Department of Health Care Policy and Financing
Line Item Description
FY 2012-13 Budget Request

November 1, 2011

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office section of the Department's budget contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contact funding for provider audits, eligibility determination, client and provider services, utilization and quality review, and information technology contacts. This division is divided into seven subdivisions. A description of each subdivision, the budget history, and the FY 2012-13 budget request amounts are presented below.

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, personal services, employee-related expenses and benefits, and operating expenses. This subdivision also contains funding for all of the centrally appropriated line items in the Department. A description of each line item, the budget history, and the FY 2012-13 budget request amounts are presented below.

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.

In the FY 2009-10 Long Bill (SB 09-259), the Department was appropriated $19,679,334 and 275.0 FTE. 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. The Department issued three Early Supplemental requests to reduce its FY 2009-10 Personal Services appropriation. 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 increased 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 included annualizations of the FY 2009-10 Long Bill, special bills, and other adjustments. As such, the total request was based on the FY 2009-10 appropriation of $20,767,444 and 287.6 FTE with the following adjustments:

- less $2,031 for FY 2009-10 ES-3 "Department Administrative Reductions";
- less $6,382 for FY 2009-10 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 FY 2009-10 BRI-2 "Medicaid Program Efficiencies";
- plus $11,596 for FY 2009-10 DI-6 "Medicaid Value-Based Care Coordination Initiative" and FY 2009-10 BA-38 "Revised Implementation of DI-6 Medicaid Value-Based Care Coordination Initiative";
- plus $5,284 and 0.1 FTE for FY 2009-10 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 FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform";
- 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 authorized pursuant to the Department's FY 2010-11 BA-5 "Accountable Care Collaborative"; 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 was reduced by $80,422 pursuant to FY 2010-11 NP ES-1 "1% Across the Board Personal Services Reduction." This brought the Department's final FY 2010-11 appropriation to $20,383,119 and 294.8 FTE. Of this amount, $7,538,461 was General Fund, $1,652,353 was cash funds, $520,127 was reappropriated funds, and $10,672,178 was federal funds.

For FY 2011-12, the Department's Long Bill appropriation was based on the prior-year appropriation of $20,383,119 and 294.8 FTE and included the following adjustments:

- plus $4,427 and 0.1 FTE for annualization of FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform";
- plus $39,900 for annualization of FY 2010-11 BA-5 "Accountable Care Collaborative";
- plus $80,422 for annualization of FY 2010-11 NP ES-1 "1% Across-the-Board Personal Services Reduction";

- plus $521,441 for annualization of FY 2010-11 NP BA-2 "Statewide PERA Adjustment";
- plus $932,351 and 15.7 FTE for annualization of HB 09-1293 "Health Care Affordability Act of 2009";
- plus $14,587 and 0.2 FTE for annualization of HB 10-1323 "Use of Tobacco Tax Master Settlement";
- plus $31,693 and 0.5 FTE for annualization of SB 10-061 "Medicaid Hospice Room and Board Charges";
- plus $10,246 for annualization of SB 10-167 "Medicaid Efficiency and False Claims";
- plus $90,345 and 0.9 FTE for FY 2011-12 DI-8 "Prenatal Plus Administration Transfer";
- less $331,628 for FY 2011-12 NP-1 "2% Across-the-Board Personal Services Reductions";
- removal of the cash funds appropriation from the Health Care Expansion Fund due to the deficit of the fund, with a corresponding increase in General Fund; and
- less $1,697 for FY 2011-12 JBC adjustment for DHS.

These adjustments brought the FY 2011-12 Long Bill (SB 11-209) appropriation to $21,775,206 and 312.2 FTE. Three pieces of legislation during the 2011 session further affected this line:
- less $508,843 for SB 11-076 "PERA Contribution Rates";
- plus $47,817 and 1.0 FTE for SB 11-177 "Repeal Sunset Teen Pregnancy and Dropout Program"; and,
- less $23,494 and 0.2 FTE for SB 11-216 "Children's Basic Health Plan General Fund Appropriation."

The year-to-date appropriation for this line in FY 2011-12 is $21,290,686 and 313.0 FTE, consisting of $7,675,241 General Fund, $1,974,533 cash funds, $448,289 reappropriated funds, and $11,192,623 federal funds.

The Department's FY 2012-13 base request is $21,847,209 and 313.5 FTE. This includes continuation funding of $21,290,686 and 313.0 FTE along with the following adjustments:
- plus $11,643 for annualization of FY 2011-12 DI-8 "Prenatal Plus Administration Transfer";
- plus $31,692 and 0.5 FTE for annualization of SB 10-061 "Medicaid Hospice room and Board Charges";
- plus $508,843 for annualization of SB 11-076 "PERA Contribution Rates"; and
- plus $4,345 for annualization of SB 11-177 "Repeal Sunset Teen Pregnancy and Dropout Program."

The Department's base request consists of $7,954,067 General Fund, $2,058,349 cash funds, $380,410 reappropriated funds, and $11,454,383 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 plus Dependant, Employee plus Spouse, etc.). Since FY 2005-06, the State has been increasing its portion 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.

For FY 2009-10, the Department's Long Bill (SB 09-259) 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 FY 2009-10 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, $38,965 reappropriated funds, and $737,015 federal funds.

The Department's FY 2010-11 Long Bill (HB 10-1376) appropriation for Health, Life, and Dental included continuation funding plus annualizations as well as Common Policy adjustments. Annualization of HB 09-1293 increased the FY 2010-11 appropriation by $297,102. The annualization of FY 2009-10 ES-4 "Reduce Funding for Indigent Care Programs" increased the appropriation by $465. A Common Policy adjustment and the transfer of the Department's information technology personnel reduced this appropriation by $130,711. Finally, the JBC reinstated $59,239 to the Department's FY 2010-11 appropriation that DPA had requested be reduced, for a total FY 2010-11 appropriation of $1,706,057, consisting of $611,752 General Fund, $205,744 cash funds, $15,219 reappropriated funds, and $873,342 federal funds.

For FY 2011-12, the Department's Long Bill (SB 11-209) appropriation was based on the prior-year appropriation of $1,706,057 with two adjustments. First, the line was increased by $27,384 from the annualization of HB 09-1293 "Health Care Affordability Act of 2009." Then, the line was increased by another $291,136 due to a Common Policy Adjustment. The adjustments brought the appropriation for this line in FY 2011-12 to $2,024,577, of which $627,749 is General Fund, $255,164 is cash funds, and $1,141,664 is federal funds.

For FY 2012-13, the Department requests $1,970,066, which includes continuation funding of $2,024,577 less $54,511 for a Common Policy Adjustment. This request includes $725,970 General Fund, $159,483 cash funds, $49,661 reappropriated funds, and $1,034,952 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 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 (JBC) (FY 2009-10 Figure Setting, March 18, 2009, page 66). This appropriation was reduced by FY 2009-10 ES-4 "Reduce Funding for Indigent Care Programs" by $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) and final appropriation was $26,138, of which $9,539 is General Fund, $2,174 is cash funds, $737 is reappropriated funds, and $13,688 is federal funds. This amount included annualizations of HB 09-1293, which removed $1,722 from the appropriation and FY 2009-10 NP S-2 "Statewide Furlough Impact," which added $844. The appropriation was reduced by $2,475 pursuant to FY 2010-11 NP-2 "Statewide Information Technology Staff Consolidation," and a Common Policy adjustment and the Department's FY 2010-11 NP BA-9 "Total Compensation Update" combined to add $5,035 to this line item.

For FY 2011-12, the Department's Long Bill (SB 11-209) appropriation was $32,206, which reflects continuation funding and a restoration of $10 removed in FY 2009-10 ES-4 "Reduce Funding for Indigent Care Programs" as well as FY 2011-12 Common Policy Adjustment that increased the line by $6,063 and an adjustment for FY 2011-12 Heath Care Expansion Fund Deficit that decreased the line by $5. Following the Long Bill appropriation, SB 11-216 "Children's Basic Health Plan General Fund Appropriation" further decreased this line by $18, bringing the FY 2011-12 appropriation to $32,188, of which $12,334 is General Fund, $2,503 is cash funds, and $17,351 is federal funds.

For FY 2012-13, the Department is requesting $39,128 for this line, which includes continuation funding plus a Common Policy adjustment of $6,940. This request consists of $15,826 General Fund, $2,957 cash funds, $629 reappropriated funds, and $19,716 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.

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 appropriation was reduced by $10,888 to account for the Statewide Furlough impact. Funding for this line was also reduced through FY 2009-10 ES-4 "Reduce Funding for Indigent Care Programs" by $135. Funding to cover the additional costs of $23,432 for implementing HB 09-1293 "Colorado Health Care Affordability Act" was subsequently added. 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 (JBC) (FY 2010-11 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%. This appropriation amount was based on the prior-year appropriation and includes the following adjustments:

- plus $37,589 for annualization of HB 09-1293 "Hospital Provider Fee";
- plus $10,888 for annualization of FY 2009-10 NP S-2 "Statewide Furlough Impact";
- less $38,314 for FY 2010-11 NP-2 "Statewide Information Technology Staff Consolidation";
- plus $9,555 for FY 2010-11 NP BA-9 "Total Compensation Update"; and,
- plus $52,638 for FY 2010-11 Common Policy Adjustment.

Of the $402,667 appropriated to this line in FY 2010-11, $145,650 is General Fund, $33,664 is cash funds, $11,411 is reappropriated funds, and $211,942 is federal funds.

For FY 2011-12, the Long Bill (SB 11-209) appropriated $533,397 to this line, which reflects continuation funding plus the following adjustments:

- plus $26,106 for annualization of HB 09-1293 "Colorado Health Care Affordability Act";
- plus $135 for annualization of HB 10-1323 "Use of Tobacco Tax Master Settlement"; and,
- plus $104,489 for FY 2011-12 Common Policy Adjustment.

SB 11-216 "Children's Basic Health Plan General Fund Appropriation" reduced this line by $543, bringing the FY 2011-12 appropriation to $532,854, of which $190,728 is General Fund, $53,148 is cash funds, and $288,978 is federal funds.

For FY 2012-13, the Department is requesting $707,419 for this line, which includes continuation funding plus $174,565 for a Common Policy Adjustment. Of this request, $286,121 is General Fund, $53,468 is cash funds, $11,380 is reappropriated funds, and $356,450 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.

The FY 2009-10 Long Bill appropriation of $197,328 was based on the Joint Budget Committee's (JBC) 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, which reduced the appropriation by $6,805. 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 as a result of FY 2009-10 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 Long Bill (HB 10-1376) and final appropriation of $292,544 was based on the prior-year appropriation of $205,654 and includes the following adjustments:

- plus $15,294 for annualization of HB 09-1293 "Health Care Affordability Act of 2009";
- plus $6,805 for annualization of FY 2009-10 NP S-2 "Statewide Furlough Impact";
- less $27,937 for FY 2010-11 NP-2 "Statewide Information Technology Staff Consolidation";
- plus $20,923 for FY 2010-11 NP BA-9 "Total Compensation Update"; and,
- plus $71,805 for FY 2010-11 Common Policy Adjustment.

Of the FY 2010-11 final appropriation of $292,544 for this line, $105,135 is General Fund, $24,547 is cash funds, $8,321 is reappropriated funds, and $154,541 is federal funds.

In FY 2011-12, the Long Bill (SB 11-209) appropriated $427,633 to this line. This amount was calculated using the prior-year appropriation as a base with the following adjustments:

- plus $20,978 for annualization of HB 09-1293 "Health Care Affordability Act of 2009";
- plus $85 for annualization of HB 10-1323 "Use of Tobacco Tax Master Settlement"; and
- plus $114,026 for FY 2011-12 Common Policy Adjustment.

SB 11-216 "Children's Basic Health Plan General Fund Appropriation" further adjusted this line by reducing it by $308 to bring the final FY 2011-12 appropriation to $427,325, consisting of $151,785 General Fund, $42,482 cash funds, and $233,058 federal funds.

For FY 2012-13, the Department is requesting $607,938 for this line, including continuation funding plus a Common Policy Adjustment of $180,613. This request consists of $245,885 General Fund, $45,949 cash funds, $9,780 reappropriated funds, and $306,324 federal funds.

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 2009-10 final appropriation of $34,252 was based on the Common Policy approved by the Joint Budget Committee (JBC) 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 Long Bill (SB 11-209) appropriated $29,652 to this line, which includes a reduction from the prior-year appropriation in the amount of $5,096 for Common Policy Adjustment. Of the $29,652 appropriated in FY 2011-12, $14,826 is General Fund and an equal amount is federal funds.

For FY 2012-13, the Department is requesting $33,584 for this line, which includes an increase of $3,932 from the prior-year appropriation for Common Policy Adjustment. This funding request amount is evenly split between General Fund and federal funds.

OPERATING EXPENSES

In addition to funding office supplies and furniture costs associated with the Department's staff, this line 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, and subscriptions to federal publications. 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 JBC 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 JBC consolidated the line item for the Single Entry Point Administration into the Operating Expenses line item.

The FY 2009-10 Long Bill (SB 09-259) appropriated $1,511,489 for this line. Subsequently, there were impacts to this line from approved budget requests 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 adjustments resulted 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 (HB 10-1376) appropriation was $1,587,445 which is based on the prior-year 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 "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 FY 2009-10 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 final FY 2010-11 appropriation to $1,626,785. This appropriation was composed of $680,628 General Fund, $120,297 cash funds, $13,461 reappropriated funds, and $812,399 federal funds.

For FY 2011-12, the Long Bill (SB 11-209) appropriated $1,508,579 to this line. This amount is based on the prior-year appropriation as well as the following adjustments:
- less $29,237 from annualization of HB 09-1293 "Health Care Affordability Act of 2009";
- plus $475 from annualization of SB 10-061 "Medicaid Hospice Room-and-Board Charges";
- less $32,690 from annualization of SB 10-167 "Medicaid Efficiency and False Claims";
- less $4,670 from annualization of FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform";
- plus $21,104 from FY 2011-12 DI-8 "Prenatal Plus Administration Transfer"; and,
- less $1,188 from FY 2011-12 BA-5 "School-Based Health Program Refinancing."

SB 11-177 "Repeal Sunset Teen Pregnancy and Dropout Program" further affected this line by adding $5,653, which brings the FY 2011-12 appropriation to $1,586,232, of which $679,994 is General Fund, $101,248 is cash funds, $13,461 is reappropriated funds, and $791,529 is federal funds.

For FY 2012-13, the Department is requesting $1,546,560 for this line. This amount is based on the prior-year appropriation of $1,586,232 along with the following adjustments:
- plus $69,140 from annualization of FY 2010-11 BA-17 "General Operating Expenses Reduction":
- less $10,086 from annualization of FY 2011-12 DI-8 "Prenatal Plus Administration Transfer";
- less $96,398 from annualization of HB 09-1293 "Health Care Affordability Act of 2009";
- plus $2,375 from annualization of SB 10-061 "Medicaid Hospice Room-and-Board Charges"; and
- less $4,703 from annualization of SB 11-177 "Repeal Sunset Teen Pregnancy and Dropout Program."

Of the FY 2012-13 requested amount of $1,546,560, $708,357 is General Fund, $53,049 is cash funds, $13,461 is reappropriated funds, and $771,693 is 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.

For FY 2009-10, the Department was 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 FY 2009-10 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 plus $59,864 for the annualization of HB 09-1293 and a reduction of $23,924 for a FY 2010-11 Common Policy adjustment. This appropriation included $337,174 General Fund, $99,121 cash funds, and $436,295 federal funds.

In FY 2011-12, the Long Bill (SB 11-209) appropriated $956,823 to this line. This amounts is based on the FY 2010-11 appropriation plus $54,654 for annualization of HB 09-1293 "Health Care Affordability Act of 2009" and $29,579 for FY 2011-12 Common Policy Adjustment. Of the appropriated $956,823, $347,930 is General Fund, $130,482 is cash funds, and $478,411 is federal funds.

For FY 2012-13, the Department is requesting $1,029,055 for this line, which is calculated using the prior-year appropriation as the base in addition to $72,232 for annualization of HB 09-1293 "Health Care Affordability Act of 2009." The requested amount consists of $347,930 General Fund, $166,598 cash funds, and $514,527 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 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 $43,154 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 FY 2011-12 Long Bill (SB 11-209) appropriated $422,830 to this line. This amount reflects continuation funding of $442,378, plus $26,120 for an annualization of HB 09-1293 "Health Care Affordability Act of 2009" and less $45,668 for Common Policy Adjustment. This appropriation includes $186,717 General Fund, $24,698 cash funds, and $211,415 federal funds.

For FY 2012-13, the Department is requesting $536,111 for this line. This amount is based upon the prior-year appropriation plus $41,602 for annualization of HB 09-1293 "Health Care Affordability Act of 2009" and $71,679 for Common Policy Adjustment. The requested amount is comprised of $222,557 General Fund, $45,499 cash funds, and $268,055 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 2009-10 Long Bill appropriation of $135,103 was reduced through FY 2009-10 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 Long Bill (SB 11-209) appropriated $835,843 to this line, which is based on the prior-year appropriation plus $537,419 for Common Policy Adjustment and $38 for a Long Bill Adjustment. Of the appropriated amount, $414,566 is General Fund, $3,375 is reappropriated funds, and $417,902 is federal funds.

For FY 2012-13, the Department is requesting $1,021,717 for this line, based on the prior-year appropriation plus $185,874 for Common Policy Adjustment. The requested amount includes $509,171 General Fund, $3,375 reappropriated funds, and $509,171 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 Long Bill (SB 11-209) appropriated $227,900 to this line and reflects a Common Policy adjustment of $28,462, issued by the Governor's Office of Information Technology on September 1, 2010, to the prior-year appropriation. This amount is composed of $113,950 General Fund and $113,950 federal funds.

For FY 2012-13, the Department is requesting $231,333 for this line, which reflects an increase of $3,433 for Common Policy Adjustment over the prior-year appropriation. This requested amount consists of $115,667 General Fund and $115,666 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. 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 2009-10, the Long Bill (SB 09-259) appropriated $482,756. However, due to an economic downturn, the Department submitted an Early Supplemental for a 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 continuation funding plus $209,859 from 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 Long Bill (SB 11-209) appropriated $631,234 to this line, which reflects the prior-year appropriation plus $7,054 for Common Policy Adjustment. This appropriation includes $315,617 General Fund and an equal amount of federal funds.

For FY 2012-13, the Department is requesting $0 for this line due to a Common Policy Adjustment. The Department has overpaid in previous years and is utilizing a credit balance in FY 2012-13 to cover its costs associated with the management and administration of OIT. The Department anticipates that this credit balance will be utilized in FY 2012-13 and that it will request funding for this line item in FY 2013-14.

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.

For the FY 2009-10 appropriation, a Common Policy adjustment of $11,193 increased the appropriation to $83,182 but was reduced through FY 2009-10 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 Long Bill (SB 11-209) appropriated $77,888 to this line, including $53,470 from Common Policy Adjustment added to the prior-year appropriation amount. Of the $77,888, $38,944 is General Fund and an equal amount is federal funds.

For FY 2012-13, the Department is requesting $84,315 for this line. The request amount is based on an increase of $6,427 for Common Policy Adjustment over the prior year appropriation and consists of $42,158 General Fund and $42,157 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).

The FY 2009-10 appropriation reflected continued funding of $394,236 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 was $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 Long Bill (SB 11-209) appropriated continuation funding in the amount of $696,564 to this line, comprised of $191,619 General Fund, $156,664 cash funds, and $348,281 federal funds.

For this line in FY 2012-13, the Department is requesting continuation funding 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 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 FY 2009-10 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 Long Bill (HB 10-1376) appropriation to $388,228, including $194,144 General Fund and $194,144 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $397,928 to this line, due to continuation funding from the prior-year appropriation plus $9,700 for Common Policy Adjustment. This amount consists of $198,964 General Fund and an equal amount of federal funds.

For FY 2012-13, the Department is requesting $459,407, comprised of $229,704 General Fund and $229,703 federal funds, for this line item. This amount is calculated using the prior-year appropriation as the base plus $61,479 for Common Policy Adjustment.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in 2008 and 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 FY 2009-10 Long Bill (SB 09-259) appropriation was $3,384,105. The following subsequent adjustments were applied to this line in FY 2009-10 contained within the FY 2009-10 Supplemental Bill (HB 10-1300):

- plus $20,000 for FY 2009-10 ES-2 "Medicaid Program Reductions";
- less $125,000 for FY 2009-10 S-6 "Accountable Care Collaborative"; and
- plus $26,695 for FY 2009-10 NP S-2 "Statewide Furlough Impact."

In the FY 2010-11 Long Bill (HB 10-1376) Add-Ons, $150,000 was added to this line through a JBC Staff Recommendation titled "Move Admin Costs for Nursing Facility Pay-for-Performance Evaluation." The following adjustments were also made to the line through 2009 legislative measures:

- plus $53,480 from HB 09-1047 "Alternative Therapies for Persons with Disabilities";
- plus $52,500 from HB 09-1073 "Electronic Prescriptions";
- plus $200,000 from HB 09-1196 "Nursing Facility Penalty Cash Fund"; and,
- plus $421,850 from HB 09-1293 "Colorado Health Care Affordability Act."

The final FY 2009-10 appropriation was $4,183,630 for this line. This amount consists of $1,304,994 of General Fund, $812,175 in cash funds, and $2,066,461 in federal funds.

For FY 2010-11, annualization of approved legislation, change requests, and supplemental requests associated with the economic downturn brought the Department's FY 2010-11 Long Bill (HB 10-1376) appropriation to $4,316,995. This amount 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";
- less $115,000 through the annualization HB 09-1196 "Nursing Facility Penalty Cash Fund";
- 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 Department's FY 2010-11 Long Bill appropriation to $4,316,995. The following 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.

The FY 2011-12 Long Bill (SB 11-209) appropriated $6,422,552 to this line. This amount reflects the prior-year appropriation in addition to 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";
- less $92,570 through the annualization of SB 10-061 "Room & Board in a Hospice Inpatient Facility";
- plus $2,000,000 from FY 2011-12 BA-8 "ARRA HITECH Provider Incentive Payments"; and,
- less $79,443 from FY 2011-12 NP BA-7 "Statewide 1% General Fund Reduction to Personal Services/Operating."

Two pieces of legislation further affected the FY 2011-12 appropriation to this line: HB 11-1242 "Medicaid Provider Integration of Service" added $113,500 and SB 11-125 "Nursing Home Fees and Order of Payments" added $60,000. As a result, the FY 2011-12 appropriation for this line totals $6,596,052, of which $1,430,918 is General Fund, $721,750 is cash funds, and $4,443,384 is federal funds.

For FY 2012-13, the Department is requesting $6,410,052 for this line. This amount is based on the prior-year appropriation along with the following adjustments:
- plus $112,500 for annualization of FY 2010-11 BA-13 "Coordinated Payment and Payment Reform";
- less $150,000 for annualization of the First Conference Committee Report on SB 09-259 for the Council for Affordable Health Insurance (CAHI);
- less $25,000 for annualization of HB 10-1027 "Medicaid Hospice Life Expectancy";
- less $10,000 for annualization of SB 10-061 "Medicaid Hospice Room-and-Board Charges"; and,
- less $113,500 for annualization of HB 11-1242 "Medicaid Provider Integration of Service."

Of the requested amount, $1,487,168 is General Fund, $497,500 is cash funds, and $4,425,384 is 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. 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. While the DPHE FTE is working in the field to survey and inspect the facilities, that FTE qualifies for 75% federal financial participation. After the FTE returns to the office to complete the paperwork associated with the inspection, the FTE time in the office qualifies for 50% federal financial participation. The FTE uses a time reporting sheet that details how each hour of work is spent, so that Medicare and Medicaid funding can be claimed as applicable.

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 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. FY 2009-10 NP S-4 "DPHE – Statewide Furlough Impact" added $9,970 total funds as approved by Joint Budget Committee (JBC) and included in the FY 2009-10 Supplemental Bill (HB 10-1300) for final 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.

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 was 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 a 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 final FY 2010-11 appropriation was $4,880,998, consisting of $1,462,495 General Fund and $3,418,503 federal funds.

To arrive at the $5,024,611 appropriation in the FY 2011-12 Long Bill (SB 11-209), the following adjustments were made to the prior-year appropriation of $4,880,990:

- annualize FY 2010-11 NP BA-3: "DPHE – Statewide PERA Adjustment" for an increase of $76,394;
- annualize FY 2010-11 NP ES-2: "DPHE – 1% Across The Board Personal Services Reduction" for an increase of $36,092;
- apply 1.5% reduction approved by the JBC for a decrease of $75,863; and,
- adjust for a different fund split allocation used in the JBC Figure Setting for DPHE for an increase of $106,990.

The resulting FY 2011-12 Long Bill SB 11-209 appropriation was $5,024,611, consisting of $1,567,498 General Fund and $3,457,113 federal funds. However, further budget balancing occurred with SB 11-076 "PERA Contribution Rates" for a reduction of $79,170. The FY 2011-12 year-to-date appropriation is $4,945,441, consisting of $1,539,788 General Fund and $3,405,653 federal funds.

For FY 2012-13, the Department's base request includes the annualization of SB 11-076 "PERA Contribution Rates" for an increase of $79,170 total funds, an increase of $17,554 for a Common Policy adjustment, as well as realigning the federal allocation for this line item resulting in an increase of $190,518 total funds with a decrease of $3,567 General Fund and an increase of $194,085 federal funds. The total base request for FY 2012-13 is $5,232,683, comprised of $1,572,708 General Fund and $3,659,975 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. The overall goal of the program is to serve all low-income, first-time mothers who want to participate.

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.

During FY 2009-10, the program served 3,679 total families. Data for FY 2010-11 will not be available until a report is finished near the end of calendar year 2011. 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 human/social services, or other governmental agencies.

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 additional 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 Joint Budget Committee (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. 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 expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $56,688 with a corresponding decrease in the federal funds appropriation. The final FY 2010-11 appropriation was $3,010,000, consisting of $1,212,729 reappropriated funds and $1,797,271 federal funds.

For FY 2011-12, the Department's Long Bill (SB 11-209) appropriation for this line item was $3,010,000, consisting of $1,505,000 reappropriated funds and, due to the expiration of ARRA, $1,505,000 federal funds.

For FY 2012-13, the Department requests continuation funding of $3,010,000, with $1,505,000 reappropriated funds and matching 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 services 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 1,895. Data for FY 2010-11 will not be available until near the end of calendar year 2011. 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 was managed by DPHE prior to FY 2011-12, within which the transferred funds were spread across a number of different lines, including Health Statistics and Vital Records, Information Technology Services, Prevention Services Division, and Women's Health.

The FY 2009-10 Long Bill (SB 09-259) appropriated $119,006 to this line item, including $58,752 General Fund and $60,254 federal funds. In the Department's 2010 Figure Setting, the Joint Budget Committee (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 final FY 2009-10 appropriation was $118,227, consisting of $58,362 General Fund and $59,865 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation was $118,227, consisting of $58,362 General Fund and $59,865 federal funds.

For FY 2011-12, the Long Bill (SB 11-209) appropriated funding of $119,006 total funds, which includes continuation funding plus the annualization of NP ES-2 "CDPHE- 1% Across the Board Personal Services Reduction." This appropriation includes $58,752 General Fund and $60,254 federal funds.

Since FY 2009-10, the Department and DPHE had been discussing the possibility of transferring this program to the Department for oversight and management, as the program is operated entirely for Medicaid clients. The Department requested this action be taken in its FY 2011-12 DI-8 "Prenatal Plus Administration Transfer." Management of the program by the Department would no longer require that funding be transferred to another department, so the funding for the administration of the program was requested to be divided between the Department's Personal Services and Operating Expenses line items. The JBC approved this decision item as requested, which eliminates this line item effective FY 2011-12.

TRANSFER TO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT FOR PRENATAL STATISTICAL INFORMATION

The Department requires statistical data to evaluate the effectiveness of the Prenatal Plus program that used to be managed by DPHE but is now managed by the Department effective FY 2011-12. DPHE had been measuring the effectiveness of the program by using data supplied by the DPHE Vital Statistics office. The departments determined that it would be more cost-effective to continue to use the Vital Statistics data rather than to create a new tracking system for this purpose, so $6,000 was allocated to reimburse DPHE for this purpose. This line item was newly established as a result of FY 2011-12 DI-8 "Prenatal Plus Administration Transfer." See the above line item for more information. The funding of $6,000 total funds for this purpose has 50% federal financial participation, with $3,000 General Fund and $3,000 federal funds as reflected in the FY 2011-12 Long Bill (SB 11-209).

The Department's base request for FY 2012-13 is continuation funding less $90 for a Common Policy adjustment. Of the $5,910 total funds requested, $2,955 is General Fund and $2,955 is 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., 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.

The FY 2009-10 Long Bill (SB 09-259) provided total funding of $325,343 for this line item, including $148,020 General Fund, $14,652 reappropriated funds from DORA, and $162,671 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated continuation funding of $325,343 to this line item. As part of budget balancing measures, FY 2011-12 NP-7 "DORA – 2% Across the Board Personal Services Reduction" decreased the appropriation by $1,302 total funds. The final FY 2010-11 appropriation was $324,041 total funds, including $147,369 General Fund, $14,652 reappropriated funds, and $162,020 federal funds.

Continuation funding of $324,041 is the base request for FY 2012-13, consisting of $147,369 General Fund, $14,652 reappropriated funds, and $162,020 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.

The FY 2009-10 Long Bill (SB 09-259) appropriated $14,000 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 was $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 was a combination of $6,500 General Fund, $500 local funds, and $7,000 federal funds.

For FY 2011-12, the Department received 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 Change Requests. In the FY 2011-12 Long Bill (SB 11-209), $14,000 total funding was appropriated, with

$7,000 being General Fund and $7,000 federal funding. No cash funds were included because local grants that previously provided $500 of funding were no longer available.

For FY 2012-13, the Department requests continuation funding of $14,000, comprised of $7,000 General Fund and $7,000 federal funds, for any reviews needed of the Department's programs.

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.

The FY 2009-10 Long Bill (SB 09-259) appropriation for this line item was $211,312 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 final FY 2009-10 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.

The FY 2011-12 appropriation include various changes to this line item. The previous year appropriation was reduced by $2,074 to eliminate a discrepancy between the Department's and the Department of Education's appropriations. The annualization of the FY 2010-11 PERA Common Policy adjustment for the Department of Education increased this line item by $1,685. Finally, the Department's FY 2011-12 BA-5 "School Based Health Program Refinancing" reduced the appropriation to this line item by $7,926. These changes brought the FY 2011-12 Long Bill (SB 11-209) appropriation for this line item to $142,073 total funds, comprised entirely of federal funds. SB 11-076 "PERA Contribution Rates" reduced the appropriation by $1,685, bringing the Department's FY 2011-12 year-to-date appropriation for this line item to $140,388 federal funds.

For the FY 2012-13 base, the Department requests an appropriation of $149,999 federal funds, which includes increases totaling $9,611 for the annualizations of FY 2011-12 BA-5 "School Based Health Program Refinancing" and SB 11-076 "PERA Contribution Rates."

(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 appropriations of $34,342,453 in total funds, comprised of $6,037,537 General Fund, $2,433,429 cash funds, $100,328 reappropriated funds, and $25,771,159 federal funds. Of this total amount, $33,679,039 was for the MMIIS contract budget item and $663,414 was for the HIPAA Web Portal Maintenance budget item. Roll forward authorization for $4,558,925 total funds was provided in the Department's FY 2010-11 Supplemental Bill (SB 11-139, footnote 7b) for the expenditure of funds appropriated to FY 2010-11 in FY 2011-12. Of the total roll forward amount, $487,762 is General Fund, $271,905 is cash funds, and $3,799,259 is federal funds.

For FY 2011-12, the Department was appropriated $32,412,990 for this line item in the FY 2011-12 Long Bill (SB 11-209): $31,749,576 for MMIS Contract and $663,414 for HIPAA Web Portal. Of the total appropriated amount, $6,581,901 is General Fund, $1,479,670 is cash funds, $100,328 is reappropriated funds, and $24,251,091 is federal funds.

For FY 2012-13, the Department is requesting $31,767,217 total funds for this line item: $31,103,803 for MMIS Contract and $663,414 for Provider Web Portal. Of the total request amount, $6,459,471 is General Fund, $1,698,513 is cash funds, $100,328 is reappropriated funds, and $23,508,905 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.

The FY 2009-10 Long Bill (SB 09-259) appropriation for the MMIS contract 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 for the MMIS contract.

The FY 2010-11 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: $347,760 total funds for the Accountable Care Collaborative; $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, $16,380 total funds for "Pharmacy Technical and Pricing Efficiencies" requested under FY 2009-10 BRI-1 "Pharmacy Technical and Pricing Efficiencies." 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 FY 2010-11 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 pursuant to FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform";
- Funding of $269,528 for an annual MMIS cost adjustment pursuant to FY 2010-11 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 pursuant to FY 2010-11 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 pursuant to FY 2010-11 BRI-1 "Prevention and Benefits for Enhanced Value (P-BEV)" and FY 2010-11 BA-12 "Evidence Guided Utilization Review (EGUR)."

Subsequently, additional funding was appropriated from SB 10-167 "Medicaid Efficiencies Act" in the amount of $430,587. The final FY 2010-11 appropriation for this budget item was $33,679,039 total funds.

For the FY 2011-12 Long Bill (SB 11-209), adjustments removed one-time funding for FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform," FY 2010-11 BRI-3 "State Maximum Allowable Cost," and FY 2010-11 BA-5 "Accountable Care Collaborative," which resulted in reduction totaling $300,636. The annualizations of FY 2010-11 BA-12 "Evidence-Guided Utilization Reform" and

BA-15 "MMIS Adjustments" resulted in a funding increase of $785,259 total funds. The annualizations of HB 09-1293 "Hospital Provider Fee" and SB 10-167 "Medicaid Efficiencies Act" decreased the appropriation by $2,810,986.

Additional funding was appropriated funding to MMIS contract for FY 2011-12 pursuant to the following Department requests: $207,900 to expand the Client Overutilization Program as requested in FY 2011-12 BRI-1 "Client Overutilization Program"; and, $189,000 to implement budget reductions approved in FY 2011-12 BRI-5 "Medicaid Reductions."

The FY 2011-12 Long Bill appropriation for the MMIS contract is $31,749,576 total funds.

For the FY 2012-13 base request, one-time funding is removed for FY 2011-12 BRI-1 "Client Overutilization Program" and FY 2011-12 BRI-5 "Medicaid Reductions," totaling $396,900. In addition, the annualization of FY 2010-11 BA-15 "MMIS Adjustments" reduces the base request by $1,064,400. The annualizations of HB 09-1293 "Hospital Provider Fee" and SB 10-061 "Medicaid Hospice Room and Board Charges" result in increases of $801,667 total funds. Additional funding totaling $13,860 was appropriated from SB 11-008 "Medicaid Eligibility for Children" and SB 11-250 "Pregnant Women Medicaid Eligibility." The Department's base request for the MMIS contract is $31,103,803 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.

The FY 2009-10 Long Bill (SB 09-259) for the provider web portal was $663,414 total funds. The Department received continuing appropriations in FY 2010-11 and FY 2011-12, and requests continuation funding in the amount of $663,414 total funds for FY 2012-13.

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.

Beginning in FY 2009-10, the Department was appropriated $250,000 total funds 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). Thus, this appropriation consists of $62,500 General Fund and $187,500 federal funds. These costs are offset by savings in the Medical Services Premiums line item from increased recoupment and recovery efforts. The Department received continuing appropriations in FY 2010-11 and FY 2011-12, and requests continuation funding in the amount of $250,000 in total funds for FY 2012-13. Of the total amount, $62,500 is General Fund and $187,500 is federal funds.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill (HB 08-1375) for the implementation and administration of a centralized eligibility vendor model. The Blue Ribbon Commission for Health Care Reform (the "208 Commission") was created to study and establish health care reform models for expanding coverage – especially for the underinsured and uninsured – and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal 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 allowed the Department to continue working towards improvements that are a necessary building block to allow for coverage of more eligible, but not yet enrolled, Coloradans 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 the Children's Basic Health Plan costs, 88% of the total funds receive a 50% federal match and 12% of the totals funds receive a 65% federal match pursuant to the Department's agreement with the Centers for Medicare and Medicaid Services for Children's Basic Health Plan administration. All Medicaid related costs receive a 50% federal match.

For FY 2010-11, the Department was appropriated $760,000 total funds from HB 09-1293, which included $366,320 from the Hospital Provider Fee Cash Fund and $393,680 federal funds. This appropriation was for any necessary contract amendments for increased application or call volume resulting from the eligibility increase in the Children's Basic Health Plan to 250% of the federal poverty level pursuant to HB 09-1293.

For FY 2011-12, the Department was appropriated $2,221,482 total funds in the FY 2011-12 Long Bill (SB 11-209) pursuant HB 09-1293 "Colorado Health Care Affordability Act." This total includes $964,169 from the Hospital Provider Fee Cash Fund and $1,257,313 federal funds. The Department's appropriation includes additional funding for increased caseload from the expansion of the Children's Basic Health Plan. In addition, the appropriation includes additional funding for Medicaid Buy-In Program for Working Adults with Disabilities and the Adults without Dependent Children (AwDC) programs, anticipated which are both scheduled to be implemented March 2012. It also includes funding for the Medicaid Disabled Buy-In Program for Children, which is anticipated to be implemented approximately four to six months later.

The Department's base request for FY 2012-13 is $4,584,648 total funds, with $2,129,467 from the Hospital Provider Fee Cash Fund and $2,455,181 federal funds. This includes continuation funding plus an annualization of $2,363,166 for increased caseloads from the expansion populations created by HB 09-1293.

(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 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, $1,593 reappropriated funds, and $61,204 federal funds.

In FY 2010-11, the Department was appropriated $120,000 total funds through the Long Bill (HB 10-1376), which included a decrease of $4,000 from the FY 2009-10 appropriation for the annualization of HB 09-1293. 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 2011-12, the Department was appropriated $120,000 total funds through the Long Bill (SB 11-209). This appropriation consists of $59,203 General Fund, $1,593 reappropriated funds, and $59,204 federal funds. The cash fund allocation of $10,759 was appropriated as General Fund in FY 2011-12 due to the insolvency of the Health Care Expansion Fund.

For FY 2012-13, the Department requests continuation funding of $120,000 total funds. This base request consists of $59,203 General Fund, $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. In FY 2009-10, School District Eligibility Determinations was eliminated pursuant to the Department's FY 2009-10 ES-3 "Department Administrative Reductions" and 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 is comprised of $828,091 General Fund, $1,542,200 cash funds, and $2,862,811 federal funds. Of this total amount, $1,173,662 is for Disability Determination Services, $985,040 is for Nursing Facility Preadmission Screening and Resident Review, and $3,074,400 is for Hospital Outstationing.

This line item received an appropriation of $7,761,238 in total funds through the FY 2011-12 Long Bill (SB 11-209), which is comprised of $828,091 General Fund, $2,806,268 cash funds, and $4,126,879 federal funds. Of this total amount, $3,701,798 is for Disability Determination Services, $985,040 is for Nursing Facility Preadmission Screening and Resident Review, and $3,074,400 is for Hospital Outstationing.

The Department's FY 2012-13 Base Request for (D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations is for funding of $7,761,238 in total funds for all four functions described below. Of this total amount, $3,701,798 is for Disability Determination Services, $985,040 is for Nursing Facility Preadmission Screening and Resident Review, and $3,074,400 is for Hospital Outstationing.

<u>DISABILITY DETERMINATION SERVICES</u>

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 appropriation includes an increase of $2,528,136 to this line item, bringing the total FY 2011-12 appropriation to $3,701,798. The appropriation consists of $581,831 General Fund, $1,269,068 cash funds, and $1,850,899 federal funds.

For FY 2012-13 the Department's total fund base request is $3,701,798; of this amount, $581,831 is General Fund, $5,000 is cash funds from Colorado Autism Treatment Fund, $1,264,068 is cash fund from the Hospital Provider Fee Cash Fund, and $1,850,899 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 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 and FY 2011-12, including $246,260 General Fund and $738,780 federal funds.

For FY 2012-13, 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. 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.

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 FY 2010-11 appropriation was $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.

In FY 2011-12, this line was appropriated $3,074,400, comprised of $1,537,200 cash funds and an equal amount of federal funds.

For FY 2012-13, the Department requests continuation funding in the amount of $3,074,400, of which $1,537,200 is cash funds from the Hospital Provider Fee Cash Fund and $1,537,200 is federal funds.

COUNTY ADMINISTRATION

This line item provides for partial reimbursement to local county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to July 1, 2006, this funding was included in the Department of Human Services (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. in order to maximize Medicaid reimbursement to the counties, thereby maximizing reimbursement of county expenditures.

The FY 2009-10 Long Bill (SB 09-259) appropriated $30,986,377 for this line item, including $9,794,550 General Fund, $5,738,771 cash funds, and $15,453,056 federal funds. HB 09-1293 "Colorado Health Care Affordability Act" appropriated an additional $730,864 for this line item, 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 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 three different types of matches resulting from participating States submitting demographic information on public assistance clients for the purposes of identifying individuals receiving Medicaid services in multiple 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 was $33,058,207, consisting of $9,894,550 General Fund, $6,674,686 cash funds, and $16,488,971 federal funds.

In order to maximize county reimbursement for FY 2010-11, a General Fund transfer was made from the Department to DHS in the amount of $693,496. 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 FY 2010-11 final expenditure for FY 2010-11 was $31,110,742.

The FY 2011-12 Long Bill (SB 11-209) appropriated $33,547,878 for this line item. This appropriation includes an annualization of $489,637 from HB 09-1293 "Colorado Health Care Affordability Act" to fund increased caseload. In addition, the cash fund appropriation of $406,240 from the Health Care Expansion Fund available in FY 2009-10 and FY 2010-11 was removed from the appropriation and replaced with General Fund due to the insolvency of the Fund. The FY 2011-12 appropriation is $33,547,878, consisting of $10,300,790 General Fund, $6,513,282 cash funds, and $16,733,806 federal funds.

For FY 2012-13, the Department is requesting continuation funding plus adjustments for two special bills. SB 11-008 "Medicaid Eligibility for Children" adds $241,325 to this line item for the maintenance of cases of clients moving from the Children's Basic Health Plan to Medicaid due to an increase in Medicaid eligibility, which will cause an increase in the volume of cases processed by

counties. In addition, there is an annualization of $219,570 from HB 09-1293 to fund increased caseload. The Department's base request for FY 2012-13 is $34,008,773, which includes $10,373,188 General Fund, $6,671,332 cash funds, and $16,964,253 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. As a result of guidance received from CMS in 2008 around which case management activities were eligible for Medicaid reimbursement, the Department's total appropriation for FY 2008-09 was reduced to $539,743. Administrative Case Management activities include completing or assisting in the Medicaid eligibility process for a child and/or their family. Case management services reimbursed by the Department do not include payment for the provision of direct services such as medical, educational, or social to which the individual is referred.

The FY 2009-10 Long Bill (SB 09-259) 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 included $434,872 General Fund and $434,872 federal funds. In FY 2010-11, a General Fund transfer was made from DHS to the Department in the amount of $208,500 in order to maximize federal funds and county reimbursement, for a total spending authority of $1,286,744 for this line. Total expenditures in FY 2010-11 were $1,115,944, and, at the end of FY 2010-11, a General Fund transfer was made back to DHS in the amount of $85,400. This transfer allowed DHS to cover more of the county expenditures related to their programs.

The FY 2011-12 Long Bill (SB 11-209) appropriated $869,744 for this line item, which included $434,872 General Fund and matching federal funds.

For FY 2012-13, 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."

The final FY 2010-11 appropriation to this line item was $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, $2,468,383 was for the Early and Periodic Screening, Diagnosis, and Treatment Program and $1,479,215 was for Enrollment Broker functions.

As a result of the FY 2011-12 Long Bill (SB 11-209), this line item was appropriated $5,213,157 in total funds, of which $2,550,470 was General Fund, $56,109 was cash funds, and $2,606,578 was federal funds. Of the total amount for the line, $2,479,343 was for the Early and Periodic Screening, Diagnosis, and Treatment Program and $2,733,814 was for Enrollment Broker functions.

The Department's FY 2012-13 Base Request for (D) Eligibility Determinations and Client Services: Customer Outreach is $4,895,961 in total funds, including $2,376,649 General Fund, $71,333 cash funds, and $2,447,979 federal funds. Of this total, $2,529,645 is for the Early and Periodic Screening, Diagnosis, and Treatment Program and $2,366,316 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 Medical Services Premiums Long Bill group.

The FY 2009-10 and FY 2010-11 appropriation for EPSDT was $2,468,383 total fund, comprised of $1,234,192 General Fund and $1,234,191 federal funds.

The Department's FY 2011-12 appropriation for EPSDT is $2,479,343, which includes continuation funding of $2,468,383 from the prior year plus $10,960 for the annualization of HB 09-1293 "Colorado Health Care Affordability Act". The appropriation includes $1,234,192 General Fund, $5,480 cash funds from the Hospital Provider Fee Cash Fund, and $1,239,671 federal funds.

The Department requests $2,529,645 for FY 2012-13, which includes continuation funding of $2,479,343 from the prior year, plus $21,326 from the annualization of HB 09-1293 "Colorado Health Care Affordability Act," and $28,976 from SB 11-008 "Medicaid

Eligibility for Children." The base request is comprised of $1,248,680 General Fund, $16,143 cash funds from the Hospital Provider Fee Cash Fund, and $1,264,822 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 2010-11, MAXIMUS, Inc. enrolled 124,183 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. Total letters mailed were 251,373. MAXIMUS, Inc. also handled 22,773 disenrollments, which does not include clients disenrolling due to loss of eligibility, change in eligibility, or health plan closure. In addition, 65,048 calls were received in FY 2010-11, with an average wait time of 70 seconds.

In FY 2009-10, the Department's appropriation for this budget item was $1,104,618 through the Long Bill (SB 09-259). 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 final FY 2009-10 appropriation of $1,140,970 the for Enrollment Broker, $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 $1,479,215 for the Enrollment Broker budget 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 $296,293 for the 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 (JBC) 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 $1,479,215 appropriated for Enrollment Broker in FY 2010-11, $665,841 was General Fund, $40,252 was cash funds from the Hospital Provider Fee Cash Fund, $33,514 was cash funds from the Health Care Expansion Fund, and $739,608 was federal funds.

In FY 2011-12, the Department was appropriated $2,733,814 for the Enrollment Broker line item. This appropriation includes continuation funding of $1,479,215 from the FY 2010-11 appropriation, an increase of $20,754 from annualization of HB 09-1293, an increase of $410,847 from annualization of FY 2010-11, S-6, BA-5 "Accountable Care Collaborative," and an increase of $822,998 for implementation of FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." Of the $2,733,814 appropriated in FY 2011-12, $1,316,278 is General Fund, $50,629 is cash funds from the Hospital Provider Fee Cash Fund, and $1,366,907 is federal funds. The Health Care Expansion Fund allocation of $33,514 was appropriated as General Fund in FY 2011-12 due to the insolvency of the Fund.

For FY 2012-13, the Department's base request for the Enrollment Broker budget item is $2,366,316, which includes continuation funding of $2,733,814 from the FY 2011-12 appropriation, a reduction of $387,358 from annualization of FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions," an increase of $9,121 from the annualization of HB 09-1293, and an increase of $10,739 for implementation of HB 11-008 "Medicaid Eligibility for Children." Of the $2,366,316 requested for FY 2012-13, $1,127,969 is General Fund, $55,190 is cash funds from the Hospital Provider Fee Cash Fund, and $1,183,157 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 was 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.

This line item received an appropriation of $7,670,839 in total funds through the FY 2011-12 Long Bill (SB 11-209), which is comprised of $2,100,370 General Fund, $60,537 cash funds, and $5,509,932 federal funds. Of this total amount, $4,056,132 is for Acute Care Utilization Review, $1,744,966 is for Long-Term Care Utilization Review, $1,261,813 is for External Quality Review, $255,121 is for Drug Utilization Review, and $352,807 is for Mental Health External Quality Review.

The Department's FY 2012-13 base request for the Professional Services Contracts line item is for $7,801,722 total funds, consisting of $2,100,370 General Fund, $100,654 cash funds, and $5,600,698 federal funds. Of this total, $4,094,732 is for Acute Care

Utilization Review, $1,744,966 is for Long-term Care Utilization Review, $284,702 is for Drug Utilization Review, $1,324,515 is for External Quality Review, and $352,807 is for Mental Health External Quality Review.

A description of the appropriation history for each review contract is provided below.

ACUTE CARE UTILIZATION REVIEW

Acute Care Utilization Review budget item 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. These reviews result in cost avoidance and recovery of provider payments should the provider or facility fail to provide the required documentation. Under Section 1903 (a)(3)(C)(i) of the Social Security Act and 42 C.F.R. §433.15 (6)(i), the Department is allowed to request enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a qualified improvement organization. The Department's acute care utilization review contractor qualifies as a quality improvement organization as defined under Section 1152 of the Social Security Act.

In FY 2009-10, the Department was appropriated $1,375,906 total funds for this budget item in the Long Bill (SB 09-259). The Department was appropriated an additional $85,400 in the Supplemental bill (HB 10-1300) pursuant to approval of the Department's FY 2009-10 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 final 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 was 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 consisted of $748,899 General Fund, $24,133 cash funds, and $2,319,092 federal funds.

