COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

SUPPLEMENTAL REQUESTS FOR FY 2013-14 AND FY 2012-13

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

Prepared By:
Eric Kurtz, JBC Staff
January 22, 2014

For Further Information Contact:

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

TABLE OF CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

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

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

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

Summary: FY 2012-13 Appropriation and Recommendation

Department of Health Care Policy and Financing: Recommended Changes for FY 2012-13

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2012-13 Appropriation						
FY 2012-13 Appropriation	$4,819,170,144	$1,484,442,214	$918,261,700	$6,003,449	$2,410,462,781	327.1
Current FY 2012-13 Appropriation	**$4,819,170,144**	**$1,484,442,214**	**$918,261,700**	**$6,003,449**	**$2,410,462,781**	**327.1**
Recommended Changes						
Current FY 2012-13 Appropriation	$4,819,170,144	1,484,442,214	$918,261,700	$6,003,449	$2,410,462,781	327.1
Release of overexpenditure restriction	5,753,845	5,290,984	462,861	0	0	0.0
Recommended FY 2012-13 Appropriation	**$4,824,923,989**	**$1,489,733,198**	**$918,724,561**	**$6,003,449**	**$2,410,462,781**	**327.1**

Department of Health Care Policy and Financing: Recommended Changes for FY 2012-13	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Recommended Increase/(Decrease)	$5,753,845	$5,290,984	$462,861	$0	$0	0.0
Percentage Change	0.1%	0.4%	0.1%	0.0%	0.0%	0.0%
FY 2012-13 Executive Request	**$4,819,170,144**	**$1,484,442,214**	**$918,261,700**	**$6,003,449**	**$2,410,462,781**	**327.1**
Request Above/(Below) Recommendation	($5,753,845)	($5,290,984)	($462,861)	$0	$0	0.0

Request/Recommendation Descriptions

Release of overexpenditure restriction: This supplemental releases a restriction placed on the FY 2013-14 appropriations because of FY 2012-13 overexpenditures for Medical Service Premiums and Behavioral Health Services. Specific statutory authority allows overexpenditures of these line items if they are consistent with the Medicaid program (Section 24-75-109, C.R.S.).

Summary: FY 2013-14 Appropriation and Recommendation

Department of Health Care Policy and Financing: Recommended Changes for FY 2013-14	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2013-14 Appropriation						
SB 13-230 (Long Bill)	$5,346,229,461	$1,674,555,265	$1,008,172,601	$8,464,594	$2,655,037,001	337.9
Other legislation	307,070,392	(7,292,216)	(123,924,315)	2,000,000	436,286,923	20.2
Current FY 2013-14 Appropriation	**$5,653,299,853**	**$1,667,263,049**	**$884,248,286**	**$10,464,594**	**$3,091,323,924**	**358.1**
Recommended Changes						
Current FY 2013-14 Appropriation	$5,653,299,853	1,667,263,049	$884,248,286	$10,464,594	$3,091,323,924	358.1
S1 Medical Service Premiums	52,387,943	17,580,433	(8,649,648)	0	43,457,158	0.0
S1 Medical Service Premiums - Technical Correction to SB 13-200	1	0	70,072,387	0	(70,072,386)	0.0
S3 Childrens Basic Health Plan	(17,385,723)	(3,309,421)	(2,569,185)	0	(11,507,117)	0.0
S4 Medicare Modernization Act	(4,917,552)	(16,805,357)	0	0	11,887,805	0.0
S6 Leased space	(459,849)	(226,872)	(3,053)	0	(229,924)	0.0
S7 Benefits Utilization Services application	201,447	100,723	0	0	100,724	0.0
S8 Hospice rates	0	0	0	0	0	0.0
Interim Sup - County Administration	10,150,361	0	0	0	10,150,361	0.0
Interim Sup - Leased space	1,078,734	539,367	0	0	539,367	0.0
Recommended FY 2013-14 Appropriation	**$5,694,355,215**	**$1,665,141,922**	**$943,098,787**	**$10,464,594**	**$3,075,649,912**	**358.1**

Recommended Increase/(Decrease)	$41,055,362	($2,121,127)	$58,850,501	$0	($15,674,012)	0.0
Percentage Change	0.7%	(0.1%)	6.7%	0.0%	(0.5%)	0.0%
FY 2013-14 Executive Request	**$5,694,692,880**	**$1,665,459,587**	**$943,118,787**	**$10,464,594**	**$3,075,649,912**	**358.1**
Request Above/(Below) Recommendation	$337,665	$317,665	$20,000	$0	$0	(0.0)

Request/Recommendation Descriptions

S1 Medical Service Premiums: The adjustment is for changes in the forecasted enrollment and expenditures for the Medicaid program under current law.

S3 Childrens Basic Health Plan: The adjustment is for changes in the forecasted enrollment and expenditures for the Children's Basic Health Plan under current law.

S4 Medicare Modernization Act: The adjustment is for changes in the forecasted state obligation under the federal Medicare Modernization Act of 2009. This act provides for the federal government to recoup from states a portion of pharmaceutical expenditures for people dually eligible for Medicare and Medicaid.

S6 Leased space: The adjustment is for lower than expected costs for the interim supplemental approved pursuant to Section 24-75-111 (1), C.R.S. for the Department to acquire approximately 25,000 square feet on the 7th floor of 303 E 17th Avenue that became available after the budget was approved.

S7 Benefits Utilization Services application: The funding is to create and maintain additional information technology environments for the Business Utilization Services (BUS) application.

S8 Hospice rates: The Department requested $317,665 General Fund for a one-time supplemental payment to hospice providers, but no funding is recommended by the JBC staff.

