COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2013-14 STAFF FIGURE SETTING

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

Department Overview

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

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

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

Committees of Reference SMART Act Recommendations

House Public Health Care and Human Services Committee

Received January 23, 2013

Recommendations

The House Public Health Care and Human Services Committee SMART Act letter recommended the Joint Budget Committee "explore the costs of expanding Medicaid Breast and Cervical Cancer Program to include treating women who are not initially diagnosed at a Women's Wellness Connection site but who otherwise meet the eligibility criteria for the Program."

This recommendation was discussed during figure setting for the Department of Public Health and Environment.

Senate Health and Human Services Committee

Received January 24, 2013

Recommendations
The Senate Health and Human Services Committee SMART Act letter recommended the Joint Budget Committee, "encourage the Department of Health Care Policy and Financing to offer Behavioral Health Organization contracts to Regional Care Collaborative Organizations when possible."

This recommendation was discussed during figure setting for the mental health programs.

(1) Executive Director's Office

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. Major funding sources for this division include the General Fund, federal funds received for the Medicaid and Children's Basic Health Plan programs, the Health Care Expansion Fund, the Children's Basic Health Plan Trust Fund, and various other cash funds.

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, personnel services, employee-related expenses and benefits, and operating expenses. This subdivision also contains funding for all of the centrally appropriated line items in the Department.

Line items set by JBC common policy

The majority of line items in this subdivision are centralized appropriations that the JBC sets through common policies. In most cases the common policy allocates costs to agencies for a centralized service based on prior year actual utilization by the Department of that service. Rather than discussing the staff recommendation for each line item individually, this section deals with all the line items set through JBC common policies at once. Line items that are not set by common policy are discussed individually following this section. This grouping of the staff recommendations on line items that are set through common policies is intended to simplify the narrative, but it does cause the descriptions of some line items to appear in an order that is different than the order in the numbers pages and in the Long Bill.

Request: The Department requests:

- Benefits associated with "R-6: Additional FTE to restore functionality" and with "BA-13: Restore ICF/IID provider fee"
- Statewide requests for "OIT enterprise asset management" and for "Employee engagement survey adjustment"
- Annualization of H.B. 12-1339 CBMS modernization and improvement

Recommendation: *Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below, which includes no benefits associated*

with small (under 20.0) increases in FTE. Note that the JBC's common policy is pending for several of the line items.

Line items set by JBC common policy					
	TOTAL	**General Fund**	**Cash Funds**	**Reappropriated**	**Federal Funds**
Health, Life, and Dental	2,198,265	748,152	166,566	72,376	1,211,171
Short-term Disability	40,277	13,671	2,827	802	22,977
Amortization Equalization Disbursement	813,297	273,870	57,497	16,232	465,698
Supplemental AED	733,353	246,370	51,907	14,654	420,422
Salary Survey/Performance Pay	671,276	199,437	54,252	10,800	406,787
Workers' Compensation	*pending*				
Legal Services	*954 hours*				
Administrative Law Judge Services	*pending*				
Purchase of Services from Computer Center	*pending*				
Multi-use Network Payments	*pending*				
Management and Administration of OIT	*pending*				
Information Technology Security	11,374	5,607	44	0	5,723
Payment to Risk Management and Property	*pending*				
Capitol Complex Leased Space	*31,512 square feet at 1570 Grant Street*				

Personal Services

This line item contains all of the personal services for the Department's employees, including employee salaries and the employer contributions to PERA and Medicare taxes. The line item also includes funding for temporary employees, employee buy-outs, and some contract services. However, most of the Department's professional contract service costs are contained in separate line items.

Request: The Department requests:

- 9.0 FTE (7.4 FTE in the first year) for "R6 Additional FTE to restore functionality"
- Staff to implement a new dental benefit for adults, requested in "R8 Medicaid dental benefit for adults"
- Continuation and annualization of additional staff that were provided in the supplemental bill to implement Medicaid payment reform pilot programs, requested in "R11 H.B. 12-1281 departmental differences"
- Staff for a transfer of the administration of the ICF/IID provider fee from Human Services to Health Care Policy and Financing, requested in "BA13 Restore ICF/IID provider fee"

In addition, the Department requests annualization of prior year legislation and budget decisions and a fund source adjustment to account for changes in indirect cost recoveries.

Recommendation: *Staff recommends the additional staff requested in "R6 Additional FTE to restore functionality" and continuation and annualization of the additional staff provided in the supplemental for implementing Medicaid payment reform pilot programs that was requested in "R11 H.B. 12-1281 departmental differences".* The rationale for these recommendations is discussed in more detail below.

Staff does NOT recommend the new staff to implement a new dental benefit for adults as requested in "R8 Medicaid dental benefit for adults" or the new staff to transfer administration of the ICF/IID provider fee from Human Services to Health Care Policy and Financing in "BA13 Restore ICF/IID provider fee". Both of these changes would require legislation. The proposed new dental benefit, financed with money from the Unclaimed Property Trust Fund that was previously dedicated to CoverColorado, was described in the JBC staff briefing for the Department of Health Care Policy and Financing. The JBC voted not to carry the requested legislation. The JBC is carrying a bill to transfer administration of the ICF/IID provider fee from the Department of Human Services to the Department of Health Care Policy and Financing and the appropriation for new FTE will be contained in that bill.

Staff recommends an adjustment to ensure that the way indirect cost recoveries are appropriated for this department complies with the standard format used by the JBC for other departments. This technical recommendation is explained in more detail below.

Staff recommends a technical fund source adjustment to show money for the administration of Public School Health Services as reappropriated funds, rather than federal funds, since the money is already appropriated once in the Other Medical Services division.

All of the staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table.

Personal Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2012-13 Appropriation:						
HB 12-1335 (Long Bill)	$21,687,551	$7,916,146	$2,038,599	$351,526	$11,381,280	314.3
S.B. 12-060 Medicaid fraud	5,216	2,608	0	0	2,608	0.1
H.B. 12-1246 Reverse biweekly payday shift	28,498	28,498	0	0	0	0.0
H.B. 12-1281 Payment reform pilot	47,538	23,769	0	0	23,769	0.8
H.B. 12-1339 CBMS improvements	825,119		0	825,119	0	11.0
S.B. 13-089 Supplemental	64,782	32,391	0	0	32,391	0.9
TOTAL	**$22,658,704**	**$8,003,412**	**$2,038,599**	**$1,176,645**	**$11,440,048**	**327.1**
FY 2013-14 Recommended Appropriation:						
FY 2012-13 Appropriation	22,658,704	8,003,412	2,038,599	1,176,645	11,440,048	327.1
Anualize prior year budget decisions	(113,621)	(12,122)	0	(117,874)	16,375	0.4
R6 Additional FTE to restore functionality	528,568	264,285	0	0	264,283	7.4
R8 Medicaid dental benefit for adults	0	0	0	0	0	0.0
R11 HB 12-1281 Departmental differences	169,669	84,834	0	0	84,835	2.1
Centralized appropriations and technical adjust	0	0	0	150,000	(150,000)	0.0
BA13 Restore ICF/IID provider fee	0	0	0	0	0	0.0
Indirect cost adjustment	0	30,141	(82,712)	528,071	(475,500)	0.0
TOTAL	**$23,243,320**	**$8,370,550**	**$1,955,887**	**$1,736,842**	**$11,180,041**	**337.0**
Increase/(Decrease)	**$584,616**	**$367,138**	**($82,712)**	**$560,197**	**($260,007)**	**9.9**
Percentage Change	2.6%	4.6%	-4.1%	47.6%	-2.3%	3.0%
FY 2013-14 Executive Request:	**$24,596,507**	**$9,533,270**	**$2,171,323**	**$1,069,555**	**$11,822,359**	340.0
Request Above/(Below) Recommendation	$1,353,187	$1,162,720	$215,436	($667,287)	$642,318	3.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the following prior year legislation and budget decisions.

Annualizations – Personal Services					
	TOTAL	General Fund	Reappropriated Funds	Federal Funds	FTE
H.B. 12-1246 Reverse payday shift biweekly employees	($28,498)	($28,498)	$0	$0	0.0
H.B. 12-1281 Medicaid payment reform pilot	15,847	7,924	0	7,923	0.2
H.B. 12-1339 CBMS improvement and modernization	(117,874)	0	(117,874)	0	0.0
FY 12-13 R-5 Medicaid fee-for-service payment reform	16,904	8,452	0	8,452	0.2
TOTAL	**($113,621)**	**($12,122)**	**($117,874)**	**$16,375**	**0.4**

➔ R6 Additional FTE to restore functionality

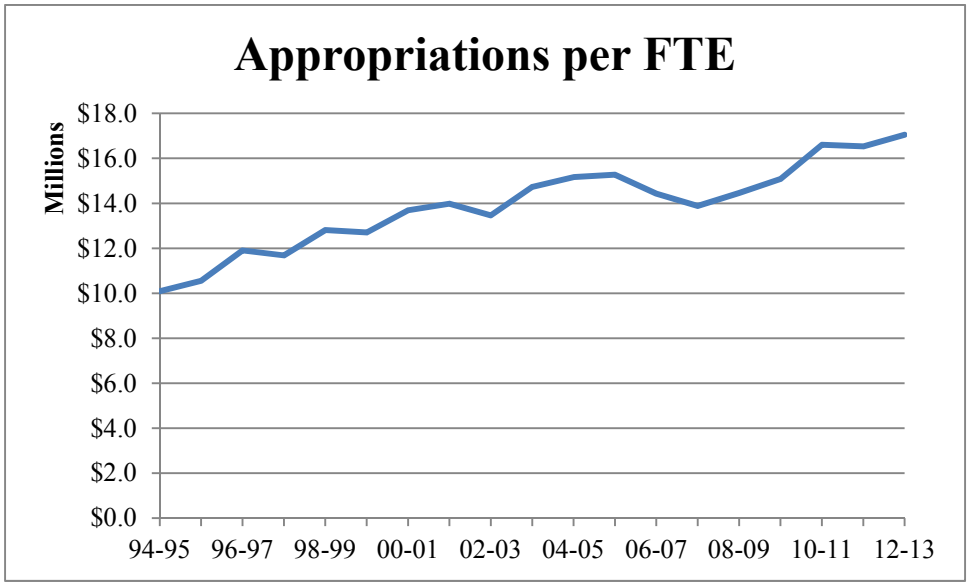
Request: The Department proposes hiring an additional nine employees (7.4 FTE in the first year) to relieve overburdened staff. When fully annualized the cost will be $653,415, including $326,708 General Fund, with all associated benefits and operating expenses. The Department argues that the mission and expectations for the Department have changed over time from simply paying health care claims to making policies that improve the quality and effectiveness of the health care system and save money. In addition, the need for and complexity of communications with an increasingly diverse group of stakeholders has grown. These increased demands have spread employee time thin, reducing performance and raising risks of audit findings, federal fund disallowances, lawsuits, lost appeals, client frustration, difficulties with provider retention, and inability to respond to deadlines.

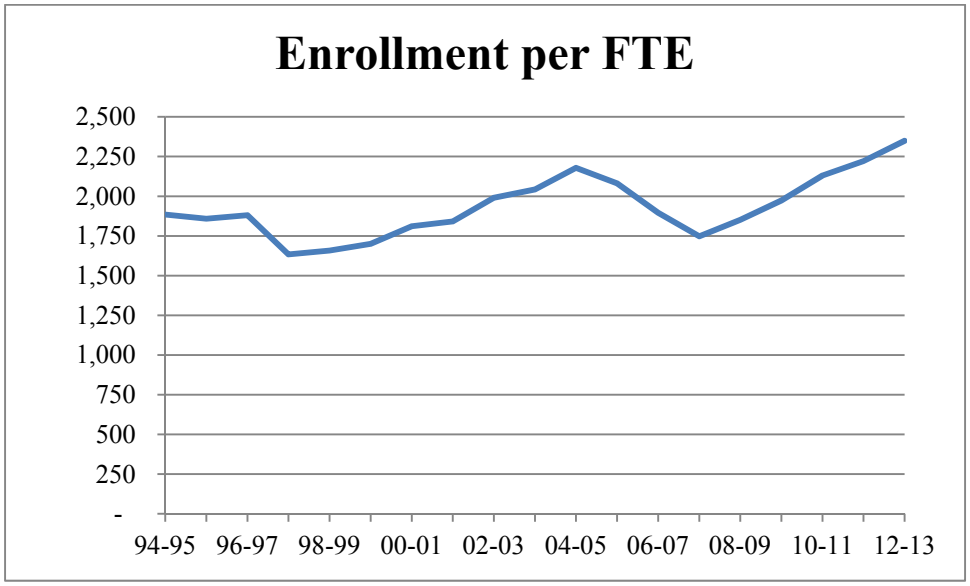
Recommendation: Staff recommends the requested FTE with funding based on the JBC's common policy assumptions for new staff. The key arguments presented by the Department are summarized in the bullets below.

- Stakeholder relations: The Department argues that the funding will increase the Department's capacity to work with stakeholders by providing more support to senior staff to free them from time-consuming operational functions. The Department is seeking more stakeholder input to improve the reasonableness and responsiveness of the Department's policies, but the Department also believes external factors have increased the demand for stakeholder contact. External factors identified by the Department include:
  - New policies from the Centers for Medicare and Medicaid Services (CMS) requiring more public input for plan changes
  - Expansions of Medicaid and CHP+ eligibility that have increased the number and diversity of stakeholders interacting with the Department
  - Reforms at the state and national level that have potentially significant impacts on provider operations and revenues, and on client services. As examples of the high interest reforms, the Department cites the Affordable Care Collaborative, the Benefits Collaborative, payment reform pilot projects authorized in H.B. 12-1281, Colorado Choice Transitions, and the Affordable Care Act.
- Expectations of policy makers: The Department believes expectations of the executive and legislative branches regarding the Department's responsibilities have changed from determining eligibility and paying claims to playing an active and guiding role in reforming the health care delivery system to improve outcomes and reduce costs. As evidence, the Department references many of the same initiatives that are increasing stakeholder contacts,

along with H.B. 10-1119 the SMART Government Act. This is a less compelling argument to staff, since policy analysis has always been a statutory function of the Department and even part of the Department's name. However, to the extent this is true, the request will provide relief to managers from some of the operational functions that are stressing their time to think strategically, thus allowing the Department to be more proactive in designing the Medicaid payment system.

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





- Changing federal oversight: Along with increasing enrollment and expenditures the Department says oversight and scrutiny from the Centers for Medicare and Medicaid Services (CMS) has increased. The regional office has hired additional staff specifically dedicated to Colorado. The Department also shared several anecdotal stories about the number of questions and level of review by CMS of submissions in the last one to two years compared to ten years prior. The Department prioritizes responding to CMS reporting requirements and inquiries, because the stakes are high for failure to comply, including potential disallowances, lawsuits, lost appeals, and audit findings. However, the Department believes that responding to CMS is currently coming at the expense of proactive planning and additional employees are needed to free up time for promoting better health outcomes and saving costs.
- Turnover: The Department believes turnover has been problematically high and provided this comparison with statewide turnover rates.

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

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

The dollars associated with the staff recommendation are summarized in the table below.

R6 Additional FTE to restore functionality					
		FY 2012-13		FY 2013-14	
	Rate	FTE	Total	FTE	Total
Accountant IV	6,041	0.8	57,994	1.0	72,492
Budget & Policy Analyst III	5,360	0.8	51,456	1.0	64,320
General Professional IV	4,733	4.2	238,543	5.0	283,980
Budget & Policy Analyst V	6,662	0.8	63,955	1.0	79,944
Pharmacy I	6,425	0.8	61,680	1.0	77,100
Salaries		7.4	473,628	9.0	577,836
PERA	10.15%		48,073		58,650
Medicare	1.45%		6,868		8,379
Personal Services			528,569		644,865
General Operating	500	7.4	3,700	9.0	4,500
Telephone	450	7.4	3,330	9.0	4,050
PC- one time	1,230	7.4	9,102		0
Furniture - one time	3,473	7.4	25,700		0
Operating			41,832		8,550
Total			$570,401		$653,415

➔ R11 H.B. 12-1281 departmental differences

The Department requested R11 to continue the June 20, 2012 emergency supplemental request for additional staff and resources to implement H.B. 12-1281, Medicaid Payment Reform Pilot. Within the Department's budget documents there are some inconsistencies regarding the exact amount requested to implement H.B. 12-1281. The staff calculation of the amounts required are summarized in the table below, and based on conversations with the Department's budget staff the JBC staff believes these match the intent of the Department.

Summary of Cost to Implement H.B. 12-1281						
	H.B. 12-1281	Supplemental S.B. 12-089	FY 12-13	Annualize H.B. 12-1281	Annualize S.B. 12-089	FY 13-14
General Administration						
FTE	0.8	0.9	1.7	0.2	2.1	4.0
Personal Services	47,538	64,782	112,320	15,847	169,669	297,836
Operating	5,541	15,172	20,713	(4,591)	(12,322)	3,800
General Professional Services	160,000	90,000	250,000	(100,000)	300,000	450,000
Eligibility Determinations						
Customer Outreach	0	0	0	0	267,220	267,220
Utilization and Quality Review						
Professional Services Contracts	0	0	0	0	202,856	202,856
TOTAL	$213,079	$169,954	$383,033	($88,744)	$927,423	$1,221,712
FTE	0.8	0.9	1.7	0.2	2.1	4.0
General Fund	106,540	84,977	191,517	(44,372)	463,712	610,856
Federal Funds	106,539	84,977	191,516	(44,372)	463,711	610,856

Pursuant to H.B. 12-1281 the Department submitted a summary of payment project proposals received by the Department. The Department must select payment projects to be included in the pilot program by July 1, 2013 and then submit a new report by September 15, 2014 on the pilot program as implemented.

→ **Indirect cost adjustment:** *Staff recommends making appropriations for indirect cost recoveries in accordance with the standard methodology adopted by the JBC this year.* Historically, both the indirect cost assessment and the offset of General Fund have been appropriated in the same line item for the Department, making it difficult to identify the indirect cost assessment without additional documentation. The staff recommendation is to pull out the indirect cost assessment in a separate, dedicated line item, and to show the application of the indirect cost recoveries to offset the General Fund as reappropriated funds in the Personal Services line item. This creates a double count, but it is more consistent with the way indirect cost recoveries are appropriated for other departments, and it complies with the JBC's standard methodology adopted this year.

The table below shows the FY 2012-13 indirect cost assessments that will be moved to a new line item and replaced with reappropriated funds transferred from the new indirect cost assessment line item. The table also shows the incremental change in indirect costs for FY 2013-14. The reduction in indirect cost recoveries in FY 2013-14 requires a backfill of General Fund. All of the amounts in the table are for statewide indirect cost recoveries. The Department does not currently have a departmental indirect cost recovery plan and instead bills all costs directly.

	FY 2012-13 Indirect	Incremental Change	FY 2013-14 Indirect
TOTAL	**$577,024**	**($30,141)**	**$546,883**
Cash Funds	**82,712**	**38,481**	**121,193**
Hospital Provider Fee	*65,559*	*30,502*	*96,061*
CHP+ Trust	*9,440*	*4,391*	*13,831*
Nursing Facility Fee	*2,227*	*1,036*	*3,263*
Primary Care Fund	*2,125*	*989*	*3,114*
Autism Treatment Fund	*1,226*	*571*	*1,797*
Disabilities Fund	*1,190*	*553*	*1,743*
Breast & Cervical Cancer	*945*	*439*	*1,384*
Reappropriated Funds	**18,812**	**10,784**	**29,596**
Human Services	*18,812*	*10,784*	*29,596*
Federal Funds	**475,500**	**(79,406)**	**396,094**

Operating Expenses

This line item pays for operating expenses associated with the staff at the Department. Examples of the expenditures include software/licenses, office supplies, office equipment, utilities, printing, and travel.

Request: The Department requests operating funds associated with the following requests for new FTE:

- R6 Additional FTE to restore functionality
- R8 Medicaid dental benefit for adults
- R11 HB 12-1281 Departmental differences reconciliation
- BA13 Restore ICF/IID provider fee

In addition, the Department requests annualization of prior year legislation and budget decisions.

Recommendation: *Staff recommends operating funds associated with R6 and R11, but not R8 and BA13, consistent with the recommendations for new staff under the Personal Services line item.* The staff recommendation for General Fund is slightly higher than the Department's request due to technical issues with the calculation of the cost to implement H.B. 12-1281 described in the Personal Services line item. The components of the staff recommendation are summarized in the table below.

Operating Expenses	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation:					
HB 12-1335 (Long Bill)	$1,555,016	$712,585	$53,049	$13,461	$775,921
H.B. 12-1281 Payment reform pilot	5,541	2,771	0	0	2,770
H.B. 12-1339 CBMS improvements	64,796		0	64,796	0
S.B. 13-089 Supplemental	15,172	7,586	0	0	7,586
TOTAL	**$1,640,525**	**$722,942**	**$53,049**	**$78,257**	**$786,277**
FY 2013-14 Recommended Appropriation:					
FY 2012-13 Appropriation	1,640,525	722,942	53,049	78,257	786,277
Anualize prior year budget decisions	(68,344)	(6,998)	0	(54,347)	(6,999)
R6 Additional FTE to restore functionality	41,832	20,916	0	0	20,916
R11 HB 12-1281 Departmental differences	(12,322)	(6,161)	0	0	(6,161)
TOTAL	**$1,601,691**	**$730,699**	**$53,049**	**$23,910**	**$794,033**
Increase/(Decrease)	**($38,834)**	**$7,757**	**$0**	**($54,347)**	**$7,756**
Percentage Change	-2.4%	1.1%	0.0%	-69.4%	1.0%
FY 2013-14 Executive Request:	**$1,609,356**	**$728,404**	**$59,177**	**$23,910**	**$797,865**
Request Above/(Below) Recommendation	$7,665	($2,295)	$6,128	$0	$3,832

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the following prior year legislation and budget decisions.

