



Department of Health Care Policy and Financing
Line Item Description
FY 2013-14 Budget Request

November 1, 2012

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(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 contract 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) 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 is 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.

HEALTH, LIFE, AND DENTAL

This line item funds the Department's insurance benefits, and 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 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 2012-13, the reimbursement was increased to 100% of the market average.

SHORT-TERM DISABILITY

This line item, a component of POTS, 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), and is based on the sum of base salaries, Salary Survey, range adjustments, and Performance Achievement Pay.

AMORTIZATION EQUALIZATION DISBURSEMENT

This line item funds the increased employer contribution to the Public Employees' Retirement Association (PERA) Trust Fund to amortize the unfunded liability in the Trust Fund beginning January 2006. 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 is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

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 line 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 is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SALARY SURVEY AND SENIOR EXECUTIVE SERVICE

The Salary Survey and Senior Executive Services appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the job and wage classification survey performed annually by the Department of Personnel and Administration.

Each employee title or class is matched to an occupational group for a percentage increase. This percentage is then multiplied by the employee's estimated salary as of June to come up with the Salary Survey amount. In the Department, most of the employees fall into the following occupational groups: financial services, administrative support and related, or professional services. Applicable PERA and Medicare amounts are added into the Salary Survey calculations.

MERIT PAY

Formerly known as "Performance Achievement Pay," Merit Pay represents the annual amount appropriated for periodic salary increases for State employees based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work. Effective July 2001, the Department of Personnel and Administration implemented a performance management plan under authority of SB 00-211. This legislation required the State Personnel Director to submit a plan to the Joint Budget Committee for payouts to occur on July 1, 2001. Due to the State's depressed fiscal situation, the payout date was delayed to July 1, 2002. The performance management component of the new system began without associated payouts on July 1, 2001.

WORKERS' COMPENSATION

This line item provides funding for payments made to the Department of Personnel and Administration (DPA) to support the State's self-insured program. Workers' Compensation is a statewide allocation to each Department based upon historic usage. 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.

OPERATING EXPENSES

In addition to funding telephones, computers, office furniture, and employee supplies 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.

LEGAL SERVICES

This Common Policy line item funds the Department's expenditures for legal services provided by the Department of Law. The Department is billed based on a blended attorney/paralegal hourly rate developed by the Department of Law.

ADMINISTRATIVE LAW JUDGE SERVICES

This Common Policy line item includes funding for services typically provided by administrative law judges and paralegals from the Office of Administrative Courts. Departmental appropriations are based upon historical utilization of these services, by applying the prior year's billable hours to the estimated billable cost for the request year. Adjustments are made based on mid-year reviews by the Department of Personnel and Administration.

PURCHASES OF SERVICES FROM COMPUTER CENTER

This Common Policy line item is appropriated 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 (MMIS) computer and long-term care computer and also incurs the printing costs associated with each. The total need to fund the General Government Computer Center is calculated by multiplying a prior year's usage ratio for each state department.

MULTIUSE NETWORK PAYMENTS

This Common Policy line item was created in 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.

MANAGEMENT AND ADMINISTRATION OF OIT

SB 08-155 created the Governor’s Office of Information Technology’s (OIT) 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. SB 08-155 also created the mechanism for billing associated executive agencies beginning in FY 2008-09 in order to fund OIT. This Common Policy line item was created during FY 2008-09 to fund OIT’s “back-office” expenses.

COFRS MODERNIZATION

This Common Policy line item resulted from the passage of HB 12-1335, the FY 2012-13 Long Appropriations Bill. It funds the first two phases of a five-phase project to replace the statewide accounting system used by the Office of the State Controller to record all state revenues and expenditures. The new system is needed to meet the State’s fiduciary responsibilities, mitigate the risk of system failure, and upgrade functionality. The new system will be built in the cloud environment by a private vendor in collaboration with state personnel. The five-phase project incorporates all of the components necessary to replace COFRS.

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS

This Common Policy line item 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.