Interim Sup - Leased space: The adjustment provides funding for the Department to acquire approximately 25,000 square feet on the 7th floor of 303 E 17th Avenue that became after the budget was approved. This funding was approved through the interim supplemental process authorized in Section 24-75-111 (1), C.R.S.

Interim Sup - County Administration: The adjustment reinvests General Fund available from an enhanced federal match for eligibility determination activities to increase payments to counties for performing eligibility determinations and address eligibility technical support and overflow capacity issues associated with the implementation of the Affordable Care Act.

Prioritized Supplemental Requests

SUPPLEMENTAL REQUEST, DEPARTMENT PRIORITY S1 MEDICAL SERVICE PREMIUMS

	Request	Recommendation
Total	**$52,407,944**	**$52,407,944**
General Fund	17,580,433	17,580,433
Hospital Provider Fee	61,442,739	61,442,739
Federal Funds	(26,615,228)	(26,615,228)

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 new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.	

Department Request

The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2013-14 appropriation incorporated trend data through December 2012 while the latest forecast used for this supplemental request incorporates data through June 2013. The Department will submit a new forecast in February that uses data through December 2013. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

Some significant factors contributing to the change in the FY 2013-14 forecast of *General Fund* expenditures include:

- Per capita rates for children – For several years the Department experienced a negative trend in per capita expenditures for children and that trend was continued into the initial forecast for FY 2013-14, but actual FY 2012-13 per capita expenditures for children were slightly positive compared to the prior year, and so the revised FY 2013-14 forecast assumes per capita rates for children will be relatively neutral. Generally, new enrollees have lower per capita expenditures, but the longer people are on Medicaid the more their per capita expenditures look like the general population.
- S.B. 11-008 Aligning Medicaid eligibility for children and S.B. 11-250 Eligibility for pregnant women in Medicaid – These bills increased the Medicaid income eligibility threshold for children from 100 percent to 133 percent of the federal poverty level (FPL) and for pregnant women from 133 percent to 185 percent FPL. The primary impact was to move children and women from CHP+ to Medicaid. The Department assumed the transition would occur gradually over the course of a year, but actual transitions are occurring at a more rapid pace.

- Primary care reimbursement rates – The ACA requires states to increase primary care physician reimbursement rates to 100 percent of Medicare rates for calendar years 2013 through 2014. The cost of increasing primary care physician rates to the rates in effect January 1, 2009 must be paid with a state fund match, but the increase beyond the rates in effect on January 1, 2009 is paid for entirely with federal funds. The initial estimate of the cost of the rate increase was made before final federal guidance regarding the eligible providers and services was issued. Actual billings for eligible service codes are much higher than expected.
- Per capita rates for Elderly, Blind, and Disabled waiver – Per capita expenditures for long-term services and supports provided to people on the Elderly, Blind, and Disabled waiver are trending higher than originally forecast, due to heavier utilization of high cost services.
- Accountable Care Collaborative (ACC) expansion – A more rapid increase in enrollment than expected requires increases in service management payments. At the same time, increased savings from the ACC are offsetting costs due to higher enrollment.
- Children, low-income parents, and people with disabilities – Enrollment among these populations is trending higher than expected, but the costs are being offset by increased savings from the ACC.
- Decrease in Tobacco Tax Revenue – A portion of the revenue from the tobacco tax is deposited in the Health Care Expansion Fund and used to offset the need for General Fund for expansion populations. A decrease in tobacco tax revenue requires an offsetting increase in General Fund.
- Long-term care enrollment – The increases noted above are partially offset by decreases in the forecasted nursing bed days, enrollment in Programs for All-inclusive Care for the Elderly, and enrollment in similar long-term care services.

The increase in cash funds is primarily due to the correction of an error in the appropriation for S.B. 13-200 Expand Medicaid Eligibility. By implementing the Medicaid expansion Colorado became eligible for an enhanced federal match for newly eligible groups enrolled after the Affordable Care Act. Colorado had enrolled some of the groups between the time of the passage of the ACA and S.B. 13-200 using money from the Hospital Provider Fee. Therefore, the appropriations clause for S.B. 13-200 included a refinance of FY 2013-14 appropriations for these populations from the Hospital Provider Fee to federal funds. However, the appropriations clause for S.B. 13-200 refinanced the entire fiscal year when the eligibility for the enhanced federal match is actually only effective beginning January 1, 2014, or half the fiscal year. The Department's *S1 Medical Service Premiums* includes an increase of $70.1 million from the Hospital Provider Fee and a decrease of a like amount from federal funds to correct the error.

The increase in federal funds is disproportionate to the net change in General Fund and cash funds. This is primarily due to the Department's increased estimate for the federal fund-only component of increasing primary care physician rates to Medicare rates pursuant to the ACA. In addition, some drug rebates are earmarked to offset federal funds only, and the Department is expecting a decrease in these drug rebates, meaning there will be an increase in federal funds. The last major contributor to the disproportionate increase in federal funds is the enhanced federal match for children and pregnant women transitioning from CHP+ to Medicaid pursuant to S.B. 11-008 and S.B. 11-250 respectively.

Staff Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law.

SUPPLEMENTAL REQUEST, DEPARTMENT PRIORITY S3 CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

	Request	Recommendation
Total	**($17,385,723)**	**($17,385,723)**
General Fund	(3,309,421)	(3,309,421)
Hospital Provider Fee	(2,569,185)	(2,569,185)
Federal Funds	(11,507,117)	(11,507,117)

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 new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.	

