COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2012-13 STAFF BUDGET BRIEFING

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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December 15, 2011

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FY 2012-13 BUDGET BRIEFING
STAFF PRESENTATION TO THE JOINT BUDGET COMMITTEE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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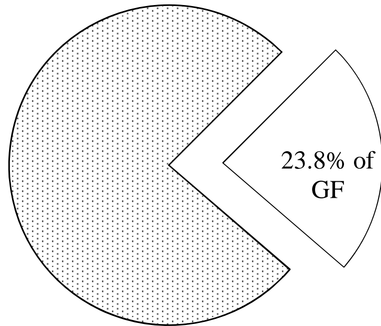
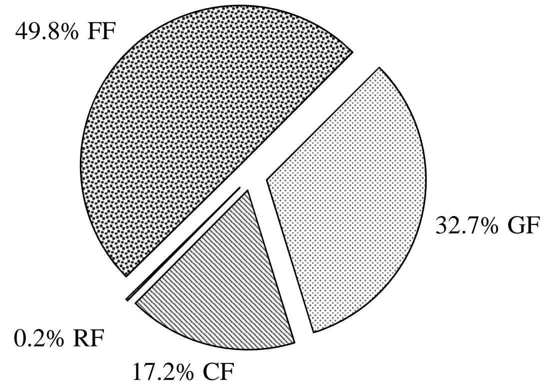
FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

GRAPHIC OVERVIEW

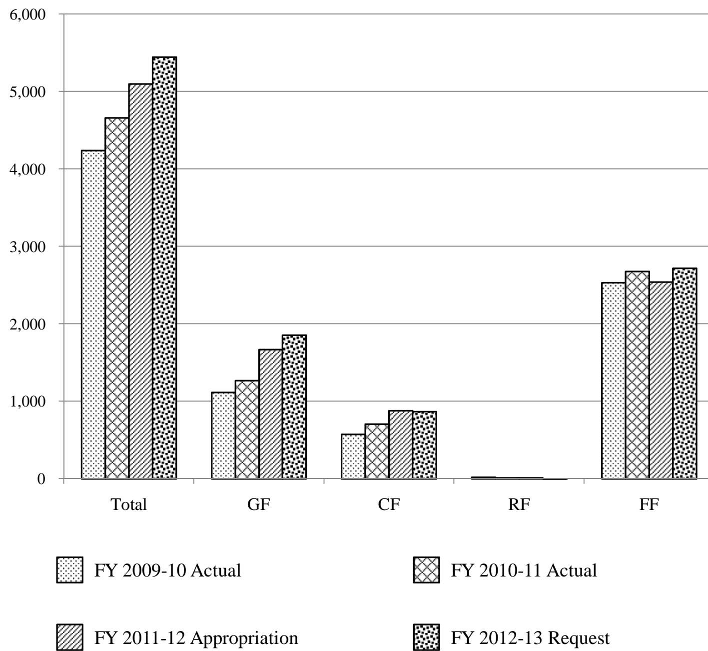
Department's Share of Statewide General Fund



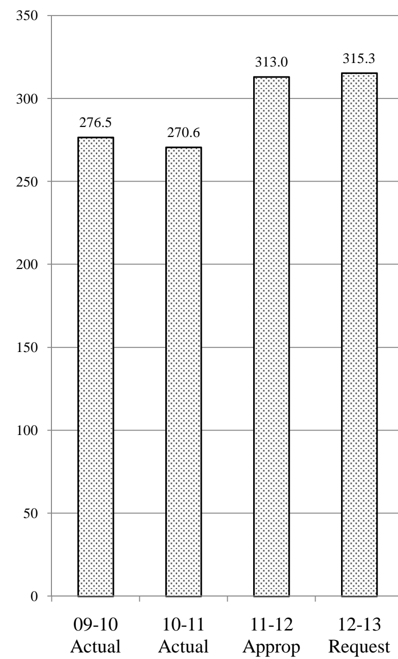
Department Funding Sources



Budget History
(Millions of Dollars)

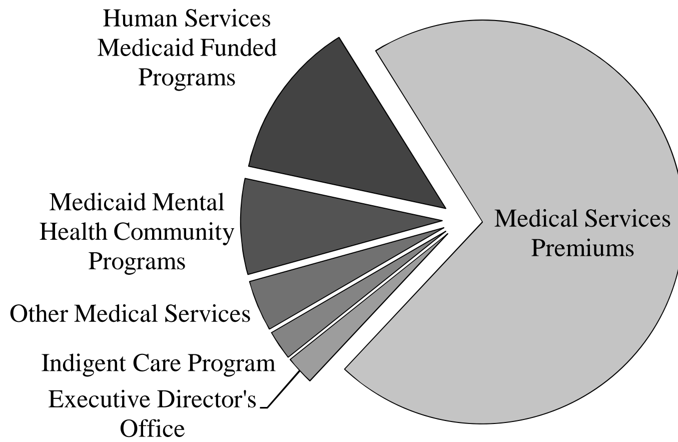


FTE History

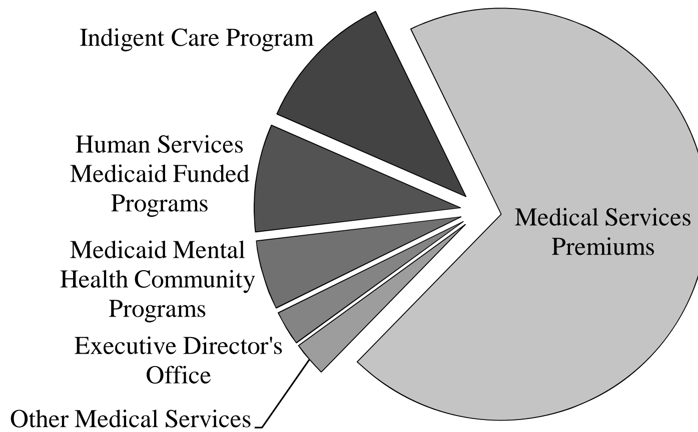


Unless otherwise noted, all charts are based on the FY 2011-12 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

DEPARTMENT OVERVIEW

Key Responsibilities

The Department operates four major programs to help pay medical and long-term care expenses for low-income and vulnerable populations:

- **Medicaid** -- serves low-income families, elderly people, people with disabilities, and more recently adults without dependent children.
- **Children's Basic Health Plan** -- a premium-based insurance option for children and pregnant women with extremely low annual membership fees and coinsurance requirements compared to commercial options.
- **Colorado Indigent Care Program** -- helps defray the costs to providers of uncompensated or under-compensated care for low-income people. This is not an insurance program, but participating providers must agree to discount their charges for some services on a sliding scale based on income.
- **Old Age Pension Health and Medical Program** -- for low-income people who qualify for a state pension but do not qualify for Medicaid or Medicare.

The first three programs above are provided through a state-federal partnership. The Department receives significant federal matching funds to operate the programs, but must adhere to federal rules regarding eligibility, benefits, and other features as a condition of accepting the federal funds.

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

Factors Driving the Budget

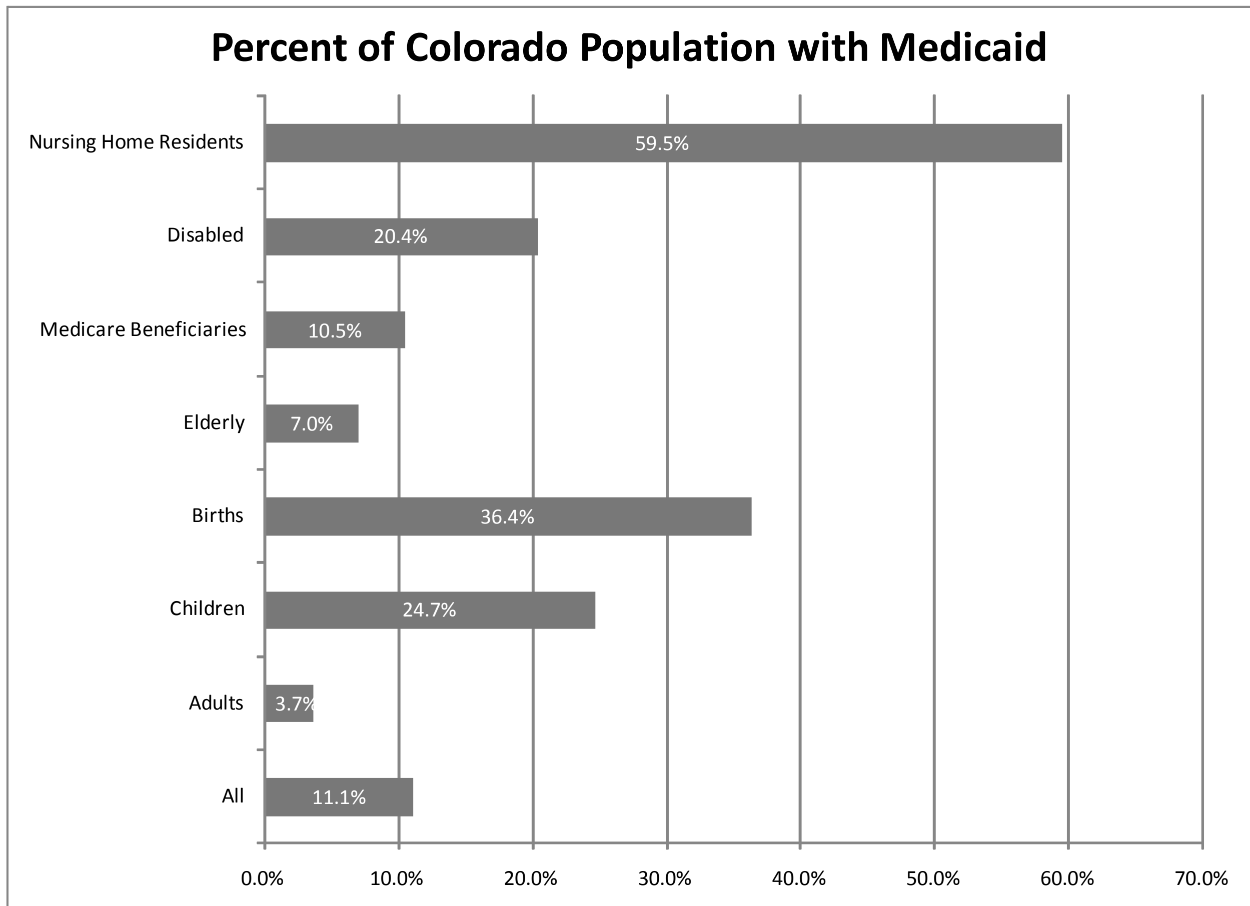
Funding for this department in FY 2011-12 consists of 49.9 percent federal funds, 34.1 percent General Fund, 15.9 percent cash funds, and 0.1 percent reappropriated funds. Major sources for the cash funds and reappropriated funds include (1) hospital and nursing facility provider fees; (2) the Health Care Expansion Fund (tobacco taxes); (3) the Primary Care Fund (tobacco taxes); (4) the Children's Basic Health Plan Trust Fund (tobacco settlement funds); (5) the Old Age Pension Health and Medical Care Fund and Supplemental Fund; and (6) various other cash funds. 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 programs

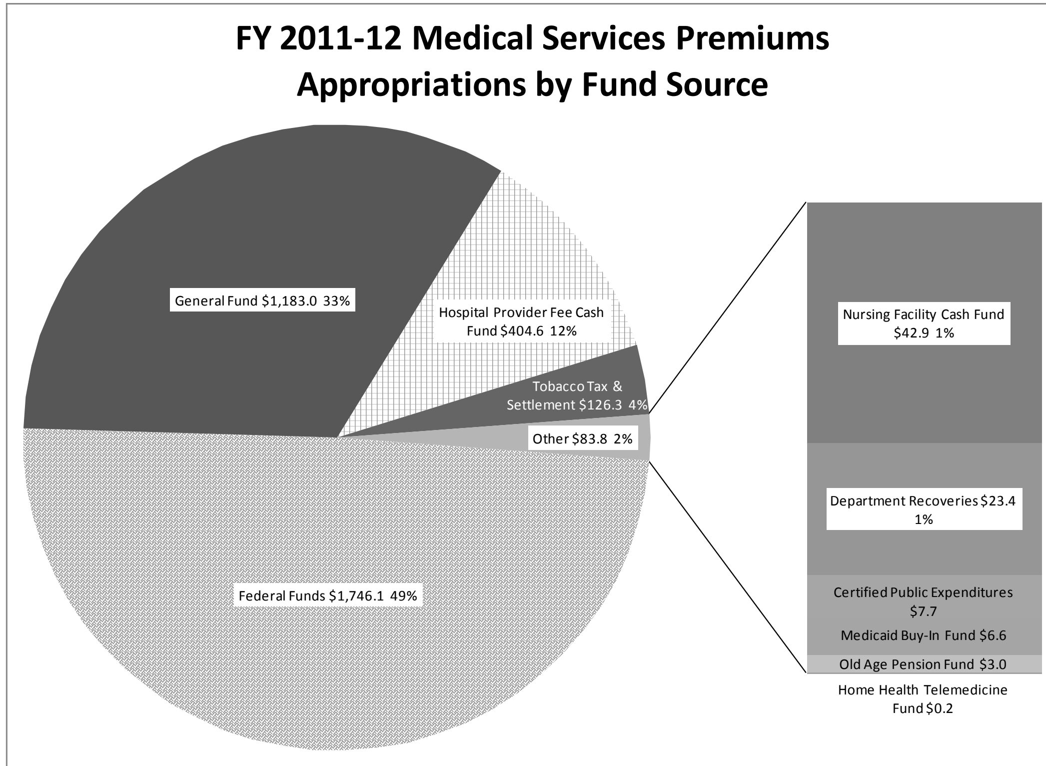
(through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

The Department's budget is comprised of the following sections: (1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Programs; (4) Indigent Care Program; (5) Other Medical Services; and (6) Department of Human Services Medicaid-Funded Programs.

Medical Services Premiums

The Medical Services Premiums section provides funding for the health care services of individuals qualifying for the Medicaid program. Health care services include both acute care services (such as physician visits, prescription drugs, and hospital visits) and long-term care services (provided within nursing facilities and community settings). The Department contracts with health care providers through fee-for-service and managed care organizations in order to provide these services to eligible clients. Total costs for the program are driven by the number of clients, the costs of providing health care services, and the utilization of health care services.



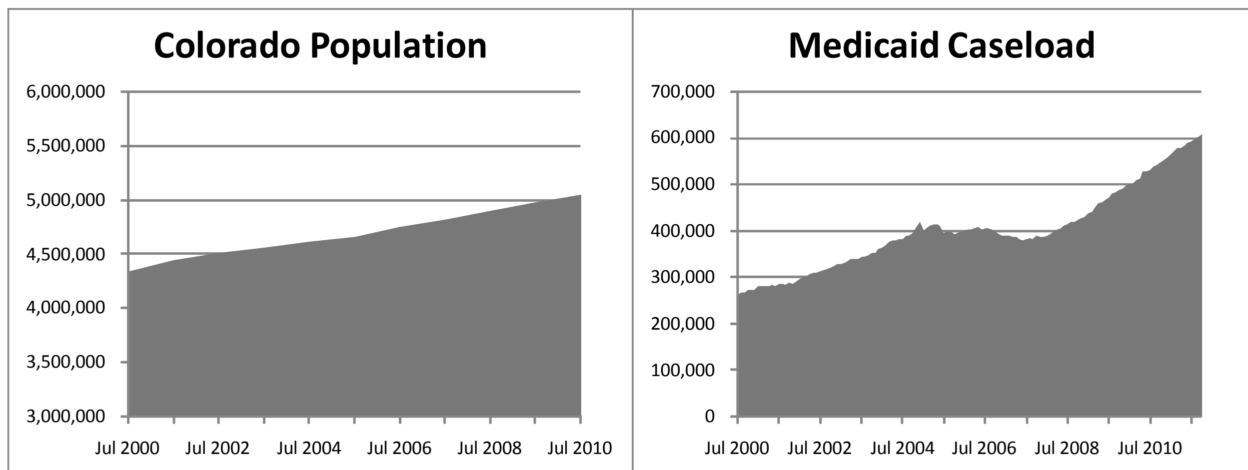


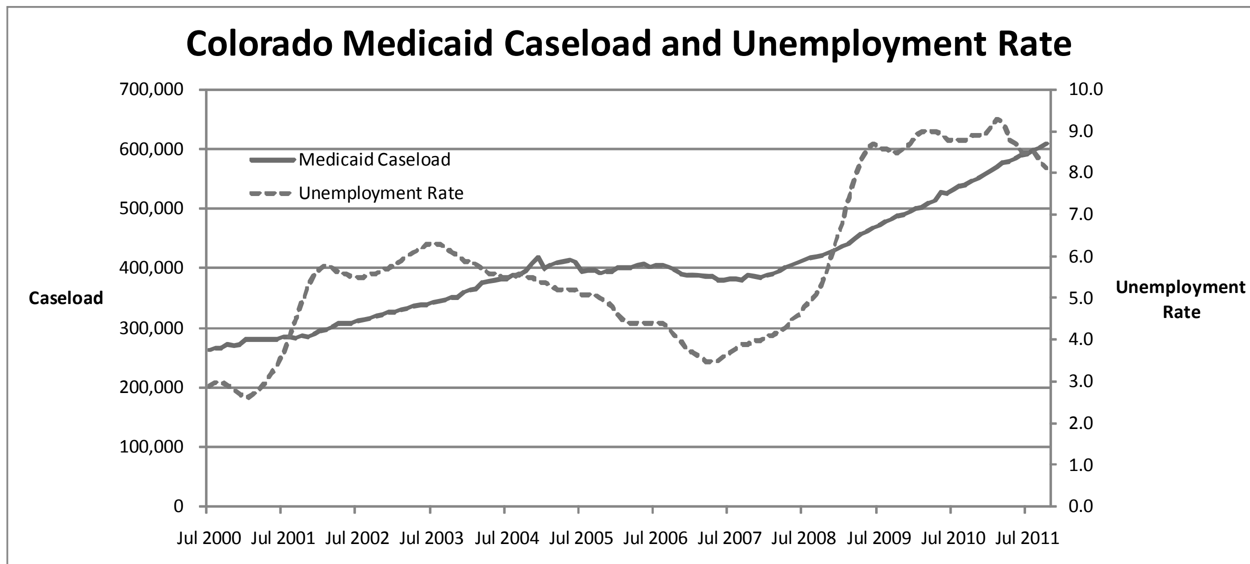
Medicaid Caseload Growth

The following factors affect the number of clients participating in the Medicaid program:

- General population growth
- Economic conditions that impact the people who meet the income eligibility criteria, and
- Policy changes at the state and federal level regarding eligibility.

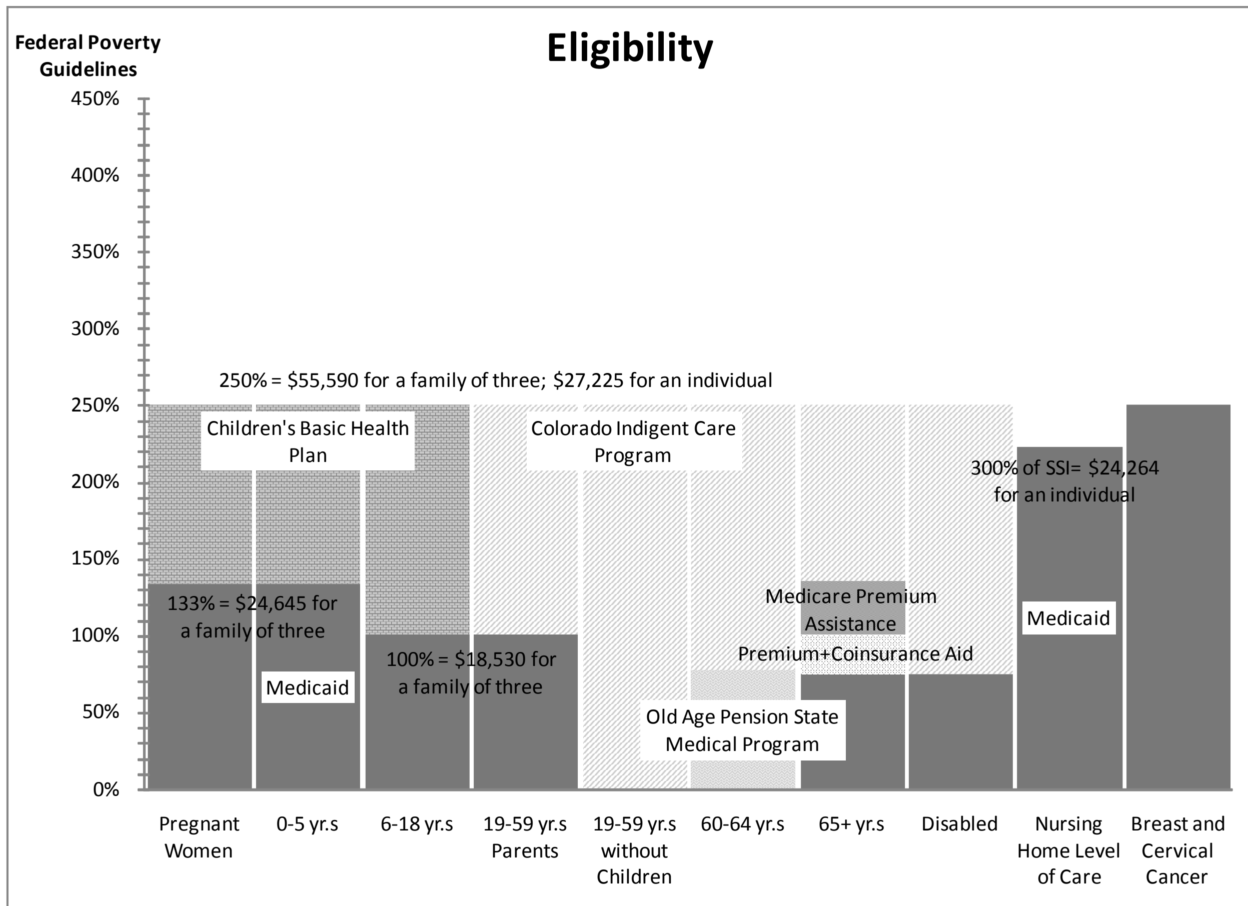
The current Medicaid caseload forecast is 560,722 clients in FY 2011-12 and 619,985 clients in FY 2012-13.





The next tables summarizes current eligibility criteria for publicly funded health care programs that are based on income.[1]

[1] 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, 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 2011 Poverty Guidelines for the
48 Contiguous States and the District of Columbia

	Poverty guideline								
	SSI	OAP		ACA	Pregnant	300% of SSI	CHP+	Tax Credits	Buy-in
Persons in family	**74%**	**77%**	**100%**	**133%**	**185%**	**223%**	**250%**	**400%**	**450%**
1	$8,088	$8,388	$10,890	$14,484	$20,147	$24,264	$27,225	$43,560	$49,005
2	$10,925	$11,330	14,710	$19,564	$27,214	$32,775	$36,775	$58,840	$66,195
3	$13,762	$14,273	18,530	$24,645	$34,281	$41,287	$46,325	$74,120	$83,385
4	$16,599	$17,215	22,350	$29,726	$41,348	$49,798	$55,875	$89,400	$100,575
5	$19,436	$20,157	26,170	$34,806	$48,415	$58,309	$65,425	$104,680	$117,765
6	$22,274	$23,100	29,990	$39,887	$55,482	$66,821	$74,975	$119,960	$134,955
7	$25,111	$26,042	33,810	$44,967	$62,549	$75,332	$84,525	$135,240	$152,145
8	$27,948	$28,984	37,630	$50,048	$69,616	$83,843	$94,075	$150,520	$169,335

Medical Cost Increases

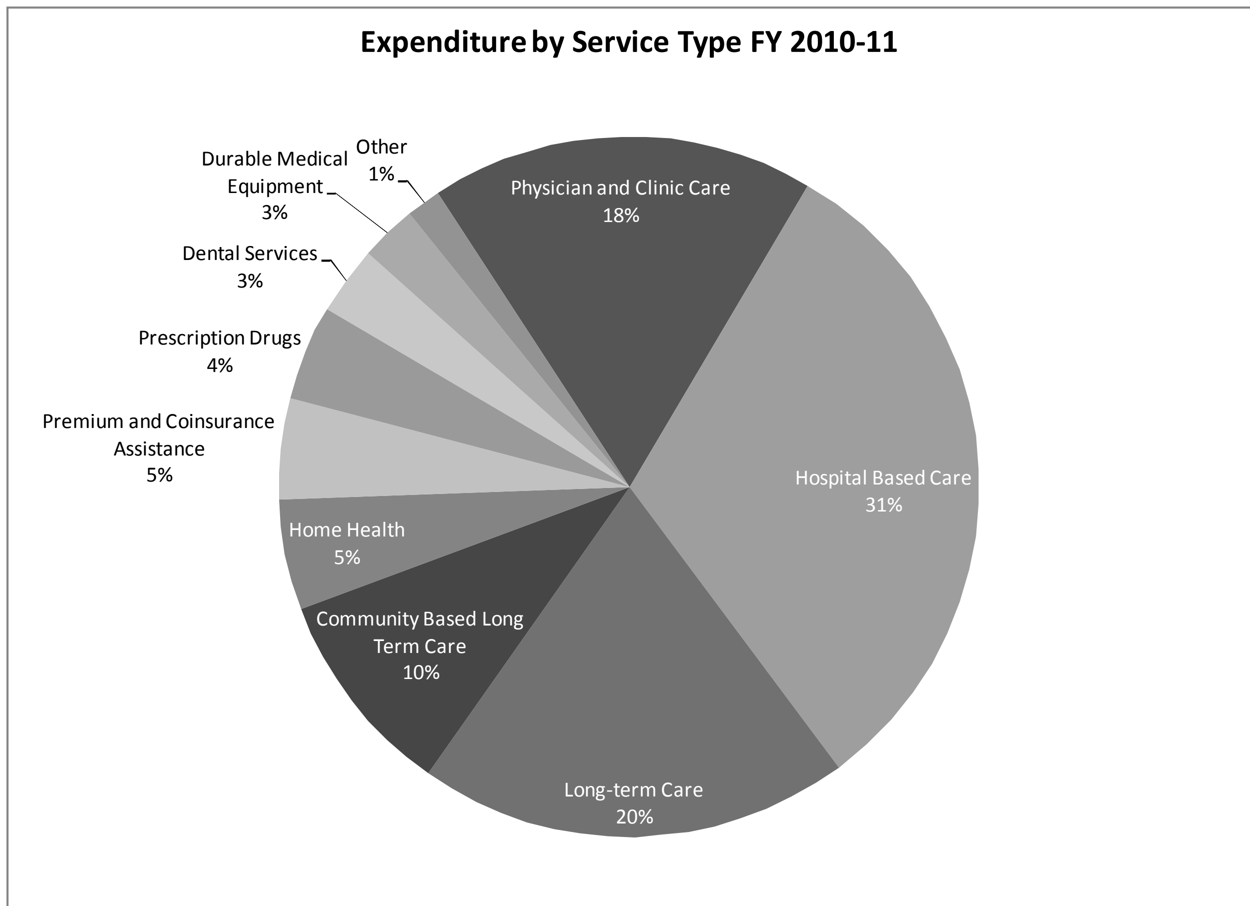
In addition to increased costs due to caseload growth, the Medicaid budget also grows as a result of higher medical costs and greater utilization of medical services. The average overall per capita cost for the Medicaid program is influenced by case mix, utilization of services, and the price of those services. Recently, the overall per capita cost for the program 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). In addition, recent provider rate reductions have also lowered the per capita costs per client.

The following table shows the overall average medical costs per Medicaid client from FY 2006-07 through the request for FY 2012-13. Figures are adjusted to remove the impact of the two-week payment delay that occurred in FY 2009-10. The per capita rates do not include supplemental hospital and nursing facility payments or other funding mechanism that are used to decrease the state obligation by increasing federal funding (these mechanism are referred to as "bottom-line financing").

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Estimate	FY 2012-13 Request
Medical Service Cost Per Capita	$5,222.57	$5,681.77	$5,742.83	$5,116.67	$4,938.80	$4,788.51	$4,832.26
Annual Percent Change	6.0%	8.8%	1.1%	(10.9)%	(3.5)%	(3.0)%	0.9%

The following table shows the allocation of expenditures by major service type.



Medicaid Mental Health Capitation

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.

	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Estimate	FY 2011-12 Appropriation
Medicaid Mental Health Capitation Funding /1	$196,011,033	$215,860,937	$223,368,053	$248,120,971	$272,492,157
Annual Dollar Change	$11,370,465	$19,849,904	$7,507,116	$24,752,918	$24,371,186
Annual Percent Change	6.2%	10.1%	3.5%	11.1%	9.8%
Individuals Eligible for Medicaid Mental Health Services (Caseload)/2	373,557	417,750	478,577	538,115	591,856
Annual Caseload Change	(1,489)	44,193	60,827	59,538	53,741
Annual Percent Change	(0.4)%	11.8%	14.6%	12.4%	10.0%

/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.

Indigent Care Program

The Safety Net Provider Payment, the Children's Hospital Clinic Based Indigent Care, and the Pediatric Speciality Hospital line items provide direct or indirect funding to hospitals and clinics that have uncompensated costs from treating approximately 217,900 under-insured or uninsured Coloradans through the Indigent Care Program (caseload is from FY 2009-10, the most recent year data is available). The Indigent Care Program is not an insurance program or an entitlement program. 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 for this program is from federal sources. State funds for the program come mainly through General Fund appropriations, certifying public expenditures at hospitals (prior to FY

2009-10), the Hospital Provider Fee Cash Fund (beginning in FY 2009-10), and a Primary Care Fund transfer (beginning in FY 2009-10).

Due to the state revenue shortfall in recent years, the General Fund for these programs has been reduced from $34.6 million in FY 2008-09 to approximately $9.0 million in FY 2011-12. However, the overall funding for the program in FY 2011-12 of $353.8 million is approximately the same amount of funding available for these line items in FY 2008-09 of $353.3 million. The increase in the program in FY 2011-12 is due mainly to increases in the hospital reimbursements pursuant to H.B. 09-1293.

	FY 2007-08 Actual	FY 2008-09 Appropriation/1	FY 2009-10 Appropriation	FY 2010-11 Appropriation	FY 2011-12 Appropriation
Safety Net Provider Payments	$296,188,630	$304,357,286	$277,769,967	$277,769,968	$309,825,106
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
Pediatric Specialty Hospital	8,439,487	12,829,721	14,913,994	14,821,994	11,799,938
Special Distribution (SB 06-044 or HB 10-1321, H.B. 10-1378 and S.B. 11-219)	31,225,421	30,000,000	27,050,247	31,085,655	26,091,930
Total	**$341,973,298**	**$353,306,767**	**$325,853,968**	**$329,797,377**	**$353,836,734**
General Fund	34,701,662	34,620,412	17,773,375	7,289,728	8,959,849
Cash Funds & Reappropriated Funds	135,668,119	139,831,861	125,063,786	137,062,097	169,249,483
Federal Funds	171,603,517	178,854,494	183,016,807	185,445,552	175,627,402
Total funding percent change	10.8%	3.3%	(7.8)%	1.2%	7.3%

/1 Federal fund offset to the General Fund expenditures in FY 2008-09 and FY 2009-10 distorts the funding allocation for these programs in FY 2008-09. Therefore, to give a better comparison of actual funding provided to the program, this chart uses the FY 2008-09 appropriation rather than the actual expenditure in FY 2008-09 and FY 2009-10.

Comprehensive Primary Care Program

In November 2004, the voters passed Amendment 35 to the Colorado Constitution which increased the taxes on tobacco products in order to expand several health care programs. During the 2005 Legislative Regular Session, the General Assembly passed H.B. 05-1262 to implement the provisions of Amendment 35. Among other provisions, H.B. 05-1262 created the Comprehensive Primary Care program. This program provides additional funding to qualifying providers with patient caseloads that are at least 50 percent uninsured, indigent, or enrolled in the Medicaid or Children's Basic Health Plan programs. In FY 2007-08 and FY 2008-09 funding for this program was $31.0 million, and $31.3 million, respectively.

The Colorado Constitution allows the Amendment 35 moneys to be used for other health-related purposes if a two-thirds majority vote the General Assembly passes a fiscal emergency resolution. Due to the budget situation in FY 2009-10 through FY 2011-12, the General Assembly has passed emergency resolutions to transfer this funding to other programs and to offset General Fund needs. The chart below provides a five year history of the funding for this program.

	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Appropriation	FY 2010-11 Appropriation	FY 2011-12 Appropriation
Primary Care Program	$30,967,650	$30,273,568	$12,125,000	$0	$0

Children's Basic Health Plan[2]

The Children's Basic Health Plan (CBHP) was implemented in 1997 to provide health care insurance to children from families with incomes at or below 185 percent of the federal poverty level (FPL). A 65 percent federal match is available for the program. Since its passage in 1997, a number of expansions to the program have occurred. In FY 2002-03, the program was expanded to include adult pregnant women up to 185 percent FPL. However, due to budget constraints in FY 2003-04, the adult prenatal program was suspended for the entire year and no new enrollment was accepted into the children's program beginning in November 2003. In FY 2004-05, the cap was lifted on the children's caseload and the adult prenatal program was reinstated.

Among other changes, H.B. 05-1262 increased eligibility for the CBHP for both children and women up to 200 percent of the FPL. During the 2007 legislative session, S.B. 07-097 expanded the program's eligibility to 205 percent FPL for FY 2007-08. During the 2008 legislative session, the program's eligibility was expanded to 225 percent FPL for children beginning in April 2009 and for pregnant women beginning in October 2009. Due to the current economic situation, S.B. 09-211

[2] A rose by any other 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, the Committee 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.

repealed the expansion to 225 percent FPL in FY 2008-09 and FY 2009-10. However, H.B. 09-1293 expanded CBHP to 250 percent FPL beginning in May 2010. The following table provides a five-year funding history for the CBHP medical and dental costs.

	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 Appropriation
Medical Services & Dental Services	$113,400,544	$130,686,358	$164,398,285	$188,081,156	$213,086,149
General Fund	0	0	0	0	29,997,908
Cash Funds	39,874,379	46,115,911	55,285,838	58,971,526	44,582,245
Reappropriated Funds/1	0	0	2,500,000	6,856,880	0
Federal Funds	73,526,165	84,570,447	106,612,447	122,252,750	138,505,996
Total funding percent increase	17.5%	15.2%	25.8%	14.4%	13.3%

/1 Represents General Fund appropriations made into the Children's Basic Health Plan Trust Fund for use in the program line items.

The following table provides a five-year history of the caseload served by the Children's Basic Health Plan.

	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 Appropriation
Children Caseload	57,795	61,582	68,725	68,448	75,811
Percent Change from prior year	22.9%	6.6%	11.6%	-0.4%	10.8%
Adult Pregnant Women Average Monthly Caseload	1,570	1,665	1,561	2,033	2,391
Percent Change from prior year	34.2%	6.1%	(6.2)%	30.2%	17.6%

Department of Human Services Medicaid-Funded Programs

Many programs administered by the Department of Human Services (DHS) qualify for Medicaid funding. The federal government requires that one state agency receive all federal Medicaid funding. Therefore, the state and federal funding for all DHS programs that qualify for Medicaid funding is first appropriated in the Department of Health Care Policy and Financing and then transferred to the Department of Human Services (as reappropriated funds). A five-year funding history for the DHS Medicaid-funded programs is provided in the table below.

	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Appropriation	FY 2011-12 Appropriation
Expenditures/ Appropriations	$351,308,449	$398,390,163	$415,140,344	$450,441,069	$430,066,566
Annual percent change	5.5%	13.4%	4.2%	8.5%	(4.5)%

For detail regarding the changes in the Department of Human Services Medicaid-Funded programs, please see the Department of Human Services section of this report.

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing
(All divisions except Medicaid Mental Health Community Programs, and
Department of Human Services Medicaid-funded Programs)

DECISION ITEM PRIORITY LIST

Decision Item	GF	CF	RF	FF	Total	FTE
1	129,303,556	36,238,486	303,982	164,960,231	330,806,255	0.0
Request for FY 2012-13 Medical Services Premiums (Base Caseload & Cost Forecast)						
Medical Services Premiums. The Department requests an increase of $330.8 million total funds ($129.3 million General Fund) related to the baseline forecast for the Medical Services Premiums (Medicaid medical and long-term care services) program. The Department is forecasting a Medicaid caseload of 656,294 clients (an increase of 6.4 percent from the Department's revised FY 2011-12 forecast) and overall average per capita cost of $4,959.38 (an increase of 0.72 percent from the Department's revised FY 2011-12 forecast). The forecast projects that FY 2011-12 expenditures will exceed the appropriation by $62.4 million ($51.3 million General Fund) and this explains a portion of the projected increase for FY 2012-13. *Statutory authority: Sections 25.5-4 et al, 25.5-5-et al, and 25.5-6 et al C.R.S. (2010).*						
2	21,388,240	(3,087,673)	(13,544)	18,327,285	36,614,308	0.0
Request for FY 2012-13 Medicaid Mental Health Community Programs (Base Caseload & Cost Forecast)						
Medicaid Mental Health Community Programs. The Department requests an increase of $36.6 million total funds ($21.4 million General Fund) for the baseline forecast for the Medicaid mental health programs. This item is discussed in greater detail in the Mental Health staff briefing. *Statutory authority: Sections 25.5-308, 25.5-5-408, and 25.5-5-411, C.R.S. (2010).*						
3	0	(862,887)	0	(2,571,569)	(3,434,456)	0.0
Children's Basic Health Plan Medical Premium and Dental Costs (Base Caseload & Cost Forecast)						
Indigent Care Programs. The Department requests a decrease of $3.4 million total funds for the baseline forecast for the Children Basic Health Plan (CHP+) program. The Department is forecasting an average monthly caseload of 67,542 children and 1,360 women will be served by this program in FY 2012-13. This is a decrease of 0.6 percent from the Department's revised FY 2011-12 caseload forecast. The projection includes the impact of S.B. 11-008, which increased Medicaid eligibility for pregnant women between 133 percent and 185 percent of the federal poverty guidelines and for children ages 6-18 between 100 percent and 133 percent of the federal poverty guidelines. Senate Bill 11-008 is projected to move women and children from CHP+ to Medicaid, reducing expenditures for CHP+. The Department is also forecasting an increase of approximately 1.0 percent in overall per capita costs. *Statutory authority: Sections 25.5-8 et al, C.R.S. (2010).*						

<table>
<tr><th>Decision Item</th><th>GF</th><th>CF</th><th>RF</th><th>FF</th><th>Total</th><th>FTE</th></tr>
<tr><td>4</td><td>5,518,142</td><td>0</td><td>0</td><td>0</td><td>5,518,142</td><td>0.0</td></tr>
<tr><td colspan="7">Medicare Modernization Act State Contribution Payment (Base Caseload & Cost Forecast)

Other Medical Programs. The Department requests an increase of $5.5 million General Fund for the caseload and cost increases forecasted for the Medicare Modernization Act State Contribution payment. This payment is required by the federal government in lieu of what the state would have had to pay for prescription drugs for people dually eligible for both Medicaid and Medicare had the federal government not assumed responsibility for prescription drugs. The request reflects the Department's estimate of Colorado's obligation under the federal formula. Statutory authority: Section 25-5-4-105 and Section 25.5-5-503, C.R.S. (2009) and 42 CFR 423.910 (g).</td></tr>
<tr><td>5</td><td>(865,469)</td><td>(57,047)</td><td>0</td><td>(922,514)</td><td>(1,845,030)</td><td>1.8</td></tr>
<tr><td colspan="7">Medicaid Fee-for-service Reform

Executive Director's Office; Medical Services Premiums. The Department proposes implementing several "gainsharing" incentive payments where providers receive a percentage of the savings that result when greater care management avoids potentially preventable episodes. Gainsharing payments would only be made when savings are achieved against benchmarks. In addition, the Department requests funding to redesign long-term care planning, to study the feasability of palliative care as a Medicaid benefit, and to study consolidating long-term care services for clients living in naturally occurring retirement communities. Statutory authority: Section 25.5-4-401 (1) (a), C.R.S.</td></tr>
<tr><td>6</td><td>(30,471,105)</td><td>15,496,446</td><td>0</td><td>(14,724,663)</td><td>(29,699,322)</td><td>0.0</td></tr>
<tr><td colspan="7">Medicaid Budget Reductions

Executive Director's Office; Medical Services Premiums. The Department proposes several rate adjustments, service restrictions, and financial efficiencies to contain health care costs. Statutory authority: Section 25.5-4-401 (1) (a), C.R.S.</td></tr>
<tr><td>7</td><td>(1,438,020)</td><td>91,841</td><td>0</td><td>(2,061,015)</td><td>(3,407,194)</td><td>0.0</td></tr>
<tr><td colspan="7">Cost Sharing for Medicaid and CHP+

Executive Director's Office; Medical Services Premiums; Indigent Care Program. The Department proposes increasing co-payments for Medicaid. Under this initiative the three largest co-pays would be $12 per day for inpatient hospital services, $7.30 for non-emergency use of the emergency room, and $3.80 for outpatient hospital services and brand name drugs. The largest increase from current co-pay rates would be the new $7.30 co-pay for non-emergency use of the emergency room.

