CHAPTER 203

HEALTH CARE POLICY AND FINANCING

SENATE BILL 09-263

BY SENATOR(S) White, Keller, Tapia, Tochtrop;
also REPRESENTATIVE(S) Pommer, Ferrandino, Marostica, Kerr J.

AN ACT

CONCERNING PAYMENTS TO MEDICAID NURSING FACILITY PROVIDERS, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 25.5-6-201, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25.5-6-201. Special definitions relating to nursing facility reimbursement. As used in this part 2, unless the context otherwise requires:

(36) "SUPPLEMENTAL MEDICAID PAYMENT" MEANS A LUMP SUM PAYMENT THAT IS MADE IN ADDITION TO A PROVIDER'S PER DIEM RATE. A SUPPLEMENTAL MEDICAID PAYMENT IS CALCULATED ON AN ANNUAL BASIS USING HISTORICAL DATA AND PAID AS A FIXED MONTHLY AMOUNT WITH NO RETROACTIVE ADJUSTMENT.

SECTION 2. 25.5-6-202 (1) (a), (3), (5), (6), (7), (8), (9) (b), and (11), Colorado Revised Statutes, are amended, and the said 25.5-6-202 (9) is further amended BY THE ADDITIONAL OF THE FOLLOWING NEW PARAGRAPHS, to read:

25.5-6-202. Providers - nursing facility provider reimbursement - rules - repeal. (1) (a) (I) Subject to available appropriations, for the purpose of reimbursing a medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the state department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. The payment shall not exceed one hundred twenty-five percent of the median cost of direct and indirect health care services and raw food as determined by an array of all facility providers; except that, for state veteran nursing homes, the payment shall not exceed one hundred thirty percent of

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Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

the median cost.

(II) FOR THE FISCAL YEAR COMMENCING JULY 1, 2009, AND FOR EACH FISCAL YEAR THEREAFTER, ANY INCREASE IN THE DIRECT AND INDIRECT HEALTH CARE SERVICES AND RAW FOOD COSTS SHALL NOT EXCEED EIGHT PERCENT PER YEAR. THE CALCULATION OF THE EIGHT PERCENT PER YEAR LIMITATION FOR RATES EFFECTIVE ON JULY 1, 2009, SHALL BE BASED ON THE DIRECT AND INDIRECT HEALTH CARE SERVICES AND RAW FOOD COSTS IN THE AS-FILED FACILITY'S COST REPORTS UP TO AND INCLUDING JUNE 30, 2009. FOR THE PURPOSES OF CALCULATING THE EIGHT-PERCENT LIMITATION FOR RATES EFFECTIVE AFTER JULY 1, 2009, THE LIMITATION SHALL BE DETERMINED AND INDEXED FROM THE DIRECT AND INDIRECT HEALTH CARE SERVICES AND RAW FOOD COSTS AS REPORTED AND AUDITED FOR THE RATES EFFECTIVE JULY 1, 2009.

(3) (a) Subject to available appropriations, for the purpose of reimbursing a medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the state department shall establish an annually readjusted schedule to pay each nursing facility provider a reasonable price for the costs, which reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one licensed beds and more, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.

(b) In computing per diem cost, each nursing facility provider shall annually submit cost reports to the state department, and actual days of care shall be counted, not occupancy-imputed days of care. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation of this subsection (3), and, for each succeeding fourth year, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

(c) (I) FOR FISCAL YEARS COMMENCING ON OR AFTER JULY 1, 2008, THROUGH THE FISCAL YEAR COMMENCING JULY 1, 2014, THE STATE DEPARTMENT SHALL COMPARE A NURSING FACILITY PROVIDER'S ADMINISTRATIVE AND GENERAL SERVICES PER DIEM RATE AS DETERMINED UNDER THIS SUBSECTION (3) TO THE NURSING FACILITY PROVIDER'S ADMINISTRATIVE AND GENERAL SERVICES PER DIEM RATE AS OF JUNE 30, 2008, AND THE STATE DEPARTMENT SHALL PAY THE NURSING FACILITY PROVIDER THE HIGHER PER DIEM AMOUNT FOR EACH OF THE FISCAL YEARS.

