DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
HEALTH AND ADMINISTRATIVE DIVISIONS

FY 2010-11 JOINT BUDGET COMMITTEE HEARING AGENDA

Thursday, January 6, 2011
9:00 am – 12:00 pm

9:00-9:25 INTRODUCTIONS AND OPENING COMMENTS

9:25-9:45 QUESTIONS COMMON TO ALL DEPARTMENTS

1. Please identify your department's three most effective programs and your department's three least effective programs, and explain why you identified them as such. How do your most effective programs further the department's goals? What recommendations would you make to increase the effectiveness of the three least effective programs?

   Response: By way of background, this is the list of goals in the strategic plan.

   The Colorado Department of Public Health and Environment aims to achieve its vision and accomplish its mission through these six key goals:

   1. Build a strong public health system
   2. Maintain an effective climate change strategy
   3. Encourage and lead Coloradans to healthier lifestyles from birth to old age
   4. Maintain an effective public health and emergency response system to address communicable disease, epidemics, and other public health and environmental problems
   5. Protect and improve air and water quality across the state
   6. Eliminate health inequities in Colorado

   List of programs

   Effective:

   1. Health Surveillance Activities
   2. Retail Food
   3. Immunization

   Ineffective:

   1. Master Settlement Oversight Annual Report
   2. Mattress and Bedding
   3. Water Quality Improvement Fund

Program Descriptions:

Most Effective

1. Health Surveillance activities

The Department collects data about a wide range of health conditions and risks across the lifespan of Coloradans. This furthers the Department's goals to: build a strong public health system; maintain an effective public health and emergency response system to address communicable disease, epidemics, and other public health and environmental problems, and; eliminate health inequities in Colorado.

Registry and survey data are collected by the Center for Health and Environmental Information and Statistics Division, which collects, analyzes, and disseminates information from the birth and death registries, the Pregnancy Risk Assessment Monitoring System, the Colorado Child Health Survey and the Behavioral Risk Factor Surveillance System.

The Communicable Disease Epidemiology Program maintains and supports the statewide communicable disease reporting system, which includes all of the conditions responsible for epidemic and communicable diseases affecting the public health of Coloradoans. This includes such infections as influenza, pertussis, hepatitis, and zoonotic diseases (e.g., rabies, plague, Hantavirus). Zoonotic disease surveillance, investigation and control are highly technical and involve low frequency but severe (potentially lethal) diseases. Through a State Public Health Veterinarian and a specialized epidemiologist in this area, the program maintains highly effective capability which local public health agencies, other state agencies, healthcare providers, veterinarians, and the public depend upon for these services.

The health information collected by the Department is used extensively by public health practitioners at the state and local level, researchers and students, community and faith based organizations, the media, and policy makers to:

- control communicable disease outbreaks and epidemics;
- monitor health trends;
- identify groups at risk for health problems;
- prioritize health issues;
- develop programs and policies; and
- evaluate the effectiveness of strategies designed to promote health.

The information is also used to pinpoint health disparities so that appropriate action can be taken to address these disparities.

2. Retail Food

The state's Retail Food Program is coordinated and overseen by the Department. This program is administered statewide and helps ensure a safe food supply is available to and provided in the 20,000+ restaurants and grocery stores throughout Colorado. Administration of the program includes in part:

- Ensuring an appropriate statutory and regulatory framework exists;
- Promulgating regulations that are uniform to national guidelines;
- Developing and implementing programmatic standards and guidelines for local public health agencies (LPHA);
- Developing and deploying trainings to ensure an appropriately trained statewide workforce is maintained, and;
- Providing uniform interpretation and application of all program laws, rules, regulations, guidelines, and standards to LPHAs and industry.

The Department collaborates directly with 36 local public health agencies and 220 inspectors who provide services in their jurisdictional areas. Additionally, the Department conducts the regulatory activities within ten (10) counties in the State that currently do not have the infrastructure to do so themselves. This cooperative and collaborative effort helps not only maintain a safe food supply but also helps in achieving the Department's strategic directions #2 Strengthen Partnerships To Improve Health and Environmental and # 3 Break Down Silos By Strategically Integrating Department Functions To Protect and Improve Public Health and the Environment.

3. Immunization Program

The Immunization Program has the dual responsibilities of preventing vaccine-preventable diseases and improving the immunization coverage rates primarily of children less than two years of age. The immunization program distributes more than 3.6 million doses of vaccine to public and private providers for administration to Colorado residents. This becomes a safety net throughout the state that assures vaccine is available at local providers for children who are uninsured, on Medicaid, or have limited access to health care.

The immunization program also includes implementation of the Colorado Immunization Information System (CIIS), Colorado's immunization registry, which directly supports CDPHE's first key objective of building a strong public health system. CIIS provides clinical decision support to all participating providers for vaccine administration through forecasting needed vaccinations and/or recalling patients overdue for vaccinations; serves as a centralized repository of consolidated patient records for authorized providers, such as

physicians and schools/colleges to assure appropriate and timely vaccinations; and tracks and manages public and private vaccine inventory. This system allows providers efficient access to the current immunization record for their patients, even if patients have seen multiple providers. With this information, providers can avoid over-vaccinating, thereby reducing health care costs, or missing a vaccination opportunity and potentially leaving the patient unprotected. Individuals may access their own immunization information by providing a notarized form.

Through the Colorado Adult Immunization Coalition (CAIC), the program connects providers with critical clinical information and promotes vaccination among adults. This includes vaccinations to protect adults from influenza, pneumococcal disease, tetanus, and pertussis. This component of the Immunization Program not only protects adults, but also reduces the potential risk of disease transmission to children and infants, particularly those that are too young to be vaccinated.

Recently, the Emergency Preparedness and Response Division, and the Immunization program worked together with Larimer County Public Health, Health District of Northern Larimer County, Colorado State University (CSU) and Centers for Disease Control and Prevention officials to help vaccinate more than 10,000 CSU students, staff and family members in November 2010. The effort was in response to an outbreak of meningococcal disease that has sickened eight people in the area, resulting in five deaths.

Most Ineffective

1. Tobacco Master Settlement Oversight Annual Report

By statute CDPHE is tasked with monitoring and oversight of the tobacco master settlement funds that are distributed to a variety of departments and programs statewide. This includes compiling an annual report of all the programs, which includes Read to Achieve, Nurse Home Visitor, and Children's Health Plan Plus, among others.

The tobacco oversight responsibilities primarily involve compiling a report of all tobacco master settlement programs for submission to the legislature. The report submitted by the Department is a summary of the reports received from individual programs.

This responsibility does not add to the strategic direction of the Department. Instead, this oversight responsibility requires the Department to prepare a summary of reports submitted by all other state programs that receive Master Settlement dollars. The Department receives about $28,000 per year for this oversight process. This is a small amount of money that is difficult to track – and adds an administrative burden to the Department to proportionately bill all of the programs for these costs. The funding does not allow the Department to do meaningful programmatic oversight, nor does the

Department have the authority to address programmatic issues were they to be identified. The statute does mandate that the state Auditor's office conduct audits of the Master Settlement programs and this may be a more value added activity. The reports submitted by the programs vary greatly from a bare minimum of a few paragraphs to reports more than 50 pages long. The Department does not have any authority to compel the other programs to submit standardized reports, therefore staff spend significant time and effort extracting information that allows for "apples to apples" reporting.

The Department recommends that this reporting requirement be abolished and the funding be kept in the individual Tobacco Master Settlement Programs, or as an alternative that the funds be transferred to the State Auditor's office to enhance the audit function of Master Settlement programs.

2. Mattress and Bedding:

The Department administers the manufacture and sale of mattresses and bedding statute, C.R.S. 25-5-302. The administration of this statute does not further the Department's goals because it only involves handling three or fewer complaints received each year. These complaints have been of very low significance to public health. Quality issues associated with the manufacturing and sale of mattresses and bedding appear to be resolved between the customer and the industry. There is no FTE or funding associated with this program.

3. Water Quality Improvement Fund

The Water Quality Improvement Fund (WQIF) also is ineffective due to the limited spending authority ($117,196 per year) and the inability to issue grants over multiple years. During the 2006 legislative session the Colorado General Assembly created the WQIF to provide grants to local communities/entities to improve water quality, health and safety. The source of revenue for the fund is penalties assessed on polluters who have committed water quality violations. In accordance with the statute the WQIF only "shall" be expended for the following purposes:

- Category 1: Improve the water quality in the community or water body impacted by the violation;
- Category 2: Fund storm water projects and assist with planning, design, construction, or repair of domestic wastewater treatment works; or
- Category 3: Provide the nonfederal match funding for nonpoint source projects.

All funds awarded during the grant cycle must be expended within the fiscal year. Due to the limited spending authority and the compressed grant period, only eight grants have

been awarded since the inception of the program despite significant need in Colorado communities.

Due to the small amount of funding available each year, projects that can be funded are small, limited scope projects. Although there is a significant need for water quality improvements and for the funds to finance construction and infrastructure projects, such as connecting homes with failing septic systems to centralized wastewater treatment plants or constructing storm water drainage systems, these projects are expensive, multiyear projects and can rarely be completed within one fiscal year. These programs, if implemented, could benefit the Department's goal to protect and improve air and water quality across the state.

Given these timing constraints, the Division feels this program is one of the least effective due to the amount of resources needed to implement the program and the resulting minimal environmental benefits achieved as a result of the grants. The Departments first choice would be to increase the spending authority for this program. As an alternative, the second choice would be to change the statute that directs the fines to this particular fund and return those fines to the General Fund.

The Department estimates approximately $800,000 in fines each year.

2. For the three most effective and the three least effective programs identified above, please provide the following information:

Response:

Effective

1. Health Surveillance Activities

a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each program;

The Department conducts surveys for and submits data to national programs funded by the Centers for Disease Control and Prevention (CDC). Local health agencies use the surveillance data to prioritize their efforts.

b. A statement of the statutory authority for these programs and a description of the need for these programs;

CRS 25-1.5-102 C.R.S and 25-1-122 C.R.S. Provides almost all of the health data that state and local health agencies use to identify trends and prioritize their activities, and includes the statewide communicable disease reporting system, and zoonotic disease surveillance

investigation and disease control.

c. A description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities;

- Prepare birth and death records for statistical searches (70,000 births/year, 30,000 deaths/year within six months of yearend).
- Conduct at least three surveys per year (15,000 respondents) to obtain enough samples for statistically valid results.
- Maintain an online query system for statistical searches (1,000 searches per year, 99% availability).
- Prepare detailed data files for health programs and counties (20 data files prepared monthly within one week of month end)
- Prepare research briefs on 10 current topics of interest per year.
- Receive disease reports by fax, phone and electronic reporting
- Review disease reports for completeness and validity
- Contact health care providers as necessary to obtain essential information.
- Contact to Local Public Health Agencies (LPHAs)to immediately notify for 24-hour reportable disease reports
- Notify program epidemiologists of prioritized disease reports
- Provide CEDRS (Colorado Electronic Disease Reporting System) user support to LPHAs and hospitals
- Manage active user lists and provide new user access to CEDRS
- Create and transmit weekly disease report file to CDC for national reporting
- Measures: in FY2010, there were 11,768 disease reports submitted
  - Animal surveillance – arrange for testing at (primarily at the CDPHE state lab)
  - Investigation of disease reports directly or indirectly with Local health departments (LPHAs)
  - Recommendation of disease control measures
  - Providing technical assistance to LPHAs, other state agencies, healthcare providers, veterinarians
  - Developing and maintaining partnerships with other state agencies and organizations to develop/implement strategies to accomplish control of communicable diseases

d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and

- Maintain staffing to manage reporting system and provide technical expertise

- Conduct surveys.
- Maintain online query system, and electronic disease reporting system.

e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.

- Health Statistics $1,200,000 (Cash and federal funds) 13 FTE
- Communicable Disease Reporting System: General and Federal Funds=$95,156 FTE=1.7
- Zoonotic Diseases: General and Federal Funds=$139,488 FTE=1.5

2. Retail Food

a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each program;

The Department provides statewide oversight to the thirty-six (36) Local Public Health Agencies (LPHAs) in Colorado that conduct retail food program activities within their jurisdictions. In order to establish and implement a uniform regulatory framework the Department is the only agency statutorily allowed to promulgate rules and regulations for the regulation of retail foods. The Department also provides program audits of local retail food programs, provides training of LPHAs staffs' and performs certification exercises with journey-level LPHA inspectors to ensure a uniform application and interpretation of the governing rules and regulations. No other state, local or federal agency performs these functions which are required by state statute.

Additionally, the Department conducts the regulatory activities within ten (10) counties in the State that currently do not have the infrastructure to do so themselves.

b. A statement of the statutory authority for these programs and a description of the need for these programs;

25-4-1600, et. seq. and 25-5-400 et. seq.

- Establishes minimum standards and rules for retail food establishments in Colorado;
- Provides authority for the uniform statewide administration, implementation, interpretation, and enforcement of the standards, rules and regulations;
- Ensures the safety of food prepared, sold or served in retail food establishments

- Identifies hazards and potential sources of contamination and take measures to prevent, reduce or eliminate the physical, chemical or biological agents in food prepared, sold or served in retail food establishments and;
- Improves the sanitary condition of all retail food establishments, reduces food-borne illness outbreaks and controls the spread of food-borne disease from retail food establishments.

c. A description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities;

- Promulgate rules for adoption by the state board of health for the uniform statewide administration, implementation, interpretation, and enforcement of this law to ensure a safe food supply in retail food establishments.
- Develop, implement and enforce uniform statewide standards of program conduct and performance to be followed and adhered to by employees of the Department and county or district boards of health;
- Provide technical assistance, equipment and product review, training and standardization, program evaluation, and other services necessary to assure the uniform statewide administration, implementation, interpretation, and enforcement of this part 16 and rules promulgated under this part 16
- Review and approve Hazardous Analysis Critical Control Points plans submitted for evaluation to verify and ensure that food handling risks are reduced to prevent food-borne illness outbreaks
- Conduct inspections, plan reviews, technical assistance, compliance and enforcement activities associated with the oversight of the retail food establishments in the ten (10) counties not covered by a LPHA;
- Grant or refuse licenses and certificates of license pursuant to the law or revoke licenses and certificates of license pursuant to the statute.

d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and

See table below.

e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.

Activity	FTE	Amount
Retail Food Activities:		Cash and General Funds
Local Assistance Program	2.5	$253,539
Training	0.5	$59,769
Inspections	6.0	$660,287
Standardization	0.9	$78,520
Survey	0.9	$72,311

3. Immunization Program

a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each;

The federal government via the Centers for Disease Control funds the vaccines.

- Locally, the Denver Health and Hospital Authority (DHHA) implements an immunization registry, VaxTrax, for all DHHA facilities and clinics. CIIS (Colorado Immunization information System) receives a weekly data file from VaxTrax for all immunizations administered during that week. Nationally, all states with the exception of New Hampshire have an immunization information system for their respective jurisdictions. Few state-to-state data sharing agreements are in place though all states have, or are developing, the technical capability to share data. No national immunization registry exists.

b. A statement of the statutory authority for these aspects and a description of the need for them;

- Statutory authority for the Immunization Fund is provided in the Infant Immunization Act (CRS §25-4-1708) and the Immunization Registry Act (CRS §25-4-2403). The need, as stated in the legislation, continues to be present: vaccine preventable diseases represent a serious public health threat to the people of the state of Colorado, and it has been well documented that vaccines are an effective way to save lives and prevent debilitating disease as every dollar spent on immunization, saves ten dollars in

later medical expenses. (Centers for Disease Control and Prevention. [1999a]. Ten great public health achievements. Morbidity and Mortality Weekly Report, 48, 241-264).

- Colorado Immunization Information System (CIIS): The passage of the 1992 Infant Immunization Act (CRS §25-4-1701, et. seq.) authorized the creation of a statewide immunization tracking system for Colorado infants and minors that is populated via Vital Statistics data. In 2007, the Immunization Registry Act (CRS §25-4-2401, et. seq.) authorized the collection of adult immunization information into the statewide immunization tracking system, the collection of data from multiple sources: public health, practitioners, clinics, schools, parents, legal guardians, or persons authorized to consent to immunization pursuant to CRS §25-4-1701, et. seq., individuals, managed care organizations or health insurance plans in which an individual is enrolled as a member or insured, hospitals, the Department Of Health Care Policy And Financing and persons/entities contracted with the state for implementation and operation of the immunization tracking system. The Immunization Registry Act also requires that individuals, parents, or legal guardians may remove such immunization information from the immunization tracking system at any time.
- Vaccine Data: CDPHE has statutory authority to review immunization records held by schools per C.R.S. 25-4-906(3), which states "The department of public health and environment may examine, audit, and verify the records of immunizations maintained by each school." Unfortunately, FERPA (Family Educational Rights and Privacy Act) has a higher authority than our state statutes and so limits our ability to review school immunization records. The statute is still needed as it provides the necessary authority to implement a survey of school immunization records that is in compliance with FERPA.

c. A description of the activities which are intended to accomplish each aspect, as well as, quantified measures of effectiveness and efficiency of performance of such activities;

- Request for applications (RFA) are developed to solicit for outreach activities and enhancement of vaccine delivery to increase immunization rates within a specific target population (in a public or private setting). These applications are reviewed against prescribed criteria and funds are awarded based upon need, feasibility, funding available if the criteria of the RFA are met. Special projects include:
- Clinics held in unique settings such as: a homeless shelter; a local food bank; in private homes within the Amish community; Interagency health fair; mobile clinic in a motor home park; Children's Festival at the mall; and elementary school cafeterias
- CIIS: As it is not legislatively required that providers utilize or submit data to CIIS, the program conducts marketing, outreach, recruitment and retention activities on an ongoing basis:

- CIIS maintains immunization records for 91% of 0 – 18 year olds and 30% of all adults 19 and older.
- 100% of public health and community health clinics, 84% of pediatric offices, 87% of rural health clinics, 64% of school districts, 55% of colleges/universities, 50% of family practice offices, and 27% of hospitals participate in CIIS.
- CIIS also receives data from State Vital Statistics, Medicaid, large pharmacy chains such as Safeway, Walgreens, Target and Walmart as well as HMO/insurance plans such as Kaiser Permanente, United Healthcare, Wellpoint and Rocky Mountain Health Plan.
- Vaccine Data: To assess if CIIS data can be utilized for vaccine analyses, the program is analyzing immunization status results from previous population studies and registry data. The results of this analysis will determine what thresholds of CIIS provider and patient participation are needed to identify where CIIS data is complete enough to use for valid data analyses. As the registry matures, it is expected that more counties will meet the participation thresholds and the areas where CIIS data is valid to use for vaccine analyses will increase. A measure of the effectiveness of this activity would be the number of counties where CIIS data can be used for valid vaccine analyses.
- The program is currently working to regain access to school immunization information. The award of an American Reinvestment and Recovery Act (ARRA) grant to develop and implement an innovative method to collect data from schools that is FERPA compliant will support this effort. A measure of the effectiveness of this activity would be the successful completion of the annual school immunization survey.

d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and

- Outreach, marketing, recruitment and retention of CIIS users
- Upgrade registry system
- Immunization data completeness, timeliness and accuracy
- Electronic exchange of data

e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.

- Outreach, marketing, recruitment and retention: 5 FTE and 4 part-time contract staff perform these duties and are funded with state funds.
- Upgrade registry system: 9.5 FTE and 4 part-time contract staff for one year. Personnel funded through state and federal funds. Registry application paid for with federal funds.

- Data completeness, timeliness and accuracy: 1 FTE and 1 contract staff person state General and federal funds.
- Electronic exchange of data: 1.5 FTE and 2 contract staff funded with state General and federal funds.
- Overall Personal Services appropriation is $2,568,977.

Ineffective

1. Tobacco Master Settlement Oversight

a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each program;

The state auditor's office audits master settlement programs as part of its ongoing audit cycle.

By Board of Health Rule, each master settlement program is required to develop an annual report specific to its program.

b. A statement of the statutory authority for these programs and a description of the need for these programs;

25-1-108.5. Additional powers and duties of state board of health and department - programs that receive tobacco settlement moneys - monitoring - annual report.

c. A description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities;

The Department gathers reports from all of the master settlement programs each year, reviews, and summarizes the reports into a master report for the General Assembly, Board of Health and the Governor. In mid December, the Department presents the report to the Board of Health and obtains their approval for the report and any recommendations for changes to the master settlement programs. The final report is submitted to the legislature by January 15, each year. The Department meets the objective of completing and submitting the report each year.

d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and

All activities currently performed need to be performed in order to meet the requirements of

publishing the report. If the report and oversight is no longer necessary, all associated activities can cease.

e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.

Approximately $28,000 (reappropriated funds) per year and 0.3 FTE. The duties are absorbed within the budget office staff. If these responsibilities are not required, then budget office staff will be redirected to other activities in the budget office. , This will allow budget Office staff to take on additional higher level responsibilities – such as programmatic reviews of departmental programs, or strategic planning.

2. Mattress and Bedding

a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each program;

There are no other agencies that administer same or similar programs.

b. A statement of the statutory authority for these programs and a description of the need for these programs;

Mattress & Bedding -25-5-302

c. A description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities;

The Division responds to inquiries on a case by case basis.

d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and

The Division responds to inquiries on a case by case basis, this is less than one or two cases per year.

e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.

This requires minimal effort – less than a couple hundred dollars per year.

3. Water Quality Improvement Fund (WQIF)

a. A statement listing any other state, federal, or local agencies that administer similar or cooperating programs, and outline the interaction among such agencies for each program;

There are other water and wastewater infrastructure financing alternatives within the State. However, grant funding has all but been eliminated due to the State's economy. There are low interest loans available through the Department's State Revolving Loan Fund, Department of Local Affairs' Energy Impact Assistance Fund (funding has been cut and/or eliminated over the last 12 months), and through the Federal USDA Rural Development.

b. A statement of the statutory authority for these programs and a description of the need for these programs;

The WQIF is authorized under CRS 25-8-608[1.5].

c. A description of the activities which are intended to accomplish each objective of the programs, as well as, quantified measures of effectiveness and efficiency of performance of such activities;

100% of funds awarded and expended within the required time frame and in accordance with state funding requirements.

d. A ranking of the activities necessary to achieve the objectives of each program by priority of the activities; and

- Notify potential applicants of funding available
- Issue grants and provide project oversight
- Administer grant funds in accordance with state statute

e. The level of effort required to accomplish each activity associated with these programs in terms of funds and personnel.

Currently there are no FTE provided to administer the WQIF. However 5% ($5,860) of the appropriation can be used for administration of the fund. This is a cash fund.

3. Detail what could be accomplished by your Department if funding for the department is maintained at the fiscal year 2009-10 level.

Response:

The following programs have not had significant changes to their appropriations from the 2009-10 final appropriation and the 2011-12 request (excluding the OIT and PERA adjustments.) Therefore service levels would be maintained if they were to be returned to the 2009-10 final appropriation:

- Air Pollution Control Division
- Water Quality Control Division
- Disease Control and Environmental Epidemiology Division.

The following programs/divisions do have a significant change between their appropriations from the 2009-10 final appropriation and the 2011-12 request (excluding the OIT and PERA adjustments.)

- If the appropriation for the Center for Health and Environmental Information and Statistics appropriation was returned to the FY 2009-10funding level, the Division would be unable to process the more than 111,000 medical marijuana applications it receives annually. This is a cash appropriation funded by the Medical Marijuana registry fee.

- The only change to the Laboratory Services Division appropriation is the request for FY 2011-12 Decision Item #2 Newborn Screening Laboratory and Genetics Counseling. If this Decision Item is not approved the state Laboratory will continue to provide the same services as in 2009-10. However, if the request is denied, Severe Combined Immunodeficiency Disorder (SCID) will not be added to the panel of newborn screening tests and follow-up confirmatory testing for Alpha Thalassemia will not be provided. Failure to add SCID to the newborn screening panel will mean that cases of SCID will not be detected in time for life saving and cost saving early intervention. Failure to add follow-up/confirmatory testing for Alpha Thalassemia will mean that parents and physicians will continue to receive a significant number of false positive results leading to unnecessary anxiety and medical expenses. This is a cash appropriation funded through the Newborn Screening and Genetics Counseling Fee.

- If the Hazardous Materials and Waste Management Division appropriation is returned to the FY 2009-10 funding level, the Division will be unable to fulfill its obligation to

maintain the Argo Tunnel Water Treatment Plant. Failure to fulfill this obligation will violate the state's agreement with the federal government and will result in increased pollution in Clear Creek. This is a cash appropriation funded through the Hazardous Substance Response fund. This funding changed from federal to cash in FY 2010-11.

