The following file contains these documents:

- A memorandum to Joint Budget Committee members dated March 23, 2012 detailing four staff technical comebacks.

- A memorandum to Joint Budget Committee members dated March 16, 2012 summarizing the staff recommendation from figure setting on the tabled item: R5 Fee-for-service reform.

- A memorandum to Joint Budget Committee members dated March 14, 2012 summarizing funding recommendations from committees of reference for the Department of Health Care Policy and Financing (submitted pursuant to the SMART Act).

- A "figure setting" packet dated March 14, 2012, concerning the Department of Health Care Policy and Financing's budget requests for FY 2012-13 (except for Mental Health programs).

M E M O R A N D U M

TO: **Joint Budget Committee**

FROM: **Eric Kurtz (303-866-4952)**

SUBJECT: **Health Care Policy and Financing**
Staff Comebacks

DATE: **March 23, 2012**

1. Staff recommends increasing the General Fund for the Department of Health Care Policy by $62,500 and reducing cash funds from the Hospital Provider Fee by a like amount to correct a technical error in the figure setting presentation.

   Staff recommended, and the JBC approved, an increase of $250,000 total funds for Utilization and Quality Review Contracts, Professional Service Contracts, but staff identified the source of the $62,500 state match for the federal funds as cash funds from the Hospital Provider Fee when it should have been General Fund. The money pays for increased prior authorization reviews associated with a number of different strategies to reduce Medicaid costs that were approved as part of the supplemental.

2. Staff recommends a reduction of $553,964, including $145,991 General Fund, for General Professional Services and for Information Technology Contracts totaling. This money was initially approved by the Committee for consulting and computer programming services necessary to implement new cost sharing initiatives proposed by the Department, but subsequently the Committee approved only the increase in cost sharing for CHP+ and no increase in cost sharing for Medicaid. This staff recommendation is to clear up any potential ambiguity about whether the JBC's action to deny the Medicaid cost sharing initiatives included the necessary adjustments to the General Professional Services and Information Technology Contracts line items.

3. Below is draft language for the new legislative request for information approved by the Committee regarding copayments:

   N **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 copayments 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 copayment requirements on enrollment and utilization.

4. Below are staff recommended modifications to the Legislative Request for Information #5. The Committee approved continuing this request for information, but updating it to reflect

current strategies and initiatives of the Department. Rather than being specific about what the Department is supposed to report on, the staff recommendation leaves the request more open ended.

5 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by ~~November 1, 2011~~ November 1, 2012 to the Joint Budget Committee regarding the Department's efforts to ensure that pharmaceuticals are purchased at the lowest possible price. ~~In the report, the Department is requested to provide cost and savings estimates that may occur on a quarterly basis if the Department did the following:~~

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

M E M O R A N D U M

TO: **Joint Budget Committee**

FROM: **Eric Kurtz, JBC Staff (303-866-4952)**

SUBJECT: **Tabled item from Health Care Policy and Financing Figure Setting -- R5 Fee-for-service Reform**

DATE: **March 16, 2012**

During figure setting for the Department of Health Care Policy and Financing the JBC tabled a decision on R5 Fee-for-service Reform. The text below is an excerpt from the JBC staff figure setting document that discusses the staff recommendation.

R5 Fee-for-service Reform

Request: The Department's top budget priority after adjustments for the new enrollment and expenditure forecast can be divided into three main components:

- implementing "gainsharing" incentive payments;
- studying prospective payments; and,
- studying long-term care reform.

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

For FY 2012-13 the Department will implement gainsharing payments for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Behavioral Health Organizations. The Department projects a 5.0 percent reduction in generic drug utilization, hospital readmissions, outpatient hospital visits, and emergency department visits by clients assigned to FQHCs and RHCs. The Department assumes that 50 percent of the total savings will be paid to the FQHCs and RHCs. The projected savings from gainsharing for Behavioral Health Organizations is related to psychotropic drug utilization.

In the **prospective payment** model providers would receive bundled rates that include money for physician, specialty, and laboratory care, based on expected expenditures for specific conditions, and then providers could retain the savings if actual costs are lower than expected. The prospective payments would be based on the PROMETHEUS model developed by the Health Care Incentives

Improvement Institute (HCI3). The Colorado Business Group on Health (CBGH) conducted an analysis of the Department's payments for 21 specific conditions and concluded that 58 percent of what the Department spends is due to potentially avoidable complications of care. The CBGH recommended that the Department focus on six specific conditions, including diabetes, gastoesopageal reflux disease, asthama, chronic obstructive pulmonary disease, pregnancy, and colonoscopy. The CBGH projected that using the PROMETHEUS payment model statewide for these six conditions the Department could achieve savings of approximately $30.0 million over a four-year period, not including costs to implement the payment model. For FY 2012-13 the Department proposes developing rates for a prospective payment system and then modeling the rate structure against actual claims experience to validate whether the CBGH findings are on the right track, and to work through any potential issues with using a prospective payment system before potential implementation in a future year.

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

With regard to **long-term care reform** the Department requests funding to redesign the assessment tool for long-term care services, and to study potential savings and qualitative impacts of enhanced palliative care, and of consolidating long-term care services in naturally occurring retirement communities. The redesign of the assessment tool will reduce non-standardized narrative responses, add key information that impacts the cost of care, such as mental health status and the level of family support, and better integrate the information with claims data. The Department sees the redesign of the assessment tool as a necessary first step toward developing incentive-based payments for long-term care services. Enhanced palliative care, the Department believes, offers an option that some clients may prefer to more invasive, risky, and costly care for illnesses and conditions that have no evidence-based therapies. The Department cites a March 2011 study in *Health Affairs* that found a savings of $6,900 per admission for patients receiving palliative care. By identifying naturally occurring retirement communities and consolidating services in these communities the Department hopes to achieve efficiencies and improve health outcomes.

The Department projects that the savings from implementing the gainsharing initiative will more than offset the costs of administration, and the costs of the proposed studies and consulting services. The Department received one-time funding in FY 2011-12 to study coordinated payments and payment reforms and the Department proposes applying the savings from the expiration of that funding to further defray the cost of these initiatives.

The FTE will be responsible for establishing the gainsharing methodology, attributing clients to providers, calculating the savings and incentive payments, procuring and maintaining contracts with the vendors for studies of the gainsharing programs, drafting and managing contracts with providers, and fielding questions and concerns from providers. The FTE will also help with developing and overseeing the contracts for consulting services.

Recommendation: The table below compares the staff recommendation to the request, and differences are described below the table. The amounts by line item are detailed in the line item descriptions.

R5 Fee-for-service Reform				
	Request		Recommendation	
Initiative	Total	General Fund	Total	General Fund
FQHC and RHC net savings from gainsharing	($1,594,121)	($750,082)	($797,061)	($375,041)
Behavioral Health Organization net gainsharing	(319,123)	(149,494)	(319,123)	(149,494)
Actuarial assessment of changes to rate method	22,500	11,250	22,500	11,250
Psychotropic utilization after gainsharing payments	(341,623)	(160,744)	(341,623)	(160,744)
1.8 FTE oversee gainsharing/prospective payments	142,714	71,357	116,204	58,102
Personal Services	116,204	58,102	116,204	58,102
Operating	11,306	5,653	11,306	5,653
Benefits	15,204	7,602	0	0
Contract - develop and test prospective payment model	112,500	56,250	112,500	56,250
Contract - redesign the assessment tool for long-term care	220,000	110,000	220,000	110,000
Contract - study palliative care	50,000	25,000	50,000	25,000
Contract - study consolidating long-term care services in naturally occurring retirement communities	75,000	37,500	0	0
Annualize previous funding to study coordinated payments and payment reforms	(532,000)	(266,000)	(532,000)	(266,000)
TOTAL requested for R-5	($1,845,030)	($865,469)	($1,138,174)	($535,530)

FQHC and RHC net savings from gainsharing: Staff recommends reducing the Department's FY 2012-13 projection of the savings from implementing gainsharing by half. The Department makes several assumptions about the gainsharing incentives that staff believes may be optimistic, including:

- The incentive payments will be sufficient to motivate FQHCs and RHCs to achieve a 5.0 percent reduction in expenditures for prescription drugs, emergency department visits, hospital readmissions, and expenditures for outpatient visits;
- At least 5.0 percent of current payments are for avoidable costs; and
- The gainsharing incentives can be implemented by January 2013.

Also, the Department is already working on several initiatives to reduce expenditures for some of these same services, including proposals in R6 Medicaid Budget Reductions. Staff is concerned about counting savings twice.

Behavioral Health Organization net savings from gainsharing: The feasibility of these savings will be discussed during the figure setting presentation on mental health programs.

1.8 FTE to oversee gainsharing and prospective payments: Staff does not recommend funding for centralized appropriations for benefits. This is generally the JBC's practice when making

appropriations for new FTE, and these costs are also excluded from Fiscal Notes prepared by Legislative Council Staff.

Contract services to study consolidating long-term care services in naturally occurring retirement communities: The objective the Department is trying to achieve was not clear from the request. The concept is to combine community-engagement type services such as education, socialization, recreation, and volunteer opportunities with more traditional independent living health services to reduce nursing home utilization. Staff believes this requires providers with a strong will to develop such a program. Perhaps the Department could do something to encourage potential providers in this direction through outreach and education, or maybe a change in the Medicaid rate structure, but the purpose of hiring the consultant was not sufficiently articulated in the request for staff to recommend the funding.

M E M O R A N D U M

TO: **Joint Budget Committee**

FROM: **Eric Kurtz, JBC Staff (303-866-4952)**

SUBJECT: **Funding Recommendations from Committees of Reference for the Department of Health Care Policy and Financing (submitted pursuant to the SMART Act)**

DATE: **March 14, 2012**

House Health and Environment Committee
Received January 25, 2012
Recommendations

The House Committee of Health and Environment Committee recommended the Joint Budget Committee approve the Department's FY 2012-13 budget request.

Senate Health and Human Services Committee
Received January 25, 2012
Recommendations

The Senate Health and Human Services Committee recommended the following changes:

1. Consider alterative sources of revenue to generate the $437,375 General Fund savings the Department proposes (in R7 Cost Sharing for Medicaid and CHP+) from new copayments for the following Medicaid services:
   a. nonemergency medical transportation
   b. outpatient substance abuse treatment;
   c. physical, occupational, and speech therapy;
   d. home health care; and
   e. private duty nursing.

2. Delay approval of the Department's R13 Colorado Benefits Management System (CBMS) Electronic Document Management System until the Committee has considered the Department's fortcoming supplemental request regarding CBMS.

For R7 Cost Sharing for Medicaid and CHP+ staff recommended the Department's request, which is not consistent with the recommendation from the Senate Health and Human Services Committee. The staff recommendation begins on page 45 of the figure setting document.

The staff recommendation for CBMS is discussed during figure setting for the Department of Human Services.

COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2012-13 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

Prepared By:
Eric Kurtz, JBC Staff
February 14, 2012

For Further Information Contact:

Joint Budget Committee Staff
200 E. 14th Avenue, 3rd Floor
Denver, Colorado 80203
Telephone: (303) 866-2061
TDD: (303) 866-3472

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Executive Director: Susan E. Birch**						
(Primary Functions:Administration of Medicaid, the Colorado Indigent Care Program, S.B. 00-71 Comprehensive Primary and Preventative Care Grant Program, Old Age Pension Health and Medical Fund Services, and the Children's Basic Health Plan).						
(1) Executive Director's Office *(Primary Functions: Provides all of the administrative, audit and oversight functions for the Department. This Division contains 7 Subdivisions.)*						
(A) General Administration						
Personal Services	20,499,157	19,017,761	21,258,993	21,963,413	21,475,070	R5
FTE	276.5	270.6	312.5	315.3	314.3	
General Fund	7,927,142	7,559,246	7,659,394	8,012,169	7,827,415	
Cash Funds	1,172,469	1,289,520	1,974,533	2,058,349	2,018,849	
Reappropriated Funds	1,187,672	520,127	448,289	380,410	371,441	
Federal Funds	10,211,874	9,648,868	11,176,777	11,512,485	11,257,365	
Health, Life, and Dental	1,479,962	1,706,057	2,024,577	1,978,172	2,160,056	R5
General Fund	640,247	611,752	627,749	730,023	796,479	
Cash Funds	63,735	205,744	255,164	159,483	174,652	
Reappropriated Funds	38,965	15,219	0	49,661	55,084	
Federal Funds	737,015	873,342	1,141,664	1,039,005	1,133,841	
Short-term Disability	24,456	26,138	32,188	39,312	31,544	R5
General Fund	9,267	9,539	12,334	15,918	12,087	
Cash Funds	1,540	2,174	2,503	2,957	2,453	
Reappropriated Funds	1,885	737	0	629	0	
Federal Funds	11,764	13,688	17,351	19,808	17,004	
S.B. 04-257 Amortization Equalization Disbursement	330,311	402,667	532,854	711,137	690,351	R5

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
General Fund	123,846	145,650	190,728	287,980	277,478	
Cash Funds	20,931	33,664	53,148	53,468	52,399	
Reappropriated Funds	25,615	11,411	0	11,380	11,153	
Federal Funds	159,919	211,942	288,978	358,309	349,321	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	205,654	292,544	427,325	611,134	592,129	R5
General Fund	76,042	105,135	151,785	247,483	237,317	
Cash Funds	13,368	24,547	42,482	45,949	45,030	
Reappropriated Funds	16,009	8,321	0	9,780	9,584	
Federal Funds	100,235	154,541	233,058	307,922	300,198	
Salary Survey and Senior Executive Service	0	0	0	0	0	
General Fund						
Cash Funds						
Reappropriated Funds						
Federal Funds						
Performance-based Pay Awards	0	0	0	0	0	
General Fund						
Cash Funds						
Reappropriated Funds						
Federal Funds						
Workers' Compensation	34,252	34,748	29,652	33,584	*Pending*	
General Fund	17,126	17,374	14,826	16,792		
Federal Funds	17,126	17,374	14,826	16,792		
Operating Expenses	1,567,155	1,345,966	1,585,757	1,557,866	1,555,016	R5
General Fund	642,384	652,128	679,756	714,010	712,585	
Cash Funds	126,000	15,244	101,248	53,049	53,049	
Reappropriated Funds	10,599	0	13,461	13,461	13,461	
Federal Funds	788,172	678,594	791,292	777,346	775,921	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Legal and Third Party Recovery							
Legal Services	754,502	816,265	956,823		1,029,055	*Pending*	
General Fund	314,430	316,867	347,930		347,930		
Cash Funds	62,393	89,525	130,482		166,598		
Reappropriated Funds	0	0	0		0		
Federal Funds	377,679	409,873	478,411		514,527		
Administrative Law Judge Services	456,922	442,378	449,127	**S**	536,111	*Pending*	
General Fund	228,461	206,884	199,865		222,557		
Cash Funds	0	14,305	24,698		45,499		
Federal Funds	228,461	221,189	224,564		268,055		
Purchase of Services from Computer Center	129,163	298,151	835,843		1,021,717	994,952	
General Fund	61,245	145,739	414,566		509,171	493,482	
Reappropriated Funds	3,337	3,337	3,375		3,375	4,017	
Federal Funds	64,581	149,075	417,902		509,171	497,453	
Multiuse Network Payments	0	160,412	227,900		231,333	244,104	
General Fund		80,206	113,950		115,667	122,052	
Federal Funds		80,206	113,950		115,666	122,052	
Management & Administration of OIT	414,321	561,419	631,234		0	0	
General Fund	207,161	280,710	315,617			0	
Federal Funds	207,160	280,709	315,617			0	
Payment to Risk Management and Property Funds	78,487	24,418	77,888		84,315	*Pending*	
General Fund	39,244	12,209	38,944		42,158		
Federal Funds	39,243	12,209	38,944		42,157		
Leased Space	385,125	554,505	696,564		696,564	696,564	
General Fund	171,512	173,962	197,119		197,119	197,119	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Cash Funds	21,050	103,290	151,164		151,164	151,164	
Federal Funds	192,563	277,253	348,281		348,281	348,281	
Capitol Complex Leased Space	395,460	388,228	397,928		442,998	*Pending*	
General Fund	197,730	194,114	198,964		221,499		
Federal Funds	197,730	194,114	198,964		221,499		
General Professional Services and Special Projects	2,739,351	2,963,577	6,476,052	**S**	6,268,052	6,193,052	R5, R7, R12
General Fund	1,189,435	1,074,923	1,430,918		1,476,168	1,438,668	
Cash Funds	303,858	310,465	661,750		437,500	437,500	
Federal Funds	1,246,058	1,578,189	4,383,384		4,354,384	4,316,884	
SUBTOTAL - (A) General Administration	29,494,278	29,035,234	36,640,705		37,204,763	34,632,838	
FTE	276.5	270.6	312.5		315.3	314.3	
General Fund	11,845,272	11,586,438	12,594,445		13,156,644	12,114,682	
Cash Funds	1,785,344	2,088,478	3,397,172		3,174,016	2,935,096	
Reappropriated Funds	1,284,082	559,152	465,125		468,696	464,740	
Federal Funds	14,579,580	14,801,166	20,183,963		20,405,407	19,118,320	
(B) Transfers to Other Departments							
(Primary Functions: Contains administrative costs that are transferred to other Departments that administer programs eligible for Medicaid funding).							
Transfer to the Department of Public Health and Environment for Facility Survey and Certification	4,523,805	4,707,033	5,162,488	**S**	5,232,683	5,180,645	
General Fund	1,372,036	1,443,433	1,539,788		1,572,708	1,554,466	
Federal Funds	3,151,769	3,263,600	3,622,700		3,659,975	3,626,179	
Transfer to the Department of Public Health and Environment for Nurse Home Visitor Program	0	1,064,517	3,010,000		3,010,000	3,010,000	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Reappropriated Funds		429,287	1,505,000	1,505,000	1,505,000	
Federal Funds		635,230	1,505,000	1,505,000	1,505,000	
Transfer to the Department of Public Health and Environment for Prenatal Statistical Information	0	0	6,000	5,910	5,865	
General Fund			3,000	2,955	2,933	
Federal Funds			3,000	2,955	2,932	
Transfer to the Department of Public Health and Environment for Enhanced Prenatal Care Training	0	82,286	0	0	0	
General Fund		41,143	0		0	
Federal Funds		41,143	0		0	
Transfer to the Department of Regulatory Agencies for Nurse Aide Certification	325,343	325,343	324,041	324,041	324,041	
General Fund	148,020	148,020	147,369	147,369	147,369	
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652	
Federal Funds	162,671	162,671	162,020	162,020	162,020	
Transfer to the Department of Regulatory Agencies for Reviews	9,576	5,998	14,000	14,000	14,000	
General Fund	4,788	2,999	7,000	7,000	7,000	
Federal Funds	4,788	2,999	7,000	7,000	7,000	
Transfer to the Department of Education for Public School Health Services Administration	129,115	71,662	140,388	149,999	139,940	
Federal Funds	129,115	71,662	140,388	149,999	139,940	
SUBTOTAL - (B) Transfers to Other						

