Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Funding Requests: 17
Number of Non Prioritized Items: 4

Total Impact					**$332,070,448**	**1.8**	**$110,790,391**	**$0**	**$43,112,083**	**$291,180**	**$177,876,794**
Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Funding Requests											
1	R-1	N/A	Request for Medical Services Premiums	No	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
2	R-2	N/A	Medicaid Mental Health Community Programs	No	$36,614,308	0.0	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
3	R-3	N/A	Children's Basic Health Plan Medical and Dental Costs	No	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
4	R-4	N/A	Medicare Modernization Act State Contribution Payment	No	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
5	R-5	N/A	Medicaid Fee-for-Service Reform	No	($1,845,030)	1.8	($865,469)	$0	($57,047)	$0	($922,514)
6	R-6	N/A	Medicaid Budget Reductions	No	($29,699,322)	0.0	($30,471,105)	$0	$15,496,446	$0	($14,724,663)
7	R-7	N/A	Cost Sharing for Medicaid and CHP+	No	($3,407,194)	0.0	($1,438,020)	$0	$91,841	$0	($2,061,015)
8	R-8	N/A	Federally Mandated CHIPRA Quality Measures	No	$236,671	0.0	$82,835	$0	$0	$0	$153,836
9	R-9	N/A	CHP+ Eligibility for Children of State Employees	No	$0	0.0	$0	$0	$0	$0	$0
10	R-10	N/A	Utilize Supplemental Payments for General Fund Relief	No	($1,006,752)	0.0	($1,006,752)	$0	$0	$0	$0
11	R-11	N/A	CHIPRA Bonus Payment True-up	No	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
12	R-12	N/A	Hospital Provider Fee Administrative True-up	No	($52,769)	0.0	$0	$0	$28,596	$0	($81,365)
13	R-13	N/A	CBMS Electronic Document Management System	No	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
14	N/A	BA-3	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
15	N/A	BA-4	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
16	N/A	BA-5	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
17	N/A	BA-6	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Funding Requests					**$326,401,893**	**1.8**	**$107,956,114**	**$0**	**$43,112,083**	**$291,180**	**$175,042,516**
Funding Requests R-1 through R-4					**$369,504,249**	**0.0**	**$156,209,938**	**$0**	**$32,287,926**	**$290,438**	**$180,715,947**
All Other Funding Requests					**($43,102,356)**	**1.8**	**($48,253,824)**	**$0**	**$10,824,157**	**$742**	**($5,673,431)**
FY 2012-13 Non-Prioritized Funding Requests											

Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Funding Requests: 17
Number of Non Prioritized Items: 4

Total Impact					**$332,070,448**	**1.8**	**$110,790,391**	**$0**	**$43,112,083**	**$291,180**	**$177,876,794**
Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
1	NP-R1	N/A	DHS - New Funding – Developmental Disabilities Services	No	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
2	NP-R2	N/A	DHS - Statewide Vehicle Replacement	No	$15,149	0.0	$7,574	$0	$0	$0	$7,575
3	N/A	NP-BA1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
4	N/A	NP-BA2	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 Non-Prioritized Funding Requests					**$5,668,555**	**0.0**	**$2,834,277**	**$0**	**$0**	**$0**	**$2,834,278**

Schedule 11
Summary of Supplemental Requests for FY 2011-12

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Prioritized Supplemental Requests: 14