Also, the Department proposes increasing the annual premium for the Children's Basic Health Plan (CHP+) for people earning more than 205 percent of the federal poverty guidelines from $25 to $75 for one child and from $35 to $105 for two or more children, and increasing co-payments for families on CHP+. The Department estimates the average annual co-payments per child would increase between $2 and $110 depending on income (since co-payments are assessed on a sliding scale).

Statutory authority: Sections 25.5-4-209 (1) (b) and 25.5-8-107 (1) (b) and (c), C.R.S..</td></tr>
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Decision Item	GF	CF	RF	FF	Total	FTE
8	82,835	0	0	153,836	236,671	0.0

Federally Mandated CHIPRA Quality Measures

Indigent Care Program. The Department requests funding to expand an existing contract for External Quality Review to survey five managed care organizations and the state's Managed Care Network more frequently, as required by federal legislation for the Children's Health Insurance Program. The requested funding would pay for administration, analysis, and reporting of the survey. *Statutory authority: Section 25.5-8-105 and 111 (1) (a) (I), C.R.S.*

Decision Item	GF	CF	RF	FF	Total	FTE
9	0	0	0	0	0	0.0

CHP+ Eligibility for Children of State Employees

Indigent Care Program. The Department proposes expanding eligibility for the Children's Basic Health Plan (CHP+) to include state employees. As part of the request, the Department proposes changing a statutory 3-month waiting period before people can enroll in CHP+ after giving up employer-sponsored health insurance. Exempting state employees from this state statutory waiting period would remove a disincentive for state employees to enroll in CHP+. The proposal would decrease expenditures for state health plans and increase expenditures for CHP+. The Department describes the net fiscal impact as a savings, but did not estimate the amount. CHP+ expenditures receive a 60 percent federal match, and per capita costs for CHP+ are estimated to be lower than the annualized premium contributions paid by the State for employees' dependents. For the employee, the cost sharing in CHP+ is less than the current state health plans. *Statutory change required: Section 25.5-8-109 (1), C.R.S.*

Decision Item	GF	CF	RF	FF	Total	FTE
10	(1,006,752)	0	0	0	(1,006,752)	0.0

Utilize Supplemental Payments for General Fund

Medical Services Premiums; Indigent Care Program. The Department proposes withholding 10.0 percent of the federal funds from the Physician Supplemental Payment and the Inpatient High Volume Supplemental Payment to reduce the need for General Fund in the Medical Services Premiums line item. These two supplemental payments were recently created to partially reimburse public providers for uncompensated, or under-compensated, costs for Medicaid clients. The Department matches the federal funds for the Physician Supplemental Payment and the Inpatient High Volume Supplemental Payment using certified public expenditures by public providers. *Statutory authority: cites***.**

Decision Item	GF	CF	RF	FF	Total	FTE
11	(15,036,785)	0	0	15,036,785	0	0.0

CHIPRA Bonus Payment True-up

Indigent Care Program. The Department's request reflects an updated projection of federal bonus payments to Colorado for meeting outreach and retention performance goals of the Children's Health Insurance Program. The Department proposes using these bonus payments to offset the need for General Fund in the Medicare Modernization Act State Contribution Payment line item. *Statutory authority: 42 U.S.C. 1397ee(a)(3)***.**

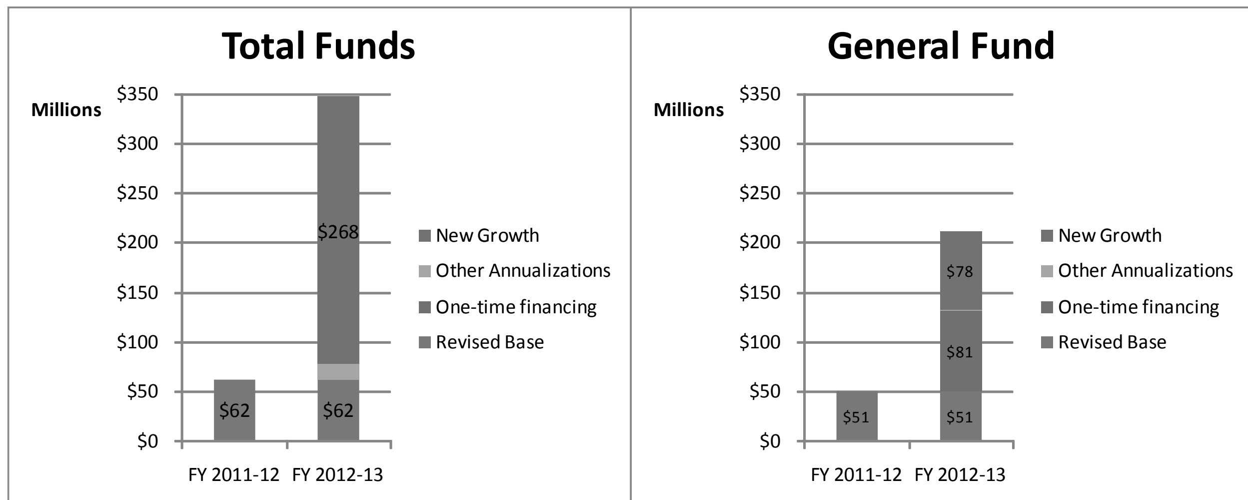
Decision Item	GF	CF	RF	FF	Total	FTE
12	0	28,596	0	(81,365)	(52,769)	0.0

Hospital Provider Fee Administrative True-up

Executive Director's Office. The Department requests fund source and total appropriation adjustments to more accurately reflect actual administrative costs associated with the Hospital Provider Fee. The request also impacts appropriations in the Department of Human Services and the Governor's Office of Information Technology. *Statutory authority: 25.5-4-402.3, C.R.S***.**

Decision Item	GF	CF	RF	FF	Total	FTE
13	230,708	462	1,392	231,564	464,126	0.0
CBMS Electronic Document Management System **Department of Human Services Medicaid-funded Programs.** The Department of Health Care Policy and Financing, Department of Human Services, and the Governor's Office of Information Technology request $1,257,600 total funds (including $533,792 General Fund) in FY 2012-13 to develop an Electronic Document Management System to be integrated into the web-based Colorado Program Eligibility and Application Kit (PEAK) component of the Colorado Benefits Management System (CBMS). The Electronic Document Management System would be used to scan and store documents in the CBMS database and index each file for retrieval. *Statutory authority: Sections 25.5-4-106 (3) and 25.5-4-204 (1), C.R.S.*						
NP - 1	2,438,770	0	0	2,438,770	4,877,540	0.0
DHS - New Funding - Developmental Disability Services						
NP - 2	7,574	0	0	7,575	15,149	0.0
DHS - Statewide Vehicle Replacement						
Total	**110,151,694**	**47,848,224**	**291,830**	**180,794,920**	**339,086,668**	**1.8**

The charts below break down the Department's base caseload and cost forecast for Medical Services Premiums, or R-1, into component parts.



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OVERVIEW OF NUMBERS PAGES

The following table summarizes the total change, in dollars and as a percentage, between the Department's FY 2011-12 appropriation and its FY 2012-13 request.

Total Requested Change, FY 2011-12 to FY 2012-13 (millions of dollars)

Category	GF	CF	RF	FF	Total	FTE
FY 2011-12 Appropriation	$1,669.2	$877.6	$10.4	$2,541.1	$5,098.3	313.0
FY 2012-13 Request	1,854.7	865.1	7.4	2,717.2	5,444.4	315.3
Increase / (Decrease)	$185.5	($12.5)	($3.0)	$176.1	$346.1	2.3
Percentage Change	11.1%	-1.4%	-28.8%	6.9%	6.8%	0.7%

The following table highlights the individual changes contained in the Department's FY 2012-13 budget request, as compared with the FY 2011-12 appropriation, for the portion of the Department covered in this briefing packet.

Requested Changes, FY 2011-12 to FY 2012-13

Category	GF	CF	RF	FF	TOTAL	FTE
Executive Director's Office						
R#7 Cost Sharing for Medicaid and CHP+	145,991	0	0	407,973	553,964	0.0
Common Policy Adjustments	144,198	(91,440)	71,450	(113,956)	10,252	0.0
R#6 Medicaid Budget Reductions	125,000	0	0	375,000	500,000	0.0
Statewide Indirect Cost Allocation	88,624	27,698	(67,879)	(48,443)	0	0.0
Annualize prior year budget decisions (includes 0.5 FTE for SB 10-61 Medicaid Hospice Room and Board Charges)	78,672	1,438,118	0	1,008,651	2,525,441	0.5
R#5 Medicaid Fee-for-Service Reform	45,357	0	0	45,357	90,714	1.8
R#12 Hospital Provider Fee Administrative True-up	0	21,576	0	(88,385)	(66,809)	0.0
Align Fund Splits for Federal Allocation	(3,567)	0	0	194,085	190,518	0.0
Subtotal - Executive Director	**624,275**	**1,395,952**	**3,571**	**1,780,282**	**3,804,080**	**2.3**

Category	GF	CF	RF	FF	TOTAL	FTE
Medical Services Premiums						
Annualize one-time financing	***81,208,585***	***(73,489,319)***	***(3,286,351)***	***4,432,915***	***8,865,830***	***0.0***
SB 11-211, Tobacco Revenues Offset Medical Services	33,000,000	(29,713,649)	(3,286,351)	0	0	0.0
SB 11-212, Use Provider Fee Offset GF Medicaid	25,000,000	(25,000,000)	0	0	0	0.0
SB 11-219, 2011 Transfers For Health Care Services	15,775,670	(15,775,670)	0	0	0	0.0
SB 11-215, 2011 Nursing Facility Rate Reduction	4,432,915	0	0	4,432,915	8,865,830	0.0
HB 10-1380 Use Supplemental Old Age Pension Health Fund for Medicaid	3,000,000	(3,000,000)	0	0	0	0.0
Eligibility Changes	***5,475,851***	***0***	***0***	***10,169,437***	***15,645,288***	***0.0***
SB 11-008 Ages 6-19 from 100% to 133%	2,904,591	0	0	5,394,241	8,298,832	0.0
SB 11-250, Pregnant Women from 133% to 185%	2,571,260	0	0	4,775,196	7,346,456	0.0
Other Annualizations	***(4,203,164)***	***(298,239)***	***0***	***(4,077,535)***	***(8,578,938)***	***0.0***
Annualize policies from FY12 Long Bill	(4,201,139)	(586,313)	0	(4,800,559)	(9,588,011)	0.0
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program	(2,025)	54,622	0	489,571	542,168	0.0
SB 11-125, Nursing Home Fees & Order of Payments	0	233,452	0	233,453	466,905	0.0
R#1 Request for Medical Services Premiums	129,303,556	36,238,486	303,982	164,960,231	330,806,255	0.0
R#6 Medicaid Budget Reductions	(30,596,105)	15,496,446	0	(15,099,663)	(30,199,322)	0.0
R#7 Cost Sharing for Medicaid and CHP+	(1,060,682)	(25,214)	0	(1,085,897)	(2,171,793)	0.0
R#10 Utilize Supplemental Payments for General Fund Relief	(1,006,752)	7,948,120	0	7,948,120	14,889,488	0.0
R#5 Medicaid Fee-for-Service Reform	(910,826)	(57,047)	0	(967,871)	(1,935,744)	0.0
Subtotal - Medical Services	**178,210,463**	**(14,186,767)**	**(2,982,369)**	**166,279,737**	**327,321,064**	**0.0**
Medicaid Mental Health Community Programs						
SB 11-008, Aligning Children's Medicaid Eligibility, FY13	353,423	0	0	656,358	1,009,781	0.0
SB 11-250, Pregnant Women Medicaid Eligibility, FY13	63,047	0	0	117,086	180,133	0.0
R#2 Medicaid Mental Health Community Programs	21,388,240	(3,087,673)	(13,544)	18,327,285	36,614,308	0.0
Subtotal - Mental Health	**21,804,710**	**(3,087,673)**	**(13,544)**	**19,100,729**	**37,804,222**	**0.0**

Category	GF	CF	RF	FF	TOTAL	FTE
Indigent Care Program						
Final FY 2011-12 Appropriation	39,230,251	215,780,182	0	316,806,860	571,817,293	0.0
Annualize one-time financing						
SB 11-219, 2011 Transfers For Health Care Services	0	14,362,170	0	(11,755,000)	2,607,170	0.0
Eligibility Changes	*(3,285,485)*	*(4,173,815)*	*0*	*(13,852,986)*	*(21,312,286)*	*0.0*
HB 09-1293, Health Care Affordability Act of 2009	0	669	0	1,243	1,912	0.0
SB 11-008, Aligning Children's Medicaid Eligibility	0	(4,174,834)	0	(7,753,263)	(11,928,097)	0.0
SB 11-250, Pregnant Women Medicaid Eligibility	(3,285,485)	350	0	(6,100,966)	(9,386,101)	0.0
R#8 Federally Mandated CHIPRA Quality Measures	82,835	0	0	153,836	236,671	0.0
Annualize policies from FY12 Long Bill	(1,200,204)	(200,873)	0	(2,602,000)	(4,003,077)	0.0
R#7 Cost Sharing for Medicaid and CHP+	(523,329)	117,055	0	(1,383,091)	(1,789,365)	0.0
R#3 Children's Basic Health Plan Medical and Dental Costs	0	(862,887)	0	(2,571,569)	(3,434,456)	0.0
R#10 Utilize Supplemental Payments for General Fund Relief	0	(7,948,120)	0	(7,948,120)	(15,896,240)	0.0
R#9 CHP+ Eligibility for Children of State Employees	0	0	0	0	0	0.0
Subtotal - Indigent Care	**34,304,068**	**217,073,712**	**0**	**276,847,930**	**528,225,710**	**0.0**
Other Medical Services						
Final FY 2011-12 Appropriation	68,074,667	27,010,155	0	42,512,896	137,597,718	0.0
R#4 Medicare Modernization Act State Contribution Payment	5,518,142	0	0	0	5,518,142	0.0
R#11 CHIPRA Bonus Payment True-up	(15,036,785)	0	0	15,036,785	0	0.0
Annualize initiatives authorized in FY12 Long Bill	(6,018,686)	2,103,154	0	8,468,623	4,553,091	0.0
Subtotal - Other Medical	**52,537,338**	**29,113,309**	**0**	**66,018,304**	**147,668,951**	**0.0**
Department of Human Services Medicaid-Funded Programs						
NP-R#1 DHS - New Funding – Developmental Disabilities Services	2,438,770	0	0	2,438,770	4,877,540	0.0
Annualize policies from FY12 Long Bill	1,239,469	14	16	1,239,492	2,478,991	0.0
FY13 Common Policy Adjustments	889,571	0	0	886,518	1,776,089	0.0
Annualize prior year bills	579,577	78	474	580,054	1,160,183	0.0
R#13 CBMS Electronic Document Management System	230,708	462	1,392	231,564	464,126	0.0
NP-R#2 DHS - Statewide Vehicle Replacement	7,574	0	0	7,575	15,149	0.0

Category	GF	CF	RF	FF	TOTAL	FTE
R#12 Hospital Provider Fee Administrative True-up	0	7,020	0	7,020	14,040	0.0
NP-R#3 DHS - Division of Youth Corrections Caseload-related Community Programs Reductions	0	0	0	0	0	0.0
Subtotal - Human Services	**5,385,669**	**7,574**	**1,882**	**5,390,993**	**10,786,118**	**0.0**

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Department of Health Care Policy and Financing

BRIEFING ISSUE

ISSUE: Performance-based Goals and the Department's FY 2012-13 Budget Request

This issue brief summarizes the Department of Health Care Policy and Financing report on its performance relative to its strategic plan and discusses how the FY 2012-13 budget request advances the Department's performance-based goals. Pursuant to the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act (H.B. 10-1119), the full strategic plan for the Department of Health Care Policy and Financing should be accessible from the Office of State Planning and Budgeting web site.

The issue brief assumes that the performance-based goals are appropriate for the Department. Pursuant to the SMART Government Act legislative committees of reference are responsible for reviewing the strategic plans and recommending changes to the departments. The issue brief also assumes that the performance measures are reasonable for the performance-based goals. Pursuant to the SMART Government Act the State Auditor periodically assesses the integrity, accuracy, and validity of the reported performance measures. Please note that the Department's full strategic plan includes five overarching highest priority objectives and performance measures and additional division-specific objectives and performance measures. This issue brief only deals with the five overarching objectives.

DISCUSSION:

Performance-based Goals and Measures

The Department's five top priority objectives are:

1. Increase the number of insured Coloradans

Increase Insured Coloradans					
	Percent of Eligible Population Enrolled			Timely Processing of	
Year	Children in Medicaid	Children in CHP+	Parents in Medicaid	New Applications	Re-determinations
2008	78.1%	52.3%			
2009	86.7%	62.8%	76.0%		
2010	87.0%	64.0%	76.0%		
FY 2012-13 Request	89.0%	67.0%	79.0%	95.0%	95.0%
FY 2013-14	91.0%	70.0%	81.0%	95.0%	95.0%
FY 2014-15	93.0%	73.0%	83.0%	95.0%	95.0%
FY 2015-16	95.0%	75.0%	85.0%	95.0%	95.0%

a. How is the Department measuring the specific goal/objective?
The percentage of eligible people enrolled is estimated by the Colorado Health Institute using data from the US Census Bureau's American Community Survey. Data for children prior to 2008 and adults prior to 2009 is not available. The Department recently revised the performance measures for this goal and did not provide historical information about the timeliness of Medicaid and Children's Basic Health Plan (CHP+) application processing.

b. Is the Department meeting its objective, and if not, why?
Because the Department recently revised the performance measures for this goal, there are no targeted benchmarks for comparison with actual performance in prior years. The limited available trend data shows improvement.

c. How does the budget request advance the performance-based goal?
The Department's R-7 to increase cost-sharing in Medicaid and CHP+ may create disincentives to enrollment, although the Department argues that any disincentives to enrollment would be significantly less than the increases in CHP+ premiums contemplated in S.B. 11-213 that the Governor vetoed. In this light, the Department views R-7 as promoting the percentage of eligible people enrolled compared to what the legislature had proposed in S.B. 11-213.

2. Improve Health Outcomes

Improve Health Outcomes

	Fiscal Year 2010-11	Fiscal Year 2011-12	Request 2012-13	Fiscal Year 2013-14	Fiscal Year 2014-15	Fiscal Year 2015-16
Reduce Medicaid children with cavities	57.2%	55.0%	55.0%	55.0%	55.0%	55.0%
Increase children receiving a dental service						
Medicaid	49.0%	51.0%	53.0%	53.0%	53.0%	53.0%
CHP+	44.0%	46.0%	48.0%	48.0%	48.0%	48.0%
Increase annual adolescent depression screenings		1,500	3,000	3,000	3,000	3,000
Provider payments linked to value-based outcomes			1.25%	2.0%	3.25%	5.0%
Reduce exposure to smoke						
Mothers smoking in third trimester			19.0%	15.0%	15.0%	15.0%
Children's homes with no smoking			baseline	baseline +5%	maintain	maintain
Adults who smoke every day			29.0%	23.0%	23.0%	23.0%
Decrease people who are overweight or obese						
Medicaid/CHP+ children					30.0%	25.0%
Medicaid adults					56.0%	51.0%

In addition to the quantifiable measures above the Department will measure performance based on achieving the following deliverables:

- Initiate development of a data strategy for long term integration of clinical and claims data (FY 2012-13)
- Develop baseline data for measuring the percent of adult Medicaid clients who report being in excellent or very good health (FY 2012-13)
- Develop a plan to integrate mental and physical health systems (FY 2012-13)

- Establish statewide Health Information Technology infrastructure for meaningful use under ARRA-HITECH (FY 2013-14)

a. How is the Department measuring the specific goal/objective?
The Department is in the process of developing the methodology to measure the percentage of Medicaid children with cavities. The measures related to smoke exposure will be based on surveys. The remaining data will be gathered from Department data systems with information about health conditions and claims.

b. Is the Department meeting its objective, and if not, why?
The Department recently revised the performance measures for this goal and did not provide historical information. The Department does not yet have data on dental carries. Available data from prior years on the percentage of people receiving dental services is not comparable to 2009 data, due to changes in reporting requirements.

c. How does the budget request advance the performance-based goal?
Elements of the Department's R-6 and R-8 relate to improving health outcomes, but most directly R-5 would provide incentives to providers who achieve performance goals regarding the avoidance of more costly care.

3. Increase Access to Health Care

	Increase the percent of medicaid clients with a medical home or focal point of care		Increase provider participation in Medicaid
Year	**Children**	**Adults**	
FY 2008-09	41.0%		23,481
FY 2007-08	8.0%		17,526
FY 2008-09	41.0%		18,887
FY 2009-10	71.0%		20,422
FY 2010-11	78.0%	38.0%	27,336
FY 2011-12	80.0%	42.0%	28,703
FY 2012-13 Request	86.0%	52.0%	TBD
FY 2013-14	92.0%	70.0%	TBD
FY 2014-15	97.0%	75.0%	TBD
FY 2015-16	100.0%	80.0%	TBD

a. How is the Department measuring the specific goal/objective?
The Department views a medical home or focal point of care as critical to positive health outcomes, and so affiliation with a medical home or focal point of care is an indicator of access to the primary care services and care management that prevent negative and costly health experiences. The Department also tracks the number of health providers participating in Medicaid, but is revising targets for the request years and beyond. The Department anticipates a need for increased provider participation with expansions in eligibility through the Hospital Provider Fee and the federal Affordable Care Act (ACA) and wants to make sure that target provider participation levels are appropriate for the need.

b. Is the Department meeting its objective, and if not, why?
Because the Department recently revised the performance measures for this goal, there are no targeted benchmarks for comparison with actual performance in prior years. The available trend data for the percentage of Medicaid clients with a medical home shows improvement. However, the data regarding the number of participating providers shows a dip in FY 2007-08 and FY 2008-09.

c. How does the budget request advance the performance-based goal?
The Department's R-5 proposes incentive payments for providers of a medical home who meet performance objectives, which may entice more providers to act as a medical home for Medicaid and CHP+ clients. The Department's R-1, R-2, and R-3 reflect eligibility expansions approved by the General Assembly in prior years for adults without dependent children up to 100 percent of the federal poverty guidelines and people with developmental disabilities who are eligible to buy into Medicaid up to 450 percent of the federal poverty guidelines. The Department has elected to limit the expansion to adults without dependent children to people with income below 10 percent of the federal poverty guidelines and the first 10,000 people who enroll. These expansions are financed from the Hospital Provider Fee. The Department also proposes a new expansion of eligibility for CHP+ to state employees in R-9.

4. Contain Health Care Costs

Reduce expenditures for nursing facilities by 0.7% from F 2011-12					
	FY 2006-07	**FY 2007-08**	**FY 2008-09**	**FY 2009-10 (DA)**	**FY 2010-11 (DA)**
Class I Nursing Facilities	$478,303,487	$486,568,498	$530,918,672	$495,900,792	$499,315,391
Class II Nursing Facilities	$2,270,136	$2,235,636	$2,271,714	$1,215,347	$3,163,194

Reduce or stabilize utilization of the top 10 cost drivers compared to "pre-health care reform" baseline of FY 2008-09						
Service Category	Description	FY 2010-11	FY 2009-10	FY 2008-09	FY 2007-08	FY 2006-07
Inpatient Hospital	Vaginal Delivery without Complicating Diagnoses	$38,746,319	$40,294,300	$42,506,722	$41,494,220	$40,806,509
Physician Service	Health Supervision of Infant or Child	$17,652,799	$16,393,716	$13,826,117	$10,146,172	$9,592,140
Inpatient Hospital	Cesarean Section without Complicating Diagnoses	$16,395,465	$16,850,351	$16,835,691	$17,580,230	$18,266,665
Inpatient Hospital	Cesarean Section with Complicating Diagnoses	$15,330,075	$16,114,114	$17,360,219	$15,185,794	$15,915,324
Federally Qualified Health Centers	Health Supervision of Infant or Child	$15,063,603	$14,670,670	$13,687,670	$12,006,874	$11,545,673
Outpatient Hospital	Other Symptoms Involving Abdomen and Pelvis	$12,762,879	$10,108,720	$8,401,874	$6,440,547	$5,710,306
Inpatient Hospital	Tracheostomy with Mechanical Ventilator with Major Operating Room Procedure	$12,289,924	$13,703,916	$15,634,685	$9,905,316	$11,022,478
Durable Medical Equipment (DME)	Oxygen Concentrator	$12,278,653	$10,607,990	$9,356,286	$8,498,293	$7,783,393
Federally Qualified Health Centers	Special Investigations and Examinations	$12,226,416	$9,950,205	$9,103,977	$7,350,927	$7,118,854
Inpatient Hospital	Vaginal Delivery with Complicating Diagnoses	$10,996,083	$11,092,672	$11,783,062	$10,500,711	$10,988,487

Top Ten Cost Drivers (FY 2010-11): Historical Unduplicated Client Count						
Service Category	Description	FY 2010-11	FY 2009-10	FY 2008-09	FY 2007-08	FY 2006-07
Inpatient Hospital	Vaginal Delivery without Complicating Diagnoses	14,177	14,517	14,476	13,996	14,159
Physician Service	Health Supervision of Infant or Child	105,734	99,546	86,893	75,408	69,838
Inpatient Hospital	Cesarean Section without Complicating Diagnoses	3,116	3,131	2,985	3,045	3,180
Inpatient Hospital	Cesarean Section with Complicating Diagnoses	2,175	2,280	2,319	2,006	2,104
Federally Qualified Health Centers	Health Supervision of Infant or Child	58,789	56,060	50,770	46,216	44,331
Outpatient Hospital	Other Symptoms Involving Abdomen and Pelvis	18,331	14,905	12,690	10,194	9,798
Inpatient Hospital	Tracheostomy with Mechanical Ventilator with Major Operating Room Procedure	130	141	140	97	111
Durable Medical Equipment (DME)	Oxygen Concentrator	12,454	11,503	9,791	9,389	8,663
Federally Qualified Health Centers	Special Investigations and Examinations	39,480	31,628	29,617	25,118	25,028
Inpatient Hospital	Vaginal Delivery with Complicating Diagnoses	3,061	2,902	2,900	2,717	2,878

In addition to the quantifiable measure above the Department will assess performance based on achieving the following deliverables:

- Complete Phase 1 of the Accountable Care Collaborative
- Implement payment reform via the Benefits Collaborative, National Correct Coding Initiative, and Behavioral Health Organization rate reform
- Reduce the number of hospital readmissions within 30 days by 4% from FY 2010-11
- initiative development of a data strategy for lon-term containment of health care costs
- Reduce Medical Services Premiums expenditures for clients enrolled in the Accountable Care Collaborative by 7% compared to clients not enrolled in the ACC
- Audit Community Mental Health Centers
- Implement the federal integrated care for dual eligibles contract
- Implement integration findings through ACC and Behavioral Health Organization contracts
- Develop a value-based reimbursement methodology for primary care providers/replace current "pay for volume" system
- Replace cost-based rate methodologies with acuity adjusted value-based payments
- Pay providers a prospective bundled payment based on the client-specific episode of care
- Reimburse Long Term Care services based on improved/modified assessment tool

a. How is the Department measuring the specific goal/objective?
The Department provided the table above for background on the Department's progress on this performance goal, but it is not clear to staff how the Department will calculate the units of events per 1,000 from the table, or what this measure means. For example, does the Department plan to reduce vaginal deliveries without complicating diagnosis? An uncomplicated delivery would appear to be a good thing, although perhaps the Department is proposing to avoid the delivery all together through policies to reduce the number of births, or maybe the Department is proposing to reduce expenditures per delivery. The proposed performance measure is not clear.

With regard to hospital readmissions within 30 days, the Department explains that it began tracking the data in FY 2009-10 and does not have information prior to that fiscal year. The Department did not provide the FY 2009-10 baseline data for hospital readmissions within 30 days.

b. Is the Department meeting its objective, and if not, why?
Because the Department recently revised the performance measures for this goal, there are no targeted benchmarks for comparison with actual performance in prior years. The available trend data for nursing facility expenses shows increases. The Department did not explain how it will calculate utilization of the top 10 cost drivers. Both caseload and expenditure trends reported by the Department for the top 10 cost drivers are mixed, but for the majority of programs caseload and expenditures are up. The major exceptions are expenditures for inpatient Tracheostomy with Mechanical Ventilator with Major Operating Room Procedure and expenditures for all types of births.

c. How does the budget request advance the performance-based goal?
The Department's R-5 and R-6 contain the primary initiatives proposed by the Department to contain health care costs. To a lesser extent R-7 and R-9 also impact health care costs.

5. Improve the Long-term Care Service Delivery System

Improve the Long-term Care Service Delivery System				
	Request 2012-13	Fiscal Year 2013-14	Fiscal Year 2014-15	Fiscal Year 2015-16
Enroll dual-eligible population in the Accountable Care Collaborative	60.0%	70.0%	70.0%	70.0%
Transition additional people each year from facilities to community-based care	100	100	100	100
Increase the percent of Colorado nursing homes in the top quartile of the Centers for Medicare and Medicaid Services' National Report Card by . . .			9.0%	4.0%
Improve the average performance of Home and Community Based Services providers and case management organizations from the prior year by . . .			10.0%	10.0%
Reduce the number of people on waiver waitlists by . . .				10.0%

In addition to the quantifiable measure above the Department will assess performance based on achieving the following deliverables:

- Develop a 5-year strategy to increase the number of dually eligible long-term care clients who have a health home (FY 2011-12)
- Develop a 5-year strategy to improve long-term care population outcomes (FY 2011-12)
- Develop a roadmap for waiver consolidation (FY 2011-12)
- Implement the roadmap for waiver consolidation (FY 2012-13)
- Reduce the total number of waivers to 6 or less (FY 2015-16)

a. How is the Department measuring the specific goal/objective?

The majority of the quantifiable measures for this goal are expressed as changes from a baseline, but the Department did not provide the baseline data to describe the overall goal or explain the calculations that will be used to determine success. For example, what does it mean to "improve the average performance of Home and Community Based Services providers and case management organizations from the prior year by 10 percent?" The proposed performance measure is not clear.

b. Is the Department meeting its objective, and if not, why?

The Department recently revised the performance measures for this goal and did not provide historical trend data.

c. How does the budget request advance the performance-based goal?

The Department's R-5 includes requested contract funding to make data system changes necessary to incorporate performance incentives into funding for long-term care providers.

Other Staff Observations About Budget Request and Performance-based Goals

Part of the objective for this common issue brief for all departments was to provide the Committee with information about what the departments are doing well and doing poorly, in order to inform decisions about where resources should be allocated, but the Department of Health Care Policy and Financing restated all of its performance goals and measures. It is reasonable to expect that a new administration would set new priorities, but the submitted strategic plan does not provide the trend information the Committee indicated that it wanted from the SMART bill process. The JBC may want to ask the Department for additional information at the hearing:

N Please identify recent major successes and failures with regard to the Department's strategic goals and objectives. Do resources need to be reallocated to address any problem areas where the Department is failing to perform?

Also, staff has concerns that several of the Department's performance measures are difficult to understand for people with a baseline of knowledge about health care policy, let alone the general public. The SMART bill requires the Office of State Planning and Budgeting to publish a "clearly written and easily understood" annual performance report summarizing each department's strategic plan in four pages or less. The requirement will be difficult to satisfy based on the strategic plan the Department submitted with the budget request.

BRIEFING ISSUE

ISSUE: Contributions of enrollment and per capita changes

SUMMARY:

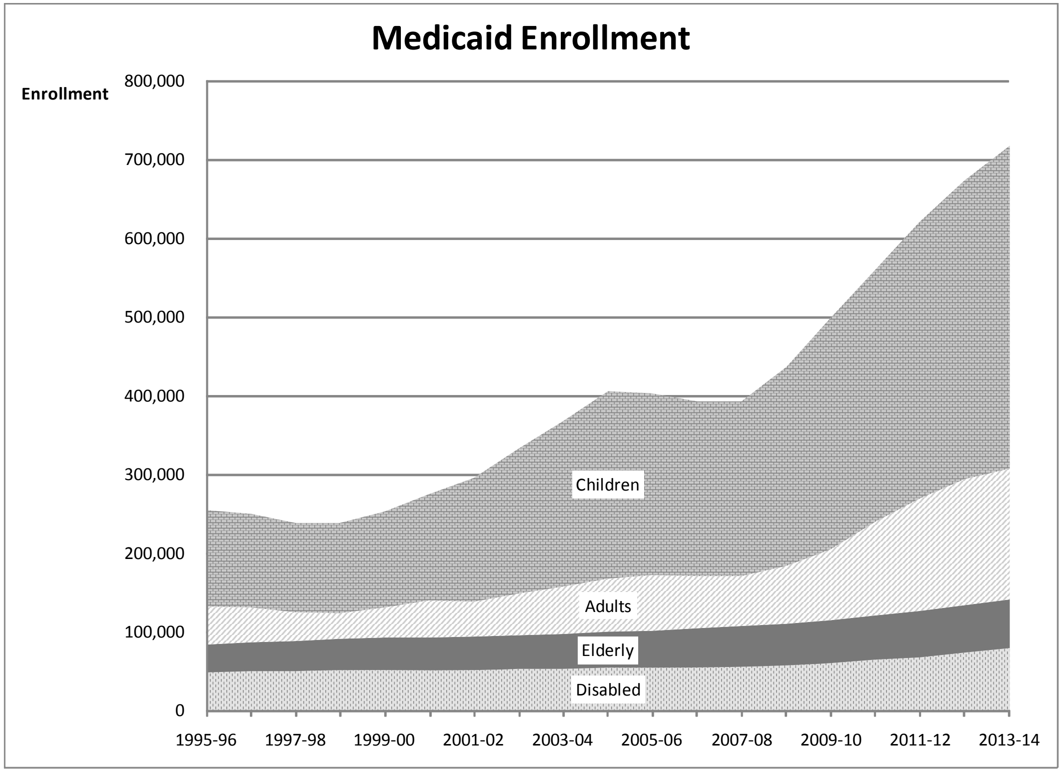
- ❑ The Department projects an increase in the overall per capita expenditures of just 0.9 percent in FY 2012-13 from $4,788.51 to $4,832.26.
- ❑ The relatively small change in the overall per capita expenditures is in large part the result of a projected increase in the number of low-cost clients (children and adults) relative to the number of high-cost clients (elderly and disabled).
- ❑ There is wide variation in per capita costs and trends for different subsets of the Medicaid population.
- ❑ Summing the impact of changes in per capita expenditures for each population subset suggests that per capita changes are a much more important contributor to increases in total Medicaid expenditures than suggested by just looking at the change in the overall per capita figure that is skewed by increasing enrollment among low-cost populations.