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request		FY 2012-13 Staff Rec.	Decision Items/ Notes
Departments	4,987,839	6,256,839	8,656,917		8,736,633		8,674,491	
General Fund	1,524,844	1,635,595	1,697,157		1,730,032		1,711,768	
Reappropriated Funds	14,652	443,939	1,519,652		1,519,652		1,519,652	
Federal Funds	3,448,343	4,177,305	5,440,108		5,486,949		5,443,071	
(C) Information Technology Contracts and Projects								
(Primary Functions: Contains funding the Medicaid Management Information System, Web Portal, and special IT projects).								
Information Technology Contracts	22,767,387	23,713,491	32,412,990		32,742,565	**A**	32,423,281	
General Fund	5,348,546	5,498,109	6,581,901		6,590,462		6,510,641	R7, R12, BA6
Cash Funds	642,364	642,824	1,479,670		1,566,666		1,566,666	
Reappropriated Funds	100,328	100,328	100,328		100,328		100,328	
Federal Funds	16,676,149	17,472,230	24,251,091		24,485,109		24,245,646	
Fraud Detection Software Contract	101,250	164,833	250,000		250,000		250,000	
General Fund	28,622	41,208	62,500		62,500		62,500	
Federal Funds	72,628	123,625	187,500		187,500		187,500	
Centralized Eligibility Vendor Contract Project	0	0	4,452,422	**S**	5,098,787		5,098,787	R12
Cash Funds	0	0	2,211,022		2,534,204		2,534,204	
Federal Funds	0	0	2,241,400		2,564,583		2,564,583	
SUBTOTAL - (C) Information Technology Contracts and Projects	22,868,637	23,878,324	37,115,412		38,091,352		37,772,068	
General Fund	5,377,168	5,539,317	6,644,401		6,652,962		6,573,141	
Cash Funds	642,364	642,824	3,690,692		4,100,870		4,100,870	
Reappropriated Funds	100,328	100,328	100,328		100,328		100,328	
Federal Funds	16,748,777	17,595,855	26,679,991		27,237,192		26,997,729	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
(D) Eligibility Determinations and Client Services							
(Primary Functions: Contains funding to determine client eligibility and to provide information services to clients about their health benefits).							
Medical Identification Cards	116,959	110,562	129,240	**S**	129,240	129,240	R12
General Fund	48,001	43,726	59,203		59,203	59,203	
Cash Funds	9,681	10,759	4,620		4,620	6,213	
Reappropriated Funds	1,594	1,593	1,593		1,593	0	
Federal Funds	57,683	54,484	63,824		63,824	63,824	
Contracts for Special Eligibility Determinations	2,332,040	2,141,327	7,761,238		7,761,238	7,761,238	
General Fund	888,543	823,747	828,091		828,091	828,091	
Cash Funds	24,717	5,000	2,806,268		2,806,268	2,806,268	
Federal Funds	1,418,780	1,312,580	4,126,879		4,126,879	4,126,879	
County Administration	31,153,170	31,110,742	31,186,376	**S**	31,427,702	31,427,701	R12
General Fund	9,627,844	9,201,053	10,300,790		10,373,188	10,373,188	
Cash Funds	5,948,741	6,354,318	5,332,531		5,380,796	5,380,796	
Federal Funds	15,576,585	15,555,371	15,553,055		15,673,718	15,673,717	
Hospital Provider Fee County Administration	0	0	2,361,502	**S**	2,581,071	2,581,071	R12
Cash Funds			1,180,751		1,290,536	1,290,536	
Federal Funds			1,180,751		1,290,535	1,290,535	
Administrative Case Management	898,270	1,115,944	869,744		869,744	869,744	
General Fund	449,135	557,972	434,872		434,872	434,872	
Federal Funds	449,135	557,972	434,872		434,872	434,872	
Customer Outreach	3,450,508	3,912,885	5,303,663	**S**	4,927,018	4,927,018	R12
General Fund	1,684,929	1,882,676	2,550,470		2,376,649	2,376,649	
Cash Funds	39,365	73,766	101,362		86,861	86,861	
Federal Funds	1,726,214	1,956,443	2,651,831		2,463,508	2,463,508	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
SUBTOTAL -(D) Eligibility Determinations and Client Services	37,950,947	38,391,460	47,611,763		47,696,013	47,696,012	
General Fund	12,698,452	12,509,174	14,173,426		14,072,003	14,072,003	
Cash Funds	6,022,504	6,443,843	9,425,532		9,569,081	9,570,674	
Reappropriated Funds	1,594	1,593	1,593		1,593	0	
Federal Funds	19,228,397	19,436,850	24,011,212		24,053,336	24,053,335	
(E)Utilization and Quality Review Contracts							
(Primary Functions: Contains contract funding to review the utilization and qualify of services provided in the acute, mental health, and long-term care programs.)							
Professional Service Contracts	4,524,545	4,802,408	8,164,451	**S**	8,414,451	8,414,451	
General Fund	1,125,802	1,345,699	2,162,870		2,225,370	2,162,870	R6, R12
Cash Funds	60,449	71,505	114,332		114,332	176,832	
Federal Funds	3,338,294	3,385,204	5,887,249		6,074,749	6,074,749	
(F) Provider Audits and Services							
(Primary Functions: Contains contract funding to audit nursing homes, federally-qualified health centers, hospitals, and other providers).							
Professional Audit Contracts	1,790,216	2,202,544	2,463,406		2,463,406	2,463,406	
General Fund	895,108	1,017,368	969,283		969,283	969,283	
Cash Funds	0	58,096	262,420		262,420	262,420	
Federal Funds	895,108	1,127,080	1,231,703		1,231,703	1,231,703	
(G) Recoveries and Recoupment Contract Costs							
(Primary Functions: Contains contract costs associated with recovery eligible Medicaid expenses.)							
Estate Recovery	428,619	351,102	700,000		700,000	700,000	
Cash Funds	214,310	175,551	350,000		350,000	350,000	
Federal Funds	214,309	175,551	350,000		350,000	350,000	
(H) Nursing Facility Penalty Cash Fund							

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request		FY 2012-13 Staff Rec.	Decision Items/ Notes
Nursing Facility Culture Change	196,572	0	0		0		0	
Cash Funds	196,572							
TOTAL - (1) Executive Director's Office	102,241,653	104,917,911	141,352,654		143,306,618		140,353,266	
FTE	276.5	270.6	312.5		315.3		314.3	
General Fund	33,466,646	33,633,591	38,241,582		38,806,294		37,603,747	
Cash Funds	8,921,543	9,480,297	17,240,148		17,570,719		17,395,892	
Reappropriated Funds	1,400,656	1,105,012	2,086,698		2,090,269		2,084,720	
Federal Funds	58,452,808	60,699,011	83,784,226		84,839,336		83,268,907	
(2) Medical Service Premiums								
(Provides acute care medical and long-term care services to individuals eligible for Medicaid).								
Medical and Long-Term Care Services for Medicaid Eligible Individuals	2,877,822,564	3,395,627,672	3,647,614,112	**S**	3,972,941,557	**A**	3,985,130,418	R1, R5, R6, R7, R10, BA1, BA3, BA4
General Fund	762,936,068	880,377,772	1,206,764,512		1,357,608,687		1,363,534,284	
Cash Funds	343,695,933	518,533,477	632,340,844		650,050,274		650,212,390	
Reappropriated Funds	3,917,255	7,414,327	6,445,828		3,215,340		3,215,340	
Federal Funds	1,767,273,308	1,989,302,096	1,802,062,928		1,962,067,256		1,968,168,404	
General Fund Exempt	*0*	*279,344,485*	*284,175,417*		*284,175,417*		*284,175,417*	
TOTAL - (2) Medical Services Premiums	2,877,822,564	3,395,627,672	3,647,614,112		3,972,941,557		3,985,130,418	
General Fund	762,936,068	880,377,772	1,206,764,512		1,357,608,687		1,363,534,284	
Cash Funds	343,695,933	518,533,477	632,340,844		650,050,274		650,212,390	
Reappropriated Funds	3,917,255	7,414,327	6,445,828		3,215,340		3,215,340	
Federal Funds	1,767,273,308	1,989,302,096	1,802,062,928		1,962,067,256		1,968,168,404	
General Fund Exempt	*0*	*279,344,485*	*284,175,417*		*284,175,417*		*284,175,417*	
(3) Medicaid Mental Health Community Programs								
(Primary Functions: Mental health programs for Medicaid eligible clients.)								

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Mental Health Capitation for Medicaid Clients	223,368,053	249,352,665	272,492,157	312,580,712	*Pending*	R2, BA2
General Fund	79,359,784	95,057,227	125,823,308	142,712,972		
Cash Funds	6,393,602	9,559,892	10,510,223	13,648,932		
Reappropriated Funds	10,833	13,000	13,544	0		
Federal Funds	137,603,834	144,722,546	136,145,082	156,218,808		
Medicaid Mental Health Fee for Service Payments	2,587,662	3,870,594	3,908,827	4,351,395	*Pending*	R2, BA2
General Fund	993,452	1,532,590	1,954,414	2,175,697		
Federal Funds	1,594,210	2,338,004	1,954,413	2,175,698		
TOTAL - (3) Medicaid Mental Health Community Programs	225,955,715	253,223,259	276,400,984	316,932,107	0	
General Fund	80,353,236	96,589,817	127,777,722	144,888,669	0	
Cash Funds	6,393,602	9,559,892	10,510,223	13,648,932	0	
Reappropriated Funds	10,833	13,000	13,544	0	0	
Federal Funds	139,198,044	147,060,550	138,099,495	158,394,506	0	

(4) Indigent Care Program

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

Safety Net Provider Payments	271,210,519	289,889,142	289,373,306	293,928,866	287,055,532	R10
General Fund	(707,378)	0	0	0	0	
Cash Funds	124,368,097	130,867,920	144,686,653	146,964,433	143,527,766	
Federal Funds	147,549,800	159,021,222	144,686,653	146,964,433	143,527,766	
Colorado Health Care Services Fund	10,390,000	0	0	0	0	
General Fund	10,390,000					

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Clinic Based Indigent Care	27,759,956	6,119,760	6,119,760	6,119,760	6,119,760	
General Fund	2,350,600	2,465,822	3,059,880	3,059,880	3,059,880	
Reappropriated Funds	8,312,000	0	0	0	0	
Federal Funds	17,097,356	3,653,938	3,059,880	3,059,880	3,059,880	
Health Care Services Fund Programs	5,410,048	29,635,144	23,510,000	0	0	
General Fund	(1)	0	0			
Cash Funds	0	11,909,853	11,755,000			
Reappropriated Funds	2,078,000	0	0			
Federal Funds	3,332,049	17,725,291	11,755,000			
Pediatric Specialty Hospital	14,909,166	14,755,860	11,799,938	11,799,938	2,211,994	
General Fund	5,098,897	5,201,789	5,899,969	5,899,969	1,105,997	
Cash Funds	283,000	307,000	0	0	0	
Reappropriated Funds	345,690	436,728	0	0	0	
Federal Funds	9,181,579	8,810,343	5,899,969	5,899,969	1,105,997	
General Fund Exempt	*104,310*	*0*	*0*	*0*	*0*	
General Fund Appropriation to Pediatric Specialty Hospital	345,690	436,728	0	0	0	
General Fund	345,690	436,728				
General Fund Exempt	*345,690*	*436,728*				
Appropriation from Tobacco Tax Fund to General Fund	0	0	446,100	446,100	435,183	
Cash Funds			446,100	446,100	435,183	
Primary Care Fund	0	0	0	28,253,000	27,561,575	
Cash Funds			0	28,253,000	27,561,575	
Primary Care Grant Program Special Distribution	2,005,000	3,560,000	2,135,830	0	0	
Cash Funds	2,005,000	3,560,000	2,135,830			