Annualizations - Operating Expenses	TOTAL	General Fund	Reappropriated Funds	Federal Funds
H.B. 12-1281 Medicaid payment reform pilot	($4,591)	($2,295)	$0	($2,296)
H.B. 12-1339 CBMS improvement and modernization	(54,347)	0	(54,347)	0
FY 12-13 R-5 Medicaid fee-for-service payment reform	(9,406)	(4,703)	0	(4,703)
TOTAL	**($68,344)**	**($6,998)**	**($54,347)**	**($6,999)**

Leased Space

This line item pays for the Department's 39,980 square feet of leased space at 225 E. 16th Street.

Request: The Department requests additional leased space associated with the new FTE requested in "R6 Additional FTE to restore functionality" and changes to account for rate increases and fund source adjustments in "R10 Leased space rent increase and true-up".

Recommendation: *Staff recommends "R10 Leased space rent increase and true-up" to match expected leased space costs and fund sources.* R10 is largely a continuation and annualization of the supplemental approved by the JBC.

Based on the JBC's common policies, staff does not recommend the additional leased space associated with the new FTE requested in R6. See the description of R6 under the Personal Services line item for more detail.

Leased Space	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2012-13 Appropriation:				
HB 12-1335 (Long Bill)	$696,564	$197,119	$151,164	$348,281
S.B. 13-089 Supplemental	(21,170)	38,615	(49,200)	(10,585)
TOTAL	**$675,394**	**$235,734**	**$101,964**	**$337,696**
FY 2013-14 Recommended Appropriation:				
FY 2012-13 Appropriation	675,394	235,734	101,964	337,696
Anualize prior year budget decisions	21,170	(38,615)	49,200	10,585
R10 Leased space rent increase and true-up	92,115	92,402	(46,344)	46,057
TOTAL	**$788,679**	**$289,521**	**$104,820**	**$394,338**
Increase/(Decrease)	**$113,285**	**$53,787**	**$2,856**	**$56,642**
Percentage Change	16.8%	22.8%	2.8%	16.8%
FY 2013-14 Executive Request:	**$849,549**	**$319,956**	**$104,820**	**$424,773**
Request Above/(Below) Recommendation	$60,870	$30,435	$0	$30,435

The annualization of prior year budget decisions removes the supplemental funding, which is replaced by R10.

➔ R10 Leased space rent increase and true-up

Request: The Department requests funding for an increase in leased space rates at 225 E 16th Avenue, Denver, from $16.77 to $21.00 per square foot as of July 2012. The Department received funding for FY 2012-13 in the supplemental bill. The request also includes a requested increase of approximately 800 square feet for 11.9 FTE added in three bills in FY 2012-13: H.B. 12-1339, Colorado Benefits Management System Project; H.B. 12-1281, Medicaid Payment Reform Pilot Project; and S.B. 12-060, Improve Medicaid Fraud Prosecution. This increase is offset by a decrease of approximately 800 square feet associated with the expiration at the end of August 2013 of a federal grant from the Health Resources Service Administration.

Recommendation: Staff recommends approval of the request to continue the JBC's supplemental decision.

General Professional Services

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility Fee, Coordinated Care for People with Disabilities Fund, Nursing Home Penalties, and gifts, grants, and donations. The federal match rate varies based on the specific contracts.

Request: The Department requests contract services associated with:

- R7 Substance use disorder benefit
- R11 HB 12-1281 Departmental differences reconciliation
- R12 Customer service technology improvements

The Department's request also includes annualization or prior year budget decisions.

Recommendation: *The recommendation on R7 was covered in the presentation on mental health services and this document reflects the JBC's actions.*

Staff recommends the funding for R11 to implement H.B. 12-1281 that is described under the Personal Services line item.

Staff recommends R12 to improve customer service technology. The recommendation on R12 is discussed in an arrowed item below the line item summary table.

General Professional Services and Special Projects	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2012-13 Appropriation:				
HB 12-1335 (Long Bill)	$5,780,552	$1,232,418	$437,500	$4,110,634
H.B. 12-1281 Payment reform pilot	160,000	80,000	0	80,000
S.B. 13-089 Supplemental	175,980	87,990	0	87,990
TOTAL	**$6,116,532**	**$1,400,408**	**$437,500**	**$4,278,624**
FY 2013-14 Recommended Appropriation:				
FY 2012-13 Appropriation	6,116,532	1,400,408	437,500	4,278,624
Anualize prior year budget decisions	(123,980)	(92,990)	31,000	(61,990)
R7 Substance use disorder benefit	100,000	50,000	0	50,000
R11 HB 12-1281 Departmental differences	300,000	150,000	0	150,000
R12 Customer service technology improvement	1,800,000	900,000	0	900,000
TOTAL	**$8,192,552**	**$2,407,418**	**$468,500**	**$5,316,634**
Increase/(Decrease)	**$2,076,020**	**$1,007,010**	**$31,000**	**$1,038,010**
Percentage Change	33.9%	71.9%	7.1%	24.3%
FY 2013-14 Executive Request:	**$8,192,552**	**$2,407,418**	**$468,500**	**$5,316,634**
Request Above/(Below) Recommendation	$0	$0	$0	$0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the following prior year legislation and budget decisions.

Annualizations - General Professional Services	TOTAL	General Fund	Cash Funds	Federal Funds
H.B. 12-1281 Medicaid payment reform pilot	($100,000)	($50,000)	$0	($50,000)
S.B. 12-159 Children with Autism Waiver	$62,000	$0	$31,000	$31,000
S.B. 13-089 Supplemental	(85,980)	(42,990)	0	(42,990)
TOTAL	**($123,980)**	**($92,990)**	**$31,000**	**($61,990)**

The increase for S.B. 12-159 is for program evaluations of the Children with Autism waiver program. The first report is due June 1, 2013. The source of funds for the state match is the Colorado Autism Treatment Fund, which receives a statutory allocation from tobacco settlement dollars.

➔ R12 Customer service technology improvements

Request: The Department's request would improve technology available to the Customer Contact Center for responding to client inquiries. Proposed changes include allowing both voice and data input to the telephone system, collecting more automated information about client needs

to direct calls, matching a caller's zip code with local contact numbers for entities such as county agencies and regional care collaborative organizations, allowing calls to be transferred to these types of entities outside the department, automating frequently requested services such as medical identification card replacements, redirecting callers seeking the Colorado Health Benefits Exchange, adding a customer relations management (CRM) system to help staff more quickly direct clients to the information they need, improving management analytics such as adding reporting on the most common reasons for client calls, and creating a new web site dedicated to Medicaid client needs that would include a live chat option with the Customer Contact Center and functional links to vendors for services such as transportation.

Recommendation: Staff recommends approval of the request. Current call abandonment rates and average response times are significantly below industry standards. The Department serves a different population and has a different mission than private insurance and health providers, and so performance expectations may not be the same. However, the industry comparison indicates that significantly better customer service is achievable, and it would promote the Department's goals and objectives.

	HCPF (July)	Health Industry
Call abandonment rate	30%	4%
Average time to response	8.6 minutes	33 seconds

Consultants hired by the Department recommended these technology improvements as industry norms to improve performance and the callers' experiences. The Customer Contact Center has 10.0 FTE and handles an average of 110,000 calls per year. The requested technology upgrades will improve the efficiency and effectiveness of this staff.

The majority of the requested funds are for one-time equipment, software, and programming expenses. The Department expects on-going annual maintenance costs of approximately $180,000 per year. The expected federal match rate is 50 percent, although the Department is exploring whether some of the purchases may qualify for an enhanced rate.

(B) TRANSFERS TO OTHER DEPARTMENTS

This subsection funds programs administered or financed by departments other than the Department of Health Care Policy and Financing, except for programs administered by the Department of Human Services, which are appropriated in Division 6.

Public Safety

Life Safety Code Inspections for Health Facilities

Pursuant to H.B. 12-1268 the responsibility to perform health facility life safety inspections was transferred from the Department of Public Health and Environment to the Department of Public Safety. Medicaid pays a portion of the cost for facilities that serve Medicaid clients.

Request: The Department's request is based on the fiscal note for H.B. 12-1268.

Recommendation: This line item is pending Committee action on comebacks for the Department of Public Health and Environment, Health Facilities Division.

Public Health and Environment

Facility Survey and Certification

This line item pays the Department of Public Health and Environment to monitor a variety of long-term care providers for safety and compliance with Medicaid regulations, including nursing homes, hospices, home health agencies, alternative care facilities, personal care/homemaking agencies, and adult day services. This monitoring is performed as part of the Department of Public Health and Environment's larger function of establishing and enforcing standards of operation for health care facilities pursuant to Section 25-1.5-103, C.R.S. Financing for the Medicaid-related regulation is provided as follows:

Minimum Data Set resident assessment (used to determine nursing home patient acuity, which is a consideration in the nursing home reimbursement formula)	100% General Fund
In-the-field surveys and inspections	75% federal match
Office time preparing reports and administering the program	50% federal match

Request: The Department's request includes annualizing H.B. 12-1268, which transferred responsibility for health facility life safety inspections to the Department of Public Safety, and adjustments for salary increases.

Recommendation: This line item is pending Committee action on comebacks for the Department of Public Health and Environment, Health Facilities Division.

Nurse Home Visitor Program

This line item pays a portion of the cost for nurses to visit first-time mothers in families with incomes up to 200 percent of the federal poverty guidelines to provide education on nutrition and general child care and to promote the health and development of children. Funding for the program is appropriated to the Department of Public Health and Environment and then a portion is transferred to the Department of Health Care Policy and Financing to match federal funds for Medicaid-eligible clients. The original source of funding is Tobacco Master Settlement Agreement moneys. The line item name "Transfer to the Department of Public Health and Environment for Nurse Home Visitor Program" is a bit misleading, because the Department of Health Care Policy and Financing pays the providers directly. Although the Department of Public Health and Environment is the lead agency for financing, the program is actually administered by the University of Colorado Health Sciences Center. The federal match rate is 50 percent.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding. Based on prior year actual expenditures, this is probably more spending authority than the line item needs, but if fewer Medicaid-eligible clients are served, then the Department of Public Health and

Environment will transfer less to the Department of Health Care Policy and Financing and use the money instead to serve clients who are not eligible for Medicaid.

Prenatal Statistical Information

This line item pays the Department of Public Health and Environment to collect and analyze data, through the Vital Statistics office, on the effectiveness of the Enhanced Prenatal Care program, more commonly known as Prenatal Plus. This program provides case management, nutrition, and mental health counseling for women assessed as at-risk for delivering low birth weight infants. The services address lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect pregnancy. Services are paid for in the Medical Services Premiums line item. This appropriation covers only the data collection and evaluation performed by the Department Public Health and Environment. The federal match rate is 50 percent.

Request: The Department requests continuation funding.

Recommendation: The staff recommendation is based on the JBC's actions during figure setting for the Department of Public Health and Environment.

Regulatory Agencies

Nurse Aide Certification

This line item pays for the Department of Regulatory Agencies to certify nurse aides working in facilities with Medicaid patients. The Department of Regulatory Agencies also receives payments from Medicare. The reappropriated funds are fees for background checks transferred from the Department of Regulatory Affairs. Only non-certified nurses are required to pay the fees. The federal match rate is 50 percent.

Request: The Department requests continuation funding.

Recommendation: The staff recommendation is based on the JBC's actions during figure setting for the Department of Regulatory Agencies. The money is transferred to the Division of Registrations in the Department of Regulatory Agencies.

Reviews

This line item pays the Department of Regulatory Affairs to conduct sunset reviews of programs administered by the Department of Health Care Policy and Financing. The federal match rate depends on the program being reviewed.

Request: The Department requests continuation funding.

Recommendation: Staff recommends a decrease of 9,840. There is one scheduled sunset review in FY 2013-14 for in-home support services with a projected cost of $4,160 and a federal match rate of 50 percent. The money is transferred to the Executive Director's Office of the department of Regulatory Agencies.

Department of Education

Public School Health Services Administration

This line item offsets costs of the Department of Education for the Public School Health Services program. The program is jointly administered by the Department of Health Care Policy and Financing and the Department of Education. Pursuant to Section 25.5-5-318, C.R.S., up to 10 percent of the federal funds received for the program may be retained for administration and these moneys are allocated between the two departments according to an interagency agreement. The source of funding used to match the federal funds is certified public expenditures by school districts. Please see the line item "Public School Health Services" in the Other Medical Services division for a discussion of the projected certified public expenditures and a description of program costs.

Request: The request includes an adjustment to align the appropriation with the funding provided to the Department of Education.

Recommendation: Staff recommends an increase of $10,059 to align the appropriation with the current interagency agreement with the Department of Education. In addition, staff recommends a fund source adjustment to show the money as reappropriated funds, rather than federal funds, since the money is already appropriated once in the Other Medical Services division.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

Information Technology Contracts

This line item pays for maintenance of the Medicaid Management Information System (MMIS) and the Web Portal. MMIS processes Medicaid claims, performs electronic prior authorization reviews for certain medical services, transmits data so that payments can be made to providers, and manages information about Medicaid beneficiaries and services. The Web Portal provides a front-end interface for providers to submit electronic information to MMIS, the Colorado Benefits Management System, and the Benefits Utilization System in a format that complies with the confidentiality standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives a 65 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

Request: The Department requests programming costs related to:

- R8 Medicaid dental benefit for adults
- R9 Dental administrative services organization for children

The Department also requests annualization of supplemental decisions in:

- BA6 Medicaid Management Information System operating rules compliance
- BA8 Medicaid Management Information System technical adjustments

Finally, the Department's request includes annualization of several bills and budget decisions from prior years.

Recommendation: Staff does not recommend programming costs related to "R9 Dental administrative services organization for children". See the description of the decision item under Medical Service Premiums for a detailed description and justification.

Staff does not recommend the programming costs associated with "R8 Medicaid dental benefit for adults". This request requires legislation to implement. The proposed new dental benefit, financed with money from the Unclaimed Property Trust Fund that was previously dedicated to CoverColorado, was described in the JBC staff briefing for the Department of Health Care Policy and Financing. The JBC voted not to carry the requested legislation.

Staff recommends the annualizations of supplemental decisions requested in "BA6 Medicaid Management Information System operating rules compliance" and in "BA8 Medicaid Management Information System technical adjustments". The JBC approved these supplementals. BA6 funds system upgrades necessary to comply with federal regulations regarding the electronic exchange of health care information. BA8 makes adjustments to the funding for two short-term programming projects for the Medicaid Management Information System (MMIS): (1) compliance with the Health Insurance Portability and Accountability Act (HIPAA); and (2) development of an alternative benefit from the standard Medicaid package for Adults without Dependent Children. The recommended amounts for these two requests are the difference between the amounts already approved in the supplemental that are in the base and the requested amounts for FY 2013-14.

Staff recommends a technical fund source adjustment to show money for the administration of Public School Health Services as reappropriated funds, rather than federal funds, since the money is already appropriated once in the Other Medical Services division.

The components of the staff recommendation are summarized in the table below.

Information Technology Contracts					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation:					
HB 12-1335 (Long Bill)	$31,899,317	$6,379,650	$1,566,666	$100,328	$23,852,673
S.B. 13-089 Supplemental	1,381,420	181,586	76,714	0	1,123,120
TOTAL	**$33,280,737**	**$6,561,236**	**$1,643,380**	**$100,328**	**$24,975,793**
FY 2013-14 Recommended Appropriation:					
FY 2012-13 Appropriation	33,280,737	6,561,236	1,643,380	100,328	24,975,793
Anualize prior year budget decisions	(2,312,720)	(363,060)	94,187	0	(2,043,847)
R9 Dental administrative services organization	1,152,144	288,036	0	0	864,108
BA6 MMIS operating rules	165,019	36,848	4,902	0	123,269
BA8 MMIS technical adjustments	2,700,653	306,844	41,841	0	2,351,968
Fund source adjustment	0	0	0	193,022	(193,022)
TOTAL	**$34,985,833**	**$6,829,904**	**$1,784,310**	**$293,350**	**$26,078,269**
Increase/(Decrease)	**$1,705,096**	**$268,668**	**$140,930**	**$193,022**	**$1,102,476**
Percentage Change	5.1%	4.1%	8.6%	192.4%	4.4%
FY 2013-14 Executive Request:	**$36,693,511**	**$6,829,904**	**$2,211,229**	**$100,328**	**$27,552,050**
Request Above/(Below) Recommendation	$1,707,678	$0	$426,919	($193,022)	$1,473,781

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the following prior year legislation and budget decisions.

Annualizations - Information Technology Contracts				
	TOTAL	General Fund	Cash Funds	Federal Funds
H.B. 09-1293 Health Care Affordability Act	$1,204,749	$0	$301,187	$903,562
S.B. 11-008 Aligning children's Medicaid eligibility	(6,930)	($1,733)	$0	($5,197)
S.B. 11-250 Pregnanant women Medicaid eligibility	(6,930)	($1,681)	($73)	($5,176)
FY 09-10 MMIS funding for HIPAA and transitions	(546,020)	($58,697)	$0	($487,323)
FY 10-11 Guided utilization review	(627,984)	($156,996)	$0	($470,988)
FY 10-11 MMIS adjustments	(1,364,572)	($143,953)	$0	($1,220,619)
FY 12-13 MMIS technical adjustments	(965,033)	0	(206,927)	(758,106)
TOTAL	**($2,312,720)**	**($363,060)**	**$94,187**	**($2,043,847)**

The increase for H.B. 09-1293 is for the increase in total claims processing by the vendor for expansion adults, the disabled buy-in, and adults without dependent children.

Medicaid Management Information System (MMIS) Reprocurement Contracted Staff
Medicaid Management Information System Reprocurement Contracts

These are two new line items requested by the Department as part of R5 Medicaid Management Information System Reprocurement. The numbers in this document reflect the JBC's action on this request during figure setting for the Department of Human Services, Office of Information Technology Services on March 11, 2013.

➔ MMIS Cash Fund Legislation

Request: In addition to requesting funding for the reprocurement of the Medicaid Management Information System, the Department sent a letter on February 28, 2013, requesting that the JBC sponsor legislation to create a MMIS cash fund. The source of revenues to the cash fund would be appropriations for MMIS projects. The purpose of the cash fund is to prevent the spending

authority for MMIS projects from expiring when unexpected delays occur. As an example of the types of delays that can occur, the Department described a scenario where new legislation passed by the General Assembly requires system changes that take priority over a multi-year project. There are limits to how much the MMIS vendor can feasibly expand or contract the hours devoted to programming changes. If there are many changes in a single fiscal year, then those changes must be prioritized and some may need to be bumped to the next fiscal year. This can cause problems for the Department if they discover the change in the spending schedule after the General Assembly's normal supplemental budget cycle and/or when waiting for a supplemental bill to be adopted causes further delays because the contractor will not initiate work until the Department has the extension of spending authority.

The Department proposes annual reporting on the fund balance and encumbrances in February. The Department would be allowed to spend money in the fund only for MMIS projects, but the General Assembly could appropriate any balance in the fund for any purpose.

Recommendation: Staff recommends that the JBC sponsor legislation allowing the Department to roll forward appropriations for the Medicaid Management Information System for one year. Rather than automatically rolling forward the entire appropriation, the Department would be required to communicate to the State Controller the amount, if any, that needs to roll forward. Staff also recommends requiring the Department to submit an annual report to the JBC by January 1 on the amount of any roll forward and the reason for the roll forward. This would allow the JBC to make changes to the appropriation, if necessary, through the supplemental process.

Staff believes this would address the Department's need to occasionally move costs into the next fiscal year, but provides time-limited spending authority where a cash fund would provide continuous spending authority. The problem the Department describes is somewhat analogous to the challenges associated with a capital construction project. In both cases a department must have enough money to procure the services of a vendor for a large project that may span multiple fiscal years, but the timing of the payout by fiscal year is not predictable and subject to change. With capital construction projects the General Assembly solved this challenge by authorizing the appropriations for three years from the effective date. This authorization appears in a headnote to the capital construction section of the Long Bill each year. Staff believes two years of spending authority for MMIS projects is probably sufficient and provides enough time for a supplemental bill if a further extension is needed.

Another option available to the Committee would be to authorize a roll forward in an annual footnote. There are precedents for providing roll forward authority in a footnote. However, Legislative Legal Services believes the staff recommended changes are better accomplished through a statutory change.

Fraud Detection Software Contract

This line item pays for maintenance and upgrades of software that detects payment, utilization, and referral patterns that may be indicators of fraud, waste, or abuse. It also monitors compliance issues and statistics related to fraud investigative costs.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Centralized Eligibility Vendor Contract

This line item pays a contractor to process applications and determine eligibility for the Children's Basic Health Plan (CHP+). Beginning in FY 2011-12, it also includes money for determining Medicaid eligibility for Adults without Dependent Children (AwDC) and the Medicaid Buy-in for People with Disabilities (Buy-in). The source of cash funds is the Hospital Provider Fee. The federal match rate for eligibility determinations is 50.0 percent for Medicaid and 65.0 percent for CHP+. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. Therefore, the federal government reimburses 88.0 percent the contract for CHP+ eligibility determinations at the Medicaid match rate and 12.0 percent at the CHP+ match rate.

Request: The Department requests an increase of $1,051,158, including $525,579 General Fund, to annualize a FY 2011-12 budget action that made several adjustments to appropriations from the Hospital Provider Fee to more accurately reflect administrative expenses attributable to the fee and to the expansion populations authorized by H.B. 09-1293.

Recommendation: Staff recommends the request, including the increase for the annualization.

Improve and Modernize Colorado Benefits Management System

This is a new line item associated with BA5 Improve and Modernize Colorado Benefits Management System. The numbers in this document reflect the JBC's action on this request during figure setting for the Department of Human Services, Office of Information Technology Services on March 11, 2013.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

Medical Identification Cards

Funding in this line item pays for production of plastic authorization cards for Medicaid and the Old Age Pension State Medical Program. The source of cash funds is the Hospital Provider Fee. The source of reappropriated funds is a transfer from the Old Age Pension Medical Program in the Other Medical Services division. The federal match rate is 50.0 percent for Medicaid cards. There is no federal match for the Old Age Pension State Medical Program.