- Returning to the FY 2009-10 appropriation would also mean that the Hazardous Materials and Waste Management Division, and the Administrative Services Division (Special Environmental Programs) would be unable to fulfill its statutory obligations under H.B. 10-1018 "Reduce waste tire stockpile risks." This is a cash appropriation funded through a fee when tires are purchased. This function was at the Department of Local Affairs in FY 2009-10.

- Consumer Protection Division: In FY 2009-10, the first half of the Retail Food increase due to a fee increase for the program was appropriated (SB 09-223 Retail Food Establishment Inspection). In FY 2010-11, the full Retail Food increase due to a fee increase was appropriated. Returning to the FY 09-10 appropriation for retail food would result in half of the surveys and standardizations being conducted as was projected on the original fiscal note. Therefore, service levels will not be maintained (eight standardizations and two program surveys fewer annually) if the appropriations were to be returned to 2009-10 final appropriation.

- If the Prevention Services Division appropriation of the tobacco excise tax cash is returned to the FY 2009-10 funding level, the Division would be able to reach 2,535,116 more people with tobacco prevention and cessation efforts and 25,998 more people through the cancer, cardiovascular disease and chronic pulmonary disease prevention grants. This is a cash appropriation funded with the tobacco excise tax. Due to fiscal emergency, the money has been transferred to the Department of Healthcare Policy and Financing to fund medical services as allowed by the State Constitution.

- If the Health Facilities and Emergency Medical Services Division appropriation is returned to the 2009-10 funding level, the Division would be unable to fulfill its statutory obligations around licensure of a variety of health facility types including hospitals, ambulatory surgical centers, hospices, nursing homes and home care agencies, among others. This is a cash appropriation funded with fees paid by licensed facilities.

- If the Emergency Preparedness and Response Division appropriation is returned to the FY 2009-10 funding level, then the Division would not be able to provide for the required federal match with Division funds. The required match was 5% for FY 2009-10 and is 10% for FY 2010-11 and out years. The FY 2009-10 of $876,000 in General Fund leveraged approximately $17 Million in federal emergency preparedness funds. This required match is $1.75 million for FY 2010-11 and future years. This is a General Fund appropriation.

- If The Administrative and Financial Services Division appropriation is returned to the FY 2009-10 funding levels there would be an impact to the legal services and leased space appropriations. The legal services appropriation has been adjusted by special bills and a FY 2011-12 Decision Item. The leased space appropriation was adjusted due to annualization of FY 2009-10 Decision Items, as well as a lease escalator that is included in the lease contract. In addition, there are adjustments to POTS (central appropriations) and common policy lines that would be impacted. Finally, the Health Disparities Program Grant line would be able to provide more grants in FY 2011-12 than what is currently in the request.

4. How much does the department spend, both in terms of personnel time and/or money, dealing with Colorado WINs or any other employee partnership group? Has the level of resources dedicated to this effort changed in the past five years?

Response:

The governor signed the executive order to create employee partnerships in November 2007.

In 2008, the department engaged in the following activities:

- Building Access – CDPHE staff revised the policy that addresses building access by outside parties for the purpose of defining when and where COWINS representatives could engage our employees in discussions about union matters. This involved four managers working on the revised policy for approximately two hours each. (8 hrs @ $50/hr = $400)
- Eligibility – CDPHE staff identified covered employees v. those exempted from joining COWINS because of management level responsibilities. This involved senior management input and the human resources office reporting names to the governor's designee, and HR staff establishing a code in the central payroll system (CPPS) to indicate the category for each CDPHE employee. (.5 hr for 10 mgrs @ $50/hr = $250, 4 hrs for HR Director = $200, 6 hrs for HR staff @ $20/hr = $120. Total = $570)

- Election - The human resources manager was involved in writing communications (i.e., newsletters and broadcast messages) for employees as well as for keeping management informed through meetings and emails regarding the election of COWINS as the official employee organization for this agency. (6 hrs = $300)
- MOU – Three managers provided input on the draft MOU between COWINS & the Governor's Designee numerous times. To date, an MOU has not been completed. (12 hrs = $600)
- Total costs for 2008 = $1,870

In 2009, the Department engaged in the following activities:

- COWINS Meetings – The Department's human resources director attended meetings of CDPHE employees who were COWINS members and consulted with them by phone. She discussed grievances, furloughs and soliciting employees at work during the meetings, and answered various other questions about the COWINS authority, activities, etc. (10 hrs = $500)

In 2010, the Department engaged in the following activities:

- Problem-Solving Session - In early July, four members of the CDPHE senior management team took part in a problem-solving session with COWINS representatives to develop a communications piece for employees regarding an indoor air quality issue at the Department's main campus in Cherry Creek. Although agency officials had been working on this matter for several months prior to involving the employee organization, COWINS representatives were invited to help craft the message to be sent to all employees about the efforts of the Department. (4 managers @ $50/hr for 6 hrs = $1,200 & 4 employees @ $30/hr for 6 hrs = $720. Total = $1,920.)

In addition to these activities involving select CDPHE managers, we have six employees who have utilized administrative leave for COWINS activities between 10/1/2008 through, 12/15/2010. The total hours of administrative leave for these employees is 218.25 ($30 x 218.25 = $6,547.50)

Grand total = $10,837.50 for 2008 through 2010.

9:45-10:45 QUESTIONS ASSOCIATED WITH THE ADMINISTRATIVE AND HEALTH DIVISIONS

GENERAL QUESTIONS

5. General Fund Pie Chart

    a. How many people are served by each of the General Fund programs in the chart on page 10 of the JBC staff briefing document? Please provide as much information as is available.

    b. What additional funding sources are used to support the programs in this chart?

Response:

1). A) The majority of the $259,664 in common policies is in the Office of Information Technology lines. This funding was moved from program lines in FY 2010-11 to the central OIT lines in order to cover the costs of information technology activities (staff and network costs, etc) for General Funded programs such as immunization, family planning, disease control, etc.

B) Common policies are funded by cash, federal and reappropriated sources in addition to the General Fund. Each specific source of funds is appropriate for the activities paid for when the Department is billed for the common policies (OIT for example).

2). A). The $4,500 in Board of Health funding covers the stipends for the nine Board of Health members to attend and participate in meetings (usually monthly).

B) There is no other source of funds for the Board of Health stipends

3). A). The $57,109 in the Office of Health Disparities does not provide direct services; therefore, it is not feasible to provide a specific number of people served. The General Fund appropriation to the office is specifically dedicated to a minimal amount of personal services and operating. The program has a statewide reach, concentrating its efforts on racial and ethnic minority populations experiencing health disparities and those systems and organizations serving those populations, in order to eliminate racial and ethnic health disparities. The Office staff works to educate the public as well as public serving organizations by collecting, publishing and presenting health disparities data and providing trainings on health disparities elimination strategies, cultural and linguistic competence, building community partnerships and addressing the social determinants of health. In addition, the office staff works towards positive system change by providing capacity

building and coordinating strategic planning efforts at the Departmental, community and state level. Staff coordinates the Minority Health Advisory Commission, the Interagency Health Disparities Leadership Council and the Recruiting and Retaining Youth of Color into the Health Professions Task Force.

B). The Health Disparities program is also funded by Amendment 35 Tobacco Tax dollars.

4). A). The $6,514,579 for distributions to local public health agencies benefits the entire population of Colorado, as well as the visitors to our state, therefore serving more than 5 million people. For example, in a state that heavily relies on tourism, insuring that food is safe to eat is a direct benefit to all residents, seasonal residents and tourists.

While the General Fund appropriation for distributions to Local Public health Agencies is significantly larger than the other General Funding to CDPHE, the funds are essentially pass-through funds distributed over all of the 64 counties through a funding formula approved by the Board of Health. The amount allocated to each Local health agency is based on the population and level of services provided. The amounts range from a low of $8,888 for a county with a population of 562 to $1,310,157 for a three county district agency serving a population of 1,305,855.

The purpose of the Distributions to Local Public Health Agencies funding is to assure that all residents of the state have basic public health services. Different counties have different population characteristics and therefore different needs. The funds are intended to be used to respond to these differing county level needs. As part of the requirement to receive the funding, each local public health agency must develop a funding plan. In addition to this state General Fund support, local health agencies seek additional funding from other state grants; local fees and other sources; federal grants; private foundations and other sources to fund their activities. One of the other sources is the Tobacco Master Settlement funding. The state General Fund support has been critical for agencies that have already faced significant cuts at the local level. In addition to reductions in local, private and federal funding, master settlement tobacco funds have also occurred in recent years.

B). The distribution to local public health agencies funding is not for programs within CDPHE, but rather for distribution to the local public health agencies in the state. In addition to the General Fund, there is also some funding from the Tobacco Master Settlement funds which is distributed in the same funding formula to local public health agencies. The additional funding that local public health agencies use may include a combination of the following: other state grant and contracts, federal funding, local contributions, license fees, Medicaid/Medicare reimbursements, clinical fees, non-clinical fees and fines and private foundation funding.

5). A). The $1,068,112 General Fund allocated to the laboratory is used for testing services that benefit the entire population of the State. These funds support outbreak response and surveillance activities. Programs include the Zoonosis, Serology, Public Health and Molecular Science program's efforts that are not fully covered through federal fund allocations and cannot be addressed by charging cash fees. The General Fund also supports Milk testing to comply with the pasteurized milk ordinance, ensure milk and milk products are safe, and allow milk and milk products to be sold within the state and across state lines.

The laboratory utilized the General Fund allocation to perform the following tests in FY2009-10:

ZOONOSIS:	Total Tests	Positives	Comments
ZOONOSIS:			
Rabies	907	121	330 w/bite exposure
Plague	18	3	
Tularemia	50	1	
West Nile Virus (Animal tests, mosquitoes, horses)	580	0	Federal Funding supported tests not included etc.
OUTBREAK/SURVEILLANCE:			
Foodborne Illness	2009	929	Salmonella, E. coli 0157, Shigella
Tuberculosis	1113	91	Costs not fully covered by FF
SEROLOGICAL:	13,538	285	Hepatitis, HIV, Hantavirus, measles, mumps, WNV (human). Costs not fully covered by FF
RADIOCHEMISTRY:	1,039	N/A	Includes gross alpha/beta and radium testing – required water testing
MILK:	6,605	N/A	Testing and milk industry laboratory certifications mandated by FDA for milk exporting

B). Limited federal funds are used to partially support zoonosis testing (West Nile Virus only,

The federally funded portion is not included in the numbers above), outbreaks and surveillance testing, and some serological testing (Hepatitis C and HIV). Cash fees also support some serological testing. Radiochemistry generates small cash revenues. The milk testing and laboratory certification program does not receive any funding from cash or federal sources.

6). A). The $774,147 in General Disease Control and Surveillance serves the entire state of Colorado as follows:

- The statewide disease reporting system monitors the incidence of communicable diseases among the population statewide and helps identify outbreaks of communicable diseases statewide so that appropriate public health investigation and disease control can be implemented to protect the health of all persons in Colorado.
- Zoonotic (animal-related diseases) disease activities for this very specialized communicable disease area include surveillance, investigation, and disease control statewide. Animal reservoirs (e.g., rabies, plague and tularemia in rodents and other mammals) are also monitored to identify geographic areas of increased human health risk so that prevention measures can be implemented to protect the health of all persons in Colorado.
- Purchase and distribution to local public health departments of immune globulin to control the spread of hepatitis A.
- Hepatitis C prevention, referral and screening services.
- The delivery of prevention case management to clients diagnosed with HIV infection that may spread the infection to others.
- The provision of neuropsychiatric and substance abuse evaluations as called for in the public health procedures for persons with HIV infection that are a danger to others (C.R.S. 25-4-1406(3) (2)).
- The collection, data entry and verification of disease reports of HIV infection, gonorrhea, syphilis and Chlamydia from physicians and/or laboratories.

B). General Disease Control and Surveillance – Federal grants help to enhance some of these programs. Federal funds cannot replace the essential role of General Fund in maintaining core public health activities. For zoonotic diseases, there are no other funds available to support this important public health activity.

Federal funds support an FTE for education and outreach programs, viral hepatitis surveillance, special studies, and case management of pregnant women who are infected with the hepatitis B Virus. Federal funds do not provide support for public awareness and prevention activities, counseling, testing and referral for hepatitis C.

7.) A). The $1,478,070 in Immunization funds serve the entire state of Colorado as they help to ensure that as many Coloradans as possible are appropriately immunized against vaccine preventable diseases. Un- or under-immunized persons can be indirectly protected, in part, when they are surrounded by fully immunized persons.

- Implementation and operation of the Colorado Immunization Information System (CIIS), Colorado's statewide immunization registry. CIIS is a secure, population-based electronic system that collects and disseminates consolidated immunization information for Coloradans of all ages. CIIS enables healthcare providers to track immunizations a person has received, even if the immunizations were administered by multiple providers, thereby maintaining an ongoing and complete record to ensure that persons receive all recommended vaccine in a timely manner. Currently, 91% of all 0 – 18 year olds and 36% of adults 19 years and older have a record within CIIS. Please see the response to question 1 above for more information.

B). Immunization – Federal grants help to enhance these programs. Federal funds cannot replace the essential role of General Fund in maintaining this core public health activity. For CIIS, one-time federal funds have been received through ARRA.

8). A). The $1,385,850 in AIDS Drug Assistance Program is used to support the distribution of formulary medications through the AIDS Drug Assistance Program (ADAP). In FY 2009-10, ADAP provided medications to 1,879 uninsured people living with HIV or AIDS at an average annual per-client cost of $6,861.

B). AIDS Drug Assistance Program (ADAP) – In addition to the General Fund appropriation, ADAP is supported by funds from the Tobacco Master Settlement Agreement and federal sources (the U.S. Health Resources and Services Administration)

9). A). The $1,314,739 for the Tuberculosis control and Treatment Program serves the entire population of the state of Colorado. The program receives reports of suspected and confirmed cases of tuberculosis from physicians, laboratories and hospitals and ensures that all cases are isolated until no longer infectious and that they receive adequate treatment to cure the disease. The TB program supplies medications to treat active cases of TB and ensures that all TB cases with infectious, pulmonary disease receive directly observed therapy. The TB program also provides consultation and oversight of contact investigations. The purpose of contact investigations is to identify additional cases of active TB and to evaluate and treat those persons who have become infected with TB.

B). TB Program receives federal funding from two additional sources: 1) CDC Division of TB Elimination cooperative agreement and; 2) CDC Preventive Health and Health Services grant. The federal funds received are used to enhance TB program activities. Federal funds alone are not sufficient to maintain the core activities of the TB program. For example, the

purchase of TB medications is not allowed with federal funds, without General Funds the medications necessary to cure TB and prevent its transmission throughout the population of Colorado would not be available.

10) A). The $118,480 for birth defects monitoring and prevention program served 13,831 children who were reported to the Colorado Responds to Children with Special Needs (CRCSN) program.

In the previous fiscal year (7/1/2009-6/30/2010) there were 68,561 live births (statewide) monitored in Colorado. Of those live births, 13,831 children were reported to the CRCSN program as having a birth defect that met the reporting criteria. Of those children that met the selection criteria, further screening indicated that 3,370 at-risk children needed to be referred to the Health Care Program for Children with Special Needs for early intervention services. These early intervention services are provided by the public health nurses in the 64 counties in Colorado.

B). Fees from issued birth certificates and federal funding from the Centers for Disease Control and Prevention (CDC) provide additional support to the Program. This additional funding allows Colorado Responds to Children with Special Needs (CRCSN) to conduct routine statistical monitoring; conduct public health program evaluation; establish baseline rates, establish rates by demographic and other variables; and monitor outbreaks and cluster investigations, time trends, capture-recapture analysis, observed versus expected analysis, and epidemiologic studies. CRCSN also screens for recurrence prevention notification of families with a previous neural tube defect affected birth and provides information on recommended folic acid consumption for future pregnancies.

11). A). The $220,939 in the cancer registry program serves the entire population of Colorado. The Colorado Central Cancer Registry (CCCR) receives cancer case reports from hospitals, physicians, outpatient treatment facilities, and pathology laboratories. Each year the registry adds about 23,000 newly diagnosed cancer cases in Colorado residents; that number is expected to climb to 35,000 by 2020. CCCR estimates that Colorado currently has close to 200,000 cancer survivors.

The CCCR is charged with monitoring cancer trends across the state including new cases diagnosed and deaths due to cancer. Data collected by CCCR is used in cancer research studies. In addition to monitoring cancer trends, the CCCR uses its data to:

- Answer the public's questions and concerns about cancer
- Confirm cancer diagnoses for Colorado residents filing claims under the federal Energy Employees Occupation Illness Compensation Program
- Inform health professionals and to educate citizens regarding specific cancer risks

- Focus cancer control activities in the state, ensuring that resources are directed to areas of the state or specific populations in need of services
- Develop health services and screening programs and to monitor outcomes.
- Monitor the effectiveness of treatment

B). Federal funds, for which the General Fund meets the maintenance of effort requirement.

12) A). The $285,591 in the suicide prevention program funds grantee trainings, educational material distribution, presentations, calls to the suicide Lifeline and media coverage of the Office of Suicide Prevention (OSP). A conservative estimate is that the OSP reached between 50,000 and 75,000 people last fiscal year. The OSP funds two evidence-based training programs designed to teach community members how to recognize suicide warning signs and how to properly intervene with a suicidal person. Question, Persuade, Refer (QPR) is a basic, 90-minute training and Applied Suicide Intervention Skills Training (ASIST) is intensive 2-day training. Last fiscal year, OSP's eight community grantees trained 625 Coloradans as gatekeepers. The Pueblo Suicide Prevention Center, with funding from the OSP, fielded 10,203 calls to their suicide prevention Lifeline last fiscal year. In addition, the following activities were accomplished by the Office:

- The OSP disseminated more than 12,700 informational and educational resource materials, including posters, bookmarks, fact sheets and brochures. Posters and other materials were requested by schools, churches, mental health centers, community centers and other agencies throughout Colorado.
- The OSP Program Manager conducted 31 presentations to 2,000 Coloradans last fiscal year.
- OSP information was handed out to the 3,000 participants of the Second Wind Fund walk in September 2009.
- The OSP responded to media requests throughout the year on television, radio, newspapers and on-line news sources.

B). The OSP currently receives federal funding from the Substance Abuse and Mental Health Services Administration for youth suicide prevention and intervention efforts only.

13). A). The $180,454 in the Oral Health programs For FY 10 Dental Assistance Program served 520 low income, elderly patients and homebound patients (this is a significant decrease as a direct result of the reduced funding)

B). Some federal funds and cash funds for the Dental Loan Repayment Program.

14). A). The $1,625,053 in the Women's Health Family Planning program provided family planning services to 60,739 primarily low income men and women across Colorado. Preventive health services provided with Family Planning funds include comprehensive

histories and physical exams, breast and cervical cancer screenings, laboratory testing including pregnancy testing, screening for sexually transmitted infections, provision of contraceptive methods (IUDs, contraceptive implants, birth control pills, patches or rings etc.), and health education and counseling. During 2009, the Title X Family Planning Program which includes federal, state and Colorado Family Planning Initiative funding provided family planning services to 60,739 primarily low income men and women across Colorado.

B). Federal and private. General Fund is expected to provide a match for the federal waiver that is in the final stages of discussion with the federal CMS.

15). A). The $132,430 in the Interagency Coordination Program provided services for more than half of Colorado's 1.2 million children and youth. The Program implements C.R.S. 25-20.5-101-109 requiring coordination among forty-two prevention, intervention, and treatment programs for children and youth across six state departments (Education, Human Services, Public Health and Environment, Public Safety, Revenue and Transportation) to ensure collaboration across programs and the availability of a continuum of services for children and youth. The total budget of these programs from all funding sources in FY 2008-09 was $250,421,285 and these funds provided services for more than half of Colorado's 1.2 million children and youth (ages 1-18).

In addition, the Program facilitates multiple collaborative efforts addressing children and youth issues across nine state agencies (Education, Health Care Policy and Finance, Human Services, Public Health and Environment, Public Safety, Revenue, Transportation, Military and Veterans Affairs and Judicial). The increase in collaborative activities within and across departments strives to create more efficiencies and less duplication of efforts for the purpose of improving outcomes for children and youth and maximizing the investment of state and federal funds. Between FY 2004 and FY 2010, the work of the Interagency Prevention Systems Program was leveraged to acquire over $30 million in federal grants for children and youth prevention and intervention programs throughout the state.

B). The program receives no other funding for coordination.

16). A). The $998,779 in the School Based Health program provided 41 school-based health centers with funding from the Colorado Department of Public Health and Environment's School-Based Health Center Program In the 2009-10 school year, Statewide, 26,296 children and youth were served through more than 84,000 visits; including more than 20,000 visits for mental health care.

B). In addition to the General Fund dollars, the School-Based Health Center Program has received a portion of the federal Maternal Child Health Block Grant funding that is awarded to the CDPHE and also had a one million dollar grant from The Colorado Trust which ended in December 2010.

17). A). The $2,543,598 in the Health Care Program for Children with Special Health Care Needs (CSHCN) program Served 146,044 children in FY 2009-10. This is an estimate of CSHCN served. These figures may be duplicated as a child may be served with multiple services. The numbers served break down the following way by type of service:

- Children served with Newborn Screening, both Newborn Hearing and Newborn Metabolic screening – 69,041. The number represents total newborn population for calendar year 2009. The CSHCN unit is responsible for the administration of both population based screening programs.
- Children served with care coordination - 7,018. Local CSHCN) offices provide resource and referral information to families who have children with special health care needs. The number represents the number of families who received this information and/or some additional assistance in accessing resources/referrals.
- Children served with Developmental and Evaluation Clinics – 395. These clinics are held in rural areas where a team of professionals works to provide a comprehensive diagnostic medical evaluation of a child with suspected special needs.
- Children served with Specialty Clinics – 1,233. These clinics are held in rural areas where medical specialists and diagnostic services are not readily available to families and providers. Specialty clinics include cardiology, orthopedics, otolaryngology, pediatrics and rehabilitation.
- Children served with Local Systems Development – Total 68,357. Local HCP [okay if identified above] offices provide assistance for children with special health care needs ages 12-17 as they 'transition' from pediatric providers to adult health care and independent living. Estimated # of CSHCN served with local systems work for Transitions (12-17) – 39,357.
- Local HCP offices collaborate with Early Intervention Colorado (Part C) to transition children with special health care needs into preschool. Estimated # of CSHCN served with local systems work for Early Intervention/Early Childhood for ages 0-5 – 29,000

B). Federal funds, for which GF provides the match.

18). A). The $266,495 Health Facilities Licensure program

This funding is appropriated for three purposes:

1). Health Facilities General Licensure $77,708
2). Assisted Living Residences Licensure $110,250

These programs serve the entire population of Colorado. Eighteen types of health facilities defined in statute must be licensed by the Department to operate in Colorado. Licensure

involves evaluating and assuring the quality of care, health, and welfare of persons receiving services from licensed facilities, by reviewing facility operating and ownership information submitted via an application, conducting on-site inspections to verify compliance with healthcare and welfare standards, investigating complaints and facility-reported incidents, providing technical assistance to licensees and information to the general public, and taking enforcement actions when other remedies do not resolve long-standing, serious deficiencies.

3). Health Care Acquired Infections Reporting $78,537
The Health Care Acquired Infections (HAI) program serves all residents of Colorado who receive surgical or other invasive procedures (such as dialysis or insertion of central lines). HAIs are infections that occur during or after treatment in a healthcare facility for a medical condition other than the infection. HAIs are commonly transmitted when infection control procedures are inadequate or not followed. Medical staff who move from patient to patient without using appropriate infection control practices serve as a means for spreading pathogens. Other reasons for infection include (but are not limited to) patients with weakened immune systems, patients with long hospitalizations that make them more susceptible to infections, and some medical procedures which bypass the body's natural protective barriers. Medical complications can range from a simple infection to amputations, other permanent disabilities, and death. The HAI statutes require hospitals, ambulatory surgical centers, and renal dialysis centers to report health care acquired infections rates and data to a national data base operated by the federal Centers for Disease Control. The HAI program uses this data to produce annual reports, and bi-annual summaries of comparative infection rates among participating Colorado facilities for various medical procedures.

B). Health Facilities General Licensure – Additional funding sources are licensure fees charged to these facilities, with the exception of government-owned facilities which are exempt from paying fees. Statute directs that no appropriation shall be made out of the health facilities general licensure cash fund for expenditures incurred by the Department in carrying out duties relating to health facilities wholly owned and operated by a governmental unit or agency [25-3-103.1 (2) C.R.S.]. Accordingly, the Department does not charge licensure fees to government-owned facilities, although it incurs licensure costs for these facilities. The General Fund appropriation provides offset to these costs for hospitals and ambulatory surgery centers.