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Comprehensive Primary Care Grant Program	0	0	0		0	0	
Cash Funds							
Children's Basic Health Plan Administration	5,145,918	4,679,134	4,894,410		5,134,993	5,134,993	
General Fund	0		272,494		355,329	0	
Cash Funds	2,277,278	2,107,643	1,948,454		1,949,823	2,305,152	
Federal Funds	2,868,640	2,571,491	2,673,462		2,829,841	2,829,841	
Children's Basic Health Plan Medical and Dental Costs	178,495,021	177,283,900	184,868,299	S	182,543,053	182,543,053	R3, R7, R8, R9
General Fund	2,710,779	14,016,193	29,859,307		24,988,890	21,988,890	
Cash Funds	59,964,880	48,323,777	35,243,257		39,460,356	42,460,356	
Federal Funds	115,819,362	114,943,930	119,765,735		118,093,807	118,093,807	
General Fund Exempt	*0*	*0*	*446,100*		*446,100*	*435,183*	
TOTAL- (4) Indigent Care Program	515,671,318	526,359,668	523,147,643		528,225,710	511,062,090	
General Fund	20,188,587	22,120,532	39,091,650		34,304,068	26,154,767	
Cash Funds	188,898,255	197,076,193	196,215,294		217,073,712	216,290,032	
Reappropriated Funds	10,735,690	436,728	0		0	0	
Federal Funds	295,848,786	306,726,215	287,840,699		276,847,930	268,617,291	
General Fund Exempt	*450,000*	*436,728*	*446,100*		*446,100*	*435,183*	
(5) Other Medical Services							
(This division provides funding for state-only medical programs including the Old-Age Pension Medical Program, MMA State Contribution, Colorado Cares Contract Costs.The division also funds 6 special purposes Medicaid programs.)							
Old Age Pension State Medical	10,185,516	8,206,192	11,000,000		11,000,000	12,398,407	
General Fund	0	0	0		0	2,400,000	
Cash Funds	10,185,516	8,206,192	11,000,000		11,000,000	9,998,407	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pnesion State Medical Fund	0	0	0		0	0	
Cash Funds						0	
Commission on Family Medicine Residency Training Programs	1,738,844	1,738,846	1,741,077	S	1,391,077	1,741,077	
General Fund	667,890	700,624	870,538		695,538	870,538	
Federal Funds	1,070,954	1,038,222	870,539		695,539	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	703,561	738,043	915,857		915,857	915,857	
Federal Funds	1,128,153	1,093,671	915,857		915,857	915,857	
State University Teaching Hospitals - University of Colorado Hospital Authority	676,782	676,785	633,314		633,314	633,314	
General Fund	259,952	272,694	316,657		316,657	316,657	
Federal Funds	416,830	404,091	316,657		316,657	316,657	
Medicare Modernization Act State Contribution Payment	57,624,126	72,377,768	93,512,819	S	96,674,862	90,656,176	R4, R11
General Fund	57,624,126	58,711,725	62,869,537		50,609,286	50,609,286	
Federal Funds	0	13,666,043	30,643,282		46,065,576	40,046,890	
Public School Health Services Contract Administration	433,700	799,699	1,138,549		1,400,780	1,138,549	
Federal Funds	433,700	799,699	1,138,549		1,400,780	1,138,549	
Public School Health Services	25,597,360	24,659,097	30,446,344		34,737,204	30,446,344	
Cash Funds	11,443,512	11,302,888	16,010,155		18,113,309	16,010,155	
Federal Funds	14,153,848	13,356,209	14,436,189		16,623,895	14,436,189	

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp		FY 2012-13 Request		FY 2012-13 Staff Rec.	Decision Items/ Notes
Transfer to Department of Public Health and Environment for Nurse Home Visitor Program	426,956	0	0		0		0	
General Fund	(84,231)						0	
Reappropriated Funds	383,128						0	
Federal Funds	128,059						0	
Transfer to Department of Public Health and Environment for Enhanced Prenatal Care Training and Technical Assistance	108,665	0	0		0		0	
General Fund	54,333						0	
Federal Funds	54,332						0	
TOTAL - (5) Other Medical Programs	98,623,663	110,290,101	140,303,817		147,668,951		138,845,581	
General Fund	59,225,631	60,423,086	64,972,589		52,537,338		55,112,338	
Cash Funds	21,629,028	19,509,080	27,010,155		29,113,309		26,008,562	
Reappropriated Funds	383,128	0	0		0		0	
Federal Funds	17,385,876	30,357,935	48,321,073		66,018,304		57,724,681	
SUBTOTAL - Department of Health Care Policy and Financing (without DHS Division)	3,820,314,913	4,390,418,611	4,728,819,210		5,109,074,943		4,775,391,355	
FTE	276.5	270.6	312.5		315.3		314	
General Fund	956,170,168	1,093,144,798	1,476,848,055		1,628,145,056		1,482,405,136	
Cash Funds	569,538,361	754,158,939	883,316,664		927,456,946		909,906,876	
Reappropriated Funds	16,447,562	8,969,067	8,546,070		5,305,609		5,300,060	
Federal Funds	2,278,158,822	2,534,145,807	2,360,108,421		2,548,167,332		2,377,779,283	
General Fund Exempt	*450,000*	*279,781,213*	*284,621,517*		*284,621,517*		*284,610,600*	
TOTAL - (6) Department of Human Services Medicaid-funded Programs	415,140,344	438,883,396	431,158,130	**S**	442,274,140	**A**		
General Fund	158,585,174	175,667,660	214,267,825		218,683,804			
Cash Funds	592,619	467,856	1,045,795		320,349			

	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Approp	FY 2012-13 Request	FY 2012-13 Staff Rec.	Decision Items/ Notes
Reappropriated Funds	2,065,986	1,870,759	18,868	1,888,405		
Federal Funds	253,896,565	260,877,121	215,825,642	221,381,582		
GRAND TOTAL - Department of Health Care Policy and Financing (with DHS Division)	4,235,455,257	4,829,302,007	5,159,977,340	5,551,349,083	4,775,391,355	
FTE	276.5	270.6	312.5	315.3	314.3	
General Fund	1,114,755,342	1,268,812,458	1,691,115,880	1,846,828,860	1,482,405,136	
Cash Funds	570,130,980	754,626,795	884,362,459	927,777,295	909,906,876	
Reappropriated Funds	18,513,548	10,839,826	8,564,938	7,194,014	5,300,060	
Federal Funds	2,532,055,387	2,795,022,928	2,575,934,063	2,769,548,914	2,377,779,283	
General Fund Exempt	450,000	279,781,213	284,621,517	284,621,517	284,610,600	

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

INITIATIVES IMPACTING MULTIPLE LINE ITEMS

Before discussing each line item individually, this section of the document addresses a few selected initiatives that impact multiple line items throughout the Department

R5 Fee-for-service Reform

Request: The Department's top budget priority after adjustments for the new enrollment and expenditure forecast can be divided into three main components:

- implementing "gainsharing" incentive payments;
- studying prospective payments; and,
- studying long-term care reform.

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

For FY 2012-13 the Department will implement gainsharing payments for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Behavioral Health Organizations. The Department projects a 5.0 percent reduction in generic drug utilization, hospital readmissions, outpatient hospital visits, and emergency department visits by clients assigned to FQHCs and RHCs. The Department assumes that 50 percent of the total savings will be paid to the FQHCs and RHCs. The projected savings from gainsharing for Behavioral Health Organizations is related to psychotropic drug utilization.

In the **prospective payment** model providers would receive bundled rates that include money for physician, specialty, and laboratory care, based on expected expenditures for specific conditions, and then providers could retain the savings if actual costs are lower than expected. The prospective payments would be based on the PROMETHEUS model developed by the Health Care Incentives Improvement Institute (HCI3). The Colorado Business Group on Health (CBGH) conducted an analysis of the Department's payments for 21 specific conditions and concluded that 58 percent of what the Department spends is due to potentially avoidable complications of care. The CBGH recommended that the Department focus on six specific conditions, including diabetes,

gastoesopageal reflux disease, asthama, chronic obstructive pulmonary disease, pregnancy, and colonoscopy. The CBGH projected that using the PROMETHEUS payment model statewide for these six conditions the Department could achieve savings of approximately $30.0 million over a four-year period, not including costs to implement the payment model. For FY 2012-13 the Department proposes developing rates for a prospective payment system and then modeling the rate structure against actual claims experience to validate whether the CBGH findings are on the right track, and to work through any potential issues with using a prospective payment system before potential implementation in a future year.

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

With regard to **long-term care reform** the Department requests funding to redesign the assessment tool for long-term care services, and to study potential savings and qualitative impacts of enhanced palliative care, and of consolidating long-term care services in naturally occurring retirement communities. The redesign of the assessment tool will reduce non-standardized narrative responses, add key information that impacts the cost of care, such as mental health status and the level of family support, and better integrate the information with claims data. The Department sees the redesign of the assessment tool as a necessary first step toward developing incentive-based payments for long-term care services. Enhanced palliative care, the Department believes, offers an option that some clients may prefer to more invasive, risky, and costly care for illnesses and conditions that have no evidence-based therapies. The Department cites a March 2011 study in *Health Affairs* that found a savings of $6,900 per admission for patients receiving palliative care. By identifying naturally occurring retirement communities and consolidating services in these communities the Department hopes to achieve efficiencies and improve health outcomes.

The Department projects that the savings from implementing the gainsharing initiative will more than offset the costs of administration, and the costs of the proposed studies and consulting services. The Department received one-time funding in FY 2011-12 to study coordinated payments and payment reforms and the Department proposes applying the savings from the expiration of that funding to further defray the cost of these initiatives.

The FTE will be responsible for establishing the gainsharing methodology, attributing clients to providers, calculating the savings and incentive payments, procuring and maintaining contracts with the vendors for studies of the gainsharing programs, drafting and managing contracts with providers, and fielding questions and concerns from providers. The FTE will also help with developing and overseeing the contracts for consulting services.

Recommendation: The table below compares the staff recommendation to the request, and differences are described below the table. The amounts by line item are detailed in the line item descriptions.

R5 Fee-for-service Reform				
	Request		Recommendation	
Initiative	Total	General Fund	Total	General Fund
FQHC and RHC net savings from gainsharing	($1,594,121)	($750,082)	($797,061)	($375,041)
Behavioral Health Organization net gainsharing	(319,123)	(149,494)	(319,123)	(149,494)
Actuarial assessment of changes to rate method	22,500	11,250	22,500	11,250
Psychotropic utilization after gainsharing payments	(341,623)	(160,744)	(341,623)	(160,744)
1.8 FTE oversee gainsharing/prospective payments	142,714	71,357	116,204	58,102
Personal Services	116,204	58,102	116,204	58,102
Operating	11,306	5,653	11,306	5,653
Benefits	15,204	7,602	0	0
Contract - develop and test prospective payment model	112,500	56,250	112,500	56,250
Contract - redesign the assessment tool for long-term care	220,000	110,000	220,000	110,000
Contract - study palliative care	50,000	25,000	50,000	25,000
Contract - study consolidating long-term care services in naturally occurring retirement communities	75,000	37,500	0	0
Annualize previous funding to study coordinated payments and payment reforms	(532,000)	(266,000)	(532,000)	(266,000)
TOTAL requested for R-5	($1,845,030)	($865,469)	($1,138,174)	($535,530)

FQHC and RHC net savings from gainsharing: Staff recommends reducing the Department's FY 2012-13 projection of the savings from implementing gainsharing by half. The Department makes several assumptions about the gainsharing incentives that staff believes may be optimistic, including:

- The incentive payments will be sufficient to motivate FQHCs and RHCs to achieve a 5.0 percent reduction in expenditures for prescription drugs, emergency department visits, hospital readmissions, and expenditures for outpatient visits;
- At least 5.0 percent of current payments are for avoidable costs; and
- The gainsharing incentives can be implemented by January 2013.

Also, the Department is already working on several initiatives to reduce expenditures for some of these same services, including proposals in R6 Medicaid Budget Reductions. Staff is concerned about counting savings twice.

Behavioral Health Organization net savings from gainsharing: The feasibility of these savings will be discussed during the figure setting presentation on mental health programs.

1.8 FTE to oversee gainsharing and prospective payments: Staff does not recommend funding for centralized appropriations for benefits. This is generally the JBC's practice when making appropriations for new FTE, and these costs are also excluded from Fiscal Notes prepared by Legislative Council Staff.

Contract services to study consolidating long-term care services in naturally occurring retirement communities: The objective the Department is trying to achieve was not clear from the request. The concept is to combine community-engagement type services such as education, socialization, recreation, and volunteer opportunities with more traditional independent living health services to reduce nursing home utilization. Staff believes this requires providers with a strong will to develop such a program. Perhaps the Department could do something to encourage potential providers in this direction through outreach and education, or maybe a change in the Medicaid rate structure, but the purpose of hiring the consultant was not sufficiently articulated in the request for staff to recommend the funding.

(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

Description: 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:

- Increases in compensation-related appropriations associated with the new FTE requested in R5 Medicaid fee-for-service reform;
- An increase of 954 hours for legal services associated with implementing H.B. 09-1293, Hospital Provider Fee; and,
- Adjustments according to OSPB's common policies.

Recommendation: **Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below.** Note that the JBC's common policy is pending for a number of the line items. The largest increase is for Health, Life, and Dental benefits, based on the JBC's decision to increase the state contribution rates to match prevailing compensation.

Line Items Set by JBC Common Policy						
	Hours	FY 12-13 Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Health, Life, and Dental		2,160,056	796,479	174,652	55,084	1,133,841
Short-term Disability		31,544	12,087	2,453	0	17,004
Amortization Equalization Disbursement		690,351	277,478	52,399	11,153	349,321
Supplemental AED		592,129	237,317	45,030	9,584	300,198
Salary Survey/Performance Pay		0	0	0	0	0
Workers' Compensation		*Pending*				
Legal Services	13,592	*Pending*				
Administrative Law Judge Services		*Pending*				
Purchase of Services from Computer Center		994,952	493,482	0	4,017	497,453
Multi-use Network Payments		244,103	122,052	0	0	122,051
Management and Administration of OIT		0	0	0	0	0
Payment to Risk Management and Property		*Pending*				
Capitol Complex Leased Space		*Pending*				

* The rates listed for the Amortization Equalization Disbursement and the Supplemental Amortization Equalization Disbursement are blended rates for the fiscal year. The blended rate for General Fund positions will be slightly different due to the pay date shift.

The recommendation does NOT include any adjustments to centralized appropriations for R5 Medicaid fee-for-service reform. Generally the Joint Budget Committee does not include funding for centralized appropriations when making appropriations for new FTE, and these costs are also excluded from Fiscal Notes prepared by Legislative Council Staff.

For Legal Services staff recommends the requested increase of 954 hours for projected costs associated with implementing H.B. 09-1293, Hospital Provider Fee. The request is consistent with the estimate in the original Fiscal Note for H.B. 09-1293. The Department does not yet have enough history with implementing H.B. 09-1293 to justify a change from the original estimate in the Fiscal Note. Staff also recommends changing the name of the line item to conform with the naming convention used for other state agencies.

For Capitol Complex Leased Space the recommendation is for a continuing 31,512 square feet of space at 1570 Grant Street. The rate per square foot will be set by common policy.

Personal Services

Description: 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:

- $116,204 and 1.8 FTE, including $58,102 General Fund, for R-5 Medicaid Fee-for-service Reform to implement gainsharing incentives and oversee consulting services;
- $556,524 and 0.5 FTE, including $190,202 General Fund, to annualize budget decisions from prior years; and
- A change in fund sources to account for updates to the statewide indirect cost recovery plan.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Personal Services						
	Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2011-12 Appropriation	**21,290,686**	**7,675,241**	**1,974,533**	**448,289**	**11,192,623**	**313.0**
Supplemental - delay in implementing SB 10-061 Hospice room/board charges	(31,693)	(15,847)	0	0	(15,846)	(0.5)

Personal Services						
	Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2011-12 Recommendation	**21,258,993**	**7,659,394**	**1,974,533**	**448,289**	**11,176,777**	**312.5**
Hospice room/board charges, SB 10-061 annualization	0	0	0	0	0	0.0
Teen pregnancy & dropout prevention, SB 11-177 annualization	4,345	2,172	0	0	2,173	0.0
PERA contribution rate increase 2.5%, SB 11-076 annualization	508,844	166,362	56,119	0	286,363	0.0
Prenatal Plus Administration Transfer, DI#8 FY12 annualization	11,643	5,822	0	0	5,821	0.0
2.0% Base Personal Services reduction	(424,959)	(153,061)	(39,501)	(8,969)	(223,428)	0.0
R5 Medicaid fee-for-service reform	116,204	58,102	0	0	58,102	1.8
Indirect cost adjustment	0	88,624	27,698	(67,879)	(48,443)	0.0
FY 2012-13 Recommendation	**21,475,070**	**7,827,415**	**2,018,849**	**371,441**	**11,257,365**	**314.3**

Supplemental - delay in implementing SB 10-061 Hospice room/board charges; and, Hospice room and board charges, SB 10-061 annualization: Staff recommends a supplemental reduction of $31,363 and 0.5 FTE, including $15,847 General Fund for a delay in implementing S.B. 10-061 Hospice room/board charges. This bill (by Tochtrop; Williams/Soper; Riesberg) required Medicaid to pay the room and board costs for someone receiving hospice care in a licensed hospice inpatient facility, and that when someone receives hospice care in a class I nursing facility the room and board costs be paid directly to the nursing facility, rather than through the hospice provider. However, the changes to hospice billing were conditional on the Department receiving sufficient gifts, grants, and donations to pay for a waiver application, and federal approval of the waiver. To date the Department has not received any gifts, grants, or donations, and the Department has not received federal approval for a waiver.