Request: The Department requests continuation funding.

Recommendation: Staff recommends continuation funding. The number of cards required each year is dependent not only on caseload, but also turnover. Periodically the Department will submit requests to update the estimate based on changing patterns in the number of cards needed, but not typically every year.

Contracts for Special Eligibility Determinations

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission and resident assessments are also required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital.

In FY 2011-12 there was a significant increase in the appropriation from the Hospital Provider Fee for disability determination services in anticipation of increased workload with the Medicaid buy-in program for people with disabilities.

Request: The Request includes annualization of a supplemental action that provided funding for an increase in Preadmission Screening and Resident Review (PASRR) level II evaluations, and to increase reimbursement rates for the providers conducting the PASRR level II evaluations, requested in BA9 Increase in PASSR Level II & Status Change Evaluation Rates. These are federally required screenings and there have been increases in both the volume and scope of the screenings.

Recommendation: Staff recommends the request, including the annualization.

County Administration

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. The cost sharing is based on 20.0 percent local (county) funds, 30.0 percent General Fund, and 50.0 percent federal funds, except for the eligibility determinations for the Old Age Pension State Medical Program, which are funded with General Fund.

Request: The Department requests continuation funding with an annualization of S.B. 11-008, which expanded Medicaid eligibility for children ages 6-19 from 100 percent of the federal poverty guidelines to 133 percent.

Recommendation: Staff recommends the request. The annualization of S.B. 11-008 will pay for an anticipated increase in county administration costs associated with the increased caseload.

Hospital Provider Fee County Administration

This line item was created to separate the funding for eligibility determinations for expansion populations authorized through the Health Care Affordability Act (H.B. 09-1293) from the funding for other populations. The state match for eligibility determinations for the expansion populations authorized by H.B. 09-1293 is funded entirely with the Hospital Provider Fee with no local county match. The federal participation rate is 50.0 percent.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Administrative Case Management
This line item provides Medicaid funding for qualifying expenditures associated with state supervision and county administration of programs that protect and care for children (out-of-home placement, subsidized adoptions, child care, and burial reimbursements). The primary activity reimbursed through this line item is completing, or assisting a child or family in the child welfare system to complete, a Medicaid application. The federal match rate is 50.0 percent.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Customer Outreach
This line item provides funding for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program provides outreach and case management services to promote access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and regulations. The source of cash funds is the Hospital Provider Fee. The federal match rate is 50.0 percent.

Request: The Department requests R11 H.B. 12-1281 departmental differences reconciliation to continue and annualize a supplemental decision that provided more money to implement Medicaid payment reform pilot projects. The Department also requests an anualization of S.B. 11-008, which expanded Medicaid eligibility for children ages 6-19 from 100 percent of the federal poverty guidelines to 133 percent.

Recommendation: Staff recommends the request, including the annualization of the supplemental and of S.B. 11-008.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

Professional Services Contracts
This line item contains the professional contracts related to reviewing acute care utilization, long-term care utilization, external quality review, drug utilization review, and mental health quality review. These contracts ensure that the benefits and services provided to Medicaid clients are medically necessary and appropriate.

Acute care utilization performs prior authorization review for services such as transplants, out-of-state elective admissions, inpatient mental health services, inpatient substance abuse rehabilitation, durable medical equipment, non-emergent medical transportation, home health service reviews, and physical and occupational therapy. It also includes retrospective reviews of inpatient hospital claims to ensure care was medically necessary, required an acute level of care, and was coded and billed correctly. The federal match rate is 75.0 percent.

Long-term care utilization review includes prior authorization reviews to determine medical necessity, level of care, and target population determinations. It also includes periodic reevaluations of services. The federal match for the majority of services is 75.0 percent.

External quality review handles provider credentialing, including activities such as verifying licensure and certification information, validating Healthcare Effectiveness Data and Information Set (HEDIS) measures, and reviewing provider performance improvement projects. The federal match rate is 75.0 percent.

Mental health external quality review is very similar to the external quality review, but for mental health providers. The federal match rate is 75.0 percent.

Drug utilization review performs prior authorization reviews, retrospective reviews, and provider education to ensure appropriate drug therapy according to explicit predetermined standards.

Request: The Department requests "R8 Medicaid dental benefit for adults" to perform anticipated prior authorization reviews associated with the requested new benefit. The Department also requests R11 H.B. 12-1281 departmental differences reconciliation to continue and annualize a supplemental decision that provided more money to implement Medicaid payment reform pilot projects.

Recommendation: Staff does not recommend the funding for prior authorization reviews associated with "R8 Medicaid dental benefit for adults". This request requires legislation to implement. The proposed new dental benefit, financed with money from the Unclaimed Property Trust Fund that was previously dedicated to CoverColorado, was described in the JBC staff briefing for the Department of Health Care Policy and Financing. The JBC voted not to carry the requested legislation.

Staff does recommend R11 to continue and annualize the JBC's supplemental decisions.

(F) PROVIDER AUDITS AND SERVICES

Professional Audit Contracts
This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.
- Hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Centers -- These federally-required audits focus on costs and rate data and serve as the basis for reimbursement. Most of the audits are completed from the Medicare cost report and tailored to Medicaid requirements.
- Single Entry Point Agencies -- Cost reports for all 23 Single Entry Point agencies are reviewed, and on-site audits are conducted to the extent possible within the appropriation.

- Payment Error Rate Measurement Project -- Each state must estimate the number of Medicaid payments that should not have been made or that were made in an incorrect amount, including underpayments and overpayments, every three years according to a staggered schedule set up by the federal government.
- Nursing facility appraisals -- Every four years this audit determines the fair rental value (depreciated cost of replacement) for nursing facilities for use in the rate setting process. The next appraisal will occur in FY 2014-15.
- Colorado Indigent Care Program -- These audits are similar to the Medicaid audits of hospitals, FQHCs and RHCs, but for the indigent care program, rather than the Medicaid program.
- Disproportionate Share Hospital Audits -- This federally-required audit looks at qualifying expenditures for Disproportionate Share Hospital (DSH) payments. These payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients.

The sources of cash funds are the Hospital Provider Fee and Nursing Facility Fee. The federal match rate is 50.0 percent.

Request: The Department requests an increase of $588,501, including $147,125 General Fund, for the Payment Error Rate Measurement Project. This federally-mandated analysis of error rates is required once every three years and FY 2013-14 is the next year that Colorado must complete a report. The source of cash funds for the increase is the Children's Basic Health Plan Trust Fund.

Recommendation: Staff recommends the request. The increase for the Payment Error Rate Measurement Project is necessary to perform the federally-required study.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

Estate Recovery

The program pursues recoveries from estates and places liens on property held by Medicaid clients in nursing facilities or clients over the age of 55. The contractor works on a contingency fee basis of 10.9 percent. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

(G) INDIRECT COSTS

Statewide Indirect Cost Assessment

This is a new line item recommended by staff to ensure that the way indirect cost recoveries are appropriated for this department complies with the standard format used by the JBC for other departments. See the description under the Personal Services Line in the Executive Director's Office for a detailed explanation.

(2) Medical Service Premiums

This division provides funding for physical health and long-term care services for individuals qualifying for the Medicaid program. Mental health services are financed in the next division. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients.

Medical and Long-term Care Services for Medicaid Eligible Individuals
Appropriations in this section are a function of three factors:

1. Number of clients
2. Cost per client, and
3. Available financing according to federal policy and state law.

Policy initiatives expected to change the forecast are typically detailed individually for the first several years until a trend is established, and then they become part of the base forecast. Thus, the request and the staff recommendation frequently include several annualizations of budget decisions from prior years that have not yet been incorporated into the base forecast.

The way Medicaid is set up in both state and federal statutes, all people who meet the eligibility criteria are entitled to the covered services. Since the exact number of eligible people and the services they will utilize are both unknown, state statutes provide the Medicaid program with unlimited over-expenditure authority, as long as the over-expenditures are consistent with the statutory provisions of the Medicaid program (Section 24-75-109, C.R.S.).

The cost per client is impacted by both the cost per unit of service and changes in the number of units of service utilized per client.

Request: The Department requests:

- R1/S1/BA1 "Medical Services Premiums" to adjust the FY 2012-13 and FY 2013-14 appropriations for the most recent caseload and expenditure forecast. BA1 was submitted on February 15 and included an update to S1. BA1 and the update to S1 incorporate data through December 2012 into the forecast.
- R7 "Substance use disorder benefit" and R8 "Medicaid dental benefit for adults" to expand the services covered under Medicaid
- R9 "Dental ASO for children" to contract with an administrative services organization (ASO) to oversee the dental benefit for children
- R13 "1.5 Provider rate increase" to increase reimbursements to people who serve Medicaid and CHP+ clients
- BA13 "Restore ICF/IID provider fee" and BA 14"Colorado Choice transitions for HCBS-DD waiver clients" to annualize supplemental requests, and
- Annualizations of prior year legislation and budget decisions.

Recommendation: *Staff recommends the requested caseload and expenditure updates in R1/S1/BA1.* These are the expenses expected to occur under current law regarding eligibility and covered services.

Based on prior JBC actions, the staff recommendation includes the benefit expansion proposed in R7 "Substance use disorder benefit" but not the benefit expansion in R8 "Medicaid dental benefit for adults". The JBC acted on the R7 during figure setting for the Department of Human Services, Mental Health and Alcohol & Drug Abuse Services, March 11, 2013. R8 requires legislation to implement. The proposed new dental benefit, financed with money from the Unclaimed Property Trust Fund that was previously dedicated to CoverColorado, was described in the JBC staff briefing for the Department of Health Care Policy and Financing. The JBC voted not to carry the requested legislation.

Staff does not recommend R9 "Dental ASO for children" because staff believes this should be performed through the Accountable Care Collaborative.

Staff recommends R13 "1.5% Provider rate increase" based on the JBC's common policy.

The staff recommendation does not include BA13 "Restore ICF/IID provider fee" based on current law. The JBC is carrying legislation to change the way the provider fee works, and that legislation will include the appropriations associated with the revamped provider fee.

The staff recommendation includes BA 14 "Colorado Choice transitions for HCBS-DD waiver clients" to continue the JBC's decision to fund this request in the supplemental. See the supplemental description for the Department of Human Services, Services for People with Disabilities for more information.

The components of the staff recommendation are summarized in the table below.

Medical and Long-Term Care Services for Medicaid Eligible Individuals					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation:					
HB 12-1335 (Long Bill)	$3,994,685,293	$1,367,321,247	$651,202,864	$3,215,340	$1,972,945,842
Recommended Long Bill Supplemental	(42,266,085)	(11,672,736)	(10,627,690)	0	(19,965,659)
S.B. 12-159 Autism waiver	6,925	0	3,463	0	3,462
H.B. 12-1340 Nursing facility rates	(9,024,676)	(4,512,338)	0	0	(4,512,338)
S.B. 12-060 Medicaid fraud	(54,156)	(2,608)	(24,470)	0	(27,078)
S.B. 13-089 Supplemental	292,407	146,204	0	0	146,203
TOTAL	**$3,943,639,708**	**$1,351,279,769**	**$640,554,167**	**$3,215,340**	**$1,948,590,432**
FY 2013-14 Recommended Appropriation:					
FY 2012-13 Appropriation	3,943,639,708	1,351,279,769	640,554,167	3,215,340	1,948,590,432
Anualize prior year budget decisions	40,919,287	17,265,530	(98,886)	(2,000,000)	25,752,643
SB 11-212 Hospital Provider Fee offset of GF	0	25,000,000	(25,000,000)	0	0
R-1: Medical Service Premiums	305,344,710	84,844,360	67,048,100	0	153,452,250
R7 Substance use disorder benefit	415,440	(11,820)	(282)	0	427,542
R13 Provider rate increase	32,584,290	14,256,080	1,090,255	14,514	17,223,441
BA14 Colorado Choice Transitions	(2,372,278)	(1,186,139)	0	0	(1,186,139)
Fund source adjustment	95,304	(315,244)	362,896	0	47,652
TOTAL	**$4,320,626,461**	**$1,491,132,536**	**$683,956,250**	**$1,229,854**	**$2,144,307,821**
Increase/(Decrease)	**$376,986,753**	**$139,852,767**	**$43,402,083**	**($1,985,486)**	**$195,717,389**
Percentage Change	9.6%	10.3%	6.8%	-61.8%	10.0%
FY 2013-14 Executive Request:	**$4,351,500,744**	**$1,490,604,275**	**$627,024,919**	**$1,215,340**	**$2,232,656,210**
Request Above/(Below) Recommendation	$30,874,283	($528,261)	($56,931,331)	($14,514)	$88,348,389

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the following prior year legislation and budget decisions.

Annualizations - Medical Service Premiums					
	TOTAL	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
S.B. 08-118 Disease management	0	2,000,000	0	(2,000,000)	0
H.B. 10-1146 Home Care Allowance	(102,745)	(51,373)	0	0	(51,372)
S.B. 11-008 Aligning children's Medicaid eligibility	26,454,555	9,259,094	0	0	17,195,461
S.B. 11-250 Pregnanant women Medicaid eligibility	8,803,834	3,081,341	0	0	5,722,493
H.B. 12-1340 Nursing per diem	9,024,676	4,512,338	0	0	4,512,338
S.B. 12-060 Fraud prosecution	(4,448)	0	(2,224)	0	(2,224)
FY 12-13 R5 Payment reform	(1,404,115)	(663,592)	(38,466)	0	(702,057)
FY 12-13 R6 Budget reductions	(1,751,563)	(863,801)	(11,981)	0	(875,781)
FY 12-13 R10 Supplemental payments	(8,477)	(8,477)	0	0	0
FY 12-13 BA3 Smoking Quitline	(92,430)	0	(46,215)	0	(46,215)
TOTAL	**$40,919,287**	**$17,265,530**	**($98,886)**	**($2,000,000)**	**$25,752,643**

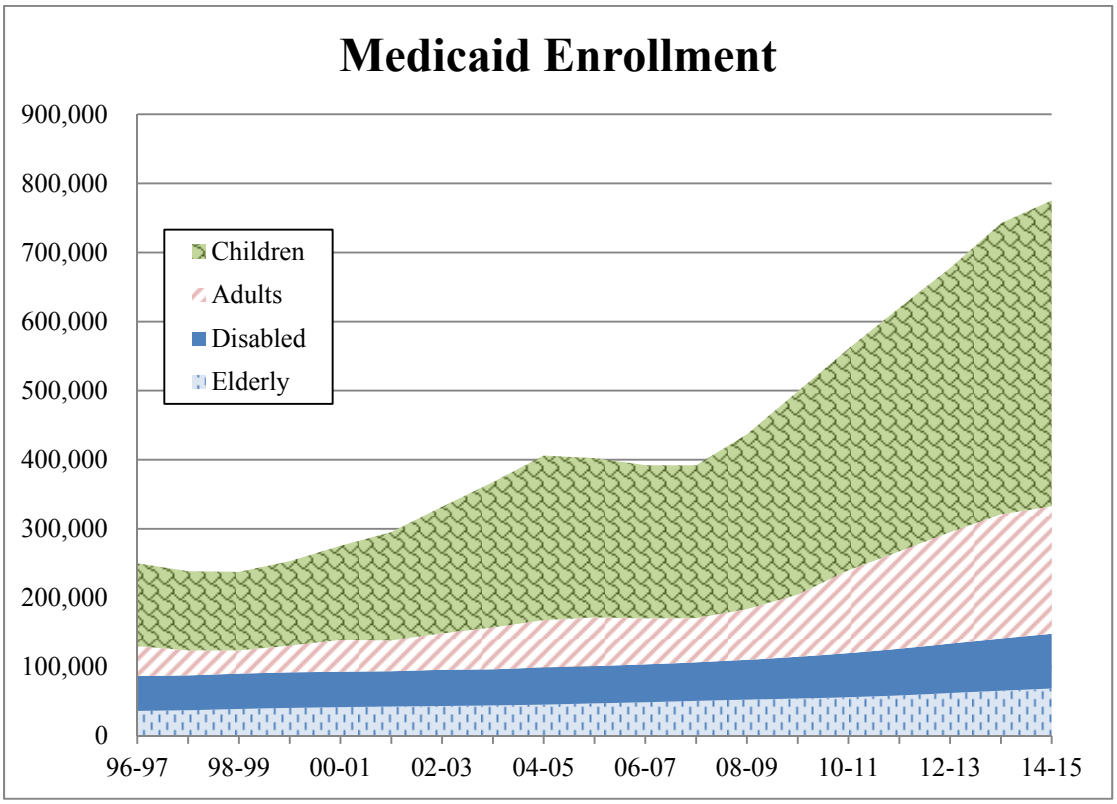
➔ R1/S1/BA1 Medical Service Premiums

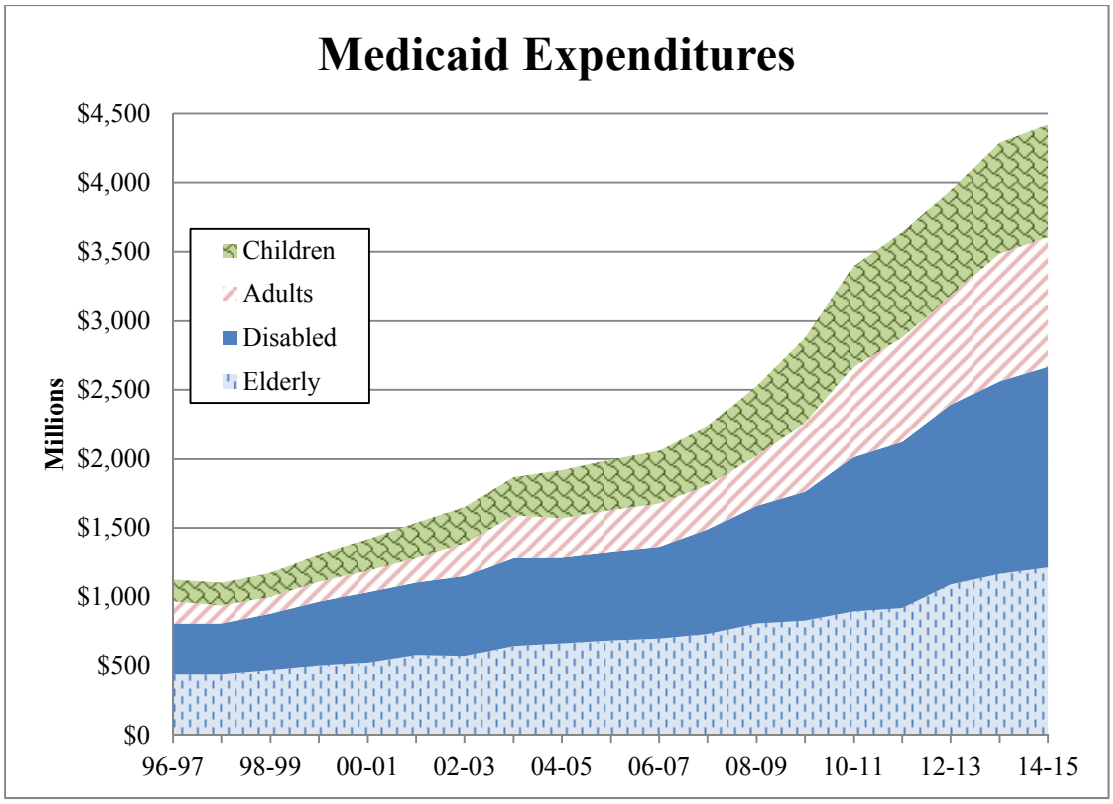
Request: These requests represent the Department's most recent caseload and expenditure forecasts based on current law and policy. BA1 was submitted on February 15 and included an update to S1. BA1 and the update to S1 incorporate data through December 2012.

Recommendation: Staff recommends using the Department's forecast of enrollment and expenditures to modify both the FY 2012-13 and FY 2013-14 appropriations. However, Staff recommends a fund source adjustment to the Department's request because the Department assumed an enhanced federal match for certain populations that Colorado will not qualify for

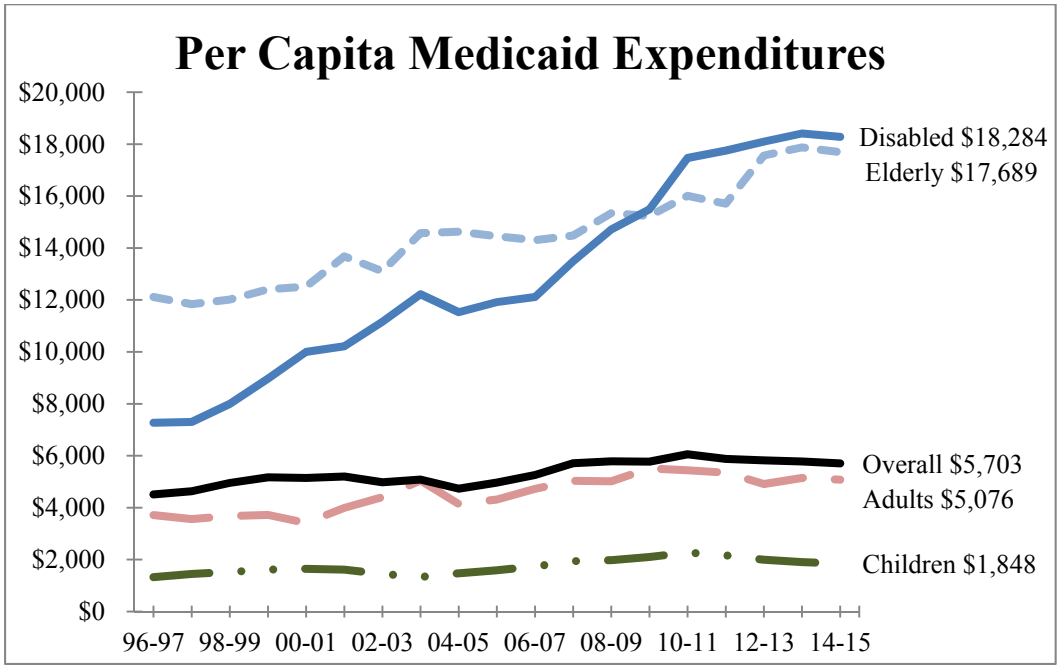
unless Medicaid eligibility is expanded pursuant to the Affordable Care Act (ACA). The legislature has not yet authorized the full ACA eligibility expansion, and so the Department's fund source assumption is premature. The populations potentially eligible for the enhanced federal match are Adults without Dependent Children and Parents from 100 percent to 133 percent of the federal poverty guidelines. The staff recommended fund source adjustment moves $70.1 million from federal funds to the Hospital Provider Fee. If the General Assembly authorizes a Medicaid expansion, this will be reversed in the appropriation clause of the bill providing for the change.

