COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

SUPPLEMENTAL REQUESTS FOR FY 2011-12 and FY 2010-11

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(All divisions except Medicaid Mental Health Community Programs)

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

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Prioritized Supplementals

Supplemental Request, Department Priority #1
Medical Services Premiums

	Request	Recommendation
Total	$62,369,672	Pending
General Fund	51,312,453	
Cash Funds	(22,107,528)	
Reappropriated Funds	80,723	
Federal Funds	33,084,024	

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made.* Specifically, new information is available regarding the caseload and expenditures for the Medicaid entitlement program.	

Department Request: The Department requests an increase of $62.4 million total funds, including $51.3 million General Fund, based on the Department's ***preliminary*** forecast of FY 2011-12 Medical Services Premiums submitted with the November 1 budget request. This is a 1.8 percent increase in total funds and a 5.7 percent increase in General Fund from the current appropriation.

The Department will be submitting a revised supplemental request for the Medicaid forecast on or before February 15, 2011.

Staff Recommendation: ***The staff recommendation is pending.*** Staff recommends waiting for the February update to the Department's caseload and expenditure forecast, and then making appropriation adjustments for the Medical Service Premiums line item in the Long Bill Supplemental Add-on (a section of the annual budget bill that amends the current year appropriation). This is consistent with the JBC's practice in prior years. Until the February update is available, staff recommends using the Department's request as a placeholder for the need for Medical Services Premiums.

Supplemental Request, Department Priority #3
Children's Basic Health Plan Medical and Dental Costs

	Request	Recommendation
Total	($29,600,573)	Pending

	Request	Recommendation
Children's Basic Health Plan Trust - CF	(6,313,755)	
Hospital Provider Fee - CF	(3,735,928)	
Federal Funds	(19,550,890)	

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, new information is available regarding the caseload and expenditures for the Children's Basic Health Plan Medical and Dental Costs.	

Department Request: The Department requests a decrease of $29.6 million total funds based on the Department's ***preliminary*** forecast of FY 2011-12 Children's Basic Health Plan Medical and Dental expenditures submitted with the November 1 request. This is a 13.9 percent decrease from the current appropriation. The Department proposes reducing cash funds from the Children's Basic Health Plan Trust and the Hospital Provider Fee.

Reduced expenditures from the Children's Basic Health Plan Trust will result in a larger year-end fund balance. The Children's Basic Health Plan Trust Fund currently receives revenue from:

- Tobacco master settlement moneys
- Enrollment fees, and
- Interest

Reduced expenditures from the Hospital Provider Fee will result in a refund of fees to the hospitals that paid the fees at the end of the federal fiscal year.

Staff Recommendation: ***The staff recommendation is pending.*** Staff recommends waiting for the February update to the Department's caseload and expenditure forecast, and then making appropriation adjustments for the Children's Basic Health Plan Medical and Dental line item in the Long Bill Supplemental Add-on (a section of the annual budget bill that amends the current year appropriation). Although in some years the JBC has made adjustments to the CHP+ appropriations before the February update, there are significant changes in the CHP+ caseload this year, and so staff recommends waiting for the additional data that will be available with the February update to confirm the trends before making changes to the appropriation.

Staff Analysis: Based on the data available to date, the JBC could reduce General Fund appropriations for CHP+. The Department did not request a reduction in General Fund appropriations, but if the November forecast is correct the CHP+ program is over-appropriated.

Historically, the General Assembly has carried a balance in the Children's Basic Health Plan Trust, and so the JBC may not want to reduce General Fund appropriations. Also, since the November forecast the CHP+ caseload has been trending higher, and so it is likely that the February update will show less of a surplus.

The lower projected expenditures for CHP+ in FY 2011-12 are primarily attributable to a lower caseload and lower per capita expenditures in FY 2010-11 than originally anticipated. Also impacting the forecast are the actuarially calculated capitation rates for FY 2011-12, which are lower than previous estimates for medical services, but higher than previous estimates for dental services.

Supplemental Request, Department Priority #4
Medicare Modernization Act State Contribution Payment

	Request	Recommendation
General Fund	$2,356,099	Pending

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the request reflects a new estimate of the state obligation under the Medicare Modernization Act to reimburse the federal government for the state share of pharmaceuticals covered by Medicare for people dually eligible for Medicare and Medicaid.	

Department Request: The Department requests an increase of $2.4 million General Fund based on the Department's ***preliminary*** forecast submitted with the November 1 request of the state's FY 2011-12 obligation under the Medicare Modernization Act. This is a 2.6 percent increase from the current appropriation.

Staff Recommendation: ***The staff recommendation is pending.*** Staff recommends waiting for the February update to the Department's caseload and expenditure forecast, and then making appropriation adjustments for the Medicare Modernization Act State Contribution Payment line item in the Long Bill Supplemental Add-on (a section of the annual budget bill that amends the current year appropriation). Based on enrollment to date, staff suspects that this amount will not likely change much in the February update, but waiting for the February update will allow the supplemental to be based on the most recent data available, and is consistent with the staff recommendation for the other requests that are based on changes in caseload and expenditures.

Staff Analysis: 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.

Supplemental Request, Department Priority #5
Medicaid Budget Reduction

	Request	Recommendation	Staff Rec. Higher/(Lower)
Total	($7,859,799)	($6,948,163)	$911,636
General Fund	(19,618,256)	(19,172,833)	445,423
Cash Funds	15,625,858	15,636,252	10,394
Federal Funds	(3,867,401)	(3,411,582)	455,819

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the Department has implemented, or proposes to implement, new rules that impact projected Medicaid expenditures.	

Department Request: This request is the supplemental companion to R-6 that was submitted with the November 1 budget request. It includes the FY 2011-12 fiscal impact of the proposals contained in R-6. The table on the next page and the narrative following the table summarize the components of the request.