Priority #	Page #	Title	IT Request	Total Request FY 2011-12	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Prioritized Supplemental Requests										
S-1	S-1.1	Request for Medical Services Premiums	No	$62,369,672	0.0	$51,312,453	$0	($22,107,528)	$80,723	$33,084,024
S-2	S-2.1	Medicaid Mental Health Community Programs	No	$4,292,211	0.0	$7,741,587	$0	($5,568,294)	($13,544)	$2,132,462
S-3	S-3.1	Children's Basic Health Plan Medical and Dental Costs	No	($29,603,573)	0.0	$0	$0	($10,052,683)	$0	($19,550,890)
S-4	S-4.1	Medicare Modernization Act State Contribution Payment	No	$2,356,099	0.0	$2,356,099	$0	$0	$0	$0
S-5	S-5.1	Medicaid Budget Reductions	No	($7,859,799)	0.0	($19,618,256)	$0	$15,625,858	$0	($3,867,401)
S-6	S-6.1	CHIPRA Bonus Payment True-up	No	$0	0.0	($5,633,177)	$0	$0	$0	$5,633,177
S-7	S-7.1	Hospital Provider Fee Administrative True-up	No	$3,920,338	0.0	$0	$0	$2,023,541	$0	$1,896,797
S-8	S-8.1	Cost Sharing for CHP+	No	($264,453)	0.0	($138,601)	$0	$136,133	$0	($261,985)
S-9	S-9.1	Smoking Cessation Quitline for Medicaid Clients	No	$577,316	0.0	$0	$0	$288,658	$0	$288,658
S-10	S-10.1	Utilize Supplemental Payments for General Fund Relief	No	($9,634,148)	0.0	($614,990)	$0	($5,306,633)	$0	($3,712,525)
S-11	S-11.1	Federally Mandated CHP+ PPS Payments to FQHCs and RHCs	No	$1,650,176	0.0	$0	$0	$577,562	$0	$1,072,614
S-12	S-12.1	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$511,406	0.0	($42,022)	$0	$298,257	($650)	$255,821
S-13	S-13.1	Commission on Family Medicine Residency Training Program Adjustment	No	$350,000	0.0	$175,000	$0	$0	$0	$175,000
S-14	S-14.1	CBMS Placeholder		$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Supplemental Request Subtotal				**$28,665,245**	**0.0**	**$35,538,093**	**$0**	**($24,085,129)**	**$66,529**	**$17,145,752**
Supplemental Requests S-1 through S-4				**$39,414,409**	**0.0**	**$61,410,139**	**$0**	**($37,728,505)**	**$67,179**	**$15,665,596**
All Other Supplemental Requests				**($10,749,164)**	**0.0**	**($25,872,046)**	**$0**	**$13,643,376**	**($650)**	**$1,480,156**
FY 2011-12 Non-Prioritized Supplemental Requests										
NP-S1	NP-S1.1	Additional Federal Funds for Medicaid Facility Survey and Certification	No	$217,047	0.0	$0	$0	$0	$0	$217,047
NP-S2	NP-S2.1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
NP-S3	NP-S3.1	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
NP-S4	NP-S4.1	Suspension of ICF/ID Provider Fee	No	($1,867,655)	0.0	$933,828	$0	$0	($1,867,655)	($933,828)
NP-S5	NP-S5.1	Common Policy True-up for CCLS and ALJ	No	$39,104	0.0	$19,552	$0	$0	$0	$19,552
NP-S6	NP-S6.1	DHS - Annual Fleet True-Up	No	($15,765)	0.0	($7,882)	$0	$0	$0	($7,883)
NP-S7	NP-S7.1	DHS - FY 2011-12 Common Policy Allocation True-Up	No	$1,272	0.0	$636	$0	$0	$0	$636
Non-Prioritized FY 2011-12 Supplemental Requests Subtotal				**($850,131)**	**0.0**	**$1,334,067**	**$0**	**$0**	**($1,867,655)**	**($316,543)**
GRAND TOTAL FY 2011-12 Supplemental Requests				**$27,815,114**	**0.0**	**$36,872,160**	**$0**	**($24,085,129)**	**($1,801,126)**	**$16,829,209**

Schedule 12
Summary of FY 2012-13 Budget Amendments

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Prioritized Budget Amendments: 6

Priority #	Page #	Title	IT Request	Total Request FY 2012-13	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Health Care Policy and Financing FY 2012-13 Late Budget Amendments										
BA-1	S-1, BA-1.1	Request for Medical Services Premiums	No		0.0					
BA-2	S-2, BA-2.1	Medicaid Mental Health Community Programs	No		0.0					
BA-3	S-9, BA-3.1	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
BA-4	S-10, BA-4.1	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
BA-5	S-12, BA-5.1	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
BA-6	BA-6.1	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Prioritized Subtotals				**($7,792,086)**	**0.0**	**$250,764**	**$0**	**($4,736,141)**	**($650)**	**($3,306,059)**
Health Care Policy and Financing FY 2012-13 Non-Prioritized Late Budget Amendments										
NP-BA1	NP-S2, NP-BA1.1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
NP-BA2	NP-S3, NP-BA2.1	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 Non-Prioritized Subtotals				**$775,866**	**0.0**	**$387,933**	**$0**	**$0**	**$0**	**$387,933**
GRAND TOTAL FY 2012-13 Late Budget Amendments				**($7,016,220)**	**0.0**	**$638,697**	**$0**	**($4,736,141)**	**($650)**	**($2,918,126)**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Request for Medical Services Premiums

Priority Number: S-1

Dept. Approval by: John Bartholomew 12/23/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$3,543,863,749	$62,369,672	$3,559,795,929	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$51,312,453	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	($22,107,528)	$534,529,617	$0	$0
	RF	$6,388,059	$80,723	$3,101,708	$0	$0
	FF	$1,746,144,065	$33,084,024	$1,756,668,882	$0	$0
(2) Medical Services Premiums						
	Total	$3,543,863,749	$62,369,672	$3,559,795,929	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$51,312,453	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	($22,107,528)	$534,529,617	$0	$0
	RF	$6,388,059	$80,723	$3,101,708	$0	$0
	FF	$1,746,144,065	$33,084,024	$1,756,668,882	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

See Page ED-2 of the Department's FY 2012-13 R-1: "Medical Services Premiums" request.