In the FY 2011-12 Long Bill (SB 11-209), the Department was appropriated $4,056,132 in total funding, including continuation of $3,092,124, $27,800 and $536,208 from annualization of HB 09-1293 and FY 2010-11 BA-12 "Evidence Guided Utilization Review" (EGUR), respectively, and the addition of $400,000 from the Department's FY 2011-12 BRI-5 "Medicaid Reductions." Due to the insolvency of the Health Care Expansion Fund, $16,520 was transferred from cash funds to General Fund and, as a result, cash funds in this appropriation are from the Hospital Provider Fee Cash Fund only. This appropriation included $999,471 General Fund, $14,563 cash funds, and $3,042,098 federal funds.

For FY 2012-13, the Department requests $4,094,732 total funds, of which $4,056,132 is continuation funding from the previous year and $38,600 is from the annualization of HB 09-1293. The request is comprised of $999,471 General Fund, $24,213 cash funds from the Hospital Provider Fee Cash Fund, and $3,071,048 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 2009-10, the Department was appropriated $1,824,966 total funds through the FY 2009-10 Long Bill (SB 09-259). 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 included 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 consisted of $598,813 General Fund, $38,429 cash funds, and $1,107,724 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated continuation funding of $1,744,966 total funds. Due to the insolvency of the Health Care Expansion Fund, $38,429 was transferred from cash funds to General Fund. The FY 2011-12 appropriation includes $637,242 General Fund and $1,107,724 federal funds

For FY 2012-13, the Department requests continuation funding of $1,744,966 total funds for this line item. The base request includes $637,242 General Fund 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 2009-10, the Department received continuation funding in the amount of $812,193 total funds in the FY 2009-10 Long Bill (SB 09-259) 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 in the FY 2010-11 Long Bill (HB 10-1376). 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.

In FY 2011-12, the Department was appropriated $1,261,813 total funds in the Long Bill (SB 11-209). This amount includes continuation funding of $1,039,156, 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 total appropriation, $291,798 is General Fund, $23,655 is cash funds, and $946,360 is federal funds.

For FY 2012-13, the Department is requesting funding in the amount of $1,324,515 total funds, which includes continuation of the appropriation from FY 2011-12 and an increase of $62,702 total funds from annualization of HB 09-1293. Of this base request, $291,798 is General Fund, $39,331 is cash funds, and $993,386 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 2012-13. 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. , 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, and continues to add new drug classes annually.

In FY 2009-10, the Department was appropriated $210,483 total funds per the FY 2009-10 Long Bill (SB 09-259). 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.

In FY 2011-12, the Department was appropriated $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. Of this amount, $83,657 is General Fund, $22,319 cash funds, and $149,145 federal funds.

For FY 2012-13, the Department is requesting $284,702 which represents continuation funding and an increase of $29,581 from annualization of HB 09-1293. This base request includes $83,657 General Fund, $37,110 cash funds, and $163,935 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 is for Nursing Facility Appraisals, $500,000 is for the Colorado Indigent Care Auditor, and $100,000 is for DSH Audits.

This line item received an appropriation of $2,463,406 through the FY 2011-12 Long Bill (SB 11-209), which is comprised of $969,283 General Fund, $262,420 cash funds, and $1,231,703 federal funds. Of this total amount, $1,252,206 is for Nursing Facility Audits, $499,200 is for Hospital and Federally Qualified Health Clinics Audits, $112,000 is for Single Entry Point Audits, $500,000 is for the Colorado Indigent Care Auditor, and $100,000 for the DSH Audits. Payment Error Rate Measurement and Nursing Facility Appraisals are not scheduled to occur in FY 2011-12.

The Department's FY 2012-13 base request for the Professional Audit Services Contracts line item is for continuation funding in the amount of $2,463,406 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 FY 2009-10 Long Bill (SB 09-259) appropriated $1,227,366 for this budget item, which included a $129,866 increase to cover the overall increase in costs associated with conducting audits of nursing facilities pursuant to the Department's FY 2009-10 DI-14 "Nursing Facility Audit Reprocurement." This appropriation includes $613,683 General Fund and $613,683 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriated $1,227,366 for this budget item. This appropriation includes $613,683 General Fund and $613,683 federal funds.

For FY 2011-12, the Department was appropriated $1,252,206 for this item, which includes an increase of $24,840 total funds pursuant to the Department's FY 2011-12 BA-4 "Nursing Facility Auditor Expansion" in order to expand the current scope of nursing facility audits to include an audit of reported Medicare days and total days. This function is essential to properly determine provider fee contributions and supplemental payments. This appropriation includes $613,683 General Fund, $12,420 cash funds, and $613,683 federal funds.

For FY 2012-13, the Department requests continuation funding of $1,252,206 for this budget item. This request includes $613,683 General Fund, $12,420 cash funds, and $613,683 federal funds.

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, including $249,600 General Fund and $249,600 federal funds. The appropriation has remained at this level through FY 2011-12, and the Department requests continuation funding of this amount for FY 2012-13.

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 its FY 2006-07 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 2011-12 , and the Department requests continuation funding of $112,000 for FY 2012-13. This amount includes $56,000 General Fund and $56,000 federal funds.

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 August 2006, the Centers for Medicare and Medicaid Services (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 and FY 2013-14.

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 (the Department's FY 2006-07 S-5 and BA-1 "Revised Federal Rule for Payment Error Rate Measurement Program"). Joint Budget Committee (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, or CHP+ in Colorado).

Colorado-specific error rates from FY 2007-08 were as follows:

Components	Medicaid Sample Size	Medicaid Error Rate	CHP+ Sample Size	CHP+ 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. The final report on the FY 2010-11 reviews had not been released at the time of this writing.

No funding is requested for FY 2011-12 or FY 2012-13, as the reviews have yet to be completed.

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 25.5-6-201, C.R.S. 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, of which $139,873 was General Fund and $139,873 was federal funds. No funding was requested for FY 2011-12, and the Department requests no funding for this line for FY 2012-13.

COLORADO INDIGENT CARE PROGRAM AUDITOR

This 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. 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 was appropriated $500,000 for FY 2011-12 and requests continuation funding of $500,000 for FY 2012-13, including $250,000 cash funds and $250,000 federal funds.

DISPROPORTIONATE SHARE HOSPITAL AUDITS

This 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 line, of which $50,000 is General Fund and $50,000 federal funds.

In FY 2011-12, the Long Bill (SB 11-209) appropriated $100,000 total funds to this line, of which $50,000 was General Fund and $500,000 was federal funds.

For FY 2012-12, the Department requests continuation funding of $100,000, comprised of $50,000 General Fund and a matching amount of federal funds.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, established by HB 91S2-1030 and authorized in 25.5-4-302, C.R.S., 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 2009-10 through FY 2011-12, the Department's appropriation for estate recovery was $700,000 total funds, including $350,000 cash funds and $350,000 federal funds. In FY 2010-11, the Department recovered $3,318,380 in estate recoveries and liens of which $361,703 was paid in contingency fee; net recoveries totaled $2,956,677. This amount represents a marginal decrease over the previous fiscal year. 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 2012-13, the Department requests continuation funding of $700,000 for this line item, including $350,000 cash funds and $350,000 federal funds.

(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 low-income 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.

2. 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, July 1, 2010 and again on July 1, 2011, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by 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 requests to reduce funding.

3. 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.

4. 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.

5. 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 the implementation of the Medicaid Disabled Buy-In Program for Working Adults and Children programs and expansion of eligibility to Adults without Dependent Children in FY 2011-12. These expansions increase Medicaid caseload, and are discussed further in Sections II and III of this narrative.

6. 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.

7. The Department's request includes a forecast for FY 2011-12, FY 2012-13 and FY 2013-14. Because previous requests included only forecasts for the current and request years, additional exhibits and changes in formatting to accommodate the additional year are present throughout.

8. Previously, the "Expansion Adults" encompassed populations that were funded through multiple cash fund sources. However, effective with this request, the eligibility category has been bifurcated. "Expansion Adults to 60%" and "Expansion Adults to 100%" are now separate eligibility types. As a result, the calculations in Exhibit F which calculated the aggregate per capita growth for all expansion adults is no longer included as part of the Department's request.

9. Due to changes in how the Department is appropriated funds from the Health Care Expansion Fund, adjustments for Expansion Adults to 60% are no longer made at the service category level. This is reflected in both exhibits A and J.

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 and/or program in sections IV and V.

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.

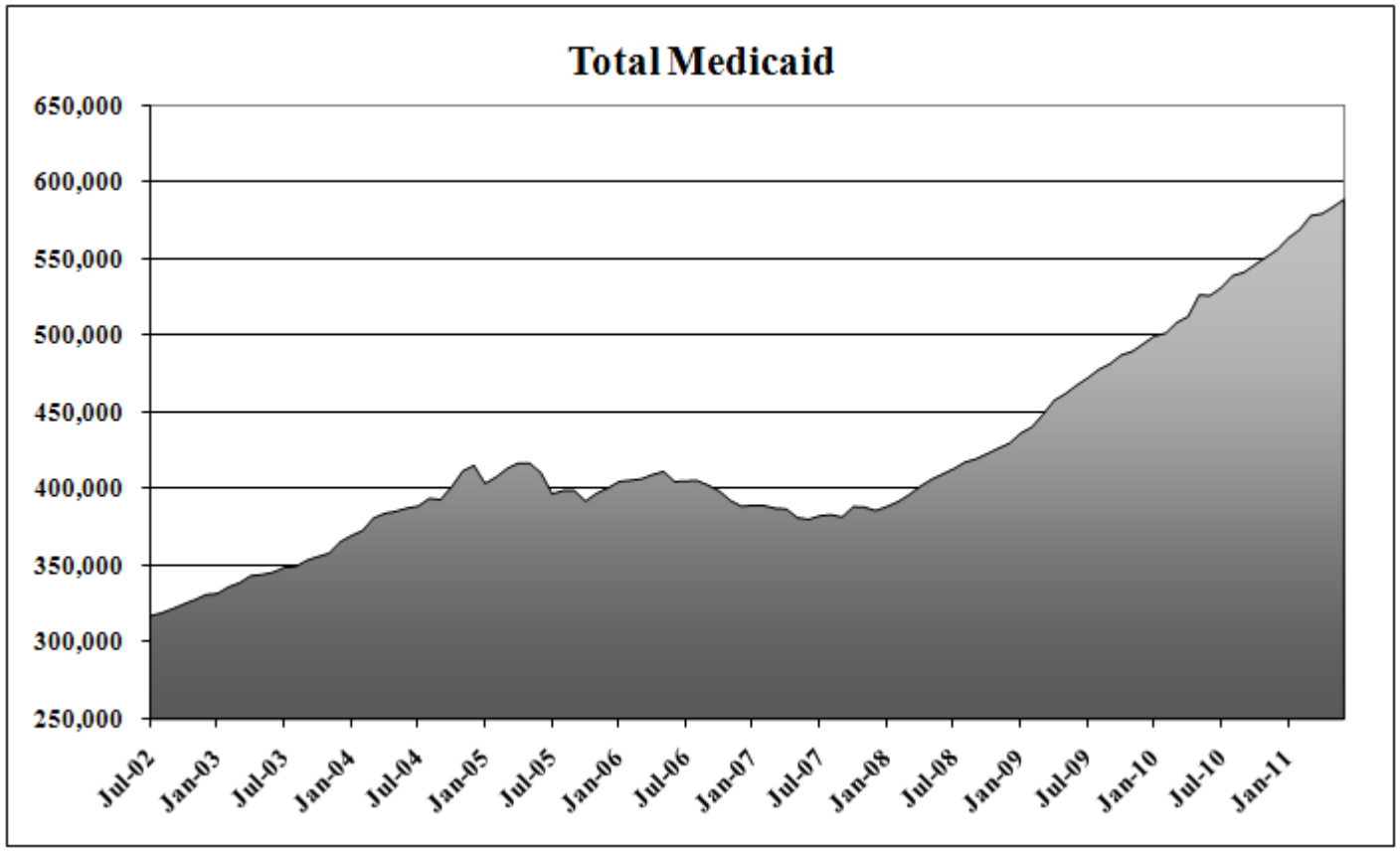
The Department has developed a new caseload report that it believes measures caseload more accurately: the REX01/COLD (MARS) R-474701. This report captures eligibility movements for the entire month in question and also stores the data table that underlies the report. As a result, the Department is able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

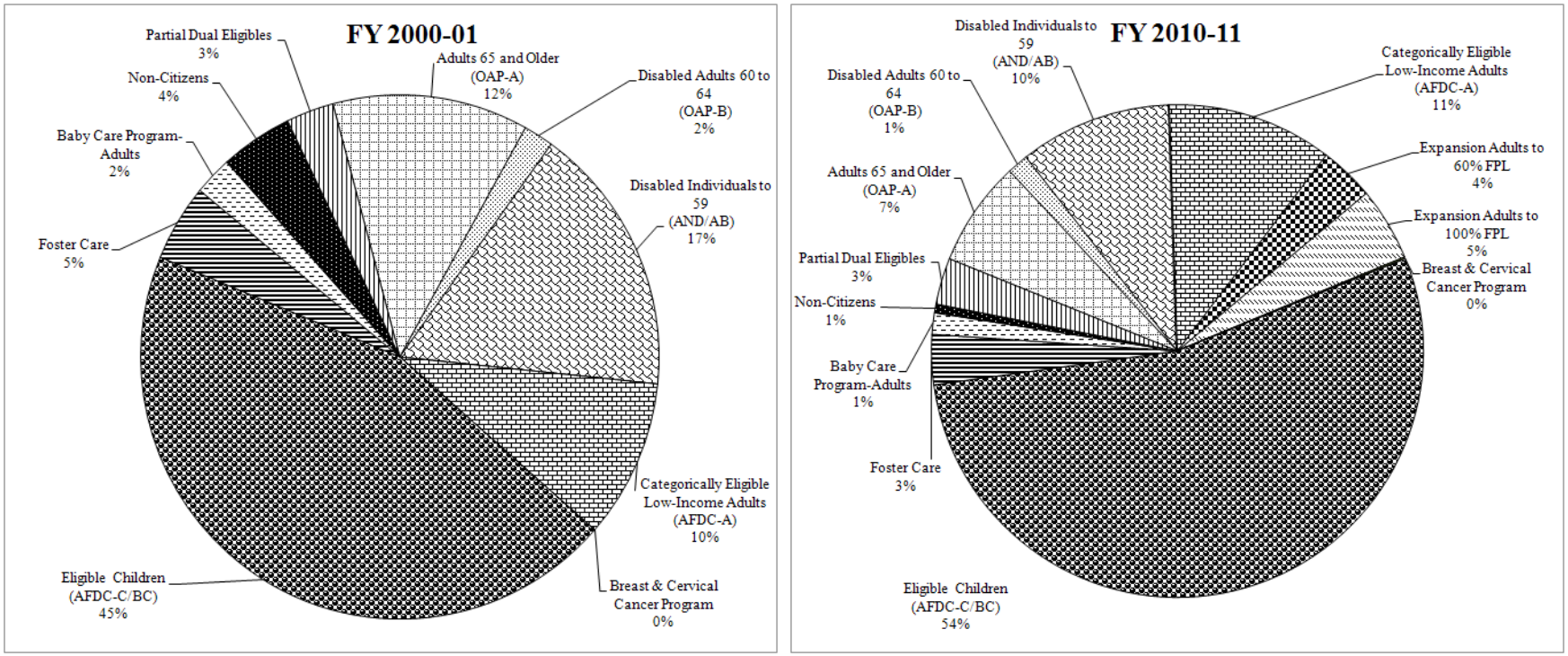
Fiscal Year	Medical Services Premiums Caseload	Less: Mental Health Ineligible Categories	Mental Health Caseload
FY 2002-03	331,800	(13,072)	318,728
FY 2003-04	367,559	(14,635)	352,924
FY 2004-05	406,024	(14,755)	391,269
FY 2005-06	402,218	(17,304)	384,914
FY 2006-07	392,228	(18,109)	374,119
FY 2007-08	391,962	(18,405)	373,557
FY 2008-09	436,812	(19,062)	417,750
FY 2009-10	498,797	(19,612)	479,185
FY 2010-11	560,722	(20,303)	540,419

Recent Caseload History

Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 1995-96 to FY 2010-11. Projections for FY 2011-12 to FY 2013-14 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 has continued to grow at double digit rates, with in annual growth of 11.44% in FY 2008-09, 14.19% in FY 2009-10, and 12.41% in FY 2010-11. Reasons for these recent growth rates will be discussed below.

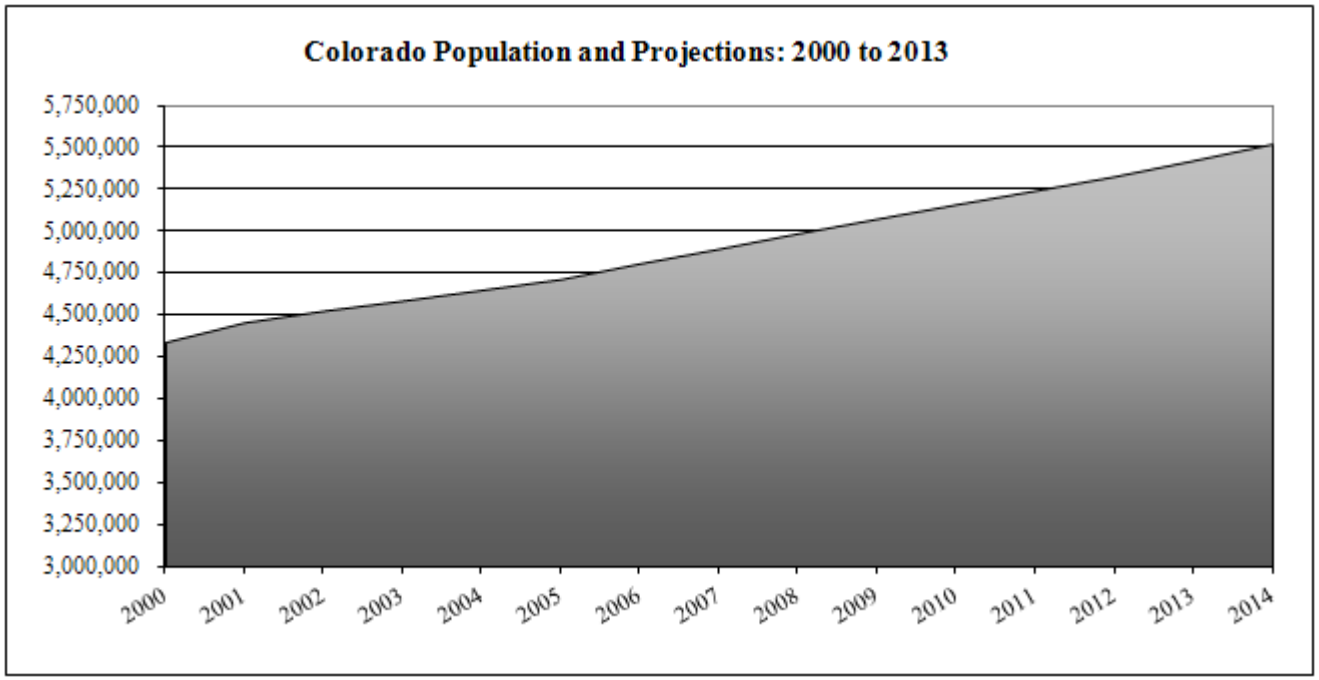


The charts below show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 2000-01 and FY 2010-11. As a percentage of the entire Medicaid caseload, Eligible Children have increased by nine percentage points, the largest gain when compared with all other categories. The percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined 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 has increased by approximately 17.65% from July of 2001 to July of 2011, an annualized rate of 1.77% per year. The Department of Local Affairs forecasts that Colorado's population will increase a further 5.30% from July of 2011 to July of 2011, with annualized growth rates in line with historical trends. 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.



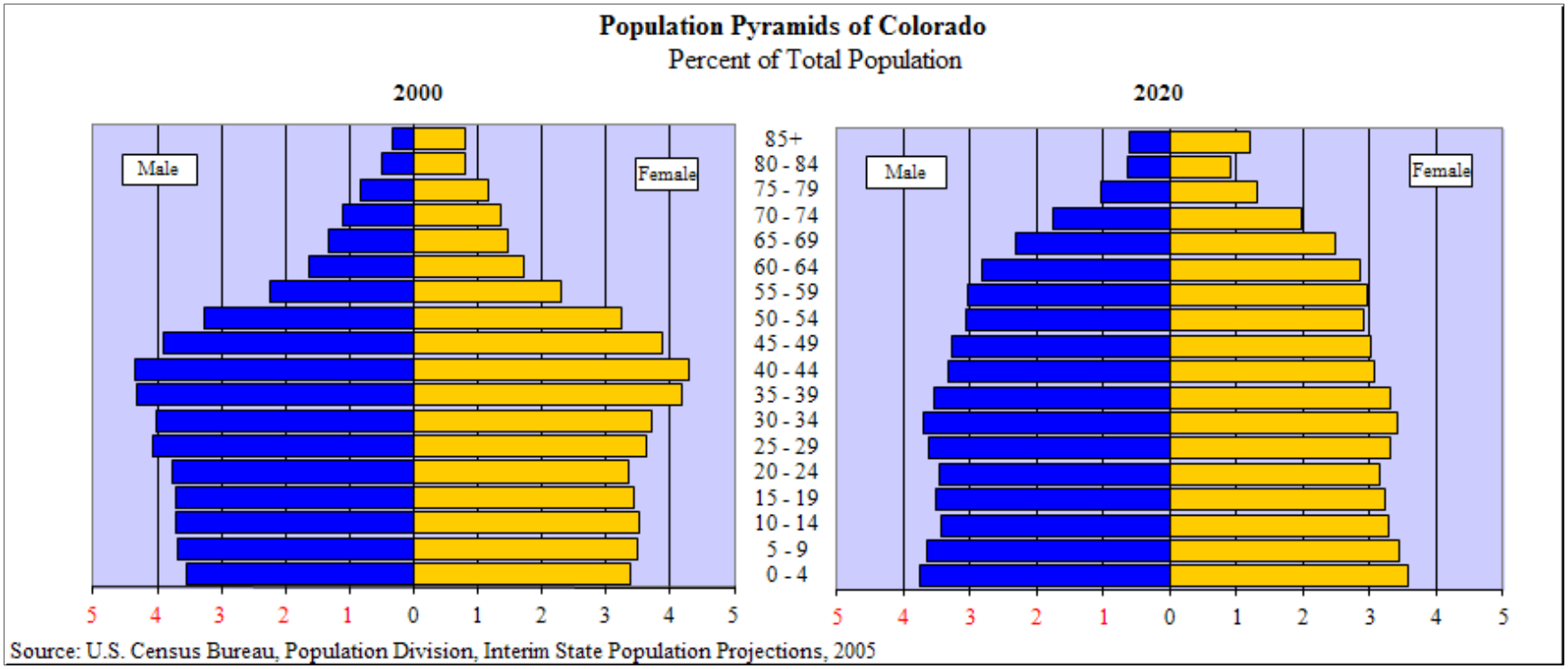
When using population data to project caseload, the Department marries population subgroups to their appropriate Medicaid category. For example, when projecting caseload for Eligible Children, the Department uses population statistics for Colorado residents aged 0 to 18. By using subgroups instead of 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. Though in-state migration is projected decrease over the forecast period, the number of individuals moving into the state is expected to remain positive, 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 2001 to 2011, Colorado's median age increased by 1.9 years, a 5.6% increase[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 2009 data from the United States Census Bureau, Colorado had the 13th lowest median age and the 4th 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 45.3% 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 24.6 in 2020, a 57.2% increase.[4] This growth is significantly higher than the nation average, which is projected to increase by 34.8% over the same timeframe. This suggests that Colorado will be aging faster than the average state over the forecast period. Since 2009, Colorado has experienced 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.

[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



Length of Stay- Medicaid caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The severity and length of the recent economic downturn has prolonged the average amount of time clients remain on the Medicaid caseload. The table below shows that the average number of months on Medicaid dropped by 10.6% for adults and 8.5% for children between FY 2003-04 FY 2004-05 and in FY 2005-06 increased to levels near those for FY 2003-04. As caseload declined in FY 2006-07 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. At this time, the Department does not have data regarding the average length of stay for FY 2010-11. However, preliminary data indicate that the average length of stay for both low-income adults and children did increase in FY 2010-11, which is expected during periods of economic weakness. The Department is in the process of revising the methodology used to estimate the length of time that clients remain in Medicaid, as well as improving and expanding the scope of data regarding enrollment periods in Medicaid.

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 4,600 jobs were shed over the year. The State experienced over-the-year job losses for two years and the annual contractions appear to have peaked in August 2009, when job losses numbered 130,800 (5.6%) over the year. The State has seen very moderate over-the-year employment increases as of October 2010. As of August 2011, the over-the-year jobs gain was estimated to be 17,200, or 0.8%. Current economic forecasts project very moderate increases in employment throughout the forecast period.

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

[5] Source: Office of State Planning and Budgeting, September 2011 Revenue Forecast

Year	Wage and Salary Income (billions)	Non-Agricultural Employment	Employment Growth	Unemployment Rate
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	$113.0	2,331,300	2.3%	3.7%
2008	$117.2	2,350,300	0.8%	4.8%
2009	$112.8	2,245,600	-4.5%	8.3%
2010	$114.4	2,220,100	-1.1%	8.9%
2011	$118.4	2,237,800	0.8%	8.8%
2012	$120.9	2,247,700	0.4%	8.7%
2013	$125.4	2,268,500	0.9%	8.1%

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, 2011. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2012-13. As illustrated in the following table, the average number of adults and children on Transitional Medicaid increased dramatically in FY 2004-05. The Department suspects that the high growth in FY 2004-05 and FY 2005-06 may be partially related to large monthly increases that occurred around the implementation of the Colorado Benefits Management System. Monthly caseload declined between December 2005 and June 2008, but caseload increased throughout FY 2008-09 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) included options for states to modify eligibility for Transitional Medicaid, including

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

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 dependent 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 Dependent 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
FY 2010-11	11,042	6,173

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 account for the implementation of HB 09-1293, Colorado Health Care Affordability Act. This legislation establishes the Medicaid Buy-In Program for Working Adults with Disabilities and an Adults without Dependent Children (AwDC) program, both of which are scheduled to be implemented in March 2012. In addition, the legislation establishes a Medicaid Disabled Buy-In Program for Children, which is scheduled to be implemented approximately four to six months after the Medicaid Buy-In Program for Working Adults with Disabilities and AwDC programs. 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 74,224 clients, growth of 22.37%. Caseload decreased in the subsequent years, resulting in a decline of 14,062, or 3.46%, between FY 2004-05 and FY 2007-08. The Department believes that the improving economic conditions were 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 and FY 2009-10, with average monthly growth increasing at an increasing rate throughout the year, resulting in annual growth of 11.44% and 14.19%, respectively. Strong monthly growth continued in FY 2010-11, with annual caseload increasing by 12.41% to a new historical high of 560,722. Given the recent trends and projected economic conditions, 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. The Department is forecasting Medicaid caseload to increase by 10.57% in FY 2011-12 to 619,985. The Colorado Health Care Affordability Act expansions are projected to account for 3,390 of the

projected 59,263 caseload increase in FY 2011-12. In FY 2012-13, the trend is projected to be 8.55%, and caseload is forecasted to reach 672,968. Expansions from the Colorado Health Care Affordability Act account for 16,674 of the projected 52,983 total Medicaid caseload increase in FY 2012-13. The following table shows actual and projected aggregate Medicaid caseload from FY 2003-04 through FY 2013-14.

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	560,722	12.41%	61,925
FY 2011-12 Projection	619,985	10.57%	59,263
FY 2012-13 Projection	672,968	8.55%	52,983
FY 2013-14 Projection	718,001	6.69%	45,033

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 1st 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 cannot 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.

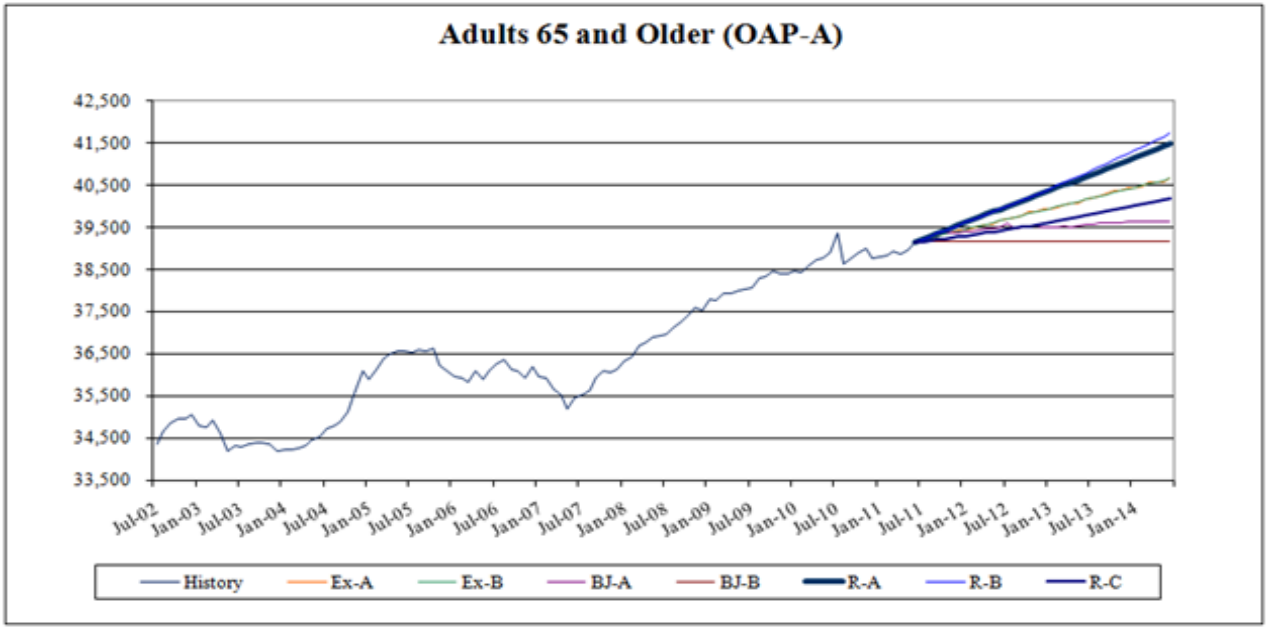
CATEGORICAL PROJECTIONS

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 2013-14 projections are included for informational purposes. Graphical representations of caseload history to FY 2002-03 are included in each categorical section.

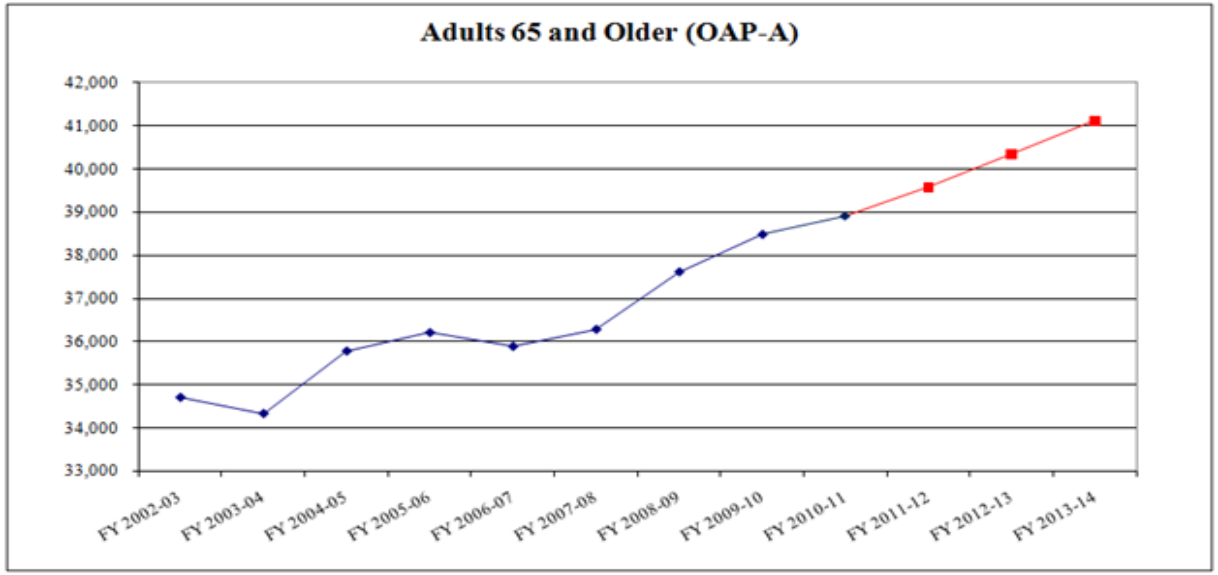
Adults 65 and Older

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

Adults 65 and Older: Model Results



Adults 65 and Older: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9967	
Exponential Smoothing B*	0.9880	
Box-Jenkins A	0.9969	
Box-Jenkins B	0.9876	
Regression A	0.9965	OAP-A [-1], OAP-A [-7], CBMS Dummy [-2], Systems Dummy
Regression B	0.9965	OAP-A [-1], Population 65+, CBMS Dummy, CBMS Dummy [-1], Auto [-1], Auto [-9]
Regression C	0.9962	OAP-A [-1], Total Population, CBMS Dummy, Trend, Auto [-11]



Adults 65 and Older: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	38,487	38,921	1.29%	39,423	502	42
Exponential Smoothing B*	38,487	38,921	1.29%	39,423	502	42
Box Jenkins A	38,487	38,921	1.19%	39,384	463	30
Box Jenkins B	38,487	38,921	0.63%	39,166	245	1
Regression A	**38,487**	**38,921**	**1.69%**	**39,579**	**658**	**65**
Regression B	38,487	38,921	1.68%	39,575	654	65
Regression C	38,487	38,921	0.94%	39,287	366	23

* Denotes Expert Selection, Bold denotes Trend Selection

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*	38,921	39,579	1.29%	40,090	511	42
Exponential Smoothing B*	38,921	39,579	1.27%	40,082	503	42
Box Jenkins A	38,921	39,579	0.37%	39,725	146	5
Box Jenkins B	38,921	39,579	0.00%	39,579	0	0
Regression A	**38,921**	**39,579**	**1.94%**	**40,347**	**768**	**64**
Regression B	38,921	39,579	2.05%	40,390	811	71
Regression C	38,921	39,579	0.82%	39,904	325	29

Adults 65 and Older: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	39,579	40,347	1.27%	40,859	512	42
Exponential Smoothing B*	39,579	40,347	1.25%	40,851	504	42
Box Jenkins A	39,579	40,347	0.24%	40,444	97	6
Box Jenkins B	39,579	40,347	0.00%	40,347	0	0
Regression A	**39,579**	**40,347**	**1.91%**	**41,118**	**771**	**65**
Regression B	39,579	40,347	2.24%	41,251	904	79
Regression C	39,579	40,347	0.96%	40,734	387	34

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

Adults 65 and Older: Trend Selections

FY 2011-12: 1.69%
FY 2012-13: 1.94%
FY 2013-14: 1.91%

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 2010-11 indicate that approximately 31.9% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (SSI). Additionally, 87.7% of this population were dual eligibles (Medicaid and Medicare) in FY 2010-11 and 31.9% were enrolled in Home- and Community-based Services waivers (HCBS). Enrollment in waivers has increased by an average of 5.1% per year for the last three years. (Source: MARS 474701 report)
- This population may be affected by provisions in the Deficit Reduction Act of 2005, notably sections 6011 (lengthening of look-back period), 6012 (treatment of annuities), 6014 (disqualification of individuals with substantial home equity), 6015 (reform of asset test rules). 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 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 2010-11 was in line with the Department's February 2011 forecast, in which the annual caseload was projected to be 38,937 and average monthly growth was projected to be 19. The Department believes that low growth is due to a change in the Colorado Benefits Management System to the Old Age Pension Program enforcing a 5-year bar on benefits in August 2010. The selected trend for FY 2011-12 is slightly higher than that from the Department's February 2011 forecast, and would result in average growth of **65 per month** for FY 2011-12.
- 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, with projected increases of an average of 5.8% per year over the forecast period.

25.5-5-101 (1), C.R.S.
(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.
(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-09	38,044	-	-
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%
Jul-10	39,382	482	1.24%
Aug-10	38,648	(734)	-1.86%
Sep-10	38,774	126	0.33%
Oct-10	38,901	127	0.33%
Nov-10	39,009	108	0.28%
Dec-10	38,769	(240)	-0.62%
Jan-11	38,808	39	0.10%
Feb-11	38,823	15	0.04%
Mar-11	38,939	116	0.30%
Apr-11	38,861	(78)	-0.20%
May-11	38,981	120	0.31%
Jun-11	39,154	173	0.44%

	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	38,921	1.13%	434
FY 2011-12	39,579	1.69%	658
FY 2012-13	40,347	1.94%	768
FY 2013-14	41,118	1.91%	771

* 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 2011 Trends			
FY 2010-11	38,937	1.17%	450
FY 2011-12	39,544	1.56%	607
FY 2012-13	40,335	2.00%	791

Actuals		
	Monthly Change	**% Change**
6-month average	64	0.17%
12-month average	21	0.06%
18-month average	41	0.11%
24-month average	46	0.12%
24-month average*	80	0.21%

*Without outliers

Base trend from June 2011 level			
FY 2011-12	39,154	0.60%	233

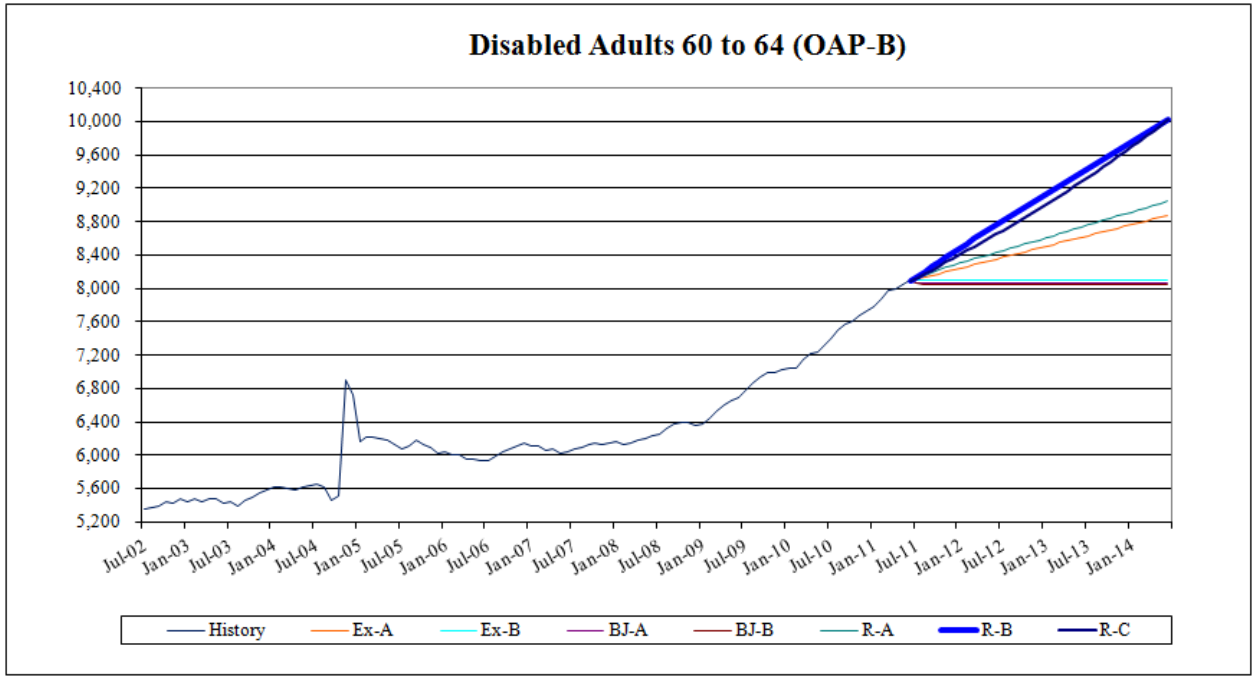
Monthly Average Growth Comparisons		
February 2011 Forecast	19	0.05%
FY 2010-11 Actuals	21	0.06%
FY 2010-11 1st Half	(22)	-0.05%
FY 2010-11 2nd Half	64	0.17%
FY 2011-12 Forecast	65	0.17%
February 2011 Forecast	63	0.16%
FY 2012-13 Forecast	64	0.16%
February 2011 Forecast	69	0.17%

Disabled Adults 60 to 64

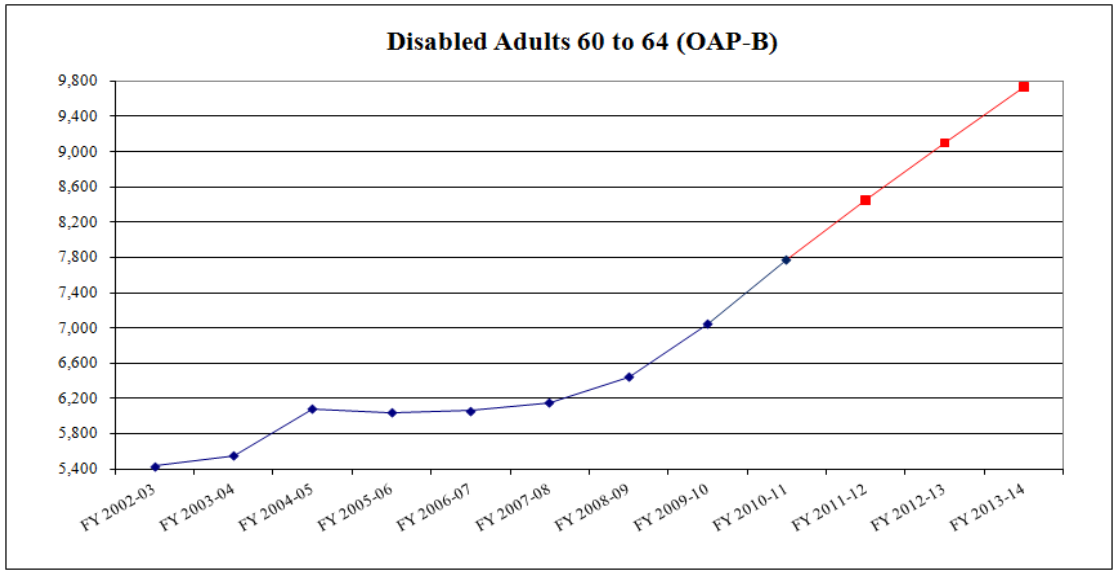
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual 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*	0.9886	
Exponential Smoothing B*	0.9623	
Box-Jenkins A	0.9908	
Box-Jenkins B	0.9653	
Regression A	0.9975	OAP-B [-1], OAP-B [-3], CBMS Dummy, Auto [-4]
Regression B	0.9987	OAP-B [-1], OAP-B [-2], Population 60-64, CBMS Dummy, CBMS Dummy [-2], Trend, Constant, Auto [-1]
Regression C	0.9986	OAP-B [-1], OAP-B [-2], Total Population, CBMS Dummy, CBMS Dummy [-2], Auto [-1]



Disabled Adults 60 to 64: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	7,049	7,767	5.97%	8,231	464	22
Exponential Smoothing B*	7,049	7,767	4.15%	8,089	322	0
Box Jenkins A	7,049	7,767	3.77%	8,060	293	(2)
Box Jenkins B	7,049	7,767	3.49%	8,038	271	(4)
Regression A	7,049	7,767	6.67%	8,285	518	28
Regression B	**7,049**	**7,767**	**8.81%**	**8,451**	**684**	**55**
Regression C	7,049	7,767	7.93%	8,383	616	46

* Denotes Expert Selection, Bold denotes Trend Selection

Disabled Adults 60 to 64: 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*	7,767	8,451	3.17%	8,719	268	22
Exponential Smoothing B*	7,767	8,451	0.00%	8,451	0	0
Box Jenkins A	7,767	8,451	-0.01%	8,450	(1)	0
Box Jenkins B	7,767	8,451	-0.01%	8,450	(1)	0
Regression A	7,767	8,451	3.73%	8,766	315	25
Regression B	**7,767**	**8,451**	**7.69%**	**9,101**	**650**	**53**
Regression C	7,767	8,451	7.16%	9,056	605	53

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	8,451	9,101	3.07%	9,380	279	22
Exponential Smoothing B*	8,451	9,101	0.00%	9,101	0	0
Box Jenkins A	8,451	9,101	0.00%	9,101	0	0
Box Jenkins B	8,451	9,101	0.00%	9,101	0	0
Regression A	8,451	9,101	3.60%	9,429	328	26
Regression B	**8,451**	**9,101**	**6.97%**	**9,735**	**634**	**53**
Regression C	8,451	9,101	7.69%	9,801	700	61

[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 2011-12: 8.81%
FY 2012-13: 7.69%
FY 2013-14: 6.97%

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 (HCBS) 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 2010-11 indicate that approximately 53.7% of this eligibility type were automatically eligible for Medicaid due to their receipt of SSI. Additionally, 44.4% of this population were dual eligibles (Medicaid and Medicare) in FY 2010-11 and 32.0% were enrolled in HCBS waivers. Enrollment in waivers has increased by an average of 10.9% per year for the last three years. (Source: MARS 474701 report)
- Growth in FY 2010-11 was higher than the Department's February 2011 forecast, in which the annual caseload was projected to be 7,743 and average monthly growth was projected to be 60. The selected trend for FY 2011-12 is higher than that from the February 2011 forecast, and would yield average growth of **55 per month** in FY 2011-12.
- 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. Population growth in this age group is forecasted to slow, with projected increases of an average of approximately 4.0% per year over the forecast period.

25.5-5-101 (1), C.R.S.
(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.
(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-09	6,691	-	-
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%
Jul-10	7,395	69	0.94%
Aug-10	7,492	97	1.31%
Sep-10	7,562	70	0.93%
Oct-10	7,602	40	0.53%
Nov-10	7,682	80	1.05%
Dec-10	7,721	39	0.51%
Jan-11	7,781	60	0.78%
Feb-11	7,870	89	1.14%
Mar-11	7,966	96	1.22%
Apr-11	7,987	21	0.26%
May-11	8,051	64	0.80%
Jun-11	8,089	38	0.47%

	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	7,767	10.19%	718
FY 2011-12	8,451	8.81%	684
FY 2012-13	9,101	7.69%	650
FY 2013-14	9,735	6.97%	634

* 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 2011 Trends			
FY 2010-11	7,743	9.85%	694
FY 2011-12	8,292	7.09%	549
FY 2012-13	8,729	5.27%	437

Actuals		
	Monthly Change	**% Change**
6-month average	61	0.78%
12-month average	64	0.83%
18-month average	59	0.79%
24-month average	58	0.79%

Base trend from June 2011 level			
FY 2011-12	8,089	4.15%	322

Monthly Average Growth Comparisons		
February 2011 Forecast	60	0.82%
FY 2010-11 Actuals	64	0.83%
FY 2010-11 1st Half	66	0.88%
FY 2010-11 2nd Half	61	0.78%
FY 2011-12 Forecast	55	0.68%
February 2011 Forecast	38	0.47%
FY 2012-13 Forecast	53	0.61%
February 2011 Forecast	35	0.41%

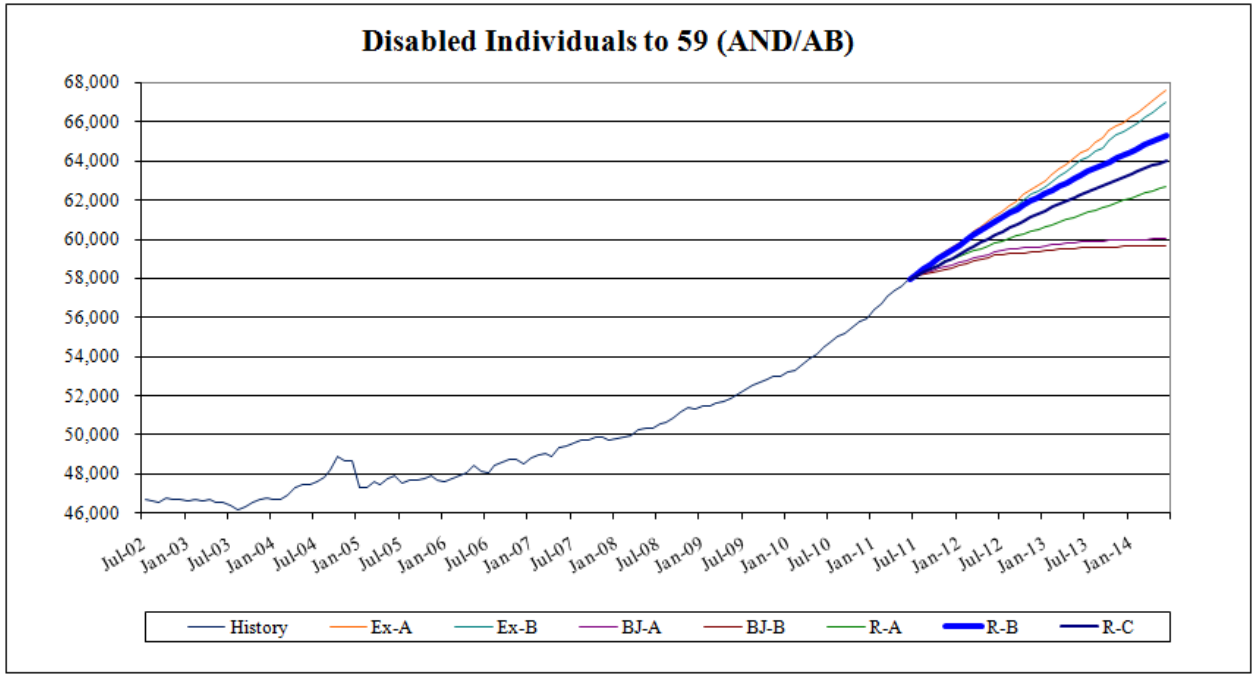
Disabled Individuals to 59

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.