	FY 2011-12				FY 2012-13				Implementation
	TOTAL	General Fund	Cash Funds	Federal Funds	TOTAL	General Fund	Cash Funds	Federal Funds	Date
Department Request									
Hospital Provider Fee Financing	0	(15,700,000)	15,700,000	0	0	(15,700,000)	15,700,000	0	Jan-11
Physician Administered Drug Pricing and Unit Limits	(359,305)	(175,555)	(4,097)	(179,653)	(416,472)	(203,488)	(4,748)	(208,236)	Jul-11
Reimbursement Rate Alignment for Developmental Screeni	(1,620,574)	(791,810)	(18,477)	(810,287)	(2,092,701)	(1,022,490)	(23,860)	(1,046,351)	Aug-11
Preterm Labor Prevention	131,615	65,807	0	65,808	(902,736)	(451,368)	0	(451,368)	Aug-11
Expansion of Physician Administered Drug Rebate Program	(1,738,620)	(869,310)	0	(869,310)	(2,418,276)	(1,209,138)	0	(1,209,138)	Oct-11
Synagis Prior Authorization Review	(211,253)	(103,217)	(2,409)	(105,627)	(419,772)	(205,100)	(4,786)	(209,886)	Nov-11
Seroquel Restrictions	(694,210)	(339,190)	(7,915)	(347,105)	(1,931,172)	(943,568)	(22,018)	(965,586)	Jan-12
Dental Efficiency	(603,812)	(295,022)	(6,884)	(301,906)	(1,641,594)	(802,081)	(18,716)	(820,797)	Jan-12
Ambulatory Surgical Centers	(500,000)	(244,299)	(5,701)	(250,000)	(1,000,000)	(488,599)	(11,401)	(500,000)	Jan-12
Augmentive Communication Devices	(184,500)	(90,146)	(2,104)	(92,250)	(492,000)	(240,391)	(5,609)	(246,000)	Jan-12
Public Transportation Utilization	(615,598)	(300,780)	(7,019)	(307,799)	(209,574)	(102,398)	(2,389)	(104,787)	Jan-12
Pharmacy Rate Methodology Transition	(1,000,000)	(488,599)	(11,401)	(500,000)	(4,000,000)	(1,954,394)	(45,606)	(2,000,000)	Apr-12
Home Health Care Cap	(652,941)	(319,026)	(7,444)	(326,471)	(4,117,163)	(2,011,640)	(46,941)	(2,058,582)	Apr-12
Home Health Therapies Cap	(60,601)	(29,609)	(691)	(30,301)	(382,453)	(186,866)	(4,360)	(191,227)	Apr-12
Continuation of Nursing Facility Reduction	0	0	0	0	(9,024,677)	(4,512,338)	0	(4,512,339)	Jul-12
Durable Medical Equipment Preferred Provider	0	0	0	0	(1,150,732)	(562,246)	(13,120)	(575,366)	Jul-12
Utilization Management Vendor Funding	250,000	62,500	0	187,500	500,000	125,000	0	375,000	Jul-11
TOTAL	**(7,859,799)**	**(19,618,256)**	**15,625,858**	**(3,867,401)**	**(29,699,322)**	**(30,471,105)**	**15,496,446**	**(14,724,663)**	
Staff Recommended Changes									
Dental Efficiency - allow time for slower implementation	(301,906)	(147,511)	(3,442)	(150,953)	0	0	0	0	
Ambulatory Surgical Centers - assume no FY 11-12 savings	500,000	244,299	5,701	250,000	0	0	0	0	
Home Health Care Cap - do not implement	652,941	319,026	7,444	326,471	4,117,163	2,011,640	46,941	2,058,582	
Home Health Therapies Cap - do not implement	60,601	29,609	691	30,301	382,453	186,866	4,360	191,227	
Subtotal - Staff Recommended Changes	**911,636**	**445,423**	**10,394**	**455,819**	**4,499,616**	**2,198,506**	**51,301**	**2,249,809**	
NEW TOTAL with staff recommended changes	**(6,948,163)**	**(19,172,833)**	**15,636,252**	**(3,411,582)**	**(25,199,706)**	**(28,272,599)**	**15,547,747**	**(12,474,854)**	

Hospital Provider Fee Financing: Prior to the Hospital Provider Fee the Department would certify public expenditures (CPE) by government-owned or operated outpatient hospitals to draw additional federal funds to the upper payment limit (UPL) set by the federal government as the maximum allowable Medicaid reimbursement. The Department would then retain a portion of the federal funds matched through the CPE process to offset the need for General Fund in the Medical Services Premiums line. The Hospital Provider Fee takes government owned or operated outpatient hospitals to the UPL, eliminating the CPE for these entities. Instead, the Department proposes retaining some of the Hospital Provider Fee to offset the need for General Fund in the Medical Services Premiums line.

Staff Recommendation: ***Staff recommends approval of the request.*** This use of the Hospital Provider Fee was specifically authorized by HB 09-1293. It appears that the FY 2011-12 appropriation did not include the refinancing of the General Fund from the Hospital Provider Fee due to an oversight. Although staff recommends the request, see the staff comments about inconsistent withholding from certified public expenditures under the recommendation on S-10.

Physician Administered Drug Pricing and Unit Limits: The Department proposes reduced rates for risperidone to match Medicare rates. The Department also increased rates for haloperidol decanoate and fluphenazine decanoate to match Medicare rates, but the Department corrected billing unit limits for these drugs to generate net savings. All three drugs are used to treat schizophrenia.

Staff Recommendation: ***Staff recommends approval of the request.*** The corrected billing unit limits addressed technical billing problems and should not impact medically necessary access to the drugs. The rate adjustments made Medicaid reimbursement more consistent with Medicaid.

Reimbursement Rate Alignment for Developmental Screenings: The Department reduced the rates paid for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. The Department also limited the number of screenings per year and the age of clients eligible for the screenings.

Staff Recommendation: ***Staff recommends approval of the request.*** The limits on screenings appear targeted at repeats due to uncoordinated care. The Department reports that the limits comply with federal and industry standards and exceptions will be granted for medical necessity. The Department used a combination of Medicare rates and private insurance rates as the index for the Medicaid rates, since some of the services are not frequently provided to Medicare clients.

Preterm Labor Prevention: The Department extended coverage to include alpha hydroxyprogesterone caproate injections that reduce the occurrence of preterm labor. There is approximately a six-month delay between implementation of the program and expected clinical effectiveness. Thus, there will be an increase in expenditures for the drug in FY 2011-12, but the Department anticipates that avoided costs related to preterm labor will result in a net savings in FY 2012-13.

Staff Recommendation: ***Staff recommends approval of the request.*** This expands Medicaid coverage, rather than contracting it. The Department cited a study from the New England Journal of Medicine as the basis for the projected efficacy of the drug in preventing preterm labor.

Expansion of the Physician Administered Drug Rebate Program: The Department expanded the list of physician-administered drugs eligible for rebates. Also, the Department is performing outreach to providers to ensure that they provide sufficient information to the Department for the Department to claim the rebates.

Staff Recommendation: ***Staff recommends approval of the request.*** The primary potential impediment to the Department achieving the projected additional drug rebates is getting providers to submit bills properly with sufficient information for the Department to claim the rebates. The Department conservatively assumed that rebates for drugs recently added to the eligible list would be collected at 50 percent of the rate for drugs on the list prior to the expansion. Also, the Department did not include retroactive rebates, but it is possible the Department will be able to collect rebates for drugs administered prior to the expansion that was implemented in September of 2011.

Synagis Prior Authorization: The Department has increased prior authorization review requirements for this drug to ensure only appropriate dosages are utilized. The drug is commonly prescribed as a prophylactic to reduce the likelihood of hospitalization from respiratory syncytial virus (RSV).

Staff Recommendation: ***Staff recommends approval of the request.*** The prior authorization review requirements are intended to limit doses to the level recommended by the American Academy of Pediatrics. The Department doesn't have detailed clinical data to support the projected savings, and instead made extrapolations from the impact of increased prior authorization requirements implemented in West Virginia and Tennessee for different drugs. While the estimating methodology is not very precise, staff views it as sufficiently conservative to recommend the proposed reduction in funding.