In FY 2011-12 the Department received $31,693 and 0.5 FTE, including $15,847 General Fund, in anticipation of the Department beginning to administer the program mid-FY 2011-12. For FY 2012-13 the Department requested another $31,692 and 0.5 FTE to annualize the FY 2011-12 appropriation. This funding request was consistent with the original fiscal note for the bill. Duties of the FTE would include drafting rules for approval by the Medical Services Board, overseeing necessary payment and information technology system changes, providing necessary documentation and reporting to the federal Centers for Medicare and Medicaid Services (CMS), handling the periodic review and renewal of the 1115 demonstration waivers, and working with the hospice provider community and client advocates regarding benefit and systems implementation. Because the Department has not yet received federal approval for a waiver, the Department has not hired the FTE. The staff recommendation removes the FY 2011-12 funding for the FTE and provides no

annualization in FY 2012-13 associated with the bill. If the Department receives gifts, grants, and donations and a federal waiver, the FTE appropriation will need to be revisited.

Teen pregnancy & dropout prevention, SB 11-177 annualization: This bill (by Nicholson/Coram) extended the repeal date and expanded the teen pregnancy and dropout prevention program. Providers who raise 10.0 percent local funds receive a 90.0 percent federal match for providing eligible services. The Department's administrative costs are not eligible for the enhanced match, but the fiscal note projected reduced medical costs due to avoided pregnancies that exceed the Department's administrative costs. The Department received $47,817 and 1.0 FTE in FY 2011-12 for administration of the program expansion. The recommended annualization costs in FY 2012-13 are attributable to the pay date shift and paying for 12 months of salary costs rather than 11.

PERA contribution rate increase 2.5%, SB 11-076 annualization: This JBC bill temporarily reduced the state contribution rate and increased the employee contribution rate for PERA by 2.5 percent. The state contribution rate returns to 10.15 percent in FY 2012-13. The recommended annualization is equal to the reduction that was taken in SB 11-076, consistent with the JBC's common policy.

Prenatal Plus Administration Transfer, DI#8 FY12 annualization: In FY 2011-12 the General Assembly transferred administration of the Prenatal Plus program from the Department of Public Health and Environment to the Department of Health Care Policy and Financing (HCPF). This program provides counseling to pregnant women regarding non-medical behavioral and lifestyle decisions that affect the risk of a low birth weight. In FY 2011-12 HCPF received funding for 11 months of salaries and benefits and used a portion of the 1 month of salary savings due to the pay date shift for capital outlay. In FY 2012-13 HCPF needs funding for 12 months of salaries and benefits, and no funding for capital outlay. Note that the way the transfer was implemented the Department of Public Health and Environment had to absorb one month of salary expenses in FY 2011-12, but did not have to give up capital equipment associated with the FTE that transferred to HCPF.

	FY 2011-12	FY 2012-13
Public Health and Environment	($113,006)	($113,006)
Health Care Policy and Financing	$111,449	$113,006
Personal Services	90,345	101,988
Operating	21,104	11,018
Net Impact of Transfer	($1,557)	$0

2.0% Base Personal Services reduction: Pursuant to the JBC's common policy, staff recommends a 2.0 percent base personal services reduction.

Indirect cost adjustment: Staff recommends the requested adjustment to account for changes in each fund source's share of statewide and departmental indirect costs. The adjustment includes consolidating appropriations from the Health Care Expansion Fund in the Medical Services Premiums line item. While staff recommends the request, staff believes the Department's indirect cost plan needs updating to account for several new sources of cash funds, including the Hospital Provider Fee, that have been used to finance the Department since the original indirect plan was developed several years ago. Also, staff believes some changes could be made to clarify which overhead costs are being funded through the indirect cost plan and which are being allocated to fund sources directly to make the indirect plan and the financing of the Executive Director's Office more transparent. Staff is not recommending any changes for FY 2012-13 because of the time required to get any modifications approved by the federal government, but staff will continue working with the Department over the summer to update the indirect cost plan for FY 2013-14.

R5 Medicaid fee-for-service reform: Staff recommends the requested increase of $116,204, including $58,102 General Fund, for 1.8 FTE (annualizes to 2.0 FTE in FY 2013-14) to manage the gainsharing, prospective payment, and long-term care initiatives proposed by the Department in R5. The FTE will be responsible for establishing the gainsharing methodology, attributing clients to providers, calculating the savings and incentive payments, procuring and maintaining contracts with the vendors for studies of the gainsharing programs, drafting and managing contracts with providers, and fielding questions and concerns from providers. The FTE will also help with developing and overseeing contracts for consulting services. See the discussion of R5 at the beginning of this document for a more detailed analysis.

Operating Expenses

Description: 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's requests:

- $11,306, including $5,653 General Fund for R5 Medicaid fee-for-service reform associated with the requested increase in FTE; and,
- A net reduction of $39,672, including a reduction of $28,363 General Fund to annualize prior year budget decisions.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Operating Expenses					
	Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2011-12 Appropriation	**1,586,232**	**679,994**	**101,248**	**13,461**	**791,529**
Supplemental - delay in implementing SB 10-061 Hospice room/board charges	(475)	(238)	0	0	(237)
FY 2011-12 Recommendation	**1,585,757**	**679,756**	**101,248**	**13,461**	**791,292**
Health Care Affordability Act, HB 09-1293 annualization	(96,398)	0	(48,199)	0	(48,199)
Hospice room and board charges, SB 10-061 annualization	0	0	0	0	0
Teen pregnancy & dropout prevention, SB 11-177 annualization	(4,703)	(2,351)	0	0	(2,352)
General Operating Expenses Reduction, FY 11 BA#17 annualization	69,140	34,570	0	0	34,570
Prenatal Plus Administration Transfer, DI#8 FY12 annualization	(10,086)	(5,043)	0	0	(5,043)
R5 Medicaid fee-for-service reform	11,306	5,653			5,653
FY 2012-13 Recommendation	**1,555,016**	**712,585**	**53,049**	**13,461**	**775,921**

Supplemental - delay in implementing SB 10-061 Hospice room/board charges; and, Hospice room and board charges, SB 10-061 annualization: Staff recommends a supplemental reduction for a delay in implementing S.B. 10-061 Hospice room/board charges. This bill (by Tochtrop; Williams/Soper; Riesberg) required Medicaid to pay the room and board costs for someone receiving hospice care in a licensed hospice inpatient facility, and that when someone receives hospice care in a class I nursing facility the room and board costs be paid directly to the nursing facility, rather than through the hospice provider. However, the changes to hospice billing were conditional on the Department receiving sufficient gifts, grants, and donations to pay for a waiver application, and federal approval of the waiver. To date the Department has not received any gifts, grants, or donations, and the Department has not received federal approval for a waiver. The staff recommendation removes the FY 2011-12 funding and provides no annualization in FY 2012-13 associated with the bill.

Health Care Affordability Act, HB 09-1293 annualization: The staff recommendation reflects the end of one-time capital outlay expenditures for 15.7 new FTE who were added in FY 2011-12 to administer H.B. 09-1293, which implemented a hospital provider fee, new supplemental payments for hospitals, and eligibility expansions.

Teen pregnancy & dropout prevention, SB 11-177 annualization: The recommendation reflects the end of one-time funding for capital outlay for the 1.0 FTE the Department received in FY 2011-12 to administer this bill.

General Operating Expenses Reduction, FY 11 BA#17 annualization: In FY 2010-11 the JBC approved a Department request for a temporary, two-year reduction in operating expenses of 5.0 percent to help balance the budget. The Department indicated it would accomplish the reduction by reducing travel expenses, replacing fewer computers, and saving on printing and publication materials. Since the request was for a temporary reduction, staff assumes the Committee's intent in approving the request was also for a temporary reduction, and therefore staff recommends restoration of the funding for FY 2012-13.

Prenatal Plus Administration Transfer, DI#8 FY12 annualization: The recommendation reflects the end of one-time funding for capital outlay for administration of the prenatal plus program that was transferred from the Department of Public Health and Environment in FY 2011-12. See the Personal Services line item for more detail.

R5 Medicaid fee-for-service reform: Staff recommends the requested funds for operating costs associated with the new 1.8 FTE responsible for managing the gainsharing, prospective payment, and long-term care initiatives proposed by the Department in R5. See the discussion of R5 at the beginning of this document for a more detailed analysis.

Leased Space

Description: This line item pays for the Department's 39,900 square feet of leased space at 225 16th Street. The rate per square foot for units above ground varies between $16.77 and $21.00 based on the location within the building and the layout.

Request: The Department requests continuation funding.

Recommendation: **Staff recommends the requested continuation funding.** The Department does not have plans to change the square feet occupied. Overall, in the Capitol Complex and private leases combined, the Department is using approximately 228 rentable square feet per office worker. The Colorado Standards for Measuring Overall Space Use Efficiency in Leased Office Spaces sets a goal for office space leased by state agencies at 70% of the average number of square feet in the Denver area for private sector office space of 291 rentable square feet per office worker, or 204 rentable square feet. This suggests the Department could get by with fewer square feet of leased space, but this would require capital outlay to update and more efficiently configure the space the Department is using.

General Professional Services

Description: 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:

- A reduction of $52,000, including $26,000 General Fund for R5 Fee-for-service Reform
- An increase of $30,000, including $15,000 General Fund for R7 Cost Sharing for Medicaid and CHP+
- R12 Hospital Provider Fee True-up to continue the adjustments to administrative expenses financed with the Hospital Provider Fee approved in the supplemental, and
- Annualizations of prior year budget decisions.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table. Note that no adjustment is necessary for R12, because the requested reduction in funding was approved in the supplemental and already incorporated in the base.

General Professional Services				
	Total	General Fund	Cash Funds	Federal Funds
FY 2011-12 Appropriation	**6,476,052**	**1,430,918**	**661,750**	**4,383,384**
Annualize prior year budget decisions	(186,000)	56,250	(224,250)	(18,000)
R5 Fee-for-service reform	(127,000)	(63,500)	0	(63,500)
R7 Cost sharing for Medicaid and CHP+	30,000	15,000	0	15,000
FY 2012-13 Recommendation	6,193,052	1,438,668	437,500	4,316,884

R5 Fee-for-service reform: Staff recommends $75,000 less than the request, including $37,500 General Fund, due to not recommending the contract services to study consolidating long-term care services in naturally occurring retirement communities. The total includes the expiration of one-time funding provided in FY 2011-12 to study coordinated payments and payment reforms. See the discussion of R5 at the beginning of this document for a more detailed analysis.

R7 Cost sharing for Medicaid and CHP+: Staff recommends the requested funding to develop the plan amendments necessary to implement the cost sharing initiatives in R7. See the Medical Services Premiums for a more detailed analysis of the request.

(B) Transfers to Other Departments

Description: All of the line items in this section fund transfers for programs operated by departments other than the Department of Health Care Policy and Financing. The amounts for these line items are set during the figure setting presentations for those other departments.

Request: The Department's request includes annualization of S.B. 11-076 that temporarily reduced the state contribution to PERA, annualization of a school-based health program refinancing, and technical adjustments to the fund sources.

Recommendation: The table below summarizes the amounts approved by the Joint Budget Committee and provides a cross reference to the date of the figure setting. However, some these amounts include portions of centralized appropriations, and so the figure in the tables may not be easy to cross reference without staff work papers for the Department that set the figure.

Transfers to/For	Date of Figure Setting	Total	General Fund	Reapprop. Funds	Federal Funds
Public Health and Environment	02/23/12				
Facility Survey and Certification		$5,180,645	$1,554,466	$0	$3,626,179
Nurse Home Visitor Program		3,010,000	0	1,505,000	1,505,000
Prenatal Statistical Information		5,865	2,933	0	2,932
Regulatory Agencies	2/14/12				
Nurse Aide Certification		324,041	147,369	14,652	162,020
Reviews		14,000	7,000	0	7,000
Education	3/5/12				
Public School Health Services Administration		149,999	0	0	149,999
TOTAL Transfers		$8,684,550	$1,711,768	$1,519,652	$5,453,130

(C) Information Technology Contracts and Projects

Information Technology Contracts

Description: 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).

Request: The Department requests:

- An increase of $523,964, including $130,991 General Fund, for R7 Cost Sharing for Medicaid and CHP+;
- A decrease of $613,974 for R12 Hospital Provider Fee true-up;
- An increase of $1,065,358 for BA6 MMIS Technical Adjustments; and,
- A net decrease of $645,773, including $122,430 General Fund, to annualize prior year budget actions.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Information Technology Contracts					
	Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2011-12 Appropriation	32,412,990	6,581,901	1,479,670	100,328	24,251,091
Health Care Affordability Act, HB 09-1293 annualization	482,383	0	218,770	0	263,613
Hospice room and board charges, SB 10-061 annualization	0	0	0	0	0
Medicaid for Ages 6-19 from 100-133%, SB 11-008 annualization	6,930	1,733	0	0	5,197
Medicaid for pregnant women 133-185%, SB 11-250 annualization	6,930	1,681	73	0	5,176
MMIS adjustments, BA#15 FY11 annualization	(1,064,400)	(106,440)	0	0	(957,960)
Client Overutilization Program (COUP), BRI#1 FY12 annualization	(207,900)	(51,975)	0	0	(155,925)
Medicaid reductions, BR#5 FY12	(189,000)	(47,250)	0	0	(141,750)
R7 Cost sharing for Medicaid and CHP+	523,964	130,991	0	0	392,973
R12/BA6 Hospital Provider Fee true-up and MMIS Technical Adjustments	451,384	0	(131,847)	0	583,231
FY 2012-13 Recommendation	32,423,281	6,510,641	1,566,666	100,328	24,245,646

Health Care Affordability Act, HB 09-1293 annualization: Staff recommends the requested net increase for Medicaid eligibility expansions authorized by H.B. 09-1293. Specifically H.B. 09-1293 provided for a new Medicaid buy-in program for people with disabilities and expanded Medicaid eligibility to adults without dependent children. The requested net increase is the result of the end of one-time programming costs and the ramping up of on-going costs to the vendor for claims

processing, claims adjustments, and prior authorization reviews (PARs). The request is consistent with the assumptions in the original fiscal note for the bill. The source of cash funds is the Hospital Provider Fee, and the federal match rate is a blend of 50.0 percent for Medicaid PARs and mailings, 75.0 percent for Medicaid claims processing, and 65.0 percent for CHP+ claims processing.

Although staff recommends the requested amount for the annualization of H.B. 09-1293, staff also recommends the Department's BA5, which adjusts several assumptions about expenditures for MMIS based in large part on new estimates of the expansion population, and R12 Hospital Provider Fee true-up.

Hospice room and board charges, SB 10-061 annualization: Staff recommends no annualization for one-time programming costs to implement S.B. 10-061 (by Tochtrop; Williams/Soper; Riesberg), which required changes to the way Medicaid pays for hospice room and board costs, contingent on sufficient gifts, grants, and donations to pay for a waiver application. The Department has not received any gifts, grants and donations to date. See the personal services line item for further explanation.

Medicaid for Ages 6-19 from 100-133%, SB 11-008 annualization : Staff recommends the requested increase for one-time computer programming changes to implement the Medicaid eligibility expansion authorized by the bill. The request is consistent with the assumptions in the original fiscal note for the bill. The bill (by Boyd/Gerou) extended Medicaid eligibility to children 6-19 years old with family income from 100.0 percent up to 133.0 percent of the federal poverty guidelines to match the Medicaid eligibility standards for children under 6 and the standards that were in place at the time for pregnant women. Senate Bill 11-008 also allowed appropriations from Tobacco Tax money deposited in the Health Care Expansion Fund (HCEF) for the expansion population. Following the practice established by the JBC last year, staff recommends consolidating appropriations from the HCEF in the Medical Service Premiums line item and using General Fund for the state match for the computer programming costs in this line item.

