COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, and Other Medical Programs)

JBC Working Document - Subject to Change
Staff Recommendation Does Not Represent Committee Decision

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

The Department helps pay medical and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the Department include:

- **Medicaid** – serves people with low income and people needing long-term care
- **Children's Basic Health Plan** – provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria
- **Colorado Indigent Care Program** – defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low income, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income
- **Old Age Pension Health and Medical Program** – serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare.

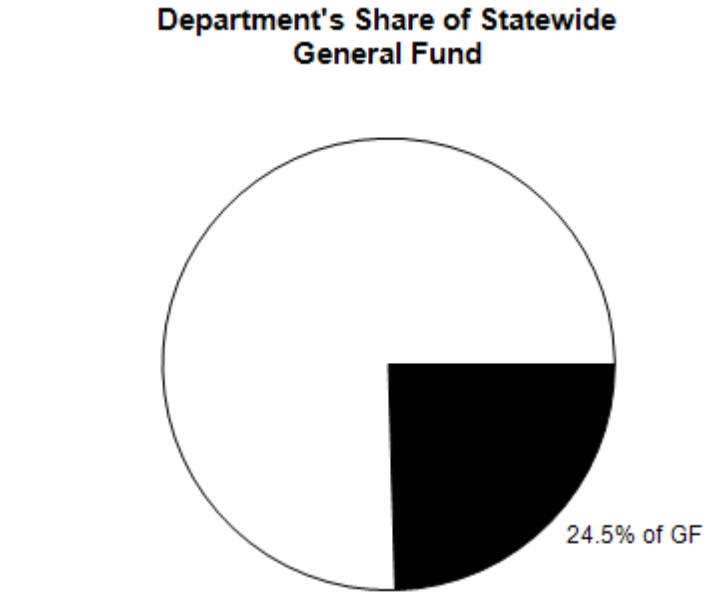
The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

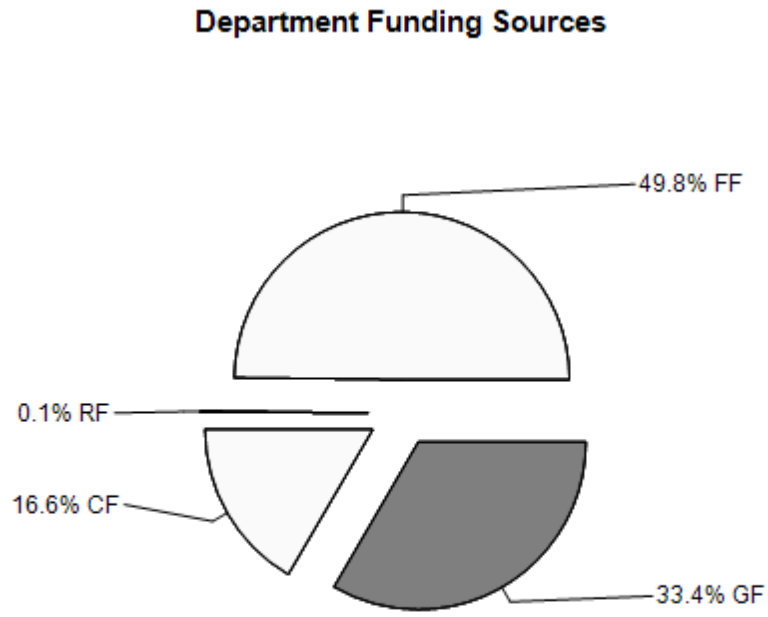
Department Budget: Recent Appropriations

Funding Source	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14 *
General Fund	$1,278,711,042	$1,698,937,482	$1,857,115,475	$2,031,840,028
Cash Funds	785,202,148	879,632,546	925,374,919	916,573,919
Reappropriated Funds	18,526,832	8,576,440	8,170,248	5,929,334
Federal Funds	2,810,778,210	2,579,167,123	2,770,497,472	3,082,378,760
Total Funds	**$4,893,218,232**	**$5,166,313,591**	**$5,561,158,114**	**$6,036,722,041**
Full Time Equiv. Staff	294.8	312.5	326.2	338.2

*Requested appropriation.

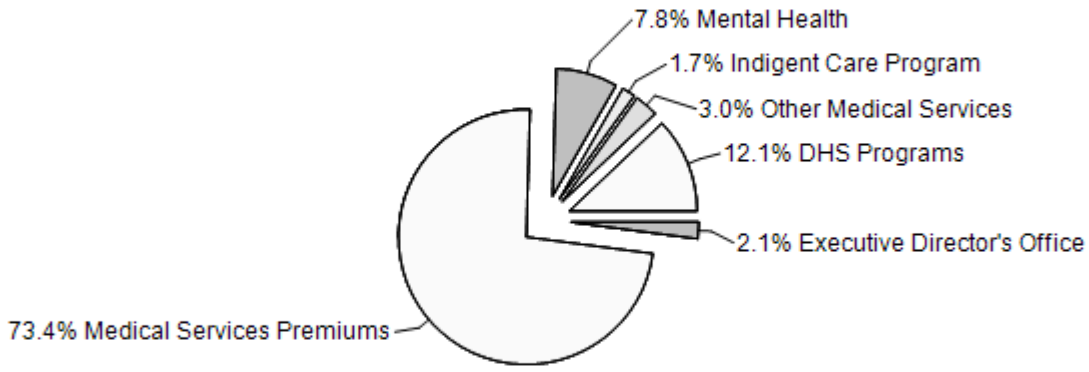
Department Budget: Graphic Overview



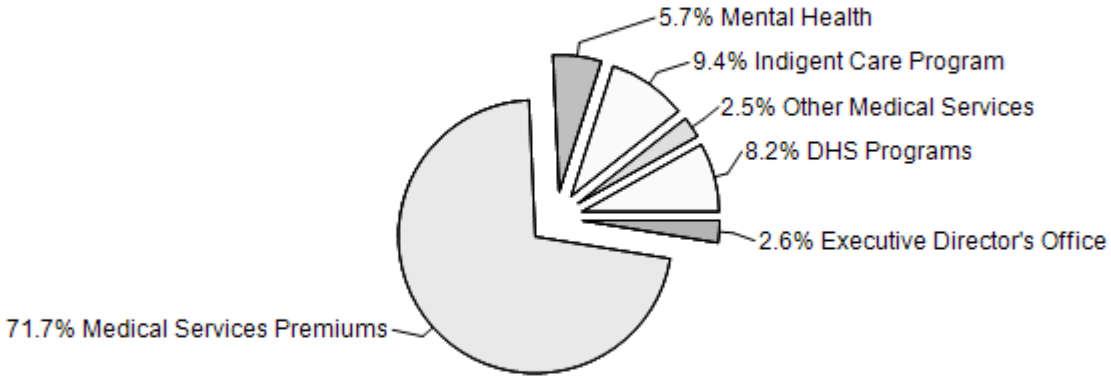


All charts are based on the FY 2012-13 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2012-13 appropriation.

General Factors Driving the Budget

Funding for this department in FY 2012-13 consists of 49.8 percent federal funds, 33.4 percent General Fund, 16.6 percent cash funds, and 0.1 percent reappropriated funds. The major sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; and (5) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

MEDICAID

Medicaid provides health care to people with low income and to people needing long-term care. Participants generally do not pay annual premiums[1] and in the limited cases where there are copayments the amounts are nominal. For most services and populations the federal government pays 50.0 percent of the cost and state funds must provide the remaining 50.0 percent as a match, although the match rate can change over time, and there are exceptions for specific services and populations that receive a different federal contribution.

These characteristics of Medi**caid** are in contrast to Medi**care**, which is a federally-financed, premium-based, insurance option for seniors, with no income-based eligibility criteria. Some people are eligible for both Medicaid, due to their income, and Medicare, due to their age. For these people (called "dual eligible") Medicaid pays the Medicare premiums and may assist with copayments, depending on the person's income. Also, there are some differences in the coverage provided by Medicaid and Medicare. Most notably from a budgeting perspective, Medicaid covers long-term care and Medicare does not.

Most of Medicaid operates as an entitlement program, meaning the state and federal government pay for all covered services for all eligible people regardless of the appropriation. In some cases federal waivers allow expenditure or enrollment caps. The Department has statutory authority in Section 24-75-109 (a), C.R.S. to overexpend the Medicaid appropriation, if necessary.

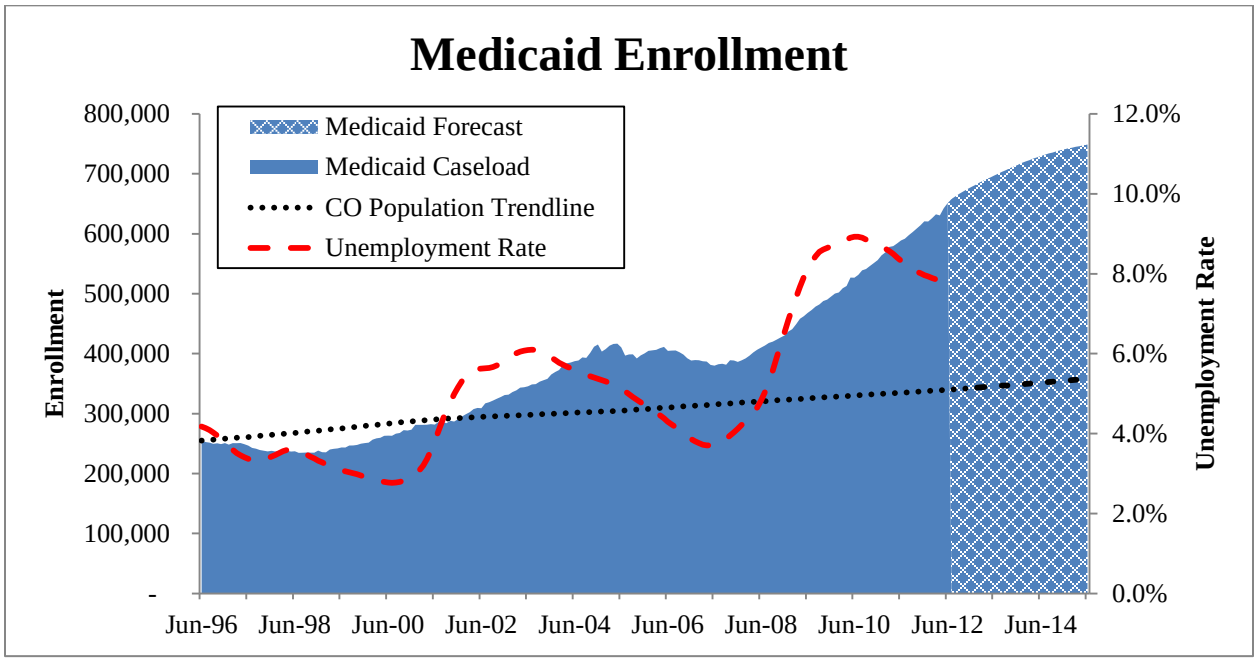
Medicaid expenditures are usually discussed and budgeted in four distinct chunks: (1) Medical Service Premiums; (2) Mental Health Community Programs; (3) the Indigent Care Program; and (4) programs administered by other departments. Each of these is discussed in more detail below.

[1] The exception where participants would pay a premium is the voluntary "buy-in" program for people with disabilities whose income is below 400 percent of the federal poverty guidelines but above the standard Medicaid eligibility criteria.

(1) Medical Service Premiums

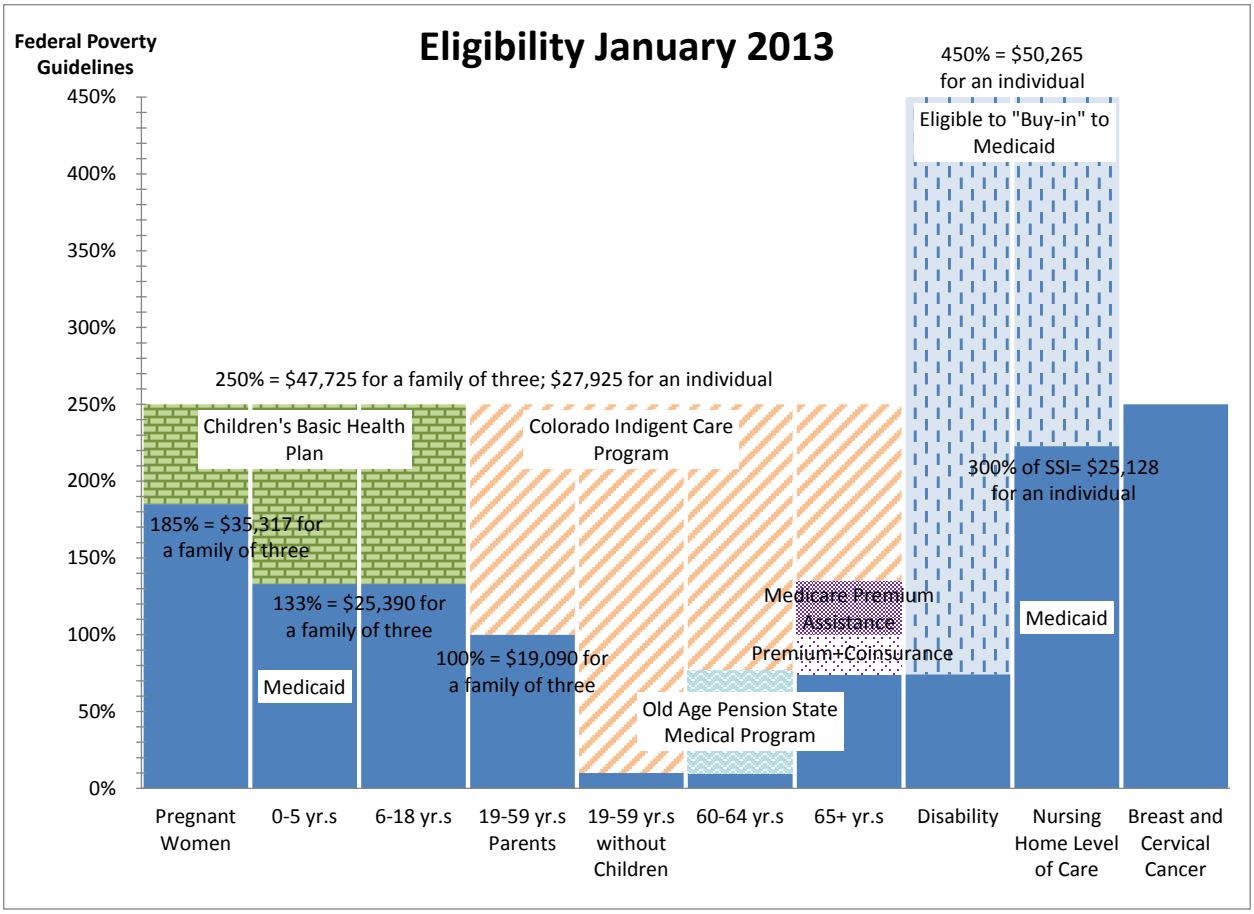
Medical Service Premiums pay for physical health and long-term care services. Expenditures for Medical Service Premiums are driven by the number of clients, the amount of services each client uses, and the cost per unit of service.

Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. The chart below shows the actual and forecasted Colorado Medicaid population. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 1996. The "Unemployment Rate" graphed on the right axis shows the relationship of Colorado's unemployment rate to Medicaid enrollment. Historically, changes in Medicaid enrollment have lagged changes in Colorado's unemployment rate.



The next table summarizes FY 2012-13 eligibility criteria for Medicaid and other state-financed health care programs[2].

[2] Note that eligibility for some of the programs is based on standards other than the federal poverty guidelines, such as eligibility for federal Supplemental Security Income (SSI), and these alternate standards have been converted to a percentage of the federal poverty guidelines for these charts. Also, note that the treatment of assets, the income of relatives, and other elements of the eligibility calculation can vary significantly between eligibility categories.

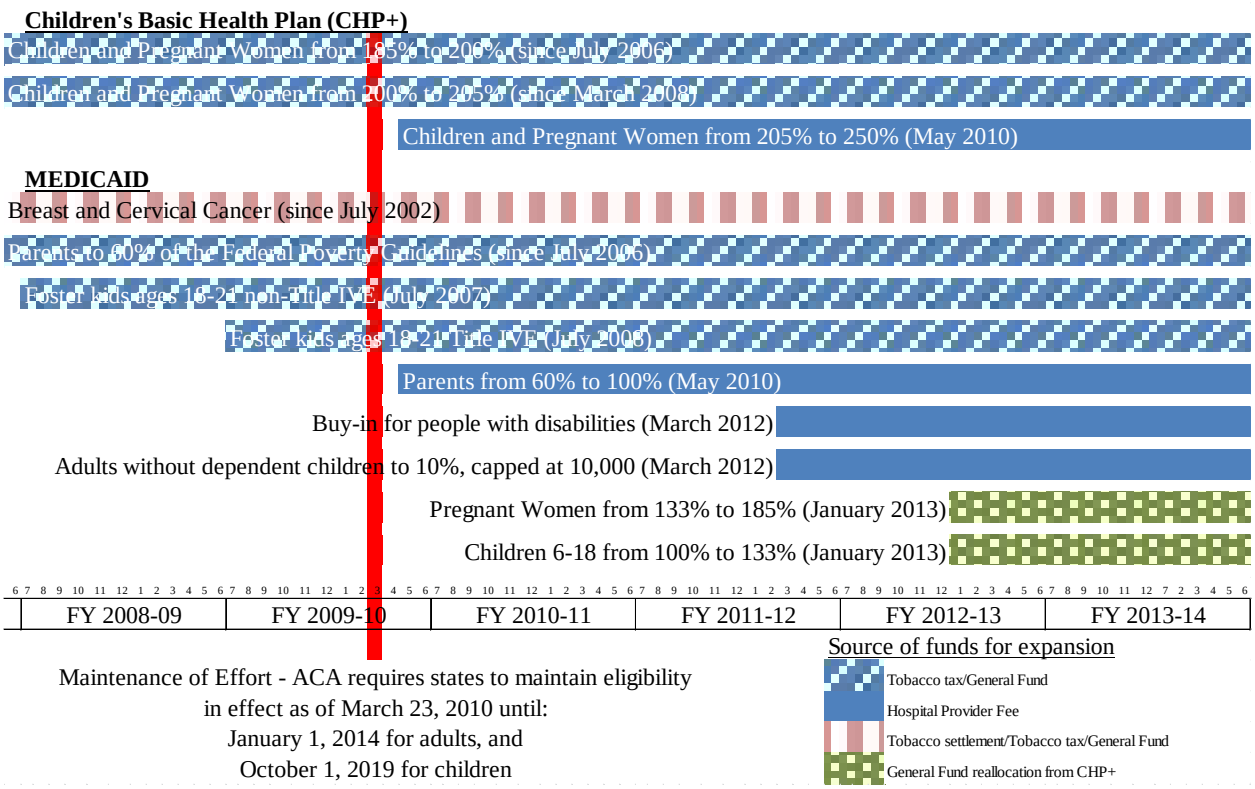


The 2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

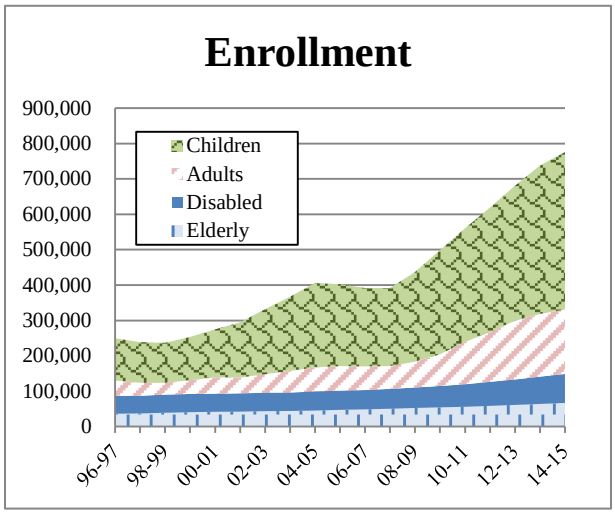
Family Size	Percent of poverty guideline									
	10%	**75%**	**75%**	**100%**	**133%**	**185%**	**225%**	**250%**	**400%**	**450%**
	AWDC	SSI	OAP		ACA	Pregnant	300% SSI	CHP+	Tax Credits	Buy-in
1	$1,117	$8,376	$8,388	$11,170	$14,856	$20,665	$25,128	$27,925	$44,680	$50,265
2	$1,513	$11,345	$11,362	15,130	$20,123	$27,991	$34,036	$37,825	$60,520	$68,085
3	$1,909	$14,315	$14,335	19,090	$25,390	$35,317	$42,945	$47,725	$76,360	$85,905
4	$2,305	$17,284	$17,309	23,050	$30,657	$42,643	$51,853	$57,625	$92,200	$103,725
5	$2,701	$20,254	$20,283	27,010	$35,923	$49,969	$60,762	$67,525	$108,040	$121,545
6	$3,097	$23,223	$23,257	30,970	$41,190	$57,295	$69,670	$77,425	$123,880	$139,365
7	$3,493	$26,193	$26,230	34,930	$46,457	$64,621	$78,578	$87,325	$139,720	$157,185
8	$3,889	$29,162	$29,204	38,890	$51,724	$71,947	$87,487	$97,225	$155,560	$175,005

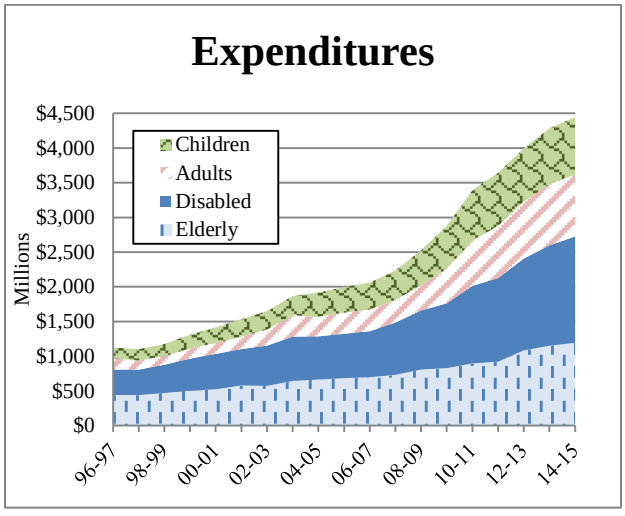
The next table summarizes recent major eligibility expansions. Most of these have been financed with sources other than the General Fund, although tobacco tax revenues have not kept pace with enrollment growth, necessitating General Fund appropriations to supplement the tobacco tax revenue for eligibility expansions funded from this source.

Timeline and funding sources for recent eligibility expansions



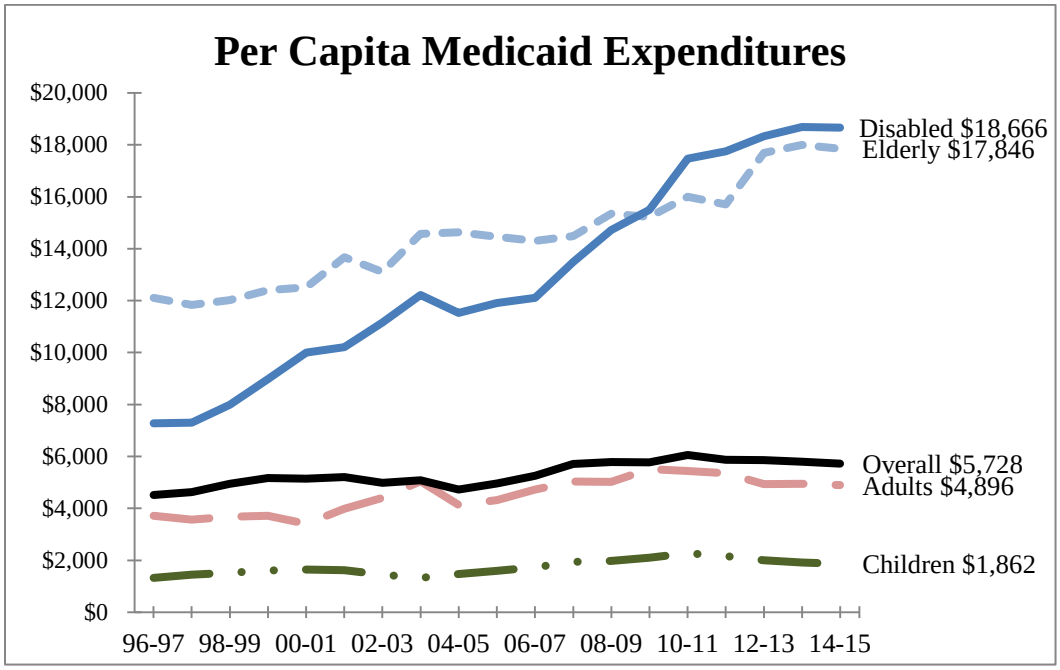
In addition to increased costs due to caseload growth, the Medicaid budget also grows as a result of higher medical costs and greater utilization of medical services. Costs for the elderly and people with disabilities have risen faster relative to the enrolled population than expenditures for children and adults.