Seroquel Restrictions: The Department is implementing procedures to prevent the utilization of Seroquel for off label use. Seroquel is designed to treat schizophrenia and mood disorders, but is sometimes prescribed for off-label use as a sleep aid or anxiety reducer.

Staff Recommendation: ***Staff recommends approval of the request.*** The Department reports there are other drugs available to aid sleep and to reduce anxiety with proven effectiveness and lower costs.

Dental Efficiencies: The Department is limiting orthodontics coverage to cases where the client has a severely handicapping malocclusion, requiring prior authorization review for preparatory diagnostics (casts, x-rays, etc), and converting from upfront reimbursements to installment payments.

Staff Recommendation: ***Staff recommends assuming half of the projected savings in FY 2011-12.*** There are two components to the projected savings. Converting upfront reimbursements to installment payments avoids paying for services that are not rendered or services for clients who are no longer eligible. The second part of the savings is due to tightening coverage limits. At the hearing the Department described the proposal as limiting coverage to cases where speech or the ability to eat is significantly impaired. The Department indicates that Colorado's current orthodontic coverage limits are worded more ambiguously than limits in other states, and that Colorado's orthodontic expenditures significantly exceed orthodontic expenditures in states with more precise limits. The Department did not detail the portion of the projected savings attributable to the stricter definition of the orthodontic service limits, and so further work would need to be done if the JBC wants to exclude this from the projected savings. In the hearing responses the Department reported: "The Department is working with stakeholders to establish reimbursement methodologies and clear definitions of qualifying criteria for this benefit to ensure clients have access to services when appropriate." This hearing response was submitted January 4, but the Department's savings estimate assumes the tighter coverage limits are in place January 1. Staff recommends reducing the projected savings to one quarter of the fiscal year, rather than half of the fiscal year, to ensure that the Department doesn't rush through negotiations with stakeholders on the parameters of the coverage limit, since the coverage limit has the potential to negatively impact clients. Staff recommends approving the request, but potentially revisiting it if the implementation results in significant issues with access to coverage.

Ambulatory Surgical Centers: The Department initiated a pilot project to shift outpatient surgery utilization from outpatient hospitals to less costly ambulatory surgical centers. In the pilot program ambulatory surgical centers perform enhanced outreach to surgeons participating in Medicaid to encourage the migration of services to the ambulatory surgical center setting. The Department hopes to implement changes in reimbursements to further provide incentives.

Staff Recommendation: ***Staff does not recommend the request.*** The goal is appropriate, but based on the Department's description of progress to date, staff is not convinced that this idea is far enough along to expect a shift in utilization during FY 2011-12.

Augmentative Communication Devices: The Department is performing outreach to increase utilization of tablet computers instead of more expensive traditional devices for people with impairments that hinder their ability to produce or comprehend verbal or visual communication.

Staff Recommendation: ***Staff recommends approval of the request.*** This proposal has no negative impact on clients.

Public Transportation Utilization: The Department is lowering base funding and adding potential bonus payments for meeting performance goals in the contracts with non emergent medical transportation providers to increase the utilization of public transportation in the Denver-metro area.

Staff Recommendation: ***Staff recommends approval of the request.*** This may make accessing health services less convenient for some clients, but it is hard to assess the degree. All clients will have access to transportation. The Department is reducing the contract with the transportation provider for the Denver metro area and offering incentives if the contractor achieves performance goals regarding the utilization of public transportation. The majority of the savings in FY 2011-12 is attributable to a one-time switch from prospective to retrospective payment of the transportation provider.

Pharmacy Rate Methodology Transition: The Department proposes switching from using the average wholesale price (AWP) for drugs to determine pharmaceutical reimbursement rates to using the costs of ingredients, as measured by the wholesale acquisition cost (WAC) or state maximum allowable cost (SMAC), plus the costs of dispensing. A recent lawsuit found flaws in the AWP and the company that produced the index is no longer publishing it. The Department expects the change in reimbursement methodology will reduce total expenditures.

Staff Recommendation: ***Staff recommends approval of the request.*** Criticism aimed at this proposal has made a big deal that the projected $4.0 million savings in FY 2012-13 ($2.0 million General Fund) has been preordained by the Department before the Colorado-specific studies of wholesale acquisition cost and dispensing costs are complete. Also, the Department has been criticized for burying a provider rate reduction in a budget the executive branch has described as not including any provider rate reductions. Both criticisms have some merit. However, to the extent that the Department gave guidance to the contractor that the goal of the Colorado-specific pricing was to be cost neutral less $4.0 million dollars, staff is more concerned that the Department biased the floor of the study, rather than the ceiling, based on the preliminary data about drug pricing presented by the Department at the hearing. The reason the Department is changing the drug pricing methodology in the first place is that the courts found the Average Wholesale Price, which was used by many state Medicaid programs and private insurers to set reimbursement rates, artificially inflated costs resulting in inappropriately high reimbursement levels.

Home Health Care Cap: The Department proposes limiting the number of hours of skilled care a patient can receive in the home health setting to eight per day, starting in April 2012. In FY 2010-11 the limit would have impacted 459 clients.

Staff Recommendation: ***Staff does not recommend the request.*** The Department indicates that, "Meeting the eight hour limit without negatively impacting those clients whose utilization exceeds the cap will require home health agencies to be more efficient with time spent attending a client's needs." However, the Department doesn't present any evidence to suggest that current home health services are inefficient, or that they could be condensed to provide the same level of service in a shorter period of time. It could be that a large portion of the skilled home health services that exceed 8 hours per day are driven by client needs. If this is the case, the Department will either end up granting a large number of exceptions for medical necessity, or deny appropriate coverage if the process for granting exceptions is too strict. The former would eat away at the projected savings and the later could result in increased expenditures if clients resort to seeking services in a more costly

setting, such as a nursing home. Staff is concerned both that the Department will not achieve the projected savings and that the policy could have significant negative impacts on some clients.

Home Health Therapies Cap: The Department proposes limiting the number of home health visits for therapy to 48 visits per calendar year, starting in April 2012.

Staff Recommendation: ***Staff does not recommend the request.*** The staff recommendation is based on similar concerns as those expressed relative to the proposed home health care cap.

Utilization Management Vendor Funding: The Department requests funding for the Department's contracted utilization management vendor to perform additional prior authorization reviews for the savings initiatives in this request.

Staff Recommendation: ***Staff recommends approval of the request.*** This increase in funding for the utilization management vendor is necessary to perform the enhanced prior authorizations described in several of the strategies above.

Supplemental Request, Department Priority #6
Child Health Insurance Program Reauthorization Act (CHIPRA) Bonus Payment True-up

	Request	Recommendation
Total	$0	$0
General Fund	(5,633,177)	(5,633,177)
Federal Funds	5,633,177	5,633,177

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the request reflects new information about bonus payments available to Colorado pursuant to CHIPRA.	

Department Request: The Department proposes using additional 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.

Staff Recommendation: ***Staff recommends the request.***

Staff Analysis: 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).