Cash or Federal Fund Name and COFRS Fund Number: Certified Funds (22V), Local Funds, Hospital Provider Fee Cash Fund (24A), Medicaid Buy-In Fund (22W), Tobacco Tax Cash Fund, Health Care Expansion Fund (18K), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Colorado Autism Treatment Fund (18A), Coordinated Care for People with Disabilities Fund (19Z), Nursing Facility Cash Fund (22X), Home Health Telemedicine Fund (25J), Tobacco Education Program Fund (18M), Supplemental Old Age Pension Health and Medical Care Fund (15K), Prevention, Early Detection, and Treatment Fund (18N), Primary Care Fund (18L), Department Recoveries, Title XIX Federal Funds

Reappropriated Funds Source, by Department and Line Item Name:

Department of Public Health and Environment

(1) Administration and Support; (B) Special Health Programs, (1) Health Disparities Program

(9) Prevention Services Division; (A) Prevention Programs, (1) Programs and Administration

(9) Prevention Services Division; (B) Women's Health - Family Planning

(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments:

Other Information: None.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Mental Health Community Programs

Priority Number: S-2

Dept. Approval by: John Bartholomew 12/23/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$276,400,984	$4,292,211	$277,590,898	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$127,777,722	$7,741,587	$128,194,192	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	($5,568,294)	$10,510,223	$0	$0
	RF	$13,544	($13,544)	$13,544	$0	$0
	FF	$138,099,495	$2,132,462	$138,872,939	$0	$0
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	Total	$272,492,157	$4,089,576	$273,682,071	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$125,823,308	$7,640,270	$126,239,778	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	($5,568,294)	$10,510,223	$0	$0
	RF	$13,544	($13,544)	$13,544	$0	$0
	FF	$136,145,082	$2,031,144	$136,918,526	$0	$0
(3) Medicaid Mental Health Community Programs; Medicaid Mental Health Fee for Services Payments	Total	$3,908,827	$202,635	$3,908,827	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,954,414	$101,317	$1,954,414	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,954,413	$101,318	$1,954,413	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

*Of this amount, ~~$10,466,206~~ $4,877,953 (H) shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., and ~~$44,017~~ $63,976 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D); Hospital Provider Fee Cash Fund (24A). FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name: Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund.

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: None.

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Children's Basic Health Plan Medical and Dental Costs

Priority Number: S-3

Dept. Approval by: John Bartholomew 12/23/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	**$213,086,149**	**($29,603,573)**	**$187,766,874**	**$0**	**$0**
	FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	GF	**$29,551,808**	**$0**	**$25,066,119**	**$0**	**$0**
	GFE	**$446,100**	**$0**	**$446,100**	**$0**	**$0**
	CF	**$44,582,245**	**($10,052,683)**	**$40,206,188**	**$0**	**$0**
	RF	**$0**	**$0**	**$0**	**$0**	**$0**
	FF	**$138,505,996**	**($19,550,890)**	**$122,048,467**	**$0**	**$0**
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$213,086,149	($29,603,573)	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	($10,052,683)	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	($19,550,890)	$122,048,467	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

Of this amount, ~~$38,737,097~~ $22,413,342 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,389,580~~ $8,650,652 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Hospital Provider Fee Cash Fund 24A and Colorado Immunization Fund; FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2011-12 Supplemental Request
January 3, 2012

Department Priority: S-3
Request Title: Children's Basic Health Plan Medical Premium and Dental Benefit Costs

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Children's Basic Health Plan Medical and Dental Costs	($29,603,573)	$0	0.0

Request Summary:
The Department is requesting to adjust the Children's Basic Health Plan Medical and Dental Costs line item to account for updated caseload and per capita estimates. The FY 2011-12 request is a decrease of $29,603,573 from the current FY 2011-12 appropriation, of which $10,052,683 is cash funds and $19,550,890 is federal funds. The request for FY 2012-13 funding is included in the Department's November 1, 2011 FY 2012-13 Budget Request R-3 "Children's Basic Health Plan Medical and Dental Costs."