The graphs below show projected Medicaid enrollment and expenditures.





The next table provides projected changes in per capita expenditures, including allocated portions of financing payments.



Included in the Department's projection is an expected expansion of eligibility for Adults without Dependent Children. This expansion was authorized in H.B. 09-1293 but not yet fully

implemented by the Department. The Department initially capped enrollment at 10,000 people. The Department plans to add 3,000 individuals from the waitlist in April and continuing adding 1,250 each month thereafter through September 2013. Selection from the waitlist will be randomized. The source of funds for the state match is the Hospital Provider Fee. If the state decides to expand Medicaid eligibility pursuant to the Affordable Care Act this population would be eligible for the enhanced federal match rate.

The Department's projection accounts for an increase in pay periods during FY 2013-14. This adds approximately $44.2 million total funds, spread over the various fund sources, to the projection.

The Department's projection includes an increase in primary care physician rates to 100 percent of Medicare rates to comply with a requirement of the Affordable Care Act. The required increase in primary care physician rates is for calendar years 2013 and 2014 only. The cost of increasing primary care physician rates to the rates in effect January 1, 2009 must be paid with a state fund match, but the increase beyond the rates in effect on January 1, 2009 is paid for entirely with federal funds.

The Department's projection includes a significant increase in expected enrollment in the Accountable Care Collaborative along with associated projected savings. The Department is expecting enrollment of 275,000 by the end of FY 2012-13. Net savings after administrative costs are projected to be $6.3 million in FY 2012-13 and $10.4 million in FY 2013-14.

➔ R9 Dental ASO for children

Request: The Department proposes contracting with a dental administrative services organization (AS0) to manage the existing dental benefit for children. The ASO would be responsible for processing claims, authorizations, and appeals, educating enrollees, and reaching out to and supporting providers. Using an ASO requires reprogramming of the Medicaid Management Information System (MMIS) to allow monthly payments to the ASO. The Department estimates the cost of the reprogramming at $1,152,144, including $288,036 General Fund. In addition there would be a per member per month (PMPM) administrative payment due to the ASO contractor that will be paid from the Medical Service Premiums line item. The Department did not estimate the PMPM. The Department anticipates that an ASO will increase preventive care and reduce preventable and costly restorative services, resulting in General Fund savings in Medical Service Premiums at least as great as the General Fund cost of the MMIS reprograming and the PMPM due to the contractor.

According to the Department, the use of preventive services by Medicaid children in Colorado exceeds national averages. The Department argues that getting better results will require the services of a contractor educating enrollees about their benefits, about the importance of prevention practices, and about maintaining dental appointments. Also, according to the Department, ASOs tend to have access to better analytical software for identifying utilization trends and where the most cost-effective improvements can be made. The Department plans to structure the contract in a way to ensure that savings as a result of reduced restorative work and emergency room visits would more than offset payments to the ASO, and indicated that this may include shared savings tied to performance outcomes.

Recommendation: Staff does not recommend approval of the request for the following reasons:

1. Staff believes the outreach and education activities described by the Department should be performed by the Accountable Care Collaborative (ACC), rather than a dedicated dental ASO.
2. The Department has not explained how it will track performance to ensure that savings achieved offset the administrative costs.
3. Staff is reluctant to make the necessary investment in reprogramming the MMIS when the MMIS will be completely overhauled in the near future.

In the hearing responses, the Department indicated, "Ultimately, the Department envisions the integration of the dental ASO with the ACC." However, the Department stated twice that, "now is not the time to integrate dental into the ACC." Staff does not understand why the Department believes the timing is not appropriate and the Department never elaborated. If the Department's analyses of the benefits associated with increased preventive care are correct, then it should be in the interest of the ACC providers to perform the outreach and education functions of an ASO to improve health outcomes and earn more of the performance-based ACC payments. Staff does not see the benefit of starting a separate relationship with an ASO that will subsequently be integrated with the ACC versus an integrated approach from the beginning.

The Department anticipates that savings generated by using an ASO will at least offset the cost of hiring an ASO, but staff does not understand how the Department will track and attribute any savings to this initiative versus any of the other initiatives the Department is pursuing, including the ACC, the shared savings projects authorized in the Long Bill last year through R5, or the payment reform pilot projects authorized by H.B. 12-1281. The Department might or might not achieve the performance goals for reasons completely unrelated to an ASO, including changes in enrollment patterns. Also, staff is not sure that the timing of any savings achieved by using an ASO will align with the initial cost. If an ASO is successful in increasing the utilization of preventive care it may improve health outcomes in the long term, but there may be an increase in costs in the short term as the Department spends more on cleanings and sealants.

One of the stated goals of using an ASO is to gain access to better analytical tools that are commonly available to such providers to inform management decisions about the dental benefit, but this is also part of the goal of the reprocurement of the MMIS. Staff does not understand why the Department would invest in the current MMIS to allow a payment to a provider to gain access to advanced analytical tools that will be available in house in a relatively short period of time when the MMIS reprocurement is complete.

➔ R13 1.5% Provider rate increase

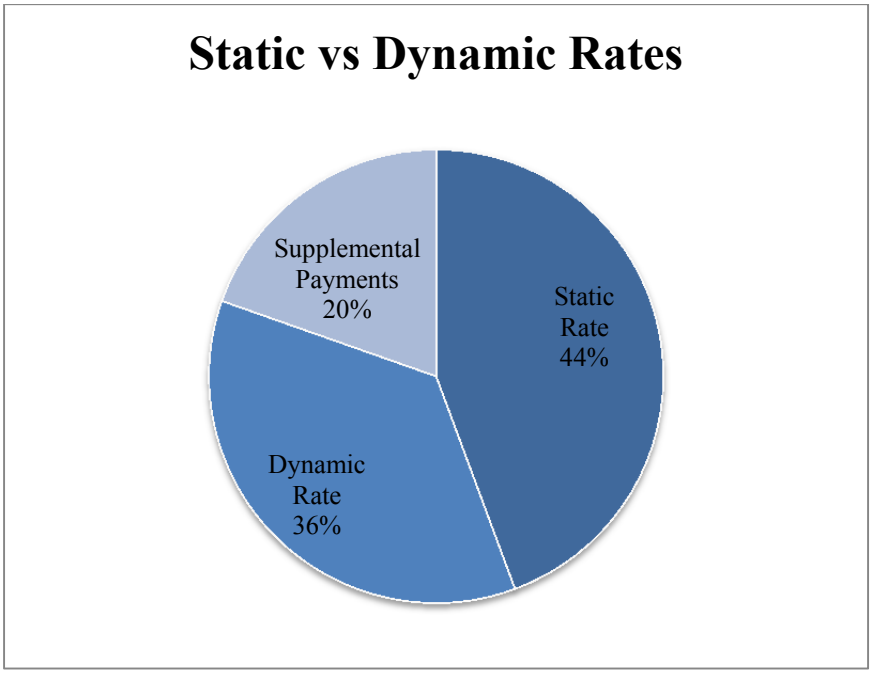
Request: The Department requests a 1.5 percent increase in rates for providers impacted by a recent rate reduction to balance the budget.

Recommendation: Staff recommends the requested 1.5 percent increase based on the JBC's common policy, but staff recommends an updated estimate of the cost using the Department's

February 15 forecast of enrollment and expenditures. The staff calculation of the cost also differs from the Department due to not including "R8 Medicaid dental benefit for adults".

During discussion of the common policy for provider rate increases the JBC expressed an interest in hearing about specific classes of providers with circumstances that may warrant a larger increase. To aid the Committee's debate, staff attempted to divide the payments from Medical Service Premiums into a few large categories.

Of the money paid to providers from Medical Service Premiums in FY 2011-12, approximately 44 percent was distributed based on rates that staff would describe as "static," meaning that the rate does not generally change unless the General Assembly takes action to provide a rate increase or decrease. Another roughly 36 percent was distributed based on "dynamic" rates that have some formulaic adjustment that takes into account changes in cost. Finally, approximately 20 percent was distributed as supplemental payments that are dynamic in the sense that they can change, but they are in a different category because they do not necessarily change with costs, and they are financed in part with money from the providers. Keeping in mind these three different categories of provider payments may be useful in understanding and evaluating the request for a provider rate increase.



Static rates primarily change when the General Assembly applies a community provider rate adjustment that impacts all providers. While static rates don't change with costs, they may change based on case mix or utilization. On rare occasions the Department will make an emergency change to an otherwise static rate to ensure access to a service. Under state statute the Department is authorized to take actions necessary to comply with federal Medicaid laws and regulations, and pursuant to 42 CFR 447.204:

> *The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.*

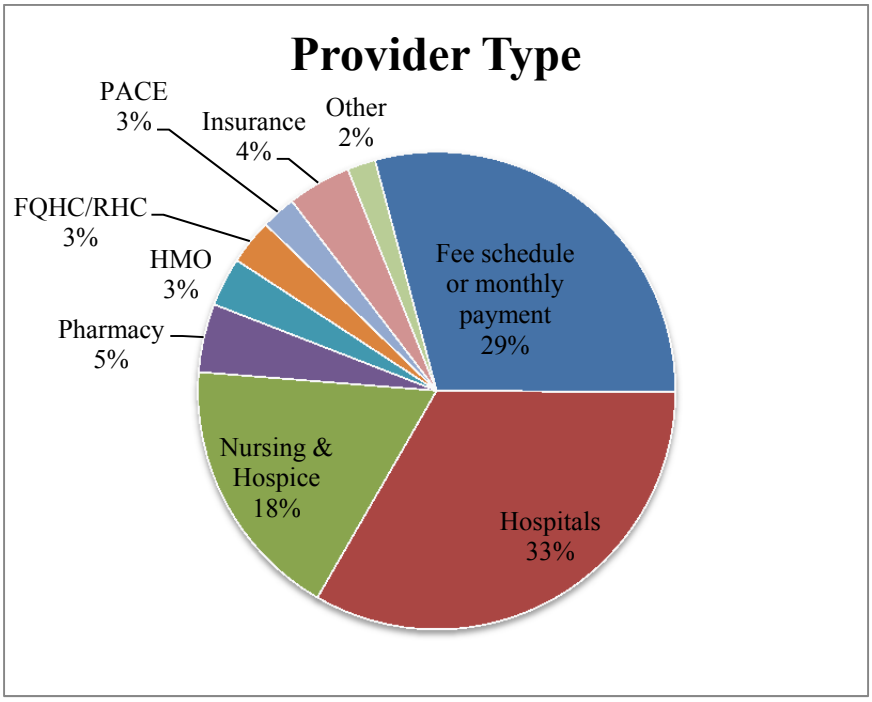
In recent years most of the emergency rate changes to preserve access have been for physician-administered pharmaceuticals. In addition to across-the-board community provider rate increases the General Assembly may also periodically make corrections to a particular static rate or rates that are misaligned with provider costs.

While dynamic rates have an adjustment for changes in cost, this does not necessarily mean the adjustment is sufficient. The adjustment may be capped, or exclude certain expenditures, or be based on an external index that is not representative of true costs, or otherwise be inadequate to fully capture changes in cost in the eyes of a particular provider. However, a provider paid with a dynamic rate will at least get some adjustment for changes in cost, no matter how deficient those adjustments, while a provider paid with a static rate will typically get only an adjustment approved by the General Assembly.

Supplemental payments use money from the provider to match federal funds. Thus, supplemental payments are paying providers in part with the providers' own money. Calculating the net benefit of supplemental payments requires knowing not only what a provider received but also what the provider paid. There are three sources of financing for supplemental payments in Medical Service Premiums: the Hospital Provider Fee, the Nursing Facility Provider Fee, and certified public expenditures. Certified public expenditures are local government funds used to support a health provider that serves low-income clients, such as Denver Health, a nursing facility, or a home health agency. These local government expenditures may be claimed as part of the state match for Medicaid. Supplemental payments can occur in the gap between the state's standard Medicaid reimbursements and the federal upper payment limit. The federal upper payment limit is a cap on what the federal government will pay. The upper payment limit can be thought of as the amount Medicare would have paid for an equivalent service, although there are complicated formulas involved in calculating the upper payment limit such that this is not always precisely the case. The amount of supplemental payments can be influenced by changes in the standard Medicaid reimbursement and the upper payment limit, and by available provider funding, and so supplemental payments don't necessarily change in the same direction as changes in actual costs.

The following table shows how some selected types of providers are impacted by static and dynamic rates and supplemental payments.

FY 2011-12 Payments to Providers				
Provider Type	Static Rate	Dynamic Rate	Supplemental Payments	TOTAL
Fee schedule or monthly payment	$1,059,801,968	-	$6,377,165	$1,066,179,133
Hospitals	362,502,617	232,479,846	614,554,259	1,209,536,722
Nursing and hospice	-	566,070,651	86,787,485	652,858,136
Pharmacy (net of rebates)	-	168,954,268	-	168,954,268
Health Maintenance Organization (HMO)	120,715,911	-	-	120,715,911
Federally Qualified Health Center (FQHC)/ Rural Health Center (RHC)	-	105,358,399	6,431,897	111,790,296
Program for All-inclusive Care for the Elderly (Pace)	31,997,672	53,482,913	-	85,480,585
Insurance	-	156,794,786	-	156,794,786
Other	40,651,634	29,071,291	-	69,722,925
TOTAL	**$1,615,669,802**	**$1,312,212,154**	**$714,150,806**	**$3,642,032,762**



Providers paid on a fee schedule, monthly payment, or fixed price contract represent 29 percent of expenditures. These fee schedules are static with the exception of some supplemental payments to home health providers using certified public expenditures. Some of the more common services paid in this way include physician and specialist services not in a hospital setting, home and community-based services, home health, dental services, durable medical equipment, lab and x-ray services, transportation, and case management-type services such as the Affordable Care Collaborative. Although staff put physician services in this category, it should be noted that for calendar years 2013 and 2014 only the federal Affordable Care Act (ACA) requires states to reimburse primary care physicians at 100 percent of Medicare rates.

Payments to hospitals represent 33 percent of expenditures and they are distributed according to a mix of static and dynamic rates and supplemental payments. For inpatient services hospitals get a hospital-specific base rate multiplied by a diagnosis-related group (DRG) factor. Staff

characterizes the payments for inpatient services as static, because the base rate does not change and the DRG factor is just an adjustment for case mix and utilization. For outpatient services hospitals get 68 percent of actual costs. The outpatient payment is dynamic, because if costs go up the hospital gets more, although the hospital still only receives 68 percent of actual costs. The supplemental payments to hospitals are financed with the Hospital Provider Fee. With the supplemental payments hospitals are essentially reimbursed at the upper payment limit, but since a portion of the supplemental payments come from money provided by the hospitals the net impact is reimbursement that is below the upper payment limit.

Nursing and hospice care represent 18 percent of expenditures and are primarily distributed according to a statutory formula that takes into account costs. The portion of hospice costs that are not for room and board are based on Medicare rates that include inflation factors. Thus, nursing and hospice rates are characterized as dynamic. However, there are statutory limitations on the cost adjustment for nursing homes such that actual costs can exceed the rate paid. In addition to their per diem rate nursing homes receive supplemental payments financed with the Nursing Facility Provider Fee. Statutory limits on the Nursing Facility Provider Fee can result in the combination of the nursing per diem and the supplemental payments being less than actual costs.

Pharmacy expenditures represent 5 percent of total expenditures and are dynamic based on cost. The Department recently made a significant change to the formula for calculating pharmacy costs that is resulting in a significant decrease in pharmacy payments.

Payments to health maintenance organizations (HMOs) account for approximately 3 percent of expenditures and staff has characterized them as static. Pursuant to federal guidance the rates for HMOs must be actuarially sound, meaning they must be within a range reasonably expected to cover the HMOs funding needs, based on the projected caseload mix and utilization. However, the HMOs funding needs are defined as what Medicaid would have paid for an equivalent service. For most of the services HMOs provide the equivalent Medicaid raid would be based on a static fee schedule, and so HMO rates tend to behave as static.

Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) represent 3.0 percent of expenditures and are described by staff as dynamic. The FQHCs and RHCs receive an annually adjusted flat rate per encounter. The annual adjustment to the encounter rate is based on either federal requirements of the Benefits Improvement and Protection Act (BIPA) that include an annual inflation factor or an alternate state formula. Colorado is currently using an alternate state formula. Because Colorado's alternate state formula results in reimbursement above the BIPA minimum, the state was able to reduce FQHC and RHC rates during the economic downturn, but after the reduction rates increased in subsequent years from the lower base according to the alternate state formula.

Payments to providers in the Program of All-inclusive Care for the Elderly (PACE) represent 3 percent of expenditures and are partially dynamic and partially static. Similar to HMO payments, the payments to PACE providers must be actuarially sound based on what Medicaid would have paid for an equivalent service. For the portion of PACE costs for a nursing home level of care, the Medicaid-equivalent rate is dynamic.

Insurance payments represent 4 percent of expenditures and are dynamic, but they are not primarily a payment to providers. Insurance payments are primarily to Medicare, but also include a few payments to third party insurance providers and copayments for services. The insurance payments fluctuate with the insurance premiums.

The Other category includes prepaid inpatient health plans, breast and cervical cancer treatment, and accounting adjustments, which for various technical reasons the Department cannot easily break out into services that are paid at a dynamic or static rate, and so staff has simply allocated them proprortionately.

Staff would not recommend providing a targeted increase in rates to providers paid with a dynamic rate. As noted above, there may be several reasons why a dynamic rate is insufficient relative to a provider's costs, but at least providers paid with a dynamic rate get some adjustment to their rate.

Among the providers paid with a static rate, staff believes a case could be made for targeting an increase for home health services and home and community based services. The providers in these service areas typically make low incomes. In addition, staff suspects their client base is primarily, if not exclusively, Medicaid, making it difficult to spread costs to private-pay clients. The only exception staff would make would be for the Children with Autism waiver, because the budget per client is capped in statute and an increase in rates would reduce services. If the JBC wanted to increase rates for home health services and home and community based services, staff estimates each additional 0.5 percent would require $2.6 million total funds, including $1,236,793 General Fund.

For a history of provider rate changes see Appendix B at the end of this document. Appendix B also includes a table providing the projected provider rates eligible for the increase with notes explaining the exclusions.

(3) Medicaid Mental Health Community Programs

Funding recommendations for the line items in this division are addressed in the figure setting presentation for mental health programs.

(4) Indigent Care Program

This division contains funding for the following programs: (1) Colorado Indigent Care Program (CICP) which partially reimburses providers for medical services to uninsured individuals with incomes up to 250 percent of the federal poverty level; (2) Children's Basic Health Plan; and (3) the Primary Care Grant Program.

Safety Net Provider Payments

This line item provides funding to partially reimburse hospitals for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to people

with income at 250 percent of the federal poverty guidelines or less who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

The maximum annual copayment for a CICP client is 10.0 percent of the client's income, or $120 for clients earning less than 40.0 percent of the federal poverty guidelines. The table below summarizes the maximum copayments for specific categories of services in effect for FY 2011-12.

Percent of Federal Poverty Level	Inpatient Facility & Ambulatory Surgery	Inpatient & Emergency Room Physician	Outpatient Clinic	Hospital Emergency Room, Specialty Outpatient Clinic & Emergency Transportation	Prescription Laboratory, Radiology & Imaging
40%	$15	$7	$7	$15	$5
62%	$65	$35	$15	$25	$10
81%	$105	$55	$15	$25	$10
100%	$155	$80	$20	$30	$15
117%	$220	$110	$20	$30	$15
133%	$300	$150	$25	$35	$20
159%	$390	$195	$25	$35	$20
185%	$535	$270	$35	$45	$30
200%	$600	$300	$35	$45	$30
250%	$630	$315	$40	$50	$35
40%	$0	$0	$0	$0	$0

Hospitals that participate in the CICP are eligible for reimbursement based on a share of the provider's estimated write-off costs for CICP clients equal to 70 percent for rural and Critical Access Hospitals, 53 percent for High Volume Medicaid and CICP Hospitals, and 54 percent for other participating CICP hospitals. High Volume Medicaid and CICP Hospitals are those that provide at least 35,000 Medicaid inpatient days per year and 30.0 percent of total inpatient days to Medicaid clients (Denver Health, University, Memorial, and Children's).

The source of cash funds is the Hospital Provider Fee and the federal match rate is 50 percent. Colorado draws the federal funds for Safety Net Provider Payments through two different methods. First, Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds, if the local match is provided. Although there are nuances to the calculation of the UPL, the additional federal funds the state can draw under the UPL are approximately equal to the difference between Colorado's Medicaid reimbursement rates and what Medicare would have paid for the same services. Second, Colorado receives a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. DSH allotments are required to decrease with the implementation of the Affordable Care Act and the expected decrease in the uninsured population, but the schedule for reductions has not yet been released by the federal government.

Request: The Department requests continuation funding.

Recommendation: Staff recommends increases in the FY 2012-13 and FY 2013-14 appropriations based on more recent information provided by the Department about the available revenue to match federal funds and the amount of room under the Upper Payment Limit.