Department Request

The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2013-14 appropriation incorporated trend data through December 2012 while the latest forecast used for this supplemental request incorporates data through June 2013. The Department will submit a new forecast in February that uses data through December 2013. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The projected decrease in CHP+ expenditures is due to declines in caseload. CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid. Actual enrollment in FY 2012-13 was lower than expected by the Department. In addition, as mentioned under Medical Service Premiums, the movement of children and pregnant women from CHP+ to Medicaid as a result of S.B. 11-008 Aligning Medicaid eligibility for children and S.B. 11-250 Eligibility for pregnant women in Medicaid has happened more quickly than the Department expected. Another factor contributing to the projected decline in CHP+ enrollment is new ACA-mandated rules for calculating Medicaid eligibility using Modified Adjusted Gross Income (MAGI). The Department believes that changes in the way the MAGI defines households will cause some clients to move from CHP+ to Medicaid.

Staff Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law. The way the additional federal bonus payments have been applied reduces the General Fund need in FY 2013-14, but increases the incremental change in General Fund that will be required in FY 2014-15. If necessary to balance the budget, the JBC could move some of the federal bonus payments from FY 2013-14 to FY 2014-15 to change the fiscal year when the General Fund savings occur.

SUPPLEMENTAL REQUEST, DEPARTMENT PRIORITY S4 MEDICARE MODERNIZATION ACT OF 2003 STATE CONTRIBUTION PAYMENT

	Request	Recommendation
Total	**($4,917,552)**	**($4,917,552)**
General Fund	(16,805,357)	(16,805,357)
Federal Funds	11,887,805	11,887,805

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 new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.	

Department Request

The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2013-14 appropriation incorporated trend data through December 2012 while the latest forecast used for this supplemental request incorporates data through June 2013. The Department will submit a new forecast in February that uses data through December 2013. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The projected decline in total expenditures is the net result of a projected increase in people dually eligible for Medicaid and Medicare and a decline in the per member per month rate assessed according to the federal formula.

The change in General Fund is due to the application of a portion of federal bonus payments for meeting performance objectives for serving low income children being applied to offset the need for General Fund for this program. This line item is normally a 100 percent General Fund obligation, but for the last few years the General Assembly has used the federal bonus payments to offset the need for General Fund. In FY 2013-14 the Department's forecast raises the

projection of available federal bonus payments by $11.9 million and decreases the estimated General Fund payments by a like amount. These bonus payments are for a time-limited duration and in FY 2014-15 the available funding begins to run out. The expiration of the federal bonus payments has been known for some time, but the magnitude of the General Fund impact in the Department's request is greater because of the increase in bonus payments in FY 2013-14.

Staff Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law.

SUPPLEMENTAL REQUEST, DEPARTMENT PRIORITY S6 LEASED SPACE

	Request	Recommendation
Total	**($459,849)**	**($459,849)**
General Fund	(226,872)	(226,872)
Hospital Provider Fee	(3,053)	(3,053)
Federal Funds	(229,924)	(229,924)

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 new data that was not available when the original appropriation was made. Specifically, the original appropriation was based on an estimate of leased space rates, but the actual rates negotiated by the Department were lower.	

Department Request

The Department requests a reduction in leased space appropriations to match actual negotiated rates. In June the Department received supplemental authority through the 1331 process for additional leased space costs associated with moving a portion of the Department to 303 E 17th Ave. The additional leased space funding was based on estimated costs. Actual negotiated rates are somewhat lower.

Staff Recommendation

Staff recommends approval of the request to match actual negotiated rates. As a companion to the supplemental request the Department submitted a budget amendment for FY 2014-15 that continues the lower lease rates, but also provides increased funding for potentially higher leased rates and moving costs associated with some rents that are expiring in FY 2014-15. The staff recommendation for approval of the request applies to the supplemental only and the budget amendment will be discussed and voted on separately at figure setting.

SUPPLEMENTAL REQUEST, DEPARTMENT PRIORITY
S7 BENEFITS UTILIZATION SERVICES APPLICATION

	Request	Recommendation
Total	**$201,447**	**$201,447**
General Fund	100,723	100,723
Federal Funds	100,724	100,724

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 or NO**
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 Business Utilization Services (BUS) application showed signs of increased instability leading to a reassessment of the adequacy of the information technology infrastructure by the Office of Information Technology (OIT) in the Fall of 2013.	

Department Request

The Department requests funding to create and maintain additional information technology environments for the Business Utilization Services (BUS) application. The BUS records (1) assessments of eligibility for long term services and supports (LTSS) and (2) service plans for eligible clients that document needs and authorize Medicaid payments. Data stored in the BUS is also used to meet federal reporting requirements. The Department has experienced excessive wait times for system changes and instability in the system leading to unplanned downtown. An assessment by the Office of Information Technology (OIT) determined that these issues are due to substandard infrastructure that uses one information technology environment for recording and viewing data, developing and testing system changes, training new users, and disaster recovery. Although the BUS is scheduled to be replaced in FY 2016-17 by the new version of the Medicaid Management Information System (MMIS) currently under development, OIT judges that the sluggishness of the system, unplanned downtown, and risks of catastrophic failure and permanent data loss warrant immediate action.

The OIT is responsible for maintenance of the BUS, and so the requested funding would be paid by the Department to OIT to perform the work. There is a corresponding request in OIT for reappropriated funds spending authority.

Staff Recommendation

Staff recommends approval of the request. System failure could delay or disrupt services for vulnerable populations needing long-term care, and prevent the Department from meeting reporting requirements to draw federal funds.