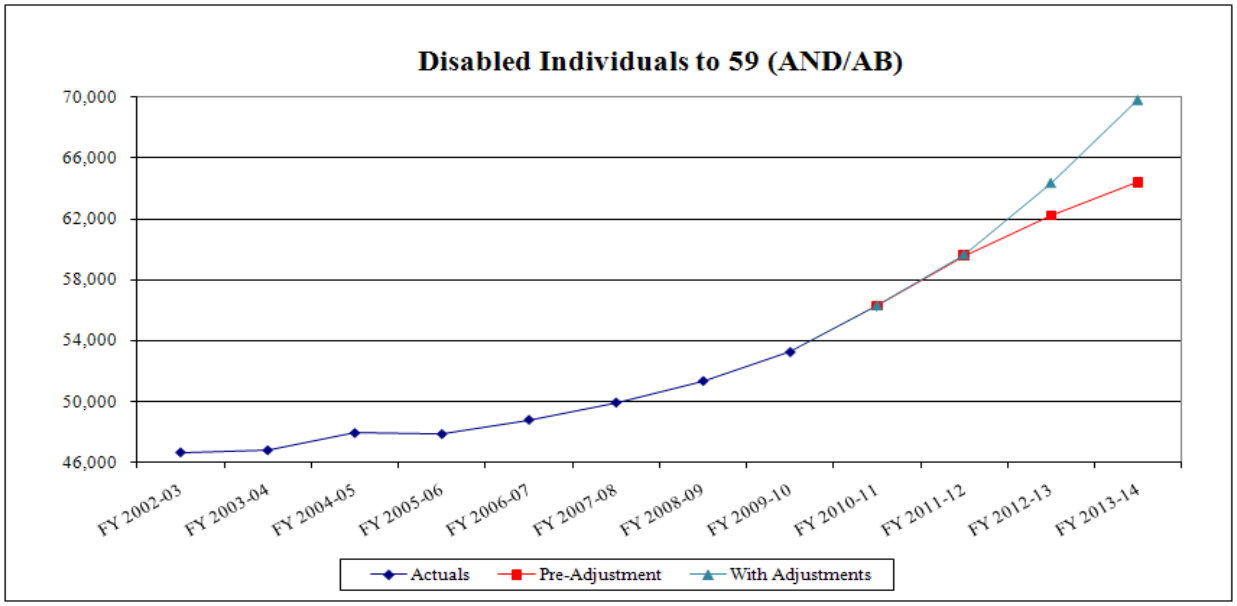
The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults. Zebley required that children's disability be measured using child-appropriate activities. As a result, the number of children determined to be disabled significantly 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*	0.9975	
Exponential Smoothing B	0.9958	
Box-Jenkins A	0.9972	
Box-Jenkins B*	0.9847	
Regression A	0.9965	AND/AB [-1], AND/AB [-3], Auto [-5]
Regression B	0.9964	AND/AB [-1], AND/AB [-9], Migration, CBMS Dummy, Auto [-4], Auto [-12]
Regression C	0.9959	AND/AB [-1], AND/AB [-24], Auto [-4]



Disabled Individuals to 59: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	53,264	56,281	6.08%	59,703	3,422	268
Exponential Smoothing B*	53,264	56,281	5.88%	59,590	3,309	251
Box Jenkins A	53,264	56,281	4.41%	58,763	2,482	116
Box Jenkins B	53,264	56,281	4.18%	58,634	2,353	100
Regression A	53,264	56,281	4.92%	59,050	2,769	150
Regression B	**53,264**	**56,281**	**5.89%**	**59,596**	**3,315**	**245**
Regression C	53,264	56,281	5.10%	59,151	2,870	185

* Denotes Expert Selection, Bold denotes Trend Selection

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*	56,281	59,596	5.39%	62,808	3,212	268
Exponential Smoothing B*	56,281	59,596	5.06%	62,612	3,016	251
Box Jenkins A	56,281	59,596	1.51%	60,496	900	41
Box Jenkins B	56,281	59,596	1.30%	60,371	775	32
Regression A	56,281	59,596	2.59%	61,140	1,544	121
Regression B	**56,281**	**59,596**	**4.41%**	**62,224**	**2,628**	**196**
Regression C	56,281	59,596	3.75%	61,831	2,235	172

Disabled Individuals to 59: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	59,596	62,224	5.12%	65,410	3,186	268
Exponential Smoothing B*	59,596	62,224	4.82%	65,223	2,999	251
Box Jenkins A	59,596	62,224	0.52%	62,548	324	14
Box Jenkins B	59,596	62,224	0.41%	62,479	255	10
Regression A	59,596	62,224	2.42%	63,730	1,506	123
Regression B	**59,596**	**62,224**	**3.49%**	**64,396**	**2,172**	**170**
Regression C	59,596	62,224	3.05%	64,122	1,898	146

[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 2011-12: 5.89%
FY 2012-13: 4.41%
FY 2013-14: 3.49%

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 (HCBS) Waiver Program and the Children's Extensive Support (CES) 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 HCBS Waiver Program and 30 in the CES Waiver Program. The Department received approval for the additional expansions from the Centers for Medicare and Medicaid Services in December 2006. All new 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 HCBS waivers showing strong growth. In addition, over the last three years, the number of individuals eligible for Medicaid due to receipt of SSI has represented most of the growth in this eligibility group. The Department believes that this may be related to economic condition in that individuals with work-limiting disabilities who were employed prior to the recession and have exhausted their federally-extended unemployment benefits may now be applying for Supplemental Security Income (SSI) if they cannot find work. Data for FY 2010-11 indicate that approximately 68.3% of this eligibility type were automatically eligible for Medicaid due to their receipt of SSI. Additionally, 33.1% of this population were dual eligibles (Medicaid

and Medicare) in FY 2010-11 and 28.9% were enrolled in HCBS waivers. Enrollment in waivers has increased by an average of 5.1% per year for the last three years. (Source: MARS 474701 report)

- Growth in FY 2010-11 was higher than the Department's February 2011 forecast, in which the annual base caseload was projected to be 55,996 and average monthly growth was projected to be 216. The selected trend FY 2011-12 is higher than the February 2011 forecast, and would yield average growth of **245 per month** for FY 2011-12. This higher forecasted growth rate reflects the continuation of strong increases seen over the last 4 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 Working Adults with Disabilities beginning March 2012 and for Disabled Children four to six months later. 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.
(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.
(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-09	52,107	-	-
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%
Jul-10	54,740	247	0.45%
Aug-10	55,032	292	0.53%
Sep-10	55,223	191	0.35%
Oct-10	55,508	285	0.52%
Nov-10	55,804	296	0.53%
Dec-10	55,937	133	0.24%
Jan-11	56,371	434	0.78%
Feb-11	56,671	300	0.53%
Mar-11	57,103	432	0.76%
Apr-11	57,385	282	0.49%
May-11	57,608	223	0.39%
Jun-11	57,986	378	0.66%

	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	56,281	5.66%	3,017
FY 2011-12	59,596	5.89%	3,315
FY 2012-13	62,224	4.41%	2,628
FY 2013-14	64,396	3.49%	2,172

* 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 2011-12	57
FY 2012-13	2,126
FY 2013-14	5,413

Actuals		
	Monthly Change	**% Change**
6-month average	342	0.60%
12-month average	291	0.52%
18-month average	277	0.50%
24-month average	245	0.45%

Monthly Average Growth Comparisons		
February 2011 Forecast	216	0.40%
FY 2010-11 Actuals	291	0.52%
FY 2010-11 1st Half	241	0.44%
FY 2010-11 2nd Half	342	0.60%
FY 2011-12 Forecast	245	0.42%
February 2011 Forecast	151	0.26%
FY 2012-13 Forecast	196	0.32%
February 2011 Forecast	137	0.23%

Projections After Adjustments			
FY 2011-12	59,653	5.99%	3,372
FY 2012-13	64,350	7.87%	4,697
FY 2013-14	69,809	8.48%	5,459

February 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2010-11	55,996	5.13%	2,732
FY 2011-12	58,090	3.74%	2,094
FY 2012-13	59,798	2.94%	1,708

Base trend from June 2011 level			
FY 2011-12	57,986	3.03%	1,705

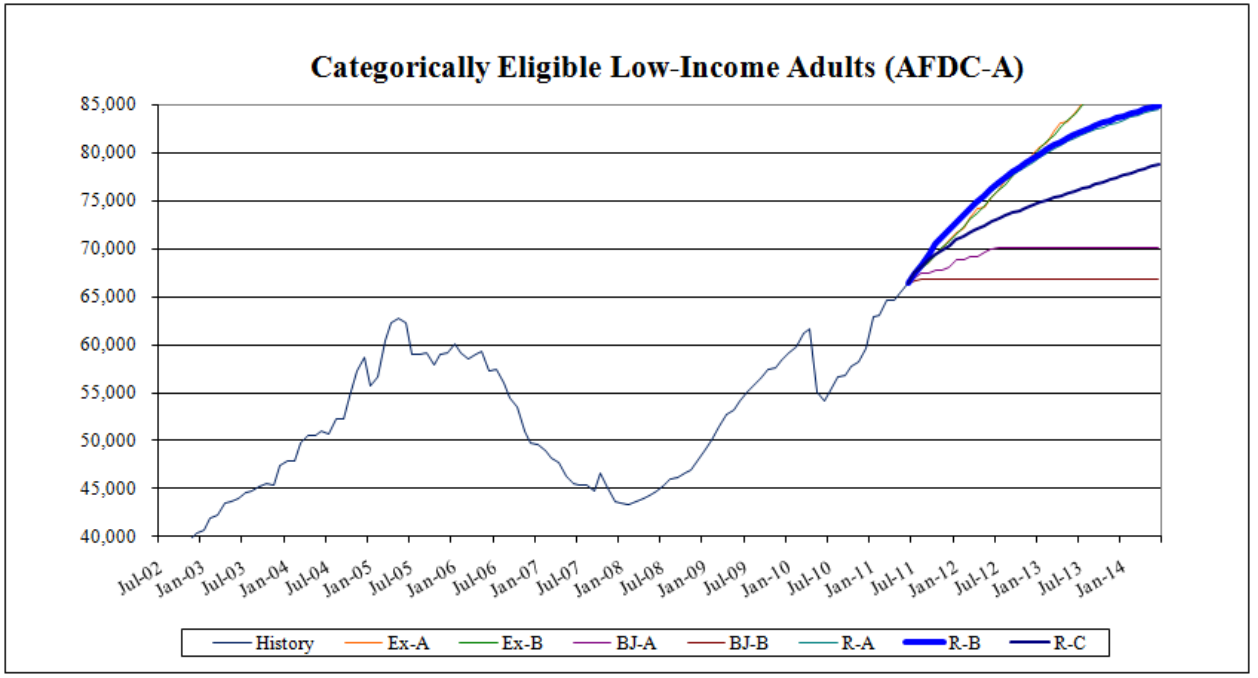
Categorically Eligible Low-Income Adults

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 2010-11, there were an average of 6,173 adults in this program. Transitional Medicaid benefits have been extended through December 31, 2011, and the Department's forecast assumes that the program will continue through FY 2012-13.

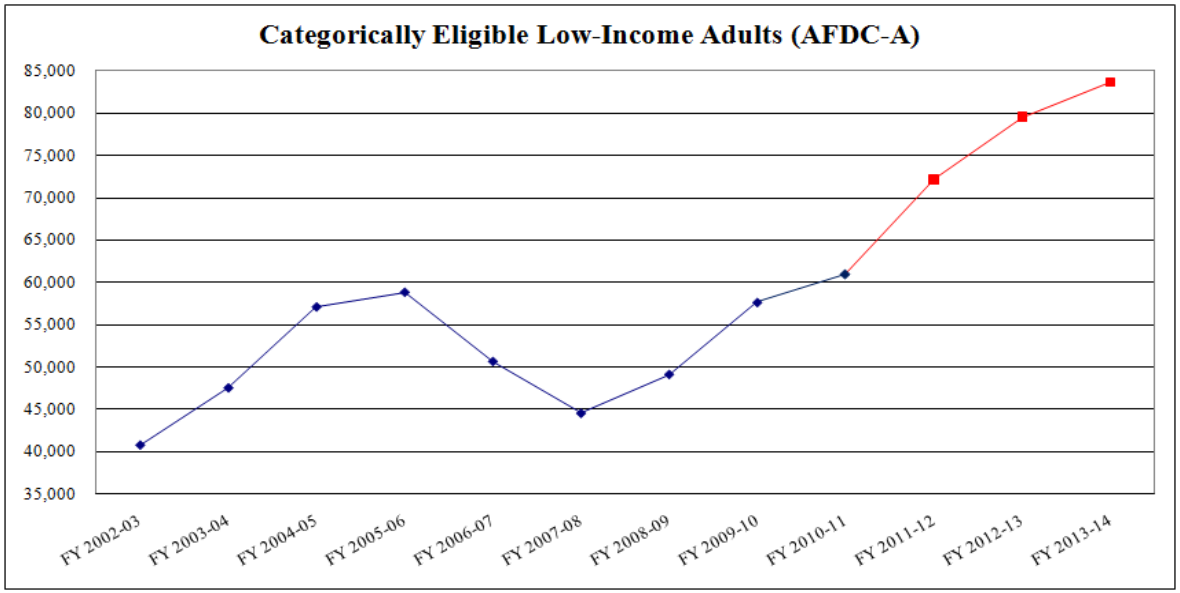
Before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash assistance for welfare and Medicaid was broken. When the Department implemented this change into the Client Oriented Information Network eligibility data system, it was estimated that 46,006[7] clients had their cases closed in error. In reaction, the Tatum lawsuit was brought against the State. Starting in May 2001, the Department began to reinstate clients who inadvertently lost their Medicaid eligibility. This may help to explain why from 1997 to 1999 caseload fell, and may have contributed to a spike in caseload in FY 2001-02. For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Budget Request, pages A-37 to A-38.

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

Categorically Eligible Low-Income Adults: Model Results



Categorically Eligible Low-Income Adults: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9940	
Exponential Smoothing B	0.9909	
Box-Jenkins A*	0.9958	
Box-Jenkins B*	0.9855	
Regression A	0.9959	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, CBMS Dummy, Systems Dummy, Auto [-6]
Regression B	0.9962	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, Total Wages, CBMS Dummy, CBMS Dummy [-2], Systems Dummy, Auto [-9]
Regression C	0.9958	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 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	57,661	60,958	16.89%	71,254	10,296	745
Exponential Smoothing B	57,661	60,958	16.76%	71,175	10,217	739
Box Jenkins A*	57,661	60,958	12.31%	68,462	7,504	301
Box Jenkins B*	57,661	60,958	9.62%	66,822	5,864	39
Regression A	57,661	60,958	18.27%	72,095	11,137	798
Regression B	**57,661**	**60,958**	**18.41%**	**72,180**	**11,222**	**821**
Regression C	57,661	60,958	15.59%	70,461	9,503	534

* Denotes Expert Selection, Bold denotes Trend Selection

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	60,958	72,180	12.55%	81,239	9,059	745
Exponential Smoothing B	60,958	72,180	12.46%	81,174	8,994	739
Box Jenkins A*	60,958	72,180	2.41%	73,920	1,740	11
Box Jenkins B*	60,958	72,180	0.03%	72,202	22	0
Regression A	60,958	72,180	9.88%	79,311	7,131	463
Regression B	**60,958**	**72,180**	**10.25%**	**79,578**	**7,398**	**475**
Regression C	60,958	72,180	5.92%	76,453	4,273	273

Categorically Eligible Low-Income Adults: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	72,180	79,578	11.15%	88,451	8,873	745
Exponential Smoothing B	72,180	79,578	11.08%	88,395	8,817	739
Box Jenkins A*	72,180	79,578	0.01%	79,586	8	0
Box Jenkins B*	72,180	79,578	0.00%	79,578	0	0
Regression A	72,180	79,578	5.09%	83,629	4,051	247
Regression B	**72,180**	**79,578**	**5.17%**	**83,692**	**4,114**	**251**
Regression C	72,180	79,578	3.89%	82,674	3,096	229

[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 2011-12: 18.41%
FY 2012-13: 10.25%
FY 2013-14: 5.17%

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 2.7% per year from FY 1995-96 to FY 2001-02 to 1.2% per year from FY 2002-03 to FY 2010-11. 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 average 8.5% between 2011 and 2013. Wage and salary income is projected to increase by 3.5% in 2011, with moderate growth of 1.0% in 2012, increasing to 3.0% in 2013.[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 2010-11 was much higher than the Department's February 2011 forecast, in which the annual caseload was projected to be 59,362 and average monthly growth was projected to be 727. The decreases in May and June 2010 were due to 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 four years, as the seasonally adjusted

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

unemployment rate increased from a low of 3.5% in March 2007 to a high of 9.3% in February 2011 (source: Bureau of Labor Statistics). The unemployment rate is at the highest level in recent history, and has also remained at this high level for an unprecedented period of time. During the 2001-2002 recession, the AFDC adults caseload was increasing by approximately 1.9% per month. The unemployment rate, however, has exceeded 8.0% since April 2009. The selected trend for FY 2011-12 is much higher than that from the February 2011 forecast, and would yield average increases of **821 per month** for FY 201-12. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which moderated in FY 2009-10 but increased in FY 2010-11. 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 2011-12. The selected trends for FY 2011-12 and FY 2012-13 are conservative due to recent volatility in the monthly data, and the Department will continue to monitor this category and economic conditions closely over the next six months. The low trend for FY 2010-11 is due to the level shift experienced at the end of FY 2009-10 with the expansion to 100% FPL.

- Current forecasts indicate that the economic conditions should begin to improve in 2012. 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.
(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.
(a) Individuals who would be eligible for but are not receiving cash assistance;
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706;

Categorically Eligible Low-Income Adults: Historical Caseload and Forecasts

Categorically Eligible Low-Income Adults: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-09	54,170	-	-
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%
Jul-10	55,213	1,040	1.92%
Aug-10	56,687	1,474	2.67%
Sep-10	56,852	165	0.29%
Oct-10	57,801	949	1.67%
Nov-10	58,276	475	0.82%
Dec-10	59,591	1,315	2.26%
Jan-11	62,908	3,317	5.57%
Feb-11	63,025	117	0.19%
Mar-11	64,697	1,672	2.65%
Apr-11	64,673	(24)	-0.04%
May-11	65,402	729	1.13%
Jun-11	66,369	967	1.48%

	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	60,958	5.72%	3,297
FY 2011-12	72,180	18.41%	11,222
FY 2012-13	79,578	10.25%	7,398
FY 2013-14	83,692	5.17%	4,114

* 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.

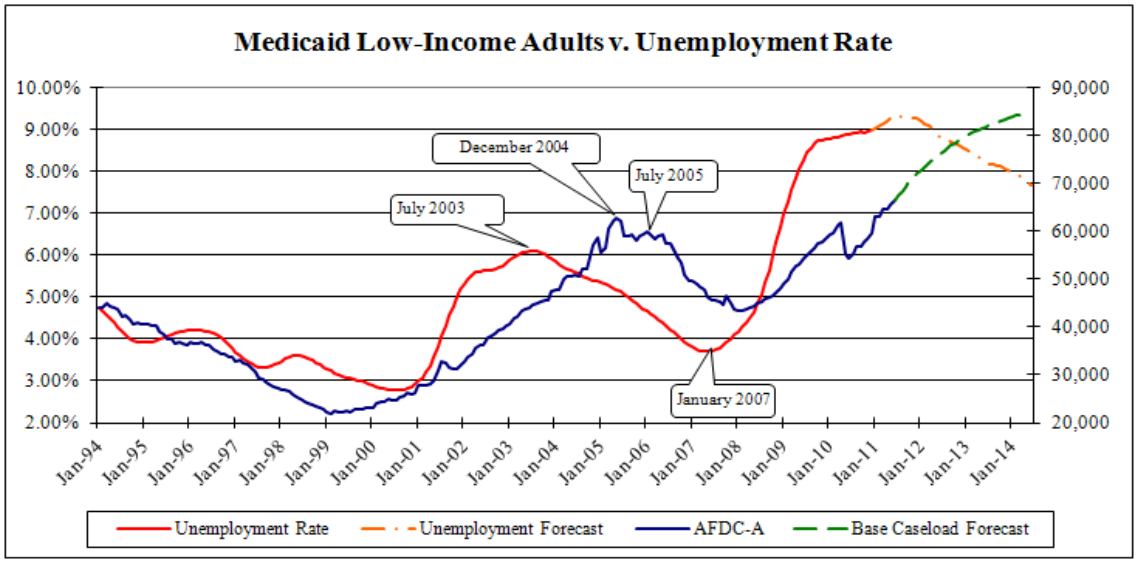
February 2011 Trends			
FY 2010-11	59,362	2.95%	1,701
FY 2011-12	65,773	10.80%	6,411
FY 2012-13	70,094	6.57%	4,321

Actuals		
	Monthly Change	**% Change**
6-month average	1,130	1.83%
12-month average	1,016	1.72%
18-month average	444	0.77%
24-month average	508	0.89%
24-month average*	781	1.34%

*Without outliers

Base trend from June 2011 level			
FY 2011-12	66,369	8.88%	5,411

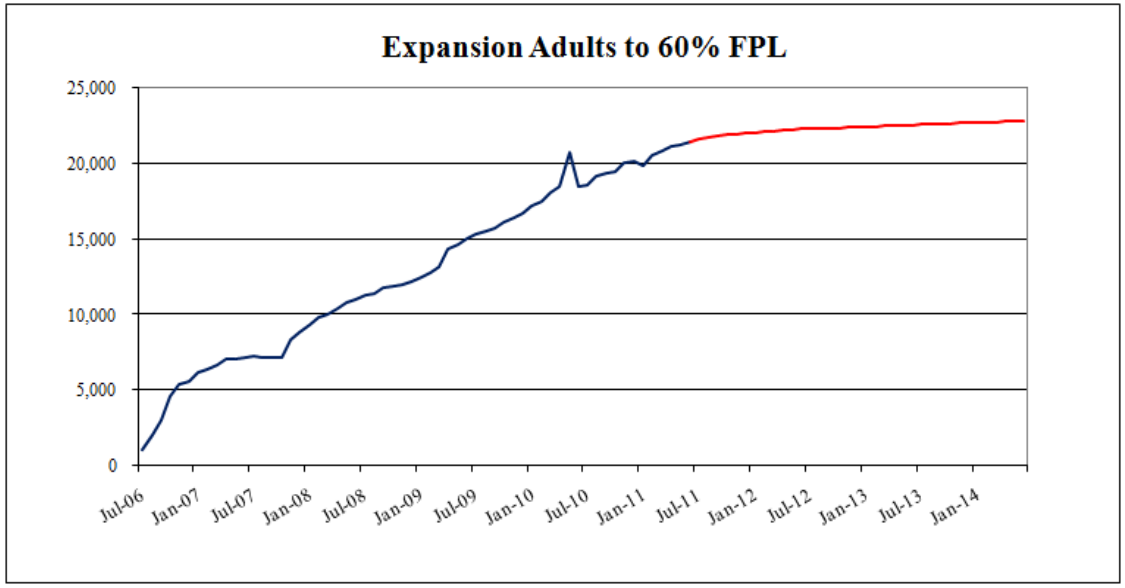
Monthly Average Growth Comparisons		
February 2011 Forecast	727	1.34%
FY 2010-11 Actuals	1,016	1.72%
FY 2010-11 1st Half	903	1.60%
FY 2010-11 2nd Half	1,130	1.83%
FY 2011-12 Forecast	821	1.24%
February 2011 Forecast	550	0.87%
FY 2012-13 Forecast	475	0.62%
February 2011 Forecast	95	0.14%

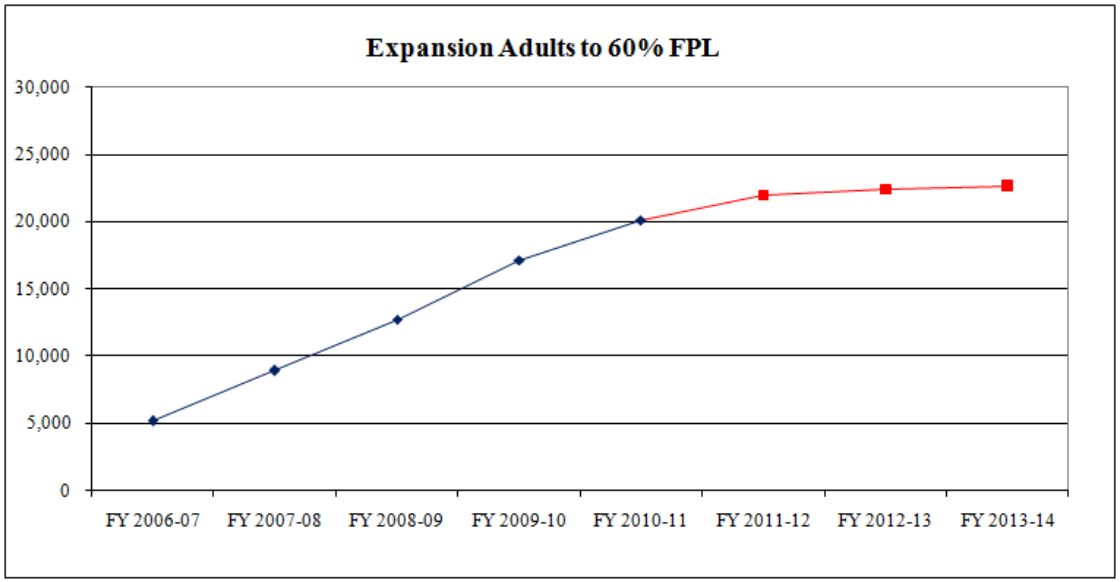


Expansion Adults to 60% FPL

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





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 2010-11 was slightly higher than the Department's February 2011 forecast, in which the annual caseload was projected to be 20,103 and average monthly growth was projected to be 221. 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. The selected trend for FY 2011-12 is in line with that from the February 2011 forecast, and would yield average growth of **67 per month** for FY 2011-12. This forecast is based on the average monthly change experienced in FY 2009-10 and FY 2010-11. The forecast assumes that monthly growth will decrease over time as the population continues to mature, and will average 0.31% per month in FY 2011-12.
- The Department assumes that growth will continue to decrease throughout the forecast period, to an average of 0.10% per month in FY 2012-13 and 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.
(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

Expansion Adults to 60% FPL: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-09	14,996	-	-
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%
Jul-10	18,556	121	0.66%
Aug-10	19,176	620	3.34%
Sep-10	19,403	227	1.18%
Oct-10	19,490	87	0.45%
Nov-10	20,002	512	2.63%
Dec-10	20,182	180	0.90%
Jan-11	19,893	(289)	-1.43%
Feb-11	20,522	629	3.16%
Mar-11	20,877	355	1.73%
Apr-11	21,090	213	1.02%
May-11	21,194	104	0.49%
Jun-11	21,458	264	1.25%

	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	20,154	17.32%	2,976
FY 2011-12	21,986	9.09%	1,832
FY 2012-13	22,413	1.94%	427
FY 2013-14	22,692	1.24%	279

February 2011 Trends			
	Caseload	**% Change**	**Level Change**
FY 2010-11	20,103	17.03%	2,925
FY 2011-12	21,607	7.48%	1,504
FY 2012-13	22,029	1.95%	422

Monthly Average Growth Comparisons		
	Monthly Change	**% Change**
FY 2011-12	67	0.31%
FY 2012-13	23	0.10%
FY 2013-14	24	0.10%

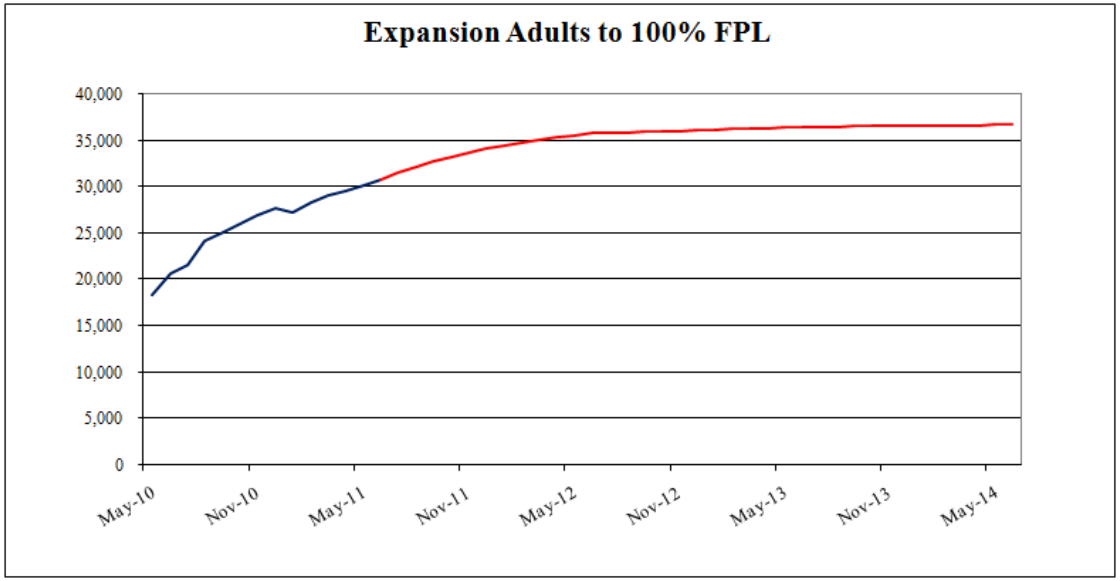
Actuals		
	Monthly Change	**% Change**
6-month average	213	1.04%
12-month average	252	1.28%
18-month average	262	1.47%
24-month average	269	1.57%

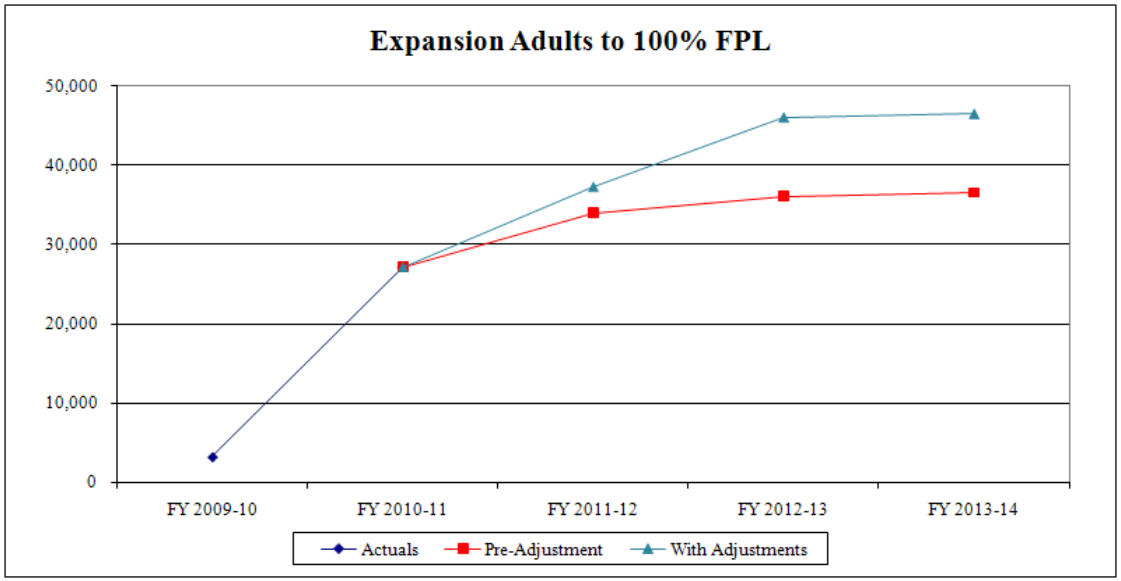
Base trend from June 2011 level			
FY 2011-12	21,458	6.47%	1,304

Monthly Average Growth Comparisons		
FY 2011-12 Forecast	221	1.13%
FY 2010-11 Actuals	252	1.28%
FY 2010-11 1st Half	291	1.53%
FY 2010-11 2nd Half	213	1.04%
FY 2011-12 Forecast	67	0.31%
February 2011 Forecast	66	0.31%
FY 2012-13 Forecast	24	0.10%
February 2011 Forecast	23	0.10%

Expansion Adults to 100% FPL

HB 09-1293 (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. Growth in FY 2010-11 was in line with that from the Department's February 2010 forecast. Thus, the forecasted caseload from February 2011 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.
- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which establishes the Adults without Dependent Children on March 2012. Enrollment in this program will initially be opened to individuals with income 0-10% of federal poverty line (FPL) and enrollment will be limited to 10,000.

Expansion Adults to 100% FPL: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
May-10	18,235	-	-
Jun-10	20,607	2,372	13.01%
Jul-10	21,446	839	4.07%
Aug-10	24,193	2,747	12.81%
Sep-10	25,071	878	3.63%
Oct-10	26,016	945	3.77%
Nov-10	26,924	908	3.49%
Dec-10	27,596	672	2.50%
Jan-11	27,180	(416)	-1.51%
Feb-11	28,323	1,143	4.21%
Mar-11	28,968	645	2.28%
Apr-11	29,451	483	1.67%
May-11	30,102	651	2.21%
Jun-11	30,724	622	2.07%

	Caseload	**% Change**	**Level Change**
FY 2009-10	3,237	-	-
FY 2010-11	27,166	739.23%	23,929
FY 2011-12	33,976	25.07%	6,810
FY 2012-13	36,083	6.20%	2,107
FY 2013-14	36,539	1.26%	456

Adjustments	
FY 2011-12	3,333
FY 2012-13	10,000
FY 2013-14	10,000

Projections After Adjustments			
FY 2011-12	37,309	37.34%	10,143
FY 2012-13	46,083	23.52%	8,774
FY 2013-14	46,539	0.99%	456

Actuals		
	Monthly Change	**% Change**
6-month average	521	1.82%
12-month average	843	3.43%

February 2011 Trends- Monthly Growth Estimates		
FY 2010-11	908	3.64%
FY 2011-12	361	1.08%
FY 2012-13	38	0.11%

Monthly Growth Estimates		
FY 2010-11	843	3.43%
FY 2011-12	414	1.26%
FY 2012-13	60	0.17%

February 2011 Trends (BEFORE ADJUSTMENTS)			
	Caseload	**% Change**	**Level Change**
FY 2010-11	27,597	742.45%	24,033
FY 2011-12	33,976	23.11%	6,379
FY 2012-13	36,083	6.20%	2,107

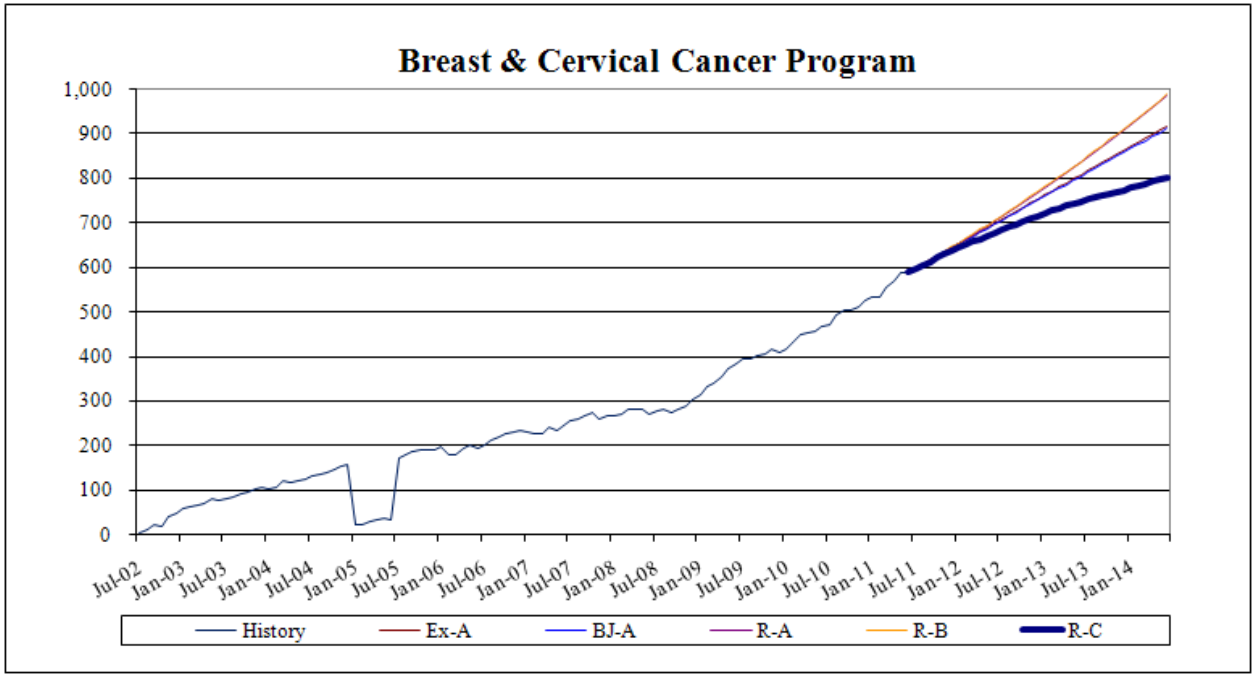
Base trend from June 2011 level			
FY 2011-12	30,724	13.10%	3,558

Breast and Cervical Cancer Program

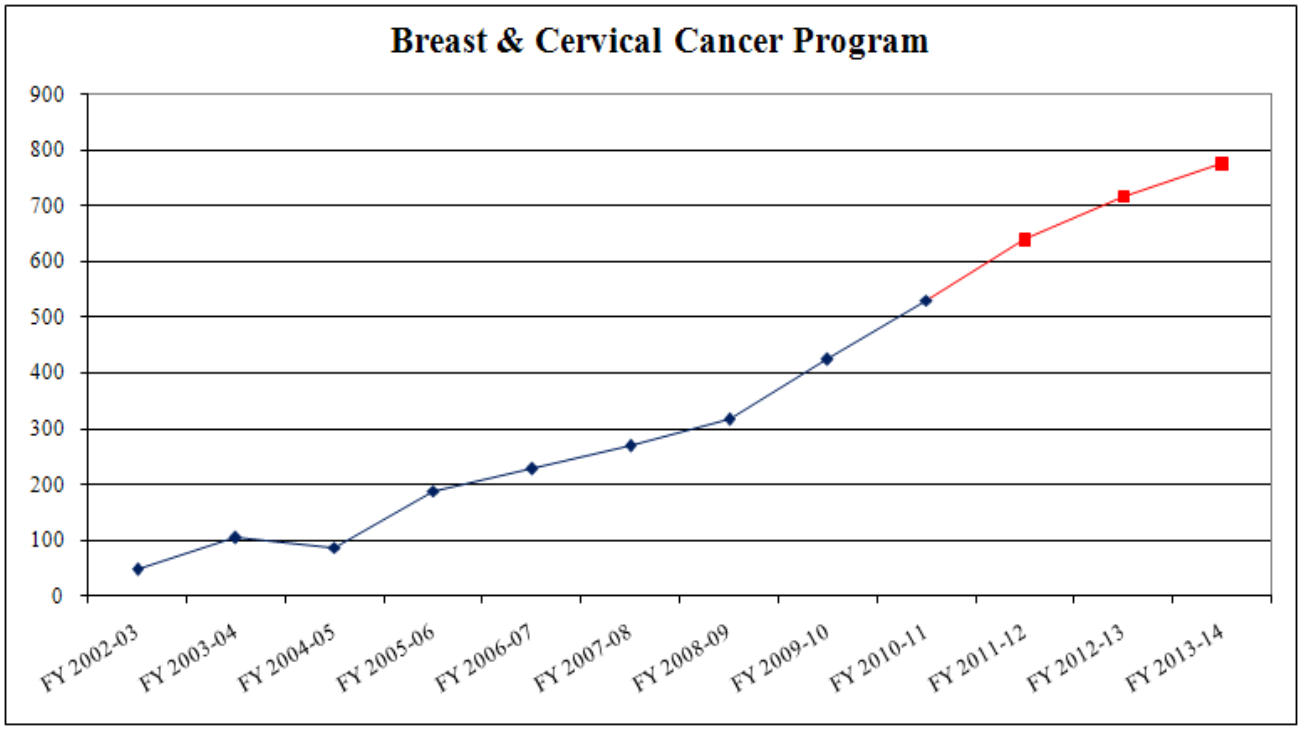
The Breast and Cervical Cancer Treatment Program was authorized under SB 01S2-012 and began enrolling eligible women in July 2002. Women under this optional coverage group were screened using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines, 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*	0.9978	
Box-Jenkins A	0.9978	
Regression A	0.9978	BCCP [-1], Female Population 19-59, Auto [-1]
Regression B	0.9978	BCCP [-1], Trend
Regression C	0.9980	BCCP [-1], Unemployment Rate, Total Wages, Female Population 19-59



Breast and Cervical Cancer Program: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	425	531	22.03%	648	117	9
Box Jenkins *	425	531	21.85%	647	116	9
Regression A	425	531	22.60%	651	120	10
Regression B	425	531	22.60%	651	120	10
Regression C	**425**	**531**	**20.53%**	**640**	**109**	**7**

* Denotes Expert Selection, Bold denotes Trend Selection

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	531	640	16.98%	749	109	9
Box Jenkins *	531	640	16.69%	747	107	9
Regression A	531	640	19.05%	762	122	11
Regression B	531	640	19.05%	762	122	11
Regression C	**531**	**640**	**12.03%**	**717**	**77**	**6**

Breast and Cervical Cancer Program: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	640	717	14.38%	820	103	9
Box Jenkins *	640	717	14.30%	820	103	9
Regression A	640	717	18.19%	847	130	12
Regression B	640	717	18.32%	848	131	13
Regression C	**640**	**717**	**8.37%**	**777**	**60**	**4**

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

Breast and Cervical Cancer Program: Trend Selections

FY 2011-12: 20.53%
FY 2012-13: 12.03%
FY 2013-14: 8.37%

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 2010-11 was higher than the Department's February 2011 forecast, in which the annual caseload was projected to be 527 and average monthly growth was projected to be 8. The selected trend for FY 2011-12 is higher than that from the February 2011 forecast, and would yield average growth of **7 per month** for FY 2011-12.

- 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.
(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-09	383	-	-
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%
Jul-10	471	5	1.07%
Aug-10	493	22	4.67%
Sep-10	503	10	2.03%
Oct-10	505	2	0.40%
Nov-10	511	6	1.19%
Dec-10	526	15	2.94%
Jan-11	532	6	1.14%
Feb-11	535	3	0.56%
Mar-11	556	21	3.93%
Apr-11	569	13	2.34%
May-11	587	18	3.16%
Jun-11	589	2	0.34%

Actuals		
	Monthly Change	**% Change**
6-month average	11	1.91%
12-month average	10	1.98%
18-month average	10	2.03%
24-month average	9	1.82%

	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	531	24.94%	106
FY 2011-12	640	20.53%	109
FY 2012-13	717	12.03%	77
FY 2013-14	777	8.37%	60

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

February 2011 Trends			
FY 2010-11	527	24.00%	102
FY 2011-12	598	13.47%	71
FY 2012-13	660	10.37%	62

Monthly Average Growth Comparisons		
February 2011 Forecast	8	1.72%
FY 2010-11 Actuals	10	1.98%
FY 2010-11 1st Half	10	2.05%
FY 2010-11 2nd Half	11	1.91%
FY 2011-12 Forecast	7	1.19%
February 2011 Forecast	5	0.89%
FY 2012-13 Forecast	6	0.85%
February 2011 Forecast	5	0.80%

Base trend from June 2011 level			
FY 2011-12	589	10.92%	58

Eligible Children

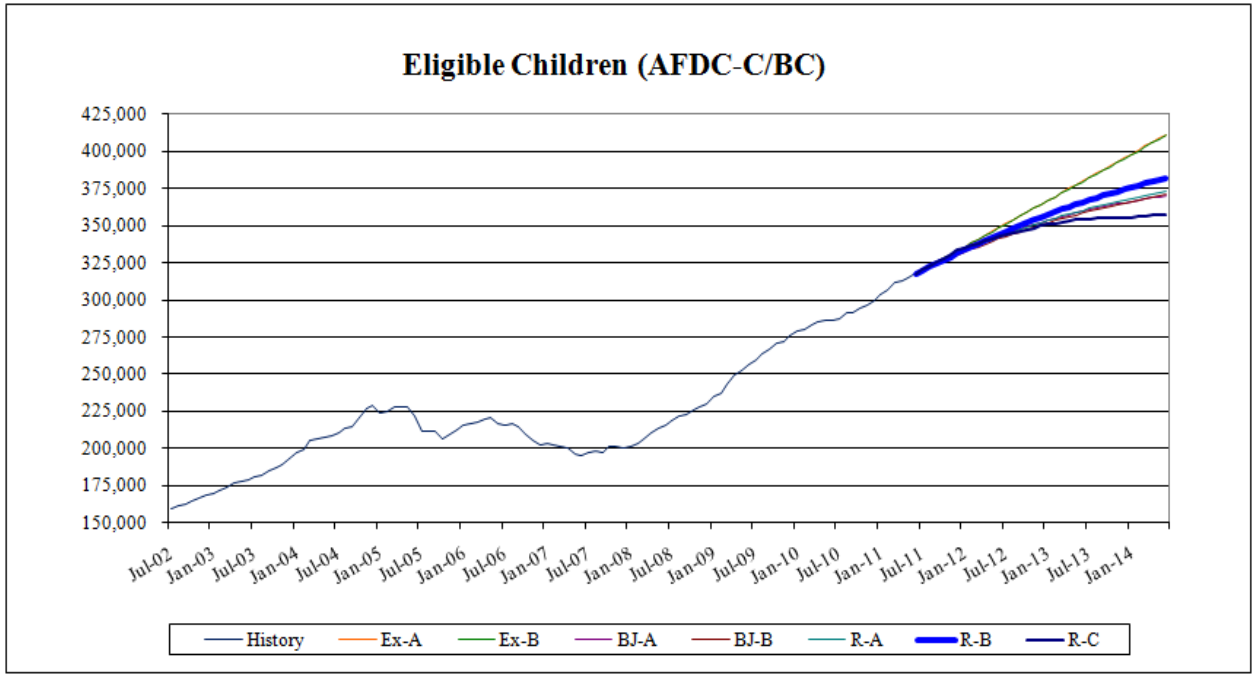
One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to 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 2010-11, there were an average of 11,042 children on Transitional Medicaid. Authorization for Transitional Medicaid benefits was extended through December 31, 2011, and the Department's forecast assumes that the program will continue through FY 2012-13.