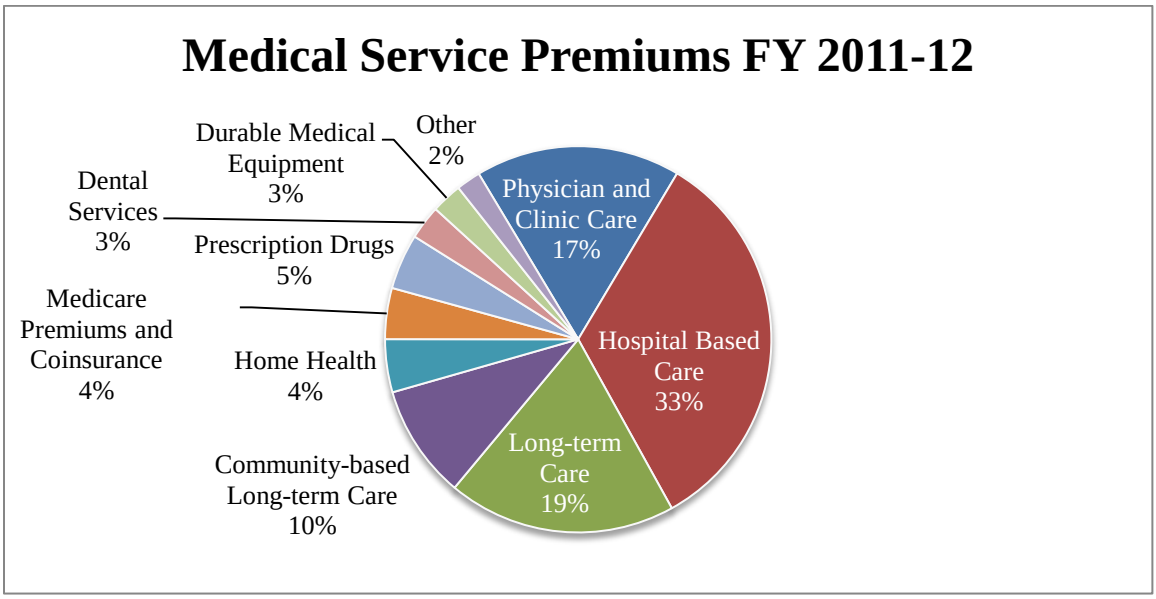


Recently, the overall per capita cost for Medicaid has decreased because the caseload growth for the program has mainly been for lower cost clients (children and their parents) rather than higher

cost clients (the elderly and disabled). Most of the volatility in Medicaid enrollment is among adults and children impacted by economic conditions, but these populations are much less expensive to serve per capita than the disabled and elderly. Per capita expenditures are influenced by case mix, utilization of services, and the price of those services. In addition, recent provider rate reductions have also lowered the per capita costs per client.



The chart below shows typical expenditures by service category for Medical Service Premiums. Approximately a third of expenditures are for the three categories of long term care, community-based long-term care, and home health services.



(2) Mental Health Community Programs

Medicaid mental health community services throughout Colorado are delivered through a managed care or "capitated" program. Under capitation, the State pays a regional entity - a Behavioral Health Organization (BHO) - a contracted amount (per member per month) for each Medicaid client eligible for mental health services in the entity's geographic area. The BHO is then required to provide appropriate mental health services to all Medicaid-eligible persons needing such services.

The rate paid to each BHO is based on each class of Medicaid client eligible for mental health services (*e.g.*, children in foster care, low-income children, elderly, disabled) in each geographic region. Under the capitated mental health system, changes in rates paid, and changes in overall Medicaid eligibility and case-mix (mix of types of clients within the population) are important drivers in overall state appropriations for mental health services. Capitation represents the bulk of the funding for Medicaid mental health community programs.

The following table provides information on the recent expenditures and caseload for Medicaid mental health capitation.

Medicaid Mental Health Capitation Funding					
	FY 2009-10 Actual	**FY 2010-11 Actual**	**FY 2011-12 Actual**	**FY 2012-13 Appropriation**	**FY 2013-14 Request/3**
Capitation Funding /1	$226,620,818	$249,352,665	$273,376,614	$312,580,712	$347,855,029
Annual Dollar Change	$10,759,881	$22,731,847	$24,023,949	$39,204,098	$35,274,317
Annual Dollar % Change	5.0%	10.0%	9.6%	14.3%	11.3%
Caseload/2	479,185	540,456	598,322	664,441	712,810
Annual Caseload Change	61,435	61,271	57,866	66,119	48,369
Annual Caseload % Change	14.7%	12.8%	10.7%	11.1%	7.3%

/1 Does not include the fee-for-service payments.
/2 Not all Medicaid caseload aid categories are eligible for mental health services. The caseload reported in this table does not reflect the Partial Dual Eligible or non-citizen aid categories.
/3 Does not include the request to add the substance use disorder benefit to the capitation program.

(3) Indigent Care Program

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Funding for this program is based on policy decisions at the state and federal levels and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding is from federal sources. State funds for the program come from the Hospital Provider Fee, certifying public expenditures at hospitals, and a small General Fund appropriation.

(4) Programs administered by other departments

The Department transfers Medicaid money to other departments for long-term care services to people with disabilities, for mental health services provided to people in youth corrections, child welfare, and the mental health institutes, for Medicaid's share of the Colorado Benefits Management System, and for the regulation of long-term care settings. The money is first appropriated to the Department and then transferred to the administering departments to comply with federal regulations that one state agency receive all federal Medicaid funding. The cost drivers for these programs are described in more detail in the "General Factors Driving the Budget" for the receiving departments, but the table below provides the magnitude of the transfers.

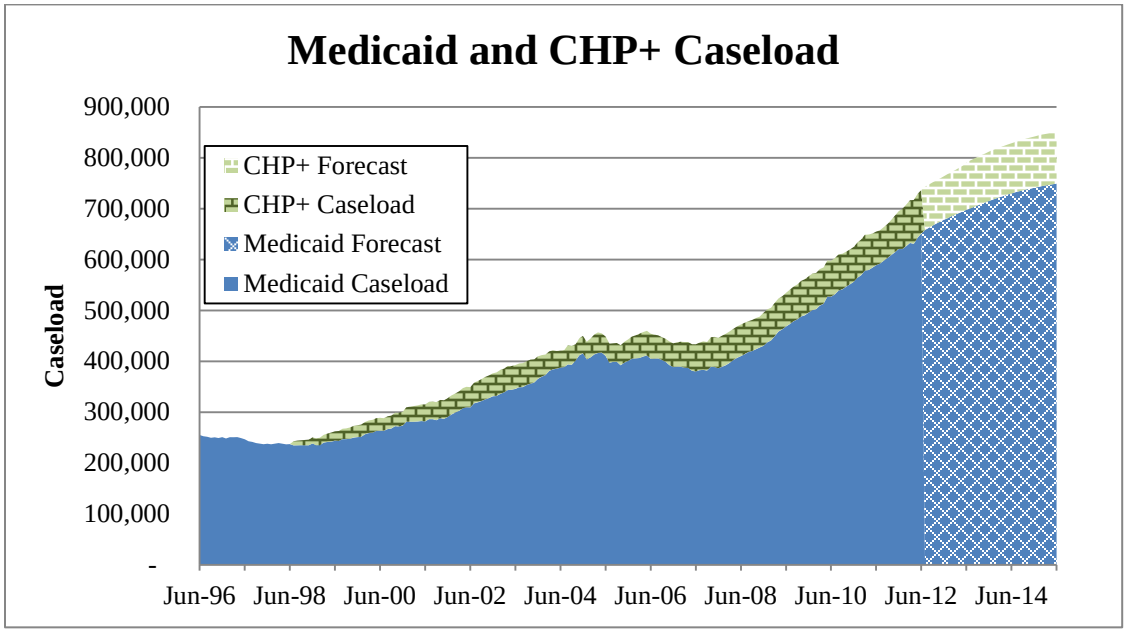
Programs Administered by Other Departments					
Program	Department	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request
Services for People with Disabilities	Human Services	$397,375,911	$383,811,656	$392,574,009	$416,545,638
IT/Maintenance/Admin.	Human Services	20,230,844	20,225,719	41,841,374	32,484,228
Child Welfare	Human Services	12,324,356	11,085,184	14,426,342	14,640,741
Mental Health Institutes	Human Services	6,350,043	6,432,434	7,827,548	7,859,288
Youth Corrections	Human Services	2,602,242	1,506,706	1,632,783	1,656,589
Regulation of long-term care facilities	Pub Health and Enviro/Pub Safety	4,707,033	4,671,998	5,205,465	5,372,914
	TOTAL	**$443,590,429**	**$427,733,697**	**$463,507,521**	**$478,559,398**

CHILDREN'S BASIC HEALTH PLAN[3]

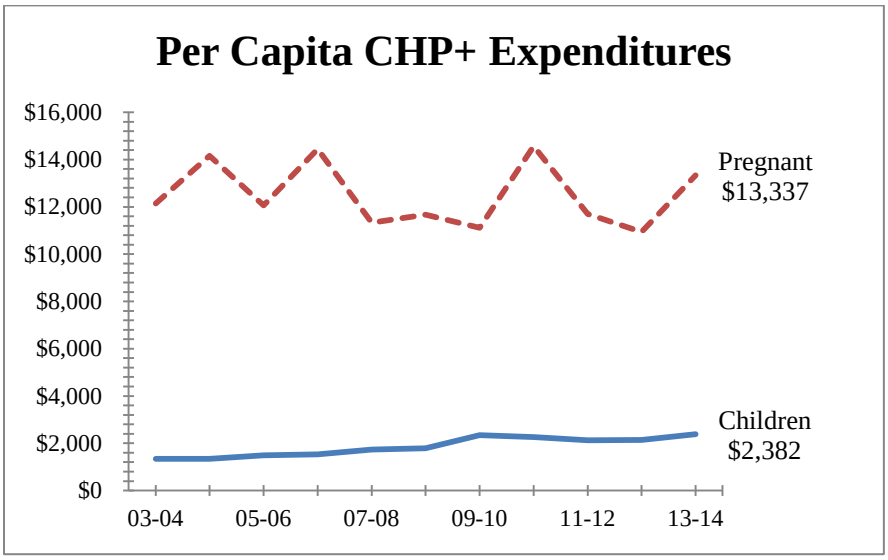
The Children's Basic Health Plan (CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than Medicaid eligibility criteria allows. Annual membership premiums are variable based on income, with an example being $75 to enroll one child in a family earning 205 percent of the federal poverty guidelines, and coinsurance costs are similarly nominal. Federal funds pay 65.0 percent of the program costs not covered by member contributions and state funds pay the remaining 35.0 percent as a match. CHP+ typically receives approximately $28 million in revenue from the tobacco master settlement agreement and the remaining state match comes from the General Fund.

[3] What's in a name? The Children's Basic Health Plan (CBHP) is the state statutory name for Colorado's version of the federal Children's Health Insurance Program (CHIP), which was formerly called the State Children's Health Insurance Program (SCHIP). The federal program was recently renewed in the Children's Health Insurance Program Reauthorization Act (CHIPRA). From the beginning the Department has marketed the state program as the Child Health Plan *Plus* (CHP+), based on feedback from advocates that this name would promote enrollment, reduce potential stigma associated with receiving public assistance, and differentiate the program from Medicaid. Thus, legislators may see or hear the program referred to as CBHP, CHIP, SCHIP, CHIPRA, or CHP+, but NOT Dr. Dynasaur, which is the name of the program in Vermont.

Enrollment in CHP+ is highly changeable, in part because eligibility for the program is sandwiched between an upper income limit and a lower income limit below which an applicant is eligible for Medicaid and not eligible for CHP+. In addition, the program has experienced frequent adjustments to state and federal eligibility criteria and to administrative procedures for handling eligibility determinations that have impacted enrollment. The chart below shows CHP+ enrollment in relation to Medicaid.



The chart below shows per capita expenditures for CHP+. Note that the total number of pregnant women enrolled is relatively small, contributing to the annual variability in per capita expenditures.



MEDICARE MODERNIZATION ACT STATE CONTRIBUTION

The Medicare Modernization Act requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This payment is sometimes referred to as the "clawback." To offset the General Fund costs in recent years Colorado has applied bonus payments received from the federal government for meeting performance goals in CHP+ toward this obligation. The table below summarizes Colorado's payments.

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Estimate
Medicare Modernization Act State Contribution	57,624,126	72,377,768	93,582,494	103,352,848	111,278,217
General Fund	57,624,126	58,711,725	62,939,212	54,304,153	62,229,522
Federal Funds	0	13,666,043	30,643,282	49,048,695	49,048,695
General Fund change	(16,096,711)	1,087,599	4,227,487	(8,635,059)	7,925,369
Percent change	-21.8%	1.9%	7.2%	-13.7%	14.6%

Summary: FY 2012-13 Appropriation & FY 2013-14 Request

Department of Health Care Policy and Financing						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated**	**Federal Funds**	**FTE**
FY 2012-13 Appropriation:						
HB 12-1335 (Long Bill)	$5,561,097,516	$1,858,056,769	$925,385,218	$7,172,593	$2,770,482,936	314.3
Other Legislation	60,598	(941,294)	(10,299)	997,655	14,536	11.9
TOTAL	**$5,561,158,114**	**$1,857,115,475**	**$925,374,919**	**$8,170,248**	**$2,770,497,472**	**326.2**
FY 2013-14 Requested Appropriation:						
FY2012-13 Appropriation	$5,561,158,114	$1,857,115,475	$925,374,919	$8,170,248	$2,770,497,472	326.2
R-1: Medical Service Premiums	255,256,258	78,363,224	(1,837,669)	0	178,730,703	0.0
R-2: Mental Health Community Programs	32,384,988	10,284,849	(1,313,268)	0	23,413,407	0.0
R-3: Children's Basic Health Plan	60,591,910	1,923,755	19,735,056	0	38,933,099	0.0
R-4: Medicare Modernization Act	14,603,355	14,603,355	0	0	0	0.0
R-5: Medicaid Management Information System reprocurement	15,624,403	1,439,072	287,834	0	13,897,497	0.0
R-6: Additional FTE to restore functionality	704,341	352,172	0	0	352,169	7.4
R-7: Substance use disorder benefit	5,788,068	1,818,130	42,035	0	3,927,903	0.0
R-8: Medicaid dental benefit for adults	32,959,416	(747,621)	13,693,726	0	20,013,311	1.2
R-9: Dental administrative services organization for children	576,072	0	0	0	576,072	0.0
R-10: Leased space true-up	92,115	92,402	(46,344)	0	46,057	0.0
R-11: HB 12-1281 departmental differences	1,096,749	497,661	0	0	599,088	3.0
R-12: Customer service tech. improvements	1,800,000	900,000	0	0	900,000	0.0
R-13: Provider rate increase	33,116,630	14,578,983	1,227,138	0	17,310,509	0.0
NP Employee engagement survey	32,448	16,225	0	0	16,223	0.0
NP OIT enterprise asset management	6,260	3,130	0	0	3,130	0.0
Dept. of Human Services Medicaid services	18,383,985	9,686,592	(9,135)	(1,768)	8,708,296	0.0
Centralized approp.s and tech. adjustments	2,250,986	1,421,572	115,253	(52,349)	766,510	0.0
Anualize prior year budget decisions	295,943	14,491,052	(15,695,626)	(2,186,797)	3,687,314	0.4
SB 11-212 Hospital Provider Fee offset GF	0	25,000,000	(25,000,000)	0	0	0.0
TOTAL	**$6,036,722,041**	**2,031,840,028**	**$916,573,919**	**$5,929,334**	**$3,082,378,760**	**338.2**
Increase/(Decrease)	$475,563,927	$174,724,553	($8,801,000)	($2,240,914)	$311,881,288	12.0
Percentage Change	8.6%	9.4%	(1.0%)	(27.4%)	11.3%	3.7%

DESCRIPTION OF REQUESTED CHANGES

R-1: Medical Service Premiums: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing.

R-2: Mental Health Community Programs: The request includes an increase of $32.4 million total funds (including $10.3 million General Fund) for FY 2013-14 for caseload changes in the managed care and fee-for-service Medicaid mental health program. SEE THE NOVEMBER 15, 2012 BRIEFING ON MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS FOR MORE INFORMATION.

R-3: Children's Basic Health Plan: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing.

R-4: Medicare Modernization Act: The Department requests an increase for the projected state obligation pursuant to the Medicare Modernization Act to pay the federal government in lieu of covering prescription drugs for people dually eligible for Medicaid and Medicare.

R-5: Medicaid Management Information System reprocurement: The Department requests funding for the first year of a multi-year process to replace the Medicaid Management Information System (MMIS), which handles medical claims, provider enrollment, and management reports. SEE THE DECEMBER 10, 2012 BRIEFING FOR THE GOVERNOR'S OFFICE OF INFORMATION TECHNOLOGY FOR MORE INFORMATION.

R-6: Additional FTE to restore functionality: The Department proposes hiring an additional nine employees (7.4 FTE in the first year) to relieve overburdened staff. When fully annualized the cost will be $800,719, including $400,361 General Fund. The Department argues that the mission and expectations for the Department have changed over time from simply paying health care claims to making policies that improve the quality and effectiveness of the health care system and save money. In addition, the need for and complexity of communications with an increasingly diverse group of stakeholders has grown. These increased demands have spread employee time thin, reducing performance and raising risks of audit findings, federal fund disallowances, lawsuits, lost appeals, client frustration, difficulties with provider retention, and inability to respond to deadlines. *Section 25.5-1-104 (3), C.R.S. allows the executive director to establish such divisions, sections, and other units necessary for the proper and efficient discharge of the powers, duties, and functions of the department.*

R-7: Substance use disorder benefit: The request seeks to increase Department appropriations by $5.8 million total funds (including $1.9 million General Fund) for FY 2013-14 to enhance the existing substance use disorder benefit through the expansion of services offered, the addition of new service offerings, and the migration of the benefit from a fee-for-service model to a managed care model administered by Behavioral Health Organizations (BHOs). SEE THE NOVEMBER 15, 2012 BRIEFING ON MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS FOR MORE INFORMATION.

R-8: Medicaid dental benefit for adults: The Department proposes adding a dental benefit with an annual $1,000 cap on services for adults on Medicaid beginning in April 2014, with the state share of costs financed from the Unclaimed Property Trust Fund (UPTF). When fully annualized in FY 2014-15 the new dental benefit would cost a projected $56.4 million, including $21.9 million from the UPTF. This would be offset by a projected reduction in expenditures on emergency dental services and concurrent medical conditions of $4.0 million, including $1.6 million General Fund. SEE THE ISSUE BRIEF "R-8 AND R-9 DENTAL BENEFITS" LATER IN THIS BRIEFING DOCUMENT FOR MORE INFORMATION. *This request requires changes in statute to add the dental benefit and to redirect money in the Unclaimed Property Trust Fund.*

R-9: Dental administrative services organization for children: The Department proposes contracting with a dental administrative services organization (AS0) to manage the Medicaid children's benefit. This change requires reprogramming of the Medicaid Management Information System (MMIS) at an estimated cost of $1,152,144, including $288,036 General

Fund to allow monthly payments to the ASO. The Department anticipates that an ASO will increase preventive care and reduce preventable and costly restorative services, resulting in savings of at least $576,072, including $288,036 General Fund, to offset the General Fund cost of reprogramming the MMIS. The Department also anticipates that savings on restorative services will offset the cost of the monthly management payments to an ASO, but these costs and savings will all occur in the same line item and are not estimated in the request. SEE THE ISSUE BRIEF "R-8 AND R-9 DENTAL BENEFITS" LATER IN THIS BRIEFING DOCUMENT FOR MORE INFORMATION. *Section 25.5-5-102 (1) (g), C.R.S. requires coverage of early and periodic screening, diagnosis, and treatment, which includes, by federal definition, dental services for children.*

R-10: Leased space rent increase and true-up: The Department requests funding for an increase in leased space rates at 225 E 16th Avenue, Denver, from $16.77 to $21.00 per square foot as of July 2012. The Department will submit a supplemental request for FY 2012-13 in January. The request also includes a requested increase of approximately 800 square feet for 11.9 FTE added in three bills in FY 2012-13: H.B. 12-1339, Colorado Benefits Management System Project; H.B. 12-1281, Medicaid Payment Reform Pilot Project; and S.B. 12-060, Improve Medicaid Fraud Prosecution. This increase is offset by a decrease of approximately 800 square feet associated with the expiration at the end of August 2013 of a federal grant from the Health Resources Service Administration. *Section 25.5-1-104 (3), C.R.S. allows the executive director to establish such divisions, sections, and other units necessary for the proper and efficient discharge of the powers, duties, and functions of the department.*

R-11: HB 12-1281 departmental differences: The Department requests annualization of the June 20, 2012 emergency supplemental approved by the JBC providing additional staff and resources to implement H.B. 12-1281, Medicaid Payment Reform Pilot Program. *Section 25.5-5-415, C.R.S. authorize the payment reform pilots.*

R-12: Customer service tech. improvements: The Department's request would improve technology available to the Customer Contact Center for responding to client inquiries. Proposed changes include allowing both voice and data input to the telephone system, collecting more automated information about client needs to direct calls, matching a caller's zip code with local contact numbers for entities such as county agencies and regional care collaborative organizations, allowing calls to be transferred to these types of entities outside the department, automating frequently requested services such as medical identification card replacements, redirecting callers seeking the Colorado Health Benefits Exchange, adding a customer relations management (CRM) system to help staff more quickly direct clients to the information they need, improving management analytics such as adding reporting on the most common reasons for client calls, and creating a new web site dedicated to Medicaid client needs that would include a live chat option with the Customer Contact Center and functional links to vendors for services such as transportation. The Customer Contact Center has 10.0 FTE and handles an average of 110,000 calls per year. Call abandonment rates and average response times are significantly below industry standards. Consultants hired by the Department recommended these technology improvements as industry norms to improve performance and the callers' experiences. *Section 25.5-1-104 (3), C.R.S. allows the executive director to establish such*

divisions, sections, and other units necessary for the proper and efficient discharge of the powers, duties, and functions of the department.

R-13: Provider rate increase: The Department requests funding to increase reimbursement rates by 1.5 percent for medical service providers who were impacted by rate reductions in prior years. The provider rate increase would not apply to capitated rates that according to federal rule must be actuarially sound, including those for the Children's Basic Health Plan (CHP+) and for Community Based Mental Health Services. The rate increase would not apply to nursing facilities, because the rates for these facilities are determined pursuant to statute, and statutory rate reductions implemented in prior years are scheduled to repeal in FY 2013-14 without a decision item. Rates for pharmaceuticals would not be adjusted, either, because the Department is transitioning to a methodology for reimbursement that reflects actual costs for acquisition and dispensing. A separate request was submitted for rate increases for programs operated by the Department of Human Services. *Section 25.5-4-401 (1) (a), C.R.S. authorizes the Department to, "establish rules for the payment of providers under this article and articles 5 and 6 of this title. Within the limits of available funds, such rules shall provide reasonable compensation to such providers…"*

NP Employee engagement survey: The request includes an increase to fund the Department's share of a survey to gauge employees' attitudes towards their work, their work environment, overall satisfaction, and trends developing within the workforce. SEE THE DECEMBER 10, 2012 BRIEFING FOR THE DEPARTMENT OF PERSONNEL AND ADMINISTRATION FOR MORE INFORMATION.

NP OIT enterprise asset management: The request includes an increase to fund the Department's share of an executive branch information technology asset management program and corresponding data system. SEE THE DECEMBER 10, 2012 BRIEFING FOR THE GOVERNOR'S OFFICE OF INFORMATION TECHNOLOGY FOR MORE INFORMATION.

Dept. of Human Services Medicaid services: The Department's request reflects adjustments for several programs that are financed with Medicaid funds but operated by the Department of Human Services. The largest of these adjustments are for Services for People with Developmental Disabilities. SEE THE BRIEFINGS FOR THE DEPARTMENT OF HUMAN SERVICES FOR MORE INFORMATION.

Centralized approp.s and tech. adjustments: The Department's request includes adjustments to centralized appropriations that are set through common policies, such as salary survey, health benefits, and risk management, and the request contains miscellaneous technical adjustments.

Anualize prior year budget decisions: The Department's request includes annualizations of several prior year budget decisions. The table below highlights selected annualizations with significant General Fund or FTE impacts.