The Department is not requesting any change to appropriations for the Children's Basic Health Plan Administration line item, though updated appropriations for internal administration (Personal Services, Operating Costs, Medicaid Management Information System, etc.) are incorporated in the Department's analysis of the Children's Basic Health Plan Trust Fund in its November 1, 2011 Budget Request R-3 "Children's Basic Health Plan Medical and Dental Costs."

The Department's decreased estimate for funding for the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+), for FY 2011-12 is the result of two factors. First, the caseload decrease during FY 2010-11 left caseload at a low starting point for FY 2011-12. To account for this downwards level shift, the Department's latest caseload estimate is lower than its previous forecast. Second, the Department has revised its per capita estimates for FY 2011-12 downwards due to lower than forecasted per capita expenditures in FY 2010-11, combined with the actuarially calculated capitation rates for FY 2011-12. The updated medical per capita estimates for children and prenatal women are lower than the Department's previous estimate, while the dental per capita estimates are higher.

These updated caseload and per capita estimates have led to lower forecasted expenditures for the CHP+ program compared to the Department's previous estimate. Thus, the Department is requesting a decrease to the current FY 2011-12 appropriation for the Children's Basic Health Plan Medical and Dental Costs to true up its latest expenditures forecast.

Anticipated Outcomes:
This request would result in an appropriation to the Children's Basic Health Plan Medical and Dental Costs line item that accounts for the Department's latest expenditures forecast.

Assumptions for Calculations:
Please see Attachment A and Exhibits C.1 through C.8 in the Department's November 1, 2011 FY 2012-13 Budget Request R-3 "Children's Basic Health Plan Medical and

Dental Costs" for detailed descriptions of the assumptions and calculations for this request.

Consequences if not Funded:
Not applicable. Under the Patient Protection and Affordable Care Act of 2009, there is a Maintenance of Effort provision on CHP+ eligibility until September 30, 2019. As such, CHP+ resembles an entitlement program like Medicaid. If the funding were not appropriated to support any increased costs, the entire CHP+ program would have to be eliminated.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj).

The Children's Basic Health Plan Trust fund is created by 25.5-8-105 C.R.S. (2011). An "eligible person" for the program is defined in 25.5-8-103 (4) C.R.S. (2011). 25.5-8-107 (1) (a) (II), C.R.S. (2011) allows the Department to provide dental benefits though the Children's Basic Health Plan.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicare Modernization Act State Contribution Payment
Priority Number: S-4

Dept. Approval by: John Bartholomew 12/23/11 (Date)

OSPB Approval by: 12/27/11 (Date)

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	**$91,156,720**	**$2,356,099**	**$91,156,720**	**$0**	**$0**
	FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	GF	**$66,146,615**	**$2,356,099**	**$60,127,929**	**$0**	**$0**
	GFE	**$0**	**$0**	**$0**	**$0**	**$0**
	CF	**$0**	**$0**	**$0**	**$0**	**$0**
	RF	**$0**	**$0**	**$0**	**$0**	**$0**
	FF	**$25,010,105**	**$0**	**$31,028,791**	**$0**	**$0**
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$91,156,720	$2,356,099	$91,156,720	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	$2,356,099	$60,127,929	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$0	$31,028,791	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-4
Medicare Modernization Act of 2003 State Contribution Payment

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
MMA State Contribution Payment	$2,356,099	$2,356,099	0.0

Request Summary:
This request is for additional General Fund totaling $2,356,099 for FY 2011-12 for the Medicare Modernization Act of 2003 State Contribution Payment line item. This request is the result of a projected increase in the caseload of dual-eligible individuals in conjunction with a projected increase in the per-member per-month (PMPM) rate paid by the State as required by federal regulations. The Department requested to adjust the FY 2012-13 appropriation for this line item in its November 1, 2011, FY 2012-13 R-4, and any FY 2012-13 amount presented in this request is for informational purposes only.

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Medicare Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients (individuals eligible for both Medicare and Medicaid). In lieu of the states' obligation to cover prescription drugs for this population, CMS began requiring states to pay a portion of what their anticipated dual-eligible drug cost would have been had this cost shift not occurred.

In January 2006, states began to pay CMS these "clawback" payments. The payments were calculated by taking 90% of the federal portion of each state's average PMPM dual-eligible drug benefit from calendar year 2003, inflated to 2006 using the average growth rate from the National Health Expenditure (NHE) per-capita drug expenditures. This inflated PMPM amount is then multiplied by the number of dual-eligible clients, including retroactive clients, back to January 2006. As each calendar year passes, the 90% factor is lowered by 1.67% each year – which is known as the phase-down percentage – until it reaches 75%, where it will remain beginning in 2015. In addition, CMS inflates each state's PMPM rates based on either NHE growth or actual growth in Part D expenditures.