SUPPLEMENTAL REQUEST, DEPARTMENT PRIORITY
S8 TECHNICAL ADJUSTMENT FOR HOSPICE RATE INCREASE

	Request	Recommendation
Total	**$317,668**	**$0**
General Fund	317,665	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**
The Department indicates that the request is the result of data that was not available when the original appropriation was made regarding the likelihood of federal approval of a rate increase for hospice providers, but the JBC staff would characterize it more as a technical error in calculating the original appropriation that assumed hospice providers could receive the rate increase. Either way, the JBC staff and the Department agree that the request meets the JBC's supplemental criteria.	

Department Request

The Department requests $317,665 General Fund money for a one-time General Fund-only supplemental payment to hospice providers in lieu of the rate increase initially approved by the General Assembly that the Department believes the federal Centers for Medicare and Medicaid Services (CMS) is not likely to approve. The FY 2013-14 Long Bill included additional funding for hospice providers, but the Department has not been able to implement the increase, because hospice rates are set according to federal criteria published in 42 CFR § 418.306. Since the hospice rate increases are not likely to be allowed, the Department's *S1 Medical Service Premiums* adjusts the Medicaid forecast to remove the associated General Fund and federal funds. In *S8 Technical adjustment for hospice rate increase* the Department proposes adding back General Fund to make a one-time payment to hospice providers.

The Department's position on whether implementing the request requires a bill is nuanced. The budget submission did not specifically request a bill, but it noted that, "the Department has no explicit statutory authority to give hospice providers a General Fund-only payment." At the hearing the Department appeared to request a bill. In response to an email from the JBC staff asking for clarification, the Department indicated:

> *It's an open question (for us) as to whether or not we truly need a bill to do this. We believe that a bill is the best way to go, because it provides explicit authority and reduces the potential for any ambiguity. If a bill is not needed (as determined by the JBC and LLS), we would still make the payments.*

Background

Last year, in estimating the cost of the Governor's request for a 1.5 percent community provider rate increase, the Department's budget staff erroneously identified a portion of hospice rates as eligible for the increase. Hospice providers are reimbursed for: (1) room and board expenses; and (2) program expenses. The room and board expenses are tied to nursing home rates and there was never any assumption that these were eligible for a discretionary increase through the budget process. However, the Department did identify the program expenses as eligible for a discretionary increase. The Department's budget staff also characterized the rates for program expenses as among those reduced during the economic downturn. Both those findings were in error due to a miscommunication between the Department staff administering the rates and the Department's budget staff estimating the cost of the Governor's proposal. The Department has thousands of rates and the Department's budget staff was not aware that this particular subset of rates is governed by a federal formula and not discretionary for states.

The misconception dates back to when across-the-board rate cuts were implemented and this subset of hospice rates was assumed to be part of the savings, meaning multiple Department and JBC budget staff have looked at the numbers and didn't recognize the error. Because this subset of hospice rates is so small relative to the total budget for Medicaid, the error was not obvious when the actuals came in different than the budget estimate of the across-the-board reduction. Neither providers nor lobbyists pointed out the faulty assumption, probably because it was at too fine a level of detail in the budget to stand out. The error only became apparent when the JBC approved a targeted rate increase for hospice that required a state plan amendment to implement.

Based on an understanding that rates had been reduced during the economic downturn and information from advocates about the inadequacy of current provider rates, the JBC approved a larger increase than the Governor's request. For home and community-based services, including hospice care, the JBC approved a 4.5 percent increase effective May 1, 2013, the Governor's proposed 1.5 percent increase effective July 1, 2013, and an additional 2.1 percent increase effective July 1, 2013. After accounting for compounding[1], the net expected result was an 8.262 percent increase in hospice rates over the FY 2011-12 rates.

Hospice Increases Approved by JBC

	FY 12-13*	FY 13-14	Cumulative Since FY 11-12
Percent Change			
Governor's request	0.0%	1.5%	
JBC-initiated increase	4.5%	2.1%	
TOTAL increase	4.5%	3.6%	8.262%
Estimated Additional Cost			
Governor's request	$0	$108,268	$108,268
JBC-initiated increase	$27,046	$457,267	$484,313
TOTAL increase	$27,046	$565,535	$592,581

* FY 12-13 increases were to take effect May 1, 2013.

[1] The two FY 2013-14 increases of 1.5 percent and 2.1 percent do not compound on each other, but they do compound on the FY 2012-13 increase of 4.5 percent.

Staff Recommendation

Staff does not recommend the request.

Approving the request would not achieve the JBC's original intent with the rate increase. The original intent was to provide an 8.262 percent increase, but the Department has asked for only the General Fund portion, or half the originally intended funds. Furthermore, the original intent was for an ongoing increase in rates, but the request is for one-time funding. The request might qualify as an acknowledgement that a mistake was made by the Department in representing that hospice rates could be increased by the General Assembly, but it doesn't correct the error.

In light of new information presented by the Department about how hospice rates are determined, staff questions whether the JBC should attempt to achieve the original intent of the appropriation. Hospice services were lumped in with home and community based services in the JBC's action and the argument for raising rates for home and community based services was that these providers were disproportionately impacted by rate reductions or a lack of rate increases from FY 2009-10 through FY 2012-13. This is not because the rate reductions were larger for these providers, but because they employ a lot of staff at low wages with Medicaid as the primary payer, and so the ability of these providers to lower wages further or cost-shift expenses to other payers was limited. This is the argument that was presented publicly for raising hospice rates. There may have been other factors that contributed to the JBC's decision that are unknown to the JBC staff. The argument for hospice providers to be treated the same as home and community based service providers is less compelling with the new information that hospice rates were not reduced or held constant like home and community based services, but rather increased in most regions pursuant to the federal formula for these rates.