Safety Net Provider Payments			
	Total Funds	**Cash Funds**	**Federal Funds**
FY 2012-13 Appropriation:			
HB 12-1335 (Long Bill)	$287,055,532	$143,527,766	$143,527,766
Recommended Long Bill Supplemental	12,119,892	6,059,946	6,059,946
TOTAL	**$299,175,424**	**$149,587,712**	**$149,587,712**
FY 2013-14 Recommended Appropriation:			
FY 2012-13 Appropriation	299,175,424	149,587,712	149,587,712
CICP True-up	12,120,762	6,060,381	6,060,381
TOTAL	**$311,296,186**	**$155,648,093**	**$155,648,093**
Increase/(Decrease)	**$12,120,762**	**$6,060,381**	**$6,060,381**
Percentage Change	4.1%	4.1%	4.1%
FY 2013-14 Executive Request:	**$287,055,532**	**$143,527,766**	**$143,527,766**
Request Above/(Below) Recommendation	($24,240,654)	($12,120,327)	($12,120,327)

Clinic Based Indigent Care

This line item is similar in purpose to the Safety Net Provider Payments line item, except that instead of funding hospitals it partially reimburses clinics for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to people with income at 250 percent of the federal poverty guidelines or less who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income (see the description of the Safety Net Provider Payments line item for a summary of the copayments).

Since clinics are not eligible for UPL or DSH financing, the federal funds for this line item are drawn through the UPL for Children's Hospital. The hospital then contracts with the clinics to distribute the money, retaining $60,000 from the total appropriation to cover administrative costs. The clinics are not necessarily affiliated with Children's other than through the contract that allows them to receive the supplemental payments.

The available CICP funding is distributed based on each clinic's share of estimated write-off costs compared to all clinics. In FY 2011-12 CICP clinic payments covered 55.2 percent of total actual write-off costs.

Unlike the Safety Net Provider Payments line item, the state participation for this line item comes from the General Fund. This line item existed prior to H.B. 09-1293, and so using the Hospital Provider Fee to match the federal funds might be viewed as supplanting existing General Fund, which is prohibited in Section 25.5-4-402.3(5)(a)(I), C.R.S. Also, these are not hospitals, and the hospitals are already giving up a share of their UPL to allow the clinics to receive these supplemental payments. The federal match rate is 50 percent.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding. This program is discretionary, rather than a required component of Medicaid.

Health Care Services Fund Programs

The appropriation for this program in FY 2011-12 was part of a financing mechanism the JBC used to reduce the need for General Fund for Medical Service Premiums with minimal impact on providers. Senate Bill 11-219, sponsored by the JBC, used half of the tobacco tax money deposited in the Primary Care Fund to finance supplemental payments to clinics, rather than primary care grants. The supplemental payments to clinics were eligible for federal financial participation, and so providers received approximately the same total funds. Then the remaining money in the Primary Care Fund was appropriated to offset the need for General Fund in the Medical Service Premiums line item. This financing was only possible under the constitutional provisions governing the tobacco tax because the General Assembly passed SJR 11-009 declaring a fiscal emergency.

Pediatric Specialty Hospital

The line item provides supplemental payments to The Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The line item also provides $2.2 million ($1.1 million General Fund) for The Children's Hospital Kids Street and Medical Day Treatment programs, which are not eligible for Medicaid fee-for-service reimbursement, but do qualify for this supplemental payment.

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

The Medical Day Treatment program serves children and adolescents aged 7 to 21 years of age with chronic illnesses or medical conditions requiring ongoing medical monitoring. Patients are served five days a week at The Children's Hospital's campus in Aurora. Aurora Public Schools provides educational staff and instruction on site. Individual education plans are developed and maintained for the patients. The services reduce hospitalizations and provide psycho social supports to patients' families.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding. This program is discretionary, rather than a required component of Medicaid.

Appropriation from Tobacco Tax Fund to General Fund

Section 24-22-117 (1) (c) (I) (A), C.R.S. requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund. Section 24-22-117 (1) (c) (I) (B.5) requires that 50 percent of those revenues appropriated to the General

Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

Request: The Department requests continuation funding.

Recommendation: The staff recommendation is $3,300 less than the Department's request based on the most recent forecast of tobacco tax revenues approved by the JBC during figure setting for the Department of Public Health and Environment and the statutory distribution formula for those funds.

Primary Care Fund

Through this line item tobacco tax funds are distributed to providers who:

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

Awards are based on the percentage of medically indigent clients the provider serves. The primary care fund receives 19 percent of tobacco tax collections annually.

In FY 2011-12 S.B. 11-219, sponsored by the JBC, used half of the tobacco tax money deposited in the Primary Care Fund to finance supplemental payments to clinics, rather than primary care grants. The supplemental payments to clinics were eligible for federal financial participation, and so providers received approximately the same total funds. Then the remaining money in the Primary Care Fund was appropriated to offset the need for General Fund in the Medical Service Premiums line item. This financing was only possible under the constitutional provisions governing the tobacco tax because the General Assembly passed SJR 11-009 declaring a fiscal emergency.

Request: The Department requests continuation funding.

Recommendation: The staff recommendation is $209,000 less than the Department's request based on the most recent forecast of tobacco tax revenues approved by the JBC during figure setting for the Department of Public Health and Environment and the statutory distribution formula for those funds.

Primary Care Grant Program Special Distributions

This line item was funded in FY 2011-12 as part of the financing that occurred in S.B. 11-219 to minimize the adverse impacts on some providers. No funding is requested or recommended for FY 2013-14.

Children's Basic Health Plan (CHP+) Administration

This line item provides funding for private contracts for administrative services associated with the Children's Basic Health Plan. There is a separate appropriation in the Executive Director's Office for the centralized eligibility vendor for CHP+ expansion populations funded from the Hospital Provider Fee. There are also appropriations in the Executive Director's Office for internal administrative costs, including personal services, operating expenses, and the Medicaid Management Information System.

The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee. The federal match rate for CHP+ is 65 percent, but much of the activities of the contractor are actually related to the Medicaid program, because children may not enroll in CHP+ unless determined ineligible for Medicaid. The portion of the line item funded at the 50 percent Medicaid match rate is based on a time allocation model approved by the federal government.

Request: The Department requests annualizations for prior year legislation.

Recommendation: Staff recommends the Department request, including the annualizations of prior year legislation. Specifically, the recommendation includes annualization of the following bills:

Annualizations - Children's Basic Health Plan (CHP+) Administration			
	TOTAL	CHP+ Trust	Federal Funds
S.B. 11-008 Aligning children's Medicaid eligibility	(814,914)	($285,220)	($529,694)
S.B. 11-250 Pregnanant women Medicaid eligibility	(1,000)	($350)	($650)
TOTAL	**($815,914)**	**($285,570)**	**($530,344)**

Children's Basic Health Plan (CHP+) Medical and Dental Costs

This line item contains the medical costs associated with serving the eligible children and adult pregnant women on the CHP+ program and the dental costs for the children. Children are served by both managed care organizations and the Department's self-insured network. The adult pregnant women on the program are served in the self-insured network.

The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, and the Health Care Expansion Fund. The federal match rate is 65 percent, except that no federal match is provided for enrollment fees.

Request: The Department requests S3/R3/BA3 to adjust both the FY 2012-13 and FY 2013-14 appropriations for the most recent caseload and expenditure forecast. BA3 was submitted on February 15 and included an update to S3. BA3 and the update to S3 incorporate data through December 2012 into the forecast. In addition, the Department requests annualizations of prior year legislation and budget actions.

Recommendation: *Staff recommends adjusting the FY 2012-13 and FY 2013-14 appropriations based on the Department's most recent forecast of enrollment and expenditures.*

In addition, staff recommends a small fund source adjustment to account for the JBC's action during figure setting for the Department of Public Health and Environment on the amount of the Colorado Immunization Fund devoted to cervical cancer vaccinations for CHP+ participants, and to account for the most recent estimate of tobacco tax funds that must be statutorily appropriated to CHP+. Pursuant to Section 24-22-117 (1) (c) (I) (A), C.R.S., 0.6 percent of revenues to the Tobacco Tax Cash Fund must be appropriated to the General Fund, and then pursuant to Section 24-22-117 (1) (c) (I) (B.5) 50 percent of those revenues appropriated to the General Fund must be appropriated to the Children's Basic Health Plan. The appropriation to the Children's Basic Health Plan has historically been categorized as General Fund Exempt. The staff recommendation adjusts expenditures from the CHP+ Trust to offset the changes in funding from the General Fund Exempt and the Colorado Immunization Fund.

The components of the staff recommendation are summarized in the table below.

Children's Basic Health Plan Medical and Dental Costs	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2012-13 Appropriation:				
HB 12-1335 (Long Bill)	$182,543,053	$22,228,955	$42,220,291	$118,093,807
Recommended Long Bill Supplemental	15,405,598	4,814,928	860,231	9,730,439
S.B. 13-089 Supplemental	9,020,710	2,795,899	361,350	5,863,461
TOTAL	**$206,969,361**	**$29,839,782**	**$43,441,872**	**$133,687,707**
FY 2013-14 Recommended Appropriation:				
FY 2012-13 Appropriation	206,969,361	29,839,782	43,441,872	133,687,707
Anualize prior year budget decisions	(49,256,733)	(1,006,076)	(16,212,364)	(32,038,293)
R3 Childrens Basic Health Plan	36,561,837	(6,261,042)	19,157,583	23,665,296
Fund source adjustment	0	(3,300)	3,300	0
TOTAL	**$194,274,465**	**$22,569,364**	**$46,390,391**	**$125,314,710**
Increase/(Decrease)	**($12,694,896)**	**($7,270,418)**	**$2,948,519**	**($8,372,997)**
Percentage Change	-6.1%	-24.4%	6.8%	-6.3%
FY 2013-14 Executive Request:	**$196,138,239**	**$22,572,664**	**$47,039,412**	**$126,526,163**
Request Above/(Below) Recommendation	$1,863,774	$3,300	$649,021	$1,211,453

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the following prior year legislation and budget decisions.

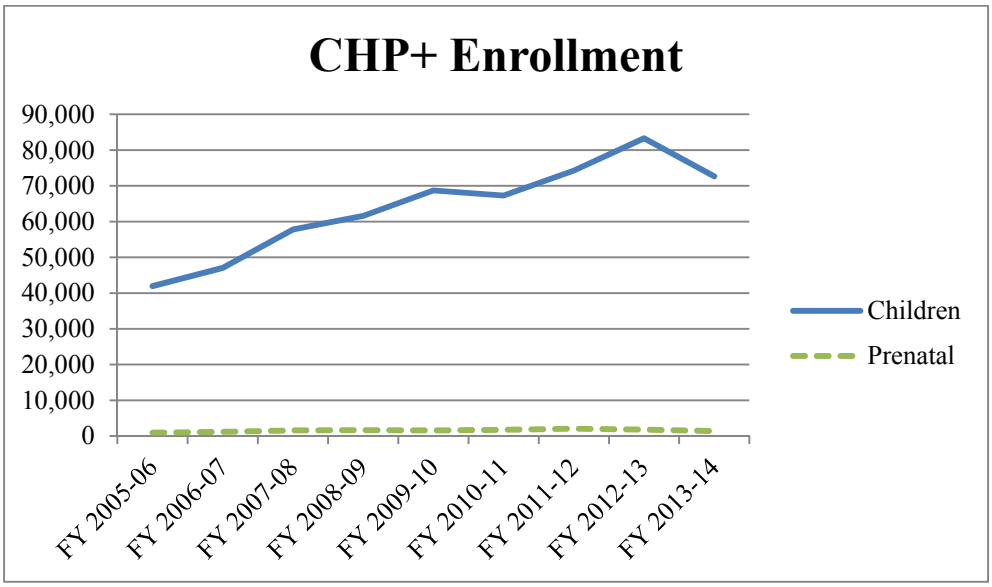
Annualizations - Children's Basic Health Plan (CHP+)	TOTAL	General Fund	Cash Funds	Federal Funds
S.B. 11-008 Aligning children's Medicaid eligibility	($37,750,557)	$0	($13,212,695)	($24,537,862)
S.B. 11-250 Pregnanant women Medicaid eligibility	(11,249,291)	($3,937,252)	$0	($7,312,039)
FY 12-13 CHP+ cost sharing	(256,885)	(68,824)	331	(188,392)
FY 12-13 CHP+ Trust financing	0	3,000,000	(3,000,000)	0
TOTAL	**($49,256,733)**	**($1,006,076)**	**($16,212,364)**	**($32,038,293)**

➔ **S3/R3/BA3 Children's Basic Health Plan**

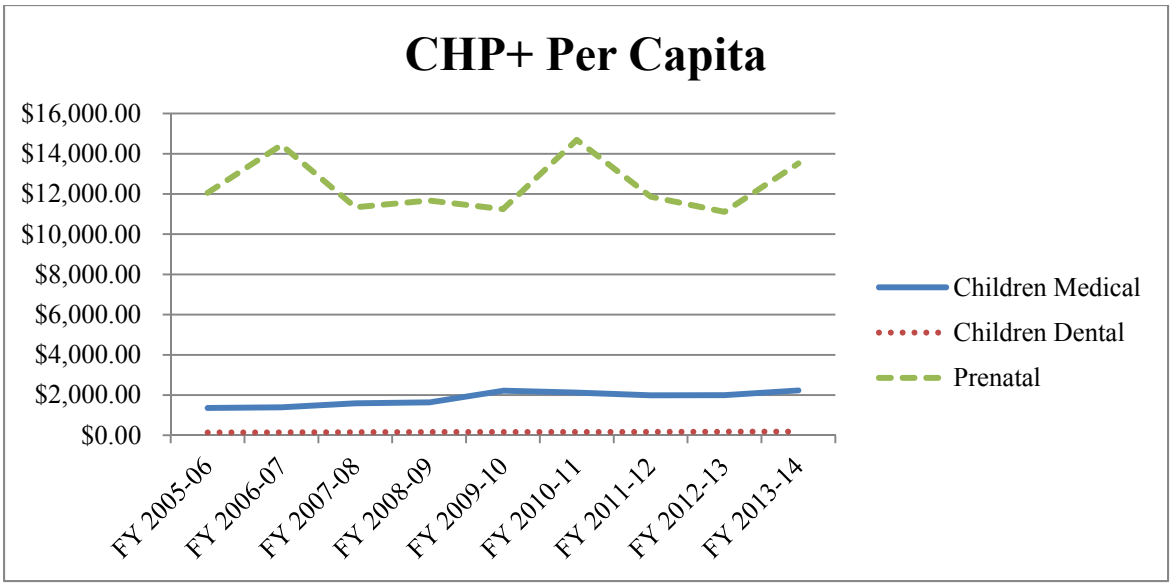
Request: These requests represent the Department's most recent caseload and expenditure forecasts based on current law and policy. BA3 was submitted on February 15 and included an update to S3. BA3 and the update to S3 incorporate data through December 2012.

Recommendation: Staff recommends using the Department's forecast of enrollment and expenditures. The total recommended by staff is slightly different than the request due to removing internal administration costs that are appropriated in the Executive Director's Office.

The graph below shows projected CHP+ enrollment. The expected decrease in FY 2013-14 is primarily attributable to continued implementation of S.B. 11-008, which increased Medicaid eligibility for children between the ages of 6 and 19 from 100 percent to 133 percent of the federal poverty guidelines, thereby reducing CHP+ enrollment. The Department's forecast also takes into account a much smaller expected shift from CHP+ to Medicaid as a result of changes in the way family size is determined for purposes of Medicaid edibility pursuant to the Affordable Care Act.



The next table summarizes projected changes in per capita expenditures. The volatility in prenatal expenses is in part due to a small population and in part due to some historic technical issues regarding when changes in expenditures were incorporated into the rates. The Department believes it has addressed the technical issues and the per capita rates for pregnant women will stabilize in future years.



In addition to the forecast model output, the Department's projection includes bottom line adjustments for a federally required change to rates for children and adults served by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The JBC authorized back payments for the FQHCs and the RHCs in the supplemental bill, and the Department's forecast for FY 2013-14 takes into account the higher rates. To prepare the graphs above staff spread the rate adjustment for the FQHCs and the RHCs across prior years and proportionally between medical, dental, and prenatal expenses. The table below shows the results for FY 2011-12 through FY 2013-14. The figures for FY 2011-12 and FY 2012-13 won't match the actual or appropriated funds primarily due to this adjustment. Staff believes the adjusted figures more accurately reflect the trends in expenditures and per capita rates.

Enrollment	FY 2011-12	FY 2012-13	FY 2013-14
Children	74,266	83,316	72,649
Prenatal	2,064	1,812	1,398
TOTAL	76,330	85,128	74,047

Expenditure	FY 2011-12	FY 2012-13	FY 2013-14
Children Medical	$147,398,355	$165,979,136	$162,084,013
Children Dental	$12,586,244	$14,831,602	$13,299,975
Prenatal	$24,488,529	$20,124,869	$18,890,477
TOTAL	$184,473,128	$200,935,608	$194,274,465

Per Capita	FY 2011-12	FY 2012-13	FY 2013-14
Children Medical	$1,984.74	$1,992.16	$2,231.06
Children Dental	$169.48	$178.02	$183.07
Prenatal	$11,864.60	$11,109.51	$13,517.34

(5) OTHER MEDICAL SERVICES

Old Age Pension State Medical Program

The Old Age Pension (OAP) Health and Medical program was established through Article XXIV of the Colorado Constitution and by Section 25.5-2-101, C.R.S. to provide health care services to persons who qualify to receive old age pensions but who are ineligible for Medicare or Medicaid. The funds are paid to providers based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation.

The sources of cash funds are a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund and, until FY 2011-12, the Supplemental Old Age Pension Health and Medical Care Fund. The Supplemental Old Age Pension Health and Medical Care Fund received a portion of tobacco tax revenue and an allocation from sales tax revenues.

In FY 2012-13 the General Assembly added $2.4 million General Fund to this line item to try to ensure that provider rates did not decrease as a percentage of Medicaid rates.

Request: The Department requests continuation funding.

Recommendation: Staff recommends eliminating the $2.4 million General Fund in FY 2012-13 and FY 2013-14. Enrollment in the OAP Health and Medical program has been less than expected. As a result, the Department not only maintained reimbursement rates but increased them as a percentage of Medicaid rates. Specifically, the Department increased pharmacy rates from 75 percent to 100 percent of Medicare and rates for Outpatient and Practitioner/Physician from 65 percent to 100 percent of Medicare.

OAP-SO Provider Reimbursement Rates	**FY 2013-14 Rates (Percent of Medicaid)**
Capitation	100.00%
Pharmacy	100.00%
Inpatient	10.00%
Outpatient	100.00%
Practitioner/Physician	100.00%
Dental	65.00%
Independent Laboratory	65.00%
Medical Supply	65.00%
Home Health	65.00%
Transportation	65.00%
Mcare Part A Crossover	100.00%
Mcare Part B Crossover	100.00%
Mcare UB92 Part B Crossover	100.00%

The intent of the additional General Fund provided for this program was not to increase rates, but to prevent rates from decreasing. Current projections of enrollment and expenditures indicate the Department can probably maintain the higher rates with just the money from the OAP Health and Medical Fund, but the staff recommended decrease in General Fund may require a mid-year rate adjustment if enrollment is higher than expected.

Old Age Pension State Medical	Total Funds	General Fund	Cash Funds
FY 2012-13 Appropriation:			
HB 12-1335 (Long Bill)	$12,400,000	$2,400,000	$10,000,000
Recommended Long Bill Supplemental	(2,400,000)	(2,400,000)	0
TOTAL	**$10,000,000**	**$0**	**$10,000,000**
FY 2013-14 Recommended Appropriation:			
FY 2012-13 Appropriation	10,000,000	0	10,000,000
TOTAL	**$10,000,000**	**$0**	**$10,000,000**
Percentage Change	0.0%	0.0%	0.0%
FY 2013-14 Executive Request:	**$12,400,000**	**$2,400,000**	**$10,000,000**
Request Above/(Below) Recommendation	$2,400,000	$2,400,000	$0

Commission on Family Medicine

This line item provides payments to eight hospitals to help offset their costs for providing residency programs for family medicine physicians (University Hospital's payments are in a separate line item). All of the funding in this line item goes directly to the residency programs. Federal regulations allow Medicaid financial participation for the payments to the hospitals enrolled in the program.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

State University Teaching Hospitals -- Denver Health and Hospital Authority

This line item provides funding for the Denver Health and Hospital Authority for Graduate Medical Education (GME). Expenses incurred when graduate students see Medicaid patients were previously appropriated in the Medical Service Premiums line item. Separating them in this line item helps to better track these costs and clarify the status of Denver Health and Hospital Authority as a "Unit of Government" with activity the state can certify as public expenditures to match federal funds. The certified public expenditures appear in other line items, including Medical Service Premiums and the Indigent Care Program.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

State University Teaching Hospitals -- University of Colorado Hospital Authority

This line item provides funding for the University of Colorado Hospital Authority for Graduate Medical Education (GME). Expenses incurred when graduate students see Medicaid patients were previously appropriated in the Medical Service Premiums line item. Separating them in this line item helps to better track these costs and clarify the status of Denver Health and Hospital Authority as a "Unit of Government" with activity the state can certify as public expenditures to match federal funds. The certified public expenditures appear in other line items, including Medical Service Premiums and the Indigent Care Program.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Medicare Modernization Act

This line item pays the state's obligation under the Medicare Modernization Act (MMA) to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

This is a 100 percent state obligation and there is no federal match. However, for the past several years the General Assembly has applied federal bonus payments for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

Request: The Department requests S4/R4 "Medicare Modernization Act of 2003 State Contribution Payment" to update both the FY 2012-13 and FY 2013-14 appropriations to match the most recent forecast of the state's obligation. In addition, the Department requests annualizing prior year budget decisions about where to apply bonus payments received for meeting federal CHIPRA performance goals.

Recommendation: *In total staff recommends approximately $1.5 million less than the Department in FY 2012-13 and $4.1 million less than the Department in FY 2013-14.* The difference between the staff recommendation and the request is primarily attributable to using the updated actual per member per month rate for calendar year 2013, rather than the Department's November 1 projection. However, staff also changed the projection for the calendar year 2014 rate.