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). Funding is appropriated to this line item to pay for leased space required beyond the capacity of the Capitol Complex Leased Space.

CAPITOL COMPLEX LEASED SPACE

This Common Policy line item 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.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in 2008 and is appropriated funding for special or temporary projects the General Assembly chooses to fund each year.

(B) TRANSFERS TO OTHER DEPARTMENTS

TRANSFER TO DPHE 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.

TRANSFER TO DEPT OF PUBLIC SAFETY FOR LIFE SAFETY CODE INSPECTIONS FOR HEALTH FACILITIES

This line item is new for FY 2013-14 and was created by HB 12-1268 “A Transfer of Functions Pertaining to Health Facility Compliance with Certain Building Safety Standards from the Department of Public Health and Environment to the Division of Fire Safety in the Office of Preparedness, Security, and Fire Safety within the Department of Public Safety.” Historically, the Life Safety Code Inspections have been performed by the Department of Public Health and Environment (DPHE) as an adjunct function to the medical inspections that DPHE performs to survey and certify various types of medical facilities for Medicare and Medicaid. The Department provides part of the funding through Medicaid for the medical inspections of nursing facilities through the “Transfer to Department of Public Health and Environment Facility for Survey and Certification” line item, and the Department will continue with

the Survey and Certification Medicaid funding. Going forward, the Department will also provide a portion of the funding, through Medicaid, to the Department of Public Safety for continuation of the Life Safety Code Inspections for nursing facilities.

TRANSFER TO DPHE FOR 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 2010-11, the program served 2,590 total families. Data for FY 2011-12 will not be available until a report is finished near the end of calendar year 2012. 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 University of Colorado Health Sciences Center. 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.

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).

TRANSFER TO DPHE 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 funding is 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 below line item for more information.

TRANSFER TO DPHE FOR 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. Enhanced prenatal services are provided at county health departments, county nursing services, community health centers, and private non-profit agencies. 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 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.

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 Department and DPHE discussed 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 eliminated this line item effective FY 2011-12.

TRANSFER TO DORA 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 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, 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.

TRANSFER TO DORA 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.

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. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care 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. 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 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. This line funds the administrative expenses of the Colorado Department of Education, which provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel.

(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.

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. The MMIS processes claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from 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 the 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. The Department is requesting funding in FY 2013-14 to competitively bid and reprocure the MMIS when the current eight-year contract ends. Please note that ACS is now owned by Xerox.

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.

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.

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.

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. It was the result of the recommendation by The Blue Ribbon Commission for Health Care Reform (the “208 Commission”) 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.

The Centralized Eligibility Vendor streamlines navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, creates expedited eligibility for medical only cases, and improves outreach and enrollment in both programs. These changes ensure easier, more reliable, and timely eligibility and enrollment processes, making the programs more efficient and effective in delivering important benefits to clients, providers, and enrollment staff. In addition, the entity modernizes the current eligibility determination process by providing technology that is not currently available in every county, such as an automated customer contact center and an electronic document and workflow management system. This provides a central repository for applications and related documents. The Centralized Eligibility Vendor also provides electronic systems that aid in managing the online application for benefits. This entity enhances and complements the current multiple county-level process.

This contract currently covers the following expansion populations from HB 09-1293, the Colorado Health Care Affordability Act of 2009: CHP+ to 250% of the federal poverty level, the Buy-In Programs for Individuals with Disabilities, and Adults without Dependent Children to 100% of the federal poverty level.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

The purpose of Medicaid authorization cards is to provide proof of a client's Medicaid eligibility to service providers so that the client can receive medical services from the provider. Currently, if clients can not show proof of Medicaid eligibility, providers can, at times, refuse to provide services.