The table on the next page lists the actual rates paid from federal fiscal year 2008-09 through 2013-14 for the hospice rates that were targeted for increases in the JBC's original motion. The federal formula that governs these rates includes a regional wage adjustment, and so the rates differ by area. There are some years where some regions experienced decreased rates, but over the six-year period the cumulative result was increased rates in all regions except Pueblo.

Hospice Rates by Federal Fiscal Year								
Region	Hospice Service	FFY 08-09	FFY 09-10	FFY 10-11	FFY 11-12	FFY 12-13	FFY 13-14	Cumulative since FFY 08-09
Boulder County	651 Routine Home Care	$150.91	$151.70	$154.20	$155.38	$157.45	$164.52	9.0%
	652 Continuous Home Care	$36.67	$36.85	$37.46	$37.78	$38.25	$39.97	9.0%
	655 Inpatient Respite	$161.63	$162.98	$165.98	$159.76	$170.33	$176.99	9.5%
	656 Gen Inpatient Care	$667.18	$671.76	$682.83	$689.86	$698.32	$728.36	9.2%
El Paso / Teller County	651 Routine Home Care	$143.65	$148.33	$149.51	$149.10	$154.85	$151.29	5.3%
	652 Continuous Home Care	$34.91	$36.03	$36.32	$36.26	$37.62	$36.76	5.3%
	655 Inpatient Respite	$155.40	$160.09	$161.96	$154.65	$168.10	$165.66	6.6%
	656 Gen Inpatient Care	$637.13	$657.64	$663.42	$663.84	$687.57	$673.62	5.7%
Denver Metro Area	651 Routine Home Care	$153.90	$157.05	$159.11	$162.39	$163.54	$163.37	6.2%
	652 Continuous Home Care	$37.40	$38.15	$38.66	$39.49	$39.73	$39.69	6.1%
	655 Inpatient Respite	$164.19	$167.56	$170.18	$165.48	$175.54	$176.01	7.2%
	656 Gen Inpatient Care	$679.57	$694.15	$703.12	$718.93	$723.53	$723.61	6.5%
Larimer County	651 Routine Home Care	$145.48	$147.19	$153.25	$153.52	$155.18	$156.42	7.5%
	652 Continuous Home Care	$35.35	$35.75	$37.23	$37.33	$37.70	$38.00	7.5%
	655 Inpatient Respite	$156.97	$159.11	$165.15	$158.25	$168.38	$170.06	8.3%
	656 Gen Inpatient Care	$644.70	$652.86	$678.87	$682.16	$688.93	$694.86	7.8%
Mesa County	651 Routine Home Care	$145.14	$146.62	$148.46	$153.06	$149.94	$151.85	4.6%
	652 Continuous Home Care	$35.27	$35.62	$36.07	$37.22	$36.43	$36.89	4.6%
	655 Inpatient Respite	$156.68	$158.63	$161.06	$157.88	$163.90	$166.14	6.0%
	656 Gen Inpatient Care	$643.31	$643.31	$659.08	$680.27	$667.25	$675.93	5.1%
Weld County	651 Routine Home Care	$134.73	$135.20	$136.32	$140.94	$142.08	$153.79	14.1%
	652 Continuous Home Care	$32.74	$32.84	$33.12	$34.27	$34.52	$37.36	14.1%
	655 Inpatient Respite	$147.77	$148.85	$150.65	$148.00	$157.16	$167.80	13.6%
	656 Gen Inpatient Care	$600.22	$602.69	$608.81	$630.04	$634.70	$683.97	14.0%
Pueblo County	651 Routine Home Care	$143.02	$145.28	$146.95	$149.27	$151.68	$142.03	-0.7%
	652 Continuous Home Care	$34.76	$35.29	$35.70	$36.30	$36.85	$34.51	-0.7%
	655 Inpatient Respite	$154.86	$157.48	$159.76	$154.78	$165.38	$157.73	1.9%
	656 Gen Inpatient Care	$634.54	$644.88	$652.81	$664.53	$674.42	$635.31	0.1%
Rural (All Hospices not found in a listed county)	651 Routine Home Care	$143.49	$144.10	$150.65	$153.52	$157.88	$160.51	11.9%
	652 Continuous Home Care	$34.87	$35.00	$36.60	$37.33	$38.36	$39.00	11.8%
	655 Inpatient Respite	$155.27	$156.47	$162.93	$158.25	$170.70	$173.56	11.8%
	656 Gen Inpatient Care	$636.49	$636.49	$668.14	$682.16	$700.11	$711.79	11.8%

The next table compares the average payment per unit of service for hospice routine home care with the rate for home and community based service personal care. These are the most commonly paid rates for hospice and for home and community based services respectively. The purpose of the chart is to compare the growth trends for the two services and not to suggest that routine home care and personal care are equivalent to each other in any respect. Because the federal formula for hospice rates includes a regional modifier, it can be confusing to track the trends, and so this table attempts to simplify the data by providing a statewide average payment per unit of service (a day), but note that the average is calculated on a state fiscal year while actual rates are set on a federal fiscal year, and so the figure is not exactly equivalent to the Hospice Rates by Federal Fiscal Year reported in the previous chart. Also, there is not yet an actual for FY 2013-14. Presumably the hospice routine home care average payment per unit of

service will increase in FY 2013-14, given that the federal fiscal year 2013-14 rates are increasing in all regions except Pueblo, but even without accounting for this last year of growth the cumulative increase in Medicaid reimbursement for hospice providers is higher than for home and community based service providers.

