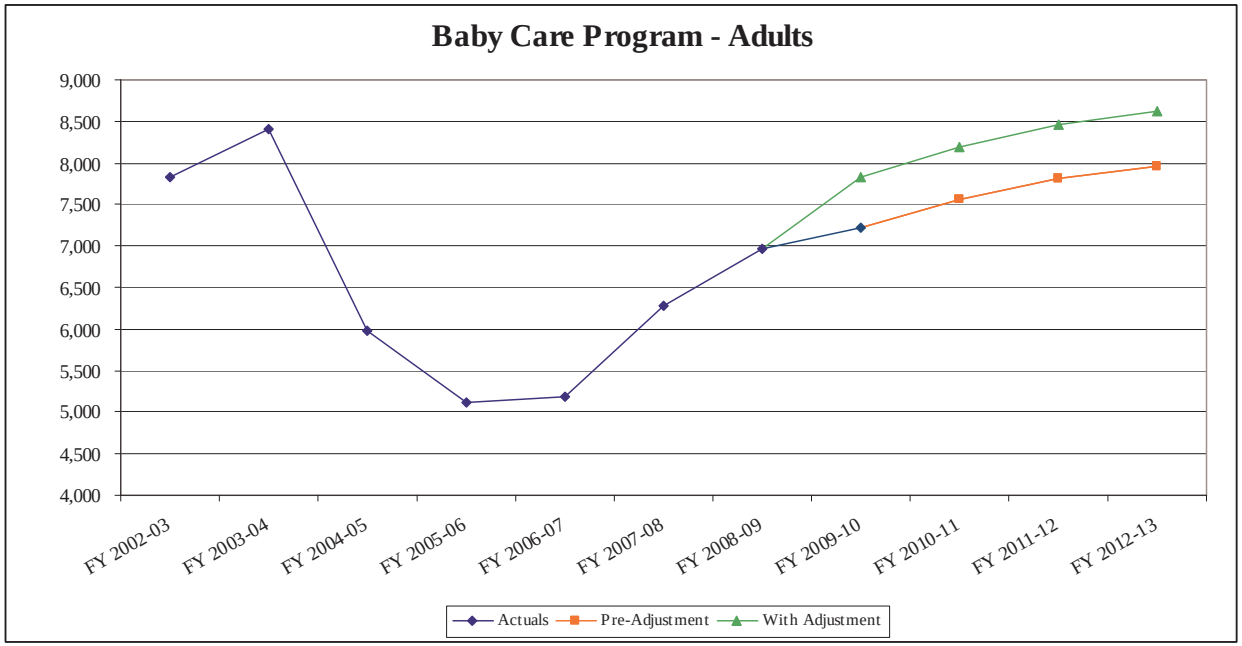
## Baby Care Adults

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* | 0.9468 | |
| Exponential Smoothing B* | 0.9320 | |
| Box-Jenkins A | 0.9471 | |
| Box-Jenkins | 0.9326 | |
| Regression A | 0.9559 | BCA [-1], BCA Dummy, Auto [-4] |
| Regression B | 0.9790 | BCA [-1], Migration, Unemployment Rate, Auto [-3] |
| Regression C | 0.9569 | BCA [-1], Unemployment Rate, Female Population 19-59, BCA Dummy |




| Baby Care Program-Adults: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 6,976 | 7,222 | 2.48% | 7,401 | 179 | 4 |
| Exponential Smoothing B* | 6,976 | 7,222 | 2.48% | 7,401 | 179 | 4 |
| Box Jenkins A | 6,976 | 7,222 | 2.48% | 7,401 | 179 | 4 |
| Box Jenkins B | 6,976 | 7,222 | 2.48% | 7,401 | 179 | 4 |
| Regression A | 6,976 | 7,222 | 2.49% | 7,402 | 180 | 7 |
| Regression B | 6,976 | 7,222 | 7.16% | 7,739 | 517 | 56 |
| **Regression C** | **6,976** | **7,222** | **4.68%** | **7,560** | **338** | **28** |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A* | 7,222 | 7,560 | 0.00% | 7,560 | 0 | 0 |
| Exponential Smoothing B* | 7,222 | 7,560 | 0.00% | 7,560 | 0 | 0 |
| Box Jenkins A | 7,222 | 7,560 | 0.00% | 7,560 | 0 | 0 |
| Box Jenkins B | 7,222 | 7,560 | 0.00% | 7,560 | 0 | 0 |
| Regression A | 7,222 | 7,560 | 0.82% | 7,622 | 62 | 5 |
| Regression B | 7,222 | 7,560 | 5.49% | 7,975 | 415 | 2 |
| **Regression C** | **7,222** | **7,560** | **3.24%** | **7,805** | **245** | **17** |

| Baby Care Program-Adults: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 7,560 | 7,805 | 0.00% | 7,805 | 0 | 0 |
| Exponential Smoothing B* | 7,560 | 7,805 | 0.00% | 7,805 | 0 | 0 |
| Box Jenkins A | 7,560 | 7,805 | 0.00% | 7,805 | 0 | 0 |
| Box Jenkins B | 7,560 | 7,805 | 0.00% | 7,805 | 0 | 0 |
| Regression A | 7,560 | 7,805 | 0.80% | 7,867 | 62 | 5 |
| Regression B | 7,560 | 7,805 | -4.94% | 7,419 | (386) | (41) |
| **Regression C** | **7,560** | **7,805** | **2.00%** | **7,961** | **156** | **10** |

[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 2010-11: 4.68%
FY 2011-12: 3.24%
FY 2012-13: 2.00%

***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 2009-10 was much higher than the Department's February 2010 forecast, in which the annual caseload was projected to be 7,067 and average monthly decreases were projected to be 1. The selected trend for FY 2010-11 is much higher than that from the February 2010 forecast, and would yield average growth of **28 per month**. Caseload in this eligibility type has been volatile for 2 years, as can be seen in the tables on the next page. 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 Colorado Department of Public Health & Environment Family Planning Initiative was awarded a grant for approximately $3.5 million to address the issue of unintended pregnancy in Colorado for Title X clients, the vast majority of which 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 pursuant to SB 08-003).

- In FY 2009-10, the Department received approval from the Centers for Medicare and Medicaid Services to grant full Medicaid eligibility to pregnant women who are legal permanent residents that have been in the country for less than 5 years, as authorized by the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). As a result, the Department will restate the FY 2009-10 monthly caseload for this eligibility type to include clients who had previously been in the State-only Prenatal population. These clients are included in the forecast through a bottom-line adjustment.

*25.5-5-101 (1), C.R.S. (2010)*
*(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 (2), C.R.S. (2010)*
*(b) Notwithstanding the five-year waiting period established in paragraph (a) of this subsection (2), but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the state department may provide benefits under this article and articles 4 and 6 of this title to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.*

*25.5-5-205 (3), C.R.S. (2010)*
*(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-08 | 7,200 | - | - |
| 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% |
| Jul-09 | 7,123 | 78 | 1.11% |
| Aug-09 | 7,214 | 91 | 1.28% |
| Sep-09 | 7,136 | (78) | -1.08% |
| Oct-09 | 7,087 | (49) | -0.69% |
| Nov-09 | 7,050 | (37) | -0.52% |
| Dec-09 | 7,017 | (33) | -0.47% |
| Jan-10 | 7,198 | 181 | 2.58% |
| Feb-10 | 7,181 | (17) | -0.24% |
| Mar-10 | 7,388 | 207 | 2.88% |
| Apr-10 | 7,474 | 86 | 1.16% |
| May-10 | 7,443 | (31) | -0.41% |
| Jun-10 | 7,348 | (95) | -1.28% |

| | **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 | 7,222 | 3.53% | 246 |
| FY 2010-11 | 7,560 | 4.68% | 338 |
| FY 2011-12 | 7,805 | 3.24% | 245 |
| FY 2012-13 | 7,961 | 2.00% | 156 |

* 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 (Prenatal State-Only)*** | |
|---|---|
| FY 2009-10 | 608 |
| FY 2010-11 | 636 |
| FY 2011-12 | 657 |
| FY 2012-13 | 670 |

* See narrative above

| **Actuals** | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 55 | 0.78% |
| 12-month average | 25 | 0.36% |
| 18-month average | 37 | 0.53% |
| 24-month average | 6 | 0.10% |

| **Projections After Adjustments** | | | |
|---|---|---|---|
| FY 2010-11 | 8,196 | 4.67% | 366 |
| FY 2011-12 | 8,462 | 3.25% | 266 |
| FY 2012-13 | 8,631 | 2.00% | 169 |

| **Monthly Average Growth Comparisons** | | |
|---|---|---|
| FY 2009-10 1st Half | (5) | -0.06% |
| FY 2009-10 2nd Half | 55 | 0.78% |
| February 2010 Forecast | (1) | -0.01% |
| FY 2010-11 Forecast | 28 | 0.38% |
| February 2010 Forecast | 2 | 0.03% |
| FY 2011-12 Forecast | 17 | 0.22% |
| February 2010 Forecast | 2 | 0.03% |

| **February 2010 Trends** | | | |
|---|---|---|---|
| FY 2009-10 | 7,067 | 1.30% | 91 |
| FY 2010-11 | 7,047 | -0.28% | (20) |
| FY 2011-12 | 7,070 | 0.33% | 23 |

| **Base trend from June 2010 level** | | | |
|---|---|---|---|
| FY 2010-11 | 7,348 | 1.74% | 126 |

**Non-Citizens**

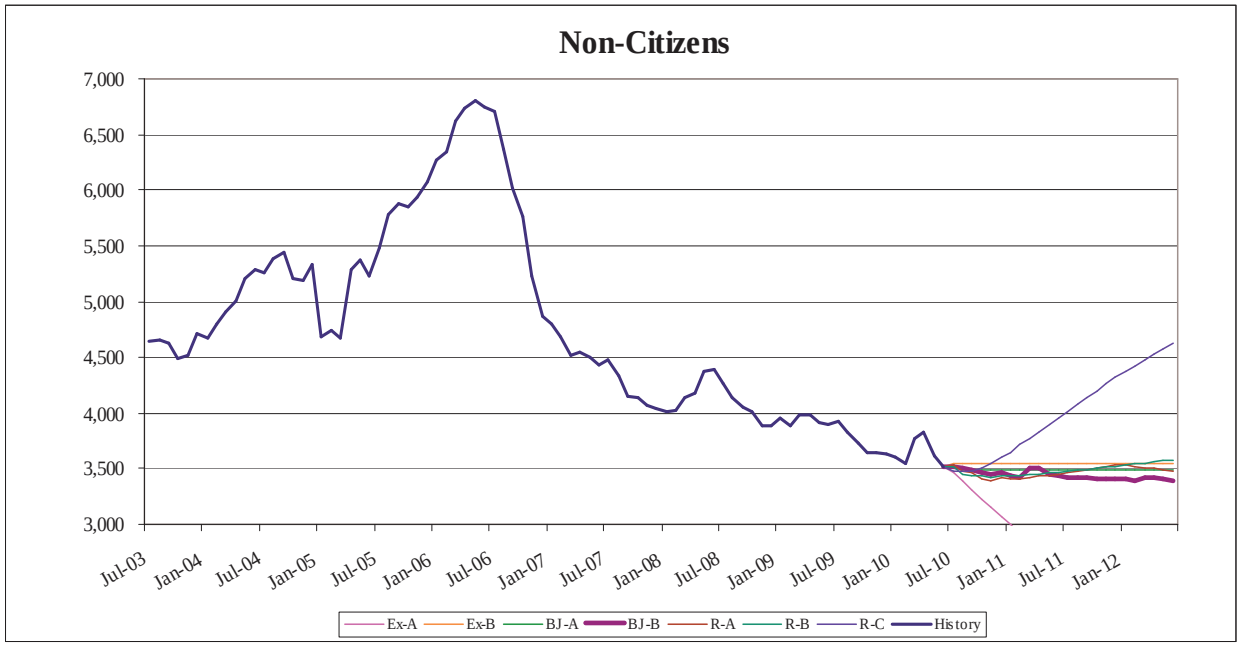
Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived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

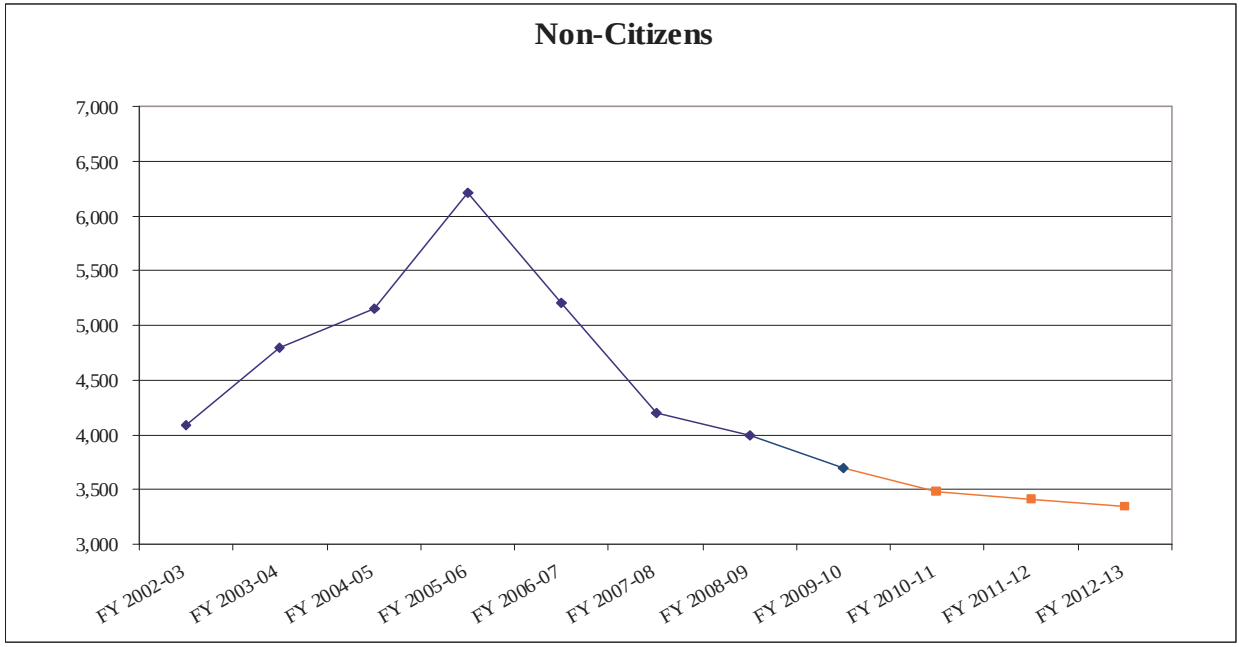
Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. citizenship.

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 | 0.9643 | |
| Exponential Smoothing B* | 0.9500 | |
| Box-Jenkins A* | 0.9779 | |
| Box-Jenkins B | 0.9663 | |
| Regression A | 0.9859 | ALIEN [-1], Female Population 19-59, Migration, Alien Dummy, Auto [-3], Auto [-7] |
| Regression B | 0.9889 | ALIEN [-1], ALIEN [-2], Alien Dummy, Auto [-3] |
| Regression C | 0.9882 | ALIEN [-1], Unemployment Rate, Alien Dummy, Auto [-1], Auto [-2] |




| Non-Citizens: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 3,987 | 3,693 | -17.79% | 3,036 | (657) | (76) |
| Exponential Smoothing B* | 3,987 | 3,693 | -4.06% | 3,543 | (150) | 2 |
| Box Jenkins A* | 3,987 | 3,693 | -5.36% | 3,495 | (198) | (3) |
| **Box Jenkins B** | **3,987** | **3,693** | **-6.04%** | **3,470** | **(223)** | **(8)** |
| Regression A | 3,987 | 3,693 | -6.93% | 3,437 | (256) | (6) |
| Regression B | 3,987 | 3,693 | -6.61% | 3,449 | (244) | (4) |
| Regression C | 3,987 | 3,693 | -0.92% | 3,659 | (34) | 36 |

* Denotes Expert Selection, Bold denotes Trend Selection

| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A | 3,693 | 3,470 | -30.86% | 2,399 | (1,071) | (78) |
| Exponential Smoothing B* | 3,693 | 3,470 | 0.00% | 3,470 | 0 | 0 |
| Box Jenkins A* | 3,693 | 3,470 | -0.11% | 3,466 | (4) | 0 |
| **Box Jenkins B** | **3,693** | **3,470** | **-1.73%** | **3,410** | **(60)** | **(3)** |
| Regression A | 3,693 | 3,470 | 1.89% | 3,536 | 66 | 2 |
| Regression B | 3,693 | 3,470 | 2.32% | 3,551 | 81 | 9 |
| Regression C | 3,693 | 3,470 | 18.42% | 4,109 | 639 | 56 |

| Non-Citizens: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A | 3,470 | 3,410 | -44.64% | 1,888 | (1,522) | (78) |
| Exponential Smoothing B* | 3,470 | 3,410 | 0.00% | 3,410 | 0 | 0 |
| Box Jenkins A* | 3,470 | 3,410 | 0.00% | 3,410 | 0 | 0 |
| **Box Jenkins B** | **3,470** | **3,410** | **-0.53%** | **3,392** | **(18)** | **(1)** |
| Regression A | 3,470 | 3,410 | -2.11% | 3,338 | (72) | (8) |
| Regression B | 3,470 | 3,410 | 3.17% | 3,518 | 108 | 10 |
| Regression C | 3,470 | 3,410 | 12.95% | 3,852 | 442 | 39 |

[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 2010-11: -6.04%
FY 2011-12: -1.73%
FY 2012-13: -0.53%

### *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.[12]
- 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.

[12] 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 volatility in this eligibility type beginning 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 this volatility is unknown at this time, the Department does not anticipate that large decreases will continue.
- Growth in FY 2009-10 was slightly higher than the Department's February 2010 forecast, in which the annual caseload was projected to be 3,662 and average monthly declines were projected to be 25. The selected trend for FY 2010-11 is much lower than that from the February 2010 forecast, and would yield average decreases of **8 per month**.
- The out-year trends assume very moderate monthly decreases. 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. (2010)*
*(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-08 | 4,389 | - | - |
| 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% |
| Jul-09 | 3,930 | 38 | 0.98% |
| Aug-09 | 3,835 | (95) | -2.42% |
| Sep-09 | 3,724 | (111) | -2.89% |
| Oct-09 | 3,650 | (74) | -1.99% |
| Nov-09 | 3,644 | (6) | -0.16% |
| Dec-09 | 3,632 | (12) | -0.33% |
| Jan-10 | 3,610 | (22) | -0.61% |
| Feb-10 | 3,550 | (60) | -1.66% |
| Mar-10 | 3,768 | 218 | 6.14% |
| Apr-10 | 3,831 | 63 | 1.67% |
| May-10 | 3,615 | (216) | -5.64% |
| Jun-10 | 3,522 | (93) | -2.57% |

| | **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 | 3,693 | -7.37% | (294) |
| FY 2010-11 | 3,470 | -6.04% | (223) |
| FY 2011-12 | 3,410 | -1.73% | (60) |
| FY 2012-13 | 3,338 | -2.11% | (72) |

* 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 2010 Trends** | | | |
|---|---|---|---|
| FY 2009-10 | 3,662 | -8.15% | (325) |
| FY 2010-11 | 3,571 | -2.48% | (91) |
| FY 2011-12 | 3,660 | 2.49% | 89 |

| **Actuals** | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | (18) | -0.44% |
| 12-month average | (31) | -0.79% |
| 18-month average | (20) | -0.51% |
| 24-month average | (36) | -0.89% |

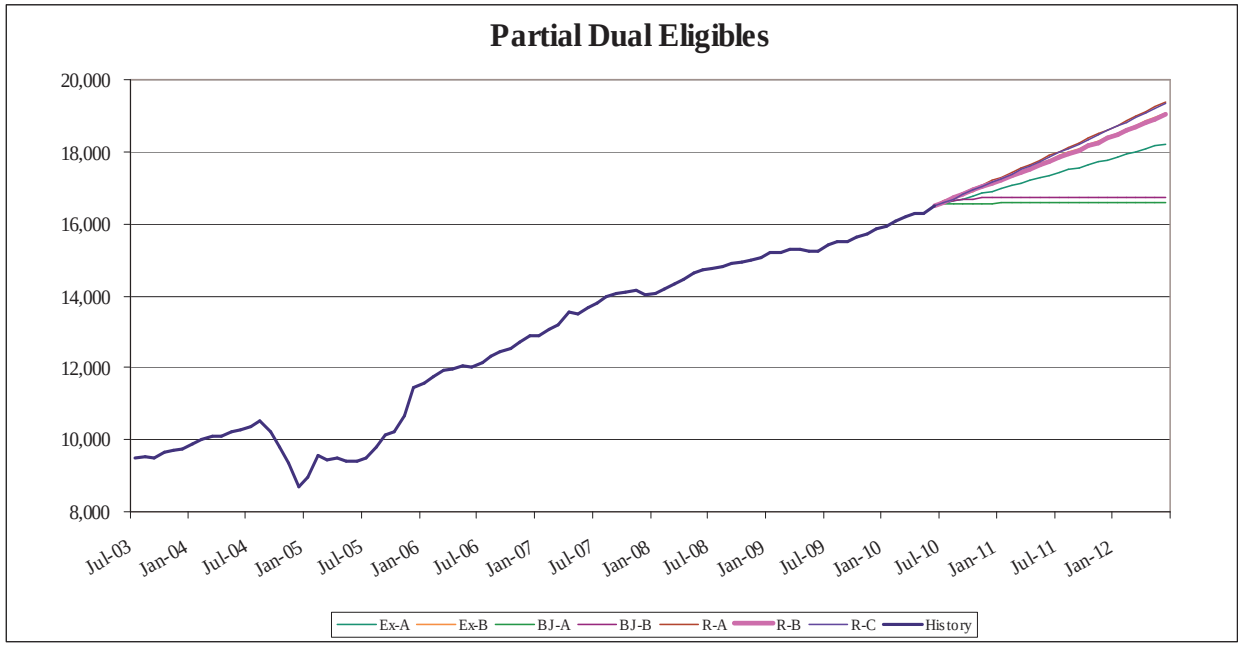
| **Monthly Average Growth Comparisons** | | |
|---|---|---|
| FY 2009-10 1st Half | (43) | -1.14% |
| FY 2009-10 2nd Half | (18) | -0.44% |
| February 2010 Forecast | (25) | -0.64% |
| FY 2010-11 Forecast | (8) | -0.23% |
| February 2010 Forecast | 1 | 0.03% |
| FY 2011-12 Forecast | (3) | -0.09% |
| February 2010 Forecast | 5 | 0.14% |

| **Base trend from June 2010 level** | | | |
|---|---|---|---|
| FY 2010-11 | 3,522 | -4.63% | (171) |

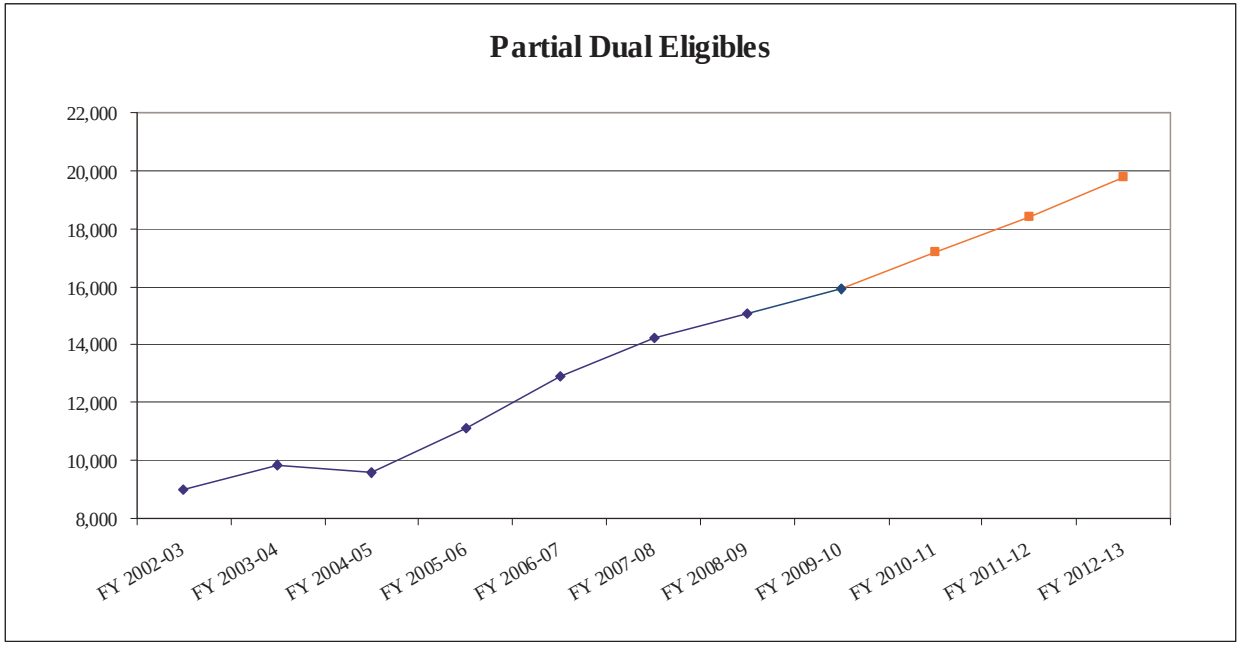
**Partial Dual Eligibles**

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* | 0.9977 | |
| Exponential Smoothing B | 0.9965 | |
| Box-Jenkins A | 0.9976 | |
| Box-Jenkins B* | 0.9970 | |
| Regression A | 0.9993 | PDE [-1], PDE Dummy, CBMS Dummy, Auto [-1] |
| Regression B | 0.9993 | PDE [-1], Population 65+, PDE Dummy, CBMS Dummy, Auto [-1] |
| Regression C | 0.9993 | PDE [-1], PDE [-2], PDE Dummy, CBMS Dummy, Auto [-3] |




| **Partial Dual Eligibles: Model Results** | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2010-11** | **FY 2008-09** | **FY 2009-10** | **Projected Growth Rate** | **Projected FY 2010-11 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 15,075 | 15,919 | 6.48% | 16,951 | 1,032 | 71 |
| Exponential Smoothing B* | 15,075 | 15,919 | 7.94% | 17,183 | 1,264 | 107 |
| Box Jenkins A | 15,075 | 15,919 | 4.10% | 16,572 | 653 | 8 |
| Box Jenkins B | 15,075 | 15,919 | 4.89% | 16,697 | 778 | 19 |
| Regression A | 15,075 | 15,919 | 8.40% | 17,256 | 1,337 | 117 |
| **Regression B** | **15,075** | **15,919** | **7.90%** | **17,177** | **1,258** | **104** |
| Regression C | 15,075 | 15,919 | 8.14% | 17,215 | 1,296 | 114 |

* Denotes Expert Selection, Bold denotes Trend Selection

| Partial Dual Eligibles: Model Results | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2011-12** | **FY 2009-10** | **Projected FY 2010-11 Caseload** | **Projected Growth Rate** | **Projected FY 2011-12 Caseload** | **Level Change** | **Average Monthly Change [1]** |
| Exponential Smoothing A* | 15,919 | 17,177 | 5.13% | 18,058 | 881 | 72 |
| Exponential Smoothing B* | 15,919 | 17,177 | 7.54% | 18,472 | 1,295 | 108 |
| Box Jenkins A | 15,919 | 17,177 | 0.11% | 17,196 | 19 | 0 |
| Box Jenkins B | 15,919 | 17,177 | 0.14% | 17,201 | 24 | 0 |
| Regression A | 15,919 | 17,177 | 8.29% | 18,601 | 1,424 | 123 |
| **Regression B** | **15,919** | **17,177** | **7.28%** | **18,427** | **1,250** | **107** |
| Regression C | 15,919 | 17,177 | 8.39% | 18,618 | 1,441 | 125 |

| **FY 2012-13** | **Projected FY 2010-11 Caseload** | **Projected FY 2011-12 Caseload** | **Projected Growth Rate** | **Projected FY 2012-13 Caseload** | **Level Change** | **Average Monthly Change [1]** |
|---|---|---|---|---|---|---|
| Exponential Smoothing A* | 17,177 | 18,427 | 4.87% | 19,324 | 897 | 72 |
| Exponential Smoothing B* | 17,177 | 18,427 | 7.01% | 19,719 | 1,292 | 108 |
| Box Jenkins A | 17,177 | 18,427 | 0.00% | 18,427 | 0 | 0 |
| Box Jenkins B | 17,177 | 18,427 | 0.00% | 18,427 | 0 | 0 |
| Regression A | 17,177 | 18,427 | 8.27% | 19,951 | 1,524 | 134 |
| **Regression B** | **17,177** | **18,427** | **7.22%** | **19,757** | **1,330** | **114** |
| Regression C | 17,177 | 18,427 | 8.38% | 19,971 | 1,544 | 135 |

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

### *Partial Dual Eligibles: Trend Selections*

FY 2010-11: 7.90%
FY 2011-12: 7.28%
FY 2012-13: 7.22%

### *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 2009-10 was equal to the Department's February 2010 forecast, in which the annual caseload was projected to be 15,919 and average monthly growth was projected to be 102. The selected trend for FY 2010-11 is slightly higher than the February 2010 forecast, and would yield average growth of **104 per month**.
- Out-year trend selections are slightly higher than 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. (2010)*
*(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. (2010)*
*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. (2010)*
*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-08 | 14,700 | - | - |
| 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% |
| Jul-09 | 15,434 | 185 | 1.21% |
| Aug-09 | 15,522 | 88 | 0.57% |
| Sep-09 | 15,513 | (9) | -0.06% |
| Oct-09 | 15,638 | 125 | 0.81% |
| Nov-09 | 15,743 | 105 | 0.67% |
| Dec-09 | 15,846 | 103 | 0.65% |
| Jan-10 | 15,954 | 108 | 0.68% |
| Feb-10 | 16,076 | 122 | 0.76% |
| Mar-10 | 16,212 | 136 | 0.85% |
| Apr-10 | 16,308 | 96 | 0.59% |
| May-10 | 16,285 | (23) | -0.14% |
| Jun-10 | 16,495 | 210 | 1.29% |

| | **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 | 15,919 | 5.60% | 844 |
| FY 2010-11 | 17,177 | 7.90% | 1,258 |
| FY 2011-12 | 18,427 | 7.28% | 1,250 |
| FY 2012-13 | 19,757 | 7.22% | 1,330 |

* 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 2010 Trends** | | | |
|---|---|---|---|
| FY 2009-10 | 15,919 | 5.60% | 844 |
| FY 2010-11 | 17,119 | 7.54% | 1,200 |
| FY 2011-12 | 18,316 | 6.99% | 1,197 |

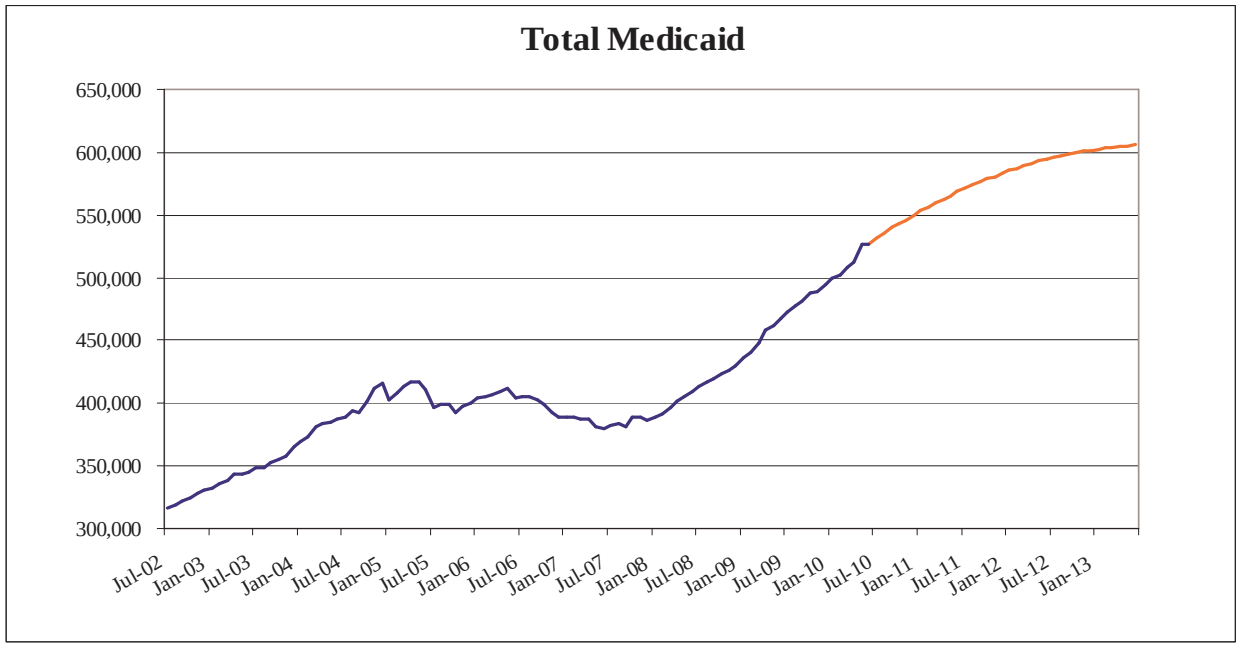
| **Actuals** | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 108 | 0.67% |
| 12-month average | 104 | 0.66% |
| 18-month average | 80 | 0.51% |
| 24-month average | 75 | 0.48% |

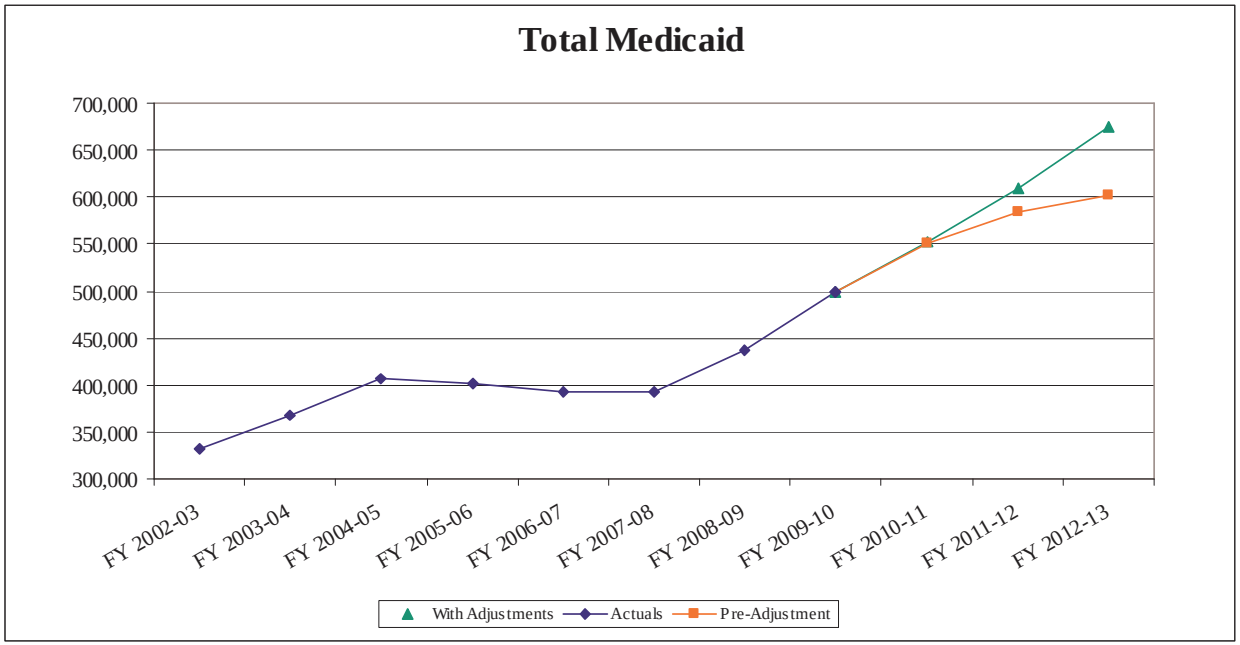
| **Base trend from June 2010 level** | | | |
|---|---|---|---|
| FY 2010-11 | 16,495 | 3.62% | 576 |

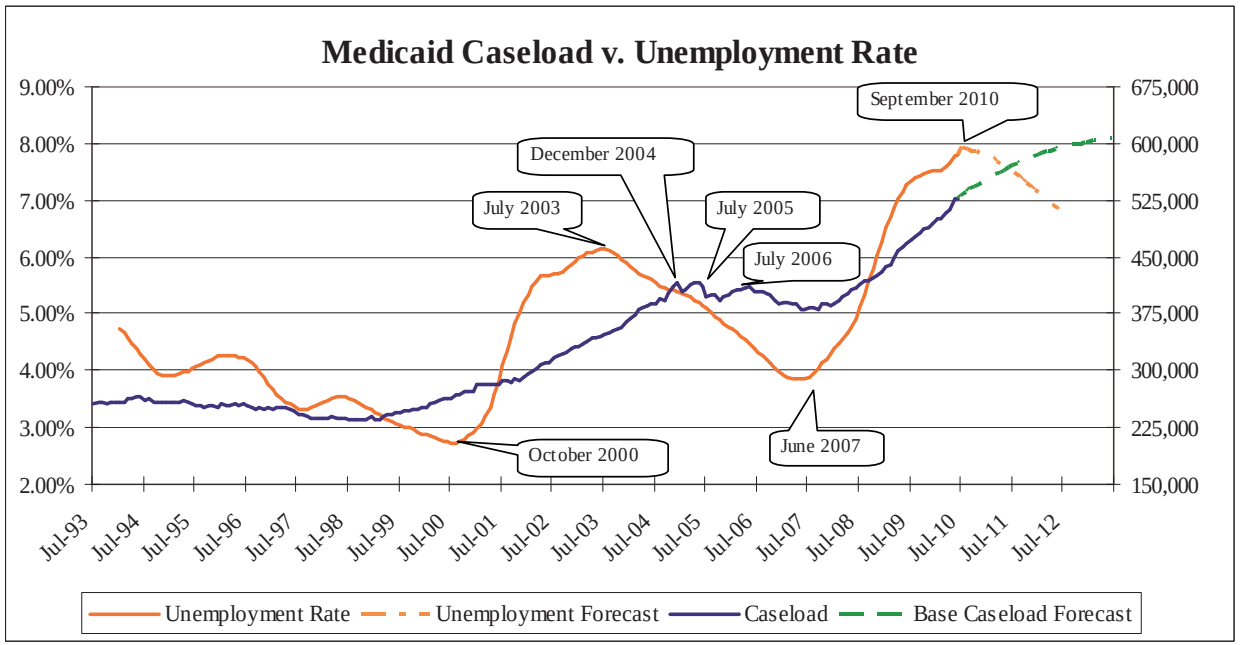
| **Monthly Average Growth Comparisons** | | |
|---|---|---|
| FY 2009-10 1st Half | 100 | 0.64% |
| FY 2009-10 2nd Half | 108 | 0.67% |
| February 2010 Forecast | 102 | 0.67% |
| FY 2010-11 Forecast | 104 | 0.68% |
| February 2010 Forecast | 100 | 0.61% |
| FY 2011-12 Forecast | 107 | 0.60% |
| February 2010 Forecast | 100 | 0.57% |

***Summary***

The Department is forecasting a FY 2010-11 total Medicaid caseload of 551,570, a 10.58% increase from FY 2009-10. The trend is projected to remain fairly constant in FY 2010-11 with caseload expected to increase by 10.60% to 610,025, with a large portion of the growth to come from the eligibility expansion in Expansion Adults to 100% FPL, the implementation of the Buy-In Program for Individuals with Disabilities Program in July 2011, and the extension of 12-month guaranteed eligibility to children in Medicaid beginning in February 2012.