The FY 2011-12 appropriation took into account a projection of the bonus payment for federal fiscal year 2011, but it needs to be adjusted for two factors. First, the FY 2011-12 appropriation did not account for a bonus payment during the state fiscal year related to enrollment during federal fiscal year 2010. This payment for federal fiscal year 2010 was to true-up bonus payments for retroactive changes in enrollment. Second, the Department is revising the forecast for bonus payments related to federal fiscal year 2011 based on enrollment to date.

The Department's November 1 request included the impact of the CHIPRA bonus payments, but this supplemental lowers the FY 2011-12 estimate of the bonus payments relative to the November request by $4.3 million. The Department has not revised the estimate for FY 2012-13, but may do so with the February projection update.

Supplemental Request, Department Priority #7
Hospital Provider Fee Administrative True-up

	Request	Recommendation
Total	$5,386,378	$5,386,378
Cash Funds	2,023,541	2,023,541
Reappropriated Funds	1,466,040	1,466,040
Federal Funds	1,896,797	1,896,797

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the request reflects new information about administrative costs associated with the Hospital Provider Fee.	

Department Request: The Department requests 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. The request includes an adjustment to reappropriated funds provided to the Governor's Office of Information Technology for the Colorado Benefits Management System. The largest adjustments are for eligibility determination expenditures and programming of the Colorado Benefits Management System.

Staff Recommendation: ***Staff recommends the request.***

Staff Analysis: The following table and narrative explanations summarize the changes.

	TOTAL	Hospital Provider Fee	Federal Funds
Eligibility Determinations	2,230,940	1,246,853	984,087
Colorado Benefits Management System	1,466,040	733,020	733,020
Utilization and Quality Review Contracts	243,612	53,795	189,817
Customer Outreach	90,506	45,253	45,253
Medical Identification Cards	9,240	4,620	4,620
County Administration of Eligibility Determinations	0	0	0
Project Manager	(120,000)	(60,000)	(60,000)
TOTAL	3,920,338	2,023,541	1,896,797

Eligibility Determinations -- The Department significantly underestimated the cost of contracting for eligibility determination services in the original fiscal note for H.B. 09-1293. Although the Department is restricting eligibility for adults without dependent children to 10 percent of the federal poverty guidelines, or 10,000 people, compared to the fiscal note assumption of eligibility to 100 percent of the federal poverty guidelines, the vendor will still need to determine eligibility for a large number of people who will ultimately not be eligible due to the wait list for services. The vendor will also be responsible for maintaining the wait list. In the original fiscal note the Department used current average expenditures per client to estimate the cost of this contract, but this did not take into

account the system upgrades required for the contractor to expand eligibility determinations. Competitive bids for the service came in much higher than the original fiscal note assumptions. The Department lowered costs through negotiations with the vendor, but still requires an additional $2,230,940 total funds, including $1,246,853 from the Hospital Provider Fee for eligibility determinations.

Colorado Benefits Management System -- The Department received approximately $1.4 million one-time money in FY 2010-11 for changes to CBMS related to expansions in eligibility for adults without dependent children and allowing people with disabilities to buy-in to Medicaid, but the Department didn't spend the money, because it was still developing a description of the Department's business needs for the contractor. The contractor is actually making the changes in FY 2011-12, and the Department has slightly increased the estimated cost. The incremental increase for FY 2011-12 required to complete the programming is $1,466,040, including $733,020 from the Hospital Provider Fee. These are one-time programming costs.

Utilization and Quality Review Contracts -- The Department proposes updating the appropriation that pays for prior authorization review of acute care services and pharmaceuticals to account for increases in the caseload. The Department proposes that all of the state share of the increase come 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. Part of the increase in caseload is because in the original fiscal note for HB 09-1293 the Department assumed the centralized eligibility vendor would perform this function for the disabled buy-in program and adults without dependent children, similar to the process for CHP+, but instead these expansions are being operated as part of Medicaid.

Customer Outreach -- The Department proposes updating the appropriation that pays for benefit packets that get distributed to clients to account for increases in the caseload. The Department proposes that all of the state share of the increase come 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. Part of the increase in caseload is because in the original fiscal note for HB 09-1293 the Department assumed the centralized eligibility vendor would perform this function for the disabled buy-in program and adults without dependent children, similar to the process for CHP+, but instead these expansions are being operated as part of Medicaid. The request also reflects elimination of FY 2011-12 funding provided for continuous eligibility for Medicaid children, since the Department has not yet implemented that eligibility expansion.

Medical Identification Cards -- This was an added expense associated with the HB 09-1293 expansions that was overlooked in the original fiscal note.

County Administration of Eligibility Determinations -- The Department proposes transferring the portion of county administration payments associated with the Hospital Provider Fee expansions to a new line item, with no net change in funding. The Department hopes this will make the Hospital

Provider Fee contribution to administration more transparent to counties, and help dispel misperceptions that counties are required to contribute local funds to administration of the Hospital Provider Fee expansions.

Project Manager -- The original fiscal note for HB 09-1293 included $120,000 for a project manager for the information technology work required to implement the bill, but the Department has been able to accomplish the work within existing resources.

Supplemental Request, Department Priority #8
Cost Sharing for the Children's Basic Health Plan (CHP+)

	Request	Recommendation
Total	($264,453)	($264,453)
General Fund	(138,601)	(138,601)
Cash Funds	136,133	136,133
Federal Funds	(261,985)	(261,985)

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the request reflects the Department's new enrollment fee policy for CHP+.	

Department Request: The Department requests a reduction in appropriations associated with higher enrollment fees for the CHP+ program as of January 2012. Last year the General Assembly passed SB 11-213 (Hodge/Gerou), authorizing the Department to change the annual enrollment fee for CHP+ to a monthly enrollment fee for families with income above 205 percent of the federal poverty guidelines, and in the process significantly increasing the annual enrollment fees for CHP+. The Governor vetoed SB 11-213. In the November budget request the Department submitted R-7 to increase revenue from client participation, but R-7 proposes smaller enrollment fee increases for CHP+ coupled with increases in co-payments for both Medicaid and CHP+. The Department implemented the enrollment fee increases for CHP+ on January 1, 2012, but the proposed increases in co-payments will occur during FY 2012-13. Thus, S-8 deals only with the enrollment fee increases and does not include the fiscal impact of the proposed co-payments.

Annual Enrollment Fees for CHP+ For families with income above 205% of the Federal Poverty Guidelines			
	Current Fees	SB 11-213 (vetoed)	Fees in S-8
One child	$25	$240 ($20 per month)	$75
Two children	$35	$360 ($30 per month)	$105
Three or more	$35	+$120 (+$10 per month) per child up to a maximum of $600	$105

The Department projects that CHP+ enrollment will decrease 3.0 percent as a result of the higher fees, but the savings from attrition will accrue to the Hospital Provider Fee and federal funds. Due to the maintenance of effort requirements of the Affordable Care Act (ACA), Colorado can only increase enrollment fees for expansion populations implemented after the ACA. This means children with family incomes between 205 percent and 250 percent of the federal poverty guidelines who are funded from the Hospital Provider Fee. Attrition will actually cost the General Fund slightly more due to lower enrollment fee revenue, although this is more than offset by the increase in the enrollment fee rate. The Department projects attrition will result in 294 fewer children on CHP+ when the higher fees are in place for a full year, using the Department's November forecast of CHP+ enrollment for FY 2012-13.