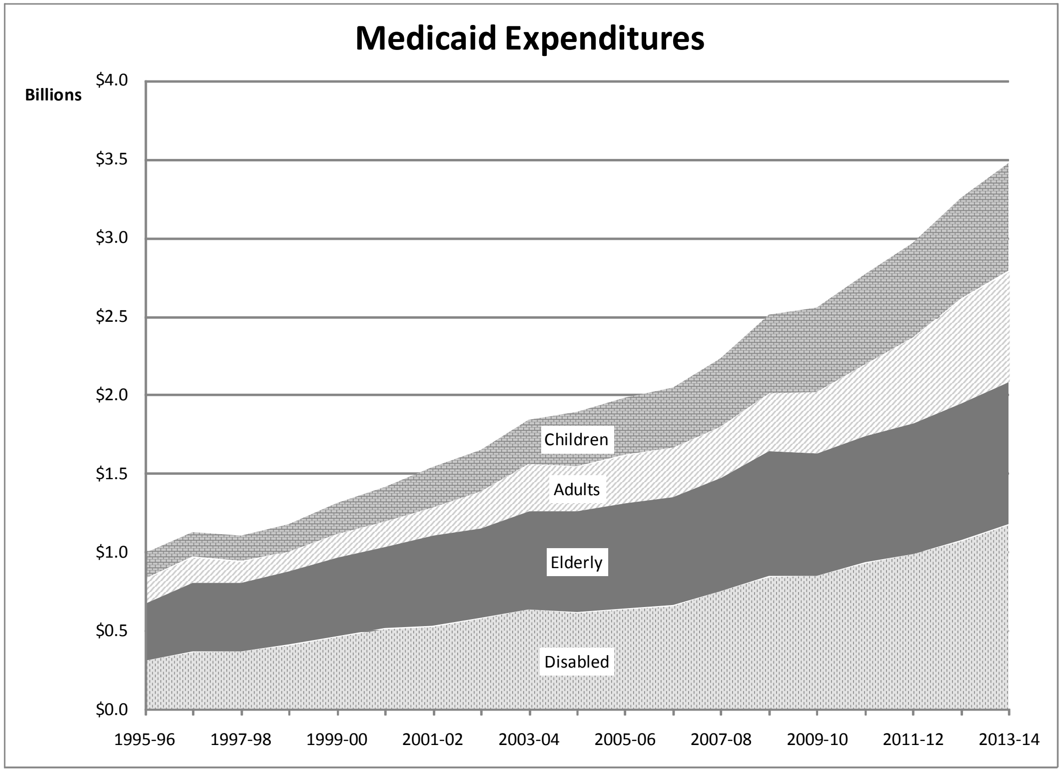
DISCUSSION:

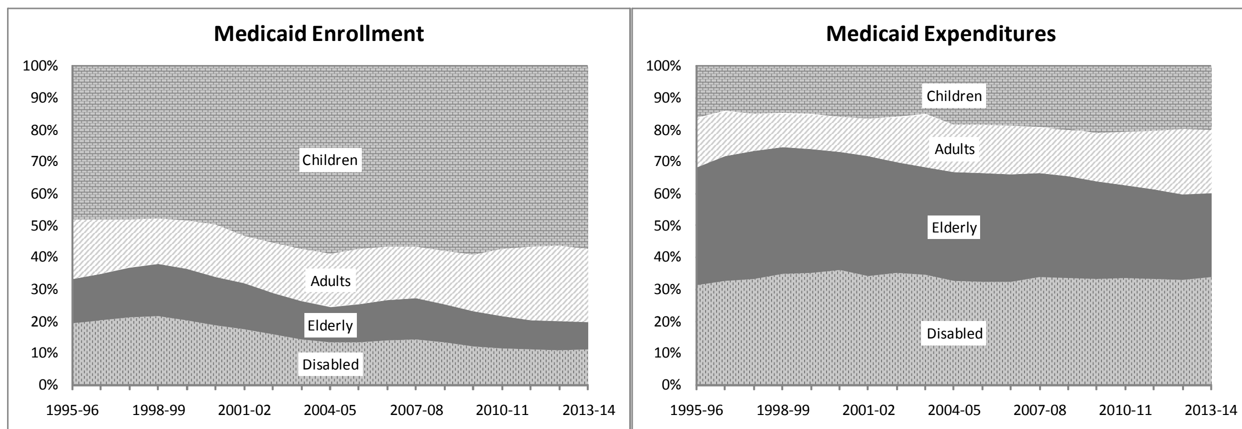
The Department projects an increase in the overall per capita expenditures of just 0.9 percent in FY 2012-13 from $4,788.51 to $4,832.26, not including supplemental hospital and nursing facility payments or other funding mechanisms that are used to decrease the state obligation by increasing federal funding. Changes in the overall per capita expenditures for the last few years have trended down. However, staff advises against concluding from this that changes in per capita expenditures are a small part of the total projected increase in expenditures.

	FY 2006-07 Actual	FY 2007-08 Actual	FY 2008-09 Actual	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Estimate	FY 2012-13 Request
Medical Service Cost Per Capita	$5,222.57	$5,681.77	$5,742.83	$5,116.67	$4,938.80	$4,788.51	$4,832.26
Annual Percent Change	6.0%	8.8%	1.1%	(10.9)%	(3.5)%	(3.0)%	0.9%

The relatively small change in the overall per capita expenditures is in large part the result of a projected increase in the number of low-cost clients (children and adults) relative to the number of high-cost clients (elderly and disabled). The series of tables below show the disproportionate impact of elderly and disabled populations on overall expenditures.


Medicaid Enrollment
Enrollment
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
Children
Adults
Elderly
Disabled
1995-96
1997-98
1999-00
2001-02
2003-04
2005-06
2007-08
2009-10
2011-12
2013-14


Medicaid Expenditures
Billions
$4.0
$3.5
$3.0
$2.5
$2.0
$1.5
$1.0
$0.5
$0.0
Children
Adults
Elderly
Disabled
1995-96
1997-98
1999-00
2001-02
2003-04
2005-06
2007-08
2009-10
2011-12
2013-14



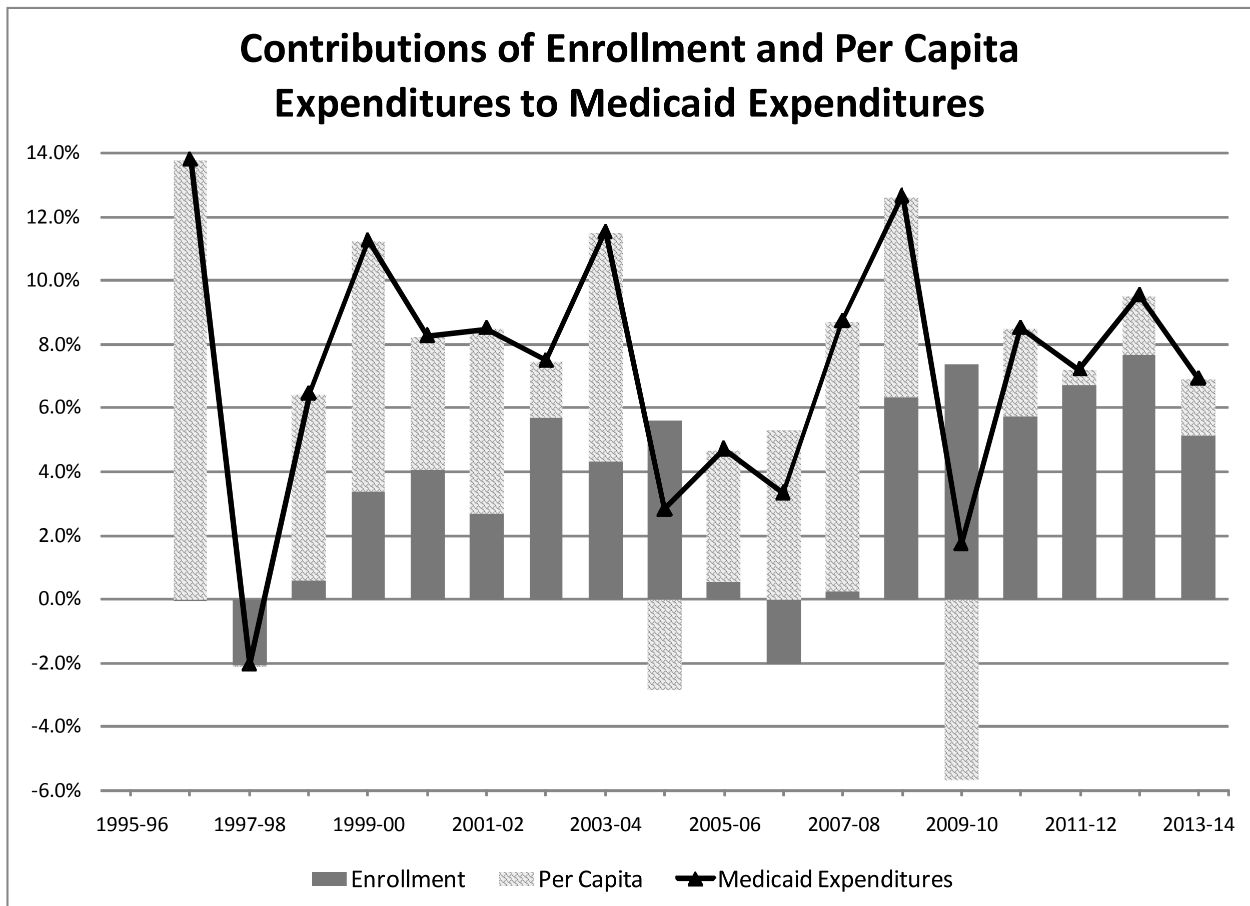
The table below illustrates the wide variation in per capita costs and trends for different subsets of the Medicaid population. The Department has selected these subsets to track and forecast separately because they share enrollment and expenditure characteristics, or a common fund source, or an event that changed eligibility.

Medicaid Cost Per Client - By Aid Category	FY 2011-12 Estimate	FY 2012-13 Request	Percent Change
Elderly 65+	$20,028	$20,267	1.2%
Breast and Cervical Cancer Treatment	18,488	17,600	-4.8%
Disabled 60-64	16,706	16,292	-2.5%
Disabled < 60	14,258	14,260	0.0%
Emergency Care for Non-Citizens	14,121	13,820	-2.1%
Disabled "buy-in"	0	9,219	
Adults without dependent children	0	8,833	
Pregnant	8,593	8,408	-2.2%
Foster Children	3,881	3,999	3.0%
Parents to Aid to Families with Dependent Children	3,597	3,308	-8.0%
Parents from 60% to 100%	2,285	2,811	23.0%
Parents from AFDC to 60%	2,802	2,798	-0.1%
Children	1,658	1,595	-3.8%
Partial Dual Eligible -- Medicare premium assistance	1,417	1,515	6.9%
Total Medicaid Caseload	**4,789**	**4,832**	**0.9%**

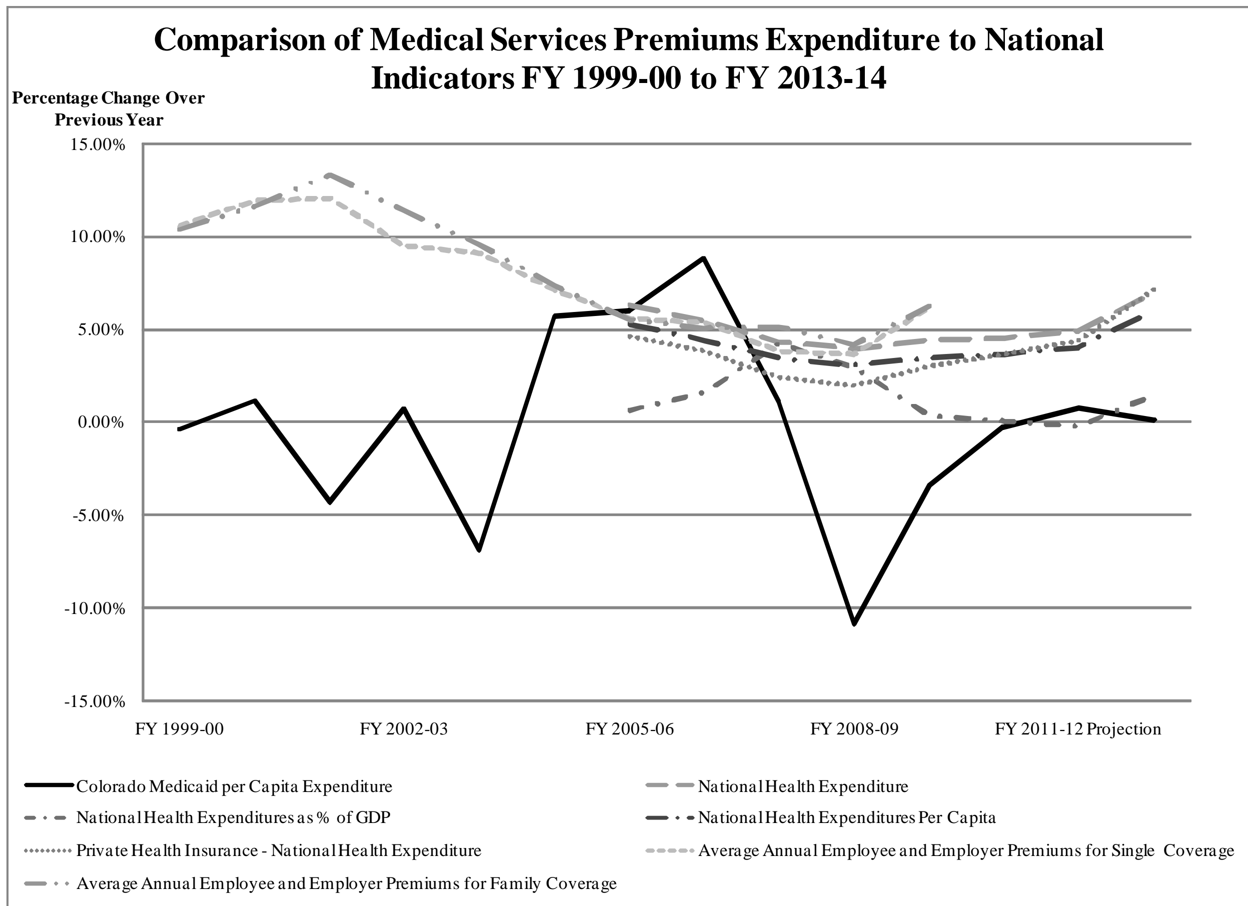
To provide a better estimate of the contribution of changes in per capita to the total cost of Medicaid, staff calculated the contribution for each subset of the population that the Department tracks and forecasts separately, and then summed the contributions.[3] Staff believes that this more accurately describes the impact on total expenditures of changes in per capita expenditures relative to changes in enrollment. However, this method also has flaws, because using different subsets of the Medicaid

[3] For each population subset the change in enrollment was multiplied by the prior year per capita expenditures to determine the contribution of enrollment, and then any remaining increase in expenditures for the subset was attributed to changes in the per capita rate for the subset.

population could provide different results. The outcome of the analysis suggest that changes in per capita expenditures are a much more important contributor to increases in total Medicaid expenditures than suggested by just looking at the change in the overall per capita figure that is skewed by increasing enrollment among low-cost populations. In fact, in several years where the overall per capita went down the sum of the impacts of per capita changes for each population subset was a positive value and a significant portion of the overall increase in expenditures.



This may help explain why the Department was unable to find a correlation between changes in Medicaid per capita expenditures and indicators of private health spending. The Medicaid "basket of goods" keeps changing due to changes in enrollment brought about by the economy and enrollment policies.



The Department also believes that some of the patterns, or lack thereof, in the chart titled "Contributions of Enrollment and Per Capita Expenditures to Medicaid Expenditures" and the chart titled "Comparison of Medical Services Premiums Expenditure to National Indicators FY 1999-00 to FY 2013-14" reflect decisions by the legislature and/or the Department over the years to increase or decrease reimbursement rates in ways that don't relate to market reimbursement rates.

The Department reports cumulative rate reductions of 6.1 percent for acute care providers and 5.86 percent for long-term care providers since 2009. Additional targeted rate cuts have been applied to specific services, such as inpatient renal dialysis and uncomplicated caesarean section deliveries. Following is the Department's estimate of the impact of recent rate reductions.

	Cumulative Impact of Rate Reductions Implemented in Prior Years	Targeted Rate Reductions Proposed in the FY 2012-13 Budget Request (see R-6)	TOTAL Rate Reductions
FY 2009-10	($29,173,973)		($29,173,973)
FY 2010-11	($51,442,066)		($51,442,066)
FY 2011-12	($75,932,308)	($1,455,964)	($77,388,272)
FY 2012-13	($73,825,420)	($7,692,710)	($81,518,130)

To provide some indication about the adequacy of Medicaid rates, staff asked the Department to compare them with Medicare rates. The following table lists the weighted average compensation in Medicaid as a percentage of Medicare by procedure code category. However, caution should be used in drawing conclusions from the data, because the two programs operate differently, cover different services, and cover different populations. The comparison is based only on procedure codes that are in common between Medicaid and Medicare, and so, for example, it does not include Federally Qualified Health Center encounter rates or inpatient hospital rates, where the Medicaid payments and/or services are dissimilar. This may explain why some of the Medicaid rates are so far below the Medicare rates, because Medicaid reimburses for the services primarily through a different mechanism, such as inpatient hospital rates.

Procedure Code Category	**Medicaid Reimbursement as a Percent of Projected Medicare Reimbursement**
Total	80.8%
Durable medical equipment (DME)	76.4%
Enteral and Parenteral Therapy	82.6%
Evaluation & Management	106.4%
Medical and Surgical Supplies	58.6%
Medicine	74.8%
Orthotic Procedures and services	69.4%
Pathology	84.1%
Pathology and Laboratory Services	32.1%
Procedures / Professional Services	65.3%
Prosthetic Procedures	74.4%
Radiology	101.1%
Surgery	63.4%
Temporary Codes	47.2%
Transportation Services Including Ambulance	48.8%
Vision Services	34.3%

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

BRIEFING ISSUE

ISSUE: Update on implementation of the Affordable Care Act (ACA)

SUMMARY:

- ❑ Reviews major provisions of the federal Affordable Care Act.
- ❑ Provides a summary of required eligibility expansions.
- ❑ All of the eligibility expansions, including those currently funded with the Hospital Provider Fee, are eligible for an enhanced federal matching rate.
- ❑ In March 2012 the U.S. Supreme Court will hear arguments regarding the Affordable Care Act including the constitutionality of the individual mandate and the required Medicaid eligibility expansions.
- ❑ Reviews the ACA tax penalties and credits intended to reduce the number of uninsured.

DISCUSSION:
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), contain six major provisions with ramifications for Colorado's publicly funded health care:

- 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, effective January 2014
- 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 beginning January 2014
- 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 below 400 percent of the federal poverty guidelines for purchasing insurance through a health exchange, and to small employers for offering qualified health plans
- Limit the ability of private insurers to deny coverage based on pre-existing conditions or lifetime or annual benefit maximums

Some of the less sweeping changes in the law with ramifications for Colorado's publicly funded health care include increasing primary care reimbursement rates to 100 percent of Medicare rates, reducing Disproportionate Share Hospital allotments, and expanding Medicaid coverage to former foster children between the ages of 21 and 26.

The ACA also makes numerous changes to private insurance regulations including:

- Requiring private insurance 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.

A more comprehensive summary of the major provisions of the ACA that was prepared by Legislative Council Staff is included in Appendix E at the end of this document.

Prior to the passage of ACA, Colorado already had plans to expand Medicaid eligibility for adult parents from 60 percent up to 100 percent of the federal poverty guidelines, and for adults without dependent children from 0 percent up to 100 percent of the federal poverty guidelines, using revenue from the Hospital Provider Fee pursuant to H.B. 10-1293. The Department has since limited the expansion for adults without dependent children to up to 10.0 percent of the federal poverty guidelines with a population cap of 10,000. Compared to current practice, the ACA minimum eligibility standards will require Colorado to expand coverage to include children and parents ages 6 to 59 between 100 percent and 133 percent of the federal poverty guidelines, plus coverage for adults without dependent children between 10,000 people below 10 percent of the federal poverty guidelines and 133 percent of the federal poverty guidelines. There is also a provision of ACA that requires expanding Medicaid coverage to former foster children between the ages of 21 and 26.

All of these expansions, including those funded with the Hospital Provider Fee, are eligible for an enhanced federal matching rate. From 2014 through 2016 the enhanced match rate is 100 percent.

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 table below summarizes the timeline for eligibility expansions either authorized in statute or required by the ACA. The table highlights the expansions that are subject to the maintenance of effort requirement of the ACA and the expansions that are required by January 1, 2014 pursuant to the ACA.

Authorized or Required Eligibility Expansions

Children's Basic Health Plan

Children and Pregnant Women from 185% to 200% (since July 2006)

Children and Pregnant Women from 200% to 205% (since March 2008)

Children and Pregnant Women from 205% to 250% (May 2010)

MEDICAID

Breast and Cervical Cancer (since July 2002)

Pregnant Women from 133% to 185% (January 2013)

Disabled Buy-in (March 2012)

Parents to 60% of the Federal Poverty Guidelines (since July 2006)

Foster kids ages 18-21 non-Title IVE (July 2007)

Foster kids ages 18-21 Title IVE (July 2008)

Parents from 60% to 100% (May 2010)

Adults without dependent children to 10%, capped at 10,000 (March 2012)

Children 6-18 from 100% to 133% (January 2013)

Parents from 100% to 133% (January 2014)

Adults without dependent children from 10,000 to 133% (January 2014)

Foster kids ages 21 to 26 (January 2014)

FY 2008-09 | FY 2009-10 | FY 2010-11 | FY 2011-12 | FY 2012-13 | FY 2013-14

Maintenance of Effort - ACA requires states to maintain eligibility in effect as of March 23, 2010 until:
January 1, 2014 for adults, and
October 1, 2019 for children

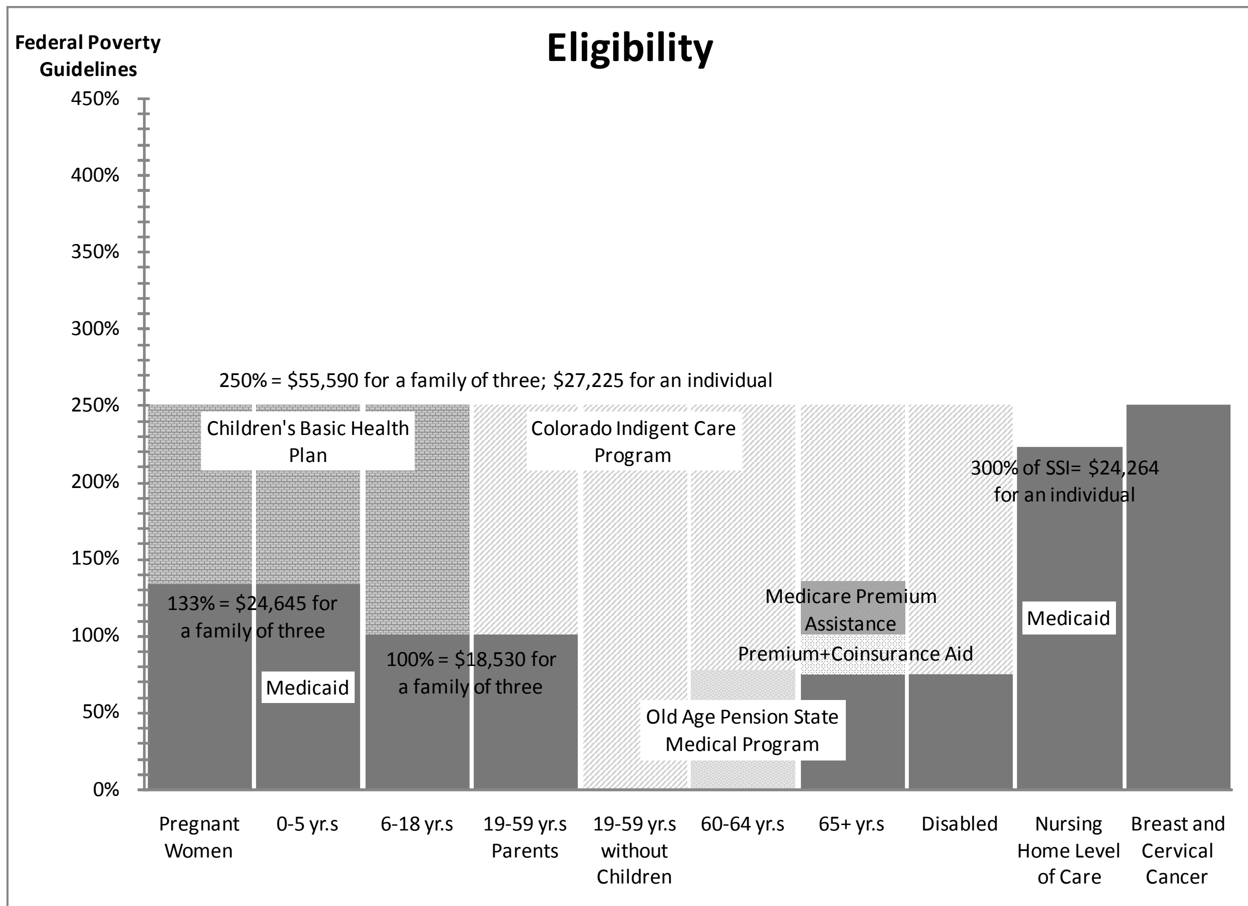
Minimum Eligibility - ACA requires states to provide eligibility to these populations as of January 1, 2014

Note that Medicaid coverage for pregnant women from 133 percent to 185 percent of the federal poverty guidelines is not required by the ACA, but it is required as a condition of CHP+ expansions. Colorado's state plan makes pregnant women eligible for CHP+ up to 200 percent of the federal poverty guidelines, and since FY 2008-09 Colorado has had a month-to-month agreement with the federal Centers for Medicare and Medicaid Services (CMS) to provide additional coverage to 250 percent of the federal poverty guidelines, but not an approved program waiver for the expansion. In order to get an approved program waiver, CMS believes that Colorado needs to first cover pregnant women on Medicaid to 185 percent of the federal poverty guidelines, based on provisions in CHIPRA 2009. Senate Bill 11-250 (Ferrandino & Summers/Boyd) authorized the expansion of Medicaid eligibility beginning January 2013. The Department currently estimates that the Medicaid expansion will SAVE the state $4.8 million ($1.7 million General Fund) in FY 2012-13 and $10.4 million ($3.7 million General Fund) in FY 2013-14, because average Medicaid reimbursement rates for pregnancy-related care are below CHP+ reimbursement rates.

Colorado could revert to covering pregnant women on CHIP to 200 percent of the federal poverty level. This would eliminate coverage for an estimated 548 pregnant women in FY 2012-13. In this scenario, the federal government could ask Colorado to repay roughly $8.0 million that the federal government provided between FY 2008-09 and FY 2011-12 for this population when Colorado didn't have an official waiver. By reducing CHP+ eligibility Colorado would save approximately $8.8 million ($3.1 million state share). However, the state share for the CHP+ population between 200 percent of the federal poverty guidelines and 250 percent of the federal poverty guidelines comes from the Hospital Provider Fee, and so there would be no General Fund savings.

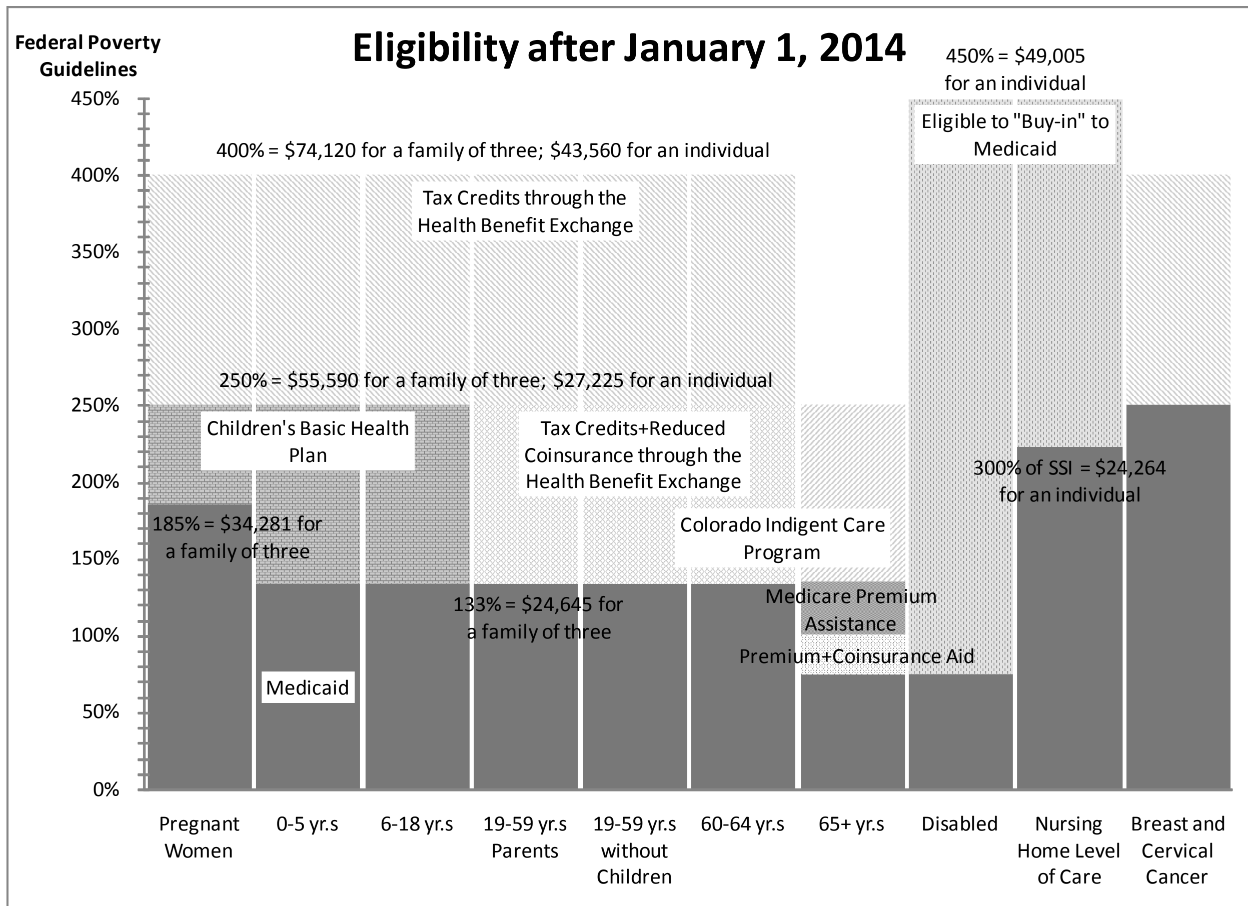
The Disabled "buy-in" program is also optional under ACA, but the financing for the program comes from the Hospital Provider Fee and premiums, and so there would be no General Fund impact associated with eliminating the program. The Disabled "buy-in" is intended to allow disabled people with the ability to work to earn up to 450 percent of the federal poverty guidelines without jeopardizing health insurance. The Department believes the potential loss of health insurance was preventing some people from seeking employment despite an ability and desire to work.

The next tables compare compare current eligibility criteria with the authorized and required required eligibility expansions by January 1, 2014.



The 2011 Poverty Guidelines for the
48 Contiguous States and the District of Columbia

	Poverty guideline								
	SSI	OAP		ACA	Pregnant	300% of SSI	CHP+	Tax Credits	Buy-in
Persons in family	**74%**	**77%**	**100%**	**133%**	**185%**	**223%**	**250%**	**400%**	**450%**
1	$8,088	$8,388	$10,890	$14,484	$20,147	$24,264	$27,225	$43,560	$49,005
2	$10,925	$11,330	14,710	$19,564	$27,214	$32,775	$36,775	$58,840	$66,195
3	$13,762	$14,273	18,530	$24,645	$34,281	$41,287	$46,325	$74,120	$83,385
4	$16,599	$17,215	22,350	$29,726	$41,348	$49,798	$55,875	$89,400	$100,575
5	$19,436	$20,157	26,170	$34,806	$48,415	$58,309	$65,425	$104,680	$117,765
6	$22,274	$23,100	29,990	$39,887	$55,482	$66,821	$74,975	$119,960	$134,955
7	$25,111	$26,042	33,810	$44,967	$62,549	$75,332	$84,525	$135,240	$152,145
8	$27,948	$28,984	37,630	$50,048	$69,616	$83,843	$94,075	$150,520	$169,335



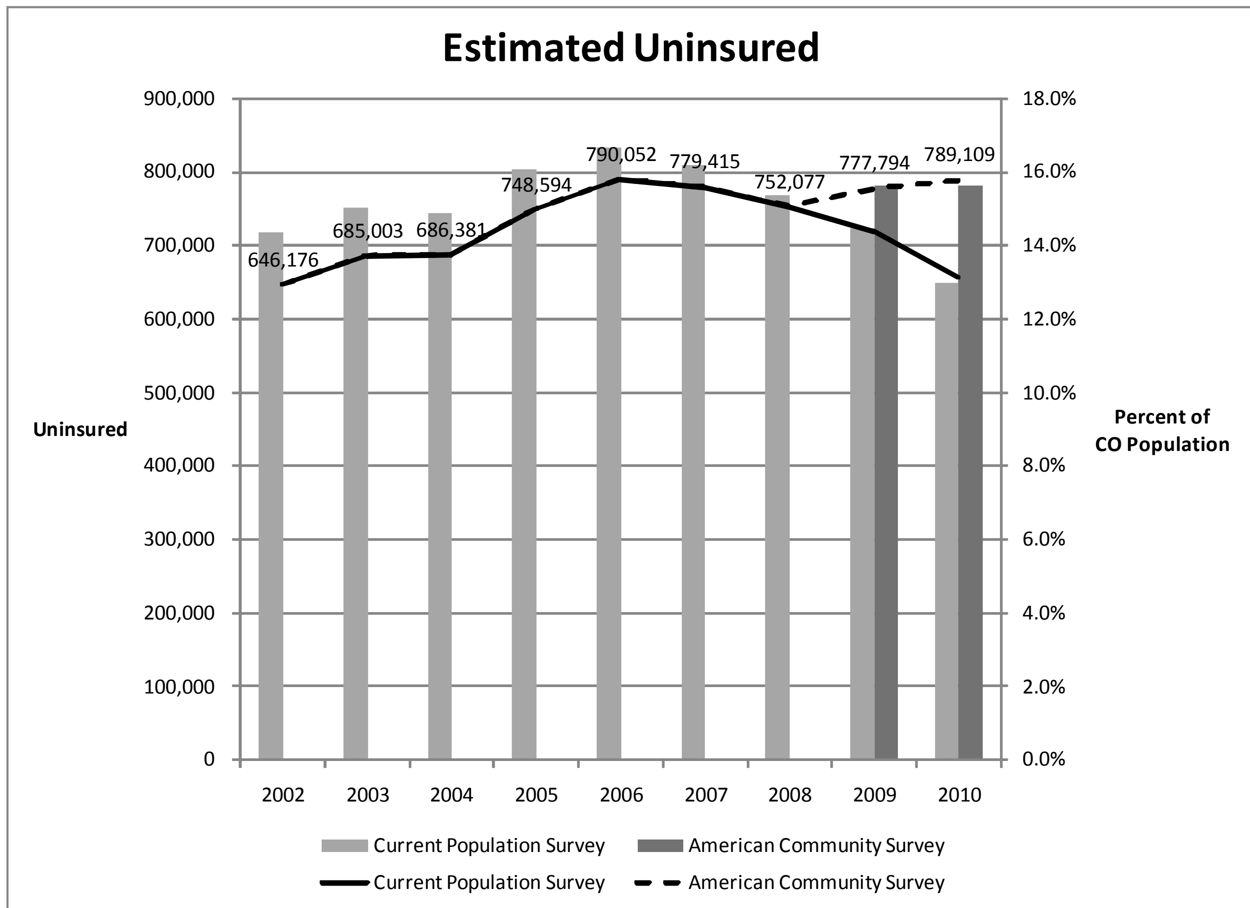
In March 2012 the U.S. Supreme Court will hear arguments regarding the Affordable Care Act, consolidated from three court cases:

1. Does the individual mandate to purchase insurance or pay a tax penalty exceed Congress' power to regulate commerce among states?If the individual mandate is unconstitutional, to what degree can the rest of the provisions of the ACA be implemented, i.e. to what degree is the individual mandate severable from the rest of the Act?
   a. Does the Tax Anti-Injunction Act prohibit challenges to the individual mandate until the first tax penalty payment in 2015?
2. Is threatening to withhold federal Medicaid funding if states don't implement the minimum ACA eligibility standards coercive and impermissible commandeering?

If the ACA maintenance of effort or mandatory expansion provisions are found unconstitutional, then the populations in the table above are the eligibility categories that would potentially become

optional. The other eligibility categories covered by the Department are required by federal provisions other than the ACA.

One of the primary goals of the ACA is to reduce the number of uninsured. The table below shows two estimates of the historic uninsured in Colorado. Both are based on data collected by the U.S. Census, but one uses the Current Population Survey (CPS) and the other uses the American Community Survey (ACS). The Department recently switched to estimating the uninsured based on the ACS. The sample size for the ACS is 25 times larger and the ACS data can be disaggregated to a sub-state level. However, ACS estimates are currently only available for 2009 and 2010.



In addition to expanding Medicaid coverage, one of the primary ways the ACA would reduce the number of uninsured is through the tax ramifications of purchasing insurance. With some exceptions, people who don't purchase insurance or join medicaid will pay a penalty (this provision is 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 below 400 percent of the federal poverty guidelines will be eligible for 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 are prospective, 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. Tax credits are also available to small businesses (under 50 employees) who offer work-based insurance to their employees.

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 costs associated with approved plans and identifies benchmark plans. Development of the exchange is currently underway with funding from federal planning grants.

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

BRIEFING ISSUE

ISSUE: Optional versus Mandatory Services

SUMMARY:

- ❏ Eliminating an optional service does not necessarily result in savings, because the same service could be provided under a mandatory service.
- ❏ Eliminating other optional services would drastically change the quality of care and could result in higher cost services.
- ❏ With these caveats, provides a summary table of optional Medicaid services that could be reduced or eliminated, and the approximate dollars associated with each.

DISCUSSION:

Strategies for reducing Medicaid expenditures generally involved one or more of the following:

1. Restricting eligibility
2. Restricting benefits
3. Reducing reimbursement rates
4. Avoiding unnecessary care
5. Using alternate financing to the General Fund

The previous issue brief "Update on the Implementation of the Affordable Care Act" discussed federally mandated eligibility criteria. This issue brief provides a summary of optional benefits. Other issue briefs discuss the Department's proposals for reducing reimbursement rates, avoiding unnecessary care, and using alternate financing to the General Fund.

Please note that eliminating an optional service does not necessarily result in savings because the same service could be provided under a mandatory service. For example, eliminating payment to a podiatrist could result in the Medicaid client receiving the same care from his family physician or an orthopedic specialist physician (physician services are a mandatory service). Eliminating other optional services, such as prescription drugs or home-and-community based services would drastically change the quality of care for the mandatory Medicaid populations and again ***could*** result in higher cost services (such as sooner placement in nursing facility care or longer hospital stays).

Lastly, under the EPSDT program, many of the services provided to children are mandatory if they are required to aid the child's development or educational needs (i.e. eye-glasses or speech therapy may be optional for an adult but mandatory for a child under EPSDT requirements). Furthermore, there are federal rules or case law that can be interpreted to make an"optional" service a "mandatory" service (see non-emergency transportation discussion below). Table 2 below shows the optional services in Colorado's Medicaid program.