Anualize prior year budget decisions	Total Funds	General Fund	Cash Funds	Reappropriated	Federal Funds	FTE
SB 11-008, Aligning Children's Medicaid Eligibility	(8,040,006)	10,666,001	(13,350,475)	0	(5,355,532)	0.0
HB 12-1340, Nursing Facility Reduction Per Diem Rate	9,024,676	4,512,338	0	0	4,512,338	0.0
SB 08-118, Transfer for Medicaid Disease Management	0	2,000,000	0	(2,000,000)	0	0.0
Annualize FY 12-13 R-6: Medicaid Budget Reductions	(1,751,563)	(863,801)	(11,981)	0	(875,781)	0.0
SB 11-250, Pregnant Women Medicaid Eligibility	(2,237,523)	(782,040)	(423)	0	(1,455,060)	0.0
Annualize FY 12-13 R-5: Payment Reform	(1,396,617)	(659,843)	(38,466)	0	(698,308)	0.2
HB 12-1281, Medicaid Payment Reform Pilot Program	(88,744)	(44,371)	0	0	(44,373)	0.2
All Other Annualizations	4,785,720	(337,232)	(2,294,281)	(186,797)	7,604,030	0.0
Anualize prior year budget decisions	295,943	14,491,052	(15,695,626)	(2,186,797)	3,687,314	0.4

SB 11-212 Hospital Provider Fee offset GF: The Department's request reflects the expiration of short-duration financing from the Hospital Provider Fee that was used to offset the need for General Fund in the Medical Service Premiums line item pursuant to S.B. 11-212. The Hospital Provider Fee provided General Fund relief of $50.0 million in FY 2011-12 and $25.0 million in FY 2012-13. This General Fund relief is scheduled in statute to phase away in FY 2013-14.

Issue: Affordable Care Act Implementation

This issue brief looks at major provisions of the federal Affordable Care Act and their budget implications.

SUMMARY:

- The Affordable Care Act calls for an expansion of Medicaid eligibility to 133 percent of the federal poverty guidelines, among other provisions, and provides an enhanced federal match to pay for the newly eligible, beginning at 100 percent in 2014 and phasing down to 90 percent by 2020.
- The Supreme Court found that states cannot be denied participation in the Medicaid program for choosing not to implement the expansions. Colorado will need to decide whether to expand eligibility. States can expand and then later choose to contract eligibility. Partial expansions will not be eligible for the enhanced federal match rate.
- With or without expansion, the ACA has several impacts on the FY 2013-14 budget. The Department assumed an enhanced federal match for partial ACA expansions already implemented by Colorado, saving the Hospital Provider Fee $54.3 million in FY 2013-14, but since the request was submitted CMS has provided guidance that the enhanced federal match is dependent on adopting all of the ACA expansions. The request does not include estimates of the cost of covering former foster children 18-26, or any woodwork/welcome mat effect of the ACA, although these will occur whether or not the state decides to expand.
- Beyond the number of people who would be eligible and the cost per enrollee, some of the key factors to consider regarding potential expansion include:
    - Whether existing statutory authority needs to be changed
    - The future of the Hospital Provider Fee
    - The crowd-out effect where people with private insurance adopt Medicaid
    - Reductions in federal disproportionate share hospital payments that support the cost of uncompensated care, whether or not a state expands Medicaid to reduce uncompensated care
    - A potential coverage gap for people who have too much income to qualify for Medicaid but too little income to qualify for federal tax credits that assist with health insurance premiums

DISCUSSION:

Key Provisions of the ACA

The federal Patient Protection and Affordable Care Act and amendments to the law in the Health Care and Education Reconciliation act of 2010, known collectively as the Affordable Care Act (ACA) and often referred to colloquially as "Obamacare," contain the following major provisions with ramifications for Colorado's publicly funded health care programs:

- Expand Medicaid coverage to people with incomes up to 133.0 percent of the federal poverty guidelines for all people under the age of 65, and to former foster children to the age of 26, effective January 2014
- Standardize eligibility determinations
- Require states to maintain at least the eligibility criteria in effect during March of 2010 through
    - January of 2014 for adults on Medicaid, and

  - September of 2019 for children on Medicaid or the Children's Health Insurance Program
- Provide enhanced federal match rates for newly eligible Medicaid populations, for the Children's Health Insurance Program, and for primary care services
- Require individuals above federal tax filing income thresholds to obtain minimum essential health care coverage or pay a tax penalty
- Provide tax credits to individuals between 400 percent and 100 percent of the federal poverty guidelines for purchasing insurance through a health exchange, and to small employers for offering qualified health plans, and
- Reduce federal disproportionate share hospital payments based on expected decreases in uncompensated and undercompensated care.

The enhanced federal match rates for populations newly eligible for public assistance through the ACA are summarized in the table below. People newly eligible for public assistance include adults 19-64 who are not pregnant and who were not eligible on the date of enactment of the ACA.

Years	Enhanced Federal Match Rate for Newly Eligible Populations
2014-2016	100.0%
2017	95.0%
2018	94.0%
2019	93.0%
2020+	90.0%

The federal match rate for the Children's Health Insurance Program increases an additional 23 percentage points from 65 percent to 88 percent from October 1, 2015 through 2019 when the authority for the program expires.

The ACA also made numerous changes to private insurance regulations, including:

- Limiting the ability of private insurers to deny coverage based on pre-existing conditions or lifetime or annual benefit maximums
- Requiring private insurers to cover children up to age 26
- Limiting co-insurance charges
- Requiring that at least 85% of premiums be used to pay claims (80% in small group markets)
- Requiring standardized reporting of benefits to facilitate comparison shopping
- Establishing appeals procedures for claims, and
- Redistributing funds among insurers if an insurer's actuarial risk of enrollees is less or more than the average risk of all enrollees of all plans in the state.

With some exceptions, people who don't purchase insurance or join Medicaid will pay a tax penalty (often referred to as the individual mandate).

Affordable Care Act Federal Tax Penalties for Failure to Purchase Insurance			
Families Pay	2014	2015	2016+
The greater of:	$95 per adult +$47.50 per child up to $285 per family	$325 per adult +$162.50 per child up to $975 per family	$695 per adult +$347.50 per child up to $2,085 per family
OR	1.0% of family income	2.0% of family income	2.5% of family income

Families with incomes between 400 percent and 100 percent of the federal poverty guidelines will be eligible for refundable federal tax credits to defer the cost of premiums, if they purchase approved plans through a Health Benefits Exchange. People with incomes below 250 percent of the federal poverty guidelines are also eligible for assistance with coinsurance. The tax credits may be paid prospectively to the insurance company, so families don't have to wait to file tax claims to get the credit. The value of the tax credits is calculated on a sliding scale with the largest tax credits limiting family expenditures for the cost of a benchmark health insurance plan to 2.0 percent of income and the smallest tax credits limiting family expenditures for the benchmark plan to 9.5 percent of family income. Families who purchase insurance that is less expensive than the benchmark plan will get the same credit. Thus, the tax credits are indexed to both family income and the cost of insurance. The Congressional Research Service provided the following example of the maximum monthly contributions a family qualifying for the tax credits would need to make for a benchmark plan, based on federal poverty guidelines for 2011:[4]

Table 3. Maximum Monthly Premium Contributions, by Family Size, If Premium Credits were Available in 2011

(for the 48 contiguous states and the District of Columbia)

Federal Poverty Line (FPL)	Maximum Premium Contribution as a % of Income ("Applicable Percentages")	Maximum Monthly Premium Contribution (2011), by Family Size			
		1	2	3	4
100%	2.0%	$18	$25	$31	$37
133.00%	2.0%	$24	$33	$41	$50
133.01%	3.0%	$36	$49	$62	$74
150%	4.0%	$54	$74	$93	$112
200%	6.3%	$114	$154	$195	$235
250%	8.05%	$183	$247	$311	$375
300%	9.5%	$259	$349	$440	$531
350%	9.5%	$302	$408	$513	$619
400%	9.5%	$345	$466	$587	$708

Source: CRS computation based on "Annual Update of the HHS Poverty Guidelines," 76 Federal Register 3637-3638, January 20, 2011, and ACA.

Notes: Under ACA, premium credits for eligible exchange coverage will not be available until 2014; the data in this table are for illustrative purposes only. Different income levels, as measured against the FPL, apply separately to Alaska and Hawaii (see "Annual Update of the HHS Poverty Guidelines" referenced under Source). The Federal Poverty Guidelines are updated annually for inflation. If individuals enroll in more expensive plans than the second lowest-cost silver plan in their respective areas, they would be responsible for the additional premium amounts. The premium contribution amounts are rounded to the nearest dollar.

[4] *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, June 13, 2012, http://www.fas.org/sgp/crs/misc/R41137.pdf

Tax credits are also available to small businesses who offer work-based insurance to their employees. To qualify a business must have 25 or fewer FTE, pay at least 50 percent of the cost of single coverage, and have average wages of less than $50,000 per year. The value of the credit is on a sliding scale based on workers and average income, with a maximum benefit in 2014 of 50 percent of the businesses' contribution to health insurance premiums.

Senate Bill 11-200 (Boyd/Stephens) authorized the creation of Colorado's Health Benefit Exchange. In addition to being the vehicle to qualify for tax credits, the Health Benefit Exchange provides standardized information about the benefits and expenditures associated with approved plans and it identifies benchmark plans. Development of the exchange is currently underway with funding from federal planning grants.

Supreme Court Decision

Although the ACA calls for Medicaid eligibility expansions, the Supreme Court found in NFIB v. Sebelius that states cannot be denied participation in the Medicaid program for choosing not to implement the expansions. A state that chooses not to expand Medicaid eligibility will forego the additional federal funds offered through the ACA for expansion populations, but will not lose federal funds for existing populations. Secretary Kathleen Sebelius of the federal Department of Health and Human Services maintains that the Court's decision applied only to the financial penalty for states that choose not to expand eligibility for low-income adults. Specifically, she argues the Court did not invalidate the maintenance of effort requirement of the ACA or the requirement for standardized eligibility determinations.[5]

To be eligible for the enhanced federal match a state must implement the Medicaid expansions in full, according to secretary Sebelius. Colorado has already partially implemented some of the expansions called for by the ACA with financing from the Hospital Provider Fee. When the Department's budget request was submitted the Department assumed that these partially implemented expansions would be eligible for the enhanced match rate, whether or not the state decided to implement the remainder of the eligibility expansions. This assumption no longer appears valid. In a letter to governors dated December 10, 2012, Secretary Sebelius indicated:

> *The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate.*

In the same letter Secretary Sebelius confirmed that there are no deadlines for a state deciding whether to expand Medicaid eligibility, and that a state choosing to expand eligibility may later

[5] Secretary Sebelius' letter to governors dated July 10, 2012, and reaffirmed in her letter to governors on December 10, 2012. The Congressional Research Service reached a similar conclusion regarding the maintenance of effort requirement and standardized eligibility determinations in, "Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act," dated July 16, 2012.

decide to stop covering that expansion population. The letter emphasized, however, that the phased federal match rate is set by calendar year, rather than by when a state begins covering the expansion population.

Impacts of the ACA on the FY 2013-14 and FY 2014-15 budgets

The tables below summarize the dollar impact of the ACA on the Department's FY 2013-14 budget request and on the Department's projection for FY 2014-15. Following the table are short descriptions of each item. Note that many of the figures for FY 2013-14 are partial-year impacts that begin when key provisions of the ACA take effect January 1, 2014.

FY 2013-14 ACA impacts on the budget				
Item	**Total**	**General Fund**	**Hospital Provider Fee**	**Federal Funds**
Parents from 60% to 100%	$0	$0	($31,103,705)	$31,103,705
Adults without dependent children	0	0	(23,192,022)	23,192,022
Former foster children 18-26	Not estimated			
Primary Care Physician Services	16,107,758	1,617,394	0	14,490,364
Standardized eligibility determinations	15,504,121	(699,151)	0	(5,350,387)
Woodwork/welcome mat effect	Not estimated			
Smoking cessation for pregnant	(142,333)	(71,166)		(71,167)
Pharmacy rebates	(14,428,315)	0	0	(14,428,315)
TOTAL	($4,512,428)	$847,077	($54,295,727)	$48,936,222

FY 2014-15 ACA impacts on the budget				
Item	**Total**	**General Fund**	**Hospital Provider Fee**	**Federal Funds**
Parents from 60% to 100%	$0	$0	($65,096,604)	$65,096,604
Adults without dependent children	0	0	(47,651,851)	47,651,851
Former foster children 18-26	Not estimated			
Primary Care Physician Services	11,203,211	1,145,654	0	10,057,557
Standardized eligibility determinations	(31,593,942)	(2,709,974)	0	(28,883,968)
Woodwork/welcome mat effect	Not estimated			
Smoking cessation for pregnant	(142,333)	(71,166)		(71,167)
Pharmacy rebates	(16,525,144)	0	0	(16,525,144)
TOTAL	($37,058,208)	($1,635,486)	($112,748,455)	$77,325,733

Parents from 60% to 100% enhanced federal match

House Bill 09-1293 authorized the Hospital Provider Fee to pay the state share for this Medicaid eligibility expansion that was implemented May 1, 2010. Absent the ACA, the federal match rate would be 50%, but with the ACA the Department's budget request assumed Colorado would receive a 100 percent match rate beginning January 1, 2014. The federal match rate decreases to

95 percent in 2017 and phases down to 90 percent by 2020. As noted above, the federal government now says that states will only receive the enhanced federal match if they implement all of the ACA expansions.

Adults without dependent children enhanced federal match
House Bill 09-1293 authorized the Hospital Provider Fee to pay the state share for expanding Medicaid eligibility to adults without dependent children up to 100 percent of the federal poverty guidelines. Due to fiscal and logistical concerns, the Department implemented a limited expansion to 10 percent of the federal poverty guidelines with a cap of 10,000 people, effective May 18, 2012. Absent the ACA, the federal match rate would be 50%, but with the ACA the Department's budget request assumed Colorado would receive a 100 percent match rate beginning January 1, 2014. The federal match rate decreases to 95 percent in 2017 and phases down to 90 percent by 2020. As noted above, the federal government now says that states will only receive the enhanced federal match if they implement all of the ACA expansions.

Former foster children 18-26
The Department did NOT include an estimate for the cost of providing Medicaid eligibility for former foster children between the ages of 18 and 26, but the Department believes that Colorado will be required to cover this population under the ACA. The cost of this eligibility expansion is not eligible for the enhanced federal match and instead will be funded at the standard fifty percent match for Colorado.

Primary care physician services
For calendar years 2013 and 2014 the ACA requires that the Medicaid reimbursement rate for primary care physician services be at least as great as the Medicare reimbursement rate. Any required increase from the Medicaid rates that were in place July 1, 2009 is eligible for a 100% federal match, regardless of whether a state implements the ACA expansions. However, Colorado reduced rates subsequent to July 1, 2009 and the cost to return to the July 1, 2009 baseline is only eligible for the standard 50 percent federal match rate. Thus, this requirement of the ACA includes a General Fund cost.

Last year the Department proposed distributing the rate increase through a gainsharing system that would reward primary care physicians who achieved better health outcomes for their patients. The Department believed this would lead to savings in preventable procedures and emergency visits that would make the boost in rates for primary care physician services sustainable beyond 2014. However, the Centers for Medicare and Medicaid Services denied the Department's proposal, setting up a decision for the General Assembly about whether to maintain the higher reimbursement rates when the enhanced federal funding expires at the end of 2014.

Standardized eligibility determinations
The ACA replaces diverse eligibility-category-specific and state-specific rules for determining income and family size with a single method for most programs. The new method is based on Modified Adjusted Gross Income (MAGI) with a standard 5 percent income disregard. There are no asset or resource limits. Because of the 5 percent income disregard the ACA is sometimes described as effectively extending coverage to 138 percent of the federal poverty guidelines, rather than 133 percent. The new eligibility determination method also defines family size as

equivalent to the tax filing unit. The new eligibility determination method will result in some changes to who qualifies for Medicaid, but comparing the new standard to the diverse old income disregards is complicated, and the Department does not yet have estimates of the magnitude or direction of the change for most populations. However, the Department's request did include estimates of people who will lose eligibility for CHP+ and gain eligibility for Medicaid based on the new definition of family size. For this group the Department assumes a 65 percent federal match rate. If the MAGI results in newly eligible people not previously served by Medicaid or CHP+, the newly eligible population will be funded at the enhanced 100 percent federal match rate.

Woodwork / welcome mat effect

Many health policy experts predict that more people will "crawl out of the woodwork" to enroll in Medicaid and CHP+ as a result of the ACA, regardless of whether a state chooses to expand eligibility. The woodwork effect is a commonly used economic term, but some object to it as being associated with insects and have begun referring to the phenomenon as the "welcome mat effect," which is also a loaded term. The woodwork effect refers to people who are currently eligible for Medicaid or CHP+ but not enrolled who may decide to enroll based on provisions of the ACA. Some of the provisions of the ACA that may produce a woodwork effect include the individual mandate and the associated tax penalty, mandatory Medicaid and CHP+ prescreening by the health exchange to determine eligibility for tax benefits, requirements for streamlined application and enrollment procedures, and the requirement that children must be covered for an individual to be eligible for tax benefits through the health exchange. Also, public education campaigns about the new law may result in increased Medicaid and CHP+ enrollment. The Department believes some woodwork effect will occur, but did not have an estimate of the magnitude in time for the November request, and informed the JBC staff that an estimate will be included when the Department presents a forecast of the cost of Medicaid expansions.

The Colorado Health Institute (CHI) estimates that in 2011 there were 46,987 uninsured parents between 0 and 100 percent of the federal poverty guidelines who were eligible for Medicaid but not enrolled. This figure comes from a not yet published analysis of data from the 2011 American Community Survey (ACS) produced by the U.S. Census. The CHI is a nonprofit dedicated to health data analysis, with primary funding from the following foundations: Caring for Colorado, The Colorado Trust, The Rose Community Foundation, and The Colorado Health Foundation.

Smoking cessation for pregnant women

The ACA requires states to provide smoking cessation services to pregnant women. Colorado already provides pharmacotherapy, but had to add counseling as a benefit in order to comply. Counseling services were added in January 2012 with a maximum of five sessions of 10 minutes and three sessions of more than 10 minutes. The Department projects a net savings from the service, due to reduced low birth weights.

Pharmacy rebates

The ACA increased rebates paid by pharmacy manufacturers to the Medicaid program as of the passage of the act (March 2010). However, the increased rebates are due entirely to the federal government, rather than shared with states at the standard match rate as are other pharmacy

rebates. Pharmacy rebates are shown in the budget request as an offset to expenditures, and so they appear as a negative number. The increase in pharmacy rebates to the federal government results in a decrease in federal fund expenditures.

Factors to Consider Regarding Expansion

Executive Branch position and forecast pending

The Department did not include a request for ACA eligibility expansions with the November budget, but this was due to needing more time to develop cost estimates, rather than a statement one way or another about whether the state should expand. The Governor's budget transmittal letter explains:

> *The current request does not include estimates related to the expansions of Medicaid pursuant to Federal health reform. We believe that sufficient uncertainty regarding important policy guidance exists at the current time. We expect more precise guidance in the coming months and will communicate this new information to you as soon as is practicable.*

In response to JBC staff questions, the Department elaborated that the executive branch is leaning toward expanding eligibility:

> *Because the Affordable Care Act is federal law, the decision to expand is an Executive Branch decision. While we are likely to choose to opt into the expansion, no decision has been made yet. If the Governor chooses to expand, we anticipate that we will use the regular budget process because of the need to true up spending authority. That said, there may also be the need for legislation to allow for the use of certain funding sources that may require new or altered statutory authority. . . Currently, the Department anticipates that it will be able to provide estimates by February 15, 2013 at the latest. However, the Department continues to work on estimates, and the results may be available sooner.*

Statutory authority

The Department's comments above about the expansion being an executive branch decision and using the budget process to request funding are worth observation. Whether the Department can implement an eligibility expansion without further statutory authority is a question Legislative Legal Services is exploring. Notably, Sections 25.5-5-201 (1) (m) (I) (A) and (p) (I), C.R.S., expand eligibility for parents and adults without dependent children respectively for people, "whose family income does not exceed a specified percentage of the federal poverty line, adjusted for family size and as set by the state board by rule, which percentage shall be not less than one hundred percent." Based on conversations with the Department, staff believes the Department plans to work closely with the legislature on whether to expand eligibility, and that the comment about the expansions being a legislative branch decision may merely reflect the executive branch being cautious about conceding authority. Similarly, staff suspects the comment about using the regular budget process to request funding signals a desire to work closely with the Joint Budget Committee on any expansion, rather than opposition to legislation to implement an expansion. However, staff would recommend asking the Department to clarify their intentions at the hearing.

No enhanced match for partial expansions
When asked for specifics about where the Department needed, "more precise guidance" from the federal government to complete a forecast, the Department indicated it was waiting for a determination of whether states could implement partial Medicaid expansions. Secretary Sebelius provided the awaited guidance on December 10, 2012, that requests for partial expansions would be considered through the waiver process, but that they would not be eligible for the enhanced federal match.

Future of the Hospital Provider Fee
The Department also indicated that it was waiting to present a recommendation on whether to expand eligibility while the Department and the Governor's Office worked with stakeholders to resolve any potential issues before implementation. Staff assumes hospitals are among the stakeholders and that one of the topics is the future of the Hospital Provider Fee.

Potentially newly eligible population
For Colorado the populations that are potentially newly eligible for Medicaid pursuant to the ACA include:

- Parents between 100 and 133 percent of the federal poverty guidelines
- Adults without dependent children between 10 and 133 of the federal poverty guidelines.

The Colorado Health Institute (CHI) provided the JBC staff with the not yet published estimates of 2011 uninsured people in the relevant income ranges that are contained in the chart below. The CHI is a nonprofit dedicated to health data analysis, with primary funding from the following foundations: Caring for Colorado, The Colorado Trust, The Rose Community Foundation, and The Colorado Health Foundation. The CHI based these estimated on data from the 2011 American Community Survey (ACS) produced by the U.S. Census.

ACA Newly Eligible Colorado Uninsured 2011			
Federal Poverty Level (FPL)	Adults without Dependent Children	Parents	Total Uninsured Adults Under 65
10,000 people-10% FPL	52,694		52,694
11-60% FPL	48,610		48,610
61-100% FPL	42,932		42,932
101-133% FPL	33,320	19,966	53,286
134-138% FPL	9,480	3,106	12,586
Total, 0-138% of FPL	187,036	70,059	257,095

This provides a picture of the potential population that could enroll, if Medicaid were expanded (not including the "crowd out" effect, which is discussed below). However, to make a forecast the Department will need to make some difficult predictions about what portion of this population will actually enroll.

Cost per capita

After making projections of enrollment, the Department will need to estimate the expenditures per capita. Generally, expenditures per capita for higher income levels are less than expenditures at lower income levels, likely due to better living conditions and less stress. The table below provides the Department's projections of FY 2012-13 per capita rates for selected populations most similar to the potential ACA expansion populations.

Selected Per Capita Rates Projected by the Department for FY 2012-13			
Eligibiliby Category	Combined Per Capita	Medical Services Per Capita	Mental Health Per Capita
Categorically Eligible Parents (AFDC-A)	$3,792.99	$3,506.78	$286.21
Parents AFDC-A to 60%	$2,981.60	$2,695.39	$286.21
Parents 60% to 100%	$2,849.32	$2,563.11	$286.21

Crowd out effect

Some health policy experts predict that a Medicaid expansion will result in people replacing private insurance with public insurance. To the extent that premium-free Medicaid crowds out private insurance there will be a shift in payers for coverage with no decrease in the uninsured. Some of the provisions of the ACA that may produce a larger than typical crowd out effect when combined with a Medicaid expansion include the individual mandate and the associated tax penalty, mandatory Medicaid and CHP+ prescreening by the health exchange to determine eligibility for tax benefits, requirements for streamlined Medicaid and CHP+ application and enrollment procedures, and the requirement that children must be covered for an individual to be eligible for tax benefits through the health exchange. Also, public education campaigns about the new law may result in increased Medicaid and CHP+ enrollment at the expense of private insurance.

The table below estimates the number of adults without dependent children and parents below 138 percent of the federal poverty guidelines who are insured but not on Medicaid. The figures for the insured by income come from not-yet published estimates by the Colorado Health Institute (CHI), and the Medicaid enrollment figures come from the Department's request.

2011 Insured under 138% FPL	
Adults without Dependent Children	341,496
Parents	123,419
Total Insured Adults Under 65	464,915
2011 Medicaid enrollment	
Disabled	66,197
Parents 0-100%	119,418
Breast & Cervical Cancer Program	578
Baby Care Program-Adults	7,698
Non-Citizens	2,994
Total Medicaid Adults Under 65	196,884
Insured and not on Medicaid	268,031

Reduction in federal Disproportionate Share Hospital (DSH) payments
If Colorado decides not to expand Medicaid eligibility, then ACA-mandated reductions in disproportionate share (DSH) payments to hospitals will not be offset by increases in Medicaid eligibility. DSH payments support hospitals that serve a large number of low-income clients. Colorado matches the federal funds with revenue from the Hospital Provider Fee. DSH supplemental payments are in addition to regular Medicaid payments to assist hospitals with uncompensated and undercompensated care.