The Department arrived at the estimated 3.0 percent attrition rate after surveying the available literature and reviewing the experiences of other states. For example, Vermont increased sliding scale fees for people between 185 percent and 300 percent of the federal poverty guidelines. The Vermont increases equated to between $20 and $100 per year, depending on where a family was on the sliding scale (the sliding scale went from $20-$50 to $25-$70 every three months), and Vermont experienced a 6.0 percent attrition rate.

After accounting for attrition, the Department estimates that the additional revenue raised from increased enrollment fees will be $338,468 when the fees are in place for a whole year in FY 2012-13. The projected additional revenue in FY 2011-12 is $138,601. The additional enrollment fees are used to offset the need for General Fund. Because enrollment fees are not eligible for a federal match, the federal share for CHP+ goes down and the share from the Hospital Provider Fee must go up to compensate. However, the net impact in FY 2011-12 of the attrition and the increase in the share from the Hospital Provider Fee is an overall savings for the Hospital Provider Fee.

	Estimated Caseload	Total	General Fund	Enrollment Fees	Hospital Provider Fee	Federal Funds
Attrition of 3.0 percent	(118)	(264,453)	2,104	(2,104)	(93,926)	(170,527)
Increased enrollment fees on attrition-adjusted caseload	7,773	0	(140,705)	140,705	91,458	(91,458)
TOTAL		(264,453)	(138,601)	138,601	(2,468)	(261,985)

Staff Recommendation: ***Staff recommends the request.*** The General Assembly already passed legislation supporting enrollment fee increases. The enrollment fee increases in this supplemental are less than those contemplated in the vetoed SB 11-213. If the JBC wants the Department to implement higher enrollment fees, more consistent with SB 11-213, it would take time for the Department to make the necessary program changes and update information technology systems. It took the Department approximately 4 months to implement the enrollment fee increases contained in S-8, and staff assumes it would take a similar time to implement even higher enrollment fees. If the JBC wants the department to implement higher enrollment fees, staff assumes any additional savings would accrue in FY 2012-13.

Supplemental Request, Department Priority #9
Smoking Cessation Quitline for Medicaid Clients

	Request	Recommendation
Total	$865,974	$865,974
Cash Funds	0	0
Reappropriated Funds	577,316	577,316
Federal Funds	288,658	288,658

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the federal government recently changed policies to allow Medicaid reimbursement of QuitLine services for Medicaid clients.	

Department Request: The Department requests an appropriation 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. Currently the QuitLine services are paid for entirely from the Tobacco Education Programs Fund. The additional federal money will allow DPHE to perform more outreach and serve a larger number of Medicaid clients.

	Total	Tobacco Education Programs Fund	Reappropriated Funds (transfer from HCPF)	Federal Funds
Health Care Policy and Financing	$577,316	$288,658	$0	$288,658
Public Health and Environment	288,658	(288,658)	577,316	0
TOTAL	$865,974	$0	$577,316	$288,658

Staff Recommendation: ***Staff recommends the request.*** Using the Tobacco Education Programs Fund to match federal funds expands the number of people who can be served through the QuitLine. Rather than expanding the population served, it may be possible to serve the same number of people, but use the additional federal funds to reduce the need for expenditures from the Tobacco Education Programs Fund for the QuitLine and then re-purpose the money in the Tobacco Education Programs Fund. However, this would require a statutory change, and the uses of the Tobacco Education Programs Fund would still be restricted to those allowed by Section 21 of Article X of the Colorado Constitution.

Supplemental Request, Department Priority #10
Utilize Supplemental Payments for General Fund Relief

	Request	Recommendation
Total	($9,634,148)	($9,634,148)
General Fund	(614,990)	(614,990)
Cash Funds	(5,306,633)	(5,306,633)
Federal Funds	(3,712,525)	(3,712,525)

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**NO**
The Department indicates that this request is the result of *data that was not available when the original appropriation was made*. However, this is only true for the portion of the request that updates the projected payments related to certified public expenditures. The request to withhold 10 percent of certain federal funds drawn through certified public expenditure is a new policy the Department wants to implement.	

Department Request: The Department proposes withholding 10 percent of the federal funds drawn from certain certified public expenditures in order to offset the need for General Fund in the Medical Services Premiums line item. Also, the Department requests updating the projected certified public expenditures. Finally, the Department requests moving appropriations for some certified public expenditures from the Safety Net Provider Payments line item to the Medical Services Premiums line item for accounting and transparency reasons.

Certifying public expenditures is a process states use to identify the contributions of publicly-owned providers to the care of Medicaid clients, and treat those contributions as part of the state match for Medicaid. Federal matching funds for Medicaid are constrained by a federally calculated upper payment limit. When a state's Medicaid payment structure results in reimbursement that is below the upper payment limit, then a provider has under-compensated care relative to the upper payment limit. If the provider is publicly owned, the federal government allows states to certify the public expenditures by the provider to cover the under-compensated care.

To provide General Fund relief the Department wants to withhold 10 percent of the federal funds drawn from certifying public expenditures for inpatient and physician services. These moneys would otherwise be used to make distributions to providers through the inpatient high volume supplemental payment and the physician supplemental payment. The two providers impacted by this policy are Denver Health Medical Center and Memorial Hospital in Colorado Springs.

Part of the request is to update the estimated supplemental payments. The FY 2011-12 appropriation significantly overestimated the supplemental payments, in part due to a change in the federal

methodology for estimating uncompensated inpatient Medicaid costs, and in part due to less under-compensated care for hospitals as a result of supplemental payments through the Hospital Provider Fee.

Finally, the Department believes that moving the appropriation for the inpatient high volume supplemental payment from the Safety Net Provider Payments line item to the Medical Services Premiums line item will make fund accounting easier, and improve transparency. The transfer would consolidate all certified public expenditure financing in the Medical Services Premiums line item and limit the purpose of the Safety Net Provider Payments line item to only Hospital Provider Fee payments.

Staff Recommendation: ***Staff recommends the request on the assumption that the Committee will need the General Fund to balance the FY 2011-12 appropriations.*** However, staff has concerns that the request does not meet the JBC's supplemental criteria, and that the Department has not articulated a consistent or rational policy for when it withholds federal funds earned through certified public expenditure, or why. The Department's withholding practices range from 100 percent of the federal funds earned through certifying public expenditures for Home Health and Nursing Facilities to none of the federal funds for Denver Health's Outstationing program. Withholding federal funds reduces payments to providers, and the primary reason for the withholding described by the Department is General Fund relief. If the Department is going to reduce provider payments, then it should do so equitably across providers. That doesn't necessarily mean that the withholding should be the same from every supplemental payment, because some supplemental payments may give a greater benefit to providers than other supplemental payments, but staff believes the Department should be able to explain the rationale for variations in withholding policies.