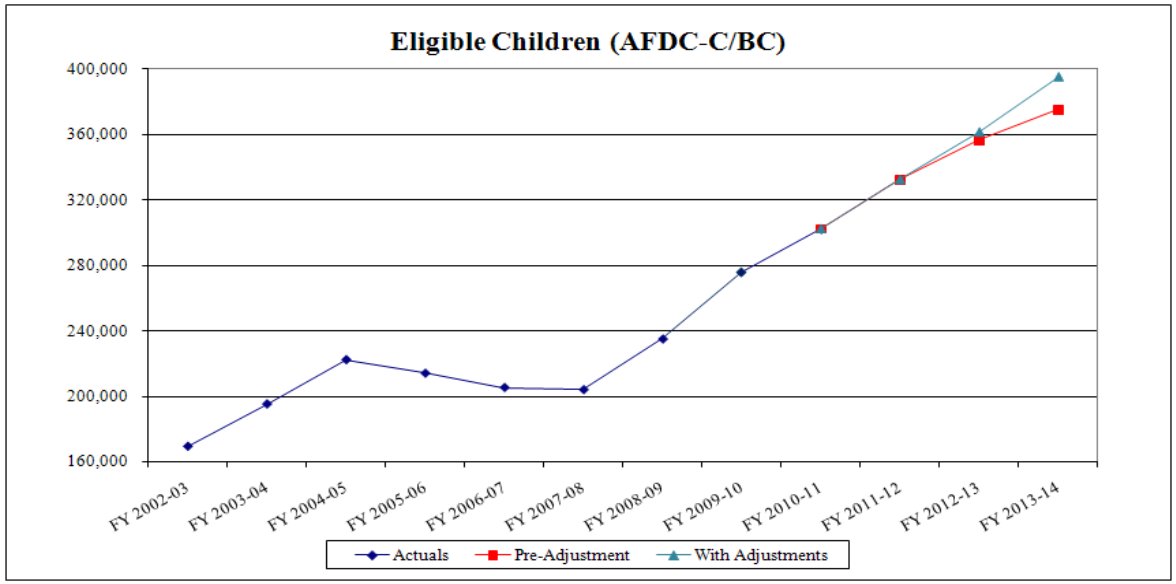
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic 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	0.9990	
Exponential Smoothing B	0.9973	
Box-Jenkins A*	0.9991	
Box-Jenkins B*	0.9974	
Regression A	0.9992	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, Systems Dummy
Regression B	0.9992	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy [-2], Systems Dummy, Auto [-2], Auto [-3]
Regression C	0.9893	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, Population Under 19, Trend, CBMS Dummy [-1], Systems Dummy, Auto [-12], Auto [-18]



Eligible Children: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	275,672	302,381	10.61%	334,464	32,083	2,600
Exponential Smoothing B*	275,672	302,381	10.57%	334,343	31,962	2,585
Box Jenkins A	275,672	302,381	9.71%	331,742	29,361	2,112
Box Jenkins B	275,672	302,381	9.43%	330,896	28,515	1,962
Regression A	275,672	302,381	9.77%	331,924	29,543	2,084
Regression B	**275,672**	**302,381**	**9.92%**	**332,377**	**29,996**	**2,229**
Regression C	275,672	302,381	10.10%	332,921	30,540	2,102

* Denotes Expert Selection, Bold denotes Trend Selection

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*	302,381	332,377	9.33%	363,388	31,011	2,600
Exponential Smoothing B*	302,381	332,377	9.28%	363,222	30,845	2,585
Box Jenkins A	302,381	332,377	6.27%	353,217	20,840	1,388
Box Jenkins B	302,381	332,377	6.06%	352,519	20,142	1,449
Regression A	302,381	332,377	6.23%	353,084	20,707	1,472
Regression B	**302,381**	**332,377**	**7.23%**	**356,408**	**24,031**	**1,795**
Regression C	302,381	332,377	5.08%	349,262	16,885	959

Eligible Children: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	332,377	356,408	8.53%	386,810	30,402	2,600
Exponential Smoothing B*	332,377	356,408	8.49%	386,667	30,259	2,585
Box Jenkins A	332,377	356,408	3.71%	369,631	13,223	872
Box Jenkins B	332,377	356,408	4.22%	371,448	15,040	1,069
Regression A	332,377	356,408	4.16%	371,235	14,827	1,042
Regression B	**332,377**	**356,408**	**5.21%**	**374,977**	**18,569**	**1,363**
Regression C	332,377	356,408	1.73%	362,574	6,166	243

[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 2011-12: 9.92%
FY 2012-13: 7.23%
FY 2013-14: 5.21%

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 2010-11. The expansion in this age group is projected to average 1.7% throughout the forecast period.[10] The economy is projected remain relatively weak over the forecast period, with the unemployment rate to average 8.5% between 2011 and 2013. Wage and salary income is projected to increase by 3.5% in 2011, with moderate growth of 1.0% in 2012, increasing to 3.0% in 2013.[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 cannot 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 2010-11 was higher than the Department's February 2011 forecast, in which the annual base caseload was projected to be 299,573 and average monthly growth was projected to be 1,981. The lack of increases in May and June 2010 were due to 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 four years, as the seasonally adjusted unemployment rate increased from a low of 3.5% in March 2007 to a high of 9.3% in February 2011 (source: Bureau of Labor Statistics). The unemployment rate is at the highest level in recent history, and has also remained at this high level for an unprecedented period of time. During the 2001-2002 recession, the Eligible Children caseload was increasing by 1.5% per month. The selected trend for FY 2011-12 is higher than that from the February 2011 forecast, and would yield average increases of **2,229 per month** for FY 2011-12. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which moderated in FY 2009-10 but increased in FY 2010-11. 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 2011-12. The selected trends for FY 2011-12 and FY 2012-13 are conservative due to volatility in the monthly data, and the Department will continue to monitor this category and economic conditions closely.
- 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 2012. 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.
- As part of the Department's efforts to increase administrative efficiencies, it is implementing Express Lane Eligibility in FY 2011-12. This will allow the program to take utilize information in the Colorado Benefits Management System (CBMS) gathered for the free/reduced price lunch program to expedite eligibility processing for children potentially eligible for Medicaid. Currently, school aged children are specifically targeted in many ways for application assistance. Many school districts hand out Medical Assistance Applications at schools, and community partners throughout the State provide application assistance to families at Back-to-School nights and other school-related events. Thus, the coordination with the free/reduced price lunch program will serve to decrease the administrative burden on school districts, community partners, and families by utilizing existing data within CBMS. The Department estimates that any caseload increases resulting from this initiative are negligible and has included them in its caseload forecast.
- There is a bottom-line adjustment to this eligibility type from SB 11-008, which increases eligibility for children age 6 to 19 in Medicaid from 100% of federal poverty line (FPL) to 133% FPL effective January 1, 2013.

25.5-5-101 (1), C.R.S.
(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.
(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.
(a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program… (b) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent…;
(c) (I) On and after July 1, 1991, children born after September 30, 1983, who have attained age six but have not attained age nineteen shall be eligible for benefits under the baby and kid care program… (II) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this paragraph (c) shall be one hundred percent;

Eligible Children: Historical Caseload and Forecasts

Eligible Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-09	256,630	-	-
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%
Jul-10	287,674	1,896	0.66%
Aug-10	290,871	3,197	1.11%
Sep-10	291,592	721	0.25%
Oct-10	294,155	2,563	0.88%
Nov-10	296,482	2,327	0.79%
Dec-10	299,499	3,017	1.02%
Jan-11	303,692	4,193	1.40%
Feb-11	307,032	3,340	1.10%
Mar-11	312,300	5,268	1.72%
Apr-11	312,603	303	0.10%
May-11	315,116	2,513	0.80%
Jun-11	317,551	2,435	0.77%

	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	302,381	9.69%	26,709
FY 2011-12	332,377	9.92%	29,996
FY 2012-13	356,408	7.23%	24,031
FY 2013-14	374,977	5.21%	18,569

* 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 2011-12	0
FY 2012-13	3,951
FY 2013-14	16,333

Actuals		
	Monthly Change	% Change
6-month average	3,009	0.98%
12-month average	2,648	0.88%
18-month average	2,316	0.79%
24-month average	2,538	0.89%
24-month average*	2,768	0.97%

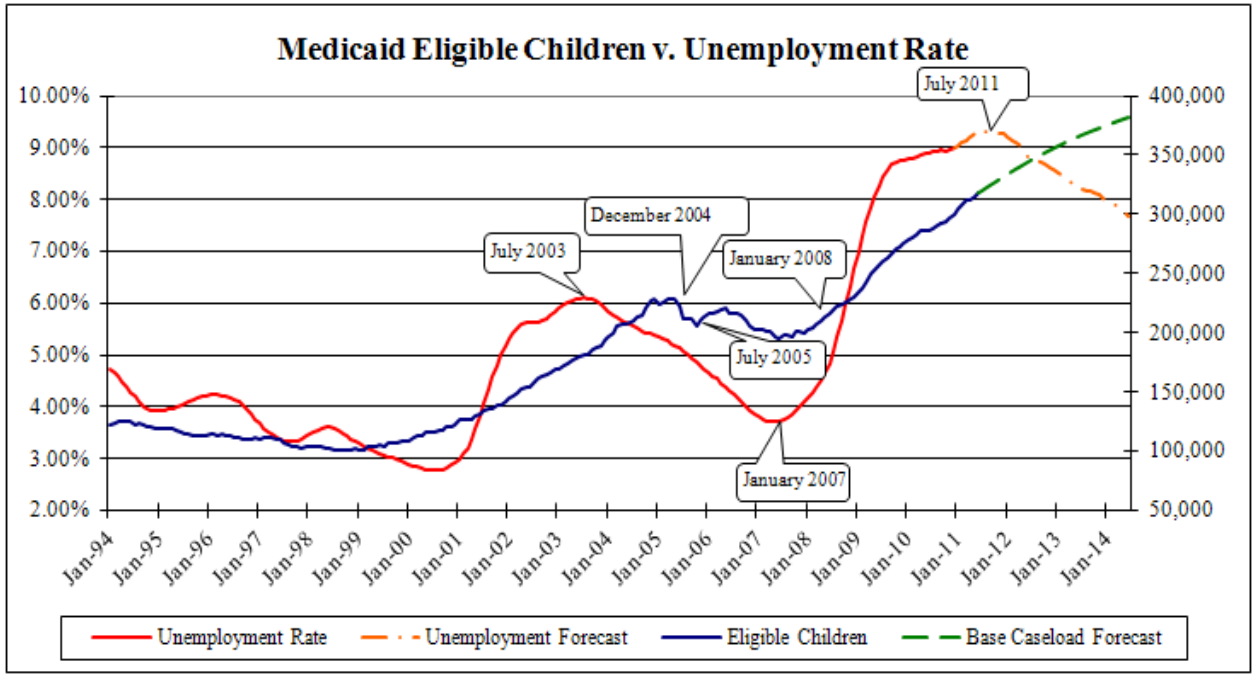
*Without outliers

Projections After Adjustments			
FY 2011-12	332,377	9.92%	29,996
FY 2012-13	360,359	8.42%	27,982
FY 2013-14	391,310	8.59%	30,951

Eligible Children: Historical Caseload and Projections		
Monthly Average Growth Comparisons		
February 2011 Forecast	1,981	0.69%
FY 2010-11 Actuals	2,648	0.88%
FY 2010-11 1st Half	2,287	0.79%
FY 2010-11 2nd Half	3,009	0.98%
FY 2011-12 Forecast	2,229	0.70%
February 2011 Forecast	1,323	0.42%
FY 2012-13 Forecast	1,795	0.52%
February 2011 Forecast	894	0.27%

February 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2010-11	299,573	8.67%	23,901
FY 2011-12	318,626	6.36%	19,053
FY 2012-13	331,562	4.06%	12,936

Base trend from June 2011 level			
FY 2011-12	317,551	5.02%	15,170

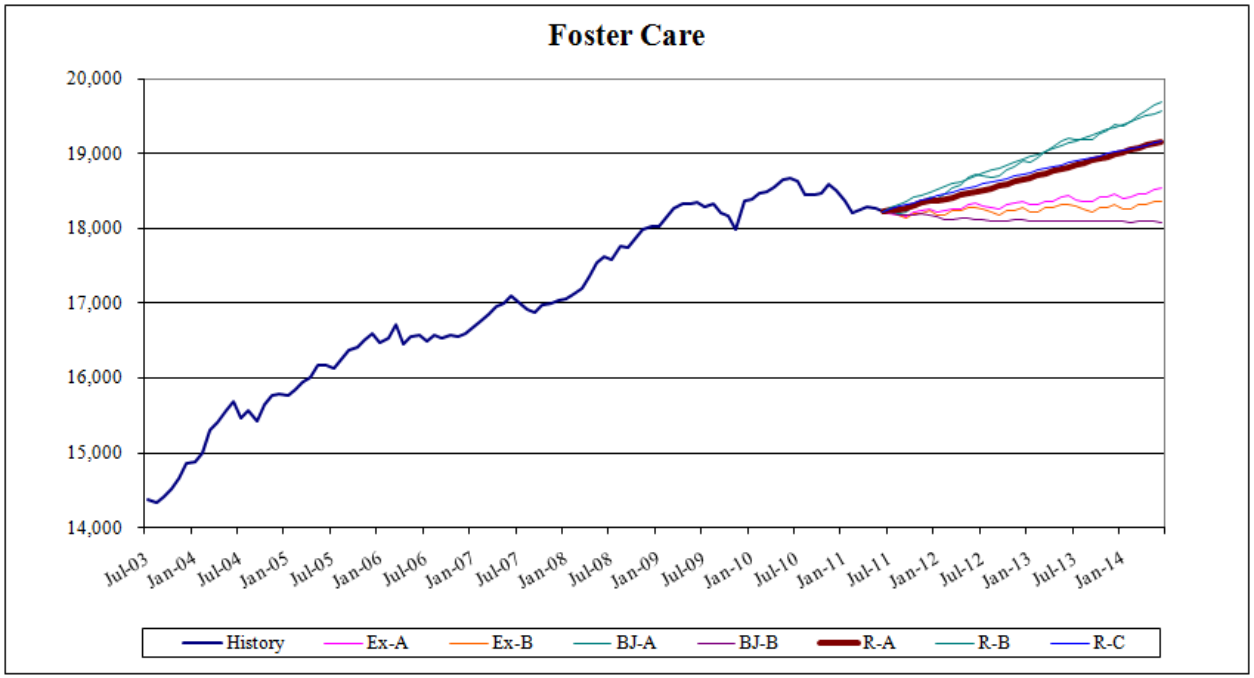


Foster Care

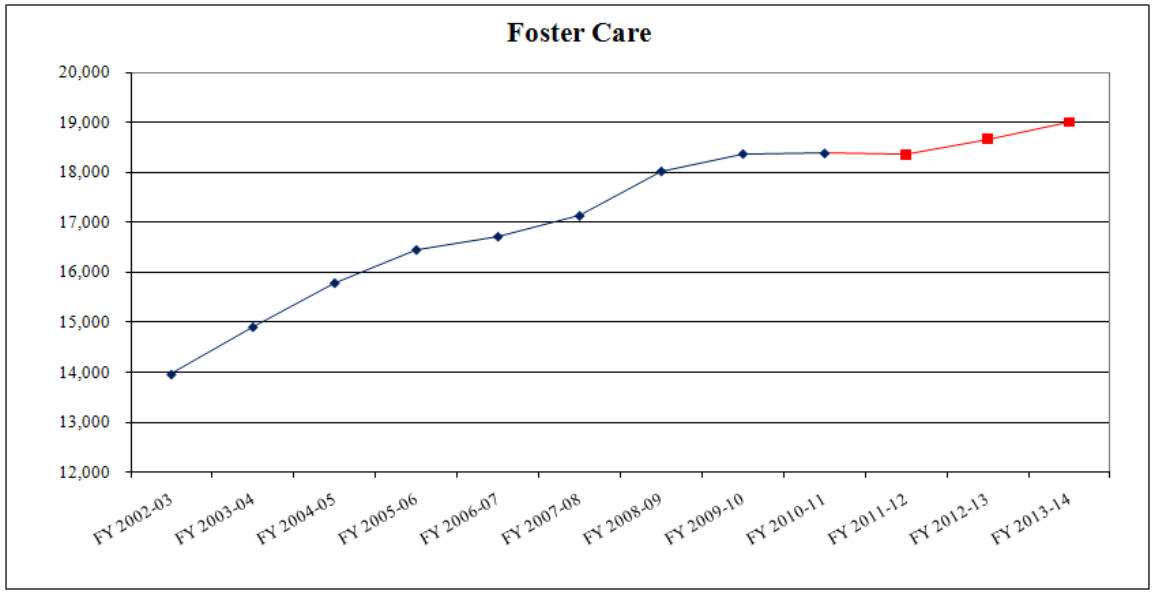
Federal law mandates that states provide Medicaid to individuals under Title IV-E of the Social Security Act (42 U.S.C. 470-479A) for adoption assistance and foster care. Title IV-E is a subpart of Title IV, Child Welfare, of the federal Social Security Act. Title IV-E provides federal reimbursement 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*	0.9990	
Exponential Smoothing B*	0.9949	
Box-Jenkins A	0.9989	
Box-Jenkins B	0.9942	
Regression A	0.9986	FOSTER [-1], Population Under 19, Auto [-12]
Regression B	0.9988	FOSTER [-1], FOSTER [-5], Total Population
Regression C	0.9989	FOSTER [-1], Trend, Auto [-1]



Foster Care: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	18,381	18,392	-0.82%	18,241	(151)	10
Exponential Smoothing B	18,381	18,392	-0.98%	18,212	(180)	4
Box Jenkins A*	18,381	18,392	0.16%	18,421	29	42
Box Jenkins B*	18,381	18,392	-1.27%	18,158	(234)	(9)
Regression A	**18,381**	**18,392**	**-0.16%**	**18,363**	**(29)**	**22**
Regression B	18,381	18,392	0.57%	18,497	105	40
Regression C	18,381	18,392	0.14%	18,418	26	29

* Denotes Expert Selection, Bold denotes Trend Selection

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	18,392	18,363	0.52%	18,458	95	8
Exponential Smoothing B	18,392	18,363	0.22%	18,403	40	3
Box Jenkins A*	18,392	18,363	2.64%	18,848	485	41
Box Jenkins B*	18,392	18,363	-0.31%	18,306	(57)	(2)
Regression A	**18,392**	**18,363**	**1.66%**	**18,668**	**305**	**28**
Regression B	18,392	18,363	2.39%	18,802	439	36
Regression C	18,392	18,363	1.73%	18,681	318	26

Foster Care: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	18,363	18,668	0.52%	18,765	97	8
Exponential Smoothing B	18,363	18,668	0.22%	18,709	41	3
Box Jenkins A*	18,363	18,668	2.58%	19,150	482	40
Box Jenkins B*	18,363	18,668	-0.07%	18,655	(13)	0
Regression A	**18,363**	**18,668**	**1.82%**	**19,008**	**340**	**29**
Regression B	18,363	18,668	2.29%	19,095	427	36
Regression C	18,363	18,668	1.58%	18,963	295	24

[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 2011-12: -0.16%
FY 2012-13: 1.66%
FY 2013-14: 1.82%

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 2011-12 was lower than the Department's February 2011 forecast, in which the annual base caseload was projected to be 18,568 and average monthly growth was projected to be 2. The selected trend for FY 2011-12 is lower than that from the February 2011 forecast, and would yield average growth of **22 per month** for the remainder of FY 2010-11.
- Out-year growth reflects a continuation of positive growth, and a return to more moderate growth in line with historical trend.

25.5-5-101 (1), C.R.S.
(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.
(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-09	18,348	-	-
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%
Jul-10	18,628	(50)	-0.27%
Aug-10	18,455	(173)	-0.93%
Sep-10	18,451	(4)	-0.02%
Oct-10	18,464	13	0.07%
Nov-10	18,597	133	0.72%
Dec-10	18,510	(87)	-0.47%
Jan-11	18,377	(133)	-0.72%
Feb-11	18,200	(177)	-0.96%
Mar-11	18,244	44	0.24%
Apr-11	18,280	36	0.20%
May-11	18,279	(1)	-0.01%
Jun-11	18,221	(58)	-0.32%

	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	18,392	0.06%	11
FY 2011-12	18,363	-0.16%	(29)
FY 2012-13	18,668	1.66%	305
FY 2013-14	19,008	1.82%	340

* 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 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2010-11	18,568	1.02%	187
FY 2011-12	18,858	1.56%	290
FY 2012-13	19,194	1.78%	336

Actuals		
	Monthly Change	**% Change**
6-month average	(48)	-0.26%
12-month average	(38)	-0.21%
18-month average	(8)	-0.04%
24-month average	(5)	-0.03%

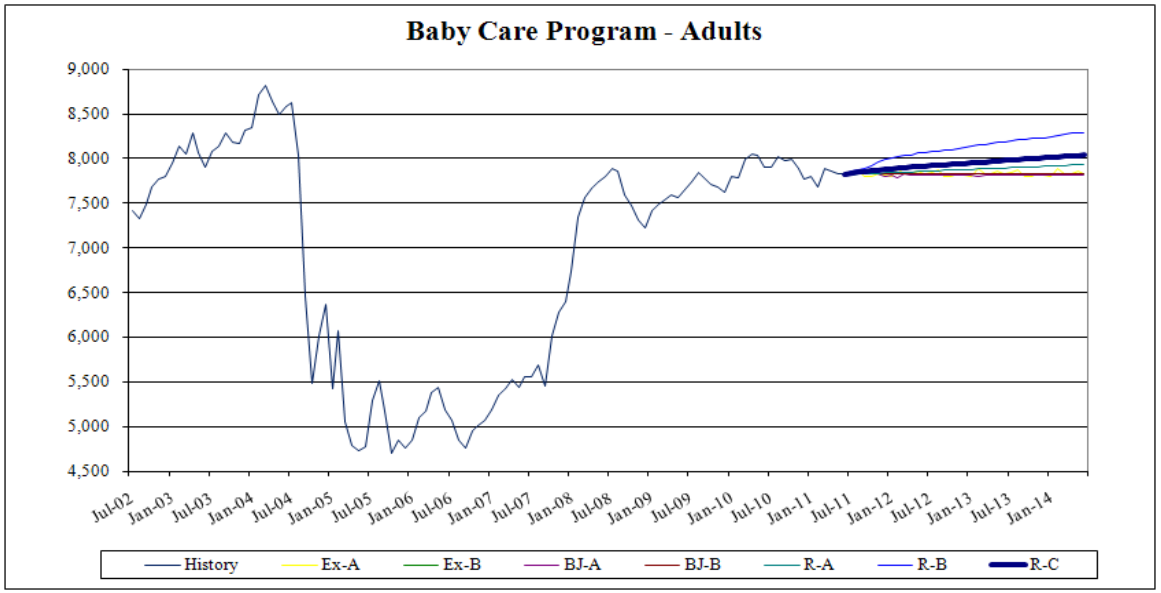
Base trend from June 2011 level			
FY 2011-12	18,221	-0.93%	(171)

Monthly Average Growth Comparisons		
February 2011 Forecast	2	0.01%
FY 2010-11 Actuals	(38)	-0.21%
FY 2010-11 1st Half	(28)	-0.15%
FY 2010-11 2nd Half	(48)	-0.26%
FY 2011-12 Forecast	22	0.12%
February 2011 Forecast	26	0.14%
FY 2012-13 Forecast	28	0.15%
February 2011 Forecast	28	0.15%

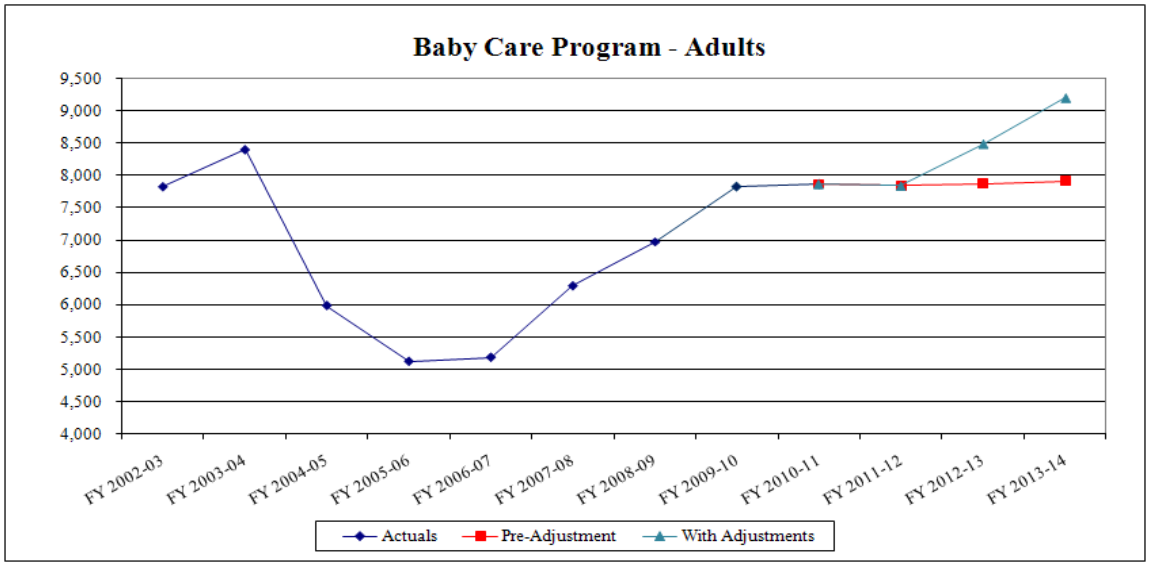
Baby Care Adults

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*	0.9533	
Exponential Smoothing B*	0.9420	
Box-Jenkins A	0.9540	
Box-Jenkins	0.9424	
Regression A	0.9536	BCA [-1], BCA Dummy, Auto [-4]
Regression B	0.9521	BCA [-1], Migration, Unemployment Rate, Auto [-3]
Regression C	0.9554	BCA [-1], Unemployment Rate, Female Population 19-59, BCA Dummy



Baby Care Program-Adults: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	7,829	7,868	-0.44%	7,833	(35)	0
Exponential Smoothing B	7,829	7,868	-0.51%	7,828	(40)	0
Box Jenkins A*	7,829	7,868	-0.60%	7,821	(47)	(1)
Box Jenkins B*	7,829	7,868	-0.51%	7,828	(40)	0
Regression A	**7,829**	**7,868**	**-0.37%**	**7,839**	**(29)**	**2**
Regression B	7,829	7,868	1.37%	7,976	108	20
Regression C	7,829	7,868	0.14%	7,879	11	7

* Denotes Expert Selection, Bold denotes Trend Selection

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	7,868	7,839	0.00%	7,839	0	0
Exponential Smoothing B	7,868	7,839	0.00%	7,839	0	0
Box Jenkins A*	7,868	7,839	-0.12%	7,830	(9)	0
Box Jenkins B*	7,868	7,839	0.00%	7,839	0	0
Regression A	**7,868**	**7,839**	**0.48%**	**7,877**	**38**	**3**
Regression B	7,868	7,839	1.93%	7,990	151	10
Regression C	7,868	7,839	0.88%	7,908	69	5

Baby Care Program-Adults: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	7,839	7,877	0.00%	7,877	0	0
Exponential Smoothing B	7,839	7,877	0.00%	7,877	0	0
Box Jenkins A*	7,839	7,877	-0.01%	7,876	(1)	0
Box Jenkins B*	7,839	7,877	0.00%	7,877	0	0
Regression A	**7,839**	**7,877**	**0.47%**	**7,914**	**37**	**3**
Regression B	7,839	7,877	1.40%	7,987	110	8
Regression C	7,839	7,877	0.79%	7,939	62	5

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

Baby Care Program- Adults: Trend Selections

FY 2011-12: -0.37%
FY 2012-13: 0.48%
FY 2013-14: 0.47%

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.
- 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 has restated 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 now included in the base caseload.
- Growth in FY 2011-12 was lower than the Department's February 2011 forecast, in which the annual base caseload was projected

to be 7,905 and average monthly declines were projected to be 11. The selected trend for FY 2011-12 is lower than that from the February 2011 forecast, and would yield average growth of **2 per month** for FY 2011-12. Caseload in this eligibility type has been volatile for 3 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 are moderate due to this Family Planning initiative (as well as the Family Planning waiver to be submitted by the Department pursuant to SB 08-003).
- There is a bottom-line adjustment to this eligibility type from SB 11-250, which increases eligibility for pregnant women in Medicaid from 133% of federal poverty line (FPL) to 185% FPL effective January 1, 2013.

25.5-5-101 (1), C.R.S.
(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.
(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.
(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-09	7,651	-	-
Jul-09	7,745	94	1.23%
Aug-09	7,849	104	1.34%
Sep-09	7,775	(74)	-0.94%
Oct-09	7,713	(62)	-0.80%
Nov-09	7,674	(39)	-0.51%
Dec-09	7,627	(47)	-0.61%
Jan-10	7,796	169	2.22%
Feb-10	7,779	(17)	-0.22%
Mar-10	7,996	217	2.79%
Apr-10	8,054	58	0.73%
May-10	8,039	(15)	-0.19%
Jun-10	7,903	(136)	-1.69%
Jul-10	7,909	6	0.08%
Aug-10	8,014	105	1.33%
Sep-10	7,971	(43)	-0.54%
Oct-10	7,985	14	0.18%
Nov-10	7,891	(94)	-1.18%
Dec-10	7,764	(127)	-1.61%
Jan-11	7,804	40	0.52%
Feb-11	7,677	(127)	-1.63%
Mar-11	7,881	204	2.66%
Apr-11	7,864	(17)	-0.22%
May-11	7,830	(34)	-0.43%
Jun-11	7,828	(2)	-0.03%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	7,223	-	-
FY 1996-97	5,476	-24.19%	(1,747)
FY 1997-98	4,295	-21.57%	(1,181)
FY 1998-99	5,017	16.81%	722
FY 1999-00	6,174	23.06%	1,157
FY 2000-01	6,561	6.27%	387
FY 2001-02	7,131	8.69%	570
FY 2002-03	7,823	9.70%	692
FY 2003-04	8,398	7.35%	575
FY 2004-05	5,984	-28.74%	(2,414)
FY 2005-06	5,119	-14.46%	(865)
FY 2006-07	5,182	1.23%	63
FY 2007-08	6,288	21.34%	1,106
FY 2008-09	6,976	10.94%	688
FY 2009-10	7,830	12.24%	854
FY 2010-11	7,868	0.49%	38
FY 2011-12	7,839	-0.37%	(29)
FY 2012-13	7,877	0.48%	38
FY 2013-14	7,914	0.47%	37

* 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 2011-12	0
FY 2012-13	597
FY 2013-14	1,194

Actuals		
	Monthly Change	**% Change**
6-month average	11	0.15%
12-month average	(6)	-0.07%
18-month average	11	0.15%
24-month average	7	0.10%

Projections After Adjustments			
FY 2011-12	7,839	-0.37%	(29)
FY 2012-13	8,474	8.10%	635
FY 2013-14	9,108	7.48%	634

Baby Care Program-Adults: Historical Caseload and Projections		
Monthly Average Growth Comparisons		
February 2011 Forecast	(11)	-0.15%
FY 2010-11 Actuals	(6)	-0.07%
FY 2010-11 1st Half	(23)	-0.29%
FY 2010-11 2nd Half	11	0.15%
FY 2011-12 Forecast	2	0.03%
February 2011 Forecast	0	0.00%
FY 2012-13 Forecast	3	0.04%
February 2011 Forecast	0	0.00%

February 2011 Trends			
FY 2010-11	7,905	0.96%	69
FY 2011-12	7,828	-0.97%	(71)
FY 2012-13	7,828	0.00%	0

Base trend from June 2011 level			
FY 2011-12	7,828	-0.51%	(40)

Non-Citizens

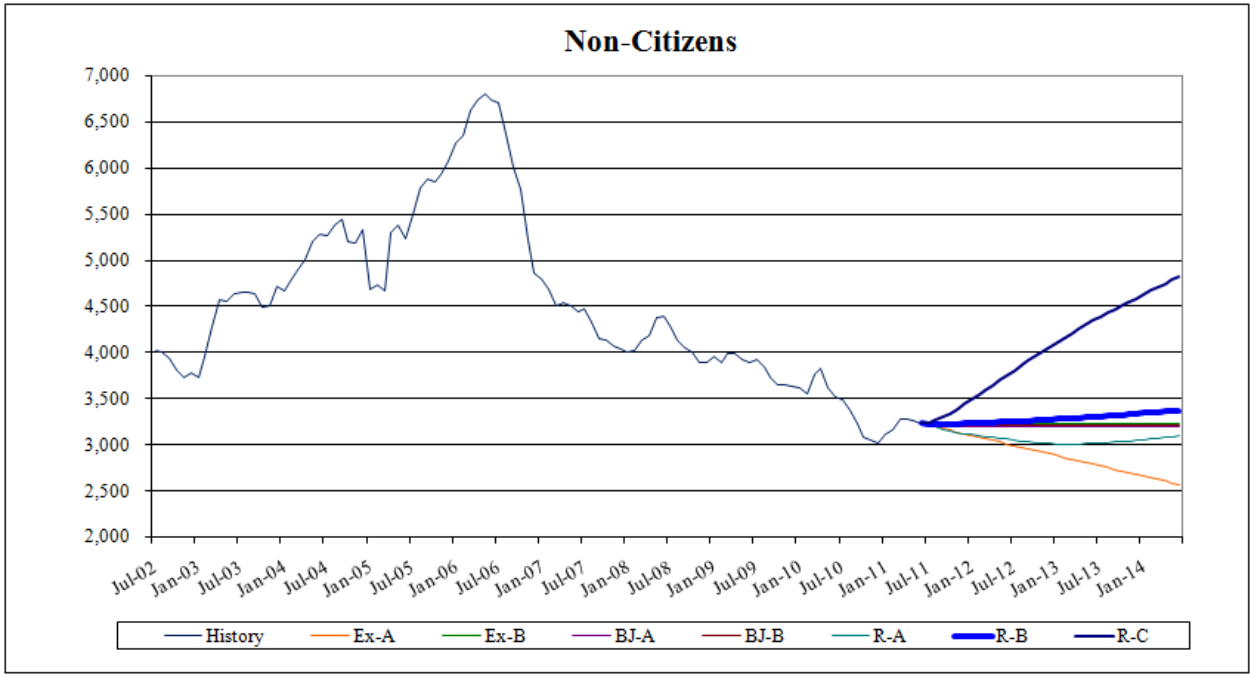
Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived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

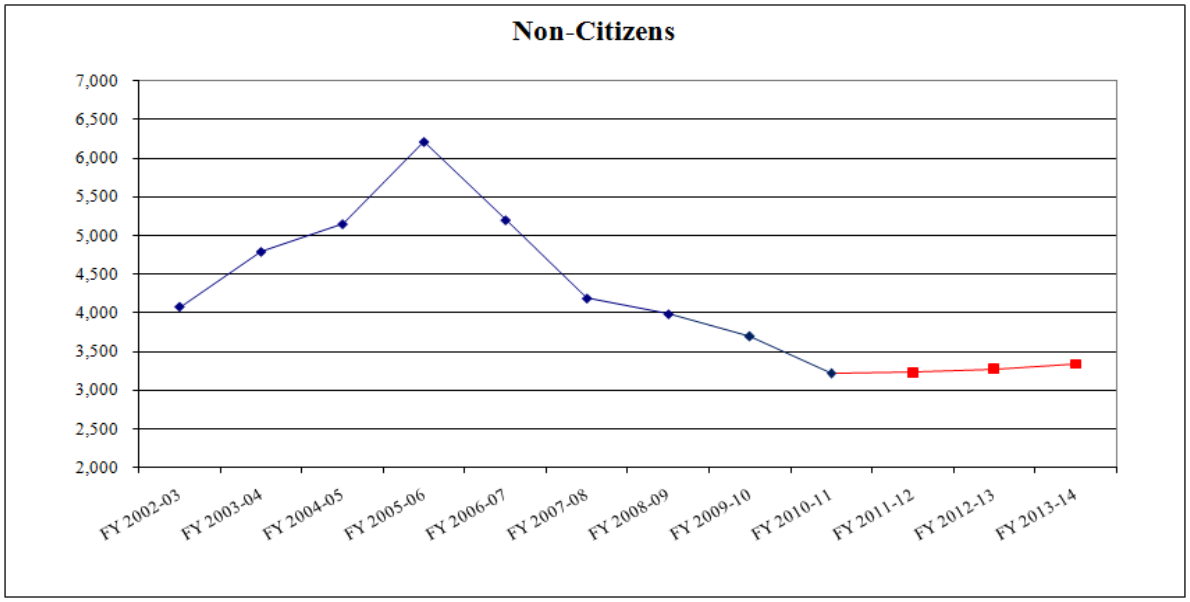
Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. citizenship.

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	0.9660	
Exponential Smoothing B*	0.9626	
Box-Jenkins A*	0.9795	
Box-Jenkins B	0.9656	
Regression A	0.9863	ALIEN [-1], Female Population 19-59, Migration, Alien Dummy, Auto [-3], Auto [-7]
Regression B	0.9893	ALIEN [-1], ALIEN [-2], CBMS Dummy [-1], Alien Dummy, Auto [-3]
Regression C	0.9888	ALIEN [-1], Unemployment Rate, Alien Dummy, Auto [-1], Auto [-2]



Non-Citizens: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	3,693	3,213	-3.21%	3,110	(103)	(18)
Exponential Smoothing B	3,693	3,213	0.50%	3,229	16	0
Box Jenkins A*	3,693	3,213	-0.31%	3,203	(10)	(2)
Box Jenkins B*	3,693	3,213	0.16%	3,218	5	(1)
Regression A	3,693	3,213	-2.86%	3,121	(92)	(14)
Regression B	**3,693**	**3,213**	**0.62%**	**3,233**	**20**	**2**
Regression C	3,693	3,213	8.12%	3,474	261	44

* Denotes Expert Selection, Bold denotes Trend Selection

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	3,213	3,233	-7.07%	3,004	(229)	(18)
Exponential Smoothing B	3,213	3,233	0.00%	3,233	0	0
Box Jenkins A*	3,213	3,233	-0.09%	3,230	(3)	0
Box Jenkins B*	3,213	3,233	0.00%	3,233	0	0
Regression A	3,213	3,233	-3.27%	3,127	(106)	(4)
Regression B	**3,213**	**3,233**	**1.33%**	**3,276**	**43**	**4**
Regression C	3,213	3,233	17.62%	3,803	570	49

Non-Citizens: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	3,233	3,276	-7.61%	3,027	(249)	(18)
Exponential Smoothing B	3,233	3,276	0.00%	3,276	0	0
Box Jenkins A*	3,233	3,276	0.00%	3,276	0	0
Box Jenkins B*	3,233	3,276	0.00%	3,276	0	0
Regression A	3,233	3,276	1.16%	3,314	38	7
Regression B	**3,233**	**3,276**	**1.92%**	**3,339**	**63**	**6**
Regression C	3,233	3,276	12.78%	3,695	419	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 2011-12: 0.62%
FY 2012-13: 1.33%
FY 2013-14: 1.92%

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 these large declines 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 2010-11 was much higher than the Department's February 2011 forecast, in which the annual caseload was projected to be 3,073 and average monthly declines were projected to be 49. The selected trend for FY 2011-12 is much higher than that from the February 2011 forecast, and would yield average increases of **2 per month** for FY 2011-12.
- The out-year trends assume relatively slow caseload growth. As discussed in the Baby Care-Adults section, a number of Family Planning initiatives will be implemented during the forecast period, which may be expected to decrease the number of pregnancies.

25.5-5-103 (3), C.R.S.
(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-09	3,892	-	-
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%
Jul-10	3,492	(30)	-0.85%
Aug-10	3,378	(114)	-3.26%
Sep-10	3,231	(147)	-4.35%
Oct-10	3,080	(151)	-4.67%
Nov-10	3,049	(31)	-1.01%
Dec-10	3,023	(26)	-0.85%
Jan-11	3,116	93	3.08%
Feb-11	3,161	45	1.44%
Mar-11	3,271	110	3.48%
Apr-11	3,274	3	0.09%
May-11	3,255	(19)	-0.58%
Jun-11	3,229	(26)	-0.80%

	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	3,213	-13.00%	(480)
FY 2011-12	3,233	0.62%	20
FY 2012-13	3,276	1.33%	43
FY 2013-14	3,339	1.92%	63

* 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 2011 Trends			
FY 2010-11	3,073	-16.79%	(620)
FY 2011-12	2,947	-4.10%	(126)
FY 2012-13	2,959	0.41%	12

Actuals		
	Monthly Change	**% Change**
6-month average	34	1.12%
12-month average	(24)	-0.69%
18-month average	(22)	-0.61%
24-month average	(28)	-0.74%

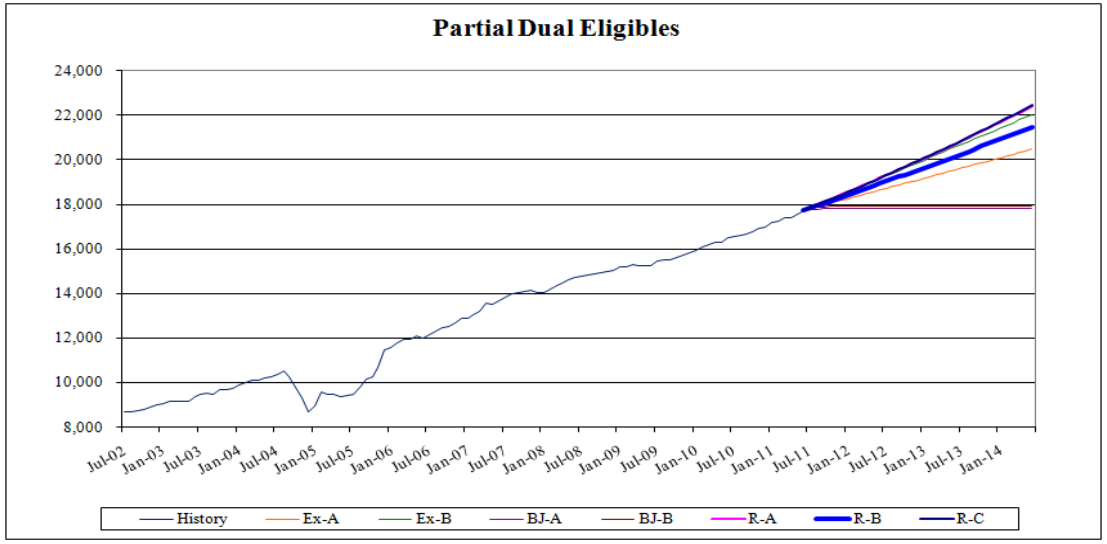
Base trend from June 2011 level			
FY 2011-12	3,229	0.50%	16

Monthly Average Growth Comparisons		
February 2011 Forecast	(49)	-1.39%
FY 2010-11 Actuals	(24)	-0.69%
FY 2010-11 1st Half	(83)	-2.50%
FY 2010-11 2nd Half	34	1.12%
FY 2011-12 Forecast	2	0.06%
February 2011 Forecast	1	0.03%
FY 2012-13 Forecast	4	0.12%
February 2011 Forecast	1	0.03%

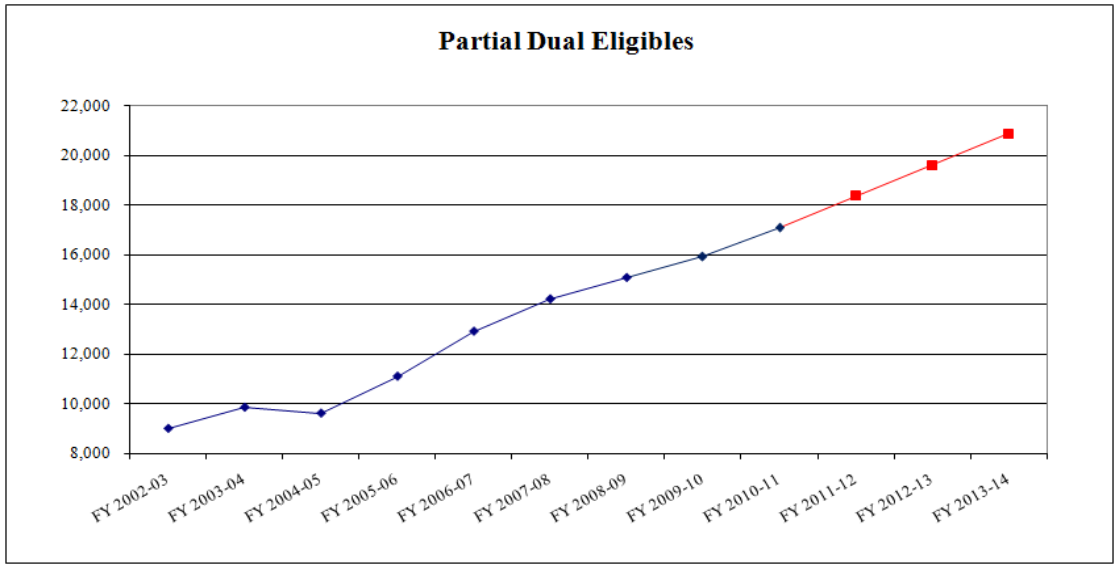
Partial Dual Eligibles

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 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	15,919	17,090	6.63%	18,223	1,133	76
Exponential Smoothing B*	15,919	17,090	8.27%	18,503	1,413	119
Box Jenkins A	15,919	17,090	4.15%	17,799	709	7
Box Jenkins B	15,919	17,090	4.74%	17,900	810	16
Regression A	15,919	17,090	8.38%	18,522	1,432	122
Regression B	**15,919**	**17,090**	**7.52%**	**18,375**	**1,285**	**100**
Regression C	15,919	17,090	8.29%	18,507	1,417	121

* Denotes Expert Selection, Bold denotes Trend Selection

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*	17,090	18,375	5.03%	19,299	924	76
Exponential Smoothing B*	17,090	18,375	7.74%	19,797	1,422	119
Box Jenkins A	17,090	18,375	0.06%	18,386	11	0
Box Jenkins B	17,090	18,375	0.09%	18,392	17	0
Regression A	17,090	18,375	8.07%	19,858	1,483	129
Regression B	**17,090**	**18,375**	**6.68%**	**19,602**	**1,227**	**104**
Regression C	17,090	18,375	8.19%	19,880	1,505	131

Partial Dual Eligibles: Model Results						
FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	18,375	19,602	4.79%	20,541	939	76
Exponential Smoothing B*	18,375	19,602	7.19%	21,011	1,409	119
Box Jenkins A	18,375	19,602	0.00%	19,602	0	0
Box Jenkins B	18,375	19,602	0.00%	19,602	0	0
Regression A	18,375	19,602	8.06%	21,182	1,580	139
Regression B	**18,375**	**19,602**	**6.49%**	**20,874**	**1,272**	**108**
Regression C	18,375	19,602	8.17%	21,203	1,601	141

[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 2011-12: 7.52%
FY 2012-13: 6.68%
FY 2013-14: 6.49%

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 2010-11 was slightly higher with the Department's February 2011 forecast, in which the annual caseload was projected to be 17,044 and average monthly growth was projected to be 89. The selected trend for FY 2011-12 is slightly higher than the February 2011 forecast, and would yield average growth of **100 per month** for FY 2011-12.
- 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.
(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.
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.
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-09	15,249	-	-
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%
Jul-10	16,539	44	0.27%
Aug-10	16,634	95	0.57%
Sep-10	16,652	18	0.11%
Oct-10	16,794	142	0.85%
Nov-10	16,941	147	0.88%
Dec-10	17,002	61	0.36%
Jan-11	17,210	208	1.22%
Feb-11	17,249	39	0.23%
Mar-11	17,390	141	0.82%
Apr-11	17,399	9	0.05%
May-11	17,546	147	0.84%
Jun-11	17,727	181	1.03%

	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	17,090	7.36%	1,171
FY 2011-12	18,375	7.52%	1,285
FY 2012-13	19,602	6.68%	1,227
FY 2013-14	20,874	6.49%	1,272

* 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 2011 Trends			
FY 2010-11	17,044	7.07%	1,125
FY 2011-12	18,172	6.62%	1,128
FY 2012-13	19,297	6.19%	1,125

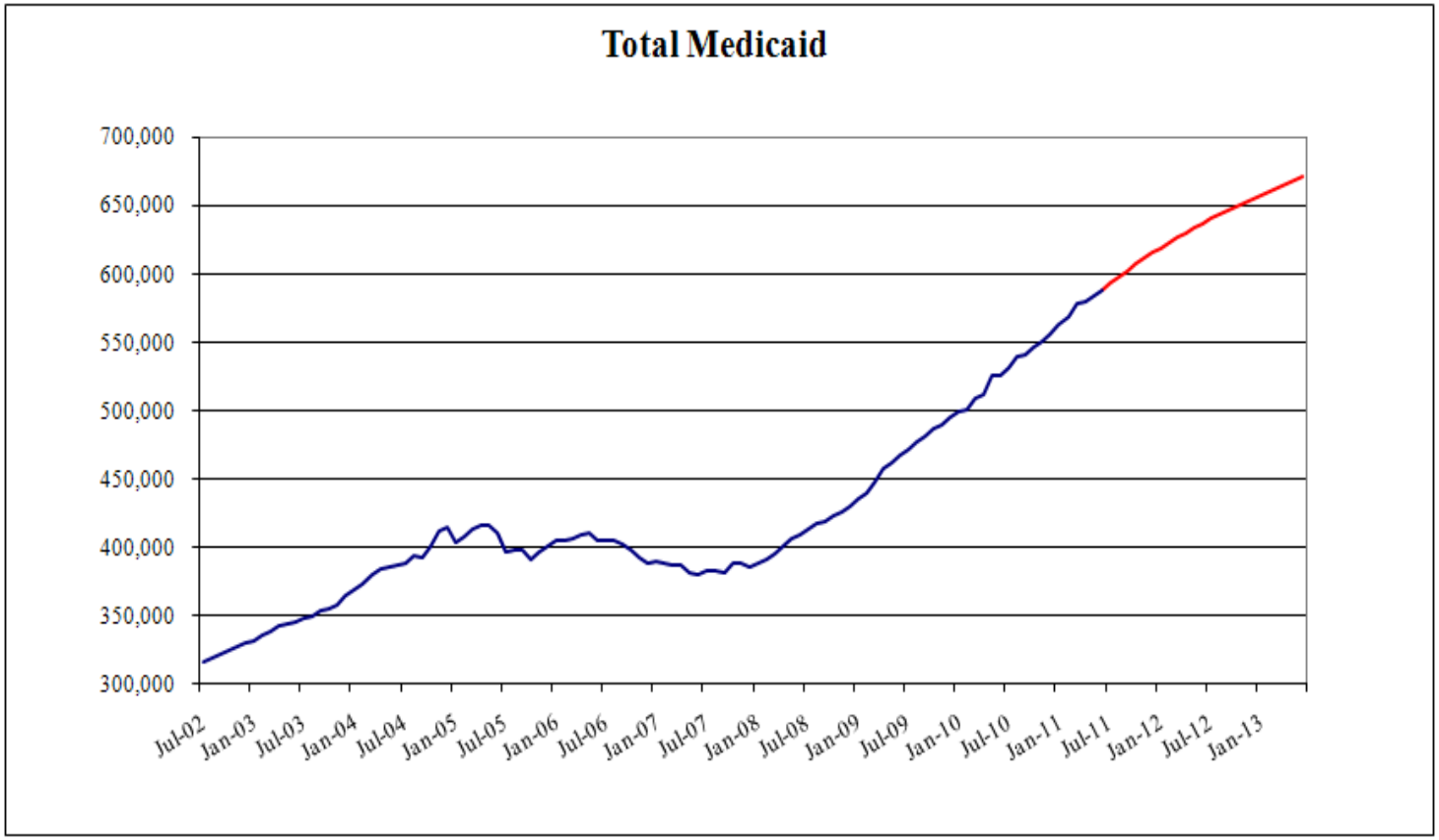
Actuals		
	Monthly Change	**% Change**
6-month average	121	0.70%
12-month average	103	0.60%
18-month average	105	0.63%
24-month average	103	0.63%