Staff also recommends a change in the fund sources to account for a proposed change in the way CHIPRA bonus payments are allocated. This recommended change in fund sources to smooth out an expected spike in General Fund expenditures in FY 2014-15 results in a staff recommendation that is $20.3 million General Fund higher than the request. See the description of the CHIPRA bonus payments below for more details.

The components of the staff recommendation are summarized in the following table.

Medicare Modernization Act State Contribution Payment			
	Total Funds	**General Fund**	**Federal Funds**
FY 2012-13 Appropriation:			
HB 12-1335 (Long Bill)	$93,512,819	$62,869,537	$30,643,282
Recommended Long Bill Supplemental	8,375,810	(10,661,915)	19,037,725
TOTAL	**$101,888,629**	**$52,207,622**	**$49,681,007**
FY 2013-14 Recommended Appropriation:			
FY 2012-13 Appropriation	101,888,629	52,207,622	49,681,007
R4 Medicare Modernization Act	5,285,240	5,285,240	0
Reallocate CHIPRA to CMTF	0	25,000,000	(25,000,000)
TOTAL	**$107,173,869**	**$82,492,862**	**$24,681,007**
Increase/(Decrease)	**$5,285,240**	**$30,285,240**	**($25,000,000)**
Percentage Change	5.2%	58.0%	-50.3%
FY 2013-14 Executive Request:	**$111,278,217**	**$62,229,522**	**$49,048,695**
Request Above/(Below) Recommendation	$4,104,348	($20,263,340)	$24,367,688

➔ S4/R4 Medicare Modernization Act of 2003 State Contribution Payment

Request: The state's obligation is a function of the per member per month (PMPM) rate, calculated according to a federal formula, multiplied by the population that is dually eligible for Medicaid and Medicare. The PMPM is based on the state average dual-eligible drug benefit for calendar year 2003 inflated using either the average growth rate from the National Health Expenditure per-capita drug expenditures or actual growth in Part D expenditures and multiplied by the federal match rate and a factor that started at 90% but decreases by 1.67 percent each year until it reaches 75 percent in 2015.

For caseload the Department projects a 4.03 percent annual growth rate. Historically caseload growth has fluctuated between 2 and 6 percent.

To estimate the PMPM the Department used a method originally recommended by the CMS Office of the Actuary several years ago, but then the Department rejected the model output, because it would have resulted in a 25 percent decrease in the rate for calendar year 2014. The National Health Expenditure projections of per-capita prescription drug expenditures are frequently restated and that seems likely in this case. Instead of using the model output the Department elected to hold the assumed PMPM constant.

Recommendation: The staff recommendation uses the Department's caseload forecast, but for the calendar year 2013 PMPM staff used the actual rate the Department is paying, rather than the Department's November 1 projection of the rate. To estimate the calendar year 2014 PMPM staff applied an inflation factor using the compound average annual rate of growth in the base rate from 2006 to 2013. The staff recommendation takes a more conservative approach than the Department by assuming inflation in the 2014 PMPM, but because it starts from a lower calendar year 2013 rate the overall staff recommended amount is less than the Department's request.

Medicare Modernization Act (MMA) Per Member Per Month (PMPM) Rates					
CY	Qtr	Base Rate	FMAP	Phasedown	PMPM
2006		$254.91	50.00%	90.00%	$114.71
2007		$272.39	50.00%	88.33%	$120.30
2008	CQ1	$276.98	50.00%	86.67%	$120.03
	CQ2	$276.98	50.00%	86.67%	$120.03
	CQ3	$276.98	50.00%	86.67%	$120.03
	CQ4	$276.97	41.22%	86.67%	$98.95
2009	CQ1	$302.62	41.22%	85.00%	$106.03
	CQ2	$302.65	38.41%	85.00%	$98.81
	CQ3	$302.65	38.41%	85.00%	$98.81
	CQ4	$302.65	38.41%	85.00%	$98.81
2010		$317.09	38.41%	83.33%	$101.49
2011	CQ1	$317.97	41.23%	81.67%	$107.07
	CQ2	$317.95	43.12%	81.67%	$111.97
	CQ3	$317.96	50.00%	81.67%	$129.84
	CQ4	$317.96	50.00%	81.67%	$129.84
2012		$331.03	50.00%	80.00%	$132.41
2013		$341.17	50.00%	78.33%	$133.62
2014		$353.83	50.00%	76.67%	$135.64

3.7% Compound Average Annual Rate of Growth From 2006 to 2013 (used to project 2014)

Projected MMA Expenditures				
	FY 2012-13		FY 2013-14	
CY	Caseload	Expenditure	Caseload	Expenditure
2011	1,953	$251,899	0	$0
2012	513,708	$68,020,076	2,032	$269,057
2013	251,584	$33,616,654	534,394	$71,405,726
2014	0	$0	261,713	$35,499,086
TOTAL	**767,245**	**$101,888,629**	**798,139**	**$107,173,869**
Request	767,245	$103,352,848	789,139	$111,278,217
Difference	0	($1,464,219)	9,000	($4,104,348)

➔ CHIPRA bonus payments

Request: The Department's request assumes continuation of the General Assembly's practice of applying the CHIPRA bonus payments to offset the need for General Fund in this line item.

Staff recommendation: Staff recommends a change in where the CHIPRA bonus payments are allocated. The FY 2012-13 actual CHIPRA bonus payments came in at $49,681,007 and staff recommends assuming this will be the amount awarded in FY 2013-14 as well. However, in the next fiscal year the federal statutory authority for the bonus payments will wind down and the Department projects that the FY 2014-15 bonus payments will be only $2.9 million. Thus, under current practice, the General Assembly would need to come up with an additional roughly $46.8 million General Fund for this line item in FY 2014-15 when the CHIPRA bonus payments are no longer available, in addition to caseload and inflationary increases.

Rather than waiting to pay the entire $46.8 million General Fund in FY 2014-15, staff recommends closing the deficit over two years. To do this, staff recommends appropriating $25.0 million of the FY 2013-14 expected CHIPRA bonus payments to the Controlled Maintenance Trust Fund, rather than offsetting the General Fund in this line item. There are no federal limits on how Colorado spends the CHIPRA bonus payments that would prohibit such an appropriation.

If the JBC would prefer to retain a relationship between the CHIPRA bonus payments and health care programs, the JBC could instead appropriate the $25.0 million to the Children's Basic Health Plan Medical and Dental Costs line item in lieu of an appropriation from the CHP+ Trust Fund. This would create a surplus in the CHP+ Trust Fund that could be spent down slowly over multiple fiscal years. This alternative approach would make the funds easier to access in a future

year (for better or worse) by simply increasing appropriations from the CHP+ Trust Fund and decreasing General Fund appropriations for the Children's Basic Health Plan Medical and Dental Costs.

Public School Health Services Contract Administration; and
Public School Health Services

When local school districts, Boards of Cooperative Education Services, or the Colorado School for the Deaf and Blind provide health care services to children who are eligible for Medicaid, the cost of services covered by Medicaid and some administrative expenses can be certified as public expenditures to match federal funds. The Department allocates the federal financial participation back to the school providers, minus administrative costs, and the school providers use the money to increase access to primary and preventative care programs to low-income, under, or uninsured children, and to improve the coordination of care between schools and health care providers. Participation by school providers is voluntary.

The source of cash funds is certified public expenditures. The federal match rate is 50.0 percent, but the Department retains some of the federal funds for administrative costs. The majority of the federal funds retained by the Department for administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office as well.

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts

Request: The Department requests BA12 "Public school health services true-up" to continue and annualize a supplemental decision that added more funding based on school participation trends. The Department does not control the health services provided by school districts and has had trouble forecasting their activity. The Department did not anticipate recent dramatic increases in the program. A combination of outreach efforts by the Department and school districts needing to pursue new revenue streams due to the economy resulted in increased claims of eligible expenses, and at the same time there was an increase in the students meeting the income thresholds for the program.

The unanticipated increase in expenditures has been problematic for the Department, because the timing of when the Department learns about an increase in expenditures does not align with the General Assembly's supplemental budget cycle. The process required to identify eligible services and certify the public expenditures by the school districts is lengthy and involved. The Department makes an initial payment during the fiscal year, but then makes a reconciliation payment in the next fiscal year. Some of the data points for that reconciliation payment are not available until the spring after the fiscal year when the service was provided, which is after the General Assembly's supplemental process. Because of this awkward timing, the Department proposed in the supplemental request that the funds be noted as "informational only" in appropriation bills to prevent the need for supplemental true-ups in future years. However, since

the supplemental was submitted the Department has backed off from the request to identify the funds as "informational only." The Department believes that with the true-up approved in the supplemental adhering to appropriation will be less problematic in future years.

Recommendation: Staff recommends the Department's request, but with no change to identify the funds as informational only.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID FUNDED PROGRAMS

Funding recommendations for the line items in this division are addressed in figure setting presentations for the Department of Human Services.

Long Bill Footnotes and Requests for Information

LONG BILL FOOTNOTES

Staff recommends **CONTINUATION** of the following footnotes:

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

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

Comment: This footnote explains the assumptions used for the appropriation. Staff will update the figures to reflect the JBC's actions.

11 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs --** This appropriation assumes the following: (1) A total children's caseload of 67,542 at an average medical per capita

cost of $2,210.13 per year; and (2) a total adult prenatal caseload of 1,360 at an average medical per capita cost of $15,818.25 per year.

Comment: This footnote explains the assumptions used for the appropriation. Staff will update the figures to reflect the JBC's actions.

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

Comment: This footnote explains the assumptions used for the appropriation. Staff will update the figures to reflect the JBC's actions.

13 **Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding --** The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the head notes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations to the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriation in this section (6) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This footnote clarifies the intent of the General Assembly.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUATION** of the following footnotes:

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: This report provides useful information to the JBC staff and is a long-standing report that the Department has provided for many years.

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

Comment: This report provides useful information to the JBC staff.

6. **Department of Health Care Policy and Financing, Medical Services Premiums --** The Department is requested to submit a report by ~~November 1, 2012~~ NOVEMBER 1, 2013, 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~~ PERFORMANCE results ~~that demonstrate savings for the pilot program~~ WITH AN EMPHASIS ON THE FISCAL IMPACT. ~~If data is not available to determine saving results, the Department shall note when such data is anticipated to be available.~~

Comment: The Accountable Care Collaborative (ACC) continues to be one of the Department's primary initiatives to improve health outcomes and save money. The Department's Medicaid forecast assumes significant savings associated with the ACC. The program warrants continued close monitoring by the JBC.

7. **Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services --** The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The Department submitted significant supplemental requests for both FY 2011-12 and FY 2012-13. The program warrants continued close monitoring by the JBC.

Staff recommends **DISCONTINUING** the following footnotes:

2. **Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program --** The Department is requested to submit a report by November 1, 2012, to the Joint Budget Committee describing the success of providers in collecting co-payments from clients for medical service programs financed by the Department, including Medicaid, the Children's Basic Health Plan, and the Colorado Indigent Care Program. The report should also discuss the impact of co-payment requirements on enrollment and utilization.

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

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

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

Comment: The report was submitted as requested and the request for information has fulfilled its purpose.

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

Comment: The report was submitted as requested and the request for information has fulfilled its purpose.

Appendix A: Number Pages

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**						
(1) EXECUTIVE DIRECTOR'S OFFICE						
Primary functions: Administration of Medicaid, the Colorado Indigent Care Program, Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan						
(A) General Administration						
Personal Services	19,017,761	20,609,604	22,658,704	24,596,507	23,243,320	*
FTE	270.6	293.4	327.1	340.0	337.0	
General Fund	7,559,246	7,727,247	8,003,412	9,533,270	8,370,550	
Cash Funds	1,289,520	1,371,016	2,038,599	2,171,323	1,955,887	
Reappropriated Funds	520,127	448,289	1,176,645	1,069,555	1,736,842	
Federal Funds	9,648,868	11,063,052	11,440,048	11,822,359	11,180,041	
Health, Life, and Dental	1,706,057	2,024,577	2,216,793	2,272,415	2,198,265	*
General Fund	611,752	627,749	796,479	780,989	748,152	
Cash Funds	205,744	255,164	174,652	171,519	166,566	
Reappropriated Funds	15,219	0	111,821	62,934	72,376	
Federal Funds	873,342	1,141,664	1,133,841	1,256,973	1,211,171	
Short-term Disability	26,138	32,188	33,497	40,939	40,277	*
General Fund	9,539	12,334	12,334	14,069	13,671	
Cash Funds	2,174	2,503	2,503	2,897	2,827	
Reappropriated Funds	737	0	1,309	611	802	
Federal Funds	13,688	17,351	17,351	23,362	22,977	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
S.B. 04-257 Amortization Equalization Disbursement	402,667	532,854	730,633	829,924	813,297	*
General Fund	145,650	190,728	283,141	284,515	273,870	
Cash Funds	33,664	53,148	53,468	58,931	57,497	
Reappropriated Funds	11,411	0	37,574	12,775	16,232	
Federal Funds	211,942	288,978	356,450	473,703	465,698	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	292,544	427,325	627,713	749,385	733,353	*
General Fund	105,135	151,785	242,160	256,855	246,370	
Cash Funds	24,547	42,482	45,949	53,201	51,907	
Reappropriated Funds	8,321	0	33,280	11,679	14,654	
Federal Funds	154,541	233,058	306,324	427,650	420,422	
Salary Survey	0	0	0	568,180	671,276	
General Fund	0	0	0	176,323	199,437	
Cash Funds	0	0	0	45,753	54,252	
Reappropriated Funds	0	0	0	8,388	10,800	
Federal Funds	0	0	0	337,716	406,787	
Merit Pay	0	0	0	384,021	373,165	
General Fund	0	0	0	130,300	119,442	
Cash Funds	0	0	0	28,429	28,429	
Reappropriated Funds	0	0	0	9,888	9,889	
Federal Funds	0	0	0	215,404	215,405	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
Worker's Compensation	34,748	29,652	30,843	46,920	46,920
General Fund	17,374	14,826	15,422	23,461	23,461
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	17,374	14,826	15,421	23,459	23,459
Operating Expenses	1,345,966	1,503,581	1,640,525	1,609,356	1,601,691 *
General Fund	652,128	677,693	722,942	728,404	730,699
Cash Funds	15,244	71,657	53,049	59,177	53,049
Reappropriated Funds	0	0	78,257	23,910	23,910
Federal Funds	678,594	754,231	786,277	797,865	794,033
Legal and Third Party Recovery Legal Services	816,265	903,975	1,049,982	1,049,982	1,049,982
General Fund	316,867	334,195	355,006	355,006	355,006
Cash Funds	89,525	123,284	169,986	169,986	169,986
Reappropriated Funds	0	0	0	0	0
Federal Funds	409,873	446,496	524,990	524,990	524,990
Administrative Law Judge Services	442,378	449,127	510,957	532,168	532,168
General Fund	206,884	199,865	212,115	222,721	222,721
Cash Funds	14,305	24,698	43,364	43,364	43,364
Federal Funds	221,189	224,564	255,478	266,083	266,083
Purchase of Services from Computer Center	298,151	835,844	1,001,906	852,266	852,266
General Fund	145,739	414,547	496,930	418,823	418,823
Cash Funds	0	0	0	0	0
Reappropriated Funds	3,337	3,375	4,046	4,046	4,046
Federal Funds	149,075	417,922	500,930	429,397	429,397

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
Multiuse Network Payments	160,412	227,900	245,162	98,881	98,881	
General Fund	80,206	113,950	122,581	49,440	49,440	
Federal Funds	80,206	113,950	122,581	49,441	49,441	
COFRS Modernization	0	0	1,006,098	1,006,098	1,006,098	
General Fund	0	0	329,397	329,397	329,397	
Cash Funds	0	0	173,190	173,190	173,190	
Reappropriated Funds	0	0	2,052	2,052	2,052	
Federal Funds	0	0	501,459	501,459	501,459	
Management and Administration of OIT	561,419	631,234	0	48,307	48,307	
General Fund	280,710	315,617	0	24,154	24,154	
Federal Funds	280,709	315,617	0	24,153	24,153	
Payment to Risk Management and Property Funds	24,418	77,888	123,841	133,491	172,888	
General Fund	12,209	38,944	61,921	66,746	86,445	
Federal Funds	12,209	38,944	61,920	66,745	86,443	
Leased Space	554,505	628,141	675,394	849,549	788,679	*
General Fund	173,962	197,846	235,734	319,956	289,521	
Cash Funds	103,290	116,224	101,964	104,820	104,820	
Federal Funds	277,253	314,071	337,696	424,773	394,338	
Capitol Complex Leased Space	388,228	397,925	394,600	490,321	490,321	
General Fund	194,114	198,962	197,300	245,161	245,161	
Federal Funds	194,114	198,963	197,300	245,160	245,160	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
General Professional Services and Special Projects	2,963,577	3,971,819	6,116,532	8,192,552	8,192,552 *
General Fund	1,074,923	1,094,416	1,400,408	2,407,418	2,407,418
Cash Funds	310,465	449,206	437,500	468,500	468,500
Federal Funds	1,578,189	2,428,197	4,278,624	5,316,634	5,316,634
SUBTOTAL - (A) General Administration	29,035,234	33,283,634	39,063,180	44,351,262	42,953,706
FTE	270.6	293.4	327.1	340.0	337.0
General Fund	11,586,438	12,310,704	13,487,282	16,367,008	15,153,738
Cash Funds	2,088,478	2,509,382	3,294,224	3,551,090	3,330,274
Reappropriated Funds	559,152	451,664	1,444,984	1,205,838	1,891,603
Federal Funds	14,801,166	18,011,884	20,836,690	23,227,326	22,578,091
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,707,033	4,671,998	5,205,465	5,036,275	5,036,275
General Fund	1,443,433	1,438,076	1,568,883	1,516,210	1,516,210
Federal Funds	3,263,600	3,233,922	3,636,582	3,520,065	3,520,065
Life Safety Code Inspections for Health Facilities, Transfer to Department of Public Safety	0	0	0	336,639	336,639
General Fund	0	0	0	114,694	114,694
Federal Funds	0	0	0	221,945	221,945
Nurse Home Visitor Program, Transfer to the Department of Public Health and Environment	1,064,517	1,001,532	3,010,000	3,010,000	3,010,000
General Fund	0	0	0	0	0
Reappropriated Funds	429,287	500,766	1,505,000	1,505,000	1,505,000
Federal Funds	635,230	500,766	1,505,000	1,505,000	1,505,000

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	0	0	5,887	5,887	5,887
General Fund	0	0	2,944	2,944	2,944
Federal Funds	0	0	2,943	2,943	2,943
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	325,343	324,041	324,041	324,041	324,041
General Fund	148,020	147,369	147,369	147,369	147,369
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652
Federal Funds	162,671	162,020	162,020	162,020	162,020
Reviews, Transfer to the Department of Regulatory Agencies	5,998	0	14,000	14,000	4,160
General Fund	2,999	0	7,000	7,000	2,080
Federal Funds	2,999	0	7,000	7,000	2,080
Public School Health Services Administration, Transfer to the Department of Education	71,662	139,649	139,940	142,073	149,999
Reappropriated Funds	0	0	0	0	149,999
Federal Funds	71,662	139,649	139,940	142,073	0
Enhanced Prenatal Care Training, Transfer to the Department of Public Health and Environment	82,286	0	0	0	0
General Fund	41,143	0	0	0	0
Federal Funds	41,143	0	0	0	0

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
SUBTOTAL - (B) Transfers to Other Departments	6,256,839	6,137,220	8,699,333	8,868,915	8,867,001	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	1,635,595	1,585,445	1,726,196	1,788,217	1,783,297	
Reappropriated Funds	443,939	515,418	1,519,652	1,519,652	1,669,651	
Federal Funds	4,177,305	4,036,357	5,453,485	5,561,046	5,414,053	
(C) Information Technology Contracts and Projects						
Information Technology Contracts	23,713,491	29,272,031	33,280,737	36,693,511	34,985,833	*
General Fund	5,498,109	6,054,212	6,561,236	6,829,904	6,829,904	
Cash Funds	642,824	1,269,332	1,643,380	2,211,229	1,784,310	
Reappropriated Funds	100,328	92,163	100,328	100,328	293,350	
Federal Funds	17,472,230	21,856,324	24,975,793	27,552,050	26,078,269	
MMIS Reprocurement Contracted Staff	0	0	0	12,625,032	12,625,032	*
General Fund	0	0	0	1,165,817	1,165,817	
Cash Funds	0	0	0	232,837	232,837	
Federal Funds	0	0	0	11,226,378	11,226,378	
MMIS Reprocurement Contracts	0	0	0	2,999,371	2,999,371	*
General Fund	0	0	0	273,255	273,255	
Cash Funds	0	0	0	54,997	54,997	
Federal Funds	0	0	0	2,671,119	2,671,119	
Fraud Detection Software Contract	164,833	208,931	250,000	250,000	250,000	
General Fund	41,208	54,565	62,500	62,500	62,500	
Federal Funds	123,625	154,366	187,500	187,500	187,500	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
Centralized Eligibility Vendor Contract Project	0	2,556,603	5,098,787	6,149,945	6,149,945	
Cash Funds	0	1,263,293	2,534,204	3,059,783	3,059,783	
Federal Funds	0	1,293,310	2,564,583	3,090,162	3,090,162	
CBMS Modernization Project	0	0	0	1,150,000	1,150,000	*
Reappropriated Funds	0	0	0	1,150,000	1,150,000	
SUBTOTAL - (C) Information Technology Contracts and Projects	23,878,324	32,037,565	38,629,524	59,867,859	58,160,181	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	5,539,317	6,108,777	6,623,736	8,331,476	8,331,476	
Cash Funds	642,824	2,532,625	4,177,584	5,558,846	5,131,927	
Reappropriated Funds	100,328	92,163	100,328	1,250,328	1,443,350	
Federal Funds	17,595,855	23,304,000	27,727,876	44,727,209	43,253,428	
(D) Eligibility Determinations and Client Services						
Medical Identification Cards	110,562	115,591	129,240	129,240	129,240	
General Fund	43,726	52,867	59,203	59,203	59,203	
Cash Funds	10,759	4,132	4,620	4,620	4,620	
Reappropriated Funds	1,593	1,593	1,593	1,593	1,593	
Federal Funds	54,484	56,999	63,824	63,824	63,824	
Contracts for Special Eligibility Determinations	2,141,327	3,509,989	7,943,121	8,327,897	8,327,897	
General Fund	823,747	828,091	873,562	969,756	969,756	
Cash Funds	5,000	661,117	2,806,268	2,806,268	2,806,268	
Federal Funds	1,312,580	2,020,781	4,263,291	4,551,873	4,551,873	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
County Administration	31,110,742	30,602,852	31,427,701	32,164,899	32,164,899	
General Fund	9,201,053	10,157,979	10,373,188	10,594,347	10,594,347	
Cash Funds	6,354,318	5,299,296	5,380,796	5,528,236	5,528,236	
Federal Funds	15,555,371	15,145,577	15,673,717	16,042,316	16,042,316	
Hospital Provider Fee County Administration	0	1,939,544	2,581,071	2,581,071	2,581,071	
Cash Funds	0	969,772	1,290,536	1,290,536	1,290,536	
Federal Funds	0	969,772	1,290,535	1,290,535	1,290,535	
Administrative Case Management	1,115,944	1,391,668	869,744	869,744	869,744	
General Fund	557,972	695,834	434,872	434,872	434,872	
Federal Funds	557,972	695,834	434,872	434,872	434,872	
Customer Outreach	3,912,885	4,694,853	4,927,018	5,315,949	5,315,949	*
General Fund	1,882,676	2,259,497	2,376,649	2,571,114	2,571,114	
Cash Funds	73,766	101,362	86,861	86,861	86,861	
Federal Funds	1,956,443	2,333,994	2,463,508	2,657,974	2,657,974	
SUBTOTAL - (D) Eligibility Determinations and Client Services	38,391,460	42,254,497	47,877,895	49,388,800	49,388,800	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	12,509,174	13,994,268	14,117,474	14,629,292	14,629,292	
Cash Funds	6,443,843	7,035,679	9,569,081	9,716,521	9,716,521	
Reappropriated Funds	1,593	1,593	1,593	1,593	1,593	
Federal Funds	19,436,850	21,222,957	24,189,747	25,041,394	25,041,394	