Under the medical ID card 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. Beginning in FY 2003-04, funding for authorization cards for the Old Age Pension State Medical Program's clients was added to the appropriation. Since these clients are not Medicaid eligible, no federal match is available for these funds.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

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

Prior to FY 2008-09, Disability Determination Services, Nursing Home Preadmission and Resident Assessments, and School District Eligibility Determinations were funded through their own separate line items within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, HB 08-1375, the FY 2008-09 Long Bill consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The three budget items for Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review, and School District Eligibility Determinations were combined into one line item titled "(D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations" within Long Bill group (1) Executive Director's Office. 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 was added as a result of the passage of HB 09-1293, "Colorado Health Care Affordability Act."

DISABILITY DETERMINATION SERVICES

Federal law mandates that disability determinations be conducted for clients who are eligible for Medicaid due to a disability. Prior to July 2004, the Disability Determination Services line provided Medicaid funding to the Department of Human Services (DHS) to conduct disability determinations for individuals waiting for eligibility determination of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, were potentially eligible for Medicaid due to a disability. In July 2004, administration of disability determinations for Medicaid eligible persons was transferred from DHS to the Department of Health Care Policy and Financing.

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, that they 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.

HOSPITAL OUTSTATIONING

This line item funds outstationing activities at hospitals in order for hospitals to provide certain on-site services to inform, educate, and assist qualifying clients in gaining enrollment into the State's medical assistance programs. Not every hospital is anticipated to participate in outstationing activities, but costs for these activities were based on 1.0 FTE at each hospital. This line item was created as a result of the passage of HB 09-1293, the "Colorado Health Care Affordability Act," to assist with the anticipated increase in caseload due to the bill.

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 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.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item provides for reimbursement to local county departments of human/social services for costs associated with performing Medicaid eligibility determinations for the "Expansion Adults to 100% Federal Poverty Level (FPL)" category funded under HB 09-1293, the "Colorado Health Care Affordability Act." This funding was included in the County Administration line item, showing up as Cash Funds and Federal Funds; however, the Department's FY 2012-13 S-7 "Hospital Provider Fee Administrative True-up," submitted with the January 3, 2012 Supplemental Budget Request, requested the separation of this funding, thereby establishing this line item to make the budget more transparent, allow for easier tracking of hospital provider fee funds, and to separate funding sources that are allocated based on differing methodologies.

While the County Administration line item reimburses county departments using a methodology including a random moment time study, a local funding match, and interagency transfers, this line item reimburses in a manner more reflective of the expansion of the Department's programs under HB 09-1293. These funds are distributed twice per state fiscal year based on total County Administration expenditures and each county's percentage of clients which fall into the "Expansion Adults to 100% FPL" expansion category funded by the Hospital Provider Fee relative to total Medicaid.

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.

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."

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;
- 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.

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 HealthColorado.

Effective July 1, 2013, the Department's contract with MAXIMUS, Inc. has been extended for two fiscal years. Additionally, per a sole source contract awarded by the Department effective January 1, 2013, MAXIMUS, Inc. will provide enrollment management services for the CHP+ program.

(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.

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.

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;
- administration of the Hospital Back-Up Program, which 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. The Department's contract with Ascend Management Innovations, LLC ended June 30, 2012. Beginning July 1, 2012, the Department contracts with Masspro for these services.

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, 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.

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. Beginning in FY 2012-13, the Department's contract with Health Services Advisory Group is amended to include conducting survey administration, analysis, and reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (Children with Chronic Conditions-Plan Specific), for six CHP+ plans.

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).

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.

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.

(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 the Department's FY 2010-11 DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures."

NURSING FACILITY AUDITS

This budget item funds statutorily required audits of costs reported by Medicaid nursing facilities for rate setting purposes. 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.

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 (FQHCs), 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, FQHC, and rural health center, per federal and State law.

SINGLE ENTRY POINT AUDITS

This budget item funds annual audits of Single Entry Point agencies provided through a contractor. The scope of work has been limited to reviews of cost reports. To the extent that funds allowed, on-site audits are conducted for agencies that posed the highest risk. In FY 2006-07, the appropriation to this line was increased in order to increase the accuracy of SEP agency billing and potentially increase recovery of improper payments.

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. Due to the three-year cycle, Colorado completed the eligibility and payment error reviews in FY 2010-11 and will do so again in FY 2013-14.