Assisted Living Residences Licensure -- Additional funding sources are licensure fees charged to these facilities. In addition to offsetting costs for government-owned ALRs this General Fund appropriation also recognizes that assuring resident safety and consumer protection is part of the general business of the state.

Health Care Acquired Infections Reporting – The Department received a federal ARRA grant to more fully develop the state's reporting system and provide technical assistance to

facilities required to monitor and submit health care infections data. This is one-time funding which ends December 31, 2011.

19). A). The Inspections for CMS (Medicaid) Net GF $1,346,798 the General Fund component of Medicaid funding transferred from the Department of Health Care Policy and Financing (HCPF) for the inspection of healthcare facilities and providers serving Medicaid clients. State funding participation, at rates specified by federal regulation, is mandatory for the state to be able to draw the related federal Medicaid funds. Medicaid certified facilities/providers include nursing homes, home health providers, personal care providers, adult day care providers, assisted living residences, group homes for the developmentally disabled, intermediate care facilities for the mentally retarded, and providers of specialized services for specific client needs such as children with autism and persons with brain injuries. Inspections focus on quality of care, patient health and welfare, and fraud detection, and are part of HCPF's Medicaid quality assurance plan. Inspections are required annually by federal regulation for nursing homes and intermediate care facilities for the mentally retarded, and at varying intervals of one to three years for other facilities/providers as set forth in state Medicaid rules.

B). No other funding sources (other than the matching Medicaid federal funds) are used to conduct the Medicaid portion of an inspection. However, when an inspection is conducted for more than one purpose – e.g. for both Medicaid and Medicare certification, or Medicaid certification and state licensure – the inspection costs are paid proportionally by each program.

20). A). The $1,421,442 in Poison Control makes poisoning intervention information available to the public 24 hours per day, 365 days per year, via a 1-800 phone number. This service, provided through a contract with the Rocky Mountain Poison and Drug Center (RMPDC) (an affiliate of Denver Health), uses nurses certified in poison control and other staff trained in poison information to provide immediate assistance and information to callers. For cases involving exposure to a poisonous substance, the specialist will gather information including medical history, current symptoms, and location of the caller and make an assessment and care plan based on that information. If the case can be managed without referral to a medical facility, follow-up calls are made on a regular basis to monitor the patient's status until the patient is medically cleared and no longer in danger from the effects of the poisonous substance. The RMPDC processed 76,840 Colorado calls during fiscal year 2009-2010. Exposure cases accounted for 58% of these calls; 42% were information calls. Of the exposure cases, 55% involved children age 5 years or younger. Over 70% of the exposure cases were managed via phone at the location from which the call originated.

B). No other funding sources are used to provide this service through the state. However, the state General Fund contribution to the Rocky Mountain Poison Center (RMPC) does not fully fund the centers activities. The RMPC receives funding from other sources such as

other states, and Denver health, to fund its full operating costs

21). A). The $1,759,935 in Emergency Preparedness and Response Program General Funds are required for federal match. The funds are distributed to local public health agencies, hospitals and rural health clinics, to serve the entire population of Colorado.

The Emergency Preparedness and Response Division works with local public health agencies, hospitals, rural health clinics and vulnerable populations throughout the state to prepare for a wide variety of disasters, natural as well as man-made, including floods, wildfires, tornados, infectious disease epidemics, food and water borne disease outbreaks, and terrorist attacks.

B). EPRD General Funds are used for a federal match requirement. No additional funding sources, beyond the General and federal funds are used to support emergency preparedness in Colorado.

6. School Based Health Centers

    a. What would be the consequences of reducing or eliminating funding for school based health centers? Could the centers rely on other funding sources?

Response: The awards provided by the School-Based Health Center Program account for anywhere from 4% (for a program with 13 school-based health centers) to 39% (for a program running a single center in the southeast part of the state) of a local program's overall budget. The average is 20%. Other sources of funding for school-based health centers include federal, county and city governments; private foundations; patients and insurers; and in-kind contributions from the school district, the medical and mental health sponsors. If General Fund support for school-based health centers is reduced or eliminated, it is likely that most centers would be forced to decrease hours and staff and some may close down entirely. While funding for the operational support of school-based health centers was written into the federal Patient Protection and Affordable Care Act, the funding is not scheduled to be available until 2014. Additionally, with 46 states having school-based health centers; the amount available for each state would likely not be enough to re-build the current infrastructure if the programs were eliminated until 2014. There is currently some funding from the Health Resources and Services Administration, but that funding is for capital expansion efforts only and cannot be used for operating expenses.

The Division is not aware of any additional sources of support that centers could rely on should the School-Based Health Center Program's funds be reduced or eliminated.

    b. How does the program work? How does it compare to other health care delivery systems?

Response: School-based health centers are typically opened in schools where the majority of the student population are either uninsured or medically-underserved and qualify for free or reduced school lunches. School-based health care is crucial to maintaining the "safety net" of care for these students. To receive funding from the CDPHE's School-Based Health Center Program, centers must provide primary health care and mental health care on site. School-based health centers are staffed by a midlevel provider (a nurse practitioner or physician assistant.)

School-based health centers located in middle and high school settings can accommodate walk-in visits by students who are enrolled in the center. The goal is to get students back to class as soon as possible. Most elementary sites utilize an appointment system so that parents can be present for the visit. Same day appointments are available and the wait time is significantly less than those for traditional primary, urgent or emergency care facilities.

c. Are there cost savings or other efficiencies because the services are delivered in a school setting rather than in a hospital or some other facility?

Response: The yearly average cost to operate a center is just over $200,000. It is much more cost-effective to have a student receive care from a school-based health center than it is for them to seek care from the Emergency Room or an Urgent Care Center. A three-year study in Ohio showed the net social benefit of school-based health care provided in four school districts to be $1.3 million[1]. Factored into this amount was the cost for parents to leave work – sometimes for four hours and other times for eight hours – to transport their child to and from the visit with a medical provider.

An article in the August 2010 edition of the Journal of School Health discusses the relationship between school-based health centers and loss of "seat time" due to early dismissal for health-related issues. According to the authors, "School-based health centers significantly reduced the number of early dismissals from school…students not enrolled in a school-based health center lost three times as much seat time as students enrolled in a school-based health center. "

7. Distributions to Local Public Health Agencies

a. What would be the consequences of reducing the General Fund appropriation for Distributions to Local Public Health Agencies or the appropriation for Environmental Health Services Not Provided by Local Health Departments? Please be as specific as possible. For example, what would be the consequences of a 20 percent reduction?

[1] Guo et al. *School-Based Health Centers: Cost-Benefit Analysis and Impact on Health Care Disparities* American Journal of Public Health Sept 2010

Response:

This portion of the state General Fund appropriation supports the state's public health system, assuring that counties can provide effective, efficient services within their communities and across jurisdictions. This funding, also referred to as "per-capita" funding, is the base funding for local public health agencies to provide core public health services in response to community needs. These services include a host of public and environmental health services from public health inspections; infectious/communicable disease surveillance and response; protection of the air, water and land; clinical services for TB, STDs and HIV; vector services to control diseases spread by insects and rodents, to name a few. A local public health agency must have enough resources to track communicable diseases and be able to respond in a timely manner to serious outbreaks. The recent deaths from meningitis in Fort Collins necessitated a rapid response to vaccinate the at risk population. It was imperative that the appropriate infrastructure was in place at the local level to identify and coordinate the response.

The state General Fund allocation typically comprises a small, but critical percent of the total budget of a local public health agency. The percentage of the budget that comes from state General Fund support varies from one local agency to another, depending on the size of the population and the services provided as presented in the table below.

Colorado Local Public Health Agencies and State Per Capita General Fund

	Total Number Agencies	Number of Counties Served	% of Total CO Population Served	Average Population	Average Total Budget	Average State General Fund (2010)	Average % State General Fund	Average 20% cut
Agencies Serving Populations less than 10,000	22	22	2%	4,757	$399,474	$13,210	6.0%	$2,642
Agencies Serving Populations 10,000 to 49,999	18	20	8%	22,514	$1,155,875	$39,387	4.7%	$7,877
Agencies Serving Populations 50,000 to 99,999	5	11	6%	60,795	$3,201,350	$102,608	3.8%	$20,522
Agencies Serving Populations 100,000 to 1,000,000	8	8	58%	366,531	$15,133,055	$386,046	2.9%	$77,209
Agencies Serving Populations greater than 1,000,000	1	3	26%	1,305,855	$32,917,390	$1,322,350	4.0%	$264,470
Total	54	64	100%					

State General Funds can be used by local health agencies to match federal or private funds; thus leveraging state support to secure additional sources of funds. The relatively small amount of state public health funding distributed through these General Fund lines is an investment that is maximized across the state.

Below are some examples of impacts of possible reductions taken from information received from local public health agencies of varying locations, sizes and demographic profiles from around the state:

In rural counties on the Western slope and the Eastern plains, a 20 % cut would result in the

further decimation of their public health programs and services. Although the smaller counties will have a smaller cut, a $1,000 cut can be just like $20,000 to a large agency. Many of the rural agencies have already lost staff positions due to the loss of tobacco funding this past year as well as local cuts and other funding reductions. Additional cuts would mean further reduction in:

- Environmental health staff, and fewer restaurant, school cafeteria, and child care inspections in a four county area. This would likely result in increased food borne illnesses, child care related illnesses and other disease risks.
- Public health nursing staff, resulting in back logs in the immunization clinics.

A larger agency on the Western Slope identified a number of reduction scenarios such as:

- Discontinuation of Travel Immunization services resulting in decreased safety for travelers and potential exposure of the community to active disease brought back into the community.
- Elimination of an environmental health specialist and the loss of the ability to conduct inspections of restaurants and other food establishments.

For the larger, urban counties, a 20% reduction in per capita funding from the state General Fund would mean that the agencies would receive cuts ranging from $50,000 to over $260,000. Examples from urban agencies include:

- Reductions in communicable and infectious disease inspection and control, potentially resulting in an increase in disease transmission, increased healthcare expenditures and loss of productivity to private business.
- The Vector Control program would no longer be funded, posing a greater risk for citizens of contracting West Nile Virus, resulting in increased healthcare costs and loss of productive work days for businesses.
- Cuts to the TB program would result in the missed opportunity to prevent future cases of tuberculosis, allowing people to transmit the infection to family, friends, and co-workers.
- Reducing staffing levels in the Residential Health and Housing program, while under increased pressure to respond to the ever expanding bed bug epidemic and the impacts provision of light, heat and water during this economic downturn.
- Reducing Family Planning Services to more than 1,000 clients will result in additional unintended pregnancies, many of whom will eventually be on Welfare and Medicaid.
- Eliminating one environmental health specialist will result in 750 fewer restaurants, 33 fewer child care and 22 fewer pool inspections increasing the likelihood of food-borne illness and communicable disease.
- Cuts to the Household Hazardous Waste collection program would result in approximately 75,000 pounds of hazardous wastes leading to exposure to hazardous materials in and around the home that cause illness and cancer.

Finally, in addition to the significant impact on our state's ability to protect the public's health, and the increase in health care expenses associated with failure to prevent illnesses and injuries, a reduction of state General Fund support for local public health agencies would mean a substantial number of jobs lost throughout the state. The more than 2,000 people who serve in local public health agencies are active members of their communities who protect public health and the environment, as well as contributing to the local economy.

8. Health facilities licensure.

    a. Please provide a five year history of licensing fees for nursing homes, assisted living facilities and the other facilities regulated by CDPHE. How are these fees set? Why have they increased?

Response:

Response: HB 07-1221, a Joint Budget Committee bill, changed the way license fees are set for health facilities. Until 2007, 25-3-105(1) (a) (I) provided that all license fees (except for Acute Treatment Units and Assisted Living Residences, see below) were $360 annually. This amount did not allow the Division to carry out its statutory mandates for issuing a license. For example, prior to passage of HB 07-1221, the Division relied on the attestation of applicants that they complied with statutory insurance and other substantive requirements of the regulations rather than having Division staff conduct an independent review. Additionally, prior to the passage of the legislation, staff were frequently unable to review Quality Management Plans; conduct on-site inspections prior to issuing a license; and review the proposed operator's fitness to operate a health facility. The fiscal analysis for HB 07-1221 noted that the increased spending authority would allow the Division to implement electronic submission of license applications and increased inspection and enforcement of facilities, neither of which would have been possible without increased fees. HB 07-1221 charged the State Board of Health with setting, through a rule-making process, a schedule of fees "at a level sufficient to meet the direct and indirect costs of administration and enforcement of this article..." Pursuant to this direction, the Health Facilities and Emergency Medical Services Division developed a model for determining the direct and indirect costs of each of its license categories based on actual time spent by staff for the various functions associated with administering and enforcing licenses. For each individual licensed category, the Division developed a proposed fee structure based on those actual costs. The Division then invited stakeholder representatives to review the proposed fees. In most cases, modifications were made to the original proposal based on this input. The proposal was then formally presented to the Board of Health, which adopted fees in a formal rule-making process. Starting in late 2007, this process was followed to set fees for hospitals, ambulatory surgical centers, renal dialysis centers, hospices and nursing homes. A table showing a five-year history of licensure fees is attached.

In the case of Assisted Living Residences, in 2008, C.R.S. 25-27-107 was amended to follow the same process as described above and a new fee structure became effective on January 1, 2009.

The same process was incorporated into SB 08-153. This bill established licensing requirements for Home Care Agencies for the first time in Colorado and also provided for fees to fund related licensure and oversight activities.

The Department is aware that this process has resulted in a significant increase in license fees. The increase was needed in order to accomplish the licensing tasks referred to above since the fee had previously been set at a level that did not allow any of those activities. The fees adopted have been well within the fiscal authorization granted by the relevant legislation and are set at a level to allow the Division to fund its activities. Now that fees have been established as set forth in statute, no additional increases are contemplated.

b. Have there been any recent developments in life-safety requirements for nursing homes. Have requirements changed? Please discuss sprinkler system requirements, including antifreeze standards. Which nursing facilities are affected by these changes? How do Colorado's standards compare with other states?

Response: There have been several changes regarding life-safety requirements for nursing homes:

- The Board of Health adopted updated Life Safety Code regulations for nursing homes and other healthcare facilities effective April 2009 and adopted construction plan review requirements for all licensed facility types, including nursing homes, effective July 1, 2009.
- The federal Center for Medicare and Medicaid Services (CMS) has adopted a new regulation requiring all participating nursing homes to have sprinkler systems by August 2013.
- The Department addressed antifreeze standards for sprinkler systems in newly constructed healthcare facilities at the November meeting of the Board of Health.

Updated State regulations:

- Effective April 30, 2009 the state Board of Health adopted the 2000 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code. This change brought outdated and inconsistent state regulations in line with current national standards, and created consistency between the state and federal life safety code regulations for the 98% of Colorado nursing homes that need to meet both state and federal requirements. The five Colorado nursing homes that do not participate in CMS funding will also have to comply with these requirements, including sprinkler

requirements unless they fall within NFPA 101 exceptions for existing nursing homes of certain construction types.

Construction plan review:

- Effective July 1, 2009, the Board of Health adopted regulations requiring review of building construction plans for all licensed facility types, including nursing homes, for conformance to life safety code requirements. These regulations apply to construction of new buildings, additions to buildings, moves to a new physical location (e.g., moving to newly leased space in an existing building), and major remodeling. Prior to this change, the Department was frequently only able to inspect construction when It was already built and, in the opinion of the owner, ready for use. This resulted in significant cost and delay when code violations were identified. It is considerably more cost effective for a licensee to receive code evaluation and technical assistance during the construction phase rather than having to make changes, based on a single final inspection, after construction is finished. The plan review fees are based on the size of the construction project.

Federal sprinkler requirement changes:

- In October 2008 CMS adopted a regulation which mandates that all nursing homes participating in CMS funding must be fully sprinklered by August 13, 2013. For Medicare and Medicaid participating nursing homes, this overrides any sprinkler exceptions contained within the NFPA 101.

Antifreeze in fire sprinkler systems:

- The use of antifreeze in sprinkler systems has come to national attention during the past year due to two fatal fires in which increased fire intensity was attributed to the use of antifreeze in the sprinkler system. (Antifreeze solutions used in sprinkler systems are alcohol-based compounds and may intensify fires under certain conditions.)
- Based on testing conducted by Underwriters Laboratories, the NFPA has promulgated recommendations to eliminate use of antifreeze in new sprinkler systems installed in residential settings. These recommendations have been adopted into NFPA sprinkler system standards for newly constructed facilities.
- There is broad consensus among the state Division of Fire Safety and the facility community that this requirement to eliminate use of antifreeze is appropriate for new or expanded facilities.

- The state Board of Health adopted rules, effective January 1, 2011, for construction of new facilities, additions to existing buildings or major remodeling to use sprinkler system design criteria other than antifreeze.
- Modification of the NFPA standards to eliminate use of antifreeze in sprinkler systems for existing facilities will be discussed at the NFPA national conference in June 2011.
- Standards for existing facilities will be addressed pending the outcome of the NFPA conference.
- Two states have adopted standards more stringent than Colorado's; many states have not taken action at this time due to the short time since these NFPA recommendations were made.

DECISION ITEMS

9. Medical Marijuana Registry Decision Item

    a. Once the Department has caught up with the backlog of applications and change requests, how much will it cost annually to run the medical-marijuana registry and make the transfers to other Departments that are required by law?

Response: The actual backlog has been caught up. We currently are working on eliminating the backlog of changes.

Based on the FY 2011-12 Budget Amendment submitted to JBC on January 3, 2011 the department estimates that it will cost $1,946,929 annually to manage the program. This number includes:

$1,150,018 for the base budget, transfer to DORA and common policies
$710,911 FY 2011-12 Decision Item (as amended)
$86,000 Medical Marijuana Computer System (Supplemental/budget amendment).
$1,946,929 Total

    b. At what level should the fee for the medical-marijuana registry be set if it is to accurately fund the cost of the registry and the transfers without generating excessive fund balances?

Response: The Department does not know what level this fee should be set at this time. The department is still implementing recent legislation which could impact the number of applicants. The legislation includes physician investigations, indigent applicants having a waived fee, among other issues. Once the Department has had a chance to analyze the impact of the legislation on overall applicant levels and composition (i.e. indigent vs, non-indigent) the department will have a better idea of what a fee level should be. The final fee level may be lower than what is currently charged.

c. Who determines the level of the medical marijuana registry fee? How often is it reviewed? What adjustments does the Department plan to make to the fee? What is the time frame for making adjustments?

Response:

The Board of Health approves the level of the Medical Marijuana fee. The Board of Health rules mandate that the fee be reviewed each year. Historically the Department has presented fee analysis in the spring, and we plan to do this again. The statekholder process for this program is extensive and includes the advisory committee that reviews all rules before the Board of Health considers them. This process includes the fee review.

d. Are the revenues and the fund balance of the Medical Marijuana Program Cash Fund sufficient to support all proposed transfers from the fund? Please provide an analysis.

Response:

The balance in the Medical Marijuana Program Fund is not sufficient to transfer the following amounts as identified in the November 1, 2010 budget submission:

$3,000,000 from HB 10-1388 – Cash Fund Transfers to Augment the General Fund
$9,000,000 proposed transfer for FY 2010-11
$10,000,000 proposed transfer for FY 2011-12.

The Department proposed in the January 3, 2011 submission to the JBC to decrease the $10,000,000 FY 2011-12 transfer to $6,460,000 (a reduction of $3,540,000).

At the current fee level and with the anticipated applicants to the registry, the fund is projected to have sufficient fund balance to meet the revised obligations as presented in the budget amendment.

Detailed Information Regarding Anticipated Fund Balance:

FY 2009-10 End of Year Cash Balance Estimate	**$9,760,838**
FY 2010-11 Long Bill appropriation, 1331 supplemental (plus POTS and Indirect)	($3,604,444)
SB 10-109 (FY 2010-11 Appropriation)	($815,224)
HB 10-1284 (FY 2010-11 Appropriation)	($59,747)
Loan to Department of Revenue for HB 10-1284 – This amount should be repaid during FY 2010-11 (however, to conservatively estimate fund balance the payback is not included in these calculations). HB 10-1284 authorized the Department of Revenue to borrow up to $1,000,000 from the Medical Marijuana Program Fund in order to implement their program before funding comes in from licenses.	($1,000,000)
Repayment of Department of Revenue Loan for HB 10-1284	$1,000,000
Transfer to General Fund on June 30, 2011 (HB 10-1388 Cash Fund Transfers Augment General Fund)	($3,000,000)
FY 2010-11 Transfer to the General Fund	($9,000,000)
Deferred revenue from FY 2010-11 adjustment	($4,760,148)
Revenue from July 1, 2010 – June 30, 2011 (estimate a total of 111,000 applications at $90 each)	$9,990,000
FY 2010-11 S-3, BA #2 – Medical Marijuana Computer System	($85,000)
FY 2010-11 End of Year Cash Balance Estimate	**($1,573,725)**
FY 2011-12 Long Bill request estimate (base budget and adjustments for common policies)	($1,150,018)
FY 2011-12 DI #1 – Medical Marijuana	($1,093,939)
FY 2011-12 BA # 1a – Medical Marijuana	$383,028
FY 2010-11 S-3, BA #2 – Medical Marijuana Computer System	($86,000)
FY 2011-12 Anticipated Revenues (estimate a total of 111,000 applications at $90 each)	$9,990,000
FY 2011-12 Transfer to the General Fund – Amended November 1 request	($6,460,000)
FY 2011-12 End of Year Cash Balance Estimate	**$9,346**

10. Newborn Screening Decision Item.

a. How many Severe Combined Immunodeficiency (SCID) cases do you expect to detect in Colorado annually? Is SCID screening likely to detect any other harmful conditions that would not otherwise be detected? What is the incidence of false positives in testing for SCID?

Response: The Department expects to detect 1 (one) SCID newborn each year based on SCID estimates of 1/66,000 births (Colorado averages 70,000 newborns annually). Although this seems low, the medical expenses of treating an undetected case can exceed $2 million and the

outcome is usually severe illness or death. However, early detection via Newborn screening and treatment via a bone marrow transplant leaves a strong possibility for a full recovery and good health.

Based on scientific journals, the incidence of false positives for SCID is between .04% and 1.0%.

It is possible that the SCID screening will also detect DiGeorge's syndrome (disorder of the heart and infections) which has an incidence of 1 in every 3,000 births. There are other means to detect this syndrome, perhaps earlier than what would otherwise occur.

b. What is the prevalence of Alpha Thalassemia? How many positive results occur? What is the incidence of false positives in initial screening and subsequent confirmatory testing?

Response: Because follow-up/confirmatory testing is not currently being done, it is not possible to say how many false positives there are. However, during a one month pilot project in July 2010, the 25 positive samples were sent to the University of Colorado laboratory for follow-up confirmatory testing. Sixty percent of the samples received a second positive reading, which indicates the need for additional screening. These results support the estimate that approximately half of the results from the initial screen are false positives.

The national prevalence is estimated at 1 in 1,500. Based on Colorado's approximately 70,000 births each year, the Department anticipates 47 cases per year.

11. Prenatal Plus Transfer to HCPF Decision Item.

a. Is part of the reason for the requested program transfer that the federal Patient Protection and Affordable Care Act is going to require smoking cessation programs for pregnant women who are in Medicaid? Will the transfer facilitate the implementation of that requirement?

Response: The primary reason for the transfer is administrative efficiency in that Prenatal Plus, as a Medicaid program, is best administered by HCPF as the state Medicaid agency. The smoking cessation benefit under *Patient Privacy and Accountable Care Act* (PPACA) is an unanticipated but additional advantage of the transfer to HCPF.

12. Amendment 35 Transfers Decision Item.

a. What will be the impact of the proposed $2.7 million transfer from the Health Disparities Cash Fund on the Health Disparities Program?

Response:

Health Disparities Grant Program: The transfer of $2.7 million would impact the program's ability to return to the previous level of funding for community based programs. These programs directly serve minority or under represented populations with prevention and treatment of undiagnosed chronic diseases (cancer, cardiovascular disease and chronic pulmonary disease). Additionally, fewer services would be available locally to the rural and urban minority populations. Individuals who are at risk for diabetes or other preventable chronic disease may turn to hospital emergency rooms seeking treatment. Illnesses that could be detected and treated through this program could go undiagnosed and untreated, resulting in permanent disability that will likely result in increased medical costs and could reduce or eliminate their ability to work and provide for their families.

b. Is it necessary to continue the current level of General Fund support for the Health Disparities Program? Could it be reduced or eliminated?