Total Medicaid
700,000
650,000
600,000
550,000
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
FY 2012-13
With Adjustments
Actuals
Pre-Adjustment


Medicaid Caseload v. Unemployment Rate
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
675,000
600,000
525,000
450,000
375,000
300,000
225,000
150,000
September 2010
December 2004
July 2003
July 2005
July 2006
October 2000
June 2007
Jul-93
Jul-94
Jul-95
Jul-96
Jul-97
Jul-98
Jul-99
Jul-00
Jul-01
Jul-02
Jul-03
Jul-04
Jul-05
Jul-06
Jul-07
Jul-08
Jul-09
Jul-10
Jul-11
Jul-12
Unemployment Rate
Unemployment Forecast
Caseload
Base Caseload Forecast

| Total Medicaid: Historical Caseload and Projections | | | |
|---|---|---|---|
| | **Actuals** | **Monthly Change** | **% Change** |
| Jun-08 | 409,640 | - | - |
| 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% |
| Jul-09 | 472,277 | 4,721 | 1.01% |
| Aug-09 | 477,915 | 5,638 | 1.19% |
| Sep-09 | 481,549 | 3,634 | 0.76% |
| Oct-09 | 487,250 | 5,701 | 1.18% |
| Nov-09 | 489,612 | 2,362 | 0.48% |
| Dec-09 | 494,699 | 5,087 | 1.04% |
| Jan-10 | 499,735 | 5,036 | 1.02% |
| Feb-10 | 501,596 | 1,861 | 0.37% |
| Mar-10 | 508,592 | 6,996 | 1.39% |
| Apr-10 | 512,398 | 3,806 | 0.75% |
| May-10 | 526,431 | 14,033 | 2.74% |
| Jun-10 | 526,221 | (210) | -0.04% |
| **Jul-10** | **531,608** | **5,387** | **1.02%** |
| **Aug-10** | **535,501** | **3,893** | **0.73%** |
| **Sep-10** | **540,420** | **4,919** | **0.92%** |
| **Oct-10** | **543,789** | **3,369** | **0.62%** |
| **Nov-10** | **545,226** | **1,437** | **0.26%** |
| **Dec-10** | **549,717** | **4,491** | **0.82%** |
| **Jan-11** | **552,927** | **3,210** | **0.58%** |
| **Feb-11** | **555,819** | **2,892** | **0.52%** |
| **Mar-11** | **559,776** | **3,957** | **0.71%** |
| **Apr-11** | **562,465** | **2,689** | **0.48%** |
| **May-11** | **565,123** | **2,658** | **0.47%** |
| **Jun-11** | **568,856** | **3,733** | **0.66%** |
| **Jul-11** | **571,434** | **2,578** | **0.45%** |

| | **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 | 406,024 | 10.46% | 38,465 |
| FY 2005-06 | 402,218 | -0.94% | (3,806) |
| FY 2006-07 | 392,228 | -2.48% | (9,990) |
| FY 2007-08 | 391,962 | -0.07% | (266) |
| FY 2008-09 | 436,812 | 11.44% | 44,850 |
| FY 2009-10 | 498,797 | 14.19% | 61,985 |
| FY 2010-11 | 550,934 | 10.45% | 52,137 |
| FY 2011-12 | 583,946 | 5.99% | 33,012 |
| FY 2012-13 | 601,603 | 3.02% | 17,657 |

* 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** | |
|---|---|
| FY 2009-10 | 608 |
| FY 2010-11 | 636 |
| FY 2011-12 | 26,079 |
| FY 2012-13 | 74,335 |

| **Projections After Adjustments** | | | |
|---|---|---|---|
| FY 2010-11 | 551,570 | 10.58% | 52,773 |
| FY 2011-12 | 610,025 | 10.60% | 58,455 |
| FY 2012-13 | 675,938 | 10.80% | 65,913 |

| **February 2010 Trends (AFTER PARENTS ADJUSTMENTS)** | | | |
|---|---|---|---|
| FY 2009-10 | 498,424 | 14.10% | 61,612 |
| FY 2010-11 | 552,877 | 10.93% | 54,453 |
| FY 2011-12 | 589,767 | 6.67% | 36,890 |

| Total Medicaid: Historical Caseload and Projections | | | |
|---|---|---|---|
| **Aug-11** | **573,975** | **2,541** | **0.44%** |
| **Sep-11** | **576,651** | **2,676** | **0.47%** |
| **Oct-11** | **579,034** | **2,383** | **0.41%** |
| **Nov-11** | **581,099** | **2,065** | **0.36%** |
| **Dec-11** | **583,496** | **2,397** | **0.41%** |
| **Jan-12** | **585,562** | **2,066** | **0.35%** |
| **Feb-12** | **587,463** | **1,901** | **0.32%** |
| **Mar-12** | **589,538** | **2,075** | **0.35%** |
| **Apr-12** | **591,295** | **1,757** | **0.30%** |
| **May-12** | **593,031** | **1,736** | **0.29%** |
| **Jun-12** | **594,824** | **1,793** | **0.30%** |

**Bold denotes projection

| Base trend from June 2010 level | | | |
|---|---|---|---|
| FY 2010-11 | 526,221 | 5.50% | 27,424 |

| Actuals | | |
|---|---|---|
| | **Monthly Change** | **% Change** |
| 6-month average | 5,254 | 1.04% |
| 12-month average | 4,889 | 0.99% |
| 18-month average | 5,358 | 1.13% |
| 24-month average | 4,858 | 1.05% |

| Monthly Averages | | |
|---|---|---|
| FY 2009-10 1st Half | 4,524 | 0.95% |
| FY 2009-10 2nd Half | 5,254 | 1.04% |
| February 2010 Forecast | 4,493 | 0.91% |
| FY 2010-11 Forecast | 3,553 | 0.65% |
| February 2010 Forecast | 2,813 | 0.52% |
| FY 2011-12 Forecast | 2,164 | 0.37% |
| February 2010 Forecast | 1,405 | 0.25% |

## 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 current and request years. 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***

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.[13] The total spending authority is compared to the total projected estimated current year expenditures from page EA-4. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

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-6. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

Totals for the base request on this page correspond with Columns 3, 5, and 8 on the Schedule 13, where appropriate.

For FY 2010-11, Column 5 in the Schedule 13 will not match Exhibit A. Exhibit A shows the correct total need for Medical Services Premiums, not the Schedule 13. See the section "Alternative Calculation of Request" for further information.

***Calculation of Fund Splits***

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 medical assistance percentage (FMAP) is listed on the right-hand side of the table. The FMAP 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 FMAP 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.

[13] For FY 2010-11, the Department's totals on this page differ from the actual spending authority due to the inclusion of the budget balancing items submitted in August 2010, request ES-1, ""Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". Page EA-3 shows the actual total spending authority. Annualizations of budget balancing items are included in the FY 2011-12 base request.

The FMAP is impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA is an enhanced FMAP for specified Medicaid programs; the effective period of this enhanced rate was originally October 1, 2008 through December 31, 2010. However, recent legislation, HR 1586, extended the effective period of ARRA to June 30, 2011. The enhanced FMAP from ARRA beyond December 31, 2010 undergoes a staged phase out. 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 FMAP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 would be less than the FMAP 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 FMAP for FY 2008-09 through FY 2011-12.

| FMAP 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 - March 2009 | Second and third quarters of FY 2008-09 |
| 61.59% | Enhanced rate per ARRA | April 2009 - December 2010 | FY 2009-10,First and second quarters of FY 2010-11 |
| 58.77% | First stage of ARRA phase out | January 2011 - March 2011 | Third quarter of FY 2010-11 |
| 56.88% | Final stage of ARRA phase out | April 2011 - June 2011 | Fourth quarter of FY 2010-11 |
| 50.00% | Post-ARRA | July 2011 forward | First quarter of FY 2011-12 forward |

The resulting FMAP for FY 2010-11 is a weighted average of the multiple FMAPs available during the fiscal year, totaling 59.71%.

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g. Acute Care) by programs which are funded with either a different state source or a different federal medical assistance percentage 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: The Department receives a 90% federal medical assistance percentage available for all documented family planning expenditures. This includes those services that are rendered through health maintenance organizations. Please see Exhibit F for calculations. This line also included reappropriated funds from the Department of Public Health and Environment to fund the state share of a family planning waiver program; see section V for additional details.
- 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. (2010). For FY 2010-11 and FY 2011-12, 100% of state funding for traditional clients 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, which is administered by the Department of Public Health and Environment. Please see Exhibit F for calculations.

- Prenatal Costs for Optional Legal Immigrants: 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, effective July 1, 2010, the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status; 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 Supplemental Payments and Nursing Facility General Fund Cap: HB 08-1114 and SB 09-263 directed 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. 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. For FY 2010-11, the Department is using the full amount to fund current expenditures for clients related to the factors above. For FY 2011-12, the Department is requesting to use a portion of the funding for the adult medical home pilot program; see Exhibit I for further details.
- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated 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. Beginning in FY 2011-12, the Department will extend the Physician Supplemental Payments to Memorial Health System, and will continue to work with other eligible providers that may benefit from such payments for potential future expansions.
- 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. However, supplemental payments will receive the enhanced federal match.

- Hospital Provider Fee Financing: At the direction of the Office of State Planning and Budgeting, the Department is requesting to draw additional Hospital Provider fee for budget balancing purposes in the Medical Services Premiums base. In FY 2011-12, the Department would collect an additional $50,000,000 in provider fee, which would leave the aggregate net benefit to all hospitals at approximately the same level as FY 2010-11. In FY 2012-13 forward, the Department would collect an additional $25,000,000 increased by an inflationary factor to be determined based on growth in hospital revenue, which will allow the net benefit to all hospitals to increase from the FY 2011-12 level. This financing mechanism will require legislation.
- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to 75 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 FMAP rate of 50%, the program is eligible for enhanced federal financial participation during the ARRA period. Clients are limited to a cap of $25,000 in waiver services. The Department estimates the funding need from the Colorado Autism Treatment Fund at 85% of the cap for each of the 75 clients, plus $163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.
- 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 with state-only funding.
- Coordinated Care for People with Disabilities Program: The coordinated care for people with disabilities pilot program, as authorized by SB 06-128, allows the Department to pay per member per month administration fees to a nonprofit organization which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations.
- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom-line adjustment to total expenditures. This is further described in Exhibit K.
- 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 2010-11 and FY 2011-12 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2009-10.
- Medical Services Premiums Contingent Liabilities: The Department's request includes funding apart from standard service category projections for potential payments for prior year financial issues which may arise in FY 2010-11.
- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers. The table below shows the impact, by cash fund for FY 2010-11 and FY 2011-12.

| **Cash Fund** | **FY 2010-11** | **FY 2011-12** |
|---|---|---|
| Primary Care Fund (HB 10-1378) | $12,800,000 | $0 |
| Supplemental Old Age Pension Health and Medical Care Fund (HB 10-1380) | $4,850,000 | $3,000,000 |
| Tobacco Education Program Fund (HB 10-1381) | $15,521,625 | $0 |
| Prevention, Early Detection, and Treatment Fund (HB 10-1381) | $5,679,358 | $0 |
| Hospital Provider Fee (SB 10-169) | $52,372,767 | $0 |
| **Total** | **$91,223,750** | **$3,000,000** |

In addition, the item includes a $2.0 million transfer of reappropriated funds for FY 2010-11 and $1.75 million in FY 2011-12, from the Prevention, Early Detection and Treatment fund. These funds are transferred from the Department of Public Health and Environment for disease management (described above), 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.

***Alternative Calculation of Request***

The Department has submitted supplemental requests prior to this request as a result of budget balancing actions. This page includes some of those actions in order to correctly calculate the incremental request on the Schedule 13. On August 23, 2010, the Department submitted supplemental request ES-1 - "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" to account for the phase down of the enhanced FMAP. On October 22, 2010, the Department submitted request ES-2, "Fee-for-Service Delay in FY 2010-11" to request additional funding to account for the FY 2009-10 payment delay. As a result of these requests, the Department's Schedule 13 and other pages from Exhibit A do not always reflect the Department's final need for Medical Services Premiums.

For FY 2010-11, the Department presents two alternative calculations for Exhibit A:

- On page EA-2, the Department presents the calculation of the request without accounting for the request ES-1. This page differs from the standard Exhibit A in that it adds the total request (from page EA-1) to the total spending authority. The total expenditure on this page matches the Schedule 13. Please note that this figure is for reference only for the purpose of showing the derivation of the Schedule 13, and does not reflect the Department's total request for Medical Services Premiums.
- On page EA-3, the Department shows the total request for Medical Services Premiums, including the total amounts requested in ES-1 and ES-2. This page demonstrates the true incremental funding need for Medical Services Premiums. This figure differs from the amounts requested on page EA-1 in order to show the sum of all FY 2010-11 requests for Medical Services Premiums through November 1, 2010.

This page does not incorporate the impact from other budget balancing requests; in particular, the Department's request for additional fee-for-service payment delays in ES-2 and managed care payment delays in ES-3 are not reflected on this page.

*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 2009-10) and projections are included for historical reference and comparison. The Department provides two separate tables. On page EC-1, the Department provides the per capita cost history based on the cash-based actuals (i.e. the actual expenditure paid in the fiscal year). On page ES-2, the Department providers the per capita cost history adjusted for the FY 2009-10 payment delay; that is, the claims which were delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals.

*EXHIBIT D – CASH FUNDS REPORT*

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. In addition, for the current year, total spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letternote amount on the Schedule 13. The Department also provides the specific requested changes to special bill appropriation clauses, when appropriate.

*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.

Starting with page EE-2, 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 16, 2010 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***

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.

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 2002-03 through FY 2009-10. 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 relatively constant. 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 2007-08, FY 2008-09, and FY 2009-10. 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 2010-11 and FY 2011-12. 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 "w/o 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 2010-11 and FY 2011-12 with the rationale for selection, are as follows:

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Adults 65 and Older (OAP-A) | 3.18% Average per capita change from FY 2006-07 to FY 2008-09 (w/o Rx) | 3.18% Average per capita change from FY 2006-07 to FY 2008-09 (w/o Rx) | Historical per capita trends have been on the rise. Expenditure containment and efficiency measures coupled with growth in caseload have resulted in declining per capita expense. While some of these measures will have lasting impacts, it is unlikely that the Department will experience the same magnitude of reduction in the upcoming years. Reverting to a historical three year trend will best reflect the Department's expectation of future growth. |
| Disabled Adults 60 to 64 (OAP-B) | 4.82% Average per capita change from FY 2006-07 to FY 2008-09 | 4.82% Average per capita change from FY 2006-07 to FY 2008-09 | Although the last fiscal year saw declines in per capita trends, it is impossible to ignore the strong growth in two years prior. Pharmacy was a strong driver a costs increases in the last year, whereas inpatient hospital and HMOs have seen a decline. Ultimately, these opposing forces balance each other out. As the trends for each stabilize, it is likely this population will continue to see the historical growth, but with a dampened magnitude. |

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Disabled Individuals to 59 (AND/AB) | 2.81% Average per capita change from FY 2006-07 to FY 2009-10 | 2.81% Average per capita change from FY 2006-07 to FY 2009-10 | The primary cost driver in this aid category is acute home health services; despite rate reductions, per capita expenditure for home health expenditure increased by 7.27% in FY 2009-10, and is expected to continue to be a driver of future costs. Despite this, expenditure for other service categories mostly declined, leading to an overall per capita decline in FY 2009-10. The Department anticipates that these trends will likely continue, but at a dampened pace, leading to per capita growth in future years. The average of FY 2006-07 to FY 2009-10 will capture the strong historical growth while accounting for the recent years decline. |
| Categorically Eligible Low-Income Adults (AFDC-A) | 5.10% Average per capita change from FY 2003-04 to FY 2007-08 | 2.55% Half of the FY 2010-11 growth rate | With high growth in caseload, per capita figures have declined in the last two years. Caseload is anticipated to decline in this eligibility category in FY 2010-11 while the key driving factors for this group have a positive trend. Consequently, the Department anticipates that this aid category will return to increases in the per capita in future years. The current year estimated trend is a long-term average of years prior to the large caseload growth; the request year halves the trend factor as caseload is projected to begin to rise again, and new clients will mitigate overall per capita cost increases. |
| Expansion Adults to 60% (Page EF-6) | 3.33% Half of FY 2009-10 per capita increase. | 3.33% Half of FY 2009-10 per capita increase. | This population continues to mature; prior year growth overstates the natural trend as it reflects a population new to receiving services. The Department anticipates that this pattern will continue for at least one more year, and selects half of the trend from FY 2009-10. This growth is similar to what is expected for other low-income adults. |
| Expansion Adults to 100% (Page EF-6) | 3.33% Half of the FY 2009-10 increase in Expansion Adults to 60% | 3.33% Half of the FY 2010-11 increase in Expansion Adults to 60% | The Department assumes that the per capita cost of this population will quickly reach the same level as Expansion Adults to 60%. Early experience with this population indicates a high per capita cost compared to the early experience of Expansion Adults to 60%; this reflects that many clients in this aid category were transitioned from other aid categories at the beginning of the program. Therefore, the Department assumes the same growth rate as the Expansion Adults to 60% aid category. |

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Breast & Cervical Cancer Program (Page EF-7) | -1.71% | -1.71% | 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) | 2.44% Average of FY 2007-08 through FY 2009-10 | 1.22% Half of the FY 2010-11 growth rate | Growth in per capita costs has been decreasing over the last three fiscal years. However, the magnitude of the most recent years decrease includes factors such as rate cuts, efficiency measures and increases in caseload. The absolute increase in caseload for FY 2010-11 is about half of the increase seen in FY 2009-10; therefore, the Department anticipates a small return to per capita growth in FY 2010-11. Caseload growth will accelerate again in FY 2011-12, and the Department halves the trend factor to compensate. |
| Foster Care | 3.76% Average per capita change from FY 2007-08 to FY 2009-10 | 3.76% Average per capita change from FY 2007-08 to FY 2009-10 | Foster care per capita costs have experienced declined in the past two years; the most recent year showed a larger decline as a result of rate cuts. However, the prior history indicates the potential for large growth. The Department anticipates that per capita costs with return to growth in FY 2010-11, although this growth will be dampened by the continued effect of the FY 2009-10 and FY 2010-11 rate cuts. |
| Baby Care Program - Adults (BCKC-A) | 0.51% Average per capita change from FY 2008-09 to FY 2009-10 | 0.51% Average per capita change from FY 2008-09 to FY 2009-10 | Recent history for these populations shows virtually no per capita growth; this is true even after the inclusion of the former prenatal state-only population in FY 2009-10, which added roughly $6.5 million in expenditure. As such, the Department selected a conservative growth factor for this population. |
| Non-Citizens | 8.85% Average per capita change from FY 2007-08 to FY 2009-10 | 4.43% Half of the FY 2010-11 growth rate | This population experienced a large expenditure decline as the former prenatal state-only population was moved to Baby Care Program – Adults effective July 1, 2009. Per capita experienced a decline in FY 2009-10, and the Department anticipates this decline was a result of budget balancing policies, including rate cuts; these clients use primarily inpatient hospital and physician services, which were both targeted as part of budget balancing. Caseload continues to decline, however, prior history indicates that expenditure for this population will remain relatively stable; the Department chooses a per capita trend which allows for stable expenditure in FY 2010-11 and FY 2011-12. |

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Partial Dual Eligibles | 3.85% Average per capita change from FY 2007-08 to FY 2009-10 | 3.85% Average per capita change from FY 2007-08 to FY 2009-10 | The last year saw a significant decline in per capita expenditure; this population was affected by budget balancing as the Department's payments for Medicaid coinsurance decreased in concert with the Department's other rate reductions. The Department anticipates that this reduction is a level shift, as opposed to a new trend, and that this population will return to growth in FY 2010-11 and FY 2011-12. |

***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. These impacts are described briefly below, and in more detail in section V, Additional Calculation Considerations:

- ES-6 (FY 2009-10), Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid to providers for Acute Care Services effective December 1, 2009. The FY 2010-11 impact represents an annualization of expected savings.
- BRI-1 (FY 2010-11), Prevention and Benefits for Enhanced Value (P-BEV) and BA-12 (FY 2010-11) Evidence Guided Utilization Review (EGUR), increased utilization review funding in order to provide an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures to be performed by dental hygienists, and improve non-emergency medical transportation policies.
- BRI-2 (FY 2010-11), Coordinated Payment and Payment Reform, implements proposed steps toward payment coordination and payment reform. Payment coordination is characterized by streamlined payment processes, enhanced recovery efforts and proactive integration of care. The payment reform component supports performance-based payment structures which incentivize desired outcomes.
- BRI-3 (FY 2010-11), Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology reduces total funds as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. This will allow the Department to take advantage of an approved reimbursement methodology, increasing opportunities for reimbursement savings associated with pharmacy claims.
- BRI-6 (FY 2010-11), Medicaid Program Reductions - Limitation on Incontinence Products - this request reduces Medicaid physical health provider rates by 1% (effective July 1, 2010) and imposes restrictions on certain durable medical equipment.
- S-6 (FY 2010-11), Accountable Care Collaborative – the Accountable Care Collaborative (ACC) is a client/family-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of members. The Department anticipates clients being enrolled in the ACC effective April 1, 2010; this bottom line impact reflects the estimated savings the Department expects as a result of the program.
- BA-16 (FY 2010-11), Implementation of Family Planning Waiver transfers funds from the Department of Public Health and Environment (DPHE) to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. Transferring this funding to the Department will allow for an enhanced federal financial participation rate of 90% to fund

family planning services for uninsured, low-income Coloradans who would otherwise be receiving services funded by the unmatched General Fund dollars currently appropriated to the Department of Public Health and Environment.

- HB 10-1005, Home Health Care – Telemedicine Changes, clarifies and enhances the Department's ability to reimburse for telemedicine services. Payment for telemedicine services comes from the newly created Home Health Telemedicine Cash Fund for FY 2010-11 and FY 2011-12.
- HB 10-1033, Add Screening, Brief Intervention and Referral to Treatment to Optional Services, adds screening, brief intervention, and referral for treatment for substance abuse to the list of optional services covered by Medicaid.
- Benefits Limits on Echocardiograms limits the number of echocardiograms available without prior authorization as defined through the Department's community engaged Benefits Collaborative process. This policy was implemented in FY 2009-10; the FY 2010-11 impact represents an annualization of the expected savings.
- 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.
- SB 10-167, Colorado False Claims Act, has three components. The first component increases enrollment in the Health Insurance Buy-in (HIBI) program. January 2011 through June 2011, 1,500 new enrollees will be added incrementally to the HIBI program. The second component of SB 10-167 is an automated prepayment review of claims. This system will produce savings by identifying coding errors prior to reimbursement of claims. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid that are eligible to enroll in the Medicaid programs of other states.
- Remove Manual Pricing of Durable Medical Equipment (DME), Injectibles, and Medical Services sets reimbursement rates to a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists rates are set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate. These policies were implemented in FY 2009-10; the FY 2010-11 impact represents an annualization of the expected savings.
- The Colorado Access contract for the Colorado Regional Integrated Care Collaborative (CRICC) was altered from a risk-based, capitated program to an Administrative Services Organization (ASO), generating a one-time cash-flow reduction in FY 2009-10 as the Department ceased paying risk-based capitations. The FY 2010-11 impact represents an annualization of the cash-flow reduction in FY 2009-10.
- 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 provided the Department with AWP information used in the pricing of Medicaid pharmacy claims. The FY 2010-11 impact represents an annualization of expected savings.
- ES-2 (FY 2009-10), Provider Rate Reductions, included a permanent 1.5% reduction, effective September 1, 2009, in the reimbursement rate paid for most Acute Care services. The effective date for managed care provider payments was October 1, 2009, to allow time to actuarially certify rates. The FY 2010-11 impact represents an annualization of expected savings.
- BA-33 (FY 2009-10), 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 below). The FY 2010-11 impact represents an annualization of expected savings.

- BA-33 (FY 2009-10), 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. The Department has reduced the estimate from previous budget requests, but still anticipates savings in FY 2010-11 and FY 2011-12.
- BRI-2 (FY 2009-10), Medicaid Program Efficiencies: Fluoride Varnish, allows trained medical and dental professionals 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. This benefit was added in FY 2009-10; the FY 2010-11 impact represents an annualization of expected expenditures.
- BRI-1 (FY 2009-10), Pharmacy Efficiencies, reduces expenditure as a result of implementing an automated prior authorization system and changing the reimbursement rates of drugs using a state maximum allowable cost structure. 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. The FY 2010-11 impact represents an annualization of expected savings.
- NEMT Supplemental Payments – this allowed for additional funds to be expended on its fixed price contract to provide Non-Emergency Transportation Services in the 8 metro counties. The contractor had recently informed the Department that it would need to cease to provide services, as the fixed price contract did not accommodate the unprecedented caseload growth facing the Department and the provider. Through contract negotiations, the Department was able to adjust the fixed price on the contract in order to ensure vital services continued. The annualization of this impact for FY 2010-11 represents the incremental difference in expense between fiscal years.
- HB 09-1293 Children's Continuous Eligibility Adjustment – as caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of this population will be 75% of the per capita rate of traditionally eligible population in the same category. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population.
- HB 09-1293 Foster Care Continuous Eligibility Adjustment – as caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of this population will be 75% of the per capita rate of traditionally eligible population in the same category. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population.
- HB 09-1293 Disability Buy-In Adjustment – as caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of this population will be 75% of the per capita rate of traditionally eligible population in the same category. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population.

***Calculation of Expansion Adults Expenditure and Fund Splits***

The Department's Expansion Adults population is comprised of two distinct groups; adults between the AFDC income limit and 60% of the federal poverty level (FPL) ("Expansion Adults to 60%"), and adults over 60% FPL up to 100% of the FPL ("Expansion Adults to 100%"). These populations have distinct funding sources: Expansion Adults to 60% are funded through the Health Care Expansion Fund, while Expansion Adults to 100% are funded through the Hospital Provider Fee Cash Fund.

This exhibit calculates the per capita cost of each population so that the Department can appropriately request the correct amount of funding from each cash fund. The presentation of the exhibit varies from other exhibits; in this case, expenditure and per capita costs are shown on the left side, while percent changes are shown on the left side. Projections for the current year and the request year are shown at the bottom. The calculations remain the same as the base Acute Care calculations; total per capita is trended forward and multiplied by projected caseload to calculate expenditure totals. Bottom line impacts, as calculated in the base Acute Care calculations, are added into the total to calculate the final expenditure. Fund split calculations for these populations are performed in Exhibit J.

The trends for each population are described in detail above. For FY 2010-11 and FY 2011-12, assumes that the per capita cost of the Expansion Adults to 100% population will quickly reach the same level as Expansion Adults to 60%. Early experience with this population indicates a high per capita cost compared to the early experience of Expansion Adults to 60%; this reflects that many clients in this aid category were transitioned from other aid categories at the beginning of the program. Therefore, the Department assumes the same growth rate as the Expansion Adults to 60% aid category.

***Breast and Cervical Cancer Program Per Capita Detail and Fund Splits***

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 funds. 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.

<u>Per-Capita Cost</u>

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 2009 through June 2010 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 adjusts 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. (2010), 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 through FY 2011-12, 100% of state funding for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Beginning FY 2012-13, state funding will be split with 50% coming from the General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2010), 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. Historically and using the methodology 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.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2011-12 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast

and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340.

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

***Antipsychotic Drugs***

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services in 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 the Department's Medicaid Mental Health Long Bill group effective with HB 08-1375.

***Prenatal Care Costs for Optional Legal Immigrants***

Pursuant to 25.5-5-103 (3), C.R.S. (2010), 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 began to receive full Medicaid benefits and therefore will receive a federal match on all Medicaid provided services. This population does not receive the enhanced federal medical assistance percentage (FMAP) specified in the American Recovery and Reinvestment Act (ARRA) because this population was granted full Medicaid eligibility after ARRA was enacted. Prior to FY 2009-10, expenditure for clients in the state-only prenatal care program was included in the Non-Citizens aid category. As a result of granting these clients eligibility, expenditure is now recorded in the Baby Care Adults column.

An analysis of yearly expenditure reveals that total expenditure for this population has been relatively stable in the past three years. The last three year-to-year changes in expenditure growth were 15.06%, 15.48%, and 16.08%. Given the economic climate, the Department anticipates continued rapid growth, but slowing as the economy begins to improve. Based on this assumption, the Department estimates total expenditure from the average percent change over the last three years for FY 2010-11 and half that growth rate for FY 2011-12. The reduction of the trend in FY 2011-12 models the anticipated economic recovery, and slowing of expenditure growth.

***Family Planning - Calculation of Enhanced Federal Match***

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. 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 2010-11 and the out-year is based on a linear regression analysis of FY 2002-03 through FY 2006-07 and the addition of FY 2010-11 BA-16 "Implementation of Family Planning Waiver". More recent family planning data was eliminated from the model because the Department assumes that recent expenditure increases have been 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.

BA-16 "Implementation of Family Planning Waiver", added $1,903,500 in FY 2010-11 and an additional $2,303,100 in FY 2011-12 to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. This additional funding was added to the family planning estimates and appears as a bottom line impact in Acute Care. The state share of the funding is transferred from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds.

***Prior-Year Expenditure***

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 capita costs 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 HCBS

census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2009-10, the Department paid HCBS claims for an average of 18,975 clients per month.

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 extended the option of receiving HCBS through the Consumer-Directed care service model to all Medicaid recipients who are enrolled in a HCBS 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 HCBS 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 HCBS 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***

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 2009-10. 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 2007-08, FY 2008-09, and FY 2009-10.