(II) FOR FISCAL YEARS COMMENCING ON OR AFTER JULY 1, 2009, THROUGH THE FISCAL YEAR COMMENCING JULY 1, 2014, IF A REALLOCATION OF MANAGEMENT COSTS BETWEEN THE ADMINISTRATIVE AND GENERAL COSTS DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (3) AND THE DIRECT AND INDIRECT HEALTH CARE COSTS DESCRIBED IN SUBSECTION (1) OF THIS SECTION CAUSES A NURSING FACILITY PROVIDER'S ADMINISTRATIVE AND GENERAL COSTS TO EXCEED THE REASONABLE PRICE ESTABLISHED BY THE STATE DEPARTMENT PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (3), PURSUANT TO RULES ADOPTED BY THE STATE BOARD, A NURSING FACILITY PROVIDER MAY RECEIVE A HIGHER PER DIEM

PAYMENT FOR ADMINISTRATIVE AND GENERAL SERVICES THAN PROVIDED FOR IN PARAGRAPH (a) OF THIS SUBSECTION (3).

(III) THIS PARAGRAPH (c) IS REPEALED, EFFECTIVE JULY 1, 2015.

(5) SUBJECT TO AVAILABLE MONEYS AND THE PRIORITY OF THE USES OF THE PROVIDER FEES AS ESTABLISHED IN SECTION 25.5-6-203 (2) (b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (4) of this section, the state department shall ~~pay an additional per diem rate~~ MAKE A SUPPLEMENTAL MEDICAID PAYMENT based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents. This amount shall be determined by the state department based upon performance measures established in rules adopted by the state board in the domains of quality of life, quality of care, and facility management. The payment shall be computed annually AS OF JULY 1, 2009, AND EACH JULY 1 THEREAFTER, and shall not be less than ~~five-tenths~~ TWENTY-FIVE HUNDREDTHS of one percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section. DURING EACH STATE FISCAL YEAR, THE STATE DEPARTMENT MAY DISCONTINUE THE SUPPLEMENTAL MEDICAID PAYMENT ESTABLISHED PURSUANT TO THIS SUBSECTION (5) TO ANY NURSING FACILITY PROVIDER THAT FAILS TO COMPLY WITH THE ESTABLISHED PERFORMANCE MEASURES DURING THE STATE FISCAL YEAR, AND THE STATE DEPARTMENT MAY INITIATE THE SUPPLEMENTAL MEDICAID PAYMENT ESTABLISHED PURSUANT TO THIS SUBSECTION (5) TO ANY PROVIDER WHO COMES INTO COMPLIANCE WITH THE ESTABLISHED PERFORMANCE MEASURES DURING THE STATE FISCAL YEAR.

(6) ~~(a)~~ SUBJECT TO AVAILABLE MONEYS AND THE PRIORITY OF THE USES OF THE PROVIDER FEES AS ESTABLISHED IN SECTION 25.5-6-203 (2) (b), in addition to the reimbursement rate components pursuant to subsections (1) to (5) of this section, the state department shall ~~pay an additional per diem rate~~ MAKE A SUPPLEMENTAL MEDICAID PAYMENT to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury AS FOLLOWS:

~~(b)~~ (a) ~~For those~~ A SUPPLEMENTAL MEDICAID PAYMENT SHALL BE MADE TO NURSING FACILITY PROVIDERS THAT SERVE residents who have severe mental health conditions that are classified at a level II by the medicaid program's preadmission screening and resident review assessment tool. ~~the nursing facility provider shall have an amount added to its per diem rate as determined by the state department.~~ The state department shall compute this payment annually AS OF JULY 1, 2009, AND EACH JULY 1 THEREAFTER, and it shall be not less than two percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section.