Medicaid for pregnant women 133-185%, SB 11-250 annualization: Staff recommends the requested one-time computer programming changes to implement the Medicaid eligibility expansion. The request is consistent with the assumptions in the original fiscal note for the bill. The bill (by Boyd/Ferrandino; Summers) extended Medicaid eligibility to pregnant women from 133.0 percent up to 185.0 percent of the federal poverty guidelines to comply with federal requirements. The source of cash funds is the Children's Basic Health Plan Trust Fund. The federal match rate for the Medicaid-related programming is 75.0 percent and for the CHP+-related programming it is 65.0 percent.

MMIS adjustments, BA15 FY11 annualization: The staff recommendation reflects the end of a portion of short-duration funding provided for federally-required maintenance of the MMIS system. There are three components to the maintenance work. One is for a migration from the International Classification of Diseases (ICD) version 9 to ICD-10. These are diagnosis and treatment codes used by providers to justify payments. Detailed and consistent coding provides a wealth of information for researchers and policy makers about the health profile of the Medicaid population, treatment modalities, and cost drivers. The second is for a migration from the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards version 4010 to HIPAA-5010. These standards address patient confidentiality and data security. The third is for an assessment of the payment processing system that looks at the level of automation and the availability and quality of management information. The federal match rate is 90.0 percent. The table below summarizes total projected costs by fiscal year to complete the required maintenance.

Description	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14	TOTAL
Project Management and Consultation Services	$546,020	$200,000	$200,000	$200,000	$66,666	$1,212,686
MMIS System Development Work	0	2,092,878	2,092,878	1,546,858	515,620	6,248,234
Independent Verification and Validation	0	0	300,000	300,000	100,000	700,000
Medicaid Information Technical Architecture Assessment	0	1,000,000	500,000	0	0	1,500,000
Total	$546,020	$3,292,878	$3,092,878	$2,046,858	$682,286	$9,660,920

Client Overutilization Program (COUP), BRI1 FY12 annualization: The staff recommendation reflects the end of one-time programming changes to MMIS intended to make payment controls through the Client Overutilization Program (COUP) more effective. In FY 2011-12 the General Assembly authorized a 200 person expansion of the COUP. Through the COUP clients are locked in with one primary care physician, pharmacy, or managed care organization when there is evidence that the client has improperly or excessively utilized Medicaid benefits (usually pharmaceuticals) that are not medically necessary. In order to accomplish the expansion of the COUP the Department is offering higher reimbursement for providers who agree to take on the workload burden associated with acting as a lock-in provider.

Medicaid reductions, BRI5 FY12: The staff recommendation reflects the end of one-time programming costs associated with a number of cost-containment initiatives implemented by the Department and authorized by the General Assembly in FY 2011-12 as part of BRI5.

R7 Cost sharing for Medicaid and CHP+: Staff recommends the requested increase for programming changes necessary to implement the cost sharing initiatives. See Medical Service Premiums for a more detailed analysis of the request.

R12/BA6 Hospital Provider Fee true-up and MMIS Technical Adjustments: The Department requested a number of changes to appropriations from the Hospital Provider Fee for administrative expenses to more closely align appropriations with actual costs, with a net impact of an increase in administrative appropriations funded from the Hospital Provider Fee. The Department reexamined actual administrative expenses associated with the Hospital Provider Fee compared to the assumptions in the original fiscal note for H.B. 09-1293 in part because the Department has a better sense of the timing and scope of the population expansions pursuant to H.B. 09-1293. It has also been 2 years since the original estimate, and the Department is due for a statutory audit of the program this year. R12 reduces the funding from the Hospital Provider Fee for lower postage costs and BA6 increases the funding for the share of several MMIS upgrades attributable to the Hospital Provider Fee.

Fraud Detection Software Contract

Description: 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 request continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Centralized Eligibility Vendor Contract

Description: 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 a net increase of $646,365 for projected enrollment changes. The request breaks the changes into components for annualizing the Health Care Affordability Act (H.B. 09-1293), annualizing S7 Hospital Provider Fee Administrative True-up, and the new FY 2012-13 request R12 Hospital Provider Fee true-up. After stepping through all the components of the Department's request, the net impact can be summarized as an adjustment for projected enrollment.

Recommendation: Staff recommends the requested increase for enrollment.

(D) Eligibility Determinations and Client Services

Medical Identification Cards

Description: 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 program in the Department of Human Services. 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 R12 Hospital Provider Fee true-up, which would continue the $9,240 increase approved as part of the supplemental. The supplemental corrected an overlooked cost in the original fiscal note for H.B. 09-1293, the Health Care Affordability Act.

Recommendation: Staff recommends the requested total, but staff recommends showing the $1,593 reappropriated funds as cash funds. The money in question is from the Old Age Pension Health and Medical Fund and should be labeled as cash funds, rather than as a transfer from the Department of Human Services.

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. For FY 2011-12 the cost per card is approximately $0.57.

Contracts for Special Eligibility Determinations

Description: 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. In FY 2010-11 2,323 disability determination cases were received by the Department's disability determination services contractor and with the fixed price contract the cost per case was approximately $505. 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. The cost of these assessments can vary widely based on the individual circumstances of clients, from $40 to $410, with an weighted average per client of $185. 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 for 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 Department requests continuation funding.

Recommendation: **Staff recommends the requested continuation funding.** The estimated amounts for each service by fund source are summarized in the table below.

Contracts for Special Eligibility Determinations						
	Total	General Fund	Hospital Provider Fee	Autism Treatment Fund	Federal Funds	Federal Match Rate
Disability determinations	$3,701,798	$581,831	$1,264,068	$5,000	$1,850,899	50.0%
Nursing home preadmission and resident assessments	985,040	246,260	0	0	738,780	75.0%
Hospital outstationing	3,074,400	0	1,537,200	0	1,537,200	50.0%
FY 2012-13 Recommendation	$7,761,238	$828,091	$2,801,268	$5,000	$4,126,879	53.2%

County Administration

Description: 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's request includes R12 Hospital Provider Fee true-up to continue the adjustment that was made in the supplemental bill to move appropriations from the Hospital Provider Fee to a unique line item. Also, the Department requests an increase of $241,325, including $72,398 General Fund, to annualize S.B. 11-008 (by Boyd/Gerou), which extended Medicaid eligibility to children 6-19 years old with family income from 100.0 percent up to 133.0 percent of the federal poverty guidelines to match the Medicaid eligibility standards for children under 6 and the standards that were in place at the time for pregnant women.

Recommendation: Staff recommends the requested funding. The slight increase from FY 2011-12 is due to the projected increase in the Medicaid caseload associated with S.B. 11-008.

Hospital Provider Fee County Administration

Description: This line item was created through the supplemental bill 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 R12 Hospital Provider Fee true-up to continue the separation of funding that occurred in the supplemental bill, and an increase in the total funding for annualization expenses associated with H.B. 09-1293.

Recommendation: Staff recommends the requested funding. The increase from FY 2011-12 is due to a projected increase in the Medicaid caseload associated with H.B. 09-1293.

Administrative Case Management

Description: 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

Description: 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 R12 Hospital Provider Fee true-up to continue the policy approved in the supplemental bill of adjusting the fund sources to reflect the proportion of the total Medicaid population paid from the Hospital Provider Fee. The Department also requests a net decrease of $105,732, including $57,940 General Fund, for annualizing prior year budget decisions.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Customer Outreach				
	Total	General Fund	Hospital Provider Fee	Federal Funds
FY 2011-12 Appropriation	5,303,663	2,550,470	101,362	2,651,831
Health Care Affordability Act, HB 09-1293 annualization	30,447	0	15,224	15,223
Medicaid for Ages 6-19 from 100-133%, SB 11-008 annualization	39,715	19,858	0	19,857
Medicaid Budget Balancing Reductions, FY12 BA9 annualization	(387,358)	(193,679)	0	(193,679)
R12 Hospital Provider Fee true-up	(59,449)	0	(29,725)	(29,724)
FY 2012-13 Recommendation	4,927,018	2,376,649	86,861	2,463,508

Health Care Affordability Act, HB 09-1293 annualization: Staff recommends the requested increase to implement the Medicaid eligibility expansions authorized by H.B. 09-1293, which implemented a hospital provider fee, new supplemental payments for hospitals, and eligibility expansions.

Medicaid for Ages 6-19 from 100-133%, SB 11-008 annualization: Staff recommends the requested increase to implement the Medicaid eligibility expansion authorized by the bill. The request is consistent with the assumptions in the original fiscal note for the bill, but updated to reflect current population projections. The bill (by Boyd/Gerou) extended Medicaid eligibility to children 6-19 years old with family income from 100.0 percent up to 133.0 percent of the federal poverty guidelines to match the Medicaid eligibility standards for children under 6 and the standards that were in place at the time for pregnant women. Senate Bill 11-008 also allowed appropriations from Tobacco Tax money deposited in the Health Care Expansion Fund (HCEF) for the expansion population. Following the practice established by the JBC last year, staff recommends consolidating appropriations from the HCEF in the Medical Service Premiums line item and using General Fund for the state match in this line item.

Medicaid Budget Balancing Reductions, FY12 BA9 annualization: Staff recommends the requested decrease to annualize the prior year budget decision.

R12 Hospital Provider Fee true-up: The supplemental updated the appropriation that pays for benefit packets that get distributed to clients to account for increases in the caseload and financed all of the increase from the Hospital Provider Fee to make the proportion of funds for the line item

from the Hospital Provider fee match the proportion of the total Medicaid population paid for from the Hospital Provider Fee. R12 continues that policy in FY 2012-13 and the small change from the amount approved in the supplemental reflects caseload projections for FY 2012-13.

(E) Utilization and Quality Review Contracts

Professional Services Contracts

Description: 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 R6 Medicaid Budget Reductions for increased prior authorization reviews associated with a number of different strategies to reduce Medicaid costs. A portion of the funding requested in R6 was already approved in the supplemental. The Department also requests R12 Hospital Provider Fee Administrative True-up to continue fund source adjustments made in the supplemental.

Recommendation: Staff recommends the requested increase for R6 Medicaid Budget Reductions. See the Medical Services Premiums section for a more detailed analysis. No change is necessary for R12 is necessary, since the base adjustment was already approved in the supplemental.

(F) Provider Audits and Services

Professional Audit Contracts

Description: 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. The following table summarizes Colorado's payment error rate compared to national averages for FY 2007-08 (the report for FY 2010-11 is not yet available). The next audit will occur in FY 2013-14.
- 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 continuation funding.

Recommendation: **Staff recommends the requested continuation funding.** The estimated amounts for each service by fund source are summarized in the table below.

Professional Audit Contracts						
	Total	General Fund	Hospital Provider Fee	Nursing Facility Fee	Federal Funds	Federal Match Rate
Nursing facilities	$1,239,786	$613,683	$0	$12,420	$613,683	49.5%
Hospitals, FQHCs, and RHCs	499,200	249,600	0	0	249,600	50.0%
Single Entry Point Agencies	112,000	56,000	0	0	56,000	50.0%
Payment Error Rate Measurement	0	0	0	0	0	??
Nursing facility appraisals	0	0	0	0	0	??
Colorado Indigent Care Program	500,000	0	250,000	0	250,000	50.0%
DSH Audits	100,000	50,000	0	0	50,000	50.0%
FY 2012-13 Recommendation	$2,450,986	$969,283	$250,000	$12,420	$1,219,283	49.7%

(G) Recoveries and Recoupment Contract Costs

Estate Recovery

Description: 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.

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(2) MEDICAL SERVICE PREMIUMS

This division provides funding for the health care services of individuals qualifying for the Medicaid program. Health care services include both medical care services (such as physician visits, prescription drugs, and hospital visits) and long-term care services (provided within nursing facilities and community settings). The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients.

Medical and Long-term Care Services for Medicaid Eligible Individuals

Description: 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:

- An increase of $441.7 million, including $125.3 million General Fund for R1/BA1 Medical Services Premiums to adjust the appropriation for updated forecasts of enrollment, cost per capita, and available financing;
- A decrease of $1.9 million, including $0.9 million General Fund, for R5 Fee-for-service Payment Reform to provide incentive payments to providers who achieve performance goals related to minimizing high cost avoidable procedures;
- A net decrease of $30.2 million, including $30.6 million General Fund, for R6 Medicaid Budget Reductions that include a number of different strategies to reduce costs, many of which were already approved in the supplemental bill;
- A decrease of $2.2 million, including $1.1 million General Fund, for R7 Medicaid and CHP+ Cost-sharing to increase copayments;
- A decrease of $1.0 million General Fund, for R10 Utilize Supplemental Payments for General Fund Relief to continue the policy approved at supplemental time to retain a portion of the federal funds earned through certified public expenditures to offset the need for General Fund in the Medical Service Premiums line item, and to transfer some certified public expenditure financing from the Safety Net Provider Payments line item to the Medical Service Premiums line item;
- An increase of $1.4 million for BA3 Smoking Cessation Quitline to continue the policy authorized in H.B. 12-1202 to match federal funds for the Smoking Cessation Quitline;

- BA4 Utilize Supplemental Payments for General Fund Relief

Recommendation:

Medical and Long-term Care Services for Medicaid Eligible Individuals					
	Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2011-12 Appropriation	**3,546,661,301**	**1,164,690,834**	**626,928,302**	**6,388,059**	**1,748,654,106**
S1 Revised enrollment/expenditure forecast	100,952,811	42,073,678	5,412,542	57,769	53,408,822
FY 2011-12 Recommendation	**3,647,614,112**	**1,206,764,512**	**632,340,844**	**6,445,828**	**1,802,062,928**
Expiration of one-time or short-duration financing	0	76,815,670	(73,529,319)	(3,286,351)	0
Nursing facility rates, SB 11-215 annualization	8,865,830	4,432,915	0	0	4,432,915
R1/BA1 Enrollment/expenditure forecast	347,830,468	84,486,093	91,707,109	55,863	171,581,403
R5 Fee-for-service reform	(1,138,683)	(535,785)	(31,706)	(1,851)	(569,341)
R6 Medicaid Budget Reductions	(5,740,990)	(2,824,585)	(45,910)	0	(2,870,495)
R7 Cost Sharing for Medicaid and CHP+	(2,171,793)	(1,060,682)	(25,214)	0	(1,085,897)
S9/BA3 Smoking cessation Quitline	796,154	0	398,077	0	398,077
S10/R10/BA4 Utilize supplemental payments for General Fund relief	(1,900,004)	8,484	(639,640)	0	(1,268,848)
FY 2012-13 Long Bill Recommendation	**3,994,155,094**	**1,368,086,622**	**650,174,241**	**3,213,489**	**1,972,680,742**
Continuation of nursing facility reduction	(9,024,676)	(4,512,338)	0	0	(4,512,338)
FY 2012-13 Recommendation	**3,985,130,418**	**1,363,574,284**	**650,174,241**	**3,213,489**	**1,968,168,404**

S1 Revised enrollment/expenditure forecast: Staff recommends the requested adjustment to the FY 2011-12 base appropriation for the revised enrollment and expenditure forecast. The recommendation represents a 2.8 percent increase in total funds and a 3.8 percent increase in General Fund compared to the FY 2011-12 appropriation.

Expiration of one-time or short-duration financing: The staff recommendation reflects the expiration of several JBC- sponsored bills that provided one-time or short-duration financing to offset the need for General Fund in FY 2011-12.

Bill	Fund Source	Amount
SB 11-212	Hospital Provider Fee	25,000,000
SB 11-211	Tobacco Education Programs Fund	17,758,594
	Prevention, Early Detection, and Treatment Fund	11,995,055
	Health Disparities Grant Program	3,286,351
SB 11-219	Primary Care Fund	15,775,670
HB 10-1380	Supplemental Old Age Pension	3,000,000
	TOTAL	76,815,670

Nursing facility rates, SB 11-215 annualization: The staff recommendation reflects a one-time reduction in FY 2011-12 of 1.5 percent to the General Fund portion of per diem rates paid to Medicaid nursing facility providers, pursuant to this JBC-sponsored bill.