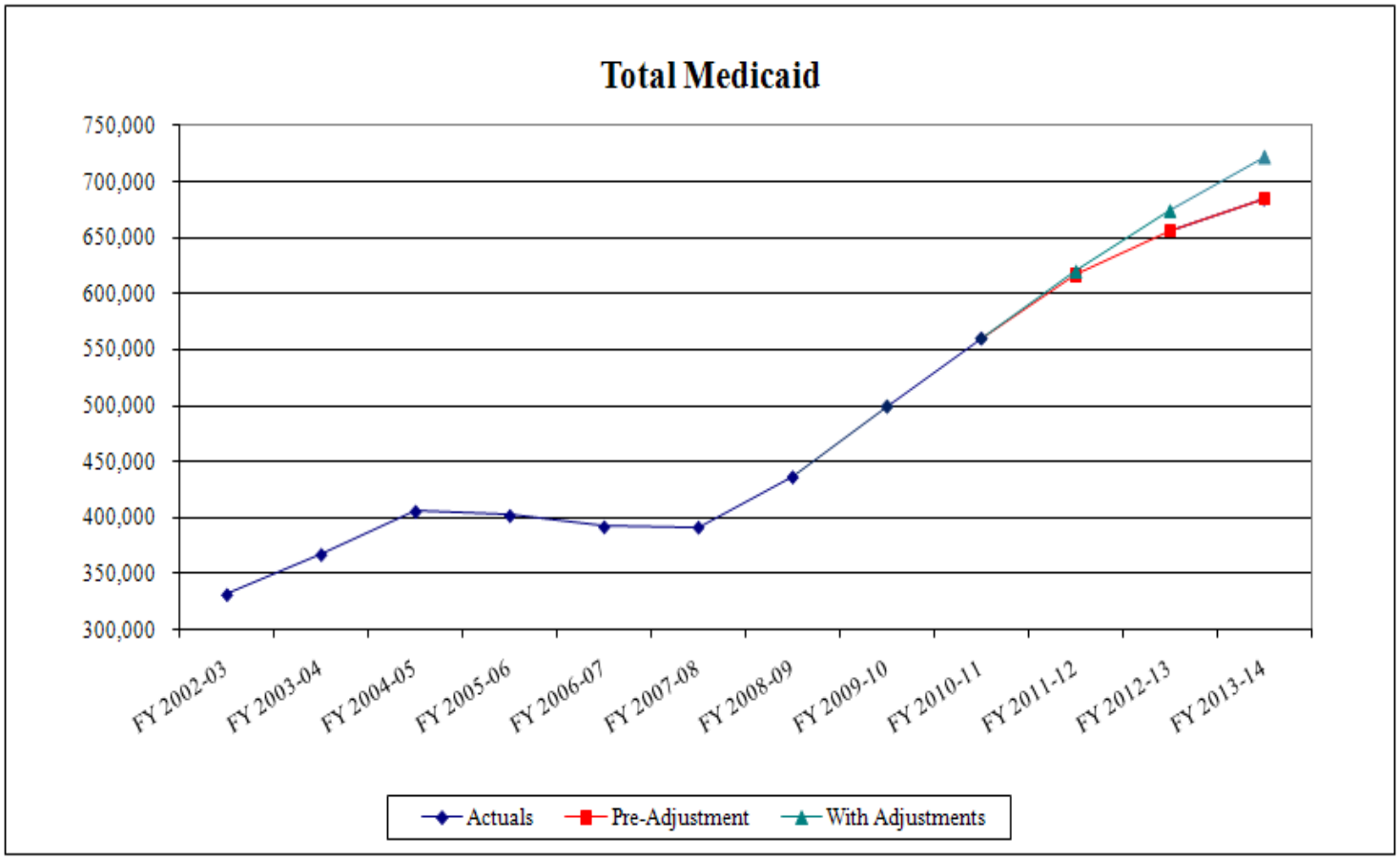
Base trend from June 2011 level			
FY 2011-12	17,727	3.73%	637

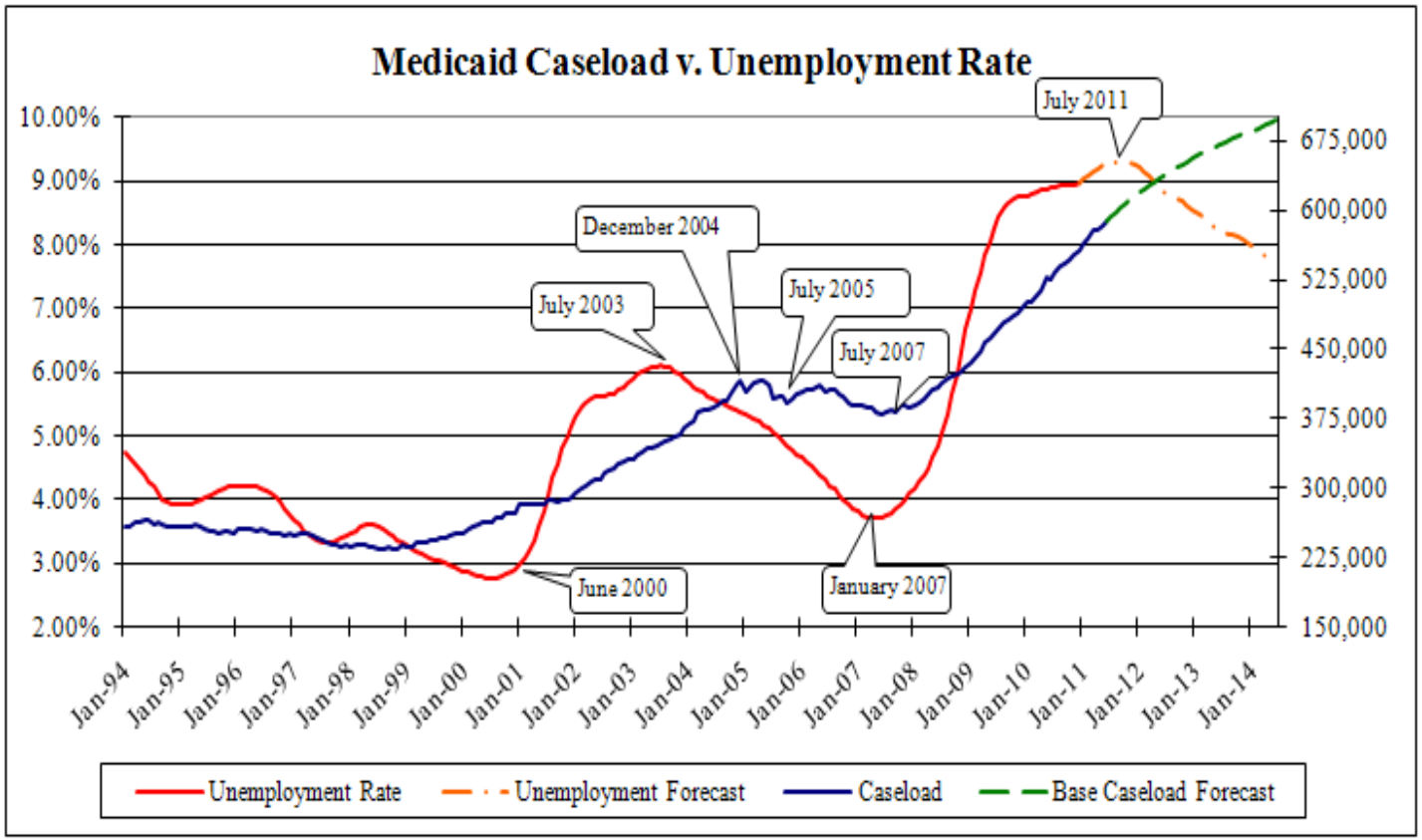
Monthly Average Growth Comparisons		
February 2011 Forecast	89	0.58%
FY 2010-11 Actuals	103	0.60%
FY 2010-11 1st Half	85	0.51%
FY 2010-11 2nd Half	121	0.70%
FY 2011-12 Forecast	100	0.56%
February 2011 Forecast	94	0.54%
FY 2012-13 Forecast	104	0.55%
February 2011 Forecast	94	0.50%

Summary

The Department is forecasting a FY 2011-12 total Medicaid caseload of 619,985, a 10.57% increase from FY 2010-11. The trend is projected to moderate slightly in FY 2012-13 with caseload expected to increase by 8.55% to 672,968, with a large portion of the growth to come from the implementation of the Medicaid Buy-In Program for Working Adults with Disabilities and Adults without Dependent Children (AwDC) programs, both of which are scheduled to be implemented in March 2012. In addition, a Medicaid Disabled Buy-In Program for Children is scheduled to be implemented approximately four to six months after the Medicaid Buy-In Program for Working Adults with Disabilities and AwDC programs.




Total Medicaid
750,000
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
FY 2013-14
Actuals
Pre-Adjustment
With Adjustments


Medicaid Caseload v. Unemployment Rate
10.00%
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
July 2011
December 2004
July 2005
July 2003
July 2007
June 2000
January 2007
Jan-94
Jan-95
Jan-96
Jan-97
Jan-98
Jan-99
Jan-00
Jan-01
Jan-02
Jan-03
Jan-04
Jan-05
Jan-06
Jan-07
Jan-08
Jan-09
Jan-10
Jan-11
Jan-12
Jan-13
Jan-14
Unemployment Rate
Unemployment Forecast
Caseload
Base Caseload Forecast

Total Medicaid: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Jun-09	467,556	-	-
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	531,445	5,224	0.99%
Aug-10	539,073	7,628	1.44%
Sep-10	541,285	2,212	0.41%
Oct-10	546,301	5,016	0.93%
Nov-10	551,168	4,867	0.89%
Dec-10	556,120	4,952	0.90%
Jan-11	563,672	7,552	1.36%
Feb-11	569,088	5,416	0.96%
Mar-11	578,192	9,104	1.60%
Apr-11	579,436	1,244	0.22%
May-11	583,951	4,515	0.78%
Jun-11	588,925	4,974	0.85%
Jul-11	**593,452**	**4,527**	**0.77%**
Aug-11	**598,152**	**4,701**	**0.79%**
Sep-11	**602,717**	**4,565**	**0.76%**
Oct-11	**607,109**	**4,392**	**0.73%**
Nov-11	**611,353**	**4,244**	**0.70%**
Dec-11	**615,597**	**4,244**	**0.69%**
Jan-12	**619,315**	**3,717**	**0.60%**
Feb-12	**623,077**	**3,762**	**0.61%**
Mar-12	**626,837**	**3,760**	**0.60%**
Apr-12	**630,376**	**3,539**	**0.56%**
May-12	**633,923**	**3,547**	**0.56%**
Jun-12	**637,298**	**3,375**	**0.53%**

**Bold denotes projection

	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	560,722	12.41%	61,925
FY 2011-12	616,595	9.96%	55,873
FY 2012-13	656,294	6.44%	39,699
FY 2013-14	685,061	4.38%	28,767

* 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 2011-12	3,390
FY 2012-13	16,674
FY 2013-14	32,940

Projections After Adjustments			
FY 2011-12	619,985	10.57%	59,263
FY 2012-13	672,968	8.55%	52,983
FY 2013-14	718,001	6.69%	45,033

February 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2010-11	555,814	11.43%	57,017
FY 2011-12	593,703	6.82%	37,889
FY 2012-13	617,960	4.09%	24,257

Total Medicaid: Historical Caseload and Projections		
Actuals		
	Monthly Change	**% Change**
6-month average	5,468	0.96%
12-month average	5,225	0.94%
18-month average	5,235	0.98%
24-month average	5,057	0.97%

Base trend from June 2011 level			
FY 2011-12	588,925	18.07%	90,128

Monthly Average Growth Comparisons		
February 2011 Forecast	4,218	0.77%
FY 2010-11 Actuals	5,225	0.94%
FY 2010-11 1st Half	4,983	0.93%
FY 2010-11 2nd Half	5,468	0.96%
FY 2011-12 Forecast	4,031	0.66%
February 2011 Forecast	2,548	0.43%
FY 2012-13 Forecast	2,811	0.43%
February 2011 Forecast	1,657	0.27%

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 contracting 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

Financing:
- Hospital Provider Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing
- Outstationing Payments
- Other Supplemental Payments

Note that for services in the Long-Term Care, Insurance, and Service Management categories and Financing, 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.

[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 and implemented (labeled with priority numbers beginning with "ES"). Page EA-3 shows the actual total spending authority. Annualizations of budget balancing items are included in the FY 2011-12 base request.

For the request year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the base request for the request year. The total base request is compared to the total projected estimated request year expenditure from page EA-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out 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 out 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 estimated need for the Medical Services Premiums line item for the out year.

Totals for the base request on this page correspond with Columns 2, 4, and 5 on the Schedule 13, where appropriate.

Federal Medical Assistance Percentages
The Department's standard federal medical assistance percentage (FMAP) is 50%. 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.

The FMAP was impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA was an enhanced FMAP for specified Medicaid programs; the effective period of this enhanced rate was originally October 1, 2008 through December 31, 2010. However, federal legislation (HR 1586) extended the effective period of ARRA to June 30, 2011. The enhanced FMAP from ARRA beyond December 31, 2010 underwent a staged phase out. Additional relief was available for states which experience increased unemployment; there were three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA included a 'hold harmless period'; if the FMAP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 was less than the FMAP for the preceding quarter, the higher percent continued to be 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. ARRA continues to be a relevant component of the Department's request as certified public expenditure receives the enhanced FMAP associated with the period of time during which the expenditure was initially included. This specifically impacts upper payment limit financing. See Exhibit K for additional details.

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 through March 2009	Second and third quarters of FY 2008-09
61.59%	Enhanced rate per ARRA	April 2009 through December 2010	FY 2009-10, First and second quarters of FY 2010-11
58.77%	First stage of ARRA phase out	January 2011 through March 2011	Third quarter of FY 2010-11
56.88%	Final stage of ARRA phase out	April 2011 through 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 was a weighted average of the multiple FMAPs available during the fiscal year, totaling 59.71%.

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 (CMS), as reported through the Federal Register, or as specified in federal law and/or regulation.

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:

- 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. For FY 2011-12, 100% of state funding for traditional clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 2012-13 and FY 2013-14, 50% of state funding for traditional clients comes from the Breast and Cervical Prevention and Treatment Fund and 50% comes from the General Fund. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive state funding through the Prevention, Early Detection, and Treatment fund, which is administered by the Department of Public Health and Environment. Please see Exhibit F for calculations.

- 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.

- Home Health Telemedicine Services: In HB 10-1005, the Department received authority to use gifts, grants, and donations to fund home health telemedicine services. The Department has been informed by CMS that these funds are not eligible for a federal match. Therefore, the Department assumes that the grant funding will be used as state only funds, and that the remainder of the expenditure will be funded with General Fund and federal funds. See section V for 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.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the state. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in exhibit A, as the increased drug rebate will offset total federal funds expenditure.

- SB 11-008 "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). The Department assumes that the FMAP for clients these clients will remain at the same level it would have had the clients enrolled in the Children's Basic Health Plan instead of Medicaid, or 65%. The Department estimates that the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.

- SB 11-250 "Eligibility for Pregnant Women in Medicaid": This bill increases the income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan to Medicaid. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients. The Department estimates that the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.

- Physician Rate Increase to 100% of Medicare (Section 1202S of the Affordable Care Act Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare reimbursement. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP) of 100%. Additional details are provided in sections IV and V.

- Nursing Facility Supplemental Payments: 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.

- 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 2011-12 and FY 2012-13, the Department is requesting to use a portion of the funding for the adult medical home pilot program; see Exhibit I for further details. In accordance with SB 08-118 "Money Transfer for Medicaid Programs," FY 2012-13 is the last year in which this transfer will occur.

- 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. 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.

- Expansion Adults to 100% Adjustment: HB 09-1293, the Colorado 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 medical assistance; and 3) pay the administrative costs to the Department in implementing and administering the program. Included in the Medicaid eligibility expansions was parents and caretaker relatives of Medicaid eligible children to 100% of the federal poverty level. These adjustments allocate Hospital Provider Fee to each applicable service categories. See Exhibit J for additional information and detailed calculations.

- Medicaid Disabled Buy-In for Working Adults and Children programs: Authorized by HB 09-1293, these populations are scheduled to be implemented in Medicaid in FY 2011-12 and FY 2012-13. Funds for these populations come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.

- Adults without Dependent Children: Authorized by HB 09-1293, this population is scheduled to be implemented in Medicaid in FY 2011-12. The population is funded with a combination of federal funds and Hospital Provider Fee. Calculations and information regarding this population can be found in Exhibit J.

- 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.

- 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. The state funding for this program comes from the Coordinated Care for People with Disabilities Fund, which was created by SB 06-128 and is generated by interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund.

- 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 2011-12, FY 2012-13, and FY 2013-14, totals are based on the amount Denver Health Medical Center was able to certify in FY 2010-11 inflated annually by four percent.

- Department Recoveries Adjustment: Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in exhibit L.

- 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 2011-12, FY 2012-13, and FY 2013-14:

Cash Funds	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Tobacco Tax Cash Fund (SB 11-210)	$2,230,500	$2,230,500	$2,230,500
Prevention, Early Detection, and Treatment Fund (SB 11-211)	$11,955,055	$0	$0
Hospital Provider Fee Cash Fund(SB 11-212)	$50,000,000	$25,000,000	$0
Primary Care Fund (SB 11-219)	$15,775,670	$0	$0
Tobacco Education Program Fund (SB 11-219)	$17,758,594	$0	$0
Total	$97,719,819	$27,230,500	$2,230,500

In addition, the Department's appropriation includes a $5,036,351 transfer of reappropriated funds for FY 2011-12 from the Prevention, Early Detection and Treatment Fund administered by the Department of Public Health and Environment. This amount is reduced to $1,750,000 in FY 2012-13 and $0 in FY 2013-14. Of this amount, $1,750,000 in FY 2011-12 and FY 2012-13 is funding associated with the Department's Disease Management program and is funded through the Department of Public Health and Environment's Prevention Programs line. The remaining $3,286,351 in FY 2011-12 is a one-time transfer for medical services funded through CDPHE's Health Disparities Program line as provided for by SB 11-211.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund is insolvent and no longer covers the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

- Old Age Pension Adult Transfer Adjustment: In FY 2011-12, the Department is appropriated $3,000,000 from the Supplemental OAP Health and Medical Care Fund to offset General Fund.

The Department's request no longer includes an adjustment for "Prenatal Costs for Optional Legal Immigrants." In 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). Because the Department is now receiving a 50% federal match on these services, the Department no longer needs to separate out prenatal expenditure.

EXHIBIT B – MEDICAID CASELOAD PROJECTION

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

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2013-14. Adjustments for HB 09-1293 funded populations such as the Medicaid Disabled Buy-In for Working Adults and Children programs and Adults without Dependent Children, and children and women that gain eligibility through SB 11-008 and SB 11-250 are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3.

Pages EB-4 and EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2010-11.

EXHIBIT C – HISTORY AND PROJECTIONS OF PER-CAPITA COSTS

Medical Services Premiums per capita costs history (through FY 2010-11) 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 EC-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, request year, and out 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. The Department has isolated individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. 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 expenditure has been restated with this request to reflect a redistribution of Prepaid Inpatient

Health Plan expenditure among eligibility types. 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.

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 2010-11. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in the three most recent historical years. 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. In light of changes resulting from the Medicare Modernization Act of 2003, trends that incorporate historical data from FY 2005-06 or earlier have been omitted for the following eligibility types: Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59. For these categories, pharmaceutical expenditure was drastically reduced in FY 2006-07 for these eligibility types resulting in artificially deflated trends.

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 2011-12, FY 2012-13, and FY 2013-14. In some cases, though not all, the Department has held the trend constant between the three years. On Exhibit F, the selected trend factors have been bolded for clarification. 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 2011-12, FY 2012-13, and FY 2013-14, with the rationale for selection, are as follows:

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	While primary cost drivers in FY 2010-11 saw low to modest levels of growth, a portion of this growth is attributed to a one-time level shift in expenditure associated with restating third-party liability recoveries as revenue instead of as a direct offset to expenditure. Consequently, the Department has selected a trend that captures the underlying stability in the per-capita growth pattern for this population.
Disabled Adults 60 to 64 (OAP-B)	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	This eligibility type displayed growth despite rate reductions and other bottom line impacts which put downward pressure on per capita growth. The Department anticipates continued per-capita growth over the next three years similar to what was experienced between FY 2009-10 and FY 2010-11.
Disabled Individuals to 59 (AND/AB)	2.39% The per-capita growth from FY 2009-10 to FY 2010-11	2.39% The per-capita growth from FY 2009-10 to FY 2010-11	2.39% The per-capita growth from FY 2009-10 to FY 2010-11	Similar to OAP-B, this eligibility category experienced modest growth in FY 2010-11. Primary cost drivers for this eligibility type (Physician, Inpatient Hospital, Outpatient Hospital, Pharmacy, and Home Health) increased by approximately 4% in per-capita expenditure in the last fiscal year. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	-4.94% The average per-capita growth from FY 2008-09 through FY 2009-10	-2.47% One half the FY 2011-12 per-capita growth rate	-1.24% One half the FY 2012-13 per-capita growth rate	With high growth in caseload, per-capita figures have declined in the last two years. Caseload is anticipated to continue to grow over the next three years. Consequently, the Department anticipates that this aid category will continue to see declines in per-capita growth in future years. The Department anticipates the rate of decline will slow over time as caseload growth stabilizes.
Expansion Adults to 60%	2.18%	2.18%	2.18%	This population is showing signs of reaching maturity as per-capita growth is beginning to slow. While FY 2010-11 growth was still strong, the Department anticipates the rate of growth to continue to decrease in FY 2011-12 as the per-capita costs get closer to that of other non-disabled adults in Medicaid. The trend selected for this population allows for a modest amount of continued growth over the next three years.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Expansion Adults to 100%	25.17%	2.18%	2.18%	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. For FY 2011-12, the selected trend is the percent change required to equalize the per-capita costs between the expansion adult populations. Cash flow analysis of prior year data validates this trend. The trends for the request year and out year are set equal to the Expansion Adults to 60% trend.
Breast & Cervical Cancer Program (Page EF-7)	-3.67%	-3.65%	-3.61%	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)	-1.01% One half the per-capita growth from FY 2009-10 to FY 2010-11	-1.01% One half the per-capita growth from FY 2009-10 to FY 2010-11	-1.01% One half the per-capita growth from FY 2009-10 to FY 2010-11	Growth in per-capita costs have 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. Continued strong caseload growth indicates continuation of decline in per capita.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Foster Care	3.93% The average per-capita growth from FY 2007-08 through FY 2010-11	1.97% One half the FY 2011-12 selected trend	1.97% One half the FY 2011-12 selected trend	Historically, this eligibility category has had significant variation in per-capita growth from year to year; on average, growth is moderate to strongly positive. FY 2010-11 growth reflected this trend of moderate positive growth. The Department expects FY 2011-12 growth to follow this trend. The request year and out-year have been reduced by 50% to allow for continued growth while accounting for increasing caseload.
Baby Care Program - Adults (BCKC-A)	2.43% The average per-capita growth from FY 2006-07 through FY 2009-10	1.22% One half the FY 2011-12 selected trend	1.22% One half the FY 2011-12 selected trend	Recent history for this population 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	3.80% One half the FY 2009-10 to FY 2010-11 per-capita growth rate	3.80% One half the FY 2009-10 to FY 2010-11 per-capita growth rate	3.80% One half the FY 2009-10 to FY 2010-11 per-capita growth rate	The Department has selected a per-capita trend for these clients that reflects the most recent years aggressive per capita growth while maintaining consideration for the volatile history of the population.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Partial Dual Eligibles	4.52% The increase in Medicare coinsurance rates from CY 2010 to CY 2011	4.52% The increase in Medicare coinsurance rates from CY 2010 to CY 2011	4.52% The increase in Medicare coinsurance rates from CY 2010 to CY 2011	Per-capita expenditure for this eligibility group increased significantly in FY 2010-11. This was the result of a one-time level shift in expenditure associated with Department third party liability recoveries no longer being classified as offsets to expenditure. Because this was a one-time impact, the Department does not anticipate the same level of growth in the next three years. Growth is anticipated to parallel the growth rate of Medicare coinsurance.

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 detail in section V, Additional Calculation Considerations:

- BRI-1 (FY 2011-12), Client Overutilization: expanded the Department's Client Over Utilization Program (COUP). The program reduced expenditure by identifying clients that over utilize emergency room, pharmaceutical, or physician services and assisting them in managing their care in a more cost effective manner.
- BRI-5 (FY 2011-12), State Allowable Cost Expansion: expands the list of drugs reimbursed under the State Maximum Allowable Cost (SMAC) pricing methodology. Savings results as drugs reimbursed under this methodology typically have lower levels of reimbursement than other pricing methodologies.
- BRI-5 (FY 2011-12), Reduce Rates for Diabetes Supplies: reduced reimbursement for diabetic test strips. Prices were reduced to reflect the current median market price for the product, $18.00 per box of 50.
- BRI-5 (FY 2011-12), Reduce Payment for Uncomplicated C-Sections: set reimbursement for uncomplicated c-sections equal to the rate paid for complicated vaginal deliveries.
- BRI-5 (FY 2011-12), Reduce Payments for Renal Dialysis: reduced the amount paid for inpatient renal dialysis from 185 percent of cost to 100 percent of cost. The Department agreed to reduce payment to 129.42 percent rather than 100 percent after negotiations with affected providers.
- BRI-5 (FY 2011-12), Deny Payment of Hospital Readmissions within 48 hours: stopped payment to hospitals for clients readmitted to the same hospital within 48 hours of the original discharge for a condition related to the original admission.
- BRI-5 (FY 2011-12), Prior Authorize Certain Radiology: requires prior authorization for MRI, CT, PET, and SPECT scans in the outpatient setting except in the case of emergency.

- BRI-5 (FY 2011-12), Limit Acute Home Health Services: requires enforcement of the Department's policy to require prior authorization for acute home health services beyond 60 days.
- BRI-5 (FY 2011-12), HMO Impact to Rates: accounts for the impact to HMO rates that results when fee-for-service rates are reduced.
- BA-9 (FY 2011-12), Expand the Accountable Care Collaborative (ACC): increased the volume of clients to be enrolled in the ACC in FY 2011-12.
- BA-9 (FY 2011-12), Limit Fluoride Application Benefit: restricts the fluoride application benefit to three applications per year.
- BA-9 (FY 2011-12), Limit Dental Prophylaxis Benefit: limits the routine dental cleaning benefit to two per year.
- BA-9 (FY 2011-12), Eliminate Reimbursement for Oral Hygiene Instruction: terminated the oral hygiene instruction benefit.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults: limited the number of units of therapy an adult can receive to 48 per year regardless of prior authorization.
- BA-9 (FY 2011-12), Require Specific Billing for Certain Home Health Visits: requires providers to utilize a brief visit billing code for services that should require only a brief home health visit.
- BA-9 (FY 2011-12), Provider Rate Reduction: reduced reimbursement for most acute care services by 0.50%. The JBC increased the amount of the rate reduction to 0.75% for Acute Care services during Figure Setting.
- Eliminate Circumcision Benefit: as part of budget balancing measures for FY 2011-12, the JBC eliminated the circumcision benefit of the Medicaid program.
- Wound Therapy Durable Medical Equipment Reduction: as part of budget balancing measures for FY 2011-12, the General Assembly specified in footnote 11a of the Long Bill that their intent was that the Department should reduce reimbursement for negative pressure wound to $88.50 per day. The Department complied with the footnote.
- Repeal of BA-9, 0.75% Pharmacy Reduction (June 2011 1331 Supplemental Request): represents an action by the JBC exempting pharmacy services from the FY 2011-12 provider rate reductions.
- SB 11-177 "Sunset of Pregnancy Prevention Program": provides for the continuation and expansion of the Department's teen pregnancy and dropout prevention program. Through the program, teens receive vocational, health and educational counseling.
- Implementation of SB 10-117 "Over the Counter Medications": accounts for savings incurred through the implementation of SB 10-117. This bill allows pharmacists to directly prescribe certain over the counter medication to Medicaid clients without prior authorization or a prescription from the client's primary care physician. The Department anticipates initial implementation by July 1, 2012.Physician Rate Increase to 100% of Medicare (Section 1202S of Affordable Care Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- 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-6 (FY 2010-11), Medicaid Program Reductions, Limitation on Incontinence Products: 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: implements the Accountable Care Collaborative, which is a client/family-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of members. 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 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.
- SB 10-167 "Colorado False Claims Act" has three components. The first component increases enrollment in the Health Insurance Buy-in (HIBI) program. Beginning in April, 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.
- 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.
- 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).
- 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. Increased Drug Rebates due to the Affordable Care Act accounts for the estimated impact of increased pharmacy rebates the Department will receive as a direct result of the implementation of the Affordable Care Act.

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.

Per-Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed that the expenditure and per-capita costs in FY 2005-06 grew at an unexpected rate. The Department has investigated the issues involved, and determined that the total expenditure in FY 2005-06 contained a large amount of retroactive transactions, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the affected 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%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per-capita expenditures. The Department assumes that the decline in the per-capita expenditures is a temporary product of the increasing caseload, and that as the new clients incur costs, the per-capita rate will begin to slow down in its decline. For the current and request years, the Department analyzed per-capita data since April 2007, when there were enough clients in the program for a robust time-series analysis. The Department performed a regression analysis of the rolling average per-capita expenditure on caseload, monthly dummy variables, and a time trend, producing a model that explained much of the variation in the per-capita expenditures with an R-squared of 0.9973. The Department calculated the average of the percent changes of the predicted values produced by the regression model for the current and request years and annualized the average for a full-year effect. The resulting trend factor is -3.67% for FY 2011-12, -3.65% for FY 2012-13, and -3.61% for FY 2013-14. The trend factor for each year is 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., 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., state funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund. Using the allocation methodology described above, 70% of clients are funded through the Breast and Cervical Cancer Prevention and Treatment Fund, while the remaining 30% of clients are funded through the Prevention, Early Detection, and Treatment Fund.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 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. On a go-forward basis, the Department will continue to limit the amount paid from this fund source for this program to this amount. Any expenditure beyond this amount will be allocated to the Breast and Cervical Cancer Prevention and Treatment Fund and the General Fund, in accordance with statute.

All Breast and Cervical Cancer Program expenditures have a 65% federal medical assistance percentage.

Antipsychotic Drugs
Antipsychotic drugs were moved from the Department's Medical Services 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 the Department's Medical Services Premiums line item. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-8 through EF-9, 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.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on FY 2010-11 data.

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 reporting to the Centers for Medicare and Medicaid Services (CMS) 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. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to CMS. The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

The total estimate for FY 2011-12 and the out-years are based on a linear regression analysis of FY 2000-01 to FY 2010-11. The Department trended FY 2010-11 expenditure forward using the percent change between the forecasted estimates, which is 5.99%. This trend is carried forward and the impacts of FY 2010-11 BA-16 "Implementation of Family Planning Waiver" and SB 11-177 "Sunset Teen Pregnancy and Dropout Program" are added separately.

Due to recent expenditure increases beginning in FY 2009-10, the Department controlled for a level shift in expenditure in the regression model. The Department believes this level shift is a result of the Department's considered effort to educate providers as to which services are billable as family planning services. Research by the Department had indicated that only a fraction of allowable services were being appropriately billed.

FY 2010-11 BA-16 "Implementation of Family Planning Waiver" adds $1,903,500 in FY 2012-13 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. The implementation timeline of this budget item has been shifted out one year to account for the delayed approval of the program from CMS and to allow time for systems changes. The Department anticipates the program will start serving clients in FY 2012-13.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" adds $386,665 in FY 2011-12, $932,883 in FY 2012-13 and $1,240,205 to extend and expand the Teen Pregnancy and Dropout Prevention Program in Colorado. This program draws a 90% FMAP with local funds to provide services such as group and individual counseling, vocational, health and educational guidance, science-based instruction concerning human sexuality and home visits. The Department currently has two providers offering such services and intends to expand the number of providers with the authority in this bill.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (P.L. 94-437) was passed with the goal of improving the health status of American Indians and Alaskan Natives and encouraging tribes to participate as much as possible in the management of their health services. The law specified that the payments for inpatient and outpatient services and emergency transportation for Medicaid clients who are Indians with a legal tribe affiliation receive 100% federal financial participation. The Indian Health Service is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities.

The Department uses historical expenditure to estimate total expenditure for services to these clients for the current and request years, all of which is federally funded. The Department applied a linear trend to the historical data and projects that expenditure will increase by 9.79% in FY 2011-12, 8.39% in FY 2012-13, and 7.74% in FY 2013-14.

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 Medical Services 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 HCBS waiver services in order to retain eligibility for the waiver.

HB 05-1243 extended the option of receiving Home- and Community-Based Services (HCBS) through the Consumer-Directed care service model to all Medicaid recipients who are enrolled in a 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 (CMS) 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 CMS 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 2002-03 through FY 2010-11. 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 2008-09, FY 2009-10, and FY 2010-11.

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 2011-12, FY 2012-13 and FY 2013-14, with the rationale for selection, are below. In all cases, the Department has kept the trend for the out year the same as the request year.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.36% FY 2008-09 through FY 2010-11	2.36% FY 2008-09 through FY 2010-11	The FY 2011-12 trend is based on the current expenditure and prior-year cash flow. The primary drivers in this eligibility category are expenditure for Elderly, Blind and Disabled waiver and Hospice clients. The growth rate of expenditure for these services has slowed substantially beginning in FY 2007-08. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns, 2.36% for three years of expenditure.
Disabled Adults 60 to 64 (OAP-B)	1.37% Half the average of FY 2008-09 through FY 2010-11	1.37% Half the average of FY 2008-09 through FY 2010-11	Per capita growth has slowed significantly from FY 2009-10 to FY 2010-11. To reflect this decline in per capita growth, the selected trend factor is half the average per capita growth rate from FY 2008-09 through FY 2010-11. The Department believes expenditure patterns will continue to follow this trend through FY 2013-14.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	5.02% Average of FY 2009-10 through FY 2010-11	2.51% Half the average of FY 2009-10 through FY 2010-11	Significant drivers of expenditure in this aid category are the Elderly, Blind and Disabled waiver, Mental Illness waiver and Private Duty Nursing service categories. Growth for these categories over the past four years has been high and positive averaging 14.85%. The FY 2011-12 trend is the average of FY 2009-10 through FY 2010-11 per capita growth rate. The Department reduces this trend in the out years to reflect potential slowing in per capita growth rates as the Department anticipates programmatic changes to slow rapid per capita growth for these clients.
Categorically Eligible Low-Income Adults (AFDC-A)	-1.16% Average of FY 2008-09 through FY 2009-10 overall per capita	-1.16% Average of FY 2008-09 through FY 2009-10 overall per capita	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. The trend factor is based on the average overall community based long-term care change in per capita spending between FY 2008-09 through FY 2009-10.
Expansion Adults to 60%	5.00% Average of FY 2006-07 through FY 2010-11 overall per capita	5.00% Average of FY 2006-07 through FY 2010-11 overall per capita	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. To account for increased per capita growth from FY 2009-10 to FY 2010-11 the Department trended expenditure 5.00%
Expansion Adults to 100%	5.00% Total average of FY 2006-07 through FY 2010-11	5.00% Total average of FY 2006-07 through FY 2010-11	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. To account for increased per capita growth from FY 2009-10 to FY 2010-11 the Department trended expenditure 5.00%
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long-term care benefits.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Eligible Children (AFDC-C/ BCKC-C)	2.75% Average of FY 2007-08 through FY 2010-11	1.38% Half the Average of FY 2007-08 through FY 2010-11	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. The Department chose a trend of 2.75% for FY 2011-12 and half that trend for FY 2012-13 and FY 2013-14.
Foster Care	17.54% Average of FY 2007-08 through FY 2010-11	8.77% Average of FY 2007-08 through FY 2010-11	Per capita growth rates is this aid category has been high for the past three years. To reflect this growth the Department selected a 17.54% trend factor for FY 2011-12, and half that trend for FY 2013-14 and FY 2014-15.
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.
Partial Dual Eligibles	-7.75% Average of FY 2007-08 through FY 2010-11	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 has seen a decline in expenditure for this aid category and therefore chose trends to reflect a continuing decrease in expenditure in FY 2011-12, leveling off in FY 2012-13 and FY 2013-14.

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:

- BRI-5 (FY 2011-12), Medicaid Reductions, Cap CDASS Wage Rates: Impose a cap on the wage rate a client enrolled in the Consumer Directed Attendant Support Services (CDASS) program is allowed to pay attendants based on current rates for similar services in the HCBS Elderly, Blind and Disabled (EBD) waiver.
- BA-9 (FY 2011-12), Medicaid Reductions, 0.50% Rate Reduction: Reduce long-term care providers by 0.5%, effective July 1, 2011.

- BA-9 (FY 2011-12), Medicaid Reductions, Clients Moved from Nursing Home: The Department intended to use grant funds from the Money Follows the Person award to provide additional transitional services to move clients from nursing facilities to Community Based Long-Term Care. The Department was unable to transition these clients due to receiving significant less grant funds than anticipated. The clients specified in this initiative would be moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
- 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 community based long-term care group to the Program of All-Inclusive Care for the Elderly (PACE) service category. The Department's calculations are contained in Section V of this part of the line item description.
- BRI-2 (FY 2010-11), 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 HCBS waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. The timeline for implementation of this program was shifted to April 2011 and was reflected appropriately in the FY 2011-12 request.
- BRI-6 (FY 2010-11), Medicaid Program Reductions: included a 1% reduction to Medicaid physical health provider rates effective July 1, 2010.
- ES-2 (FY 2009-10), HCBS Waiver Transportation Limitations: This request included a cap on the amount of non-medical transportation a client enrolled in an HCBS waiver program can receive per week. Clients are limited to 2 roundtrips per week, with the exception of trips to adult day programs, which are not subject to the cap. The implementation of this program had been delayed to FY 2011-12 to allow time for necessary rule changes or waiver amendments. Savings derived from the limitation were shifted to FY 2011-12.
- HB 10-1146 "State Funded Public Assistance Programs": This bill clarifies that persons currently receiving both Home Care Allowance program and Medicaid 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 agencies for the Home Care Allowances and Adult Foster Care programs as of July 1, 2010. While the Department anticipated an increase in HCBS enrollment as a result of this bill, implementation of the project has been delayed. DHS has assumed responsibility for payment to single entry points for enrollment of clients into the Home Care Allowance program but system changes necessary to move clients into solely HCBS waivers delayed implementation to FY 2011-12. Therefore, the cost estimate to community based long-term care for this bill has been shifted to FY 2011-12.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2010-11 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). Recent history indicates this trend is changing and the Department no longer anticipates a continued decline in patient days.

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.

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non Medicare day. These changes, however, had no impact on the General Fund portion of nursing facility rates. As of the time of this request, implementation of the changes put forth by this bill is pending CMS approval. The calculations in the Department's request assume approval will be granted.

SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[14]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2011-12.
- 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 2011-12. 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 2011-12 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2011-12.
- 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 2011-12.

[14] For clarity, FY 2011-12 is used as an example. The estimates for FY 2012-13 and FY 2013-14 are based on the estimate for FY 2011-12, and follows the same methodology.

- Of the estimated total reimbursement for claims incurred in FY 2011-12, only a portion of those claims will be paid in FY 2011-12. The remainder is assumed to be paid in FY 2012-13. The Department estimates that 92.30% of claims incurred in FY 2011-12 will also be paid during FY 2011-12. Footnote 4 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 2010-11 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2010-11 to calculate an estimate of outstanding claims to be paid in FY 2011-12.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2011-12 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 5 through 9.
- Legislative impacts are added as bottom-line adjustments. For FY 2011-12, this includes run out from HB 10-1324, which introduced a 1.5% rate reduction effective March 1, 2009. Additionally, HB 10-1379 introduced an additional 1% rate reduction effective July, 1 2010. SB 11-215, which continued the HB 10-1324 rate reduction into FY 2011-12, is also included.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2011-12 expenditure.

For FY 2012-13 and FY 2013-14, the same methodology is applied, taking into account the estimate 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 2011-12, FY 2012-13, and FY 2013-14 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2011-12 through FY 2013-14. Please refer to Footnote 6 on page EH-8 for more detail.
- Prior to FY 2010-11 the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2011-12, FY 2012-13, and FY 2013-14. FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform" increased the number of Department auditors resulting in additional audits of nursing facilities. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-9 contains additional detail about these recoveries.

- 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 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 9 on page EH-9 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% 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 9 on page EH-9.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments, but will be unable to fully fund growth beyond the General Fund cap. The Department estimates that approximately 68% of growth beyond the General Fund cap will be supported by the provider fee.
- SB 11-215 continued the 1.5% rate cut of HB 10-1324, effective July 1, 2012.

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 4 and 5 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 2011-12, and the percentage of claims incurred in FY 2011-12 which will be paid in FY 2011-12 and subsequent years. The Department applies the same factor to the FY 2012-13 and FY 2013-14 estimates.

The Department uses the IBNR adjustment calculation for the November 2011 Budget Request, using paid claims data through April 2011. 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%
February 2011	92.46%
November 2012	92.30%

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 cannot 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:

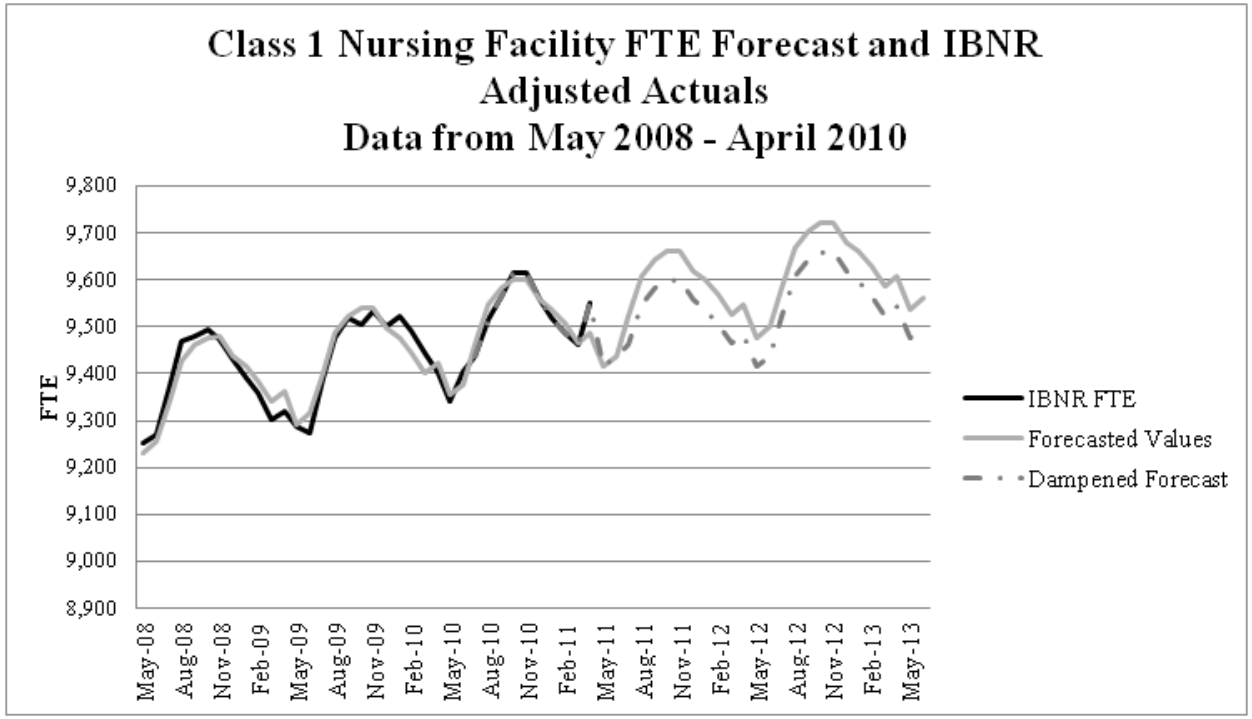
Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	**P-Value**
Augmented Dickey-Fuller Test Statistic	**-4.3924**	**0.0073**
Conclusion: Reject that null hypothesis that there is a unit root at the 99 percent confidence level. An auto-regressive model can be used with this series.		

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.

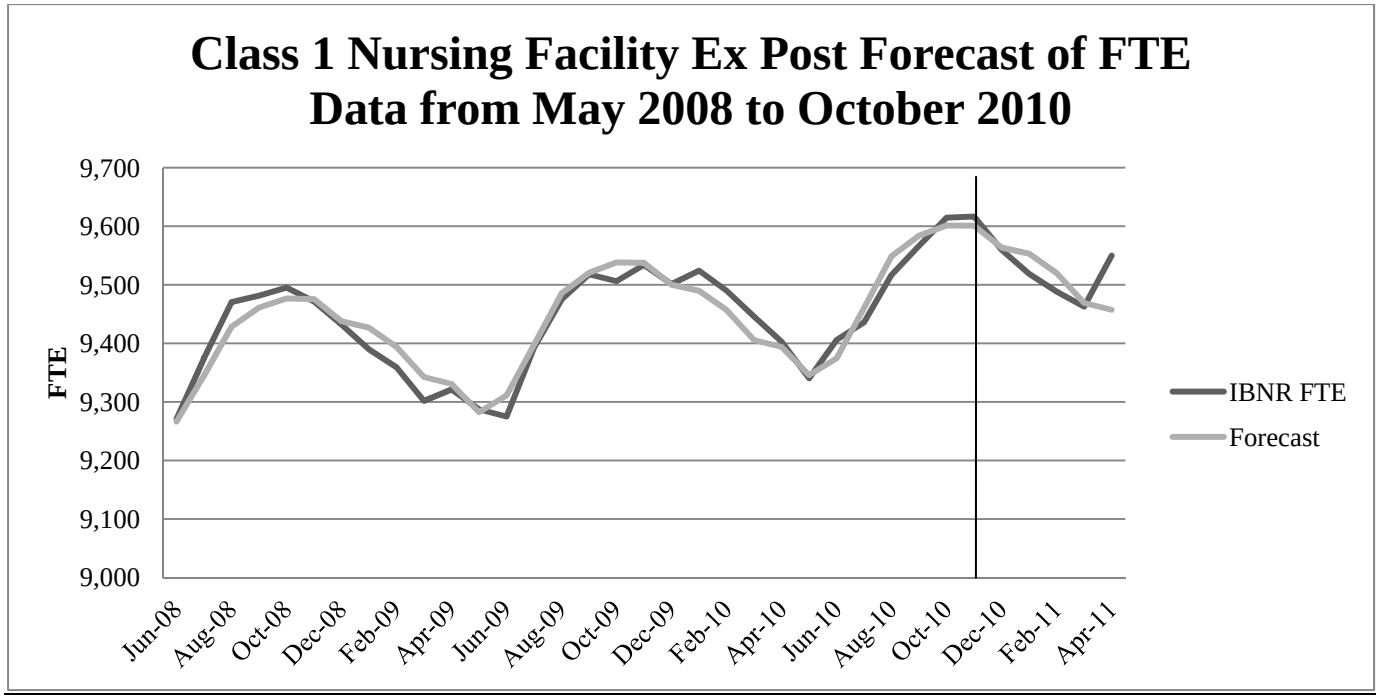
Historically, the Department's efforts toward increasing utilization of Home- and Community-Based Services have resulted in downward pressure on the class one nursing facility days trend. However, in face of an aging population and ever increasing demand for long-term care services, the most recent years have displayed a stabilization of the days trend. In light of these two counter-balancing factors, the Department believes the patient days trend will remain flat in FY 2011-12 and FY 2012-13. Consequently, the Department has dampened the FTE forecast produced by the seasonal autoregressive model with linear trend by 0.65%.

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 trend that has forecasted values which are dampened by approximately 0.65%.



Ex Post/In-sample Forecasts

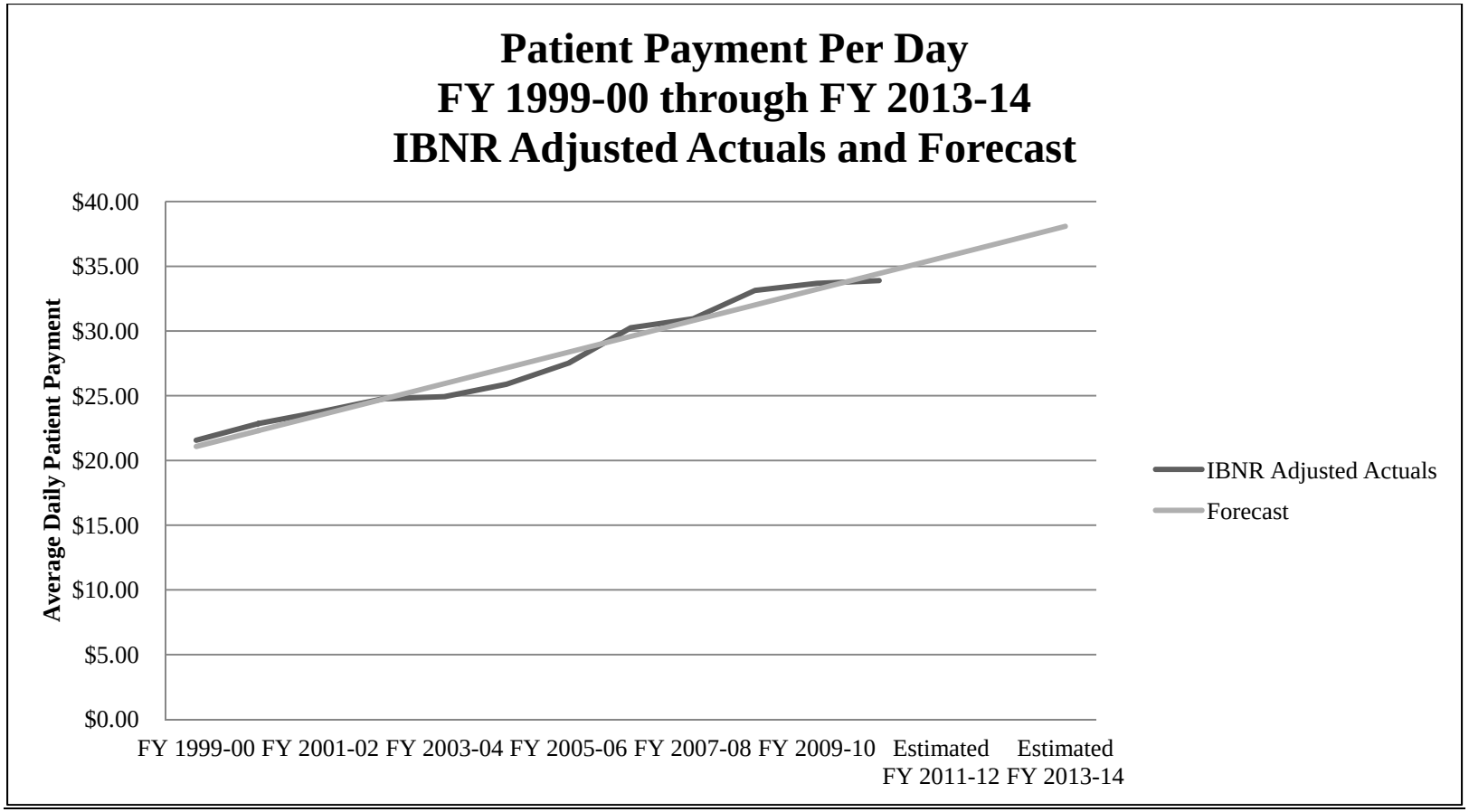
As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from May 2008 through November 2010) and compared the results to actual data reported for December 2010 through April 2011.