Category	C.R.S. Cite	Estimated Cost	Comments
Prescribed Drugs (Including Over the Counter Medication)	25.5-5-202 (1)(a), (a.5)	$145,560,164	Not a "mandatory" service under federal law but is a core service in modern medicine. Total pharmacy costs and drug rebates. Includes over the counter medication offered in order to avoid prescription drugs that may be more costly (i.e. Tylenol instead of codeine).
Clinic Services	25.5-5-202 (1)(b)	$6,517,242	Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients. Without this service, the clients would use inpatient or other physician services. Costs based on place of service; these are direct substitutes for costs at other locations.
Home and Community-Based Services	25.5-5-202 (1)(c)	$252,143,475	Individuals must be at risk of institutional care in order to receive these waiver services. The Department had to prove budget neutrality when the waiver was approved. Eliminating the service would not result in the "full" amount of cost because it is anticipated that there would be greater nursing facility care (if capacity existed) or hospital utilization. However, there could be some savings resulting from family or other care givers providing more services and from premature death. Totals do not include HCBS waivers administered by the Department of Human Services. Those waivers would be considered an optional benefit as well.
Optometrist Services	25.5-5-202 (1)(d)	$215,803	
Eyeglasses when necessary after surgery	25.5-5-202 (1)(e)	$94,970	
Prosthetic Devices	25.5-5-202 (1)(f)	$3,022,794	
Rehabilitation Services as appropriate to community mental health centers	25.5-5-202 (1)(g)	Included in BHO capitations	Eliminating services could have public safety concerns, added costs to county jails, and inpatient hospitalization.
Intermediate care facilities for the mentally retarded;	25.5-5-202 (1)(h)	$3,163,194	HCPF costs for Class II Nursing Facilities. DHS has additional costs for these services.
Inpatient psychiatric services for persons under twenty-one years of age; Inpatient psychiatric services for persons over the age of sixty-five	25.5-5-202 (1)(i),(j)	Included in BHO capitations	Eliminating service does not eliminate need. Would lose federal match and probably would cost the state more in General Fund. Would push more individuals into state institutional care. Would also reduce Medicaid funding for the institutes.
Case Management	25.5-5-202 (1)(k)	Included in BHO capitations	Same as above.

Category	C.R.S. Cite	Estimated Cost	Comments
Therapies under home health services, including: Speech and audiology; Physical; Occupational	25.5-5-202 (1) (l) (I), (II), (III)	$16,047,411	Home health is a mandatory federal requirement. However, therapy services (speech, occupational, physical) are optional if provided by home health agencies (but could be mandatory if provided through outpatient hospital care). Staff would not anticipate a lot of savings from eliminating home health agencies from providing the service (these are services that are usually part of patient's discharge plan -- i.e. a stroke victim is discharged and receives care at home health with physical, speech and occupational therapies). Only savings that would result would be if reimbursement is different between home health agencies and outpatient.
Services of a licensed psychologist;	25.5-5-202 (1)(m)	$1,303,125	No real savings anticipated. Service could be provided by family physician or psychiatrist (mandatory) This is a partial accounting of cost, contained primarily in the Mental Health Fee for Service line item; however, the majority of expenditure for this is included in the BHO capitation payments
Private duty nursing services;	25.5-5-202 (1)(n)	$27,325,957	Eliminating service could result in longer hospitalization or premature death.
Podiatry services;	25.5-5-202 (1)(o)	$3,328,790	No real savings anticipated. Services could be provided by family physician or orthopedic physician. Physician services are mandatory.
Hospice care;	25.5-5-202 (1)(p)	$39,547,635	Could result in longer hospital stays or nursing facility stays (both mandatory services).
The program of all-inclusive care for the elderly;	25.5-5-202 (1)(q)	$84,414,277	This is a managed care long-term care service. Eliminating the provider group doesn't change the need for services -- it would just revert to the fee-for-service nursing facility and HCBS waivers (if waiver services are eliminated then this service category would need to be adjusted also).
For any pregnant woman ... alcohol and drug and addiction counseling and treatment, including outpatient and residential care but not including room and board while receiving residential care;	25.5-5-202 (1)(r)	Total not available yet. DHS program: "Special Connections"	This program provides counseling in residential and outpatient settings to stop pregnant women from abusing substances that can harm their unborn child. Could result in higher neonatal care if infants are born with substance abuse problems.
Outpatient substance abuse treatment.	25.5-5-202 (1)(s)	$1,966,668	If provided inpatient -- would be mandatory. If the Audit Committee finds this service results in overall cost increases, the statute repeals this program July 1, 2011. The audit staff's results from the audit were inconclusive.
Cervical cancer immunization for all females under twenty years of age;	25.5-5-202 (1)(t)	$261,059	Could be eliminated. Future costs from cervical cancer could be anywhere from 2 to 25 years in the future.
Screening, brief intervention, and referral to treatment for individuals at risk of substance abuse, including referral to the appropriate level of intervention and treatment.	25.5-5-202 (1)(u)	Services were added in HB 10-1033; totals are not available yet.	This uses medical marijuana cash funds to provide screening, brief intervention, and referral to treatment for individuals at risk of substance abuse.

Category	C.R.S. Cite	Estimated Cost	Comments
Non-emergency transportation	25.5-5-202 (2)		While this is considered an optional service, federal regulations (42 C.F.R. Section 431.53) and case law (several cases) would prevent Colorado from eliminating the service. This was tested in 2003 when the General Assembly attempted to limit the service to only wheel chair transport and CMS rejected our rule change under federal law.

BRIEFING ISSUE

ISSUE: Provider Fee Financing

SUMMARY:

- ❑ Colorado collects fees from selected providers in order to match additional federal funds and then redistribute the money back to providers for under-compensated and uncompensated care
- ❑ A portion of the revenue from the Hospital Provider Fee has been used for General Fund relief since the creation of the fee
- ❑ The Department's decision to delay the expansion of eligibility for adults without dependent children may impact the need for appropriations for the Old Age Pension State Health and Medical Care Program
- ❑ Some of the eligibility expansions financed with the Hospital Provider fee will be eligible for an enhanced federal match under the federal Affordable Care Act (ACA), saving hospitals an estimated $119.5 million

RECOMMENDATION:

1. Staff recommends discussing with the Department whether legislation should authorize the Old Age Pension Health and Medical Care Fund to pay the state share of costs to expand Medicaid eligibility to people who qualify for the Old Age Pension State Health and Medical Care Program.
2. Staff recommends authorizing the Hospital Provider Fee to offset the need for General Fund in the Medical Services Premiums line in FY 2013-14 in the amount of the benefit to the Hospital Provider Fee from the ACA enhanced federal match.

DISCUSSION:

Colorado collects fees from selected providers in order to match additional federal funds and then redistribute the money back to providers for under-compensated and uncompensated care. The majority of the money is returned to providers in the form of increased rates for Medicaid, Children's Basic Health Plan (CHP+), and indigent care. A smaller portion is returned to providers through

expanding eligibility for Medicaid and CHP+, and thus providing a payer for care that would otherwise likely be under-compensated, or uncompensated, or not provided at all.

By far the largest of the provider fees, and the main subject of this briefing, is the Hospital Provider Fee. Smaller provider fees are collected from nursing homes and intermediate care facilities for people with developmental disabilities.

In addition to reducing under-compensated and uncompensated care, the legislative intent for the Hospital Provider Fee expressed in H.B. 09-1293 (Riesberg & Ferrandino/Keller & Boyd) includes expanding health care access, reducing cost-shifting to private payers, and improving the quality of care for low-income and uninsured populations. In designing the fee schedule and supplemental reimbursements, and determining how to expand eligibility up to the limits authorized in the legislation, the Department considers the impacts on the supply of providers as well as the ability of people to pay for services. To measure the impact on cost-shifting the Department submits an annual report to the legislature estimating the difference between actual and compensated costs for Medicaid, Medicare, and private-pay clients. And, to address the quality of care the reimbursement schedule includes distributions based on achieving performance goals.

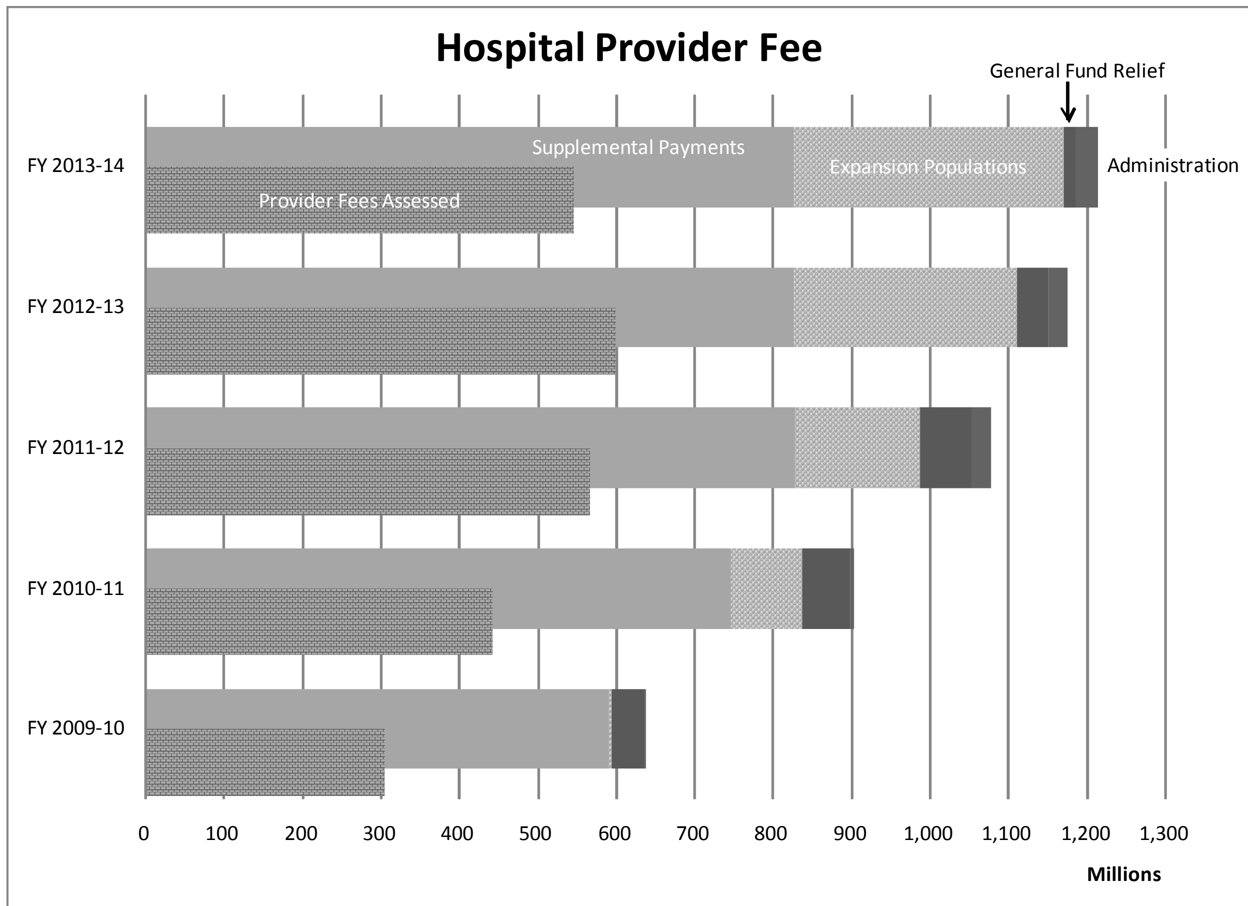
Provider fees draw down an underutilized allocation of federal funds potentially available to Colorado within the "upper payment limit" (UPL). There are nuances to the calculation of the UPL, and a couple of different methods that can be used by states, but the underutilized funds within the UPL can be thought of as the difference between actual public compensation for health care and the amount Medicare would have paid. Up to the UPL the federal government will match state and local expenditures. Provider fees are an alternate way to raise public funds, other than using general tax dollars, to increase the state match and draw more of the available federal funds within the UPL.

However, the federal government limits how states can design provider fees and one of the criteria is that the fees must redistribute the money among providers, creating winners and losers. One of the underlying principals of Medicaid is a shared sacrifice between the federal and state governments. The requirement that a provider fee redistribute the money can be viewed as preserving this principal. It prevents states from collecting provider fees and then giving them back to the same providers who paid them, only with matching federal funds. Such a system would arguably circumnavigate the state share in the sacrifice of paying for Medicaid.

Although Colorado's Hospital Provider Fee redistributes money among providers, the benefit from the fee accumulates primarily to the class of providers who paid it. This was an important consideration in a memorandum from Legislative Legal Services concluding that the charges to hospitals represent a fee rather than a tax, which is significant because taxes require approval by a

vote of the people. Using the revenue from the provider fee to support general government purposes rather than purposes that primarily benefit the class of providers who paid the fee would potentially weaken the argument that the Hospital Provider Fee is constitutional.

In addition to supplemental payments for hospitals and medical service payments for expansion populations, a portion of the revenue from the Hospital Provider Fee has been used for General Fund relief since the creation of the fee. Initially this occurred in an indirect way. The federal government offered an enhanced federal match for Medicaid and CHP+ through the American Recovery and Reinvestment Act of 2009 (ARRA), but rather than reducing the Hospital Provider Fee the JBC supported S.B. 10-169 (Boyd/Riesberg) to allow the Hospital Provider Fee to pay the state share for Medical Service Premiums in an amount equal to the benefit from the enhanced federal match in FY 2009-10 and FY 2010-11. This didn't change the net impact of the fee to hospitals compared to the projections when the Hospital Provider Fee concept was originally developed. More recently, the JBC sponsored S.B. 11-212 (Hodge/Gerou) with the support of the Colorado Hospital Association to use $50 million in FY 2011-12 and $25 million in FY 2012-13 from the Hospital Provider Fee to offset the need for General Fund in the Medical Services Premiums line item. This arguably still benefitted hospitals, because large portions of the Medical Services Premiums are paid to hospitals. Also, the hospitals were potentially facing reductions in reimbursement rates among the alternatives if the General Assembly had not authorized this new use of the Hospital Provider Fee.



There have been discussions recently at the federal level about limiting, or eliminating, the ability of states to draw federal funds using provider fees. This is despite the protection afforded by the requirement that provider fees be redistributive. More than 40 states have implemented provider fees to draw more federal funds, significantly increasing federal health care expenditures. The potential impact on Colorado of a federal limit or elimination of provider fees could be significant.

Of the states with provider fees, Colorado is one of only three states that use provider fees to expand eligibility. The other states that expand eligibility using provider fees are Wisconsin, for low-income adults without dependent children, and New Jersey, for people with developmental disabilities. Colorado's use of the provider fee to expand eligibility may provide justification for differential treatment if federal limits are imposed on provider fees.

The Medical Services Board is ultimately responsible for designing both the fee schedule and the redistribution of the fees plus the matching federal funds back to the providers, but the Board makes decisions in this area with input and advice from the Hospital Provider Fee Oversight and Advisory

Board. The total fees collected are supposed to be, "approximately equal to or less than the amount of the appropriation specified for the fee." Fees collected that do not receive federal matching funds must be refunded to the hospitals. Otherwise, the Board has significant authority to determine the amount of fees collected and the way they are redistributed to providers through supplemental payments.

The use of the Hospital Provider Fee to expand Medicaid and CHP+ eligibility is permissive in statute, rather than mandatory. The Hosptial Provider Fee may be used to expand eligibility to:

1. Adult parents from 60 percent up to 100 percent of the federal poverty guidelines;
2. Adults without dependent children up to 100 percent of the federal poverty guidelines;
3. People with disabilities up to 450 percent of the federal poverty guidelines who pay a premium to "buy-in" to Medicaid;
4. Children from 205 percent up to 250 percent who pay a premium to participate in CHP+; and,
5. Pregnant women from 205 percent up to 250 percent who pay a premium to participate in CHP+.

As noted in the issue brief "Update on the Implementation of the federal Accountable Care Act" the population expansions authorized by H.B. 09-1293 occurred after the maintenance of effort requirement of the ACA and are thus optional. However, in January of 2014 the expansions for adult parents from 60 percent up to 100 percent of the federal poverty guidelines and for adults without dependent children up to 100 percent of the federal poverty guidelines become mandatory under ACA. Also, reducing or eliminating any of the H.B. 09-1293 expansions saves money for the Hospital Provider Fee, rather than the General Fund. To achieve General Fund savings with an eligibility limitation the Hospital Provider Fee would also need to be repurposed.

Limiting the Medicaid expansion for adults without dependent children
(and the interaction with the Old Age Pension State Health and Medical Care Program)
The Department has decided to delay the expansion of eligibility to adults without dependent children, limiting it initially to people under 10 percent of the federal poverty guidelines with a hard cap of 10,000 people. The Department explains the decision to delay the expansion as follows:

> *The Department made the decision to expand Medicaid eligibility more slowly than anticipated because the cost estimates developed more recently and data from other states that have recently expanded to this population are higher than those developed when the legislation was passed. In order to ensure the expansion costs do not exceed the dollars generated by the hospital provider fee, the expansion plan was*

adjusted. In addition, based on the estimates of uninsured in the applicable income range and information from other states that have recently expanded to this population, the Department was concerned about the volume of clients that would become immediately eligible and apply for Medicaid, which could overwhelm the on-boarding process.

The Department intends to monitor costs and client volume closely over the next year, and may seek to increase the number of enrollment slots if expenditures indicate that there is available budget to do so.

Staff would note that the Department had other options to ensure that costs for the expansion population did not exceed the Hospital Provider Fee revenue, including increasing the Hospital Provider Fee rates and/or decreasing the supplemental payments to hospitals. Such actions would be within the scope of authority granted to the Medical Services Board to manage the program.

The limited expansion probably benefits hospitals, because some portion of the payment for the expansion population would have gone to providers other than hospitals. However, the Department indicates that this was not a consideration in the decision to limit the expansion.

The Department is still in the process of developing a methodology for estimating the portion of expansion payments that go to hospitals versus other providers. In August the Department staff estimated for the Hospital Provider Fee Oversight and Advisory Board that roughly $62.9 million, or 83 percent, of the projected $76.2 million total FY 2011-12 payments for expansion populations will go to hospitals. However, the Department and the Hospital Association are working together to refine the estimating methodology.

The Department's decision to delay the expansion of eligibility for adults without dependent children may impact the need for appropriations for the Old Age Pension State Health and Medical Care Program. This program receives a portion of excise taxes and licensing fees up to $10.0 million, pursuant to the Colorado Constitution, in order to provide health benefits to people who qualify for the state Old Age Pension. In addition, the program used to receive $2,235,000 in Tobacco Tax revenue and $2,850,000 in sales and use taxes. The Tobacco Tax revenue was eliminated in FY 2011-12 and the sales and use tax revenue was scheduled for elimination in FY 2012-13 pursuant to S.B. 11-210 (Hodge/Ferrandino), as part of budget reduction measures, but also based on the assumption that most of the clients of the Old Age Pension State Health and Medical Care Program would qualify for Medicaid under the expansion to adults without dependent children that was authorized as part of the Hospital Provider Fee. With the slower than anticipated expansion, the caseload for the Old Age Pension State Health and Medical Care Program will be higher than

anticipated and the Department may need to reduce reimbursement rates and/or request reinstatment of some of the supplemental funding to support the program.

Staff recommends discussing with the Department whether legislation should authorize the Old Age Pension Health and Medical Care Fund to pay the state share of costs to expand Medicaid eligibility to people who qualify for the Old Age Pension State Health and Medical Care Program. The Department believes the constitutional language regarding the money is sufficiently broad to allow this purpose. Section 7(c) of Article XXIV states:

> *(c) Any moneys remaining in the old age pension fund, after full payment of basic minimum awards and after establishment and maintenance of the stabilization fund in the amount of five million dollars, shall be transferred to a health and medical care fund. The state board of public welfare, or such other agency as may be authorized by law to administer old age pensions, shall establish and promulgate rules and regulations for administration of a program to provide health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or mental disease; the costs of such program, not to exceed ten million dollars in any fiscal year, shall be defrayed from such health and medical care fund...*

The state is required to expand Medicaid eligibility to the majority of the population eligible for the Old Age Pension State Health and Medical Care Program by January 2014 pursuant to provisions of the ACA. If the Department believes that Hospital Provider Fee revenue cannot support the expansion now, then the Old Age Pension Health and Medical Care Fund could pay for the expansion.

Even without the expanded eligibility requirement of the ACA there are policy arguments for enrolling the OAP population in Medicaid. Benefits and reimbursement rates for the current OAP program are extremely limited to keep expenditures within the available revenues. Enrolling the population in Medicaid would draw additional federal funds into the state and finance significantly better benefits and provider reimbursement rates.

Interaction of the ACA enhanced federal match with the Hospital Provider Fee

The Medicaid expansions authorized by H.B. 09-1293 for adult parents from 60 percent up to 100 percent of the federal poverty guidelines and for adults without dependent children up to 100 percent of the federal poverty guidelines are both eligible for an enhanced federal match starting January 2014. For fiscal years 2014 and 2015 the enhanced match rate is 100 percent.

The Department estimates that without the federal enhanced match rate through the ACA the Hospital Provider Fee collections would need to increase by $28.6 million between FY 2012-13 and FY 2013-14 in order to pay for the population expansions funded from the fee. This assumes that adults without dependent children who are funded from the fee continue to be limited to a hard cap of 10,000 people, and implementation of all the Department's FY 2012-13 budget initiatives. If the federal enhanced match rate through the ACA were in effect for the entire FY 2012-13 fiscal year the Department estimates the need for Hospital Provider Fee collections would decrease by $90.8 million. The net savings to hospitals is $119.5 million.

	FY 2012-13	FY 2013-14	Difference
Medical Services Premiums	$238,800,304	$287,166,506	$48,366,202
Mental Health	$14,749,739	$22,387,831	$7,638,092
CHP+	$29,786,820	$33,716,035	$3,929,215
Total	$283,336,863	$343,270,372	$59,933,509
Federal Funds @ Regular Match	$146,459,368	$177,747,458	$31,288,090
Provider Fee @ Regular	**$136,877,495**	**$165,522,913**	**$28,645,418**
Federal Funds @ Enhanced Match	$146,459,368	$297,235,024	$150,775,656
Provider Fee @ Enhanced Match	**$136,877,495**	**$46,035,347**	**($90,842,148)**

This situation is analogous to when the American Recovery and Reinvestment Act of 2009 (ARRA) offered an enhanced match rate, and Staff recommends that the JBC treat the ACA enhanced match in a similar way. In response to the ARRA match the General Assembly passed S.B. 10-169 to ensure that the benefit of the enhanced match accumulated to the General Fund, rather than the Hospital Provider Fee. The General Assembly does not need to pass legislation during the 2012 session, because the ACA enhanced match does not take effect until January 2014. The JBC may want to wait to see if the U.S. Supreme Court overturns any of the provisions of the ACA after its March 2012 hearing before sponsoring legislation to address the enhanced match rate. However, the JBC may want to address the interaction of the ACA enhanced match with the Hospital Provider Fee at the hearing with the Department to begin establishing expectations with both the Department and providers.

Another consideration in discussions about the benefit to the Hospital Provider Fee from the ACA enhanced match is the additional required expansions of Medicaid eligibility and reimbursement rates pursuant to the ACA. In addition to the eligibility expansions authorized by H.B. 09-1293 the ACA will require eligibility expansions for:

- Parents from 100% to 133% of the federal poverty guidelines
- Adults without dependent children from 100% to 133% of the federal poverty guidelines, and
- Foster kids ages 21 to 26

The ACA also requires an increase in primary care physician reimbursement rates to 100 percent of Medicare levels. Initially these expansions of eligibility and reimbursement rates will be financed with a 100 percent federal match, but when the enhanced match rate begins to step down in 2017 the General Assembly may want to authorize the Hospital Provider Fee to pick up some or all of the state share.

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

BRIEFING ISSUE

ISSUE: Pending Medicaid Waivers

SUMMARY:

Provides a summary of pending Medicaid waivers and comments by the Department about the potential applicability of the waiver to Colorado

DISCUSSION:

In limited circumstances the Centers for Medicaid and Medicare Services (CMS) can approve waivers from federal Medicaid requirements for states to test new ways to pay for or deliver services. There are four types of waivers CMS can approve:

- ❑ Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- ❑ Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- ❑ Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- ❑ Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.

The table on the next page reviews current waiver requests pending before CMS and adds comments from the Department on the potential applicability of the waiver to Colorado. Several of the waivers would expand eligibility, but none of them would restrict eligibility. There is no evidence to date of a willingness by the CMS to approve waivers from the ACA eligibility standards.

Some of the waivers that expand eligibility or services may save money to the extent preventive care reduces the need for more expensive services. Otherwise, the pending waivers with the most obvious potential to save money call for mandatory enrollment in managed care programs.

The Department does not believe Colorado has sufficient geographic coverage to mandate enrollment in managed care. However, the Department is implementing the Accountable Care Collaborative to provide a medical home for clients, enhanced medical management, care coordination, and integrated disease management. Rather than paying capitated rates that transfer all risk to the providers, the Department will make fee-for-service payments, but provide incentive payments for providers who meet performance goals related to avoiding more costly care.

State	Official Program Name	Waiver Authority	Status	Description	Type	Expiration Date	Applicability to Colorado
Alabama	Alabama Plan First	1115 Family Planning	Current,Pending	The Alabama Family Planning Demonstration provides coverage for family planning and family related services to women, ages 19 to 55, with a family income at or below 133 percent of the Federal poverty level, who are not otherwise eligible for Medicaid or Medicare, and do have any other health insurance coverage.	Renewal	9/30/2011	CO has already submitted a Family Planning Waiver
Arizona	Arizona Health Care Cost Containment System	1115	Current,Pending	The Arizona Health Care Cost Containment System (AHCCCS) Demonstration allows the State to offer health care coverage to several groups of individuals who normally are not eligible for Medicaid. Working age adults without dependent children can qualify to receive the same comprehensive benefit as other groups traditionally eligible for Medicaid. Women who had Medicaid coverage due to a pregnancy can qualify afterwards for family planning coverage for up to 24 months, provided they do not have other health insurance. Persons eligible for the full Medicaid benefit generally must enroll in a health plan in order to receive their coverage. Persons in need of long-term care services can receive access to nursing home and community-based alternative services through the Arizona Long Term Care Services program. Families with children eligible for CHIP may choose instead to receive help with paying premiums for employer-sponsored health insurance.	Renewal	9/30/2011	CO is submitting a waiver to cover adults without dependent children; CO has already submitted a Family Planning Waiver; CO has the ACC, but the state does not have provider infrastructure to support mandatory enrollment in managed care; CO provides access to nursing home and community-based alternative services; CO has a small pilot program for CHP+ that helps pay premiums for employer sponsored health insurance that is logistically difficult to expand statewide.
Arkansas	Arkansas Safety Net Benefit Program	1115	Current,Pending	This demonstration provides a safety net benefit package to working age adults who are employed, but do not have health insurance and do not qualify for the regular Medicaid program. Employers must agree to offer this coverage, and participants must pay a monthly premium and co-insurance. Others who are Medicaid eligible may be required to enroll with a primary care case manager in order to receive benefits, under the State's ConnectCare program.	Renewal	9/30/2011	Expansion of Medicaid; mandatory managed care enrollment
California	California Bridge to Health Reform	1115	Current,Pending	California's Bridge to Reform is a demonstration program that allows California to provide health care coverage through county-based Low Income Health Programs, to adults, ages 19 to 64, with incomes at or below 133 percent of FPL, who do not qualify for Medi-Cal under the usual rules. Currently, Low Income Health Programs are offered in Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura Counties, and the City of San Francisco. The list of covered benefits varies by county, and participants may receive care from public providers in their county of residence. The demonstration also provides for alternative and enhanced funding for hospital care and public health initiatives. Finally, some persons qualifying for Medi-Cal may be required to join a health plan in order to receive coverage.	Current	10/31/2015	Expansion of Medicaid to AwDC, CO is sumbitting a waiver to phase-in this population
Connecticut	Connecticut Medicaid Transfer of Assets Reform	1115	Pending	No information	NA	NA	NA
Connecticut	Connecticut HUSKY Plan Part A	1915(b)	Pending	The State of Connecticut submitted a proposal under Section 1915(b) of the Social Security Act (the Act) authority to provide comprehensive medical and social services to the State's Medicaid population. On 7/20/95, the State was awarded an approval to operate a managed care program for children and families receiving Medicaid. The waiver is limited to the AFDC/TANF and AFDC/TANF related beneficiary group. Voluntary enrollment began in August in two counties and mandatory enrollment began in approved counties in October 1995. When the program was originally implemented it was known as the Connecticut Access Program, in 1997, the name was changed to the HUSKY Program Part A.	Renewal	In process	CO has the ACC, but the state does not have provider infrastructure to support mandatory enrollment in managed care
Delaware	Delaware Diamond State Health Plan	1115	Current,Pending	The Diamond State Health Plan demonstration allows the State to offer health care coverage to working age adults without dependent children who normally are not eligible for Medicaid. Participants may have to enroll with a health plan in order to receive coverage. Women whose Medicaid coverage ends following their pregnancy can receive coverage for family planning services for up to two years, depending on their income.	Current	12/31/2013	Expansion of Medicaid to AwDC, CO is sumbitting a waiver to phase-in this population;CO has already submitted a Family Planning Waiver
Florida	Florida Medicaid Reform	1115	Current,Pending	The Florida Medicaid Reform Demonstration, requires mandatory enrollment in managed care for TANF related populations and the aged and disabled, with some exceptions. Managed care plans offer customized benefit plans, incentives are provided for healthy behaviors, and enrollees can opt out of Medicaid to take advantage of employer sponsored insurance. The demonstration is operating in Baker, Broward, Clay, Duvall, and Nassau Counties. Enrollees receive comprehensive benefits and and may be assessed nominal co-payments. Children and pregnant women are exempt from co-pays.	Renewal	9/30/2011	CO has the ACC, but the state does not have provider infrastructure to support mandatory enrollment in managed care
Indiana	Indiana Family Planning 1115 Demonstration	1115 Family Planning	Pending	Indian submitted a new proposal for a section 1115 demonstration project for family planning. Currently under review by CMS.	New	In process	CO has already submitted a Family Planning Waiver
Iowa	Iowa Family Planning Network	1115	Current,Pending	The Iowa Family Planning Demonstration provides coverage for family planning and family planning related services to women, ages 12-44, with a family income at or below 200 percent of the Federal poverty level, who are not otherwise eligible for Medicaid (other than IowaCare) or the Children's Health Insurance Program (CHIP), and do not have any other health insurance coverage that provides family planning services.	Renewal	9/30/2011	CO has already submitted a Family Planning Waiver

State	Official Program Name	Waiver Authority	Status	Description	Type	Expiration Date	Applicability to Colorado
Iowa	IowaCare	1115	Current,Pending	The IowaCare Demonstration allows the State to offer health care coverage to working age adults with and without dependent children who normally are not eligible for Medicaid or CHIP and spend-down pregnant women. Participants receive a limited benefit package consisting of inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, and a limited dental benefit. Spend-down pregnant women also receive obstetric services.	Current	12/31/2013	Expansion of Medicaid to AwDC, CO is sumbitting a waiver to phase-in this population
Louisiana	Louisiana Greater New Orleans Community Health Connection	1115	Current,Pending	The Greater New Orleans Community Health Connection Demonstration allows the State to provide health care coverage to individuals who are non-pregnant adults ages 19 through 64 years, who are residents of the Greater New Orleans region, and whose family incomes do not exceed 200 percent of the FPL. Coverage is provided for a limited set of outpatient services provided by participating health clinics, or in the case of physician specialists services, for which referral was made by a participating clinic. All participating clinics are former recipients of grant funding under the Primary Care Access Stabilization Grant program, which expired on 09/30/2010.	Current	12/31/2013	Expansion of Medicaid to AwDC, CO is sumbitting a waiver to phase-in this population
Maryland	Maryland Health Choice	1115	Current,Pending	The Health Choice Demonstration allows the State to offer health care coverage to working age adults and persons with disabilities who normally do not qualify for Medicaid. Persons with disabilities receive the same coverage as Medicaid, while working age adults receive a benefit focusing on primary and preventive care, and may receive discounts on prescription drugs. Women who lose Medicaid at the end of their pregnancy can receive coverage for family planning services. Persons eligible for Medicaid benefits may have to enroll with a health plan in order to receive coverage.	Current	12/31/2013	Expansion of Medicaid; CO has already submitted a Family Planning Waiver
Massachusetts	Massachusetts MassHealth	1115	Current,Pending	The MassHealth Demonstration allows the State to offer health care coverage to additional children, persons with disabilities, working age adults, families affected by unemployment, and persons with HIV/AIDS who normally are not eligible for Medicaid. Some of these individuals receive assistance to purchase health insurance, through the Commonwealth Care Health Connector, Insurance Partnership, or other program. Persons eligible for the regular Medicaid program may have to enroll with a health plan in order to receive coverage, and co-payments for some services may be higher than what Medicaid usually allows. Other participants must pay a monthly premium to receive coverage. Finally, the demonstration program provides additional funding for hospitals and public health efforts.	Renewal	9/30/2011	Expansion of Medicaid
Michigan	Michigan Comprehensive Health Care Program 1915 (b)	1915(b)	Pending	No information	NA	NA	NA
Minnesota	Minnesota Family Planning Project	1115 Family Planning	Current,Pending	The Minnesota Family Planning Demonstration provides coverage for family planning services to men and women, ages of 15-50, with a family income at or below 200 percent of the Federal poverty level.	Renewal	9/30/2011	CO has already submitted a Family Planning Waiver
Mississippi	Mississippi Family Planning	1115	Current,Pending	The Mississippi Family Planning Demonstration provides coverage for family planning and family planning related services to women, ages 13-44, with a family income at or below 185 percent of the Federal poverty level, who are not otherwise eligible for Medicaid, Medicare or the Children's Health Insurance Program (CHIP), and do not have any other health insurance coverage.	Renewal	9/30/2011	CO has already submitted a Family Planning Waiver
Missouri	Missouri Gateway to Better Health	1115	Current,Pending	Under the Demonstration, the State will spend up to $30 million annually to preserve and improve primary and specialty care in the St. Louis region.	Current	12/31/2013	Unsure
New York	New York Federal-State Health Reform Partnership (F-SHRP)	1115	Current,Pending	The Federal-State Health Reform Partnership program allows the State to require certain groups of Medicaid eligible individuals to enroll with a health plan in order to receive coverage. Families and children who live in selected counties, and persons with disabilities are subject to this requirement. The demonstration also provides enhanced funding to support health system reform in New York.	Current	3/31/2014	CO has the ACC, but the state does not have provider infrastructure to support mandatory enrollment in managed care
New York	New York Partnership Plan	1115	Current,Pending	The Partnership Plan Demonstration allows the State to offer Family Health Plus health care coverage (Family Health Plus) to several groups of individuals who are not normally eligible for Medicaid. These include working age adults without children and other adults who do not qualify for the regular Medicaid program. These individuals could also receive assistance to pay premiums for health insurance offered by their employer. Most persons eligible for the regular Medicaid must enroll with a health plan in order to receive coverage. Those who do not participate in a full benefit coverage program may receive coverage for family planning services.	Current	12/31/2014	Expansion of Medicaid; CO has already submitted a Family Planning Waiver
North Carolina	North Carolina Be Smart	1115 Family Planning	Current,Pending	The North Carolina Be Smart Family Planning Demonstration provides coverage for family planning services to men and women over the age of 18, with a family income at or below 185 percent of the Federal poverty level, who are not otherwise eligible for Medicaid, and do not have any other health insurance coverage.	Renewal	11/30/2011	CO has already submitted a Family Planning Waiver

State	Official Program Name	Waiver Authority	Status	Description	Type	Expiration Date	Applicability to Colorado
Oregon	Oregon Health Plan 2	1115 HIFA	Current,Pending	Most individuals who qualify for medical assistance or CHIP are participants in the ""Oregon Health Plan 2 Demonstration."" Under this program, the State uses a Prioritized List of Health Services to help determine what health care services Medicaid will cover. Participants enroll with a health plan or a primary care case manager in order to receive Medicaid coverage. Persons who are eligible for Medicaid or CHIP may choose to receive assistance to pay premiums for employer-sponsored or other private health insurance, if available. The program provides health care coverage, or help with purchasing private health insurance, to low income working age adults who normally are not eligible for Medicaid. These individuals receive a more limited benefit (known as OHP Standard), and some may only be offered assistance with private health insurance. There may be a waiting list for enrollment in OHP Standard or for premium assistance.	Current	10/31/2013	CO has the ACC, but the state does not have provider infrastructure to support mandatory enrollment in managed care; CO has a small pilot program for CHP+ that helps pay premiums for employer sponsored health insurance that is logistically difficult to expand statewide.
Rhode Island	Rhode Island Rx + 1115	1115	Pending	The demonstration is a statewide program that extends pharmacy services and related medical management interventions to certain low-income adults with disabilities and seniors with incomes at or below 200 percent of the Federal Poverty Level (FPL). The current state-only programs Rhode Island Pharmacy Assistance Program for the Elderly (RIPAE), General Public Assistance Program (GPA), and Community Medical Assistance Program (CMAP) will be partially subsumed by the demonstration. The RIx+ demonstration proposed to cover not more than 40,000 enrollees.	New	In process	CO provides Rx as an optional benefit to all Medicaid clients
Tennessee	Tennessee TennCare	1115	Current,Pending	All individuals who qualify for medical assistance in Tennessee are enrolled in the TennCare II Demonstration. Demonstration participants must enroll with a health plan in order to receive coverage, and receive benefits that exceed what is provided in the Medicaid State plan. The demonstration also allows the State to offer health care coverage to additional low-income children who normally are not eligible for Medicaid. Persons in need of long-term care may receive access to nursing home and community-based alternative services through the TennCare CHOICES program. The demonstration program also provides enhanced funding hospital care and graduate medical education.	Current	6/30/2013	Expansion of Medicaid; CO has the ACC, but the state does not have provider infrastructure to support mandatory enrollment in managed care; CO provides access to nursing home and community-based alternative services
Virginia	Virginia Family Expansion Project	1115 Family Planning	Current,Pending	The Virginia Family Planning Expansion Project Demonstration provided coverage for family planning services to men and women of childbearing age, with a family income at or below 133 percent of the Federal poverty level, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP) or the State's Health Insurance Flexibility and Accountability (HIFA) Demonstration, and do not have any other health insurance coverage. The Demonstration has since been expired. The State currently provides coverage for family planning services to this population through the Medicaid State Plan.	Renewal	9/30/2011	CO has already submitted a Family Planning Waiver
Washington	Washington Take Charge	1115 Family Planning	Current,Pending	The Washington Take Charge Family Planning Demonstration provides coverage for family planning and family planning related services to women and men of childbearing age, with a family income at or below 200 percent of the Federal poverty level, who are not otherwise eligible for Medicaid, Medicare or the Children's Health Insurance Program (CHIP), and do not have any other health insurance coverage.	Renewal	9/30/2011	CO has already submitted a Family Planning Waiver
Wisconsin	Wisconsin BadgerCare Plus	1115	Current,Pending	The BadgerCare Plus Health Insurance Childless Adults Demonstration is designed to provide limited preventative and primary care benefits for adults, 19 to 64 years, without dependent children who are uninsured who have family incomes that do not exceed 200 percent of the FPL. A few unique features of the demonstration include: centralized eligibility and enrollment functions and requirement for enrollees to complete a health needs questionnaire at the time of enrollment.	Current	12/31/2013	Expansion of Medicaid to AwDC, CO is sumbitting a waiver to phase-in this population
Wyoming	WY Family Planning 1115 Demonstration	1115 Family Planning	Pending	WY submitted a proposed Family Planning demonstration and is currently under review by CMS.	New	In process	CO has already submitted a Family Planning Waiver

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

BRIEFING ISSUE

ISSUE: Accountable Care

SUMMARY:

- ❏ The Department believes fee-for-service payments provide incentives for volume rather than quality and is experimenting with several ideas to change the payment methodology to reward outcomes
- ❏ The accountable care model rewards networks of providers with higher reimbursements if they improve outcomes for patients over time compared to expected benchmarks based on patient risk characteristics
- ❏ The Department's R-5 proposes "gainsharing" incentive payments to providers participating in the ACC
- ❏ The Department is also requesting funding in R-5 for a separate proposal to provide performance incentives using prospective payments
- ❏ The projected savings from the gainsharing payments will be partially offset by costs for contract services and FTE to study the prospective payment reimbursement system and design and implement the gainsharing proposals

DISCUSSION:

The majority of the Medicaid funds administered by the Department are distributed through fee-for-service payments that the Department believes provide incentives for volume rather than quality. The Department is experimenting with several ideas for how to change the dominant fee-for-service payment model to encourage health outcomes, and most of these ideas can be grouped under the umbrella term of accountable care.