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. The claims review is conducted by federal contractors, whereas the eligibility review is 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.

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.

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 "Health 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.

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. For more information regarding these types of payments, please see the Safety Net Provider Payments section of this document.

(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.

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

NURSING FACILITY PENALTY CASH FUND, NURSING FACILITY CULTURE CHANGE

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

HB 09-1196 created a Nursing Facility Culture Change Accountability Board within the Department to make recommendations to the Department and the Department of Public Health and Environment regarding the distribution of funds. In addition, HB 09-1196 requires a new annual report to be submitted jointly by the Department and the Department of Public Health and Environment to the Governor and the Health and Human Services Committee beginning each October. The report details information regarding the amount of moneys expended for culture change, the recipients of the funds, and the effectiveness of the funds.

(2) MEDICAL SERVICES PREMIUMS

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, adults, and children. Medical services are grouped into the following categories, each of which include several programs: acute care, community-based long-term care, and long-term care. Additional expenditures are incurred for insurance, service management, and financing payments. For a program-level description of each of the aforementioned categories of services, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-1, "Request for Medical Services Premiums."

To calculate the funding need for the Medical Services Premiums Line, the Department must forecast Medicaid caseload. In past years, the caseload forecast was included in the Line-Item Description. This year, the caseload presentation is included in the budget request as a separate exhibit. For a detailed narrative of the caseload forecast, please see the "Medicaid Caseload" Section included in this budget submission.

(3) MEDICAID MENTAL HEALTH

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. 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. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Mental Health Community Services."

MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

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. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Mental Health Community Services."

(4) INDIGENT CARE PROGRAM

The Indigent Care Program section of the Department budget consists of the Colorado Indigent Care Program, the Primary Care Fund Program, the Children's Basic Health Plan, and other Safety Net provider payments. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. A description of each program is 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 2010-11, total payments to indigent care providers through the Colorado Indigent Care Program equaled \$325,584,047 and 225,906 clients were served by the program, up 3.6% from 217,946 in FY 2009-10. As of FY 2012-13, the program consists of the following four line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; the Primary Care Fund Program; and, Pediatric Specialty Hospital. The Primary Care Fund program was suspended in FY 2010-11 and FY 2011-12, and Tobacco Tax revenues were redistributed to clinics through the Health Care Services Fund Program and General Fund relief. Pursuant to HB 10-1323 and effective July 1, 2010, the Comprehensive Primary and Preventive Care Program 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. The Department received a final DSH allotment of \$92,189,191 for state fiscal year (SFY) 2010-11 and a preliminary allotment of \$94,727,736 for SFY 2011-12.

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 2009 data, this information can be found in

Exhibit K in the Department’s November 1, 2012 FY 2013-14 Budget Request. This information will be available for calendar year 2010 in Exhibit K in the Department’s February 15, 2013 FY 2013-14 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 CICIP providers: the CICIP Disproportionate Share Hospital Payment and the CICIP 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
<p>CICIP 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.</p> <p>For federal fiscal year (FFY) 2010-11, the final DSH cap, after inclusion of ARRA, for Colorado was equal to \$92,507,555. 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.</p>	<p>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.</p>	<p>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.</p>

Payment Type	Public Hospitals	Private Hospitals
<p>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.</p>	<p>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.</p>	<p>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.</p>

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 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 fiscal year (SFY) 2010-11, the Department received a final DSH allotment of \$92,507,555. For SFY 2011-12, this figure increased 2.4% based on the Consumer Price Index for All Urban Consumers (CPI-U) to a preliminary \$94,727,736.

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%.

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.

HEALTH CARE SERVICES FUND PROGRAMS

In 2006, SB 06-044 created the 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. SB 06-044 required 18% of the available funding to be distributed to Denver Health and Hospital Authority (Denver Health) and the remaining 82% to be distributed to clinics. Of the 82% 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 (FQHCs). The Health Care Services Fund Programs line item contains only the funding for Denver Health and the clinics operated by licensed or certified health care facilities. This line allows the Department to secure matching Title XIX funds for these programs using Upper Payment Limit financing. The Health Care Services Fund was funded by Referendum C General Fund moneys, which expired at the end of FY 2009-10. This line item was funded in HB 10-1378 and in FY 2011-12 through SB 11-219 with refinanced Tobacco Tax funding from the allocation to the Primary Care Fund.