R1/BA1 Forecast changes: Staff recommends the requested increase for changes in the enrollment and expenditure forecast. The total shown in the table is the forecast with annualized impacts from SB 11-008 Medicaid Eligibility for Children, SB 11-177 Pregnancy and Dropout Prevention, SB 11-125 Nursing Home Fees and Order of Payments, SB 11-250 Eligibility for Pregnant Women, and budget policy decisions made in SB 11-209 the FY 2011-12 Long Bill.

The recommendation represents a 9.5 percent increase in total funds and a 7.0 percent increase in General Fund compared to the revised FY 2010-11 forecast. The largest enrollment growth is projected among children and adults, who typically have lower per capita costs than the elderly and disabled populations. Although the projected enrollment increases for the elderly and disabled are smaller, they contribute significantly to the overall increase in expenditures, due to the high expenditure per capita for these populations.

The best options currently available to the General Assembly to contain Medicaid enrollment growth are policies that improve the overall economy and reduce the number of uninsured. The General Assembly has little control over the total population in the state or the age distribution of the population. As for eligibility criteria, a combination of federal policies effectively prohibits Colorado from restricting eligibility for any of the Medicaid populations Colorado finances from the General Fund.

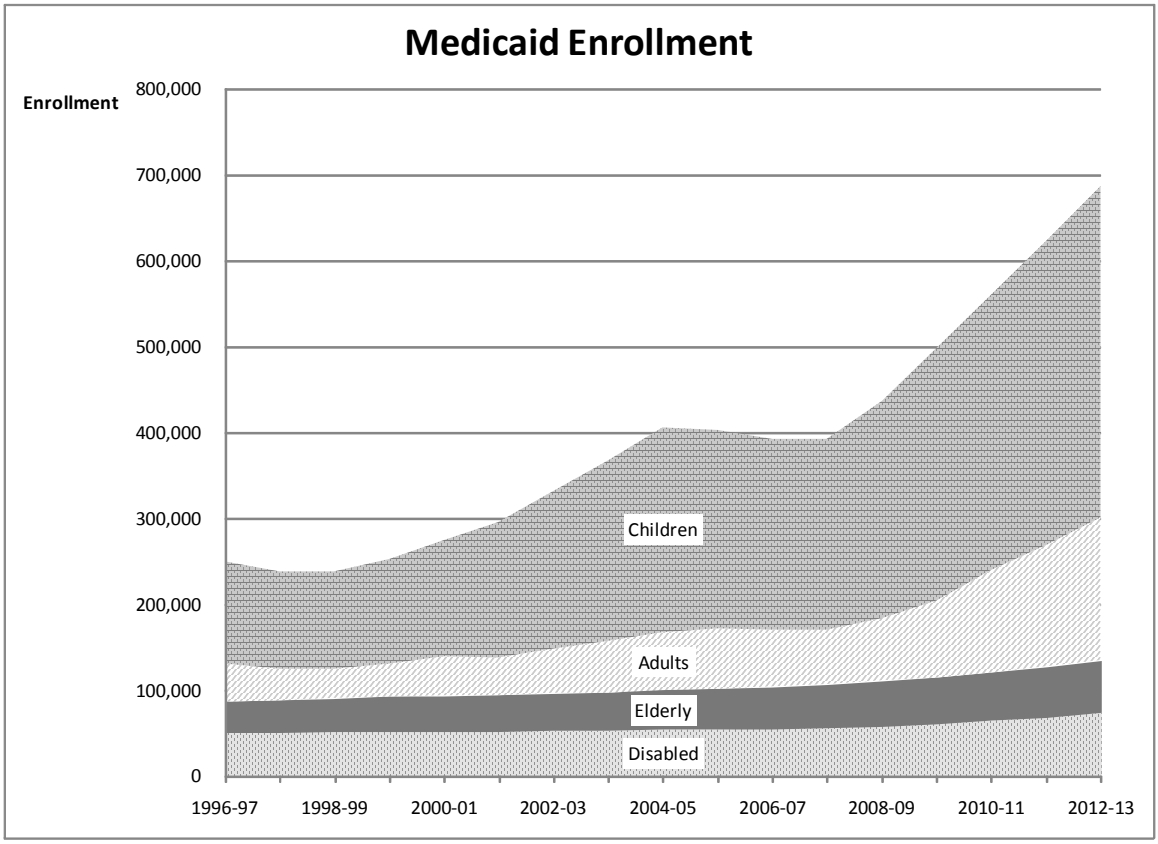
The most significant barrier to changing eligibility criteria is the maintenance of effort requirement of the federal Affordable Care Act (ACA). This provision requires states to maintain at least the eligibility criteria in effect during March of 2010 through January of 2014 for adults on Medicaid, and through September of 2019 for children on Medicaid or the Children's Health Insurance Program. Later this month the Supreme Court will hear arguments consolidated from three court cases challenging provisions of the Affordable Care Act. The outcome from those arguments could change federal policies regarding eligibility. Until the Supreme Court makes a decision, however, the only types of eligibility criteria Colorado could restrict would not save General Fund.

The are six eligibility expansions that will be in effect for FY 2012-13 that were implemented after the maintenance of effort requirement of the ACA, and therefore not subject to the requirement:

- Children and Pregnant Women from 205% to 250%
- Pregnant Women from 133% to 185%
- Buy-in for people with disabilities

- Parents from 60% to 100%
- Adults without dependent children to 10%, capped at 10,000
- Children 6-18 from 100% to 133%

All of these expansion categories are financed from the Hospital Provider Fee except Children 6-18 from 100% to 133% and Pregnant Women from 133% to 185%. Medicaid eligibility for Children 6-18 from 100% to 133% could be reduced, but Colorado would need to cover these children on CHP+, because they were eligible for CHP+ prior to the ACA maintenance of effort, and the Department anticipates Colorado will get the same federal match rate for this population in the Medicaid program as it would in the CHP+ program. While Pregnant Women from 133% to 185% are not subject to the ACA maintenance of effort, CMS is requiring Colorado to cover this population as a condition of authorizing Colorado's CHP+ plan, based on CMS' interpretation of provisions in the Children's Health Insurance Plan Reauthorization Act of 2009. Also, the Department projects that covering this population on Medicaid actually saves General fund, because the average Medicaid reimbursement rates for pregnancy-related care are below CHP+ reimbursement rates.



DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2012-13 FIGURE SETTING

JBC WORKING DOCUMENT -- DECISIONS SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE ACTION

Enrollment	2010-11	2011-12	2012-13
Adults 65 and Older (OAP-A)	38,921	39,867	40,820
Disabled Adults 60 to 64 (OAP-B)	7,767	8,399	8,948
Disabled Individuals to 59 (AND/AB)	56,281	59,589	62,098
Disabled Buy-In	0	58	2,208
Categorically Eligible Low-Income Adults (AFDC-A)	60,958	70,299	77,455
Expansion Adults to 60% FPL	20,154	24,050	26,498
Expansion Adults to 100% FPL	27,166	35,406	42,381
Adults Without Dependent Children (AwDC)	0	1,667	10,000
Breast & Cervical Cancer Program	531	610	679
Eligible Children (AFDC-C/BC)	302,381	336,582	367,649
Foster Care	18,392	18,141	18,159
Baby Care Program-Adults	7,868	7,472	7,546
Non-Citizens	3,213	2,659	2,529
Partial Dual Eligibles	17,090	18,796	20,503

Expenditures	2010-11	2011-12	2012-13
Adults 65 and Older (OAP-A)	$779,503,885	$790,299,421	$824,699,781
Disabled Adults 60 to 64 (OAP-B)	$129,754,347	$137,872,355	$148,784,777
Disabled Individuals to 59 (AND/AB)	$802,436,988	$841,750,042	$896,295,326
Disabled Buy-In	$0	$566,364	$23,492,951
Categorically Eligible Low-Income Adults (AFDC-A)	$219,293,316	$245,486,587	$268,471,049
Expansion Adults to 60% FPL	$56,465,514	$68,184,677	$76,149,713
Expansion Adults to 100% FPL	$62,070,599	$89,960,988	$113,036,833
Adults Without Dependent Children (AwDC)	$0	$6,626,200	$98,333,000
Breast & Cervical Cancer Program	$9,817,196	$11,044,992	$12,113,260
Eligible Children (AFDC-C/BC)	$501,363,403	$539,226,913	$580,420,727
Foster Care	$71,385,668	$71,281,528	$72,787,602
Baby Care Program-Adults	$67,611,716	$62,768,063	$63,486,317
Non-Citizens	$45,370,006	$40,620,820	$41,131,798
Partial Dual Eligibles	$24,223,258	$24,296,262	$27,698,537

Per Capita	2010-11	2011-12	2012-13
Adults 65 and Older (OAP-A)	$20,027.85	$19,823.40	$20,203.33
Disabled Adults 60 to 64 (OAP-B)	$16,705.85	$16,415.33	$16,627.71
Disabled Individuals to 59 (AND/AB)	$14,257.69	$14,125.93	$14,433.56
Disabled Buy-In	$0.00	$9,764.90	$10,639.92
Categorically Eligible Low-Income Adults (AFDC-A)	$3,597.45	$3,492.04	$3,466.16
Expansion Adults to 60% FPL	$2,801.70	$2,835.12	$2,873.79
Expansion Adults to 100% FPL	$2,284.86	$2,540.84	$2,667.16
Adults Without Dependent Children (AwDC)	$0.00	$3,974.93	$9,833.30
Breast & Cervical Cancer Program	$18,488.13	$18,106.54	$17,839.85
Eligible Children (AFDC-C/BC)	$1,658.05	$1,602.07	$1,578.74
Foster Care	$3,881.34	$3,929.31	$4,008.35
Baby Care Program-Adults	$8,593.25	$8,400.44	$8,413.24
Non-Citizens	$14,120.76	$15,276.73	$16,264.06
Partial Dual Eligibles	$1,417.39	$1,292.63	$1,350.95

R5 Fee-for-service reform: Staff recommends a decrease of $797,061, including $375,041 General Fund, for the projected impact of implementing the gainsharing proposals contained in R5. The staff recommendation is half of the requested amount, due to more conservative estimates of the savings that will occur. See the description of R5 at the beginning of this document for a more detailed explanation.

R6 Medicaid Budget Reductions: Staff recommends a total decrease of $5,740,990, including $2,824,585 General Fund, for a collection of cost containment initiatives proposed by the Department. Of the recommended change, a total of $1,150,732, including $562,246 General Fund, is for a new initiative the JBC has not yet considered, and the remainder is for initiatives approved by the General Assembly as part of the supplemental package[1]. Note that R6 also included a request for continuation of a nursing facility reduction, but that requires a bill and is discussed below.

The initiative the JBC has not yet considered is to use a sole source contract for diabetic testing supplies. The Department believes that competitively bidding a sole source contract will result in manufacturer rebates that exceed current practice, including the provision of free glucose meters and free client education and outreach. The only potential negative impact on clients would be from real or perceived defects in the quality and accuracy of the products, and staff assumes the contracting process will protect the state from such problems. The projected rebates are based on feedback the Department received from vendors who expressed interest in bidding on such a sole source contract.

R7 Cost sharing for Medicaid and CHP+: Staff recommends the requested decrease in funding as a result of increasing copayments.

The specific proposed increases in copayments by service, and the projected General Fund savings associated with each, are summarized in the table on the next page.

[1] For descriptions of the previously approved initiatives, please see the JBC staff supplemental recommendations for the Department of Health Care Policy and Financing, dated January 19, 2012, beginning on page 4. The document can be accessed from the JBC's web site, or at this location: http://www.state.co.us/gov_dir/leg_dir/jbc/2011-12/hcpsup1.pdf

	GENERAL FUND Impact				
	FY 2011-12	FY 2012-13	FY 2013-14	Current Rate	Proposed Rate
Medicaid					
Inpatient Hospital Services	0	(20,659)	(28,347)	Lesser of $10 per day or 50% of the averaged allowable daily rate.	Lesser of $12 per day or 50% of the averaged allowable daily rate.
Outpatient Hospital Services	0	(120,175)	(164,896)	$3.00 per visit	$3.80
Practitioner Services	0	(257,696)	(353,593)	$2.00 per visit	$2.55
Optometrist Visit	0	(2,695)	(3,698)	$2.00 per visit	$2.55
Podiatrist Visit	0	(698)	(959)	$2.00 per visit	$2.55
Psychiatric Services	0	(4)	(5)	$0.50 per unit of service (15	$0.65
Community Mental Health Center Services	0	(1,235)	(1,694)	$2.00 per visit	$2.55
Rural Health Clinic/ FQHC Services	0	(299)	(411)	$2.00 per date of service	$2.55
Durable Medical Equipment	0	(25,868)	(35,494)	$1.00 per unit or period of service	$1.30
Laboratory	0	(42)	(57)	$1.00 per date of service	$1.30
Radiology (X-ray) Services	0	(478)	(655)	$1.00 per date of service	$1.30
Prescription Services - Brand Name Drugs	0	(52,815)	(72,469)	$3.00	$3.80
Prescription Services - Generic Drugs	0	(555,255)	(761,884)	$1.00	$1.30
Non-Emergency Medical Transportation	0	0	(19,077)	$0.00	$1.30
Outpatient Substance Abuse	0	0	(15,713)	$0.00	$1.25
Physical, Occupational and Speech Therapy	0	0	(116,104)	$0.00	$2.45
Home Health	0	0	(279,613)	$0.00	$2.45
Private Duty Nursing	0	0	(6,868)	$0.00	$2.45
Non-Emergent Hospital Services	0	(22,786)	(93,797)	$3.65	$7.30
SUBTOTAL - Medicaid	**0**	**(1,060,704)**	**(1,955,336)**		

				Percent of Federal Poverty Guidelines					
				Current Rate			Proposed Rate		
				101-150%	151-200%	201-250%	101-150%	151-200%	201-250%
Children's Basic Health Plan (CHP+)									
CHP+ Enrollment Fees - net after attrition	(138,601)	(338,468)	(371,416)		$25 annually			$75 annually	
Emergency Care and Urgent/After Hours Care	0	(18,413)		$3.00	$15.00	$20.00	$3.00	$20.00	$50.00
Emergency Transport/Ambulance Services	0	(7,125)					$2.00	$15.00	$25.00
Inpatient (Includes mental illness, intractable pain, and autism services in this setting)	0	(15,654)					$2.00	$20.00	$50.00
Physician	0	(12,519)					$2.00	$5.00	$10.00
Outpatient/ Ambulatory	0	(45,990)					$2.00	$5.00	$25.00
Laboratory and X-Ray	0	(54,745)					$0.00	$5.00	$10.00
Prescription Services - Brand Name Drugs	0	(30,415)		$1.00	$5.00	$10.00	$1.00	$10.00	$15.00
SUBTOTAL - CHP+	**(138,601)**	**(523,329)**	**(371,416)**						
Administrative Costs									
MMIS System Changes	0	130,991	0						
Rural Hospital Contractor	0	15,000	0						
SUBTOTAL - Administration	**0**	**145,991**	**0**						
TOTAL	**(138,601)**	**(1,438,042)**	**(2,326,752)**						

The following services would be exempt from the Medicaid copayments:

- Services to children under 19
- Services to pregnant women
- Services to individuals in an institution who are required to spend down their assets
- Emergency services
- Family planning services
- Services to individuals receiving hospice care
- Services to Native Americans
- Services provided under a Community Mental Health Services program, and
- Managed care program services.

The table below provides the estimated average annual cost sharing per client for different populations, based on historic utilization patterns for different services.

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

The Department will achieve the savings by reducing reimbursement rates to providers by the amount of the expected copay for each service. If a provider chooses not to charge the additional copay, or is unable to collect the copay, then the provider will receive less money for the service. So, to the extent that this proposal results in copayments that clients are unable to afford, then the effect of the proposal is to reduce provider payments.