The accountable care model rewards networks of providers with higher reimbursements if they improve outcomes for patients over time compared to expected benchmarks based on patient risk characteristics. It encourages and pays for enhanced managed care for patients. Some previous attempts at managed care were perceived as intruding on diagnosis and treatment decisions, locking patients into preferred provider networks, and rationing care. In the accountable care model providers control care recommendations and patients are free to choose their providers and course of treatment from among the efficacious remedies.

The backbone of the Department's accountable care initiatives is the Accountable Care Collaborative (ACC), which 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 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 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. The Department views the ACC as a platform for expanding incentive-based payments in future years.

The Department passively enrolls clients who have an existing relationship with a primary care provider who participates in the ACC, and those with no existing relationship with any Medicaid primary care provider. Passively enrolled clients may choose to opt out of the ACC program. The Department does not currently enroll people who are dually eligible for Medicaid and Medicare in the ACC. As of October 20 there were 45,823 clients enrolled in the ACC. Enrollment in the ACC will continue to expand in FY 2012-13 and the Department describes it as eventually encompassing all clients statewide.

The Department has not yet reported on cost savings associated with the ACC. In response to Legislative Request for Information #9 the Department indicates that a preliminary savings report for FY 2011-12 will be available by June 2012, with the final report complete by November 2012. The cost savings report will compare expenditures per member per month and health care utilization per 1,000 members per year for the ACC population with an initial baseline period and a control group of Medicaid clients who are not in the ACC.

The Department's R-5 proposes "gainsharing" incentive payments to providers participating in the ACC. In the gainsharing system the Department will assign clients to providers based on where they historically sought service and assign risk scores for each client developed by the Statewide Data Analytics Contractor. Then expected baseline expenditures will be calculated for each client based on the Department's history with similar clients. If actual expenditures are less than the expected baseline, then providers assigned to the client will get a share of the savings in the form of incentive payments. The highest incentive payments will be associated with the highest risk clients and the Department believes this, combined with the adjustment of expected baseline expenditures for risk, will prevent providers from trying to skim only the healthiest clients.

The Department is also requesting funding in R-5 for a separate proposal to provide performance incentives using prospective payments, rather than retrospective gainsharing. The prospective

payments would be based on the PROMETHEUS model developed by the Health Care Incentives Improvement Institute (HCI3). In this model bundled rates would include physician, specialty, and laboratory care and providers would receive incentives if actual costs are lower than expected.

The Colorado Business Group on Health (CBGH) conducted an analysis of the Department's payments for 21 specific conditions and concluded that 58 percent of what the Department spends is due to potentially avoidable complications of care. The CBGH recommended that the Department focus on six specific conditions including diabetes, gastoesopageal reflux disease, asthama, chronic obstructive pulmonary disease, pregnancy and colonoscopy. The CBGH estimated that using the PROMETHEUS payment model statewide for these six conditions the Department could achieve savings of approximately $30.0 million over a four-year period, not including costs to implement the payment model.

The ACA requires states to increase Medicaid rates for specific primary care services to 100.0 percent of the Medicare reimbursement rates. The Department perceives gainsharing and prospective payments as potential ways of satisfying the requirement to increase reimbursement rates, but with increased performance expectations that the services of primary care physicians impact expenditures in other parts of the health care delivery system.

The Department is not requesting new money for the gainsharing incentives, as the payments will come from savings from the base budget request. The Department is projecting a net savings as a result of gainsharing payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) and requesting a reduction in base funding accordingly. The projected savings is based on a 5 percent reduction in generic drug utilization, hospital readmissions, outpatient hospital visits, and emergency department visits by clients assigned to FQHCs and RHCs. The Department assumes that 50 percent of the total savings will be paid to the FQHCs and RHCs. The Department is also projecting a net savings from gainsharing for Behavioral Health Organizations related to psychotropic drug utilization.

The projected savings from the gainsharing payments will be partially offset by costs for contract services and FTE to study the prospective payment reimbursement system and design and implement the gainsharing proposals described above, including: establishing the gainsharing methodology, attributing clients to providers, calculating the savings and incentive payments, procuring and maintaining contracts with the vendors for studies of the gainsharing programs, drafting and managing contracts with providers, and fielding questions and concerns from providers. The Department projects that the gainsharing initiatives will save more money than the cost of the increases in contract services and FTE.

The Department's R-5 also includes some costs associated with changes to long term care that are discussed in the next issue brief.

	Total	General Fund	FTE
FQHC and RHC net savings from gainsharing	(1,594,121)	(750,082)	
Behavioral Health Organization net savings from gainsharing	(319,123)	(149,494)	
State staff to oversee gainsharing and prospective payments	142,714	71,357	1.8
Contract services to develop and test prospective payment model	112,500	56,250	
Contract services to redesign the assessment tool for long-term care	220,000	110,000	
Contract services to study palliative care	50,000	25,000	
Contract services to study consolidating long-term care services in naturally occurring retirement communities	75,000	37,500	
Annualize previous funding to study coordinated payments and payment reforms	(532,000)	(266,000)	
TOTAL requested for R-5	(1,845,030)	(865,469)	

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

BRIEFING ISSUE

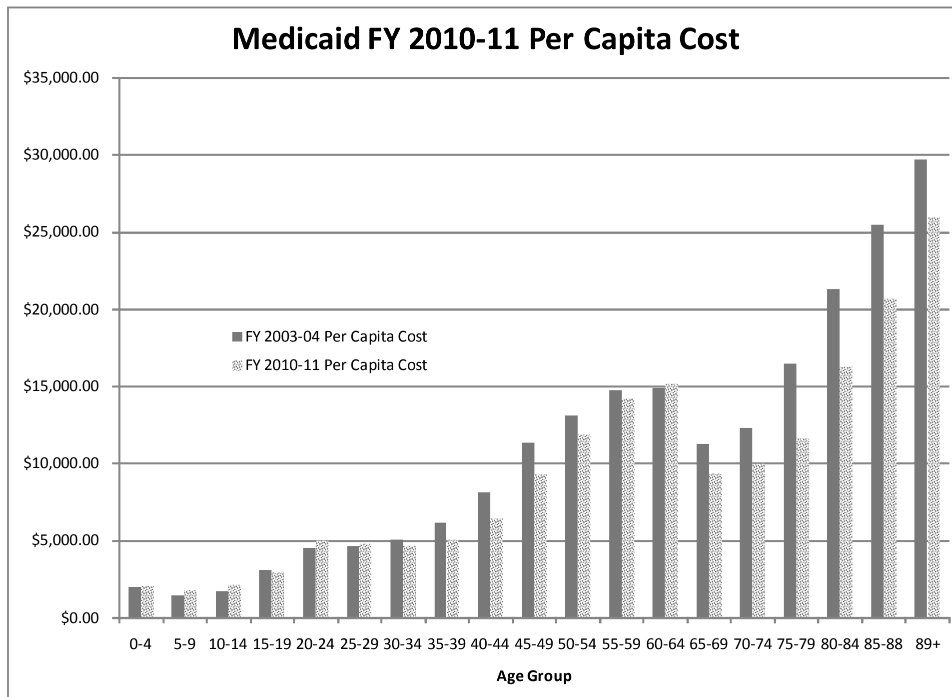
ISSUE: Long-term care

SUMMARY:

- ❑ The Department spends more per capita on older populations than younger populations
- ❑ Population projections from the U.S. Census Bureau project that Colorado's population will skew older in coming years
- ❑ Medicaid is a significant provider of long-term care services
- ❑ To contain costs the Department has taken measures to encourage utilization of community-based long-term care, rather than more expensive nursing homes
- ❑ Reviews proposals in R-5 intended to further reduce the growth in long-term care expenditures

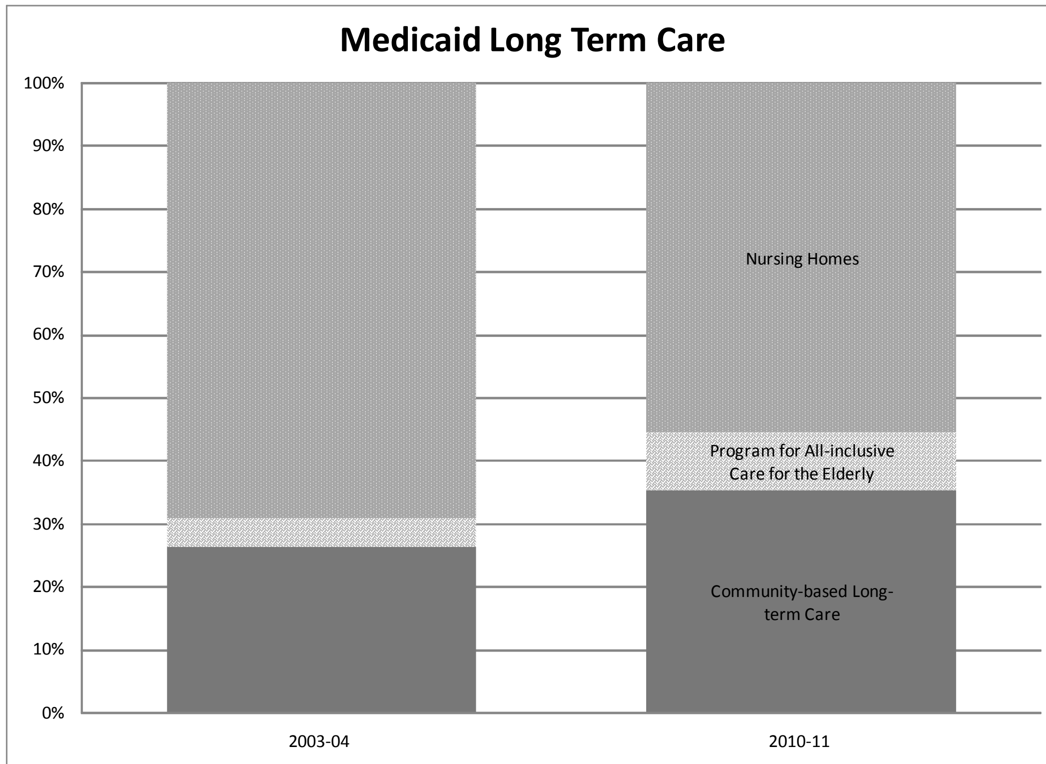
DISCUSSION:

The Department spends more per capita on older populations than younger populations. A variety of factors contribute to this phenomenon, including variations in eligibility criteria and the number of enrollees in different age ranges, but a significant part of the explanation is increasing risk factors as people age, and in particular the risk of being disabled.

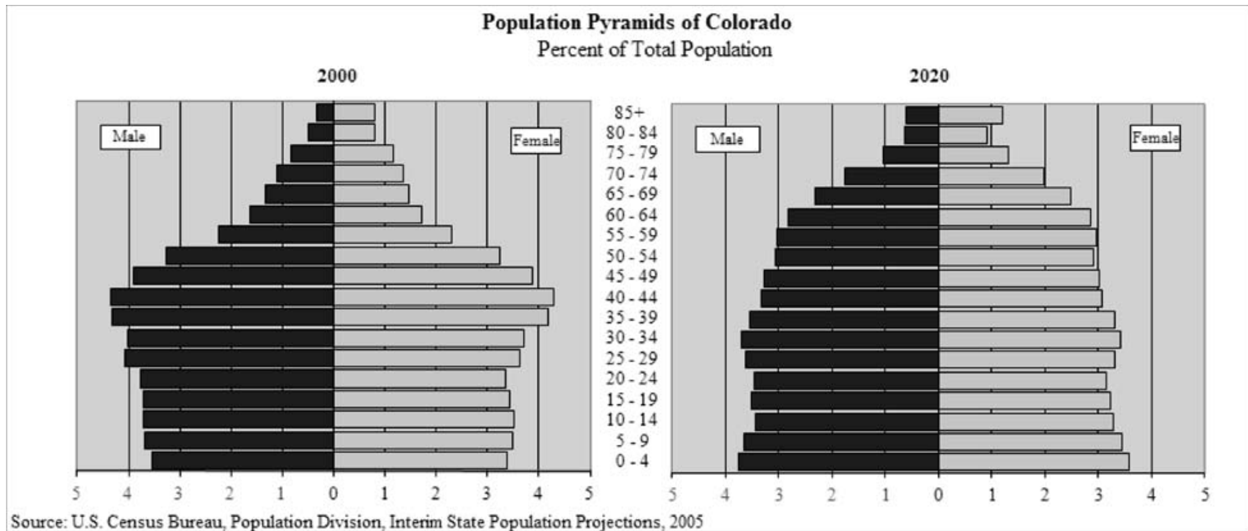


The dip in per capita expenditures at age 65 corresponds with when Medicare picks up a portion of medical expenses. At age 65 Medicaid provides assistance with Medicare premiums and coinsurance, and continues to pay for some medical services not covered by Medicare. It also pays for long-term care services not covered by Medicare.

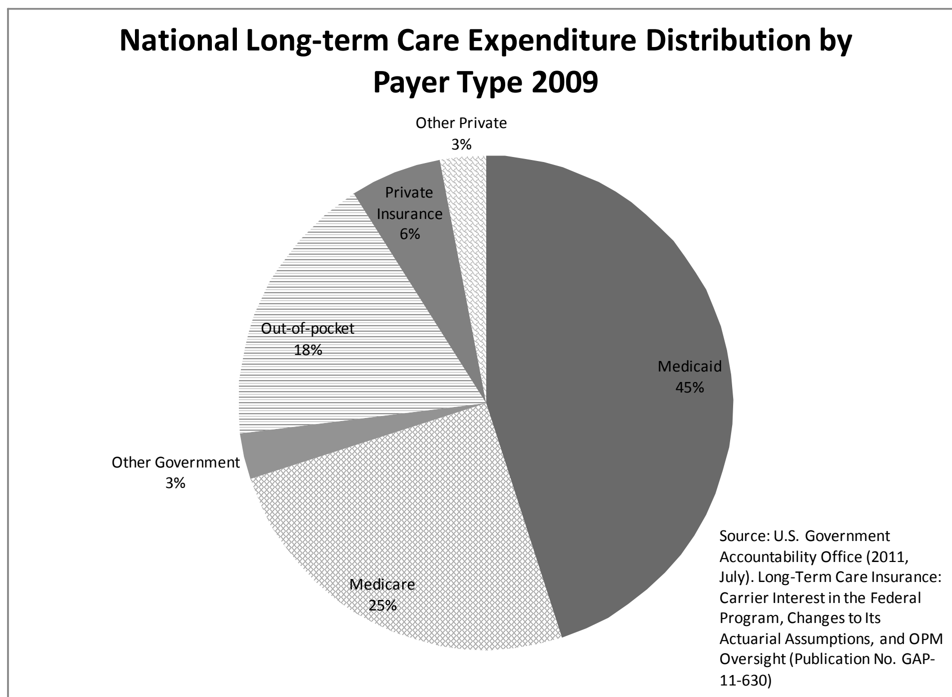
Part of the change in per capita expenses for the elderly from FY 2003-04 to FY 2010-11 is attributable to increasing utilization of community-based long-term care as an alternative to more expensive nursing homes.



Population projections from the U.S. Census Bureau project that Colorado's population will skew older in coming years, toward the age ranges with historically higher Medicaid expenditures per captia.



Medicaid is a significant provider of long-term care services. Nationally Medicaid represents approximately 45 percent of expenditures for long-term care services. The Department was not able to provide recent Colorado-specific estimates, but the Department noted that Colorado has a higher utilization of home and community-based services than typical nationally, and Colorado uses cost-based reimbursement plus a nursing facility provider fee for class I nursing facilities. These may skew Colorado's experience somewhat from the national data, but not enough to change the point that Medicaid is the most significant payer for long-term care services, and by a wide margin.



The Department's R-5 includes several proposals to address long-term care expenses. Among these proposals is $50,000 total funds and $25,000 General Fund for consulting services to study potential savings and qualitative impacts of enhanced palliative care for Medicaid clients, and to develop enhanced palliative care demonstration programs. The Department argues that some illnesses and conditions have no evidence-based therapies, but clients are given invasive, risky, and costly care, when they may actually prefer palliative care. The Department cites a March 2011 study in *Health Affairs* that found a savings of $6,900 per admission for patients receiving palliative care.

Another proposal includes $75,000 total funds and $37,500 General Fund to study the feasibility of consolidating long-term care services in naturally occurring retirement communities. According to the Department, studies have found that many people needing services congregate in close proximity to each other naturally. By identifying naturally occurring retirement communities and consolidating services in these communities the Department hopes to achieve efficiencies and improve health outcomes.

Another proposal includes $220,000 total funds and $110,000 General Fund to redesign the assessment tool for long-term care and better integrate the data collected from the assessment tool with claims information. The Department indicates that the current assessment tool focuses on how well a client can perform activities of daily living, but lacks some key information that impacts the cost of care, such as mental health status and the level of family support. Also, most of the responses on the assessment tool are not standardized entries but narrative responses that make comparisons difficult. The current lack of connection between the assessment tool and claims data is a barrier to the Department designing performance-based payments for long-term care, because the Department can't establish expected baseline expenditures for different levels of assessed needs.

The Department also reported as part of R-5 on two studies underway that don't require new resources. The Department is studying the Consumer First Choice program as a state plan service for disabled individuals to replace the Consumer Directed Attendant Support Services that is currently offered as a home and community based waiver benefit. The Department believes the benefits are similar and the Consumer First Choice program is eligible for an additional 6.0 percent enhanced federal match. The Department is also studying whether to implement a home health program for clients with chronic conditions that would integrate physical health, mental health, and long-term care services and be eligible for a 90 percent enhanced federal match for eight quarters.

In addition to R-5 the executive branch is proposing moving some programs from the Department of Human Services to the Department of Health Care Policy and Financing to consolidate administration of long-term care services. This proposal will be discussed in more detail during the briefing on the Department of Human Services, Services for People with Disabilities.

BRIEFING ISSUE

ISSUE: Cost containment measures proposed in R-6

SUMMARY:

Summarizes the cost containment measures proposed in R-6

RECOMMENDATION:

Staff recommends that the JBC sponsor legislation to continue the 1.5% reduction in Class I nursing facility reimbursement rates originally implemented in FY 2010-11 by H.B. 10-1324 and continued in FY 2011-12 by S.B. 11-215.

DISCUSSION:

The table below summarizes the cost containment measures proposed in R-6 and the Department's projected FY 2012-13 fiscal impact for each. The proposals are sorted by projected date of implementation. Several of the proposals have FY 2011-12 impacts, too. The total FY 2011-12 savings is $19.6 million, of which $15.7 million is attributable to the *Hospital Provider Fee Financing*.

The first six proposals have already been implemented and the Department plans to implement another five proposals at the beginning of January, so that 11 of the 16 cost containment measures will be in place before the JBC has time to take supplemental action to approve the request. The *Hospital Provider Fee Financing* was actually implemented during FY 2010-11, but the savings have not yet been recognized in the budget. It is not clear what the Department would do if the JBC denied any of the proposals that have already been implemented. All of the proposals are within the Department's current statutory authority to implement without legislative action except the *Continuation of Nursing Facility Reduction*, which would require a bill.

Total	General Fund	Policy Change	Date
0	(15,700,000)	*Hospital Provider Fee Financing*: Prior to the Hospital Provider Fee the Department would certify public expenditures (CPE) by government owned or operated outpatient hospitals to draw additional federal funds to the upper payment limit (UPL) set by the federal government as the maximum allowable Medicaid reimbursement. The Department would then retain a portion of the federal funds matched through the CPE process to offset the need for General Fund in the Medical Services Premiums line. The Hospital Provider Fee takes government owned or operated hospitals to the UPL, eliminating the CPE for these entities. Instead, the Department proposes retaining some of the Hospital Provider Fee to offset the need for General Fund in the Medical Services Premiums line.	01/2011
(416,472)	(203,488)	*Physician Administered Drug Pricing and Unit Limits:* Decrease rates for risperidone to match Medicare rates. Also to match Medicare rates, increase rates for haloperidol decanoate and fluphenazine decanoate, but correct billing unit limits to generate net savings. All three drugs are used to treat schizophrenia.	07/2011
(2,092,701)	(1,022,490)	*Reimbursement Rate Alignment for Developmental Screenings:* Reduce the rates paid for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers and implement age limits.	08/2011
(902,736)	(451,368)	*Preterm Labor Prevention*: Offer coverage of alpha hydroxyprogesterone caproate injections that reduce the occurrence of preterm labor	08/2011
(2,418,276)	(1,209,138)	*Expansion of the Physician Administered Drug Rebate Program:* Expand the list of physician-administered drugs eligible for rebates and perform outreach to providers to ensure sufficient information is provided for the Department to claim rebates.	10/2011
(419,772)	(205,100)	*Synagis Prior Authorization:* Increase prior authorization review to ensure only appropriate dosages are utilized of this drug that is commonly prescribed as a prophylactic to reduce the likelihood of hospitalization from respiratory syncytial virus (RSV).	11/2011
(1,931,172)	(943,568)	*Seroquel Restrictions*: Prevent the utilization of Seroquel for off label use. Seroquel is designed to treat schizophrenia and mood disorders, but is sometimes prescribed for off-label use as a sleep aid or anxiety reducer.	01/2012
(1,641,594)	(802,081)	*Dental Efficiencies*: Limit orthodontics to cases where the client has a severely handicapping malocclusion, require prior authorization review for preparatory diagnostics (casts, x-rays, etc), and convert from upfront reimbursements to installments.	01/2012
(1,000,000)	(488,599)	*Ambulatory Surgical Centers:* The Department initiated a pilot project to shift outpatient surgery utilization from outpatient hospitals to less costly ambulatory surgical centers.	01/2012
(492,000)	(240,391)	*Augmentative Communication Devices*: Perform outreach to increase utilization of tablet computers instead of more expensive traditional devices for people with impairments that hinder their ability to produce or comprehend verbal or visual communication.	01/2012
(209,574)	(102,398)	*Public Transportation Utilization*: Provide incentives in the form of lower base funding and potential bonus payments for meeting performance goals in the contracts with non emergent medical transportation providers to increase the utilization of public transportation in the Denver-metro area.	01/2012

Total	General Fund	Policy Change	Date
(4,117,163)	(2,011,640)	*Home Health Care Cap*: Limit the number of hours of skilled care a patient can receive in the home health setting to eight per day.	04/2012
(382,453)	(186,866)	*Home Health Therapies Cap*: Limit the number of home health visits for therapy to 48 visits per calendar year.	04/2012
(9,024,677)	(4,512,338)	*Continuation of Nursing Facility Reduction:* The Department proposes an indefinite continuation of the 1.5% reduction in Class I nursing facility reimbursement rates originally implemented in FY 2010-11 by H.B. 10-1324 and continued in FY 2011-12 by S.B. 11-215. ***THIS REQUIRES A STATUTORY CHANGE.***	07/2012
(4,000,000)	(1,954,394)	*Pharmacy Rate Methodology Transition*: The Department proposes switching from using the average wholesale price (AWP) for drugs to determine pharmaceutical reimbursement rates to using the costs of ingredients, as measured by the wholesale acquisition cost (WAC) or state maximum allowable cost (SMAC), plus the costs of dispensing. A recent lawsuit found flaws in the AWP and the company that produced the index is no longer publishing it. The Department expects the change in reimbursement methodology will reduce total expenditures.	7/2012
(1,150,732)	(562,246)	*Durable Medical Equipment Preferred Provider:* Leverage state purchasing power through a sole contract for diabetic testing supplies to achieve prospective rebates, free glucose meters, and client education and outreach.	07/2012
500,000	125,000	*Utilization Management Vendor Funding*: The Department requests funding for the Department's contracted utilization management vendor to perform additional prior authorization reviews for the savings initiatives in this request.	
(29,699,322)	(30,471,105)	TOTAL	

The following proposals would reduce the level of services provided for some clients from previous practice:

- *Home Health Care Cap*
- *Home Health Therapies Cap*
- *Dental Efficiencies (January 2011)*

The *Hospital Provider Fee Financing* results in a lower net benefit to hospitals, and the following proposals would result in lower reimbursement rates for providers:

- *Continuation of Nursing Facility Reduction*
- *Pharmacy Rate Methodology Transition*
- *Reimbursement Rate Alignment for Developmental Screenings (implemented)*
- *Physician Administered Drug Pricing and Unit Limits (implemented)*

The other proposals provide incentives or changes in authorization procedures intended to steer utilization to lower cost and best practice alternatives, while continuing to allow exceptions for medical necessity.

FY 2012-13 Joint Budget Committee Staff Budget Briefing
Department of Health Care Policy and Financing

BRIEFING ISSUE

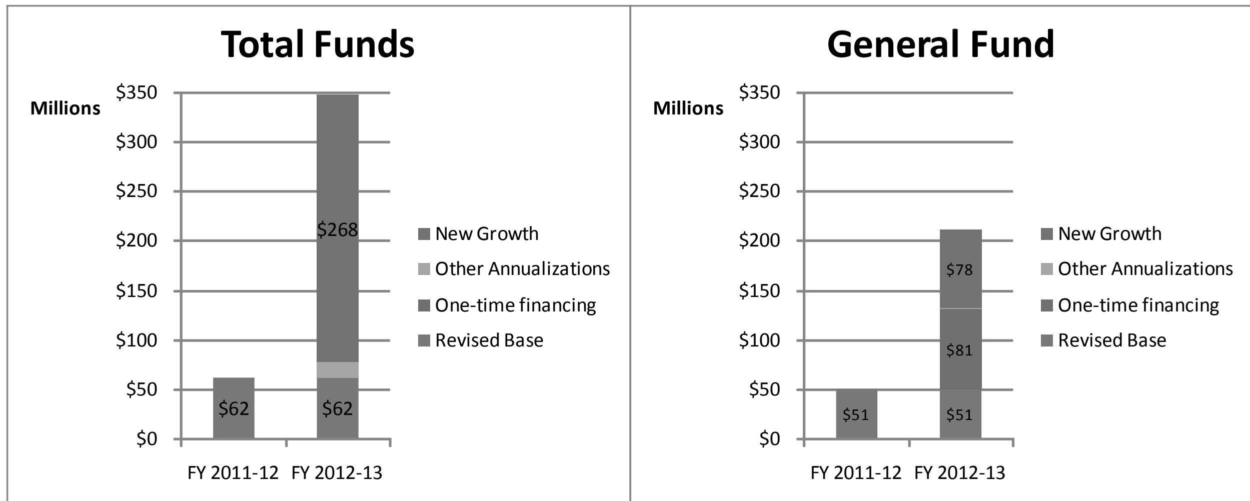
ISSUE: Alternate financing to the General Fund

SUMMARY:

- ❑ Of the Department's base caseload and cost forecast for Medical Services Premiums, or R-1, $81.2 million of the General Fund increase is attributable to the end of one-time financing mechanisms used to offset the need for General Fund in FY 2010-11.
- ❑ Reviews proposals included in the Department's request that involve alternate financing to the General Fund
- ❑ Provides background on the use of Amendment 35 Tobacco Tax revenues to support Medicaid expenditures. Notably, the Department did NOT request continuing this policy for FY 2012-13.

DISCUSSION:

Of the Department's base caseload and cost forecast for Medical Services Premiums, or R-1, $81.2 million of the General Fund increase is attributable to the end of one-time financing mechanisms used to offset the need for General Fund in FY 2010-11.



These bills and their General Fund impacts are as follows:

SB 11-211 Tobacco Revenues Offset Medical Services	$33,000,000
SB 11-212 Use Provider Fee Offset Medicaid	25,000,000
SB 11-215 2011 Nursing Facility Rate Reduction	4,432,915
HB 10-1380 Use Supplemental OAP Health Fund for Medicaid	$3,000,000
SB 11-219 2011 Transfers for Health Care Services	15,775,670
	$81,208,585

For FY 2012-13 the Department's request includes several proposals for alternative financing to the General Fund. R-6 includes a holdback of $15.7 million from the Hospital Provider Fee. In R-10 the Department proposes withholding 10.0 percent of the federal funds from the Physician Supplemental Payment and the Inpatient High Volume Supplemental Payment to reduce the need for General Fund in the Medical Services Premiums line item. These two supplemental payments were recently created to partially reimburse public providers for uncompensated, or under-compensated, costs for Medicaid clients. The Department matches the federal funds for the Physician Supplemental Payment and the Inpatient High Volume Supplemental Payment using certified public expenditures by public providers. In R-11 the Department proposes using bonus payments to Colorado for meeting outreach and retention performance goals of the Children's Health Insurance Program to offset the need for General Fund in the Medicare Modernization Act State Contribution Payment line item.

The Department's R-7 provides alternate financing to the General Fund through increased cost sharing by Medicaid and CHP+ clients. The table below estimates the average impact on different populations.

Average Estimated Cost Sharing per Client Per Year			
Population	Current Cost Sharing	Proposed Cost Sharing	Difference
Medicaid			
Ages 65+	$8.44	$16.30	$7.86
Disabled Ages 60-64	$42.21	$69.57	$27.36
Disabled Ages 0-59	$46.12	$82.93	$36.81
Categorically Eligible Parents	$19.29	$26.93	$7.64
Parents to 60%	$16.70	$25.75	$9.05
Parents to 100%	$11.53	$17.78	$6.25
Children's Basic Health Plan (CHP+)			
Children from 100% to 150%	$10.00	$12.00	$2.00
Children from 151% to 200%	$56.00	$79.00	$23.00
Children from 201% to 250%	$82.00	$192.00	$110.00

The Department projected a 3.0 percent attrition rate in CHP+ as a result of tripling enrollment fees, based on analysis of the impact of higher enrollment fees in other states.

Part of the stated purpose of R-7 is to, "encourage a more involved decision-making process when clients decide whether or not they need to visit a physician or hospital" and "reduce unnecessary emergency or specialty care" and "slow long-term Medicaid and CHP" cost growth." However, the Department assumes no change in utilization patterns with higher co-payments. The Department explains that it believes changes in utilization patterns are possible, but did not find sufficient evidence showing a specific relationship between changes in co-payments and utilization patterns. Therefore, the Department estimated the savings conservatively. For FY 2012-13 the benefit of the proposal is primarily from identifying an alternative source of funding to the General Fund, rather than changing utilization patterns.

Notably the Department's request does not include continuation of transfers from Amendment 35 Tobacco Tax revenues to support Medical Service Premiums, which would require a declaration of a fiscal emergency. This accounts for $33.0 of the requested increase in General Fund for the Medical Services Premiums line item.

Amendment 35, was approved by the voters during the 2004 election, and added Section 21 of Article X to the Colorado Constitution. Section 21 of Article 10 added two cigarette and tobacco taxes:

1. An additional $0.64 tax on each pack of cigarettes sold in Colorado (a pack is equal to twenty cigarettes); and
2. A statewide tobacco products tax, on the sale, use, consumption, handling, or distribution of tobacco products by distributors, at the rate of 20.0 percent of the manufacturer's list price.

Amendment 35 was implemented in Colorado Statute in Section 24-22-117, C.R.S. by H.B. 05-1262 (Boyd / Hagedorn). Section 24-22-117, C.R.S. outlines how revenue from Amendment 35 is distributed to various state agencies including: the Departments of Health Care Policy and Financing, Public Health and Environment, and Human Services. The following table outlines the how Amendment 35 moneys are distributed.

Distribution of Amendment 35 Moneys		
Dept.	**Program and/or Fund**	**Percent**
HCPF	Health Care Expansion Fund, to provide funding to the Children's Basic Health Plan and Medicaid.	46.0%
HCPF	Primary Care Fund, to provide funding to clinics and hospitals that offer health care services to the uninsured or medically indigent.	19.0%
DPHE	Tobacco Education Programs Fund, to support grants for tobacco education, prevention and cessation.	16.0%
DPHE	Prevention, Early Detection and Treatment Fund, to support grants for cancer, cardiovascular and pulmonary disease.	16.0%
DHS	Old Age Pension Fund.	1.5%
DOR	Local governments, to compensate for lost revenue from tobacco taxes	0.9%

Distribution of Amendment 35 Moneys		
Dept.	**Program and/or Fund**	**Percent**
HCPF	Health Care Expansion Fund, to provide funding to the Children's Basic Health Plan and Medicaid.	46.0%
DPHE	Immunizations performed by small local public health agencies.	0.3%
HCPF	Children's Basic Health Plan	0.3%
Total		**100.0%**

There is additional formula distribution of the 16.0 percent that goes into the Prevention, Early Detection and Treatment Fund, the largest of which is 20.0 percent (up to $5.0 million) to the HCPF for the Breast and Cervical Cancer Treatment Program and 15.0 percent to the Health Disparities Program in DPHE. Note these funds are shown in the Long Bill as reappropriated from the Prevention, Detection and Treatment Fund.

During the 2010 and 2011 Legislative Sessions, H.B. 10-1381 and S.B. 11-211 reduced funding from the Tobacco Education Programs Fund and the Prevention, Early Detection and Treatment Funds in DPHE and transferred these funds to the HCPF. The graphs on the following page compare what funding for these programs would have looked like if the transfer of Amendment 35 funds was not done in FY 2010-11 and FY 2011-12, and what the funding looked like as a result of the transfers.

Impact of Transfers on Specific Public Health Programs

The three programs are the programs administered by the Department of Public Health and Environment have been impacted by the previous two fiscal years reduction of Amendment 35 funds, and would be impacted by any future reductions to Amendment 35 moneys.

- Health Disparities Grants
- Tobacco Education, Prevention and Cessation Grants
- Cancer, Cardiovascular Disease and Pulmonary Disease Grants
- Breast and Cervical Screening

Health Disparities Grants

The Health Disparities Grant Program provides grants for the prevention, early detection, and treatment of cancer, cardiovascular, and pulmonary diseases amount African Americans, Latinos, Native Americas, and other groups.

Summary of Reductions to Health Disparities Grants			
	Amendment 35 Reduction	**Total Funds Prior to Reduction**	**Amendment 35 Percent of Total**
FY 2010-11	($4,450,435)	$5,163,148	86.2%
FY 2011-12	(3,068,241)	3,564,512	86.1%

Tobacco Education, Prevention, and Cessation Grants

These grants are award to organizations that are working on projects aimed at the prevention of tobacco use among young people, reduce exposure to second hand smoke, especially among children, and projects that promote quitting among young people and adults.

Summary of Reductions to Tobacco Education, Prevention and Cessation Grants			
	Amendment 35 Reduction	Total Funds Prior to Reduction	Amendment 35 Percent of Total
FY 2010-11	($15,346,625)	$22,354,436	68.7%
FY 2011-12	(17,428,594)	23,212,262	75.1%

Breast and Cervical Cancer Screening

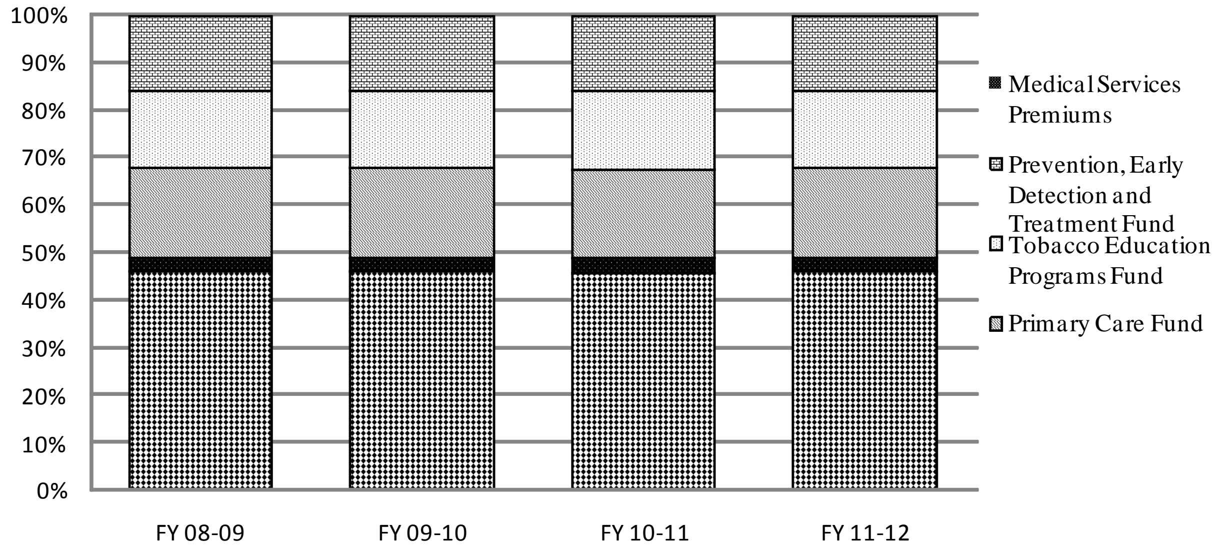
Funding in this line item is used to provide breast and cervical cancer screenings. The Amendment 35 money in this line item was not reduced in FY 2010-11

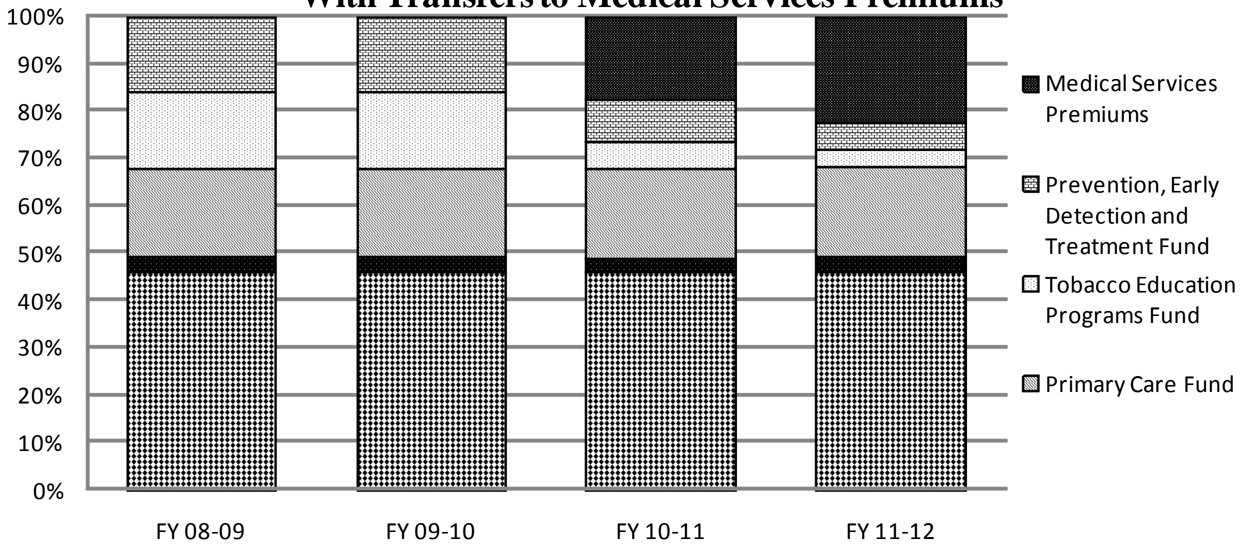
Summary of Reductions to Breast and Cervical Cancer Screening			
	Amendment 35 Reduction	Total Funds Prior to Reduction	Amendment 35 Percent of Total
FY 2010-11	n/a	n/a	
FY 2011-12	(1,625,000)	6,953,253	23.4%

Cancer, Cardiovascular Disease, and Pulmonary Disease Grants

The grants funded with dollars in this line item are used for the early detection and prevention of cancer, cardiovascular, and chromic pulmonary diseases.