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 selected per capita trend factors for FY 2010-11 and FY 2011-12, with the rationale for selection, are as follows:

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Adults 65 and Older (OAP-A) | 4.54% Average of FY 2008-09 through FY 2009-10 | 4.54% Average of FY 2008-09 through FY 2009-10 | The FY 2010-11 trend is based on the current expenditure and prior-year cash flow. The primary drivers in this eligibility category are expenditures for Elderly, Blind and Disabled waiver and Hospice clients. Elderly, Blind, and Disabled waiver clients account over 70% of expenditure. The growth rate of expenditure for these waiver services has slowed substantially from FY 2008-09 to FY 2009-10, from approximately 12% growth between FY 2007-08 and FY 2008-09 to 3% from FY 2008-09 to FY 2009-10. The same overall trend appears to be true for Hospice as well. As such, the Department has selected a moderate growth trend. The FY 2011-12 trend is held constant from FY 2010-11. |
| Disabled Adults 60 to 64 (OAP-B) | 6.15% Average of FY 2008-09 through FY 2009-10 | 6.15% Average of FY 2008-09 through FY 2009-10 | Expenditure growth in this category in the first half of FY 2009-10 was primarily driven by growth in hospice expenditure, primarily due to federally mandated increases and retroactive adjustments. Despite a large expenditure increase, per capita growth was relatively small. The selected trend factor in FY 2010-11 averages the per capita expenditure between FY 2008-09 and FY 2009-10, reflecting this population's historical propensity for large growth. The FY 2011-12 trend factor is held constant from FY 2010-11. |

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Disabled Individuals to 59 (AND/AB) | 12.44% Average of FY 2008-09 through FY 2009-10 | 2.07% One sixth the average of FY 2008-09 through FY 2009-10 | 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 Department experienced low per capita growth in FY 2009-10 as a result of rate reductions, but the Department does not anticipate that this trend continues. The FY 2010-11 trend is a long-term historical average which allows for the growth that has historically been present. The FY 2011-12 per capita cost is skewed by the influx of clients into this eligibility category from the implementation of the Disabled Buy-In program; the clients from the buy-in program are not anticipated to use a significant amount of HCBS services. The Department takes one sixth of the trend factor in FY 2011-12 to account for the change. |
| Categorically Eligible Low-Income Adults (AFDC-A) | 3.38% Average of overall per capita spending between FY 2007-08 through FY 2009-10 | 1.69% Half of the average of overall per capita spending between FY 2007-08 through FY 2009-10 | 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 FY 2010-11 trend factor is based on the average overall CBLTC change in per capita spending between FY 2007-08 through FY 2009-10. The FY 2011-12 trend set at half of the FY 2010-11 rate allows for a relatively slower rate of movement out of this aid category as the expenditure level decreases. |

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Expansion Adults | 10.00% | 5.00%<br>Half of FY 2010-11 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 be 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. Therefore the FY 2010-11 trend factor is selected at 10% and the FY 2011-12 trend at half of the FY 2010-11 rate. |
| 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) | 13.56%<br>Average of FY 2005-06 through FY 2009-10 | 6.78%<br>Half of the average of FY 2005-06 through FY 2009-10 | The FY 2010-11 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 experienced significant growth in FY 2009-10. The FY 2010-11 selected trend is the average per capita growth rate between FY 2005-06 to FY 2009-10. The Department halves the FY 2010-11 trend selection to estimate FY 2011-12 based on historical experience. |
| Foster Care | 10.11%<br>Average of FY 2005-06 through FY 2009-10 | 10.11%<br>Average of FY 2005-06 through FY 2009-10 | The FY 2010-11 trend is based on the current expenditure, prior-year cash flow and historical growth rates. Expenditure for Foster Care children is typically limited to private duty nursing services. The FY 2011-12 selected growth rate is believed to be the same as that of FY 2010-11. |
| Baby Care Program - Adults (BCKC-A) | 0.00% | 0.00% | Clients in this eligibility category are not eligible for community based long term care benefits. |
| Non-Citizens | 0.00% | 0.00% | Clients in this eligibility category are not eligible for community based long term care benefits. |

| Aid Category | FY 2010-11 Trend Selection | FY 2011-12 Trend Selection | Justification |
|---|---|---|---|
| Partial Dual Eligibles | 0.00% | 0.00% | 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. Based on expenditure to date, the Department anticipates there will not be an increase of expenditure in this aid category in FY 2010-11 or FY 2011-12. |

***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:

- FY 2010-11 BRI-2 Coordinated Payment and Payment Reform: This request, estimated to be implemented July 2010, requested a reduction in totals funds as a result of savings generated by payment coordination and payment reform. An initiative directed at Home and Community Based Services waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services.
- FY 2010-11 BRI-6, Medicaid Program Reductions, included a 1% reduction to Medicaid physical health provider rates effective July 1, 2010.
- FY 2009-10 BA-15 Community Transitions Services for Mental Illness Waiver Clients: This request originally 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. However, due to program delays, the implementation of this initiative is expected to occur in FY 2010-11.
- FY 2009-10 ES-2, Provider Rate Reductions, included a permanent 1.5% reduction, effective September 1, 2009, in the reimbursement rate paid for most Community Based Long Term Care services.
- FY 2009-10 ES-2, Medicaid Program Reductions: This request 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 are limited to 2 round trips per week, with the exception of trips to adult day programs, which are not subject to the cap.
- 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.
- FY 2009-10 ES-6, Provider Rate Reductions, included a permanent 1.0% reduction in the reimbursement rate paid for Community Based Long Term Care for FY 2009-10, effective December 1, 2009.

- 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..
- FY 2009-10 BA-33 Provider Volume and Rate Reductions: In addition to a 2% permanent provider volume and rate reduction in FY 2009-10, the proposal estimates the FY 2009-10 implementation of 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. This initiative is now anticipated to generate savings in FY 2010-11.
- HB 10-1146 State Funded Public Assistance Programs, clarifies persons currently receiving both Home Care Allowance program and Medicaid Home and Community Based Services benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010. The Department estimates an increase in HCBS utilization as a result of this bill.

***Prior-Year Expenditure***
As an additional reasonableness check, the Department has split FY 2009-10 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***
This exhibit summarizes the total requests from the worksheets within Exhibit H.

***Class I Nursing Facilities***
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 20.8% (through the FY 2009-10 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. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

HB 10-1324 imposed a 1.5% reduction to FY 2009-10 rates, effective March 1, 2010. HB 10-1379 imposed a 2.5% reduction to FY 2010-11 rates, effective July 1, 2010. The effect of the rate reductions is not cumulative; that is, the total reduction in FY 2010-11 is 2.5%. The rate is restored to the full level effective July 1, 2011. HB 10-1379 also reduced the maximum General Fund growth of the core per diem rate to 1.9% for FY 2010-11, increasing to 3% in FY 2011-12 and subsequent years.

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]:

[14] For clarity, FY 2010-11 is used as an example. The estimate for FY 2011-12 is based on the estimate for FY 2010-11, and follows the same methodology.

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2010-11.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment for claims that will be incurred in FY 2010-11. The difference between the estimated per diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2010-11 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2010-11.
- 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 2010-11.
- Of the estimated total reimbursement for claims incurred in FY 2010-11, only a portion of those claims will be paid in FY 2010-11. The remainder is assumed to be paid in FY 2011-12. The Department estimates that 92.89% of claims incurred in FY 2010-11 will also be paid during FY 2010-11. Footnote 5 details the calculation of the percentage of claims that will be incurred and paid in FY 2010-11.
- During FY 2010-11, the Department will also pay for some claims incurred during FY 2009-10 and prior years ("prior year claims"). In Footnote 6, the Department applies the percentages calculated in Footnote 5 to claims incurred during FY 2009-10 to calculate an estimate of outstanding claims to be paid in FY 2010-11.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2010-11 prior to adjustments.
- Other non-rate factors are then added or subtracted from this 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 footnotes 6 through 9.
- Legislative impacts are added as bottom-line adjustments. For FY 2010-11, this includes HB 10-1324, which introduced a 1.5% rate reduction effective March 1, 2009. Additionally, HB 10-1379 introduced an additional 1.0% rate reduction effective July, 1 2010.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2010-11 expenditure.

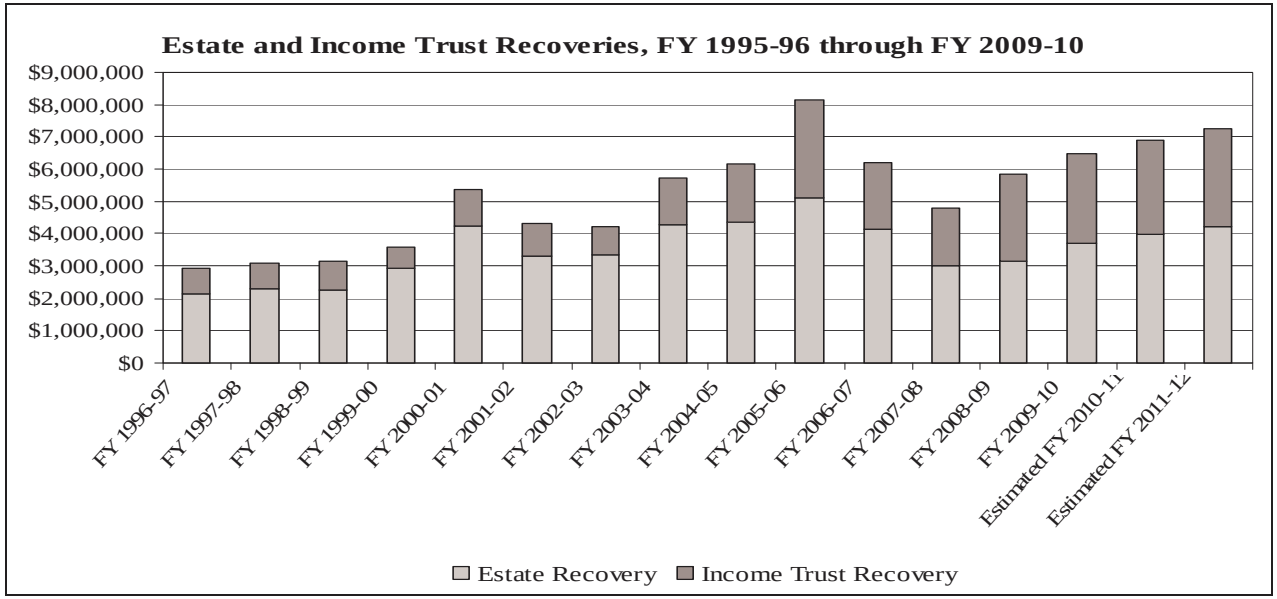
For FY 2011-12, the same methodology is applied, taking into account the estimate for FY 2010-11.

***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 impacts have been included in the FY 2010-11 and FY 2011-12 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2010-11 and FY 2011-12. 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 2010-11 and FY 2011-12. The following chart illustrates the history of estate and income trust recoveries from FY 1995-96 through FY 2009-10. 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, and saw modest growth in both categories in FY 2009-10.




- 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 2010-11 and FY 2011-12. Footnote 9 on page EH-7 contains additional detail about these recoveries.
- FY 2010-11 BRI-2: Coordinated Payment and Payment Reform – Expand Audits Performed by the Nursing Facilities Section adds an additional auditor to the Nursing Facilities Section to increase Department recoveries. The FY 2010-11 impact is the full amount of additional recoveries due to the addition of an auditor. The enhanced recoveries will be seen in the recovery trends for FY 2010-11. Consequently, only the incremental increase in enhanced recoveries represents the bottom line impact of this budget reduction item for FY 2011-12.
- HB 10-1324 resulted in a rate reduction to Class I nursing facilities of 1.5% effective March 1, 2010 and continuing through June 30, 2011. Due to a portion of claims for both FY 2009-10 and FY 2010-11 not being paid in the fiscal year in which they are incurred, the fiscal impact of this bill extends into FY 2011-12. Footnote 10 on page EH-7 contains additional detail regarding the fiscal impact of this bill.

- HB 10-1379 resulted in a rate reduction to Class I nursing facilities of an additional 1.0% above HB 10-1324 reductions effective July 1, 2010 and continuing through June 30, 2011. Due to a portion of claims for FY 2010-11 not being paid in the fiscal year in which they are incurred, the fiscal impact of this bill extends into FY 2011-12. Additionally, this bill reduced the maximum allowable general fund growth cap to 1.9%. The general fund growth cap reduction is not included in the bottom line impacts as it is incorporated into the base calculation of the core component rate. To include it as a bottom line reduction would double count the impact. Additional detail regarding the fiscal impact of the rate reduction can be found in Footnote 10 on page EH-7.

***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 2010-11 which will be paid in FY 2010-11, and the percentage of claims incurred in FY 2010-11 which will be paid in FY 2011-12 and subsequent years. The Department applies the same factor to the FY 2011-12 estimate.

For the November 2010 Budget Request, the Department uses the IBNR adjustment calculation using paid claims data through June 2010. 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 2009, November 2009, February 2010 | 92.27% |
| November 2010 | 92.89% |

***Patient Days Forecast Model***

To forecast patient days, the Department selected a seasonal, auto-regressive model with a linear trend. This model was selected because the data exhibits 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. A non-stationary time series can not be forecast without additional manipulation to the data. The Department tested for 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 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 patient days 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, while 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 corresponding coefficient from this regression can used to test for a unit root. The Department utilized EViews statistical analysis software to test for a unit root in the FTE series. The result is summarized in the following table:

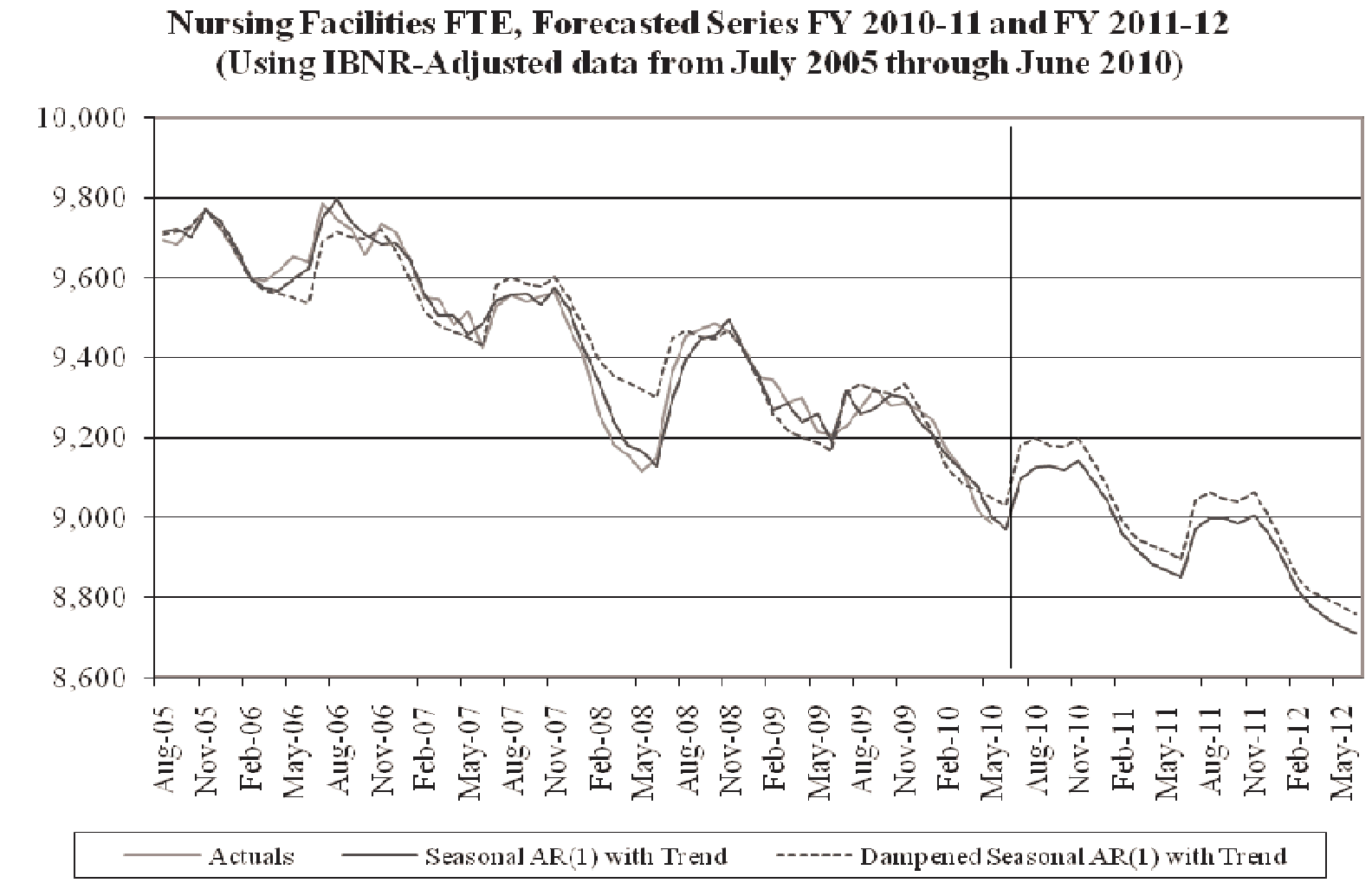
| **Augmented Dickey-Fuller Unit Root Test of Stationarity** | | |
|---|---|---|
| | **T-Statistic** | **P-Value** |
| Augmented Dickey-Fuller Test Statistic | **-4.262317** | **0.0069** |
| Conclusion: Reject that null hypothesis that there is a unit root at the 99 percent confidence level. An auto-regressive model can be used with this series. | | |

Forecasting Patient Days

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.

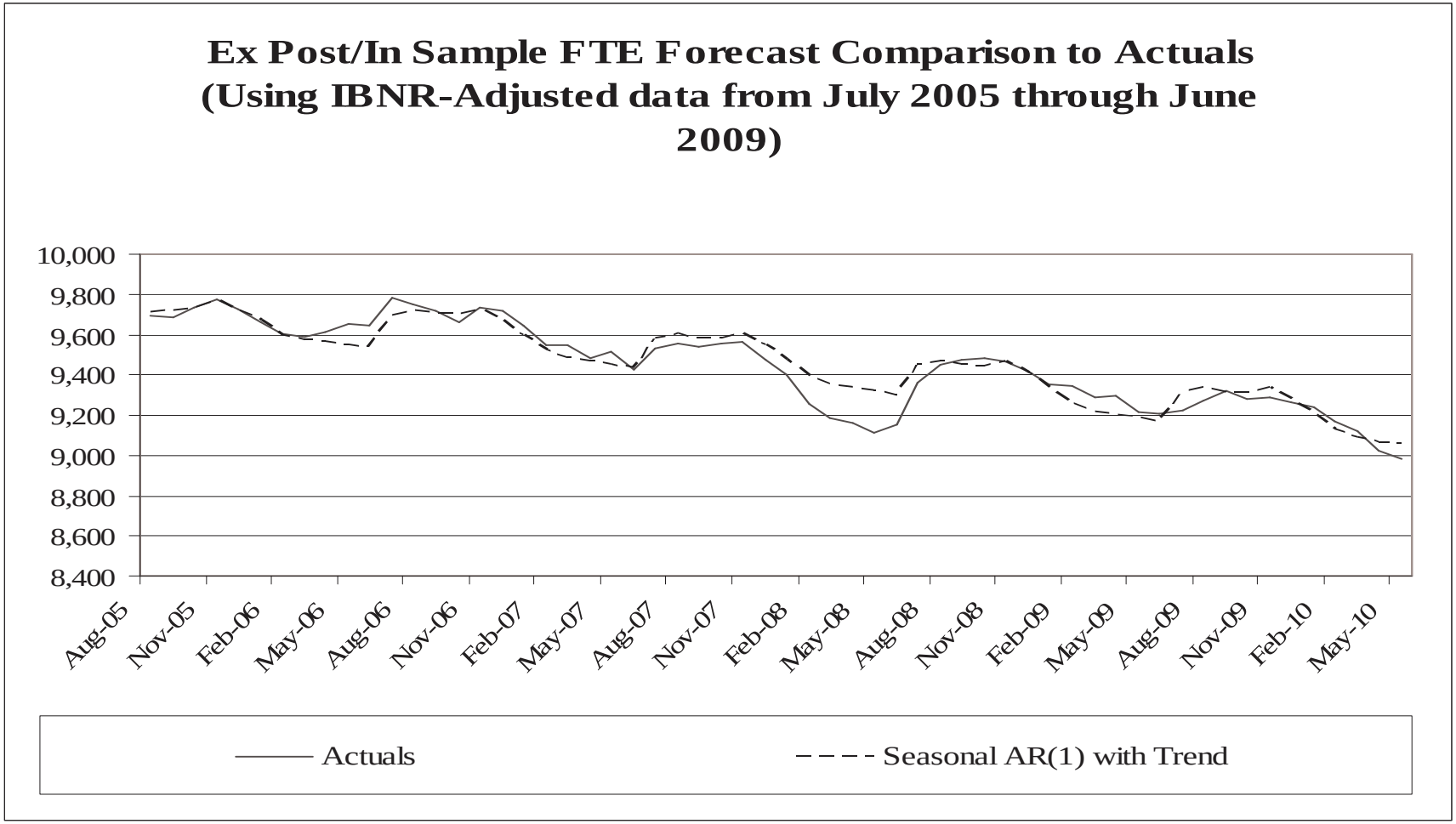
The declining trend in patient days is consistent with Department program policies; clients are enrolled in home care or alternative care facilities rather than nursing facilities, if appropriate. From FY 2005-06 to FY 2009-10, the average annual patient days decreased by -5.02%. From FY 2005-06 to FY 2009-10, home and community-based services average monthly paid enrollment was up approximately 29.61% (from 14,640).

The Department believes that the pronounced negative trend observed in recent data will carry forward into FY 2010-11 and FY 2011-12, but at a dampened rate. Therefore, the Department utilizes the seasonal and autoregressive components of the forecast model, but dampens the forecast by 1%. The dampening factor has the result of increasing the forecast FTEs above the results of the model. The graph below shows actual FTEs, the seasonal auto-regressive model with trend, and the seasonal auto-regressive model with trended in which forecast values are dampened by 1%.




Ex Post/In-sample Forecasts

As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from July 2005 through June 2009) and compared the results to actual data reported for July 2009 through May 2010.



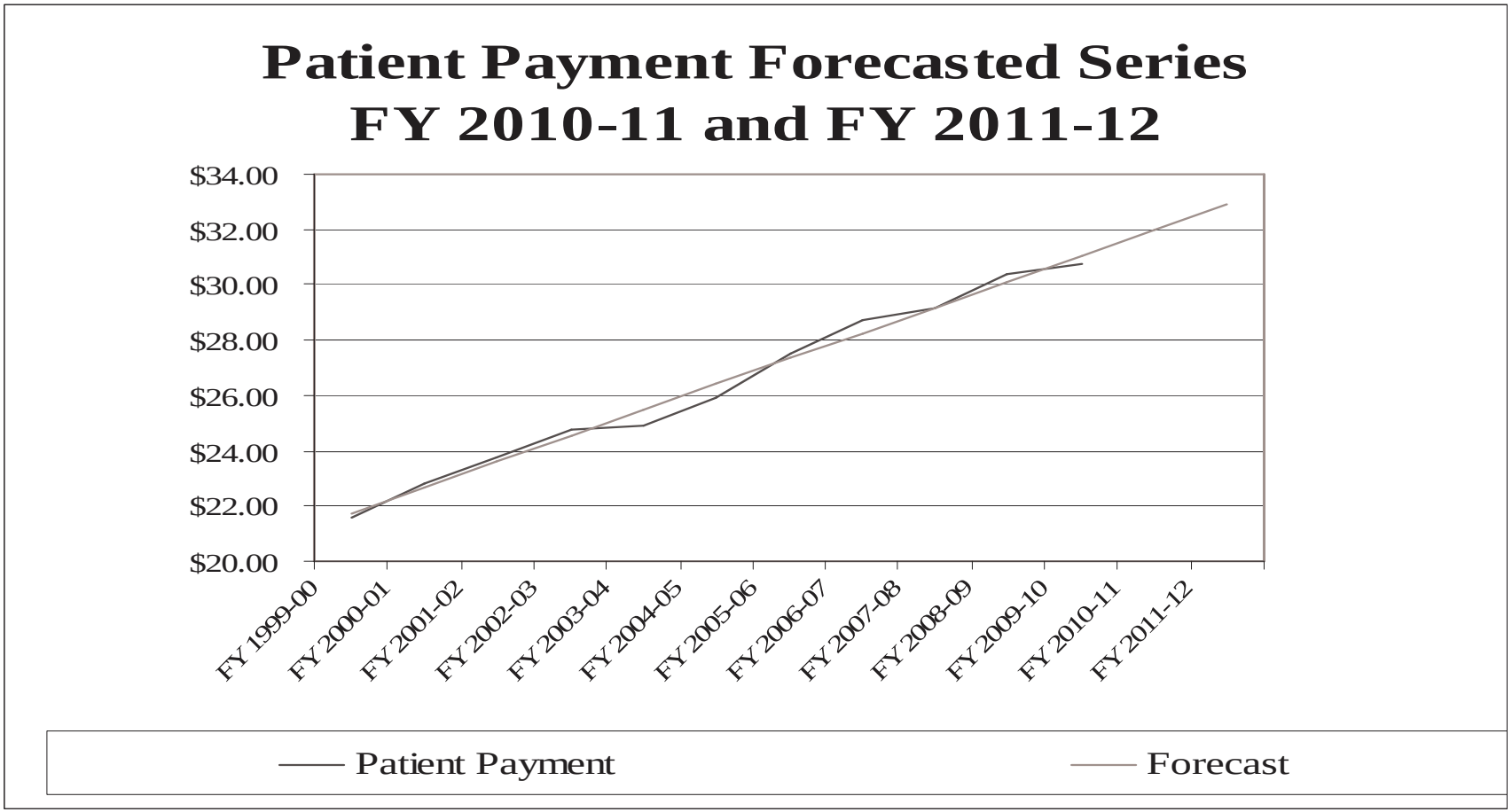

With an p-value of 0.0000, the ex post forecast is statistically significant at the 99% confidence level; the model's F-statistic of 62.23 indicates that the regressors are jointly statistically significant, also at the 99% confidence level . As a test of robustness, this suggests that the FTE series can be strongly predicted using a seasonal auto-regressive with trend model.

***Patient Payment Forecast Model***

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.

In previous submissions, patient payment was forecasted using a seasonal auto-regressive model with trend. Due to structural changes in the last fiscal year's monthly data series, the time series is no longer stationary, and an autoregressive process will no longer produce a statistically valid result. However, this series has historically demonstrated a strong linear relationship. As a result, the Department has selected a linear trend based on the annual average patient payment. The F-statistic and R-squared are presented as justification of the Department's selection of this model.



Testing the Overall Predictive Ability of the Model

Again utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. Like the patient days model, the patient payment model also has a p-value of 0.0000, and is statistically significant at the 99% confidence level. R-squared for the linear model is 0.989 suggesting that 98.9% of the variation in this series can be explained by the linear trend.

***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 a maximum for 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. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.

FY 2010-11 HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010 through June 30, 2011. This bill also reduced the maximum general funds portion of the core per diem rate to 1.9% growth for FY 2010-11.

***Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category***

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***

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**.** 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. FY 2009-10 enrollment rates were slightly lower than in the previous year. The facility averaged between 18 and 19 clients. However, for FY 2010-11 and FY 2011-12 there the Department anticipates enrollment will return to the 20 client enrollment level. The estimated growth rates for FY 2010-11 and FY 2011-12 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)***

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 2010-11 projection for PACE alters the previous methodology slightly. First, the Department believes that the trend used to estimate average enrollment growth is captured in the additional enrollment from new providers. Therefore, a separate trend for average enrollment growth is not selected. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2009-10 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2010-11 base expenditure. Then, the Department adjusts for any bottom-line impacts not incorporated in the trend (described below). The sum of the base expenditure, bottom-line adjustments, and adjustment to expenditure is the estimated FY 2010-11 total expenditure. FY 2011-12 is calculated in the same fashion, excluding the adjustment to expenditure.

To estimate the average increase in cost per enrollee in FY 2010-11, the Department selected the average percent increase in cost per enrollee between FY 2004-05 and FY 2008-09 for Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to age 59 aid categories. FY 2009-10 data was excluded from the trend because the Department believes cost per enrollee will revert back to the long run trend after a sharp decline in FY 2009-10 due to rate reductions. For FY 2011-12, the Department held the FY 2010-11 trend selections constant.

In recent years, the Department has added a number of new 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. Total Longterm Care, the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo and is looking to expand facilities to additional locations in Spring 2011. The organization also plans to expand the current facility in the Brighton area; this is planned for Spring 2011.

***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 2010-11 and FY 2011-12 calculations for the Program of All-Inclusive Care for the Elderly (PACE):

- FY 2009-10 ES-2, Medicaid Program Reductions: This 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 annualized reduction is a bottom line adjustment for FY 2010-11.
- FY 2010-11 ES-6, Medicaid Provider Rate Reductions: This 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 annualized reduction is a bottom line adjustment for FY 2010-11.
- FY 2010-11 BRI-6, Medicaid Program Reductions: This request included a 1% reduction to Medicaid physical health provider rates for both FY 2010-11 and FY 2011-12, effective July 1, 2010. In addition, the request impacts the PACE program by imposing restrictions on certain durable medical equipment and restricting nursing facility per diem growth to 0% in FY 2010-11.

***Supplemental Medicare Insurance Benefit (SMIB)***

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B, and in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[15] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types, and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

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

[15] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

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:[16]

**History of 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% |
| 2010 | $461.00 | 4.06% | $110.50 | 14.63% |

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, however, the Department is only required to pay the base premium cost.

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 used 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 2010-11, the Department first inflates the actual expenditure from the second half of FY 2009-10 by the estimated caseload trend for the first to second half of FY 2010-11. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium, which the Department has estimated at 15.0% for 2011. In July 2010, the Centers for Medicare and Medicaid Services (CMS) asked the Department to provide an estimate of QI expenditure for upcoming federal fiscal years, assuming a Part B premium of $145.00, an increase of 31.22%. However, information provided by the Kaiser Family Foundation indicates that the upcoming Part B premium may be $120.20, an increase of 8.78%. Based on this information, the

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

Department believes that the 8.78% trend is appropriate; it is not clear that the staff at CMS which asked for the QI estimate have actual information about the Part B premium for CY 2011. The total estimated expenditure for FY 2010-11 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2011-12, the Department first inflates the estimated expenditure from the second half of FY 2010-11 by the estimated caseload trend for FY 2011-12 from Exhibit B, Caseload. This figure represents the approximate expenditure for the first half of FY 2011-12. 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 2011-12 is the sum of the first half and second half estimates.

***Health Insurance Buy-In (HIBI)***

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. (2010). 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 2010-11 expenditure. The Department selected half of the overall average growth rate in expenditure between FY 2008-09 and FY 2009-10 to trend expenditure in FY 2010-11 for the Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), Eligible Children, Categorically Eligible Low-Income Adults (AFDC-A), and Baby Care Program Adults aid categories. All FY 2010-11 trend selections were held constant for FY 2011-12.

***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 2010-11 and FY 2011-12 calculations for the Health Insurance Buy-In Program:

- SB 10-167 Medicaid Efficiency and Colorado False Claims Act impacts the HIBI program in FY 2010-11 by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the state. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. This request is then annualized in FY 2011-12.

*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***

This exhibit summarizes the total requests from the worksheets within Exhibit I.

***Single Entry Points***

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, pursuant to 25.5-6-105, C.R.S. (2010). A SEP 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.

The SEP 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.

The major functions of SEP 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. SEP agencies also serve as the utilization review coordinator for all community based long term care services.

SEP agencies are paid a case management fee for each client admitted into a community based service program. SEP 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 SEP agency contract amounts are determined using data from each SEP'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 SEP 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 SEP 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 SEP 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 SEP 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, SEPs 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 SEPs has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, SEPs 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 SEP 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 SEP caseload.

For FY 2010-11, the Department's projection uses the total base contracts amount, which is the current amount allocated to single SEPs in the FY 2010-11 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For FY 2011-12, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2006-07 through FY 2009-10 for the Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 aid categories. The overall HCBS utilization growth rate from FY 2008-09 to FY 2009-10 was selected to trend expenditure for the remaining aid categories; Categorically Eligible Low-Income Adults, Eligible Children, Foster Care, Non-Citizen, and Partial Dual Eligibles. The estimated FY 2010-11 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2011-12 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 2010-11 and FY 2011-12 calculations for Single Entry Points:

- FY 2009-10 ES-2: Medicaid Program Reductions: This request included a 1.5% reduction in the reimbursement rate paid for SEPs for FY 2009-10. This reduction is annualized as a bottom line adjustment for FY 2010-11.
- FY 2009-10 ES-6: Provider Rate Reductions: This request included a 1.0% reduction in the reimbursement rate paid for SEPs for FY 2009-10. This reduction is a bottom line adjustment for FY 2009-10, the annualized impact is a bottom line adjustment for FY 2010-11.
- FY 2010-11 BRI-6, Medicaid Program Reductions, included a 1% reduction to SEPs effective July 1, 2010.
- HB 10-1146 State Funded Public Assistance Programs, clarifies persons currently receiving both Home Care Allowance program and Medicaid Home and Community Based Services benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with SEP agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010.

***Disease Management***

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. (2010)). 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. (2010), 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 24-22-117(2)(d)(V), C.R.S. (2010) (further described in Exhibit A). 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 did not renew the telemedicine contract when it expired on September 30, 2009.

In the estimate of expenditure for FY 2011-12, the Department requests $500,000 total funds to continue its Adult Medical Home pilot program. Although currently funded through the Department's Health Resources and Services Administration (HRSA) grant, the state share for this program would be paid for from the Prevention, Early Detection, and Treatment funds described above.

***Prepaid Inpatient Health Plan Administration***

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. In FY 2005-06, the Department ended its contract with Management Team Solutions. Since then, the Department contracted with only one prepaid inpatient health plan, Rocky Mountain Health Plans, until FY 2009-10. The Department contracted with three additional prepaid inpatient health plans in FY 2009-10. These include: Colorado Access and Kaiser Foundation Health Plan, which are jointly part of the Colorado Regional Integrated Care Collaborative (CRICC); and, Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department anticipates the implementation of the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that will be incorporated in the prepaid inpatient health plan exhibit.

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care. Because the administrative fees remain the same in FY 2010-11 and FY 2011-12, the Department has used actual enrollment in its current administrative service organizations to forecast expenditure in FY 2010-11 and FY 2011-12 for programs with available enrollment data (Rocky Mountain Health Plans and Colorado Access) and its projections for capped enrollment for the newest programs, as described below. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group; for this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010.

Expenditure for administrative fees to Colorado Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The shift to an ASO did not affect enrollment trends, however, allowing the Department to use enrollment data from the program's inception in June 2008 to the present to forecast future enrollment. Kaiser Foundation Health Plan began enrolling clients for CRICC in September 2009. The claims for Kaiser are not paid for through the Medicaid Management Information System (MMIS); therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. To forecast future enrollment, the Department averaged the expected capped enrollment by month for the current and request years. Please see the table below for the enrollment forecasts for Kaiser by month for FY 2010-11. For FY 2011-12, Kaiser enrollment will stay steady at an enrolled caseload of 950.

CRICC was originally requested in FY 2009-10 BRI-6, "Medicaid Value-Based Care Coordination Initiative" as a two-year program, set to expire June 30, 2011. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. This request assumes that the program will continue in FY 2011-12 until more information is made available for a decision.