Part of the stated purpose of R-7 is to, "encourage a more involved decision-making process when clients decide whether or not they need to visit a physician or hospital" and "reduce unnecessary emergency or specialty care" and "slow long-term Medicaid and CHP+ cost growth." However, the

Department assumes no change in utilization patterns with higher co-payments. The Department explains that it believes changes in utilization patterns are possible, but did not find sufficient evidence showing a specific relationship between changes in co-payments and utilization patterns. Therefore, the Department estimated the savings conservatively. For FY 2012-13 the benefit of the proposal is primarily from identifying an alternative source of funding to the General Fund, rather than changing utilization patterns.

This proposal is in part an executive branch response to the JBC-sponsored S.B. 11-213, which would have increased annual enrollment fees for CHP+ for families with income above 205 percent of the federal poverty guidelines. The Governor vetoed S.B. 11-213 out of concern that it would have a significant negative impact on enrollment. In R7 the executive branch attempts to achieve an increase in cost-sharing, but spreads the impact over both CHP+ enrollment fees and a number of copayments for services in both CHP+ and Medicaid. The JBC approved the enrollment fee increases for CHP+ in the supplemental. R7 continues and annualizes that policy into FY 2012-13 and adds the copayments for CHP+ and Medicaid. The savings from the Medicaid copayments are reflected in this line item and the savings from the CHP+ copayments are reflected in the Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs line item.

S9/BA3 Smoking cessation Quitline: Staff recommends the requested increase from the Tobacco Education Programs Fund (tobacco tax moneys) to match federal funds and pay for telephone-based smoking cessation coaching and nicotine replacement therapy for Medicaid clients. After the Tobacco Education Programs Fund moneys are matched with federal funds, the total will be transferred to the Department of Public Health and Environment to administer the QuitLine services. Previously the QuitLine services were paid for entirely from the Tobacco Education Programs Fund, but HB 12-1202, sponsored by the JBC, allowed the appropriation of some of the Tobacco Education Programs Fund to match Medicaid funds for the program. The additional federal money will allow DPHE to perform more outreach and serve a larger number of Medicaid clients. The request annualizes the fiscal impact of HB 12-1202.

R10/BA4 Utilize supplemental payments for General Fund relief: Staff recommends the requested R10/BA4 to continue the policy approved in the supplemental of withholding 10.0 percent of the federal funds earned through certifying public expenditures for inpatient and physician services in order to offset the need for General Fund. If not withheld, the money would be distributed through the inpatient high volume supplemental payment and physician supplemental payment to Denver Health and Memorial Hospital.

Continuation of nursing facility reduction: Staff recommends that the JBC sponsor the requested legislation to continue indefinitely the 1.5 percent reduction in the General Fund share of nursing facility per diem rates. This reduction was initially implemented in FY 2010-11 through HB 10-

1324 and continued in FY 2011-12 through SB 11-215. Both bills were sponsored by the JBC. Similar rate reductions implemented in FY 2010-11 for other providers have been carried forward in the base appropriation. Without the proposed legislation, nursing facilities would receive an increase in rates for FY 2012-13 that is not being offered to other providers, and has not been analyzed with a business case for the need or comparisons of rates relative to other providers.

The proposed legislation applies to the per diem component of nursing facility rates that pay for direct and indirect health care, raw food, administrative and general services, and fair rental value. Nursing facilities also receive supplemental payments financed with the nursing facility provider fee and HB 10-1324 and SB 11-215 allowed these supplemental payments to increase to mitigate the impact of the adjustment to the per diem, within the limits on the provider fee allowed by law.

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(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.

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(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

Description: 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 2010-11.

Percent of Federal Poverty Guidelines	Hospital Inpatient	Hospital Emergency Room	Hospital Physician	Outpatient Clinic	Specialty Outpatient Clinic	Prescription/ Lab Services
40% & Homeless	$0	$0	$0	$0	$0	$0
40%	$15	$15	$7	$7	$15	$5
62%	$65	$25	$35	$15	$25	$10
81%	$105	$25	$55	$15	$25	$10
100%	$155	$30	$80	$20	$30	$15
117%	$220	$30	$110	$20	$30	$15
133%	$300	$35	$150	$25	$35	$20
159%	$390	$35	$195	$25	$35	$20
185%	$535	$45	$270	$35	$45	$30
200%	$600	$45	$300	$35	$45	$30
250%	$630	$50	$315	$40	$50	$35

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 100 percent for rural and Critical Access Hospitals, 64 percent for High Volume Medicaid and CICP Hospitals, and 75 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 sources of cash funds are the Hospital Provider Fee and certified public expenditures 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 R10 Utilize Supplemental Payments for General Fund Relief to continue the policy approved by the General Assembly in the supplemental bill of transferring the Inpatient High Volume Supplemental Payment to the Medical Services Premiums section, and then

retaining 10 percent of the federal funds drawn through certified public expenditures to serve as an offset to General Fund in the Medical Services Premiums line item.

Recommendation: **Staff recommends using an updated estimate of the Safety Net Provider Payments to adjust both the FY 2011-12 and FY 2012-13 appropriations.** Although the Department did not submit an official request for a supplemental or budget amendment, the Department did provide the latest projection of the maximum federal funds available through the UPL and DSH financing mechanisms with the February 15 forecast.

Safety Net Provider Payments				
	Total	Hospital Provider Fee	Certified Public Expenditures	Federal Funds
FY 2011-12 Appropriation	**293,928,866**	**144,686,653**	**2,277,780**	**146,964,433**
Forecast adjustment	(4,555,560)	0	(2,277,780)	(2,277,780)
FY 2011-12 Recommendation	**289,373,306**	**144,686,653**	**0**	**144,686,653**
Forecast adjustment	(2,317,774)	(1,158,887)		(1,158,887)
FY 2012-13 Recommendation	**287,055,532**	**143,527,766**	**0**	**143,527,766**

No additional adjustment is needed for R10 as the fiscal impact on the base was already accounted for in the supplemental.

Clinic Based Indigent Care

Description: This line item is similar in purpose to the Safety Net Provider Payments line item, except that instead 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 2010-11 CICP clinic payments covered 67.2 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. The Department is implementing the expansion of Medicaid eligibility for Adults without Dependent Children more slowly than anticipated last year, when the JBC staff recommended eliminating funding for this line item. Funding in this line item may make it easier for people with low-income to receive care in a setting that is less costly than a hospital, saving money for the client and the health care delivery system as a whole. However, funding in this line item is not required by any federal rules or regulations and reducing or eliminating funding to help balance the budget remains an option for the JBC.

Health Care Services Fund Programs

Description: The appropriation for this program in FY 2011-12 was part of a creative 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.

Request: The Department requests no funding in FY 2012-13.

Recommendation: Staff recommends no funding, consistent with the request. The statutory authority that allowed the financing that occurred in FY 2011-12 expires in FY 2012-13, and the only way to

renew it would be for the General Assembly to declare another fiscal emergency. The executive branch is not requesting such a declaration.

Pediatric Specialty Hospital

Description: 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 a reduction of $9,587,944, including $4,793,972 General Fund to eliminate all of the funding not related to the Kids Street Program and the Medical Day Treatment program. This recommendation is similar to a JBC staff recommendation last year that the Committee rejected. The funding in this line item is not required by federal law or regulation. The impact of the staff recommendation would likely be to reduce all funding for hospitals by a small amount. This is because all hospitals receive supplemental payments financed with the Hospital Provider Fee that are allocated at least in part on the hospital's share of financial losses associated with serving Medicaid and CHP+ clients. Absent the funding in this line item, Children's share of the Hospital Provider Fee supplemental payments would increase and the share allocated to other hospitals would decrease.

Appropriation from Tobacco Tax Fund to General Fund

Description: 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: Staff recommends a reduction of $10,917 to reflect the most recent forecast from Legislative Council Staff of the available tobacco tax revenues.

Primary Care Fund

Description: 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 an increase of $28.2 million due to the expiration of the financing authorized by S.B. 11-219.

Recommendation: Staff recommends slightly less than the Department's request, based on the most recent Legislative Council Staff forecast of tobacco tax revenue to the Primary Care Fund. The

distribution of tobacco taxes to the Primary Care Fund is statutory and changing the distribution would require a bill. The statutory authority that allowed the financing that occurred in FY 2011-12 expires in FY 2012-13, and the only way to renew it would be for the General Assembly to declare another fiscal emergency. The executive branch is not requesting such a declaration.

Primary Care Grant Program Special Distributions

Description: 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.

Request: The Department requests no funding.

Recommendation: Staff recommends no funding, consistent with the request, since the statutory authority for the line item provided in S.B. 11-219 expires in FY 2012-13.

Children's Basic Health Plan (CHP+) Administration

Description: 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 MMIS.

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 an increase of $236,671, including $82,835 General Fund for R8 Federally Mandated CHIPRA Quality Measures. The Department's request also includes increases totaling $3,912 to annualize prior year budget decisions.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Children's Basic Health Plan Administration					
	Total	General Fund	CHP+ Trust	Hospital Provider Fee	Federal Funds
FY 2011-12 Appropriation	4,894,410	272,494	1,939,762	8,692	2,673,462

Children's Basic Health Plan Administration					
	Total	General Fund	CHP+ Trust	Hospital Provider Fee	Federal Funds
Health Care Affordability Act, HB 09-1293 annualization	1,912	0	0	669	1,243
Medicaid for Ages 6-19 from 100-133%, SB 11-008 annualization	1,000	0	350	0	650
Medicaid for pregnant women 133-185%, SB 11-250 annualization	1,000	0	350	0	650
R8 Federally mandated quality measures	236,671	82,835	0	0	153,836
Consolidate GF in Medical and Dental	0	(355,329)	355,329	0	0
FY 2012-13 Recommendation	5,134,993	0	2,295,791	9,361	2,829,841

Health Care Affordability Act, HB 09-1293 annualization: Staff recommends the requested increase for Medicaid eligibility expansions authorized by H.B. 09-1293. The request is consistent with the assumptions in the original fiscal note for the bill. The source of cash funds is the Hospital Provider Fee, and the federal match rate is 65.0 percent.

Medicaid for Ages 6-19 from 100-133%, SB 11-008 annualization : Staff recommends the requested increase for one-time costs associated with recomputing the CHP+ capitation rates to account for more children being eligible for Medicaid. The request is consistent with the assumptions in the original fiscal note for the bill. The bill (by Boyd/Gerou) extended Medicaid eligibility to children 6-19 years old with family income from 100.0 percent up to 133.0 percent of the federal poverty guidelines to match the Medicaid eligibility standards for children under 6 and the standards that were in place at the time for pregnant women. Senate Bill 11-008 also allowed appropriations from Tobacco Tax money deposited in the Health Care Expansion Fund (HCEF) for the expansion population. Following the practice established by the JBC last year, staff recommends consolidating appropriations from the HCEF in the Medical Service Premiums line item and using General Fund for the state match for this line item.

Medicaid for pregnant women 133-185%, SB 11-250 annualization: Staff recommends the requested increase for one-time costs associated with recomputing the CHP+ capitation rates to account for more children being eligible for Medicaid. The request is consistent with the assumptions in the original fiscal note for the bill. The bill (by Boyd/Ferrandino; Summers) extended Medicaid eligibility to pregnant women from 133.0 percent up to 185.0 percent of the federal poverty guidelines to comply with federal requirements. The source of cash funds is the Children's Basic Health Plan Trust Fund. The federal match rate for the Medicaid-related programming is 75.0 percent and for the CHP+-related programming it is 65.0 percent.

R8 Federally mandated quality measures: Staff recommends the requested increase to survey five managed care organizations and the state's Managed Care Network more frequently, as required by federal legislation for the Children's Health Insurance Program. The requested funding would pay for administration, analysis, and reporting of the survey.

Consolidate GF in Medical and Dental: Staff recommends a financing adjustment to increase the appropriations from the Children's Basic Health Plan Trust Fund and decrease appropriations from the General Fund line item. The intent of this staff recommendation is to consolidate the General Fund appropriations for CHP+ in the Medial and Dental Costs line item. Over the years administrative costs associated with bills and department initiatives have been requested and appropriated from the General Fund, but staff projects there will be sufficient money in the Children's Basic Health Plan Trust Fund to cover these costs in FY 2012-13. The staff recommendation is ultimately General Fund neutral, because the increase in appropriations from the Trust in this line item will reduce the funds available from the Trust for the Medical and Dental Costs line item, requiring an increase in General Fund for that line item equal to the decrease in General Fund for this line item.

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

Description: 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:

- Adjustments to FY 2011-12 and FY 2012-13 for the most recent enrollment/expenditure forecast, detailed in S3 and R3;
- A decrease for R7 Medicaid and CHP+ Cost Sharing; and,
- A net reduction of $25.3 million, including $4.5 million General Fund, to annualize prior year budget decisions.

The Department also requested that the JBC sponsor legislation in R9 CHP+ Eligibility for Children of State Employees.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Children's Basic Health Plan Medical and Dental Costs						
	Total	General Fund	CHP+ Trust	Hospital Provider Fee	Other Cash	Federal Funds
FY 2011-12 Appropriation	**214,471,872**	**29,859,307**	**32,409,453**	**12,424,786**	**461,701**	**139,316,625**
S3 Revised enrollment/expenditure forecast	(29,603,573)	0	(6,313,755)	(3,738,928)	0	(19,550,890)
FY 2011-12 Recommendation	**184,868,299**	**29,859,307**	**26,095,698**	**8,685,858**	**461,701**	**119,765,735**
FQHC/RHC provider rates, annualize S11	(1,650,176)	0	(539,888)	(37,674)	0	(1,072,614)
R3 Enrollment/expenditure forecast	849,842	(4,485,689)	2,297,562	2,516,177	0	521,792
R7 Cost sharing for Medicaid and CHP+	(1,524,912)	(384,728)	199,867	(218,945)	0	(1,121,106)
Tobacco tax	0	0	0	0	0	0
Colorado Immunization Fund	Pending					0
CHP+ Trust financing	0	(3,000,000)	3,000,000	0	0	0
FY 2012-13 Recommendation	182,543,053	21,988,890	31,053,239	10,945,416	461,701	118,093,807

S3 Revised enrollment/expenditure forecast: Staff recommends the requested decrease to the FY 2011-12 base appropriation for the revised enrollment and expenditure forecast. The recommendation represents a 13.8 percent decrease in total funds compared to the FY 2011-12 appropriation.

R3 Enrollment/expenditure forecast: Staff recommends the requested increase for changes in the enrollment and expenditure forecast. The total shown in the table is the forecast with annualized impacts from SB 11-008 Medicaid Eligibility for Children and SB 11-250 Eligibility for Pregnant Women.

The recommendation represents a 0.5 percent reduction in total funds and a 15.0 percent reduction in General Fund compared to the revised FY 2010-11 forecast.

Enrollment	FY 2010-11	FY 2011-12	FY 2012-13
Children Medical	67,267	67,432	67,542
Children Dental	67,267	67,432	67,542
Prenatal	1,741	1,869	1,360

Expenditure	FY 2010-11	FY 2011-12	FY 2012-13
Children Medical	$141,195,482	$143,574,191	$150,739,560
Children Dental	$10,718,975	$11,393,985	$11,869,156
Prenatal	$177,284,054	$183,482,575	$184,332,418

Per Capita	FY 2010-11	FY 2011-12	FY 2012-13
Children Medical	$2,099.03	$2,129.17	$2,231.79
Children Dental	$159.35	$168.97	$175.73
Prenatal	$14,571.85	$15,256.50	$15,973.31

R7 Cost sharing for Medicaid and CHP+: Staff recommends the requested decrease in funding as a result of increasing copayments. See the Medical Service Premiums line item for a more detailed analysis of the request.

Tobacco tax: Staff recommends a reduction of $10,917 General Fund Exempt and an increase in the same amount from regular General Fund to reflect the most recent forecast of tobacco tax revenue by Legislative Council Staff. 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.

Colorado Immunization Fund: During figure setting for the Department of Public Health and Environment the JBC heard a proposal to reduce the allocation from the Colorado Immunization Fund to CHP+ in order to increase the funds available for other immunizations. At the time this document was prepared, the JBC's decision was pending. A reduction in the allocation from the Colorado Immunization Fund to CHP+ would require an offsetting increase in appropriations from the General Fund.