Summary of Reductions to Cancer, Cardiovascular Disease and Pulmonary Disease Grants and Program Administration			
	Amendment 35 Reduction	Total Funds Prior to Reduction	Amendment 35 Percent of Total
FY 2010-11	($5,524,358)	$12,482,157	44.3%
FY 2011-12	(10,090,055)	13,583,880	74.3%


Distribution of Amendment 35 Moneys FY 2008-09 to FY 2011-12 Without The Transfers to Medical Services Premiums
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 08-09
FY 09-10
FY 10-11
FY 11-12
Medical Services Premiums
Prevention, Early Detection and Treatment Fund
Tobacco Education Programs Fund
Primary Care Fund


Distribution of Amendment 35 Moneys FY 2008-09 to FY 2011-12 With Transfers to Medical Services Premiums
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 08-09
FY 09-10
FY 10-11
FY 11-12
Medical Services Premiums
Prevention, Early Detection and Treatment Fund
Tobacco Education Programs Fund
Primary Care Fund

Budget Balancing Option
The following is a discussion on the maximum amount of Amendment 35 moneys that could be used in FY 2012-13 to offset General Fund in Health Care Policy and Financing (HCPF). **This does not represent a staff recommendation.** Based on the amount of Amendment 35 revenue collected July through October, and a five year historical percentage of how much the first three months of revenue account for the total fiscal year collection, staff estimates a total of $150.7 million will be collected in FY 2011-12. The following table shows the maximum amount of Amendment 35 moneys could be utilized to offset the General Fund shortfall. Note this figure assumes that all funding distributed to the Tobacco Education Programs Fund and the Prevention, Detection, and Early Treatment Fund are transferred.

Estimation of the Amount of Amendment 35 Moneys That Could be Used to Offset General Fund	
Description	**Numeric Amount**
Amendment 35 Revenue - July 2011-October 2011	$40,848,636
Five year Average of the amount of Amendment 35 Revenue collected July 2011-October 2011	27.1%
Total Estimate Amendment 35 Revenue	$150,732,974
Tobacco Education Programs Fund Amount (16.0%)	$24,117,576
Prevention, Detection, and Early Treatment Fund (16.0%)	$24,117,576
Maximum that could be transferred to HCPF	**$48,235,152**

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Executive Director: Susan E. Birch

(Primary Functions:Administration of Medicaid, the Colorado Indigent Care Program, S.B. 00-71 Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan).

(1) Executive Director's Office

(Primary Functions: Provides all of the administrative, audit and oversight functions for the Department. This Division contains 7 Subdivisions.)

(A) General Administration

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Personal Services	20,499,157	19,017,761	21,290,686	21,963,413	R5
FTE	276.5	270.6	313.0	315.3	
General Fund	7,927,142	7,559,246	7,675,241	8,012,169	
Cash Funds	1,172,469	1,289,520	1,974,533	2,058,349	
Reappropriated Funds	1,187,672	520,127	448,289	380,410	
Federal Funds	10,211,874	9,648,868	11,192,623	11,512,485	
Health, Life, and Dental	1,479,962	1,706,057	2,024,577	1,978,172	R5
General Fund	640,247	611,752	627,749	730,023	
Cash Funds	63,735	205,744	255,164	159,483	
Reappropriated Funds	38,965	15,219	0	49,661	
Federal Funds	737,015	873,342	1,141,664	1,039,005	
Short-term Disability	24,456	26,138	32,188	39,312	R5
General Fund	9,267	9,539	12,334	15,918	
Cash Funds	1,540	2,174	2,503	2,957	
Reappropriated Funds	1,885	737	0	629	

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Federal Funds	11,764	13,688	17,351	19,808	
S.B. 04-257 Amortization Equalization Disbursement	330,311	402,667	532,854	711,137	R5
General Fund	123,846	145,650	190,728	287,980	
Cash Funds	20,931	33,664	53,148	53,468	
Reappropriated Funds	25,615	11,411	0	11,380	
Federal Funds	159,919	211,942	288,978	358,309	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	205,654	292,544	427,325	611,134	R5
General Fund	76,042	105,135	151,785	247,483	
Cash Funds	13,368	24,547	42,482	45,949	
Reappropriated Funds	16,009	8,321	0	9,780	
Federal Funds	100,235	154,541	233,058	307,922	
Salary Survey and Senior Executive Service	0	0	0	0	
General Fund					
Cash Funds					
Reappropriated Funds					
Federal Funds					
Performance-based Pay Awards	0	0	0	0	
General Fund					
Cash Funds					
Reappropriated Funds					
Federal Funds					
Worker's Compensation	34,252	34,748	29,652	33,584	

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
General Fund	17,126	17,374	14,826	16,792	
Federal Funds	17,126	17,374	14,826	16,792	
Operating Expenses	1,567,155	1,345,966	1,586,232	1,557,866	R5
General Fund	642,384	652,128	679,994	714,010	
Cash Funds	126,000	15,244	101,248	53,049	
Reappropriated Funds	10,599	0	13,461	13,461	
Federal Funds	788,172	678,594	791,529	777,346	
Legal and Third Party Recovery Legal Services	754,502	816,265	956,823	1,029,055	
General Fund	314,430	316,867	347,930	347,930	
Cash Funds	62,393	89,525	130,482	166,598	
Reappropriated Funds	0	0	0	0	
Federal Funds	377,679	409,873	478,411	514,527	
Administrative Law Judge Services	456,922	442,378	422,830	536,111	
General Fund	228,461	206,884	186,717	222,557	
Cash Funds	0	14,305	24,698	45,499	
Federal Funds	228,461	221,189	211,415	268,055	
Purchase of Services from Computer Center	129,163	298,151	835,843	1,021,717	
General Fund	61,245	145,739	414,566	509,171	
Reappropriated Funds	3,337	3,337	3,375	3,375	
Federal Funds	64,581	149,075	417,902	509,171	
Multiuse Network Payments	0	160,412	227,900	231,333	
General Fund		80,206	113,950	115,667	
Federal Funds		80,206	113,950	115,666	

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Management & Administration of OIT	414,321	561,419	631,234	0	
General Fund	207,161	280,710	315,617		
Federal Funds	207,160	280,709	315,617		
Payment to Risk Management and Property Funds	78,487	24,418	77,888	84,315	
General Fund	39,244	12,209	38,944	42,158	
Federal Funds	39,243	12,209	38,944	42,157	
Leased Space	385,125	554,505	696,564	696,564	
General Fund	171,512	173,962	197,119	197,119	
Cash Funds	21,050	103,290	151,164	151,164	
Federal Funds	192,563	277,253	348,281	348,281	
Capitol Complex Leased Space	395,460	388,228	397,928	442,998	
General Fund	197,730	194,114	198,964	221,499	
Federal Funds	197,730	194,114	198,964	221,499	
General Professional Services and Special Projects	2,739,351	2,963,577	6,596,052	6,268,052	R5, R7, R12
General Fund	1,189,435	1,074,923	1,430,918	1,476,168	
Cash Funds	303,858	310,465	721,750	437,500	
Federal Funds	1,246,058	1,578,189	4,443,384	4,354,384	
					Request vs Approp.
SUBTOTAL - (A) General Administration	29,494,278	29,035,234	36,766,576	37,204,763	1.2%
FTE	276.5	270.6	313.0	315.3	
General Fund	11,845,272	11,586,438	12,597,382	13,156,644	4.4%
Cash Funds	1,785,344	2,088,478	3,457,172	3,174,016	-8.2%
Reappropriated Funds	1,284,082	559,152	465,125	468,696	0.8%

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Federal Funds	14,579,580	14,801,166	20,246,897	20,405,407	0.8%

(B) Transfers to Other Departments

(Primary Functions: Contains administrative costs that are transferred to other Departments that administer programs eligible for Medicaid funding).

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request
Transfer to the Department of Public Health and Environment for Facility Survey and Certification	4,523,805	4,707,033	4,945,441	5,232,683
General Fund	1,372,036	1,443,433	1,539,788	1,572,708
Federal Funds	3,151,769	3,263,600	3,405,653	3,659,975
Transfer to the Department of Public Health and Environment for Nurse Home Visitor Program	0	1,064,517	3,010,000	3,010,000
Reappropriated Funds		429,287	1,505,000	1,505,000
Federal Funds		635,230	1,505,000	1,505,000
Transfer to the Department of Public Health and Environment for Prenatal Statistical Information	0	0	6,000	5,910
General Fund			3,000	2,955
Federal Funds			3,000	2,955
Transfer to the Department of Public Health and Environment for Enhanced Prenatal Care Training	0	82,286	0	0
General Fund		41,143		
Federal Funds		41,143		

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	Request vs Approp.
Transfer to the Department of Regulatory Agencies for Nurse Aide Certification	325,343	325,343	324,041	324,041	
General Fund	148,020	148,020	147,369	147,369	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,671	162,671	162,020	162,020	
Transfer to the Department of Regulatory Agencies for Reviews	9,576	5,998	14,000	14,000	
General Fund	4,788	2,999	7,000	7,000	
Federal Funds	4,788	2,999	7,000	7,000	
Transfer to the Department of Education for Public School Health Services Administration	129,115	71,662	140,388	149,999	
Federal Funds	129,115	71,662	140,388	149,999	
SUBTOTAL - (B) Transfers to Other Departments	4,987,839	6,256,839	8,439,870	8,736,633	3.5%
General Fund	1,524,844	1,635,595	1,697,157	1,730,032	1.9%
Reappropriated Funds	14,652	443,939	1,519,652	1,519,652	0.0%
Federal Funds	3,448,343	4,177,305	5,223,061	5,486,949	5.1%

(C) Information Technology Contracts and Projects

(Primary Functions: Contains funding the Medicaid Management Information System, Web Portal, and special IT projects).

Information Technology

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Contracts	22,767,387	23,713,491	32,412,990	31,677,207	
General Fund	5,348,546	5,498,109	6,581,901	6,590,462	R7, R12
Cash Funds	642,364	642,824	1,479,670	1,341,526	
Reappropriated Funds	100,328	100,328	100,328	100,328	
Federal Funds	16,676,149	17,472,230	24,251,091	23,644,891	
Fraud Detection Software Contract	101,250	164,833	250,000	250,000	
General Fund	28,622	41,208	62,500	62,500	
Federal Funds	72,628	123,625	187,500	187,500	
Centralized Eligibility Vendor Contract Project	0	0	2,221,482	5,098,787	R12
Cash Funds	0	0	964,169	2,534,204	
Federal Funds	0	0	1,257,313	2,564,583	
					Request vs Approp.
SUBTOTAL - (C) Information Technology Contracts and Projects	22,868,637	23,878,324	34,884,472	37,025,994	6.1%
General Fund	5,377,168	5,539,317	6,644,401	6,652,962	0.1%
Cash Funds	642,364	642,824	2,443,839	3,875,730	58.6%
Reappropriated Funds	100,328	100,328	100,328	100,328	0.0%
Federal Funds	16,748,777	17,595,855	25,695,904	26,396,974	2.7%

(D) Eligibility Determinations and Client Services

(Primary Functions: Contains funding to determine client eligibility and to provide information services to clients about their health benefits).

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Medical Identification Cards	116,959	110,562	120,000	129,240	R12
General Fund	48,001	43,726	59,203	59,203	

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Cash Funds	9,681	10,759	0	4,620	
Reappropriated Funds	1,594	1,593	1,593	1,593	
Federal Funds	57,683	54,484	59,204	63,824	
Contracts for Special Eligibility Determinations	2,332,040	2,141,327	7,761,238	7,761,238	
General Fund	888,543	823,747	828,091	828,091	
Cash Funds	24,717	5,000	2,806,268	2,806,268	
Federal Funds	1,418,780	1,312,580	4,126,879	4,126,879	
County Administration	31,153,170	31,110,742	33,547,878	31,427,702	R12
General Fund	9,627,844	9,201,053	10,300,790	10,373,188	
Cash Funds	5,948,741	6,354,318	6,513,282	5,380,796	
Federal Funds	15,576,585	15,555,371	16,733,806	15,673,718	
Hospital Provider Fee County Administration	0	0	0	2,581,071	R12
Cash Funds				1,290,536	
Federal Funds				1,290,535	
Administrative Case Management	898,270	1,115,944	869,744	869,744	
General Fund	449,135	557,972	434,872	434,872	
Federal Funds	449,135	557,972	434,872	434,872	
Customer Outreach	3,450,508	3,912,885	5,213,157	4,927,018	R12
General Fund	1,684,929	1,882,676	2,550,470	2,376,649	
Cash Funds	39,365	73,766	56,109	86,861	
Federal Funds	1,726,214	1,956,443	2,606,578	2,463,508	
					Request vs Approp.
SUBTOTAL -(D) Eligibility Determinations and Client Services	37,950,947	38,391,460	47,512,017	47,696,013	0.4%

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
General Fund	12,698,452	12,509,174	14,173,426	14,072,003	-0.7%
Cash Funds	6,022,504	6,443,843	9,375,659	9,569,081	2.1%
Reappropriated Funds	1,594	1,593	1,593	1,593	0.0%
Federal Funds	19,228,397	19,436,850	23,961,339	24,053,336	0.4%

(E)Utilization and Quality Review Contracts

(Primary Functions: Contains contract funding to review the utilization and qualify of services provided in the acute, mental health, and long-term care programs.)

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Professional Service Contracts	4,524,545	4,802,408	7,670,839	8,414,451	
General Fund	1,125,802	1,345,699	2,100,370	2,225,370	R6, R12
Cash Funds	60,449	71,505	60,537	114,332	
Federal Funds	3,338,294	3,385,204	5,509,932	6,074,749	

(F) Provider Audits and Services

(Primary Functions: Contains contract funding to audit nursing homes, federally-qualified health centers, hospitals, and other providers).

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request
Professional Audit Contracts	1,790,216	2,202,544	2,463,406	2,463,406
General Fund	895,108	1,017,368	969,283	969,283
Cash Funds	0	58,096	262,420	262,420
Federal Funds	895,108	1,127,080	1,231,703	1,231,703

(G) Recoveries and Recoupment Contract Costs

(Primary Functions: Contains contract costs associated with recovery eligible Medicaid expenses.)

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request
Estate Recovery	428,619	351,102	700,000	700,000
Cash Funds	214,310	175,551	350,000	350,000
Federal Funds	214,309	175,551	350,000	350,000

Appendix A: Numbers Pages	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request		
(H) Nursing Facility Penalty Cash Fund							
Nursing Facility Culture Change	196,572	0	0		0		
Cash Funds	196,572						
							Request vs Approp.
TOTAL - (1) Executive Director's Office	102,241,653	104,917,911	138,437,180		142,241,260		2.7%
FTE	276.5	270.6	313.0		315.3		
General Fund	33,466,646	33,633,591	38,182,019		38,806,294		1.6%
Cash Funds	8,921,543	9,480,297	15,949,627		17,345,579		8.8%
Reappropriated Funds	1,400,656	1,105,012	2,086,698		2,090,269		0.2%
Federal Funds	58,452,808	60,699,011	82,218,836		83,999,118		2.2%
(2) Medical Service Premiums							
(Provides acute care medical and long-term care services to individuals eligible for Medicaid).							
Medical Services Premiums	2,877,822,564	3,395,627,672	3,543,863,749		3,871,184,813		R1, R5, R6, R7, R10
General Fund	762,936,068	880,377,772	1,183,014,450	0	1,361,224,913	0	
Cash Funds	343,695,933	518,533,477	608,317,175		594,130,408		
Reappropriated Funds	3,917,255	7,414,327	6,388,059		3,405,690		
Federal Funds	1,767,273,308	1,989,302,096	1,746,144,065		1,912,423,802		
General Fund Exempt	*0*	*279,344,485*	*284,175,417*		*284,175,417*		
							Request vs Approp.
TOTAL - (2) Medical Services Premiums	2,877,822,564	3,395,627,672	3,543,863,749		3,871,184,813		9.2%
General Fund	762,936,068	880,377,772	1,183,014,450		1,361,224,913		15.1%
Cash Funds	343,695,933	518,533,477	608,317,175		594,130,408		-2.3%
Reappropriated Funds	3,917,255	7,414,327	6,388,059		3,405,690		-46.7%
Federal Funds	1,767,273,308	1,989,302,096	1,746,144,065		1,912,423,802		9.5%

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	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request		
General Fund Exempt	*0*	*279,344,485*	*284,175,417*	*284,175,417*		

(3) Medicaid Mental Health Community Programs
(Primary Functions: Mental health programs for Medicaid eligible clients.)

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request		Request vs Approp.
Mental Health Capitation for Medicaid Clients	223,368,053	249,352,665	272,492,157	309,782,499	R2	
General Fund	79,359,784	95,057,227	125,823,308	147,371,079		
Cash Funds	6,393,602	9,559,892	10,510,223	7,422,550		
Reappropriated Funds	10,833	13,000	13,544	0		
Federal Funds	137,603,834	144,722,546	136,145,082	154,988,870		
Medicaid Mental Health Fee for Service Payments	2,587,662	3,870,594	3,908,827	4,422,707	R2	
General Fund	993,452	1,532,590	1,954,414	2,211,353		
Federal Funds	1,594,210	2,338,004	1,954,413	2,211,354		
TOTAL - (3) Medicaid Mental Health Community Programs	225,955,715	253,223,259	276,400,984	314,205,206		13.7%
General Fund	80,353,236	96,589,817	127,777,722	149,582,432		17.1%
Cash Funds	6,393,602	9,559,892	10,510,223	7,422,550		-29.4%
Reappropriated Funds	10,833	13,000	13,544	0		-100.0%
Federal Funds	139,198,044	147,060,550	138,099,495	157,200,224		

(4) Indigent Care Program
(Primary Functions: Provides assistance to hospitals and clinics serviing a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifyingchildren and pregnant women who are ineligible for Medicaid, and provides grants to providers to improve access to primary and preventive care for the indigent population.)

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Safety Net Provider Payments	271,210,519	289,889,142	309,825,106	293,928,866	R10
General Fund	(707,378)	0	0	0	
Cash Funds	124,368,097	130,867,920	154,912,553	146,964,433	
Federal Funds	147,549,800	159,021,222	154,912,553	146,964,433	
Colorado Health Care Services Fund	10,390,000	0	0	0	
General Fund	10,390,000				
The Children's Hospital, Clinic Based Indigent Care	27,759,956	6,119,760	6,119,760	6,119,760	
General Fund	2,350,600	2,465,822	3,059,880	3,059,880	
Reappropriated Funds	8,312,000	0	0	0	
Federal Funds	17,097,356	3,653,938	3,059,880	3,059,880	
Health Care Services Fund Programs	5,410,048	29,635,144	23,510,000	0	
General Fund	(1)	0	0		
Cash Funds	0	11,909,853	11,755,000		
Reappropriated Funds	2,078,000	0	0		
Federal Funds	3,332,049	17,725,291	11,755,000		
Pediatric Specialty Hospital	14,909,166	14,755,860	11,799,938	11,799,938	
General Fund	5,098,897	5,201,789	5,899,969	5,899,969	
Cash Funds	283,000	307,000	0	0	
Reappropriated Funds	345,690	436,728	0	0	
Federal Funds	9,181,579	8,810,343	5,899,969	5,899,969	
General Fund Exempt	*104,310*	*0*	*0*	*0*	
General Fund Appropriation to Pediatric Specialty Hospital	345,690	436,728	0	0	

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
General Fund	345,690	436,728			
General Fund Exempt	*345,690*	*436,728*			
Appropriation from Tobacco Tax Fund to General Fund	0	0	446,100	446,100	
Cash Funds			446,100	446,100	
Primary Care Fund	0	0	0	28,253,000	
Cash Funds				28,253,000	
Primary Care Grant Program Special Distribution	2,005,000	3,560,000	2,135,830	0	
Cash Funds	2,005,000	3,560,000	2,135,830		
Comprehensive Primary Care Grant Program	0	0	0	0	
Cash Funds					
Children's Basic Health Plan Administration	5,145,918	4,679,134	4,894,410	5,134,993	
General Fund	0		272,494	355,329	
Cash Funds	2,277,278	2,107,643	1,948,454	1,949,823	
Federal Funds	2,868,640	2,571,491	2,673,462	2,829,841	
Children's Basic Health Plan Medical and Dental Costs	178,495,021	177,283,900	213,086,149	182,543,053	R3, R7, R8, R9
General Fund	2,710,779	14,016,193	29,997,908	24,988,890	
Cash Funds	59,964,880	48,323,777	44,582,245	39,460,356	
Federal Funds	115,819,362	114,943,930	138,505,996	118,093,807	
General Fund Exempt	*0*	*0*	*446,100*	*446,100*	

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	Request vs Approp.
TOTAL- (4) Indigent Care Program	515,671,318	526,359,668	571,817,293	528,225,710	-7.6%
General Fund	20,188,587	22,120,532	39,230,251	34,304,068	-12.6%
Cash Funds	188,898,255	197,076,193	215,780,182	217,073,712	0.6%
Reappropriated Funds	10,735,690	436,728	0	0	
Federal Funds	295,848,786	306,726,215	316,806,860	276,847,930	-12.6%
General Fund Exempt	*450,000*	*436,728*	*446,100*	*446,100*	

(5) Other Medical Services

(This division provides funding for state-only medical programs including the Old-Age Pension Medical Program, MMA State Contribution, Colorado Cares Contract Costs.The division also funds 6 special purposes Medicaid programs.)

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	Request vs Approp.
Old Age Pension State Medical	10,185,516	8,206,192	11,000,000	11,000,000	
Cash Funds	10,185,516	8,206,192	11,000,000	11,000,000	
Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pnesion State Medical Fund	0	0	0	0	
Cash Funds					
Commission on Family Medicine Residency Training Programs	1,738,844	1,738,846	1,391,077	1,391,077	
General Fund	667,890	700,624	695,538	695,538	
Federal Funds	1,070,954	1,038,222	695,539	695,539	
State University Teaching Hospitals - University of Colorado Hospital					

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
Authority	676,782	676,785	633,314	633,314	
General Fund	259,952	272,694	316,657	316,657	
Federal Funds	416,830	404,091	316,657	316,657	
State University Teaching Hospitals - Denver Health and Hospital Authority	1,831,714	1,831,714	1,831,714	1,831,714	
General Fund	703,561	738,043	915,857	915,857	
Federal Funds	1,128,153	1,093,671	915,857	915,857	
Medicare Modernization Act State Contribution Payment	57,624,126	72,377,768	91,156,720	96,674,862	R4, R11
General Fund	57,624,126	58,711,725	66,146,615	50,609,286	
Federal Funds	0	13,666,043	25,010,105	46,065,576	
Public School Health Services Contract Administration	433,700	799,699	1,138,549	1,400,780	
Federal Funds	433,700	799,699	1,138,549	1,400,780	
Public School Health Services	25,597,360	24,659,097	30,446,344	34,737,204	
Cash Funds	11,443,512	11,302,888	16,010,155	18,113,309	
Federal Funds	14,153,848	13,356,209	14,436,189	16,623,895	
Transfer to Department of Public Health and Environment for Nurse Home Visitor Program	426,956	0	0	0	
General Fund	(84,231)				
Reappropriated Funds	383,128				
Federal Funds	128,059				
Transfer to Department of Public Health and Environment for Enhanced Prenatal Care					

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	Request vs Approp.
Training and Technical Assistance	108,665	0	0	0	
General Fund	54,333				
Federal Funds	54,332				
TOTAL - (5) Other Medical Programs	98,623,663	110,290,101	137,597,718	147,668,951	7.3%
General Fund	59,225,631	60,423,086	68,074,667	52,537,338	-22.8%
Cash Funds	21,629,028	19,509,080	27,010,155	29,113,309	7.8%
Reappropriated Funds	383,128	0	0	0	
Federal Funds	17,385,876	30,357,935	42,512,896	66,018,304	55.3%
					Request vs Approp.
SUBTOTAL - Department of Health Care Policy and Financing (without DHS Division)	3,820,314,913	4,390,418,611	4,668,116,924	5,003,525,940	7.2%
FTE	276.5	270.6	313.0	315.3	
General Fund	956,170,168	1,093,144,798	1,456,279,109	1,636,455,045	12.4%
Cash Funds	569,538,361	754,158,939	877,567,362	865,085,558	-1.4%
Reappropriated Funds	16,447,562	8,969,067	8,488,301	5,495,959	-35.3%
Federal Funds	2,278,158,822	2,534,145,807	2,325,782,152	2,496,489,378	7.3%
General Fund Exempt	*450,000*	*279,781,213*	*284,621,517*	*284,621,517*	
					Request vs Approp.
TOTAL - (6) Department of Human Services Medicaid-funded Programs	415,140,344	438,883,396	430,066,566	440,852,684	2.5%
General Fund	158,585,174	175,667,660	212,885,132	218,270,801	2.5%
Cash Funds	592,619	467,856	14,518	22,092	52.2%
Reappropriated Funds	2,065,986	1,870,759	1,887,173	1,889,055	0.1%
Federal Funds	253,896,565	260,877,121	215,279,743	220,670,736	2.5%
					Request vs Approp.

Appendix A: Numbers Pages

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	
GRAND TOTAL - Department of Health Care Policy and Financing (with DHS Division)	4,235,455,257	4,829,302,007	5,098,183,490	5,444,378,624	6.8%
FTE	276.5	270.6	313.0	315.3	
General Fund	1,114,755,342	1,268,812,458	1,669,164,241	1,854,725,846	11.1%
Cash Funds	570,130,980	754,626,795	877,581,880	865,107,650	-1.4%
Reappropriated Funds	18,513,548	10,839,826	10,375,474	7,385,014	-28.8%
Federal Funds	2,532,055,387	2,795,022,928	2,541,061,895	2,717,160,114	6.9%
General Fund Exempt	450,000	279,781,213	284,621,517	284,621,517	

Key:
ITALICS = non-add figure, included for informational purposes
A = impacted by a budget amendment submitted after the November 1 request
S = impacted by a supplemental appropriation approved by the Joint Budget Committee

APPENDIX B: SUMMARY OF MAJOR LEGISLATION

2011 Session Bills

S.B. 11-008: The bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). It also allows tobacco tax cash funds to be used to offset General Fund expenditures for persons who enroll in Medicaid as a result of the bill, and provided they were eligible for the Children's Basic Health Plan (CBHP) prior to September 1, 2011.

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. 11-139: Supplemental appropriation to the Department of Health Care Policy and Financing to modify the FY 2010-11 appropriations contained in the FY 2010-11 Long Bill (H.B. 10-1376). Lastly, the bill also released over-expenditures that occurred in the Department's programs in FY 2009-10.

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, $2,230,000 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 $2,230,000 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.B. 11-250: This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan (CBHP) to Medicaid.

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.

APPENDIX C: UPDATE OF FY 2011-12 LONG BILL FOOTNOTES AND 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	39,556	$899,448,464	$22,738.61
Disabled Adults 60 to 64 Years of Age	8,098	146,395,601	18,077.99
Disabled Individuals up to 59 Years of Age	57,841	957,740,203	16,558.15
Medicaid Buy-In for Disabled Adults	4,329	71,682,771	16,558.74
Categorically Eligible Low-Income Adults	64,432	298,737,940	4,636.48
Pregnant Adults up to 133 Percent of Federal Poverty Level	7,657	87,987,159	11,491.07
Expansion Adults up to 60 Percent of Federal Poverty Level	23,628	51,129,238	2,163.93
Expansion Adults between 61 Percent to 100 Percent of Federal Poverty Level	34,050	87,757,439	2,577.31
Adults without Dependent Children up to 100 percent of Federal Poverty Level	16,400	51,474,921	3,138.71
Breast and Cervical Cancer Treatment and Prevention Program Adults	595	13,201,320	22,187.09
Eligible Children	316,392	662,890,819	2,095.16
Foster Care Children	18,878	93,511,704	4,953.48
Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries	18,210	27,279,701	1,498.06
Non-Citizens Qualifying for Emergency Services	3,082	72,164,693	23,414.89
Total	613,148	$3,521,401,973	$5,743.15

Comment: The footnote explains assumptions used to prepare the appropriation. In prior years line items in the Medical Services Premiums section provided similar information, but the appropriation for Medical Services Premiums was controlled and financed at the bottom line. The footnote provides an alternative way of explaining the assumptions without creating multiple line items in the Medical Services Premiums section.

Note that the table is calculated for caseloads and funding in the Long Bill only. Therefore, the table will not match similar information provided in the Long Bill Narrative or Appropriations Report that includes all appropriations for all law changes.

11 **Department of Health Care Policy and Financing, Medical Services Premiums --** The appropriation assumes that rates for medical services will be reduced by 0.75 percent and community long-term care rates will be reduced by 0.50 percent in FY 2011-12.

Comment: The footnote explains assumptions used to prepare the appropriation. The Department reduced rates consistent with the assumptions.

11a **Department of Health Care Policy and Financing, Medical Services Premiums --** It is the intent of the General Assembly that the Department reduce the reimbursement for procedure code E2402 to $88.50 per day. This procedure code is used for negative pressure wound therapy.

Comment: The footnote expresses legislative intent. The Department complied with the footnote and reduced reimbursement rates for negative pressure wound therapy.

12 **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 75,811 at an average medical per capita cost of $2,288.21 per year; and (2) a total adult prenatal caseload of 2,391 at an average medical per capita cost of $14,711.52 per year.

Comment: The footnote explains assumptions used to prepare the appropriation.

13 **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 $171.04 per child per year for the dental benefit.

Comment: The footnote explains assumptions used to prepare the appropriation.

14 **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 (5) 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.

Comment: The footnote provides limited transfer authority between line items for centralized appropriations.

Requests for Information

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

1 **Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Services for People with Disabilities --** The General Assembly requests that the departments work together with Community Centered Boards and submit a report to the Joint Budget Committee, the House Health and Environment Committee, and the Senate Health and Human Services Committee by November 1, 2011 with recommendations regarding whether the administration and funding for services for people with developmental disabilities should be transferred from the Department of Human Services to the Department of Health Care Policy and Financing. The report should discuss pros and cons associated with such a move and any potential savings. In preparing the recommendations the departments should solicit input from stakeholders.

Comment: This information request is addressed in the briefing for the Department of Human Services, Services for People with Disabilities.

2 **Department of Health Care Policy and Financing, Executive Director's Office; and Department of Human Services, Division of Child Welfare and Division of Youth Corrections** -- The Departments are requested to submit a report by November 1, 2011on the feasibility of refinancing multi-systemic therapy, functional family therapy, and similar intensive, evidence-based therapies that support family preservation and reunification for youth involved in the child welfare and youth corrections systems. The report is specifically requested to examine whether related General Fund expenditures could be refinanced with Medicaid funds for qualifying youth and families and whether this could be done in a manner that would not drive an overall increase in Medicaid costs.

Comment: This information request is addressed in the briefing for the Department of Human Services, Division of Child Welfare and Division of Youth Corrections.

5 **All Departments, Totals** -- Every department is requested to submit to the Joint Budget Committee, by November 1, 2011 information on the number of additional federal and cash funds FTE associated with any federal grants or private donations that were received in FY 2010-11 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 2011-12.

Comment: In FY 2011-12 the Department anticipates 0.5 FTE through a federal Medicaid Infrastructure Improvement Grant, 6.1 FTE through the federal "Money Follows the Person"

grant, and 2.0 FTE through the Dual Eligible Individuals Integration contract with the federal government. The Department has been awarded federal funding of $1,315,000 to date in FY 2010-11 for salaries associated with federal grants and contracts beyond the appropriated funding.

6 **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 keep the House Health and Environment Committee, the Senate Health and Human Services Committee, and the Joint Budget Committee informed on activities of the working group charged with exploring options for how to implement the home and community based waiver programs, and to provide a progress report by November 1, 2011.

Comment: This information request is addressed in the briefing for the Department of Human Services, Services for People with Disabilities.

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** -- The Department is requested to submit a report on the managed care organizations' capitation rates for each population and the estimated blended rate for each aid category in effect for FY 2011-12 to the Joint Budget Committee by September 1, 2011. The Department is requested to include in the report a copy of each managed care organization's certification that the reimbursement rates are sufficient to assure the financial stability of the managed care organization with respect to delivery of services to the Medicaid recipients covered in their contract pursuant to Section 25.5-5-404 (1) (l), C.R.S.

Comment: This information request is addressed in the briefing for Medicaid Mental Health programs.

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, 2012,

to the Joint Budget Committee, estimating the disbursement to each hospital from the Safety Net Provider Payment line item for FY 2011-12.

Comment: The requested report is not due until February 1, 2012.

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, 2011, 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 for FY 2012-13, FY 2013-14, and FY 2014-15;
(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: This information request is addressed in the briefing for the Governor's Office of Information Technology.

5 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, 2011 to the Joint Budget Committee regarding the Department's efforts to ensure that pharmaceuticals are purchased at the lowest possible price. In the report, the Department is requested to provide cost and savings estimates that may occur on a quarterly basis if the Department did the following:

(a) tracked changes in the price of pharmaceuticals;
(b) checked the availability and price of generic drugs and compared those prices to the cost of brand drugs after rebate;
(c) reviewed and updated the state's maximum allowable cost list; and
(d) compared pharmaceutical costs of the state Medicaid program to available pharmacy price lists.

Comment: The Department believes that option "b" to expand net-cost comparison analysis done on brand and generic drug pricing could result in additional savings, but the Department

needs to complete system changes to allow expansion of this type of analysis. The current Preferred Drug List (PDL) considers safety, effectiveness, and clinical outcomes of different drugs, and compares net costs based on utilization from claims data, current product reimbursement, federally mandated rebates, and supplemental rebates. The PDL attempts to drive utilization to the most proven and cost-effective agents.

Drugs on the PDL do not require prior authorization. Prior authorization is not generally granted for drugs that are not on the PDL unless the client has failed treatment with, or is unable to take, the preferred drugs. Claims submitted for non-preferred drugs without prior authorization are not paid.

To develop a good PDL the Department has to include the impact on price of both federally required rebates and supplemental rebates paid by manufacturers to achieve PDL status. The Department considers new drugs for inclusion on the PDL quarterly, and reviews the status of existing drugs on the PDL annually. The process is time-consuming, because it requires manually matching claims with rebates. The Department is working toward better integration between the Department's Decision Support System (DSS) and rebate processing system (DRAMS) to make analysis of the net cost of drugs less time-consuming, which could lead to expanded use of the PDL. The necessary changes to the information technology systems are being funded using a pool of contract programming hours budgeted for ad hoc projects. However, this change is a lower priority for the Department than federally mandated information technology upgrades to comply with the International Classification of Diseases, Tenth Revision and the Health Insurance Portability and Accountability Act. Thus, the Department does not anticipate completion of the integration of data systems necessary for a significant expansion of the PDL until January 2013.

Also, the Department warns that there are limits to how much the PDL approach can achieve:

- Federal rules require the Department to cover all products that meet the definition of a "covered outpatient drug";
- Product availability is unpredictable and shortages or supply chain issues can undermine policies designed to take advantage of the savings associated with a particular drug;
- Generic drugs are not always cheaper after rebates;
- Not all drugs have therapeutic alternatives; and,
- Clinical factors must be considered to avoid shifting costs to other benefits such as physician-administered products, increased medical visits, or increased emergency services.

The Department is in the process of developing a new pharmaceutical reimbursement method based on the costs of ingredients and the costs of dispensing drugs. This new pharmaceutical reimbursement method is expected to save $4.0 million in FY 2012-13 that is accounted for in R-6 "Medicaid Budget Reductions." The new method replaces an historic method that relied on the Average Wholesale Price for drugs. The Department is already tracking changes in the price of pharmaceuticals weekly and adjusting reimbursements, and so there

are no opportunities for further savings from additional price tracking (option "a"). While the new pharmaceutical reimbursement method is being developed, the Department is using an interim method that incorporates the state's maximum allowable cost (SMAC) list for all drugs where data is available, and so there is no opportunity for further savings through expanding the use of the SMAC (option "c"). Once the new reimbursement method is implemented, it will set prices based on the weekly Average Acquisition Cost, which the Department believes is the lowest possible level without risking barriers to access for clients, and so no further savings are expected from comparing Medicaid pharmaceutical reimbursements to other pharmacy price lists (option "d").

6 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs** -- The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing the monthly premium charged to clients in the Children's Basic Health Plan program for any children and pregnant women enrolled in the program with incomes over 205 percent of the federal poverty level. In the report, the Department is requested to provide information about the monthly premiums charged by other states in their Children's Health Insurance Programs and what similar premium charges would save in the Colorado program. In the report, the Department is also requested to provide information regarding the barriers to health care that monthly premiums cause at this income level.

7 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing co-payments in the Medicaid program to the maximum amount allowed under federal law.

8 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs** -- The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing co-payments in the Children's Basic Health Plan program to the maximum amount allowed under federal law.