Response:

Yes. The General Fund is critical to support the office and its mission to serve the citizens of Colorado. The General Fund appropriation to the office is specifically dedicated to a minimal amount of personal services and operating. The program has a statewide reach, concentrating its efforts on racial and ethnic minority populations experiencing health disparities and those systems and organizations serving those populations, in order to eliminate racial and ethnic health disparities. The Office staff works to educate the public as well as public serving organizations by collecting, publishing and presenting health disparities data and providing trainings on health disparities elimination strategies, cultural and linguistic competence, building community partnerships and addressing the social determinants of health. In addition, the office staff works towards positive system change by providing capacity building and coordinating strategic planning efforts at the departmental, community and state level. Staff coordinates the Minority Health Advisory Commission, the Interagency Health Disparities Leadership Council and the Recruiting and Retaining Youth of Color into the Health Professions Task Force.

ISSUES

13. State Laboratory Issue, which proposes the creation of a cash fund for the state lab that will receive lab revenues that do not currently go into cash funds. This would permit the lab to accumulate funds for purchase of laboratory equipment, as opposed to leasing arrangements.

    a. Please discuss options for cash funding the lab. Could the fee structure be changed in a way that would increase the portion of lab costs paid through fees, i.e. reduce the lab's cost to the General Fund? Could the lab be entirely cash funded?

Response:

The Laboratory set cash fees for all tests (except milk) when the Division lost all General Fund appropriation (except funding for milk testing) in FY 2001-02 and FY 2002-03. The Laboratory was initially able to supplement cash funding through federal funding for a number of tests for which there is no easily identifiable payer but where there is a critical public health surveillance and response need. In many cases, the grants allowed the Division to charge lower fees or to waive fees altogether.

However, as these grant funds have been eliminated or reduced, the cost for public health laboratory testing, including testing for dangerous animal born diseases such as rabies, West Nile virus, and foodborne illness, has been shifted to local health departments, animal control agencies, and individual citizens. Local agencies as well as individuals are increasingly unable and unwilling to absorb these costs. Failure to perform tests, such as on infected animals, has significantly curtailed essential surveillance activities, thus placing the health of Colorado residents at increased risk. That is, assessing fees or increasing fees is counterproductive because test volumes decrease resulting in decreased cash revenues in some programs. Without sufficient cash flow, overall Laboratory capacity decreased as vacant positions were held open due to lack of revenues to support program costs.

The Laboratory submitted a Decision Item in FY 2009-10 that resulted in a restoration of $894,000 in the General Fund appropriation. If the General Fund is again reduced, the Laboratory will revert to the FY 2008-09 funding level and will again face diminished Laboratory capacity and capability.

b. Could some or all of the lab's functions be privatized? Could newborn screening be privatized? Would privatization reduce costs?

Response:

Yes some functions can be privatized and others cannot.

Private labs cannot perform many of the essential public health tests. However, some test services (i.e., human testing) in Serology can be privatized. A number of private laboratories perform the same human testing as the Serology Laboratory but not many perform the zoonotic (animal) testing. The Laboratory would need to continue to test animal specimens even if the human serological tests are privatized as zoonotic testing is crucial for public health outbreak and surveillance activities. The primary disadvantage of privatizing human serological testing is ensuring test data is promptly submitted to the Epidemiology Division. The impact to Colorado citizens is increased costs at private laboratories which may be a deterrent to submitting specimens for public health testing.

The activities that cannot be privatized (by state or federal law) include milk certification. The State Lab is designated under federal law as the Laboratory that ensures that any other labs performing milk tests are functioning adequately.

CDPHE is responsible for the implementation of the Newborn Screening and Genetic Counseling and Education Act pursuant to CRS 25-4-1001-1006. This Act requires that all newborns be screened for certain conditions and that medical follow-up services, including genetic counseling and education, are provided. The Department can designate the lab to perform these tests. One of the benefits to the state lab performing the tests is the coordination of services with the medical follow-up and genetics counseling portion of the program.

Cost for Newborn screening in Colorado: **$60** for 1st and 2nd Screen
Cost for Newborn screening by Private Vendor (Genetics – PerkinElmer): $32 for each screen or **$64** for 1st and 2nd
Cost for Newborn screening by Oregon State Lab: $32 for 1st screen, $30 for second screen or **$62** for 1st and 2nd

Also, Colorado hospitals would have additional shipping costs for overnight mailing to outside vendor (most Colorado hospitals use Lab courier service which is included in Colorado fee). If there is no oversight by CDPHE and the hospitals/submitters send directly to Lab, Colorado has no tracking of which Colorado children are tested or how long it takes for tests to be resulted.

Privatizing the lab test would not include the follow up portion of the program.

In addition, the state lab is not a profit earning entity and the Department is accountable for fee increases to the public through stakeholder processes.

Finally, there are several federally funded programs that are only available to state labs. Private laboratories are not eligible to participate. These include:

EIP – Emerging Infections Program
ELC - Epidemiology and Laboratory Capacity for Infectious Diseases
PHEP - Public Health Emergency Preparedness
FERN - FERN Food Safety and Security Monitoring and Microbiological Cooperative Agreement Program
CLIA – Clinical Laboratory Improvement Amendment
TB – EPI Lab TB Elimination

c. Please provide a breakdown showing who purchases services from the lab and who pays the fees.

Response:

Please see attached customer listing for November 2010 Laboratory services. Customers vary monthly and services requested vary as well, especially in the Environmental testing program, but this month is typical for the majority of the customer base.

Currently the Laboratory bills the specimen submitter and the submitter is responsible for billing insurance or Medicaid. Please note that many of the customers are public health agencies. If the General Fund allocation is decreased, the customer list will show even more local public health agencies as the Laboratory is currently using General Fund to cover the costs of tests submitted by these agencies.

d. How does the lab currently finance capital outlays?

Response:

The Laboratory obtains equipment through reagent rental agreements (cost of equipment lease is included in product cost), lease purchase (first used in FY2010), and purchase using cash or Federal Funds. Outright purchases using cash allocations are limited to equipment under $50,000 (must submit Capital Construction request if over $50,000) and are generally used for smaller cost items (less than $25,000) based on cash revenue and spending authority limitations.

e. JBC staff presented an example, based on data provided by the lab, that shows the potential savings from purchasing an inductively coupled plasma optical emissions spectrometer, as compared to a lease or a lease-purchase of the same equipment. Would equipment provided under a lease or a lease-purchase be replaced more frequently and thus on average be more up-to-date? Does the example adequately account for issues of technological obsolescence?

Response:

It is likely that equipment provided under a lease will be replaced at the end of the five year lease term (five years) if the equipment is old or obsolete. This is also true of equipment leased through reagent rental agreement. The equipment may be replaced even more frequently than every five years if a vendor introduces new products that require updated equipment.

Equipment purchased under a lease purchase or through an outright purchase may be retained longer than five years if it still has a useful life and is in good condition. In an effort to maximize resources, the Laboratory utilizes equipment until it is obsolete or the condition deteriorates to the point that is no longer usable. The example used a five-year replacement for the lease option and a seven-year replacement for purchase and lease purchase options as this is typical for Laboratory equipment (5-7 year replacement cycles) although there are cases when

equipment purchased can become obsolete in as little as 2-3 years with technological advances and/or changes in regulatory requirements.

The cash fund will provide the Department the flexibility to purchase equipment outright, or to do lease purchase. The Department will evaluate the options in each case and pursue the most cost effective option.

f. What is the department's opinion of the JBC staff proposal to create a cash fund for lab revenues that currently lack a cash fund? How would you transition to the new system? Would the change affect fees?

Response:

The Laboratory is in support of the JBC staff proposal as it would allow the Laboratory to accumulate revenues that will assist the Division in making equipment purchases and allow for increased flexibility to manage expenditures within the appropriation.

There would be no change to the current practice for billing and collecting fees. Funds would simply be deposited into the newly created cash fund. The accounting changes necessary to make the adjustments are minimal, especially if the change is made at the beginning of the fiscal year.

There would be no change to the fees as a result of creating a new cash fund.

In the cases where it makes more sense to purchase equipment, the Department needs the flexibility to pursue these options.

g. What areas of the lab are currently operating at a breakeven point? What would it take to get all laboratories at a breakeven point and what would be the impact on their services? Are there any programs that cannot operate at a breakeven point and why?

Response:

Through the support of cash funds and federal appropriations, the following areas of the Lab are currently operating at a breakeven point:

Newborn Screening Program: cash fees, Fund 121
Toxicology: cash fees, Fund 100 and Law Enforcement Assistance Fund (LEAF), Fund 122
Evidential Breath Alcohol Testing (EBAT): LEAF, Fund 122
Certification (except for milk)**:** cash fees, Fund 100 and federal grant (Clinical Laboratory Improvement Amendments – CLIA)
Inorganic Chemistry: cash fees, Fund 100 and reappropriated funds (WQCD testing)
Organic Chemistry: cash fees, Fund 100 and federal grants (FERN and Chemical Terrorism)

Environmental Microbiology (except for milk)**:** cash fees, Fund 100 and federal grants (FERN and Consumer Protection Division Food Safety)

It is impossible to get all laboratories at a breakeven point without severely impacting surveillance and outbreak response. Some programs, such as milk and radiochemistry, have no other funding source but the General Fund.

The Laboratory programs that do not operate at a breakeven point without General Fund appropriations and the reasons they cannot operate at a breakeven point are listed below:

Milk Testing: Testing and certification of industry milk laboratories is mandatory per Food and Drug Administration rules and regulations. No cash fees are currently assessed nor is there any federal funding for this program. If cash fees were assessed for this program, the fees could be assessed at a level to have the program breakeven.

Radiochemistry: There are no other funding sources for this program, and the low volume of testing is insufficient to sustain the necessary infrastructure through fees. This program tests humans for exposure to radioactive materials and assesses radiation levels in water and soil. There is not an independent laboratory available to perform radiochemistry testing for water and hazardous material compliance actions, so these samples also would have to be sent out of state. Also, the State Lab would be unable to provide emergency response for radioactive materials testing needs, including for the threat of a "dirty bomb", which federal Homeland Security experts have identified as vulnerability, but for which they have not allocated funds. Without this key capacity, state and local officials who have come to rely on this service will have to respond without the support of laboratory data. This could potentially put the state's first responders in high-risk situations involving unknown radiological hazards.

Serology, Public Health Microbiology and Molecular Science: These programs generate modest cash revenues and receive limited (and designated) federal funding. However, the testing needs exceed the amount of federal and cash funding available.

The Lab's conversion to a fee-based state public health laboratory in FY2003 resulted in adverse impacts on disease surveillance and control systems. The Lab saw a significant reduction in the number of sample submissions, especially for surveillance activities. The Lab received fewer specimens for rabies, Hantavirus and plague, such that the State was left with an incomplete picture of the changing impact of these organisms in the statewide community. For example, the Department had evidence that skunk rabies, not seen in Colorado for the past 30 years, had re-emerged as a public health threat, yet the fee associated with testing surveillance specimens was a significant barrier to local health agencies or individual citizens, such that the Department lacked a robust picture of where and to what extent this disease had returned, and what interventions needed to be considered to address it before it became a significant human health problem.

In addition, the Lab had to limit outbreak investigation testing for diseases such as whooping cough and West Nile Virus, thus far without obvious adverse outcomes. And, as the Lab sees fewer tests, there is a reduction in the analytic capacity to identify unknown human pathogens, key to gauging disease activity. Without General Fund, these problems will worsen and the State Lab will be faced with eliminating certain testing ability.

Private labs cannot perform many of the essential public health tests. CDPHE is designated as the CDC's State Laboratory Response Network Reference lab, using federally developed and approved methods for analyses while maintaining the required secure facility with capabilities for a dedicated, rapid, high capacity response to microbes designated as "select agents" (those biological agents or toxins deemed a threat to public health, animal or plant health). For many other tests, the CDPHE lab serves as the reference lab to confirm the results for tests done at private labs. Without additional funding, Colorado could have to send select agent specimens to state labs in neighboring states, at increased cost and with inevitable delays in detection, response and mitigation. This would have a direct negative effect on the health of our citizens.

14. Tobacco Settlement Issue, which proposes that the state stop using tobacco-settlement revenue to fund the Tony Grampsas Youth Services (TGYS) Program, the Read-to-Achieve program, and the program that provides Short Term Grants for Innovative Health Programs. The savings would be used to bolster the General Fund during the current economic downturn and would subsequently be placed in a rainy day fund.

    a. Does TGYS make grants to other agencies of state government, such as the Division of Youth Corrections?

Response:
Yes, grants can be made to state agencies, however none have applied. Grants were awarded to local non-profit organizations and municipalities.

Although state agencies may apply for funding pursuant to CRS 25-20.5-201, state agencies were not awarded any grants in FY 2009-10.

    b. Is there a health component to TGYS programs? A tobacco education/cessation component? Are there health benefits to participants?

Response: Yes there are health components to the TGYS programs. There are no tobacco education/cessation components; however there can be a reduction in tobacco use among the participants. There are health benefits to the participants.

Summary Health Impacts of TGYS: The two goals of the Tony Grampsas Youth Services Program (TGYS), to reduce youth crime and violence and to prevent child abuse and neglect, are directly related to public health outcomes as defined by the Centers for Disease Control and Prevention.

- **Youth Violence** is the second leading cause of death for young people between the ages of 10 and 24 throughout the United States. Deaths resulting from youth violence are only part of the problem. Many young people seek medical care for violence-related injuries. These injuries can include cuts, bruises, broken bones, and gunshot wounds. Some injuries, like gunshot wounds, can lead to lasting disabilities. [2] According to the National Violent Death Reporting system in 2008 in Colorado there were 48 children and youth ages 0 – 19 who died due to firearms, sharp instruments or being struck.
- **Child Maltreatment**, including physical abuse, sexual abuse, emotional abuse and neglect, has a negative effect on health. Abused children often suffer physical injuries including cuts, bruises, burns, and broken bones. In addition, abuse causes stress that can disrupt early brain development. Extreme stress can harm the development of the nervous and immune systems. As a result children who are abused or neglected are at higher risk for health problems as adults. These problems include alcoholism, depression, drug abuse, eating disorders, obesity, sexual promiscuity, smoking, suicide, and certain chronic diseases.[3] According to the Annie E Casey Foundation's Kids Count Data Center the child abuse rate in Colorado for 2009 is 9.1 per 1,000 children.

TGYS Impacts:

- In 2009 -10 The TGYS Program funded 145 local non-profit, local government, and school districts. These organizations served 52,161 children, youth and parents in 57 of the 64 counties of Colorado. The majority of grantees are non-profit organizations that provide services including violence and abuse prevention programs. TGYS funds programs in six categories: early childhood, before and after school, youth mentoring, restorative justice, student dropout prevention and violence prevention. Evaluation of the TGYS Program has shown positive outcomes for youth served in TGYS funded programs. These outcomes include: increased school performance; decreased delinquency, including recidivism; increased life skills, including conflict resolution, decision making and goal setting; decreased bullying; decreased alcohol, tobacco and other drug use; increased self efficacy and self esteem; increased parenting skills; and progress towards developmental milestones.

Tobacco education/cessation benefits:

- The TGYS Program funds programs that increase protective factors and decrease risk factors that impact youth crime and violence and child abuse and neglect. These same

[2] Centers for Disease Control and Prevention, Understanding Youth Violence Fact Sheet (2010) http://www.cdc.gov/violenceprevention/pdf/YV-FactSheet-a.pdf
[3] Centers for Disease Control and Prevention, Understanding Child Maltreatment Fact Sheet (2010) http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf

risk and protective factors are also linked to the prevention of tobacco use. For example, whether or not a child/youth has a positive caring adult in their life has been shown to impact tobacco use:

- In the 2008 Healthy Kids Colorado Survey children and youth were asked if they had someone to call for help in case of a problem:
  - Of the 1,770 that responded "No" 84.8% had never smoked and 15.2% were current smokers.
  - Of the 14,977 that responded "Yes" 91.6% had never smoked and 8.4% were current smokers.
  - Of the 1,887 that responded "Not Sure" 88.6% had never smoked and 11.4% were current smokers.
- In the 2008 Healthy Kids Colorado Survey children and youth were asked if they had a teacher or adult that cared for them:
  - Of the 2,443 that responded "No" 85.3% had never smoked and 14.7% were current smokers.
  - Of the 14,977 that responded "Yes" 92% had never smoked and 8% were current smokers.
  - Of the 1,887 that responded "Not Sure" 90.7% had never smoked and 9.3% were current smokers.

- Many of the TGYS Programs promote and strengthen relationships between the child/youth and a caring adult through mentorship, before and after school programming, etc. This data highlights how working to increase shared protective factors in Colorado can help promote multiple positive health outcomes, including the prevention of tobacco use.

10:45-11:00 BREAK

11:00-12:00 QUESTIONS ASSOCIATED WITH THE ENVIRONMENTAL DIVISIONS

Decision Item #4 – Legal Services (for Air Pollution Control Division and Water Quality Control Division)

[As discussed in the Decision Item Priority List on page 9 of the staff briefing document on the environmental divisions, the Department is requesting $132,066 reappropriated funds to pay for additional legal services hours for the Air Pollution Control Division and the Water Quality Control Division.]

15. Please provide additional detail on the unanticipated need for legal services associated with H.B. 10-1365. The bill's fiscal note did not anticipate an additional need for legal services but

the Department lists legal action associated with that bill as one of the drivers of additional legal services costs in the Air Pollution Control Division.

Response: While neither the Department nor the Department of Law (DOL) anticipated legal services hours because of H.B. 10-1365, the opponents of the legislation have filed, and are continuing to file, various legal actions challenging PUC, Air Quality Control Commission or CDPHE decisions. The legal actions and the associated impact to CDPHE and DOL are described below:

1. The Department has had to respond to numerous filings before the PUC, the magnitude of which was not anticipated (staff anticipated some filings, but assumed this work could be absorbed within existing resources).
2. Legal expertise has been needed to consistently articulate and explain the Department's duties, actions and determinations with regard to the legislation in various administrative and court settings.
3. As a result of the process that unfolded at the PUC under the bill, the Department had to file extensive written and direct testimony with the PUC between August and December, all of which required significant support and involvement of DOL.
4. Additional legal resources were required when the Department, along with several other state agencies, received an expansive Colorado Open Records Act (CORA) request that required extensive legal resources to evaluate and respond to the request, and defend it in district court. Ultimately the Department prevailed in its defense regarding its CORA responses in district court.
5. The Department and DOL did not anticipate any party filing a request for emergency rulemaking with the AQCC regarding the Department's consultative role with respect to HB 10-1365. However, two such motions have now been made before the AQCC requiring an immediate response by the DOL.

Based on this recent experience, the Department and DOL now anticipate that future legal challenges to various steps in the implementation of HB 10-1365 are likely. The Department also believes that the related Regional Haze State Implementation Plan process currently scheduled with the Air Quality Control Commission will be contentious and may lead to further challenges. For these reasons (and other reasons identified in the request) and have requested additional legal resources so that it can respond to these matters. Further appeals/challenges are anticipated. The Department is hearing comments from the coal industry that indicate the matter is "far from over" and they will continue to challenge what the PUC (and we believe the AQCC also) ultimately approve with respect to HB 1365.

16. Please provide additional detail on the Department's collection and use of indirect cost recoveries, including specific information on how you will recoup the indirect cost recoveries to pay for additional legal services hours. What sources of funding will you use for the indirect costs and how do you make those decisions?

Response:

Indirect costs are defined as those costs that are incurred for common or joint objectives and cannot be linked to a specific program or project without significant effort.

Since legal services expenditures vary by program from year to year, they are part of the Department's indirect cost recovery pool, which is funded by federal and cash sources, and is appropriated annually by the JBC. Each year CDPHE identifies common agency expenses that meet the definition of indirect and submits an indirect cost proposal to the federal government seeking approval of its plan and associated indirect rate based on the amount of those costs. Other indirect expenses include utility payments, lease payments, general business operations costs, workers' comp. claims, etc.

Upon approval of the federal rate, the estimated amount of indirect revenue that will be generated is calculated based on anticipated federal awards and expenditures and then compared to the total estimated indirect cost need. Subsequently, the cash indirect rate is calculated based on estimated cash fund expenditures to ensure there is sufficient revenue to cover the balance of the indirect cost pool expenditures.

Both federal and cash fund sources are used to support indirect costs. Because the federal rate is established and approved annually, the Department closely monitors the cash rate throughout the fiscal year to assure it does not collect more or less than is actually needed.

If this request is approved, the Department will likely increase the cash indirect rate slightly (approximately one percent) to ensure that the correct amount of revenue is collected to cover the expense.

17. Please provide an update on the status of legal services for the CERCLA program as addressed by H.B. 10-1329. Has that legislation solved the legal services issue associated with CERCLA? Please explain.

Response:

HB10-1329 authorized the Solid and Hazardous Waste Commission to promulgate rules to establish the Solid Waste Users Fee of which a portion is for use by the Department of Law for costs incurred in the implementation of its responsibilities under CERCLA. The fee set by the Commission on November 16, 2010, along with the reappropriation of $511,159 from the Hazardous Substance Response Fund in FY 2010-11 will provide adequate resources for the Department of Law to implement any legal activities necessary for the implementation of CERCLA in the state.

Waste Tire Program Consolidation Pursuant to H.B. 10-1018

[H.B. 10-1018 consolidated all waste tire-related activities (including those previously performed by the Department of Local Affairs) within the Department of Public Health and Environment.]

18. Please provide an update on the consolidation of waste tire operations within the Department under H.B. 10-1018. For example, are all of the waste tire programs operating at this point? Please describe the status of each waste tire program.

Response:

Thus far, all funds and activities scheduled for implementation during SFY 2010-11 have been established and implemented.

HMWMD: A stakeholder process was convened in August 2010 to develop draft waste tire management regulations. The stakeholder process ended on December 20, 2010 with draft regulations set for rulemaking with the Solid and Hazardous Waste Commission on February 15, 2011. The first waste tire staff person has been hired. The second position is at the final interview stage such that the new staff person should be on board by the end of January, 2011. These two staff members will be responsible for implementing the new waste tire regulations resulting from HB10-1018, including tracking and issuing registration numbers and vehicle decals; tracking waste tire manifests; staffing the Waste Tire Advisory Board; performing inspections of waste tire facilities throughout Colorado; and implementing any necessary enforcement resulting from the inspections. The Waste Tire Advisory Committee has been appointed by the Governor and has held its first three meetings. Waste tire manifests, facility registration forms, vehicle and facility decals, and annual reporting forms have all been designed and reviewed by stakeholders. A Waste Tire website has been established: www.cdphe.state.co.us/hm/sw/section10/index.htm.

Sustainability: Since the passage of HB 10-1018, the Department has hired an individual to administer the Waste Tire Grant and Rebate Programs. This position is separate from the positions hired in the Hazardous Materials Division and will be working on the different grant programs. There are currently two grant programs that are operating under the Department. The first, the Waste Tire Incentives Program, has awarded $494,512 to nine entities for projects that reuse waste tires in applications such as building new artificial turf fields and installing new surfaces for playgrounds. The second, the Illegal Waste Tire Grant Program, has awarded $50,000 to one governmental agency (Conejos County) to clean up a stock pile of waste tires at the County public works site. The tires were not generated by the County, they were picked up along roadways in the County by Road and Bridge crews and stockpiled on the County site.. The Department's Solid and Hazardous Waste Program is in the process of creating a priority abatement list for illegal waste tire piles in the state that the grant program will focus its efforts on in the next year. A third program, the Waste Tire Market Development Fund, will be created and administered starting on July 1, 2011, as per statute. The Department shall use this fund to

encourage waste tire market development pursuant to a market development plan created by the Waste Tire Advisory Committee.

The Department has also been administering the Processors and End Users Fund since July 1, 2010. To date, the Department has distributed $935,140 to five different companies in the state for processing waste tires or using waste tires in an end use. These rebates have covered 19,653 tons of waste tires. This equates to $47.58 per ton, with statute setting the cap at $65.00 per ton.

House Bill 10-1018 has allowed for the Sustainability Program to work closely with the Hazardous Materials and Waste Management Division (HMWMD) on technical issues of the rebate and grant programs. For example, the HMWMD has been able to give clarification on applications that request money for processing, end use or illegal tire piles. These are questions that HMWMD has the expertise to review and answer.