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	4,802,408	6,384,617	8,414,451	8,972,307	8,617,307 *
General Fund	1,345,699	1,806,527	2,225,370	2,276,084	2,276,084
Cash Funds	71,505	57,620	114,332	203,082	114,332
Federal Funds	3,385,204	4,520,470	6,074,749	6,493,141	6,226,891
SUBTOTAL - (E) Utilization and Quality Review Contracts	4,802,408	6,384,617	8,414,451	8,972,307	8,617,307
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,345,699	1,806,527	2,225,370	2,276,084	2,276,084
Cash Funds	71,505	57,620	114,332	203,082	114,332
Federal Funds	3,385,204	4,520,470	6,074,749	6,493,141	6,226,891
(F) Provider Audits and Services					
Professional Audit Contracts	2,202,544	1,841,190	2,463,406	3,051,907	3,051,907
General Fund	1,017,368	908,175	969,283	1,116,408	1,116,408
Cash Funds	58,096	12,420	262,420	365,408	365,408
Federal Funds	1,127,080	920,595	1,231,703	1,570,091	1,570,091
SUBTOTAL - (F) Provider Audits and Services	2,202,544	1,841,190	2,463,406	3,051,907	3,051,907
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,017,368	908,175	969,283	1,116,408	1,116,408
Cash Funds	58,096	12,420	262,420	365,408	365,408
Federal Funds	1,127,080	920,595	1,231,703	1,570,091	1,570,091

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	351,102	315,578	700,000	700,000	700,000
Cash Funds	175,551	157,789	350,000	350,000	350,000
Federal Funds	175,551	157,789	350,000	350,000	350,000
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	351,102	315,578	700,000	700,000	700,000
FTE	0.0	0.0	0.0	0.0	0.0
Cash Funds	175,551	157,789	350,000	350,000	350,000
Federal Funds	175,551	157,789	350,000	350,000	350,000
(H) Indirect Cost Assessment					
Indirect Cost Assessment	0	0	0	0	546,883
Cash Funds	0	0	0	0	121,193
Reappropriated Funds	0	0	0	0	29,596
Federal Funds	0	0	0	0	396,094
SUBTOTAL - (H) Indirect Cost Assessment	0	0	0	0	546,883
FTE	0.0	0.0	0.0	0.0	0.0
Cash Funds	0	0	0	0	121,193
Reappropriated Funds	0	0	0	0	29,596
Federal Funds	0	0	0	0	396,094

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
TOTAL - (1) Executive Director's Office	104,917,911	122,254,301	145,847,789	175,201,050	172,285,785
FTE	270.6	293.4	327.1	340.0	337.0
General Fund	33,633,591	36,713,896	39,149,341	44,508,485	43,290,295
Cash Funds	9,480,297	12,305,515	17,767,641	19,744,947	19,129,655
Reappropriated Funds	1,105,012	1,060,838	3,066,557	3,977,411	5,035,793
Federal Funds	60,699,011	72,174,052	85,864,250	106,970,207	104,830,042

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,395,627,672	3,642,032,762	3,943,639,708	4,351,500,744	4,320,626,461 *
General Fund	601,033,287	833,239,176	1,039,077,145	1,178,401,651	1,178,929,912
General Fund Exempt	279,344,485	373,508,751	312,202,624	312,202,624	312,202,624
Cash Funds	518,533,477	629,762,743	640,554,167	627,024,919	683,956,250
Reappropriated Funds	7,414,327	6,445,828	3,215,340	1,215,340	1,229,854
Federal Funds	1,989,302,096	1,799,076,264	1,948,590,432	2,232,656,210	2,144,307,821
TOTAL - (2) Medical Services Premiums	3,395,627,672	3,642,032,762	3,943,639,708	4,351,500,744	4,320,626,461
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	601,033,287	833,239,176	1,039,077,145	1,178,401,651	1,178,929,912
General Fund Exempt	279,344,485	373,508,751	312,202,624	312,202,624	312,202,624
Cash Funds	518,533,477	629,762,743	640,554,167	627,024,919	683,956,250
Reappropriated Funds	7,414,327	6,445,828	3,215,340	1,215,340	1,229,854
Federal Funds	1,989,302,096	1,799,076,264	1,948,590,432	2,232,656,210	2,144,307,821

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
(4) INDIGENT CARE PROGRAM					
Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women ineligible for Medicaid, and provides grants to providers to improve access to primary and preventative care for the indigent population.					
Safety Net Provider Payments	289,889,142	288,633,447	299,175,424	287,055,532	311,296,186
Cash Funds	130,867,920	144,316,724	149,587,712	143,527,766	155,648,093
Federal Funds	159,021,222	144,316,723	149,587,712	143,527,766	155,648,093
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
General Fund	2,465,822	3,059,880	3,059,880	3,059,880	3,059,880
Federal Funds	3,653,938	3,059,880	3,059,880	3,059,880	3,059,880
Health Care Services Fund Programs	29,635,144	23,510,000	0	0	0
Cash Funds	11,909,853	11,755,000	0	0	0
Federal Funds	17,725,291	11,755,000	0	0	0
Pediatric Specialty Hospital	14,755,860	11,799,938	11,799,938	11,799,938	11,799,938
General Fund	5,201,789	5,899,969	5,899,969	5,899,969	5,899,969
Cash Funds	307,000	0	0	0	0
Reappropriated Funds	436,728	0	0	0	0
Federal Funds	8,810,343	5,899,969	5,899,969	5,899,969	5,899,969
General Fund Appropriation to Pediatric Specialty Hospital	436,728	0	0	0	0
General Fund Exempt	436,728	0	0	0	0

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
Appropriation from Tobacco Tax Fund to the General Fund	436,728	445,214	441,600	441,600	438,300
Cash Funds	436,728	445,214	441,600	441,600	438,300
Primary Care Fund	0	0	27,968,000	27,968,000	27,759,000
Cash Funds	0	0	27,968,000	27,968,000	27,759,000
Primary Care Grant Program Special Distribution	3,560,000	2,135,830	0	0	0
Cash Funds	3,560,000	2,135,830	0	0	0
Children's Basic Health Plan Administration	4,679,134	4,759,499	5,134,993	4,319,079	4,319,079
General Fund	0	272,494	0	0	0
Cash Funds	2,107,643	1,941,946	2,305,152	2,019,582	2,019,582
Federal Funds	2,571,491	2,545,059	2,829,841	2,299,497	2,299,497
Children's Basic Health Plan Medical and Dental Costs	177,283,900	182,454,122	206,969,361	196,138,239	194,274,465
General Fund	0	29,413,207	29,398,182	22,131,064	22,131,064
General Fund Exempt	0	446,100	441,600	441,600	438,300
Cash Funds	55,483,090	35,148,096	43,441,872	47,039,412	46,390,391
Reappropriated Funds	6,856,880	0	0	0	0
Federal Funds	114,943,930	117,446,719	133,687,707	126,526,163	125,314,710
Comprehensive Primary and Preventive Care Grants	0	0	0	0	0
Cash Funds	0	0	0	0	0
Children's Basic Health Plan Trust	14,016,193	0	0	0	0
General Fund	14,016,193	0	0	0	0

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation
TOTAL - (4) Indigent Care Program	540,812,589	519,857,810	557,609,076	533,842,148	556,006,728
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	21,683,804	38,645,550	38,358,031	31,090,913	31,090,913
General Fund Exempt	436,728	446,100	441,600	441,600	438,300
Cash Funds	204,672,234	195,742,810	223,744,336	220,996,360	232,255,366
Reappropriated Funds	7,293,608	0	0	0	0
Federal Funds	306,726,215	285,023,350	295,065,109	281,313,275	292,222,149

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

	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Appropriation	FY 2013-14 Request	FY 2013-14 Recommendation	
Medicare Modernization Act State Contribution Payment	72,377,768	93,582,494	101,888,629	111,278,217	107,173,869	*
General Fund	58,711,725	62,939,212	52,207,622	62,229,522	82,492,862	
Federal Funds	13,666,043	30,643,282	49,681,007	49,048,695	24,681,007	
Public School Health Services Contract Administration	799,699	824,064	2,339,025	2,491,722	2,491,722	*
Federal Funds	799,699	824,064	2,339,025	2,491,722	2,491,722	
Public School Health Services	24,659,097	46,873,870	51,300,028	54,353,956	54,353,956	*
Cash Funds	11,302,888	22,390,960	25,650,014	27,176,978	27,176,978	
Federal Funds	13,356,209	24,482,910	25,650,014	27,176,978	27,176,978	
TOTAL - (5) Other Medical Services	110,290,101	154,634,818	169,733,787	184,730,000	178,225,652	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	60,423,086	65,042,264	54,310,674	66,732,574	84,595,914	
Cash Funds	19,509,080	31,539,245	35,650,014	37,176,978	37,176,978	
Federal Funds	30,357,935	58,053,309	79,773,099	80,820,448	56,452,760	
TOTAL - Department of Health Care Policy and Financing	4,151,648,273	4,438,779,691	4,816,830,360	5,245,273,942	5,227,144,626	
FTE	270.6	293.4	327.1	340.0	337.0	
General Fund	716,773,768	973,640,886	1,170,895,191	1,320,733,623	1,337,907,034	
General Fund Exempt	279,781,213	373,954,851	312,644,224	312,644,224	312,640,924	
Cash Funds	752,195,088	869,350,313	917,716,158	904,943,204	972,518,249	
Reappropriated Funds	15,812,947	7,506,666	6,281,897	5,192,751	6,265,647	
Federal Funds	2,387,085,257	2,214,326,975	2,409,292,890	2,701,760,140	2,597,812,772	

Appendix B: Provider Rate History

MEDICAID RATE METHDOLOGY CHANGE HISTORY	FY 2000-01 (Methodology in Place)	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14 (Proposed)
ACUTE CARE														
Physician Services and Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	Medicaid fee schedule	(No change)	(No change)	(No change)	(No change)	2% increase (Top 9 E&M codes to 80% of Medicare rate)	3.25% increase (top 25 E&M codes)	Targeted rate increases for selected services	E&M Codes to 90% of Medicare rates Targeted rate increases for selected services, including: Medical Home Substance Abuse ~~Prenatal Plus~~	Eff. July 2009: 2% decrease (certain services only). Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	ACA 1202 Primary Care Physician Rate Increase (Effective January 1, 2013, fiscal impact to be revised based on CMS requirements) Eff. July 2013: 1.5% increase
Emergency Transportation	Medicaid fee schedule	(No change)	5% decrease	(No change)	(No change)	(No change)	(No change)	5% increase	(No change)	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Non-emergency Medical Transportation	Medicaid fee schedule	(No change)	5% decrease	(No change)	Moved to Executive Director's Office as Administrative Service	(No change)	2.57% increase Some services moved to a fixed price contract	31% increase in fee-for-service rates; fixed priced contracts unaffected	(No change)	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease (non metro county impact only)	(No Change)	Eff. July 2013: 1.5% increase (non metro only)
Dental Services	68% of 1999 ADA mean	(No change)	(No change)	(No change)	(No change)	(No change)	3.25% increase	(No change)	Rates set at 52% of the 2008 ADA mean	Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Family Planning	Medicaid fee schedule	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Targeted rate increases for selected services	(No change)	(No change)	Eff. July 2010: 1% decrease	(No change)	(No Change)	Eff. July 2013: 1.5% increase
Health Maintenance Organizations	95% of FFS (Acute Care only)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Rates at 99% of FFS One-Time Quality incentive payment added	Rates at 100% of FFS	Rates decreased commensurate with FFS reductions	Rates decreased commensurate with FFS reductions Assumed 0.80% decrease	Rates decreased commensurate with FFS reductions	(No Change)	Rates increase commensurate with FFS increases
Inpatient Hospitals	Rates rebased on Medicaid cost reports every there years; inflationary increase in intervening years.	(No change)	Rural hospitals: 2% decrease Urbran, rehabilitation, and pediatric hospitals, 6.98% decrease Critical Access Hospitals held harmless	Hospital rates required to be budget neutral to FY 2002-03 rates, plus caseload increase and case-mix adjustment	1% Reduction ($3.1 million total)	2% increase (July 2005) 1% increase (April 2006)	3.25% increase	1.5% increase	1.5% increase	Eff. July 2009: 3% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease. HB 09-1293: Hospitals paid at 100% of cost via supplemetal payments (with provider fee funds)	Eff. July 2010: 1% decrease	Reduce Payment for Uncomplicated Cesarean Section Deliveries; Reduce Payment for Renal Dialysis; Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Outpatient Hospitals	72% of cost	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Increase to PT/OT/ST rates (Approx. 9.05%)	(No change)	Eff. July 2009: Out of state reimbursement lowered to 30% of billed charges Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease. HB 09-1293: Hospitals paid at 100% of cost via supplemetal payments (with provider fee funds)	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Lab & X-Ray	Medicaid fee schedule	(No change)	5% decrease	(No change)	(No change)	(No change)	(No change)	(No change)	17.7% increase to Radiology services	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Durable Medical Equipment	Lesser of Medicaid fee schedule, or submitted charge + a handling fee	(No change)	5% decrease	(No change)	$747,000 reduction (wheelchair replacements)	2.25% increase to fee-schedule (April 1, 2006)	3.25% increase to fee-schedule 1% increase to cost-based services	Targeted rate increases for selected services	Targeted rate increases for selected services	Eff. July 2009: 1.97% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Reduce Rates for Certain Diabetes Supplies (blood glucose/reagent strips); Reduce rate for negative pressure wound therapy equipment Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Prescription Drugs*	AWP - 10%	*July 2003 - March 2004* AWP - 11% *April - June 2004* AWP - 12%	*July - Sept. 2003* Brand: AWP - 14% Generic: AWP - 45% *October - June, 2004* Brand: AWP - 13.5% Generic: AWP - 35%	Brand: AWP - 13.5% Generic: AWP - 35%	(No change)	Implementation of the Medicare Modernization Act (Most prescription drugs for dual eligibles covered by Medicare) (January 1, 2006)	(No change)	(No change)	(No change)	Eff. July 2009: AWP - 14% (Brand), AWP - 40% (Generic) Eff. Sept. 2009: AWP - 14.5% (Brand), AWP - 45% (Generic)	(No change)	State Maximum Allowable Cost Expansion resulting in aggregate decrease in reimburement of $2,000,000 annually	AAC transition revised estimate in FY 2013-14 R-1 - $7 million reduction	Annualized impact of AAC transition $14 million reduction
Drug Rebate	CMS rebate schedule	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Implementation of PDL; Department receives supplemental rebates on preferred drugs	(No change)	(No change)	(No change)	(No Change)	(No Change)
Rural Health Centers	100% of cost (Effective January 1, 2001)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No Change)	Eff. July 2013: 1.5% increase
Federally Qualified Health Centers	Encounter rate based on audited provider cost (Effective January 1, 2001)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Eff. Sept. 2009: Rates decreased ~5%, by adjusting to halfway between BIPA rate and Department "Alternative Rate"	(No change)	(No change)	(No Change)	Eff. July 2013: 1.5% increase
Co-Insurance (Title XVIII-Medicare)	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Per Medicare	Eff. July 2010: 1% decrease	(No change)	(No Change)	(No Change)
Breast and Cervical Cancer Treatment Program	-	-	FFS rates	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Rates decreased commensurate with other FFS reductions Assumed 0.80% decrease	Eff. July 2011: 0.75% decrease	(No Change)	(No Change)
Administrative Service Organizations - Services	-	-	-	FFS rates except some pharmacy	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Rates decreased commensurate with other FFS reductions Assumed 0.80% decrease	Eff. July 2011: 0.75% decrease	(No Change)	(No Change)

Appendix B: Provider Rate History

MEDICAID RATE METHDOLOGY CHANGE HISTORY	FY 2000-01 (Methodology in Place)	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14 (Proposed)
Home Health	Medicaid fee schedule	Home Health Aides, 3% increase; Home Health Skilled Nursing, 3% increase	(No change)	(No change)	(No change)	2% increase (July 2005) Physical therapy 36.3% increase; Occupational therapy 29.2% increase; Speech therapy 35.9% increase; Skilled Nursing, 7.20% increase; Home Health Aides, 4.20% increase; (April 2006)	Physical therapy 23.6% increase; Occupational therapy 23.6% increase; Speech therapy 23.6% increase; Skilled Nursing, 23.6% increase (April 2007)	1.5% increase	1.5% increase	Eff. July 2009: 2% decrease (certain services only). Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Presumptive Eligibility	-	-	-	-	-	FFS rates (cost settled)	(No change)	End of administrative contract; claims paid fee-for-service effective January 2008	(No change)	(No change)	Rates decreased commensurate with other FFS reductions Assumed 0.80% decrease	Eff. July 2011: 0.75% decrease	(No Change)	(No Change)
COMMUNITY BASED LONG TERM CARE														
HCBS - Elderly, Blind, and Disabled HCBS - Mental Illness HCBS - Disabled Children HCBS - Persons Living with AIDS HCBS - Consumer Directed Attendant Support HCBS - Brain Injury HCBS - Children with Autism HCBS - Pediatric Hospice	Medicaid fee schedule	Alternative Care Facility, 12.5% increase; Personal Care Homemaker, 11.6% increase; Home Health Aides, 3% increase; Adult Day Care and Home Health Skilled Nursing, 3% increase	(No change)	(No change)	(No change)	2% increase (July 2005) Assisted Living Facilities, 15.07% increase; Adult Day Care services, 3.57% increase; Skilled Nursing, 7.20% increase; Home Health Aides, 4.20% increase; Personal Care Homemaker, 10% increase. (April 2006)	Assisted Living Facilities, 12.5% increase; Adult Day Care services, 1% increase; Skilled Nursing, 23.6% increase (April 2007)	1.5% increase Implementation of Children with Autism and Pediatric Hospice waiver.	1.5% increase	Eff. July 2009: 2% decrease (certain services only). Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease. Limits to non-medical transportation trips	Eff. July 2010: 1% decrease	Cap Consumer Directed Attendant Support Services Wage Rates Eff. July 2011: 0.50% decrease	(No Change)	Eff. July 2013: 1.5% increase with exception of Children with Autism Waiver
Private Duty Nursing	Medicaid fee schedule	1% increase	5% decrease	(No change)	Decrease to maximum allowable hours (no rate change)	Registered nursing 3.8% increase Licensed nursing 8% increase (April 2006)	Registered nursing 23.4% increase Licensed nursing 23.6% increase (April 2006)	1.5% increase	1.5% increase	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
Hospice	Medicare rate; Room and Board costs are set at 95% of Class I Nursing Facility Rate (per federal law)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Eff. July 2011: 0.75% decrease	(No Change)	Eff. July 2013: 1.5% increase
LONG TERM CARE and INSURANCE														
Class I Nursing Facilities**	Case-mix adjusted cost-based per diem rate with 8% health care cost cap and 6% admin cost cap	8% health care cost cap removed	Administrative Incentive Allowance removed for 3 months	(No change)	8% health care cost cap reinstated	(No change)	Partial removal of 8% health care cost cap; rate floor of 85% of statewide average or 10% increase from prior year	8% health care cost cap reinstated; rate floor removed. Grant program established for providers affected by the removal of the rate floor.	Comprehensive changes to NF rates (HB 08-1114). Imposition of provider fee, added pay-for-performance, severe behavorial add-on, caps on indirect health, food, and administration. Instituted General Fund cap on expenditure growth. Not effective until approval of Federal Waiver (pending)	SB 09-263: Converted add-on payments to Supplemental payments; limited GF growth to 0% in FY 2009-10; limited provider fee to $7.50; imposed 8% cap on direct and indirect health care Eff. March 2010: 1.5% rate decrease	Eff. July 2010: 1% decrease (HB 10-1379)	Eff. July 1.5% decrease (SB 11-215)	Eff. July 2012: 1.5% rate reduction (HB 12-1340)	(No Change)
Class II Nursing Facilities	Cost-based per diem rate	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Eff. July 2010: 1% decrease	(No change)	(No change)	(No change)
Program for All-Inclusive Care for the Elderly	95% of FFS, including nursing facility and HCBS costs	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	Rates increased to maximum of 100% FFS.	Rates decreased commensurate with FFS reductions	Rates decreased commensurate with FFS reductions Assumed 0.84% decrease	Rates decreased commensurate with FFS reductions	Eff. July 2012: Rates decrease commensurate with FFS reductions	Eff. July 2013: Rates increase commensurate with FFS increases
Supplemental Medicare Insurance Beneficiaries	Published Medicare Part A and Part B rates	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No Change)	(No Change)
Health Insurance Buy-In Program	Premium charges	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	(No Change)	(No Change)
SERVICE MANAGEMENT														
Single Entry Points	Fixed rate per client	(No change)	(No change)	(No change)	(No change)	(No change)	(No change)	20.5% increase	Inflationary increase based on caseload	Eff. July 2009: 2% decrease. Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	Eff. July 2010: 1% decrease	(No change)	(No Change)	(No Change)
Disease Management	-	-	-	-	Fixed contracts	(No change)	(No change)	(No change)	Disease management programs ceased in early 2009; Tobacco tax funding was used as GF offset	(No change)	(No change)	(No change)	(No Change)	(No Change)
Administrative Service Organization Administrative Fee	-	-	-	-	Varied by Provider (Between $21.55 and $22 per member per month)	(No change)	$25 per member per month	(No change)	(No change)	Eff. Sept. 2009: 1.5% decrease. Eff. Dec. 2009: 1% decrease.	(No change)	(No change)	(No Change)	(No Change)

* Presciption Drugs AWP: "Average Wholesale Price." All prescription drug claims include a dispensing fee paid to the provider, and are reduced for patient copayment. Pharmacy claims may also be priced at the maximum allowable federal or state cost, or at the charge submitted by the pharmacy if that charge is less than the standing pricing methodology.