Comment: The Legislative Requests for Information 6-8 all deal with increasing cost-sharing for Medicaid and the Children's Basic Health Plan. In the last legislative session the Governor vetoed S.B. 11-213 (Hodge/Gerou) that would have established new monthly enrollment fees for families enrolling in the Children's Basic Health Plan with incomes between 205 and 250 percent of the federal poverty guidelines. The fees would have been $20 per month for the first child and $10 per month for each additional child, up to a maximum of $50 per month per family. As an alternative to S.B. 11-213 and in response to these Legislative Requests for Information the Department submitted R-7 to increase coinsurance for Medicad and premiums and coinsurance for the Chilrden's Basic Health Plan. The Department projects R-7 will save $1.4 million General Fund in FY 2012-13. See the issue brief above titled "Alternate financing to the General Fund" for more information.

9 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by November 1, 2011, 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: See the issue brief titled "Accountable care" above for a discussion of the Accountable Care Collaborative Organization project and the information submitted by the Department in response to this Legislative Request for Information.

10 **Department of Health Care Policy and Financing, Services for Old Age Pension State Medical Program** -- The Department is requested to inform the Joint Budget Committee of any planned reimbursement increases for the program prior to presentation to the Medical Services Board.

Comment: The Department is not currently planning reimbursement increases for the program. As noted previously, the decision to delay expanding eligibility to adults without dependent children will result in a larger eligible population than anticipated, and may require the Department to decrease reimbursement rates to remain within the appropriation.

11 **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 was 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. In FY 2010-11 the program served 11,310 children through 74 providers. The total federal funds matched with certified public expenditures was $11,652,788.

APPENDIX D: STATE AUDITOR'S OFFICE RECOMMENDATIONS NOT ENTIRELY IMPLEMENTED

Office of the State Auditor Recommendations

Financial Recommendations Not Entirely Implemented As of Fiscal Year Ending June 30, 2010

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve controls over the calculation of the Incurred But Not Reported expenditure estimate for Medicaid by: (a) implementing an independent review of the calculation, including the drug rebate amounts.	7a	Significant Deficiency	Not Implemented	August 2011	4a	Significant Deficiency	N/A	Agree - original implementation date is July 2010								
Department of Health Care Policy and Financing	Improve controls over the calculation of the Incurred But Not Reported expenditure estimate for Medicaid by: (b) continuing to annually evaluate the calculation methodology and modify it, if necessary, to ensure a more accurate estimate.	7b	Significant Deficiency	Not Implemented	August 2011	4b	Significant Deficiency	N/A	Agree - original implementation date is August 2010								
Department of Health Care Policy and Financing	Improve internal controls over financial reporting process by: (a) creating and documenting the process for communicating financial adjustments to the accounting section and the Office of the State Controller.	6a	Deficiency in Internal Control	Partially Implemented	August 2011	6a	Deficiency in Internal Control	N/A	Agree - original implementation date is June 2010								
Department of Health Care Policy and Financing	Improve internal controls over financial reporting process by: (b) providing training throughout the Department on this process.	6b	Deficiency in Internal Control	Partially Implemented	August 2011	6b	Deficiency in Internal Control	N/A	Agree - original implementation date is June 2010								
Department of Health Care Policy and Financing	Establish and implement policies and procedures for recording, investigating, and refunding, if appropriate, excess amounts repaid by providers.	8	Significant Deficiency	Not Implemented	October 2011	9	Significant Deficiency	N/A	Agree - original implementation date is April 2010								
Department of Health Care Policy and Financing	Improve controls over documentation in Medicaid case files to support eligibility by: (a) continuing to monitor counties and Medical Assistance (MA) sites to ensure that they are obtaining and maintaining the required case file documentation to support eligibility determinations.	63a	Significant Deficiency	Not Implemented	April 2011	53a	Material Weakness	N/A	Agree - original implementation date is from February 2010 through December 2013								
Department of Health Care Policy and Financing	Improve controls over documentation in Medicaid case files to support eligibility by: (b) requiring that counties and MA sites review case files to ensure consistency of information between the case file and the Colorado Benefits Management System (CBMS).	63b	Significant Deficiency	Not Implemented	April 2011	53b	Material Weakness	N/A	Agree - original implementation date is from February 2010 through December 2013								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve controls over Medicaid program eligibility determinations and data entry into the Colorado Benefits Management System (CBMS) by: (a) ensuring that county departments of human/social services and medical assistance sites have in place effective supervisory reviews of CBMS data entry, including comparisons of case file data with CBMS data as part of the eligibility determination process.	60a	Material Weakness	Not Implemented	June 2011	54a	Material Weakness	N/A	Agree - original implementation date is from February through December 2010								
Department of Health Care Policy and Financing	Improve controls over Medicaid program eligibility determinations and data entry into the Colorado Benefits Management System (CBMS) by: (b) reviewing counties' and medical assistance sites' data input and monitoring their supervisory reviews.	60b	Material Weakness	Not Implemented	June 2011	54b	Material Weakness	N/A	Agree - original implementation date is from February through December 2010								
Department of Health Care Policy and Financing	Ensure that county departments of human/social services and medical assistance sites are addressing Income, Eligibility, and Verification System data discrepancies within 45 days of receiving notification of a discrepancy, including discrepancies related to Department of Labor and Employment data, as required by federal regulations and in accordance with its state plan filed with the federal government.	59	Material Weakness	Not Implemented	July 2011	55	Material Weakness	N/A	Agree - original implementation date is January 2011								
Department of Health Care Policy and Financing	Improve controls over eligibility of Medicaid providers by: (a) ensuring that the Medicaid Management Information System contains current licensing information for all Medicaid providers that are required to have a license.	58a	Material Weakness	Partially Implemented	June 2011	56a	Material Weakness	N/A	Agree - original implementation date is June 2010								
Department of Health Care Policy and Financing	Improve controls over eligibility of Medicaid providers by: (b) developing and implementing a process for verifying the current licensure of all providers that are required to have a license, including out-of-state providers.	58b	Material Weakness	Not Implemented	June 2011	56b	Material Weakness	N/A	Agree - original implementation date is June 2010								
Department of Health Care Policy and Financing	Improve controls over eligibility of Medicaid providers by: (c) ensuring that all providers have valid current provider participation agreements or contracts.	58c	Material Weakness	Not Implemented	June 2011	56c	Material Weakness	N/A	Agree - original implementation date is November 2010 (interim) and July 2011								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve controls over requests for federal funds through the American Recovery and Reinvestment Act (Recovery Act) by: (b) documenting written procedures and ensuring adequate review of federal draws and supporting information to ensure their accuracy.	57b	Deficiency in Internal Control	Partially Implemented	August 2011	57b	Material Weakness	N/A	Agree - original implementation date is March 2010								
Department of Health Care Policy and Financing	Reduce eligibility determination errors for the Children's Basic Health Plan (CBHP) by improving oversight and training of eligibility sites by: (a) continuing to provide eligibility sites with CBHP training and technical assistance on eligibility and documentation requirements.	63a	Significant Deficiency	Partially Implemented	April 2011	59a	Material Weakness	N/A	Agree - original implementation date is February 2010 through December 2013								
Department of Health Care Policy and Financing	Reduce eligibility determination errors for the Children's Basic Health Plan (CBHP) by improving oversight and training of eligibility sites by: (b) enforcing eligibility sites' supervisory review processes and corrective action plans by following up on problems identified through the Department's monitoring program and this audit.	63b	Significant Deficiency	Not Implemented	April 2011	59b	Material Weakness	N/A	Agree - original implementation date is February 2010 through December 2013								
Department of Health Care Policy and Financing	Reduce eligibility determination errors for the Children's Basic Health Plan (CBHP) by improving oversight and training of eligibility sites by: (c) investigating the causes of the CBMS errors identified in the audit and modify CBMS as needed to correct them.					59c	Material Weakness	N/A	Agree - original implementation date is February 2010 through December 2013								
Department of Health Care Policy and Financing	Ensure that all county departments of human/social services and medical assistance sites have access to Income, Eligibility, and Verification System (IEVS) data and address any discrepancies, including those related to Department of Labor and Employment data, as required by state regulations. Additionally, the Department should incorporate IEVS requirements within the CBHP program's state plan and within the Department rules for this program.	59	Material Weakness	Not Implemented	January 2012	60	Material Weakness	N/A	Partially agree - implementation date is January 2011								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve controls over the Children's Basic Health Plan (CBHP) program data entry into CBMS by: (a) ensuring that county departments of human/social services and medical assistance sites have in place effective supervisory reviews of CBMS data entry, including comparisons of case file data with CBMS data as part of the eligibility determination process.	62a	Deficiency in Internal Control	Partially Implemented	March 2011	62a	Significant Deficiency	N/A	Agree - original implementation date is February 2010 through December 2013								
Department of Health Care Policy and Financing	Improve controls over the Children's Basic Health Plan (CBHP) program data entry into CBMS by: (b) reviewing counties' and medical assistance sites' data input and monitoring their supervisory reviews.	62b	Deficiency in Internal Control	Partially Implemented	March 2011	62b	Significant Deficiency	N/A	Agree - original implementation date is February 2010 through December 2013								
Department of Health Care Policy and Financing	Ensure compliance with federal regulations governing Medicaid and the Children's Basic Health Plan (CBHP) programs by: (a) ensuring that all Medicaid applications include the citizenship and identity documentation required by the Deficit Reduction Act (DRA) prior to approving or denying eligibility for Medicaid.	67a	Deficiency in Internal Control	Partially Implemented	January 2011	63a	Deficiency in Internal Control	N/A	Agree - original implementation date is January 2010								
Department of Health Care Policy and Financing	Ensure compliance with federal regulations governing Medicaid and the Children's Basic Health Plan (CBHP) programs by: (b) maintaining DRA documentation received with Medicaid applications in CBHP case files.	67b	Deficiency in Internal Control	Partially Implemented	January 2011	63b	Deficiency in Internal Control	N/A	Agree - original implementation date is January 2010 through December 2013								
Department of Health Care Policy and Financing	Ensure that all program processing requirements for Medicaid and Children's Basic Health Plan (CBHP) eligibility are met by: (a) using existing mechanisms, such as CBMS reports and the Monitoring and Quality Unit, to identify all cases, including long-term care cases, which exceed processing guidelines.	64a	Significant Deficiency	Not Implemented	June 2011	64a	Significant Deficiency	N/A	Agree - original implementation date is February 2010 through December 2013								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
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Department of Health Care Policy and Financing	Ensure that all program processing requirements for Medicaid and Children's Basic Health Plan (CBHP) eligibility are met by: (b) working with county departments of human/social services and Medical Assistance sites to improve the application processing timeliness by offering technical assistance that focuses on the cause of untimely processing to ensure that new cases and redeterminations for Medicaid and for the CBHP program are processed within state and federal guidelines.	64b	Significant Deficiency	Partially Implemented	June 2011	64b	Significant Deficiency	N/A	Agree - original implementation date is February 2010 through December 2013								
Department of Health Care Policy and Financing	Improve controls over the calculation and reporting of family planning expenditures under the Medicaid Managed Care Program by: (d) ensuring that supervisors review the data used, calculations, and the supporting documentation for compliance with the established methodology prior to submission of reports to the federal government.	61e	Material Weakness	Not Implemented	August 2011	65d	Material Weakness	N/A	Agree - original implementation date is June 2010								
Department of Health Care Policy and Financing	Improve controls over the calculation and reporting of family planning expenditures under the Medicaid Managed Care Program by: (e) ensuring all data from COFRS are extracted in a consistent manner and in accordance with policies and procedures.	61f	Material Weakness	Not Implemented	August 2011	65e	Material Weakness	N/A	Agree - original implementation date is June 2010								
Department of Health Care Policy and Financing	Improve controls over payments to laboratory providers for the Medicaid program by: (a) ensuring that MMIS edits necessary for accepting complete certification information from providers are working as intended to ensure compliance with the Clinical Laboratory Improvement Amendment (CLIA) requirements.	57a	Material Weakness	Partially Implemented	July 2011	66a	Material Weakness	N/A	Agree - original implementation date is July 2011								
Department of Health Care Policy and Financing	Improve controls over payments to laboratory providers for the Medicaid program by: (b) until system edits can be completed, establishing an alternative method to verify that only providers with CLIA certification are receiving payment through the Medicaid program.	57b	Material Weakness	Not Implemented	July 2011	66b	Material Weakness	N/A	Agree - original implementation date is December 2009								
Department of Health Care Policy and Financing	Improve controls over payments to laboratory providers for the Medicaid program by: (c) identifying and recovering any payments erroneously made to laboratories that were not CLIA-certified.	57c	Material Weakness	Not Implemented	December 2011	66c	Material Weakness	N/A	Agree - original implementation date is March 2010								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve controls over occupational and physical therapy claims processed through the Medicaid Management Information System by working with Affiliated Computer Services, Inc., and policy staff to ensure that the resolution text related to these claims is consistent with Department policy, including the requirement to receive authorization prior to processing these claims when the annual service limit has been reached.	66	Significant Deficiency	Not Implemented	June 2011	67	Significant Deficiency	N/A	Agree - original implementation date is December 2009								
Department of Health Care Policy and Financing	Improve the Medicaid Management Information System (MMIS) user access controls by immediately implementing our prior year recommendation and strengthening MMIS's operating system, including: (a) evaluating MMIS user access profiles and identifying those profiles, or combinations of profiles, that are appropriate for different system users. This information should be shared with the supervisors of MMIS users.	73a	Deficiency in Internal Control	Not Implemented	December 2010	73a	Deficiency in Internal Control	N/A	Agree - original implementation date is March 2010								
Department of Health Care Policy and Financing	Improve the Medicaid Management Information System (MMIS) user access controls by immediately implementing our prior year recommendation and strengthening MMIS's operating system, including: (b) establishing a written procedure that HCPF IT security staff follow when MMIS access is requested.	73b	Deficiency in Internal Control	Not Implemented	December 2010	73b	Deficiency in Internal Control	N/A	Agree - original implementation date is January 2010								
Department of Health Care Policy and Financing	Improve the Medicaid Management Information System (MMIS) user access controls by immediately implementing our prior year recommendation and strengthening MMIS's operating system, including: (c) ensuring that profiles or profile combinations that provide escalated system privileges are identified and tightly controlled, including the establishment of compensating controls.	73c	Deficiency in Internal Control	Not Implemented	December 2010	73c	Deficiency in Internal Control	N/A	Agree - original implementation date is May 2010								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
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Department of Health Care Policy and Financing	Improve the Medicaid Management Information System (MMIS) user access controls by immediately implementing our prior year recommendation and strengthening MMIS's operating system, including: (d) periodically reviewing MMIS user access levels for appropriateness and promptly removing access for terminated users, including comparing active MMIS users to termination information contained in the Colorado Personnel Payroll System and requiring business managers to annually verify the accuracy and relevance of access levels belonging to the MMIS users they supervise.	73d	Deficiency in Internal Control	Not Implemented	December 2010	73d	Deficiency in Internal Control	N/A	Agree - original implementation date is May 2010								
Department of Health Care Policy and Financing	Ensure a comprehensive and uniform assessment process for determining functional eligibility and the services necessary to address the needs of individuals seeking long-term care services by: (a) improving written guidance to direct Single Entry Point (SEP) agencies on all aspects of the intake, functional assessment, and service planning processes, including how case managers should document information in the Benefits Utilization System.	81a	Deficiency in Internal Control	Partially Implemented	June 2011	81a	Significant Deficiency	N/A	Agree - original implementation date is October 2009								
Department of Health Care Policy and Financing	Ensure a comprehensive and uniform assessment process for determining functional eligibility and the services necessary to address the needs of individuals seeking long-term care services by: (b) modifying State Medicaid Rules to more clearly define how to score functioning when the individual uses an assistive device, and making appropriate corresponding changes to the Department's functional assessment instrument.	81b	Deficiency in Internal Control	Not Implemented	June 2011	81b	Significant Deficiency	N/A	Agree - original implementation date is October 2009								
Department of Health Care Policy and Financing	Ensure a comprehensive and uniform assessment process for determining functional eligibility and the services necessary to address the needs of individuals seeking long-term care services by: (c) strengthening its state-sponsored training by making standard core training courses available to all SEP agencies.	81c	Deficiency in Internal Control	Not Implemented	June 2011	81c	Significant Deficiency	N/A	Agree - original implementation date is October 2009								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Ensure a comprehensive and uniform assessment process for determining functional eligibility and the services necessary to address the needs of individuals seeking long-term care services by: (d) setting minimum standards for SEP agencies' quality assurance and case file review practices. Standards should include steps for measuring inter-rater reliability of functional assessment scoring and for systematically compiling, reporting, and addressing the results of the case file reviews.	81d	Deficiency in Internal Control	Not Implemented	June 2011	81d	Significant Deficiency	N/A	Agree - original implementation date is October 2009								
Department of Health Care Policy and Financing	Ensure eligible individuals have timely access to Medicaid long-term care services by developing an integrated approach to monitor the timeliness of all components of the eligibility determination process, identify problems, and make improvements by: (a) providing clear and consistent written guidance to Single Entry Point (SEP) agencies regarding how the timeliness of the functional assessment and other processes will be measured.	82a	Deficiency in Internal Control	Partially Implemented	June 2011	82a	Deficiency in Internal Control	N/A	Agree - original implementation date is October 2009								
Department of Health Care Policy and Financing	Ensure eligible individuals have timely access to Medicaid long-term care services by developing an integrated approach to monitor the timeliness of all components of the eligibility determination process, identify problems, and make improvements by: (b) making improvements to the Benefits Utilization System to capture all dates necessary to evaluate the timeliness of SEP agencies' intake and functional assessment processes.	82b	Deficiency in Internal Control	Partially Implemented	December 2010	82b	Deficiency in Internal Control	N/A	Agree - original implementation date is December 2009								

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Ensure eligible individuals have timely access to Medicaid long-term care services by developing an integrated approach to monitor the timeliness of all components of the eligibility determination process, identify problems, and make improvements by: (d) making changes to weekly reports in CBMS to identify all pending Medicaid long-term care applications that exceed required processing time frames and compile summary statistics on the timely processing of Medicaid applications by county and statewide.	64	Significant Deficiency	Not Implemented	Spring 2011	82d	Deficiency in Internal Control	N/A	Contingent upon funding and joint prioritization								
Department of Health Care Policy and Financing	Ensure eligible individuals have timely access to Medicaid long-term care services by developing an integrated approach to monitor the timeliness of all components of the eligibility determination process, identify problems, and make improvements by: (f) capturing and analyzing data on an ongoing basis to monitor and evaluate how long it takes eligible individuals to gain access to Medicaid long-term care services from the time they first enter the system.	82f	Deficiency in Internal Control	Partially Implemented	December 2010	82f	Deficiency in Internal Control	N/A	Agree - original implementation date is October 2010								
Department of Health Care Policy and Financing	Improve controls over updating Medicaid provider licenses in the Medicaid Management Information System (MMIS) by: (a) ensuring that all Medicaid providers required to have a license have current license information entered into MMIS.	58	Material Weakness	Not Implemented	June 2011	56a	Material Weakness	Not Implemented	June 2010	64a	Material Weakness	N/A	Agree - original implementation date is June 2009				
Department of Health Care Policy and Financing	Improve controls over updating Medicaid provider licenses in the Medicaid Management Information System (MMIS) by: (b) continuing to develop and implement a plan to automate the process for updating licenses for providers participating in the Medicaid program.	58	Material Weakness	Not Implemented	June 2011	85	Material Weakness	Deferred	June 2010	64b	Material Weakness	N/A	Agree - original implementation date is December 2010				
Department of Health Care Policy and Financing	Improve controls over updating Medicaid provider licenses in the Medicaid Management Information System (MMIS) by: (c) developing a process for obtaining all current licenses for all out-of-state providers.	58	Material Weakness	Not Implemented	June 2011	56c	Material Weakness	Not Implemented	July 2011	64c	Material Weakness	N/A	Agree - original implementation date is June 2009				

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve controls over subrecipient monitoring for the Medicaid and the Children's Health Insurance programs by: (c) requiring all subrecipients with federal expenditures of $500,000 or more within a fiscal year to provide annual audits performed in accordance with Circular A-133 requirements.	62	Significant Deficiency	Not Implemented	July 2011	62c	Deficiency in Internal Control	Not Implemented	No new implementation date provided	62c	Material Weakness	N/A	Agree - original implementation date is June 2009				
Department of Health Care Policy and Financing	Improve its oversight of certifications required for nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR) by: (a) maintaining written notification of the Department of Public Health and Environment recommendations to certify or terminate certifications, to document compliance with the interagency agreement.	65a	Deficiency in Internal Control	Partially Implemented	June 2011	65a	Deficiency in Internal Control	Partially Implemented	No new implementation date provided	65a	Significant Deficiency	N/A	Agree - Implemented				
Department of Health Care Policy and Financing	Improve its oversight of certifications required for nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR) by: (b) developing and implementing a certification tracking mechanism to monitor and document recommendations for certifications and terminations of certifications.	65b	Deficiency in Internal Control	Partially Implemented	June 2011	65b	Deficiency in Internal Control	Partially Implemented	No new implementation date provided	65b	Significant Deficiency	N/A	Agree - Implemented				
Department of Health Care Policy and Financing	Improve its monitoring of application processing for the Children's Basic Health Plan (CBHP) by eligibility sites to ensure eligibility decisions are made timely, in accordance with federal and state rules and guidelines. Specifically, the Department should: (b) work with the eligibility sites to investigate the underlying factors contributing to processing delays, including the reasons CBHP applications, supporting documentation, or enrollment fees have not been entered or processed in CBMS.	69b	Deficiency in Internal Control	Partially Implemented	September 2010	69b	Deficiency in Internal Control	Partially Implemented	September 2010	69b	Deficiency in Internal Control	N/A	Agree - original implementation date is January 2009				

Agency	Recommendation	Statewide Single Audit, Fiscal Year Ending June 30, 2010 Current Recommendation or Disposition of Prior Recommendation				Statewide Single Audit, Fiscal Year Ending June 30, 2009 Report # 1994				Statewide Single Audit, Fiscal Year Ending June 30, 2008 Report # 1970				Statewide Single Audit, Fiscal Year Ending June 30, 2007 Report # 1901			
		Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition	Rec Number	Finding Classification	Implementation Status	Implementation Date or Disposition
Department of Health Care Policy and Financing	Improve its monitoring of application processing for the Children's Basic Health Plan (CBHP) by eligibility sites to ensure eligibility decisions are made timely, in accordance with federal and state rules and guidelines. Specifically, the Department should: (c) further target training and technical assistance to address the underlying problems of late processing.	69c	Deficiency in Internal Control	Partially Implemented	September 2010	69c	Deficiency in Internal Control	Partially Implemented	September 2010	69c	Deficiency in Internal Control	N/A	Agree - original implementation date is January 2009				
Department of Health Care Policy and Financing	Ensure ineligible women and children are properly and timely disenrolled from the Children's Basic Health Plan (CBHP) program. Specifically, the Department should: (b) strengthen efforts to ensure that, until the planned changes to CBMS and the Medicaid Management Information System (MMIS) are fully implemented and working properly, participants are disenrolled from CBHP as soon as their eligibility ends.	71b	Deficiency in Internal Control	Partially Implemented	June 2012	71b	Deficiency in Internal Control	Partially Implemented	June 2012	71b	Significant Deficiency	N/A	Agree - original implementation date is September 2008				

Office of the State Auditor Audit Recommendations

All Performance and IT Recommendations That Agency Agreed to Implement But Are Past Due

Agency	Date Audit Released by LAC	Name of Audit	Audit Rec Number	Agency Response	Original Implementation Date *1	Current Implementation Date *2	Main Recommendation Text	Recommendation Sub-part Text	Implementation Status	Source of Implementation Status	Date of Implementation Status Report	Agency Comments from Status Report
Department of Health Care Policy & Financing	2008 June	Children's Basic Health Plan	1844-14b	Agree	2009 June		The Department of Health Care Policy and Financing should ensure it has adequate and accurate information to effectively manage CBHP by:	b. Establishing data collection and analysis processes to meet the identified needs.	Not Implemented	Self-Reported by Agency	2011 October	Oct 2011 - This recommendation remains in progress. The Department has defined reporting requirements for new reports to be generated out of CBMS by Deloitte, a contractor for OIT. The implementation of the change request remains pending. Due to competing priorities, including requirements issued in the recent CBMS lawsuit, this change request has been delayed by OIT. This is on the 18-month calendar; OIT has given no timeline for implementation. Mar 2011 - The implementation of this recommendation is in progress. Children's Basic Health Plan (CBHP) staff has defined reporting requirements for new reports to be generated out of Colorado Benefits Management System (CBMS). At this point, CBHP is waiting for those reports to be implemented. A timeline for implementation has not been provided by the CBMS contractor (Deloitte).

*1 The original implementation date is the date provided by the agency in the report.
*2 The current implementation date is the date by which the agency currently projects that the recommendation will be implemented.

Colorado
Legislative
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MEMORANDUM

Pursuant to section 24-72-202(6.5)(b), research memoranda and other final products of Legislative Council Staff research that are not related to proposed or pending legislation are considered public records and are subject to public inspection. If you think additional research is required and this memorandum is not a final product, please call the Legislative Council Librarian at (303) 866-4011 by August 31, 2010.

August 24, 2010

TO:

FROM: Elizabeth Burger, Senior Analyst, 303-866-6272
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Kerry White, Fiscal Analyst, 303-866-3469

SUBJECT: State Implementation of Federal Health Care Reform Legislation

This memorandum responds to your request for information on federal health care reform legislation, including the federal Patient Protection and Affordable Care Act, and the Health Care and Education Reconciliation Act of 2010, which were signed into law in March of 2010 and are referred to throughout this memo as the "act." Specifically, you asked:

- What items within the act require state implementation and on what timeline?
- What items within the act allow for state variation?
- What resources will be available to the states for implementation of the act, and which resources has Colorado applied for?

Table 1 summarizes the provisions of the act, organized by specific topics described on page 2. The table provides a description of specific requirements of the law, information on the state actions that are required to implement the provision, and funding available to states for implementation. When available, the table also includes information on the funds for which the state has applied or is planning to apply.

Table 1 provides information on the portions of the act that require or allow for state involvement in implementation, and does not summarize the provisions of the act for which there is little to no state role. For instance, Table 1 does not summarize the provisions of the act that affect Medicare, as that program is administered entirely by the federal government. However, for your information and overall understanding of the act, Table 1 does provide information in a few specific areas, including taxation and grants for healthcare workforce development, in which there is little state involvement in implementation.

Table 1 contains summaries of the act's provisions related to the following topics.

Health insurance. Health insurance provisions of the act include changes to coverage requirements for health plans, oversight of health insurance rates, and required reporting related to health insurance plan premiums and expenses. The act also requires the creation of Health Insurance Exchanges, which allow consumers to shop for plans that offer federally acceptable benefits and coverage levels.

Medicaid and Children's Basic Health Plan (CHP+). The act implements a number of changes that affect the eligibility of low-income adults for the Medicaid program. In addition, the act makes specific changes to the programs and benefits that may be offered to Medicaid enrollees, processes for enrollment of adults and children in the Medicaid and CHP+ programs, and payments to states for the costs of these changes.

Funding for providers that serve the uninsured. The act provides direct funds and grants to providers, such as community health centers, that primarily serve individuals who are uninsured or who are enrolled in public health care programs. In general, these funds are provided directly to health care professionals and facilities rather than to the state.

Workforce. The act provides direct funding and grants to health care providers, academic institutions, and health care facilities to increase the number of health care providers. In general, these funds pass directly to individuals and health care and academic institutions rather than to the state.

Long-term care. A number of provisions of the act affect long-term care services for older adults. The act creates a program to fund community living assistance services and supports through payroll contributions. The act also makes a number of changes to long-term care services provided through Medicaid.

Public health. The act provides funds to state and local public health agencies to support epidemiology research, vaccination, and other public health activities.

Other. The act creates a number of grant programs to fund various health-related purposes.

Taxation and fees. Tax provisions of the act include credits to offset some of the costs of health care coverage for low income individuals and small businesses. Provisions also include tax and fee increases, which are intended to offset the costs of expanding coverage. According to estimates from the Congressional Budget Office, the net impact of these changes will raise $525 billion in revenue to the federal government between 2010 and 2019. All taxes and fees will be implemented at the federal level and do not require any state administration. Because state taxes are based on federal taxable income, state tax revenue is expected to increase as a result of the changes in tax policy.

Table 1
Summary of the Federal Health Care Reform Legislation

Provision	Description	State Action Required	Funding Available to States
Health Insurance			

Requirements for Health Plans	The act makes the following changes to requirements for group and individual health insurance plans:
	
	• beginning September 23, 2010:
	  • prohibits plans from establishing lifetime or annual limits on the dollar value of benefits. Annual limits may be placed on benefits that are not "essential;"
	  • prohibits an insurer from rescinding coverage except in the case of fraud;
	  • requires insurers to provide coverage, without any cost sharing, for immunizations and other specified preventative health services;
	  • requires health plans that offer coverage for dependent children to continue coverage for an adult child until the child turns 26 years of age; and
	  • prohibits pre-existing coverage limitations for dependents under 19 years of age;
	
	• beginning in 2014:
	  • requires the Secretary of the Federal Department of Health and Human Services (Secretary) to develop a single set of operating rules to process insurance transactions;
	  • prohibits plans from applying pre-existing coverage limitations;
	  • specifies that rates may only vary based on the following factors:
	
	    ▸ family size;
	    ▸ geographic area;
	    ▸ age; and
	    ▸ tobacco use.
	
	  • requires health insurers to offer coverage to any individual or group that applies;
	  • requires health insurers to renew coverage at the option of the plan sponsor or the covered individual;
		Colorado may need to conform its existing laws regulating insurers to comply with federal legislation.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Requirements for Health Plans (Cont.)	• prohibits plans from establishing any rules for eligibility based on any of the following factors: ‣ health status; ‣ medical condition; ‣ claims experience ‣ receipt of medical care; ‣ genetic information; ‣ evidence of insurability; ‣ disability; and ‣ any other health status-related factor; and • prohibits a plan from applying a waiting period for coverage longer than 90 days.		
Oversight of Rates	The act requires the Secretary to implement an annual review process of insurance premiums to determine if increases in rates are unreasonable.	Grants will be awarded to states to provide information and recommendations on rate reviews and to establish centers to collect, analyze and organize medical reimbursement information. As a condition of receiving a grant, states must provide the Secretary with information regarding trends in rating and premium increases.	Over a five-year period beginning in 2010, $250 million is available to fund grants to states. The Department of Regulatory Agencies (DORA) applied for a $1 million grant through the Grants to States for Health Insurance Premium Review Cycle I program. Future funding may be awarded on an annual basis.
Medical Loss Ratios and Rebates	The act requires insurers to: • submit a report to the Secretary on the insurer's premium/loss ratio; and • beginning January 11, 2011, provide an annual rebate to each plan enrollee if the premium/loss ratio is less than 85% for large group markets or 80% for small group markets.	None specified or unknown at this point.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Consumer Assistance and Protection	The act requires: • insurers to implement an effective process through which enrolles can appeal coverage determinations and claims; • the Secretary, in conjunction with the state, to establish a website to allow residents of a state to identify affordable coverage options in the state; • insurers to provide uniform summary of benefit forms, developed from standards issued by the Secretary, to enrolles; and • the Secretary to distribute grants to states to establish or expand offices or ombudsmen to assist consumers with insurance-related issues.	In order to receive a grant for consumer assistance, states must comply with specific criteria and collect and report data to the federal government on the types and volumes of complaints submitted by consumers.	For 2014, $30 million is available for grants to states that establish or expand consumer assistance offices. DORA plans to apply for a portion of the total funding. A total of 56 awards are anticipated, ranging from $120,000 to $3.4 million.
High Risk Pool	The act requires the Secretary to establish, or contract with states or nonprofit entities to establish, high risk pools to provide health insurance coverage to individuals with pre-existing conditions. The high risk pool will be in place until 2014, when state health insurance exchanges are established.	In July 2010, Colorado formed a high-risk pool to comply with the provisions of the act called GettingUsCovered. The pool is jointly administered by Rocky Mountain Health Plans and CoverColorado. In order to qualify for coverage through the pool, individuals must be U.S. and Colorado residents, have been uninsured for at least six months, and have a pre-existing condition that has prevented them from obtaining commercial health insurance in the past.	A total of $5 billion across all states is available to subsidize premiums in the high risk pool. DORA applied for and received $90 million over a three-year period.
Wellness Programs	The act defines "wellness programs" as programs of health promotion or disease prevention offered by an employer. The act establishes the certain conditions for the operation of wellness programs. Wellness programs that were established prior to the enactment of the act may continue to operate. No later than July 1, 2014, the Secretary, along with the Treasury Secretary, are to establish a 10-state pilot program for wellness programs in the individual insurance market.	States must apply to participate in the pilot program. In order to participate, a state must demonstrate that the project is designed in a manner that: • will not result in any decrease in coverage; and • will not increase the costs to the federal government.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Qualified Health Plans and Essential Benefits Package	***Qualified health plans.*** As defined in the act, qualified plans: • have a certification that the plans may be offered through an exchange; • provide the essential health benefit package (described below); and • are offered by a health insurer in good standing that agrees to offer a plan in the silver and gold levels of the exchange, agrees to charge the same rates for plans offered inside and outside of an exchange, and complies with any additional rules issued by the Secretary. Qualified plans must meet specific marketing requirements and ensure a sufficient choice of providers, including essential community providers such as community health centers. Qualified plans are subject to a rating system, to be developed by the Secretary, and an enrollee satisfaction system. States may require that qualified plans offer benefits in addition to the essential health benefits package described below. States must assume the costs of these additional benefits. ***Essential health benefits package.*** The essential health benefits package is defined in the act as plans that provide coverage for certain essential health benefits, specified in the act, and limit cost-sharing. Essential health benefits include: • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance abuse treatment; • prescription drugs; • preventative and wellness services; and • pediatric services, including oral and vision care.	States may pass a law to prohibit coverage of abortions in qualified health plans offered through the exchange. States may add addition benefits to qualified health plans above those required by federal law.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Qualified Health Plans and Essential Benefits Package (Cont.)	Beginning in 2014, plans are subject to an annual limit on cost-sharing, and the deductibles of plans offered in the small group market are limited to $2,000 for an individual and $4,000 for a family. The act establishes four benefit categories, equal to a specified percentage of the full value of benefits provided under the essential health benefits package: • bronze, 60%; • silver, 70%; • gold, 80%; and • premium, 90%. Health insurers may also offer catastrophic plans to individuals under the age of 30 in the individual market. States may pass laws to prohibit abortion coverage in qualified plans. Federal funds may not be used to provide voluntary abortions, and funds for abortion coverage must be segregated.		
Health Insurance Exchanges	***Establishment of state health insurance exchange.*** The act requires states to establish, by January 1, 2014: • a health insurance exchange through which individuals may purchase qualified health plans; and • a Small Business Health Options Program (SHOP exchange), designed to assist a qualified small employers in enrolling their in employees in qualified health plans offered in the state's small group market. States may combine the individual and SHOP exchanges into one exchange. States that do not establish an operational exchange by 2014 will have one established in the state by the Secretary.	States must determine: • whether to operate an exchange or allow the federal government to set up the exchange within the state; • whether to operate separate exchanges for individuals and small businesses, or to combine these exchanges; • whether to operate a regional exchange with other states, or to operate multiple exchanges within geographically distinct regions of the state; • whether to permit large employers to purchase coverage through the exchanges in 2017; and	By September 1, 2010, the Secretary must award Planning and Establishment Grants to states to establish an exchange. Each state's amount is to be determined on an annual basis through 2015, at which time the exchanges must be self-sustaining. DORA and HCPF will apply for the Colorado's planning grants. Grants are expected to be up to $1 million each year.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Health Insurance Exchanges	Exchanges must: • either be a governmental agency or a nonprofit entity that is established by the state; • only offer qualified health plans;. • develop procedures for the certification of plans as qualified health plans; • maintain telephone lines and websites where consumers can access information about the plans in the exchange; • provide information to individuals about their eligibility for public programs, such as Medicaid, and grant certifications for individuals who are exempt from the mandate for coverage; and • require plans seeking to continue to participate in the exchange to submit a justification of any increase in premiums prior to the implementation of the increase. States may operate regional exchanges. States may also establish multiple exchanges in one state if each exchange operates in a geographically distinct areas of the state. Employers may select a level of coverage to be made available to employees through an exchange. Employees may enroll in any qualified plan that meets the level of coverage selected by the employer. ***Health insurance markets.*** The act specifies that health insurers must consider all individuals who are enrolled in individual plans offered by the insurer in the exchange a single individual risk pool. Similar provisions apply to small group pools. A state may require the individual and small group markets to be merged. Health insurers may continue to offer plans outside of the exchange. ***Eligibility for exchange.*** Individuals must not be incarcerated and must be a lawful resident of the United States in order to purchase an exchange plan. Employers must make all full-time employee eligible for coverage. Initially, participation in the exchange is limited to small employers. Beginning in 2017, states may allow large employers to participate in the exchange.	• a funding mechanism for the exchanges when federal funding ends in 2015. Department of Health Care Policy and Financing (HCPF) and the State Health Care Reform Implementation Board are currently hosting a series of forums around the state to gain input from stakeholders regarding how the exchange should be structured in Colorado.	