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64, designed to provide a network of services that are high-quality and cost effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. Similar to Kaiser, the claims for CAHI are not paid for through the MMIS, preventing the Department from forecasting enrollment based on actual clients served by month. The enrollment forecasts for FY 2010-11 and FY 2011-12 were based on the Department's estimate of when periods of passive enrollment would take place and how many clients the provider would be allowed to enroll, as well as reports from the Department's enrollment broker, Maximus, on how many clients were enrolled from January to June of 2010. Please see the table below for the enrollment forecasts for CAHI by month for FY 2010-11. For FY 2011-12, CAHI enrollment is anticipated to stay steady at an enrolled caseload of 225.

| FY 2010-11 Enrollment by Provider for Kaiser and CAHI | | |
|---|---|---|
| | Kaiser Foundation Health Plan | Colorado Alliance Health & Independence |
| July | 850 | 119 |
| August | 850 | 119 |
| September | 850 | 90 |
| October | 850 | 90 |
| November | 850 | 90 |
| December | 850 | 90 |
| January | 950 | 225 |
| February | 950 | 225 |
| March | 950 | 225 |
| April | 950 | 190 |
| May | 950 | 190 |
| June | 950 | 190 |
| **Average Enrollment per Month** | **900** | **154** |

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6, "Medicaid Value-Based Care Coordination Initiative" and revised in FY 2010-11 S-6,BA-5, "Accountable Care Collaborative." The cost savings estimated for this program are included in acute care; please see Exhibit F and Section V for more information on its impact to acute care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2010-11 include $750,000 paid to the SDAC, $12.00 per member per month (PMPM) paid to the RCCOs, and $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month. The fees in FY 2011-12 include $3,000,000 paid to the SDAC; $12.00 PMPM paid to the RCCOs; $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, with the exception of children, for whom providers will only be paid $1.23 PMPM; and, a $2.00 monthly incentive payment divided between the providers and the RCCOs. The Department plans to begin enrolling clients into RCCOs in April 2011 and reach full enrollment of 60,000 clients by July 2011. Enrollment and PMPM figures reflect the Department's implementation plan and were used to forecast expenditure directly instead of including the ACC as a bottom line impact.

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 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 MMIS.

Concurrent with the project to include all encounter data in the MMIS, 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 are no longer made, and payments for administrative fees are recorded on a cash-accounting basis.

The Department holds the estimated amount of cost avoidance for the contract years FY 2005-06 and FY 2006-07 constant from prior budget requests. This bottom line adjustment of $943,802 is projected to impact FY 2010-11. 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 2008 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 2011-12 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 2010-11 and FY 2011-12 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.
- FY 2009-10 ES-2: Medicaid Program Reductions: This request included a 1.5% reduction in the reimbursement rate paid to Rocky Mountain Health Plans for FY 2009-10, which was implemented on September 1, 2009. FY 2010-11 ES-6, "Medicaid Provider Rate Reductions" included an additional 1.0% reduction to the reimbursement rate paid to Rocky Mountain and was implemented on December 1, 2009. Since expenditure was calculated using the actual rate paid to Rocky Mountain for FY 2010-11 and FY 2011-12, this adjustment is already implicitly accounted for in the expenditure calculation.

*EXHIBIT J – CASH-FUNDED EXPANSION POPULATIONS*

***Summary of Cash Funded Expansion Populations***

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 and Tobacco Tax cash funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A.

***Health Care Expansion Fund Populations***

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 optional 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 notes 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 2010-11 | | FY 2011-12 | |
|---|---|---|---|---|
| **Health Care Expansion Fund Programs** | **Total Funds** | **Health Care Expansion Fund** | **Total Funds** | **Health Care Expansion Fund** |
| Expansion Adults | $53,017,937 | $21,360,926 | $58,745,674 | $29,372,838 |
| Expansion Foster Care | $4,019,075 | $1,619,285 | $4,614,045 | $2,307,023 |
| Presumptive Eligibility | $3,010,717 | $1,213,018 | $3,043,286 | $1,521,643 |
| Legal Immigrants | $34,199,974 | $13,779,170 | $38,370,442 | $19,185,221 |
| Removal of Medicaid Asset Test | $71,569,089 | $28,835,186 | $77,882,353 | $38,941,177 |
| Children's Home and Community Based Services | $21,749,108 | $8,762,716 | $22,542,951 | $11,271,476 |
| Children's Extensive Support | $3,502,987 | $1,411,353 | $3,630,840 | $1,815,420 |
| **Total** | **$191,068,887** | **$76,981,654** | **$208,829,591** | **$104,414,798** |

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 shown in detail in the Tobacco Tax Update included with of this Budget Request.

Expansion Adults

Eligibility for low-income adults was expanded to 60% of the federal poverty level via HB 05-1262. These clients do not qualify as Categorically Eligible Low-Income Adults (AFDC-A), which has an income limit of approximately 29% of the federal poverty level,

and have a child that is Medicaid eligible. This population receives the full Family Medicaid benefits package, and is forecast as part of the standard per capita development in Exhibits F, G, H, and I.

Expansion Foster Care

Foster care eligibility was extended to children up to age 21 via SB 07-002 and SB 08-099. 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 at least FY 2011-12.

Presumptive Eligibility

The Department discontinued Medicaid presumptive eligibility for pregnant women on September 1, 2004. Pursuant to HB 05-1262 the Department reinstated the presumptive eligibility process for pregnant women, effective July 1, 2005. Similar to pregnant women in the Children's Basic Health Plan, presumptive eligibility for Medicaid was handled through the State's self-funded network through December 2007. To be eligible for presumptive eligibility, a woman shall have a verified pregnancy, declare that her household's income does 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 the Children's Basic Health Plan Third Party Administrator that managed the State's self-funded network based on the estimated cost per client per month. 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 2010-11 and FY 2011-12 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

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) may 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 and a provision was added to HB 05-1262 to provide funding from the Health Care

Expansion Fund on an ongoing basis. Due to the reinstatement of services to legal immigrants granted by HB 05-1086, $2,638,343 was funded through the Health Care Expansion Fund for FY 2004-05. Effective August 2007, the Department implemented system changes enabling it to track actual expenditures and monthly enrollment levels for the Optional Legal Immigrants population.

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 previously eligible for the Children's Basic Health Plan may 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 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 within 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 waive 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 average 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 expansion 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 the methodology described above, 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 began applying this methodology to the CES waiver program as well.

***Hospital Provider Fee Funded Populations***

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. The Department received federal approval for the Hospital Provider Fee model in March 2010, and clients began to enroll in expansion programs in April 2010.

The Department began enrolling new clients into Medicaid beginning in May 2010. The populations, described, below, will be funded through two State cash funds, the Hospital Provider Fee Fund and the Medicaid Buy-in Fund, and any matching federal funds.

**Hospital Provider Fee Cash Fund**
HB 09-1293 established the Hospital Provider Fee Cash Fund which provides for the costs of administering Medicaid programs to the three HB 09-1293 expansion populations that impact the Medical Services Premiums budget (a fourth expansion population will impact a new line item in the (4) Indigent Care Program long bill group, and 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 from approximately 29% to least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund covers expenditures for parents from 61% to 100% of the federal poverty level. This expansion population receives the standard Medicaid benefits. Eligibility for this population under Medicaid was effective May 1, 2010.

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 to 60% FPL population. Per capita cost estimates for this population have been updated to reflect the most recent projection of per capita costs for the Expansion Adults population.

For caseload estimates and methodology, please see the Section II of this narrative.

Continuous Eligibility for Medicaid 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, 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 at the beginning of their eligibility period. 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. To account for this, the Department has reduced the Eligible Children and Foster Care Medical Services Premiums per capita costs by 25%.

**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 to purchase 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.

To project caseload for this population, the Department utilized data from the Colorado Health Institute and the American Community Survey on economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed a baseline enrollment rate for this reduced eligible population of 80%, which reflects historical population figures concerning the eligible but not enrolled population. Furthermore, the Department assumes that as individuals' incomes increase, they will be more likely to obtain their own insurance through other sources than buy-in to the program. As the premium contribution from enrolled clients will be a percentage of their income, with increases in income the incentive to purchase alternative coverage will be reinforced, decreasing caseload in higher income tiers.

The Department assumes that the Medical Services Premiums 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 higher 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 lower 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. In addition, clients that are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid

services are utilized. The Medicaid Disabled Individuals to 59 per capita is decreased by 25%, which is the proportion of total expenditures for Medicaid Disabled Individuals to 59 that were for Home- and Community-Based Services waivers and other Long Term Care services, excluding Private Duty Nursing, Hospice, Program of All-Inclusive Care for the Elderly, and Supplemental Medicare Insurance Benefit, all of which the Department assumes these clients may utilize. This adjustment is applied to the total per capita rather than at the service category level, and the Department will research this methodology for its February 2011 budget submission.

| | FY 2010-11 | | FY 2011-12 | |
|---|---|---|---|---|
| **Hospital Provider Fee Programs** | **Total Funds** | **Cash Funds** | **Total Funds** | **Cash Funds** |
| Expansion Adults to 100% | $73,604,906 | $36,802,454 | $93,869,012 | $46,934,507 |
| Continuously Eligible Children: Family Medical Program | $0 | $0 | $25,423,209 | $12,711,605 |
| Continuously Eligible Children: Foster Care | $0 | $0 | $3,217,451 | $1,608,727 |
| Buy-in for Individuals with Disabilities | $0 | $0 | $44,089,608 | $25,363,914 |
| **Total** | **$73,604,906** | **$36,802,454** | **$166,599,280** | **$86,618,753** |

*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; and,
- 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 BRI- 2 (November 15,

2005) was approved, which was submitted to more accurately reflect the amount of certified public expenditures as the state portion only, rather than the total; starting in FY 2006-07, the Department will record only the certified amount as cash funds.

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.

During FY 2010-11, the Department will only be able to certify public expenditure up to the midpoint of CY 2010 for Outpatient Hospital services. This is due to HB 09-1293 which will allow the Department will use other state funds to draw federal funds to the upper payment limit. In future years, the Department will no longer be able to certify outpatient hospital expenditure.

Projections for all provider types are provided in Exhibit K.

*EXHIBIT L – APPROPRIATIONS AND EXPENDITURES*

This exhibit displays the FY 2009-10 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2009-10 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 is computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

Effective with the November 1, 2007 Budget Request, the Department has made several labeling changes to this exhibit:

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

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

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

Effective with the November 1, 2010 Budget Request, the Department has provided 3 pages for FY 2009-10 expenditure: cash-based actuals, the total amount delayed in FY 2009-10 as a result of a mandated payment delay, and the estimated FY 2009-10 expenditure adjusted for the payment delay.

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.

Effective with the November 1, 2010 Budget Request, the Department has a second version of this exhibit which adjusts for the payment delays imposed in FY 2009-10.

*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 2008-09, FY 2009-10 and FY 2010-11 in the chronological order of the requests/appropriations. Shaded areas indicate that the Request or appropriation has not yet taken place.

*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 2010 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 2009 and 2010 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.

***New Legislation and Impacts from FY 2010-11 Budget Cycle Requests***

This section describes the impact from legislation passed during the 2010 legislative session, and also includes impacts from the Department's FY 2010-11 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

*HB 10-1005 - Concerning Home Health Care through Telemedicine Pursuant to the "Colorado Medical Assistance Act"*

HB 10-1005 alters the provision of home health telemedicine services established in SB 07-196. This bill asserts that telemedicine services are now eligible for Medicaid reimbursement, reimbursement rates are no longer required to be budget-neutral, reductions in travel costs by home health care and home- and community-based service providers are no longer required to be considered when setting reimbursement rates, and incorrect references to the way reimbursement payments are made are removed.

Additionally, payments of telemedicine reimbursements are contingent upon the receipt of gifts, grants, and donations in the newly created Home Health Telemedicine Cash Fund for FY 2010-11 and FY 2011-12. The bill increases Department expenditure $123,270 in FY 2010-11, annualizing to $312,572 in FY 2011-12.

*HB 10-1033 - Concerning the Addition of Screening, Brief Intervention, and Referral to Treatment to Optional Services*

In 2006, the Governor's Office, and Departments of Human Services and Public Health and Environment were awarded a five-year $2.8 million dollar grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), to implement a Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative in Colorado. The initiative teaches health care providers to use the ASSIST tool to conduct screenings for substance and tobacco use; provide brief interventions to persons with positive screening results; and, make referrals for more extensive treatment where appropriate. The SBIRT protocol is currently being used in 12 clinics and hospitals in 9 Colorado counties. This bill adds screening, brief intervention, and referral for treatment for substance abuse to the list of optional services covered by Medicaid. The bill is estimated to increase Department expenditure $870,155 in FY 2010-11, annualizing to $1,230,285 in FY 2011-12.

*HB 10-1146 - Concerning State-funded Public Assistance Programs*

HB 10-1146 clarifies persons currently receiving both Home Care Allowance program and Medicaid Home- and Community-Based Services (HCBS) benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010.

As a result, the Department's appropriation was reduced by $1,000,902 as it will no longer reimburse SEPs for HCA determinations (the Department of Human Services will assume that responsibility). Offsetting this decrease, the Department anticipates an increase in HCBS services of $296,481 as clients who are currently receiving both HCA and HCBS benefits will shift to receiving HCBS services only.

In total, the bill reduces Department expenditure $704,421 in FY 2010-11, annualizing to $1,018,891 in FY 2011-12.

*HB 10-1324 – Concerning Medicaid Nursing Facilities Per Diem Rates*

HB 10-1324 initiated a Class I Nursing Facility rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. This bill reduces Department expenditure $8,416,927 in FY 2010-11. Due to issues related with claims runout, the Department has also estimated an FY 2011-12 impact to this bill which was not incorporated in the fiscal note. See Exhibit H, footnote 10 for further details.

*HB 10-1376 – FY 2010-11 Long Bill*

The FY 2010-11 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2010 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.

- *Evidence Guided Utilization Review (EGUR) (BA-12) and Prevention and Benefits for Enhanced Value (P-BEV) (BRI-1):* This budget reduction item increases FY 2010-11 expenditure by an estimated $282,653, with an additional $481,092 in FY 2011-12, in order to provide increased utilization review funding in order to create an evidence guided utilization review program. Savings are expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures including fluoride treatment, and improve non-emergency medical transportation policies.
- *Implementation of Family Planning Waiver (BA-16):* This budget amendment transfers $190,350 in FY 2010-11 and an additional $230,310 in FY 2011-12 from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds. This funding will be used to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. Transferring this funding to the Department will allow for an enhanced federal financial participation rate of 90% to fund family planning services for uninsured, low-income Coloradans who would otherwise be receiving services funded by the unmatched General Fund dollars currently appropriated to the Department of Public Health and Environment.
- *Coordinated Payment and Payment Reform (BRI-2):* This budget reduction item reduces expenditure in FY 2010-11 and FY 2011-12 for both Acute Care Services and Community Based Long Term Care Services through the implementation of proposed steps toward payment coordination and payment reform. This request included four proposed initiatives which work in tandem to serve the goal of lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care. The initiatives aim to consolidate payment and billing processes, expand audits conducted by the Nursing Facilities Section, initiate a pilot audit of a Community Mental Health Center, and increase enrollment of Medicare-eligible clients into Medicare. In addition, the Department is targeting three payment rate reform initiatives. The first, directed at Home- and Community-Based Services waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. A similar approach will be taken to investigate the potential to apply outcomes-based approach to the payment of physician payment rates. The third initiative targeted at changing the methodology of Federally Qualified Health Centers (FQHCs) payments aims to investigate the feasibility of creating an outcomes-based performance payment for FQHCs. The table below demonstrates these reductions by service category.

| FY 2010-11 BRI -2 Coordinated Payment and Payment Reform Request | | |
|---|---|---|
| | FY 2010-11 | FY 2011-12 |
| Acute Care | ($3,205,876) | ($3,447,290) |
| Community Based Long Term Care | ($421,550) | ($405,630) |
| **Total** | **($3,627,426)** | **($3,852,920)** |

- *Expansion of State Maximum Allowable Cost Pharmacy Rate Methodology (BRI-3):* This budget reduction item reduces FY 2010-11appropriations by $1,057,450. The request reduces total funds as a result of an expansion of the State Maximum Allowable Cost reimbursement rate for pharmacy claims by including more drugs in the State Maximum Allowable Cost methodology. This will allow the Department to take advantage of an approved reimbursement methodology, increasing opportunities for reimbursement savings associated with pharmacy claims. Footnote 8a in the Long Bill notes savings of $1,057,450.
- *Medicaid Program Reductions (BRI-6):* This budget reduction item imposes restrictions on certain durable medical equipment and reduces Medicaid physical health provider rates by 1%.
    - *Limitation on Incontinence Products:* The Department would impose a 210-unit limit on incontinence products (down from the current limit of 240), and eliminate coverage for oral nutritional products for adults 21 years and older, although exceptions would be granted for individuals with innate errors of metabolism or malnourishment conditions. This initiative reduces Acute Care services expenditure $637,311 in FY 2010-11 and an additional $457,965 in FY 2011-12.
    - *1% Rate Reduction:* As part of this request, the Department reduced rates paid to Medicaid physical health fee-for-service and managed care providers by 1.0% effective July 1, 2010. This request reduces Acute Care services expenditure $13,661,969, Community Based Long Term Care services expenditure $2,773,803, PACE expenditure $418,628, and Single Entry Point expenditure $131,499 in FY 2010-11. These reductions are annualized in FY 2011-12 to additional reductions of $2,698,858 for Acute Care services, $441,287 for CBLTC services, $130,355 for PACE expenditures, and $33,712 for Single Entry Points.
- *Accountable Care Collaborative (S-6, BA-5):* The Department was appropriated an overall reduction in expenditure of $514,730 in FY 2010-11, annualizing to $10,268,779 in FY 2011-12 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system called the Accountable Care Collaborative (ACC) beginning January 1, 2011. To ensure that the Department's goals are being achieved, the Department will limit enrollment to 60,000 clients until the efficacy of the program can be demonstrated.
    - The Department's current estimate deviates from the appropriated amount as the implementation date and plan of the program has changed. In the Department's original request these clients were to be enrolled starting in January 2011 with a gradual enrollment plan of 2,500 clients per month. After further consideration, the Department now believes an accelerated enrollment plan beginning in April, 2011 will be most effective to realize cost savings from the program. Under the April enrollment plan approximately 25,000 clients will be enrolled in April 2011 with the remaining clients

enrolling in June 2011, resulting in full enrollment by July 2011. The chart below illustrates the difference between the appropriated amounts and Department's request by service category.

- The ACC Program's goals are to improve health outcomes for Medicaid clients through a coordinated, client/family-centered system that proactively addresses clients' health needs, whether simple or complex, and to control costs by reducing avoidable, duplicative and inappropriate use of health care resources. The Department intends to regionally procure services from seven Regional Care Collaboration Organizations (RCCOs) providing enhanced Primary Care Case Management services (ePCCM) clients. The Department also is procuring a Statewide Data & Analytics Contractor (SDAC). Collectively, the Department, the eight contracted organizations, and participating providers would form the "Accountable Care Collaborative."

| Accountable Care Collaborative FY 2010-11 Appropriation to Request Comparison | | | | |
|---|---|---|---|---|
| | FY 2010-11 Appropriated Amount | FY 2010-11 Request | FY 2011-12 Appropriated Amount | FY 2011-12 Request |
| Estimated Administration Payments (PIHP Admin) | $1,728,731 | $2,033,048 | $13,009,140 | $14,304,180 |
| Estimated Savings (Acute Care) | ($2,243,461) | ($2,755,976) | ($23,277,919) | ($24,511,092) |
| **Total** | **($514,730)** | **($722,928)** | **($10,268,779)** | **($10,206,912)** |

*HB 10-1378 – Concerning Moneys Appropriated in the 2010-11 Fiscal Year for Health Clinics*

HB 10-1378, recommended by the Joint Budget Committee as part of its budget package for FY 2010-11, allows $12,800,000 for Medical Services Premiums from the Primary Care Fund Cash fund to be used to offset General Fund expenditures in FY 2010-11. This bill has a net effect in the Department's budget of $0 Total Funds.

HB 10-1379 – Concerning a Reduction in the General Fund Portion of the Per Diem Rates Paid to Nursing Facilities for the 2010-11 Fiscal Year

HB 10-1379 initiated a Nursing Facilities rate reduction of 1.0% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. The rate reductions apply to all days incurred under the effective periods of each bill. This bill reduces Department expenditure $5,591,531 in FY 2010-11. Due to issues related with claims runout, the Department has also estimated an FY 2011-12 impact to this bill which was not incorporated in the fiscal note. See Exhibit H, footnote 10 for further details.

*HB 10-1380 – 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*

HB10-1380, recommended by the Joint Budget Committee as part of its budget package for FY 2010-11, allows moneys in the Supplemental Old Age Pension and Medical Care Fund to be used to offset General Fund expenditures for Medicaid for persons 65

years of age and older. A General Fund offset from the cash fund of up to $4,850,000 is allowed in FY 2010-11 and up to $3,000,000 in FY 2011-12. The provisions of the bill are repealed on July 1, 2012.

*HB 10-1381 – Concerning the Use of Tobacco Revenues for Health-related Purposes during a State Fiscal Emergency*
This bill allows certain Tobacco Tax Cash Funds to be used in FY 2010-11 to offset expenditures for persons enrolled in Medicaid or the Children's Basic Health Plan (CHP+). The bill appropriates $25.7 million to the Department, including $15,521,625 from the Tobacco Education Programs Fund, $5,679,358 from the Prevention, Early Detection and Treatment Fund, and $4,490,435 from the Health Disparities Grant Program Fund under the Colorado Department of Public Health and Environment (CDPHE). The bill's provisions are repealed as of July 1, 2012.

*HB 10-1382 – Concerning the Repeal of the Delay of Certain Payments made under Public Medical Assistance Programs*
This bill, recommended by the Joint Budget Committee as a budget package bill, repeals provisions of SB 09-265. SB 09-265 authorized the Department to delay the last normal fee-for-service payment cycle to managed care organizations (MCOs) for FY 2009-10 until after July 1, 2010. Another provisions specified that after June 1, 2010, capitation payments to MCOs are to be made on the first of day of the month following a client's enrollment. The effect of these provisions was to allow for 51 weeks of fee-for-service and 11 months of MCO payments to be made in FY 2009-10. This bill allows the normal payment cycle to be followed in FY 2010-11.

The Department does not make any adjustments in its estimates for HB 10-1382. The appropriation in the Long Bill was for 53 weeks of payments, and the appropriation from HB 10-1382 reduced the number of weeks appropriated to 52. Because the Department uses a 52 week base for FY 2009-10 for its projections, no further adjustment is necessary to maintain the 52 week base for FY 2010-11 and FY 2011-12.

*SB 10-167 - Concerning Increased Efficiency in the Administration of the "Colorado Medical Assistance Act", and, in Connection Therewith, Creating the "Colorado Medicaid False Claims Act"*
This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill reduces Department expenditure $2,390,570 in FY 2010-11, annualizing to $3,699,827 in FY 2011-12 by requiring the Department to;

- appoint an internal auditor and to ensure that duplicate benefits are not being paid by other states to clients enrolled in the Department's programs by creating access to the Public Assistance Reporting Information System (PARIS) which will allow the Department to identify and eliminate clients receiving medical services premiums in other states;
- implement an automated, pre-payment review system to reduce medical services coding errors in Medicaid claims using the National Correct Coding Initiative; and,
- purchase private health insurance coverage through the Health Insurance Buy-In Program for up to 2,000 eligible clients to create cost savings for the state by enrolling clients into individual insurance plans where enrollment is deemed cost effective..

Colorado Medicaid False Claims Act:
Anyone who knowingly submits a false claim or intends to defraud the state or a political subdivision is liable for up to three times the amount of damages, the costs of civil action, and a civil penalty of between $5,000 and $10,000. Persons ineligible to receive state funds and who report to the Attorney General within 30 days of receiving such funds may be liable for two times the amount of damages and no civil penalty, provided certain conditions are met. The bill specifies certain investigative, notification, and court procedures for false claims and requires the Attorney General to prepare an annual report for certain legislative committees.

*SB 10-169 –Concerning Authority for Moneys in the Hospital Provider Fee Cash Fund Generated by an Enhanced Federal Match through the 2010-11 Fiscal Year to be used to Offset General Fund Expenditures in the Medicaid Program*
The bill allows funds in the Hospital Provider Fee Cash Fund to offset General Fund appropriations to the Medicaid program in FY 2009-10 and FY 2010-11. Under HB 09-1293 funds generated by the hospital provider fee were prohibited from use to offset the General Fund. However, SB 10-169 amends this clause and allows the General Fund to be offset by hospital provider fees equal only to the enhanced federal funds match, or 9.71%, for Medicaid received under the American Reinvestment and Recovery Act (ARRA). The following table illustrates SB 10-169 FY 2010-11 request and spending authority. This difference was transferred to the General Fund at the end of FY 2009-10.

| **SB 10-169 Request and Authority** | |
|---|---|
| SB 10-169 "Provider Fee Enhanced Match" – Medical Services Premiums | ($40,210,648) |
| SB 10-169 "Provider Fee Enhanced Match" - Safety Net Provider Payments | ($12,162,119) |
| Total Request | ($52,372,767) |
| Spending Authority[(1)] | ($46,329,388) |
| Difference Between Request and Spending Authority | ($6,043,379) |

[(1)]Per SB 10-169 Appropriation Clause

***Prior-Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments***
This section describes the impact from legislation passed during legislative sessions prior to 2010, and also includes any relevant impacts from the Department's budget requests prior to the FY 2010-11 budget cycle. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

*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 – 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 $1/12^{th}$ of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

| **Estimated Savings due to PACE Enrollments** | | | | |
|---|---|---|---|---|
| **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 | ($354,826) | ($75,712) | ($35,302) | ($465,840) |
| CBLTC | ($611,082) | ($99,110) | ($46,211) | ($756,403) |
| **Total** | **($965,908)** | **($174,822)** | **($81,513)** | **($1,222,243)** |
| **FY 2011-12** | **Adults 65 and Older (OAP-A)** | **Disabled Adults 60 to 64 (OAP-B)** | **Disabled Individuals to 59 (AND/AB)** | **Total** |
| Acute Care | ($503,472) | ($100,485) | ($50,046) | ($654,003) |
| CBLTC | ($867,080) | ($131,540) | ($65,513) | ($1,064,133) |
| **Total** | **($1,370,552)** | **($232,025)** | **($115,559)** | **($1,718,136)** |

*Colorado Access Contract for CRICC*

The Colorado Access contract for the Colorado Regional Integrated Care Collaborative (CRICC) was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. The reimbursement rates for the ASO have been set such that the ASO reimbursement for the expected life of the program (through June 2011) do not exceed the estimate cash flow savings from shifting clients from risk-based managed care to non-risk based care. The Department has accounted for this change with bottom line impacts in Acute Care and PIHP Administration.

*Remove Manual Pricing of DME, Injectibles, and Medical Services*

In an effort to continuously find efficiencies within the Medicaid programs, the Department identified a number of antiquated, manual price setting methodologies around Durable Medical Equipment (DME), injectibles, and medical services. The Department initiated adjustments to these methodologies so that reimbursement rates would automatically be set to a percentage of Medicare while ensuring that for goods and services where no Medicare rate information exists, rates were set using the Department's average paid, other states' Medicaid average paid, or the commercial average paid rate.

This effort ensures that rates will be adjusted on medical goods and services are prices fluctuate, often downwards, over time.

*Benefits Limits on Echocardiograms*

Through the Department's community-involved Benefits Collaborative, the Department and its stakeholders identified appropriate limits to set on the use of echocardiograms. The Benefits Limits on Echocardiograms limits the number of echocardiograms provided and the number of echocardiogram readings available without prior authorization. The Department set these policies in consultation with physicians and clients, and adhered to best practices in diagnosis requirements. The limitations should reduce the number of unnecessary echocardiograms received, and in greater volume, the number of unnecessary readings when readings by certified professionals are already available and recorded in patient records.

*NEMT Supplemental Payments*

The Department provided additional funds to be expended on its fixed price contract to provide Non-Emergency Transportation Services in the 8 metro counties. The contractor had recently informed the Department that it would need to cease to provide services, as the fixed price contract did not accommodate the unprecedented caseload growth facing the Department and the provider. Through contract negotiations, the Department was able to adjust the fixed price on the contract in order to ensure vital services continued.

In the long-term, the Department is actively exploring altering the contract from a fixed-price to a per-member-per-month (PMPM) structure to avoid any similar problems in the future while simultaneously ensuring the Department does not pay an inflated rate when caseload ceases to grow.

*HB 09-1293 Adjustments*

As caseload increases due to HB 09-1293, it is necessary to make an adjustment for the anticipated lower utilization rates of the expansion population. The Department assumes that per capita expenditure of the expansion populations will be 75% of the per capita rate of traditionally eligible population in the same categories. As a result, the calculation for expenditure for this population will be overstated. Therefore, in FY 2011-12, the Department reduces the total expenditure estimate by the product of the number of clients in the expansion and the difference in per capita cost for the overall population. The following table contains the calculation of adjustments for each eligibility category.

| HB 09-1293 Expansion Population Adjustments | | | | |
|---|---|---|---|---|
| **Eligibility Category** | **Per Capita** | **Reduced Utilization** | **Expansion Caseload** | **Bottom Line Adjustment** |
| Foster Care | $3,423.60 | 25% | 1,123 | $961,176.46 |
| Eligible Children (AFDC-C/BC) | $1,719.89 | 25% | 19,970 | $8,586,550 |
| Disabled Individuals to 59 (AND/AB) | $9,360.44 | 25% | 4,329 | $10,130,335 |

*HB 08-1114 -- "Reimbursement of Nursing Facilities Under Medicaid"*

HB 08-1114 had a retroactive impact 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 in the original fiscal note and was included as an adjustment in FY 2009-10, annualized as a corresponding reduction in FY 2010-11.

*FY 2009-10 BRI-1 Pharmacy Technical and Pricing Efficiencies*

This budget reduction item reduced FY 2009-10 expenditure by an estimated $1,022,887, with an expected additional $1,848,763 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.

*FY 2009-10 BA-33 Provider Volume and Rate Reductions*

This budget reduction item requested funding to add anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses in coordination with the FY 2009-10 BRI-1, Pharmacy Efficiencies. In addition, the Department requested, and was appropriated, a 2.0% provider volume and rate reduction effective July 1, 2009. This impact is fully annualized in the Department's base. The FY 2010-11 impact also includes an annualization of expected savings from the pharmaceutical changes. In addition, the Department is increasing efforts to coordinate with the Department of Veterans Affairs (VA) to enroll eligible veterans in the VA health care system. The program is anticipated to start enrollment in FY 2010-11. The Department has reduced the estimate from previous budget requests, but still anticipates savings in FY 2010-11 and FY 2011-12.

*FY 2009-10 BA-15 Community Transitions Services for Mental Illness Waiver Clients*

This request originally 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. However, due to program delays, the implementation of this initiative is expected to occur in FY 2010-11.

The annualized impacts of these initiatives were included in JBC figure setting for HB 10-1300, the Department's FY 2009-10 Supplemental Bill. The current year of this request (FY 2010-11) is affected by the annualization.

*FY 2009-10 ES-2, Medicaid Program Reductions*

This request reduces expenditure through a combination of rate reductions, service restrictions, elimination of certain programs, increased cost-sharing, and financial efficiencies. Included in the request are three initiatives which have an annualized impact in this 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 effective September 1, 2009. Rates paid to managed care organizations, including PACE, decreased by approximately 1.2%; effective October 1, 2009. The annualized impacts of these rate reductions are bottom line adjustments for FY 2010-11.
- 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. The annualized impact of this rate change is a bottom line impact for FY 2010-11 in Acute Care.
- 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 (HCBS) waiver program can receive per week. Clients are limited to two round trips per week. Trips to adult day programs are not to be subject to the cap included limitations on the HCBS waiver transportation benefit. This impact is annualized for FY 2010-11 as bottom line adjustments in Community Based Long Term Care.

*FY 2009-10 ES-6, Provider Rate Reductions*

This request included a permanent 1.0% reduction in the reimbursement rate paid to providers for Acute Care Services and Community Based Long Term Care services for the remainder of FY 2009-10, effective December 1, 2009. The impact of this rate reduction is annualized for FY 2010-11.

*NP-ES-5, Department of Human Services budget reduction initiative*

This initiative requested to close 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; it is annualized as a bottom line impact for Class I Nursing Facilities in FY 2010-11.

*NP-ES-8, Department of Human Services budget reduction initiative*

This initiative requested to close 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; it is annualized as a bottom line impact for Class I Nursing Facilities in FY 2010-11.

## *(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, all Low-Income Adult groups, 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 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.
- 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.
- 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:
    - 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.
    - 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 current year and the out-year requests and are elaborated below.
- 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. 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.
- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.

- HB 08-1373 designates funding sources for the Breast and Cervical Cancer Treatment 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, effective until FY 2011-12. Beginning FY 2012-13, state funding for the Breast and Cervical Cancer Program will be shifted to 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund.
- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates above the actuarial midpoint of the rate setting range. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from the Centers for Medicare and Medicaid Services, the Department has gradually put more weight on the encounter data. FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found that the estimated service expenditures were generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes that there are two primary reasons for this discrepancy. First, the non-traditional, federally waivered (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices cause some difficulties in the encounter pricing methodology. To offset the discrepancy the Department paid its mental health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.
- HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans. The bill was implemented in April 2010 when the Department began collecting the hospital provider fee. Mental health services were subsequently expanded to parents up to 100% of the federal poverty line using the Hospital Provider Fee Cash Fund to cover the additional expenses. Mental health services will be expanded further in FY 2011-12 by extending guaranteed eligibility for children and foster care children to twelve months. In addition, disabled individuals with income up to 450% of the federal poverty level will become eligible to purchase Medicaid benefits beginning in July 2011. For more detail, please see Exhibit J in Medical Services Premiums.
- 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:
    - As a part of FY 2009-10 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.
    - 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 allowed them to be eligible to receive Medicaid funded benefits and increased expenditure for mental health services.

- Effective January 1, 2010, the Department calculated a new set of mental health rates and set them below the actuarial midpoint. Three of the Behavioral Health Organizations (BHOs) were paid 2.5% below the actuarially set midpoint of the new set of rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). Effective April 1, 2010, all five of the contracted BHOs were paid 2.5% below the actuarially set midpoint of the new set of rates. See description of Exhibit GG for additional information.

***Potential Impact of Further Reductions to BHO Rates***

The Department will further reduce capitation rates by 2.0% to the behavioral health capitation program for quarter 3 and quarter 4 of FY 2010-11. This rate cut was originally requested in FY 2010-11 BRI-6, "Medicaid Program Reductions." Given the difficulties of two BHOs to actuarially certify rates prior to this proposed cut, the Department is working to anticipate and mitigate potential difficulties the BHOs may have with certifying these rate reductions. The Department cannot require services be delivered beyond those that are actuarially sound within the limits of available funding for each individual BHO. Therefore, the Department will work with the BHOs to determine the most appropriate way to achieve the required savings without impairing the operation of the program.

Before the Department can propose any cuts, the Department will need input from stakeholders about how to minimize the impact to client care. In particular, the Department is exploring the possibility of achieving the necessary savings though changes to the rate setting methodology and administrative reductions. While the Department is confident that it can achieve the required savings though methodology and administrative changes, if the Department and the BHOs cannot reach an agreement on these items, the Department may have to consider service or benefit reductions. Additionally, the Department will be required to gain approval for any reduction from the Centers for Medicare and Medicaid Services (CMS). Ultimately, CMS must approve any change to the Department's rate methodology, regardless of whether the changes are technical or tied to service reductions.