This proposal disproportionately impacts Denver Health and Memorial Hospital. Through the certified public expenditure process these two providers get more federal funds for Medicaid clients than other providers, and this could be viewed as an advantage that they have over other providers. On the other hand, these providers serve more Medicaid clients and have more under-compensated care than other providers. The Department did not explain how the 10 percent withholding results in an appropriate net level of reimbursement for Denver Health and Memorial Hospital relative to other providers.

The nearest the Department came to providing a rationale for the 10 percent withholding level was to equate it with the caps on administrative expenses for the CHP+ and School Health Services programs. There are some administrative expenses for the Department in certifying public expenditures, although the Department did not attempt to quantify these expenses. This may provide some basis for the 10 percent withholding threshold, but it does not explain the variation in the withholding level for other certified public expenditures that are also administered by the Department.

Staff believes the Department needs to work toward a consistent and transparent policy for when and why and at what level it withholds federal funds earned through the certified public expenditure process. Staff does not believe the withholding necessarily needs to be the same for every supplemental payment, but the Department should be able to explain the differences.

Supplemental Request, Department Priority #11
Federally Mandated Children's Health Insurance Program (CHP+) Prospective Payment System (PPS) payments for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

	Request	Recommendation
Total	$1,650,176	$1,650,176
Children's Basic Health Plan Trust - CF	539,888	539,888
Hospital Provider Fee - CF	37,674	37,674
Federal Funds	1,072,614	1,072,614

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
The Department and the JBC Staff agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, the request reflects new information about a breakdown in negotiations about reimbursement rates for FQHCs and RHCs.	

Department Request: The Department requests one-time funding for retroactive reimbursements to FQHCs and RHCs for certain services where the state's CHP+ rates were below levels required by federal statute. The money will come from balances in the Children's Basic Health Plan Trust fund and the Hospital Provider Fee Cash Fund. The federal statutes require reimbursement according to a federal formula, or an alternative payment system that reimburses at or above the federal formula. Colorado received a grant to develop an alternative payment system that included incentive payments based on health outcomes, but the Department was not able to reach agreement with the FQHCs and RHCs on the specifics of the incentive-based alternative payment system. As a result, the Department is implementing the federal formula rates retroactively to October 1, 2009, when they were required. The Department can increase rates for services that were below the federal formula levels, but it cannot retroactively reduce rates that were above the federal formula levels. Thus, the Department needs one-time funding to make the retroactive payments, but going forward the Department will reduce the rates for some services that were above the federal formula to ensure budget neutrality.

Staff Recommendation: ***Staff recommends the request.*** The additional funding is necessary to comply with federal statute. The Committee could consider some punitive penalty for the Department administration's failure to negotiate a budget-neutral solution, but complicated negotiations sometimes fail, and staff has no evidence that the administration failed to perform due diligence in negotiating with the FQHCs and RHCs. Also, the Department's administration was trying to develop a new incentive-based payment system that would improve health outcomes and ultimately reduce state expenditures. Staff does not fault the Department for attempting to implement a payment methodology that improved on the federal formula. However, the

Department's experience with this foray into incentive-based payments raises questions about whether the Department can deliver on the projected savings associated with the FY 2012-13 request labeled R-5 Medicaid Fee-for-service Reform, which proposes a more ambitious implementation of several incentive-based reimbursements.

The fund balances in both the Children's Basic Health Plan Trust and the Hospital Provider Fee Cash Fund are sufficient to support the requested one-time funding. If the balance in the Children's Basic Health Plan Trust was not used for this purpose, it could be used to reduce the General Fund appropriation for CHP+.

Supplemental Request, Department Priority #13
Commission on Family Medicine Residency Training Program Adjustment

	Request	Recommendation
Total	$350,000	$350,000
General Fund	175,000	175,000
Federal Funds	175,000	175,000

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
The Department and the JBC Staff agree that this request is the result of *data that was not available when the original appropriation was made*. Specifically, it appears that the balance in the Tax Amnesty cash funds will be sufficient to support an increase in expenditures for the Family Medicine Residency Training Program pursuant to SB 11-184.	

Department Request: The Department requests an increase in state funding for the Advisory Commission on Family Medicine to comply with SB 11-184 (Steadman/Ferrandino). The bill added Section 39-21-202 (2) (b), C.R.S., which stipulates that if the fund balance of the Tax Amnesty Cash Fund is sufficient on December 31, 2011, then $175,000 shall be transferred to the General Fund and, "it is the intent of the general assembly that such amount be included in a supplemental appropriation to the department of health care policy and financing for the fiscal year commencing on July 1, 2011, for allocation to the commission on family medicine residency training programs."

Staff Recommendation: ***Staff recommends the request.*** The fund balance in the Tax Amnesty Cash Fund was sufficient to make the transfer. The statute does not require an appropriation to the Commission on Family Medicine, but it expresses legislative intent, and the staff recommendation is based on complying with that legislative intent.

Non-Prioritized Supplementals

JBC Staff Initiated Supplemental
Technical Correction to SB 11-216

	Request	Recommendation
Total	$0	$0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforseen contingency.]	**YES**
This supplemental is the result of *a technical error in calculating the original appropriation*. Specifically, there was a drafting error in SB 11-216.	

This request requires separate legislation.

Department Request: The Department has not requested this supplemental.

Staff Recommendation: ***Staff recommends that the Committee sponsor legislation to correct a technical error that occurred in the drafting of SB 11-216 (Hodge/Ferrandino) that dealt with tobacco funding for the Children's Basic Health Plan.*** In short, the bill preserved the Primary Care Fund, but erroneously eliminated statutes authorizing expenditures from the fund. Pursuant to Section 24-22-117 (b) (I), C.R.S., the Primary Care Fund receives 19 percent of tobacco tax revenues. The money is supposed to be spent on grants to primary care providers who serve a large portion of people with low-income, for the purpose of improving the infrastructure of the providers, pursuant to part 3 of article 3 of title 25.5. However, due to a drafting error, SB 11-216 eliminated part 3 of article 3 of title 25.5, and so the Department will not be able to spend the roughly $28 million that will be deposited in the Primary Care Fund in FY 2012-13, unless the error is corrected. Legislative Legal Services identified this drafting error. SB 11-216 was a JBC-sponsored bill.

Previously Approved Interim Supplemental

Interim Supplemental Request #1
Technical Correction to Fund Source

	Previously Approved
Total	$0
FTE	0.0

	Previously Approved
Cash Funds -- Certified Public Expenditures by the Counties	(38,666)
Cash Funds -- Local Funds	38,666

JBC Action: The Committee approved the Department request that the appropriation clause in S.B. 11-177 for the Medical Service Premiums division be adjusted to reference local funds instead of certified public expenditures by counties. Without this change, the Department will not have the proper expenditure authority to expend moneys for the Teen Pregnancy and Dropout Prevention Program.