The ACA requires the secretary of the federal Department of Health and Human Services to reduce Medicaid DSH payments in aggregate by $18.1 billion over 6 years, beginning with $500 million in federal fiscal year 2014. The secretary must devise a formula that takes the largest reductions from states with the lowest percentage of uninsured and from states that don't target DSH payments based on the volume of Medicaid patients or uncompensated costs. DSH payments normally grow based on an inflation factor every year. Total DSH allotments nationally in FY 2011 were $11,277,992,961 and Colorado's share of $92,557,505 represented 0.8 percent. Because the secretary has not published a formula yet, it is not clear how much the reduction for Colorado will be or in which state fiscal years it will occur.

In addition to reducing Medicaid DSH payments, the ACA also reduces Medicare DSH payments. The Medicare DSH payments go directly to hospitals, rather than passing through the state, and so they do not appear in the state budget. The formula for distributing the Medicare DSH reductions will take into account changes in uncompensated costs, and so a state that doesn't expand Medicaid will likely receive less of a reduction in Medicare DSH payments.

Although the distribution of the Medicaid and Medicare DSH reductions is not known, presumably Colorado hospitals will receive less through both payments. The reductions in DSH payments are based on the assumption that uncompensated and undercompensated care at hospitals will decrease under the ACA. This assumption stems in part from the individual mandate and in part from the Medicaid eligibility expansions. If Colorado decides not to expand

Medicaid eligibility, then the DSH reductions for the hospitals will not be offset by increases in Medicaid eligibility, although hospitals may still see a decrease in uncompensated care due to the individual mandate.

Coverage gap

Federal tax credits to assist with premiums are available for people between 100 percent and 400 percent of the federal poverty guidelines, but adults without dependent children below 100 percent of the federal poverty guidelines could be without assistance if Colorado does not expand Medicaid eligibility. House Bill 09-1293 authorized an eligibility expansion for this population to be financed with the Hospital Provider Fee, but the Department has not yet implemented the expansion due fiscal and logistical concerns. It is not clear if the Department would expand eligibility to the 100 percent threshold without the ACA enhanced federal match, which is only available if Colorado adopts the full ACA expansion to 133 percent.

Administrative costs

In addition to costs for services, a significant Medicaid eligibility expansion would require increases for the Department's administration. The fiscal note for H.B. 09-1293 that authorized the expansions financed with the Hospital Provider Fee may provide an indication of the magnitude of administrative expenses.

Excerpt from the final Legislative Council Staff Final Fiscal Note, dated May 5, 2009, for H.B. 09-1293:

Table 2. Total Expenditures Under HB09-1293				
Cost Components	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
Department Administration	$3,898,392	$9,275,658	$11,685,500	$12,987,925
FTE	12.0	41.0	57.0	57.0

Changes in expenditures for other programs and departments

An expansion of Medicaid eligibility would have ripple impacts on expenditures by other state departments. For example, General Fund appropriated for mental health services provided by the Department of Health and Human Services for the medically indigent would decrease. Funding for the Old Age Pension Medical Program in the Department of Health Care Policy and Financing would need to be repurposed, since this population would be eligible for Medicaid. In the Department of Corrections medical costs would decrease as more inmates would become eligible for Medicaid when they receive inpatient services.

Economic impacts

Both proponents and opponents of expanding Medicaid eligibility raise concerns about the economic impacts. Some of the arguments raised by proponents include:

- Expanding will result in a significant increase in federal funds to the state, leading to new jobs and additional tax revenues.
- Lower premiums will be achieved for all through spreading risk, reducing uncompensated and undercompensated care, and greater access to preventive care that reduces future medical costs.

- Preventive care will increase employability, reduce absenteeism, and improve productivity.
- States that don't expand will be at a competitive disadvantage in attracting businesses, due to quality of life issues and higher health premiums that result from cost shifting of uncompensated care.
- Colorado taxpayers are paying for the expansion through their federal taxes, but those dollars will go to other states if Colorado does not expand.

Economic arguments from opponents include:

- The expansion will bankrupt the federal government, leading to overall economic decline, and each state that adopts the expansion contributes to the problem.
- The federal government cannot afford to sustain the expansion, putting states at risk of picking up the tab when the federal contribution is reduced at a future date.
- This legislature will not have to pay General Fund for the expansion populations, but future legislatures will have to pick up the tab.

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

This issue brief relates to all five of the Department's performance objectives: Increase the number of insured Coloradans, Improve health outcomes, Increase access to health care, Contain health care costs, Improve long-term care service delivery system .

Issue: Administrative Staff (R-6)

This issue brief discusses the Department's request priority R-6 for nine additional staff.

SUMMARY:

- The Department requests four staff for the Finance Office, two for the Clinical Services Office, and one each for the Health Programs Office, Policy and Communications Office, Community Partnerships Office. Their duties are described. Generally the new positions are operational and intended to free up time among program and managerial staff for strategic planning.

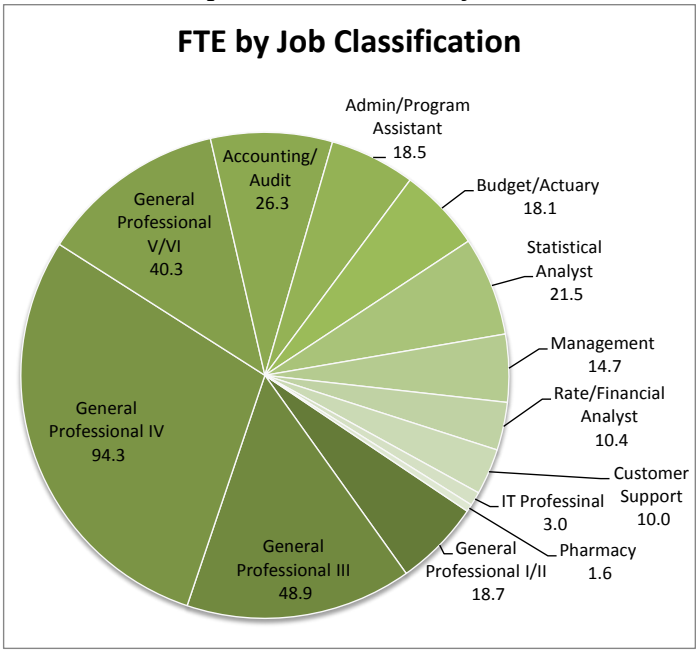
- The following changes in the Department's working environment contributed to the request:
  - Increased volume and complexity of stakeholder input
  - Higher expectations from policy makers about the role of the Department in guiding reform of the health care system to improve outcomes and save money
  - Increases in enrollment and expenditures over time
  - Greater oversight and scrutiny from CMS
  - High turnover rates

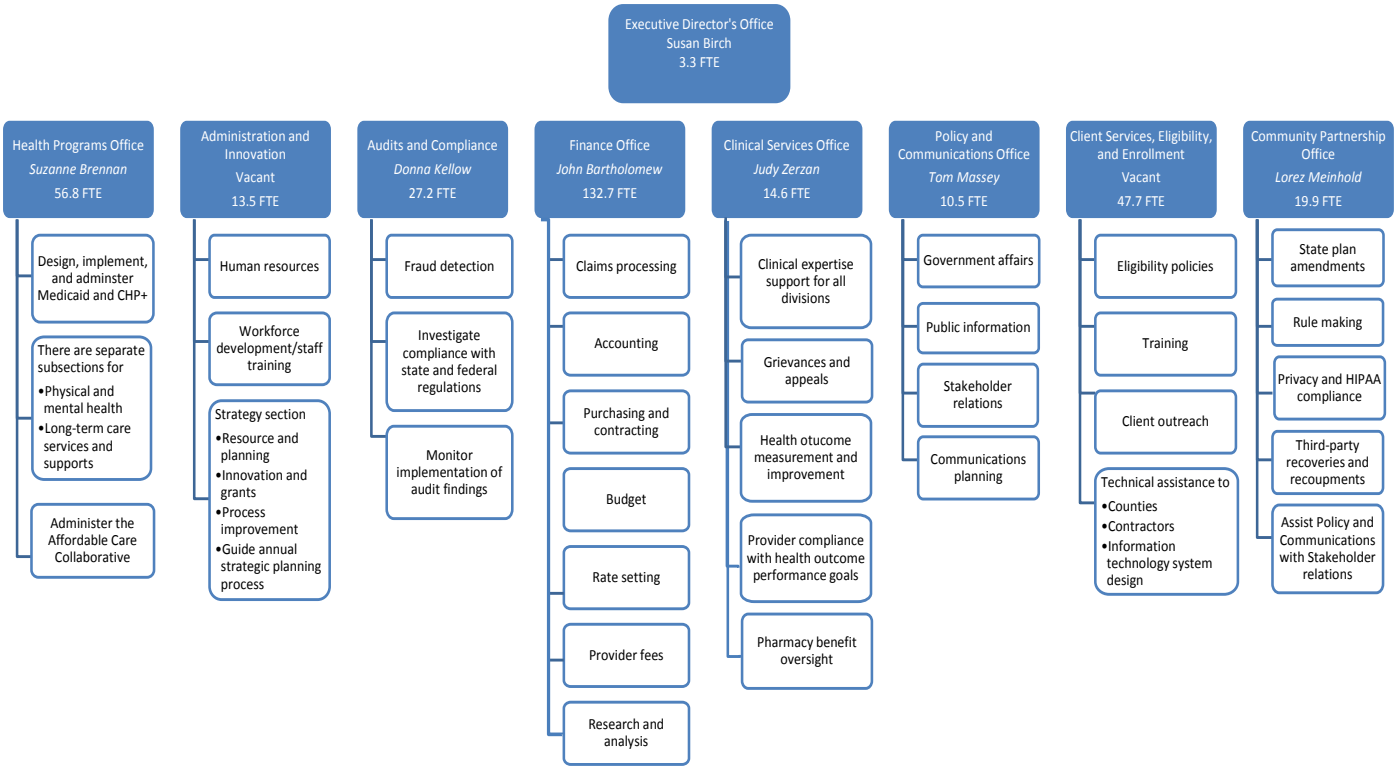
DISCUSSION:

The department's R-6 asks for an additional nine employees (7.4 FTE in the first year) to relieve overburdened staff. When fully annualized the cost will be $800,719, including $400,361 General Fund. The primary goal of the request is to free up time for strategic thinking and to allow the department to be more proactive rather than reactive in responding to trends in health care.

Structure of the Department

To understand the request it is useful to know how the Department is currently staffed. For FY 2012-13 the Department is appropriated 326.2 FTE in a single line item. The most common job classification employed by the Department is General Professional IV, which is a position that earns between $56,796 and $81,936, depending on where an employee is within the pay range. The executive director has organized the Department into eight divisions with the duties described in the table below.





Proposed Positions

Four of the proposed positions would go to the ***Finance Office***, including:

- **Budget Analyst V:** This position would head the budget section of the Finance Office. Currently the director of the Finance Office runs this section in addition to overseeing all the other sections of the Finance Office and participating in the Executive Committee.
- **Budget Analyst III:** This position would add another forecaster to the budget section.
- **Accountant IV:** This position would head a Financial Reporting and Cash Management Unit responsible for documentation to the Centers for Medicare and Medicaid Services, the Office of Inspector General, and the Office of the State Auditor. Currently the Controller runs this unit in addition to overseeing units responsible for claims processing, purchasing and contracting, and provider fee collections and payments.
- **General Professional IV:** This position would process documentation from providers about the adoption, cost, and use of electronic health records. This lengthy documentation is necessary for providers to qualify for federal incentive payments.

Two of the proposed positions would go to the ***Clinical Services Office***, including:

- **General Professional IV:** This position would perform data analysis to assess the effectiveness of health outcome improvement projects.
- **Pharmacist I:** This position would help with the Department's programs that require prior authorization of selected drugs to ensure appropriate use, with expanding the Rx Review program for clients taking five or more medications for three months, and especially with handling pharmacy issues that are escalated to the Department.

One of the proposed positions would go to the ***Health Programs Office*** for:

- **General Professional IV:** This position would deal with compliance issues regarding State Plan submissions to the Centers for Medicare and Medicaid Services, create rule drafts, and assist with fiscal notes. These functions are currently performed by benefit managers.

One position would go to the ***Policy and Communications Office*** for:

- **General Professional IV:** This position would manage stakeholder relations, including facilitating meetings with providers, advocates, and other departments, addressing comments and feedback, and acting as a point of contact for the Department's myriad boards and committees.

One position would go to the ***Community Partnerships Office*** for:

- **General Professional IV:** This position would help with third-party recoveries, including generating adverse action letters, setting up case files, and tracking recovery payments.

Reasons for the request

Stakeholder contacts

In the request and in meetings with the JBC staff the Department emphasized several changes in the working environment contributing to the request, perhaps chief among them an increase in the number and complexity of stakeholder contacts. In part this is due to efforts by the Department to seek more input to improve the reasonableness and responsiveness of the Department's policies. However, increased public input requirements from the Centers for Medicare and Medicaid Services are also driving the request. In addition, the Department argues, growth in Medicaid and CHP+ enrollment, alongside new eligibility categories, has led to an increase in the number and diversity of stakeholders with which the Department interacts. Finally, the Department believes there has been an increase in the intensity of interest in the Department's activities, due to reforms at the state and national level that have potentially significant impacts on provider operations and revenues, and on client services. As examples of the high interest reforms, the Department cites the Affordable Care Collaborative, the Benefits Collaborative, payment reform pilot projects authorized in H.B. 12-1281, Colorado Choice Transitions, and the Affordable Care Act. The Department indicates that other states and national organizations have submitted numerous inquiries for information and data regarding Colorado's reforms.

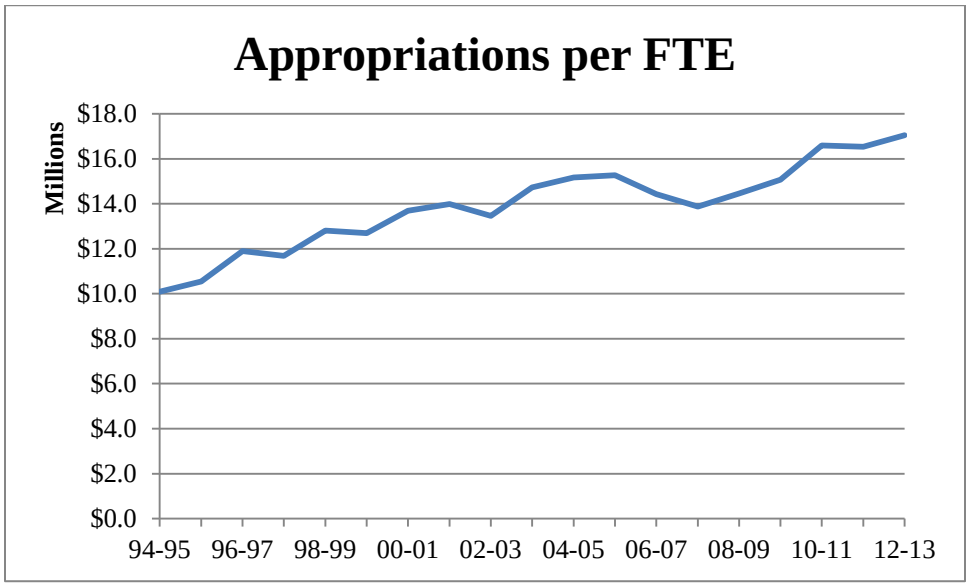
Expectations of policy makers

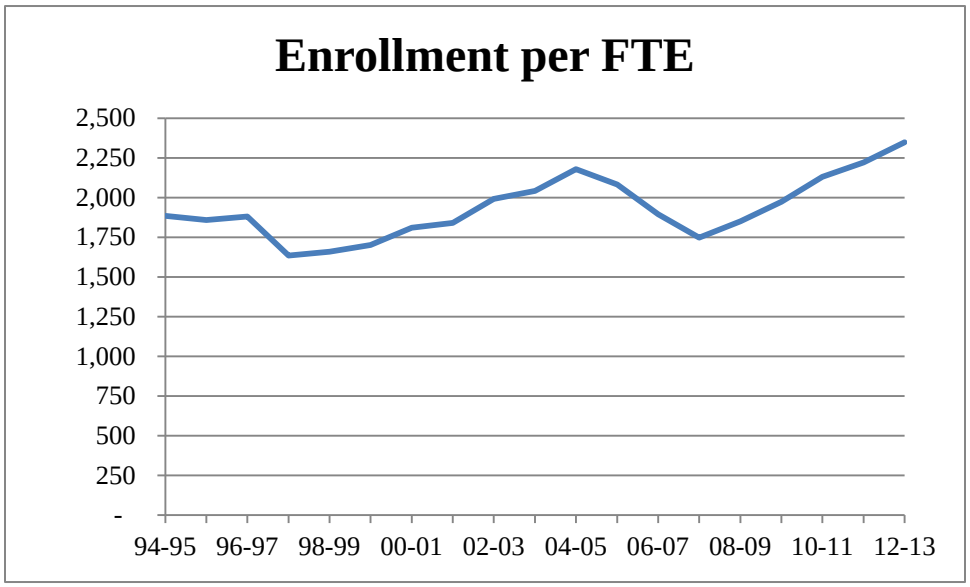
In addition to the time pressures from an increase in stakeholder contacts, the Department believes expectations of the executive and legislative branches have changed for how the Department operates. Beyond determining eligibility and paying claims, the Department believes policy makers expect the Department to play an active and guiding role in reforming the health care delivery system to improve outcomes and reduce costs. As evidence, the Department references many of the same initiatives that are increasing stakeholder contacts, along with H.B. 10-1119 the SMART Government Act. To be more proactive in designing the Medicaid

payment system, managers need relief from some of the operational functions that are stressing their time to think strategically.

Increases in enrollment and expenditures

Over time incremental increases in enrollment and expenditures have added to the time required for these operational functions. For example, both pharmacy issues escalated to the Department and the number of third party recoveries have increased with enrollment. The tables below chart appropriations per FTE and enrollment (including both Medicaid and CHP+) per FTE over time.





Federal oversight

Along with increasing enrollment and expenditures the Department says recently oversight and scrutiny from CMS has increased. The regional office has hired additional staff specifically

dedicated to Colorado. The Department also shared several anecdotal stories about the number of questions and level of review by CMS of submissions in the last one to two years compared to ten years prior. The Department prioritizes responding to CMS reporting requirements and inquiries, because the stakes are high for failure to comply, including potential disallowances, lawsuits, lost appeals, and audit findings. However, the Department believes that responding to CMS is currently coming at the expense of proactive planning and additional employees are needed to free up time for promoting better health outcomes and saving costs.

Turnover

The Department believes turnover has been problematically high and provided this comparison with statewide turnover rates.

Turnover Rates		
Year	State Personnel System	Health Care Policy and Financing
FY 2009-10	8.60%	10.70%
FY 2010-11	10.10%	15.00%

Exit interviews identify limited advancement opportunities within the department and compensation that is not competitive with alternatives as the primary reasons for employees leaving. These concerns might not be addressed directly by the request, but an increase in staff would make managing turnover easier, and reduce the time stresses on continuing employees.

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

Indirectly this relates to all five of the Department's strategic objectives. The Department argues that additional positions are necessary to maintain and advance the performance goals.

Issue: Dental Benefits (R-8 and R-9)

This issue brief discusses the Department's request priorities R-8 and R-9 to improve dental services.

SUMMARY:

- In R-8 the Department proposes adding a new dental benefit for adults capped at $1,000 annually and financed from money in the Unclaimed Property Trust Fund (UPTF) that is currently devoted to CoverColorado, which provides an insurance option for people with preexisting conditions. Implementing this proposal requires legislation to add the benefit and to change the allowable uses of the UPTF.

- In both R-8 and R-9 the Department proposes using an Administrative Service Organization (ASO) or organizations to manage dental benefits for adults and children.

- The Department identifies compelling research showing a correlation between routine dental care and expenditures for emergency room visits and chronic health conditions such as diabetes. However, the Department does not attempt to estimate and score any savings from the proposed changes other than an offset of existing emergency dental services and administrative costs.

RECOMMENDATION:

Staff recommends that the JBC strongly consider sponsoring legislation to add a dental benefit for adults.

DISCUSSION:

Overview of the request

The Department's R-8 proposes adding a dental benefit with an annual $1,000 cap on services for adults on Medicaid. Currently, Medicaid provides dental coverage for children pursuant to the Early, Periodic Screening, Detection, and Treatment (EPSDT) criteria, but for adults the Department only covers emergency dental services for relief of pain or infection, or when there is an approved concurrent medical condition. When fully annualized the projected cost of the new dental benefit is $56.4 million, and this will be offset by a projected reduction of $4.0 million in emergency dental expenditures. The Department proposes that the state share of the new dental benefit come from money in the Unclaimed Property Trust Fund that is currently devoted to the CoverColorado program, which provides insurance to people unable to obtain health coverage except at prohibitive rates or with restrictive exclusions. Beginning in October 2013 the Affordable Care Act prohibits insurers from coverage exclusions for preexisting conditions, and so CoverColorado anticipates all current enrollees will be able to obtain private insurance coverage by May 2014. This request requires changes in state statute to add the dental benefit to Medicaid and to change the allowable uses of money in the Unclaimed Property Trust Fund.

The Department proposes contracting with a dental administrative services organization (AS0) or organizations to manage both the new adult dental benefit and the existing children's benefit. The proposed transition to using an ASO for the children's benefit is contained in the Department's R-9. An ASO would be responsible for processing claims, authorizations, and appeals, educating enrollees, and reaching out to and supporting providers. Using an ASO requires reprogramming of the Medicaid Management Information System (MMIS) to allow monthly payments to the ASO. The Department estimates the cost of the reprogramming at $1,152,144, including $288,036 General Fund. This cost is included in both the R-8 and R-9 requests, but if both requests are approved the Department needs the funding only once. The Department anticipates that an ASO will increase preventive care and reduce preventable and costly restorative services, resulting in General Fund savings at least as great as the General Fund cost of the MMIS reprograming.

The new capped benefit for adults would supplement, rather than supplant, existing coverage for emergency services. If a person has a dental condition causing pain or infection, or that is found to be contributing to an approved concurrent medical condition, the person would be eligible to receive emergency dental services regardless of the $1,000 annual cap. Medicaid clients could also work with dentists to stagger procedures over multiple years to manage expenses within the $1,000 annual cap.

The Department estimates that the Unclaimed Property Trust Fund (UPTF) generates relatively stable revenues of approximately $33 million annually. When fully annualized, R-8 is projected to require $21.3 million from the UPTF.

Projected outcomes

The Department indicates several studies have found strong correlations between routine dental care and overall patient health. The department believes that the proposed dental benefit will lead to a decrease in expenditures for emergency room visits and chronic health conditions such as diabetes. As examples of the research on dentistry the Department cited the following (in this context the abbreviation ED stands for emergency department):

> *A study published in JADA in 2012 found that adults in Oregon with Type II diabetes who received routine preventive dental care had significantly fewer diabetes-specific hospital admissions and ED visits than individuals who received no preventive dental treatment.*
> http://jada.ada.org/content/143/1/20
>
> *A study published in the AJPH in 2011 found that Medicaid enrollees who lost dental benefits had large and statistically significant increases in dental-related ED use (101.7%), ED expenditures (98.8%), and in all ambulatory medical care use (77.0%), and ambulatory medical care expenditures (114.5%).*
> http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2010.300031
>
> *A study conducted by the Kaiser Commission on Medicaid and the Uninsured found that elimination of the Medicaid adult dental benefit led to serious pain due to untreated dental problems, which then exacerbated other chronic or disabling health conditions for some individuals.*
> http://www.kff.org/medicaid/upload/7378.pdf

A study conducted by the Pew Center for the States found that dental professional in Michigan reported that ED use increased by more than 10% after a two-year period during which the state reduced Medicaid dental coverage for adults
http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/Pew_Report_A_Costly_Dental_Destination.pdf

The Department expects that the dental benefit will reduce expenditures for emergency room visits and chronic diseases, but the Department did not attempt as part of the request to estimate the savings Colorado would achieve, noting that it is not clear how quickly these expenditures would decrease, or by how much.

The Department does assume that expenditures for the new dental benefit would replace a portion of current expenditures for emergency dental services. Colorado is one of 20 states that do not cover dental services beyond emergencies. No states have recently increased dental benefits, but several have reduced benefits and each experienced an increase in emergency dental services.

State reducing dental benefit	Increase in emergency dental services	Time period
Michigan	11%	6 months
Massachusetts	30%	6 months
Maryland	21%	12 months
Iowa	225%	7 years, during which enrolment increased 16.3 percent

Based on the experiences of these states that reduced dental benefits, the Department assumes that increasing dental benefits will reduce emergency dental services by 15 percent in FY 2013-14 and 30 percent in FY 2014-15. The Department expects this will save $1.9 million, including $0.7 million General Fund in FY 2013-14, and $4.0 million, including $1.6 million General Fund, in FY 2014-15.