One issue the Department is facing is the adoption of new rules for the Processors and End Users Fund. Businesses that use tires for an end use (such as burning for energy) don't believe businesses that just process tires, but do not have an end use for them, should get a rebate for processing the tires. The statute clearly says rebates can go for **Processing OR End Use.** The DOLA rules would only pay processors if they also used the tires after processing in the same rebate period. We will be taking draft rules through a stakeholder process and then to the Solid and Hazardous Waste Commission for adoption to clarify this point.
The Department is in the process of holding stakeholder meetings to establish new draft rules to take before the Solid and Hazardous Waste Commission. This process should be complete by the end of May, 2011.

Programmatic Status and Resource Needs of the Water Quality Control Division (WQCD)
[As discussed in the issue paper beginning on page 17 of the staff briefing document on the environmental divisions, the Department reports that the WQCD is unable to meet its statutory and regulatory responsibilities with current levels of resources. The WQCD estimates that doing so would require an additional 31.8 FTE in FY 2011-12 and a total of 66.3 additional FTE from FY 2011-12 through FY 2013-14.]

19. Please describe the Department's stakeholder process for negotiating potential changes to fees for the Water Quality Control Division? What stakeholders are involved (who are you negotiating with) and how are they involved? Are special districts involved as stakeholders as well?

Response: The Division always has included all interested parties in discussions concerning fees. These parties include special districts, municipalities, and industries that have discharge permits, public water systems, and the environmental community. The Division maintains and utilizes a stakeholder email list. When stakeholder meetings are scheduled, information is sent to the stakeholders via email and is also provided through postings on the Division's Web site. Staff

also notifies water interests groups such as the Wastewater Utility Council and Drinking Water Utility Council. During the 2006 and 2007 legislative sessions, the Division was able to secure an additional 22.2 FTE of the needed 32.7 FTE identified in Senate Bill 03-276 Report. These FTE were supported by an increase in both General Fund and cash fees. There was an expectation from all involved that the Division would seek additional resources in the future. Since 2007 the Division's workload has continued to increase. The Division has discussed fee resources with stakeholders at a variety of regularly scheduled meetings including the Water Quality Forum, the Wastewater Utility Council and Water Quality Council. The Division has also held meetings with stakeholders to specifically discuss resource needs. These meetings occurred in October 2008, March 2009 and September 2010. At all of these meetings, members of the regulated community did not support fee increases. Stakeholders expressed an understanding of the Division's resource challenges. However, stakeholders have pointed to the severe economic downturn, stakeholders did not support a fee bill in 2008, 2009, 2010 and have indicated that introducing a fee bill in the 2011 session of the General Assembly would also not be supported.

20. Please answer the following series of questions regarding the Water Quality Control Division's workload.

    a. How many stormwater permits are issued by CDPHE each year? And how many of those are for construction projects?

Response: In federal fiscal year 2010 (10/09 - 9/10), the Division issued 1,445 new stormwater permits, of which 1,344 were for new construction projects. There are currently just over 5,600 active stormwater permits, of which 3,400 are construction stormwater permits. The remaining permits are either for stormwater discharges from industrial sites or from municipal separate storm sewer systems (MS4s).

    b. How many stormwater inspections are performed annually by the Water Quality Control Division? How many of those are on construction sites? How many MS4 inspections occur annually?

Response: In federal fiscal year 2010 the Division performed 195 stormwater inspections and 10 audits of MS4 stormwater programs. Of the 195 stormwater inspections, 127 (109 planned inspections and 18 complaint responses) were at construction sites and 68 were at industrial sites (e.g., manufacturing, auto salvage, and mines).

    c. Is the revenue from current water quality permit fees adequate to support the regulations that are being considered during FY 11-12 (i.e., nutrient criteria standards that are schedule for hearing by WQCC in August 2011)?

Response: No. The Division does not have resources to implement nutrient requirements. In the event that the Water Quality Control Commission (WQCC) establishes numeric nutrient requirements through rulemaking, implementation of these requirements in discharge permits

would not be immediate, but would occur over the following 10 to 20 years. Over that period of time, implementation of nutrient requirements would increase the Division's workload in permits, compliance assurance, engineering (design reviews), and site specific standards revisions.

The Division has been working since 2001 to explore options for developing numeric nutrient criteria that would make sense in Colorado. This effort has largely been funded through federal funding. Nutrient pollution can come from many sources, including discharges from municipal and other wastewater treatment plants, lands used for agricultural activity, and stormwater runoff. Adverse effects of high concentrations of nutrients include reduced oxygen levels and higher pH in water which can negatively affect aquatic life, a decrease in the clarity of the water, and increased algae, which creates a slimy mat on the surface of the water and can create bad taste, odor, and toxic byproducts in drinking water. Barr Lake, in Adams County, is an example of a lake with severe nutrient pollution.

Over the past decade, EPA has strongly encouraged states to prepare plans for the development of nutrient criteria. In Florida where the state had not developed nutrient criteria, EPA was ordered by the court to develop criteria for the state. In Colorado, the Water Quality Control Commission (WQCC) has adopted numeric nutrient standards for specific reservoirs when site-specific concerns have arisen. Standards have been adopted for Dillon, Cherry Creek, Chatfield, Bear Creek and Standley Lake reservoirs. To date, the WQCC has not adopted numeric requirements that might be applied more broadly to Colorado surface waters.

d. Please provide us with a picture of the overall general fiscal impact related to proposed nutrient criteria standards. For example, Colorado Water and Power Development requested a delay due to projected cost impacts to projects funded by their revolving funds.

Response: The infrastructure costs vary significantly depending on the size and current level of treatment at the facility. The costs of installing nutrient treatment can be millions of dollars. The Division has been discussing treatments costs with stakeholders as part of the process of developing a nutrients proposal for a rulemaking hearing. In December, the Colorado Water Resources and Power Development Authority (Authority) requested that the WQCC postpone the rulemaking hearing for the consideration of nutrient standards and/or control regulations. The Authority requested a delay for a period of at least six months or such additional time as is deemed necessary to allow completion and consideration of a more robust cost-benefit study. The hearing had been scheduled for June 13, 2011 and the Commission will schedule a new rulemaking hearing at its January meeting. The Authority offered up to $400,000 to fund the study. This study is to analyze both the cost of treating to remove nutrients at wastewater treatment plants to levels currently being considered by the Division, as well as the economic benefits that would result from the improvement in the quality of state waters. Division staff is currently working with the Authority to refine the scope of the study.

e. Please discuss how CDOT projects will be impacted by new standards?

Response: As an entity holding several stormwater permits CDOT is required to implement a program to ensure that the construction activities of its contractors are conducted in a manner that does not cause applicable water quality standards to be exceeded. Historically, the stormwater permits for construction require the implementation of Best Management Practices (BMPs), such as silt fences and settling ponds, to control pollution in the runoff from construction sites to acceptable levels. However, where the Division finds that "typical" BMPs do not provide adequate control, additional measures, such as treatment ponds or wetlands, may be required. Current nutrient requirements being developed by the Division would only require minor adjustments to CDOT's permit requirements, such as a requirement to identify and further control known sources of nutrients including fertilizers used for re-vegetation of areas disturbed during construction. In studies reviewed by the Division, nutrients from stormwater runoff have been found to contain a fraction of the level of nutrients in municipal discharges. Therefore, extensive controls are not seen as being necessary during the initial implementation phase over the next decade. The Division has been in contact with CDOT regarding the development of nutrient requirements.

21. Does the Water Quality Control Division levy fines against other state agencies that are found to be in violation of water quality permit requirements (during construction projects, for example)?

Response: State agencies that are conducting activities (e.g., construction) that result in a point source discharge of pollutants are required to obtain a permit from the Division. Where the state agency is significantly violating a permit, the Division has issued enforcement actions to compel compliance, including levying fines. The most recent enforcement action taken against a state agency was issued to CDOT on January 11, 2006 for stormwater permit violations. As a result of that action which consolidated multiple violations over the course of several months, CDOT paid the fine, and some of that funding went toward a Supplemental Environmental Projects (SEP) including the construction of a Best Management Field Training Facility (BMP Facility) on its property located in Denver. They agreed to use the facility to train construction companies, contractors, consultants, municipalities or other related organizations and individuals on the proper purpose, use, installation and maintenance of erosion and sediment control BMPs. In addition, CDOT helped sponsor the Regional Air Quality Control Ozone Reduction Strategy Vehicle Scrappage Program known as the "Cash for Clunkers" and CDOT agreed to translate its "Erosion Control and Stormwater Quality Field Guide" to Spanish.

22. The Department's description of the Water Quality Control Division's future resource needs highlights a court case which will require the Division to issue permits for pesticide applications in or near waters. The Department estimates that this change will require approximately 2,000 new permits. Who were the litigants in this case?

Response: This case (National Cotton Council of America, et al. V. EPA) was a consolidation of several cases filed in every federal district circuit court in the nation by industry and environmental litigants who, respectively, were:

Industry:
Agribusiness Association of Iowa, BASF Corporation, Bayer CropScience LP, CropLife America, Delta Council, Eldon C. Stutsman, Inc., FMC Corporation, Illinois Fertilizer & Chemical Association, The National Cotton Council of America, Responsible Industry for a Sound Environment, Southern Crop Production Association, and Syngenta Crop Protection, Inc., LP.

Environmental:
Baykeeper, Californians for Alternatives to Toxics, California Sportfishing Protection Alliance, National Center for Conservation Science and Policy, Oregon Wild, Saint John's Organic Farm, Waterkeeper Alliance, Inc., Peconic Baykeeper, Inc., Soundkeeper, Inc., Environmental Maine, and Toxics Action Center.

23. The Department's discussion of future resource needs for the Division also says that over 900 process water discharges are not getting inspected. Please explain this situation. For example, is there a list of facilities that the Department has decided are the best facilities not to inspect given current resource constraints?

Response: The Division has historically excluded several industrial sectors of discharges from its inspection planning process based on a perceived lower risk to the environment and based on EPA's emphasis on inspections of facilities with treatment plants. The 900 facilities that we are unable to inspect include sand and gravel mines, some coal mines, hydrostatic pipeline testing, and construction dewatering.

24. Given the number of facilities that the WQCD is unable to inspect in a given year how does the Division prioritize its inspection resources? Are there specific facilities or types of facilities that the Department feels are most important to inspect? Are there facility types that are lower priority for inspections? Please explain.

Response: The Division historically has prioritized its process water inspection resources based on: (1) the risk to the environment from the discharge, (2) size of the facility, (3) EPA's inspection requirements and (4) where the Division receives a complaint. Under this approach, the majority of inspection resources have been allocated to major domestic and industrial facilities and to minor domestic and treatment-oriented minor industrial facilities. This was done primarily to meet EPA inspection frequency requirements for major facilities, but also because the Division had presumed that the 900 non-treatment oriented minor facilities posed a lower risk to water quality in Colorado.

Starting this current inspection year (October 1, 2010 - September 30, 2011), the Division is allocating a portion of the resources to facilities that have previously had few or no routine

inspections. This shift in resource allocation is being done to confirm the Division's assumption that the 900 facilities present a lower risk to public health and/or the environment. The information gathered during this year will be used to decide if permanent adjustments to the types of facilities that are inspected are needed.

For stormwater, the Division prioritized inspections based on: (1) risks to the environment, (2) EPA's inspection requirements and (3) where the Division receives a complaint. Recently, the Division shifted inspection resources from construction sites to auditing the municipal MS4 permitting programs due to the fact that municipalities, as a requirement of their stormwater permits, oversee construction activities within their jurisdiction. The Division saw this as a better way to effect improvement in the compliance of that sector. Once the Division determines that MS4s are properly overseeing construction activities within their respective jurisdictions the Division will be able to reallocate its inspection resources to other stormwater sites.

25. The Department's report on WQCD resource needs discusses "5,500 permitted stormwater dischargers" and "over 5,500 activities covered under stormwater permits." Please explain the difference.

Response: The activities such as municipal storm sewer systems, major manufacturing facilities and large construction sites are dischargers. In order to discharge, these activities must be covered under a stormwater permit issued by the Division. The terms activity and discharger are interchangeable.

26. Does EPA have a list of impaired water bodies in Colorado? If so, or if the WQCD has a list, please provide the list.

Response: Yes, the Department (and the EPA) has a list of impaired water bodies. The list of impaired water bodies can be found at:

http://www.cdphe.state.co.us/regulations/wqccregs/100293wqlimitedsegtmdlsnew.pdf.

The report documents the data we have available. Specifically:

- Total River Miles in State: 105,344
- Total Miles Assessed: 71,013
- Total Miles Impaired: 10,673
- Total Lake Acres in State: 249,787
- Total Acres Assessed: 150,223
- Total Acres Impaired: 78,997

However, it should be noted that 33% of Colorado's rivers and streams and 40% of lakes and reservoirs do not have adequate state or federal monitoring data to determine if they are meeting water quality standards.

27. Have municipalities ever claimed sovereign immunity over water quality regulation issues?

Response: No.

Water Quality Control Division Budget Options for FY 2011-12

[The issue paper beginning on page 21 of the staff briefing document on the environmental divisions presents budget options for the WQCD in FY 2011-12 and recommends that the Committee carry legislation eliminating the WQCD's General Fund and raising water quality fees to offset the General Fund reduction as well as provide additional resources.]

28. Given the impact of water quality on wildlife, could Division of Wildlife cash funds be used for water quality regulation or restoration activities? Please explain.

Response: The CDPHE contacted the Department of Natural Resources for their input on this response.

Use of Division of Wildlife (DOW) cash funds to support water quality regulation or restoration activities would require amending state statutes, would constitute a diversion relative to Federal aid, and consequently would make the DOW ineligible to receive $20 million per year in federal aid until those moneys were repaid, with interest, from the General Fund.

Section 33-1-112 (1) (a) C.R.S. authorizes the Wildlife Cash Fund and establishes the parameters by which these funds can be used *"… all moneys received from wildlife license fees and all moneys from all other wildlife sources, and all interest earned on such moneys shall be deposited in the state treasury and credited to the wildlife cash fund, which fund is hereby created, and such moneys shall be utilized for expenditures authorized or contemplated by and not inconsistent with the provisions of articles 1 to 6 of this title for wildlife activities and functions and for the financing of impact assistance grants pursuant to part 3 of article 25 of title 30, C.R.S. All moneys so deposited in the wildlife cash fund shall remain in such fund to be used for the purposes set forth in the provisions of articles 1 to 6 of this title and shall not be deposited in or transferred to the General Fund of the state of Colorado or any other fund." (emphasis added)*

The DOW also receives wildlife and sportfish restoration funds from the U.S. Fish and Wildlife Service (USFWS). As a condition of receiving federal funds, the State of Colorado, by statute, has agreed that all hunting and fishing license fee revenues (Wildlife Cash) shall not be used for any purpose other than the administration of DOW. See §§ 33-1-117 and 118, C.R.S- Assent Legislation to the Pitman-Robertson Act and Assent Legislation to Dingell-Johnson Act. Such statutory agreement is a specific requirement of eligibility for federal funding under these programs.

The Water Quality Control Division is responsible for maintaining the quality of the state's water resources so that they are safe to drink, support a diversity and abundance of aquatic life, and are suitable for recreation, irrigation, and commercial use. The Division has authority to

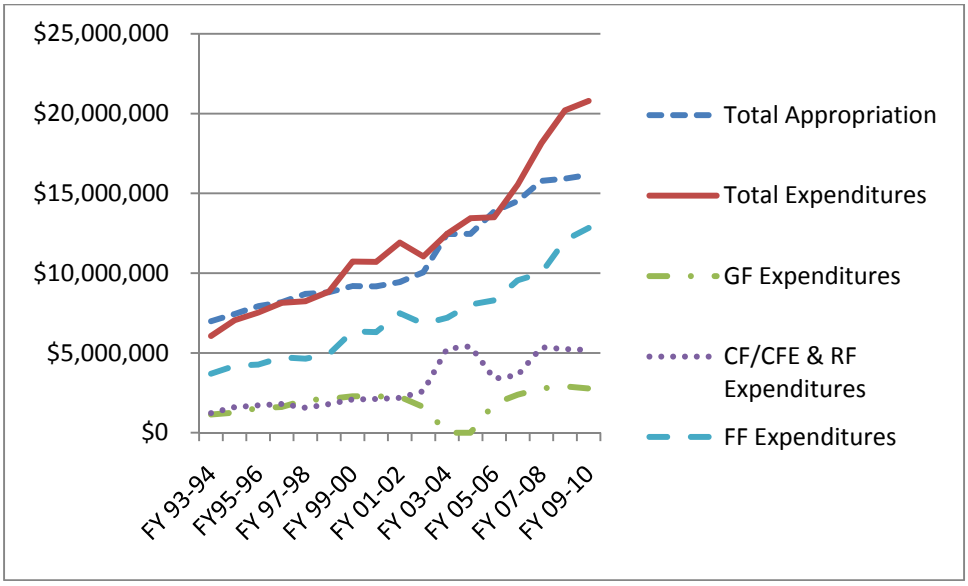
implement two federal water quality laws: 1) the Clean Water Act; and 2) the Safe Drinking Water Act. The main piece of state legislation that the Division is responsible for implementing is the Water Quality Control Act.

Federal law and regulations, and Colorado law (Sections 33-1-117 and 33-1-118, C.R.S.), do not allow for Wildlife Cash expenditure for water quality or restoration projects whose primary purpose is not wildlife, such as projects to meet municipal, industrial, or agricultural needs. Additionally, the statutes and regulations require that the projects be under the control and direction of the state wildlife agency (DOW). The use of wildlife cash funds for these purposes as well as the DOW's loss of control over these funds would be deemed diversion by the USFWS.

50 CFR 80.4, (b)-(d) Diversion of License Fees: *"Revenues from license fees paid by hunters and fisherman shall not be diverted to purposes other than administration of the State fish and wildlife agency. (b) for the purposes of this rule, administration of the State fish and wildlife agency include only those functions required to manage the fish and wildlife-oriented resources of the state for which the agency has authority under state law. (c) A diversion of license fee revenues occurs when any portion of license revenues is used for any purpose other than the administration of the State fish and wildlife agency. (d) If a diversion of license revenues occurs, the state becomes ineligible to participate under the pertinent Act from the date the diversion is declared by the Director until: (1) Adequate legislative prohibitions are in place to prevent diversion of license revenue, and (2) All license revenues or assets acquired with license revenues are restored, or an amount equal to license revenue diverted or current market value of assets diverted (whichever is greater) is returned and properly available for use for the administration of the State fish and wildlife agency,"*

By rule and in practice, the USFWS considers two elements in evaluating whether a diversion of game cash has occurred, either of which if present constitute diversion. Those elements are use of moneys for purposes other than a primary wildlife purpose (the test generally being whether it is a required function of the state wildlife agency and whether the agency would have otherwise chosen to do that for wildlife management purposes). Incidental, non-primary wildlife benefits of an expenditure of game cash funds do not constitute a wildlife purpose, and therefore would be considered a diversion. The second element is loss of control by the state wildlife agency. In the past the USFWS has considered movement of game cash funds to other funds outside the control of the state wildlife agency a diversion, regardless of whether those funds are expended for other purposes or not. In this case moving game cash funds to the Division for water quality regulation or water restoration work would be considered diversion by the USFWS. If diversion of any amount of wildlife cash occurs, the State of Colorado and the DOW would be ineligible for all future funding under these acts (approximately $20 million annually) until the amount of money that was diverted is repaid with interest, and this repayment must be made from funds other than those derived from hunter and angler sales. In other words, the legislature would have to use General Fund dollars to repay the diversion.

29. Please produce a chart similar to the graph on page 22 of the staff briefing document on the environmental divisions but showing actual expenditures by fund source for the years shown (since FY 1993-94) and showing a line for the WQCD's total funds over that period as well.



The total expenditures include federal funds that are designated for specific purposes.

Beginning in 2005 there was an increase in total expenditures. The majority of the total expenditures are related to an increase in spending levels in federally funded contracts. Federal funds are awarded to municipalities, public water systems, non-profit watershed groups and contractors. The activities supported by these contracts include training and technical assistance, watershed restoration projects, and grants to assist small drinking water systems with costs associated with planning/design of treatment plant improvements.

30. As discussed on pages 23 and 24 of the staff briefing document on the environmental divisions, water quality permit holders continue to operate while awaiting permit renewal, even after a permit has expired. Please explain why this is true for water and not for air quality. Is there a difference in state statute or regulation, or is the difference at the federal level?

Response: Permits issued by the Water Quality Control Division are subject to section 4 of article 24 (the "Administrative Procedures Act") in which §24-4-104(7) provides:

"(7) In any case in which the licensee has made timely and sufficient application for the renewal of a license or for a new license for the conduct of a previously licensed activity of a continuing nature, the existing license shall not expire until such application has been finally acted upon by the agency, and, if the application is denied, it shall be treated in all respects as a denial. The licensee, within sixty days after the giving of notice of such action, may request a hearing before

the agency as provided in section 24-4-105, and the action of the agency after any hearing shall be subject to judicial review as provided in section 24-4-106."

With respect to the Clean Water program, standards are not self-implementing. How water quality standards are implemented into a permit depends on site specific conditions. For example, a permitted entity may discharge into a stream that has significant flow. The effluent limit that is put in the permit is calculated using an equation that takes into consideration the established water quality standard for a specific pollutant for a specific stream as well as the stream flow. The calculated limit that is put into the permit is to be protective of the water quality in the stream. This is a very labor intensive process and is usually specific to a permitted entity. Therefore, at the end of the water quality permit term, if a new application has been filed but not acted upon, the discharger may continue to operate under the terms of the existing permit, as it is not possible to determine what new terms and conditions would need to be included in the permit without completing the complicated calculations.

To clarify with respect to air permit requirements, state air construction permits do not expire once issued (however they may be amended over time, or withdrawn or canceled by a source), and state Title V operating permits issued under the authority of the federal Clean Air Act expire and must be renewed every five years, however a source may continue to operate if done in accordance with the terms and conditions contained in the new, timely filed application, as long as the new application contains all new applicable regulatory requirements.

31. According to the staff briefing document, the WQCD does not track expenditures according to fund source *or* the use of the funds within a given line item. For example, the Department has argued that certain activities such as emergency response may be more appropriately funded with General Fund than cash funds but has been unable to provide information on how much the WQCD spends on those activities in a given year. Please explain why the Division does not have that information? That is, why is the Division not tracking expenditures in this way?

Response: The Division does track expense detail by funding source. This information is submitted to the JBC with the annual budget submission. The Division uses a combination of General Fund, Cash Funds, and Federal funds to resource the various programs that ensure safe water for Colorado's citizens, wildlife, and visitors. The funds that support these programs are appropriated and expended by the major program areas of administration, clean water, and drinking water. Although the Division can identify the costs of personnel and operating for programs at the appropriation level, it cannot report expenses for specific activities conducted by the individual programs. For example, the Division can report the total personal services costs associated with managing the clean water program but cannot provide a detail of how much of the cost represents construction storm water vs. process water. The same is true for emergency response; the Division responds to emergencies using existing resources. Like most programs within the state, the Division does not track the level of effort for each of its functions but rather the total resources needed to accomplish its mission. To meet federal reporting

requirements a few Division's within the Department track to this level of detail. However, funding for this level of detail is supported and funded by federal funds. If the Department is directed to implement a tracking system that itemizes activities funded with General Funds, resources to implement and support these efforts will be required.

32. According to the staff briefing document and the Department's report on WQCD resource needs there are 900 process water discharge facilities that the WQCD does not inspect. Of the other approximately 1,100 discharge permit holders, how many does the WQCD inspect in a given year? Does the Division manage to visit each facility at least once every five years? Please provide data on the inspection rate for process water discharges as a group.

Response: The Division averaged roughly 200 inspections annually between federal fiscal years 2008 through 2010. The Division's inspection plan requires a minimum of 220 inspections, 20% of the total dischargers, annually in order to inspect each of the 1,100 dischargers at least once in a five year period. At the end of five years, assuming no increase in permitted facilities the Division will be approximately 100 facilities behind in inspections.

Options for General Fund Savings in Consumer Protection Division

[The issue paper beginning on page 26 of the staff briefing document on the environmental divisions presents options for General Fund savings in the Consumer Protection Division in FY 2011-12 and recommends cash funding the Dairy Program through increased fees and considering cash funding the remaining General Fund in the Retail Food Program.]

Dairy Program

33. Please provide some background on the economic importance of the dairy industry in Colorado? How much of an economic driver is the industry?

Response: The Department does not track this information. However, CDPHE contacted the Department of Agriculture regarding this question. At that department's request CDPHE is proposing to defer the question to the Department of Agriculture as it is better equipped to provide the requested information.