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 transferring funding of the Children's Hospital Kid's Street and Medical Day Treatment Programs from the Department's Medical Services Premiums line item to the Pediatric Specialty Hospital. This was recommended because these 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.

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. In 2011, SB 11-216 "Children's Basic Health Plan General Fund Appropriation" moved this revenue stream

from the Pediatric Specialty Hospital Fund to the Children's Basic Health Plan Trust Fund, eliminating this line item effective FY 2011-12.

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. 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 General Fund.

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. 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.

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 that receive money from the Primary Care Fund, which was reallocated in FY 2009-10, FY 2010-11, and FY 2011-12 through HB 10-1321, HB 10-1378 and SB 11-219, respectively.

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANTS PROGRAM

The Comprehensive Primary and Preventive Care Grants Program was authorized by Sections 25.5-3-201 through 207, C.R.S. to provide 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.

During the 2011 Legislative Session, the General Assembly passed SB 11-216 "Children's Basic Health Plan General Fund Appropriation." This legislation moved the Tobacco Master Settlement Agreement revenue for this program to the Children's Basic Health Plan Trust Fund beginning in FY 2011-12 and eliminated the Comprehensive Primary and Preventive Care Grants Program.

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 (FPL). 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% 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. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund. However, there is no federal financial participation on the annual enrollment fees collected from families. 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 legislation 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 legislation 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.

During the 2011 Legislative Session, two bills were passed that altered Medicaid eligibility for children and pregnant women and changed the structure of the Children's Basic Health Plan. SB 11-008 increases Medicaid eligibility for children aged 6 through 18 with family incomes up to 133% FPL beginning in January 2013. SB 11-250 implements a federal mandate to expand Medicaid eligibility for pregnant women with family incomes from 134% to 185% FPL beginning in January 2013. Although the children and pregnant women newly eligible for Medicaid will receive standard Medicaid benefits, the Department will continue to receive federal funding through Title XXI and the enhanced 65% federal financial participation rate for their expenditures. The Department is working with the Centers for Medicare and Medicaid Services to convert its separate Title XXI program into a combination program that will allow this funding.

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 and a small amount of Tobacco Tax revenues.

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.

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) quality data. Beginning in FY 2012-13, the Department also administers, analyzes, and reports results from the Agency for Healthcare Research and Quality’s Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, as required by the Children’s Health Insurance Program Reauthorization Act of 2009.

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%

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.

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.

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.

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.

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.

(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 is 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 60 and ineligible for Medicaid. The Old Age Pension State Medical Program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the constitution and supplemental General Fund appropriations to ensure adequate funding.

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.

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 to the Department from the Department of Human Services, 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 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). 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.

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, since the Colorado Constitution caps the revenue deposited into the Old Age Pension Health and Medical Care Fund at \$10,000,000 annually. 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 cities and counties. 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. Funding in this line contains was 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.

SB 11-210 “Phase-Out Supplemental OAP Health Fund” gradually eliminated funding to the Supplemental Old Age Pension Health Care Program and Fund. Beginning in FY 2011-12, the Amendment 35 revenues usually appropriated to the Supplemental Old Age Pension State Medical Fund and then transferred to this line item were used to fund medical cost for Old Age Pension clients served in Medicaid. The Supplemental Old Age Pension Medical Care line item and Fund were abolished in July 2012.

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.

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 legislation 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.

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.

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.

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 Public School Health Services Program uses 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.

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 (MMIS). 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. Also included in this line item is funding for the Department's contract with Public Consulting Group, Inc. (PCG). PCG's scope of work includes planning and administering time studies to support the rate-setting methodology, training school staff, defining allowable cost, and providing assistance in the certification of public expenditures process.