The Department believes using an ASO for the adult and children benefits will result in greater utilization of preventive services. According to the Department, the use of preventive services by Medicaid children in Colorado exceeds national averages. The Department argues that getting better results will require the services of a contractor educating enrollees about their benefits, about the importance of prevention practices, and about maintaining dental appointments. Also, according to the Department, ASOs tend to have access to better analytical software for identifying utilization trends and where the most cost-effective improvements can be made. The Department plans to structure the contract in a way to ensure that savings as a result of reduced restorative work and emergency room visits would more than offset payments to the ASO, and indicated that this may include shared savings tied to performance outcomes. The Department did not estimate the specific savings associated with R-9 other than to state that it will be at least as great as the General Fund cost.

Other key assumptions in the Department's request for the new adult benefit include:

- 27 percent of clients will utilize the adult dental service
- The average cost per utilizing client will be $600
- A contract with an ASO will cost between $1 and $3 per member per month

The table below summarizes the Department's R-9 request.

Item	FY 2013-14	FY 2014-15
Caseload	292,687	302,944
ASO payments per member per month	$2.00	$2.00
ASO payments	$7,024,488	$7,270,656
Clients utilizing dental benefit	14.6%	27.0%
Average cost per utilizing client	$600.00	$600.00
Claims	$25,683,000	$49,077,000
Service Costs Subtotal	$32,707,488	$56,347,656
General Fund	-	-
Hospital Provider Fee	305,354	778,132
Unclaimed Property Trust Fund	12,843,931	21,889,159
Federal Funds	19,558,203	33,680,365
Current emergency dental expenditures	$12,692,270	$13,477,922
Estimated savings	-15.0%	-30.0%
Service Savings Subtotal	($1,903,841)	($4,043,377)
General Fund	(747,621)	(1,570,715)
Hospital Provider Fee	(17,774)	(55,837)
Unclaimed Property Trust Fund	-	-
Federal Funds	(1,138,446)	(2,416,825)
MMIS reprogram to pay ASO	1,152,144	-
MMIS reprogram to add capped benefit	555,534	-
2.0 FTE salaries/operating to manage benefit	93,091	126,910
Utilization and quality review contracts	355,000	355,000
Administration Subtotal	$2,155,769	$481,910
General Fund	-	-
Hospital Provider Fee	562,215	152,205
Unclaimed Property Trust Fund	-	
Federal Funds	1,593,554	329,705
Total	$32,959,416	$52,786,189
General Fund	(747,621)	(1,570,715)
Hospital Provider Fee	849,795	874,500
Unclaimed Property Trust Fund	12,843,931	21,889,159
Federal Funds	20,013,311	31,593,245

The Department's estimated savings rate for FY 2013-14 is half of the projected annualized savings. However, the Department estimates the proposed dental benefit will not be implemented until April 2014, meaning it will be effective for only three months of FY 2013-14. Similarly, the Department's estimate of FY 2012-13 clients utilizing the dental benefit seems high with only three months of benefits. The Department's estimates of the savings and costs, along with the available money in the UPTF, may need refinement, particularly for the phase-in during FY 2013-14.

Staff observations

The Department's research about the relationship between dental care and health outcomes and expenditures is compelling. Money from the Unclaimed Property Trust Fund (UPTF) should no longer be needed for CoverColorado as it currently operates, regardless of whether Colorado decides to expand Medicaid eligibility, due to prohibitions in the ACA on insurance exclusions for preexisting conditions. **Staff recommends that the JBC strongly consider sponsoring legislation to add a dental benefit for adults.**

However, staff encourages the Committee to discuss with the Department how the proposed benefit fits with other reforms. For example, should the Department hire a separate ASO or ASOs for the adult and children's benefit, or fold the outreach responsibilities into the Affordable Care Collaborative (ACC) and perform the administrative functions internally? Is there a benefit from having multiple organizations managing dental and physical health benefits separately from each other? Will the redesign of the Medicaid Management Information System (MMIS) eliminate the need to hire an ASO to access sophisticated software for tracking utilization? If the Department implements this new benefit at the same time as a significant expansion in Medicaid eligibility and payment reforms through the ACC and H.B. 12-1281, how will the Department track the impact of the dental benefit on health outcomes? Many of the adults who would receive the benefit have no history with the Department that could be used as a baseline. Also, with multiple reforms occurring at once it may be difficult to attribute a change in behavior to a specific initiative.

Staff would also encourage the Committee to consider whether a new dental benefit for adults is a priority use for the Unclaimed Property Trust Fund. Staff does not see much of a nexus between unclaimed property and health care, although the money in the UPTF has been used in the past for the CoverColorado program. If the Committee believes there is a nexus, staff wonders how the Department would prioritize using the UPTF for a new dental benefit versus offsetting a portion of the cost of expanding Medicaid eligibility.

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

The Department's R-8 and R-9 address the Department's strategic objectives of Improve health outcomes, Increase access to care, and Contain health care costs

Issue: Nursing Facility Rates

This issues discusses the expiration of a statutory 1.5 percent reduction in nursing facility reimbursement rates, and whether the General Assembly should extend the reduction.

SUMMARY:

- Nursing home reimbursement consists of a General Fund per diem rate plus supplemental payments that are financed with a nursing facility provider fee.

- The per diem is the lesser of allowable costs or a statutory cap on expenditures. The calculation of the statutory cap is complicated, but it is essentially a theoretical base per diem that can grow by approximately 3.0 percent each year less any statutory reductions. If a statutory reduction is applied, it does not reduce the theoretical base per diem used to calculate the next year's statutory cap. Thus, if statutory reductions remain constant between fiscal years, nursing home rates can increase by 3.0 percent. If a statutory reduction expires, nursing home rates will increase by more than 3.0 percent.

RECOMMENDATION:

Staff recommends that the JBC sponsor legislation to extend the 1.5 percent reduction in nursing facility rates indefinitely.

DISCUSSION:

Overview

A 1.5 percent statutory nursing home rate reduction expires at the end of FY 2012-13, resulting in an estimated increase in FY 2013-14 expenditures of $9.7 million, including $4.8 million General Fund. As originally introduced, H.B. 12-1340, sponsored by the JBC, would have made the rate reduction permanent, but the bill was amended so that the rate reduction lasted only for FY 2012-13. There appeared to be considerable confusion during legislative debate on the JBC's bill about the impact of the rate reduction and how nursing home rates are calculated in general. For FY 2013-14 the General Assembly will need to decide whether to allow the rate reduction to expire, or to introduce a bill to extend it.

There are two main components to nursing home reimbursement: (1) a per diem rate where the state match is financed with General Fund; and (2) supplemental payments where the state match is financed with a nursing facility provider fee. The 1.5 percent reduction applies to the per diem rate, and so that will be discussed first, but there are interactions with the supplemental payments that will be discussed later in this briefing.

Calculating the Nursing Home Per Diem

To calculate the per diem the Department goes through a complex statutory process of adding up allowable costs, including depreciation, for each nursing home in order to determine what the

Department dubs a "core rate." The "core rate" is not in statute, but it is a name the Department gives to an intermediate step in the calculation of the per diem rate.

Most of the allowable costs in the core rate are tied to audited prior year actual expenditures, adjusted by the Medicare inflation rate. However, there are some exceptions that may cause the core rate to be less than actual costs for a particular nursing facility. For example, the direct and indirect health care and raw food costs for an individual nursing facility may not exceed 125 percent of the median for all facilities (130 percent for veterans' homes) and may not increase more than eight percent in a year. Similarly, administrative and general services costs may not exceed 110 percent of the median (105 percent for facilities larger than 60 beds).

The core rate for each nursing facility is then compared to the prior year per diem. The new per diem is the lesser of the core rate or the maximum allowable growth in the per diem. Thus, an individual facility can receive less than the maximum allowable growth in the per diem if their costs are less.

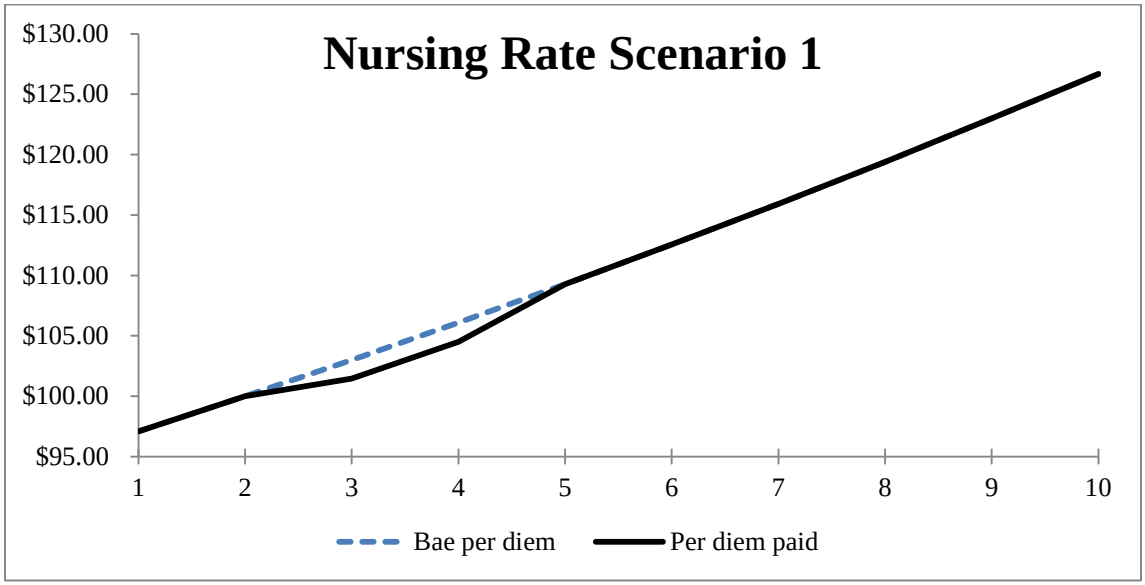
The maximum allowable growth in the per diem is determined in aggregate and limited to approximately 3.0 percent of the prior year average per diem for all nursing facilities before any statutory reductions to the nursing rate. The limit is described here as "approximately 3.0 percent" of the total per diem, because technically it is the General Fund share of the per diem that is limited by statute, rather than the total per diem. The General Fund share of the per diem is influenced by patient payments, and so a 3.0 percent change in the General Fund share of the per diem may not equal a 3.0 percent change in the total per diem, if average patient payments increase or decrease. Historically, patient payments have been relatively stable over time, meaning a 3.0 percent change in the General Fund share is approximately, though not exactly, equal to a 3.0 percent change in the total per diem.

Because the maximum allowable growth is determined in aggregate, if there are nursing facilities that don't use all of their allowable growth, then the difference is reallocated to other nursing facilities. While the increase for all nursing facilities is limited to the approximately 3.0 percent cap, individual nursing facilities can receive increases that are larger than that amount.

The application of the 3.0 percent cap to the prior year per diem before any statutory reductions means there is essential a base per diem, which is the per diem before statutory reductions, that can grow at 3.0 percent every year. When a statutory reduction is applied, it impacts the actual per diem paid for that year, but it does not change the base per diem for the next year's calculation.

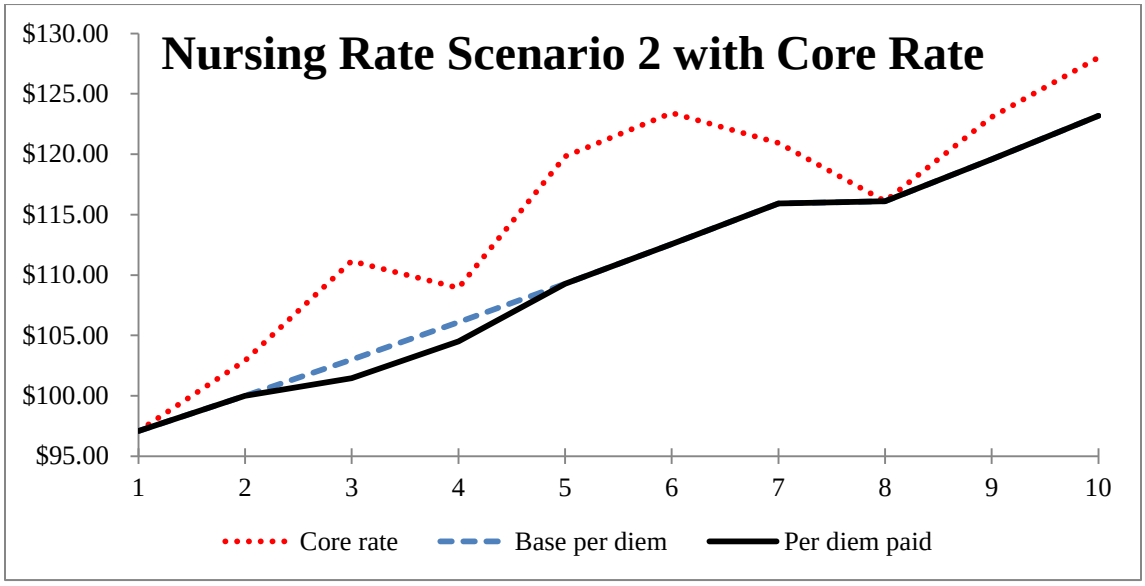
In the illustration below the base per diem before statutory reductions is $100 in year 2 and it grows by 3.0 percent to $103 in year 3. However, a statutory reduction in year 3 reduces the actual per diem paid by 1.5 percent. In year 4 the 1.5 percent statutory reduction is extended. The growth in the actual per diem paid between year 3 and year 4 is parallel to the growth in the base per diem without statutory reductions, or 3.0 percent. In year 5 the statutory reduction is allowed to expire. For that one year the growth in the actual per diem paid is greater than 3.0 percent to "catch up" to the base per diem without statutory reductions. The necessary catch up

payment is slightly more than the 1.5 percent difference in the statutory reductions for the two fiscal years.



Nursing Rate Scenario 1										
	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
Bae per diem	$97.09	$100.00	$103.00	$106.09	$109.27	$112.55	$115.93	$119.41	$122.99	$126.68
Statutory reduction			($1.55)	($1.59)						
Per diem paid	$97.09	$100.00	$101.46	$104.50	$109.27	$112.55	$115.93	$119.41	$122.99	$126.68
Percent Change										
Base per diem	NA	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Statutory reduction			-1.5%	-1.5%						
Per diem paid	NA	3.0%	1.5%	3.0%	4.6%	3.0%	3.0%	3.0%	3.0%	3.0%

The next graphic presents a similar scenario, but adds a wrinkle to show the relationship between the core rate and the base per diem rate. As described above, the core rate is the audited approved costs for nursing facilities. In the Nursing Rate Scenario 2 there are two dips in the core rate. The first dip occurs between years 3 and 4, but because the core rate is so much higher than the base per diem rate, there is no change to the base per diem rate. This could be described as a case of "pent up demand" for growth in the base per diem rate that is unaffected by a small reduction in the core rate. The second dip in the core rate occurs between years 6 and 8 and in this case the core rate actually falls below the base per diem. This causes the base per diem to ratchet down so that in year 9 the base per diem is calculated from a lower year 8 base per diem than if the core rate had remained above the base per diem.



Actual per diem rates

The previous section presented hypothetical scenarios to illustrate the nursing rate calculation while this section looks at some real world examples. The real world examples may be somewhat more difficult to follow, because the current rate structure has only been around since FY 2008-09, and there have been multiple statutory reductions of varying sizes in that time frame.

The table below presents the actual core rate, base per diem rate, and per diem paid for five nursing facilities over the last four years. In FY 2009-10 and FY 2010-11 complicated variables impacted the rate calculation to account for the enhanced federal match available through the American Recovery and Reinvestment Act of 2009, and to help balance the state budget. In FY 2011-12 and FY 2012-13 the picture becomes slightly clearer. In FY 2011-12 the maximum allowable aggregate General Fund growth was 3.0 percent. The FY 2010-11 statutory rate cut of 2.5 percent expired and was replaced by a new statutory rate cut of 1.5 percent resulting in a "catch up" increase for the nursing facilities of slightly more than 1.0 percent. After accounting for the difference between a cap on the General Fund share and a cap on the total per diem, and accounting for the reallocation of funds from nursing facilities using less than their maximum allowable growth, four of the five providers received a 4.24 percent increase in their per diem rate. The fifth provider, Amberwood Court Care Center, had a core rate that when adjusted for the statutory reduction did not support an increase in the per diem.

	Core Rates				Percent Changes		
Provider Name	**FY 09-10**	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 10-11**	**FY 11-12**	**FY 12-13**
Allison Care Center	$183.15	$199.66	$202.15	$217.65	9.01%	1.25%	7.67%
Alpine Living Center	$206.09	$215.66	$223.01	$223.81	4.64%	3.41%	0.36%
Amberwood Court Care Center	$183.83	$200.01	$195.64	$222.15	8.80%	-2.18%	13.55%
Applewood Living Center	$179.91	$185.78	$198.97	$196.21	3.26%	7.10%	-1.39%
Arksansas Valley Regional Living Center	$165.93	$177.41	$189.25	$191.95	6.92%	6.67%	1.43%

	Final Paid Rates*				Percent Changes		
Provider Name	**FY 09-10**	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 10-11**	**FY 11-12**	**FY 12-13**
Allison Care Center	$174.98	$175.38	$182.83	$188.65	0.23%	4.24%	3.19%
Alpine Living Center	$178.88	$179.29	$186.90	$192.85	0.23%	4.24%	3.19%
Amberwood Court Care Center	$192.35	$192.79	$192.71	$198.84	0.23%	-0.05%	3.19%
Applewood Living Center	$171.45	$171.84	$179.13	$184.84	0.23%	4.24%	3.19%
Arksansas Valley Regional Living Center	$148.81	$149.15	$155.48	$160.43	0.23%	4.24%	3.19%

* FY 2012-13 rates have not been finalized yet because of appeal issues.

	FY 09-10	**FY 10-11**	**FY 11-12**	**FY 12-13**
Statutory Rate Cuts	0.50%	2.50%	1.50%	1.50%
Maximum Allowable Aggregate General Fund Growth		1.90%	3.00%	3.00%

The FY 2012-13 rates are particularly informative, because there was a lot of legislative debate last year about whether the JBC's H.B. 12-1340 that extended the 1.5 percent statutory rate reduction would result in a 1.5 percent increase for the nursing providers or a 3.0 percent increase. This table clearly shows that the result was a 3.0 percent increase, plus a little to account for both (1) the difference between a cap on the General Fund share and a cap on the total per diem, and (2) the reallocation of cap space from some facilities using less than the cap. All of the providers in this sample received a 3.19 percent increase, even though three of them had smaller changes in their core rates, including Applewood Living Center's core rate decrease of 1.39 percent. This is due to the phenomenon of "pent up demand" for growth in the base per diem rate described above.

Based on historic trends in nursing facility expenditures and the way that the per diem calculation stores pent up demand, staff believes it will be unusual for a nursing facility to receive a decrease in the facility's per diem as a result of the statutory rate formula. The FY 2012-13 nursing rates are not finalized due to appeal issues, but in FY 2011-12 only 16 of 187 nursing homes received less than a 4.2 percent increase in their per diem rate, and the per diem rate actually decreased for only two nursing homes.

Supplemental payments

In addition to the per diem rate nursing homes may receive supplemental payments. To match federal funds for the supplemental payments the Department charges a nursing facility provider fee. For most nursing homes the supplemental payments they receive are greater than the fee that they pay, and so there is a net benefit, but pursuant to federal policy provider fees must be redistributive, and so there are some nursing facilities that receive less in supplemental payments than their fee. The amount of the fee may increase each year to support larger supplemental payments, but the growth in the fee is capped in state statute at the rate of the national skilled nursing facility market basket index. In addition, federal law caps provider fees at 6.0 percent of a provider's net patient revenue for the applicable service. There is room to increase the statutory cap on the nursing facility fee, but there is a federal limit on the maximum nursing facility fee.

One of the criteria for distributing supplemental payments is to close any gap between a nursing facility's core rate and the actual per diem paid. However, this is the last priority use in statute

and the supplemental payments do not always cover the full gap. The statutory priority uses of the supplemental payments are, in order:

1. Paying administrative costs and offsetting the Medicaid cost of the provider fee;
2. Helping facilities with a higher acuity or case mix of patients;
3. Rewarding performance;
4. Assisting facilities serving residents with severe mental health conditions, cognitive dementia, or acquired brain injury; and
5. Closing the gap between the core rate and the per diem.

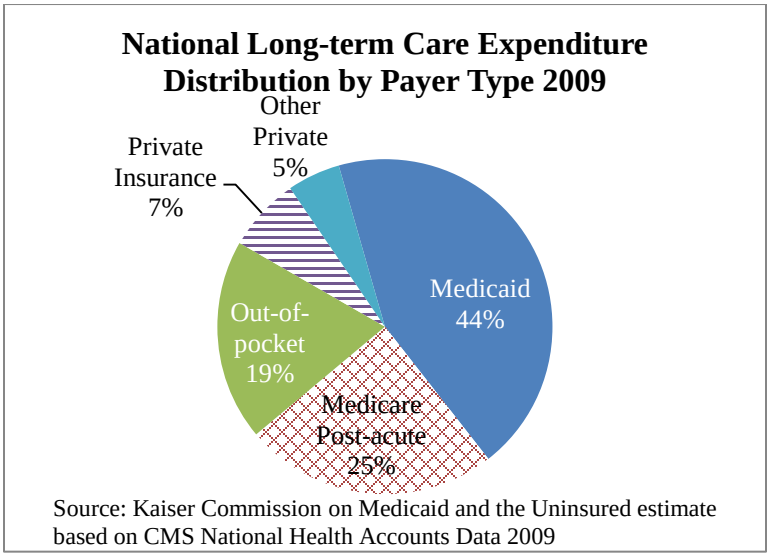
It is possible that when supplemental payments according to these priorities are added to the per diem rate for a nursing home the combined total for the nursing home exceeds the core rate for the facility. However, it is important to remember that the income from supplemental payments has to be compared to the cost of paying the fee to determine the net benefit to a nursing facility.

Pros and cons

One of the arguments the JBC has used to support rate reduction bills in prior years is that nursing homes are the only providers with a statutory rate structure. This rate structure almost always results in an increase in per diem payments, and at the worst it results in a per diem that pays for approved costs, which are very similar to actual costs.

Although the nursing homes are the only providers with a state statutory rate structure, there are other providers with a federally guided rate structure that adjusts with costs. These providers include pharmacies, federally qualified health centers (FQHCs), CHP+ managed care providers, behavioral health organizations, and for calendar years 2013 and 2014 primary care physicians. For FQHCs there is some flexibility in the federal rate structure that allowed Colorado to implement rate reductions in prior years, and for the Governor to request a rate increase this year. These providers with federally guided rate structures represent a significant portion of total Medicaid and CHP+ provider payments. There is a difference between a federal mandate and the state choosing to tie its own hands through a statutory rate formula, but it would not be accurate to say that the nursing facilities are unique in getting an annual cost-based rate adjustment.

Where some providers are able to spread costs over private pay clients, nursing homes are highly dependent on Medicaid reimbursement. This happens because nursing home residents tend to exhaust their resources to the point that they meet the income qualifications for Medicaid. Adequate compensation is a concern with all providers, but it may be especially true with providers such as nursing homes that rely heavily on government payers and serve a vulnerable population.



Putting the nursing rate formula in statute provides protection to the nursing homes, but it is also inflexible. The Department is unable to adjust the formula to address potentially unintended consequences, such as the ratchet that occurs if the core per diem dips below the base per diem.

Generally, one would expect a statutory formula to be more transparent than a formula set by rule, but in this case staff believes the statutory language is so convoluted that the formula is less transparent than if the Department were given flexibility to simplify it.

Staff recommends that the JBC sponsor legislation to extend the 1.5 percent reduction in nursing facility rates indefinitely. With such a bill, nursing rates will increase by approximately 3.0 percent in FY 2013-14, according to the method described above, which is more than the 1.5 percent increase in rates proposed by the Governor for other providers. Without a bill nursing facilities will see a boost in rates of more than 3.0 percent. The projected savings from the Department's request would be approximately $9.7 million, including $4.8 million General Fund.

If the General Assembly approves the Governor's proposed 1.5 percent community provider rate increase, Medicaid providers will recover a portion of lost ground over the last several years of budget reductions. However, providers would not be restored in full as the nursing facilities would be if the statutory rate reduction is allowed to expire.

The statutory rate structure for the nursing facilities presents many challenges, but it also provides some benefits in ensuring adequate funding for services to a vulnerable population. For this reason, staff is not recommending eliminating the statutory formula.

Assuming that any economic recovery will take a long time and there will continue to be pressure on the state budget, staff would like to see the default position be that the statutory rate reduction continues, rather than that it expires, requiring legislation to extend it each year. In the Department's budget request no justification was provided for allowing nursing homes a bump in rates other than that the statutory rate reduction was expiring. If the statutory rate reduction

extended indefinitely, then the Department and nursing homes would need to present a case for why increases were needed.