34. Please provide information on how other states pay for dairy inspections. For example, do other states use fees, General Fund, a combination, etc.? How do Colorado's fees compare to other states?

Response:

Funding for Dairy Programs in states that responded to a survey conducted in 2009

State	General Fund %	Fees %	Other %
Colorado	95%	5%	
Utah	95%	0%	5%
Nebraska	50%	50%	
Missouri	7%	93%	
Texas*			100%
New Mexico	100%		
Iowa	15%	85%	
Kansas	35%	65%	

* Texas charges a fee for milk (see below). That revenue is deposited in the General Fund and the program is supported by General Fund appropriations.

Fees for Dairy Programs in Colorado and Comparable States

State	Plant	Farm	Samplers	Haulers	Tankers
Colorado	$300-$1,600	$0	$50	$50	$0
Utah	$79	$79	$0	$0	$0
Nebraska	$100-$1,000	$0	$0	$25	$25
Missouri	$10	$0	$3	$3	$0
	In addition to the above fees, Missouri charges $.045/cwt* for in-state produced milk. This fee is paid by both the processors and the farms.				
Texas	$800	$400	$0	$0	$100
	In addition to the above fees, Texas charges $0.45/cwt*on Grade A Milk products (paid by processors).				
New Mexico	$0	$0	$0	$0	$0
Iowa	$400-$2,000	$.005 per cwt* - $.015 per cwt*	$20	$20	$50
Kansas	$155	$0	$0	$35	$0
	Kansas also charges multiple production fees by the cwt*.				

*Cwt is price per hundred pounds. For example, utilizing the hundred weight fee structure concept established in Missouri and Texas, the average annual fee that would be paid by Colorado's average facility would be $88,400.

35. Please discuss the impact of the New Frontier Bank situation on Colorado's dairy industry.

Response: CDPHE contacted the Department of Agriculture regarding this question. At that department's request CDPHE is proposing to defer the question to the Department of Agriculture as it is better equipped to provide the requested information.

Retail Food and Child Care Inspection Programs

36. According to the staff briefing document for the environmental divisions, the Consumer Protection Division conducts inspection activities for retail food and child care facilities in ten counties that do not have local health agencies (Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache, Garfield, Moffat, Grand, and Jackson counties). Please explain: 1) why these counties would not have local health agencies (either for each county or for regions); 2) why the state has historically subsidized these inspections for the counties in question while other counties/regions are forced to handle their own inspections; and 3) why the counties should or should not be required to manage inspections going forward.

Response: CDPHE is statutorily required to provide these inspection activities statewide and does so unless a local government chooses to provide these programs. No local public health agency is forced to provide services; those local agencies that choose to provide these services use a variety of available funding sources, such as licensing fees, state General Fund per-capita funds, and local tax dollars. CDPHE encourages local agencies to provide services, but does not have the authority to mandate that services be provided on the local level.

The passage of "The Public Health Revitalization Act" (SB194) in 2008, facilitates the provision of public health services at the local level by each county or by regionalization. The local public health agencies that provide retail food, childcare inspection and other public and environmental health services at a local level are able to accomplish this more economically than CDPHE, however, fees do not cover the entire cost of these programs and therefore , local tax dollars are needed to augment program costs. Inability to fund services is one reason why a county may choose not to provide these services. Also, some local areas have difficulty recruiting employees with the needed education and necessary qualifications to perform the inspections.

37. According to the staff briefing document, the Consumer Protection Division conducts inspections in counties that do not have local health agencies and *oversees local inspection programs in counties that do have local health age*ncies. Please describe the oversight process for counties that do have local health agencies.

Response: The State's Retail Food and Child Care Programs are coordinated and overseen by the Division. These programs are administered statewide and help to ensure that a safe food

supply is available to and provided in the 20,000+ restaurants and grocery stores throughout Colorado and that a safe environment is provided within the over 5,000 inspected child care centers within the State. "Oversight" of the program includes in part:

- Ensuring an appropriate statutory and regulatory framework exists;
- Promulgating regulations that are uniform to national guidelines;
- Developing and implementing programmatic standards and guidelines for local public health agencies;
- Developing and deploying training to ensure an appropriately trained statewide workforce is maintained, and
- Providing uniform interpretation and application of all program laws, rules, regulations, guidelines and standards to local public health agencies and industry.

The Division collaborates directly with 36 local public health agencies and 220 inspectors in the State who provide programmatic services in their jurisdictional areas. Additionally, the Division conducts the regulatory activities within ten (10) counties in the State that currently do not have the infrastructure to do so themselves. The Division's oversight role is accomplished via survey's of local health agencies programs; quarterly meetings with LPHAs Environmental Health Directors and LPHAs Retail Food Program Managers; audits; and standardization exercises with LPHAs inspectors. The Division's "oversight" approach tends to be more focused on education, mentoring and partnership, rather than an enforcement role that might typically be associated with "oversight."

38. Do retail food establishments inspected by local agencies pay fees for this service? Do those fees vary by county? Please explain.

Response: Yes, throughout Colorado retail food establishments pay an annual license fee. No, the fees do not vary by county. C.R.S 25-4-1607. License fees are set in statute and vary depending upon the number of seats in a restaurant or the square footage if the establishment is a grocery store.

39. The state has not provided the Department authority to collect fees for the inspection of child care facilities. Do local health agencies collect fees for the inspection of child care facilities?

Response: Yes, local public health agencies have the ability to collect fees for child care inspections. Some local public health agencies collect a fee and others do not. The statutory ability for locals to charge a fee for the inspection of child care facilities is listed in C.R.S., §25-5-508(5)(j). The Department does not have a similar provision within its authorities listed in C.R.S., §25-1.5-101 et. seq. The local health agencies do not have to do child care inspections, however if the locals do not perform the inspections, then the Department would be required to perform the inspections.

40. The Department of Human Services (DHS) licenses child care facilities. Does DHS collect license fees from such facilities? If so, could some of those revenues be used to support the Consumer Protection Division's inspection activities? Also, given the DHS role in licensing, would it make sense to transfer the inspection responsibility to DHS as well to avoid redundancy between the departments?

Response: Yes. The DHS collects license fees from child care facilities. The use of the revenues from these fees to support the inspection activities performed by Consumer Protection Division or local public health is not appropriate. These fees are collected to support DHS regulatory/inspection roles within these facilities that are defined within their statutory authority. CPD authority is separate and defined within CDPHEs general Department authority under C.R.S.,§25-1.5-101(1)(h). The DHS regulations and CPD regulations for child care facilities are not duplicative by design and therefore there is no inspection redundancy. DHS regulates and inspects for child wellbeing and program quality issues such as staff qualifications, including background checks, staffing ratios, age-appropriate toys and surroundings that foster a suitable learning environment. CPD, on the other hand, regulates and inspects for health and sanitation issues such as food safety, facility cleanliness and sanitization, modes of disease transmission, and immunization records. The skill sets, educational backgrounds and technical expertise needed to inspect child care facilities are unique for each agency and therefore it would be very difficult for either agency to conduct both necessary functions individually.

41. Why do retail food and child care inspections have to be conducted by government agencies? Couldn't the State simply require inspections by licensed or certified inspectors at a given frequency and allow the counties or facilities to contract with independent inspectors that would be held to statewide standards? Would this option allow for budgetary savings for the State?

Response: Currently, the Division is not aware of any licensed or certified third party inspectors or companies within the State or any other States that provide inspection activities in this manner. However, whether services are provided in this manner or by the local public health agency, the Division is still required to provide the program oversight activities under state law, that are described in the answer to question #37. Therefore, removing the inspections by having them performed by a third party does not remove the programmatic functions (see question #37) funded by the General Fund appropriation. In fact, having these services contracted out could result in the need for additional program dollars since the oversight activities could potentially increase because of third party entities performing inspections.

Vector Program

42. The Consumer Protection Division's vector program appears to be redundant with local agency programs. Please explain the utility of the program and whether or not it is redundant with other programs.

Response: The program provides vector services in local areas that do not have a vector program. There are only 11 local public health agencies that have their own vector programs. However, as noted earlier, some local agencies have indicated that if per capita funding decreases they might eliminate their vector program.

In addition to providing direct vector monitoring and incident response services, the Consumer Protection Division provides coordination functions to the agencies that have their own program. This includes assisting with strategies to coordinate activities between two or more jurisdictions in cases where vector-borne disease incidents are not isolated and where there is the possibility for movement across the state (e.g. West Nile and rabies). Consumer Protection staff also attend nationwide educational conferences on relevant topics and work in conjunction with other state counterparts and the Centers for Disease Control and Prevention to maintain expertise in vector-borne diseases. Staff also maintains expertise on vectors that may be used in potential bioterrorism events such as tularemia and plague, as well as ensuring that they are prepared to take appropriate actions to respond to these events. These statewide coordination functions could not be provided by local programs.

43. Why is the vector program housed within the Consumer Protection Division rather than one of the other health divisions within the Department? Please explain why the Consumer Protection Division is the best agency to implement the program.

Response: The Disease Control and Environmental Epidemiology Division investigates the human disease portion of the vector program and coordinates this aspect with the duties performed by the Consumer Protection Division. The duties performed by the Consumer Protection Division address the environmental aspects of the program. This includes:

- Performing an environmental assessment of the property or area in which a human case of West Nile, Plague or Hantavirus has occurred. The environmental assessment involves visiting the area and collecting dead birds, swabbing prairie dog burrows for fleas, trapping mice, and collecting feces. Once collected, the samples are analyzed, usually by the state laboratory, and occasionally by the Centers for Disease Control, to determine if they are the source of the human disease that has been identified.
- Once disease has been found, the program develops strategies for informing the public about what precautions should be taken to prevent future disease cases. Strategies generally involve issuing press releases, developing fliers for distribution to the public, and providing information at public meetings.

- The program also provides general public service announcements and education including speaking to groups and answering telephone and email inquiries on how to manage vector issues such as bed bugs, insect and spider infestations, bats, lice, etc.

Health Fraud

44. The Health Fraud program appears to be redundant with programs at the Departments of Human Services and Health Care Policy and Finance, as well as the Department of Law. Please explain why this program should continue to exist within the Consumer Protection Division *and* whether it would make more sense to move the program to one of the other departments.

Response: The Division's fraud program involves products in which the false claims are associated with foods, drugs or cosmetics. This is not to be confused with the health fraud task force that deals with Medicaid fraud, among other issues. False claims are the result of the food, drug or cosmetic being adulterated or misbranded. The Consumer Protection Division has the authority, under the state's Pure Food and Drug Law, to take actions such as removing product. The Division does not believe the agencies listed above have the authority to take such actions, and therefore the activities associated with health fraud in CPD are not redundant with programs at the Departments of Human Services, Health Care Policy and Financing, and Law.

45. Is the health fraud program based in statute? Please explain what the approximately $3,500 associated with the program pays for on an annual basis.

Response: The statutory authority to take action against fraudulent products (e.g. removal from the market, recalled, embargoed or condemned) lies within 25-5-401 C.R.S. "Pure Food and Drug Law," the state's comparable statute to the US Food, Drug and Cosmetic Act.

Health fraud, rather than being a program; is a number of activities that can be taken when needed to address a problem. These activities include protecting consumers from fraudulent products that claim to cure a wide spectrum of diseases such as cancer and HIV/AIDS, to weight loss. These fraudulent products may contain ingredients that cause harm to the individual (e.g. drugs such as ephedrine- known to cause serious cardiac abnormalities and deaths, Aristolochic Acid- known to cause kidney damage**,** and Kava, which damages the liver) or products that are misleading and are more of an economic fraud than a health hazard to the consumer.

Staff work is conducted to address products manufactured within Colorado or nationally under a cooperative agreement with the U.S. Food and Drug Administration. Consumer Protection Division staff activities include responding to consumer complaints. Examples of activities the division has been involved with include an investigation of spring water labeled as a cure for cancer, an ethnic market selling antibiotics over the counter without requiring a prescription, fraudulent products claiming to cure or prevent HIV and other sexually transmitted diseases, removal of weight loss products and body building products which contained ephedrine.

ADDENDUM: QUESTIONS REQUIRING ONLY A WRITTEN RESPONSE

Questions Common to All Departments

46. Please provide a table comparing the actual number of Department FTEs in FY 2000-01 and the requested number of Department FTEs in FY 2011-12, by division or program.

Response:

CDPHE FTE History FY 2000-01 Actuals to FY 2011-12 Request		
Division	2000-01	2011-12
(1) Administration & Support	69.9	90.7
(2) Center for Health and Environmental Information Statistics	71.2	71.2
(3) Laboratory Services Division	87.4	77.7
(4) Air Pollution Control Division	151.4	161.1
(5) Water Quality Control Division	104.1	133.9
(6) Hazardous Materials and Waste Management Division	125.6	134.6
(7) Consumer Protection Division	24.7	30.5
(8) Disease Control and Environmental Epidemiology Division	103.9	150.5
(9) Prevention Services Division	166.8	165.8
(10) Health Facilities and Emergency Medical Services Division	111.6	170.0
(11) Emergency Preparedness and Response Division*	N/A*	42.5
Totals	1,016.6	1,228.5

*Was not included in Long Bill in FY 2000-01

Over this time period, while some FTE has been added via Decision Item requests of the Department; the majority of FTE has either been added by the General Assembly or federal programs that require additional resources. If you would like further information on this we would be happy to provide it.

47. Please provide a table comparing the actual number of FTEs in FY 2008-09 and FY 2009-10 to the appropriated level of FTE for each of those fiscal years, by division or program. If there is a discrepancy of 5.0 percent or more between your FY 2009-10 FTE appropriation and actual usage for that year, please describe the impact of adjusting the FY 2011-12 FTE appropriation to align with actual usage from FY 2009-10.

Response: Please see attachment.

Attachment Question 8.A

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
General Hospitals:					
1. Initial Application for Licensure	$360	$360			
1-25 beds			$8,000	$8,000	$8,000
26-50 beds			$10,000	$10,000	$10,000
51-100 beds			$12,500	$12,500	$12,500
101 + beds			$9,800 plus $50 per bed, not to exceed $20,000	$9,800 plus $50 per bed, not to exceed $20,000	$9,800 plus $50 per bed, not to exceed $20,000
Facilities licensed as general hospitals but Medicare-certified as long-term hospitals			$5,700 plus $50 per bed, not to exceed $10,500	$5,700 plus $50 per bed, not to exceed $10,500	$5,700 plus $50 per bed, not to exceed $10,500
2. Building Plan [Life Safety Code] Review - Initial License or New Construction			$0.37 per sq. foot up to 35,000 sq feet; $0.03 per sq. ft. for additional sq. ft. above 35,000 up to 200,000 sq. ft.; $0.01 per sq. ft. for additional sq. ft over 200,000		
3. Renewal Licensure (annual fee)	$360	$360			
1-50 beds			$900 pus $12 per bed	$900 pus $12 per bed	$900 pus $12 per bed
51-150 beds			$1,400 plus $12 per bed	$1,400 plus $12 per bed	$1,400 plus $12 per bed
151 + beds			$2,000 plus $12 per bed, not exceed $8,000	$2,000 plus $12 per bed, not exceed $8,000	$2,000 plus $12 per bed, not exceed $8,000
4. Off-Campus Locations					
Initial licensure	n/a	n/a	n/a	n/a	$1,000
Initial licensure - federal classification as a Critical Access Hospital	n/a	n/a	n/a	n/a	$500
Renewal Licensure	n/a	n/a	n/a	n/a	$500
Addition of an Off-Campus Location to an existing license	n/a	n/a	n/a	n/a	$1,000
Removal of an Off-Campus Location from an existing license	n/a	n/a	n/a	n/a	$360
5. Remodeling [existing license] Building Plan Review - General			$2,000 minimum. $0.25 per sq. foot up to 35,000 sq feet; $0.03 per sq. ft. for additional sq. ft. above 35,000 up to 200,000 sq. ft.; $0.01 per sq. ft. for additional sq. ft over 200,000		
Egress or Specific systems			Egress $2,000; Specific systems: 1-4 compartments $2,000, each additional compartment $500.		
6. Change of Ownership	$360	$360	$2,500	$2,500	$2,500
7. Provisional License	$360	$360	$2,500	$2,500	$2,500

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
8. Conditional License	$0	$360	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee
9. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
10. Application to Change Facility Name	$360	$360	$360	$360	$360
11. Renewal Application Late Fee					equals renewal fee
Psychiatric, Rehabilitation and Maternity Hospitals:					
1. Initial Application for Licensure	$360	$360	$5,700 plus $50 per bed, not to exceed $10,500	$5,700 plus $50 per bed, not to exceed $10,500	$5,700 plus $50 per bed, not to exceed $10,500
2. Building Plan [Life Safety Code] Review - Initial License or New Construction			$0.37 per sq. foot up to 35,000 sq feet; $0.03 per sq. ft. for additional sq. ft. above 35,000 up to 200,000 sq. ft.; $0.01 per sq. ft. for additional sq. ft over 200,000		
3. Renewal Licensure (annual fee)	$360	$360	$1,600 plus $12 per bed, not to exceed $8,000	$1,600 plus $12 per bed, not to exceed $8,000	$1,600 plus $12 per bed, not to exceed $8,000
4. Remodeling [existing license] Building Plan Review - General			$2,000 minimum. $0.25 per sq. foot up to 35,000 sq feet; $0.03 per sq. ft. for additional sq. ft. above 35,000 up to 200,000 sq. ft.; $0.01 per sq. ft. for additional sq. ft over 200,000		
Egress or Specific systems			Egress $2,000; Specific systems: 1-4 compartments $2,000, each additional compartment $500.		
5. Change of Ownership	$360	$360	$2,500	$2,500	$2,500
6. Provisional License	$360	$360	$2,500	$2,500	$2,500
7. Conditional License	$0	$360	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee
8. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
9. Application to Change Facility Name	$360	$360	$360	$360	$360
10. Renewal Application Late Fee					equals renewal fee
Ambulatory Surgical Centers:					
1. Initial Application for Licensure	$360	$360	$6,600	$6,600	$6,600
2. Building Plan [Life Safety Code] Review - Initial License or New Construction			$2,500 for 0-2 operating or procedure rooms; $5,000 for 3 or more rooms.		
3. Renewal Licensure (annual fee)	$360	$360	$1,440 plus $200 per operating and/or procedure room; not to exceed $3,000	$1,440 plus $200 per operating and/or procedure room; not to exceed $3,000	$1,440 plus $200 per operating and/or procedure room; not to exceed $3,000
4. Remodeling [existing license] Building Plan Review			$500 for desk review; $1,500 for desk plus on-site review for 0-2 rooms, $250 each add'l room.		

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
5. Existing License - Replacement building / change physical location			$3,100 for 0-2 operating or procedure rooms, $5,600 for 3 or more rooms.		
6. Change of Ownership	$360	$360	$4,100	$4,100	$4,100
7. Provisional License	$360	$360	$2,500	$2,500	$2,500
8. Conditional License	$0	$360	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee
9. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
10. Application to Change Facility Name	$360	$360	$360	$360	$360
11. Renewal Application Late Fee					equals renewal fee
Acute Treatment Units:					
1. Initial Application for Licensure	$3,500 plus $100 per bed	$3,500 plus $100 per bed	$3,500 plus $100 per bed	$3,500 plus $100 per bed	$3,500 plus $100 per bed
2. Renewal Licensure (annual fee)	$1,500 plus $20 per bed	$1,500 plus $20 per bed	$1,500 plus $20 per bed	$1,500 plus $20 per bed	$1,500 plus $20 per bed
3. Remodeling [existing license] Building Plan Review	$500 Desk review only; Desk review plus on-site review $1,000.				
4. Regulated Contiguous Occupancies					
Annual fee	n/a	n/a	$250 for 20,000 sq. ft. or less; $500 over 20,000 sq. ft.	$250 for 20,000 sq. ft. or less; $500 over 20,000 sq. ft.	$250 for 20,000 sq. ft. or less; $500 over 20,000 sq. ft.
Building Plan Review - conversion of an adjacent occupancy into a regulated contiguous occupancy	n/a	n/a	$1,350 + $0.20 per sq. ft additional over 20,000 sq. ft.		
5. Application to Increase Number of Licensed Beds	$100	$100	$100	$100	$100
6. Application to Change Facility Name	$100	$100	$100	$100	$100
Hospital Units:					
1. Initial Application for Licensure	$360	$360	$5,300 + $50/bed	$5,300 + $50/bed	$5,300 + $50/bed
2. Building Plan [Life Safety Code] Review - Initial License or New Construction			$0.37 per sq. foot up to 35,000 sq feet; $0.03 per sq. ft. for additional sq. ft. above 35,000 up to 200,000 sq. ft.; $0.01 per sq. ft. for additional sq. ft over 200,000		
3. Renewal Licensure (annual fee)	$360	$360	$1,600 + $12/bed	$1,600 + $12/bed	$1,600 + $12/bed
4. Remodeling [existing license] Building Plan Review - General			$2,000 minimum. $0.25 per sq. foot up to 35,000 sq feet; $0.03 per sq. ft. for additional sq. ft. above 35,000 up to 200,000 sq. ft.; $0.01 per sq. ft. for additional sq. ft over 200,000		
Egress or Specific systems			Egress $2,000; Specific systems: 1-4 compartments $2,000, each additional compartment $500.		
5. Change of Ownership	$360	$360	$2,500	$2,500	$2,500
6. Provisional License	$360	$360	$2,500	$2,500	$2,500

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
7. Conditional License	$0	$360	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee	10%-25% of the applicable renewal fee
8. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
9. Application to Change Facility Name	$360	$360	$360	$360	$360
10. Renewal Application Late Fee					equals renewal fee
Dialysis Centers:					
1. Initial Application for Licensure	$360	$360	$560	$5,140	$5,140
2. Building Plan [Life Safety Code] Review - Initial License or New Construction				$2,500 + $0.10 per sq. foot up to 25,000 sq feet and $0.02 per additional sq. ft. above 25,000	
3. Renewal Licensure (annual fee)	$360	$360	$560	$560	1-12 treatment stations - $1,750; 13-23 stations $2,750; 24 or more stations $3,750
4. Remodeling [existing license] Building Plan Review				$1,750 + $0.07 per sq. foot up to 20,000 sq feet and $0.02 per additional sq. ft. above 20,000	
5. Change of Ownership	$360	$360	$360	$5,140	$5,140
6. Provisional License	$360	$360	$360	$1,000	$1,000
7. Conditional License	$0	$360	$360	$1,500	$1,500
9. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
10. Application to Change Facility Name	$360	$360	$360	$360	$360
11. Renewal Application Late Fee					equals renewal fee
Hospiccs:					
1. Initial Application for Licensure	$360	$360	$360	$360	$6,370
If no licensed Hospice with 60 mile radius of applicant					$4,150
2. Building Plan [Life Safety Code] Review - Initial License or New Construction				$2,500 + $0.10 per sq. foot up to 25,000 sq feet and $0.02 per additional sq. ft. above 25,000	
3. Renewal Licensure (annual fee) October 2010-September 2011 *	$360	$360	$360	$360	$1,950
Excecpt, for a hospice located in a county other than Adams, Arapahoe, Boulder, Broomfield, Devner, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld, that provides at least 75% of its services in counties other than those named					$1,200
For hospices with less than 2,000 annual patient days					$750
For hospices with less than 1,000 annual patient days					$375

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
For hospices where the same business entity owns separately licensed hospices at more than one location in Colorado					$150 decrease in fee
For hospices deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services					$212 decrease in fee
For hospices having the same ownership and governing body which provide care in both the home and an inpatient setting					$3,200
4. Workstation fees					$50 per work station
5. Remodeling [existing license] Building Plan Review				$2,000 plus $0.08 per sq. ft. for first 20,000 sq. ft., plus $0.01 per additional sq. ft. in excess of 20,000 sq. ft.	
6. Change of Ownership	$360	$360	$360	$360	$6,370
7. Provisional License	$360	$360	$360	$1,000	$1,000
8. Conditional License	$0	$360	$360	$1,500	$1,500
9. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
10. Application to Change Facility Name	$360	$360	$360	$360	$360
11. Renewal Application Late Fee					equals renewal fee
* These fees represent a 50% reduction for the first twelve months of implementation (October 2010 - September 2011) in order to phase-in the increase.					
Nursing Homes					
1. Initial Application for Licensure *	$360	$360	$360	$360	$360 / $6,000
2. Building Plan [Life Safety Code] Review - Initial License or New Construction				$2,500 plus $0.10 per sq. ft. for first 25,000 sq. ft, plus $0.01 per additional sq. ft. in excess of 25,000 sq. ft.	
3. Renewal Licensure (annual fee)	$360	$360	$360	$360	
Facility is Medicare and/or Medicaid certified **					$1,600 plus $ 8 per bed
Facility is not Medicare and/or Medicaid certified **					$3.480 plus $8 per bed.
4. Remodeling [existing license] Building Plan Review				$2,000 plus $0.08 per sq. ft. for first 20,000 sq. ft., plus $0.01 per additional sq. ft. in excess of 20,000 sq. ft.	
5. Change of Ownership *	$360	$360	$360	$360	$6,000
6. Application to Open a Secured Unit *					$1,600
7. Provisional License	$360	$360	$360	$1,000	$1,000
8. Conditional License	$0	$360	$360	$1,500	$1,500
9. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
10. Application to Change Facility Name	$360	$360	$360	$360	$360