With a P-value of 0.0000, the ex post forecast is statistically significant at the 99% confidence level; the model's adjusted R-squared of 0.898 indicates that 89.8% of the variation in the FTE series can be explained by the model. 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

In previous submissions, patient payment has been forecasted using a seasonal auto-regressive model with trend similar to the days forecast. While this type of statistical model could be used to forecast patient payment as well, the series has historically demonstrated a strong linear relationship and produces stronger statistical results with alternative modeling methodologies. 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 0.972 suggesting that 97.2% 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.
FY 2011-12	SB 11-125 increased the level of the provider fee to $12.00 per non Medicare day plus annual inflation. Additionally, the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
FY 2011-12	SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2012.

Department Forecast Methodology Change

With the Department's November 2011 request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate setting methodology in statute. To generate the nursing facility

forecast using the previous methodology, claims that were 100 percent patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100 percent patient payment impact the next year's rate. To more accurately forecast the per diem rates, the revised forecast methodology, claims with 100 percent patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

This methodology allows for a more accurate forecast of the statewide aggregate per diem net of patient payments. Additionally, with this methodology, patient payment and patient days more accurate reflect what were actually paid or incurred.

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. Supplemental payments made to Class I nursing facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

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. Since 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.

Corrections to claims for facilities incorrectly classified as Class II nursing facilities resulted in significant under expenditure in FY 2009-10 and over expenditure in FY 2010-11. As these shifts are one-time adjustments, FY 2011-12 expenditure is expected to return to historical levels.

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 2011-12 projection for PACE is computed in several parts: First, the Department estimates the growth in the average enrollment at PACE providers using an enrollment model compiled with historical and provider-stated enrollment goals. This projection is then added as a bottom-line impact. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2010-11 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2011-12 base expenditure. The Department then adjusts for any bottom-line impacts not incorporated in the trend (described below). The sum of the base expenditure and the bottom-line adjustments is the estimated FY 2011-12 total expenditure. FY 2012-13 and FY 2013-14 expenditure is calculated in the same fashion.

To estimate the average increase in cost per enrollee in FY 2011-12, the Department selected the estimated growth rate between PACE rates from FY 2010-11 to FY 2011-12. Because the PACE program is capitated, the Department believes the best estimate for cost per enrollee is based on the actual rate that will be paid. For FY 2011-12 the Department selected the estimated growth rate in

PACE rates for Total Long-Term Care (TLC), the Department's largest PACE provider for all applicable eligibility categories, specifically Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to age 59. For FY 2012-13 and FY 2013-14 the Department took the average growth rate in TLC PACE rates from FY 2008-09 to FY 2010-11.

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 Long-Term Care, the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo. The organization also expanded its current facility in Thornton in 2010 and is looking to expand into Larimer and Weld county in 2012.

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 of this narrative. For FY 2011-12, FY 2012-13 and FY 2013-14 no bottom line adjustments have been added. However, in FY 2010-11 a reconciliation was paid to PACE providers for rates which were paid below the true cost of providing the services due to erroneous patient payment reporting. This was a one-time payment the Department accounted for through a bottom line impact. To account for this payment, the Department subtracted it out when calculating per capita and per enrollee costs and trended costs forward using the adjusted amounts.

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 originally scheduled to expire September 30, 2003. However, eligibility has been

[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.

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

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients, and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[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%
2011	$450.00	-2.39%	$115.40	4.43%

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

[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 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 2011-12, the Department inflates the actual expenditure from the second half of FY 2010-11 by the increase caseload from FY 2010-11 to FY 2011-12. This generates the anticipated expenditure for the first half of FY 2011-12 as there will be no increases to Medicare premiums during this period. Expenditure for the second half of FY 2011-12 is calculated by inflating the estimated first half of the year's expenditure by the anticipated increase in Medicare premiums effective January 1, 2012, or 8.30%. This increase in premiums is the average increase over the last five calendar years. The total estimated expenditure for FY 2011-12 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2012-13, the Department first inflates the estimated expenditure from the second half of FY 2011-12 by the estimated caseload trend for FY 2012-13 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2012-13. 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 2012-13 is the sum of the first half and second half estimates.

The forecast of FY 2013-14 expenditure utilizes the same methodology as the forecast of FY 2012-13.

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. 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.

Contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget, for FY 2011-12 through FY 2013-14 the Department examined total expenditure trends to estimate expenditure. The Department believes

this methodology to be more accurate as per capita growth has fluctuated significantly historically because HIBI enrollment does not bear a direct relationship to Medicaid caseload. The Department selected 3.27%, the FY 2010-11 expenditure growth rate for AND/AB clients to trend expenditure in FY 2011-12 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 2011-12 trend selections were held constant for FY 2012-13 and FY 2013-14.

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 2011-12, FY 2012-13 and FY 2013-14 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. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per-member per-month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline. Please see section V for a complete description of the bill and changes.

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. A single entry point agency is an agency in a local community through which persons eighteen years or older, who are in need of long-term care services, can access needed long-term care services.

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home- and Community-Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune

deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. Single entry point agencies also serve as the utilization review coordinator for all community based long-term care services.

Single entry point agencies are paid a case management fee for each client admitted into a community based service program. Single entry point agencies also receive payment for services provided in connection with the development and management of long-term home health prior authorization requests, for work associated with client appeals and for utilization review services related to home- and community-based services and nursing facilities.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for single entry point agencies. However, recently it has come to light that the process described in the footnote report is not being used. Instead, individual single entry point agency contract amounts are determined using data from each single entry point agency's previous year's history of client and activity counts. At the end of the contract year the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to single entry point agencies for services delivered in excess of funds received, or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjusts for underpayment up to the amount allocated. This payment methodology, combined with close Department oversight, encourages single entry point agencies to enroll only those clients who are appropriate for community based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and that to assure single entry point agency compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008.

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer directed care to home- and community-based waiver services. These services must be approved by single entry point agencies. The Department

received approval from the Centers for Medicare and Medicaid Services to add consumer directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007; the Department began to provide these services effective January 1, 2008. Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in HCBS utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs, nor do they reflect actual single entry point caseload; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the cash accounting basis of Medical Services Premiums. The Department believes that growth in paid enrollment is a good proxy for growth in single entry point caseload.

In FY 2010-11 the Department began reporting cost per HCBS waiver utilizer to provide additional information about SEP expenditure and to use in trending expenditure forward.

For FY 2011-12, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points 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 2012-13, 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 2010-11 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 2006-07 to FY 2010-11 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 2011-12 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2012-13 and FY 2013-14 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. The Department does not currently have any new changes that impact expenditure for FY 2011-12 through FY 2013-14.

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.). 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 provide 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 administered by the Department of Public Health and Environment, and federal funds. Certain restrictions, specified in section 24-22-117 (2)(d)(IV.5), C.R.S., 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. (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's appropriation includes $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.

FY 2012-13 remains at the same level as FY 2011-12. However, in FY 2013-14, the statutory authorization for this funding expires. Expenditure in the out year and any year following is expected to be zero.

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 implemented 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 are 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 and Community Based Long-Term Care. In the current request, the Department forecasts enrollment and costs for each program separately.

Rocky Mountain Health Plans

Because the administrative fees remain the same in FY 2011-12 and FY 2012-13, the Department uses actual enrollment to forecast expenditure in FY 2011-12 and FY 2012-13 for Rocky Mountain Health Plan. 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.

To forecast enrollment in Rocky Mountain Health Plan for the current and request years, the Department assumes that the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its Health Plan. Therefore, the Department estimates that the only growth into the Health Plan in FY 2011-12 will be the base trend from the June 2011 level. In FY 2012-13 and FY 2013-14, the Department assumes that there will be no enrollment growth in the Health Plan.

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 Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan 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 made. 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. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department anticipates completing all CMS requirements pertaining to Rocky Mountain Health Plan by the first half of FY 2011-12. At that time, the Department will make a cost avoidance payment to Rocky Mountain Health Plan for services rendered in FY 2009-10; Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed that no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department will also make a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the year prior to it.

The Department included the cost avoidance amount for FY 2009-10 services as a bottom line impact for FY 2011-12 and multiplied it by two, which takes into account the need to pay an additional cost avoidance payment in that fiscal year for FY 2010-11 services. For the FY 2012-13 and FY 2013-14 fiscal years, the Department assumed that the cost avoidance payments would be similar in magnitude to the calculated payment for FY 2009-10 and carried that amount forward for both fiscal years. 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.

Colorado Regional Integrated Care Collaborative Programs (Colorado Access and Kaiser Foundation Health Plan)
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 Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. 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. MDRC's evaluation of Colorado Access will be completed and available to the Department at the beginning of 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the 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. The Department estimates that enrollment will grow until it reaches its cap of 800 clients in October 2011. At the end of FY 2010-11, the Department had not yet paid for the last four months of administrative fees incurred in that fiscal year, and as a result, the payments for these months will be made in FY 2011-12. The Department assumes that the payments are now caught up to the point where the lag time between month of service and month paid is only one month. For this reason, it is assumed that the Department will make payments to Kaiser for fifteen months of case management fees in FY 2010-11, including four from FY 2010-11 plus eleven from FY 2011-12. Kaiser will continue to serve CRICC clients until June 30, 2012, when its part of the pilot program will end. Due to the lag in payments, it is expected that there will be one additional payment to be made in FY 2012-13. MDRC is currently studying the effectiveness of the program at Kaiser, and will complete the evaluation for the Department at the beginning of 2013.

Colorado Alliance & Health Independence (CAHI)

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 2011-12 and FY 2012-13 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 its brief historical experience of how many clients were enrolled from January 2010 to June 2011. The payments to CAHI were lagged by one month at the end of FY 2010-11. The Department assumes that there will be a one-month lag in payment at the end of FY 2011-12, resulting in payments of twelve months in that fiscal year, including one from FY 2010-11 plus eleven from FY 2011-12. Similarly, it is assumed that the Department will make payments for twelve months in FY 2012-13 (one from FY 2011-12 plus eleven from FY 2012-13) and FY 2013-14.

Accountable Care Collaborative (ACC)

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 Department enrolled the first clients into the program in May 2011 and estimate that enrollment will increase to 60,000 by October 2011. The program will begin expanding in November 2012 to 123,000 clients as requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." 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 2011-12 include $2,700,000 paid to the SDAC, $12.00 per-member per-month (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, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. The fees in FY 2012-13 are the same, except the SDAC costs will increase to $3,000,000. In FY 2011-12, the SDAC will not have as much data to analyze as the ACC is still ramping up; by FY 2012-13, however, the SDAC will have a full year's data to analyze and will be assisting the Department in integrating more information to evaluate the program. The contract will increase by $300,000 in that year, and the Department anticipates that it will remain at that level for future years. In the current and request year, the Department assumes that the full $2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members. This is the case for the current year, but starting in FY 2012-13, the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in FY 2012-13 and may request a lower PMPM depending on the average percentage of the incentive payments paid to providers. The FY 2013-14 estimate incorporates the same PMPM amounts and enrollment levels as FY 2012-13.

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 2011-12, FY 2012-13, and FY 2013-14 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.

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 cash funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A. Information regarding Tobacco Tax funds has been removed from this exhibit with the Department's November 1, 2011 request as Tobacco Tax funding is now appropriated to the

Department at a fixed value that is independent of the actual caseload or per capita costs associated with clients that would have otherwise been funded by Tobacco Tax.

Hospital Provider Fee Cash Fund

HB 09-1293 established this fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

Expansion Adults to 100%

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 29% to at least 60% of the federal poverty level, the Hospital Provider Fee Fund extends eligibility to 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. 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.

Adults without Dependent Children

This expansion allows Adults without Dependent Children up to 100% of the federal poverty level (FPL) to be eligible for Medicaid benefits. Eligibility for this population is scheduled for March 2012, and the Department will be pursuing a Section 1115 Demonstration Waiver in order to implement it. The Department plans to submit the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) by November 2011, and to present rules to the State Medical Services Board (MSB) by December 2011.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed that there were 143,191 uninsured Adults without Dependent Children in Colorado in 2009, 49,511 of which were in the 0-10% FPL range. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion at 10,000. The Department assumes that due to the number of uninsured individuals in this income group, the enrollment cap will be reached very quickly and monthly caseload will remain static at 10,000.

The Department assumes the per-capita costs for this population will be a blend of the per capitas for the Low-Income Adults from 29% to 60% of the FPL and the Disabled Individuals to 59 (AND/AB). The experiences from other states and a literature review on this population confirm this assumption. As the Department is only implementing up to 10% FPL, the Department assumes that these clients will be the most high-cost high-need clients, with a lot of pent-up demand. With these assumptions, the Department assumed a

blended per capita with 25% resembling the Low-Income Adults from 29% to 60% of the FPL, with the other 75% resembling the Disabled Individuals to 59 (AND/AB) population. These proportions were applied to the per capitas for the Low-Income Adults and the Disabled Individuals to 59 calculated by the Department's contractor using the historical data of both populations.

Medicaid Buy-In Cash Fund

This fund is administered by the Department to collect buy-in premiums and support expenditures for the Buy-in for Individuals with Disabilities expansion populations, as authorized by HB 09-1293.

Buy-in Programs for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities is scheduled for March 2012, with eligibility to children following four to six months later. The Department does not have an implementation timeframe for non-working adults with disabilities at this time. The Department plans to submit a State Plan Amendment to CMS by September 2011 and receive approval by December 2011, and to present rules to the MSB by November 2011.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the 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 penetration rates depending on FPL bracket and adult/child category. The Department assumed that children would have a higher penetration rate than adults, and also that the penetration rate would vary by FPL group due to interactions with other programs. Furthermore, while the Department acknowledges that as individuals' incomes increase they may be more likely to have other insurance, the Department believes that many may buy into the program to receive "wraparound" benefits that are not available through their own plan.

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 most clients in the Buy-In program will have lower utilization of many Home- and-Community Based Services (HCBS) 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. In addition, the Department also assumes that 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for many services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers

or the existing state plan option, and the Department assumes 10% of the population will use these services. Overall, the Medicaid Disabled Individuals to 59 Acute Care per capita has been adjusted based on all of the above factors, some of which act to increase and some of which act to decrease the per capita. These adjustments were applied to the total per capita rather than at the service category level.

Projected Hospital Provider Fee Expansion Population Expenditures						
	FY 2011-12		FY 2012-13		FY 2013-14	
Hospital Provider Fee Programs	**Total Funds**	**Cash Funds**	**Total Funds**	**Cash Funds**	**Total Funds**	**Cash Funds**
Expansion Adults to 100%	$95,490,227	$47,745,114	$102,630,877	$51,315,440	$106,528,358	$53,264,180
Buy-in for Individuals with Disabilities	$525,479	$239,856	$22,542,913	$10,417,952	$61,487,458	$28,571,817
Adults Without Dependent Children	$29,439,789	$14,719,894	$114,135,800	$57,067,900	$119,842,600	$29,960,650

EXHIBIT K – UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

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

Funds received through the Upper Payment Limit for home health services and nursing facilities are used to offset General Fund expenditures. These offsets started in FY 2001-02. While nursing facilities account for the larger 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.

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.

In prior fiscal years, the Department was able to utilize Upper Payment Limit financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department was able to certify public expenditure for Outpatient Hospital services. This was due to HB 09-1293, which allowed the Department to use other state funds to draw federal funds to the upper payment limit.

EXHIBIT L – APPROPRIATIONS AND EXPENDITURES

This exhibit displays the Department's forecast for estate recoveries, trust recoveries, and tort/casualty recoveries. Prior to FY 2010-11, these recoveries were utilized as an offset to expenditure in Medical Services Premiums. In compliance with State Fiscal Rule 6-6, the Department now reports the recovery types listed above as revenue.

In addition to anticipated recovery revenue, Exhibit L also shows the anticipated contingency fee to be paid to contractors for recovery efforts. Total revenue used to offset General Fund and federal funds, as shown in Exhibit A, is the sum of all recoveries less contingency fee paid to contractors.

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 data obtained from the Department's Medicaid Management Information System. This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long-term Care, Long-Term Care and Insurance (including subtotals for long-term care and insurance pieces separately), and Service Management.

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

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

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

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

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.

Effective with the November 1, 2011 Budget Request, the Department has made numerous changes to this exhibit:

- The Department has restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2002-03 forward. The Department has altered the methodology for distributing expenditure between eligibility types to more accurately reflect expenditure actually incurred in the service category.
- The Department has separated Expansion Adults into Expansion Adults to 60% and Expansion Adults to 100%.

- The Department has included totals for financing categories in Medical Services Premiums. As a result, this exhibit now matches the totals shown in other places in the budget, notably the Schedule 3.
- The Department has removed historical totals prior to FY 2002-03. These pages remain available on the Department's website, and upon request.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2010-11 final actual expenditures are included in this Budget Request for historical purpose and comparison.

Effective with the November 1, 2010 Budget Request, the Department has included 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 displays the FY 2010-11 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2010-11 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.

Additionally, 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 through FY 2011-12 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 2011-12 year-to-date expenditures through September 2011 and the cash flow pattern of actual expenditures for the first quarter of FY 2011-12 to determine a rough estimate of FY 2011-12 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.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during prior 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 2011-12 Budget Cycle Requests

This section describes the impact from legislation passed during the 2011 legislative session, and also includes impacts from the Department's FY 2011-12 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

SB 11-209 – FY 2011-12 Long Bill

The FY 2011-12 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2011 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.

- *Client Overutilization Program Expansion (BRI-1):* Increases enrollment by 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication, but also include inappropriate use of emergency room and/or physician services. The expansion is anticipated to begin in March 2012 and result in a reduction in acute care expenditure of $136,000 in FY 2011-12 and an additional $1,098,200 in FY 2012-13. These savings amounts combine the net effect of paying participating providers a $30.00 per-member per-month incentive payment and the savings that accrue from decreasing expenditure in other service categories.

- *Medicaid Reductions (BRI-5):* This budget reduction item included a series of initiatives that were proposed to reduce Medicaid expenditure and meeting budget balancing goals. The initiatives imposed a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies, as listed below.
    - Pharmacy State Maximum Allowable Cost (SMAC) Expansion: Add more drugs to be placed on the SMAC list, reducing expenditure by $1,833,334 in FY 2011-12 and annualized in FY 2012-13 to an additional reduction of $166,666.
    - Reduce Rates for Specific Diabetes Supplies: Reduce payment for blood glucose/reagent strips from $31.80 per box of 50 strips to the current median market price of $18.00. This rate cut reduces expenditure by $842,728 in FY 2011-12 and an additional $150,066 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
    - Reduce Payments for Uncomplicated Cesarean Section Deliveries: Reduce the amount paid for uncomplicated cesarean section deliveries to the amount paid for complicated vaginal deliveries, which reduces expenditure by $6,276,004 in FY

2011-12 and an additional $811,545 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.

- Reduce Payments for Inpatient Renal Dialysis: Reduce the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers. This results in a reduction of $1,418,733 in FY 2011-12 and an additional $183,455 in FY 2012-13. The request amount also includes an adjustment to account for cash accounting.
- Deny Hospital Readmissions within 48 Hours: Cease making a separate payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition, reducing expenditure by $2,475,418 in FY 2011-12 and an additional $320,094 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Prior Authorize Specific Radiology Services at Outpatient Hospitals: Require prior authorization in outpatient hospitals for MRIs, CT scans, PET scans and SPECT scans, except for in emergency situations. This policy reduces expenditure by $672,136 in FY 2011-12 and an additional $3,720,409 in FY 2012-13. It is on track to be implemented in April 2012.
- Normalize Consumer Directed Attendant Support Services (CDASS) Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. This results in a reduction of $1,065,519 in FY 2011-12 and an additional reduction of $612,189 in FY 2012-13 to community based long-term care. The request amount was adjusted for a delay in the implementation date from July 2011 to October 2011, and it includes an adjustment to account for cash accounting.
- Enforce Existing Limitations on Acute Home Health Services: Enforce requirement that prior authorization is needed for acute home health services beyond 60 days, reducing expenditure by $1,131,555 in FY 2011-12 and an additional $286,551 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Reduction to Managed Care Organization: Incorporate the reductions to Medicaid fee-for-service in the rates paid to the Department's managed care organization, resulting in a reduction of $1,906,233 in FY 2011-12 and an additional reduction of $81,968 in FY 2012-13. The Department has adjusted its request to account for initiatives that were not appropriated and will therefore not affect the rates paid to the managed care organization.

- *Medicaid Budget Balancing Reductions (BA-9):* In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions.
  - Expand the Accountable Care Collaborative (ACC): Enroll 63,000 additional clients in the ACC by November 2011, for a total program enrollment of 123,000. The expansion was delayed, pushing the date for reaching total program enrollment to January 2012. The estimated savings and administrative costs from enrolling additional clients were adjusted to account for the delay. The per capita savings assumption implicit in the appropriation was applied to the revised enrollment timeline to adjust the savings. The savings in Acute Care for the expansion are $10,250,663 in FY 2011-12 and are annualized in FY 2012-13 to an additional reduction of $8,520,553. The administrative costs, which are calculated in

Exhibit I, Prepaid Inpatient Health Plan, will increase by $7,497,000 in FY 2011-12 and an additional $5,355,000 in FY 2012-13.

- Money Follows the Person Deinstitutionalization Efforts: Use grant funds to provide additional transitional services to move clients from nursing facilities to Community Based Long-Term Care. The Department was unable to transition these clients due to receiving significant less grant funds than anticipated. The clients specified in this initiative would be moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
- Limit Fluoride Application Benefit: Limit fluoride application benefit to a maximum of three applications per year, reducing expenditure by $30,982 in FY 2011-12 and an additional $6,101 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Limit Dental Prophylaxis Benefit: Restrict dental prophylaxis (routine dental cleaning) to two procedures per fiscal year, reducing expenditure by $161,936 in FY 2011-12 and an additional $31,892 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Eliminate Reimbursement for Oral Hygiene Instruction: Eliminate reimbursement for oral hygiene instruction. This results in a reduction of $4,241,026 in FY 2011-12 and an additional $835,251 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until October 2011. The Department adjusted its request accordingly; for FY 2011-12, expenditure is reduced by $347,012 and for FY 2012-13, it is reduced by an additional $208,056. The request amount also includes an adjustment to account for cash accounting.
- Require Specific Billing for Certain Home Health Visits: Require home health providers to specifically bill codes for brief visits in circumstances in which only a short visit is required, reducing expenditure by $2,511,443 in FY 2011-12 and an additional $636,809 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Provider Rate Reduction: Reduce acute care physical health provider rates by 0.75% and community based long-term care providers by 0.5%, effective July 1, 2011. This results in a $12,092,847 reduction in FY 2011-12 and an additional $2,904,019 in FY 2012-13 to Acute Care, and a $1,561,829 reduction in FY 2011-12 and an additional $361,468 in FY 2012-13 to Community Based Long-Term Care.

The following table shows the original request amount, FY 2011-12 appropriation, and FY 2012-13 R-1 request amount for each of the FY 2011-12 impacts requested in BRI-5 and BA-9, as detailed above:

FY 2011-12 BRI-5 and BA-9 Request to Appropriation Comparison				
Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount
State Allowable Cost Expansion	BRI-5	($1,833,333)	($1,833,334)	($1,833,334)
Reduce Rates for Diabetes Supplies	BRI-5	($842,727)	($919,340)	($842,728)
Reduce Payment for Uncomplicated C-Section	BRI-5	($6,276,004)	($6,846,550)	($6,276,004)
Reduce Payments for Renal Dialysis	BRI-5	($2,169,701)	($2,366,947)	($1,418,733)
Deny Payment of Hospital Readmissions 48 hrs	BRI-5	($2,475,418)	($2,700,456)	($2,475,418)
Prior Authorize Certain Radiology	BRI-5	($672,136)	($672,136)	($672,136)
Cap CDASS Wage Rates	BRI-5	($1,420,692)	($1,549,846)	($1,065,519)
Limit Acute Home Health Services	BRI-5	($1,131,555)	($1,234,424)	($1,131,555)
HMO Impact to Rates	BRI-5	($2,945,547)	($2,707,680)	($1,906,233)
Estimated ACC Net Savings	BA-9	($9,537,806)	($4,768,903)	($2,753,663)
Clients Moved from Nursing Home	BA-9	($624,975)	($625,704)	$0
Limit Fluoride Application Benefit	BA-9	($29,898)	($33,798)	($30,982)
Limit Dental Prophylaxis Benefit	BA-9	($156,274)	($176,658)	($161,936)
Limit Oral Hygiene Instruction	BA-9	($4,092,739)	($4,626,574)	($4,241,026)
Limit Physical and Occupational	BA-9	($446,504)	($504,744)	($347,012)
Home Health Billing Changes	BA-9	($2,423,629)	($2,739,756)	($2,511,443)
0.75% Acute Care Provider Rate Reduction	BA-9	($8,261,265)	($11,711,574)	($12,092,847)
0.5% CBLTC Provider Rate Reduction	BA-9	($1,507,220)	($2,260,830)	($1,561,829)
Total		($46,847,423)	($48,279,254)	($41,322,398)

In cases where savings estimates have been reduced due to implementation delays, the Department accounts for the full impact in FY 2012-13.

SB 11-209 also included the following reductions that were not part of the Department's original requests:

- *Wound Therapy Code Reduction:* Reduce payment for negative pressure wound therapy to $88.50 per day, reducing expenditure by $100,000 in FY 2011-12.
- *Elimination of Circumcision Benefit:* Eliminate circumcision as a covered benefit. This results in a reduction of $373,000 in FY 2011-12.

SB 11-008 – Concerning Medicaid Eligibility for Children
This bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). The Department assumes that the federal match for clients these clients will remain at the same level it would have had the clients enrolled in the Children's Basic Health Plan instead of Medicaid, or 65%. The impact of this bill will not be seen until FY 2012-13 due to needed system changes.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	3,951	$6,072,134
FY 2013-14	16,333	$25,005,496

SB 11-125 – Concerning Nursing Home Fees and Order of Payments
This bill alters the hierarchy of the supplemental payment components funded by the Nursing Facility Provider Fee and increases the maximum allowable fee assessed to nursing facilities.

Nursing facility rates are cost-based. However, the General Fund portion of a nursing facility's rate is limited by statute regardless of the amount of growth seen. Facilities are compensated for cost growth beyond the General Fund cap though supplemental payments from the Nursing Facility Cash Fund. On the aggregate level, nursing facilities typically see approximately 4.25% growth in costs each fiscal year.

As quality and performance incentives were previously funded after growth beyond the General Fund Cap and the provider fee was unable to fully fund all components of the supplemental payments, these quality and performance components were not always funded. Under this statute, quality and performance incentives take priority over growth beyond the General Fund cap. As a result, the provider fee is able to fully fund quality and performance incentives, but can no longer fully fund growth beyond the General Fund cap. The Department estimates that the provider fee is able to fund approximately 68% of growth beyond the General Fund cap in FY 2011-12.

SB 11-177 – Concerning Pregnancy and Dropout Prevention
This bill extended the sunset deadline and expanded the Teen Pregnancy and Dropout Prevention program for Medicaid clients. The Department currently offers teen pregnancy prevention services to at-risk teenagers through two providers: Hilltop Community Resources, Incorporated (Hilltop) and the Montrose County Department of Health and Human Services (Montrose). This program provides services such as group and individual counseling, vocational, health and educational guidance, science-based instruction concerning human sexuality and home visits. In FY 2008-09, Hilltop served approximately 150 teens at a cost of $98,776 total funds. Montrose served

approximately 140 teens at a cost of $125,453 total funds in FY 2008-09. The program receives a 90% federal financial participation match rate which is drawn through local funds paid to the Department.

Through this bill the Department is able to hire a FTE to administer this program which was historically absorbed by other Departmental resources. The Department believes the increased administration will allow the program to expand to addition providers at a rate of two to three new providers per year. The Department assumes the cost of the FTE will be offset in Acute Care through avoided births.
In FY 2011-12 the Department anticipates receiving $38,666 local funds, annualizing to $93,288 in FY 2012-13 and $124,020 in FY 2013-14 to run the program and expansion.

SB 11-210 – Concerning the Phase Out of Supplemental Old Age Pension Health Fund
As part of the Joint Budget Committee's (JBC) budget balancing package, this bill allows for an annual transfer of $2,230,500 from the Supplemental Old Age Pension Health and Medical Care Fund to be used as a General Fund offset for services in the Medical Service Premiums for persons 65 years of age and older beginning FY 2011-12. This statute eliminates the additional step of transferring funds from tobacco tax to the Supplemental Old Age Pension Health and Medical Care Fund and then appropriating funds from the Supplemental Old Age Pension Health and Medical Care Fund to the Medical Services Premiums line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-211 – Concerning Tobacco Revenues Offsetting Medical Services
Also part of the JBC budget balancing package, this bill allows for the use of $33,000,000 in tobacco tax funds for services in the Medical Services Premiums line. Of this amount, $17,758,594 is from the Tobacco Education Program Fund, $11,955,055 is from the Prevention, Early Detection, and Treatment fund, and $3,286,351 is reappropriated funds from the Department of Public Health and Environment. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-212 – Concerning the Use of Provider Fee to Offset Medicaid Expenditure
This bill authorizes the Department to utilize $50,000,000 in Hospital Provider Fee funds as a direct offset to General Fund expenditure for services in the Medical Services Premiums line in FY 2011-12 and $25,000,000 in FY 2012-13.

SB 11-215 – Concerning the 2011 Nursing Facility Rate Reduction
Effective July 1, 2011, SB 11-215 continues the 1.5% reduction to class I nursing facility reimbursement from HB 10-1324 which expired on June 30, 2011. The total fiscal impact of this bill will depend on the number of patient days incurred in FY 2011-12. Exhibit H of the Department's request contains detailed calculations for the fiscal impact of this bill.

SB 11-219 – Concerning 2011 Transfers for Health Care Services
This bill authorizes the Department to use $15,775,670 in funds from the Primary Care fund as offset to General Fund expenditure in the Medical Services Premiums line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-250 – Concerning Eligibility for Pregnant Women

This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan to Medicaid. As with SB 11-008, the Department assumes that the federal match for clients these clients will remain at the same level it would have had the clients enrolled in the Children's Basic Health Plan instead of Medicaid, or 65%. The impact of this bill will not be seen until FY 2012-13 due to needed system changes.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	597	$5,054,333
FY 2013-14	1,194	$10,616,582

Federal Legislation

Section 1202S of the Affordable Care Act states that, for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate will apply to certain primary care services, including evaluation and management and immunizations, performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

The Department estimates that the difference in rates between July 1, 2009 and January 1, 2013 will generate an estimated $4,950,838 total funds in FY 2012-13 and $12,872,971 total funds in FY 2013-14, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July 1, 2009; this gap represents rate cuts that were taken since July 1, 2009 due to budget reduction measures. The Department estimates that increasing rates to the July 1, 2009 level will increase expenditure by $1,347,828 in FY 2012-13 and $3,234,787 in FY 2013-14. These amounts will be matched by the federal government at the standard FMAP rates.

Prior Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments

This section describes the impact from legislation passed during the 2009 and 2010 legislative sessions, and also includes impacts from the Department's budget cycle requests prior to FY 2011-12. Information from budget requests has been updated to be consistent with any approval granted by the legislature. Please note that the descriptions in this section only discuss those portions of approved initiatives which have an impact in this budget request. The budget requests, or portions of budget requests, from prior cycles which have been implemented and do not require further adjustment in this request (such as a bottom line impact) are not discussed in this narrative. For information on the Department's complete requests, please consult the narrative for prior years, or the original requests.

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. Budget actions listed in this section are from the FY 2010-11 budget cycle.

- *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. Delayed implementation has shifted anticipated Medical Services Premiums savings from FY 2010-11 to FY 2011-12. FY 2011-12 savings total $887,437. The revised implementation date for this initiative is October 1, 2011.

- *Implementation of Family Planning Waiver (BA-16):* 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.

  The implementation of the program has been delayed to FY 2012-13 to allow sufficient time for required systems changes and approval from the Centers for Medicare and Medicaid Services (CMS). Through the application review process, CMS has requested revised calculations and program adjustments to the 1115 family planning waiver application. The Department anticipates these adjustments to be submitted in the fall of FY 2011-12 and waiver approval by July 2012. The Department has shifted costs of the program implementation from FY 2011-12 to FY 2012-13 and FY 2013-14.
  This Budget Reduction Item transfers $190,350 in FY 2012-13 and an additional $230,310 in FY 2013-14 from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds.

- *Coordinated Payment and Payment Reform (BRI-2):* This budget reduction item reduces expenditure in FY 2011-12 for both Acute Care Services and Community Based Long-Term Care Services. The table below demonstrates these reductions by service category.

  This budget reduction item implements 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.

FY 2010-11 BRI -2 Coordinated Payment and Payment Reform Request	
Acute Care	($5,060,838)
Community Based Long-term Care	($616,405)
Total	($5,122,243)

- *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). Implemented in FY 2010-11, this Budget Reduction Item is expected to reduce Acute Care services expenditure by an additional $125,098 in FY 2011-12.
    - 1% Rate Reduction: As part of this request, the Department proposes to reduce rates paid to Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2010. 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 beginning January 1, 2011. For this initiative the Department will limit enrollment to 60,000 clients with the anticipation of enrolling more clients as the program becomes established.

  The Accountable Care Collaborative (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."

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. However, enrollment into the program was slower than anticipated and in June 2011, approximately 20,000 clients were enrolled into the program. The Department anticipates enrollment will continue to increase and all 60,000 clients will be enrolled by November 2011. The Department has adjusted cost and savings estimates to account for the delayed enrollment and for actual FY 2010-11 per capita costs. The chart below illustrates the difference between the appropriated amounts and Department's request by service category.

Accountable Care Collaborative FY 2011-12 Appropriation to Request Comparison			
Service Category	**FY 2011-12 Appropriated Amount**	**FY 2011-12 S-1 Request**	**FY 2012-13 R-1 Request**
Estimated Administration Payments (PIHP Admin)	$13,009,140	$14,272,918	$11,822,246
Estimated Savings (Acute Care)	($23,277,919)	($22,029,755)	($20,085,549)
Total	**($10,268,779)**	**($7,756,837)**	**($8,263,303)**

HB 10-1005 - Concerning Home Health Care through Telemedicine Pursuant to the "Colorado Medical Assistance Act"
This bill alters the provision of home health telemedicine services established in SB 07-196. This bill declares 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 2011-12 and FY 2012-13. The bill increases Department expenditure $234,432 in FY 2011-12, annualizing to $312,576 in FY 2012-13.

As of December 2010 the Department has received donations to implement the telemedicine program. However, after review by the Centers for Medicare and Medicaid Services the donated funds will not receive a federal match. Within this bill the Department is given authority to request General Fund to continue operating the program after donated funds are completely utilized. The Department believes this authority grants the Department an exemption from requirements in HB 10-1178 which prohibits agencies from requesting General Fund to continue grant and donated fund programs.

The Department anticipates client enrollment will begin in October 2011 as program implementation has been delayed due to rule change requirements and completion of the documented quote for the vendor.

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 for clients 12 and older. 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 statewide. 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. Billing codes for SBIRT services opened in December 2010 completing the implementation of the program.

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
This bill initiated a Nursing Facilities rate reduction of 1%, 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. Due to issues related with claims run out, the Department has also estimated an FY 2011-12 impact. See Exhibit H, footnote 9 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
This bill, 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 $3,000,000 in FY 2011-12. The provisions of the bill are repealed on July 1, 2012.

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. The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, annualizing to $3,699,827 in FY 2011-12 by requiring the Department to implement a number of initiatives. While the Department has been able to partially implement the components of SB 10-167, full implementation is not anticipated until spring of 2012. Consequently, a portion of the savings originally anticipated in FY 2010-11 has been shifted to FY 2011-12 and FY 2012-13. The initiatives are as follows:

- National Correct Coding Initiative: With this initiative, the Medicaid Management Information System (MMIS) will be enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit

quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over three million in total) to achieve savings despite delays in implementation. The FY 2011-12 NCCI impact of $200,325 reflect both delays in implementation and savings achieved through the manual implementing codes in FY 2010-11.

- Rx Coordination of Benefits: The Rx Coordination of benefits program implements system changes that allow the Department to perform prepayment review of pharmacy claims to determine whether another party should be primary payer for the claim. Delay in system change implementation has resulted in a shift of savings from FY 2011-12 to FY 2012-13. Estimates savings for FY 2012-13 total $351,262 with a like amount in FY 2013-14. Revised implementation is scheduled for July 1, 2012.
- 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.
- Enhanced Internal Audits: 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 through 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.
- Health Insurance Buy-In Program (HIBI) Expansion: Purchase private health insurance coverage through the Health Insurance Buy-In Program for and additional 1,500 eligible clients to create cost savings for the state by enrolling clients into individual insurance plans where enrollment is deemed cost effective. This initiative has been delayed to implement in January 2012 to allow for contract negotiations. The Department submitted the request for proposal into the internal clearance process in July 2011 and believes the new contract to be in place in order to begin additional enrollment in January 2012. The Department anticipates 250 clients will be enrolled per month until the maximum of 2,000 clients is reached.

  In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to per-member per-month payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2010-11 per capita costs. Finally, the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2011-12 through FY 2012-13.

FY 2011-12 and FY 2012-13 Total HIBI Impact from SB 10-167		
Item	**FY 2011-12**	**FY 2012-13**
Provider Payment	$174,075	$658,075
Premiums Payment	$799,879	$4,003,663
Savings (Realized in Acute Care)	($1,310,349)	($6,558,734)
Total Impact	**($336,395)**	**($1,896,996)**

SB 10-117 – Concerning Over the Counter Medication for Medicaid Clients
This bill allows pharmacists to directly prescribe certain medications, as approved by the Department, to Medicaid clients. By including only drugs that, when access is increased, reduce the likelihood of more expensive exacerbation of conditions, savings can be achieved. Avoided emergency room visits, physician office visits to obtain prescriptions for over-the-counter drugs (as is current policy for over-the-counter drug coverage under Medicaid), and avoided births are the primary vectors of savings. Through an extensive stakeholder outreach process, the Department has developed a list of medications that is anticipated to generate savings. Emergency contraceptives generate the most significant amount of savings as the costs associated with birth are nontrivial. The Department's analysis excludes first year of life costs and thus represents a conservative estimate of savings.

Because of the significant health consequences associated with smoking, expenditure on nicotine replacement therapies have been shown to reduce health care expenditure as quickly as one year post investment. Returns continue to increase over time. While there is an initial increase in expenditure associated with covering nicotine replacement therapy under the provisions of SB 10-117, the Department anticipates short-term returns on investment. Further, the increase in expenditure is completely offset by savings achieved by other drugs in the program.

Over the counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the Department believes that as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

The Department anticipates full implementation by July 1, 2012. The Department will continue to evaluate the list of medications to determine any needed changes or additional opportunities for savings.

Benefit Type	FY 2012-13	FY 2013-14
Emergency Contraceptive	($186,215)	($193,966)
Nicotine Replacement	$28,585	($332)
Children's Over the Counter Medications	$7,876	$10,018
Total	**($149,754)**	**($184,280)**

Estimated Impact of Increasing PACE Enrollment

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

The impact to Acute Care and Community Based Long-Term Care 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 a Home- and Community-Based Services (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 2011-12	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($805,654)	($258,481)	($181,415)	($1,245,550)
CBLTC	($1,199,570)	($94,723)	($48,694)	($1,342,987)
Total	**($2,005,224)**	**($353,204)**	**($230,109)**	**($2,588,537)**

FY 2012-13	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Total
Acute Care	($745,965)	($242,104)	($157,784)	($1,145,853)
CBLTC	($1,110,699)	($88,722)	($42,351)	($1,241,772)
Total	**($1,856,664)**	**($330,826)**	**($200,135)**	**($2,387,625)**
FY 2013-14	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($756,931)	($245,663)	($160,105)	($1,162,699)
CBLTC	($1,127,027)	($90,026)	($42,973)	($1,260,026)
Total	**($1,883,958)**	**($335,689)**	**($203,078)**	**($2,422,725)**

HB 09-1047 – Concerning a program for providing additional therapies to certain persons with disabilities who are eligible to receive Medicaid

This bill enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services are to include massage, acupuncture and chiropractic care. Programmatic design and budgeting constraints delayed timely implementation of this bill. However, in June 2011 the Department applied to CMS for 1915(c) waiver authority to run the pilot program. The Department anticipates that, should the waiver be approved, implementation would occur in January 2012 and serve approximately 60 eligible clients.

The Department estimates increased costs of $93,720 to Community Based Long-Term Care in FY 2011-12, annualizing $79,415 in FY 2012-13 and reducing expenditure $9,950 in FY 2013-14 as clients establish lower service utilization patterns as a result of alternative therapies.

FY 2009-10 BA-33: Prior Authorization of Anti-Convulsants

Anticonvulsants can be used to treat a variety of conditions. By ensuring this drug class is used only for the treatment of organically originating conditions, expenditure is reduced. This initiative, originally scheduled for implementation in FY 2009-10, requires the automated prior authorization ("auto PA") system to be in place prior to implementation. Savings estimates have been adjusted to account for the delayed implementation the auto PA. The Department now estimates FY 2011-12 savings of $720,000 with an additional $240,000 in FY 2012-13. See FY 2009-10 BRI-1 below for additional information regarding the auto PA.

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. The Department has adjusted savings estimates to reflect a delay in the implementation of the automated prior authorization system. The system is estimated to be online October 2011. The Department estimates a fiscal impact in FY 2011-12 of $1,217,310 and an annualization of $405,770 in FY 2012-13.

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 is one initiative which has an annualized impact in this request:

- 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 roundtrips per week. Trips to adult day programs are not to be subject to the cap included limitations on the HCBS waiver transportation benefit. The program was delayed due to necessary system changes and rule changes. The Department anticipates system changes to be complete in FY 2011-12, though the Single Entry Point agencies have been aware of and compliant with the rule change. Therefore the Department believes it will realize savings in Community Based Long-Term Care in FY 2011-12.

(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 51 counties of the State was complete, with the remaining twelve counties added in 1998. A 64th 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 (BHOs) effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible Adults 65 and Older, Disabled Adults 60-64 and Disabled Individuals to 59, Categorically Eligible Low-Income Adults, Health Care Expansion Fund Low-Income Adults, and Baby Care Program - Adults, Eligible Children, Foster Care children, and Breast and Cervical Cancer Program Adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to, inpatient hospitalization, psychiatric care, rehabilitation and outpatient care; clinic services, case management, medication management and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Medicaid Mental Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY 2004-05 Long Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Medicaid Mental Health

Community Programs – Program Administration to the Executive Director's Office Long Bill group, (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums, and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Medicaid Mental Health Community Programs expenditures are addressed in this section.

The recent history of the Medicaid Mental Health Community Programs is summarized as follows:

- HB 02-1420 provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.

- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 and the entire FY 2003-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System

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

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 2003-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. and the remaining $500,000 was from federal funds for mental health capitation and performance incentive awards.

- Within the appropriation for Medicaid Mental Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered that the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005 began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.

- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group into the following sections:
  1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 2005-06.
  2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from the Centers for Medicare and Medicaid Services to cease making Child Placement Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the current year and the out-year requests and are elaborated below.

- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately.
  The Goebel Lawsuit Settlement line item was created in FY 2003-04 to fund specialized and enhanced mental health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 2003-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Medicaid Mental Health Community Programs payments.

  On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined that an actuarially certified payment would become part of the Mental Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 2006-07 capitations.

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

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

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

- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund, 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 per-member per-month (PMPM). 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 funding to expand health care coverage to 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 allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. 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:
  1. As a part of FY 2010-11 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.
  2. As a part of NP-ES-5 "Close Beds at the Mental Health Institutes," the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients of the capitated mental health program. While treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the "payer of last resort." Displacing these clients 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). These rates remained in effect through CY 2010. See the description of Exhibit GG for additional information.

- Effective January 1, 2011, the Department calculated a new set of mental health rates for calendar year 2011. The new rates implicitly included the 2.5% reductions taken by the BHOs as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of $2,170,355. The Department worked with the BHOs in order to ensure that they were able to certify the rates and continue to provide quality services to their clients, even while their rates were being reduced. The result of that negotiation process was to begin a series of rate reforms, the first of which was to include a new component in the rate called a "case rate" adjustment that was applied to the CY 2011 rates. The case rate is the BHO statewide average cost by diagnosis category. The case rate allows the Department to comply with CMS's direction by increasing the weight of the encounter data in the rate-setting process. The BHOs can accept the increased weight of encounter data because the case rate allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department's goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients.

- The Department requested to continue to apply the 1.71% reduction to the BHO rates in the current and request years in FY 2011-12 BRI-5 "Medicaid Reductions." The reduction was appropriated in the FY 2011-12 Long Bill.

- The FY 2011-12 Long Bill transferred $616,044 from the Division of Youth Corrections appropriation, which is administered by the Department of Human Services, to the appropriation for Medicaid Mental Health Community Programs to fund mental health services provided to children living at the Ridge View Youth Services Center. In FY 2009-10, the Ridge View 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 Ridge View 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. Prior to FY 2011-12, the expenditure for mental health services provided to Ridge View clients was transferred from the appropriation for Medicaid Mental Health Community Programs and into the appropriation for the Division of Youth Corrections. The appropriation was transferred to the Medicaid Mental Health long bill group to streamline the process and avoid manually transferring expenditure. Since the Ridge View clients have been incorporated in the caseload data since FY 2009-10, the Department assumes that the impact of these clients on mental health expenditures will be captured in the caseload forecasts and does not need to be added as a bottom line impact to Exhibit BB.

- SB 11-008, "Aligning Medicaid Eligibility for Children," will expand Medicaid eligibility from 100% to up to 133% of the federal poverty line for children ages 7 to 18. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan. SB 11-250, "Eligibility for Pregnant Women in Medicaid," will expand Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill

shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

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 (BHOs) 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 below. Partial Dual Eligibles and Non-citizens are ineligible for Medicaid mental health services.

The eligible Medicaid Mental Health populations are:
- Adults 65 and Older (OAP-A)
- Disabled Individuals Through 64 (AND/AB, OAP-B)
- Low Income Adults
- Eligible Children (AFDC-C/BC)
- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

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

Description of Transition to New Methodology

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the

impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

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

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

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

The following narrative describes in greater detail the assumptions and calculations used in developing the 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, 2011 Budget Request, Section F.

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT:

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is

compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Medicaid Mental Health Programs. In previous budget requests, the Department 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 request 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.

EXHIBIT BB - CALCULATION OF FUND SPLITS:

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. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately, below. Capitation expenditures are split between traditional clients and expansion clients funded 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. Expansion clients funded through HB 09-1293 receive state share funding from the Hospital Provider Fee Cash Fund. 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.

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 sections 25.5-5-308(8), (9), and (10) C.R.S. Exhibit BB details funds splits for Mental Health Community Programs Capitations lines. The funding for the clients already enrolled in the program, called "traditional clients," is 35% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and 65% federal funds in FY 2011-12. Starting in FY 2012-13, the funding is 17.5% General Fund, 17.5% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds. In addition, 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," were previously 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 was 35% reappropriated funds and 65% federal funds.

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 R-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill group with the Breast and Cervical Cancer Prevention and Treatment Fund.

Mental Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill is parents of Medicaid-eligible children with income up to 100% of the federal poverty level (FPL). Services for these clients are 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 also receive funding through the Hospital Provider Fee Cash Fund. These include disabled individuals with income limits up to 450% of the federal poverty line and Adults without Dependent Children. In this request, the Department included the projected caseload and per capita costs for the disabled expansion population, since these clients will receive services through the BHOs as part of their benefit package. The Department did not include Adults without Dependent Children in this request, as it has not yet been determined which services will be included in the benefit package for that eligibility category. If necessary, the Department will add the projected costs of providing mental health services to this population in future mental health requests once the benefit package for these clients is known.