~~(c)~~ (b) ~~To reimburse the~~ A SUPPLEMENTAL MEDICAID PAYMENT SHALL BE MADE TO nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury. The state department shall ~~pay an additional per diem rate~~ CALCULATE THE PAYMENT based upon the resident's cognitive assessment established in rules adopted by the state board. The state department shall compute this payment annually AS OF JULY 1, 2009, AND EACH JULY 1 THEREAFTER, and it

shall be not less than one percent of the statewide average per diem rate for the combined rate components determined under subsections (1) to (4) of this section.

(7) SUBJECT TO AVAILABLE MONEYS AND THE PRIORITY OF THE USES OF THE PROVIDER FEES AS ESTABLISHED IN SECTION 25.5-6-203 (2) (b), in addition to the ~~per diem~~ REIMBURSEMENT rate components paid pursuant to subsections (1) to (6) of this section, the state department shall pay a nursing facility provider ~~an additional per diem amount~~ A SUPPLEMENTAL MEDICAID PAYMENT for care and services rendered to medicaid residents to offset payment of the provider fee assessed under the provisions of section 25.5-6-203. ~~This amount shall not be equal to the amount of the fee charged and collected but shall be an amount equal to the per diem fee charged in accordance with section 25.5-6-203 multiplied by the number of medicaid resident days for the facility.~~ THE STATE DEPARTMENT SHALL COMPUTE THIS PAYMENT ANNUALLY, AS OF JULY 1, 2009, AND EACH JULY 1 THEREAFTER.

(8) ~~(a) For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general services per diem rate as determined under subsection (3) of this section to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.~~

~~(b) This subsection (8) is repealed, effective July 1, 2015.~~

(9) (b) (I) EXCEPT FOR CHANGES IN THE NUMBER OF PATIENT DAYS, the general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to subsections (1) to (4) of this section shall be limited to an annual increase of three percent. The state's share of the reimbursement rate components pursuant to subsections (1) to (4) of this section may be funded through the provider fee assessed pursuant to the provisions of section 25.5-6-203 and any associated federal funds. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. FOR THE FISCAL YEAR COMMENCING JULY 1, 2009, AND FOR EACH FISCAL YEAR THEREAFTER, THE GENERAL FUND SHARE OF THE AGGREGATE STATEWIDE AVERAGE PER DIEM RATE NET OF PATIENT PAYMENT PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION SHALL BE CALCULATED USING THE RATES THAT WERE EFFECTIVE ON JULY 1 OF THAT FISCAL YEAR.

(II) IF THE AGGREGATE STATEWIDE AVERAGE PER DIEM RATE NET OF PATIENT PAYMENT PURSUANT TO SUBSECTIONS (1) TO (4) OF THIS SECTION EXCEEDS THE GENERAL FUND SHARE, THE AMOUNT OF THE AVERAGE STATEWIDE PER DIEM RATE THAT EXCEEDS THE GENERAL FUND SHARE SHALL BE PAID AS A SUPPLEMENTAL MEDICAID PAYMENT USING THE PROVIDER FEE ESTABLISHED UNDER SECTION 25.5-6-203. SUBJECT TO THE PRIORITY OF THE USES OF THE PROVIDER FEE ESTABLISHED UNDER SECTION 25.5-6-203 (2) (b), IF THE PROVIDER FEE IS INSUFFICIENT TO FULLY FUND THE SUPPLEMENTAL MEDICAID PAYMENT, THE SUPPLEMENTAL MEDICAID PAYMENT SHALL BE REDUCED TO ALL PROVIDERS PROPORTIONATELY.

(b.3) (I) FOR THE FISCAL YEAR COMMENCING JULY 1, 2009, AND FOR EACH FISCAL

YEAR THEREAFTER, IF THE PROVIDER FEE ESTABLISHED UNDER SECTION 25.5-6-203 IS INSUFFICIENT TO FULLY FUND THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SUBSECTIONS (5) TO (7) OF THIS SECTION, SUBJECT TO THE PRIORITY OF THE USES OF THE PROVIDER FEE ESTABLISHED PURSUANT TO SECTION 25.5-6-203 (2) (b), THE STATE DEPARTMENT MAY SUSPEND OR REDUCE THE SUPPLEMENTAL MEDICAID PAYMENT SUBJECT TO THE USES OF THE PROVIDER FEE ESTABLISHED UNDER SECTION 25.5-6-203.