Nursing advocates argue that annual extensions of the statutory rate reduction are not a big deal, because the legislature's history with nursing facility rates has been to run some sort of legislation nearly every year. However, staff would point out that the JBC's historic standard for carrying legislation has been a unanimous vote. With an annually expiring statutory nursing rate reduction, the votes required each year for nursing home rates to increase by more than 3.0 percent is less than the votes required for nursing home rates to grow by only 3.0 percent.

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

This issue brief relates to the Department's performance objectives to Improve health outcomes, Increase access to health care, Contain health care costs, and Improve long-term care service delivery system.

Issue: Pharmaceutical Reimbursement

This issue brief discusses recent changes in the pharmacy reimbursement method and the impact on the budget.

SUMMARY:

- The publisher of the index that was previously used to set pharmacy rates was accused of artificially inflating rates and forced by a court order to stop publishing the index.
- The Department has been encouraged by the Centers for Medicare and Medicaid Services (CMS) to adopt a new method based on actual acquisition costs.
- The new method, along with a change to dispensing fees, will result in a projected $14 million decrease in pharmacy expenditures.

DISCUSSION:

The Department is dramatically redesigning reimbursement for pharmaceuticals. The old method was based largely on an index called Average Wholesale Price that was used by several state Medicaid agencies and private insurers, but a change was necessary when the publisher of the index was accused of artificially inflating drug pricing, and forced by a court settlement to stop producing the index. As an interim measure, the Department is basing reimbursement on a combination of Wholesale Acquisition Cost and State Maximum Allowable Cost rates, plus an inflation factor from 51 percent to 233 percent that attempts to provide pharmacies similar compensation to what they received under the old payment method. As a long-term solution the Department is developing a Colorado-specific index for Actual Acquisition Cost (AAC).

In addition to paying for drugs, Colorado Medicaid pays pharmacies a dispensing fee for their operating expenses and in reviewing the entire pharmacy reimbursement system the Department determined that dispensing fees needed reform as well. While the new reimbursement system will generally pay less per drug, the new dispensing fees will generally pay more for operating expenses.

The new reimbursement system based on AAC plus a revised dispensing fee has been controversial, because the Department projects it will reduce pharmacy payments by $14 million ($7 million in FY 2012-13 when the new methodology takes effect mid-year). The new payment system is pending final approval from the Medical Services Board and the Department's budget request assumed it would be implemented in February 2013, although that assumption may need to be revised due to implementation delays.

With regard to the AAC, the Department says it has been strongly encouraged by the Centers for Medicare and Medicaid Services (CMS) to adopt this reimbursement method. The Department also notes that an Office of Inspector General OIG report, "Replacing Average Wholesale Price: Medicaid Drug Payment Policy" dated July 2011, encouraged the adoption of a national

benchmark for drug pricing based on acquisition cost. The OIG stated, "Although we recognize that CMS currently does not mandate the method States use to set reimbursement rates, we believe CMS should encourage all States to adopt the national benchmark." CMS agreed with the recommendation and has developed a draft National Average Drug Acquisition Cost, "to create a new national price benchmark that is more reflective of the prices that pharmacies pay to acquire prescription and over-the-counter drugs."[6] The Department speculates that states will eventually be faced with a choice between a state-specific AAC and the National Average Drug Acquisition Cost, and the Department would prefer a state-specific calculation.

Regarding the dispensing fee, the Department's contractor (Mercer Government Human Services Consulting) identified an average cost of $11.67. However, in response to stakeholder input the Department created tiers based on prescription volume, and then with further input decided to expand those tiers from three to four. The proposed dispensing fees by tier range from $4 to $23. The tiers are intended to ensure that small-volume pharmacies can continue to accept Medicaid patients, so that the ability of Medicaid clients to access care is at least as great as the general population, as required by federal law.

The Department estimates the reduction represents 3.95 percent of total pharmacy expenditures. Originally the Department provided an estimate of 5.5 percent in response to Legislative Request for Information #5 concerning the purchase of pharmaceuticals at the lowest possible price, but since then has revised that estimate. In FY 2011-12 pharmacy expenditures were $318.7 million and the average percent growth in pharmacy expenditures over the last three years has been 11.7 percent. Based on that trend, a $14.0 million reduction would equate to a 3.95 percent decrease in expenditures. Using the surveys administered to develop the AAC the Department estimates that Medicaid payments represent 10 percent of total revenue to pharmacies statewide. This suggests that the reduction in statewide pharmacy revenues is 0.395 percent, but it is important to consider that the impact by individual pharmacy may vary significantly.

The Department believes that with the adoption of the new reimbursement method pharmacies will still have an incentive to see Medicaid patients. The AAC does not take into account prompt pay discounts or volume discounts frequently offered by drug manufacturers. Also, pharmacies benefit from ancillary purchases of pick up items when they serve Medicaid clients.

Some pharmacy representatives have argued that any savings from implementation of the AAC plus dispensing fee should be devoted to initiatives that promote more effective use of pharmaceuticals to improve health outcomes and reduce long-term costs. As an example of such a program they point to RX Review that provides voluntary medication therapy counseling to Medicaid clients who obtain five or more medications in a period of three months. These counseling sessions review drugs to maximize effectiveness and minimize adverse interactions or side effects. They also focus on medication adherence and safety. The Department is not in favor of expanding RX Review as it operates currently. The Department says participation has been low, and speculates that this is due to a combination of clients being unfamiliar with the

[6] *Part II: Draft Methodology for Calculating the National Drug Acquisition Cost (NADAC),* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Survey-of-Retail-Prices.html

contractors performing the reviews, and rates for the contractors of $75 per consultation that can require five hours for the drug review and discussion with the client. The Department adds that the program is time-intensive for HCPF staff to administer. If the program were improved and expanded, the Department believes it should be accessible statewide. The Department did not provide an estimate of the statewide expansion cost. The Department also noted that the statewide competitive bid process may not result in a vendor who uses local pharmacists for the review.

RELEVANCE OF BRIEFING ISSUE TO THE DEPARTMENT'S STRATEGIC PLAN:

The issue brief relates to the department's objectives: Contain Health Care Costs, Improve Health Outcomes, and Increase Access to Health Care.

Appendix A: Number Pages

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(1) EXECUTIVE DIRECTOR'S OFFICE					
Primary functions: Administration of Medicaid, the Colorado Indigent Care Program, Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan					
(A) General Administration					
Personal Services	19,017,761	20,609,604	22,593,922	24,490,598	*
FTE	270.6	293.4	326.2	338.2	
General Fund	7,559,246	7,727,247	7,971,021	9,533,270	
Cash Funds	1,289,520	1,371,016	2,038,599	2,118,369	
Reappropriated Funds	520,127	448,289	1,176,645	1,069,555	
Federal Funds	9,648,868	11,063,052	11,407,657	11,769,404	
Health, Life, and Dental	1,706,057	2,024,577	2,216,793	2,264,311	*
General Fund	611,752	627,749	796,479	780,989	
Cash Funds	205,744	255,164	174,652	167,467	
Reappropriated Funds	15,219	0	111,821	62,934	
Federal Funds	873,342	1,141,664	1,133,841	1,252,921	
Short-term Disability	26,138	32,188	33,497	40,771	*
General Fund	9,539	12,334	12,334	14,069	
Cash Funds	2,174	2,503	2,503	2,813	
Reappropriated Funds	737	0	1,309	611	
Federal Funds	13,688	17,351	17,351	23,278	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	402,667	532,854	730,633	826,508	*
General Fund	145,650	190,728	283,141	284,515	
Cash Funds	33,664	53,148	53,468	57,223	
Reappropriated Funds	11,411	0	37,574	12,775	
Federal Funds	211,942	288,978	356,450	471,995	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	292,544	427,325	627,713	746,301	*
General Fund	105,135	151,785	242,160	256,855	
Cash Funds	24,547	42,482	45,949	51,659	
Reappropriated Funds	8,321	0	33,280	11,679	
Federal Funds	154,541	233,058	306,324	426,108	
Salary Survey	0	0	0	568,180	
General Fund	0	0	0	176,323	
Cash Funds	0	0	0	45,753	
Reappropriated Funds	0	0	0	8,388	
Federal Funds	0	0	0	337,716	
Merit Pay	0	0	0	384,021	
General Fund	0	0	0	130,300	
Cash Funds	0	0	0	28,429	
Reappropriated Funds	0	0	0	9,888	
Federal Funds	0	0	0	215,404	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Worker's Compensation	34,748	29,652	30,843	46,920	
General Fund	17,374	14,826	15,422	23,461	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	17,374	14,826	15,421	23,459	
Operating Expenses	1,345,966	1,503,581	1,625,353	1,607,614	*
General Fund	652,128	677,693	715,356	728,404	
Cash Funds	15,244	71,657	53,049	58,306	
Reappropriated Funds	0	0	78,257	23,910	
Federal Funds	678,594	754,231	778,691	796,994	
Legal and Third Party Recovery Legal Services	816,265	903,975	1,049,982	1,049,982	
General Fund	316,867	334,195	355,006	355,006	
Cash Funds	89,525	123,284	169,986	169,986	
Reappropriated Funds	0	0	0	0	
Federal Funds	409,873	446,496	524,990	524,990	
Administrative Law Judge Services	442,378	449,127	510,957	532,168	
General Fund	206,884	199,865	212,115	222,721	
Cash Funds	14,305	24,698	43,364	43,364	
Federal Funds	221,189	224,564	255,478	266,083	
Purchase of Services from Computer Center	298,151	835,844	1,001,906	852,266	
General Fund	145,739	414,547	496,930	418,823	
Cash Funds	0	0	0	0	
Reappropriated Funds	3,337	3,375	4,046	4,046	
Federal Funds	149,075	417,922	500,930	429,397	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Multiuse Network Payments	160,412	227,900	245,162	98,881	
General Fund	80,206	113,950	122,581	49,440	
Federal Funds	80,206	113,950	122,581	49,441	
COFRS Modernization	0	0	1,006,098	1,006,098	
General Fund	0	0	329,397	329,397	
Cash Funds	0	0	173,190	173,190	
Reappropriated Funds	0	0	2,052	2,052	
Federal Funds	0	0	501,459	501,459	
Management and Administration of OIT	561,419	631,234	0	48,307	
General Fund	280,710	315,617	0	24,154	
Federal Funds	280,709	315,617	0	24,153	
Payment to Risk Management and Property Funds	24,418	77,888	84,444	133,491	
General Fund	12,209	38,944	42,222	66,746	
Federal Funds	12,209	38,944	42,222	66,745	
Leased Space	554,505	628,141	696,564	849,549	*
General Fund	173,962	197,846	197,119	319,956	
Cash Funds	103,290	116,224	151,164	104,820	
Federal Funds	277,253	314,071	348,281	424,773	
Capitol Complex Leased Space	388,228	397,925	394,600	490,321	
General Fund	194,114	198,962	197,300	245,161	
Federal Funds	194,114	198,963	197,300	245,160	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
General Professional Services and Special Projects	2,963,577	3,971,819	5,940,552	8,192,552	*
General Fund	1,074,923	1,094,416	1,312,418	2,407,418	
Cash Funds	310,465	449,206	437,500	468,500	
Federal Funds	1,578,189	2,428,197	4,190,634	5,316,634	
SUBTOTAL - (A) General Administration	29,035,234	33,283,634	38,789,019	44,228,839	14.0%
FTE	270.6	293.4	326.2	338.2	3.7%
General Fund	11,586,438	12,310,704	13,301,001	16,367,008	23.1%
Cash Funds	2,088,478	2,509,382	3,343,424	3,489,879	4.4%
Reappropriated Funds	559,152	451,664	1,444,984	1,205,838	(16.6%)
Federal Funds	14,801,166	18,011,884	20,699,610	23,166,114	11.9%
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,707,033	4,671,998	5,205,465	5,036,275	
General Fund	1,443,433	1,438,076	1,568,883	1,516,210	
Federal Funds	3,263,600	3,233,922	3,636,582	3,520,065	
Life Safety Code Inspections for Health Facilities, Transfer to Department of Public Safety	0	0	0	336,639	
General Fund	0	0	0	114,694	
Federal Funds	0	0	0	221,945	
Nurse Home Visitor Program, Transfer to the Department of Public Health and Environment	1,064,517	1,001,532	3,010,000	3,010,000	
General Fund	0	0	0	0	
Reappropriated Funds	429,287	500,766	1,505,000	1,505,000	
Federal Funds	635,230	500,766	1,505,000	1,505,000	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	0	0	5,887	5,887	
General Fund	0	0	2,944	2,944	
Federal Funds	0	0	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	325,343	324,041	324,041	324,041	
General Fund	148,020	147,369	147,369	147,369	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,671	162,020	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	5,998	0	14,000	14,000	
General Fund	2,999	0	7,000	7,000	
Federal Funds	2,999	0	7,000	7,000	
Public School Health Services Administration, Transfer to the Department of Education	71,662	139,649	139,940	142,073	
Federal Funds	71,662	139,649	139,940	142,073	
Enhanced Prenatal Care Training, Transfer to the Department of Public Health and Environment	82,286	0	0	0	
General Fund	41,143	0	0	0	
Federal Funds	41,143	0	0	0	
SUBTOTAL - (B) Transfers to Other Departments	6,256,839	6,137,220	8,699,333	8,868,915	1.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,635,595	1,585,445	1,726,196	1,788,217	3.6%
Reappropriated Funds	443,939	515,418	1,519,652	1,519,652	0.0%
Federal Funds	4,177,305	4,036,357	5,453,485	5,561,046	2.0%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(C) Information Technology Contracts and Projects					
Information Technology Contracts	23,713,491	29,272,031	31,899,317	32,446,419	*
General Fund	5,498,109	6,054,212	6,379,650	6,304,626	
Cash Funds	642,824	1,269,332	1,566,666	2,087,772	
Reappropriated Funds	100,328	92,163	100,328	100,328	
Federal Funds	17,472,230	21,856,324	23,852,673	23,953,693	
MMIS Reprocurement Contracted Staff	0	0	0	12,625,032	*
General Fund	0	0	0	1,165,817	
Cash Funds	0	0	0	232,837	
Federal Funds	0	0	0	11,226,378	
MMIS Reprocurement Contracts	0	0	0	2,999,371	*
General Fund	0	0	0	273,255	
Cash Funds	0	0	0	54,997	
Federal Funds	0	0	0	2,671,119	
Fraud Detection Software Contract	164,833	208,931	250,000	250,000	
General Fund	41,208	54,565	62,500	62,500	
Federal Funds	123,625	154,366	187,500	187,500	
Centralized Eligibility Vendor Contract Project	0	2,556,603	5,098,787	6,149,945	
Cash Funds	0	1,263,293	2,534,204	3,059,783	
Federal Funds	0	1,293,310	2,564,583	3,090,162	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
SUBTOTAL - (C) Information Technology Contracts and Projects	23,878,324	32,037,565	37,248,104	54,470,767	46.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	5,539,317	6,108,777	6,442,150	7,806,198	21.2%
Cash Funds	642,824	2,532,625	4,100,870	5,435,389	32.5%
Reappropriated Funds	100,328	92,163	100,328	100,328	0.0%
Federal Funds	17,595,855	23,304,000	26,604,756	41,128,852	54.6%
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	110,562	115,591	129,240	129,240	
General Fund	43,726	52,867	59,203	59,203	
Cash Funds	10,759	4,132	4,620	4,620	
Reappropriated Funds	1,593	1,593	1,593	1,593	
Federal Funds	54,484	56,999	63,824	63,824	
Contracts for Special Eligibility Determinations	2,141,327	3,509,989	7,761,238	7,761,238	
General Fund	823,747	828,091	828,091	828,091	
Cash Funds	5,000	661,117	2,806,268	2,806,268	
Federal Funds	1,312,580	2,020,781	4,126,879	4,126,879	
County Administration	31,110,742	30,602,852	31,427,701	32,164,899	
General Fund	9,201,053	10,157,979	10,373,188	10,594,347	
Cash Funds	6,354,318	5,299,296	5,380,796	5,528,236	
Federal Funds	15,555,371	15,145,577	15,673,717	16,042,316	
Hospital Provider Fee County Administration	0	1,939,544	2,581,071	2,581,071	
Cash Funds	0	969,772	1,290,536	1,290,536	
Federal Funds	0	969,772	1,290,535	1,290,535	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request		Request vs. Appropriation
Administrative Case Management	1,115,944	1,391,668	869,744	869,744		
General Fund	557,972	695,834	434,872	434,872		
Federal Funds	557,972	695,834	434,872	434,872		
Customer Outreach	3,912,885	4,694,853	4,927,018	5,315,949	*	
General Fund	1,882,676	2,259,497	2,376,649	2,571,114		
Cash Funds	73,766	101,362	86,861	86,861		
Federal Funds	1,956,443	2,333,994	2,463,508	2,657,974		
SUBTOTAL - (D) Eligibility Determinations and Client Services	38,391,460	42,254,497	47,696,012	48,822,141		2.4%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	12,509,174	13,994,268	14,072,003	14,487,627		3.0%
Cash Funds	6,443,843	7,035,679	9,569,081	9,716,521		1.5%
Reappropriated Funds	1,593	1,593	1,593	1,593		0.0%
Federal Funds	19,436,850	21,222,957	24,053,335	24,616,400		2.3%
(E) Utilization and Quality Review Contracts						
Professional Service Contracts	4,802,408	6,384,617	8,414,451	8,972,307	*	
General Fund	1,345,699	1,806,527	2,225,370	2,276,084		
Cash Funds	71,505	57,620	114,332	203,082		
Federal Funds	3,385,204	4,520,470	6,074,749	6,493,141		
SUBTOTAL - (E) Utilization and Quality Review Contracts	4,802,408	6,384,617	8,414,451	8,972,307		6.6%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	1,345,699	1,806,527	2,225,370	2,276,084		2.3%
Cash Funds	71,505	57,620	114,332	203,082		77.6%
Federal Funds	3,385,204	4,520,470	6,074,749	6,493,141		6.9%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(F) Provider Audits and Services					
Professional Audit Contracts	2,202,544	1,841,190	2,463,406	3,051,907	
General Fund	1,017,368	908,175	969,283	1,116,408	
Cash Funds	58,096	12,420	262,420	365,408	
Federal Funds	1,127,080	920,595	1,231,703	1,570,091	
SUBTOTAL - (F) Provider Audits and Services	2,202,544	1,841,190	2,463,406	3,051,907	23.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,017,368	908,175	969,283	1,116,408	15.2%
Cash Funds	58,096	12,420	262,420	365,408	39.2%
Federal Funds	1,127,080	920,595	1,231,703	1,570,091	27.5%
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	351,102	315,578	700,000	700,000	
Cash Funds	175,551	157,789	350,000	350,000	
Federal Funds	175,551	157,789	350,000	350,000	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	351,102	315,578	700,000	700,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds	175,551	157,789	350,000	350,000	0.0%
Federal Funds	175,551	157,789	350,000	350,000	0.0%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
TOTAL - (1) Executive Director's Office	104,917,911	122,254,301	144,010,325	169,114,876	17.4%
FTE	270.6	293.4	326.2	338.2	3.7%
General Fund	33,633,591	36,713,896	38,736,003	43,841,542	13.2%
Cash Funds	9,480,297	12,305,515	17,740,127	19,560,279	10.3%
Reappropriated Funds	1,105,012	1,060,838	3,066,557	2,827,411	(7.8%)
Federal Funds	60,699,011	72,174,052	84,467,638	102,885,644	21.8%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,395,627,672	3,642,032,762	3,985,613,386	4,345,486,362 *	
General Fund	601,033,287	833,239,176	1,050,603,677	1,184,732,830	
General Fund Exempt	279,344,485	373,508,751	312,202,624	312,202,624	
Cash Funds	518,533,477	629,762,743	651,181,857	638,603,669	
Reappropriated Funds	7,414,327	6,445,828	3,215,340	1,215,340	
Federal Funds	1,989,302,096	1,799,076,264	1,968,409,888	2,208,731,899	
TOTAL - (2) Medical Services Premiums	3,395,627,672	3,642,032,762	3,985,613,386	4,345,486,362	9.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	601,033,287	833,239,176	1,050,603,677	1,184,732,830	12.8%
General Fund Exempt	279,344,485	373,508,751	312,202,624	312,202,624	0.0%
Cash Funds	518,533,477	629,762,743	651,181,857	638,603,669	(1.9%)
Reappropriated Funds	7,414,327	6,445,828	3,215,340	1,215,340	(62.2%)
Federal Funds	1,989,302,096	1,799,076,264	1,968,409,888	2,208,731,899	12.2%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request		Request vs. Appropriation
(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS						
Primary functions: Provides mental health services and programs for eligible Medicaid clients.						
Mental Health Capitation for Medicaid Clients	249,352,665	273,376,614	312,580,712	353,127,657	*	
General Fund	95,057,227	131,782,602	142,712,972	155,707,217		
Cash Funds	9,559,892	5,791,948	13,648,932	12,377,981		
Reappropriated Funds	13,000	25,046	0	0		
Federal Funds	144,722,546	135,777,018	156,218,808	185,042,459		
Medicaid Mental Health Fee for Service Payments	3,870,594	3,894,039	4,147,628	4,755,308	*	
General Fund	1,532,590	1,917,565	2,073,815	2,377,654		
Federal Funds	2,338,004	1,976,474	2,073,813	2,377,654		
TOTAL - (3) Medicaid Mental Health Community Programs	253,223,259	277,270,653	316,728,340	357,882,965		13.0%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	96,589,817	133,700,167	144,786,787	158,084,871		9.2%
Cash Funds	9,559,892	5,791,948	13,648,932	12,377,981		(9.3%)
Reappropriated Funds	13,000	25,046	0	0		0.0%
Federal Funds	147,060,550	137,753,492	158,292,621	187,420,113		18.4%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women ineligible for Medicaid, and provides grants to providers to improve access to primary and preventative care for the indigent population.					
Safety Net Provider Payments	289,889,142	288,633,447	287,055,532	287,055,532	
Cash Funds	130,867,920	144,316,724	143,527,766	143,527,766	
Federal Funds	159,021,222	144,316,723	143,527,766	143,527,766	
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	
General Fund	2,465,822	3,059,880	3,059,880	3,059,880	
Federal Funds	3,653,938	3,059,880	3,059,880	3,059,880	
Health Care Services Fund Programs	29,635,144	23,510,000	0	0	
Cash Funds	11,909,853	11,755,000	0	0	
Federal Funds	17,725,291	11,755,000	0	0	
Pediatric Specialty Hospital	14,755,860	11,799,938	11,799,938	11,799,938	
General Fund	5,201,789	5,899,969	5,899,969	5,899,969	
Cash Funds	307,000	0	0	0	
Reappropriated Funds	436,728	0	0	0	
Federal Funds	8,810,343	5,899,969	5,899,969	5,899,969	
General Fund Appropriation to Pediatric Specialty Hospital	436,728	0	0	0	
General Fund Exempt	436,728	0	0	0	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Appropriation from Tobacco Tax Fund to the General Fund	436,728	445,214	441,600	441,600	
Cash Funds	436,728	445,214	441,600	441,600	
Primary Care Fund	0	0	27,968,000	27,968,000	
Cash Funds	0	0	27,968,000	27,968,000	
Primary Care Grant Program Special Distribution	3,560,000	2,135,830	0	0	
Cash Funds	3,560,000	2,135,830	0	0	
Children's Basic Health Plan Administration	4,679,134	4,759,499	5,134,993	4,319,079	
General Fund	0	272,494	0	0	
Cash Funds	2,107,643	1,941,946	2,305,152	2,019,582	
Federal Funds	2,571,491	2,545,059	2,829,841	2,299,497	
Children's Basic Health Plan Medical and Dental Costs	177,283,900	182,454,122	182,543,053	193,878,230	
General Fund	0	29,413,207	21,787,355	22,705,034	
General Fund Exempt	0	446,100	441,600	441,600	
Cash Funds	55,483,090	35,148,096	42,220,291	45,742,983	
Reappropriated Funds	6,856,880	0	0	0	
Federal Funds	114,943,930	117,446,719	118,093,807	124,988,613	
Comprehensive Primary and Preventive Care Grants	0	0	0	0	
Cash Funds	0	0	0	0	
Children's Basic Health Plan Trust	14,016,193	0	0	0	
General Fund	14,016,193	0	0	0	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
TOTAL - (4) Indigent Care Program	540,812,589	519,857,810	521,062,876	531,582,139	2.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	21,683,804	38,645,550	30,747,204	31,664,883	3.0%
General Fund Exempt	436,728	446,100	441,600	441,600	0.0%
Cash Funds	204,672,234	195,742,810	216,462,809	219,699,931	1.5%
Reappropriated Funds	7,293,608	0	0	0	0.0%
Federal Funds	306,726,215	285,023,350	273,411,263	279,775,725	2.3%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Primary functions: This division provides funding for the following three state-only Medical programs: (1) Old Age Pension Medical Program, (2) the Medicare Modernization Act State Contribution Payment, and (3) the Colorado Cares RX Program. This division also contains funding for programs that eligible for Medicaid funding but are not part of the Medical Services Premiums or Mental Health Programs.					
Old Age Pension State Medical	8,206,192	9,148,285	12,400,000	12,400,000	
General Fund	0	0	2,400,000	2,400,000	
Cash Funds	8,206,192	9,148,285	10,000,000	10,000,000	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical	0	0	0	0	
Cash Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	1,738,846	1,741,077	1,741,077	1,741,077	
General Fund	700,624	870,538	870,538	870,538	
Federal Funds	1,038,222	870,539	870,539	870,539	
State University Teaching Hospitals Denver Health and Hospital Authority	1,831,714	1,831,714	1,831,714	1,831,714	
General Fund	738,043	915,857	915,857	915,857	
Federal Funds	1,093,671	915,857	915,857	915,857	
State University Teaching Hospitals University of Colorado Hospital	676,785	633,314	633,314	633,314	
General Fund	272,694	316,657	316,657	316,657	
Federal Funds	404,091	316,657	316,657	316,657	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Medicare Modernization Act State Contribution Payment	72,377,768	93,582,494	90,656,176	111,278,217	*
General Fund	58,711,725	62,939,212	50,609,286	62,229,522	
Federal Funds	13,666,043	30,643,282	40,046,890	49,048,695	
Public School Health Services Contract Administration	799,699	824,064	1,138,549	1,138,549	
Federal Funds	799,699	824,064	1,138,549	1,138,549	
Public School Health Services	24,659,097	44,781,920	30,446,344	30,446,344	
General Fund	0	(2,091,950)	0	0	
Cash Funds	11,302,888	22,390,960	16,010,155	16,010,155	
Federal Funds	13,356,209	24,482,910	14,436,189	14,436,189	
TOTAL - (5) Other Medical Services	110,290,101	152,542,868	138,847,174	159,469,215	14.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	60,423,086	62,950,314	55,112,338	66,732,574	21.1%
Cash Funds	19,509,080	31,539,245	26,010,155	26,010,155	0.0%
Federal Funds	30,357,935	58,053,309	57,724,681	66,726,486	15.6%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
Primary functions: This division reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this division and then transferred to the Department of Human Services. See the Department of Human Services for additional details about the line items contained in this division.					
(A) Executive Director's Office - Medicaid Funding					
Executive Director's Office - Medicaid Funding	12,070,429	11,608,558	15,276,073	17,007,403	
General Fund	5,632,925	5,804,279	7,638,037	8,504,040	
Federal Funds	6,437,504	5,804,279	7,638,036	8,503,363	
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	12,070,429	11,608,558	15,276,073	17,007,403	11.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	5,632,925	5,804,279	7,638,037	8,504,040	11.3%
Federal Funds	6,437,504	5,804,279	7,638,036	8,503,363	11.3%
(B) Office of Information Technology Services - Medicaid Funding					
Colorado Benefits Management System	8,547,537	9,447,008	9,040,363	8,405,843	
General Fund	4,242,887	4,147,409	4,489,039	4,173,836	
Cash Funds	19,715	550,920	14,481	13,660	
Reappropriated Funds	0	25,562	20,577	18,809	
Federal Funds	4,284,935	4,723,117	4,516,266	4,199,538	
CBMS SAS-70 Audit	50,545	50,850	55,204	55,204	
General Fund	25,114	25,294	27,416	27,416	
Cash Funds	65	53	89	89	
Reappropriated Funds	132	112	119	119	
Federal Funds	25,234	25,391	27,580	27,580	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Colorado Benefits Management System, HCPF Only	0	812,400	611,520	611,520	
General Fund	0	107,460	0	0	
Cash Funds	0	298,740	305,760	305,760	
Federal Funds	0	406,200	305,760	305,760	
CBMS Modernization	0	0	7,591,074	564,113	
General Fund	0	0	3,287,514	280,262	
Cash Funds	0	0	10,708	2,394	
Federal Funds	0	0	4,292,852	281,457	
Other Office of Information Technology Services line items	540,941	555,484	500,820	484,931	
General Fund	220,082	277,742	250,410	242,465	
Federal Funds	320,859	277,742	250,410	242,466	
CBMS Client Services Improvement Project	795,719	0	0	0	
General Fund	396,274	0	0	0	
Cash Funds	456	0	0	0	
Reappropriated Funds	2,972	0	0	0	
Federal Funds	396,017	0	0	0	
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	9,934,742	10,865,742	17,798,981	10,121,611	(43.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,884,357	4,557,905	8,054,379	4,723,979	(41.3%)
Cash Funds	20,236	849,713	331,038	321,903	(2.8%)
Reappropriated Funds	3,104	25,674	20,696	18,928	(8.5%)
Federal Funds	5,027,045	5,432,450	9,392,868	5,056,801	(46.2%)