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Consumer Operated and Oriented (CO-OP) Plan	The Secretary must create a program to facilitate the creation of nonprofit health insurers through loans and grants.	None specified or unknown at this point.	None specified.
Authority to Establish Alternative Programs	***Standard Health Plans.*** The act allows states to enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits to eligible individuals in lieu of offering such individuals coverage through an exchange. Individuals who have a household income that exceeds 133%, but is below 200%, of the Federal Poverty Level (FPL) and who do not have access to an employer-sponsored plan are eligible for this coverage. ***Waivers.*** Beginning January 1, 2017, states may apply for waivers of specific requirements of the act, including the requirement to establish and operate an exchange. ***Health Care Choice Compacts.*** The act allows for the creation of Health Care Choice Compacts under which two or more states may enter into agreements. Under the agreements, individual health insurance plans may be sold in each state that enters into an agreement and be subject only to the laws of the state in which the plan was issued, with certain exceptions.	States must determine whether to avail themselves of any of the options to develop alternative programs.	***Standard Health Plans.*** Approved programs may receive federal funding in an amount equal to 85% of tax credits and cost-sharing subsidies that would have been provided to eligible individuals had they enrolled in an exchange plan. ***Waivers.*** The Secretary must develop an alternative means to transfer funds to the state that otherwise would have been paid to participants in the exchange.
Reinsurance Program	By January 1, 2014, states are required to establish a reinsurance program. The reinsurance program will be funded through payments made by group health plans, and the program will provide payments to individual insurers that cover high-risk individuals in the insurance market. States must coordinate with or eliminate any existing high-risk pool in the state in order to implement this provision.	The state must adopt state law or regulations to implement the reinsurance program, and must determine if additional costs will be collected from insurers to cover the administrative costs of the program.	None specified.
Risk Adjustment	States are required to assess a charge on health plans if the actuarial risk of the enrollees of the plan is less than the average actuarial risk of all enrollees in all plans. States must provide payments to health plans if the actuarial risk of the enrollees of the plan is greater than the average actuarial risk of all enrollees in all plans.	Legislation or rules establishing how the charge will be assessed on health plans, the amount of the charge, and how the charges will be redistributed to other plans is necessary.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Individual Mandate	The act requires individuals to maintain minimal essential health care coverage beginning in 2014. Those individuals who do not maintain adequate coverage are subject to a Shared Responsibility Payment. The act waives criminal and civil penalties for failure to pay the Shared Responsibility Payment. Individuals who met the following requirements are not assessed a penalty for failure to maintain coverage: • individuals who claim an exemption based in their religious beliefs; • individuals who are not covered for only short periods of time; • individuals who are required to pay more than 8% of their household income towards the cost of coverage; • individuals with a taxable income of less than 100% FPL; • Native Americans; and • individuals who have a hardship with respect to obtaining coverage. Individuals may obtain acceptable coverage through: • a plan offered inside or outside of the exchange; • a plan that was grandfathered in under the act; • an employer-sponsored plan; • Medicaid, Medicare, or the Children's Health Insurance Program; • TRICARE or the Veterans' Administration; or • a federal employee health benefit plan.	The individual mandate is enforced through a federal tax penalty.	None specified.
Employer Responsibilities	The act requires employers with more than 200 employees to automatically enroll new employees in a health care plan and provide information about how the employee can opt out of coverage. Employers must also provide information to employees about the exchange.	Employer responsibilities with regard to reform are enforced through federal penalties.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Insurance (Cont.)			
Employer Responsibilities (Cont.)	The act imposes fines on large employers (employers with 50 or more employees) who fail to offer full-time employees the opportunity to enroll in health care coverage or who have a waiting period of more than 60 days for the employee to enroll in coverage. Large employers must also submit an annual report on the health insurance coverage provided to their full-time employees.		
Health Information Technology Standards	The act requires the Secretary to develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs. Grants are available to states and local governments to develop and adapt technology systems to implement the standards and protocols.	The state must submit a needs analysis of current systems to determine whether enrollment standards and protocols can be met.	Funding of $20 million is anticipated to be available for Enrollment Health and Information Technology grants, although no announcements have been made. HCPF and the Office of Information Technology will apply for funding.
Medicaid and the Children's Basic Health Plan			
Medicaid Coverage Expansions	Beginning in 2014, the act makes the following changes to the state's Medicaid program: • expands coverage to children and adults with incomes up to 133% of the FPL. All newly eligible adults are guaranteed a benefit package that meets the essential health benefits available through the exchange; • requires the essential health benefits package to include coverage of prescription drugs and mental health services; • extends coverage to former foster care children who are under 26 years of age; and • allows the states the option of providing Medicaid coverage to all non-elderly individuals with incomes above 133% of the FPL.	States may expand coverage to adults with incomes up to 133% of the FPL as early as April 1, 2010, but are required to do so by 2014. States may extend Medicaid coverage to individuals with incomes above 133% beginning January 1, 2011.	States will receive: • 100% federal funding for the Medicaid expansion for 2014 through 2016; • 95% funding for 2017; • 94% funding for 2018; • 93% funding for 2019; and • 90% funding for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% of the FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for childless adults.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Medicaid Eligibility	The act: • requires states to use an individual's or household's modified gross income to determine eligibility, without applying a disregard for income or expenses or an asset or resource test; • allows a state to offer Medicaid wrap-around benefits to individuals who are eligible for Medicaid but who are enrolled in an employer-sponsored insurance program; • prohibits the state from requiring, as a condition of Medicaid eligibility, that an individual apply for enrollment in qualified employer-sponsored coverage; • requires the state to maintain income eligibility levels for children who are eligible for Medicaid until 2019; • allows states to cover family planning services and supplies under a presumptive eligibility period for a categorically needy group of individuals; and • creates an optional eligibility category to provide full Medicaid benefits to individuals receiving home- and community-based services.	Colorado may need to conform its existing laws and rules concerning Medicaid eligibility to comply with federal legislation.	None specified.
Enrollment Simplification	The act: • requires the state to enroll newly eligible participants who apply through the exchange in the Medicaid program; • requires states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail, or by phone; • requires states to establish procedures to allow individuals to enroll and reenroll in Medicaid through a website, and requires that the website be linked to the exchange's website; • permits exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges; and • permits hospitals to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.	The state will have to coordinate the development of the health insurance exchange with the eligibility determination processes of Medicaid and CHP+.	None specified.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Benefits and Services	The act makes the following changes to Medicaid benefits and services requirements: • effective immediately, requires coverage of free- standing birth center services; • effective immediately, allows children who are receiving hospice care to continue to receive full Medicaid benefits; • effective January 1, 2013, requires states to cover preventative care, including vaccines for adults, and gives states financial incentives to implement this provision without any cost-sharing requirements; and • effective October 1, 2010, requires coverage for tobacco cessation services for pregnant women; and • allows Medicaid coverage of certain drugs used to promote smoking cessation, barbiturates, and benzodiazepines.	Colorado may need to conform its existing laws and rules concerning Medicaid eligibility to comply with federal legislation.	Awards states that remove cost-sharing for preventive services with a one percentage point increase in the FMAP for these services.
Emergency Psychiatric Demonstration Program	The act establishes a three-year demonstration program to allow up to eight states to increase the number of Medicaid emergency inpatient psychiatric care beds in the state.	States must apply to be part of the program. Funds may not be awarded to a public institution.	A total of $75 million is available over the three-year period. HCPF and DHS will apply for the grants.
Medicaid Health Homes	Beginning January 1, 2011, allows states to implement, through a Medicaid state plan amendment, a program to provide coordinated care to individuals with chronic illness through a health home. A health home is a model of care that uses a health assessment plan, integrates service providers, tracks referrals, reviews all medications, and allows for the use of health information technology to provide services in the home.	States must meet specified requirements regarding coordination of physical health services with substance abuse and mental health services, reporting, and payment of home health services.	For the first two years a state operates a program, the state will receive an enhanced FMAP of 90% of the costs of the program. Beginning January 1, 2011, planning grants are available to states to implement this provision. States must match the amount received based on their FMAP. A total of $25 million is available.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Payments to Disproportionate Share Hospitals	Medicaid Disproportionate Share Hospital (DSH) allotments are distributed to providers who serve a large number of uninsured patients. The act reduced DSH payments provided to states in the aggregate by: • $0.5 billion in 2014; • $0.6 billion in 2015; • $0.6 billion in 2016; • $1.8 billion in 2017; • $5 billion in 2018; • $5.6 billion in 2019; and • $4 billion in 2020. Effective October 1, 2011, the act requires the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured individuals or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for certain Medicaid waivers.	Colorado will have to determine how to implement the reduction in DSH payments. Over the long-term, the state will have to consider how existing programs that are funded through DSH payments, namely the Colorado Indigent Care Program, will operate with the broader changes required by the act, including the health care exchange and the Medicaid coverage expansions.	Not applicable.
Payments to Primary Care Providers	The act increases Medicaid payments for primary care services to 100 percent of the Medicare payment rates for 2013 and 2014.	Colorado will likely need to revise its current payment rates to comply with this provision. Payment rates are generally set through rules issued by the state Board of Medical Services.	States will receive 100% federal funding for the increase payment rates.
Demonstration Projects for Payments to Providers	The act establishes three demonstration projects related to payment of providers. The projects are: • a project to allow up to eight states to evaluate the use of bundled payments for the provision of integrated care to a Medicaid beneficiary; • a project in which a participating state may adjust payments to an eligible safety net hospital from a fee-for-service structure to a capitated payment model; and • a project to allow pediatric medical providers to be recognized as accountable care organization for the purpose of receiving incentive payments.	Selected states must submit plans to the federal government and report specific data.	No specific funding was included in the act for the demonstration projects, but HCPF and the Center for Improving Value in Health Care will apply when funding is available.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Medicaid and the Children's Basic Health Plan (Cont.)			
Grants for Wellness Programs	The act provides grants to states to provide incentives to Medicaid beneficiaries who participate in wellness programs to lower health risk and demonstrate improved outcomes.	In order to receive a grant, states must continue the wellness program for at least three years. The programs must be based on criteria developed by the Secretary. States must set standards and health status targets for beneficiaries, and evaluate the success of the program in meeting the standards.	Grants for state wellness programs will be awarded as soon as January 1, 2011. A total of $100 million over a five-year period is available. HCPF and the Department of Public Health and Environment (DPHE) will apply for the grants.
Children's Health Insurance Program	The act makes the following changes to the Children's Health Insurance Program (CHIP): • requires states to maintain current income eligibility levels until 2019; • requires states to enroll newly eligible participants who apply through the exchange; • specifies that children who are eligible for enrollment, but cannot enroll due to enrollment caps, are eligible for tax credits in the exchange; and • provides states with the option to provide coverage to children of state employees who are eligible for health benefits if certain conditions are met.		Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. The amount funded depends on prior years' spending. The act extended funding for existing CHIP Obesity Demonstration Programs for fiscal years 2009-10 through 2013-14. Total funds available are $25 million. HCPF will apply for funding.
Funding for Providers that Serve the Uninsured			
Strengthening Community Health Centers	Effective federal fiscal year 2010-11, the act provides funds to build new and expand existing community health centers, school-based health clinics, and other health facilities. In most cases, the funds or programs must be applied for by individual health centers, not the state. ***Community Health Center Fund.*** The act establishes a Community Health Center Fund to provide additional funding for community health centers. ***Demonstration Project for the Uninsured.*** The act establishes a three-year demonstration project for up to 10 states to provide access to health care services to the uninsured at a reduced rate. Participating entities must be a state-based, nonprofit, public-private partnership.	Varies, but in general, funds are distributed directly to providers.	***Community Health Center Fund.*** Total funding under this program ranges from $1 billion in FY 2010-11 to $3.6 billion in FY 2015-16. ***Demonstration Project for the Uninsured.*** Each selected state will receive $2 million to carry out the program. ***School-based Health Centers.*** A total of $50 million will be awarded for FY 2009-10 through FY 2012-13. ***Trauma Care Centers Grants.*** Trauma Care Centers grants are available for FY 2009-10 through FY 2014-15. Approximately $100 million is authorized for each fiscal year as matching funds for safety net trauma centers. The DPHE will apply and award sub-grants to eligible entities when the program is funded.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Funding for Providers that Serve the Uninsured (Cont.)			
Strengthening Community Health Centers (Cont.)	***School-based Health Centers.*** School-based Health Center grants are available to individual centers. ***Trauma Care Centers Grants.*** Grants are available to qualified public and private trauma centers to assist in defraying uncompensated care costs and provide emergency relief to ensure the continued operation of trauma centers. ***Co-locating Primary and Specialty Care in Community-Based Mental Health Settings Grants.*** Grants are available for demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services. ***Health Care Quality Improvements Grants.*** Grants are available to eligible entities that establish community-based interdisciplinary teams to support primary care practices. ***Grants to Promote the Community Health Workforce*** which are available to eligible entities to promote positive health behaviors for populations in medically-underserved areas of the state through the use of community health workers. Funds are also used to educate individuals regarding public health programs such as CHIP, Medicaid, and Medicare.		***Co-locating Primary and Specialty Care in Community-Based Mental Health Settings Grants*** are anticipated to be available for FY 2009-10 through FY 2013-14. The program has been authorized, but not yet funded. HCPF, the Department of Human Services (DHS), and DPHE will apply. ***Health Care Quality Improvements grants*** are not yet funded. DPHE will apply for the grants. A number of other grant opportunities are anticipated, including ***Grants to Promote the Community Health Workforce***. Funding announcements have not been made yet, but will be applied for by DPHE.
Health Care Workforce			
Health Care Workforce Analysis	***State Health Care Workforce Development Grants.*** The program will award grants to facilitate state partnerships to complete comprehensive planning and to facilitate workforce strategies. ***State and Regional Centers for Health Workforce Analysis.*** The Secretary must award grants to states and other entities to collect, analyze, and report data on the health care workforce.	To receive State and Regional Centers for Health Workforce Analysis funds, the state must coordinate with the national center. Eligible entities, including the state, must apply for funding.	***State Health Care Workforce Grants.*** State Health Care Workforce Grants are being awarded for both planning and implementation phases. DPHE requested $150,000 as a planning grant, and a two-year $2 million implementation grant. ***Health Care Workforce Analysis.*** A total of $4.5 million for FY 2009-10 to FY 2013-14 is available for State and Regional Centers for Health Workforce Analysis grants. Funding announcements have not been made yet, but DPHE will apply for the grants.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Health Care Workforce (Cont.)		
Increasing the Supply of the Health Care Workforce	The act expands and improves several low-interest student loan programs, scholarships, and loan repayments for health students and professionals. These programs, in general, do not provide funding to the state, but rather directly to health care professionals, academic institutions, or health care facilities. Some of the programs affected or created by the act include: • the ***Primary Care Extension Program,*** which will provide funding to allow states to establish state or multi-state level state hubs. Hubs will consist of designated state health agencies, health professionals, associations, consumer groups and other entities. The hubs will provide support and assistance to educate primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques. • the ***Nursing Student Loan Program***, which raises the cap on the maximum annual loan amount from $2,500 to $3,300 per year, except for a student's final two years where limits are increased from $4,000 to $5,200 per year, and raises the overall aggregate amount from $13,000 to $17,000 beginning in FY 2009-10 and FY 2010-11; • the ***Pediatric Specialty Loan Repayment Program*** which requires recipients to commit to two years of employment in a pediatric specialty field in an area with identified shortages, and allows payments to be made on student loans of up to $35,000 per year up to three years of service;	Varies.	***The Primary Care Extension Program*** is currently authorized to provide a total of $120 million per year, but is not yet funded. For fiscal years 2009-10 through 2013-14, $5 million is available for ***Continuing Educational Support for Health Professionals Serving in Underserved Communities*** grants. The state is evaluating the grant opportunity. The Public Health Service Act authorizes $338 million for fiscal year 2009-10, and sums as necessary for FY 2010-11 through FY 2015-16 to fund nursing development programs. The state is evaluating the grant opportunity.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Care Workforce (Cont.)			
Increasing the Supply of the Health Care Workforce (Cont.)	• the ***Public Health Workforce Recruitment and Retention Program*** which provides loan repayment to public health professionals employed by federal, state, or local public health agencies. Individuals must be employed for up to three years of service, and may receive up to $35,000 in loan repayment. Additional funding is available for to fund scholarships for mid-career public health professionals to receive additional training; • the ***Continuing Educational Support for Health Professionals Serving in Underserved Communities*** grant program, which provides grants to eligible entities to improve health care, increase retention, increase representation of minority faculty members and to provide educational support to reduce professional isolation.		
Improving Workforce Training	With regard to training programs for individuals in the health care workforce, effective July 1, 2010, the act: • increases flexibility in laws and regulations that govern Graduate Medical Education (GME) training positions to promote training in outpatient settings; • supports the development of interdisciplinary mental and behavioral health training programs and establishes a training program for oral health professionals; • addresses the projected shortage and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing; and • supports the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services.	Varies.	Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship funds will be available to develop and operate training programs for FY 2009-10 through FY 2013-14. Awards will be for five years. The program has been authorized, but not yet funded. DPHE and the University of Colorado will apply for funding. Enhancing Health Care Workforce Education and Training grants will be available for FY 2009-10 through FY 2013-14. Funding information is not yet available. The state is evaluating the grant opportunity.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Health Care Workforce (Cont.)			
Improving Workforce Training (Cont.)	Effective July 1, 2011, the act: • increases the number of GME training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios; • establishes Teaching Health Centers, defined as community-based, ambulatory patient care centers; • provides grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics; and • funds research on emergency medicine and develop demonstration programs for models for emergency care systems. In most cases, the state will not directly receive funds related to workforce training. Funding will be distributed directly to health professionals, educational institutions, and health care facilities.		
Medical Malpractice	The act awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.	States must submit applications specifying the terms of the alternative program, the areas of the state in which the alterative program will operate, and how compensation will be distributed under the program.	The Governor's Office is evaluating whether to apply for the State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation. For the five fiscal years beginning with 2010-11, $50 million is authorized but not yet funded.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Long-term Care	
CLASS Act	Effective January 1, 2011, the act establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS Independence Benefit Plan). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions; all working adults will be automatically enrolled in the program, unless they choose to opt-out.	The state must coordinate CLASS coverage with Medicaid benefits. In addition, the state must, in 2012, assess the extend to which providers of long-term care services are serving or have the capacity to serve individuals receiving benefits under the CLASS program. States must designate or create entities to serve as fiscal agents for employing workers serving individual in the CLASS program.	None; the program will be funded through voluntary payroll deductions.
Older Adults	Effective October 1, 2010, the act creates the Elder Justice Act to add federal programs and authorization for federal appropriations for Adult Protective Services, the Long-term Care Ombudsman Program, long-term care facilities and licensing entities, and other programs that provide services for at-risk elders.	Varies.	Up to $100 million per year for FY 2010-11 through FY 2013-14 has been authorized, but not yet funded. DHS will apply for grants under this act. State Demonstration Program Concerning Elder Abuse Grants of $25 million total are authorized for fiscal years 2010-11 through 2013-14. DHS will apply for these grants.
Medicaid	Several of the act's changes to Medicaid impact long-term care. Specifically, the act: Effective October 1, 2010: • provides states with new options for offering home- and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes of up to 300% of the maximum SSI payment and who have a higher level of need; • permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan; • extends the Medicaid Money Follows the Person Rebalancing Demonstration through September 2016 and allocates $10 million per year for five years to continue the Aging and Disability Resource Center initiatives; and • continues the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities.	Participation in the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers Program requires Colorado to contribute matching funds to the program. Participation in the State Plan Option Promoting Health Homes for Enrollees for Chronic Conditions requires a state Medicaid plan amendment.	The State Plan Option Promoting Healthy Homes for Enrollees for Chronic Conditions provides an enhanced match of 90% FMAP for two years for states that take up the option as of January 1, 2011. Planning grants have been authorized but not yet funded. HCPF will apply for the grants. HCPF has applied for a Medicaid Money Follows the Person Rebalancing Demonstration grant. Funding is competitive and could be up to $1 million. The state does not qualify for the portion of these funds that are for nursing home transitions. Six additional FMAP points will be available for states that implement the Community First Choice Option as of October 1, 2011. Medicaid Infrastructure grants are available to help implement a Medicaid Buy-in Program. HCPF will apply for the grants.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Long-term Care (Cont.)			
Medicaid (Cont.)	Effective October 1, 2011: • establishes the Community First Choice Option to provide community-based services to individuals with disabilities who require an institutional level of care. Provide states with an additional 6% federal match for reimbursable expenses; • creates the State Balancing Incentive Program to provide matching funds to eligible states to increase the proportion of non-institutionally-based long-term care services, effective through 2015; and • requires skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures.		Federal funds of three times the amount a state guarantees will be available for the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers. Funds will not exceed $3 million for newly participating states and $1.5 million for previously participating states. Other funding is anticipated to be available to increase home and community-based services through the State Balancing Incentives Program, although no announcements have been made. Funding will total a 2 to 5% increase in FMAP. A total of $10 million annually will be distributed for Aging and Disability Resource Centers. DHS expects to receive a portion of these funds on a formula basis for FY 2009-10 through FY 2013-14. DHS's application was for $492,469. There is a total of $40 million available through 50 grants under the Medicare Improvements for Patients and Providers (MIPPA). DHS requested $345,072. The Hospital Care Transition Models program, a program to assist individuals in navigating the long-term care system, was appropriated a total of $2.5 million in funding, which will be awarded in five to seven competitive grants. DHS applied for $399,183.
Public Health			
Public Health Infrastructure	The act establishes a Prevention and Public Health Fund to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.	Not specified.	Total funding for all states ranges from $500 million in FY 2009-10 to $2 billion in FY 2014-15. Colorado is eligible for $300,000 each year for five years. The DPHE applied for a grant on August 5, 2010.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Public Health (Cont.)			
Community Preventative Health	***Community Transformation Grants.*** The act requires the Secretary, acting through the Director of the Centers for Disease Control and Prevention (CDC), to award grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming. ***Healthy Aging, Living Well Grants.*** The act requires the Secretary, acting through the Director of CDC, to award grants to state or local health departments and Indian tribes to carry out pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age.	***Community Transformation Grants.*** Eligible entities must submit a detailed community transformation plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities. ***Healthy Aging, Living Well Grants.*** Eligible entities must design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and demonstrate the ability to implement the interventions.	The DPHE estimates that the state may be eligible to receive $200,000 to $1.3 million under these initiatives. The department will apply for grant moneys when they are made available.
Oral Healthcare Prevention	The act requires the Secretary, through the Director of CDC, to carry out oral health activities, including: • establishing a national public education campaign that is focused on oral health care prevention and education; • awarding demonstration grants for research-based dental caries disease management activities; • awarding grants for the development of school-based dental sealant programs; and • entering into cooperative agreements with state, territorial, and Indian tribes or tribal organizations for oral health data collection and interpretation, a delivery system for oral health, and science-based programs to improve oral health.	Applications must be submitted for funds, and a 20% state match is required.	The DPHE will apply for grant moneys when they are made available.
Epidemiology and Laboratory Capacity	Requires the Secretary, acting through the Director of CDC, to establish an Epidemiology and Laboratory Capacity Grant Program to award grants to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance.	Not specified.	A total of $190 million is available for FY 2009-10 through FY 2012-13. The DPHE is applying for $2 million in funding.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
		Public Health (Cont.)	
Immunizations	The act authorizes the Secretary to negotiate and enter into contracts with vaccine manufacturers for the purchase and delivery of vaccines for adults. States are allowed to purchase additional quantities of adult vaccines from manufacturers at the applicable price negotiated by the Secretary. The act requires the Secretary, through the Director of CDC, to establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children and adults through the use of evidence-based, population-based interventions for high-risk populations.	States must submit a state plan explaining how the grant moneys will be used for specific interventions, and how the interventions will align with local need.	A total of $1 million in FY 2009-10 is available. DPHE and DHS will apply for funding.
Environmental Health Hazards	Competitive grants are available to state and health care facilities for the purpose of screening individuals for environmental health conditions and disseminating information regarding environmental health and the availability of treatment for certain individuals through Medicare.	Eligible entities must submit an application containing specified information.	For FY 2009-10 through FY 2013-14, $23 million is available; $20 million will be available for each five-year fiscal year period thereafter.
		Other	
Home Visitation Services	States, or if a state does not apply, eligible nonprofit entities may apply for grants to establish early childhood home visitation programs for certain at-risk families.	By September 2010, states must conduct needs assessments of communities and measure certain health-related indicators. Entities that are awarded grants must establish certain benchmarks, and report on their progress in meeting the benchmarks.	The total funding available for grants to states and other eligible entities is: • $100 million in 2010; • $250 million in 2011; • $350 million in 2012; • $400 million in 2013; and • $400 million in 2014. The DPHE applied for initial funding in the amount of $500,000. Additional applications are due September 1, 2010.
Funding for Research on Postpartum Depression	States may apply for grants to provide services related to postpartum depression.	States, as well as nonprofit entities, may apply for the funding.	A total of $3 million is available in 2010. DPHE will apply for funding.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Other (Cont.)			
Support for Young Women Diagnosed with Breast Cancer	Grants are available to organizations that provide information from credible sources and assistance to young women diagnosed with breast cancer.	Priority is to be given to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.	A total of $9 million will be available for FY 2009-10 through FY 2013-14. DPHE will apply for funding.
Pregnancy Assistance Fund	States may be awarded grants to assist teens and women who are pregnant or parenting. Funds may be used by institutions of higher education, high schools, or community services centers to offer services. In addition, funds may be used to assist victims of domestic violence or to create a public awareness campaign.	Institutions of higher education that are awarded funding must contribute 25% matching funds.	A total of $25 million is available annually through FY 2018-19. DHS will apply for funding.
Personal Responsibility Education for Adulthood Training	[illegible] inancial literacy, and healthy relationships.	A state may not receive funding until the state submits a two-part application for the funds, but funds are awarded to all states that apply.	A total of $55 million is available each year from 2010 through 2014. Colorado is expected to receive $793,058 per year for five years. Colorado's application is being coordinated by DHS, DPHE, and the Department of Education.
Regionalized Systems for Emergency Care	States, or partnerships of states and local governments, may be awarded four multiyear contracts or grants to support pilot projects that design, implement, and evaluate innovative models of regionalist, comprehensive, and accountable emergency care and trauma systems.	Eligible entities must apply for the program. States must contribute matching funds of $1 for every $3 of federal funding received.	Not specified.
Taxation			
Premium Assistance Tax Credits	The act provides premium tax credits and cost-sharing reductions available through the exchanges to make coverage more affordable to lower income individuals. Premium tax credits are available for individuals not eligible for qualified coverage, with incomes above 100% and below 400% of poverty (under $88,000 for a family of four).	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Taxation (Cont.)			
Small Business Health Insurance Tax Credit	The act provides a sliding-scale tax credit for small businesses (25 or fewer employees with average annual wages under $50,000) that purchase health insurance for employees if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. • Phase I (tax years 2010 through 2013): provides a tax credit of up to 35% of the employer's contribution toward the employee's health insurance. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25 percent of the employer's contribution. • Phase II (tax years 2014 and 2015): provides a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution.	None.	Not applicable.
Adoption Tax Credit	For tax years 2010 and 2011, the act increases the adoption tax credit and adoption assistance exclusion by $1,000 and makes the credit refundable.	None.	Not applicable.
Therapeutic Project Tax Credit	The act provides a tax credit for businesses with 250 or fewer employees that invest in acute and chronic disease research during 2009 and 2010.	None.	Not applicable.
Tax Relief for Health Professional State Loan Repayments	Excludes state loan repayment or loan forgiveness programs intended to provide increased availability of health care services in under-served areas from gross income payments. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Taxation (Cont.)		
Blue Cross Blue Shield (BCBS) Non-Profit Organization Tax Benefit	Starting tax year 2010, the act requires that non-profit BCBS organizations devote 85% or more of their premium dollars to patient care in order to claim the special tax benefits under Internal Revenue Code (IRC) Section 833. Special tax benefits include a 25% deduction of claims and expenses and a 100% deduction for unearned premium reserves.	None.	Not applicable.
Individual Coverage Requirement	Beginning tax year 2014, the act requires that individuals maintain minimum essential health insurance coverage. Failure to obtain minimum coverage will result in a penalty on the individual's federal tax return. The penalty will be phased in starting in 2014, reaching the greater of $695 for individuals ($2,250 for families) or 2.5% of income in 2016.	None.	Not applicable.
Medicare Hospital Insurance (HI) Rate	Starting tax year 2013, the provision increases the Medicare Hospital Insurance (HI) tax rate from 0.5 to 0.9% on single taxpayers earning more than $200,000 and joint filers earning more than $250,000.	None.	Not applicable.
High Cost Plan Excise Tax	Beginning tax year 2018, the act imposes a nondeductible 40% excise tax on excess benefits provided in any month under a employer-sponsored health plan.	None.	Not applicable.
Tax on Indoor Tanning Services	Starting tax year 2010, imposes a 10% tax on amounts paid for indoor tanning services.	None.	Not applicable.
Medical Device Excise Tax	Starting in 2013, imposes a 2.3% excise tax on the sale of medical devices by manufacturers and importers.	None.	Not applicable.
Deductions for Executive Compensation	Starting tax year 2013, limits deductions for executive compensation for insurance providers to $500,000 if at least 25% of the provider's gross premium income from health business is derived from health insurance plans that meet the minimum essential coverage requirements. The $500,000 limit applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider.	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
	Taxation (Cont.)		
Deductions for Medicare Part D Subsidy	Employers are entitled to a subsidy if they offer retiree prescription drug coverage that is at least as valuable as Medicare Part D. Employers can deduct the entire cost of providing the coverage, even though a portion is offset by the subsidy. Starting tax year 2013, eliminates deductions for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.	None.	Not applicable.
Deductions for Medical Expenses	Starting tax year 2013, increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10%. Those 65 and older can claim at 7.5% until tax year 2017.	None.	Not applicable.
Corporate Estimates Tax	For tax year 2014, increases the Corporate Estimates Tax imposed under the Corporate Estimated Tax Shift Act of 2009 by 15.75%.	None.	Not applicable.
"Black Liquor" Tax Credit Exclusion	In 2009, the IRS found that "black liquor," a byproduct of the process for making paper, may qualify for both the cellulosic biofuel producer credit and the refundable alternative fuel mixture credit. Starting tax year 2010, the act *excludes* black liquor as eligible for this tax credit.	None.	Not applicable.
Health Insurance Provider Fee	Starting in 2010, imposes an annual flat fee of $6.7 billion on the health insurance sector, allocated across the industry based on market share.	None.	Not applicable.
Pharmaceutical Manufacturing Fee	Starting in 2011, imposes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector, allocated across the industry based on market share. The funds generated from the fee are intended to offset some of the costs of implementing the act.	None.	Not applicable.

Table 1
Summary of the Federal Health Care Reform Legislation (Cont.)

Provision	Description	State Action Required	Funding Available to States
Taxation (Cont.)			
Employer Fee	The act does not require that employers offer health coverage but imposes penalties encouraging them to do so. Penalties apply to employers with more than 50 employees. Starting in 2014, employers with 50 or more full time employees that do not offer health insurance coverage but have at least one employee receiving a premium tax credit must pay a fee of $2,000 per year ($166 per month) per employee, excluding the first 30 employees (e.g., a firm with 51 workers will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount).	None.	Not applicable.
Fees to Support the Patient Centered Outcome Research Trust Fund	For fiscal years 2012-13 through 2018-19, imposes a fee on each specified health insurance policies and self-insured health plan. The fee is equal to the product of $2 multiplied by the average number of lives covered under the policy or plan.	None.	Not applicable.

FY 2010-11 Medical Services Premiums Appropriation to Expenditure Comparison

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Acute Care	$100,768,747	$57,772,325	$518,486,688	$221,102,160	$91,516,554	$9,871,678	$486,854,271	$63,670,761	$70,907,462	$49,726,910	$3,582,631	$1,674,260,187
Community Based Long Term Care	$149,985,415	$22,263,075	$132,884,248	$209,485	$33,455	$0	$887,310	$7,065,836	$0	$1,290	$212,673	$313,542,788
Long Term Care	$521,171,935	$39,315,104	$89,634,823	$6,088	$0	$0	$0	$0	$0	$0	$72,212	$650,200,162
Insurance	$62,167,413	$3,658,942	$33,638,951	$239,886	$0	$0	$12,286	$228	$0	$0	$19,246,872	$118,964,577
Service Management	$12,208,228	$2,335,580	$12,430,327	$1,058,554	$386,024	$0	$4,380,882	$387,734	$157,345	$59,922	$7,145	$33,411,741
Services Sub Total	**$846,301,739**	**$125,345,026**	**$787,075,036**	**$222,616,173**	**$91,936,034**	**$9,871,678**	**$492,134,748**	**$71,124,559**	**$71,064,807**	**$49,788,122**	**$23,121,534**	**$2,790,379,456**
Bottom Line Impacts												
Financing	$37,654,981	$16,796,904	$145,876,733	$69,915,574	$14,237,219	$2,767,560	$143,234,210	$18,077,704	$17,916,939	$15,991,090	$1,214,120	$483,683,032
FY 2010-11 Roll Forward from FY 2009-10	$18,980,234	$3,052,058	$20,032,251	$6,281,214	$2,211,871	$271,389	$13,642,582	$1,915,342	$1,910,608	$1,412,405	$522,533	$70,232,486
Final FY 2010-11 Appropriation	**$902,936,953**	**$145,193,988**	**$952,984,021**	**$298,812,960**	**$108,385,123**	**$12,910,627**	**$649,011,539**	**$91,117,606**	**$90,892,353**	**$67,191,617**	**$24,858,186**	**$3,344,294,974**

Expenditure By Service Category

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Acute Care Costs	$97,388,620	$61,036,898	$529,213,760	$218,112,253	$117,825,312	$9,817,196	$497,319,012	$62,802,717	$67,507,543	$45,331,275	$5,066,688	$1,711,421,275
Community Long Term Costs	$142,698,517	$22,313,208	$144,648,196	$181,275	$130,625	$0	$566,227	$8,341,459	$0	$0	$137,560	$319,017,067
Long Term Care Costs	$463,757,141	$40,246,469	$82,317,334	$7,615	$0	$0	$0	$0	$0	$0	$564,302	$586,892,862
Insurance Premiums	$63,753,805	$3,718,263	$34,443,659	$214,125	$0	$0	$2,021	$1,059	$0	$0	$18,447,446	$120,580,378
Service Management	$11,905,802	$2,439,509	$11,814,039	$778,047	$580,176	$0	$3,476,143	$240,433	$104,173	$38,731	$7,262	$31,384,315
Total Expenditure By Service Category	**$779,503,885**	**$129,754,347**	**$802,436,988**	**$219,293,316**	**$118,536,113**	**$9,817,196**	**$501,363,403**	**$71,385,668**	**$67,611,716**	**$45,370,006**	**$24,223,258**	**$2,769,295,897**
Bottom Line Impacts												
Financing	$80,467,449	$21,209,175	$140,933,589	$79,567,093	$38,741,817	($38)	$126,406,344	$10,425,920	$28,077,153	$30,171,128	$99,658	$556,099,288
FY 2010-11 Roll Forward from FY 2009-10	$18,980,234	$3,052,058	$20,032,251	$6,281,214	$2,211,871	$271,389	$13,642,582	$1,915,342	$1,910,608	$1,412,405	$522,533	$70,232,486
Final FY 2010-11 Actuals	**$878,951,568**	**$154,015,580**	**$963,402,828**	**$305,141,623**	**$159,489,801**	**$10,088,547**	**$641,412,329**	**$83,726,931**	**$97,599,476**	**$76,953,539**	**$24,845,450**	**$3,395,627,671**

Overexpenditure Analysis

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Service Costs	($66,797,854)	$4,409,321	$15,361,951	($3,322,857)	$26,600,079	($54,482)	$9,228,655	$261,109	($3,453,091)	($4,418,116)	$1,101,725	($21,083,559)
Financing	$42,812,468	$4,412,271	($4,943,144)	$9,651,520	$24,504,599	($2,767,598)	($16,827,866)	($7,651,784)	$10,160,214	$14,180,037	($1,114,461)	$72,416,256
Total Overexpenditure / (Underexpenditure)	**($23,985,385)**	**$8,821,593**	**$10,418,807**	**$6,328,663**	**$51,104,678**	**($2,822,080)**	**($7,599,211)**	**($7,390,675)**	**$6,707,123**	**$9,761,921**	**($12,736)**	**$51,332,697**
Percentage Variance from Appropriation	-2.66%	6.08%	1.09%	2.12%	47.15%	-21.86%	-1.17%	-8.11%	7.38%	14.53%	-0.05%	1.53%

Decomposition of Difference in Service Costs

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Service Costs - Appropriation	$846,301,739	$125,345,026	$787,075,036	$222,616,173	$91,936,034	$9,871,678	$492,134,748	$71,124,559	$71,064,807	$49,788,122	$23,121,534	$2,790,379,456
Service Costs - Actual	$779,503,885	$129,754,347	$802,436,988	$219,293,316	$118,536,113	$9,817,196	$501,363,403	$71,385,668	$67,611,716	$45,370,006	$24,223,258	$2,769,295,897
Difference	**($66,797,854)**	**$4,409,321**	**$15,361,951**	**($3,322,857)**	**$26,600,079**	**($54,482)**	**$9,228,655**	**$261,109**	**($3,453,091)**	**($4,418,116)**	**$1,101,725**	**($21,083,559)**
Percentage Variance	-7.89%	3.52%	1.95%	-1.49%	28.93%	-0.55%	1.88%	0.37%	-4.86%	-8.87%	4.76%	-0.76%

Note: Totals do not include the bottom line impacts in the tables above, including the Financing section and the FY 2010-11 Roll Forward section.

Caseload Variance

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Appropriated Caseload	38,942	7,706	56,032	60,881	47,036	524	300,625	18,502	7,867	3,098	17,094	558,307
Actual Caseload	38,921	7,767	56,281	60,958	47,320	531	302,381	18,392	7,868	3,213	17,090	560,722
Difference	**(21)**	**61**	**249**	**77**	**284**	**7**	**1,756**	**(110)**	**1**	**115**	**(4)**	**2,415**
Error Rate	-0.05%	0.79%	0.44%	0.13%	0.60%	1.34%	0.58%	-0.59%	0.01%	3.71%	-0.02%	0.43%

Per Capita Variance

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Estimated Services Per Capita - Appropriation	$21,732.36	$16,265.90	$14,046.88	$3,656.58	$1,954.59	$18,839.08	$1,637.04	$3,844.16	$9,033.28	$16,071.05	$1,352.61	$4,997.93
Estimated Service Per Capita - Actual	$20,027.85	$16,705.85	$14,257.69	$3,597.45	$2,504.99	$18,488.13	$1,658.05	$3,881.34	$8,593.25	$14,120.76	$1,417.39	$4,938.80
Difference	**($1,704.52)**	**$439.95**	**$210.80**	**($59.13)**	**$550.40**	**($350.95)**	**$21.01**	**$37.19**	**($440.03)**	**($1,950.29)**	**$64.78**	**($59.13)**
Error Rate	-7.84%	2.70%	1.50%	-1.62%	28.16%	-1.86%	1.28%	0.97%	-4.87%	-12.14%	4.79%	-1.18%

Variance Decomposition

Service Category	Adults 65 and Older	Disabled Adults to 64	Disabled Individuals to 59	Categorically Eligible Low-Income Adults	Expansion Adults	Breast and Cervical Cancer Program	Eligible Children	Foster Care	Baby Care Program- Adults	Non-Citizens	Partial Dual Eligibles	Total
Cost Associated With Extra Caseload Growth	($456,380)	$992,220	$3,497,674	$281,557	$555,103	$131,874	$2,874,640	($422,857)	$9,033	$1,848,171	($5,410)	$9,305,625
Cost Associated With Extra Per Capita Costs	($66,377,269)	$3,390,264	$11,811,787	($3,599,860)	$25,888,662	($183,899)	$6,317,116	$688,057	($3,461,684)	($6,042,004)	$1,107,394	($30,461,436)
Compounding	$35,795	$26,837	$52,490	($4,553)	$156,314	($2,457)	$36,899	($4,091)	($440)	($224,284)	($259)	$72,252
Total	**($66,797,854)**	**$4,409,321**	**$15,361,951**	**($3,322,857)**	**$26,600,079**	**($54,482)**	**$9,228,655**	**$261,109**	**($3,453,091)**	**($4,418,116)**	**$1,101,725**	**($21,083,559)**