The rules governing interim supplementals in Section 24-75-111 (5), C.R.S., require the Committee to introduce all interim supplementals that it approves. Staff will include this supplemental in the Department's supplemental bill.

Interim Supplemental Request #2
Adjustment to Medical Services Premiums line item in order to reverse the pharmacy rate reduction contained in the current appropriation assumptions

	Previously Approved
Total	$1,250,589
General Fund	595,575
Cash Fund	23,003
Federal Funds	632,011

JBC Action: The Committee approved the Department request that the Medical Services Premiums line item be increased by $1,250,589 total funds (including $595,575 General Fund), because the Department did not implemented the pharmacy reimbursement reduction contained in the current appropriation's calculations per the Committee's request. On June 20, 2011, the Committee sent a letter to the Department requesting that the Department not implement the pharmaceutical reimbursement rate reduction contained in the FY 2011-12 appropriation assumptions. In the letter, the Committee expressed concern that implementing both the rate reduction and expansion of the State Maximum Allowable Cost (SMAC) drug list would restrict access to the pharmacy benefit for Medicaid clients.

The rules governing interim supplementals in Section 24-75-111 (5), C.R.S., require the Committee to introduce all interim supplementals that it approves. Staff will include this supplemental in the Department's supplemental bill.

Supplemental Requests Addressed During a Different Presentation

The following supplemental requests impacting the Department of Health Care Policy and Financing will be addressed during a different presentation to the JBC by a different JBC analyst. The table summarizes the requested fiscal impact on the Department of Health Care Policy and Financing only.

Priority		Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
HCP 2	Medicaid Mental Health Community Programs	$4,292,211	$7,741,587	($5,568,294)	($13,544)	$2,132,462	0.0
HCP 12	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	511,406	(42,022)	298,257	(650)	255,821	0.0
PHE 10	Additional federal Funds for Medicaid Facility Survey and Certification	217,047	0	0	0	217,047	0.0
HUM	Utilities Funding Request	(350,000)	(175,000)	0	0	(175,000)	0.0
HUM	Colorado Mental Health Institutes Revenue Adjustment	1,125,866	562,933	0	0	562,933	0.0
HUM	Suspension of ICF/ID Provider Fee	(1,867,655)	933,828	0	(1,867,655)	(933,828)	0.0
HUM	Annual Fleet True-up	(15,765)	(7,882)	0	0	(7,883)	0.0
HUM	Common Policy Allocation True-up	1,272	636	0	0	636	0.0
	Total Requests Addressed During a Different Presentation	$3,914,382	$9,014,080	($5,270,037)	($1,881,849)	$2,052,188	0.0

Statewide Common Policy Supplemental Requests

These requests are not prioritized and are not analyzed in this packet. The JBC will act on these items later when it makes decisions regarding common policies.

Department's Portion of Statewide Supplemental Request	Total	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Administrative Law Judges	$26,297	$13,148	$0	$0	$13,149	0.0
Capital Complex Leased Space	12,807	6,404	0	0	6,403	0.0
Department's Total Statewide Supplemental Requests	$39,104	$19,552	$0	$0	$19,552	0.0

Staff Recommendation: The staff recommendation for these requests is pending Committee approval of common policy supplementals. **Staff asks permission to include the corresponding appropriations in the Department's supplemental bill when the Committee approves this common policy supplemental.** If staff believes there is reason to deviate from the common policy, staff will appear before the Committee later to present the relevant analysis.

FY 2010-11 Supplemental Issues

JBC Staff Initiated Supplemental
Release FY 2010-11 Overexpenditures

	Request	Recommendation
Total	$0	$42,632,483
General Fund		$11,956,060
Cash Funds		$30,676,423

Department Request: The Department has not submitted any requests regarding over-expenditures from FY 2010-11.

Staff Recommendation: Staff recommends the release of FY 2011-12 General Fund and cash fund restrictions based on over-expenditures from FY 2010-11 for the following items.

Title	General Fund	Cash Funds
Medical Services Premiums	$8,471,270	$30,676,423
Mental Health Capitation Payments	2,909,851	
Medicaid Mental Health Fee for Service Payments	135,964	
Pediatric Specialty Hospital	42,475	
Clinic Based Indigent Care	171	
Commission on Family Medicine Residency Training Programs	43	
Medicare Modernization Act State Contribution Payment	396,224	
State University Teaching Hospitals, Denver Health and Hospital Authority	45	
State University Teaching Hospitals, University of Colorado Hospital Authority	17	
TOTAL	11,956,060	30,676,423

Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided 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.). However, the State Controller restricts the current fiscal year's appropriation until the General Assembly approves a supplemental for the prior year over expenditure. This restriction allows the JBC an opportunity to review the reasons for over expenditures and to decide if the over-expenditure could have been avoided with better management of the appropriation or if the over-expenditure occurred as a result of an unforeseen event or forecast error. The FY 2010-11 over-expenditures were due to forecast error and errors in the calculation of the enhanced federal matching rate pursuant to the American Recovery and Reinvestment Act.

	FY 2010-11	FY 2011-12	Fiscal Year 2011-12 Interim Supplemental		
	Actual	Appropriation	Requested Change	Recommended Change	New Total with Recommendation

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
Executive Director - Sue Birch

Supplemental #1 - Medical Services Premiums					
Medical Services Premiums	3,395,627,672	3,543,863,749	62,369,672	*Pending*	3,543,863,749
General Fund	880,377,772	1,183,014,450	51,312,453		1,183,014,450
Cash Funds	518,533,477	608,317,175	(22,107,528)		608,317,175
Reappropriated Funds	7,414,327	6,388,059	80,723		6,388,059
Federal Funds	1,989,302,096	1,746,144,065	33,084,024		1,746,144,065
General Fund Exempt	*279,344,485*	*284,175,417*	*0*		*284,175,417*
Supplemental #3 - Children's Basic Health Plan Medical and Dental Costs					
Children's Basic Health Plan Medical and Dental Costs	177,283,900	213,086,149	(29,603,573)	*Pending*	213,086,149
General Fund	14,016,193	29,997,908	0		29,997,908
Cash Funds	48,323,777	44,582,245	(10,052,683)		44,582,245
Federal Funds	114,943,930	138,505,996	(19,550,890)		138,505,996
General Fund Exempt	*0*	*446,100*	*0*		*446,100*
Supplemental #4 - Medicare Modernization Act State Contribution Payment					
Medicare Modernization Act State Contribution Payment	72,377,768	91,156,720	2,356,099	*Pending*	91,156,720
General Fund	58,711,725	66,146,615	2,356,099		66,146,615
Federal Funds	13,666,043	25,010,105	0		25,010,105
Supplemental #5 - Medicaid Budget Reduction					
(E)Utilization and Quality Review Contracts					
Professional Service Contracts	4,802,408	7,670,839	250,000	250,000	7,920,839