Mental Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the federal poverty level for all children under the age of 19. Formerly, the eligibility limit for children ages 7 to 18 was 100%, and it was 133% for children 6 and under. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The

Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

EXHIBIT CC - MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS SUMMARY:

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.

EXHIBIT DD - MENTAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY:

Exhibit DD contains the caseload, per capita, and expenditure history for each of the nine eligibility categories. 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 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 per capitas, while the current fiscal year and the request year per capitas are estimates.

Medicaid Mental Health Community Programs Expenditures Historical Summary
The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Financial Reporting System. Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the Colorado Financial Reporting System. The Medicaid Management Information System does provide expenditures by eligibility category, but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the Colorado Financial Reporting System as fiscal periods close. Because the variance is minor, data from the Medicaid Management Information System can be used to distribute total expenditures from the Colorado Financial Reporting System across eligibility categories.

A ratio is calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures by the total Medicaid Management Information System expenditures. The ratio is multiplied by the total expenditures from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY:
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 into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate 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 the current year and the first half of the request year are known and only the final two quarters of the request year 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 for 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.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a 10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

Incurred but not Reported Estimates

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. Pages F.EE-4 through F.EE-5 presents the percentage of claims paid in a six month period that come from that same period and those which come from previous 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 Individuals Through 64, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the Disabled groups, it takes a full eighteen months 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 exist 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-6 through F.EE-7, 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 F.EE-1, F.EE-2, and F.EE-3.

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.

EXHIBIT FF - MEDICAID MENTAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER:
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 Multiplier
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. However, the Department analyzed the data and has determined that the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories except Disabled Individuals through 64. For this reason, the Department assumes that the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

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 five 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. The percentages are similar across years, indicating that the claims-based trends are matching capitation trends. However, the Department analyzed the data and has determined that the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes that the most recent period with adequate time for runout of claims is the best representation of how much partial month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - MEDICAID MENTAL HEALTH CAPITATION RATE TRENDS AND FORECASTS:

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 "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note that the overall weighted point estimate 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 point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates 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 a new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year and 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 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. These two BHOs continued to be paid their September 1, 2009 rates through CY 2010. The 2.5% reductions to the BHOs' rates will continue to be in effect through FY 2010-11 and FY 2011-12, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates were reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011, and appropriated it as a savings of $2,170,355 to be achieved in FY 2010-11. The Department determined that it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%. This rate reduction will continue to be built into the rates in the current and request years, as requested in FY 2011-12 BRI-5.

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 Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Eligible Children (AFDC-C/BC)	Foster Care
January 1, 2009 Midpoint Rate	$13.15	$124.52	$18.25	$14.25	$232.64
% 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	$126.71	$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	$126.71	$18.57	$14.50	$237.59
September 1, 2009 Midpoint Rate	$13.37	$126.71	$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	$123.54	$18.11	$14.14	$231.65
January 1, 2010 Midpoint Rate	$13.43	$136.44	$20.00	$14.90	$204.05
% Change in the Rate Range	0.00%	-4.20%	-3.45%	-3.96%	8.49%
Paid Rate, January 1, 2010 to June 30, 2010	$13.43	$130.71	$19.31	$14.31	$221.37
July 1, 2010 Midpoint Rate	$13.43	$136.44	$20.00	$14.90	$204.05
% Change in the Rate Range	-1.41%	-1.35%	-0.90%	-1.07%	-1.36%
Paid Rate, July 1, 2010 to December 31, 2010	$13.24	$134.60	$19.82	$14.74	$201.28
January 1, 2011 Point Estimate	$14.17	$141.46	$21.76	$15.88	$186.88
% Change in the Rate Range	-1.69%	-1.71%	-1.75%	-1.70%	-1.71%
Paid Rate, January 1, 2011 to December 31, 2011	$13.93	$139.04	$21.38	$15.61	$183.69

Note: Rates for each eligibility category are weighted by the proportion of claims incurred by each BHO within that category. The paid rate from January 1, 2010 to December 31, 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.

EXHIBIT HH - FORECAST MODEL COMPARISONS:

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages F.HH-1 and F.HH-2 present 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-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages F.HH-1 and F.HH-2. 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-3 (see below). For decision items, the 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. 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 2010-11 ES-2 budget action, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. For Q3 and Q4 of FY 2010-11, the Department reduced rates by an additional 1.71%. The Department requested this reduction in FY 2010-11 BRI-6 "Medicaid Reductions" for the full year, but will be implemented for only two quarters of FY 2010-11 per instructions from the Office of State Planning and Budgeting. The 1.71% reduction will continue to be in effect in the current and request years.

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 is impacted by payments made for partial months of eligibility; this type of payment will not 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 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-3 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 a regression 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.

The following table shows the trends selected for the current and request years by eligibility category:

Aid Category	CY 2012 Trend Selection	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.99% Rate change from FY 2009-10 to FY 2010-11	2.99% Rate change from FY 2009-10 to FY 2010-11	2.99% Rate change from FY 2009-10 to FY 2010-11	Historical capitation rates for Adults 65 and Older have increased slowly over time. The percentage change for the most recent fiscal year was the largest growth in four years, although it was still moderate compared to the changes in rates in other eligibility categories. It is anticipated that the rate will continue to increase by a moderate growth rate for the CY 2012, CY 2013, and CY 2014 rates.
Disabled Individuals Through 64 (AND/AB, OAP-B)	8.37% Linear trend using post-Goebel settlement years	5.60% Rate change from FY 2009-10 to FY 2010-11	5.60% Rate change from FY 2009-10 to FY 2010-11	The rate for the Disabled populations has increased along a linear trend since the incorporation of the Goebel settlement into the rate methodology. The Department used the historical rates since the Goebel settlement to trend the CY 2012 rate. The Department expects that the rate will grow more slowly in future years due to rate reform initiatives that reward BHOs for cost-savings efforts. Therefore, the most recent percentage change in weighted fiscal year rates was selected to trend the CY 2013 and CY 2014 rates.
Low Income Adults	3.54% Half of linear trend	3.54% Half of linear trend	3.54% Half of linear trend	The Low Income Adults category has also seen steady increases in its rate, and that growth has followed closely to a linear trend since FY 2002-03. The Department divided the percentage change produced by this model by two as it anticipates that this growth will begin to decline, especially as the rate reform initiatives are anticipated to slow down cost growth. This growth rate was selected to trend the CY 2012, CY 2013, and CY 2014 rates.

Aid Category	CY 2012 Trend Selection	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Eligible Children (AFDC-C/BC)	4.76% Rate change from FY 2009-10 to FY 2010-11	3.78% Linear trend	3.78% Linear trend	The rate for the Children category has been steadily increasing over recent years, particularly in FY 2010-11. The Department expects it to increase again to a similar degree in CY 2012. For CY 2013 and CY 2014, the Department selected the linear trend model as it fits the historical data well and assumes that the rates will grow at a more moderate pace in future years.
Foster Care	-4.81% Average growth rate from FY 2005-06 through FY 2010-11	-2.41% Half of average growth rate from FY 2005-06 through FY 2010-11	-1.20% One-fourth of average growth rate from FY 2005-06 through FY 2010-11	The percentage change from FY 2010-11 to FY 2011-12 as predicted by the average growth model was chosen to trend the CY 2012 rate for the Foster Care population. The rate for this eligibility category has decreased over the last several years; the Department expects that this will continue, but will begin to level off. The trend selected is negative but lower in magnitude than the decline experienced over the last two years. For the CY 2013 and CY 2014 rate, half of the previous year's growth rate was selected assuming that the rate decline will continue to level off.

The selected point estimates of the capitation rates are adjusted on pages F.HH-1 and F.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - RECOUPMENT OF PAYMENTS MADE FOR CLIENTS FOUND TO BE INELIGIBLE FOR MEDICAID:

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 latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department will recoup expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments 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. After the recoupment is complete for FY 2008-09, all historical recoupments will be collected. Each fiscal year recoupments will be made for ineligible clients from two years prior to it. 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. Recoupments from FY 2010-11 will be collected in FY 2012-13, and those from FY 2011-12 will be collected in FY 2013-14.

The Department has preliminary figures on the amount that will be recouped for FY 2008-09. The methodology used to calculate the recoupment for that year differs slightly from previous years. The data for that fiscal year is also more reliable than past fiscal years due to data standardization and verification efforts undertaken by the BHOs and the Department. For those reasons, the Department estimated future recoupments using the FY 2008-09 estimate as a base and inflating it by the growth rate in caseload for that fiscal year.

EXHIBIT JJ - EXPANSION POPULATIONS:

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293) and other bills 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.

This exhibit previously included projections for populations funded through the Health Care Expansion Fund. However, the Health Care Expansion Fund became insolvent in FY 2010-11. Any additional revenue that comes into the fund will be used to offset General Fund expenditure in Medical Services Premiums. There will no longer be any mental health services funded by the Health Care Expansion Fund starting in FY 2011-12.

Colorado Health Care Affordability Act
HB 09-1293, the "Colorado Health Care Affordability Act" provided funding to provide 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 parents of Medicaid-eligible children up to 100% of the federal poverty level. The Department 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. An additional population will be added in FY 2011-12 consisting of disabled individuals with income limits up to 450% of the federal poverty line. As with adults, the Department assumes that the costs for this population will be the same as for the traditional population. 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).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid
SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the federal poverty level for all children under the age of 19. Formerly, the eligibility limit for children ages 7 to 18 was 100%, and it was 133% for children 6 and under. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan. As with the Hospital Provider Fee populations, the Department assumes that the per capita costs for this expansion population will be the same as for the traditional population since the majority of mental health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate and that the per capita costs will be the same as for the traditional population.

(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.

EXHIBIT KK - MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS:

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 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 Home- and Community-Based Services Developmentally Disabled waiver - as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

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 actual expenditures made in the previous year, trended forward based upon the expected change in caseload from the previous to the current year. The actual FY 2010-11 expenditures exclude the amount that was paid at the beginning of the fiscal year as a result of the two-week payment delay in FY 2009-10. This expenditure is subtracted from the totals in order to forecast from a 52-week base instead of a 54-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 inflated. 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, and this is then trended forward by the anticipated change in caseload for the out year estimate.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Mental health fee-for-service expenditure has increased drastically over precious years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. In the process, the Department discovered that there is an error in the Medicaid Management Information System in which certain services billed as fee-for-service claims for BHO-enrolled clients are paying when they should be denied by the Medicaid Management Information System and billed to the appropriate BHO. This error will be corrected through a system change effective sometime towards the beginning of FY 2011-12. At that time, the Department expects that there will be a decline in the expenditure paid as mental health fee-for-service. The Department will monitor the impact of the system change once it is implemented and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR MENTAL HEALTH CAPITATION PAYMENTS:
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 2011-12 appropriation is 8.50% higher than FY 2010-11 actual expenditures, primarily due to caseload growth. The FY 2011-12 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 10.13% increase from FY 2010-11 actual expenditures and a 1.50% increase from the current appropriation. The FY 2012-13 Budget Request is built on the FY 2011-12 estimate and presents a

12.00% 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 2012-13 request represents a 13.68% increase over the current FY 2011-12 appropriation. The FY 2013-14 Budget Request is built on the FY 2012-13 estimate and presents an 11.01% expenditure increase over the FY 2012-13 request and a 26.20% increase over the FY 2011-12 appropriation.

(4) INDIGENT CARE PROGRAM

The Indigent Care Program section of the Department budget 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 2012-13 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 2009-10, total payments to indigent care providers through the Colorado Indigent Care Program equaled $310,879,968 and 217,916 clients were served by the program, up 10.3% from 197,597 in FY 2007-08. As of FY 2011-12, 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. The Primary Care Fund program has been suspended since FY 2010-11 and Tobacco Tax revenues have been redistributed to clinics and General Fund relief. 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. 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. For State FY 2010-11, the Department received a final DSH allotment of $92,189,191.

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 2008 data, this information can be found in Exhibit K, pages EK-6-7 in the Department's November 1, 2011 FY 2011-12 Budget Request, Volume I. This information will be available for calendar year 2009 in Exhibit K, pages EK-6-7 in the Department's February 15, 2012 FY 2012-13 Budget Request.

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 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. For federal fiscal year (FFY) 2010-11, the final DSH cap, after inclusion of ARRA, for Colorado was equal to $92,598,516. The federal limit is a projection based on information in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. For FFY 2012 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.

Payment Type	Public Hospitals	Private Hospitals
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 as cash funds in the Long Bill. 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 federal fiscal year 2010-11 was $92,598,516. 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 (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 2010-11, the Department received a final DSH allotment of $92,189,191.

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, ARRA authorized an enhanced federal financial participation rate 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 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 continued through FY 2010-11, after which the federal financial participation rate returned to 50%.

Appropriation History

The FY 2009-10 Long Bill (SB 09-259) appropriated $310,715,422 to this line item. The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor

directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee (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, page 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 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the expectation 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 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $2,354,767 with a corresponding decrease in the federal funds appropriation.

In December 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new Hospital Provider Fee model for federal fiscal year 2010-11. This required the Department to request its appropriation be adjusted to reflect the funding required under the new model. On March 17, 2011, JBC staff submitted a memo to the JBC requesting the appropriation be adjusted to reflect the new

model, which was included in the FY 2011-12 Long Bill Add-ons (SB 11-209). This action increased the appropriation by $12,119,174 total funds, of which $4,145,067 consisted of cash funds and $7,974,107 federal funds. The final FY 2010-11 appropriation was $289,889,142, consisting of $130,867,931cash funds and $159,021,211federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $309,825,106 total funds to this line item. This includes an increase due to the annualization of HB 09-1293 equal to $4,039,725 total funds, and an increase due to the Department's FY 2011-12 DI-7 "Maximize Reimbursement for High Volume Medicaid and CICP Hospitals" which increased the appropriation $15,896,239. This request sought to fully utilize estimated federal reimbursement available under the UPL specific to the State's three High Volume Medicaid and CICP Hospitals, utilizing the certified public expenditures reimbursement methodology which was eliminated during the implementation of HB 09-1293. A technical correction was also made during the FY 2011-12 Figure Setting process, to bring the appropriation back to a 50% FMAP rate, increasing the appropriation by $14,516,887 cash funds and decreasing the appropriation an equal amount of federal funds (FY 2011-12 Figure Setting dated March 8, 2011, page . The FY 2011-12 year-to-date appropriation to this line is $309,825,106, made up of $154,912,553 cash funds and an equal amount of federal funds.

For FY 2012-13, the Department's base request for this line item is continuation funding of $309,825,106, consisting of $154,912,553 cash funds and an equal amount of 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., the Health Care Services Fund was appropriated $15,000,000 in FY 2008-09 through the FY 2008-09 Long Bill (HB 08-1375). Funding for this line item was Referendum C General Fund moneys, which expired at the end of FY 2009-10.

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 "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009'," which resulted in a total fund decrease to the line of $3,057,000 due to the enhanced federal financial participation provided under the American Recovery and Reinvestment Act (ARRA). 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 expired at the end of FY 2009-10 pursuant to 25.5-3-112 (1)(b), C.R.S.

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.

Per the FY 2009-10 Long Bill (SB 09-259), this line item was appropriated $27,767,760, including $3,059,880 General Fund, $10,824,000 reappropriated funds from the Health Care Services Fund, and $13,883,880 federal funds. HB 10-1321 "Health Care Services Fund Moneys" 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 federal medical assistance percentage (FMAP) from the American Recovery and Reinvestment Act (ARRA) decreased General Fund appropriations to this line $709,280 with a corresponding increase in federal funds. Finally, SB 09-264 "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009'" again decreased the reappropriated funds $2,205,931 with a corresponding increase in federal funds due to the enhanced FMAP under ARRA. The final FY 2009-10 appropriation was $27,759,958 total funds, which was 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, consisting of $2,350,600 General Fund and $3,769,160 federal funds. This includes a total fund decrease in the amount of $21,640,198 due to the statutorily-defined appropriations to the Health Care Services Fund expiring at the end of FY 2009-10 pursuant to 25.5-3-112 (1)(b), C.R.S., which removed all reappropriated funds and corresponding federal funds appropriations to this line item line item. 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 section 5001(h)(3) of ARRA. 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 expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $115,051 with a corresponding decrease in the federal funds appropriation. The final FY 2010-11 appropriation to the line item was $6,119,760 total funds, consisting of $2,465,651 General Fund and $3,654,109 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $6,119,760 total funds, comprised of $3,059,880 General Fund and a corresponding amount of federal funds to this line item. The annualization of all ARRA adjustments restored the line item to a 50% FMAP consistent with the expiration of ARRA.

For FY 2012-13, the Department is requesting continuation of the FY 2011-12 appropriation of $6,119,760, including $3,059,880 General Fund and an equal amount of federal funds.

HEALTH CARE SERVICES FUND PROGRAMS

In 2006, SB 06-044 appropriated $15,000,000 General Fund to the Colorado Health Care Services Fund for fiscal years 2007-08, 2008-09, and 2009-10. SB 06-044 required that 18% of the available funding be distributed to Denver Health and Hospital Authority (Denver Health) and the remaining 82% to clinics. Of the 82% to be distributed to clinics, 18% must be distributed to clinics operated by licensed or certified health care facilities (hospitals) and the remaining 82% must be distributed to federally qualified health centers. This line item contains only the funding for both Denver Health and the clinics that are operated by licensed or certified health care facilities.

The FY 2009-10 Long Bill (SB 09-259) appropriated $8,352,000 total funds, comprised of $4,176,000 reappropriated funds from the Health Care Services Fund and an equal amount of federal funds. The Long Bill appropriation was set prior to the passage of SB 09-264, "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009,'" which 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 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 Health Care Services Fund expiring at the end of FY 2009-10 pursuant to 25.5-3-112 (1)(b), C.R.S., which removed all reappropriated funds and corresponding 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 a declaration of a state fiscal emergency. This appropriation included $11,940,000 cash funds from the Primary Care Fund and $19,145,655 federal funds.

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 federal medical assistance percentage (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 expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $1,450,510 with no increase in the cash fund appropriation as this is in statute. The final FY 2010-11 appropriation of $29,635,145 consisted of $11,940,000 cash funds from the Primary Care Fund and federal funds in the amount of $17,695,145.

The FY 2011-12 Long Bill (SB 11-209) appropriated $0 for this line item as the statutory appropriations to the line expired at the end of FY 2010-11 with the annualization of HB 10-1378. SB 11-219 "2011 Transfers for Health Care Services," however, appropriated $23,510,000 total funds, consisting of $11,755,000 cash funds from the Primary Care fund and a corresponding amount of federal funds.

The Department's base request for FY 2012-13 is $0 as the statutory appropriation to this line through SB 11-219 will expire at the end of FY 2011-12.

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. 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 FY 2009-10 Long Bill appropriation was $15,032,712, consisting of $6,656,997 General Fund, $355,359 cash funds, $504,000 reappropriated funds, and $7,516,356 federal funds. This appropriation was set prior to the passage of SB 09-264 "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009,'" which resulted in a decrease to the line of $557 total funds for FY 2009-10. 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 FY 2010-11 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 appropriation was decreased by a further $44,456 due to an updated 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 American Recovery and Reinvestment Act (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, and the annualization of SB 09-264 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 federal medical assistance percentage (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 expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $278,653 with a corresponding decrease in the federal funds appropriation. The final FY 2010-11 appropriation to this line was $14,821,994 total funds, made up of $5,217,781 General Fund, $307,000 cash funds, $447,000 reappropriated funds, and $8,850,213 federal funds.

The FY 2011-12 Long Bill (SB 11-209) included several adjustments to the prior year's appropriations. The annualizations of all ARRA adjustments increased the General Fund appropriation by a combined $1,439,216 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP. Additionally, the JBC adjusted this appropriation downward by $22,056 total funds to reflect the most recent Legislative Council forecast for Tobacco Tax revenue. Pursuant to the Department's FY 2011-12 BRI-3 "Indigent Care Program Financing Reductions," the appropriation was reduced by $1,514,056 total funds. The FY 2011-12 Long Bill appropriated $13,285,882 total funds to this line item, including $5,899,969 General Fund, $296,872 cash funds, $446,100 reappropriated funds, and $6,642,941 federal funds. Subsequently, SB 11-216 "Children's Basic Health Plan General Fund Appropriation" reduced the amount of General Fund appropriated to the Children's Basic Health Plan by reallocating various tobacco-related revenue streams from other programs to the Children's Basic Health Plan Trust Fund. In doing so, SB 11-216 removed the

cash funds appropriation of $296,872 from Tier II Tobacco Master Settlement Agreement monies and the reappropriated funds appropriation of $446,100 from Amendment 35 Tobacco Tax revenues from this line item in FY 2011-12, along with matching federal funds. The year-to-date appropriation for FY 2011-12 is $11,799,938 total funds, of which $5,899,969 are General Fund with a corresponding amount of federal funds.

For FY 2012-13, the Department is requesting a continuation funding of $11,799,938 total funds, comprised of $5,899,969 General Fund and a matching amount of 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. 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., 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 2009-10 Long Bill (SB 09-259) appropriation for this line was set at $504,000. The Long Bill appropriation was set prior to the passage of SB 09-264 "Concerning the Increased Moneys Received Due to the Federal 'American Recovery and Reinvestment Act of 2009,'" which resulted in a decrease to the line of $103,000. The appropriation was also decreased by $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 10-1300 due to a revised Amendment 35 revenue forecast, 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 all American Recovery and Reinvestment Act (ARRA) adjustments from the line item and a decrease in Amendment 35 revenue, resulting in a net increase to the line of $101,310. The final appropriation for FY 2010-11 was $447,000 General Fund Exempt.

For FY 2011-12, this line item received an appropriation of $446,100 through the Long Bill (SB 11-209). This includes a revision to the prior year appropriation by the JBC to adjust for the Legislative Council's most recent Tobacco Tax revenue forecast which was lower by $900. SB 11-216 "Children's Basic Health Plan General Fund Appropriation" eliminated the funding to this line as it moved this revenue stream from this line item to the Children's Basic Health Plan Trust Fund.

As this line was effectively eliminated through SB 11-216, the Department is not requesting funding for this line item in FY 2012-13.

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. 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 2009-10 Long Bill (SB 09-259) to this line item was $504,000 cash funds. However, revenue 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 FY 2011-12 Long Bill (SB 11-209) appropriated $446,100 cash funds. This includes a revision to the prior year appropriation by the JBC to adjust for the Legislative Council's most recent Amendment 35 revenue forecast which was lower by $900.

For FY 2012-13, the Department is requesting continuation funding of $446,100 cash funds.

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., 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 this Budget Request. To be a qualified provider, an entity must:

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

The FY 2009-10 Long Bill (SB 09-259) appropriated $31,920,000 cash funds to this line item. 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 Department's Medical Services Premiums line item and the newly created Primary Care Special Distribution Fund to offset General Fund 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 in the Medical Services Premiums line item, 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 increased the appropriation by $7,400,000 and $12,395,000 respectively. It also included a Joint Budget Committee (JBC) staff recommendation that reduced the appropriation $3,620,000 due to a lower forecast of Amendment 35 revenue. HB 10-1378 later reduced this appropriation to $0, diverting the money to the Health Care Services Fund Programs, Medical Services Premiums, and the Primary Care Special Distribution Fund line items in the amounts of $11,940,000, $12,800,000, and $3,560,000 respectively. The final FY 2010-11 appropriation was $0.

For FY 2011-12, this line was appropriated $28,253,000 total funds through the FY 2011-12 Long Bill (SB 11-209), comprised entirely of cash funds. This included the restoration of the $28,300,000 appropriation after the annualization of HB 10-1378 and a $47,000 decrease to this line to account for the most recent Amendment 35 revenue forecast. Subsequently, SB 11-219 "2011 Transfers for Health Care Services" diverted $11,755,000 to the Health Care Services Fund Programs line item, $2,135,830 to the Primary Care Special Distribution Fund line item, and the remainder to Medical Services Premiums line item, resulting in a year-to-date FY 2011-12 appropriation of $0.

For FY 2012-13, the Department is requesting $28,253,000 cash funds for this line, which assumes the restoration of the appropriation after annualizing SB 11-219.

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. This line item 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) initially had a $0 appropriation to the line item 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.

The FY 2011-12 Long Bill (SB 11-209) once again appropriated $0 to this line item. SB 11-219 "Transfers for Health Care Services" appropriated $2,135,830 to this line by transferring that amount from the Primary Care Fund Program.

The Department's base request for FY 2012-13 is $0 due to the elimination of the fund through annualization of SB 11-219.

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. 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 2009-10 Long Bill (SB 09-259) appropriation for this line was $866,075 cash funds. 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 final appropriation for FY 2010-11 for this line item was $0.

The FY 2011-12 Long Bill (SB 11-209) appropriated $2,706,995 cash funds to this line item. Pursuant to SB 11-216 "Children's Basic Health Plan General Fund Appropriation," all appropriations to this line item have been diverted to the Children's Basic Health Plan Medical and Dental Costs line item indefinitely. Thus, the Department is not requesting future funding for this line item.

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 Tier II Settlement funding (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. 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 2009-10 Long Bill (SB 09-259) appropriation was $6,041,096, which included $3,020,548 cash funds and matching federal funds. 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 future funding for this line item.

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. 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 (FPL). To participate in the plan, families with incomes over 150% FPL (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.

Until FY 2010-11, the Children's Basic Health Plan consisted 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 the FY 2010-11 Supplemental Bill (SB 11-139), the Children's Basic Health Plan Premium Costs line item was combined with the Children's Basic Health Plan Dental Benefit costs line item into a single line item titled Children's Basic Health Plan Medical and Dental 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% FPL 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% FPL. Eligibility in the Children's Basic Health Plan was further expanded to 225% of the FPL 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% FPL 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 partially 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 fund appropriation for annual enrollment fees in its annual Change Request for the Children's Basic Health Plan Premium Costs line. Beginning with the FY 2008-09 Supplemental bill, the cash fund 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.

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 final FY 2009-10 appropriation was $2,710,779 General Fund.

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. The FY 2010-11 Long Bill appropriation to the Trust Fund was $6,856,880 General Fund. Since the Department's ES-3 "Delay of Managed Care Payments" was not adopted, the JBC increased the appropriation to the Trust by $1,500,000 cash funds from the Health Care Expansion Fund in the FY 2010-11 Supplemental Bill (SB 11-139). The Long Bill Add-ons (SB 11-209) also included a technical adjustment that increased the appropriation to the Trust by $4,604,711 General Fund. Finally, the annualization of HB 10-1382 "Repeal Delay of Payments" resulted in an increase of $2,554,602 to this appropriation. The final FY 2010-11 appropriation was $15,516,193 total funds, of which $14,016,193 was General Fund and $1,500,000 was cash funds.

The FY 2011-12 Long Bill (SB 11-209) did not include an appropriation to this line item. Given the recent insolvency of the Trust, which has required General Fund appropriations to this line, the Joint Budget Committee (JBC) staff recommended that these General Fund appropriations be made directly to the Children's Basic Health Plan Medical and Dental Costs line (FY 2011-12 Figure Setting document dated March 8, 2011, page 82). This effectively eliminated this line item as any other transfers to the Trust Fund are just transferred rather than appropriated to the Trust. Thus, the Department will not be requesting future appropriations for this line.

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%

The FY 2009-10 Long Bill (SB 09-259) appropriation for administrative costs was $5,537,590 total funds, consisting of $2,473,301 cash funds and $3,064,289 federal funds. The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009 the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to the Joint Budget Committee (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 (FPL) in late FY 2009-10. The final FY 2009-10 appropriation was $5,410,917, including $2,420,452 cash funds and $2,990,465 federal funds.

The FY 2010-11 Long Bill (HB 10-1376) appropriation for administrative costs included 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 also 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 final FY 2010-11 appropriation was $4,889,503, including $2,219,230 cash funds and $2,670,273 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $4,894,410 to this line, which includes continuation funding of $4,889,503 and an increase of $4,907 for the annualization of HB 09-1293. As described in the Department's November 1, 2010 DI-6 "Cash Fund Insolvency Financing," the Health Care Expansion Fund is insolvent as a result of the combination of increasing medical costs for expansion populations established by HB 05-1262 and the continuing decrease in Tobacco Tax collections by the state. During the Department's FY 2011-12 Figure Setting , the Joint Budget Committee (JBC) backfilled the Health Care Expansion Fund appropriation with $272,494 General Fund to account for this insolvency (Figure Setting document dated March 8, 2011, page 71).

As a result, the FY 2011-12 year-to-date appropriation to this line item totals $4,894,410, consisting of $272,494 General Fund, $1,948,454 cash funds, and $2,673,462 federal funds.

The Department's base request for FY 2012-13 is $4,898,322, consisting of $272,494 General Fund, $1,949,823 cash funds, and $2,676,005 federal funds. This request includes continuation funding from the prior year, as well as an increase of $1,912 for annualization of HB 09-1293. It also includes appropriations for two other bills expanding Medicaid eligibility that passed during the 2011 Legislative Session. SB 11-008 "Aligning Children's Medicaid Eligibility" increases Medicaid eligibility for children between the ages of 6 and 18 from 100% FPL to 133% FPL beginning in January 2012. Additionally, SB 11-250 "Pregnant Women Medicaid Eligibility" expands Medicaid eligibility to pregnant women from 133% FPL to 185% FPL beginning in January 2012. Both of these bills require an additional calculation of per member per month capitation rates by the Children's Basic Health Plan's actuary as the legislation will move low-income clients from the Children's Basic Health Plan to Medicaid. Thus, the Department's base request includes an additional $1,000 for SB 11-008 and $1,000 for SB 11-250 over the previous year's funding to allow the Department's actuary to calculate new capitation rates resulting from the change in enrollment expected to take place in FY 2012-13.

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 State's self-insured network. This rate includes the expected costs of providing medical benefits to enrollees as well as medical management services such as case 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 includes appropriations 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 and dental 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 are spent in this line item 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.

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 subsequently decreased by $12,225,344 due to the adoption of SB 09-265, "Timing of Medicaid and CHP+ Payments," which shifted 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 (FPL). 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 final FY 2009-10 appropriation was $153,157,421 total funds, consisting of $51,351,535 cash funds, $2,500,000 reappropriated funds, and $99,305,886 federal funds.

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. The FY 2010-11 Long Bill appropriation was $202,521,966 total funds, consisting of $64,352,642 cash funds, $6,856,880 reappropriated funds, and $131,312,444 federal funds. During the Department's Supplemental Hearing on January 19, 2011, the Joint Budget Committee Staff (JBC) staff combined the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items into one line called the Children's Basic Health Plan Medical and Dental Costs (see page 24 of the JBC staff document). As a result, the final FY 2010-11 appropriation for this line item was $0. The Department will not request future funding for this line.

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 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 including 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.

The FY 2009-10 Long Bill (SB 09-259) 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 subsequently decreased by $886,113 due to the adoption of SB 09-265, "Timing of Medicaid and CHP+ Payments," which shifted 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 (FPL). 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 final FY 2009-10 appropriation was $11,240,864 total funds, consisting of $3,934,303 cash funds and $7,306,561 federal funds.

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. The FY 2010-11 Long Bill appropriation was $13,878,070 total funds, consisting of $4,857,325 cash funds and $9,020,745 federal funds. During the Department's Supplemental Hearing on January 19, 2011, the Joint Budget Committee (JBC) staff combined the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items into one line called the Children's Basic Health Plan Medical and Dental Costs (see page 24 of the JBC staff document). As a result, the final FY 2010-11 appropriation for this line item was $0. The Department will not request future funding for this line.

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

This line item was created during the Department's Supplemental Hearing on January 19, 2011, by the Joint Budget Committee (JBC) Staff as the combination of the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items. The costs of medical and dental services provided to eligible children and medical premiums for prenatal and delivery services for pregnant women enrolled in the Children's Basic Health Plan are funded through this line item beginning in FY 2010-11. The Children's Basic Health Plan offers a medical benefits package comparable to those offered on the private insurance market as well as dental benefits for children. The Department currently has a $600 yearly maximum benefit per child and a statewide network with several hundred participating dentists and contracts with Essential Community Providers.

The Department establishes annual enrollment projections for the Children's Basic Health Plan. Each year, the actuary contracted by the Department recommends a per-member per-month rate for health maintenance organizations, the State's self-insured network, and the dental benefits organization. These rates include the expected costs of providing medical or dental benefits to enrollees, as well as medical management services such as case 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 and dental premiums includes appropriations 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), though this appropriation was reduced to $1 per year beginning in FY 2011-12 due to the insolvency of the Health Care Expansion Fund. 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 and dental premiums. Annual enrollment fees collected from families with children enrolled in the program are deposited in the Children's Basic Health Plan Trust Fund as cash funds. Beginning in FY 2008-09, enrollment fees are expended from this line item 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.

The FY 2010-11 appropriation for this line item combined the FY 2010-11 Long Bill (HB 10-1376) appropriations for the Children's Basic Health Plan Premiums Costs of $202,521,966 and the Children's Basic Health Plan Dental Benefits Costs of $13,878,070. Subsequently, pursuant to the Department's FY 2010-11 S-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," this appropriation was decreased by $27,136,826 total funds. Due to revised caseload estimates by JBC staff, the appropriation was further reduced by $1,182,054. The final FY 2010-11 appropriation for this line item was $188,081,156 total funds, comprised of $58,971,526 cash funds, $6,856,880 reappropriated funds, and $122,252,750 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $213,086,149 total funds to this line, of which $33,001,755 is General Fund, $41,578,378 is cash funds, and $138,505,996 is federal funds. This included several adjustments to the prior year's appropriation. The Department's FY 2011-12 DI-3 "Children's Basic Health Plan Medical Premiums and Dental Benefit Costs" increased the appropriation to this line by $33,532,290 total funds due to increased caseload and per capita forecasts. As part of the Department's budget balancing efforts, the FY 2011-12 BRI-4 "CHP+ Program Reductions" reduced the appropriation to this line by $8,527,297 total funds though five initiatives:

- eliminating reinsurance;
- 3% CHP+ HMO Rate Reduction;
- CHP+ out-of-network reimbursement changes;
- eliminating CHP+ pre-HMO and retroactive enrollment periods; and
- eliminating inpatient coverage for CHP+ Prenatal presumptive eligibility.

Due to the increasing costs associated with expansions created by HB 05-1262 and decreasing Tobacco Tax collections, revenue in the Health Care Expansion Fund is no longer sufficient to fund all the program costs under current statute. Therefore, at the Department's FY 2011-12 Figure Setting, JBC staff recommended General Fund be used only for the Medicaid program costs and to appropriate $1 to meet the Constitutional requirement that a portion of that Fund be used to finance the Children's Basic Health Plan caseload from 186% to 200% of federal poverty line (FPL) and beyond the FY 2003-04 level (Figure Setting document dated March 8, 2011, page

77). As a result, the FY 2011-12 Long Bill also includes an increase of $26,890,745 General Fund to account for the Health Care Expansion Fund deficit, as well as a $6,439,289 General Fund increase to account for the insolvency of the Children's Basic Health Plan Trust Fund's insolvency with corresponding decreases in cash fund appropriations. Subsequently, SB 11-216 "Children's Basic Health Plan General Fund Appropriations" reduced the General Fund appropriation to this line by $3,449,967 total funds by diverting Tobacco Master Settlement monies and Amendment 25 Tobacco Tax funds from the Comprehensive Primary and Preventive Care Grants Program and Pediatric Specialty Hospital Fund, respectively, to this line item beginning in FY 2011-12. Thus, the year-to-date FY 2011-12 appropriation of $213,086,149 is comprised of $29,551,808 General Fund, $446,100 General Fund exempt, $44,582,245 cash funds, and $138,505,996 federal funds.

For FY 2012-13, the Department is requesting $187,766,874 total funds, comprised of $25,066,119 General Fund, $446,100 General Fund exempt, $40,206,188 cash funds, and $122,048,467 federal funds. This includes several decreases in funding to this line. The annualization of the Department's FY 2011-12 BRI-4 "CHP+ Program Reductions" decreased the appropriation by $4,003,077. During the 2011 Legislative Session, two bills were passed expanding Medicaid eligibility that are expected to result in lower enrollment in the Children's Basic Health Plan. SB 11-008 "Aligning Children's Medicaid Eligibility" increases Medicaid eligibility for children between the ages of six and 18 from 100% FPL to 133% FPL beginning in January 2012. This bill is anticipated to move a large number of children in the Children's Basic Health Plan to Medicaid, and results in a decrease to the appropriation of $11,929,097. SB 11-250 "Pregnant Women Medicaid Eligibility" expands Medicaid eligibility to pregnant women from 133% FPL to 185% FPL beginning in January 2012. This bill is anticipated to move a large number of pregnant women in the Children's Basic Health Plan to Medicaid, and results in a decrease to this appropriation of $9,387,101.

(5) OTHER MEDICAL SERVICES

The Other Medical Services section of the Department's budget contains funding for programs not administered by the Department through the Medicaid or Indigent Care programs. Some of the line items receive federal Medicaid funding but are administered by other departments, Commissions, or hospitals. This long bill group also contains funding for the Old Age Pension State Medical Program and the Medicare Modernization Act of 2003 State Contribution Payment. A description of each program, the budget history, and the FY 2012-13 budget request amounts are presented below.

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 a federal 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.

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 line item 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. 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 (5) "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). 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. 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 was 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 effective 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 and FY 2010-11, 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 is 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 (Adults 65 and 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 modifications were implemented associated 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 was been reset to a new base from which normal caseload growth occurred in FY 2009-10. Pursuant to HB 10-1384 "Old Age Pension Eligibility," the Department of Human Services implemented a five-year bar for qualified aliens from eligibility for the Old Age Pension effective August 2010. This effectively limited eligibility for the Old Age Pension State Medical Program, as eligibility for the medical program is dependent upon receipt of the State pension payment. The Department estimates that this change resulted in approximately 1,000 clients losing eligibility for the Old Age Pension State Medical Program in FY 2010-11.

Old Age Pension State Medical Program Caseload History and Projection			
Year	**Caseload**	**% Change**	**Source**
FY 1990-91 Actual	3,586	N/A	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
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
FY 2010-11 Actual	3,340	-22.00%	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 allocated a certain portion of the rebate payment to the Old Age Pension State Medical Program, as the purchase of drugs by the Old Age Pension State Medical Program could not be separated 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
FY 2010-11 Actual	$8,206,636	$0	$8,206,636	3,340	$2,457.08

Appropriation History and Request

Pursuant to Article XXIV of the Colorado Constitution, the Old Age Pension Health and Medical Care Fund receives $10,000,000 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 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 allocated 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 2009-10 Long Bill (SB 09-259) appropriated $15,368,483 for this line item. 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. During the Department's Figure Setting on March 8, 2011 (page 88 of the Figure Setting document), JBC staff recommended that funding to the Old Age Pension State Medical Program be gradually reduced due to the declining caseload in this program. SB 11-210 "Phase out Supplemental OAP Health Fund" eliminates funding to the Supplemental Old Age Pension Health Fund which, in turn, reduces the reappropriated funds appropriation to this line item. Beginning in FY 2011-12, the 1.5% of Amendment 35 revenues usually appropriated to the Supplemental Old Age Pension State Medical Fund and then transferred to this line item will be used to fund medical cost for Old Age Pension clients served in Medicaid. Beginning in FY 2012-13, the $2,850,000 in sales and use tax allocated to the Supplemental Old Age Pension Medical Care Fund is eliminated. Finally, this bill abolishes the Supplemental Old Age Pension Medical Care Fund in July 2012. As a result of this bill and lowered projections for expenditures, the FY 2010-11 Long Bill Add-ons (SB 11-209) eliminated the reappropriated funds to this line and reduced the cash funds appropriation to $11,000,000.

The FY 2011-12 Long Bill (SB 11-209) appropriated $11,000,000, all cash funds, which continued the same funding from the prior year to account for decreased caseload estimates for the Old Age Pension State Medical Program.

The Department's FY 2012-13 base request is for continuation funding of $11,000,000 cash funds.

SUPPLEMENTAL OLD AGE PENSION MEDICAL CARE 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 per year, 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 2009-10 Long Bill (SB 09-259) appropriated this line $2,520,000. 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.

The FY 2011-12 Long Bill (SB 11-209) appropriated $2,230,500 cash funds to this line. This included a $4,500 decrease due a change in the most recent Tobacco Tax revenue forecast. During the 2011 Legislative session, SB 11-210 "Phase Out Supplemental OAP Health Fund" was passed, which gradually eliminates funding to the Supplemental Old Age Pension Health Fund. Beginning in FY 2011-12, the 1.5% of Amendment 35 revenues usually appropriated to the Supplemental Old Age Pension State Medical Fund and then transferred to this line item will be used to fund medical cost for Old Age Pension clients served in Medicaid. Thus, the FY 2011-12 appropriation to this line is $0. This bill also eliminates the $2,850,000 in sales and use tax allocated to the Supplemental Old Age Pension Medical Care Fund beginning in FY 2012-13 and abolishes the fund in July 2012. As a result, the Department will not be requesting future funding for this line item.

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.

Based upon the state's increased unemployment rate, the American Recovery and Reinvestment Act (ARRA) authorized an enhanced federal financial participation rate which affected this line item beginning in the second half of FY 2008-09 and continued through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriated $1,932,052 to this line item, 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. 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 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $32,690 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation is $1,738,846, consisting of $700,581 General Fund and $1,038,265 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $1,391,077 to this line, comprised of $695,538 General Fund and $695,539 federal funds. This included the annualizations of all ARRA adjustments, which increased the General Fund appropriation by a combined $168,842 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP. A part of the JBC's budget balancing reductions during the 2011 Legislative Session, this appropriation also included a 20%, or $357,769, total fund reduction.

For FY 2012-13, the Department is requesting continuation funding of $1,391,077 total funds for this line, of which $695,538 is General Fund and $695,539 is 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 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.

Based upon the state's increased unemployment rate, the American Recovery and Reinvestment Act (ARRA) authorized an enhanced federal financial participation rate which affected this line item beginning in the second half of FY 2008-09 and continued through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriation to this line was $1,831,714, including $915,857 General Fund and matching federal funds. ARRA adjustments, however, 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 funding was 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. 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 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $34,437 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation was $1,831,714 consisting of $737,998 General Fund and $1,093,716 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $1,831,714 to this line, comprised of $915,857 General Fund and $915,857 federal funds. This included the annualizations of all ARRA adjustments, which increased the General Fund appropriation by a combined $177,859 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP.

For FY 2012-13, the Department is requesting continuation funding of $1,831,714 total funds, consisting of $915,857 General Fund and a matching amount of federal funds.

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 Medical Services Premiums and 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.

Based upon the state's increased unemployment rate, the American Recovery and Reinvestment Act (ARRA) authorized an enhanced federal financial participation rate which affected this line item beginning in the second half of FY 2008-09 and continued through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriated $700,935 to the line, which included $350,468 General Fund and $350,467 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 $24,150. ARRA adjustments, however, 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 $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. 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 assumed that the enhanced FMAP would continue through the end of FY 2010-11, under the expectation 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $12,724 with a corresponding decrease in the federal funds appropriation. The FY 2010-11 appropriation was $676,785 consisting of $272,677 General Fund and $404,108 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $633,314 to this line, comprised of $316,657 General Fund and $316,657 federal funds. This included the annualizations of all ARRA adjustments, which increased the General Fund appropriation by a combined $65,716 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP. This appropriation also included a $43,471 total fund reduction to this line from the previous year, which was part of the JBC's budget balancing reductions during the 2011 Legislative Session.

For FY 2012-13, the Department is requesting continuation funding of $633,314 total funds, of which $316,657 is General Fund and an equal amount of federal funds.

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 state funds that do not receive federal matching 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 continued through FY 2010-11.

The FY 2009-10 Long Bill (SB 09-259) appropriated $88,808,586 to this line. This 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 federal medical assistance percentage (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 included increases of $4,501,720 for BA-4 "Medicare Modernization Act State Contribution Payment" for caseload and per-client cost adjustments, $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 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 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 contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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.

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities. On December 23, 2010, the Department was notified that it had qualified for a bonus payment for FFY 2010 in the amount of $13,671,043 federal funds. Because these federal funds could not be appropriated to a line item that draws federal matching funds, the Department requested to use this bonus payment in the Medicare Modernization Act State Contribution Payment line item as a General Fund offset. As a result, the General Fund appropriation to this line item was reduced by $13,671,043 in FY 2010-11, with a corresponding increase in federal funds.

The Department later submitted S-4 "Medicare Modernization Act State Contribution Payment" to adjust caseload and per-client cost estimates, which resulted in a reduction of $781,258 General Fund. The final FY 2010-11 appropriation was $71,986,544, consisting of $58,315,501 General Fund and $13,671,043 federal funds.

For FY 2011-12, this line was impacted by annualizations from FY 2010-11 ES-1 "Decrease Amount for Extended FMAP," BRI-2 "Coordinated Payment and Payment Reform," and BA-25 "ARRA FMAP Adjustment to Medicare Modernization Act State Contribution Payment," which resulted in a net increase to this line item of $18,591,806 General Fund. The appropriation was increased by $578,370 General Fund pursuant to the Department's DI-4 "Medicare Modernization Act State Contribution Payment" for updated caseload and rate projections. FY 2011-12 BA-11 "Cash Fund Insolvency Financing True-Up" added $11,339,062 federal funds to the line with a corresponding decrease to the General Fund appropriation due to the annualization of the CHIPRA bonus payment. These changes bring the FY 2011-12 Long Bill (SB 11-209) appropriation for this line to $91,156,720 total funds, including $66,146,615 General Fund and $25,010,105 federal funds.

The Department's base request for FY 2012-13 for the Medicare Modernization Act State Contribution Payment totals $91,156,720, consisting of $60,127,929 General Fund and $31,028,791 federal funds. This request includes the annualization of FY 2011-12 BA-11 "Cash Fund Insolvency True-Up," which adds $6,018,686 federal funds to the line, offsetting the General Fund by the same amount.

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION

This 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 Department's personal services, the transfer of funds to the Department of Education, and costs associated with processing claims in the Medicaid Management Information System. Funding for this line consists of a transfer of spending authority from the "(1) Executive Director's Office; (A) General Administration, Operating Expenses" line item, "(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts" line item and 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 federal funds.

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." The final FY 2010-11 appropriation to the line was $799,700 consisting entirely of federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $1,138,549 to this line item. This includes the Department's FY 2011-12 BA-5 "School Health Program Refinancing," which reorganized the budget so that all administrative expenses for the Public School Health Services, less personal services, the transfer to the Department of Education, and claims processing costs, appear under this line item.

This Budget Amendment also increased the appropriation to this line to perform additional outreach and training activities in an effort to increase participation in the Public School Health Services Program. This amounted to an increase of $338,849 over the prior year's appropriation. The FY 2011-12 year-to-date appropriation to this line is $1,138,549, consisting entirely of federal funds.

The Department's FY 2012-13 base request for this line item is $1,400,780 federal funds. This includes the annualization of the Department's FY 2011-12 BA-5 "School Health Program Refinancing," which increased the appropriation by $262,231.

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. Beginning in FY 2010-11, however, the Department's FY 2011-12 BA-5 "School Health Program Refinancing" moved funding from "(1) Executive Director's Office; (A) General Administration, Operating Expenses" line item to the "Public School Health Services Contract Administration" line in order to simplify the budget for this program. 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., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The FY 2009-10 Long Bill (SB 09-259) made an appropriation to the line of $20,004,856 total funds, including $10,472,200 cash funds and $9,532,656 federal funds. 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 Joint Budget Committee (JBC) staff comeback memo following the FY 2009-10 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 2010 JBC staff comeback regarding reconciliation payments. The Long Bill appropriation differed from the JBC comeback memo by $6,000, resulting in a final FY 2010-11 appropriation of $29,537,394 total funds. This consists of $15,391,007 cash funds and $14,146,387 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $30,446,344 to this line. This includes the annualization of the indirect cost assessment from the Department of Education, which increased the request by $388 total funds. The Department's FY 2011-12 BA-5 "School Health Program Refinancing" increased the appropriation to this line by $908,562 total funds due to expectations of increased participation. The FY 2011-12 year-to-date appropriation to this line consists of $16,010,155 cash funds and $14,436,189 federal funds.

The Department's FY 2012-13 base request is continuation of funding plus the annualization of FY 2011-12 BA-5 "School Health Program Refinancing," increasing the request by $4,290,860 total funds. Thus, the FY 2012-13 request is $34,737,204 total funds, consisting of $18,113,309 cash funds and $16,623,895 federal funds.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department's budget 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, individuals with mental health needs, 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 transferred from the Department to DHS as reappropriated funds. 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 19 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, and any inquiries related to the Department's Budget Request should be directed to DHS. 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 federal 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.

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 appropriation through the FY 2012-13 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 2010-11 appropriation through the FY 2012-13 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 the Department of Personnel and Administration (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.

Personal Services actual expenditures from the line item for Regional Centers for the Developmentally Disabled (see later in this section of the line item description) are transferred into the Executive Director's Office line item as a way to track Personal Services for the Regional Centers.

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 through the end of FY 2010-11.