Average Hospice Payment per Unit of Service (day) by State Fiscal Year							
	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14	Cumulative since FY 08-09
651 Routine Home Care	$144.47	$149.51	$151.04	$153.91	$155.71	Not	
Percent Change		3.5%	1.0%	1.9%	1.2%	Available	7.8%
Personal Care - 15 minutes	$3.63	$3.53	$3.49	$3.47	$3.47	$3.76	
Percent Change		-2.8%	-1.1%	-0.6%	0.0%	8.4%	3.6%

One possible justification for approving the request would be if the JBC believes that the federal formula for hospice rates results in too little money for Colorado providers. There are specific federal statutes and regulations governing hospice rates, presumably in recognition of the need to ensure adequate reimbursement. Because of this, staff does not believe a change from the federal formula should be implemented lightly without compelling evidence of the need. The request does not provide any analysis to suggest that the federally-established hospice rates are insufficient. If the JBC finds evidence that hospice rates are insufficient, then staff believes that on-going funds, rather than a one-time payment, would be most appropriate.

Staff has heard concerns that recent reductions in Medicare reimbursements are presenting challenges for hospice providers. Medicare, rather than Medicaid, is the primary payer for hospice services. Hospice providers are scheduled to present to the JBC on January 23, 2014, at 5:20 PM, and staff has been told that information about the changes in Medicare reimbursement will be a part of that presentation. The supplemental request does not mention the changes to Medicare reimbursement rates, but to the extent this is a consideration for the JBC, staff has concerns about cost-shifting from Medicare to Medicaid and using state funds to backfill reductions in federal funding.

If the JBC decides to provide funding, the JBC staff and Legislative Legal Services both agree that the best way to do so would be through a bill. Legislative Legal Services notes that there is no statutory language in articles 4, 5, or 6 of title 25.5 that affirmatively contemplates department "supplemental payments" to hospice providers, or the use of state-only moneys for this purpose. Further, there is nothing in the statute that appears to allow the Department to create a new non-Medicaid program for this purpose and to fund it through a budget action. There is language in Section 25.5-5-304, C.R.S. that requires the state's medical assistance program include hospice care, that hospice must be provided in accordance with state board rules, and those rules must comply with federal Medicaid law. As mentioned, federal law determines the reimbursement rate for hospice services. Also, the statutory language authorizing optional eligibility groups and optional services in the Medicaid program (Sections 25.5-5-201, 202, and 203, C.R.S.) provides for those groups and services "for which federal participation is available" and "subject to the availability of federal financial aid funds". From this statutory framework, Legislative Legal Services concludes that there is significant risk that approving the supplemental request through

a budget action would constitute substantive law improperly made through the general appropriations bill.

From a policy perspective, staff believes a narrow interpretation of the Department's statutory purpose is valuable in preventing the Department from inventing new ways to spend state money after the budget has been set. The vast majority of the Department's funding is in a single line item and the Department has statutory authority to overexpend the appropriation. An overly broad interpretation of the Department's statutory authority could lead to abuse of the appropriation on a large scale. If the General Assembly were to authorize a General Fund only payment to hospice providers through the budget process, it would imply a broad interpretation of the Department's existing statutory authority that could result in unintended consequences in the future.

On the other hand, Legislative Legal Services found no statutory language that appeared to prohibit the Department from reimbursing hospice providers above the federal match with additional state funds. Also, hospice services are covered under Medicaid and the Department is required to reimburse for hospice services provided. Furthermore, the Colorado Court of Appeals decision in *Dodge v. State Department of Social Services*, 657 P.2d 969 (Colo. App. 1982) may support the proposition that the General Assembly may provide reimbursement for services for which there is no federal reimbursement, including the abortion services at issue in the case. This same reasoning may also permit the Department to reimburse above the allowable federal amount with state-only funds. However, the state and federal statutes have changed since the case and there were many case-specific facts involved, and so more legal research would be necessary for the Legislative Legal Services to support this position.

Other than the abortion services at issue in the *Dodge v. State Department of Social Services* case, the only other time that the Department's budget staff could recall a General Fund-only payment for a Medicaid service was for prenatal services and labor and delivery services for legal immigrants who meet eligibility requirements other than citizen status. The General Fund-only payment was specifically authorized by statute in Section 25.5-5-201 (4), C.R.S. The program was later refinanced with a mix of state and federal funds when federal Medicaid eligibility rules changed. Staff has concerns about the precedent of a General Fund-only payment to providers without specific statutory authority, and this is especially a concern if the purpose is to make a one-time symbolic gesture without actually fixing a material problem with hospice rates.

Non-prioritized Supplemental Requests

JBC STAFF-INITIATED SUPPLEMENTAL OVEREXPENDITURES IN FY 2012-13

	Request	Recommendation
Total	**$0**	**$5,896,130**
General Fund	0	5,433,269
Cash Funds	0	462,861

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 or NO**
The JBC staff recommendation is based on data that was not available when the original appropriation was made. Specifically, actual expenditures for Medicaid programs for FY 2012-13 are now known.	

Department Request

Consistent with prior years, the Department did not submit an official request for a release of the restrictions on the FY 2013-14 appropriations imposed by the State Controller as a result of FY 2012-13 overexpenditures. However, the Department did provide explanations for the overexpenditures for inclusion in the State Controller's letter, and a release of the restrictions is necessary to complete FY 2013-14.

Staff Recommendation

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 2012-13 over-expenditures were due to a combination of forecast errors and a disallowance of approximately $3.0 million federal funds. The disallowance was for a settlement to a provider for the Program of All-Inclusive Care for the Elderly (PACE) that the Centers for Medicare and Medicaid Services (CMS) ruled was outside of timely filing requirements. The Department has changed reconciliation procedures to ensure that any future similar settlements occur within the timely filing window. To relieve FY 2012-13 overexpenditures that are restricting the FY 2013-14 appropriations, staff recommends the FY 2012-13 supplemental appropriations contained in the table on the following page.