	FY 2010-11 Actual	FY 2011-12 Appropriation	Fiscal Year 2011-12 Interim Supplemental Requested Change	Recommended Change	New Total with Recommendation
General Fund	1,345,699	2,100,370	62,500	62,500	2,162,870
Cash Funds	71,505	60,537	0	0	60,537
Federal Funds	3,385,204	5,509,932	187,500	187,500	5,697,432
Medical Services Premiums	3,395,627,672	3,543,863,749	(8,109,799)	(7,198,163)	3,536,665,586
General Fund	880,377,772	1,183,014,450	(19,680,756)	(19,235,333)	1,163,779,117
Cash Funds	518,533,477	608,317,175	15,625,858	15,636,252	623,953,427
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	1,989,302,096	1,746,144,065	(4,054,901)	(3,599,082)	1,742,544,983
General Fund Exempt	*279,344,485*	*284,175,417*	*0*	*0*	*284,175,417*
Total Supplemental #5	3,400,430,080	3,551,534,588	(7,859,799)	(6,948,163)	3,544,586,425
General Fund	881,723,471	1,185,114,820	(19,618,256)	(19,172,833)	1,165,941,987
Cash Funds	518,604,982	608,377,712	15,625,858	15,636,252	624,013,964
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	1,992,687,300	1,751,653,997	(3,867,401)	(3,411,582)	1,748,242,415
General Fund Exempt	*279,344,485*	*284,175,417*	*0*	*0*	*284,175,417*
Supplemental #6 - Child Health Insurance Program Reauthorization Act (CHIPRA) Bonus Payment True-up					
Medicare Modernization Act State Contribution Payment	72,377,768	91,156,720	0	0	91,156,720
General Fund	58,711,725	66,146,615	(5,633,177)	(5,633,177)	60,513,438
Federal Funds	13,666,043	25,010,105	5,633,177	5,633,177	30,643,282
Supplemental #7 - Hospital Provider Fee Administrative True-up					
Various Line Items			3,920,338	3,920,338	
Cash Funds			2,023,541	2,023,541	
Federal Funds			1,896,797	1,896,797	

	FY 2010-11	FY 2011-12	Fiscal Year 2011-12 Interim Supplemental		
	Actual	Appropriation	Requested Change	Recommended Change	New Total with Recommendation
Supplemental #8 - Cost Sharing for the Children's Basic Health Plan (CHP+)					
Children's Basic Health Plan Medical and Dental Costs	177,283,900	213,086,149	(264,453)	(264,453)	212,821,696
General Fund	14,016,193	29,997,908	(138,601)	(138,601)	29,859,307
Cash Funds	48,323,777	44,582,245	136,133	136,133	44,718,378
Federal Funds	114,943,930	138,505,996	(261,985)	(261,985)	138,244,011
General Fund Exempt	*0*	*446,100*	*0*	*0*	*446,100*
Supplemental #9 - Smoking Cessation Quitline for Medicaid Clients					
Medical Services Premiums	3,395,627,672	3,543,863,749	577,316	577,316	3,544,441,065
General Fund	880,377,772	1,183,014,450	0	0	1,183,014,450
Cash Funds	518,533,477	608,317,175	288,658	288,658	608,605,833
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	1,989,302,096	1,746,144,065	288,658	288,658	1,746,432,723
General Fund Exempt	*279,344,485*	*284,175,417*	*0*	*0*	*284,175,417*
Supplemental #10 - Utilize Supplemental Payments for General Fund Relief					
Medical Services Premiums	3,395,627,672	3,543,863,749	6,262,092	6,262,092	3,550,125,841
General Fund	880,377,772	1,183,014,450	(614,990)	(614,990)	1,182,399,460
Cash Funds	518,533,477	608,317,175	2,641,487	2,641,487	610,958,662
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	1,989,302,096	1,746,144,065	4,235,595	4,235,595	1,750,379,660
General Fund Exempt	*279,344,485*	*284,175,417*	*0*	*0*	*284,175,417*
Safety Net Provider Payments	289,889,142	309,825,106	(15,896,240)	(15,896,240)	293,928,866
General Fund	0	0	0	0	0
Cash Funds	130,867,920	154,912,553	(7,948,120)	(7,948,120)	146,964,433

	FY 2010-11 Actual	FY 2011-12 Appropriation	Fiscal Year 2011-12 Interim Supplemental Requested Change	Recommended Change	New Total with Recommendation
Federal Funds	159,021,222	154,912,553	(7,948,120)	(7,948,120)	146,964,433
Total Supplemental #10	3,685,516,814	3,853,688,855	(9,634,148)	(9,634,148)	3,844,054,707
General Fund	880,377,772	1,183,014,450	(614,990)	(614,990)	1,182,399,460
Cash Funds	649,401,397	763,229,728	(5,306,633)	(5,306,633)	757,923,095
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	2,148,323,318	1,901,056,618	(3,712,525)	(3,712,525)	1,897,344,093
General Fund Exempt	*279,344,485*	*284,175,417*	*0*	*0*	*284,175,417*
Supplemental #11 - Federally Mandated Children's Health Insurance Program (CHP+) Prospective Payment System (PPS) payments for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)					
Children's Basic Health Plan Medical and Dental Costs	177,283,900	213,086,149	1,650,176	1,650,176	214,736,325
General Fund	14,016,193	29,997,908	0	0	29,997,908
Cash Funds	48,323,777	44,582,245	577,562	577,562	45,159,807
Federal Funds	114,943,930	138,505,996	1,072,614	1,072,614	139,578,610
General Fund Exempt	*0*	*446,100*	*0*	*0*	*446,100*
Supplemental #13 - Commission on Family Medicine Residency Training Program Adjustment					
Commission on Family Medicine Residency Training Programs	1,738,846	1,391,077	350,000	350,000	1,741,077
General Fund	700,624	695,538	175,000	175,000	870,538
Federal Funds	1,038,222	695,539	175,000	175,000	870,539
JBC Staff Initiated Supplemental - Technical Correction to SB 11-216					
Primary Care Fund Program	0	0	0	0	0
Cash Funds	0	0	0	0	0

	FY 2010-11 Actual	FY 2011-12 Appropriation	Fiscal Year 2011-12 Interim Supplemental Requested Change	Recommended Change	New Total with Recommendation
Interim Supplemental #1 - Adjustment to Appropriation Clause in S.B. 11-177					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,344,294,974	3,543,863,749	0	0	3,543,863,749
General Fund	874,013,997	1,183,014,450	0	0	1,183,014,450
Cash Funds	487,857,054	608,317,175	0	0	608,317,175
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	1,975,009,596	1,746,144,065	0	0	1,746,144,065
Interim Supplemental #2 - Adjustment to Appropriation Clause in S.B. 11-177					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,344,294,974	3,543,863,749	1,250,589	1,250,589	3,545,114,338
General Fund	874,013,997	1,183,014,450	544,874	595,575	1,183,610,025
Cash Funds	487,857,054	608,317,175	73,704	23,003	608,340,178
Reappropriated Funds	7,414,327	6,388,059	0	0	6,388,059
Federal Funds	1,975,009,596	1,746,144,065	632,011	632,011	1,746,776,076