**Rate reductions for this service category typically expire after one year and rates revert back to the cost-based reimbursement methodology

Appendix B: Provider Rates

Service Category	FY 2011-12 Actuals*	Percent of Service Group	Base Appropriation	Adjustments	Remaining Appropriation	Percent Remaining in FY	Total Available for Rate Increase	Notes
ACUTE CARE								
Physician Services & EPSDT	$287,020,239	15.97%	$342,154,965	($119,754,238)	$222,400,727	94.00%	$209,056,683	A portion of expenditure is not eligible for the increase due to duplication with Section 1202 of the Affordable Care Act.
Emergency Transportation	$6,361,058	0.35%	$7,582,976		$7,582,976	94.00%	$7,127,997	
Non-emergency Medical Transportation	$10,462,166	0.58%	$12,471,880	($6,000,000)	$6,471,880	94.00%	$6,083,567	A portion of expenditure in this service category is not eligible for an increase due to services being rendered under a fixed price contract.
Dental Services	$103,911,787	5.78%	$123,872,567		$123,872,567	94.00%	$116,440,213	
Family Planning	$578,957	0.03%	$690,171	($690,171)	$0	94.00%	$0	This service has historically been excluded from rate reductions due to the financing sources.
Health Maintenance Organizations	$120,715,911	6.72%	$143,904,654		$143,904,654	94.00%	$135,270,375	
Inpatient Hospitals	$362,502,617	20.17%	$432,137,018		$432,137,018	94.00%	$406,208,797	
Outpatient Hospitals	$232,479,846	12.93%	$277,137,716		$277,137,716	94.00%	$260,509,453	
Lab & X-Ray	$39,978,003	2.22%	$47,657,518		$47,657,518	94.00%	$44,798,067	
Durable Medical Equipment	$93,706,452	5.21%	$111,706,853	$0	$111,706,853	94.00%	$105,004,442	
Prescription Drugs	$318,741,461	17.73%	$379,969,628	($379,969,628)	$0	94.00%	$0	Pharmacy reimbursement is not eligible for the increase - see narrative.
Drug Rebate	($149,787,193)	-8.33%	($178,560,341)	$178,560,341	$0	94.00%	$0	Drug rebates are not affected by changes in provider rates.
Rural Health Centers	$10,567,916	0.59%	$12,597,944		$12,597,944	94.00%	$11,842,067	
Federally Qualified Health Centers	$94,790,483	5.27%	$112,999,120		$112,999,120	94.00%	$106,219,173	
Co-Insurance (Title XVIII-Medicare)	$37,036,552	2.06%	$44,151,033		$44,151,033	94.00%	$41,501,971	
Breast and Cervical Cancer Treatment Program	$10,272,613	0.57%	$12,245,915		$12,245,915	94.00%	$11,511,160	
Prepaid Inpatient Health Plan Services	$56,463,119	3.14%	$67,309,318		$67,309,318	94.00%	$63,270,759	
Other Medical Services	$15,295	0.00%	$18,233	($18,233)	$0	94.00%	$0	
Home Health	$161,607,733	8.99%	$192,651,530		$192,651,530	94.00%	$181,092,438	
Presumptive Eligibility	$0	0.00%	$0		$0	94.00%	$0	
Subtotal of Acute Care	$1,797,425,015	100.00%	$2,142,698,698	($327,871,928)	$1,814,826,770	94.00%	$1,705,937,164	
COMMUNITY BASED LONG TERM CARE								
HCBS - Elderly, Blind, and Disabled	$225,185,711	65.18%	$261,779,980		$261,779,980	94.00%	$246,073,182	
HCBS - Mental Illness	$25,934,255	7.51%	$30,148,755		$30,148,755	94.00%	$28,339,829	
HCBS - Disabled Children	$3,130,073	0.91%	$3,638,732		$3,638,732	94.00%	$3,420,408	
HCBS - Persons Living with AIDS	$516,036	0.15%	$599,895		$599,895	94.00%	$563,902	
HCBS - Consumer Directed Attendant Support	$3,461,683	1.00%	$4,024,231		$4,024,231	94.00%	$3,782,777	
HCBS - Brain Injury	$12,587,131	3.64%	$14,632,629		$14,632,629	94.00%	$13,754,671	
HCBS - Children with Autism	$1,022,387	0.30%	$1,188,532	($1,188,532)	$0	94.00%	$0	This service has historically been excluded from rate reductions to the financing sources.
HCBS - Pediatric Hospice	$170,910	0.05%	$198,684		$198,684	94.00%	$186,763	
Private Duty Nursing	$31,144,153	9.01%	$36,205,298		$36,205,298	94.00%	$34,032,980	
Hospice	$42,326,808	12.25%	$49,205,213	($36,600,000)	$12,605,213	94.00%	$11,848,901	A portion of expenditure in this service category is not eligible for an increase due to rates being directly tied to skilled nursing facility rates.
Subtotal of Community Based Long Term Care	$345,479,147	100.00%	$401,621,950	($37,788,532)	$363,833,418	94.00%	$342,003,413	
LONG TERM CARE and INSURANCE								
Class I Nursing Facilities	$521,244,769	100.00%	$577,832,319	($577,832,319)	$0	94.00%	$0	Prior year rate reductions do not apply to FY 2013-14 for this service; a rate increase is not needed.
Class II Nursing Facilities	$2,499,074	100.00%	$4,721,954	($4,721,954)	$0	94.00%	$0	Prior year rate reductions do not apply to FY 2013-14 for this service; a rate increase is not needed.
Program for All-Inclusive Care for the Elderly	$85,480,585	100.00%	$125,586,211	($30,329,340)	$95,256,871	94.00%	$89,541,459	PACE rates are a blend of rates in other service categories. The impact on PACE is different than other service Categories as a result.
Subtotal Long Term Care	$566,372,167	100.00%	$708,140,484	($612,883,614)	$95,256,871	94.00%	$89,541,459	
Supplemental Medicare Insurance Benefit	$118,598,927	100.00%	$133,862,139	($133,862,139)	$0	94.00%	$0	Medicare premiums are not impacted by Medicaid rates.
Health Insurance Buy-In Program	$1,159,307	100.00%	$6,175,855	($6,175,855)	$0	94.00%	$0	Third part insurance premiums are not impacted by Medicaid rates.
Subtotal Insurance	$119,758,234	100.00%	$140,037,994	($140,037,994)	$0	94.00%	$0	
Subtotal of Long Term Care and Insurance	$686,130,401	100.00%	$848,178,478	($752,921,608)	$95,256,871	94.00%	$89,541,459	
SERVICE MANAGEMENT								
Single Entry Points		100.00%	$28,279,251	$0	$28,279,251	94.00%	$26,582,496	
Disease Management		100.00%	$1,185,736	($1,185,736)	$0	94.00%	$0	These services are not eligible for rate increases.
Prepaid Inpatient Health Plan Administration		100.00%	$65,413,795	($57,109,503)	$8,304,292	94.00%	$7,806,034	Only applied to RMHP
Subtotal Service Management	$28,890,920	100.00%	$94,878,782	($58,295,239)	$36,583,543	94.00%	$34,388,530	
TOTAL MEDICAL SERVICES PREMIUMS	$2,857,925,483	100.00%	$3,487,377,908	($1,176,877,307)	$2,310,500,601	94.00%	$2,171,870,565	

Department of Health Care Policy and Financing					
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Appropriation:					
HB 12-1335 (Long Bill)	4,797,361,220	1,492,220,746	911,415,955	5,284,242	2,388,440,277
H.B. 12-1246 Reverse biweekly payday shift	28,498	28,498	0	0	0
H.B. 12-1281 Payment reform pilot	213,079	106,540	0	0	106,539
S.B. 12-060 Medicaid fraud	(48,940)	0	(24,470)	0	(24,470)
H.B. 12-1339 CBMS improvements	997,655		0	997,655	0
Recommended Long Bill Supplemental	(5,908,142)	(7,659,472)	(3,707,513)	0	5,458,843
S.B. 12-159 Autism waiver	6,925	0	3,463	0	3,462
H.B. 12-1340 Nursing facility rates	(9,024,676)	(4,512,338)	0	0	(4,512,338)
S.B. 13-089 Supplemental	33,204,741	3,355,441	10,028,723	0	19,820,577
TOTAL	**$4,816,830,360**	**$1,483,539,415**	**$917,716,158**	**$6,281,897**	**$2,409,292,890**
FY 2013-14 Recommended Appropriation:					
FY 2012-13 Appropriation	4,816,830,360	1,483,539,415	917,716,158	6,281,897	2,409,292,890
Anualize prior year budget decisions	(9,796,273)	16,043,263	(15,749,414)	(2,172,221)	(7,917,901)
SB 11-212 Hospital Provider Fee offset of GF	0	25,000,000	(25,000,000)	0	0
R-1: Medical Service Premiums	305,344,710	84,844,360	67,048,100	0	153,452,250
R3 Childrens Basic Health Plan	36,561,837	(6,261,042)	19,157,583	0	23,665,296
R4 Medicare Modernization Act	5,285,240	5,285,240	0	0	0
R5 MMIS reprocurement	15,624,403	1,439,072	287,834	0	13,897,497
R6 Additional FTE to restore functionality	570,400	285,201	0	0	285,199
R7 Substance use disorder benefit	515,440	38,180	(282)	0	477,542
R9 Dental administrative services organization	1,152,144	288,036	0	0	864,108
R10 Leased space rent increase and true-up	92,115	92,402	(46,344)	0	46,057
R11 HB 12-1281 Departmental differences	927,423	412,997	0	0	514,426
R12 Customer service technology improvements	1,800,000	900,000	0	0	900,000
R13 Provider rate increase	32,584,290	14,256,080	1,090,255	14,514	17,223,441
BA5 Improve and modernize CBMS	1,150,000	0	0	1,150,000	0
BA6 MMIS operating rules compliance	165,019	36,848	4,902	0	123,269
BA8 MMIS technical adjustments	2,700,653	306,844	41,841	0	2,351,968
BA9 Increase in PASSR Level II rates	384,776	96,194	0	0	288,582
BA12 Public school health services true-up	3,206,625	0	1,526,964	0	1,679,661
BA14 Colorado Choice Transitions	(2,372,278)	(1,186,139)	0	0	(1,186,139)
NP Employee engagement survey adjustment	32,448	16,225	0	0	16,223
NP OIT enterprise asset management	6,260	3,130	0	0	3,130
Centralized approps and technical adjustments	1,617,875	48,781	341,790	433,790	793,514
Dept. of Human Services Medicaid services	93,514	32,730	0	0	60,784
Reallocate CHIPRA to CMTF	0	25,000,000	0	0	(25,000,000)
CICP True-up	12,120,762	0	6,060,381	0	6,060,381
Indirect cost adjustment	546,883	30,141	38,481	557,667	(79,406)
TOTAL	**$5,227,144,626**	**$1,650,547,958**	**$972,518,249**	**$6,265,647**	**$2,597,812,772**
Increase/(Decrease)	**$410,314,266**	**$167,008,543**	**$54,802,091**	**($16,250)**	**$188,519,882**
Percentage Change	8.5%	11.3%	6.0%	-0.3%	7.8%
FY 2013-14 Executive Request:	**$5,245,273,942**	**$1,633,377,847**	**$904,943,204**	**$5,192,751**	**$2,701,760,140**
Request Above/(Below) Recommendation	$18,129,316	($17,170,111)	($67,575,045)	($1,072,896)	$103,947,368

Executive Director's Office	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2012-13 Appropriation:						
HB 12-1335 (Long Bill)	142,765,877	38,598,357	17,740,127	2,068,902	84,358,491	314.3
H.B. 12-1246 Reverse biweekly payday shift	28,498	28,498	0	0	0	0.0
H.B. 12-1281 Payment reform pilot	213,079	106,540	0	0	106,539	0.8
S.B. 12-060 Medicaid fraud	5,216	2,608	0	0	2,608	0.1
H.B. 12-1339 CBMS improvements	997,655		0	997,655	0	11.0
S.B. 13-089 Supplemental	1,837,464	413,338	27,514	0	1,396,612	0.9
TOTAL	**$145,847,789**	**$39,149,341**	**$17,767,641**	**$3,066,557**	**$85,864,250**	**327.1**
FY 2013-14 Recommended Appropriation:						
FY 2012-13 Appropriation	145,847,789	39,149,341	17,767,641	3,066,557	85,864,250	327.1
Anualize prior year budget decisions	(642,913)	(216,191)	847,406	(172,221)	(1,101,907)	0.4
R5 MMIS reprocurement	15,624,403	1,439,072	287,834	0	13,897,497	0.0
R6 Additional FTE to restore functionality	570,400	285,201	0	0	285,199	7.4
R7 Substance use disorder benefit	100,000	50,000	0	0	50,000	0.0
R9 Dental administrative services organization	1,152,144	288,036	0	0	864,108	0.0
R10 Leased space rent increase and true-up	92,115	92,402	(46,344)	0	46,057	0.0
R11 HB 12-1281 Departmental differences	927,423	412,997	0	0	514,426	2.1
R12 Customer service technology improvements	1,800,000	900,000	0	0	900,000	0.0
BA5 Improve and modernize CBMS	1,150,000	0	0	1,150,000	0	0.0
BA6 MMIS operating rules compliance	165,019	36,848	4,902	0	123,269	0.0
BA8 MMIS technical adjustments	2,700,653	306,844	41,841	0	2,351,968	0.0
BA9 Increase in PASSR Level II rates	384,776	96,194	0	0	288,582	0.0
NP Employee engagement survey adjustment	32,448	16,225	0	0	16,223	0.0
NP OIT enterprise asset management	6,260	3,130	0	0	3,130	0.0
Centralized approps and technical adjustments	1,734,871	367,325	187,894	433,790	745,862	0.0
Dept. of Human Services Medicaid services	93,514	32,730	0	0	60,784	0.0
Indirect cost adjustment	546,883	30,141	38,481	557,667	(79,406)	0.0
TOTAL	**$172,285,785**	**$43,290,295**	**$19,129,655**	**$5,035,793**	**$104,830,042**	**337.0**
Increase/(Decrease)	**$26,437,996**	**$4,140,954**	**$1,362,014**	**$1,969,236**	**$18,965,792**	**9.9**
Percentage Change	18.1%	10.6%	7.7%	64.2%	22.1%	3.0%
FY 2013-14 Executive Request:	**$175,201,050**	**$44,508,485**	**$19,744,947**	**$3,977,411**	**$106,970,207**	340.0
Request Above/(Below) Recommendation	$2,915,265	$1,218,190	$615,292	($1,058,382)	$2,140,165	3.0

Medical Services Premiums	Total Funds	General Fund	Cash Funds	Reappropriated	Federal Funds
FY 2012-13 Appropriation:					
HB 12-1335 (Long Bill)	3,994,685,293	1,367,321,247	651,202,864	3,215,340	1,972,945,842
S.B. 12-060 Medicaid fraud	(54,156)	(2,608)	(24,470)	0	(27,078)
Recommended Long Bill Supplemental	(42,266,085)	(11,672,736)	(10,627,690)	0	(19,965,659)
S.B. 12-159 Autism waiver	6,925	0	3,463	0	3,462
H.B. 12-1340 Nursing facility rates	(9,024,676)	(4,512,338)	0	0	(4,512,338)
S.B. 13-089 Supplemental	292,407	146,204	0	0	146,203
TOTAL	**$3,943,639,708**	**$1,351,279,769**	**$640,554,167**	**$3,215,340**	**$1,948,590,432**
FY 2013-14 Recommended Appropriation:					
FY 2012-13 Appropriation	3,943,639,708	1,351,279,769	640,554,167	3,215,340	1,948,590,432
Anualize prior year budget decisions	40,919,287	17,265,530	(98,886)	(2,000,000)	25,752,643
SB 11-212 Hospital Provider Fee offset of GF	0	25,000,000	(25,000,000)	0	0
R-1: Medical Service Premiums	305,344,710	84,844,360	67,048,100	0	153,452,250
R7 Substance use disorder benefit	415,440	(11,820)	(282)	0	427,542
R13 Provider rate increase	32,584,290	14,256,080	1,090,255	14,514	17,223,441
BA14 Colorado Choice Transitions	(2,372,278)	(1,186,139)	0	0	(1,186,139)
Centralized approps and technical adjustments	95,304	(315,244)	362,896	0	47,652
TOTAL	**$4,320,626,461**	**$1,491,132,536**	**$683,956,250**	**$1,229,854**	**$2,144,307,821**
Increase/(Decrease)	**$376,986,753**	**$139,852,767**	**$43,402,083**	**($1,985,486)**	**$195,717,389**
Percentage Change	9.6%	10.3%	6.8%	-61.8%	10.0%
FY 2013-14 Executive Request:	**$4,351,500,744**	**$1,490,604,275**	**$627,024,919**	**$1,215,340**	**$2,232,656,210**
Request Above/(Below) Recommendation	$30,874,283	($528,261)	($56,931,331)	($14,514)	$88,348,389

Indigent Care Program	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation:					
HB 12-1335 (Long Bill)	521,062,876	31,188,804	216,462,809	0	273,411,263
Recommended Long Bill Supplemental	27,525,490	4,814,928	6,920,177	0	15,790,385
S.B. 13-089 Supplemental	9,020,710	2,795,899	361,350	0	5,863,461
TOTAL	**$557,609,076**	**$38,799,631**	**$223,744,336**	**$0**	**$295,065,109**
FY 2013-14 Recommended Appropriation:					
FY 2012-13 Appropriation	557,609,076	38,799,631	223,744,336	0	295,065,109
Anualize prior year budget decisions	(50,072,647)	(1,006,076)	(16,497,934)	0	(32,568,637)
R3 Childrens Basic Health Plan	36,561,837	(6,261,042)	19,157,583	0	23,665,296
CICP True-up	12,120,762	0	6,060,381	0	6,060,381
Centralized approps and technical adjustments	(212,300)	(3,300)	(209,000)	0	0
TOTAL	**$556,006,728**	**$31,529,213**	**$232,255,366**	**$0**	**$292,222,149**
Increase/(Decrease)	**($1,602,348)**	**($7,270,418)**	**$8,511,030**	**$0**	**($2,842,960)**
Percentage Change	-0.3%	-18.7%	3.8%	0.0%	-1.0%
FY 2013-14 Executive Request:	**$533,842,148**	**$31,532,513**	**$220,996,360**	**$0**	**$281,313,275**
Request Above/(Below) Recommendation	($22,164,580)	$3,300	($11,259,006)	$0	($10,908,874)

Other Medical Services	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2012-13 Appropriation:				
HB 12-1335 (Long Bill)	$138,847,174	$55,112,338	$26,010,155	$57,724,681
Recommended Long Bill Supplemental	8,832,453	(801,664)	0	9,634,117
S.B. 13-089 Supplemental	22,054,160		9,639,859	12,414,301
TOTAL	**$169,733,787**	**$54,310,674**	**$35,650,014**	**$79,773,099**
FY 2013-14 Recommended Appropriation:				
FY 2012-13 Appropriation	169,733,787	54,310,674	35,650,014	79,773,099
R4 Medicare Modernization Act	5,285,240	5,285,240	0	0
BA12 Public school health services true-up	3,206,625	0	1,526,964	1,679,661
Reallocate CHIPRA to CMTF	0	25,000,000	0	(25,000,000)
TOTAL	**$178,225,652**	**$84,595,914**	**$37,176,978**	**$56,452,760**
Increase/(Decrease)	**$8,491,865**	**$30,285,240**	**$1,526,964**	**($23,320,339)**
Percentage Change	5.0%	55.8%	4.3%	-29.2%
FY 2013-14 Executive Request:	**$184,730,000**	**$66,732,574**	**$37,176,978**	**$80,820,448**
Request Above/(Below) Recommendation	$6,504,348	($17,863,340)	$0	$24,367,688