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 2009-10 Long Bill (SB 09-259) appropriated $13,011,981 total funding, including $6,659,567 General Fund, $388 reappropriated funds, and $6,352,026 federal funds. The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. Consequently, on June 25, 2009, the Governor directed all state agencies to develop budget reduction proposals that would reduce the agency's General Fund by 10%. These Early Supplemental Requests (ES) were submitted to JBC on August 24, 2009. As a part of FY 2009-10 NP ES-19 "DHS - Risk Management Reduction of Liability, Property, and Workers' Compensation Volatility," the line item was reduced by $135,008, and FY 2009-10 NP ES-20 "DHS - Risk Management Contract Review and Reduction" reduced the line by $42,710. FY 2009-10 NP S-3 "DHS - Statewide Furlough Impact"

reduced the appropriation by $30,330. FY 2009-10 NP S-9 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" was approved and reduced the appropriation by $280,492. Additional details related to FY 2009-10 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 actions:

- FY 2009-10 NP S-3 "DHS - Statewide Furlough Impact," adding back $30,330;
- FY 2009-10 NP ES-19 "DHS - Risk Management Reduction of Liability, Property, and Workers' Compensation Volatility," adding back $135,008;
- FY 2009-10 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;
- FY 2009-10 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,
- a Medicaid Indirect Costs technical error, resulting in a $160,000 increase.

Additionally, several actions were taken in response to the ongoing, state-wide fiscal crisis. The Joint Budget Committee (JBC) approved a 2.5% adjustment to PERA through FY 2010-11 NP BA-4 "DHS – PERA Contribution Change," removing $23,759 from the appropriation. The JBC also approved FY 2010-11 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 this line. The JBC approved FY 2010-11 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 House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77%

for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $98,932 with a corresponding decrease in the federal funds appropriation. A further reduction from FY 2010-11 NP ES-3 "DHS-1% Across-the-Board Personal Services Reduction" cut $9,275, leading to the final FY 2010-11 appropriation of $12,071,067 total funds, comprised of $5,509,452 General Fund, $388 Reappropriated Funds, and $6,561,227 federal funds.

To arrive at the FY 2011-12 Long Bill (SB 11-209) appropriation, the following adjustments were made:

- all ARRA related adjustments were annualized to remove enhanced federal funding levels from the appropriation;
- annualize and restore amount for FY 2010-11 NP ES-3 "DHS – 1% Across the Board Personal Services Reduction" of $9,275;
- annualize and restore the FY 2010-11 NP BA-4 "DHS – PERA Contribution Change" that totaled $23,759;
- a decrease of $13,598 for FY 2011-12 NP-9 "2% Across-the-Board Personal Services Reductions" that was approved by the JBC to be only a 1.5% reduction;
- a reduction of $9,066 for FY 2011-12 NP BA-5 "DHS – Statewide 1% General Fund Reduction to Personal Services Operating";
- an addition of $1,281,901 for FY 2011-12 "Common Policy Adjustment"; and
- a true up by JBC staff for the funding splits by adding $16,215 to General Fund and reducing $388 from Reappropriated Funds as well as reducing $15,827 from federal funds.

The above adjustments resulted in the FY 2011-12 Long Bill (SB 11-209) amount of $13,363,338. SB 11-076 "PERA Contribution Rates" was approved by the General Assembly and resulted in a decrease of $18,819. The year-to-date FY 2011-12 appropriation is $13,344,519 total funds, consisting of $6,672,241 General Fund and $6,672,278 federal funds.

To build to the FY 2012-13 base request, the following adjustments were made in addition to continuation funding of $13,344,519:

- annualize the FY 2009-10 NP BA-12 "DHS – 5% Operating Reduction" by restoring $3,300;
- annualize SB 11-076 "PERA Contribution Rates" by restoring $18,819 that was reduced in the prior year; and
- add FY 2012-13 Common Policy Adjustment of $1,831,314.

The Department requests $15,197,952 total funding as a base for FY 2012-13. The base includes $7,600,503 General Fund and $7,597,449 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 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.

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 human/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 its 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 CBMS from the 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 2009-10 Long Bill (SB 09-259) appropriation of $8,957,494 included $4,427,478 General Fund, $28,758 cash funds, $31,995 reappropriated funds, and $4,469,263 federal funds. 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. FY 2009-10 NP S-3 "DHS-Statewide Furlough Impact" 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 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 $123,228 total funds for HB 09-1293 "Health Care Affordability Act" and $17,309 total funds for HB 10-1384 "Old Age Pension Eligibility for FY 2009-10." 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, including $4,641,210 General Fund, $19,152 cash funds, $22,385 reappropriated funds, and $4,676,778 federal funds. 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;
- an increase of $13,375 from the annualization of FY 2009-10 NP S -3 "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."

Subsequently, passage of HB 10-1146 "Circumstances of Receiving State-Funded Public Assistance Programs" added $184,387 and HB 10-1384 "Alignment of Eligibility for the Old Age Pension Program" added $17,220. As a result of the continuation of budget balancing, this appropriation was decreased by $1,958 pursuant to FY 2010-11 NP ES-1 "1% Across-the-Board Personal Services Reduction." A technical adjustment for the appropriation from HB 09-1293 "Hospital Provider Fee" resulted in an increase of $31,468 total funds, but shifted fund splits to align with originally intended fund sources. The final funding for FY 2010-11 was $9,590,642, which included $4,481,216 General Fund, $294,997 cash funds, $22,561 reappropriated funds, and $4,791,868 federal funds.

For FY 2011-12, the appropriated amount included continuation funding plus adjustments for the following:

- a reduction of $393,502 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;
- an increase of $1,958 for the annualization of NP ES-1 "1% Across-the-Board Personal Services Reduction";
- an addition of $15,184 for FY 2011-12 BRI-4 "CHP+ Program Reductions";
- an increase of $214,920 for FY 2011-12 DI-5 "CBMS Compliance with Low-Income Subsidy and Disability Determination Services Federal Requirements";
- a reduction of $3,169 for FY 2011-12 NP-1 "2% Across-the-Board Personal Services Reduction" that was modified by the JBC to be only a 1.5% reduction;
- a net-zero fund split reconciliation by the JBC that added $113,660 General Fund, reduced cash funds by $114,225, added $495 in reappropriated funds, and added $70 federal funds;
- a further realignment of fund splits to match with changes in the CBMS calculator that relies on Random Moment Sampling results to decrease total funds by $247,051; and,
- a JBC initiated true-up to add back $6,464 total funds. The intent of various technical corrections and true-ups was to get as close as possible to most recent Random Moment Sampling results that drive the division of funding between the Department and DHS that share costs for operating CBMS.

The FY 2011-12 Long Bill (SB 11-209) appropriation was $8,983,839 total funds, with $4,461,609 of it being General Fund, $14,428 cash funds, $19,399 reappropriated funds, and $4,488,403 federal funds.

To arrive at the FY 2012-13 base request, the Department requests continuation funding plus the following adjustments:
- annualization of FY 2009-10 NP BA-12 "DHS-5% Operating Reduction" to restore $21,910 total funding;
- annualization of FY 2011-12 BRI-4 "CHP+ Program Reductions" for a reduction of $15,184 total funds;
- annualization of FY 2011-12 DI-5 "CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements" for a reduction of $214,920 total funds;
- annualization of HB 09-1293 "Health Care Affordability Act of 2009" for a reduction of $83,272 total funds;
- annualization of SB 10-061 "Medicaid Hospice Room and Board Charges" for an addition of $151,453 total funds;
- new funding for SB 11-008 "Aligning Children's Medicaid Eligibility" of $25,728 total funds; and,
- new funding for SB 11-250 "Pregnant Women Medicaid Eligibility" of $25,728 total funds.

The above adjustments result in a base request for FY 2012-13 of $8,895,282 total funds, consisting of $4,416,786 General Fund, $14,520 cash funds, $19,889 reappropriated funds, and $4,444,087 federal funds.

CBMS SAS-70 AUDIT

Funding for this line item 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 Joint Budget Committee (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. 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.

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% for FY 2008-09 and FY 2009-10. The Department's share declined to 37.63% in FY 2010-11 and continued to decline to 37.05% for FY 2011-12.

For FY 2009-10, the Long Bill (SB 09-259) appropriated $57,075 to this line, including $28,231 General Fund, $144 cash funds, $203 reappropriated funds, and $28,497 federal funds.

For FY 2010-11, JBC staff recommended refinancing of this line to $56,069, a reduction of $1,006. This amount included $27,804 General Fund, $115 cash funds, $134 reappropriated funds, and $28,016 federal funds.

For FY 2011-12, refinancing lowered the total funding to $55,204 total funds in the Long Bill (SB 11-209). This amount includes $27,416 General Fund, $89 cash funds, $119 reappropriated funds, and $27,580 federal funds.

The Department requests continuation funding of $55,204 total funds for FY 2012-13, consisting of $27,416 General Fund, $89 cash funds, $119 reappropriated funds, and $27,580 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 $1,623,982 total funding that could then be shared by both departments according to the Random Moment Sampling methodology used by the regular CBMS projects. The funding was placed into this 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, $2,995,100 reverted to the original line item of the CBMS Medical Assistance Project per the FY 2009-10 Long Bill (SB 09-259).

During FY 2009-10, both Departments again requested to share funding between the Departments through FY 2009-10 S-11 "Refinance Colorado Benefit Management System Improvements." The amount appropriated was $3,302,100 in total funding, and the Department's share was $1,242,581 as codified in the FY 2009-10 Supplemental Bill (HB 10-1300). The same amount was appropriated again in FY 2010-11 Long Bill (HB 10-1376). This appropriation included $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 has no funding for FY 2011-12 and is not requesting funds for FY 2012-13.

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.

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 continued through the end of FY 2010-11.

Appropriation History

For the FY 2009-10 Long Bill (SB 09-259), $399,192 was appropriated, including $199,597 General Fund and $199,595 federal funds. 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 FY 2009-10 NP ES-1 "DHS – Information Technology Services, Personal Services FTE Reduction," DHS proposed that there would be vacancy savings in the agency, which resulted in a total fund Medicaid reduction of $18,000. This was a permanent reduction due to a transfer of the associated FTE to the Governor's Office of Information Technology. Further, as part of FY 2009-10 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, which resulted in a total fund reduction of $5,686. Due to an economic downturn, the governor implemented mandatory furlough days for non-essential state employees, and FY 2009-10 NP S-3 "DHS - Statewide Furlough Impact" reduced the appropriation by $2,597. As a result of the adjustments, the Department's final FY 2009-10 appropriation was $372,909, consisting of $149,057 General Fund and $223,852.

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. 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 FY 2010-11 NP BA-4 "DHS – PERA Contribution Change," removing $5,024 from the appropriation. JBC also approved FY 2010-11 NP BA-12 "DHS – 5% Operating Reduction," removing $684 from the appropriation. The Department submitted and JBC approved 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 impact to this line was a permanent increase in total funding of $59,512. FY 2010-11 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 increase of $44,642 total funds to this line.

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 House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 final appropriation was $540,940, consisting of $225,030 General Fund and $315,910 federal funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated $556,271 to this line. The annualizations of all ARRA adjustments increased the General Fund appropriation by a combined $45,440 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP. Other changes in funding for FY 2011-12 were Common Policy adjustments totaling $17,018 as recommended by Joint Budget Committee (JBC) staff and an operating reduction of $1,687 that partly offset the increase for Common Policies. The resulting appropriation for FY 2011-12 was $556,271 total funds, with $278,136 General Fund and $278,135 federal funds.

To arrive at a base request for FY 2012-13, the Department requests continuation funding of $556,271 and the annualization of FY 2009-10 NP BA-12 "DHS – 5% Operating Reduction" to add $684 total funds. The FY 2012-13 Common Policy adjustment reduces the request by $59,552 total funds. The Department's base request for FY 2012-12 is $497,403 total funds, with $248,701 General Fund and $248,702 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.

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 funded. 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 continued through the end of FY 2010-11.

Appropriation History

The amount appropriated in the FY 2009-10 Long Bill (SB 09-259) was $5,503,619 for this line item, and included $2,751,809 General Fund and $2,751,810 federal funds. 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 FY 2009-10 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, FY 2009-10 NP S-6 BA-7 "DHS - Annual Fleet Vehicle Replacements Technical True-up" resulted in a Medicaid total fund reduction of $12,707. FY 2009-10 NP S-7 BA-8 "DHS - Mail Equipment Upgrade Supplemental and Budget Amendment" further reduced the appropriation by $518, and FY 2009-10 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 the annualizations of FY 2009-10 NP S-3 "DHS - Statewide Furlough Impact," adding back $18,096; FY 2009-10 Common Policy Adjustment, decreasing the appropriation by $34,680; FY 2009-10 JBC initiated 1.82% Personal Services reduction, adding back $73,167; FY 2009-10 NP ES-4 "DHS – Office of Operations Personal Services and Operating Reduction," reducing the appropriation by $17,119; FY 2009-10 NP S- 6 BA-7 "DHS - Annual Fleet Vehicle Replacements Technical True-up," adding back $15,715; and, FY 2009-10 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 FY 210-11 NP BA-4 "DHS – PERA Contribution Change," removing $87,031 from the appropriation, FY 2010-11NP BA-12 "DHS – 5%

Operating Reduction," which removed $21,246 from the appropriation, and FY 2010-11 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 House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction." A further reduction was FY 2010-11 NP S-6 "DHS – Vehicle Lease Line Reconciliation" for a reduction of $2,686 total funds. These actions led to the final FY 2010-11 appropriation of $5,082,877 total funds, with $1,951,830 General Fund and $3,131,047 federal funds.

The FY 2011-12 Long Bill (SB 11-209) included continuation funding plus the following adjustments:

- all ARRA related adjustments were annualized to remove enhanced federal funding levels from the appropriation;
- annualization of FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction," for a total funds increase of $24,067;
- annualization of FY 2010-11 NP BA-4 "DHS – PERA Contribution Change," for a total funds increase of $87,031;
- FY 2011-12 NP-9 "DHS – 2% Across-the-Board Personal Services Reductions" for $46,431 less total funds;
- FY 2011-12 NP BA-5 "DHS – Statewide 1% General Fund Reduction to Personal Services/Operating" for a decrease of $24,763 total funds; and,
- FY 2011-12 Common Policy Adjustment recommended by JBC staff for an increase of $36,617 total funds.

The above adjustments resulted in the FY 2011-12 Long Bill (SB 11-209) appropriation of $5,159,398 total funds, with $2,579,699 General Fund and $2,579,699 federal funds. SB 11-076 "PERA Contribution Rates" was passed by the General Assembly and reduced this line by $66,044 total funds. The FY 2011-12 appropriation is $5,093,354 total funds, with $2,546,677 General Fund and $2,546,677 federal funds.

The FY 2012-13 base request includes continuation funding plus the annualizations of FY 2009-10 NP BA-12 "DHS – 5% Operating Reduction" and SB 11-076 "PERA Contribution Rates," which restore $21,246 and $66,044 total funds, respectively. The FY 2012-

13 Common Policy adjustment adds $4,327 total funds, for a total FY 2012-13 request of $5,184,971, comprised of $2,592,486 General Fund and $2,592,485 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 human/social 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.

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 Department's budget 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 2009-10 Long Bill (SB 09-259) appropriated $135,195 for this line item, including $67,598 General Fund and $67,597 federal funds. 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 FY 2010-11 NP BA-4 "DHS-PERA Contribution Change"; and,
- a decrease of $646 from FY 2010-11 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 FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction." The final FY 2010-11 appropriation was $132,627 and included $66,314 General Fund and $66,313 federal funds.

The FY 2011-12 Long Bill (SB 11-209) contained continuation funding and adjustments for the following:

- annualization of FY 2010-11 NP ES-3 "DHS – 1% Across-the-Board Personal Services Reduction" to add back $1,279 total funds;
- annualization of FY 2010-11 NP BA-4 "DHS –PERA Contribution Change" to restore $3,025 total funds;
- FY 2011-12 NP-9 "DHS – 2% Across-the-Board Personal Services Reductions" to reduce $1,963 total funds, although the JBC changed the reduction from 2% to 1.5%; and,
- FY 2011-12 NP BA-5 "DHS – Statewide 1% General Fund Reduction to Personal Services/Operating" to reduce $1,309 total funds.

The FY 2011-12 Long Bill (SB 11-209) appropriated amount was $133,659 total funds, with $66,830 General Fund and $66,829 federal funds. SB 11-076 "PERA Contribution Rates" was approved by the General Assembly and decreased funding by $2,721 total funds. The resulting year-to-date FY 2011-12 appropriation is $130,938 total funds with $65,469 General Fund and $65,469 federal funds.

The Department's FY 2012-13 base request includes continuation funding and the restoration of $646 total funds for the annualization of FY 2009-10 NP BA-12 "DHS – 5% Operating Reduction" and $2,721 total funds for the annualization of SB 11-076 "PERA Contribution Rates." Thus, the resulting FY 2012-13 base request is $134,305, consisting of $67,153 General Fund and $67,152 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. 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 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.

The Division of Child Welfare tries to achieve permanency for children by moving a child from foster care to adoption if the child cannot 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 federal 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. 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 Joint Budget Committee (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. 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 continued through the end of FY 2010-11.

Appropriation History

The FY 2009-10 Long Bill (SB 09-259) appropriated $18,746,950 to this line item, which included $9,373,475 General Fund and $9,373,475 federal funds. 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 FY 2009-10 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 "DHS – Reduction to the Child Welfare Services Block" led to an appropriation of $14,218,063 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, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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.

In the FY 2011-12 Long Bill Add-Ons (SB 11-209), $225,912 was added back to this line for the two-week delay in processing payments in the Medicaid Management Information System (MMIS) at the end of FY 2009-10 that needed to be covered in FY 2010-11. Final FY 2010-11 funding for this line item was $14,519,184 total funds, with $5,845,850 General Fund and $8,673,334 federal funds.

Leading up to the FY 2011-12 appropriation, The annualizations of all ARRA adjustments increased the General Fund appropriation by a combined $1,378,842 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP, the $225,912 for delay of provider payments from FY 2009-10 into FY 2010-11 was removed, and a leap year adjustment for FY 2011-12 was added for $35,266 per JBC approval. The FY 2011-12 Long Bill (SB 11-209) appropriation is $14,328,538 total funds, with $7,164,269 General Fund and $7,164,269 federal funds.

The Department's FY 2012-13 base request includes continuation funding less $35,266 total funds from the annualization of the prior year's leap year adjustment, resulting in the FY 2012-13 request totaling $14,293,272, with $7,146,636 General Fund and $7,146,636 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. 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 included in the Department's Medical Services Premiums line item.

The FY 2010-11 appropriation for this line item was $34,766. As a result of the continuation of budget balancing, this appropriation was decreased by $326 pursuant to FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction" to $34,440. The FY 2010-11 appropriation included $17,220 General Fund and $17,220 federal funds.

For budget-balancing purposes, another reduction was taken through FY 2011-12 NP-9 "DHS – 2% Across-the-Board Personal Services Reduction," which decreased $489 total funds (the Joint Budget Committee actually adjusted it to 1.5%). After this reduction, the FY 2011-12 Long Bill (SB 11-209) appropriation was $33,951 total funds, with $16,976 General Fund and $16,975 federal funds. SB 11-076 "PERA Contribution Rates" was approved by the General Assembly, which reduced this line item by $740 total funds. The resulting FY 2011-12 appropriation is $33,211 total funds, with $16,606 General Fund and $16,605 federal funds.

The Department is requesting $33,951 total funds for FY 2012-13, which includes the restoration of $740 from SB 11-076 "PERA Contribution Rates." Of the base request, $16,976 is General Fund and $16,975 is 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.

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 2009-10 appropriation as authorized by the FY 2009-10 Long Bill (SB 09-259) was $348,973, of which $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 continuation funding plus adjustments for FY 2010-11 NP BA-4 "DHS-PERA Contribution Change" that reduced funding by $11,703 and FY 2010-11 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 FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction" to $333,568. The FY 2010-11 amount included $166,784 General Fund and $166,784 federal funds.

For FY 2011-12, the following adjustments occurred:

- annualization of FY 2010-11 NP ES-3 "DHS – 1% Across-the-Board Personal Services Reduction" to add back $3,260 total funding;
- annualization of FY 2010-11 NP BA-4 "DHS – PERA Contribution Change" for an increase of $11,703 total funding;
- FY 2011-12 NP-9 "DHS – Statewide 2% Across-the-Board Personal Services Reductions" that decreased total funding by $5,065 because the JBC adjusted the reduction to 1.5%;
- FY 2011-12 NP BA-5 "DHS – Statewide 1% General Fund Reduction to Personal Services/Operating" for a decrease of $3,377 total funding with the intention that the reduction be ongoing and not reversed in future years; and
- JBC staff recommendation to add $52,759 total funding into this line that would have otherwise been appropriated in the separate line item of "Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding, Alcohol and Drug Abuse Division, Administration" with the intention to consolidate all Mental Health Administration Medicaid appropriations into only one line item.

The above items resulted in $392,848 total funding per FY 2011-12 Long Bill (SB 11-209). SB 11-076 "PERA Contribution Rates" was approved by the General Assembly and reduced total funding to the line by $7,666 to $385,182 total funds, with $192,579 General Fund and $192,603 federal funds.

The Department continuation funding for FY 2012-13 plus the restoration of $442 total funds and $7,666 total funds for the annualizations of FY 2009-10 NP BA-12 "DHS – 5% Operating Reduction" and SB 11-076 "PERA Contribution Rates," respectively. The Department's FY 2012-13 base request is $393,290 total funding, with $196,645 General Fund and $196,645 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. This legislation was passed to help mitigate parents' difficulty in navigating the various governmental systems 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 human/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 continued through the end of FY 2010-11.

Appropriation History

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 FY 2010-11 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, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 final FY 2010-11 appropriation was $116,840 and consisted of $47,077 General Fund and $69,763 federal funds.

For the FY 2011-12 Long Bill (SB 11-209), all ARRA adjustments increased the General Fund appropriation by a combined $11,343 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP. The FY 2011-12 appropriation consists of $58,420 General Fund and $58,420 federal funds.

For FY 2012-13, the Department requests continuation funding of $116,840 total funds, with $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. 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 have included: 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. However, the Circle Program for inpatient treatment of substance abuse at the Pueblo location closed at the end of FY 2010-11. The Fort Logan location does not have an inpatient treatment program for substance abuse.

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 continued through the end of FY 2010-11.

Appropriation History

For the FY 2009-10 Long Bill (SB 09-259) appropriated $3,451,818 for this line item, including $1,725,909 General Fund and $1,725,909 federal funds. 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 FY 2009-10NP 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) for final FY 2009-10 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 reductions 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 $20,362 for FY 2010-11 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, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $4,329 pursuant to FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction."

During FY 2010-11, NP S-3 "DHS – Mental Health Institutes Revenue Adjustment" for total funding of $1,302,222 was requested based on a reforecast from DHS. The additional funding was approved by the JBC and enacted into law by FY 2010-11 Supplemental Bill (SB 11-139). An additional increase of $348,250 for FY 2010-11 was later included to cover the two weeks of delayed payments through the Medicaid Management Information System (MMIS) that occurred at the end of FY 2009-10 as a budget-balancing measure. The final FY 2010-11 total appropriation was $4,562,351, including $1,831,687 General Fund and $2,730,664 federal funds.

FY 2011-12 funding included continuation funding plus the following actions:

- the annualizations of all ARRA adjustments increased the General Fund appropriation by a combined $283,100 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP;
- annualization of FY 2010-11 NP ES-3 "DHS – 1% Across-the-Board Personal Services Reduction" to add back $4,329 total funds;
- annualization of the two weeks of delayed payments from FY 2009-10 to remove the $348,250 extra funding in FY 2010-11;
- FY 2011-12 NP-9 "DHS – 2% Across-the-Board Personal Services Reductions" to reduce $31,909 total funding that the JBC adjusted to be a 1.5% reduction;
- FY 2011-12 NP BA-5 "DHS – Statewide 1% General Fund Reduction to Personal Services/Operating" for a decrease of $4,354 total funds; and,
- Common Policy Adjustment for a decrease of $5,617 as recommended by JBC staff.

The above adjustments brought the FY 2011-12 Long Bill (SB 11-209) to $4,176,550 total funds, with $2,088,275 General Fund and $2,088,275 federal funds. SB 11-076 "PERA Contribution Rates" was approved by the General Assembly and reduced the appropriation by $46,631 total funds to $4,129,919, with $2,064,959 General Fund and $2,064,960 federal funds.

The FY 2012-13 base request includes continuation funding plus the restoration of $46,631 total funds for the annualization of SB 11-076 and $20,362 total funds for the annualization of FY 2009-10 NP BA-12 "DHS – 5% Operating Reduction." The Department's FY 2012-13 base request is $4,196,912 total funds, with $2,098,456 General Fund and $2,098,456 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.

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.

During the figure setting process for the FY 2011-12 Long Bill, JBC staff recommended that funding for this line item be added to the line item for regular administration of "Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding," so that all Mental Health Administration could be combined for efficiencies. The JBC accepted this recommendation, thus, this smaller line item ceased to exist as a separate line item for FY 2011-12 and going forward.

The FY 2009-10 Long Bill (SB 09-259) appropriated $53,136 to this line item, which consisted of $26,568 General Fund and $26,568 federal funds.

For FY 2010-11, a JBC staff technical correction resulted in the restoration of $952 in Operating Expenses, and the resulting appropriation per the Long Bill (HB 10-1376), was $54,088. As a result of the continuation of budget balancing, this appropriation was decreased by $531 pursuant to FY 2010-11 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.

For FY 2011-12, the Department received continuation funding and FY 2011-12 NP-9 "DHS – 2% Across-the-Board Personal Services Reductions" removed $798 total funding from this line item, although the JBC recommendation was for only a 1.5% reduction. JBC staff recommended that this line item be consolidated with the main administration line for mental health "Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding, Administration," as part of FY 2011-12 figure setting. Therefore, no separate appropriation was included in the FY 2011-12 Long Bill (SB 11-209).

The Department requests no appropriation for this line item in FY 2012-13.

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. The Medicaid Assistance portion of this program is also authorized by 25.5-5-310 through 312, C.R.S.

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 continued through the end of FY 2010-11.

Appropriation History

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, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 FY 2011-12 Long Bill (SB 11-209) appropriated $1,999,146 total funds to this line item. The annualizations of all ARRA adjustments increased the General Fund appropriation by a combined $194,073 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP. With this adjustment, the appropriation consists of $999,573 General Fund and $999,573 federal funds.

For the FY 2012-13 base request, the Department requests continuation funding of $1,999,146, with $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). 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 95% of operating expenses and 100% of the Medicaid waiver transition costs.

Appropriation History

The FY 2009-10 Long Bill (SB 09-259) appropriation to this line item was $2,931,565. In response to the economic downturn, a Personal Services cut was approved as NP S-3 "DHS – Statewide Furlough Impact," which removed $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, 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. The Joint Budget Committee (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. The JBC approved a 2.5% adjustment to PERA through FY 2010-11 NP BA-4 "DHS – PERA Contribution Change," removing $52,493 from the appropriation, as well as FY 2010-11 NP BA-12 "DHS – 5% Operating Reduction," removing $12,632 from the appropriation. The 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 dated March 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 the JBC to approve FY 2010-11 NP-BA-13 "DHS - Correction to FY 2010-11 Base Budget," increasing funding by $52,054. In the autumn of 2009, as a result of the ongoing fiscal revenue shortfall, this appropriation was decreased by another $26,359 pursuant to FY 2010-11 NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." This brought the final FY 2010-11 appropriation to $2,921,350, comprised of $1,460,675 General Fund and $1,460,675 federal funds.

To build to the FY 2011-12 Long Bill (SB 11-209) appropriation of $2,923,329, the FY 2010-11 ES-3 "DHS- 1% Across the Board Personal Services Reduction" was annualized, returning $26,359 to the appropriation. FY 2010-11 "DHS – PERA Contribution Change" was also annualized returning $52,493. However, as a result of the ongoing uncertainty of state revenue generation, additional reductions were required. FY 2011-12 NP-9 "DHS - 2% Across the Board Personal Services Reductions" reduced the line by $40,326; FY 2011-12 NP-BA 5 "DHS - Statewide 1% General Fund Reduction to Personal Services/Operating" reduced the line by $26,884; and JBC Staff Recommendation for SIS Training and Audits, which reduced the line by $9,663. Additionally, SB 11-076 "PERA Contribution Rates" reinstituted the prior year's one-time action and reduced the appropriation by $50,650. This brings the year-to-date FY 2011-12 appropriation to $2,872,679, comprised of $1,436,340 General Fund and $1,436,339 federal funds.

For FY 2012-13, the Department is requesting $2,935,961 for this line item. This requested amount is based off the $2,872,679 appropriated in the prior fiscal year and includes the annualizations for a 2009 action NP BA-12 "DHS – 5% Operating Reduction" returning $12,632, as well as the above referenced SB 11-076 "PERA Contribution Rates," returning $50,650 to the appropriation. Of the base request, $1,467,981 is General Fund and $1,467,980 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" line in FY 2007-08. This line item currently appropriates funds for Medicaid-eligible services for approximately 8,000 clients through three waivers (described below) supporting the Adult Comprehensive Services, Adult Supported Living Services, and Children's Extensive Support Services Programs. Twenty Community Centered Boards (CCBs) provide case-management, utilization review/quality assurance (UR/QA), and 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 8,400 Medicaid clients under the new consolidated line item. The number of clients served has increased each of the past five 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 (SLS), Comprehensive Developmental Disabilities (DD, or Adult Comp), and Children's Extensive Support (CES).

The SLS 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 SLS waiver also helps individuals with pre-vocational and supported employment. The Comprehensive DD waiver provides services and support to persons with developmental disabilities, allowing them to continue to live in the community outside of the family home, yet within a 24-hour care model. 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 CES 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 assisting SLS and DD waiver clients are paid a 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 then drive higher payments in the Department of Human Services (DHS) rate structure.

The Department is the federally recognized Single State Agency responsible for administering the Medicaid program. Based upon the State's increasing unemployment rate in 2008, 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 the end of FY 2010-11.

During the 2011 legislative session, the Joint Budget Committee (JBC) issued a Legislative Request for Information (LRFI) asking the Department and DHS to consider the possible transfer of the DHS Developmental Disabilities Division to the Department and to report back to the committee. The governor provided alternative guidance to the two departments. (Please refer to the Hot Issues section of the Department Description in this budget request for specific information.)

Prior to July 1, 2006, the Department of Human Services operated under a "Systems Change Project," which applied a quasi-managed care approach, akin to a block grant, to delivering developmental disability services, which allowed community-centered boards to negotiate rates with their providers to get a better rate for each service. DHS used a bundled rate methodology to reimburse the community-centered boards through the CCMS for client services. However, based on results of an audit issued by the Centers for Medicare and Medicaid Services on April 26, 2004, indicating a lack of accountability of and eligibility for federal Medicaid funding, the State was instructed to establish a new, uniform, rate-setting methodology for the Home- and Community-Based Services – Developmental Disabilities waiver, which included the mandatory "unbundling" of rates. In addition, the audit required the State to: 1) provide evidence assuring State administrative authority over the waiver; 2) ensure an effective quality management system to address incidents and other health and welfare issues; and 3) place all financial accountability for waivered programs on the Department.

Based on these audit requirements, the State, in order to address the aforementioned problem areas, organized a steering committee comprised of DHS and Department representatives, Office of State Planning and Budgeting staff, and members from the community-centered boards. Based on committee efforts, a new, interim, seven-tiered services matrix, based upon a fee-for-service reimbursement methodology, was developed and put into use beginning July 1, 2006. The interim rate structure would serve until the final rate methodology could be completed. Under this new methodology, clients are assigned to one of seven acuity levels according to his/her required service needs, and all providers must bill the State directly or as a contractor of the community-centered board may bill through the community-centered boards. However, the community-centered boards must now bill through the Medicaid Management Information System (MMIS) to ensure the required audit trail is established.

To implement the new rate setting methodology, the State hired a consultant to modify an existing, behavioral-assessment tool, the Supports Intensity Scale (SIS) Tool, to effectively gauge the level of care needed for every individual enrolled in the Home- and Community-Based Services - Developmental Disabilities waiver. Once the level of care has been established for each client, the State will be able to adjust its estimated expenditures accordingly.

In FY 2006-07, DHS wrote a 1331 Supplemental to remove a considerable amount of funding from the Community Services Adult Program Costs and CCMS Replacement line. The request cited underutilization of the Home- and Community-Based Services, Supported Living Services, and Children's Extensive Support waiver programs as justification for the under-expenditure. The 1331

Supplemental requested that a portion of the under-expenditure be used to pay for the purchase, modification, and user training for the aforementioned Supports Intensity Scale Tool, temporary assistance in processing Prior Authorization Reviews, and modifications to the Community Contract and Management System. These changes, according to the request, were necessary to keep the developmental disabilities programs running smoothly.

During FY 2007-08, a steering committee -- composed of members from the Department, DHS, representatives of the community-centered boards, and representatives from the community -- met monthly to develop the contents of an updated waiver to be submitted to the federal Centers for Medicare and Medicaid Services (CMS). The updated waiver amendment was submitted April 29, 2008. Also during FY 2007-08, a Rates Development Committee met frequently to develop current rates on a fee-for-service basis to be implemented July 1, 2008. Implementation of the new rates was postponed until January 1, 2009, to allow time for further study of the new rates.

More recently, due to the consistent increases in expenditures, the fee-for-service model is being closely monitored. The Department and DHS are working together and with various stakeholders to explore ways to reduce expenditures within the existing model. The Department is currently statutorily prohibited from using a managed-care model. The departments will continue to explore available and potential options.

Due to the passage of Referendum C and HB 05-1262 "Tobacco Tax Implementation," the State elected to reduce the number of waiting-list clients for the Children's Home- and Community-Based Services and Children's Extensive Support by increasing the number of slots available within the waivers. As these additional waiver slots met the definition of expansion populations as defined in HB 05-1262, state funding for these new clients was appropriated from tobacco tax revenues and matching federal funds.

The FY 2006-07 Long Bill appropriation was $248,194,905. DHS submitted a 1331 Supplemental request recommending a 3.25% provider rate increase for FY 2006-07 to support existing demands in this program. DHS identified this funding source due to the CMS disapproval of requests for expanding the number of waiver slots and concerns with the existing program. This did not allow for the 3.25% provider rate to be distributed as a cost-of-living adjustment. The JBC's approval of this recommendation adjusted the spending authority for this program in FY 2006-07 down to $240,711,455. The General Fund saved as a result of this request was used to hold providers harmless and to pay for additional resources within the program itself. In addition to the adjustment of the funding for the 3.25% cost-of-living adjustment, this line item was appropriated an additional $15,215,890 in total funds. This additional funding allowed the State to use General Fund in place of local match, which CMS disallowed on the basis that county-specific expenditures cannot substitute for other counties' expenditures or community-centered board catchments. Finally, the FY 2006-07 appropriation received a one-time adjustment that decreased the appropriation by $14,128,082 as a result of changing the yearly billing methodology from 304 days to 365 days. The final FY 2006-07 appropriation was $233,407,633.

The FY 2007-08 Long Bill (SB 07-239) appropriated $281,791,710 total funds to this line item. During the fiscal year, FY 2007-08 NP S-19 "DHS–Division of Developmental Disabilities Medicaid Appropriation Reduction" was submitted, requesting a funding

reduction because Medicaid expenditures for DD services and case management were less than originally anticipated. The JBC reduced the appropriation by $4,153,700 for under-expenditures and another $5,753,055 for the removal of roll-forward funds from FY 2006-07. Total funding for FY 2007-08 ended up at $271,884,955. DHS was authorized to roll forward up to 3% of unspent Medicaid funds from FY 2007-08 to assist in and provide contingency funds for the transition from the bundled rate Medicaid system to the new fee-for-service system, and the Department rolled forward $5,057,748 into FY 2008-09. Final actual expenditures for FY 2007-08 were $262,895,206, and $3,932,001 total funds were reverted.

To build to the FY 2008-09 appropriation, the $271,884,955 appropriated for FY 2007-08 served as the base. The annualization of FY 2006-07 NP-3 "DHS – Provide Resources to Specific Populations," which requested new developmental disability resources for FY 2007-08, increased the appropriation by $3,320,685. The Department submitted FY 2008-09 NP-10 "DHS – Division for Developmental Disabilities New Resource Request" and FY 2008-09 NP BA-17 "Governor's New Resources for Developmental Disabilities." These requests were approved, and $12,658,599 was added as part of the FY 2008-09 Long Bill (HB 08-1375). The Department submitted FY 2008-09 NP-9 "DHS Provider Rate Increases," which requested an increase of 1.35% for all client service providers. The JBC enacted a 1.5% increase, and an increase of $4,266,097 was included as part of the FY 2008-09 Long Bill (HB 08-1375). The final FY 2008-09 Long Bill appropriation to the line 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 FY 2008-09 NP S-11 "DHS Fee for Service versus Bundled Billing," eliminating $5,300,000 in total funding (January 15, 2009, FY 2008-09 Budget Reduction Proposals). The Committee also took action on FY 2008-09 NP S-12 "DHS Vacancy Savings due to Systematic Client Turnover," removing another $1,668,362 total funds, and FY 2008-09 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.

Unlike previous years, the Department received no roll-forward authority in FY 2008-09 to carry funds into the next fiscal year. Expenses for the year exceeded appropriations by less than 1%, funds were transferred from DHS in the amount of $227,697 total funds and from the Department's Regional Centers line item in the amount of $2,281,772 total funds as year-end transfers into this line item. FY 2008-09 final total expenditures were slightly less than initially estimated, totaling $291,337,532, and $49,436 General Fund was reverted.

To build to the FY 2009-10 appropriation, the final FY 2008-09 appropriation of $288,877,499 served as the base. The annualizations of FY 2008-09 NP S-11 "DHS – Fee for Service versus Bundled Billing" and FY 2008-09 NP S-13 "DHS – Developmental Disability Services 2007-08 Roll Forward" were reversed, restoring $10,357,748 in funding to the line. Annualizations for FY 2008-09 NP-10 "DHS – Division for Developmental Disabilities New Resource Request" and FY 2008-09 NP BA-17 "Governor's New Resources for Developmental Disabilities" increased the FY 2009-10 appropriation by $12,658,599 total funds. Consistent with past practice, the Department submitted a request for funding as a result of the addition new developmentally disabled caseload, FY 2009-10 NP-3

"DHS – Community Funding for Individuals with Developmental Disabilities." This request was approved, and $5,189,494 was appropriated. The JBC also appropriated $590,620 for Regional Center Transition Placements and Staff Adjustment for Case Management. The regional centers' transition involved the transfer of clients with less intensive needs to community-center providers, decreasing costs in the Regional Centers line and increasing costs into this line.

General Revenue forecasts in early 2009 projected continued deterioration in the state economy, and the JBC reviewed funding for the line due to state budget-balancing requirements. The JBC reviewed past appropriations approved for the line item and enacted reductions to specific requests. Reductions totaling $3,406,407 were made to previously approved appropriations for new resources. The JBC 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.

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 FY 2009-10 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. 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 and 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 FY 2010-11 NP BA-15 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center," resulted in an increase of $3,256,351 total funds. FY 2009-10 NP ES-7 "DHS – DDD Medicaid Waivers Provider Rate Reduction" was annualized, reducing the appropriation by $2,022,230, and FY 2009-10 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 FY 2010-11 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 House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77%

for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 state funds appropriations of $35,391,151 with a corresponding decrease in the federal funds appropriation.

Toward the end of FY 2009-10, it became apparent that the line was at risk of significantly overexpending. Because of continuing budget shortfall pressures, the decision was made to shut off the electronic billing and payment system used by providers seeking reimbursement from the Department. This shutdown delayed reimbursements, in effect rolling them over into FY 2010-11. JBC staff estimated the total fund amount to be $4,745,219, and the JBC included funding in the FY 2011-12 Long Bill Add-ons (SB 11-209).

Several factors contributed to an increase in expenditures in FY 2010-11. DHS submitted a Supplemental Request (the Department's FY 2010-11 NP-2, "DHS Reallocation of Resources and Funding Increase for Emergency Placements in Community Services for People with Developmental Disabilities Program Costs") for additional funding to address this issue. After conducting thorough analysis, JBC staff recommended, and the JBC approved, an increase in funding of $35,470,053. This was also included in the Long Bill Add-ons for FY 2010-11. Due to these actions, the FY 2010-11 final appropriation was $346,209,183. This appropriation included $139,263,780 General Fund, $447,620 cash funds, and $206,497,783 federal funds.

To build to the FY 2011-12 Long Bill (SB 11-209) appropriation of $328,231,550, the prior-year appropriation of $346,209,183 served as the base. All ARRA related adjustments were annualized to remove enhanced federal funding levels from the appropriation. Additionally, two funding adjustments from the prior year were annualized. The annualization of FY 2010-11 NP-2 "DHS Reallocation of Resources and Funding Increase for Emergency Placements in Community Services for People with Developmental Disabilities Program Costs" removed $14,115,777 from the line, and the roll-over for the provider reimbursement delay from FY 2009-10 of $4,745,219 was also removed. FY 2011-12 NP-4 "DHS – Services for People with Disabilities-New Funding Developmental Disabilities Services" added $176,028 to the appropriation. Because FY 2011-12 is a leap year, funding of $707,335 was added to cover the extra day of program costs. JBC staff, noting that the Health Care Expansion Fund is insolvent, recommended the reduction of the cash fund component of this appropriation be reduced to $1 to fulfill constitutionally required appropriations. The funding for the FY 2011-12 appropriation totaled $328,231,550, comprised of $164,115,774 General Fund, $1 cash funds, and $164,115,775 federal funds.

For FY 2012-13, the Departing is requesting funding of $330,772,221 for this line. This includes continuation funding of the FY 2011-12 appropriation, the annualization of FY 2011-12 NP-4 "DHS - Services for People with Disabilities-New Funding Developmental Disabilities Service" for an increase of $3,248,006, and an annualization of the prior year Leap-Year Adjustment reducing the appropriation by $707,335. The base request consists of $165,386,111 General Fund, $1 cash funds, and $165,386,109 federal funds.

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 Community-Centered Board (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 continued through the end of FY 2010-11.

Appropriation History

The FY 2009-10 Long Bill (SB 09-259) appropriated total funding of $50,049,730, consisting of $22,931,984 General Fund, $2,092,881 reappropriated funds, and $25,024,865 federal funds. 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%. FY 2009-10 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. The 1.82% personal services reduction approved during the FY 2009-10 Figure Setting process was partially reversed through FY 2009-10 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, FY 2009-10 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.

The FY 2010-11 Long Bill appropriated total funding of $46,888,625. The prior year-end appropriation of $49,644,680 served as the base, and 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 an increase to the appropriation, and the FY 2009-10 1.82% personal services reduction was also annualized, adding back $863,840 total funds. The annualization of FY 2010-11 NP-8 "DHS – Direct Care Capital Outlay" resulted in a decrease of $164,250, and the annualization of FY 2009-10 NP-6 "DHS – Regional Centers – High Need Clients" added $28,417. FY 2010-11 NP BA-15 "DHS - Closure of the Skilled Nursing Facility at Grand Junction Regional Center" decreased the appropriation by $2,782,528 total funds. The JBC approved FY 2010-11 NP BA-8 "DHS - Mail Equipment Upgrade Supplemental and Budget Amendment," which, combined with the annualization of FY 2009-10 NP-5 "DHS Postage Increase and Mail Equipment Upgrade," added $112. Additionally, actions were taken in response to the ongoing statewide fiscal crisis. The JBC approved a 2.5% adjustment to PERA through FY 2010-11 NP BA-4 "DHS – PERA Contribution Change," removing $960,576 from the appropriation. The JBC also approved FY 2010-11 NP BA-12 "DHS – 5% Operating Reduction," removing $125,770 from the appropriation. The 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 House and signed by the President on August 10, 2010. The extension contained a phase-down of the FMAP rate, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 $881,507 with a corresponding decrease in the federal funds appropriation. As a result of the continuation of budget balancing, this appropriation was decreased by $84,657 pursuant to FY 2010-11 NP ES-3 "DHS- 1% Across the Board Personal Services Reduction." As a result, the final FY 2010-11 revised total appropriation was $46,803,968, consisting of $16,989,664 General Fund, $1,867,655 reappropriated funds, and $27,946,649 federal funds.

To build to the FY 2011-12 Long Bill Appropriation (SB 11-209) of $47,676,045, the final FY 2010-11 appropriation of $46,803,968 served as a base. All ARRA related adjustments were annualized to remove enhanced federal funding levels from the appropriation. FY 2010-11 NP BA-4 "DHS – PERA Contribution Change" was annualized, adding back $960,576 total funds. Additionally, the JBC

approved an additional reduction of $86,578 as part of FY 2011-12 NP BA-5 "DHS - Statewide 1% General Fund Reduction to Personal Services/Operating." The FY 2011-12 Long Bill appropriation totaled $47,676,045 and was comprised of $21,970,368 General Funds, $1,867,655 reappropriated funds, and $23,838,022. During the 2011 legislative session, SB 11-076 "PERA Contribution Rates" was passed by the General Assembly, which reduced funding for the Regional Centers appropriation by $846,245 total funds in FY 2011-12. The FY 2011-12 year-to-date appropriation is $46,829,800 total funds, comprised of $21,547,245 General Fund, $1,867,655 reappropriated funds, and $23,414,900 federal funds.

For FY 2012-13, the Department is requesting funding of $47,801,815 total funds, from which the FY 2011-12 Long Bill appropriation of $47,676,045 served as the base. In addition, FY 2009-10 NP BA-12 and SB 11-076 are annualized, increasing the request by $125,770 and $846,245, respectively. Of the total request of $47,801,815, $22,033,253 is General Fund, $1,867,655 is reappropriated funds, and $23,900,907 is federal funds.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line enables the State to capture depreciation payments from federal authorities associated with regional centers of the Department of Human Services (DHS). The line item was added through the 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.

For FY 2009-10, the Long Bill (SB 09-259) appropriation for this line was $1,258,084, comprised of $629,042 General Fund and $629,042 federal funds.

In FY 2010-11, the JBC decreased this appropriation from the FY 2009-10 appropriation by $70,259 to reflect revised depreciation figures based on the annual calculations completed by DHS. Consequently, 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.

The FY 2011-12 Long Bill (SB 11-209) appropriation was $1,187,825 for this item, again consisting of $593,913 General Fund and $593,912 federal funds.

For FY 2012-13, 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 human/social 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.

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. This line item continues to have a stable funding amount in each fiscal year. For FY 2012-13, 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.

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 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 continued through the end of FY 2010-11.

Appropriation History

The FY 2009-10 Long Bill (SB 09-259) appropriation for 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 FY 2009-10 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 FY 2009-10 NP S-3 "DHS-Statewide Furlough Impact," which reduced total funding by $494. Finally, late Supplemental Request FY 2009-10 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 appropriation included:

- 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 FY 2010-11 NP-6 "DHS-Two Percent (2%) Community Provider Rate Base Decrease";
- a reduction of $990 from FY 2010-11 NP BA-4 "DHS-PERA Contribution Change"; and,
- an increase of $253,047 from FY 2010-11 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, establishing the FMAP rates of 58.77% for the 3rd quarter of FY 2010-11 and 56.88% for the 4th quarter of FY 2010-11. 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 FY 2010-11 NP ES-3 "DHS- 1% Across-the-Board Personal Services Reduction." Approval for a late supplemental request FY 2010-11 NP S-11 "DHS – Purchase of Contract Placements Line Item Appropriation Reduction" resulted in a decrease of $204,688 total funds, resulting in a final FY 2010-11 appropriation of $2,481,054 total funds with $1,006,537 General Fund and $1,474,517 federal funds.

To arrive at the FY 2011-12 appropriation, the following adjustments were made:

- the annualizations of all ARRA adjustments increased the General Fund appropriation by a combined $251,487 while decreasing the federal funds by the same amount to account for the end of the enhanced FMAP;
- annualization of FY 2010-11 NP ES-3 "DHS – 1% Across-the-Board Personal Services Reduction" to restore $459 total funds;
- annualization of FY 2010-11 NP BA-4 "DHS – PERA Contribution Change" to restore $990 total;
- FY 2011-12 NP-9 "DHS – 2% Across-the-Board Personal Services Reductions" to remove $703 total funds because the JBC reduced the reduction to 1.5%;
- FY 2011-12 NP BA-5 "DHS – Statewide 1% General Fund Reduction to Personal Services/Operating" to remove $469 total funds;
- FY 2011-12 NP BA-9 "DHS – Purchase of Contract Placements Line Item Appropriation Reduction" to remove $208,653 total funds;
- fund split reconciliation of $17,453 less General Fund and $17,453 more federal funds resulting in a net zero change to total funding;
- Leap Year Adjustment recommended by JBC Staff added $3,303 total funds; and,
- JBC Staff recommendation removed $989,000 total funds for the Ridge View youth classified as foster children from this line item and placed the funding instead in the Department's Medical Services Premiums line item where other foster care children's medical expenses are covered.

The resulting FY 2011-12 Long Bill (SB 11-209) appropriation was $1,286,981 total funds, with $643,491 General Fund and $643,490 federal funds. SB 11-076 "PERA Contribution Rates" was approved by the General Assembly and decreased the total funds appropriation by $1,030. The revised FY 2011-12 appropriation is $1,285,951, with $642,976 General Fund and $642,975 federal funds.

To arrive at the base request for FY 2012-13, the Department requests continuation funding plus $1,030 total funds for the annualization of SB 11-076 "PERA Contribution Rates" and a reduction of $3,302 total funds for the annualization of the Leap Year Adjustment. Therefore, the Department requests $1,283,679 total funds, with $641,840 General Fund and $641,839 federal funds for FY 2012-13.

(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.

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.

The Department was appropriated $500,000 for this line item in FY 2008-09 through FY 2011-12. For FY 2012-13, 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.

This line item was appropriated $74,564 from FY 2006-07 through FY 2009-10. No funding was provided for FY 2010-11 and FY 2011-12. The Department requests no funding for this line in FY 2012-13.