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
© Office of Operations - Medicaid Funding					
Office of Operations - Medicaid Funding	4,573,767	4,082,810	4,824,525	4,819,463	
General Fund	1,859,383	2,041,406	2,412,263	2,409,732	
Federal Funds	2,714,384	2,041,404	2,412,262	2,409,731	
SUBTOTAL - © Office of Operations - Medicaid Funding	4,573,767	4,082,810	4,824,525	4,819,463	(0.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,859,383	2,041,406	2,412,263	2,409,732	(0.1%)
Federal Funds	2,714,384	2,041,404	2,412,262	2,409,731	(0.1%)
(D) Division of Child Welfare - Medicaid Funding					
Administration	132,627	130,938	133,070	133,070	
General Fund	66,315	65,470	66,535	66,535	
Federal Funds	66,312	65,468	66,535	66,535	
Child Welfare Services	12,176,287	10,935,479	14,293,272	14,507,671	
General Fund	4,890,172	5,467,740	7,146,636	7,253,836	
Federal Funds	7,286,115	5,467,739	7,146,636	7,253,835	
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	12,308,914	11,066,417	14,426,342	14,640,741	1.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,956,487	5,533,210	7,213,171	7,320,371	1.5%
Federal Funds	7,352,427	5,533,207	7,213,171	7,320,370	1.5%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
(E) Office of Self Sufficiency - Medicaid Funding					
Systematic Alien Verification for Eligibility	34,398	33,211	33,951	33,951	
General Fund	309	27	16,976	16,976	
Federal Funds	34,089	33,184	16,975	16,975	
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	34,398	33,211	33,951	33,951	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	309	27	16,976	16,976	0.0%
Federal Funds	34,089	33,184	16,975	16,975	0.0%
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding					
Administration	283,757	287,245	388,784	388,784	
General Fund	141,878	143,623	194,392	194,392	
Federal Funds	141,879	143,622	194,392	194,392	
Residential Treatment for Youth (H.B. 99-1116)	147,846	201,542	116,840	118,593	
General Fund	62,164	100,771	58,420	59,297	
Federal Funds	85,682	100,771	58,420	59,296	
Mental Health Institutes	4,622,208	4,755,640	5,322,778	5,322,778	
General Fund	1,868,406	2,377,820	2,661,389	2,661,389	
Federal Funds	2,753,802	2,377,820	2,661,389	2,661,389	
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	1,191,166	1,126,310	1,999,146	2,029,133	
General Fund	489,860	563,155	999,573	1,014,567	
Federal Funds	701,306	563,155	999,573	1,014,566	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Alcohol and Drug Abuse Division, Administration	53,557	0	0	0	
General Fund	26,778	0	0	0	
Federal Funds	26,779	0	0	0	
SUBTOTAL - (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding	6,298,534	6,370,737	7,827,548	7,859,288	0.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,589,086	3,185,369	3,913,774	3,929,645	0.4%
Federal Funds	3,709,448	3,185,368	3,913,774	3,929,643	0.4%
(G) Services for People with Disabilities - Medicaid Funding					
Community Services for People with Developmental Disabilities, Administration	2,734,593	2,705,995	2,897,037	2,897,037	
General Fund	1,367,296	1,352,998	1,448,519	1,448,519	
Federal Funds	1,367,297	1,352,997	1,448,518	1,448,518	
Community Services for People with Developmental Disabilities, Program Costs	340,614,513	329,836,283	340,502,802	364,960,693	*
General Fund	136,790,848	164,927,548	170,251,400	182,480,347	
Cash Funds	447,620	1	1	1	
Federal Funds	203,376,045	164,908,734	170,251,401	182,480,345	
Regional Centers	46,026,870	43,301,047	47,986,346	47,500,083	*
General Fund	15,943,159	22,340,689	22,125,518	21,882,387	
Reappropriated Funds	1,867,655	0	1,867,655	1,867,655	
Federal Funds	28,216,056	20,960,358	23,993,173	23,750,041	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
Regional Center Depreciation and Annual Adjustments	1,187,825	1,187,825	1,187,825	1,187,825	
General Fund	593,913	593,913	593,913	593,913	
Federal Funds	593,912	593,912	593,912	593,912	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	390,563,801	377,031,150	392,574,010	416,545,638	6.1%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	154,695,216	189,215,148	194,419,350	206,405,166	6.2%
Cash Funds	447,620	1	1	1	0.0%
Reappropriated Funds	1,867,655	0	1,867,655	1,867,655	0.0%
Federal Funds	233,553,310	187,816,001	196,287,004	208,272,816	6.1%
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding					
Community Services for the Elderly	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	
Federal Funds	900	900	900	900	
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,800	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	900	900	900	900	0.0%
Federal Funds	900	900	900	900	0.0%
(I) Division of Youth Corrections - Medicaid Funding					
Division of Youth Corrections - Medicaid Funding	2,597,008	1,501,271	1,632,783	1,656,589	
General Fund	1,048,994	750,636	816,392	828,295	
Federal Funds	1,548,014	750,635	816,391	828,294	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	2,597,008	1,501,271	1,632,783	1,656,589	1.5%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,048,994	750,636	816,392	828,295	1.5%
Federal Funds	1,548,014	750,635	816,391	828,294	1.5%
(J) Other					
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	500,000	500,000	500,000	500,000	
Federal Funds	500,000	500,000	500,000	500,000	
SUBTOTAL - (J) Other	500,000	500,000	500,000	500,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
Federal Funds	500,000	500,000	500,000	500,000	0.0%
TOTAL - (6) Department of Human Services Medicaid-Funded Programs	438,883,393	423,061,696	454,896,013	473,186,484	4.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	175,667,657	211,088,880	224,485,242	234,139,104	4.3%
Cash Funds	467,856	849,714	331,039	321,904	(2.8%)
Reappropriated Funds	1,870,759	25,674	1,888,351	1,886,583	(0.1%)
Federal Funds	260,877,121	211,097,428	228,191,381	236,838,893	3.8%

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	Request vs. Appropriation
TOTAL - Department of Health Care Policy and Financing	4,843,754,925	5,137,020,090	5,561,158,114	6,036,722,041	8.6%
FTE	270.6	293.4	326.2	338.2	3.7%
General Fund	989,031,242	1,316,337,983	1,544,471,251	1,719,195,804	11.3%
General Fund Exempt	279,781,213	373,954,851	312,644,224	312,644,224	0.0%
Cash Funds	762,222,836	875,991,975	925,374,919	916,573,919	(1.0%)
Reappropriated Funds	17,696,706	7,557,386	8,170,248	5,929,334	(27.4%)
Federal Funds	2,795,022,928	2,563,177,895	2,770,497,472	3,082,378,760	11.3%

Appendix B: Recent Legislation Affecting Department Budget

2011 Session Bills

S.B. 11-076: For the 2011-12 state fiscal year only, reduces the employer contribution rate for the State and Judicial divisions of the Public Employees' Retirement Association (PERA) by 2.5 percent and increases the member contribution rate for these divisions by the same amount. In effect, continues the FY 2010-11 PERA contribution adjustments authorized through S.B. 10-146 for one additional year. Reduces the Department's total appropriation by $1,630,244 total funds, of which $714,347 is General Fund, $56,118 is cash funds, and $859,779 is federal funds.

S.B. 11-125: Beginning in FY 2011-12, this bill increases the provider fee assessed on nursing facilities $7.75 to a cap of $12.00 per non Medicare-resident day. The cap can be adjusted by inflation on an annual basis. The bill also reorders the priorities for the supplemental payments paid from the nursing facility fee to nursing facilities: (1) the administrative costs of the program; (2) payments for acuity or case-mix of the residents; and (3) payments to keep the General Fund growth under 3.0 percent. The bill increases appropriations to the Department by $31,054,411. Of this amount, $30,000 is General Fund, $15,497,206 is cash funds from the Nursing Facility Cash Fund, and $15,527,205 is federal funds.

S.B. 11-177: This bill extends the repeal date of the Teen Pregnancy and Dropout Prevention Program from July 1, 2011, to September 1, 2016. The bill also expands the requirements of the program to include better collaboration between state agencies and stakeholders. Pursuant to S.B. 11-177, providers are directed to survey participating at specific intervals and report required data elements to the Department. The bill increases appropriations to the Department by $386,665 total funds. Of this amount, $38,666 is local funds and $347,999 is federal funds.

S.B. 11-209: General Appropriations Act for FY 2011-12.

S.B. 11-210: The bill provides that in FY 2011-12, $2,230,500 million from the Tobacco Tax Cash fund shall be appropriated to fund the health-related costs of Old Age Pension (OAP) clients served through the Medicaid program. This appropriation replaces a $2,230,500 cash fund appropriation from the Tobacco Tax Cash Fund to fund the health-related costs of OAP clients served through the Supplemental OAP Health and Medical Care Program.

The bill also transfers any fund balance in the Supplemental OAP Health and Medical Care Fund to the General Fund on June 30, 2012. Effective July 1, 2012 (FY 2012-13), the bill: (a) eliminates the annual transfer of $2,850,000 sales tax revenue to the Supplemental OAP Health and Medical Care Fund; and (b) repeals the Supplemental OAP Health and Medical Care Fund and the Supplemental OAP Health and Medical Care Program.

S.B. 11-211: Senate Bill 11-211 is a companion bill to S.J.R. 11-009, which declares a state fiscal emergency and thus, pursuant to Section 20 of Article X of the State Constitution, allows Amendment 35 tobacco-tax revenues to be used for any health related purpose. This bill allows Amendment 35 tobacco-tax moneys that normally support grants and programs in the Department of Public Health and Environment to be used to offset General Fund appropriations in the Department of Health Care Policy and Financing (HCPF). Specifically, the bill appropriates $33.0 million of Amendment 35 money to HCPF for Medical Services Premiums. Of this amount, $17.8 million is from the Tobacco Education Programs Fund, $12.0 million is from the Prevention, Early Detection and Treatment Fund, and $3.3 million is from the Health Disparities Grant Program Fund. These appropriations allow HCPF General Fund appropriations to be reduced by $33.0 million. For more information on this bill, please see the Recent Legislation Section in the Department of Public Health and Environment.

S.B. 11-212: For FY 2011-12 and FY 2012-13, S.B. 11-212 authorizes the use of $50.0 million and $25.0 million, respectively, from the Hospital Provider Fee Cash Fund to offset General Fund expenditures in the Medicaid program.

S.B. 11-215: This bill reduces the per diem rates paid to class I nursing facilities by 1.5 percent. The bill also allows the Department to increase the supplemental Medicaid payments made to providers due to this reduction. This would allow the nursing facilities to use their provider fee to reduce the overall impact of the reduction.
In FY 2011-12, a 1.5 percent per diem rate reduction to nursing facilities results in savings of $8,865,830 total funds. Of this amount, $4,432,915 is General Fund and $4,432,915 is federal funds.

S.B. 11-216: The bill changes the distribution of master tobacco settlement moneys to decrease moneys provided to various cash-funded programs. Beginning in FY 2011-12, these moneys are redirected to the Children's Basic Health Plan (CBHP) Trust Fund to offset the program's General Fund costs. Specifically the bill does the following:

- reallocates an additional 3 percent of the Tier 1 distribution of master tobacco settlement moneys to the CBHP program instead of the Comprehensive Primary and Preventative Care Grant (CPPCG) program;

- reallocates an additional 1 percent of the Tier 2 distribution of master tobacco settlement moneys to the CBHP program instead of the Pediatric Specialty Hospital Fund;
- eliminates the transfer of moneys from the Tobacco Tax Cash Fund to the Pediatric Specialty Hospital Fund and redirects this money to the CBHP Trust Fund; and

- eliminates the CPPCG Fund and the Pediatric Specialty Hospital Fund, as these cash funds no longer have any sources of revenue.

In FY 2011-12, the bill reduces appropriations to the Department by $4,663,402 total funds and 0.2 FTE. Of this amount, $3,449,967 is General Fund, $24,363 is cash funds, $446,100 is reappropriated funds, and $742,972 is federal funds.

S.B. 11-219: This bill makes several transfers between funds to increase the amount of federal moneys that can be drawn down and used to offset General Fund expenditures in the Medicaid program. Specifically, the bill authorizes the following amounts to be appropriated from tobacco tax revenues that would normally be credited to the Primary Care Fund:

- $15,775,670 for health-related purposes, and to serve populations enrolled in the Children's Basic Health Plan and the Colorado Medical Assistance Program;

- $21,510,000 to the Colorado Health Care Services Fund; and

- $1,722,330 to the Primary Care Special Distribution Fund.

These transfers were only allowed because the General Assembly enacted S.J.R. 11-009, which declared a fiscal emergency to allow cigarette tax revenue to be used for any health related purpose.

S.J.R. 11-009: Declares a state fiscal emergency for FY 2011-12, which allows Amendment 35 tobacco-tax revenues to be used in that year for any health-related purpose. See the description of S.B. 11-211 for a list of related adjustments to appropriations (both in this Department and the Department of Public Health and Environment).

H.B. 11-1242: This bill requires the Department to study issues concerning the integrated delivery of mental and physical health. The Department, with input from behavior health organizations, community mental health centers, and other health care providers, is required to review existing regulations, reimbursement policies, barriers, and incentives that affect the integrated delivery of health care. The study is to be paid for with gifts, grants, and donations, and matching federal moneys. The Department is required to report its findings to the Joint Budget Committee and legislative committees. In FY 2011-12, the bill appropriates $113,500 total funds to the Department. Of this amount, $56,750 is cash funds from gifts, grants, and donations and $56,750 is federal funds.

2012 Session Bills

S.B. 12-060: Allows counties to retain all fraud recoveries (rather than 50.0 percent) from cases initiated by a county department, county board, district attorney, or the Department of Health Care Policy and Financing on behalf of the county. Requires the Department of Health Care Policy and Financing and the Attorney General to submit annual reports to the legislature on client and provider fraud respectively. Appropriates for the Department of Health Care Policy and Financing, in FY 2012-13, $5,216 (including $2,608 General Fund and $2,608 Federal Funds) and 0.1 FTE for administration, and reduces appropriations for medical services by $54,156 ($2,608 General Fund, $24,470 cash funds from recoveries and recoupments, and $27,078 federal funds).

S.B. 12-159: Makes changes to the process for evaluating children receiving long-term care services and supports through the Medicaid autism waiver program and program reporting

requirements. Requires the Department to annually review available funding to determine if eligibility can be expanded, and to prioritize services for people on wait lists based on objective criteria. Appropriates $6,925 ($3,463 Colorado Autism Treatment Fund and $3,462 federal funds) to the Department of Health Care Policy and Financing for Medical Service Premiums in FY 2012-13.

H.B. 12-1184: Supplemental appropriation to the Department of Health Care Policy and Financing to modify the FY 2011-12 appropriations contained in the FY 2011-12 Long Bill (S.B. 11-209).

H.B. 12-1202: Allows appropriations from the Tobacco Education Programs Fund to the Department of Health Care Policy and Financing to match federal funds for the Colorado QuitLine program operated by the Department of Public Health and Environment. Moves $288,658 cash funds from the Tobacco Education Programs Fund out of the Department of Public Health and Environment and into the Department of Health Care Policy and Financing in FY 2011-12 to match $288,658 federal funds, and then reappropriates the total $577,316 to the Department of Public Health and Environment to operate the QuitLine program.

H.B. 12-1246: Reverses the payday shift for state employees who are paid on a biweekly basis. Appropriates $285,719 to the Department for FY 2012-13, including $157,109 General Fund and $128,610 Federal Funds. For additional information, see the "Recent Legislation" section at the end of the Department of Personnel.

H.B. 12-1281: Creates the Medicaid Payment Reform and Innovation Pilot Program. Requires the Department of Health Care Policy and Financing to review proposals and select projects to pilot by July 1, 2013. Appropriates $213,079, ($106,540 General Fund and $106,539 federal funds), and 0.8 FTE to the Department of Health Care Policy and Financing in FY 2012-13 to evaluate payment projects and for reporting requirements.

H.B. 12-1335: General Appropriations Act for FY 2012-13.

H.B. 12-1339: Establishes design criteria, details reporting requirements, and appropriates funding for the Colorado Benefits Management System (CBMS) improvement and modernization project. Appropriations for the Department of Health Care Policy and Financing include $3.7 million in FY 2011-12 and $8.6 million in FY 2012-13. For more detail about the bill and the appropriations see the description in the Department of Human Services section of this report.

H.B. 12-1340: For FY 2012-13, continues a 1.5 percent reduction in the General Fund portion of per diem rates paid to class I nursing facilities that was in place in FY 2010-11 and FY 2011-12. Allows the Department of Health Care Policy and Financing to increase the supplemental Medicaid payments made to nursing providers to offset this reduction. Reduces appropriations for Medical Service Premiums by $9,024,676, including $4,512,338 General Fund and $4,512,338 federal funds.

Appendix C:
Update on Long Bill Footnotes & Requests for Information

LONG BILL FOOTNOTES

10 **Department of Health Care Policy and Financing, Medical Services Premiums –** The appropriations in this division assume the following caseload and cost estimates:

Aid Category	Caseload	Estimated Costs	Average Cost Per Client
Adults 65 Years of Age and Older	40,820	$1,015,050,729	$24,866.50
Disabled Adults 60 to 64 Years of Age	8,948	183,126,151	20,465.60
Disabled Individuals up to 59 Years of Age	62,098	1,103,171,414	17,765.01
Medicaid Buy-In for People with Disabilities	2,208	28,915,416	13,095.75
Categorically Eligible Low-Income Adults	77,455	330,437,500	4,266.19
Expansion Adults up to 60 Percent of Federal Poverty Level	26,498	93,726,012	3,537.10
Expansion Adults between 61 Percent to 100 Percent of Federal Poverty Level	42,381	139,127,138	3,282.77
Adults without Dependent Children up to 100 percent of Federal Poverty Level	10,000	121,029,477	12,102.95
Breast and Cervical Cancer Treatment and Prevention Program Adults	679	14,909,151	21,957.51
Eligible Children	367,649	714,389,037	1,943.13
Foster Care Children	18,159	89,587,884	4,933.53
Pregnant Adults up to 185 Percent of Federal Poverty Level	7,546	78,139,747	10,355.12
Non-Citizens Qualifying for Emergency Services	2,529	50,625,528	20,018.00
Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries	20,503	34,091,703	1,662.77
Total	**687,473**	**$3,996,326,887**	**$5,813.07**

11 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs --** This appropriation assumes the following: (1) A total children's caseload of 67,542 at an average medical per capita cost of $2,210.13 per year; and (2) a total adult prenatal caseload of 1,360 at an average medical per capita cost of $15,818.25 per year.

12 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs --** This appropriation assumes an average cost of $174.02 per child per year for the dental benefit.

13 **Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding --** The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the head notes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations to the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the

Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriation in this section (6) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

REQUESTS FOR INFORMATION

Requests Affecting Multiple Departments

1. **Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Division of Child Welfare, Mental Health and Alcohol and Drug Abuse Services, and Division of Youth Corrections --** The Departments are requested to submit a report by November 1, 2012, that examines how to provide an effective system of care for youth who are involved in the child welfare, youth corrections, and behavioral health systems. The services provided within such a system of care may include, but need not be limited to, multi-systemic therapy; functional family therapy, targeted case management, and similar intensive, evidence-based therapies that support family preservation and reunification. The report is specifically requested to examine whether related General Fund expenditures could be refinanced with Medicaid funds for Medicaid-eligible youth and families and whether this could be done in a manner that would promote more coordinated service delivery and would not drive an overall increase in state General Fund costs.

   Comment: See the December 17, 2012 briefing on the Department of Human Services, Division of Youth Corrections, Child Welfare, and Child Care for a discussion of this request for information.

4. **All Departments, Totals --** Every department is requested to submit to the Joint Budget Committee, by November 1, 2012, information on the number of additional federal and cash funds FTE associated with any federal grants or private donations that were received in FY 2011-12. The Departments are also requested to identify the number of additional federal and cash funds FTE associated with any federal grants or private donations that are anticipated to be received during FY 2012-13.