(II) IF IT IS DETERMINED BY THE STATE DEPARTMENT THAT THE CASE-MIX REIMBURSEMENT INCLUDES A FACTOR FOR NURSING FACILITY PROVIDERS WHO SERVE RESIDENTS WITH SEVERE COGNITIVE DEMENTIA OR ACQUIRED BRAIN INJURY, THE STATE DEPARTMENT MAY ELIMINATE THE SUPPLEMENTAL MEDICAID PAYMENT TO THOSE PROVIDERS WHO SERVE RESIDENTS WITH SEVERE COGNITIVE DEMENTIA OR ACQUIRED BRAIN INJURY.

(b.5) NOTWITHSTANDING ANY OTHER PROVISION OF LAW OR ANY FEDERAL LAW THAT TEMPORARILY INCREASES THE FEDERAL MATCHING PARTICIPATION RATE FOR ANY FISCAL YEAR, PAYMENTS TO NURSING FACILITY PROVIDERS FROM THE GENERAL FUND SHARE OF THE AGGREGATE STATEWIDE AVERAGE OF THE PER DIEM RATE SHALL BE CALCULATED BASED ON A FIFTY-PERCENT FEDERAL MATCH.

(b.7) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH (I) OF PARAGRAPH (b) OF THIS SUBSECTION (9):

(I) FOR THE FISCAL YEAR COMMENCING JULY 1, 2009, THE GENERAL FUND SHARE OF THE AGGREGATE STATEWIDE AVERAGE OF THE PER DIEM RATE SHALL NOT INCREASE FROM THE PRIOR FISCAL YEAR.

(II) FOR THE FISCAL YEAR COMMENCING JULY 1, 2010, THE GENERAL FUND SHARE OF THE AGGREGATE STATEWIDE AVERAGE OF THE PER DIEM RATE SHALL BE LIMITED TO A FIVE-PERCENT INCREASE FROM THE PRIOR FISCAL YEAR.

(III) THIS PARAGRAPH (b.7) IS REPEALED, EFFECTIVE JULY 1, 2011.

(11) ~~The provisions of this section shall not take effect unless and until the federal government approves a waiver authorizing the provider fees specified in section 25.5-6-203. To establish the reimbursement rate for class I nursing facilities until the waiver is granted, the state department shall apply the laws and procedures used immediately prior to July 1, 2008.~~

SECTION 3. 25.5-6-203 (1) (a), (1) (g), and (2) (b), Colorado Revised Statutes, are amended, and the said 25.5-6-203 (1) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

25.5-6-203. Nursing facilities - provider fees - federal waiver - fund created - rules. (1) (a) (I) Beginning with the fiscal year commencing July 1, 2008, and each fiscal year thereafter, the state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program as described in articles 4 to 6 of this title. AS SPECIFIED BY THE PRIORITY OF THE USES OF THE PROVIDER FEE IN PARAGRAPH (b) OF SUBSECTION (2)

OF THIS SECTION, the provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

(II) FOR THE FISCAL YEAR COMMENCING JULY 1, 2009, THE PROVIDER FEE SHALL NOT EXCEED SEVEN DOLLARS AND FIFTY CENTS PER NONMEDICARE-RESIDENT DAY. FOR THE FISCAL YEAR COMMENCING JULY 1, 2010, AND EACH FISCAL YEAR THEREAFTER, THE PROVIDER FEE SHALL NOT EXCEED SEVEN DOLLARS AND FIFTY CENTS PER NONMEDICARE-RESIDENT DAY PLUS INFLATION BASED ON THE NATIONAL SKILLED NURSING FACILITY MARKET BASKET INDEX AS DETERMINED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 U.S.C. SEC. 1395yy (e) (5) OR ANY SUCCESSOR INDEX.