The Department and the BHOs are committed to finding a solution that will reduce costs but will continue to provide quality care to the clients. The Department and the BHOs will continue to work together, along with the stakeholders and CMS, to develop a proposal of reductions that will best serve the needs of the program.

***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 current year and out-year requests 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 (MMIS). Monthly payments were paid based on eligibility categories. The MMIS provides detailed expenditures by behavioral health organization and eligibility category but does not include offline transactions and accounting adjustments. The only source that includes all actual expenditure activity is the Colorado Financial Reporting System (COFRS). The drawback is that COFRS provided total expenditures, but not by eligibility category. The exception is the Breast and Cervical Cancer Treatment Program eligibility category, which is reported separately in COFRS. Since an allocation has to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category is multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from COFRS. This calculation estimates actual COFRS expenditures across each eligibility category. Variance between the two systems is 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 (IBNR) 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 current year and out-year for Medicaid Mental Health Community Programs. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted. The exhibits being referenced can be found in the Department's November 1, 2010, 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. The Department's incremental supplemental request for FY 2010-11 is calculated on page F.AA-2.

Exhibit AA now presents a concise summary of spending authority affecting the Medicaid Mental Health Programs. In previous budget requests, the Department 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. The Department's incremental request for FY 2011-12 is calculated on page F.AA-3.

***Alternative Calculation of Request***

The Department has submitted supplemental requests prior to and concurrent with this request as a result of budget balancing actions. On August 23, 2010, the Department submitted supplemental request ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage," to account for the phase down of the enhanced FMAP. On October 22, 2010, the Department submitted request ES-2, "Fee-for-Service Delay in FY 2010-11," to request additional funding to account for the FY 2009-10 payment delay. As a result of these requests, the Department's Schedule 13 and other pages from Exhibit A do not always reflect the Department's final need for Medicaid Mental Health Community Programs.

For FY 2010-11, the Department presents two alternative calculations for Exhibit A:

- On page F.AA-1, the Department presents the calculation of the request without accounting for the request ES-1. This page differs from the standard Exhibit AA in that it adds the total request (from page F.AA-2) to the total spending authority. The total expenditure on this page matches the Schedule 13. Please note that this figure is for reference only for the purpose of showing the derivation of the Schedule 13, and does not reflect the Department's total request for Mental Health Community Programs.
- On page F.AA-4, the Department shows the total request for Mental Health Community Programs, including the total amounts requested in ES-1 and ES-2. This page demonstrates the true incremental funding need for Mental Health Community Programs. This figure differs from the amounts requested on page F.AA-2 in order to show the sum of all FY 2010-11 requests for Medicaid Mental Health Community Programs through November 1, 2010.

***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. Finally, the recoupments from prior years for mental health capitation overpayments and retractions for capitations paid for clients later determined to be deceased 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 the Hospital Provider Fee Cash 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.

The federal match rate is adjusted for the American Recovery and Reinvestment Act (ARRA), which will be phased out in FY 2010-11. For that fiscal year, those populations of clients not already receiving an enhanced federal match (e.g. Breast and Cervical Cancer Clients) receive an increased federal match of 61.59% (from the established 50% match) for the first two quarters of that fiscal year, as well as an increased match of 58.77% for the third quarter and an increased match of 56.88% for the fourth quarter. The weighted average over the whole year is 59.71%, which is applied to all populations that receive the enhanced match. 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. There is no ARRA impact in FY 2011-12.

*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. (2010). 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. Historically, the Department has assumed that 30% of the Breast and Cervical Cancer clients are expansion clients and 70% are traditional clients.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2011-12 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. The Department is requesting $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request DI-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to consider all Breast and Cervical Cancer Program clients in mental health

community programs as traditional Breast and Cervical Cancer Program clients funded by the Breast and Cervical Cancer Prevention and Treatment Fund.

*Mental Health Services for Tobacco Tax Expansion Clients:*
HB 05-1262 established a Tobacco Tax for a series of expansion clients. Services for these clients will be funded through the Health Care Expansion Fund. The Health Care Expansion Fund provides capitated mental health funding for expansion adults to 60 % of the federal poverty level, 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 SB 07-002 and SB 08-099.

*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). Starting in FY 2011-12, additional expansion populations will receive funding through the Hospital Provider Fee Cash Fund, including continuously eligible children, continuously eligible foster care children, and disabled individuals with income limits up to 450% of the federal poverty limit.

***Medicaid Mental Health Community Programs Summary (Exhibit CC):***
Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 2.5%, as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. 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 that 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 (COFRS). Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from COFRS. The Medicaid Management Information System (MMIS) 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 in COFRS as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the COFRS across eligibility categories.

A ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures by the total Medicaid MMIS expenditures. The ratio is multiplied by the total expenditures from COFRS. This calculation estimates actual COFRS expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are taken 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 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). For the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for FY 2010-11 and the first half of FY 2011-12 are known and only the final two quarters of the out-year request are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. 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.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

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 Retroactivity Adjustment and Partial Month 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 partial-month adjustment multiplier.

*Retroactivity 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. The most recent data, however, does not fully account for the fact that there are retroactive claims that have not been paid. It is the case, then, that a period removed from the most recent will be the most predictive of future experience (being the most recently available data that does not suffer from this problem of retroactivity). Therefore, the average of the percentages across each eligibility category is weighted, pulling 70% of that weight from two prior-periods ago, 10% form the most recent period, and 20% from the average of the remaining historical periods.

*Partial Month Adjustment Multiplier:*

To derive the partial month 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. For FY 2009-10, only data from the first two quarters were used to calculate the claims-based rates as the claims data for the last two quarters are incomplete; this occurs because there are claims that have been incurred but not yet received. The percentages are similar across years, indicating that 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.

It is important to note that the overall weighted midpoint 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.

Exhibit GG presents the weighted midpoint rates, and the trend of those rates is used for forecasting. The weighted midpoint rates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit GG in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

From January 1, 2009 to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2009-10 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year, set 2.5% below their certified midpoint rates. However, the Department's rate setting process and federal regulation require that both the Department and the BHOs actuarially

certify that they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify the proposed rates. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates. Beginning April 1, 2009, the two remaining BHOs were able to certify the 2.5% rate cut, resulting in all five BHOs being paid at 2.5% of the new midpoint. The 2.5% rate cut will continue to be in effect through FY 2010-11 and FY 2011-12, as well as an additional 2% cut, which was requested in FY 2010-11 BRI-6, to be in place for the third and fourth quarter of FY 2010-11.

The following table presents the estimated paid rates (as opposed to midpoint rates) across eligibility categories beginning with the January 1, 2009 rates with their plus 3% adjustment.

| Fiscal Year | 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 |
|---|---|---|---|---|---|
| January 1, 2009 Midpoint Rate | $13.15 | $124.52 | $18.25 | $14.25 | $232.63 |
| % Change in the Rate Range | 3.00% | 3.00% | 3.00% | 3.00% | 3.00% |
| Paid Rate, January 1, 2009 to June 30, 2009 | $13.54 | $128.26 | $18.80 | $14.68 | $239.61 |
| July 1, 2009 Midpoint Rate | $13.37 | $126.65 | $18.57 | $14.50 | $237.59 |
| % Change in the Rate Range | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Paid Rate, July 1, 2009 to August 31, 2009 | $13.37 | $126.65 | $18.57 | $14.50 | $237.59 |
| September 1, 2009 Midpoint Rate | $13.37 | $126.65 | $18.57 | $14.50 | $237.59 |
| % Change in the Rate Range | -2.50% | -2.50% | -2.50% | -2.50% | -2.50% |
| Paid Rate, September 1, 2009 to December 31, 2009 | $13.04 | $123.48 | $18.11 | $14.14 | $231.65 |
| January 1, 2010 Midpoint Rate | $13.43 | $136.30 | $20.00 | $14.89 | $204.04 |
| % Change in the Rate Range | -1.27% | -3.34% | -2.95% | -3.22% | 3.01% |
| Paid Rate, January 1, 2010 to June 30, 2010 | 13.26 | 131.75 | 19.41 | 14.41 | 210.18 |
| Note: Rates for each eligibility category are weighted by the proportion of claims incurred by each BHO within that category. The weighted average midpoint rates and weighted average paid rates are determined by the Department every six months based on the rates certified by the actuaries. The paid rate from January 1, 2010 to June 30, 2010 is the result of two of the BHOs having their previous rates carried forward; the blend of those rates with the new rates for three BHOs yields unique weighted average rates, as presented. | | | | | |

***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 known rates from those already set through the actuarial process and the remaining point estimates 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 the FY 2009-10 ES-2 budget action, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. For Q3 and Q4 of FY 2010-11, the Department will cut rates by an additional 2.0%, setting them 4.5% below the actuarial midpoint. This was requested in FY 2010-11 BRI-6, "Medicaid Program Reductions" for the full year, but will be implemented for only two quarters per instructions from the Office of State Planning and Budgeting.

The forecasted rate is also adjusted by the partial month 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 retroactivity 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 midpoint 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. Beginning with FY 2008-09 the Department has experienced unusual trends 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 most recent years' experience is the most predictive of the likely current year and future year experiences.

For Q3 and Q4 of FY 2010-11 and Q1 and Q2 of FY 2011-12:

- The rate of change from FY 2007-08 to FY 2008-09 was applied for 1) Adults 65 and Older and 2) Foster Care eligibility categories. The rate for Adults 65 and Older has been increasing slowly over the past two years, with almost zero growth in FY 2009-10. As it is unlikely that it will remain stagnant, the percentage from FY 2008-09 was chosen. The rate for the Foster Care population has continued to decrease over the last several years; the Department expects that this will decline will continue, but will begin to level off. The percentage smallest in magnitude (but still negative) from the last three years was chosen.
- The linear growth model was selected for the Disabled Adults 60 to 64 (OAP-B) and Disabled Individuals to 59 (AND/AB) populations. The rate for the disabled population has seen a steady year-to-year increase, from 6.39% to 8.43% annually, but for

the Goebel settlement year (see the "History and Background" section of this narrative). The Department anticipates this linear growth to continue.

- The rate of change from FY 2007-08 to FY 2009-10 was applied the Adults eligibility category. Although the linear growth model fits the past eight years of data well, the rate increased much slower in the last two years than the preceding years. The linear growth model would likely overestimate the rate for Q3 and Q4.
- For the Children category, the rate of change from FY 2006-07 to FY 2009-10 was applied as the rate for this population has increased steadily over the past three years.

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. Exhibit II summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. 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 collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the later half of FY 2009-10. In FY 2010-11, recoupments will be collected for FYs 2004-05 and 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. Starting in FY 2011-12, all historical recoupments will be collected. Each fiscal year recoupments will be made for the year two years prior to the current one. Recoupments from FY 2009-10 will be collected in FY 2011-12 and will be altered by the enhanced federal match from the year the claims were processed.

***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 SB 07-002 and SB 08-099.

The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program, and historically 30% of the Breast and Cervical Cancer Program caseload is paid for out of this Fund. The Department is requesting a change to the allocation of traditional and expansion clients in FY 2011-12 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. The Department is requesting $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request DI-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to consider all Breast and Cervical Cancer Program clients in mental health community programs as traditional Breast and Cervical Cancer Program clients funded by the Breast and Cervical Cancer Prevention and Treatment 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, 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 per capita costs and rate of per capita growth for this expanded Foster Care population is assumed to be the same as for the traditional Foster Care population.

The Health Care Expansion Fund also pays for individuals that are eligible for Medicaid as a result of the removal of the asset test, as required by HB 05-1262. Due to the fact that many Medicaid recipients are no longer required to submit information for the asset test, the Department has found it difficult to track expenditures for this population. 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. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

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 also assumes that the costs for this population will be the same as for the traditional population, as the vast majority of mental health services payments are made via capitation, and do not change based on client utilization. Additional populations will be added in FY 2011-12. These include continuously eligible children, continuously eligible foster care children, and disabled individuals with income limits up to 450% of the federal poverty line. As with adults, the Department assumes that the costs for these populations will be the same as for their corresponding traditional populations. The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see Exhibit B in Medical Services Premiums).

## ***(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 total estimated expenditure is based on the prior year's actual expenditures, trended forward based upon the expected change in caseload. The actual expenditure for FY 2009-10 includes the expenditure amount that was paid after the fiscal year ended in response to the two-week payment delay that occurred in the last two weeks of the fiscal year. This expenditure is

included in order to forecast from a 52-week base instead of a 50-week base, thereby preventing the forecasts for the current and request years (both of which are assumed to be 52-week years) from being artificially deflated. 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. FY 2009-10 has seen significant increases in fee-for-service expenditure. The Department is currently performing data analysis using fee-for-service claims in an attempt to determine if this increase in expenditure reflects a permanent shift in expenditure patterns or if the last fiscal year is an anomaly. The Department will continue to monitor the situation. In the interim and until data analysis can prove or disprove any theories, the Department takes the conservative view for forecasting purposes, assuming the increase fee-for-service expenditure will continue into the foreseeable future.

***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 2010-11 appropriation is 10.86% higher than FY 2009-10 actual expenditures, primarily due to caseload growth. The FY 2010-11 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 9.17% increase from FY 2009-10 actual expenditures and a 1.53% decrease from the current appropriation. The FY 2011-12 Budget Request is built on the FY 2010-11 estimate, and presents an 11.86% expenditure increase. This increase is primarily due to 1) increased caseload projections for traditional clients and 2)

increased caseload due to the Colorado Health Care Affordability Act expansion populations. The FY 2011-12 Request represents a 10.16% increase over the current FY 2010-11 appropriation.

## *(4) INDIGENT CARE PROGRAM*

The Indigent Care Program Long Bill group consists of the Colorado Indigent Care Program, Colorado Health Care Services Fund payments, the Primary Care Fund Program, the Children's Basic Health Plan, 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 2011-12 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 low-income 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 2008-09, total payments to indigent care providers through the Colorado Indigent Care Program equaled $202,722,534 and 197,597 clients were served by the program, up 1.5% from 194,710 in FY 2007-08. As of FY 2010-11, the program consists of the following four line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; Health Care Services Fund Programs; and, Pediatric Specialty Hospital. Pursuant to HB 10-1323 and effective July 1, 2010, the Comprehensive Primary and Preventive Care Rural and Public Hospital Payments line item has been permanently eliminated. These line items allow providers to receive partial compensation for uncompensated costs due to 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, the Colorado Indigent Care Program was created as a partial solution to the health care needs of Colorado's indigent citizens. The financial eligibility requirement for the 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. The program contracts directly with hospitals and community health clinics to provide specific services to eligible individuals. 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 as financing allows. Providers are required to provide on-site eligibility and co-payment determinations. To determine eligibility, providers assign a rating 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 financial participation: 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 cash funds to draw down these federal funds, although the contribution of General Fund dollars to the state match is minimal relative to more innovative sources of state funds. Prior to FY 2009-10, the State utilized certification of public expenditures for all publicly-owned facilities (seen as cash funds in the budget) to draw down matching federal funds. Beginning in FY 2009-10, the use of certification has been replaced with fees assessed on hospital providers, as will be discussed later. 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 DSH 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 DSH 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. 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. In FFY 2009, the DSH cap for Department expenditures is equal to $93,235,244. Converting this to State FY 2009-10, the DSH allotment was equal to $94,619,485.

As required by HB 04-1438, the Department must include in the annual Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. For calendar year 2007 data, this information can be found in Exhibit K, pages EK-8-9 in the Department's November 6, 2009 FY 2010-11 Budget Request, Volume I. For calendar year 2008 data, this information can be found in Exhibit K, pages EK-8-9 in the Department's November 1, 2010 FY 2011-12 Budget Request, Volume I.

**COLORADO HEALTH CARE AFFORDABILITY ACT**

Authorized by the passage of HB 09-1293, the Colorado Health Care Affordability Act, also referred to as the Hospital Provider Fee, represents the single largest expansion of eligibility under Medicaid and the Children's Basic Health Plan since those authorized by the Tobacco Tax Bill HB 05-1262. The bill allows the Department to expand eligibility in a number of ways on the following timeline:

- Increase eligibility under Medicaid for parents of Medicaid-eligible children from 60% to 100% of the Federal Poverty Level (FPL) effective May 1, 2010;
- Increase eligibility under the Children's Basic Health Plan to 250% of the FPL effective May 1, 2010;
- Implement a buy-in program under Medicaid for disabled adults and children up to 450% of the FPL effective July 1, 2011;
- Provide medical benefits to adults without dependent children up to 100% of the FPL effective January 1, 2012; and,,
- Ensure continuous eligibility for children enrolled in Medicaid for twelve months effective February 1, 2012.

In addition, the Health Care Affordability Act enables the Department to increase reimbursement rates to Medicaid and Colorado Indigent Care Program (CICP) hospital providers through targeted supplemental payments to a variety of hospital provider classes. In addition to ensuring continued access to medical services for Medicaid and CICP clients, these payments are intended to lessen the degree and scope of cost-shifting to private consumers of health care by reducing the uncompensated costs associated with providing medical services to these clients. The administrative costs to the Department of collecting the fee, implementing eligibility expansions, calculating and transmitting supplemental payments, and monitoring the usage of provider fee funds will also be paid with provider fee funds. Expenditures for these administrative functions are expected to equal 1.16% of total expenditures associated with HB 09-1293 in FY 2009-10.

Beginning in FY 2009-10, these expansions and rate increases are being financed by the collection of fees from hospital providers according to federal regulations and based on inpatient and outpatient hospital revenues, with certain exceptions. In FY 2009-10, the Department collected a total of $340,869,957 in fees from hospitals through the mechanism established in State Plan Amendments and approved by the federal Centers for Medicare and Medicaid Services on March 31, 2010.

In FY 2009-10, the Department was appropriated $338,228,916 total funds throughout its budget for costs associated with the HB 09-1293, including the reduction of Certified Public Expenditures (CPE) which the provider fee replaced[17]. The Department has been appropriated $485,275,252 total funds for Hospital Provider Fee expenditures in FY 2010-11.

**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. The Department's FY 2003-04 DI-6, "Change Methodology for Financing the Indigent Care Program

[17] Certification of Public Expenditures and associated federal funds equal to $274,562,626 were replaced with provider fee funds and matching federal funds in FY 2009-10.

and Disproportionate Share Hospital Through Proposed Safety Net Funding Allocation" submitted with the November 1, 2002 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.

Prior to FY 2009-10, the Safety Net Provider Payments line item was composed of four payments: Low-Income, Bad Debt, High-Volume, and Medicaid Shortfall. However, HB 09-1293 combined the Low-Income, Bad Debt, High Volume, and Medicaid Shortfall payments into two more broadly-based supplemental payments to CICP providers: the CICP Disproportionate Share Hospital Payment and the CICP Supplemental Medicaid Payment. A summary of the rules related to the reimbursement of Safety Net providers under these two payments is given in the following matrix.

| Payment Type | Public Hospitals | Private Hospitals |
|---|---|---|
| **CICP Disproportionate Share Hospital Payment:** Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of available Disproportionate Share Hospital federal funds limit imposed by federal law.<br><br>For FY 2009-10, the final DSH cap after inclusion of ARRA (which extends through the end of FFY 2010) for Colorado was equal to $94,619,485. The federal limit is a projection based on information in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. For FFY 2011 this information is not yet known. | The State share of payments to public hospitals is from provider fees assessed on hospitals 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 from provider fees assessed on hospitals. The federal share of payment is from Disproportionate Share Hospital federal funds. |
| **CICP Supplemental Medicaid Payment:** Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit for inpatient hospital services. | The State share of payments to public hospitals is from provider fees assessed on hospitals 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 from provider fees assessed on hospitals. The federal share is from the federal Medicaid matching rate for Colorado. |

Under the distribution model, CICP hospital providers are reimbursed up to 100% of uncompensated costs associated with treating indigent clients funded in sum by two separate payment calculations (CICP Disproportionate Share Hospital Payment and CICP Supplemental Inpatient Hospital Medicaid Payment). 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 made available in FY 2009-10 was $90,961,214. The federal limit is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. The CICP Disproportionate Share Hospital Payment is a payment of this type. Under the American Recovery and Reinvestment Act of 2009, States will be receiving a 2.5% annual increase in their respective DSH allotments, if so needed, until the end of FFY 2010. Also pursuant to ARRA, DSH expenditures are not eligible for the enhanced federal financial participation granted for other payments to

hospitals and client service providers. For State FY 2009-10, the Department received a final DSH allotment of $94,619,485.

The Upper Payment Limit for inpatient hospital services is determined on a hospital-by-hospital basis and aggregated by hospital type: state-owned public hospitals, non-state owned public hospitals, and private-owned hospitals. Total inpatient hospital expenditures cannot exceed the available aggregated Upper Payment Limit by type. The CICP Supplemental Inpatient Hospital Medicaid Payment is funded by assessed hospital provider fees and federal matching funds under the available Upper Payment Limit for inpatient hospital services.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

*Appropriation History*

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 (JBC) staff recommended several changes that were subsequently included in the FY 2009-10 Long Bill Add-ons (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 $456,976 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. This appropriation consisted of $13,090,782 General Fund, $139,087,861 certified public expenditures, and $152,178,643 federal funds.

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 $6,358,136 from the FY 2008-09 appropriation which resulted in a FY 2009-10 Long Bill 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 JBC 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. During the Department's FY 2010-11 Figure Setting, JBC Staff recommended the elimination of the remaining General Fund and a reduction in the cash fund spending authority (Figure Setting dated March 16, 2010, pg. 137), which resulted in a total funds reduction of $20,518,476 to the appropriation.

The appropriations clause for HB 09-1293, Colorado Health Care Affordability Act, increased the FY 2009-10 appropriation to the line item by $52,192,934 split evenly between cash funds and federal funds, and changed the state funds source for this line item from certified public expenditures to hospital provider fee cash funds. The Department's Supplemental Bill (HB 10-1300) modified the appropriations clause by reducing the total funds appropriation to the line to account for lower than anticipated supplemental payments from the line and adjusting the fund split to account for increased Federal Medical Assistance Percentage (FMAP) provided by ARRA. These changes resulted in a total funds reduction equal to $48,985,592, of which $38,544,623 was cash funds and $10,440,969 was federal funds. HB 10-1372, Changes to HB 09-1293 Appropriations Clause, further updated appropriations to several Department line items to account for revised estimates of expansion population enrollment and costs, as well as adjusted the fund split for updated ARRA estimates, increasing the federal funds appropriation to this line item by $465,060 and decreasing the cash fund appropriations by $465,060. These bills resulted in a final FY 2009-10 appropriation to the Safety Net Provider Payments line item of $277,769,968, consisting of $124,368,097 cash funds and $153,401,871 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated continuation funding of $277,769,968 to the line item, consisting of $124,368,097 cash funds and $153,401,871 federal funds. During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4$^{th}$ quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the cash fund appropriation of $2,357,542 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation is $277,769,968, consisting of $126,725,639 cash funds and $151,044,329 federal funds.

For FY 2011-12, the Department is requesting $292,225,957 total funds, which includes the annualization of HB 09-1293 equal to an increase of $14,755,989 total funds. Of the base request amount, $131,596,092 is cash funds and $160,629,865 is 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. (2010), the Health Care Services Fund was appropriated $15,000,000 in FY 2008-09 through the FY 2008 09 Long Bill (HB 08-1375).

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.

The FY 2009-10 Long Bill (SB 09-259) initially set the appropriation for FY 2009-10 at $15,000,000. However this was set 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. HB 10-1321, "Health Care Services Fund Moneys" further reduced the appropriation by $1,553,000 for budget balancing purposes. These actions resulted in a final FY 2009-10 appropriation of $10,390,000 General Fund.

The FY 2010-11 Long Bill (HB 10-1376) set the appropriation to $0. 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. (2010).

**THE CHILDREN'S HOSPITAL, CLINIC BASED INDIGENT CARE**

The Children's Hospital, Clinic Based Indigent Care line item was created in FY 2002-03 utilizing 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 relative to uncompensated costs reported by all recipients as reported in the Colorado Indigent Care Program Annual Report, increased for two years using the Consumer Price Index, All Workers, Denver Medical Costs for July of the most recent year.

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) C.R.S. (2010) 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 (JBC) staff during the Department's FY 2008-09 Figure Setting, approved by the JBC 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.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

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 certain line items, 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 continuation funding plus 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). It also included the annualization of SB 09-264, which in turn resulted in an increase to the line of $1,450,631 reappropriated funds and corresponding decrease in federal funds. HB 10-1321 then reduced the appropriation to this line from the Health Care Services Fund by $306,069 and increased the federal funds by $298,267, for a total fund decrease of $7,802. Adjustments for the enhanced FMAP from ARRA decreased General Fund appropriations to this line $709,280 with a corresponding increase in federal funds. Finally, SB 09-264 again decreased the reappropriated funds $2,205,931 with a corresponding increase in federal funds. The final FY 2009-10 appropriation was $27,759,958 total funds, which is composed of $2,350,600 General Fund, $8,312,000 reappropriated funds, and $17,097,358 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $6,119,760 total funds to this line item. This includes a total fund decrease in the amount of $21,640,198 due to 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. (2010). This removed all reappropriated funds appropriations from this line item and associated federal funds. During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the cash fund appropriation of $115,187 with a corresponding decrease in the federal funds appropriation. The year-to-date FY 2010-11 appropriation to the line item is $6,119,760 total funds, consisting of $2,465,787 General Fund and $3,653,973 federal funds.

For FY 2011-12, the Department's base request is $6,119,760 total funds, comprised of $3,059,880 General Fund and a corresponding amount of federal funds. The annualization of the FY 2010-11 ARRA Adjustment restores the line item to a 50% Federal Medicaid Assistance Percentage (FMAP) consistent with the expiration of ARRA.

**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 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 statutory requirements 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 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 (JBC) and incorporated into that year's Supplemental Bill (SB 09-187) resulting in a decrease to the FY 2008-09 appropriation of $738,000.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

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 certain line items, 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. HB 10-1321, "Health Care Services Fund Moneys," also impacted the line item, reducing the appropriation by $2,941,951 total funds. The final year-to-date appropriation for FY 2009-10 was $5,410,049 total funds, comprised of $2,078,000 reappropriated funds and $3,332,049 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) included an appropriation to this line item in the amount of $0. This is due to 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. (2010), which removed all reappropriated funds and federal funds appropriations to this line item line item. Subsequently, HB 10-1378, "2010 Transfers for Health Care Services" reinstated funding to this line item in the amount of $31,085,655 total funds pursuant to the declaration of a state fiscal emergency.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the Joint Budget Committee (JBC) adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions

for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in a decrease in the federal funds appropriation of $1,380,411 with no increase in the cash fund appropriation as this is in statute. These FY 2010-11 appropriation of $29,705,244 consists of $11,940,000 cash funds from the Primary Care Fund and federal funds in the amount of $17,765,244.

For FY 2011-12, the Department's base request for the line item is $0, as the statutory appropriations to the line expire at the end of FY 2010-11 with the annualization of HB 10-1378.

**PEDIATRIC SPECIALITY HOSPITAL**

The creation of this line item was recommended during a Joint Budget Committee (JBC) meeting on March 24, 2005 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.

The FY 2008-09 Long Bill (HB 08-1375) set the appropriation for this line at $12,865,212. During the supplemental process for FY 2008-09, JBC staff recommended and the Committee approved a reduction to the line due to revised estimates of Tobacco Master Settlement Agreement revenue that would be received by the State. This common adjustment was subsequently incorporated into the FY 2008-09 Supplemental Bill (SB 09-187) decreasing the appropriation to the line by $36,628.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

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 JBC 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 JBC 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 annualization of SB 09-264 decreased the total funds appropriation by $1,137, resulting in the FY 2009-10 Long Bill appropriation of $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 for FY 2010-11. 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 by 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. Also during Figure Setting on March 16, 2010, JBC staff recommended a revenue and technical adjustment to fix fund splits and to reduce the Amendment 35 revenue forecast, resulting in a decrease of $68,903 total funds. Finally, the FY 2010-11 Long Bill Add-ons (HB 10-1376) decreased the appropriation by a further $44,456 due to a further revenue adjustment. The final FY 2009-10 appropriation was $14,913,994 total funds. Of this total, $4,928,465 was General Fund, $104,310 General Fund Exempt, $350,000 cash funds, $345,690 reappropriated funds, and $9,185,529 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $14,821,994 total funds to this line item. While the annualizations of SB 09-264 and ARRA impacts had no total fund changes from the FY 2009-10 appropriations, JBC staff technical adjustments for FY 2010-11 resulted in a net decrease of $136,456 total funds. The annualization of SB 09-264 changes made in the FY 2010-11 Long Bill Add-ons resulted in an increase to the line in the amount of $44,456.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was

originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the General Fund appropriation of $278,982 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 year-to-date appropriation to this line is $14,821,994 total funds, made up of $5,218,110 General Fund, $307,000 cash funds, $447,000 reappropriated funds, and $8,849,884 federal funds.

For FY 2011-12, the Department's base request is for $14,950,860 total funds, and includes the annualizations of JBC Staff recommendations for revenue and technical adjustments from FY 2009-10 and FY 2010-11, which increased the appropriation by $210,718 total funds from the FY 2010-11 year-to-date appropriations. Subsequently, the base request was reduced by $81,852 to reflect the most recent Legislative Council forecast for Tobacco Tax revenue. In addition, the removal of all ARRA adjustments results in an increase of $1,438,887 General Fund and a corresponding decrease in federal funds. Of the total base request, $6,656,997 is General Fund, $355,359 is cash funds, $422,148 is reappropriated funds, and $7,516,356 is federal funds.

**HB 05-1262 APPROPRIATION FROM THE GENERAL FUND TO PEDIATRIC SPECIALITY HOSPITAL 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. (2010) 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. (2010), 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 2008-09 Long Bill (HB 08-1375) appropriated $495,000 to this line item. 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), 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. This included an increase of $9,000 from updates to the Amendment 35 revenue forecast and an increase from the annualization of SB 09-264 in the amount of $68,000, for a total increase of $77,000. 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, in addition to a decrease in the appropriation of $41,483 due to the Amendment 35 revenue forecast being lowered. The appropriation from SB 09-264 to the line item was further reduced by $13,827 in HB-1300, resulting in a final FY 2009-10 appropriation of $345,690 General Fund Exempt.

The FY 2010-11 Long Bill (HB 10-1376) appropriation for the line was set at $447,000 General Fund Exempt, and included the removal of ARRA adjustment from the line item and a decrease in Amendment 35 revenue, resulting in a net increase to the line of $101,310. The year-to-date appropriation for FY 2010-11 is $447,000 General Fund Exempt.

For FY 2011-12, the Department's base request for this line item is $422,148 General Fund Exempt, which includes continuation funding plus an increase of $57,000 for the annualizations of SB 09-264 and the FY 2009-10 and FY 2010-11 revenue adjustments, which occur quarterly along with presentations by the Office of Legislative Counsel of Amendment 35 Revenue Forecasts. Subsequently, the base request was reduced by $81,852 to reflect the most recent Legislative Council forecast for Tobacco Tax revenue.

**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. (2010) 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.

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. However, estimates were later revised downward, leading to a decrease in the appropriation of $54,000. The final FY 2009-10 appropriation was $450,000 cash funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $447,000, again incorporating a revised Amendment 35 revenue forecast, which led to a decrease in the appropriation of $3,000. The year-to-date FY 10-11 appropriation is $447,000 cash funds.

For FY 2011-12, the Department's base request for this line item is $422,148 cash funds, which includes continuation funding and the annualizations of the two most recent Amendment 35 revenue adjustments of $3,000 and $54,000. Subsequently, the base request was reduced by $81,852 to reflect the most recent Legislative Council forecast for Tobacco Tax revenue.

**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. (2010) 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 1, 2010 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.

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 Amendment 35 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.

The FY 2009-10 Long Bill (SB 09-259) appropriated $31,920,000 to this line item, which included an increase of $625,343 to account for anticipated growth in Amendment 35 revenues during FY 2009-10. HB 10-1321, "Health Care Service Fund Moneys," then reduced funding to this line by $12,395,000. The reduced funding to this line was diverted to the (2) Medical Services Premiums line item and the newly created Primary Care Special Distribution Fund to offset General Fund money in the (2) Medical Services Premiums line item and to minimize adverse effects on clinics due to reduced funding to the Primary Care Fund. SB 09-271, which concerns the emergency use of tobacco tax revenues during a state fiscal emergency, also 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 the final FY 2009-10 appropriations to the line item to $12,125,000 total funds, comprised entirely of cash funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $28,300,000 to this line. This included the annualizations of SB 09-271 and HB 10-1321, which increase the appropriation by $7,400,000 and $12,395,000 respectively. It also included a JBC staff recommendation reducing the appropriation $3,620,000 due to a reduced forecast of Amendment 35 revenue. HB 10-1378 later reduced this appropriation to $0, diverting the money to the Health Care Services Fund, Medical Services Premiums, and the Primary Care Special Distribution Fund in the amounts of $11,940,000, $12,800,000, and $3,560,000 respectively. This leaves the FY 2010-11 year-to-date appropriation at $0.

For FY 2011-12, the Department's base request for this line item is $31,920,000 cash funds, which includes the annualizations of the Amendment 35 revenue adjustment from FY 2010-11 and HB 10-1378.

**PRIMARY CARE GRANT PROGRAM SPECIAL DISTRIBUTION**

The Primary Care Grant Program Special Distribution fund was created during the 2010 legislative session with the passage of HB 10-1321, establishing the fund pursuant to 25.5-3-112 (4) (a), C.R.S. (2010). It was created with the intent of minimizing losses to clinics who receive money from the Primary Care Fund, which was reallocated through HB 10-1321 and HB 10-1378. This line received an appropriation of $2,005,000 total funds in FY 2009-10, all of which were cash funds from the Primary Care Fund.

The FY 2010-11 Long Bill (HB 10-1376) also initially had a $0 appropriation to the line as the Special Distribution Fund was due to be eliminated at the end of FY 2009-10 with the expiration of HB 10-1321. However, with the passage of HB 10-1378, "2010 Transfers for Health Care Service," the line was again appropriated money from the Primary Care Fund in the amount of $3,560,000.

For FY 2011-12, the Department's base request is $0. This is due to the elimination of the fund once more with the annualization of HB 10-1378.

***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. The Children's Basic Health Plan was reauthorized at the federal level through the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). 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.

Governor Ritter signed HB 09-1293, the Colorado Health Care Affordability Act on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee to increase eligibility in Medicaid and the Children's Basic Health Plan, as well as increase hospital reimbursement. As part of the Act, eligibility in the Children's Basic Health Plan was increased to 250% of the federal poverty level on May 1, 2010.

**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 2008-09 Appropriation for the Trust*

The FY 2008-09 Long Bill (HB 08-1375) 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 (JBC) 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). Pursuant to the Department's FY 2009-10 S-11 "Refinance Colorado Benefits Management System Improvements" and S-13 "Colorado Benefits Management System Client Correspondence", the appropriation to the Trust was increased by $2,919 in the Department's Supplemental Bill (HB 10-1300). The FY 2009-10 appropriation was increased by $207,860 due to the adoption of SB 10-1382, Repeal Delay of Payments, which repeals the shift in the date of payment for managed care capitations from the concurrent month to the beginning of the month following enrollment as set forth in SB 09-265. The FY 2009-10 appropriation is $2,710,779 General Fund.