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, personnel, and contracting costs. The Department of Education provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. The costs incurred by the two departments for administration 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.

(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 21 line items in the Department's budget within the DHS Medicaid-Funded Long Bill group. A description of each of the line items currently within the Department's budget follows.

All funding requests in this Long Bill group originate with DHS, 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.
- 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.
- 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.

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.

(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. 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. 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.

The Governor's Office of Information Technology (OIT) currently has oversight of daily operations for the vendor, Deloitte Consulting. However, both DHS and HCPF have CBMS funding appropriated to them because the two departments can claim federal funding from their federal government partners that, in turn, increases the total amount of funding available to OIT as reappropriated funding to cover CBMS expenditures.

COLORADO BENEFITS MANAGEMENT SYSTEM, HCPF-ONLY

Confusion has previously occurred about oversight and payment for Colorado Benefits Management System (CBMS) projects requested and funded only by the Department. To address this issue, the Department submitted S-12, BA-5 "CBMS Technical Adjustment for Fund Splits and HCPF Only Projects" in its January 3, 2012 budget submission, which was approved by passage of the Supplemental Bill HB 12-1184 to create this line item. The initial appropriation to this line contained CBMS funding for HB 09-1293 (Hospital Provider Fee) related projects, but the line item can be used for CBMS projects funded from other sources if the projects are

intended for the benefit of Medicaid and the Department, without benefit to DHS. Authorization for this line item can be inferred from 25.5-4-106, C.R.S. and 25.5-4-204, C.R.S.

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.

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 the FY 2012-13 Long Bill, 37.05% was the continued percent allocated to the Department.

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 funding from the Department's "Colorado Benefits Management System (CBMS) Medical Assistance Project" line item to combine with program funding from DHS for CBMS projects. 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.

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 the major DHS 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.

(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 the various DHS 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.

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.

(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.

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 will 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.

(E) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) was 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.

(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.

RESIDENTIAL TREATMENT FOR YOUTH

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 of ental Health Institutes line item). 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 physical and mental health medical care is covered beginning in FY 2006-07.

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. 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.

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.

ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION

The DHS appropriation was 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, Joint Budget Committee (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. All of the same functions are covered but under only one line item. The JBC approved this recommendation, thus, this line item is eliminated beginning in FY 2011-12.

ALCOHOL AND DRUG ABUSE DIVISION, HIGH-RISK PREGNANT WOMEN PROGRAM

This line item 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 through 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.

(G) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ADMINISTRATION

This line item supports approximately 90% of the total costs associated with 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 approximately 95% of operating expenses and 100% of the Support Level Administration costs.

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 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 8,000 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; supported employment; home modification; personal assistance; supported living consultation; and transportation. 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 rates based on an individual’s evaluated Support Level. In turn, the Support Level is based primarily on the Supports Intensity Scale (SIS) assessment tool. 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 generally result in higher Support Level assignments, which then drive higher payments in the Department of Human Services (DHS) rate structure. In addition to the SIS evaluation, two external factors – “Danger to Self” and “Community Safety Risk” – are considered when determining an individual’s Support Level.

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 CCBs to negotiate rates with their providers to get a better rate for each service. DHS used a bundled rate methodology to reimburse the CCBs 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 waived 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 CCBs. 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 their required service needs, and all providers must bill the State directly or through the CCBs. However, the CCBs 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 CCBs, 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.

An executive order was issued by the governor in the summer of 2012 establishing the Office of Community Living within the Department. The general purpose for the Office is to help meet the growing need for long-term services and supports by people with disabilities and aging adults.

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 Intellectual Disabilities (ICF/ID).

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.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item 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 based accounting method used by the Department and the accrual based 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.

(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.

(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.

(J) OTHER CONTRACTUAL SERVICES

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS 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 §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 on 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 a portion of the costs for Payment to Risk Management and Property Funds in the Executive Director’s Office at the Department of Human Services (DHS) and 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.