(III) IN CALCULATING THE AMOUNT OF THE PROVIDER FEE PORTION OF THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SECTION 25.5-6-202 (5), THE STATE DEPARTMENT MAY INCLUDE AN ADDITIONAL AMOUNT OF UP TO FIVE PERCENT OF THE PROVIDER FEE PORTION OF SAID SUPPLEMENTAL MEDICAID PAYMENTS TO INITIATE THE PAYMENT TO ANY PROVIDER WHO COMPLIES WITH THE ESTABLISHED PERFORMANCE MEASURES DURING THE STATE FISCAL YEAR.

(g) The state department shall ESTABLISH A SCHEDULE TO assess the provider fee on a monthly basis and shall collect the fee from nursing facility providers by no later than the end of the next succeeding calendar month. THE STATE BOARD SHALL ESTABLISH RULES SO THAT PROVIDER FEE PAYMENTS FROM A NURSING FACILITY PROVIDER AND THE STATE DEPARTMENT'S SUPPLEMENTAL MEDICAID PAYMENTS TO THE NURSING FACILITY ARE DUE AS NEARLY SIMULTANEOUSLY AS FEASIBLE; EXCEPT THAT THE STATE DEPARTMENT'S SUPPLEMENTAL MEDICAID PAYMENTS TO THE NURSING FACILITY SHALL BE DUE NO MORE THAN FIFTEEN DAYS AFTER THE PROVIDER FEE PAYMENT IS RECEIVED FROM THE NURSING FACILITY. The state department shall require each nursing facility provider to report monthly its total number of days of care provided to nonmedicare residents.

(j) A NURSING FACILITY PROVIDER SHALL NOT INCLUDE ANY AMOUNT OF THE PROVIDER FEE AS A SEPARATE LINE ITEM IN ITS BILLING STATEMENTS.

(2) (b) (I) All moneys in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative costs of implementing section 25.5-6-202 and this section and to pay ~~a portion of the per diem rates established pursuant to section 25.5-6-202 (1) to (4)~~ THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SECTION 25.5-6-202 (7).

(II) Following the payment of the amounts described in subparagraph (I) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the ~~rates established under section 25.5-6-202 (5) to (7)~~ SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SECTION 25.5-6-202 (9) (b) (II).

(II.3) (A) EXCEPT AS PROVIDED IN SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH (II.3), AFTER THE PAYMENT OF THE AMOUNTS DESCRIBED IN

SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH (b), THE MONEYS REMAINING IN THE FUND SHALL BE SUBJECT TO FEDERAL MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE PURPOSE OF PAYING THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SECTION 25.5-6-202 (5).

(B) NOTWITHSTANDING ANY OTHER PROVISION OF THIS PARAGRAPH (b), THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED PURSUANT TO SECTION 25.5-6-202 (5) SHALL NOT BE LESS THAN TEN PERCENT OF THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SECTION 25.5-6-202 (7) IN THE PRIOR STATE FISCAL YEAR.

(II.5) FOLLOWING THE PAYMENT OF THE AMOUNTS DESCRIBED IN SUBPARAGRAPHS (I) TO (II.3) OF THIS PARAGRAPH (b), THE MONEYS REMAINING IN THE FUND SHALL BE SUBJECT TO FEDERAL MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE PURPOSE OF PAYING THE SUPPLEMENTAL MEDICAID PAYMENTS ESTABLISHED UNDER SECTION 25.5-6-202 (6).

(III) Any moneys in the fund not expended for these purposes may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

SECTION 4. Part V (2), and the affected totals of section 2 of chapter 474, Session Laws of Colorado 2008, as amended by section 1 of Senate Bill 09-187, are amended to read:

Section 2. **Appropriation.**

		APPROPRIATION FROM				
ITEM & SUBTOTAL	TOTAL	GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
$	$	$	$	$	$	$

PART V
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(2) MEDICAL SERVICES PREMIUMS[9, 10, 11, 12, 13]

Services for 37,483 Supplemental Security Income Adults 65 and Older (SSI 65 +) at an average cost of $20,120.77	754,186,704
Services for 6,368 Supplemental Security Income Adults 60 to 64 Years of Age (SSI 60 - 64) at an average cost of $17,368.19	110,600,623