*FY 2010-11 Appropriation for the Trust*

The FY 2010-11 Long Bill (HB 10-1376) included a reduction of $376 for the annualization of FY 2009-10 S-13 "Colorado Benefits Management System Client Correspondence. In addition, the Department received a General Fund appropriation of $4,099,816 to the Trust Fund for anticipated funding needs in FY 2010-11 pursuant to DI-3 and BA-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs." (November 6, 2009 FY 2010-11 Budget Request and FY 2010-11 Budget Request Amendment for the Children's Basic Health Plan, February 16, 2010). Pursuant to the Department's FY 2010-11 BA-6 "Federally Mandated CHP+ Program Changes", the appropriation to the Trust was increased by a further $46,661. HB 10-1382, Repeal Delay of Payments, resulted in an increase of $2,554,602 to this appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $2,696,994 pursuant to ES-3 "Delay Managed Care Payments." The FY 2010-11 appropriation to the Trust Fund is $6,714,488 General Fund.

*FY 2011-12 Base Request for the Trust*

The base request is to remove one-time funding of $6,714,488 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% and that 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 2008-09 Appropriation for Administration*

The FY 2008-09 Long Bill (HB 08-1375) 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 $15,000 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. These actions resulted in a reduction of $815,000 from the FY 2008-09 appropriation.

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 (JBC) 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. This reduction, along with an increase of $113,527 pursuant to the Department's FY 2009-10 S-7 "Federally Mandated CHP+ Program Changes" for enhanced external quality review activities, were included in the Department's Supplemental Bill (HB 10-1300). With the approval of HB 09-1293, Colorado Health Care Affordability Act, the appropriation was increased by $9,800 for administrative costs associated with the additional caseload resulting from the increase in eligibility in the Plan to 250% of the federal poverty level in late FY 2009-10. The FY 2009-10 appropriation is $5,410,917, including $2,420,452 cash funds and $2,990,465 federal funds.

*FY 2010-11 Appropriation for Administration*

The FY 2010-11 Long Bill (HB 10-1376) appropriation for administrative costs include the removal of one-time funding of $1,000 from SB 08-160, Health Care for Children and an increase of $10,126 for the annualization of HB 09-1293. The appropriation was subsequently increased by $19,460 for the Department's FY 2009-10 BA-6 "Federally Mandated CHP+ Program Changes" for enhanced external quality review activities. The Department's BA-19 "CHP+ Administrative Savings" further reduced the Department's funding for outreach activities by $550,000. The FY 2010-11 appropriation is $4,889,503, including $2,219,230 cash funds and $2,670,273 federal funds.

*FY 2011-12 Base Request for Administration*

The FY 2011-12 base request is for $4,894,410, which includes continuation funding of $4,889,503 and an increase of $4,907 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 $2,220,948 cash funds and $2,673,462 federal funds.

**CHILDREN'S BASIC HEALTH PLAN PREMIUM COSTS**

This line item funds the costs of medical services provided to eligible children enrolled in the Children's Basic Health Plan and medical premiums for prenatal and delivery services for pregnant women.

The Department establishes annual enrollment projections. Each year the actuary contracted by the Department recommends a per-member-per-month rate for health maintenance organizations and the self-insured network. This rate includes the expected costs of providing medical benefits to enrollees as well as medical management services such as claims management. The Department uses the rates to develop estimated per capita costs. For children in the Plan, the per capita is a "blended" cost that is based on the ratio of the number of children expected to be enrolled in health maintenance organizations to the number of children in the Children's Basic Health Plan's self-insured network.

The State share of funding for medical premiums is appropriated from the Children's Basic Health Plan Trust Fund as either cash funds or reappropriated funds. Beginning in FY 2005-06, the State share of funding includes the Health Care Expansion Fund which funds program expansions created in HB 05-1262 (Tobacco Tax). Beginning in FY 2009-10, the State share also includes funding from the Hospital Provider Fee Cash Fund for the expansion created in HB 09-1293, Colorado Health Care Affordability Act. The federal share of funding is from Title XXI (State Children's Health Insurance Program), which 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 2008-09 Appropriation for Premiums Costs*

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 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 (SB 09-259) 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 increased in the FY 2010-11 Long Bill Add-ons (HB 10-1376) by $6,230,398 for caseload and per capita cost adjustments included in the Department's FY 2009-10 S-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs." The appropriation was further 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. HB 10-1382, Repeal Delay of Payments, reinstated the last capitation payment in FY 2009-10 and reversed this reduction. HB 09-1293, Colorado Health Care Affordability Act, increased the appropriation by $20,298,641 for the medical costs associated with the caseload from the increase in eligibility to 250% of the federal poverty level. This appropriation was subsequently reduced by $19,035,830 in HB 10-1372, Changes to HB 09-1293 Appropriation Clause, to reflect reduced caseload estimates due to a delay in implementation of the expansion. The FY 2009-10 appropriation is $153,157,421 total funds, consisting of $51,351,535 cash funds, $2,500,000 reappropriated funds, and $99,305,886 federal funds.

*FY 2010-11 Appropriation for Premiums Costs*

The FY 2010-11 Long Bill (HB 10-1376) appropriation included an increase of $29,084,865 for the annualization of HB 09-1293. In addition, the appropriation was increased by $20,814,875 as a result of the Department's DI-3 and BA-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," (November 6, 2009 FY 2009-10 Budget Request and FY 2009-10 Budget Request Amendment for The Children's Basic Health Plan, February 16, 2010) which requested an increase to the caseload forecasts and estimated per client costs. The appropriation was reduced by $535,195 pursuant to the Department's BA-19 "CHP+ Administrative Savings" as a result of holding the administrative rate paid to the no-risk administrator of the state's self-funded network constant from that paid in FY 2009-10. As a result of the continuation of budget balancing, this appropriation was decreased by $17,624,416 pursuant to ES-3 "Delay Managed Care Payments," which moves all managed care capitation payments from a concurrent to a retrospective payment process. The FY 2010-11 appropriation is $184,897,500 total funds, consisting of $58,184,096 cash funds, $6,856,880 reappropriated funds, and $119,856,574 federal funds.

*FY 2011-12 Base Request for Premiums Costs*

The FY 2011-12 base request is for continuation funding of $184,897,500 plus the annualization of one-time savings from ES-3 "Delay Managed Care Payments" and the removal of one-time funding from the Trust Fund, which results in a reduction of $6,856,880 in reappropriated funds and a corresponding increase in cash funds. The base request is $202,521,966, and includes $71,209,522 cash funds and $131,312,444 federal funds.

**CHILDREN'S BASIC HEALTH PLAN DENTAL BENEFIT COSTS**

In FY 2001-02, the Department issued a request for proposals to provide dental services for all children enrolled in the Children's Basic Health Plan (pregnant women enrolled in the plan are currently excluded), and selected the vendor who offered the most complete dental benefit package. The Department currently has a $600 yearly maximum benefit per client, and a statewide network with several hundred participating dentists and contracts with Essential Community Providers. As is the case with Children's Basic Health Plan Premium Costs, Title XXI funds provide 65% of the total funding need for the Children's Basic Health Plan Dental Benefits Costs, while the remaining 35% State share is cash funds appropriated from the Children's Basic Health Plan Trust Fund. Beginning in FY 2005-06, the State share of funding includes the Health Care Expansion Fund which funds program expansions created in HB 05-1262 (Tobacco Tax). Beginning in FY 2009-10, the State share also includes funding from the Hospital Provider Fee cash fund for the expansion created in HB 09-1293, Colorado Health Care Affordability Act.

*FY 2008-09 Appropriation for Dental Benefit Costs*

The FY 2008-09 Long Bill (HB 08-1375) appropriation was $12,168,394, consisting of $4,258,938 cash funds and $7,909,456 federal funds. The appropriation was decreased by $1,763,681 in the Department's Supplemental bill (SB 09-187) based on caseload and per capita cost 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 $10,076,035 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 increased in the FY 2010-11 Long Bill Add-ons (HB 10-1376) by $230,574 for caseload and per capita cost adjustments included in the Department's FY 2009-10 S-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs." The appropriation was further 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. HB 10-1382, Repeal Delay of Payments, reinstated the last capitation payment in FY 2009-10 and reversed this reduction. HB 09-1293, Colorado Health Care Affordability Act, increased the appropriation by $1,016,820 for the dental costs associated with the caseload from the increase in eligibility to 250% of the federal poverty level. This appropriation was subsequently reduced by $954,992 in HB 10-1372, Changes to HB 09-1293 Appropriation Clause, to reflect reduced caseload estimates due to a delay in implementation of the expansion. The FY 2009-10 appropriation is $11,240,864 total funds, consisting of $3,934,303 cash funds and $7,306,561 federal funds.

*FY 2010-11 Appropriation for Dental Benefit Costs*

The FY 2010-11 Long Bill (HB 10-1376) appropriation included an increase of $1,456,896 for the annualization of HB 09-1293. In addition, the appropriation was increased by $1,180,310 as a result of the Department's DI-3 and BA-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," (November 6, 2009 FY 2009-10 Budget Request and FY 2009-10 Budget Request Amendment, February 16, 2010) which requested an increase to the caseload forecasts and estimated per client costs. As a result of the continuation of budget balancing, this appropriation was decreased by $1,295,640 pursuant to ES-3 "Delay Managed Care Payments," which moves all managed care capitation payments from a concurrent to a retrospective payment process. The FY 2010-11 appropriation is $12,582,430 total funds, consisting of $4,403,851 cash funds and $8,178,579 federal funds.

*FY 2011-12 Base Request for Dental Benefit Costs*

The FY 2011-12 base request is for continuation funding of $13,878,070 total funds plus the annualization of one-time savings from ES-3 "Delay Managed Care Payments." The base request is $13,878,070, consisting of $4,857,325 cash funds and $9,020,745 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. (2010), 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 intention of using 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 2008-09 Long Bill (HB 08-1359) was $6,459,236 cash 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 that reduced the appropriation from FY 2008-09. During the Department's FY 2009-10 Figure Setting on March 13, 2009, Joint Budget Committee (JBC) 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 JBC 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, JBC 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 JBC 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, which was at the time all of the uncommitted funding for the program. The final FY 2009-10 appropriation to the line item was $127,816 cash funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation for this line was $0. This is due to the passage of HB 10-1323, "Use of Tobacco Tax Master Settlement," during the 2010 legislative session. This bill redirected all of the money that would have been allocated to this program in FY 2010-11 to the General Fund. The year-to-date appropriations for FY 2010-11 for this line item is $0.

For FY 2011-12, the Department's base request for this line is $866,075 cash funds, which includes the annualizations of SB 09-269 and HB 10-1323.

**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 was 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 distributed this pool of funding based on the volume of uncompensated care costs incurred by a given provider.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

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 (JBC) 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 FMAP to be received by the line under 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. 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 JBC 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 HB 10-1323, "Use of Tobacco Tax Master Settlement," the final FY 2009-10 appropriation to this line was $0 as the bill eliminated the line and redirected the revenue to the Children's Basic Health Plan Trust Fund.

As of the FY 2010-11 Long Bill (HB 10-1376) all appropriations to this line item are discontinued indefinitely pursuant to HB 10-1323, and the Department will not be requesting funding for this line item.

**CHILDLESS ADULT BENEFIT COSTS**

Authorized by the passage of HB 09-1293, the Colorado Health Care Affordability Act, also referred to as the Hospital Provider Fee, represents the single largest expansion of eligibility under Medicaid and the Children's Basic Health Plan since those authorized by the Tobacco Tax Bill HB 05-1262. The bill allows the Department to expand eligibility in a number of ways, including extending medical benefits to adults without dependent children up to 100% of the federal poverty level effective January 1, 2012. The Department assumes that most of the individuals that will be served in this program are currently receiving services in the Colorado Indigent Care Program, and that a limited benefit package will be offered to enrollees. Based on the fiscal note for HB 09-1293, the Department is requesting $62,045,300 as the FY 2011-12 base, consisting of $31,022,650 cash funds and $31,022,650 federal funds.

**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. (2010), 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 was 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.

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 was 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.

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.

## *(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 $10,000,000 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 at 25.5-2-101, C.R.S. (2010).

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, amounts for administration and for services were still transferred as cash funds exempt to the Department.

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. (2010), was transferred from the Department of Human Services to the Department effective July 1, 2003.

Beginning in FY 2003-04, this line item was placed in the "Other Medical Services" Long Bill group. The "Other Medical Services" Long Bill group is more suitable than Medical Services Premiums for three main reasons: 1) the program is a non-Medicaid program; 2) the program is not subject to 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 $1,000,000 to $750,000 per 39-26-123 (3)(a)(IV)(B), C.R.S. (2010). Effective July 1, 2009, this allocation was changed to $2,850,000 pursuant to SB 08-131.

*Reimbursement Rate History*

The growing demand for health care services by this client population causes the program to implement reduction measures where 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 2008-09 to contain costs and, in a handful of occasions, increase reimbursements for the Old Age Pension State Medical Program:

- 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.
- For FY 2009-10, all reimbursement rates were unchanged from those rates set above on April 15, 2009.

*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 rose steadily between FY 2002-03 and 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 (CBMS) 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 CBMS had no record that the client provided acceptable documentation of sufficient residency. Also in June 2007, the Date of Entry field in CBMS 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 CBMS.

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. It appears 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% | COLD MARS R4600 Reports |

| Old Age Pension State Medical Program Caseload History and Projection | | | |
|---|---|---|---|
| **Year** | **Caseload** | **% Change** | **Source** |
| 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 | -15.90% | |
| FY 2008-09 Actual | 4,271 | -0.50% | |
| FY 2009-10 Actual | 4,306 | 0.82% | COLD MARS R4701 Reports |

*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 (MMIS). 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 of the Department's FY 2005-06 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 1.0 FTE in order to implement this program. This supplemental request was recommended by the Joint Budget Committee (JBC) 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. Using a cost-benefit analysis, the Department determined that a Drug Rebate Program would not be financially feasible for the Old Age Pension State Medical Program. Therefore, the Department did not anticipate any savings from the Old Age Pension State Medical Program Drug Rebate Program and the rebate program was not 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*

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 |
| FY 2009-10 Actual | $10,185,516 | $0 | $10,185,516 | 4,306 | $2,365.42 |

*Appropriation 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, HB 02-1276 created the Supplemental Old Age Pension Health and Medical Care Fund in the amount of $1,000,000 in FY 2002-03; 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 dated March 9, 2004 (page 134), the JBC combined funding sources into a single line item for FY 2004-05 for a total of $10,750,000.

HB 05-1262 "Tobacco Tax Bill" was then passed, which 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. This funding is reappropriated funds to this line and is to be in addition to the cash funds appropriated to the line.

The FY 2008-09 Long Bill (HB 08-1375) appropriation was $15,311,715, which was an increase of $2,018,043 from the final FY 2007-08 appropriation. The increase is due to several actions, including the removal of one-time funding of $725,468 from the Supplemental Old Age Pension Fund balance, a reduction of $25,500 due to revised estimated revenue from the Tobacco Tax Cash Fund based on Legislative Council's December 2007 Revenue Forecast, an increase of $680,779 from the annualization of one-time savings due to SB 07-133, and an increase of $2,088,232 for a one-time increase in funding to allow the Department to maintain the current reimbursement rates and provide stability for the program pursuant to the Department's BA-8 "FY 2008-09 Funding Increase for Old Age Pension State Medical Program." In response to this request, the statutorily defined $750,000 from the Supplemental Old Age Pension Health and Medical Care Fund was changed to $2,850,000 effective July 1, 2009 pursuant to SB 08-131. HB 08-1320,

while it did not make any changes in the appropriations, clarified differences between fund sources by changing the cash funds exempt appropriation from the Old Age Pension Health and Medical Care Fund to cash funds and the cash funds exempt appropriation from the Supplemental Old Age Pension Health and Medical Care Fund to reappropriated funds. The final FY 2008-09 appropriation to the line was $15,311,715, comprised of $12,836,715 cash funds and $2,475,000 reappropriated funds.

The FY 2009-10 Long Bill (SB 09-259) appropriated $15,368,483 for this line. The $56,768 increase from the FY 2008-09 appropriation is due to two JBC actions. The JBC approved an increase in funding totaling $11,786 to allow the Department to maintain the reimbursement increases of July 1, 2007 (the Department's FY 2009-10 Figure Setting, March 18, 2009, page 170-173). The JBC also increased the appropriation by $45,000 to reflect the most recent tobacco tax revenue updates. Later however, the appropriation was decreased by $270,000 due to a lower anticipated amount of Amendment 35 revenue. The final FY 2009-10 appropriation to the line was $15,098,483, comprised of $12,848,483 cash funds and $2,250,000 reappropriated funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $15,083,483 to this line. This includes a $15,000 decrease to the line due to a revised Amendment 35 revenue forecast for FY 2010-11. As a result of the continuation of budget balancing, this appropriation was decreased by $470,132 pursuant to ES-2 "Fee-For-Service Delay." The FY 2010-11 appropriation to the line is $14,613,351, comprised of $12,378,351 cash funds and $2,235,000 reappropriated funds.

For FY 2011-12, the Department's base request is $15,368,483, comprised of $12,848,483 cash funds and $2,520,000 reappropriated funds. The increase from FY 2010-11 is due to the annualizations of the revised Amendment 35 revenue forecasts for FY 2009-10 and FY 2010-11 as well as ES-2 "Fee-For-Service Delay."

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

In 2002, the General Assembly passed HB 02-1276, which 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 $10,000,000 annually. In 2003, the $1,000,000 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. This line contains funding to be reappropriated to the Services for Old Age Pension State Medical Program Clients line item, to be used in addition to the cash funds appropriated to that line.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $2,475,000 to this line, consisting entirely of cash funds. As far as the actual fund is concerned, 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 expenditures for clients who are 65 years of age or older. The bill also authorized 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 FY 2009-10 Long Bill (SB 09-259) appropriated this line $2,520,000. This included a $45,000 increase due to a tobacco tax revenue forecast change. Later however, the appropriation was decreased $270,000 due to a lower amount of Amendment 35 tobacco tax revenue anticipated in FY 2009-10. The final appropriation for FY 2009-10 was $2,250,000, consisting entirely of cash funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated this line $2,235,000 cash funds. This included a $15,000 decrease due to a FY 2010-11 tobacco tax revenue forecast change.

For FY 2011-12, the Department's base request is $2,520,000. This includes the annualizations of both the FY 2009-10 and FY 2010-11 tobacco tax revenue forecast changes, which increase the request by $285,000.

**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 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 restricted. 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 cancelation 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 and will allow the state to continue to draw federal funding for these entities regardless of the implementation of the new rules. This change also allows 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 program is administered by the Advisory Commission on Family Medicine in the Department of Higher Education, Health Sciences Center. Before FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education. Beginning in FY 1994-95, however, 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 federal financial participation for payments to hospitals enrolled in the program. Since federal Medicaid funds were involved, a line item appropriation to the Department was established.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $2,173,558 total funds to this line item. 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.

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 affected 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 state funds required to maintain the

total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriated this line item continuation funding of $1,932,052, including $966,026 General Fund and $966,026 federal funds. Later however, the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10% for budget balancing purposes. The Department submitted FY 2009-10 NP-ES#14 "Commission on Family Medicine General Fund Reduction," which reduced the appropriation by $193,206 total funds. Finally, ARRA adjustments made a change in the composition of the funding to account for the enhanced Federal Medical Assistance Percentage (FMAP) received by this line item, with no change in total funding. The final FY 2009-10 appropriation to the line was $1,738,846 total funds, comprised of $667,891 General fund and $1,070,955 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) made appropriations to the line in the amount of $1,738,846. This amount includes the annualization of ARRA from the previous year and the reinstatement of ARRA for FY 2010-11. During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the Joint Budget Committee (JBC) adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the General Fund appropriation of $32,729 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation is $1,738,846, consisting of $700,620 General Fund and $1,038,226 federal funds.

For FY 2011-12, the Department's base request for this line item is $1,738,846, consisting of $869,423 General Fund and, due to the expiration of ARRA, $869,423 federal funds.

**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. Second, 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.

The FY 2008-09 Long Bill (HB 08-1375) originally appropriated $0 for this line item. Later however, SB 08-230 "Hospitals to Levy Sales Tax" increased the appropriation by $1,829,008 total funds, which included $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 final FY 2008-09 appropriation to this line was $1,829,008 total funds, which included $914,504 General Fund and $914,504 federal funds.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriation to this line was $1,831,714. This included the annualization of SB 08-230 "Hospitals to Levy Sales Tax," which increased the appropriation by $2,706. ARRA adjustments, however, made a change in the composition of the funding to account for the enhanced FMAP received by this line item, with no change in total funding. This funding is split with $703,561 being General Fund and $1,128,153 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated this line $1,831,714. This amount includes the annualization of ARRA from the previous year and the reinstatement of ARRA for FY 2010-11. During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the Joint Budget Committee (JBC) adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4$^{th}$ quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the General Fund appropriation of $34,447 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation is $1,831,714 consisting of $738,038 General Fund and $1,093,676 federal funds.

For FY 2011-12 the Department's base request is $1,831,714, consisting of $915,857 General Fund and $915,857 federal funds due to the expiration of ARRA.

**STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY**

This line item was created through SB 08-230 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. Second, lump sum payments are also received when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Third, the University of Colorado Hospital Authority receives funding for one of nine family medicine residency training programs administered by the Commission on Family Medicine, namely A.F. Williams Family Residency. 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.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $0 to this line item. Later however, SB 08-230 "Hospitals to Levy Sales Tax" increased the appropriation by $697,838 total funds, which included $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 had a net zero fiscal impact. The final FY 2008-09 appropriation to this line was $697,838 total funds, which included $348,919 General Fund and $348,919 federal funds.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) originally appropriated $700,935 to the line, which included the annualization of SB 08-230 "Hospitals to Levy Sales Tax," increasing the appropriation by $3,097. Later however, the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10% for budget balancing purposes. The Department submitted FY 2009-10 NP-ES#14 "Commission on Family Medicine General Fund Reduction," which reduced the

appropriation by $24,150. ARRA adjustments, however, made a change in the composition of the funding to account for the enhanced FMAP received by this line item, with no change in total funding. The final FY 2009-10 appropriation to the line was $676,785, consisting of $259,953 General Fund and $416,832 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) made appropriations to the line in the amount of $676,785. This amount includes the annualization of ARRA from the previous year and the reinstatement of ARRA for FY 2010-11. During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the Joint Budget Committee (JBC) adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the General Fund appropriation of $12,739 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation is $676,785 consisting of $272,692 General Fund and $404,093 federal funds.

For FY 2011-12, the Department's base request is $676,785, consisting of $338,393 General Fund and $338,392 federal funds due to the expiration of ARRA.

**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. The funding source for this line item is entirely General Fund.

The FY 2008-09 Long Bill (HB 08-1375) appropriation for this line was $81,155,195. The appropriation was later increased by $955,878 pursuant to the Department's FY 2008-09 S-4 "Medicare Modernization Act State Contribution Payment" due to expected increases in caseload and per-client per-month costs. 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 (JBC) 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 the Department is not required to make the state contribution payment before it is required by federal rules and regulations. As a result of this action, there was a reduction to this appropriation of $6,827,682. The appropriation was further reduced by $1,074,557 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 General Fund. This appropriation was reduced by $313,036 pursuant to the Department's 1331 Supplemental Request "Federal Funds Replacement for Transfer to Department of Public Health and Environment for Facility and Certification," resulting in a total appropriation of $73,895,798 General Fund.

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 affected 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 state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continues through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriated $88,808,586 to this line. This appropriation included restoration of one-time savings totaling $7,285,736 as a result of delaying the May invoice payment until the following fiscal year. This appropriation also included an increase of $8,189,674 pursuant to the Department's BA-4 "Medicaid Modernization Act State Contribution Payment," which covered increases in the estimated dual eligible caseload and increases in the per-client per-month rate. 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. The Long Bill appropriation was subsequently reduced by $2,177,124 as a result of the Department's FY 2009-10 S-4 "Medicare Modernization Act State Contribution Payment" for caseload and per-client cost adjustments and further by $29,108,257 as a result of S-19 "ARRA FMAP Adjustment to Medicare Modernization Act State Contribution Payment." This request was the result of a February 18, 2010, determination by the federal Department of Health and Human Services that the enhanced FMAP provided under ARRA should have been applied to the Medicare Modernization Act State Contribution Payments. The federal Centers for Medicare and Medicaid Services applied the adjustment retroactively to payments going back to the original implementation of ARRA in October 2008, which temporarily reduced General Fund appropriations. These reductions resulted in a final appropriation of $57,523,205 General Fund for FY 2009-10.

In the FY 2010-11 Long Bill (HB 10-1376), this line item was appropriated $70,700,172, which includes increases of $4,501,720 for BA-4 "Medicare Modernization Act State Contribution Payment," $792,720 for BRI-2 "Coordinated Payment and Payment Reform" to implement proposed steps toward lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care, and $7,882,527 for BA-25 "ARRA FMAP Adjustment to Medicare Modernization Act State

Contribution Payment." During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumes that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contains an extension of enhanced FMAP provisions for 6 months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contains a phase-down of the FMAP rate, and the Department anticipates that the FMAP rate for the 3rd quarter of FY 2010-11 will be 58.77%, and that the FMAP rate for the 4th quarter will be 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage". This resulted in an increase in the General Fund appropriation of $2,067,630 General Fund. The FY 2010-11 appropriation is $72,767,802 General Fund.

The Department's base request for FY 2011-12 for Medicare Modernization Act State Contribution Payment is $89,106,681, which is comprised of continuation funding of $70,700,172 plus $842,040 for the annualization of BRI-2 "Coordinated Payment and Payment Reform," and $15,496,839 for the removal of all ARRA adjustments.

**PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION**

This new line item was created with the approval of the Department's S-9, BA-7 "Public School Health Services Administrative Claiming" during the FY 2010-11 budget cycle. The line item contains all administrative funding for the program excluding the transfer of funds to the Department of Education through the "(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration." Funding for this line consists of a transfer of spending authority from the "(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts" line item and a transfer of federal funds to this line item from the "(5) Other Medical Services; Public School Health Services" line item.

The FY 2009-10 Long Bill (SB 09-259) appropriated this line $0. With the passage of the Department's Supplemental Bill HB 10-1300, the line item was appropriated $525,200.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $799,700 to this line item. This includes an increase of $274,500 due to the annualization of the Department's FY 2010-11 BA-7 "Public School Health Services Administrative Claiming." Year-to-date appropriations to the line are $799,700 consisting entirely of federal funds.

For FY 2011-12, the Department's base request is for continuation funding of $799,700, fully comprised of federal funds.

**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 most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services 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 (the Department) 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 the "(1) Executive Director's Office; (A) General Administration, Operating Expenses" 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. (2010), the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The FY 2008-09 Long Bill (HB 08-1375) made an appropriation to this line in the amount of $27,501,534. During the Department's FY 2009-10 Figure Setting on March 18, 2009, Joint Budget Committee (JBC) staff recommended a reduction to the appropriation of $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.

The FY 2009-10 Long Bill (SB 09-259) made an appropriation to the line of $20,004,856 total funds. This included an adjustment for indirect cost assessments from the Department of Education, which reduced the appropriation to this line item by $3,564 federal funds (FY 2009-10 Figure Setting document dated March 18, 2009, page 21). It also included the Department's FY 2009-10 DI-17 "School Health Services Program Auditor," 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. Later, the Department submitted FY 2009-10 S-9 "Public School Health Services Administrative Claiming," which increased the appropriation by $499,780 to allow school districts to begin certifying administrative expenses, which a recently repealed federal regulation formerly prevented. Lastly, a JBC staff comeback memo following Figure Setting in March 2010, increased the appropriation by $11,512,580 for public school health services reconciliation payments for claims incurred in FY 2008-09. This was

approved, bringing the final FY 2009-10 appropriation to $32,017,216, comprised of $16,493,474 cash funds and $15,523,742 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated the line $29,537,394. This included the Department's FY 2010-11 BA-7 "Public School Health Services Administrative Claiming," which increased the appropriation $3,282,856. It also included a technical correction for an indirect cost assessment from the Department of Education, decreasing the appropriation by $388. The appropriation to the line item for reconciliation payments was reduced by $5,756,290 decrease per the JBC staff comeback regarding reconciliation payments. The Long Bill appropriation differed from the JBC comeback memo by $6,000, resulting in a FY 2010-11 year-to-date appropriation of $29,537,394 total funds. This consists of $15,391,007 cash funds and $14,146,387 federal funds.

For FY 2011-12, the Department's base request is continuation funding plus the annualization of the indirect cost assessment from the Department of Education, increasing the request by $388 to $29,537,782 total funds. The base request consists of $15,391,007 cash funds and $14,146,775 federal funds.

**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 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 website, and the Department has promoted the program through press releases in news media, 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 (CBMS), 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 CBMS 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 (JBC) 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" line item. As a result, all Colorado Cares appropriations were part of "(5) Colorado Cares Rx Program Contract Costs." These funds would have been used to finalize CBMS 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. In February 2008, the Department began advertising Express Scripts' Rx Outreach discount drug program as Colorado Cares Rx. 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 was cash funds through the Colorado Cares Rx Program Fund. The Department's FY 2008-09 Base Request of $1,896,085 assumed 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, JBC 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 were 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 2011-12 Budget Request is for Medicaid funding for services provided or administered by the Colorado Department of Human Services (DHS). Programs include services for persons with developmental disabilities, high-risk (substance abuse) pregnant women, mental health, certain youth who are in the juvenile justice system, other child welfare clients, and community services for the elderly. DHS also receives the Department's share of the costs to support the Colorado Benefits Management System (CBMS) 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 DHS. Although the funds are considered reappropriated from the perspective of DHS, the funding sources for these transfers from the Department are General Fund, federal funds, and cash funds.

Until FY 2001-02, Medicaid funding for DHS was appropriated in one line item. In FY 2001-02, the General Assembly separated the DHS appropriations into 18 separate line items to improve expenditure tracking and reconciliation. These lines have changed over time, and there are currently 21 line items in the Department's budget within the DHS Medicaid-Funded Long Bill group. A description of each of the line items currently within the Department's budget follows.

All funding requests in this Long Bill group originate with DHS. Inquiries related to the FY 2011-12 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 the DHS funding request is for a Medicaid-allowable purpose as outlined by the Centers for Medicare and Medicaid Services (CMS). 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 (DHS) and contains staff and associated resources for implementing policy. This appropriation in the Department's budget includes Medicaid funding for two sections in the DHS 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 (2010).

General Administration includes the DHS 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 DHS, 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 DHS 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 DHS 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 Public Employees' Retirement Association (PERA) paid by state government – a centralized appropriation for DHS 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 DHS 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 – 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 (DPA), partly funded by Medicaid. This item is not included in FY 2010-11 or the FY 2011-12 base request due to the economic downturn;
- Performance Based Pay – a Common Policy, achievement pay added to Personal Services according to guidelines established by DPA for quality and quantity of each employee's work, partly funded by Medicaid. This item is not included in FY 20101—or the FY 2011-12 base request due to the economic downturn;
- Shift Differential – 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 hours, 7 days a week and primarily used by the Mental Health Program and the Developmentally Disabled Program, partly funded by Medicaid;
- Workers Compensation – a Common Policy, estimated share for inclusion in the state workers compensation plan as administered by DPA and allocated based on the total number of employees, also designated as an indirect cost, partly funded by Medicaid;
- Operating Expenses – 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 – a Common Policy, funding for a share of statewide costs for two programs operated by DPA: (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 with no Medicaid funding are line items for Legal Services, Administrative Law Judges, and Staff Training.

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 DHS. The above mentioned staff members are FTE in DHS, 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 (HIPAA) of 1996 comprises part of the Special Purpose funding. DHS provides many health-related services to Medicaid eligible clients and non-Medicaid eligible clients. Therefore, it is legally required to comply with HIPAA 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 login 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.

HIPAA 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 DHS auspices, but these components are not Medicaid funded.

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 medical assistance percentage (FMAP) beginning in FY 2008-09 that affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*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 DPA.

The FY 2008-09 Long Bill (HB 08-1375) appropriation was $14,426,718. The Supplemental Bill (SB 09-187) included adjustments to reduce $28,762 from NP S-15 "DHS-Hiring Freeze Savings" and to reduce $46,918 as a technical adjustment by the Joint Budget Committee (JBC) to adjust the Department's funding so it is in line with the reappropriated amount in the corresponding appropriations in DHS. The final appropriation for FY 2008-09 was $14,351,038, including $7,263,455 General Fund, $388 reappropriated funds, and $7,087,195 federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriated $13,011,981 total funding. This amount included continuation funding from FY 2008-09 and the following adjustments: remove the prior year Salary Survey for a reduction of $1,771,491; 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; FY 2009-10 Common Policy adjustments for an increase of $2,621,515; approval of FY 2009-10 NP-6 "DHS – Regional Centers, High Needs Clients" for an increase of $120,284; approval of FY 2009-10 NP-15 "DHS – Ombudsman 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; Common Policy adjustment for Payment to Risk Management and Property Funds for an increase of $10,044; Common Policy adjustment for Short Term Disability for an increase of $7,346; remove funding of $160,000 based on JBC action to make a

Medicaid Indirect Costs adjustment related to Regional Center costs (see line item "Federal Medicaid Indirect Cost Reimbursement for DHS Programs"); Common Policy adjustment for Amortization Equalization Disbursement for a decrease of $28,746; Policy adjustment for Supplemental Amortization Equalization Disbursement for a decrease of $23,483; Common Policy adjustment for Shift Differential for a decrease of $279,586; approval of FY 2009-10 BA-22 "DHS – Salary Survey" for a decrease of $1,429,321; and, reduced funding for the General Assembly conference committee action to achieve budget balancing by decreasing 1.82%, or $18,847 in Personal Services, and an increase to Workers' Compensation of $517,446. The appropriation also contained a technical error that reducing funding an additional $160,000 for Medicaid Indirect Costs. This technical error included an increase to the General Fund of $80,000 and a decrease to federal funds of $240,000. This error was later identified and corrected as a reversal when building to the FY 2010-11 appropriation.

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 JBC on August 24, 2009. As a part of NP ES-19 "DHS - Risk Management Reduction of Liability, Property, and Workers' Compensation Volatility," the line item was reduced by $135,008. NP ES-20 "DHS - Risk Management Contract Review and Reduction" reduced the line by $42,710. NP S-3 "DHS - Statewide Furlough Impact" reduced the appropriation by $30,330. NP S-9 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" was submitted as a Supplemental request and recommended for approval to the General Assembly by JBC. This action became part of the FY 2010-11 Long Bill Add-ons (HB 10-1376) and reduced the appropriation by $280,492. Additional details related to NP S-9 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" can be found in the "Services for People with Disabilities-Medicaid Funding, Regional Centers" line item description. The FY 2009-10 appropriation was also affected by the enhanced federal financial participation authorized by ARRA, which reduced the General Fund portion of the appropriation by $631,533 while increasing the federal portion by the same amount. The Department's final FY 2009-10 appropriation was $12,523,441, consisting of $5,783,703 General Fund, $388 reappropriated funds, and $6,739,350 federal funds.