Release Overexpenditure Restrictions from FY 2012-13			
	Total	General Fund	Nursing Facility Provider Fee
Medical Service Premiums	$5,753,845	$5,290,984	$462,861
Behavioral Health Fee for Service	142,285	142,285	0
TOTAL	$5,896,130	$5,433,269	$462,861

Previously Approved Interim Supplementals

LEASE SPACE

	Previously Approved
Total	**$1,078,734**
General Fund	539,367
Federal Funds	539,367

Summary

The JBC approved funding for the Department to acquire approximately 25,000 square feet on the 7th floor of 303 E 17th Avenue that became available during the interim. The lease will ensure adequate space for 99.0 new positions authorized during the 2013 legislative session, including: (1) 33.5 new FTE approved in various bills; (2) 31.0 contract staff approved in the Long Bill associated with the reprocurement of the Medicaid Management Information System (MMIS); and (3) 34.5 FTE working on programs for people with developmental disabilities transferred from the Department of Human Services pursuant to H.B. 13-1314. The Department received funding for leased space for some, but not all, of the new positions authorized. Most notably, the Department did not receive funding for leased space for the staff transferring from the Department of Human Services. The appropriation is for the difference between funding provided to date and the estimated cost of the lease.

COUNTY ADMINISTRATION

	Previously Approved
Total	**$10,150,361**
General Fund	0
Federal Funds	10,150,361

Summary

The JBC approved reinvesting the General Fund savings from an enhanced federal match available for eligibility determination activities in two activities. First, the JBC approved a total of $2,449,793, including $585,870 General Fund and $1,863,923 federal funds, in a new line item for an Affordable Care Act Implementation Technical Support and Eligibility Determination Overflow Contingency. This line item addresses data transfer issues with Connect for Health Colorado and overflow capacity in the event of spikes in eligibility determinations as a result of S.B. 13-200 and the Affordable Care Act. Second, the JBC approved reducing the General Fund in the County Administration line item by $585,870 and increasing the federal funds by $8,286,438 for a net increase in county payments of $7,700,568 to help with increased enrollment volume.

Appendix A: Number Pages

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
Sue Birch, Executive Director					
S1 Medical Service Premiums					
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,937,400,734	4,736,824,877	52,407,943	52,387,943	4,789,212,820
General Fund	847,647,042	1,036,017,966	17,580,433	17,580,433	1,053,598,399
General Fund Exempt	507,235,957	469,842,084	0	0	469,842,084
Cash Funds	639,607,454	593,882,063	(8,629,648)	(8,649,648)	585,232,415
Reappropriated Funds	2,936,892	2,936,892	0	0	2,936,892
Federal Funds	1,939,973,389	2,634,145,872	43,457,158	43,457,158	2,677,603,030
Total for S1 Medical Service Premiums	3,937,400,734	4,736,824,877	52,407,943	52,387,943	4,789,212,820
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	847,647,042	1,036,017,966	17,580,433	17,580,433	1,053,598,399
General Fund Exempt	507,235,957	469,842,084	0	0	469,842,084
Cash Funds	639,607,454	593,882,063	(8,629,648)	(8,649,648)	585,232,415
Reappropriated Funds	2,936,892	2,936,892	0	0	2,936,892
Federal Funds	1,939,973,389	2,634,145,872	43,457,158	43,457,158	2,677,603,030

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
S1 Medical Service Premiums - Technical Correction to SB 13-200					
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,937,400,734	4,736,824,877	1	1	4,736,824,878
General Fund	847,647,042	1,036,017,966	0	0	1,036,017,966
General Fund Exempt	507,235,957	469,842,084	0	0	469,842,084
Cash Funds	639,607,454	593,882,063	70,072,387	70,072,387	663,954,450
Reappropriated Funds	2,936,892	2,936,892	0	0	2,936,892
Federal Funds	1,939,973,389	2,634,145,872	(70,072,386)	(70,072,386)	2,564,073,486
Total for S1 Medical Service Premiums - Technical Correction to SB 13-200	3,937,400,734	4,736,824,877	1	1	4,736,824,878
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	847,647,042	1,036,017,966	0	0	1,036,017,966
General Fund Exempt	507,235,957	469,842,084	0	0	469,842,084
Cash Funds	639,607,454	593,882,063	70,072,387	70,072,387	663,954,450
Reappropriated Funds	2,936,892	2,936,892	0	0	2,936,892
Federal Funds	1,939,973,389	2,634,145,872	(70,072,386)	(70,072,386)	2,564,073,486

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
S3 Children's Basic Health Plan					
(4) INDIGENT CARE PROGRAM					
Children's Basic Health Plan Medical and Dental Costs	191,570,458	196,282,277	(17,385,723)	(17,385,723)	178,896,554
General Fund	29,398,182	22,825,770	(3,309,421)	(3,309,421)	19,516,349
General Fund Exempt	441,600	438,300	0	0	438,300
Cash Funds	37,761,085	46,413,329	(2,569,185)	(2,569,185)	43,844,144
Federal Funds	123,969,591	126,604,878	(11,507,117)	(11,507,117)	115,097,761
Total for S3 Children's Basic Health Plan	191,570,458	196,282,277	(17,385,723)	(17,385,723)	178,896,554
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	29,398,182	22,825,770	(3,309,421)	(3,309,421)	19,516,349
General Fund Exempt	441,600	438,300	0	0	438,300
Cash Funds	37,761,085	46,413,329	(2,569,185)	(2,569,185)	43,844,144
Federal Funds	123,969,591	126,604,878	(11,507,117)	(11,507,117)	115,097,761