	ITEM & SUBTOTAL	TOTAL	APPROPRIATION FROM GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
	$	$	$	$	$	$	$
Services for 15,172 Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs) at an average cost of $1,330.45	20,185,656						
Services for 51,263 Supplemental Security Income Disabled Individuals at an average cost of $14,120.57	723,862,731						
Services for 48,328 Categorically Eligible Low-income Adults at an average cost of $4,482.29	216,619,998						
Services for 6,922 Baby Care Program Adults at an average cost of $8,801.03	60,920,717						
Services for 301 Breast and Cervical Cancer Treatment Clients at an average cost of $22,938.31	6,904,430						

Services for 12,514 Expansion Health Care Low-Income Adult Clients at an average cost of $1,780.03	22,275,238						
Services for 231,030 Eligible Children at an average cost of $1,802.05	416,328,602						
Services for 18,003 Foster Children at an average cost of $3,722.25	67,011,705						
Services for 4,030 Non-Citizens at an average cost of $15,193.07	61,228,080						
Repayment of Federal Disallowance	3,176,846						
		2,463,301,330	~~769,068,351(M)~~ 765,356,392(M)	369,000,000	~~92,737,346~~[b] 96,449,305[a]	661,475[b]	1,231,834,158

[a] Of this amount, $73,929,336 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.; $18,180,399 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program; $3,711,959 SHALL BE FROM THE NURSING FACILITY CASH FUND CREATED IN SECTION 25.5-6-203 (2) (a), C.R.S., and $627,611 shall be from the Autism Treatment Fund created in Section 25.5-6-805, C.R.S.

[b] This amount shall be transferred from the Department of Public Health and Environment pursuant to Section 24-22-117 (2) (d) (II) (D), C.R.S.

ITEM & SUBTOTAL	TOTAL	APPROPRIATION FROM GENERAL FUND	GENERAL FUND EXEMPT	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
$	$	$	$	$	$	$
TOTALS PART V (HEALTH CARE POLICY AND FINANCING)	$3,849,682,072	~~$1,210,844,196~~ $1,207,132,237	$369,495,000[a]	~~$367,532,737~~[b] $371,244,696[b]	$22,948,578	$1,878,861,561

[a] Of this amount, $369,000,000 shall be from the General Fund Exempt Account created in Section 24-77-103.6 (2), C.R.S., and $495,000 shall be General Fund Exempt pursuant to Section 24-22-117 (1) (c) (I) (B), C.R.S. Further, said $495,000 is also not subject to the statutory limitation on General Fund appropriations imposed by Section 24-75-201.1, C.R.S.

[b] This amount includes $725,598 the Colorado Autism Treatment Fund created in Section 25.5-6-805, C.R.S., and represents the total amount that the State Treasurer shall transfer from the Tobacco Litigation Settlement Cash Fund created in Section 24-22-115 (1) (a), C.R.S., to the Colorado Autism Treatment Fund pursuant to Section 24-22-115 (1) (a), C.R.S.

SECTION 5. Appropriation - adjustments in the 2009 long bill. (1) For the implementation of this act, appropriations in the annual general appropriation act to the department of health care policy and financing, for the fiscal year beginning July 1, 2009, shall be adjusted as follows:

(a) The appropriation for medical service premiums is decreased by thirty million three hundred sixty-eight thousand sixty-nine dollars ($30,368,069). Of said sum, seventeen million one hundred forty thousand eighty-nine dollars ($17,140,089) shall be from the general fund and thirteen million two hundred twenty-seven thousand nine hundred seventy-nine dollars ($13,227,979) shall be from federal funds.

(b) The appropriation for medical service premiums cash fund is increased by three million nine hundred twelve thousand one hundred fourteen dollars ($3,912,114). Said amount shall be from the nursing facility cash fund created in section 25.5-6-203 (2) (a), Colorado Revised Statutes, and shall be subject to the (H) notation as defined in the general appropriation act.

SECTION 6. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: May 1, 2009