To build to the FY 2010-11 Long Bill (HB 10-1376) appropriation of $12,080,342, the Department received continuation funding and annualizations for the following FY 2009-10 actions:

- NP S-3 "DHS - Statewide Furlough Impact," adding back $30,330;
- NP ES-19 "DHS - Risk Management Reduction of Liability, Property, and Workers' Compensation Volatility," adding back $135,008;
- NP ES-20 "DHS - Risk Management Contract Review and Reduction," adding back $42,710;
- 1.82% Personal Services General Assembly conference committee action, adding back $18,847;
- NP S-9 BA-15 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center," an annualization reducing the appropriation by $406,930; and,
- the previously mentioned Medicaid Indirect Costs technical error, a $160,000 increase.

Additionally, several actions were taken in response to the ongoing, state-wide fiscal crisis. The JBC approved a 2.5% adjustment to PERA through NP BA-4 "DHS – PERA Contribution Change," removing $23,759 from the appropriation. The JBC also approved NP BA-12 "DHS – 5% Operating Reduction," removing $3,300 from the appropriation. Due to the closure of the Grand Junction Skilled Nursing Facility, the JBC approved a Shift Differential adjustment, removing another $29,246 from the appropriation. The Department submitted, and JBC recommended for approval, NP-7 "DHS - Statewide Information Technology Staff Consolidation" as part of the transfer of IT to the Governor's Office of Information Technology, permanently removing $189,466 from the appropriation. A combination of Common Policy adjustments to Risk Management and Property Funds, Short-term Disability, AED, SAED, Shift Differential, and Worker's Compensation reduced the appropriation by $342,431. However, a JBC recommendation to restore Health Life Dental cuts returned $165,138 to the appropriation.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the U.S. Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at lower rate for the third and fourth quarters of the fiscal year. HR 1586 was passed by the U.S. House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated that the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 would be 58.77%, and 56.88% for the 4$^{th}$ quarter. The Department requested in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP. This resulted in an increase in the General Fund appropriation of $8,810 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $8,828 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." The FY 2010-11 revised total appropriation is $12,071,514, consisting of $5,419,163 General Funds, $388 reappropriated funds, and $6,651,963 federal funds.

For FY 2011-12, the Department is requesting an appropriation of $14,456,805. This request is based off the $12,071,514 appropriation from FY 2010-11, plus $23,759 being returned to this line as a result of annualization of NP BA-4 "DHS – PERA Contribution Change," the annualization of NP ES-3 "DHS- 1% Across the Board Personal Services Reduction," and FY 2011-12 Common Policy adjustments totaling $2,352,704. With the removal of the enhanced FMAP provided under ARRA, the base request includes $7,223,972 General Fund, $388 reappropriated funds, and $7,232,445 federal funds.

***(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING***

Many of the staff members for the Office of Information Technology have been transferred to the Governor's Office of Information Technology as part of the ongoing reorganization of information-technology services for Colorado State Government. However, some

of the budget lines remain at the Department of Human Services (DHS) or the Department in order to access federal funding for the particular projects. The budget line items discussed in this section do utilize federal Medicaid funding.

**COLORADO BENEFITS MANAGEMENT SYSTEM**

The Colorado Benefits Management System (CBMS) 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 statute that specifically mentions CBMS; however, authorization can be inferred from 26-1-112, C.R.S. (2010).

Prior to February 15, 2007, the development and operational phases of CBMS were overseen by three state agencies: the Governor's Office of Colorado Benefits Management System, DHS, and the Department. CBMS replaced the following six legacy systems: Client Oriented Information Network; Colorado Automated Food Stamps System; Colorado Automated Client Tracking System; Colorado Adult Protection System; the Children's Basic Health Plan eligibility determination system; and, Colorado Employment First. 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. Because CBMS handles clients enrolled in programs that receive varying levels of federal participation rates, the CBMS calculator was developed to allocate costs among the various programs. The following discussion reflects only the Department's portion of CBMS costs. Expenditures are currently divided between the Department and DHS based on the calculator, which 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 the Department and DHS as well as federal regulators. The Department's appropriation since FY 2008-09 reflects 38.31% of the total costs of the system, as indicated by the last major change in percentages reflected in the Random Moment Sampling results. The remaining percentage of expenditures is paid from the appropriation to DHS. (Please refer to DHS for a description of their portion of total expenditures.) When future Random Moment Sampling results reflect another major change in percentages, both departments anticipate 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. In August 2008, management and operation of the system was reprocured, and Deloitte Consulting LLP (Deloitte Consulting) was awarded the new contract. Deloitte Consulting took over full responsibility for operation of the system on April 1, 2009.

A broad range of components are paid from the appropriation for CBMS. Besides contracted payments to the vendor, the following items are also paid from the appropriation: computer hardware maintenance and repairs; computer software maintenance and upgrades; non-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; non-capitalized 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.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriated $7,971,202 for this line item. A number of special bills increased the FY 2008-09 appropriation: HB 08-1046 "Offenders Apply for Public Benefits" by $26,408; SB 08-006 "Suspension of Medicaid Benefits" by $94,092; SB 08-161 "Medicaid and Children's Basic Health Plan" by $5,554; and, SB 08-160 "Health Care for Children" by $31,866.

Other budget actions occurred in FY 2008-09 that were formally appropriated in the Supplemental Bill (SB 09-187), including an increase of $911,590 for FY 2008-09 NP S-9 "Colorado Benefits Management System Refinancing" that updated the 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. A one-time increase of $867,750 resulted from a 1331 Supplemental Request "Colorado Benefits Management System New Vendor Transition." A Joint Budget Committee (JBC) technical correction removed $37,475 that had been included in the Department's appropriation but was not included in the DHS appropriation, while 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, consisting of $3,729,063 General Fund, $1,136,712 cash funds, $31,223 reappropriated funds, and $4,879,897 federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriation of $8,957,494 included continuation funding plus the following adjustments:

- a decrease of $867,750 from the removal of one-time funding for the 1331 Supplemental Request "Colorado Benefits Management System New Vendor Transition";
- a decrease of $94,092 from the removal of one-time funding for SB 08-006 "Suspension of Medicaid Benefits";
- a decrease of $14,452 from the removal of one-time funding for SB 08-160 "Health Care for Children";
- a decrease of $5,554 from the removal of one-time funding for SB 08-161 "Medicaid and Children's Basic Health Plan";
- a decrease of $26,408 from the removal of one-time funding for HB 08-1046 "Offenders Apply for Public Benefits";
- an increase of $68,109 for prior-year Salary Survey funding;
- an increase of $14,054 for prior-year Performance Based Pay funding;
- an increase of $94,092 from the annualization of FY 2008-09 S-22 "Postpone Implementation of SB 08-006";
- an increase of $118,325 from funding for NP-5 "Postage Increase and Mail Equipment Upgrade";
- an increase of $832,031 from funding for NP BA-17 "DHS – Colorado Benefits Management System FY 2009-10 Refinance" to establish the Department's share at 38.31% ongoing (until another change occurs in the Random Moment Sampling);
- a decrease of $911,590 from removal of prior-year impact of the Random Moment Sampling methodology based on FY 2008-09 NP S-9 "DHS – Colorado Benefits Management System Refinancing"; and,
- a decrease of $26,166 from the removal of 1.82% from Personal Services resulting from the General Assembly First Conference Committee action to balance the budget.

In June of 2009, however, the General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, the Governor directed all state agencies to develop budget reduction proposals that would reduce General Fund expenditures by 10%. These Early Supplemental Requests (ES) were submitted to the JBC on August 24, 2009. A reduction affecting CBMS was FY 2009-10 NP S-3 "DHS-Statewide Furlough Impact", which resulted in a reduction of $13,375 total funds. FY 2009-10 NP S-7 "DHS-Mail Equipment Upgrade Supplemental and Budget Amendment" resulted in a reduction of $83,998 total funds. However, this action was more than offset by an increase for FY 2009-10 S-13 "CBMS Client Correspondence Caseload Increase" that added $183,899 total funds. The FY 2009-10 funding was further modified by FY 2010-11 Long Bill Add-ons (HB 10-1376), which added increases for HB 09-1293 "Health Care Affordability Act" of $123,228 total funding and HB 10-1384 "Old Age Pension Eligibility for FY 2009-10" of $17,309 total funding. The final FY 2009-10 appropriation was $9,184,557, consisting of $4,540,550 General Fund, $28,647 cash funds, $32,608 reappropriated funds, and $4,582,752 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $9,359,525 to this line item. This included continuation funding plus the impacts of several actions including:

- an increase of $467,672 from annualization of HB 09-1293;
- a decrease of $17,309 from annualization of HB 10-1384;
- an increase of $26,166 from the annualization of FY 2009-10 Joint Budget Committee Action for 1.82% Personal Services Cut;
- a decrease of $183,899 from the annualization of FY 2009-10 S-13 "CBMS Client Correspondence Caseload Increase";
- an increase of $13,375 from the annualization of FY 2009-10 NP S -3 "DHS CBMS Client Correspondence Costs";
- an increase of $183,899 from NP-1 "DHS CBMS Client Correspondence Costs";
- a decrease of $210,517 for NP-7 "DHS-Statewide Information Technology Staff Consolidation";
- a decrease of $28,786 for NP BA-4 "DHS-PERA Contribution Change";
- a decrease of $112,625 for NP BA-5 "DHS Child Care Automated Tracking System (CHATS) - Infrastructure";
- an increase of $58,902 for NP BA-8 "DHS-Mail Equipment Upgrade Supplemental and Budget Amendment"; and,
- a decrease of $21,910 for NP BA-12 "DHS 5% Operating Reduction."

Two Special Bills contributed extra funding, with HB 10-1146 "Circumstances of Receiving State-Funded Public Assistance Programs" adding $184,387 and HB 10-1384 "Alignment of Eligibility for the Old Age Pension Program," adding $17,220. As a result of the continuation of budget balancing, this appropriation was decreased by $1,958 pursuant to NP ES-1 "1% Across the Board Personal Services Reduction." The FY 2010-11appropriation is $9,559,174 total funds, including $4,740,204 General Fund, $20,046 cash funds, $22,385 reappropriated funds, and $4,776,539 federal funds.

For FY 2011-12, the base amount includes continuation funding plus adjustments for the following:

- a reduction of $362,034 from annualization of HB 09-1293;
- a reduction of $17,220 from annualization of HB 10-1384;
- a reduction of $184,387 from annualization of HB 10-1146; and,

- an increase of $1,958 for the annualization of NP ES-1 "1% Across the Board Personal Services Reduction."

These adjustments result in a base request of $8,997,491 for FY 2011-12 for the CBMS line item. The base request includes $4,345,760 General Fund, $133,744 cash funds, $22,385 reappropriated funds, and $4,495,602 federal funds.

**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), which was recommended by JBC staff. There is no specific authorization for the line item in statute; however, authorization can be inferred from 26-1-112, C.R.S. (2010). SAS-70 applies to all service organizations, not just to the contractor for CBMS.

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 (DHS 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.

SAS-70, 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 organization's description of operating controls and the suitability of the design of these controls to achieve specified objectives. This audit assures both the user organization – in this case, the State of Colorado – and the service organization – in this case, Deloitte Consulting, the contracted vendor – that CBMS has adequate controls in place to handle whatever usual or unusual situations arise in order to operate in 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. These annual appropriations are paid by the Department and DHS 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 (HIPAA) of 1996 were developed independently of each other, the standards of the SAS-70 audit are very similar to the requirements

from HIPAA. 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 audited service organization was Electronic Data Systems, the prior CBMS vendor. 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 was audited for the first time in its role in the operation of CBMS. The Governor's Office of Information Technology is currently addressing the FY 2009-10 audit findings.

Because the SAS-70 audit directly relates to CBMS, both departments rely on the Random Moment Sampling methodology to determine how the funding to pay for the audit is shared. 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 was changed to 38.31% as updated during FY 2008-09. The 38.31% was also used during FY 2009-10.

In FY 2008-09, the Long Bill (HB 08-1375) appropriated $51,718 to this line item, 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 of $57,075. For FY 2010-11, JBC staff recommended refinancing of this line to $56,069, a reduction of $1,006.

The Department is requesting continuation funding of $56,069 for FY 2011-12. The base request includes $27,804 General Fund, $115 cash funds, $134 reappropriated funds, and $28,016 federal funds.

**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 (DHS) to the Joint Budget Committee (JBC), which approved the 1331 request for FY 2008-09 on June 22, 2009. The request used the remaining $1,462,175 in the Department's appropriation from the line item of "Colorado Benefits Management System (CBMS) Medical Assistance Project" to combine with program funding from DHS, resulting in the total funds being increased to $1,623,982 total funding that would then be shared by both Departments, according to the Random Moment Sampling methodology used by the regular CBMS project. This additional funding was possible because DHS has several other programs that also use CBMS, and extra funding from those programs added to the total funds available by reallocating the costs among all of the affected programs. The funding was placed into this separate line item, and the Department's share of funding for the Client Services Improvement Project for FY 2008-09 was $621,098. The Improvement Project added a Web portal to be used specifically for CBMS. Intelligent Data Entry software also allows clients to enter much of their own information into CBMS, thus reducing the need to travel to local social services offices. Although computer programming work continued on both the CBMS Web portal and the Intelligent Data Entry software, expenditures for FY 2009-10 reverted to the original line item of the CBMS Medical Assistance Project, per the FY 2009-10Long Bill (SB 09-259) in the amount of $2,995,100.

During FY 2009-10, both Departments again requested to share funding between the Departments through S-11 "Refinance Colorado Benefit Management System Improvements." The amount leveraged was $3,302,100 in total funding. The Department's share was $1,242,581, as codified in the Supplemental Bill (HB 10-1300). The same amount was appropriated again in FY 2010-11 Long Bill (HB 10-1376) by continuing the same sharing arrangements. The FY 2010-11 appropriation includes $616,172 General Fund, $2,543 cash funds, $2,972 reappropriated funds, and $620,894 federal funds.

Because the original request for funding indicated that the improvement projects would be spread over three fiscal years beginning in FY 2008-09, the Department is making no funding request for FY 2011-12.

**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 DHS Information Systems but specifically excludes CBMS and CBMS SAS-70 funding. The Office of Information Technology is responsible for developing and maintaining DHS's 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 DHS. Because the elements covered by this line item vary, there is no one specific source in the Colorado Revised Statutes, but authorization can be inferred from 26-1-120, C.R.S (20010).

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 DHS application systems. This team is further organized into three separate units to support: institutional and community functions, disability determinations, and DHS 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 DHS. Some DHS staff 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 DHS and to the Director of the Governor's Office of Information Technology Services. In FY 2009-10, a new component was added, called Administration for OIT, and was 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 DHS staff 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. In addition, 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.

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 affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

To arrive at the FY 2008-09 Long Bill (HB 08-1375) appropriated $427,453, the FY 2007-08 final funding of $411,630 served as the base. Adjustments included an increase of $6,552 from NP-5 "DHS – IT Infrastructure Support" ; an increase of $12,377 from NP-6 "DHS – Adjustment to Statewide Multiuse Network Payments," which was further adjusted by NP BA-2 "DHS – Adjustment to Statewide Multiuse Network Payments" with a decrease of $1,650; and, a decrease of $138 from NP BA-3 "GGCC Supplemental True-up." The line was also decreased as the result of an adjustment of $1,318 in Microcomputer Lease Payments as agreed to by the vendor Hewlett Packard. 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 the "Other Office of Information Technology Services" line item.

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 were:

- an increase of $7,261 for the annualization of FY 2008-09 NP-5 "DHS – IT Infrastructure Support";
- an increase of $9,405 for prior year Salary Survey;
- an increase of $2,702 for prior year Performance Based Pay;
- a decrease of $4,303 for the General Assembly First Conference Committee action to balance the budget by reducing Personal Services by 1.82%;
- an increase of $1,749 for the annualization of a Common Policy adjustment for Management and Administration;
- a decrease of $2,738 to correct Management and Administration; and,
- a decrease of $57,075 for a technical error resulting in a difference between the Department and DHS.

The FY 2009-10 appropriation was also affected by the enhanced federal financial participation authorized by ARRA, which reduced the General Fund portion of the appropriation by $37,398 while increasing the federal portion by the same amount.

The June 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. As a part of NP ES-1 "DHS – Information Technology Services, Personal Services FTE Reduction" DHS 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 also represented a permanent reduction due to a transfer of the associated FTE to the Governor's Office of Information Technology. Further, as part of NP ES-21 "DHS – FY 2009-10 OIT Management and Administration One-Time Adjustment," DHS 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. Due to an economic downturn, the governor implemented mandatory furlough days for non-essential state employees. NP S-3 "DHS - Statewide Furlough Impact" reduced the appropriation by $2,597. This Supplemental adjusted Personal Services to a 1.82% cut that was part of the Long Bill. As a result of the adjustments, the Department's final FY 2009-10 appropriation was $372,909.

To build to the FY 2010-11 appropriation of $540,940 in the Long Bill (HB 10-1376), the $372,909 appropriated in FY 2009-10 served as the base. Since the $37,398 federal fund FY 2009-10 ARRA adjustment was a function of the bottom line funding for the appropriation, that reapportionment was reversed. Several FY 2009-10 actions were one-time and required reversal. Those include:

- NP S-3 "DHS - Statewide Furlough Impact," adding back $2,597;
- NP ES-21 "DHS – FY 2009-10 OIT Management and Administration One-Time Adjustment," adding back $5,686;
- General Assembly First Conference Committee action to Personal Services – 1.82% adjustment, adding back $4,303; and,
- Technical error difference between the Department and DHS, adding back $57,075.

Additionally, several actions were taken in response to the state-wide fiscal crisis. JBC approved a 2.5% adjustment to PERA through NP BA-4 "DHS – PERA Contribution Change," removing $5,024 from the appropriation. JBC also approved NP BA-12 "DHS – 5% Operating Reduction," removing $684 from the appropriation. This reduction is expected to continue through FY 2011-12, and, if the reduction is not made permanent, the reversal would not take place until at least FY 2012-13.

The Department submitted, and JBC recommended for approval, FY 2009-10 NP-7 "DHS - Statewide Information Technology Staff Consolidation" as part of the transfer of IT authority to the Governor's Office of Information Technology. This action affected several different line items and the affect to this line was a permanent increase in total funding of $59,512. NP BA-5 "DHS - Child Care Automated Tracking System (CHATS) – Infrastructure" was also approved, resulting in a permanent reduction to the appropriation of $76. The Department's appropriation represents reappropriated funds in several DHS lines. Technical corrections were made to some of the DHS lines, resulting in an adjustment that carried into this line. This technical adjustment resulted in a total funds increase of $44,642. FY 2010-11 BA-23 "ARRA Adjustment" increased the federal funds portion of this line by $54,250, with an equal offsetting reduction to the General Fund of $54,250.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the U.S. Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at lower rate for the third and fourth quarters of the fiscal year. HR 1586 was passed by the U.S. House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated that the FMAP rate for the 3rd quarter of FY 2010-11 would be 58.77%, and 56.88% for the 4th quarter. The Department requested in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP. This resulted in an increase in the General Fund appropriation of $8,810 with a corresponding decrease in the federal funds appropriation. As a result, the FY 2010-11 revised total appropriation is $540,940, consisting of $225,030 General Funds and $315,910 federal funds.

For FY 2011-12, the Department is requesting total funding of $566,877, which includes continuation funding of $540,940 plus a FY 2011-12 Common Policy adjustment of $25,937. Since ARRA is not expected to continue into FY 2011-12, BA-23 "ARRA Adjustment" and ES-1 "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" are annualized, resulting in an appropriation that includes $283,439 General Fund and $283,438 federal funds.

### ***(C) OFFICE OF OPERATIONS – MEDICAID FUNDING***

The Department of Human Services' (DHS) 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. (2010).

This line funds various support services for DHS. The funding is appropriated into two groupings: 1) Administration, and 2) Special Purposes. Within Administration are the Division of Accounting, Division of Contract Management, and Division of Procurement. The Health Insurance Portability and Accountability Act (HIPAA) 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 DHS financial operations and resources, including payments to counties and service providers throughout the State for Medicaid, Medicare, and private-party billing for DHS's various community and institutional programs. 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 has autonomous authority by the Department of Personnel and Administration (DPA) and is responsible for purchasing goods and services for DHS 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. 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 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. However, these are considered to be room and board and not medical services, thus, they are not Medicaid-paid. Office of Operations' Utilities and Vehicle Lease Payments from the Regional Centers are considered Medicaid-related. These expenditures originate in the "Regional Centers" line item and are transferred to the Office of Operations as a financial transaction. 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 DPA 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 DHS on the "Operating Costs" line. Because some of the vehicles are used by programs with Medicaid funding, the Department reimburses DHS which, in turn, makes payments to DPA.

Utilities expenditures include payments for natural gas, electricity, water, and waste water at DHS 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 DHS.

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 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 medical assistance percentage (FMAP) beginning in FY 2008-09 that affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriated the final amount of $6,054,395 to this line item, consisting of $3,027,198 General Fund and $3,027,197 federal funds.

To build to the FY 2009-10 Long Bill (SB 09-259), the final FY 2008-09 appropriation of $6,054,395 served as the base. FY 2009-10 NP-5 "DHS – Postage Increase and Mail Equipment Upgrade" added $791; Prior-year Salary Survey increases as a Common Policy added $121,320; prior-year Performance Based Pay added $45,600; and, Common Policy adjustments such as POTS added $34,680. The Joint Budget Committee (JBC) recommended the removal of $680,000 for Indirect Costs associated with the Regional Centers, with the federal portion of $340,000 being moved into a new line item called Federal Medicaid Indirect Cost Reimbursement for DHS Programs. The General Assembly First Conference Committee action to balance the budget by reducing Personal Services by 1.82% removed $73,167. The amount appropriated in the FY 2009-10 Long Bill (SB 09-259) was $5,503,619 for this line item.

The June 2009 General Revenue forecast indicated that additional General Fund reductions would be necessary in FY 2009-10. Consequently, the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. As a part of NP ES-4 "DHS – Office of Operations Personal Services and Operating Reduction" DHS 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. Further, NP S-6 BA-7 "DHS - Annual Fleet Vehicle Replacements Technical True-up" resulted in a Medicaid total-fund reduction of $12,707. NP S-7 BA-8 "DHS - Mail Equipment Upgrade Supplemental and Budget Amendment" further reduced the appropriation by $518, and NP S-3 "DHS - Statewide Furlough Impact" reduced the appropriation by another $18,096. The final amount appropriated in FY 2009-10 was $5,432,376, consisting of $2,086,577 General Fund and $3.345.799 federal funds.

To build to the Long Bill (HB 10-1376) appropriation of $5,109,630 for FY 2010-11, the final FY 2009-10 appropriation served as a base, with numerous adjustments. These actions included reversals of NP S-3 "DHS - Statewide Furlough Impact," adding back $18,096; a Common Policy Adjustment, decreasing the appropriation by $34,680; First Conference Committee Action, adding back $73,167; NP ES-4 "DHS – Office of Operations Personal Services and Operating Reduction," reducing the appropriation by $17,119; NP S- 6 BA-7 "DHS - Annual Fleet Vehicle Replacements Technical True-up," adding back $15,715; and, NP BA-8 "DHS - Mail

Equipment Upgrade Supplemental and Budget Amendment," reducing the appropriation by $155. Further, the JBC approved a 2.5% adjustment to PERA through NP BA-4 "DHS – PERA Contribution Change," removing $87,031 from the appropriation, NP BA-12 "DHS – 5% Operating Reduction," which removed $21,246 from the appropriation. , and NP-5 "DHS - Annual Fleet Vehicle Replacement," adding $15,123 to the appropriation. The closure of the Skilled Nursing Facility at the Grand Junction Regional Center (see Regional Centers line item description) impacted this line, reducing the appropriation by $284,616.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the U.S. Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at lower rate for the third and fourth quarters of the fiscal year. HR 1586 was passed by the U.S. House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated that the FMAP rate for the 3rd quarter of FY 2010-11 would be 58.77%, and 56.88% for the 4th quarter. The Department requested in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP. This resulted in an increase in the General Fund appropriation of $96,174 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $24,067 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." As a result, the FY 2010-11 revised total appropriation is $5,085,563, consisting of $2,049,539 General Funds and $3,036,024 federal funds.

For FY 2011-12, the Department is requesting total funding of $5,225,002, which includes continuation funding from FY 2010-11 plus increases of $87,031 and $24,067 due to the annualizations of NP BA-4 "DHS – PERA Contribution Change" and NP ES-3 "DHS- 1% Across the Board Personal Services Reduction," respectively. In addition, the base request includes a FY 2011-12 Common Policy adjustment of $28,341. With the reversal of all enhanced FMAP provided under ARRA, the base request includes $2,612,502 General Fund and $2,612,5000 federal funds.

## ***(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 (DHS) 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 residential care of a child when the court determines it is in the best interest of the child to remove them 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 to eliminate service duplication and assure service integration; policy development and subsequent program development; implementation and monitoring; and, responding to consumer requests for information. Child Welfare is a state-supervised but county-administered system. Authorization for this line item can be found at 26-1-201 (f), (g), (i) and (j), C.R.S. (2010).

Although the Division of Child Welfare Administration was created as a separate line item in the budget for DHS 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 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 be separated.

Staff 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 the portion of the staff salaries related to Medicaid-oversight work. Generally, the automated case-management system used by DHS for child welfare cases (known as Colorado Trails) starts the enrollment process and passes information onto the Colorado Benefits Management System.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriated $130,712to this line item. The appropriation was subsequently reduced by $3,026 due to FY 2008-09 NP S-15 "DHS – Hiring Freeze Savings" through the Supplemental Bill (SB 09-187). The final FY 2008-09 appropriation was $127,686, consisting of $63,843 General Fund and $63,843 federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriated $135,195 for this line item. This amount included continuation funding plus the following adjustments:

- an increase of $5,341 for prior-year Salary Survey;
- an increase of $1,524 for prior-year Performance-Based Pay;
- an increase of $3,026 for the prior-year reduction from NP S-15 "DHS – Hiring Freeze Savings;" and
- a decrease of $2,382 for the 1.82% one-time reduction to Personal Services made by the General Assembly First Conference Committee.

The economic downturn necessitated budget balancing actions through the FY 2009-10 NP S-3 "DHS-Statewide Furlough Impact," which reduced this line item by $1,776. This reduction was codified in the Supplemental Bill (HB 10-1300), leaving a final appropriation for FY 2009-10 of $133,419, including $66,710 General Fund and $66,709 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation of $133,906 included continuation funding plus the following adjustments:

- an increase of $2,382 from the annualization of the FY 2009-10 Joint Budget Committee (JBC) action of "1.82% Personal Services Cut";
- an increase of $1,776 from the annualization of FY 2009-10 NP S-3 "DHS-Statewide Furlough Impact";
- a decrease of $3,025 from NP BA-4 "DHS-PERA Contribution Change"; and,
- a decrease of $646 from NP BA-12 "DHS-5% Operating Reduction."

As a result of the continuation of budget balancing, this appropriation was decreased by $1,279 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." The FY 2010-11 appropriation is $132,627 and includes $66,314 General Fund and $66,313 federal funds.

The base request for FY 2011-12 is $136,931, including continuation funding and the annualizations of FY 2010-11 NP BA-4 and NP ES-3, which resulted in an increase of $4,304. The base request consists of $68,466 General Fund and $68,465 federal funds.

**CHILD WELFARE SERVICES**

The Child Welfare Services line item is 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, C.R.S. (2010). The line item provides funding for: (1) county administration for child welfare 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. These services comprise Colorado's effort to meet the needs of children who must be placed or are at risk of placement outside their homes for their own protection or for community safety.

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. Children who enter foster care typically qualify for Medicaid, based upon the circumstances of their case. Each child in foster care is considered to be a family of one person and normally meets Medicaid requirements because the child generally has no income of their own. HB 09-1293 ("Health Care Affordability Act") guarantees 12-months of continuous eligibility for children in Medicaid, regardless of whether the child remains in foster care for less than one year.

The Division of Child Welfare tries to achieve permanency for children by moving a child from foster care to adoption if the child can not be reunited with that child's birth parents. When adoptive parents need financial assistance to provide medical care for the adopted children, the adopted children continue to qualify for Medicaid for as long as needed, up until the child turns 18, at which point children age out of eligibility for Child Welfare Services. In cases where the adopted child has developmental disabilities, the time period may extend to age 21 to address the child's continuing needs. A young person who has aged out of the foster care program at 18 and enters into independent living due to not having been adopted may continue to qualify for Medicaid until age 21.

In FY 2006-07, DHS 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 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 13 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.

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.

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 and reimbursed using a fee-for-service methodology. Only a minor portion of this total program is eligible for Medicaid funding.

The Colorado Children's Habilitation Residential Program (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. These children are in foster care because their disabilities are so great that their parents are unable to care for them. Children may enter into CHRP at any age from birth through 21 years. Although this waiver relates to developmental-disability services, the services are provided through child welfare services rather than through the separate program for adults with developmental disabilities. After reaching age 21, the children are transitioned into the adult program for developmental disabilities. Authorization for this waiver was

provided by SB 96-178. On-going federal approval of this waiver is conditional on having a State FTE administer the waiver, which DHS continues to meet.

The CHRP waiver requires the State to: approve the entry of a child into CHRP; 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. The CHRP waiver is not an entitlement program. If the federally approved capacity is exceeded, a waiting list is established on a first-come, first-serve basis.

Only 80% of all child welfare services are funded by the State pursuant to Section 26-1-122, C.R.S. (2010). 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: 1) the over-expenditures have been authorized; 2) are the result of unanticipated caseload increases; and, 3) are not attributable to administrative or support functions. DHS is directed by statute to annually develop formulas for allocating child welfare funding among the 64 counties through the use of an optimization model. DHS receives input from the Child Welfare Allocations Committee, which consists of eight members – four members appointed by Colorado Counties, Inc. and four members appointed by DHS. Should DHS and the Child Welfare Allocations Committee fail to agree to an allocation methodology, the two entities each present alternative methodologies to the JBC for selection.

The Department and DHS have statutory authorization to transfer unlimited amounts of General Fund between the two departments when required by changes from the levels in the amount of Medicaid cash funds (or reappropriated funds in the DHS budget) earned through programs or services provided under the supervision of the departments per 24-75-106, C.R.S. (2010). 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, DHS may transfer extra General Fund to the Department to receive federal financial participation for the services provided. Conversely, if child welfare Medicaid services are lower than the amounts reflected in the appropriation, DHS can request that the Department transfer the General Fund portion of the associated Medicaid appropriation back to DHS so that the General Fund may be used to provide other child welfare services that are not eligible for federal financial participation for Medicaid.

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 medical assistance percentage (FMAP) beginning in FY 2008-09 that affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriation for this line item was $18,508,228, consisting of $9,254,114 General Fund and $9,254,114 federal funds.

The FY 2009-10 Long Bill (SB 09-259) appropriated $18,746,950 to this line item, which included continuation funding and an increase of $238,722 for NP-4 "DHS – Child Welfare Caseload."

The June 22, 2009, General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, 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 JBC on August 24, 2009. As a part of NP ES-9, "DHS – Reduction to the Child Welfare Services Block," DHS proposed that overall funding for child welfare services be reduced. This resulted in a Medicaid total fund reduction of $4,238,722, as approved by the Supplemental Bill (HB 10-1300). The final FY 2009-10 appropriation was $14,508,228, consisting of $5,572,610 General Fund and $8,935,618.

For FY 2010-11, a reduction of $290,165 from annualization of FY 2009-10 NP ES-9 led to an appropriation of $14,218,062 in the FY 2010-11 Long Bill (HB 10-1376). Subsequently, HB 10-1338 "Probation Eligible Two Prior Felony" increased the line item appropriation by $75,209.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 at 58.77%, and the FMAP rate for the 4$^{th}$ quarter at 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage." This request resulted in an increase in the General Fund appropriation of $269,032 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $106,584 pursuant to ES-2 "Fee-For-Service Delay." The revised FY 2010-11 appropriation is $14,186,688, including $5,705,477 General Fund and $8,484,211 federal funds.

The Department is requesting $14,328,538 for this line item for FY 2011-12. This base amount is based upon the prior-year appropriation, the annualization of ES-2 "Fee-For-Service Delay," and an increase of $35,266 as a leap-year adjustment for 2012. The removal of all enhanced FMAP provided under ARRA results in the base request including $7,164,270 General Fund and $7,164,268 federal funds,

## ***(E) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING***

### SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) is a new line item beginning with the FY 2010-11 Long Bill (HB 10-1376). The system is part of the website for U.S. Citizenship and Immigration Services that is now part of the federal Department of Homeland Security. The database is a nationally accessible database of selected immigration-status information on legal immigrants entering the United States. SAVE enables federal, state, and local government agencies and licensing bureaus to obtain immigration status information that they need to determine a non-citizen applicant's eligibility for many public benefits. The SAVE database also administers employment verification programs to enable employers to verify quickly and easily the work authorization of their newly hired employees. The Colorado Department of Human Services (DHS) has a Memorandum of Understanding with the federal SAVE program to verify eligibility for public benefits. The Department shares with DHS in the use of the database to verify eligibility for the Medicaid program. Accessing SAVE is done in addition to the regular Colorado Benefits Management System determination of eligibility for benefits. Because of the cost sharing arrangement between the departments, the Department receives funding to transfer to DHS.

*Appropriation History*

The FY 2010-11 appropriation for this line item was $34,766. Although this line item appeared for the first time in the FY 2010-11 Long Bill, the line has existed for several years in appropriations for DHS. Previously, the Department's share of the funding for SAVE was assigned to the "Medical Services Premiums" line item. As a result of the continuation of budget balancing, this appropriation was decreased by $326 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction" to $34,440. The FY 2010-11 appropriation includes $17,220 General Fund and $17,220 federal funds.

For FY 2011-12, the Department is requesting $34,766, including continuation funding and the annualization of NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." This base request consists of $17,383 General Fund and $17,383 federal funds.

## ***(F) 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 (DHS). 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 statutory reference for Mental Health Administration, but a reference may be inferred from 24-1-120, C.R.S. (2010).

The Deputy 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, the Division of Supportive Housing and Homelessness, and the Domestic Violence Program. 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 within DHS.

The administration at DHS, however, 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 DHS. Since 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. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally appropriated in the Executive Director's Office of DHS and are transferred into this administrative line throughout the fiscal year as needed.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriation was $325,197, consisting of $162,598 General Fund and $162,599 federal funds.

The FY 2009-10 appropriation increased to $348,973, as authorized by the FY 2009-10 Long Bill (SB 09-259). This amount included additions of $18,156 for prior year Salary Survey and $5,620 for prior year Performance-Based Pay. Of the appropriated amount, $174,487 was General Fund and $174,486 was federal funds.