CHP+ Trust financing: Staff recommends a reduction of $3.0 million General Fund and an increase of a like amount of cash funds from the Children's Basic Health Plan Trust Fund. Based on the Department's enrollment and expenditure forecast, and the staff recommendations thus far, the CHP+ Trust will end both FY 2011-12 and FY 2012-13 with a balance. The JBC's policies

with regard to carrying a balance in the CHP+ trust have varied over the years. Sometimes the JBC has carried large balances, as a way to store funding for potential future needs, either in the CHP+ program or other areas of the budget. Other times the JBC has appropriated every available dollar in the CHP+ Trust.

Children's Basic Health Plan Trust Fund		FY 2011-12	FY 2012-13
Funds Available			
Beginning Balance		$7,745,026	$8,093,193
Enrollment Fees (includes fees from R7)		613,321	860,273
Tobacco Master Settlement		28,292,000	28,230,480
	TOTAL	$36,650,347	$37,183,946
Expenditures			
Executive Director's Office			
Personal Services		$220,448	$226,982
Health, Life, and Dental		21,453	14,684
Short-term Disability		392	274
AED		5,403	5,850
SAED		5,025	5,027
Operating Expenses		768	768
Legal Services (pending)		6,933	6,933
Information Technology Contracts and Projects		246,755	246,828
DHS Medicaid Funded Programs			
Colorado Benefits Management System (pending)		14,517	14,923
Indigent Care Program			
CHP+ Administration		1,939,762	2,212,956
CHP+ Medical and Dental		26,095,698	28,393,260
	TOTAL	$28,557,154	$31,128,485
Ending Balance		$8,093,193	$6,055,461

The staff recommendation doesn't take the full balance in the CHP+ Trust for a couple of reasons:

1. Since annual revenue to the CHP+ Trust is significantly less than the annual total state funds required to match federal funds for the program, any FY 2012-13 reduction in the General Fund for CHP+ will likely need to be restored in FY 2013-14. By taking only half of the balance in FY 2012-13 the staff recommendation potentially allows the Committee to maintain a reduced level of General Fund for two years, rather than one

year, if the JBC does not need the money in the CHP+ Trust for another priority before then.

2. Some of the estimated expenditures from the CHP+ Trust are for line items where the appropriation is pending JBC action, and so staff didn't want to try to appropriate the CHP+ Trust to the dollar.
3. The staff recommendation leaves money in the CHP+ Trust that could be used for balancing during comebacks or supplementals.
4. Spending all of the money in the CHP+ Trust leaves no cushion for errors in the CHP+ forecast.

The JBC may prefer to take a more conservative approach and leave all of the projected balance in the CHP+ Trust for future potential contingencies. The staff recommendation assumes that the JBC will need the $3.0 million to balance.

Please note that the staff recommendation applies to FY 2012-13, but the JBC could do the proposed refinancing in FY 2011-12, instead. Any change to FY 2011-12 appropriations from the CHP+ Trust will change the projected balance in the CHP+ Trust in FY 2012-13.

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(5) OTHER MEDICAL SERVICES

Old Age Pension State Medical Program

Description: 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 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.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Old Age Pension State Medical Program				
	Total	General Fund	OAP Health	Supplemental OAP Health
FY 2011-12 Appropriation	**11,000,000**	**0**	**9,998,483**	**1,001,517**
Phase out Supplemental OAP Health Fund, SB 11-210 annualization	(1,001,517)	0	0	(1,001,517)
Medical Identification Cards	(76)	0	(76)	0
Maintain FY 2011-12 reimbursement rates	2,400,000	2,400,000	0	0
FY 2012-13 Recommendation	12,398,407	2,400,000	9,998,407	0

Phase out Supplemental OAP Health Fund, SB 11-210 annualization: Staff recommends eliminating appropriations from the Supplemental Old Age Pension Health and Medical Fund, consistent with S.B. 11-210. The Department failed to account for this bill in the request. The bill eliminates the Supplemental OAP Health and Medical Fund in FY 2012-13 and transfers any remaining balance to the General Fund.

Medical Identification Cards: The Old Age Pension Health and Medical Fund receives a total of $10.0 million annually. Of this amount $1,593 is spent on medical identification cards. At some point the remainder available for appropriation in this line item got out of sync, and this recommendation corrects the technical error.

Maintain FY 2011-12 reimbursement rates: Staff recommends an appropriation of $2,400,000 General Fund to provide enough money for the Department to maintain reimbursement rates at the FY 2010-11 levels. The JBC sponsored S.B. 11-210 with the assumption that the population eligible for the OAP Health and Medical Program would decrease dramatically as Medicaid eligibility was expanded to include adults without dependent children up to 100 percent of the federal poverty guidelines (an expansion authorized by H.B. 09-1293 and financed with the Hospital Provider Fee). Since S.B. 11-210 was adopted, the planned Medicaid expansion has been reduced to adults without dependent children up to 10 percent of the federal poverty guidelines with a cap of 10,000 on the total number of people eligible. This means that the population eligible for the OAP Health and Medical Program will not decrease as dramatically as anticipated.

Based on the Department's current forecast of enrollment and expenditures for the program, the Department would need to reduce provider reimbursement rates to stay within the available funds from the Old Age Pension Health and Medical Fund.

Claim Type	FY11-12 Rates (Percent of Medicaid)	FY 2012-13 Projected Expenditures	Rate Reduction Needed	Rates with Reduction

	FY11-12 Rates	FY 2012-13	Rate Reduction	Rates with
Capitation	100.0%	$0	0.0%	100.0%
Pharmacy Claim	75.0%	$4,188,955	15.0%	60.0%
Inpatient	10.0%	$402,302	0.0%	10.0%
Outpatient	65.0%	$3,757,673	15.0%	50.0%
Practitioner/Physician	65.0%	$3,014,623	15.0%	50.0%
Dental	65.0%	$51,763	15.0%	50.0%
Independent Laboratory	65.0%	$156,361	15.0%	50.0%
Medical Supply	65.0%	$444,277	15.0%	50.0%
Home Health	65.0%	$249,492	15.0%	50.0%
Transportation	65.0%	$46,961	15.0%	50.0%
Mcare Part A Crossover	100.0%	$3,068	0.0%	100.0%
Mcare Part B Crossover	100.0%	$34,857	0.0%	100.0%
Mcare UB92 Part B Crossover	100.0%	$27,742	0.0%	100.0%
Total		**$12,378,073**		
Old Age Pension Health and Medical Fund		$9,998,483		
Shortfall		$2,379,590		

Commission on Family Medicine

Description: 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 a decrease of $350,000, including $175,000 General Fund. The Department's request treats the supplemental increase that occurred as a result of sufficient revenues from the tax amnesty program authorized in SB 11-184 (Steadman/Ferrandino) as a one-time, rather than on-going, increase.

Recommendation: Staff recommends continuation funding. The JBC tried to reduce funding last year and the General Assembly restored the reduction. The money used for restoring the funds came from a one-time source (the tax amnesty bill), but staff assumes the intent was to maintain the funding level into the future. While staff is recommending continuation funding, the JBC should note that (1) the staff interpretation of the General Assembly's intent may not be accurate; and, (2) the same arguments that led to the JBC's decision to reduce funding last year would still apply in FY 2012-13. This program is not required by any federal law or regulation and rather than impacting clients a reduction to this program would impact institutions (i.e. teaching hospitals) that have the ability to cost shift the loss, reduce their own operating expenses, or absorb it. Staff believes a strong case can

be made for reducing this line item consistent with the request, instead of adopting the staff recommendation.

State University Teaching Hospitals -- Denver Health and Hospital Authority

Description: This line item provides funding for the Denver Health and Hospital Authority for Graduate Medical Education (GME). It also helps 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.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

State University Teaching Hospitals -- University of Colorado Hospital Authority

Description: This line item provides funding for the University of Colorado Hospital Authority for Graduate Medical Education (GME). It also helps 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.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Medicare Modernization Act

Description: This line item pays the state's obligation under the Medicare Modernization Act 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.

Request: In S4 and R4 the Department requests adjustments to the FY 2011-12 and FY 2012-13 appropriations for the most recent forecast of the state's obligation. In R11 the Department proposes continuing the policy approved in the supplemental bill of applying federal bonus payments earned by meeting performance objectives for CHP+ to offset the need for General Fund in this line item. The Department's request also includes annualizations of prior year budget decisions.

Recommendation: Staff recommends the changes described in the following table. Each component of the staff recommendation is discussed in the narrative below the table.

Medicare Modernization Act			
	Total	General Fund	Federal Funds
FY 2011-12 Appropriation	**91,156,720**	**60,513,438**	**30,643,282**
S4 Revised expenditure forecast	2,356,099	2,356,099	0
FY 2011-12 Recommendation	**93,512,819**	**62,869,537**	**30,643,282**
R4 Expenditure forecast	(2,856,643)	(2,856,643)	0
R11 CHIPRA bonus payments	0	(9,403,608)	9,403,608
FY 2012-13 Recommendation	90,656,176	50,609,286	40,046,890

S4 Revised expenditure forecast: Staff recommends the requested adjustment for the Department's most recent forecast of Colorado's obligation under the Medicare Modernization Act.

The variables that impact the state obligation under the Medicare Modernization Act are increases in the caseload of people dually eligible for Medicaid and Medicare, and inflation in drug expenditures. The federal formula uses the state's 2003 drug benefit per member per month for people dually eligible for Medicaid and Medicare, inflated by either the average growth rate from the National Health Expenditure per-capita drug expenditures or actual growth in drug expenditures. The inflated rate per member per month is multiplied by the number of dual-eligible clients, and then multiplied by a declining percentage contained in the Medicare Modernization Act to determine the state obligation (80 percent in calendar year 2012).

Both dual-eligible enrollment and the National Health Expenditures per-capita drug expenditures have come in higher than expected. Since the Department already has the National Health Expenditures per-capita drug expenditures, the only variable that may change in the February update is the enrollment projection.

R4 Expenditure forecast: Staff recommends the requested adjustment for the Department's most recent forecast of Colorado's obligation under the Medicare Modernization Act. The figure in the table is the forecast with the of annnualizations of prior year budget decisions.

R11 CHIPRA bonus payments: Staff recommends the requested application of bonus payments from the federal government for meeting outreach and retention performance goals for children in the Medicaid and Children's Health Insurance Program (CHP+) to offset the need for General Fund in the Medicare Modernization Act State Contribution Payment line item.

Colorado earned the money as a result of implementing outreach and retention policies encouraged by the federal government. Specifically, Colorado implemented 12-month continuous eligibility for children in CHP+, liberalized asset test requirements for children for CHP+ and Medicaid,

eliminated in-person interview requirements for applying for Medicaid and CHP+, established a joint application and verification process for enrollment in Medicaid and CHP+, implemented presumptive eligibility for children for Medicaid and CHP+, and implemented an option to provide premium assistance under Medicaid and CHP+. Colorado has not implemented continuous enrollment for children in Medicaid, automatic renewal of eligibility for Medicaid and CHP+, or the use of express lane agencies to enroll people in Medicaid and CHP+. But, these are not required to meet the minimum eligibility for the bonus payments.

After meeting the minimum eligibility criteria for the bonus payments, funding is based on enrollment growth relative to target levels that are set using 2007 enrollment inflated by the state's child population growth and a national factor based on national caseload growth. Enrollment between 100 and 110 percent of the target level is rewarded at a rate of 15 percent of the state share of the average per capita cost of a Medicaid child and enrollment above 110 percent of the target level is rewarded at a rate of 62.5 percent of state's share of the average cost per child. If Colorado were to implement strategies to further increase child enrollment in Medicaid and CHP+, the net impact after taking into account the bonus payment would be an effective lower state share per child (31.25 percent per Medicaid child above 110 percent of the target enrollment level).

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

Description: 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 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. In FY 2010-11 participation included 74 school providers that served 11,310 children.

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 an increase of $4,290,860 for the Public School Health Services line to annualize BA5 from FY 2011-12.

Recommendation: Staff recommends continuation funding. Staff does not recommend the annualization of BA5, because the Department is not on track to achieve the increase in participating providers that was the objective of the budget amendment. The budget amendment assumed that with additional administrative funding the Department could raise the number of participating providers from 64 in FY 2010-11 to 70 in FY 2011-12 and 82 in FY 2012-13. The Department currently reports 54 participating providers. The appropriation in the Public School Health Services line is an estimate of the federal funds that the Department will draw with certified public expenditures, but it is important because pursuant to statute the Department may not spend more than 10.0 percent of the appropriated federal funds for administration. The staff recommendation allows the Department to continue spending the roughly $330,000 increased federal funds for administration authorized by BA 5 for one more year to try to increase participation.

(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.

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

Comment: The footnote explains assumptions used to prepare the appropriation. Staff will update the figures in the table to reflect the JBC's decisions.

12 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs** -- This appropriation assumes the following: (1) A total children's caseload of 75,811 at an average medical per capita cost of $2,288.21 per year; and (2) a total adult prenatal caseload of 2,391 at an average medical per capita cost of $14,711.52 per year.

Comment: The footnote explains assumptions used to prepare the appropriation. Staff will update the figures in the table to reflect the JBC's decisions.

13 **Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs --** This appropriation assumes an average cost of $171.04 per child per year for the dental benefit.

Comment: The footnote explains assumptions used to prepare the appropriation. Staff will update the figures in the table to reflect the JBC's decisions.

14 **Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding --** The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the head notes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations to the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriation in this section (5) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

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

Staff recommends discontinuing the following footnotes:

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

Comment: The Department reduced rates consistent with the assumptions. This is no longer an assumption for FY 2012-13.

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

Comment: The Department reduced rates consistent with the assumptions. This is no longer an assumption for FY 2012-13.

REQUESTS FOR INFORMATION

Staff recommends continuing the following requests for information.

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 is an ongoing standard report the Department has been providing for several 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~~, 2012~~ EACH YEAR, to the Joint Budget Committee, estimating the disbursement to each hospital from the Safety Net Provider Payment line item ~~for FY 2011-12~~.

Comment: Staff recommends making this an annual report.

4 **Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project --** The Department of Health Care Policy and Financing is requested to submit a report by ~~November 1, 2011~~ 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 ~~for FY 2012-13, FY 2013-14, and FY 2014-15~~;
(b) information comparing the cost effectiveness of this contract when compared to eligibility performed by the counties;

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

Comment: The JBC did not focus this year on how to handle eligibility determinations, but the issue remains. Staff sees arguments for a county-based system and for a centralized eligibility system, but in Colorado a hybrid system has developed that includes elements of both. The Department views this as a positive, with "no wrong door" for entry into the Medicaid and CHP+ systems, but staff believes this is an area to continue to monitor for whether there is a more efficient or better way to perform eligibility determinations.

9 **Department of Health Care Policy and Financing, Medical Services Premiums** -- The Department is requested to submit a report by ~~November 1, 2011~~ NOVEMBER 1, 2012, to the Joint Budget Committee providing information on the implementation of the Accountable Care Collaborative Organization project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the pilot program, the current administrative fees and costs for the program, and any initial results that demonstrate savings for the pilot program. If data is not available to determine saving results, the Department shall note when such data is anticipated to be available.

Comment: The Department submitted the report as requested, but it was hard to draw conclusions so soon into the implementation of the Accountable Care Collaborative, and so staff recommends requesting an update again for the FY 2013-14 budget cycle.

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

Comment: The Department submitted the report as requested, but the Department has not achieved goals for increasing participation in the program, and so staff recommends an update for the FY 2013-14 budget cycle.

Staff recommends discontinuing the following footnotes:

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

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

Comment: The Department submitted the report as requested. See the JBC staff budget briefing for a summary of the results.

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

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

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

Comment: The Legislative Requests for Information 6-8 all dealt with increasing cost-sharing for Medicaid and the Children's Basic Health Plan. The Department submitted the reports as requested. This issue was addressed in the Department's R7 Cost Sharing for Medicaid and CHP+

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

Comment: The Department is not planning any reimbursement increases, and in fact staff is recommending a General Fund increase for the program to avoid any potential decrease in rates.