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
11. Renewal Application Late Fee					equals renewal fee
** Fee change effective 1/01/2011. ** Fee changes effective April 1, 2011.*					
All Other Facility Types: *Intermediate Care Facilities for the Mentally Retarded (ICFMR), Grouphomes for the Developmentally Disabled (DD Homes), Community Mental Health Centers, Community Clinics, Community Clinics with Emergency Centers, Convalescent Centers, and Birth Centers*					
1. Initial Application for Licensure	$360	$360	$360	$360	$360
2. Building Plan Review - Initial Licensure or New Construction					
ICFMRs at Healthcare occupancy standard; Convalescent Centers				$2,250 to $2,500 + $0.10 per sq. foot up for first 25,000 sq feet, plus $0.01 per additional sq. ft. above 25,000 sq .ft.	
ICFMRs at Board & Care occupancy standard; DD Homes				$2,300 plus $0.10 per sq. ft. for first 25,000 sq. ft, plus $0.01 per additional sq. ft. in excess of 25,000 sq. ft.	
Community Clinics; Birth Centers				$2,250 plus $0.10 per sq. ft. for first 25,000 sq. ft, plus $0.02 per additional sq. ft. in excess of 25,000 sq. ft.	
3. Renewal Licensure	$360	$360	$360	$360	$360
4. Remodeling [existing license] Building Plan Review					
ICFMRs at Healthcare occupancy standard; Convalescent Centers				$2,000 plus $0.08 per sq. ft. for first 20,000 sq. ft., plus $0.01 per additional sq. ft. in excess of 20,000 sq. ft.	
ICFMRs at Board & Care occupancy standard; DD Homes				$1,800 plus $0.08 per sq. ft. for first 20,000 sq. ft., plus $0.01 per additional sq. ft. in excess of 20,000 sq. ft.	
Community Clinics; Birth Centers				$1,750 plus $0.07 per sq. ft. for first 20,000 sq. ft., plus $0.02 per additional sq. ft. in excess of 20,000 sq. ft.	
5. Change of Ownership	$360	$360	$360	$360	$360
6. Provisional License	$360	$360	$360	$1,000	$1,000
7. Conditional License	$0	$360	$360	$1,500	$1,500
9. Application to Increase Number of Licensed Beds	$360	$360	$360	$360	$360
10. Application to Change Facility Name	$360	$360	$360	$360	$360
11. Renewal Application Late Fee					equals renewal fee
Assisted Living Residences:					
1. Initial Application for Licensure	$5,000	$5,000			
3-8 beds *			$5,000	$5,000	$5,000
9 or more beds *			$5,000 / $6,000	$6,000	$6,000
2. Building Plan Review - Initial Licensure or New Construction *					
0-8 beds			/ $2,500	$2,500	$2,500

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
9-16 beds			/ $3,200	$3,200	$3,200
17-30 beds			/ $4,000	$4,000	$4,000
31-50 beds			/ $4,400	$4,400	$4,400
50-100 beds			/ $4,800	$4,800	$4,800
101-150 beds			/ $5,200	$5,200	$5,200
151-200 beds			/ $5,600	$5,600	$5,600
200-251 beds			/ $6,000	$6,000	$6,000
251 or more beds			/ $6,300	$6,300	$6,300
3. ALR Licensure Renewal application fee	$150	$150	$150	$150	$150
ALR Licensure Renewal per bed **	$23	$23	$23 / $43	$43 / $56	$56
ALR Licensure Renewal per bed High Medicaid Utilization	$15	$15	$15	$15	$15
4. Remodeling [existing license] Building Plan Review	not to exceed $2,000				
Up to 1,500 sq. ft.			/ $1,875	$1,875	$1,875
1,501 to 4,500 sq. ft.			/ $2,250	$2,250	$2,250
4,501 to 15,000 sq. ft			/ $2,625	$2,625	$2,625
15,001 to 30,000 sq. ft.			/ $3,000	$3,000	$3,000
30,001 to 45,000 sq. ft.			/ $3,375	$3,375	$3,375
45,001 to 60,000 sq. ft.			/ $3,750	$3,750	$3,750
60,001 to 75,000 sq. ft.			/ $4,125	$4,125	$4,125
75,000 + sq. ft.			/ $4,500	$4,500	$4,500
5. Change of Ownership *	$2,500	$2,500	$2,500 / $5,000	$5,000	$5,000
6. Application to Open a Secured Unit *		$1,150	$1,150 / $1,600	$1,600	$1,600
7. Provisional License *	$360	$360	$360 / $1,000	$1,000	$1,000
8. Conditional License	$0	$360	$360	$1,500	$1,500
9. Application to Increase Number of Licensed Beds *	$150 plus $23 or $15 per new bed	$150 plus $23 or $15 per new bed	$150 plus $23 or $15 per new bed	$360	$360
10. Application to Change Facility Name				$360	$360
11. Change of Administrator *			/ $500	$500	$500
12. Renewal Application Late Fee					equals renewal fee
** Fee change effective 1/01/2009. ** Fee changes effective 1/01/2009 & 1/01/2010.*					
Home Care Agencies					
1. Initial Licensure					

Colorado Department of Public Health and Environment

Five Year History of Health Facility Licensure Fees

Fees	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Medicaid certified agency - in operation prior to June 1, 2009	n/a	n/a	If total wages paid to direct care staff is $150,000 or less fee = $525. If total wages paid to direct care is more than $150,000 fee = $525 + 0.10 % of the total wage amount. Total fee not to exceed $1,500.		
Not a Medicaid certified agency - in operation prior to June 1, 2009	n/a	n/a	If total wages paid to direct care staff is $150,000 or less fee = $525. If total wages paid to direct care is more than $150,000 fee = $525 + 0.15 % of the total wage amount. Total fee not to exceed $8,000.		
Opening after June 1, 2009	n/a	n/a	Class A agency $3,000; Class B $2,200		
2. Renewal Licensure					
Medicaid certified agency	n/a	n/a	Annual fees: If total wages paid to direct care staff is $150,000 or less fee = $525. If total wages paid to direct care is more than $150,000 fee = $525 + 0.10 % of the total wage amount. Total fee not to exceed $1,500.		
Not a Medicaid certified agency	n/a	n/a	Annual fees: If total wages paid to direct care staff is $150,000 or less fee = $525. If total wages paid to direct care is more than $150,000 fee = $525 + 0.15 % of the total wage amount. Total fee not to exceed $8,000.		
4. Branch fee	n/a	n/a	$200 per branch	$200 per branch	$200 per branch
5. Workstation fee (applicable only to an HCA with reportable wages over $525,000)	n/a	n/a	$50 per workstation	$50 per workstation	$50 per workstation
6. Provisional License	n/a	n/a	15% of the applicable initial licensure fee		
7. Conditional License	n/a	n/a	$1,500	$1,500	$1,500
8. Revisit fee (if more than one on-site revisit is required to verify correction of deficiencies)	n/a	n/a	equal to 50% of the agency's initial or renewal fee for each additional revisit		
9. Performance incentive fee reduction *	n/a	n/a	equal to 10% of the renewal fee (paid back to the licensee)		
10. Application to Change Facility Name			$360	$360	$360
11. Change of Address			$360	$360	$360
12. Renewal Application Late Fee					equals renewal fee
Licensure of Homc Care Agencies was a new statutory requirement effective June 1, 2009.					
** Performance incentive payment is applicable if a renewal inspection identifies no deficiencies that have negatively affected, or have the potential to negatively affect, consumers; an acceptable plan of correction is submitted timely; and correction of the deficient practice is verified by the due date.*					

Attachment - Question 13.C.

LABORATORY CUSTOMERS NOVEMBER 2010

Customer:	Amount Billed
Microbiology:	
Alpha Center	$ 1,520
Boulder Community Hospital	$ 57
Boulder Valley Women's Center - Ab Clinic	$ 360
Childrens Hospital Microbiology	$ 210
Colorado School of Mines	$ 140
Colorado State Judicial	$ 525
Community Health Services Aspen	$ 320
CSU Hartshorn Health Services	$ 994
Delta County Health Department	$ 220
Denver Health Medical Center Micro Lab	$ 110
Exempla Good Samaritan Medical Center	$ 370
Fort Lewis College Student Health Center	$ 680
It Takes a Village	$ 155
Jefferson County Health Dept FP Lakewood	$ 2,540
Jefferson County Health Dept FP Arvada	$ 660
Jefferson County Health Dept STD Clinic	$ 140
Kaiser Microbiology Laboratory	$ 10,046
Lake County Public Health Agency	$ 240
Larimer County Health Dept STD Clinic	$ 40
Las Animas Huerfano County HD Trinidad	$ 80
Lutheran Med Ctr Exempla Laboratory	$ 190
McKee Medical Center/Laboratory	$ 80
Montrose Memorial Hospital	$ 1,022
North Suburban Medical Center Microbiology Lab	$ 880
Northwest CO VisIting Nurses Assn.	$ 260
Northwest Colorado Visiting Nurses Assn	$ 80
Parkview Medical Center	$ 2,540
Presbyterian St.Lukes Medical Center	$ 226
Pueblo City County Health Dept STD	$ 640
Rio Blanco County Nursing FP Rangely	$ 20
Rose Medical Center HCA Micro Lab	$ 660
San Juan Basin Health Department	$ 140
San Juan Basin Health Dept	$ 620
San Juan Basin Health Dept FP	$ 300
San Luis Valley Regional Medical Center	$ 318
Seventh Judicial District Montrose County	$ 25
Sky Ridge Medical Center	$ 110
Southwest Open School	$ 200
Spanish Peaks Reg Health Ctr Outreach Clinic	$ 460
St Joseph Hospital Immediate Response Lab	$ 174
Summit Community Care Clinic	$ 1,565
Swedish Medical Center	$ 440
University Hospital - Micro Clinical Lab	$ 770
Western Colorado AIDS Project	$ 155
Western Colorado Pediatric & Associates	$ 140
Environmental:	
$ Dallas Creek Water Company	$ 115
$ Hilltop Water Co.	$ 30
$ Jefferson County Open Space	$ 133
$-Chatfield South Water Dist.	$ 20
$Inspection and Testing Services	$ 135
$Mesa Verde National Park	$ 250
.Barr Lake State Park	$ 20
.CDNR - Rifle Falls State Park	$ 40
.CDOC - Limon Correctional Facility	$ 54

.CDOT - Aurora	$	267
.CDOT - Eisenhower-Johnson Memorial Tunnel	$	1,547
.CDPR - Golden Gate State Park	$	40
.Rifle Gap State Park	$	40
.Roxborough State Park	$	20
Alamosa City of WWTP	$	309
Alpine Lodge	$	30
Aqua Chem, Inc	$	100
AQUA SERVE	$	115
Arapaho National Wildlife Refuge	$	20
Arapahoe County Water	$	700
Arriba, Town Of	$	267
Aurora City of	$	254
Blanco James	$	250
BP Wattenberg Gas Plant	$	20
Branson Town of	$	30
Breckenridge Ski Resort	$	40
Buena Vista KOA Camp Ground	$	30
Burlington City of	$	80
Butala Construction	$	318
C&P Septic Service	$	80
Calcuim Control Inc.	$	140
Carter Lake N & S WTP	$	15
Castle Rock Town of	$	2,080
Castlewood Christian School	$	20
Cemex Construction Materials South LLC	$	115
Cheyenne Wells Town of	$	180
Christ Haven Lodge	$	60
Colby Ed	$	250
Colo Hunt Club LLC	$	20
Colorado Analytical Laboratories Inc	$	600
Colorado Division of Reclamation & Mining	$	101
Colorado Water Well	$	40
Consolidated Mutual Water Co	$	288
Consolidated Mutual Water Co	$	2,630
Consolidated Pumps and Services	$	100
Cottonwood W&SD	$	200
Country Gardens MHP	$	20
Crandall Drilling & Pump Service LLC	$	20
Crotzer Ronald	$	100
Crystal Waters LLC	$	500
Custom Environmental Services Inc.	$	81
Darling International	$	498
Denman William	$	100
Denver Coliseum	$	40
Denver's Best Home Inspection	$	40
Dignam Frank	$	100
Dillon Town of	$	80
Dodge Susan	$	20
Double C Enterprise	$	20
Drifters Cookhouse	$	30
Durango West Metro District #1	$	30
Eagles Watch	$	30
East Cherry Creek Valley W&SD	$	1,240
East End Water Company	$	160
Eaton Town of	$	1,000
Ecology Programs Div - Taos Pueblo War Chiefs C	$	120
Environmental Investigations Bruce Bevirt	$	280
Federal Heights City of	$	200
Ferguson Joan	$	110
Flagler Town of	$	275

Forest Lakes Metro District	$	320
Freedom Real Estate Group	$	94
Galambs Mobile Home Park	$	20
Genesee W&SD	$	15
Granby WTP	$	15
Grand County W&SD 1	$	120
Green Acres MHP - Aurora	$	60
Greenwood Plaza Water Dist.	$	1,540
Gulliford Harry	$	77
Gunnison Lakeside Resort	$	60
Gypsum Town Of	$	1,580
Halder Josh(Verde Farms)	$	100
Hammer, James	$	20
Haun Brenda	$	200
Haxtun Town of	$	5,900
Henrickson Carl	$	58
Hier Drilling Co	$	78
Holland Jerry	$	100
Horn Creek Conf Grounds	$	150
Idledale Water Dept	$	20
Inverness W&SD	$	300
Ishmael Ken	$	20
Jaramillo Judy	$	20
John's Well Service	$	676
Kahn Shere	$	35
Kiowa Town of	$	20
Kit Carson Town of	$	80
Klopstad Jeff	$	100
Kohler Monte	$	38
Lamar City of	$	155
Loren and Assoc Inc	$	40
Loveland City of	$	255
Malloy Rod	$	75
Martinez Daniel	$	60
May Valley Water	$	1,400
McDonald Farms Ent Inc	$	80
McGee Bobby	$	100
Meeker Golf Course	$	100
Miers Tom	$	100
Mount Elbert Lodge	$	20
Mount Elbert Power Plant	$	20
Mountain Air Ranch	$	80
Nederland Town of	$	40
Nelson Rhonda	$	35
Nicholas Stephanie	$	75
NP KOA	$	90
Nucla Town of	$	175
Olsen Siri	$	100
Patterson Valley Water Company	$	30
Payne Lisa	$	20
Perry Park W&SD	$	80
Phils Auto Repair Service	$	122
Pichot, Teri	$	20
Pinery Water District	$	240
Polar Heat Inc	$	20
Puckett Land Company	$	250
Quaker Ridge Camp	$	55
Ralston Valley Water	$	40
Redi Services	$	145
Reed Randy	$	35
Reed Winegar	$	20

Rentech Energy Technology Center	$	100
Riverside Cottages	$	40
Riverside Water Company	$	30
Royal Crest Dairy	$	880
Ryan Robin	$	250
San Juan Basin Health Dept Env	$	60
San Souci MHP	$	160
Sanford Town of	$	1,875
Scheer Debbie	$	19
Scott Monroe Operations	$	350
Sells Brian	$	100
Shanahan Keith	$	100
Sierra Club	$	472
Skaggs Cheryl	$	398
Ski Cooper	$	40
Slaughter Carol	$	20
South Swink W/C	$	360
ST Sampling	$	160
Story Tammy	$	250
Sutton Brian	$	100
Telluride Regional Airport	$	30
Tetratech Information Rocky Mountain Arsenal	$	115
Toyne Jan	$	350
Tres Valles West Owners Association	$	30
TZA Water Engineers	$	20
Ute Lodge	$	40
Wagner Gary	$	19
Walden WTP	$	353
Washington State Dept of Health Office of Radiatio	$	3,298
Water Tec	$	164
Weld County Health Dept Env Health	$	19
West Grand Valley Water	$	30
Westerman Charlie	$	200
Wiley Sanitation District	$	70
Winter Park Resort	$	540
Winter Park W&SD	$	180
Wondervu Conference Center	$	50
Woodbine Ecology Center	$	80

Newborn Screening:

.NORTH COLORADO MEDICAL CENTER	$	13,600
A BETTER BEGINNING	$	85
ARKANSAS VALLEY REGIONAL MED CTR	$	1,785
ASPEN VALLEY HOSPITAL DISTRICT	$	1,700
AVISTA HOSPITAL LAB	$	15,385
BABYS BREATH MIDWIFERY	$	170
BIRTH MATTERS MIDWIFERY	$	340
BIRTHWISE	$	85
BOULDER COMMUNITY FOOTHILLS	$	11,475
BRIGHTON MEDICAL GROUP	$	85
CHILDBIRTH AWARENESS	$	85
CHILDREN'S HOSPITAL	$	2,210
CHILDREN'S MEDICAL CENTER	$	85
CIBECUE HEALTH CENTER	$	80
COLORADO PLAINS MEDICAL CENTER	$	2,720
CRAIG MEMORIAL HOSPITAL	$	1,020
DEBRA BERRY	$	85
DELTA COUNTY MEMORIAL HOSPITAL	$	1,445
DENVER MEDICAL CENTER (DGH)	$	24,225
EKLUND	$	255

ESTES PARK MEDICAL CENTER	$	680
EVAN'S U.S. ARMY COMMUNITY HOSPITAL	$	10,240
FAMILY BIRTH SERVICES	$	170
GENTLE TOUCH MIDWIFERY	$	85
GOOD SAMARITAN MEDICAL CENTER	$	14,620
GUAM MEMORIAL HOSPITAL	$	9,260
GUNNISON VALLEY HOSPITAL	$	765
HEART OF THE ROCKIES REGIONAL MED CTR	$	1,275
JOHNSON	$	255
JOY OF LIFE FAMILY MEDICINE	$	170
KAISER PERMENENTE - DENVER/LAFAYETTE	$	595
KARBERG		
KAYENTA HEALTH	$	395
KIT CARSON COUNTY MEMORIAL HOSP	$	595
LAPETINO	$	85
LINCOLN COMMUNITY HOSPITAL	$	85
LITTLETON ADVENTIST (PORTER) HOSPITAL	$	10,115
LONGMONT UNITED HOSPITAL	$	9,095
LUTHERAN MEDICAL CENTER	$	12,070
MC KEE MEDICAL CENTER	$	5,950
MCKAY DEE HOSPITAL	$	35
MEDICAL CENTER OF THE ROCKIES	$	3,655
MELISSA MEMORIAL HOSPITAL	$	85
MEMORIAL HOSPITAL - COLO SPRINGS	$	35,700
MERCY REGIONAL MEDICAL CENTER - DURAN	$	6,715
MONTROSE MEMORIAL HOSPITAL	$	85
MOORE, ELIZABETH	$	170
NORTH COLORADO MIDWIFERY	$	255
NORTH SUBURBAN MEDICAL CENTER	$	11,050
PARKER ADVENTIST HOSPITAL	$	12,240
PARKVIEW EPISCOPAL MEDICAL CTR	$	9,775
PETERSEN AFB	$	770
PHOENIX INDIAN MEDICAL CENTER	$	4,430
PLATTE VALLEY MEDICAL CENTER	$	7,140
POUDRE VALLEY HOSPITAL	$	16,660
PRESBYTERIAN-ST LUKE'S MED CTR	$	10,285
PRIMARY CHILDREN'S MEDICAL CENTER	$	45
PROWERS MEDICAL CENTER	$	935
QUEST DIAGNOSTICS	$	27,200
RAYNES	$	85
ROSE MEDICAL CENTER	$	28,815
SAN LUIS VALLEY REGIONAL MED CTR	$	3,825
SEDGWICK COUNTY MEMORIAL HOSPITAL	$	85
SOUTHWEST MEMORIAL HOSPITAL	$	1,700
ST ANTHONY HOSPITAL CENTRAL/FMC WEST	$	4,845
ST ANTHONY HOSPITAL NORTH	$	5,610
ST FRANCIS MEDICAL CENTER	$	21,080
ST JOSEPH HOSPITAL	$	32,810
ST MARY CORWIN REGIONAL MED CTR	$	4,420
ST MARY'S HOSPITAL	$	14,620
ST THOMAS MORE HOSPITAL	$	1,190
STERLING REGIONAL MEDICAL CENTER	$	1,445
SUMMIT MEDICAL CENTER	$	2,550
SWEDISH MEDICAL CENTER	$	14,620
THE MEDICAL CENTER OF AURORA	$	11,730
UNIVERSITY OF COLO HEALTH SCIENCES CEN	$	19,635
VAIL VALLEY MEDICAL CENTER	$	3,145
VALLEY VIEW HOSPITAL	$	5,440
WHITE RIVER/PHS INDIAN	$	1,295
WRAY COMMUNITY DISTRICT HOSPITAL	$	510
YAMPA VALLEY MEDICAL CENTER	$	2,805

YUMA DISTRICT HOSPITAL	$	425
STATE OF WYOMING (Separate Billing)	$	26,160

Toxicology:

$ Police Dept. - Englewood	$	175
$ Police Dept. - Littleton	$	125
$ Police Dept. - Vail	$	105
.CDPR - Chatfield State Park	$	220
.CO Dept. of Transportation, Safety Office	$	2,505
.CO State Patrol - Broomfield	$	595
.CO State Patrol - Castle Rock Troop 1C	$	1,050
.CO State Patrol - Colorado Springs	$	1,388
.CO State Patrol - Craig	$	485
.CO State Patrol - Fort Collins	$	850
.CO State Patrol - Fruita	$	740
.CO State Patrol - Golden	$	1,065
.CO State Patrol - Lamar	$	498
.CO State Patrol - Limon	$	185
.CO State Patrol - Montrose-Gunnison Troop 5C	$	1,086
.CO State Patrol - Pueblo Troop 2D	$	1,890
.CO State Patrol - Sterling	$	246
Brady Jax	$	220
CO State Patrol Alamosa	$	435
CO State Patrol - Canon City Troop 2A2	$	168
CO State Patrol - Durango	$	230
CO State Patrol - Evans (Greeley)	$	625
CO State Patrol - Frisco Troop 6B	$	480
CO State Patrol - Glenwood Springs Troop 4C1	$	745
CO State Patrol - Trinidad Troop 2D	$	445
CO State Patrol Adams County Troop 1	$	1,220
Denver Health	$	3,815
Montezuma County Sheriff's Office	$	315
Phillips County Sheriff's Office	$	25
Police Dept - Cripple Creek	$	25
Police Dept - Denver/Sex Crimes Unit	$	175
Police Dept - Dillon	$	270
Police Dept - Glenwood Springs	$	65
Police Dept - Granby	$	25
Police Dept - Idaho Springs	$	25
Police Dept - Ignacio	$	25
Police Dept - Lakeside	$	25
Police Dept - Lone Tree	$	515
Police Dept - Loveland	$	390
Police Dept - Monument	$	305
Police Dept - Northglenn	$	186
Police Dept - Rocky Ford	$	25
Police Dept - Silverthorne	$	105
Police Dept - Wheat Ridge	$	200
Police Dept - Wray	$	25
Police Dept - Yuma	$	93
Police Dept- Basalt	$	25
Police Dept- Berthoud	$	155
Police Dept- Springfield	$	25
Police Dept-Westminster	$	850
Police Dept. - Brush	$	25
Police Dept. - Alamosa	$	75
Police Dept. - Arvada	$	1,335
Police Dept. - Aurora	$	1,580
Police Dept. - Avon	$	135
Police Dept. - Boulder	$	2,205