For FY 2010-11, the Long Bill (HB 10-1376) appropriation for this line item was $336,828, which included an adjustment for NP BA-4 "DHS-PERA Contribution Change" that reduced funding by $11,703 and NP BA-8 "Mail Equipment Upgrade Supplemental and Budget Amendment" that reduced funding by $442. As a result of the continuation of budget balancing, this appropriation was decreased by $3,260 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction" to $333,568. The FY 2010-11 amount includes $166,784 General Fund and $166,784 federal funds,

For FY 2011-12, the Department is requesting continuation funding plus the annualizations of NP BA-4 "DHS-PERA Contribution Change" and NP ES-3 "DHS- 1% Across the Board Personal Services Reduction", which added back $14,963 total funds. The base request is $348,531, of which $174,266 is General Fund and $174,265 is federal funds.

**RESIDENTIAL TREATMENT FOR YOUTH (HB 99-1116)**

HB 99-1116 created the Child Mental Health Treatment Act to improve the probability that children with significant mental health needs receive treatment. Children served under this Act are often referred to as 1116 Kids. This act is codified in 27-10.3-101, C.R.S. (2010). This legislation was passed to help mitigate parents' difficulty 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 from 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, 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, also become eligible for Medicaid. These children are served under the Medicaid funding for this line item of Residential Treatment for Youth. Children who need this service but do not qualify for either SSI or Medicaid are considered to be private-pay clients at the Residential Treatment Centers, and the child's parents are expected to pay for the treatment if the costs are not covered by private insurance. If none of the aforementioned payment options are available, the Department of Human Services (DHS) pays for treatment from the larger appropriation for Residential Treatment for Youth, which includes reappropriated Medicaid funds to be use only for Medicaid clients.

Although there had been a therapeutic residential child care facility located at the Colorado Mental Health Institute at Fort Logan, the therapeutic residential child care section was closed during FY 2009-10 as a budget-balancing measure. (See additional discussion of closures in the line item of Mental Health Institutes.) Other Residential Treatment Centers – privately operated facilities or local government owned – have been 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 DHS or in the custody of the Division of Youth Corrections at DHS 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 would not cover room and board, so that only mental health medical care is covered beginning in FY 2006-07.

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 medical assistance percentage (FMAP) beginning in FY 2008-09 that affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriated $119,225, of which $35,499 was General Fund and $83,726 was federal funds.

For FY 2009-10, continuation funding of $119,225 was provided by the Long Bill (SB 09-259). Pursuant to FY 2009-10 NP BA-2 "DHS - Technical Supplemental", the Joint Budget Committee (JBC) increased the cash fund appropriation by $24,114 with a corresponding decrease in federal funds. The FY 2009-10 appropriation included $21,681 General Fund, $24,114 cash funds, and $73,430 federal funds.

In FY 2010-11, due to the economic downturn, funding for this line item was reduced by $2,385 through NP-6 "Two Percent (2%) Community Provider Rate Base Decrease," resulting in a FY 2010-11 Long Bill (HB 10-1376) appropriation of $116,840. Also incorporated in the FY 2010-11 Long Bill was the discontinuation of cash funding for this line item for Medicaid clients. Since 1999, a limit of $300,000 cash funds had been provided from Tobacco Litigation Master Settlement Funds for this line item. This $300,000 had been shared by both the Department and DHS. However, the need for funding for non-Medicaid clients served by DHS had increased significantly while the Medicaid clients' needs had remained stable, leading to the total allowable Tobacco Litigation Master Settlement funds being shifted entirely to DHS in FY 2010-11.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 at 58.77%, and the FMAP rate for the 4$^{th}$ quarter at 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage." This request resulted in an increase in the General Fund appropriation of $2,199 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 revised appropriation consists of $47,077 General Fund and $69,763 federal funds.

The Department is requesting continuation funding of $116,840 total funds as the base request for FY 2011-12. With the removal of the enhanced FMAP provided under ARRA, the base consists of $58,420 General Fund and $58,420 federal funds.

**MENTAL HEALTH INSTITUTES**

The State operates two hospitals for the severely mentally ill: the Colorado Mental Health Institute at Fort Logan, established in 1961 in Denver, and the Colorado Mental Health Institute, established in 1879 in Pueblo. These institutes are codified in 27-13-101 and 27-15-101, C.R.S. (2010). 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 to providing active treatment in a secure setting with the goal of reintegrating mentally ill individuals back into the community. Availability of modern, effective, psychotropic prescription drugs has assisted and enhanced the reintegration process for mentally ill clients. The intention is that the institutes provide short-term secure stabilization services only to the most severely mentally ill citizens. The majority of the clients in the institutes are referred by Community Mental Health Centers or Behavioral Health Centers if a client is too unstable for effective treatment in the community.

The capacity of the Mental Health Institutes has also been affected by State budget balancing needs caused by the economic downturn. During FY 2009-10, the facility for children and youths was closed at the Fort Logan location, causing a shift of inpatient care to private facilities. The facility for elderly mentally ill clients was also closed at the Fort Logan location, causing a shift of these clients to nursing care facilities, other private mental health facilities, or to family care and local Community Mental Health Centers. This action saved $258,000 in the Mental Health Institutes budget.

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.

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 (such as the Department of Corrections or the Department of Education). These institutes also transfer a portion of their revenues to other offices in DHS that provide support for

operations of the institutes. Such 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.

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.

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 medical assistance percentage (FMAP) beginning in FY 2008-09 that affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

For FY 2008-09, funding of $3,704,738 was appropriated by the Long Bill (HB 08-1375). This amount was later decreased by $250,505 through late Supplemental Request NP S-23 "DHS – Mental Health Institutes Revenue Adjustment" resulting in a final appropriation of $3,454,233. Of this amount, $1,727,117 was General Fund and $1,727,116 was federal funds.

For the FY 2009-10 Long Bill (SB 09-259), a reduction of $2,415 was made to the appropriation as a result of the JBC action regarding funding the General Hospital section at the Colorado Mental Health Institute in Pueblo. Thus, the FY 2009-10 appropriation was $3,451,518 for this line item.

The June 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10, and 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," DHS proposed that 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 total fund reduction of $257,624. This reduced funding was effective during the last six months of FY 2009-10 and was reflected in the FY 2009-10 Supplemental Bill (HB 10-1300) with a revised total funding of $3,194,194 for this line item. This amount included $1,226,890 General Fund and $1,967,304 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) of $2,916,208 included continuation funding and adjustments for the following:

- a reduction of $257, 624 from annualization of FY 2009-10 NP ES-5 "DHS-Close 59 beds at the Colorado Mental Health Institute at Fort Logan"; and,
- a reduction of $20,362 for NP BA-12 "DHS-5% Operating Reduction.".

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated the FMAP rate for the 3rd quarter of FY 2010-11 at 58.77%, and the FMAP rate for the 4th quarter at 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage." This request resulted in an increase in the General Fund appropriation of $54,889 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $181,568 pursuant to ES-2 "Fee-For-Service Delay" and $4,329 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." The FY 2010-11 revised appropriation is $2,730,311 and consists of $1,078,646 General Fund and $1,651,665 federal funds.

For FY 2011-12, the Department is requesting $2,916,208 for this line item, which includes continuation funding and annualizations for ES-2 "Fee-For-Service Delay" and NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." With the removal of the enhanced FMAP provided under ARRA, this base request includes $1,458,104 General Fund and $1,458,104 federal funds.

**ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION**

The DHS appropriation 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 6th, 8th, 10th, and 12th 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. (2010).

Medicaid funding has been provided to the Alcohol and Drug Abuse Division (ADAD) to assure that substance abuse treatment programs meet distinct requirements of ADAD licensure and to ensure that substance abuse clinicians meet certification or licensure requirements to abide by treatment standards. All client services are delivered according to the current versions of the American Society of Addiction Medicine patient placement criteria, which is the accepted national standard for substance abuse treatment services in both public and private sector programs.

The Medicaid funding covers the portion of the Personal Service and Operating Expenses pro-rated for Medicaid purposes. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) 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*

For FY 2008-09, the Long Bill (HB 08-1375) appropriated $54,088 for this line item. This amount included $27,044 General Fund and $27,044 federal funds.

The Department requested continuation funding of $54,088 for FY 2009-10, however, a technical error occurred in the FY 2009-10 Long Bill (SB 09-259) because only the Personal Services portion of $53,136 was appropriated while the Operating Expenses portion of $952 was inadvertently left out. This appropriation consisted of $26,568 General Fund and $26,568 federal funds.

For FY 2010-11, the Department a JBC staff technical correction achieved the restoration of the $952 in Operating Expenses, and the resulting appropriation per the Long Bill (HB 10-1376), was again $54,088. As a result of the continuation of budget balancing, this appropriation was decreased by $531 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction" to $53,557. This amount includes $26,778 General Fund and $26,779 federal funds.

The Department requests funding of $54,088 for FY 2011-12, consisting of continuation funding plus the annualization of NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." The base request includes $27,044 General Fund and $27,044 federal funds.

**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 state-wide 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 includes cessation treatment for abuse of alcohol, hallucinogens, opiates, amphetamines, stimulants, barbiturates, inhalants, tranquilizers, sedatives, and cocaine. Infants who have been exposed to those substances require extensive and expensive medical treatment after birth. The program is an entitlement program fully funded by Medicaid but administered by the Alcohol and Drug Abuse Division in DHS. Authority for the program is provided at 25-1-212 through 25-1-213, C.R.S., (2010). The Medicaid Assistance portion of this program is also authorized by 25.5-5-310 through 312, C.R.S. (2010).

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 cannot 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 DHS.

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.

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 medical assistance percentage (FMAP) beginning in FY 2008-09 that affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) authorized $1,013,700 total funds for this line item. As a result of increased caseload in addition to an extension of the program from 60 days postpartum to 12 months postpartum, an increase of $597,350 was requested for FY 2008-09 in NP S-22 "DHS – High Risk Pregnant Women Program". Thus, the final appropriation for FY 2008-09 was $1,611,048, consisting of $805,524 General Fund and $805,524 federal funds.

For FY 2009-10, an increase of $428,897 was requested in NP-13 "DHS – High Risk Pregnant Women Program." The FY 2009-10 Long Bill (SB 09-259) appropriation was$2,039,945, including $783,543 General Fund and $1,256,402 federal funds.

In response to worsening economic conditions, the FY 2010-11 NP-6 "DHS-Two Percent (2%) Community Provider Rate Base Decrease" reduced funding by $40,799. As a result, an appropriation of $1,999,146 was reflected in the FY 2010-11 Long Bill (HB 10-1376).

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 at 58.77%, and the FMAP rate for the 4$^{th}$ quarter at 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage." This request resulted in an increase in the General Fund appropriation of $37,628 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 revised appropriation consists of $805,500 General Fund and $1,193,646 federal funds.

The Department requests continuation funding of $1,999,146 for FY 2011-12. With the removal of the enhanced FMAP provided through ARRA, this base request consists of $999,573 General Fund and $999,573 federal funds.

***(G) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING***

**COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ADMINISTRATION**

This line item supports almost 90% of the total costs associated with 36 Administrative FTE at the Department of Human Services (DHS). These FTE are responsible for the oversight of state programs for persons with developmental disabilities, including services directly administered by Community Centered Boards (CCBs), and for services provided in the state-operated regional centers. This line also funds 70% of the costs for the Community and Contract Management System (CCMS), which is used to authorize services, collect individual data, bill for services, and collect demographic data for people with developmental disabilities. CCMS also tracks disability resources and contracts, as well as wait list information. This line funds over 95% of operating expenses in addition to Medicaid waiver transition costs.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriation was $2,742,062. In response to the economic downturn, NP S-15 "DHS – Hiring Freeze Savings" was approved by the JBC and became part of the FY 2008-09 Supplemental Bill (SB 09-187), reducing the line item appropriation by $117,283 as a one-time reduction. Subsequently, SB 08-002 "Family Caregiver for Developmental Disabled" added $34,264 for Personal Services and Operating Expenses. The final FY 2008-09 appropriation for this line was $2,659,043, consisting of $1,329,521 General Fund and $1,329,522 federal funds.

For FY 2009-10, the Long Bill (SB 09-259) annualized SB 08-002 "Family Caregiver for Developmentally Disabled," adding $72,582. The one-time 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 (JBC) approved NP-5 "DHS Postage Increase and Mail Equipment Upgrade," which added $72 and addressed increasing postage costs and equipment upgrade needs in DHS as requested by the Department of Personnel and Administration (DPA). JBC recommended, and the Legislature approved, an across-the-board Personal Services cut of 1.82% throughout the State budget, and this became part of the FY 2009-10 Long Bill, reducing this line item appropriation by $47,913. The FY 2009-10 Long Bill appropriation to this line item was $2,931,656. The Personal Services cut was later refined when JBC approved NP S-3 "DHS – Statewide Furlough Impact," which removed an additional $24,187. The final line item appropriation for FY 2009-10 was $2,907,378, comprised of $1,453,689 General Fund and $1,453,689 federal funds.

To build to the FY 2010-11 Long Bill (HB 10-1376) appropriation of $2,947,709, the one-time furlough impacts from FY 2009-10 totaling $72,100 were added as an annualization. SB 08-002 "Family Caregiver for Developmentally Disabled" was annualized, removing $5,183 for one-time costs for computers, desks, and other office equipment. JBC approved NP BA-8 "DHS - Mail Equipment Upgrade Supplemental and Budget Amendment," which – combined with the annualization of the prior year NP-5 "DHS Postage Increase and Mail Equipment Upgrade" – removed $38 in Operating Funds by correcting an annualization technicality. Additionally, several actions were taken in response to the state-wide fiscal crisis. JBC approved a 2.5% adjustment to PERA through

NP BA-4 "DHS – PERA Contribution Change," removing $52,493 from the appropriation, as well as NP BA-12 "DHS – 5% Operating Reduction," removing $12,632 from the appropriation. JBC recommended, and the Legislature approved, a reduction of $13,477 in Medicaid Waiver Transition Costs related to bringing the Supports Intensity Scale (SIS) online system in-house (FY 2010-11 Department of Human Services Developmental Disabilities Figure-setting 3/15/2010, page 17). As a result of the many cost-saving measures enacted, the funding for this line item was left at an inadequate level, leading JBC approve FY 2010-11 NP-BA-13 "DHS - Correction to FY 2010-11 Base Budget", increasing funding by $52,054. As a result of the continuation of budget balancing, this appropriation was decreased by $26,359 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction" to $2,921,350. This includes $1,460,675 General Fund and $1,460,675 federal funds.

For FY 2011-12, the Department is requesting $3,000,202 for this line item. This requested amount is based off the $2,921,350 appropriated in the prior fiscal year and includes the annualizations of NP BA-4 "DHS – PERA Contribution Change" and NP ES-3 "DHS- 1% Across the Board Personal Services Reduction," adding $78,852 back to the appropriation. Of the base request, $1,500,101 is General Fund and $1,500,101 is federal funds.

**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 7,877 clients through three waivers (described below) supporting the Adult Comprehensive Services, Adult Supported Living Services, and Children's Extensive Support Services Programs. Twenty CCBs 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 CCBs and three, state-operated regional centers. Case Management services are currently appropriated for approximately 8,295 Medicaid clients under the new consolidated line item. The number of clients served has increased each of the past four years.

The "Comprehensive Home and Community-Based Services Waiver for People with Developmental Disabilities" line item (under the former "Adult Program Costs" and "Services for Children and Families, Program Funding" line items) was replaced by funding 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.

Service providers are paid a daily rate, based on the Supports Intensity Scale (SIS) score of the individual served. Over the past few years, there has been an unanticipated increase in the number of people whose needs are being re-evaluated and these re-evaluations overwhelmingly result in higher SIS scores, which drive higher payments in the DHS rate structure. This may result in providers and consumers adapting so as to maximize payments and services in the new pay structure.

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 affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriation was $300,903,609. During the winter of FY 2008-09, deteriorating economic conditions required the Department to recommend areas where budget reductions could be made. The JBC took action on NP S-11 "DHS Fee-for-Service versus Bundled Billing," eliminating $5,300,000 in total funding. The Committee also took action on NP S-12 "DHS Vacancy Savings due to Systematic Client Turnover," removing another $1,668,362 total funds, and NP S-13 "DHS Developmental Disability Services 2007-08 Roll Forward," eliminating $5,057,748. 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 to $288,877,499. Of this amount, $143,826,022 was General Fund, $579,886 was cash funds, and $144,471,591 was federal funds.

For the FY 2009-10 appropriation, the prior-year final appropriation of $288,877,499 served as the base. NP S-11 "DHS – Fee for Service versus Bundled Billing" and NP S-13 "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," which was approved and $5,189,494 was appropriated. JBC also appropriated $590,620 for Regional Center Transition Placements and Staff Adjustment for Case Management. Revenue forecasts in early 2009 projected continued deterioration in the state economy, and JBC reviewed funding for the line due to state budget-balancing requirements. Reductions totaling $3,406,407 were made to previously approved appropriations for new resources. The JBC also 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 2009 General Revenue forecast indicated that additional 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%. As a part of NP ES-7 "DHS – DDD Medicaid Waivers Provider Rate Reduction," the Department proposed to reduce provider rates/services by 2.5% for Adult Comprehensive Services, Adult Supported Living Services, and Children's Extensive Support. This resulted in a total fund reduction of $5,888,663 to this line in FY 2009-10. NP S-9 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" was submitted as a budget-reducing mechanism, in which certain clients from a regional center would be transitioned to lower-cost community centers, resulting in an increase to this line, totaling $419,502. Due to these actions, the FY 2009-10 final appropriation was $308,630,857. This appropriation included $118,485,765 General Fund, $438,515 cash funds, and $189,706,577 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation of $305,993,911 was based off the prior-year appropriation of $308,630,857 and adjusted by numerous budgetary actions. The previous year's NP S-9, along with its companion NP BA-15, "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" resulted in an annualization increase of $3,256,351 total funds as it only funded for part of fiscal year FY 2009-10. NP ES-7 "DHS – DDD Medicaid Waivers Provider Rate Reduction" was annualized reducing the appropriation by $2,022,230. NP-3 "DHS – Community Funding for Individuals with Developmental Disabilities" was annualized adding $2,373,707 total funds. Additional budget-cutting measures were required, and NP BA-15 "DHS – Two Percent (2%) Community Provider Rate Base" reduced the appropriation by $6,244,774.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the U.S. Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at lower rate for the third and fourth quarters of the fiscal year. HR 1586 was passed by the U.S. House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated that the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 would be 58.77%, and 56.88% for the 4$^{th}$ quarter. The Department requested in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP. This resulted in an increase in the General Fund appropriation of $5,680,205 and $18,212 to cash funds with an offsetting decrease of $5,698,417 in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $2,591,966 pursuant to ES-2 "Fee-For-Service Delay." As a result, the FY 2010-11 revised total appropriation of $303,401,945 consists of $121,821,379 General Funds, $445,219 reappropriated funds, and $181,135,347 federal funds.

For FY 2011-12, the Departing is requesting funding of $306,759,066 for this line. This includes continuation funding, an annualization of $2,591,966 pursuant to ES-2 "Fee-For-Service Delay," and a leap-year adjustment of $765,155. With the removal of the enhanced FMAP provided under ARRA, the base request consists of $152,840,386 General Fund, $539,150 cash funds, and $153,379,530 federal funds.

**COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES - FEDERALLY-MATCHED LOCAL PROGRAM COSTS**

The Federally-Matched Local Program Costs line enabled 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.

HB 08-1220 "Developmental Disabilities Statutory Cleanup" enabled remittance of local funds to the state for the purchase of services for people with developmental disabilities. The passage of HB 08-1220 modified provisions concerning services for people with developmental disabilities to comply with federal requirements and practices of DHS 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 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.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriated $2,000,000 for this line.

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, and, as a result, JBC elected to eliminate this line item from the Long Bill (SB 09-259) for FY 2009-10.

**REGIONAL CENTERS**

The state operates three regional centers that provide direct support for adults with developmental disabilities. These are individuals who have significant needs and for whom adequate services and support are not available in the CCB 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).

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 CCB 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.

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 affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

The FY 2008-09 Long Bill (HB 08-1375) appropriated total funding of $46,137,930. DHS submitted a late supplemental request for $2,205,696 in March of 2009, which JBC approved but levied a penalty of $415,000 against DHS for not having submitted the request in conformance with the JBC calendar. The penalty only passed through the Department's budget and was removed from the FY 2009-10 appropriation. This brought the appropriation for FY 2008-09 for this line item to $48,343,626, including $23,192,312 General Fund, $979,501 reappropriated funds, and $24,171,813 federal funds.

To build to the FY 2009-10 Long Bill (SB 09-259) appropriation, the $48,343,626 appropriated the previous year served as the base. NP-4 "Regional Center ICF/MR Conversion and Year 2 of the Staffing Study" was annualized as an increase of $1,605,055. The FY 2008-09 one-time increase of $2,205,696 from NP S-31 "DHS – Regional Centers Prior Year Accounting Issues" was reversed, and the associated penalty of $415,000 was also applied as an appropriation reduction. JBC reduced the funding for leased space by $127,389 but added $1,247,280 for provider fees. JBC also recommended and approved a budget-balancing action to reduce personal services by 1.82%, or $863,840. Common Policy adjustments for salary survey and performance based pay increased the appropriation by $1,456,662 and $520,295, respectively, as annualization from the previous year. JBC 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 – JBC approved a fund-split adjustment for ICF/MR provider fees from FY 2008-09, moving $40,126 out of the General Fund and into reappropriated funds. The final amount appropriated to the line through the FY 2009-10 Long Bill was $50,049,730.

The June 2009 General Revenue forecast indicated that additional General Fund reductions would be necessary in FY 2009-10. Consequently, the governor directed all state agencies to develop budget-reduction proposals that would reduce the agency's General Fund by 10%. NP ES-8 (later revised as NP S-9) "DHS – Closure of 32 bed Nursing Facility at Grand Junction Regional Center" resulted in a total fund reduction of $974,182 to this line in FY 2009-10. The 1.82% personal services reduction was partially reversed through NP S-3 "DHS – Statewide Furlough Impact" because certain levels of critical staff must be maintained in the state's regional centers, adding $569,484 total funds back to the appropriation. Additionally, NP S-7 "DHS – Mail Equipment Upgrade Supplemental and Budget Amendment" was approved, reducing the appropriation by $652. As a result of these actions, the FY 2009-10 final appropriation was $49,644,380, comprised of $17,035,272 General Fund, $2,033,135 reappropriated funds, and $30,575,973 federal funds.

To build to the FY 2010-11 Long Bill appropriation of $46,888,625, the prior-year appropriation of $49,644,680 served as the base. Several FY 2009-10 budget-reduction actions required annualization or reversal as well. The one-time penalty of $415,000 levied in FY 2009-10 was annualized as a reversal. The previous year's NP S-9, along with its companion NP BA-15 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" was annualized, decreasing total funds by $2,782,528. The prior year's 1.82% JBC action reducing personal services was also annualized, adding back $863,840 total funds. JBC approved NP BA-8 "DHS - Mail Equipment Upgrade Supplemental and Budget Amendment," which, combined with the annualization of the prior year NP-5 "DHS Postage Increase and Mail Equipment Upgrade," added $112. The NP-8 "DHS – Direct Care Capital Outlay" increase of $164,250 was a one-time action and was annualized. JBC recommended that NP-6 "DHS – Regional Centers – High Need Clients" be annualized, adding $28,417. Additionally, actions were taken in response to the ongoing statewide fiscal crisis. JBC approved a 2.5% adjustment to PERA through NP BA-4 "DHS – PERA Contribution Change," removing $960,576 from the appropriation. JBC also approved NP BA-12 "DHS – 5% Operating Reduction," removing $125,770 from the appropriation. JBC recommended and approved a $30,000 reduction due to the smaller amount of space being leased at the Wheat Ridge facility.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 appropriation assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the U.S. Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at lower rate for the third and fourth quarters of the fiscal year. HR 1586 was passed by the U.S. House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated that the FMAP rate for the 3$^{rd}$ quarter of FY 2010-11 would be 58.77%, and 56.88% for the 4$^{th}$ quarter. The Department requested in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage" that its

appropriations be adjusted to reflect the current expiration date of the enhanced FMAP. This resulted in an increase in the General Fund appropriation of $882,545 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $1,357,815 pursuant to ES-2 "Fee-For-Service Delay" and $84,657 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." As a result, the FY 2010-11 revised total appropriation of $45,446,153 consists of $16,342,613 General Fund, $1,814,656 reappropriated funds, and $27,288,884 federal funds.

For FY 2011-12, the Department is requesting $47,849,201 for this line item, based upon the $45,446,153 appropriated the year before, in addition to annualizations of NP BA-4 "DHS – PERA Contribution Change", ES-2 "Fee-For-Service Delay," and NP ES-3 "DHS- 1% Across the Board Personal Services Reduction," which adds $2,403,048 back to the line. With the removal of the enhanced FMAP provided under ARRA, the base request consists of $22,056,946 General Fund, $1,867,655 reappropriated funds, and $23,924,600 federal funds.

**REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS**

This line enables the State to capture depreciation payments from federal authorities associated with DHS's regional centers. The line item was added through a FY 2003-04 supplemental bill (HB 04-1320) to reflect historic department practice. DHS 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 DHS 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 DHS operating budget, DHS 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 by the Department and the accrual accounting method used by DHS (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 2008-09, the Long Bill (HB 09-1375) appropriation for this line was $1,142,912, comprised of $571,456 General Fund and $571,456 federal funds.

In FY 2009-10, JBC action increased funding by adding $115,172, based on revised depreciation calculations by DHS. The FY 2009-10 Long Bill (SB 09-259) appropriation was $1,258,084, including $629,042 General Fund and $629,042 federal funds.

For FY 2010-11, the Department requested continuation funding of $1,258,084. JBC decreased this appropriation by $70,259 to reflect revised depreciation figures based on the annual calculations completed by DHS. The FY 2010-11 Long Bill (HB 10-1376) appropriation was $1,187,825 for this item, consisting of $593,913 General Fund and $593,912 federal funds.

For FY 2011-12, the Department is requesting continuation funding of $1,187,825, including $593,913 General Fund and $593,912 federal funds.

***(H) ADULT ASSISTANCE PROGRAMS; COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING***

This line item was created to support funding of the State Ombudsman program of the Department of Human Services (DHS), which manages the program through a contract with the Legal Center for Persons with Disabilities and Older Persons. This program provides liaison services between DHS 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. (2010).

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.

Since FY 2003-04, funding for this line item has remained at $1,800, comprised of $900 General Fund and $900 federal funds. For FY 2011-12, the Department is requesting continuation funding of $1,800.

***(I) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING***

The Division of Youth Corrections is under the direction of the Deputy Executive Director for Children, Youth, and Families at the Department of Human Services (DHS). 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; are detained while awaiting adjudication; or are committed to the Division of Youth Corrections after adjudication. Facilities for youth offenders include intensive secure units, medium care units, staff secure units, and non-secure community residential programs. Only residents in non-secure, community residential programs would qualify for Medicaid. Other youths in secured, locked facilities have their medical care paid entirely through State General Fund.

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, and vocational and educational assistance. Youth Corrections in the Colorado Revised Statutes can be found in 19-2-402 through 418, C.R.S. (2010).

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 covers 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 has been combined with parole officers so the same individual manager tracks a juvenile through the system from commitment to the end of parole. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability and other items) associated with the Personal Services are centrally appropriated in the "DHS Executive Director's Office, General Administration" section. This 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, which 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 that 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 DHS 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.

In FY 2009-10, the Ridgeview Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridgeview to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children. Tracking the Ridgeview clients is done on an individual basis, as they blend into the

foster care category in Medicaid caseload. The federal Centers for Medicare and Medicaid Services continues to review this change in applicability for Medicaid eligibility of youths under the jurisdiction of Colorado Division of Youth Corrections.

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 affected 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 beginning in the second half of FY 2008-09 and continuing through FY 2010-11, but it is not expected to continue into FY 2011-12.

*Appropriation History*

For FY 2008-09, the Long Bill (HB 08-1375) appropriated $2,885,273 total funding, including $44,520 for Personal Services, $2,807,417 for Purchase of Contract Placements, and $33,336 for a managed care pilot project. A reduction of $1,247,600 through Supplemental Request NP S-21 "DHS – Purchase Contract Placement – Continuum of Care" was approved in the FY 2009-10 Long Bill Add-ons (SB 09-259), resulting in a final appropriation of $1,637,673 for FY 2008-09. Of this amount, $818,837 was General Fund and $818,836 was federal funds.

Several adjustments were figured into the calculation of the FY 2009-10 Long Bill (SB 09-259) appropriation for this line item. These adjustments include:

- an increase of $1,819 from prior-year adjustment for Salary Survey;
- an increase of $651 from prior-year adjustment for Performance-Based Pay;
- a reduction of $130 from Common Policy adjustment;
- a 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; and,
- a reduction of $24,362 from annualization of Supplemental Request NP S-21 "DHS – Purchase Contract Placement – Continuum of Care."

After the above adjustments, the Long Bill appropriation for FY 2009-10 totaled $1,614,799. Of that amount, the Personal Services component was $46,008, the Purchase of Contract Placement component was $1,535,455, and the Managed Care Pilot Project component was $33,336. The subsequent effect of NP ES-6 "DHS – Reclassification of Licensing Category of Ridgeview Youth Services Center for Medicaid Billing," which re-classified Ridgeview as a residential treatment center, was a Medicaid total fund increase of $412,083. Another budget-balancing measure was NP S-3 "DHS-Statewide Furlough Impact," which reduced total funding by $494. The FY 2009-10 Supplemental Bill (HB 10-1300) appropriated these changes, resulting in a $2,026,388 appropriation for this line item. Finally, late Supplemental Request NP S-8 "DHS-Caseload Adjustment for the Division for the Division of Youth Corrections Purchase of Contract Placements Appropriation" resulted in a reduction of $41,897 total funding,

which made the final appropriation for this line item $1,984,491 for FY 2009-10. Of this amount, $770,432 was General Fund and $1,214,059 was federal funds.

For FY 2010-11, the Long Bill appropriated $2,686,201 to this line item. Using the prior-year's appropriation of $1,984,491 as a base, the FY 2010-11 appropriation includes:

- an increase of $852 from annualization of FY 2009-10 Joint Budget Committee action of 1.82 Personal Services Cut;
- an increase of $494 from annualization FY 2009-10 NP S-3 "DHS-Statewide Furlough Impact";
- an increase of $576,917 from annualization of FY 2009-10 NP ES-6 "DHS-Reclassification of Licensing Category of Ridgeview Youth Corrections Center for Medicaid Billing";
- a reduction of $94,909 from Joint Budget Committee (JBC) staff recommendation to operate at $110% capacity;
- a reduction of $33,701 from NP-6 "DHS-Two Percent (2%) Community Provider Rate Base Decrease";
- a reduction of $990 from NP BA-4 "DHS-PERA Contribution Change"; and,
- an increase of $253,047 from NP BA-14 "DHS-Caseload Adjustment for the Division of Youth Corrections Purchase of Contract Placements Appropriation."

Of the $2,686,201 appropriated for this line item in the FY 2010-11 Long Bill (HB 10-1376), the Personal Services component was $45,870, the Purchase of Contract Placements component was $1,618,662, and the Managed Care Pilot Project component was $32,669.

During the FY 2010-11 Figure Setting process, in response to the Governor's Budget Balancing plan, the JBC adjusted the Department's appropriation to account for the enhanced FMAP specified in ARRA, section 5001(h)(3). The enhanced FMAP was originally set to expire December 31, 2010; however, the Department's FY 2010-11 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the assumption that Congress would pass legislation containing an extension. On August 5, 2010, the Senate passed HR 1586, which contained an extension of enhanced FMAP provisions for six months, to June 30, 2011, albeit at a lower rate. HR 1586 was passed by the House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, and the Department anticipated the FMAP rate for the 3rd quarter of FY 2010-11 at 58.77%, and the FMAP rate for the 4th quarter at 56.88%. The Department requested that its appropriations be adjusted to reflect the current expiration date of the enhanced FMAP in its FY 2010-11 ES-1, "Decrease Amount for Extended Enhanced Federal Medical Assistance Percentage." This request resulted in an increase in the General Fund appropriation of $48,760 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $459 pursuant to NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." The FY 2010-11 revised appropriation of $2,685,742 consists of $1,091,386 General Fund and $1,594,356 federal funds.

For FY 2011-12, the Department is requesting $2,691,626 for this line item. This amount is based upon the prior-year appropriation of $2,685,742, plus an increase of $990 from annualization of FY 2010-11 NP BA-4 "DHS-PERA Contribution," an increase of $459 from annualization of NP ES-3 "DHS- 1% Across the Board Personal Services Reduction," and an increase of $4,435 from a leap-year

adjustment. With the removal of the enhanced FMAP provided under ARRA, the base request consists of $1,345,815 General Fund and $1,312,811 federal funds.

## ***(J) 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 (JBC). An indirect cost is for a service that is provided for one department but used jointly by several divisions within the Department. As such, it is difficult to assign costs to a particular 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, including 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 single state agency for Medicaid is found in 25.5-4-104, C.R.S. (2010).

Federal regulations describe the requirements for federal indirect costs as listed in Appendix E of 2 CFR Part 225, A.1: "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 states that, "A State plan under Title XIX of the Social Security Act must provide that the single 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 (DHS) and $340,000 for Vehicle Lease Payments and Utilities in the Office of Operations at DHS. 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 DHS, 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 Department was appropriated $500,000 for this line item in FY 2008-09 through FY 2010-11. For FY 2011-12, the Department requests continuation funding of $500,000 for this line item.

**TRANSFER TO THE DEPARTMENT OF HUMAN SERVICES FOR RELATED ADMINISTRATION**
This line item continued through FY 2009-10 but was discontinued for FY 2010-11 because all information technology related Personal Services funding – including help desk functions – were transferred to the Governor's Office of Information Technology budget. This line item is no longer needed.

Previously, the Department had an Interagency Agreement with the Department of Human Services (DHS) to support, or at least partially support, 1.0 FTE to staff the Information Technology Help Desk. Funding contained only basic Personal Services salary items. DHS, through the Common Policy funding of benefits in the Executive Director's Office for General Administration, provided 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 DHS budget was 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 (CBMS) for the Medicaid Baby Care/Kids Care Program, the presumptive eligibility applications for Baby Care/Kids Care are now automated in CBMS. The help desk assisted with the manual process of presumptive eligibility applications for the Breast and Cervical Cancer Treatment Program in CBMS if the eligibility application could not be processed from a location that is a regular Medical Assistance site. In addition, to the help desk provided computer support for end users of the Colorado Financial Reporting System because the Department does not have full supervision of all end-user functions for the financial system.

Transfers to DHS related to this line item typically occurred quarterly, based on Interagency Transfer Requests that were processed by both departments after both departments had signed an Interagency Agreement that must be renewed and resigned each fiscal year. Likewise, DHS transferred the POTS funding to the Department on a quarterly basis, so that the Department could, in turn, transfer both the Personal Services payments along with the associated POTS payments back to DHS.

*Appropriation History*
This line item had the same appropriation of $74,564 from FY 2006-07 through FY 2009-10. No funding was provided for FY 2010-11. The Department requests no funding for this line in FY 2011-12.