   Comment: The Department reports hiring, or expecting to hire, the following FTE with federal funds:

Grant	Description	FY 11-12 FTE	FY 12-13 FTE
Health Resources and Services Administration	The HRSA grant, and the employees funded under it, work on policies that will lead to greater access to health care, increase positive health outcomes and reduce cost-shifting. This includes making investments in infrastructure and technology, and also includes implementing new strategies around benefit design and cost-sharing.	16.2	9.1
Money Follows the Person	This grant is to support the state's effort to reform the long term care system for people of all ages with long term care needs and rebalance funding and policy towards home and community based services.	3.8	4.8
Medicaid Infrastructure Grant for the Competitive Employment of People with Disabilities	This grant supports the implementation of the Medicaid Buy-In Program for Working Adults with Disabilities (Adult Buy-In) and the enhancement of employment options for people with disabilities.	1.8	2.1
State Demonstrations to Integrate Care for Dual Eligible Individuals Cooperative Agreement	This grant is for the development of new ways to better coordinate care for full benefit Medicare-Medicaid enrollees, including improving client experience, health outcomes for dual eligibles, and decreasing costs associated with unnecessary and duplicative services.	1.6	3.4
Children's Health Insurance Program Reauthorization Act - Adult Medicaid Quality Measures Grant	This grant provides funds to States to further enhance and standardize the collection, reporting and analysis of data, specifically the adult Initial Core Set of Measures, on the quality of health care provided to adults covered by Medicaid.	2.3	3.8
Pending grant applications (State Innovations Model Testing Cooperative Agreement and Colorado Health Foundation Client Centered/Stakeholder Engagement Implementation Grant)	**State Innovations Model Testing Cooperative Agreement:** This cooperative agreement is designed for states to test new and innovative payment and service delivery models that achieve the Triple Aim goals of better care, better health, and lower costs for Medicare, Medicaid and CHIP beneficiaries. **Colorado Health Foundation Client Centered/Stakeholder Engagement Implementation Grant** This grant focuses on Client Centered Care and Stakeholder Engagement. Increasing client and stakeholder engagement in HCPF processes and initiatives, enhancing staff ability to communicate with and work with clients and stakeholders, increasing patient engagement in their own care, and improving customer service are the goals under this grant.	0.0	3.0
Total Additional Federal FTE		**25.7**	**26.2**

5. **Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Services for People with Disabilities** -- The Departments are requested to submit to the Joint Budget Committee by October 15, 2012, a report on the high-level outline of the initial steps required to modify Colorado long-term care system into a new model of service delivery. The report is requested to include the following information: summary of the information gathered through community forums including participants of the forums; the status and results of the fiscal and programmatic analysis done of the existing waivers, including what methods were explored for streamlining existing waivers while maintaining waiver expenditures at current levels; and the status of the nation-wide search of best practice service delivery models and the advantages and disadvantages of implementation of the alternative models.

   Comment: The Department provided an initial response to the request for information and promised a follow-up focusing specifically on services for people with developmental disabilities, "Division of Developmental Disabilities: Analysis of Community Centered Boards." However, the follow-up has not yet been provided.

   High-level outline of the initial steps to modify the long-term care system: The Department reports that visioning and planning for the long-term care delivery system is being led by a Community Living Advisory Group (CLAG), created by executive order, with representation from the legislature, executive agencies, counties, consumers, and

providers. The CLAG is supported by the Long-term Care Advisory Committee (LTCAC), a group of stakeholders and executive agency staff appointed by the executive director of the Department of Health Care Policy and Financing that predates the CLAG and has done significant work conducting outreach, gathering data, and developing strategic recommendations. The same executive order that created the CLAG also created an Office of Community Living in the Department of Health Care Policy and Financing and instructed all state agencies engaged in activities related to community living to coordinate with the Office.

The meeting schedules, agendas, and work products of the CLAG and LTCAC are available from their web sites:

Community Living Advisory Group (CLAG):
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251627784788

Long-term Care Advisory Committee (LTCAC):
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1220351442908

Summary of information gathered from community forums: The Department reports holding at least 29 meetings with stakeholders and details in the response the number of stakeholders invited and in some cases the number who attended the meetings. It is not clear from the report how many of the stakeholders are unique versus duplicate. The Department summarizes the findings from these stakeholder meetings as follows:

Information gathered at these various community meetings included:
- *Concerns that the process was happening too fast;*
- *Stakeholders wanted to create planning sessions to discuss the proposed relocation of programs;*
- *Concerns about unintended consequences;*
- *Need for easier navigation of the developmental disabilities system;*
- *Streamlining of the multiple developmental disabilities waivers to increase clarity;*
- *Streamlining of administrative functions associated with the management and oversight of the developmental disabilities programs between the two departments; and*
- *Inclusion of the community in the development and implementation of relocating programs from the Department of Human Services to the Department of Health Care Policy and Financing.*

Program analysis of the existing waivers: The Department calculated the cost of each long-term care option, and the cost of medical services (non-long-term care) associated with the people enrolled in each long-term care option.

In addition, the Department provided an analysis focused specifically on services for people with developmental disabilities that looks at cost drivers for that sector. SEE THE DECEMBER 13, 2012 BRIEFING ON THE DEPARTMENT OF HUMAN SERVICES, SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR MORE INFORMATION ON THIS COMPONENT OF THE REPORT.

Streamlining waivers at current expenditure levels: The Department reports that the LTCAC is developing recommendations for consolidating waivers for consideration by the CLAG. The outcome of the CLAG's deliberations will serve as the basis for recommendations to the Governor and the Legislature. While no decisions have been made, the LTCAC is considering consolidating waivers into three categories focused on seniors, children, and persons with disabilities.

Best practices from other states: The LTCAC has identified several documents from the federal Aging and Disability Resource Center (ADRC) initiative that discuss best practices by states for system entry, assessment, service planning, and case management. One of these ADRC reports is included in full with the response.

Regarding care coordination, the LTCAC believes the experiences of Wisconsin and Massachusetts may be informative and has identified some reports from the American Association of Retired Persons Policy Institute that explore these in more detail. A subcommittee of the LTCAC is in the process of mapping the various entities in Colorado performing case management/care coordination, with an eye toward consolidation and/or making hand-offs more efficient. The subcommittee will also be developing recommended standards for care coordination.

In the area of waiver modernization the LTCAC identifies Pennsylvania, Nebraska, and Delaware as leaders. The Department is hiring a contractor to research the experiences of these states and others for lessons learned.

For consumer-directed services the LTCAC identifies Massachusetts as a leader. The LTCAC is looking at information from the National Resource Center for Participant-Directed Services and from the National Clearing House for HCBS. The LTCAC is also looking at the Department of Health Care Policy and Financing's Community Choice Council and the Department's Participant Director Policy and Procedures Committee.

Department of Health Care Policy and Financing

1. **Department of Health Care Policy and Financing, Executive Director's Office --** The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums and mental health capitation line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report.

   Comment: The Department is submitting the monthly information as requested.

2. **Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program --** The Department is requested to submit a report by November

1, 2012, to the Joint Budget Committee describing the success of providers in collecting co-payments from clients for medical service programs financed by the Department, including Medicaid, the Children's Basic Health Plan, and the Colorado Indigent Care Program. The report should also discuss the impact of co-payment requirements on enrollment and utilization.

Comment: ***The Governor instructed the Department not to comply*** with this request for information, noting that providers are not legally required to provide information regarding co-payments they receive, and arguing that trying to collect accurate and consistent information from providers would require a substantial diversion of existing staff resources away from other critical activities. The Department added concerns about sample bias from using information from a small number of providers such as might respond to a voluntary email request. To get an accurate picture the Department believes a contractor would need to be hired to conduct a survey. The Department did not estimate the cost of a contract survey.

3. **Department of Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payments --** The Department is requested to submit a report by February 1 of each year, to the Joint Budget Committee, estimating the disbursement to each hospital from the Safety Net Provider Payments line item.

Comment: This report is due in February.

4. **Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project --** The Department of Health Care Policy and Financing is requested to submit a report by November 1, 2012, to the Joint Budget Committee providing information on the current contract expenditures and the strategic plan for the centralized eligibility vendor contract project. In the report, the Department is requested to provide the following information:

(a) a three-year expenditure plan for the contract;
(b) information comparing the cost effectiveness of this contract when compared to eligibility performed by the counties;
(c) information regarding the number of clients who have eligibility performed by the centralized eligibility vendor but may also be eligible for other state assistance programs with eligibility determined by the counties;
(d) information comparing the ability of the contractor to meet federal guidelines for determining eligibility compared to eligibility performed by the counties; and
(e) information about the amount of oversight the Governor's Office of Information Technology provides on the contract.

Comment: The Centralized Eligibility Vendor determines eligibility for the Children's Basic Health Plan (CHP+), Adults without Dependent Children (AwDC), and the Medicaid Buy-in for People with Disabilities (Buy-in). The Department has always used a contractor to determine eligibility for CHP+, but engaging the contractor to determine

eligibility for selected expansion populations grew out of a recommendation of the Blue Ribbon Commission for Health Care Reform (S.B. 06-208) to create a single state-level entity for determining Medicaid and CHP+ eligibility. The Commission indicated this should be, "instead of current multiple county-level systems," but the Department views the project as enhancing and complimenting, rather than replacing, county administration within the Department's "no wrong door" philosophy toward eligibility determinations. The Department believes the Centralized Eligibility Vendor streamlines eligibility determinations and improves outreach for Medicaid and CHP+, especially for people applying only for medical benefits and not for other human services.

Through a competitive bid the Department selected MAXIMUS, Inc. to act as the Centralized Eligibility Vendor through June 2015. According to the Department, MAXIMUS provides technology not available in all counties, including an automated customer contact center and an electronic document and workflow management system. The money to pay MAXIMUS is split between the Children's Basic Health Plan Administration line item for traditional CHP+ clients and the Centralized Eligibility Vendor Contract Project line item for the expansion populations where the state match is provided from the Hospital Provider Fee. The federal match rate for eligibility determinations is 50.0 percent for Medicaid and 65.0 percent for CHP+. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. Therefore, the federal government reimburses 88.0 percent of the contract for CHP+ eligibility determinations at the Medicaid match rate and 12.0 percent at the CHP+ match rate.

FY 2012-13				
Line Item	TOTAL	CHP+ Trust	Hospital Provider Fee	Federal Funds
Centralized Eligibility Vendor Contract Project	$4,252,668	$0	$2,126,334	$2,126,334
Children's Basic Health Plan Administration	$3,747,444	$1,781,535	$0	$1,965,909
TOTAL Contract with MAXIMUS	$8,000,112	$1,781,535	$2,126,334	$4,092,243

FY 2013-14				
Line Item	TOTAL	CHP+ Trust	Hospital Provider Fee	Federal Funds
Centralized Eligibility Vendor Contract Project	$5,226,120	$0	$2,613,060	$2,613,060
Children's Basic Health Plan Administration	$3,750,000	$1,782,750	$0	$1,967,250
TOTAL Contract with MAXIMUS	$8,976,120	$1,782,750	$2,613,060	$4,580,310

FY 2014-15				
Line Item	TOTAL	CHP+ Trust	Hospital Provider Fee	Federal Funds
Centralized Eligibility Vendor Contract Project	$5,297,520	$0	$2,648,760	$2,648,760
Children's Basic Health Plan Administration	$3,750,000	$1,782,750	$0	$1,967,250
TOTAL Contract with MAXIMUS	$9,047,520	$1,782,750	$2,648,760	$4,616,010

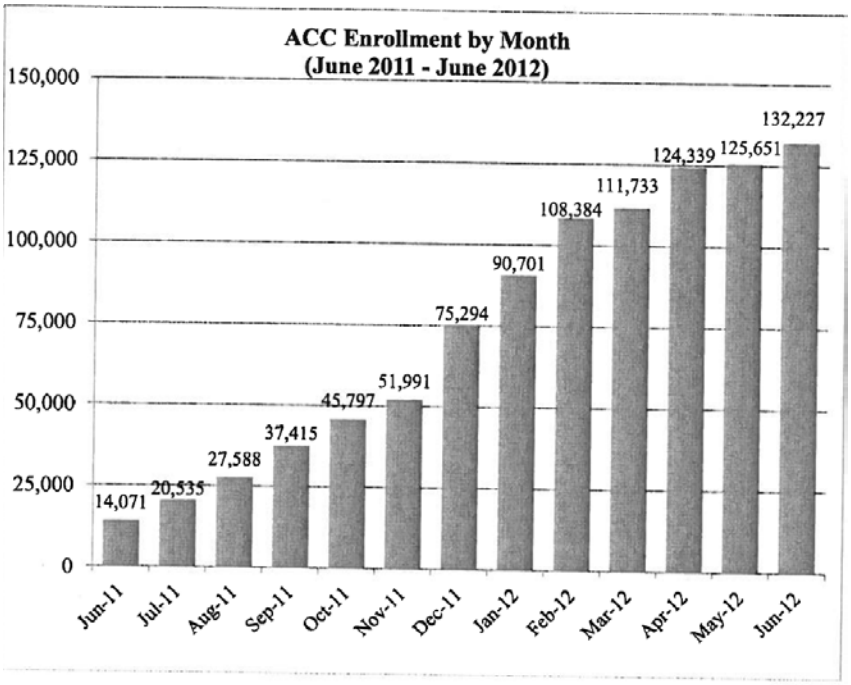
5. **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, 2012, to the Joint Budget Committee regarding the Department's efforts to ensure that pharmaceuticals are purchased at the lowest possible price.

   Comment: Please see the issue brief above on Pharmaceutical Reimbursement.

6. **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, 2012, to the Joint Budget Committee, providing information on the implementation of the Accountable Care Collaborative Organization project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the pilot program, the current administrative fees and costs for the program, and any initial results that demonstrate savings for the pilot program. If data is not available to determine saving results, the Department shall note when such data is anticipated to be available.

   Comment: The Department submitted the report as requested. The Accountable Care Collaborative (ACC) is composed of seven Regional Care Collaborative Organizations (RCCOs) and within each RCCO there are Primary Care Medical Providers (PCMPs) that function as a medical home for clients. The RCCOs receive a per member per month fee of $12.00 to integrate and coordinate the provider care network and are eligible for an increase in the rate for achieving performance objectives related to health outcomes. The PCMPs receive a per member per month fee of $3.00 to coordinate care for clients and are eligible for increases in the rate for achieving health outcome goals. For FY 2012-13 the potential incentive payments available to RCCOs and PCMPs for meeting performance goals are $1 per member per month.

   As of June 2012 enrollment was 132,277 clients.



Administration fees for FY 2011-12 totaled $17.9 million, including $12.3 million for the Regional Care Collaborative Organizations, $2.9 million for Primary Care Medical Providers, and $2.7 million for the Statewide Data and Analytics Contractor.

The Department identified the following performance outcomes:

- Hospital readmissions decreased 8.6 percent
- Emergency room utilization increased 0.23 percent for ACC enrollees compared to 1.47 percent for non-enrollees
- High-cost imaging services decreased 3.0 percent points more among ACC enrollees
- The Department also found improvements in the treatment outcomes for patients with asthma, diabetes, and hypertension.

The Department used two methods to estimate savings from the model. The "counterfactual" method uses risk-adjustment techniques to normalize disparities in health status and predict health care costs. The Department describes this as the industry standard. The "difference-in-difference" method compares outcomes to a control group with similar risk characteristics that is not in the ACC. Based on the counterfactual method the Department estimated savings of $30.9 million and based on the difference-in-difference method the Department estimated savings of $8.5 million.

7. **Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services --** The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how

those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The Department submitted the report as requested. The program pays for medically necessary services that are part of a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of covered services include direct medical services, rehabilitative therapies, and Early and Periodic Screening, Diagnostic and Treatment Services. Medical necessity is determined through the federally and state regulated IEP or IFSP process. In FY 2010-11 the program served 12,328 children. The total federal funds matched with certified public expenditures was $16,783,362.

Appendix D: Indirect Cost Assessment Methodology

The following description of the Department's indirect cost plan was provided by the Department.

Description of Indirect Cost Assessment Methodology
The Department of Health Care Policy and Financing's (the Department) indirect cost assessment methodology is unique when compared to most other Departments. The Department's federal fiscal agent, the Centers for Medicare and Medicaid Sevices (CMS), requires the Department to have a Public Assistance Cost Allocation Plan (PACAP).The PACAP is calculated based on two main components: an "*Indirect Cost Pool*" and a "Step-down" methodology used to allocate indirect costs to various major program groups benefiting from those services.

The *Indirect Cost Pool* is comprised of approved Executive Director's Office (EDO) and other FY 2011-12 overhead actual costs, including statewide indirect costs, used to provide support to the entire department. Unlike other Departments, Health Care Policy and Financing's PACAP allocates cost pools by Organization Codes, which are codes used to identify different programs within the Department, as opposed to appropriation codes. While indirect costs occur in many line items throughout the Department, all Accounting entries made to account and adjust for indirect costs are done in one line item, namely Personal Services. ***Table 1*** below outlines the line item where the Indirect Cost Pool is accounted for.

Table 1: Department of Health Care Policy and Financing Indirect Cost Pool

Division	Line Item	FY 2011-12 Actual
Executive Director's Office	Personal Services	$12,638,930
Total Indirect Cost Pool		$12,638,930

The *"Step-down" methodology* is a sequential method of allocating administrative or indirect service costs to the programs benefiting from the services. The Department uses an Excel workbook developed by an outside vendor to process the indirect cost allocation on a quarterly basis. Input data is gathered from the Colorado Financial Reporting System (COFRS), the Colorado Personnel Payroll System (CPPS), and other internal reports, and is then allocated based on a suitable basis, such as transaction or FTE counts, to arrive at the format needed to allocate the costs to the final major program groups which draw different federal match rates. All indirect costs are initially charged to Medicaid Administration, which draws a 50% federal participation rate. Through the step-down procedure, these costs are allocated to other major program groups such as the Children's Basic Health Plan and the School Based Health Program, which draw federal match rates that differ from basic Medicaid Administration. As can be seen in Table 2 and Table 3 below, by following the current CMS approved Cost Allocation methodology, the Department actually requires additional General Fund to support the loss of federal funds that occurs when indirect costs are reallocated as the weighted average federal financial participation rate is less than the initial rate of 50% for Medicaid Administration.

Table 2 below shows the major program groups indirect costs were allocated to in FY 2011-12:

Table 2: Department of Health Care Policy and Financing Indirect Cost Allocation Major Program Groups				
Major Program Group	Amount Initially Allocated	Final Allocation	Federal Participation Rate	Revenue Change (Assessment)
State Only	$0	$1,561,217	0%	$0
Medicaid Administration 50%	$12,638,930	$9,699,894	50%	($1,469,518)
Medicaid Admin 75%	$0	$982,395	75%	$736,796
Children's Basic Health Plan	$0	$257,727	65%	$167,523
Refugee Program	$0	$6,015	100%	$6,015
School Based Health	$0	$51,284	100%	$51,284
Prospective Payment System	$0	$7,298	100%	$7,298
CHIPRA	$0	$73,100	100%	$73,100
Total	**$12,638,930**	**$12,638,930**	**46.62%**	**($427,502)**

Table 3: Department of Health Care Policy and Financing Revenue Change Due to Indirect Cost Allocation		
	Indirect Costs	Federal Funds Drawn
Pre Cost Allocation	$12,638,930	$6,319,465
Post Cost Allocation	$12,638,930	$5,891,963
Change	**$0**	**($427,502)**

FY 2013-14 Indirect Cost Assessment Request

For FY 2013-14 the Department has not made a request for indirect cost assessments. If the Department were to make a request, it would have been equal to the Total Revenue Change (Assessment) in Table 2 above. ***Table 4*** shows the FY 2013-14 Department indirect cost assessment based on the November 1 request for each division. The FY 2013-14 request would represent a new letternote in the Department's budget as the Department has not historically calculated and accounted for indirect costs separately.

The Department recognizes its current indirect cost allocation methodology is outdated. This methodology was created to ensure compliance with CMS requirements at a time when the Department's only two programs were Medicaid and the Children's Basic Health Plan (CBHP). The current methodology was not meant to be a tool to provide for cost assessment allocations by appropriation or cash fund source. Since that time, the Department has grown in terms of the number of financing sources and the number of additional programs administered by the Department, including a number of new federal grant funded programs. The Department recognizes these changes require a new cost allocation methodology which meets not only CMS

requirements but also budget presentation requirements. The Department is currently working to secure an outside vendor to create a new indirect cost allocation tool that will provide the Department with a plan that will meet the current needs of the Department and the requirements of CMS.

Table 4: Department Indirect Cost Assessment Request

Division	Total	CF	RF	FF
Executive Director's Office	($427,502)			($427,502)
Total FY 2013-14 Request	**($427,502)**			**($427,502)**
FY 2012-13 Indirect Cost Assessment	N/A			N/A
Difference (FY 14 - FY 13)	N/A			N/A

DEPARTMENT OF Health Care Policy and Financing FY 2013-14
SOURCES OF INDIRECT COST RECOVERIES IN LONG BILL

		FY 2013-14 Proposed Sources of Indirect					
		Total	Cash Funds	HUTF "Off the Top"	Reappropriated Funds	Federal Funds	
(1) Executive Director's Office		98,338				98,338	
TOTAL AVAILABLE INDIRECT TO OFFSET GI		**98,338**	**-**	**-**	**-**	**98,338**	
FY 2011-12 Collections		98,338				98,338	
Difference		-	-	-	-	-	

DEPARTMENT OF Health Care Policy and Financing FY 2013-14
USES OF INDIRECT COST RECOVERIES IN LONG BILL

		FY 2013-14 Proposed Uses of Indirect					
		FY2013-14 GF REQUEST	DEPT INDIRECT	STATEWIDE INDIRECT	TOTAL INDIRECT TO OFFSET GF	BALANCE AVAILABLE INDIRECT	BALANCE GF
						98,338	
(1) Executive Director's Office						98,338	
	Personal Services	10,756,293	(427,502)	525,840	98,338	-	10,657,955
TOTAL FOR DEPARTMENT		**10,756,293**	**(427,502)**	**525,840**	**98,338**	**196,676**	**10,657,955**

Appendix E: Change Requests' Relationship to Performance Measures

This appendix will show how the Department of Health Care Policy and Financing indicates each change request ranks in relation to the Department's top priorities and what performance measures the Department is using to measure success of the request.

Change Requests' Relationship to Performance Measures			
R	**Change Request Description**	**Goals / Objectives**	**Performance Measures**
1	Medical Service Premiums	Increase the number of insured Coloradans Improve health outcomes Increase access to health care Contain health care costs Improve long-term care service delivery system	All. This request is for projected changes in enrollment and expenditures under current law and necessary to maintain current performance levels for all goals and objectives.
2	Mental Health Community Programs	Increase the number of insured Coloradans Improve health outcomes Increase access to health care Contain health care costs Improve long-term care service delivery system	All. This request is for projected changes in enrollment and expenditures under current law and necessary to maintain current performance levels for all goals and objectives.
3	Children's' Basic Health Plan	Increase the number of insured Coloradans Improve health outcomes Increase access to health care Contain health care costs	All. This request is for projected changes in enrollment and expenditures under current law and necessary to maintain current performance levels for all goals and objectives.
4	Medicare Modernization Act	Federal mandate	All. This request is for projected changes in enrollment and expenditures under current law and necessary to maintain current performance levels for all goals and objectives.
5	Medicaid Management Information System reprocurement	Improve health outcomes	Development of a data strategy for long-term integration of clinical and claims data
6	Additional FTE to restore functionality	Increase the number of insured Coloradans Improve health outcomes Increase access to health care Contain health care costs Improve long-term care service delivery system	While the many of the specific positions requested are operational positions in nature, the Department's goal in requesting these positions is to alleviate demands on existing staff. The job duties for the proposed positions are composed of work that current staff have had to absorb, and this ongoing situation prevents many of the Department's policy staff from allocating time to improving the Medicaid program. Additional staff will help the Department eliminate backlogs and be more responsive to client, provider, and stakeholder inquiries; in turn, this will allow the Department's policy staff to better address the Department's strategic plan goals.
7	Substance use disorder benefit	Improve health outcomes	Annual depression screenings for adolescents
8	Medicaid dental benefit for adults	Improve health outcomes Increase access to care Contain health care costs	Implement payment reform Hospital readmissions within 30 days
9	Dental administrative services organization for children	Improve health outcomes Contain health care costs	Medicaid children with dental carries Medicaid children who receive a dental service
10	Leased space true-up	Technical	All, indirectly. Without adequate space to house its employees, the Department would be

Change Requests' Relationship to Performance Measures			
R	**Change Request Description**	**Goals / Objectives**	**Performance Measures**
			unable to deliver on any performance measure.
11	HB 12-1281 departmental differences	Improve health outcomes Increase access to care Contain health care costs	
12	Customer service tech. improvements	Improve health outcomes Increase access to care Contain health care costs	
13	Provider rate increase	Increase access to health care	Number of providers participating in Medicaid