Police Dept. - Breckenridge	$	130
Police Dept. - Broomfield	$	980
Police Dept. - Canon City	$	50
Police Dept. - Castle Rock	$	710
Police Dept. - Cherry Hills Village	$	315
Police Dept. - Colorado Springs	$	6,305
Police Dept. - Commerce City	$	255
Police Dept. - CSU (DRE)	$	185
Police Dept. - Denver - Trafffic Investigati (DRE)	$	3,135
Police Dept. - Durango (DRE)	$	640
Police Dept. - Erie	$	25
Police Dept. - Fort Collins	$	835
Police Dept. - Fort Lupton	$	690
Police Dept. - Fort Morgan	$	130
Police Dept. - Fountain	$	545
Police Dept. - Golden	$	1,630
Police Dept. - Grand Junction - Laboratory	$	703
Police Dept. - Greenwood Village (DRE)	$	200
Police Dept. - La Junta	$	25
Police Dept. - Lafayette	$	405
Police Dept. - Lakewood	$	905
Police Dept. - Leadville	$	25
Police Dept. - Longmont	$	568
Police Dept. - Manitou Springs	$	530
Police Dept. - Montrose	$	590
Police Dept. - Palisade	$	100
Police Dept. - Parker	$	455
Police Dept. - Pueblo (DRE)	$	866
Police Dept. - Steamboat Springs	$	480
Police Dept. - Sterling	$	50
Police Dept. - Thornton Records	$	740
Police Dept. - Trinidad	$	25
Police Dept. - Woodland Park	$	25
Police Dept.- Buena Vista	$	130
Sheriff's Dept - Gilpin County	$	305
Sheriff's Dept - Rio Blanco County	$	234
Sheriff's Dept - Sedgwick County	$	220
Sheriff's Dept - Washington County	$	25
Sheriff's Dept- Clear Creek County (DR)	$	25
Sheriff's Dept. - Arapahoe County	$	670
Sheriff's Dept. - Boulder County	$	715
Sheriff's Dept. - Douglas County	$	1,864
Sheriff's Dept. - Eagle County	$	380
Sheriff's Dept. - El Paso County	$	1,430
Sheriff's Dept. - Elbert County	$	25
Sheriff's Dept. - Jeffco- Evidence Vault	$	885
Sheriff's Dept. - Lake County	$	275
Sheriff's Dept. - Larimer County	$	785
Sheriff's Dept. - Mesa County	$	725
Sheriff's Dept. - Morgan County	$	160
Sheriff's Dept. - Park County	$	270
Sheriff's Dept. - Pueblo County	$	125
Sheriff's Dept. - Routt County	$	25
Sheriff's Dept. - Summit County	$	168
Sheriff's Dept. - Teller County	$	93
Sheriff's Dept.- Adams County	$	525
Sheriffs Dept - Costilla County	$	25
Sherrif's Dept. - Logan County	$	130
1st Judicial District	$	395
2nd Judicial District	$	793
3rd Judicial District	$	85

4th Judicial District	$	843
7th Judicial District	$	285
8th Judicial District	$	265
10th Judicial District	$	50
13th Judicial District	$	448
13th Judicial District	$	35
14th Judicial District	$	35
14th Judicial District	$	50
17th Judicial District	$	119
17th Judicial District	$	80
18TH JUDICAL DISTRICT	$	35
18th Judicial District	$	299
18th Judicial District	$	35
18th Judicial District	$	399
18th Judicial District Office of Dist Attorney	$	154
19th Judicial District	$	344
Bayfield Marshal's Office	$	36
CO State Patrol - Castle Rock Troop 1C	$	90
CO State Patrol - Colorado Springs	$	900
CO State Patrol - Craig	$	150
CO State Patrol - Durango	$	150
CO State Patrol - Fort Collins	$	150
CO State Patrol - Glenwood Springs Troop 4C1	$	225
CO State Patrol - Pueblo (DRE)	$	600
CO State Patrol - Sterling	$	120
Hypsher & Associates, LLC	$	50
Lloyd Boyer, PC	$	50
Police Dept - Parachute	$	30
Police Dept. - Canon City	$	90
Police Dept. - Glendale	$	60
Police Dept. - Leadville	$	36
Police Dept. - Palisade	$	75
Police Dept. - Pueblo (DRE)	$	150
Police Dept. - Westminster	$	300
Schaffer & Chase LLC	$	345
Sheriff's Dept. - Arapahoe County	$	150
Sheriff's Dept. - Clear Creek County (DRE)	$	30
Sheriff's Dept. - Douglas County	$	300
Sheriff's Dept. - Mesa County	$	45
Sheriff's Dept. - Summit County	$	45
Sheriff's Dept. - Washington County	$	12
The Law Office of Ann Toney	$	35
Total	**$**	**658,709**
Fund 100 Cash	**$**	**149,209**
Fund 121 (NBS Fund) Cash	**$**	**509,500**

(Includes Genetic Counseling Revenues of $134,400)

Attachment to Question 47.								
DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT								
	FY 2008-09 appropriated	FY 2008-09 actual	Percent filled	2009-10 appropriated	2009-10 actual	Percent filled	2011-12 request	Explanation re adjusting 2011-12 to actual 2009-10 usage
(1) ADMINISTRATION AND SUPPORT								
(A) Administration	60.4	60.2	99.7%	61.1	60.8	99.5%	61.1	N/A
(B) Special Health Programs, (1) Health Disparities Program, Personal Services	6.3	6.4	101.6%	6.3	6.0	95.2%	6.3	N/A
(C) Local Public Health Planning and Support, Assessment and Planning Program	8.0	5.2	65.0%	8.4	6.1	72.6%	8.4	The unused FTE reflect staff turnover due to several retirements. The vacant positions have since been filled.
(D) Special Environmental Programs, Program Costs	7.0	8.2	117.1%	7.8	9.9	126.9%	7.8	Excess FTE are federally funded.
(D) Special Environmental Programs, Animal Feeding Operations (AFO) Program	0.5	0.5	100.0%	3.5	3.2	91.4%	3.5	Due to the small FTE appropriation, a small reversion in FTE can lead to a large percentage variance. This appropriation needs to be kept at the FY 2011-12 request level.
(D) Special Environmental Programs, Recycling Resources Economic Opportunity Program	1.6	1.5	93.8%	1.6	1.6	100.0%	1.6	N/A
(D) Special Environmental Programs, Oil and Gas Consultation, Personal Services	0.0	0.0	0.0%	2.0	1.4	70.0%	1.0	This appropriation has already been reduced below the FY 2009-10 actual level, based on JBC action.
(D) Special Environmental Programs, Waste Tire Program costs	0.0	0.0	0.0%	0.0	0.0	0.0%	1.0	This is a new FTE based on HB 10-1018. without the FTE the division would not be able to implement the legislation
Admin sub-total	**83.8**	**82.0**	**97.9%**	**90.7**	**89.0**	**98.1%**	**90.7**	**N/a**
(2) CENTER FOR HEALTH AND ENVIRONMENTAL INFORMATION								
(A) Health Statistics and Vital Records, Personal Services	55.2	51.1	92.6%	55.2	53.1	96.2%	69.4	Additional FTE have been added in response to the increase in Medical Marijuana applications
(B) Information Technology Services, Personal Services	24.4	20.5	84.0%	23.7	20.1	84.8%	1.8	Unused FTE were transferred to OIT for FY 2010-11 and beyond. The FY 2011-12 appropriation is below the FY 2009-10 actual usage.
CHEIS sub-total	**79.6**	**71.6**	**89.9%**	**78.9**	**73.2**	**92.8%**	**71.2**	**N/A**
(3) LABORATORY SERVICES								
(A) Director's Office, Personal Services	8.1	7.4	91.4%	8.1	5.9	72.8%	5.3	Reversions in FTE are due to reduced federal and or cash revenues. The Laboratory FTE has already been adjusted to better reflect actual Federal Funding.
(B) Chemistry and Microbiology, Personal Services	65.6	55.8	85.1%	65.6	51.7	78.8%	61.9	Reversions in FTE are due to reduced federal and or cash revenues. The Laboratory FTE has already been adjusted to better reflect actual Federal Funding. Further restricting the FTE to FY 2009-10 actual levels will inhibit the division's ability to perform work if revenues increase, especially from cash sources.
(C) Certification, Personal Services	10.3	9.0	87.4%	10.3	9.2	89.3%	10.5	Reversions in FTE are due to reduced federal and or cash revenues. The Laboratory FTE has already been adjusted to better reflect actual Federal Funding. Further restricting the FTE to FY 2009-10 actual levels will inhibit the division's ability to perform work if revenues increase, especially from cash sources.
Lab Sub-total	**84.0**	**72.2**	**86.0%**	**84.0**	**66.8**	**79.5%**	**77.7**	**N/A**

(4) AIR POLLUTION CONTROL DIVISION								
(A) Administration, Personal Services	4.5	4.3	95.6%	4.5	4.1	91.1%	4.5	Reverted FTE are federally funded.
(B) Technical Services, Personal Services	35.1	30.7	87.5%	35.1	29.3	83.5%	34.1	The majority of reverted FTE are federally funded. Reverting to the FY 2009-10 actual usage would impact the ability of the division to perform their statutory and regulatory duties, and result in increased backlogs of work
(C) Mobile Sources, Personal Services	30.2	27.5	91.1%	31.7	28.8	90.9%	32.1	The majority of reverted FTE are federally funded. Reverting to the FY 2009-10 actual usage would impact the ability of the division to perform their statutory and regulatory duties, and result in increased backlogs of work
(C) Mobile Sources, Diesel Inspection/ Maintenance Program	6.6	6.6	100.0%	6.6	6.4	97.0%	6.6	N/A
(D) Stationary Sources, Personal Services	87.5	80.8	92.3%	85.7	75.8	88.4%	81.8	The majority of reverted FTE are federally funded. Reverting to the FY 2009-10 actual usage would impact the ability of the division to perform their statutory and regulatory duties, and result in increased backlogs of work
(D) Stationary Sources, Preservation of the Ozone Layer	2.0	2.0	100.0%	2.0	2.0	100.0%	2.0	N/A
APCD Sub-total	**165.9**	**151.9**	**91.6%**	**165.6**	**146.4**	**88.4%**	**161.1**	**N/A**
(5) WATER QUALITY CONTROL DIVISION								
(A) Administration, Personal Services	13.8	13.2	95.7%	13.8	11.8	85.5%	17.7	The majority of reverted FTE are federally funded
(B) Clean Water Program, Personal Services	84.1	78.9	93.8%	84.1	75.9	90.2%	80.0	Cash spending authority was not sufficient to support 3.0 FTE. For FY 2010-11 the Department pursued a Decision Item to fully fund those three FTE to perform critical tasks. Reverting to FY 2009-10 actual levels in FTE authority would negate the progress made in FY 2010-11.
(C) Drinking Water Program, Personal Services	44.9	55.9	124.5%	44.9	59.1	131.6%	36.2	Excess FTE are federally funded.
WQCD Sub-total	**142.8**	**148.0**	**103.6%**	**142.8**	**146.8**	**102.8%**	**133.9**	**N/A**
(6) HAZARDOUS MATERIALS AND WASTE MANAGEMENT DIVISION								
(A) Administration, Program Costs	3.4	1.4	41.2%	3.4	1.2	35.3%	3.4	The Administration line has an appropriation of 3.4 FTE. In 2009-10, 1.2 FTE were used. Effective in 2010-11, the Solid and Hazardous Waste Commission transferred to the division which will utilize slightly over one (1) FTE. An additional .6 FTE will be needed to support division administrative staff previously covered at the program level.
(B) Hazardous Waste Control Program, Personal Services	42.7	34.7	81.3%	42.7	35.8	83.8%	42.0	The majority of reverted FTE are federally funded. Reverting to the FY 2009-10 actual usage would impact the division's ability to perform their statutory and regulatory duties.
(C) Solid Waste Control Program, Program Costs	21.2	15.8	74.5%	20.4	15.9	77.9%	20.8	Due to the economic slowdown, the Solid Waste Program did not have sufficient cash fee revenue to fund all the authorized positions. Because of increasing revenues and a revised fee schedule, there will be sufficient revenue in the Solid Waste cash fund to fund all positions in 2011-12.
(C) Solid Waste Control Program, Waste Tire Management Program	0.0	0.0	0.0%	0.0	0.0	0.0%	2.1	This is a new activity created by H.B. 10-1018. Without the staff, the division will be unable to carry out the statutory mandate.
(D) Uranium Mill Tailings Remedial Action Program, Program Costs	3.1	2.5	80.6%	3.1	2.3	74.2%	3.1	The UMTRA program had a vacancy due to retirement. The program is now fully staffed and is utilizing the appropriated FTE level of 3.1.
(E) Contaminated Site Cleanups, Personal Services	38.4	29.1	75.8%	38.4	23.0	59.9%	37.8	The underutilization of FTE in the Contaminated Sites Program was due to a reduction in the federally funded Department of Defense sites remediation program. that federal program has increased and will fund and utilize staffing levels consistent with the 2011-12 request.
(F) Rocky Flats Agreement, Program Costs	2.3	1.2	52.2%	2.3	0.9	39.1%	2.3	The reverted FTE are federally funded. Reverting to the FY 2009-10 actual usage would impact the division's ability to perform their statutory and regulatory duties.
(G) Radiation Management, Personal Services	21.5	21.5	100.0%	23.5	24.0	102.1%	23.1	Excess FTE are federally funded
HMWMD sub-total	**132.6**	**106.2**	**80.1%**	**133.8**	**103.1**	**77.1%**	**134.6**	**N/a**
(7) CONSUMER PROTECTION								
Personal Services	28.4	23.5	82.7%	29.6	25.1	84.8%	30.5	FTE reversions were due to the hiring freeze, turn over and uncertainty about cash fee revenue. Restricting the FTE to the FY 2009-10 actual levels will inhibit the division's ability to conduct inspections and oversight and thereby protect public health.
CPD Sub-Total	**28.4**	**23.5**	**82.7%**	**29.6**	**25.1**	**84.8%**	**30.5**	**N/a**

(8) DISEASE CONTROL AND ENVIRONMENTAL EPIDEMIOLOGY DIVISION								
(A) Administration, General Disease Control and Surveillance, Personal Services	14.5	9.0	62.1%	15.3	10.3	67.3%	13.1	The FTE reversions are due to turnover and the use of contract and temporary staff. Since temporary and Contract staff are not reflected in the FTE count, the FTE reversions appear, erroneously, to be significant. Reverting to FY 2009-10 actuals would restrict the department's ability to permanently fill positions.
(B) Special Purpose Disease Control Programs, (1) Immunization, Personal Services	30.1	24.9	82.7%	31.0	29.2	94.2%	35.6	The reversion of FTE was due to staff turnover. Vacancies have since been announced and/or filled. Reverting to FY 2009-10 actuals would force the department to lay off people who have since filled the positions.
(2) Sexually Transmitted Infections, HIV and AIDS, Personal Services	55.8	47.2	84.6%	55.8	46.5	83.3%	45.7	Reversions in FTE were in federally funded positions.
(3) Ryan White Act, Personal Services	4.0	11.8	295.0%	4.0	12.3	307.5%	11.7	Excess FTE are federally funded
(4) Tuberculosis Control and Treatment, Personal Services	6.8	11.5	169.1%	6.8	14.5	213.2%	12.0	Excess FTE are federally funded
(C) Environmental Epidemiology, (1) Birth Defects Monitoring and Prevention, Personal Services	5.8	2.9	50.0%	5.8	3.8	65.5%	3.6	The FTE reversions are due to turnover. The division is working to fill these vacancies. Returning to the FY 2009-10 actual FTE levels will inhibit the program's ability to perform its responsibilities.
(C) Environmental Epidemiology, (2) Federal Grants	15.5	8.5	54.8%	15.5	10.2	65.8%	8.3	Reversions in FTE were in federally funded positions.
(D) Federal Grants	50.3	22.3	44.3%	49.3	30.1	61.1%	20.5	Reversions in FTE were in federally funded positions.
DCEED sub-total	**182.8**	**138.1**	**75.5%**	**183.5**	**156.9**	**85.5%**	**150.5**	**N/a**
(9) PREVENTION SERVICES DIVISION								
(A) Prevention Programs, Personal Services	23.7	21.4	90.3%	23.7	21.7	91.6%	22.9	The majority of FTE reversions are federally funded
(A) Prevention Programs, (1) Programs and Administration, Cancer, Cardiovascular Disease, and Pulmonary Disease Grants	0.0	0.0	0.0%	1.0	0.0	0.0%	0.0	N/A
(A) Prevention Programs, (1) Programs and Administration, Short Term Innovative Health Program Grants	1.0	0.4	0.0%	0.0	0.0	0.0%	0.0	N/A
(A) Prevention Programs, (2) Cancer Registry, Personal Services	10.0	10.2	102.0%	10.0	10.4	104.0%	10.2	Excess FTE are federally funded
(A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program								
(A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program, Chronic Disease and Cancer Prevention Grants	23.8	27.0	113.4%	25.8	28.6	110.9%	27.5	Excess FTE are federally funded, or funded by a private donation
(A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program, Breast and Cervical Cancer Screening	0.0	1.5	100.0%	0.0	1.3	100.0%	0.0	The FTE used in this line were financed by a private donation
(A) Prevention Programs, (4) Suicide Prevention	2.0	2.0	100.0%	2.0	2.1	105.0%	2.0	Additional hours worked resulted in the overage in the FTE calculation.
(A) Prevention Programs, (5) Tobacco Education, Prevention, and Cessation, Personal Services	10.0	9.4	94.0%	10.0	6.5	65.0%	10.0	For FY 2009-10, the reversion is due to the request of the Tobacco Review Committee to revert as much as possible in vacancy savings in order to use the saved revenue towards grants. Reverting to the FY 2009-10 actual FTE expenditures will inhibit the division's ability to fill positions and appropriately administer the program when full funding is restored.
(A) Prevention Programs,(6) Oral Health Programs	3.0	3.7	123.3%	3.0	4.9	163.3%	3.0	Excess FTE are federally funded
(B) Women's Health - Family Planning, Personal Services	19.3	15.9	82.4%	17.3	12.6	72.8%	13.0	The majority of FTE reversions are federally funded
(B) Women's Health - Family Planning, Federal Grants	3.0	4.0	133.3%	3.0	4.0	133.3%	3.8	Excess FTE are federally funded
(C) Primary Care Office, Program Costs	0.0	0.0	0.0%	1.5	0.6	40.0%	1.5	The program FTE was new in FY 2009-10; the FTE was not hired until the mid-year.
(C) Primary Care Office, Federal Grants	1.5	1.2	80.0%	1.5	1.2	80.0%	1.2	Reverted FTE are from federal funds
(D) Prevention Partnerships, (1) Interagency Prevention Programs Coordination, Personal Services	3.2	2.8	87.5%	2.0	1.9	95.0%	2.0	N/A
(D) Prevention Partnerships, (2) Tony Grampsas Youth Services Program, Prevention Services Programs	3.0	2.8	93.3%	3.0	3.0	100.0%	3.0	N/A
(D) Prevention Partnerships, (3) Colorado Children's Trust Fund, Personal Services	1.5	1.6	106.7%	1.5	1.3	86.7%	1.5	Change in FTE is due to staff fluctuations.
(E) Family and Community Health , (1) Maternal and Child Health	13.0	9.8	75.4%	13.0	18.9	145.4%	9.8	Excess FTE are federally funded
(E) Family and Community Health , (2) Child, Adolescent, and School Health, Nurse Home Visitor Program	4.0	3.2	80.0%	4.0	3.5	87.5%	3.0	The FY 2011-12 request is lower than FY 2009-10 actuals due to the elimination of 1.0 FTE from SB 10-073. No further adjustment is necessary.

(E) Family and Community Health , (2) Child, Adolescent, and School Health, School-based Health Centers	0.7	0.6	85.7%	0.7	0.5	71.4%	0.7	Actual FTE is lower due to hours worked being impacted by the Furlough.
(E) Family and Community Health , (2) Child, Adolescent, and School Health, Federal Grants	2.2	3.2	145.5%	2.2	3.1	140.9%	3.2	Excess FTE are federally funded
(E) Family and Community Health , (3) Children With Special Needs, (a) Health Care Program for Children with Special Needs, Personal Services	17.5	13.2	75.4%	17.5	11.6	66.3%	15.9	2.5 Reverted FTE are GF and 3.4 reverted FTE are federal. The General Fund appropriation is insufficient to fund all FTE in this line. Due to retirements, costs will be reduced in the future, but there will not be sufficient savings to fund all the GF positions. One GF FTE in this line can be reduced. There were 3.4 reverted FTE funded by federal funds.
(E) Family and Community Health , (3) Children With Special Needs, (a) Health Care Program for Children with Special Needs, Traumatic Brain Injury Services	1.0	0.0	0.0%	1.0	0.4	40.0%	1.0	This FTE is funded via reappropriated funds from Human Services for oversight of contract obligations for this program. The position was vacant during the hiring process.
(E) Family and Community Health , (3) Children With Special Needs, (b) Genetics Counseling, Personal Services	1.0	0.9	90.0%	1.0	1.0	100.0%	1.0	N/A
(E) Family and Community Health , (4) Department of Human Services Grant	0.2	0.2	100.0%	0.2	0.0	0.0%	0.2	This grant does not support personal services expenses. Elimination of the FTE would be appropriate.
(E) Family and Community Health, (5) Federal Grants	4.6	2.4	52.2%	4.6	3.2	69.6%	1.2	reverted FTE are from federal funds
(F) Nutrition Services, Women, Infants, and Children Supplemental Food Grant	21.3	22.8	107.0%	21.3	22.9	107.5%	17.8	Excess FTE are federally funded
(F) Nutrition Services, Child and Adult Care Food Program	12.8	7.7	60.2%	12.8	7.9	61.7%	7.7	This appropriation has already been reduced below the FY 2009-10 actual level, based on JBC action to adjust federal FTE
(G) Federal Grants	5.3	2.7	50.9%	5.3	3.1	58.5%	2.7	This appropriation has already been reduced below the FY 2009-10 actual level, based on JBC action to adjust federal FTE
PSD Sub-total	**188.6**	**170.6**	**90.5%**	**188.9**	**176.2**	**93.3%**	**165.8**	**N/A**
(10) HEALTH FACILITIES AND EMERGENCY MEDICAL SERVICES DIVISION								
(A) Licensure. Health Facilities General Licensure Program	16.4	10.9	66.5%	34.9	18.3	52.4%	44.8	Under-expenditures resulted from delays in implementation of newly funded changes in the general licensure program and start-up of the home care agency licensure program. The division received significant increases in FTE authority in FY 2008-9 and 9-10, but the increases were tied to fees that had to be developed in phases and go through a regulatory process. this meant that filling positions has significantly lagged authorization. Reverting to FY 2009-10 actual expenditures would prohibit the division from fulfilling its statutory obligations.
(A) Licensure. Assisted Living Facilities Program	9.9	10.2	103.0%	11.4	10.2	89.5%	11.2	The under-expenditures resulted from a higher than usual vacancy rate and from staff being on extended medical leave. Reverting to FY 2009-10 actual expenditures would prohibit the division from fulfilling necessary duties.
(A) Licensure. Medication Administration Program	0.9	0.7	77.8%	1.0	0.6	60.0%	1.0	Any change in status for 1.0 FTE will affect the % execution. The program requires 1.0 FTE in FY 2011-12 to continue operations.
(A) Licensure. Medicaid/Medicare Certification Program	97.4	94.2	96.7%	97.4	94.8	97.3%	93.6	N/A
(B) Emergency Medical Services. State EMS Coordination, Planning and Certification Program	12.9	11.1	86.0%	16.3	11.6	71.2%	16.4	Several positions were open during the year, and employees were on extended medical leave. Reverting to FY 2009-10 actual expenditures would prohibit the division from fulfilling necessary duties.
(B) Emergency Medical Services. Trauma Facility Designation Program	2.1	1.7	81.0%	2.1	1.9	90.5%	2.1	Due to the small FTE appropriation, a small reversion in FTE can lead to a large percentage variance. This appropriation needs to be kept at the FY 2011-12 request level.
(B) Emergency Medical Services. Federal Grants	0.8	1.2	150.0%	0.8	2.5	312.5%	0.9	Excess FTE are federally funded
HFEMSD Sub-total	**140.4**	**130.0**	**92.6%**	**163.9**	**139.9**	**85.4%**	**170.0**	**N/A**
(11) EMERGENCY PREPAREDNESS AND RESPONSE DIVISION								
Emergency Preparedness and Response Program	1.8	47.1	0.0%	31.9	33.8	106.0%	42.5	Excess FTE are federally funded
EMSD Sub-Total	**1.8**	**47.1**	**0.0%**	**31.9**	**33.8**	**106.0%**	**42.5**	
Department total	**1230.7**	**1141.2**	**92.7%**	**1293.6**	**1157.2**	**89.5%**	**1228.5**	