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
S4 Medicare Modernization Act					
(5) OTHER MEDICAL SERVICES					
Medicare Modernization Act State Contribution Payment	101,817,855	107,173,869	(4,917,552)	(4,917,552)	102,256,317
General Fund	52,136,848	82,492,862	(16,805,357)	(16,805,357)	65,687,505
Reappropriated Funds	0	0	0	0	0
Federal Funds	49,681,007	24,681,007	11,887,805	11,887,805	36,568,812
Total for S4 Medicare Modernization Act	101,817,855	107,173,869	(4,917,552)	(4,917,552)	102,256,317
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	52,136,848	82,492,862	(16,805,357)	(16,805,357)	65,687,505
Reappropriated Funds	0	0	0	0	0
Federal Funds	49,681,007	24,681,007	11,887,805	11,887,805	36,568,812

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
S6 Leased Space					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Leased Space	659,770	866,780	(459,849)	(459,849)	406,931
General Fund	216,966	289,521	(226,872)	(226,872)	62,649
Cash Funds	99,625	143,871	(3,053)	(3,053)	140,818
Federal Funds	343,179	433,388	(229,924)	(229,924)	203,464
Total for S6 Leased Space	659,770	866,780	(459,849)	(459,849)	406,931
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	216,966	289,521	(226,872)	(226,872)	62,649
Cash Funds	99,625	143,871	(3,053)	(3,053)	140,818
Federal Funds	343,179	433,388	(229,924)	(229,924)	203,464

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
S7 Benefits Utilization Services application					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Payments to OIT	0	0	201,447	201,447	201,447
General Fund	0	0	100,723	100,723	100,723
Federal Funds	0	0	100,724	100,724	100,724
Total for S7 Benefits Utilization Services application	0	0	201,447	201,447	201,447
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	0	0	100,723	100,723	100,723
Federal Funds	0	0	100,724	100,724	100,724

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
S8 Technical adjustment for hospice rate increase					
(4) INDIGENT CARE PROGRAM					
Hospice Supplemental Payment	0	0	317,665	0	0
General Fund	0	0	317,665	0	0
Total for S8 Technical adjustment for hospice rate increase	0	0	317,665	0	0
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	0	0	317,665	0	0

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
Interim Supplemental - Leased space					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Operating Expenses	1,503,436	1,764,066	728,014	728,014	2,492,080
General Fund	663,213	733,525	364,007	364,007	1,097,532
Cash Funds	43,601	131,410	0	0	131,410
Reappropriated Funds	64,796	23,910	0	0	23,910
Federal Funds	731,826	875,221	364,007	364,007	1,239,228
Leased Space	659,770	866,780	350,720	350,720	1,217,500
General Fund	216,966	289,521	175,360	175,360	464,881
Cash Funds	99,625	143,871	0	0	143,871
Federal Funds	343,179	433,388	175,360	175,360	608,748
Total for Interim Supplemental - Leased space	2,163,206	2,630,846	1,078,734	1,078,734	3,709,580
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	880,179	1,023,046	539,367	539,367	1,562,413
Cash Funds	143,226	275,281	0	0	275,281
Reappropriated Funds	64,796	23,910	0	0	23,910
Federal Funds	1,075,005	1,308,609	539,367	539,367	1,847,976

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
Interim Supplemental - County administration					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(D) Eligibility Determinations and Client Services					
County Administration	25,338,161	32,591,259	6,969,696	6,969,696	39,560,955
General Fund	9,894,404	10,731,704	(585,870)	(585,870)	10,145,834
Cash Funds	0	5,604,460	0	0	5,604,460
Federal Funds	15,443,757	16,255,095	7,555,566	7,555,566	23,810,661
Hospital Provider Fee County Administration	2,029,164	3,630,334	730,872	730,872	4,361,206
Cash Funds	1,014,582	1,755,168	0	0	1,755,168
Federal Funds	1,014,582	1,875,166	730,872	730,872	2,606,038
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	0	0	2,449,793	2,449,793	2,449,793
General Fund	0	0	585,870	585,870	585,870
Federal Funds	0	0	1,863,923	1,863,923	1,863,923
Total for Interim Supplemental - County administration	27,367,325	36,221,593	10,150,361	10,150,361	46,371,954
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	9,894,404	10,731,704	0	0	10,731,704
Cash Funds	1,014,582	7,359,628	0	0	7,359,628
Federal Funds	16,458,339	18,130,261	10,150,361	10,150,361	28,280,622

	FY 2012-13 Actual	FY 2013-14 Appropriation	FY 2013-14 Requested Change	FY 2013-14 Rec'd Change	FY 2013-14 Total W/ Rec'd Change
Totals Excluding Pending Items					
HEALTH CARE POLICY AND FINANCING					
TOTALS for ALL Departmental line items	5,191,473,774	6,537,643,053	41,393,027	41,055,362	6,578,698,415
FTE	315.9	358.1	0 .0	0 .0	358.1
General Fund	1,186,441,290	1,592,879,212	(1,803,462)	(2,121,127)	1,590,758,085
General Fund Exempt	507,677,557	470,280,384	0	0	470,280,384
Cash Funds	903,853,168	888,516,606	58,870,501	58,850,501	947,367,107
Reappropriated Funds	5,216,474	10,483,522	0	0	10,483,522
Federal Funds	2,588,285,285	3,575,483,329	(15,674,012)	(15,674,012)	3,559,809,317