With new data available, the Department has recalculated its estimate for FY 2011-12 and projects the MMA clawback payment will total $93,512,819, which is $2,356,099 higher than the FY 2011-12 appropriation.

On July 26, 2011, CMS released the National Health Expenditure Projections for 2010-2020, which the Department is currently analyzing to determine the impact these projections may have on the MMA State Contribution Payment line item. While the Department's analysis is ongoing, initial results indicate that MMA FY 2011-12 total expenditures could increase by as much as 3.2%.

Anticipated Outcomes:
Approval of this request would allow the Department to meet its obligation to the federal

government and ensure the Department would not have the amount of payment plus interest deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under-funded to provide services and would necessitate a General Fund appropriation or program cuts to make up the difference, as Medicaid is an entitlement program in which the Department cannot cap enrollment.

Assumptions for Calculations:
The Department assumes the changes in the PMPM rate paid by the Department will be based on the growth in the 2009 NHE prescription-drug per-capita estimates between years 2012 and 2013 and offset by the corresponding phase-down percent. The Department further assumes the changes in dual-eligible caseload will follow a trend of 3.75% annual growth, as has been evidenced historically.

Tables detailing these calculations are attached in Appendix A of the Department's November 1, 2011, FY 2012-13 R-4 funding request.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
42 C.F.R. §423.910 (a) (2011) General rule: *Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.*

25.5-5-503, C.R.S. (2011) *(1) The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients. (2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.*

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Budget Reduction

Priority Number: S-5

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$3,551,534,588	($7,859,799)	$3,567,597,651	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$900,939,403	($19,618,256)	$983,420,675	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,377,712	$15,625,858	$534,630,271	$0	$0
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,751,653,997	($3,867,401)	$1,762,269,580	$0	$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	Total	$7,670,839	$250,000	$7,801,722	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,100,370	$62,500	$2,100,370	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$60,537	$0	$100,654	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,509,932	$187,500	$5,600,698	$0	$0
(2) Medical Services Premiums	Total	$3,543,863,749	($8,109,799)	$3,559,795,929	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($19,680,756)	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$15,625,858	$534,529,617	$0	$0
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	($4,054,901)	$1,756,668,882	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2012-13: b Of this amount, ~~$354,642,186~~ $370,277,142 shall be from the Hospital Provider Fee Cash Fund Created in Section 25.5-4-402.3 (4),...~~$2,743,722~~ $2,734,624 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I)

Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee Cash Fund (24A), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Title XIX

Reappropriated Funds Source, by Department and Line Item Name: None.

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: None.

Other Information: None.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Funding Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-5
Request Title: Medicaid Budget Reductions

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Medicaid Budget Reductions	($7,859,799)	($19,618,256)	0.0

Request Summary:
The Department requests a reduction of $7,859,799 total funds and $19,618,256 General Fund in FY 2011-12 to account for the current year impact of the savings initiatives the Department proposed in its November 1, 2011 budget request R-6, "Medicaid Budget Reductions". The Department is not requesting funding changes for any initiatives that were not detailed in R-6 as part of this request.

Initiatives with FY 2011-12 impacts include the following: Preterm Labor Prevention, Synagis PAR Review, Expansion of the Physician Administered Drug Rebate Program, Reimbursement Rate Alignment for Developmental Screenings, Physician Administered Drug Pricing and Unit Limits, Public Transportation Utilization, Home Health Therapies Cap, Home Health Care Cap, Seroquel Restrictions, Dental Efficiencies, Augmentative Communication Devices, Ambulatory Surgical Centers, Utilization Management Vendor Funding, Pharmacy Rate Methodology Transition, and Hospital Provider Fee Financing. A detailed description of each initiative can be found in the Department's FY 2012-13 Budget Request R-6: "Medicaid Budget Reductions".

Assumptions for Calculations:
Calculations for the FY 2011-12 impact of each initiative are included in the Department's FY 2012-13 Budget Request R-6: "Medicaid Budget Reductions".

Consequences if not Funded:
The Department has already begun implementing these initiatives. If the Department's FY 2011-12 appropriation is not reduced to account for these initiatives, the Department will be overfunded.

Cash Fund Projections:
See Table 5.1 in Appendix A of the Department's FY 2012-13 Budget Request R-6, "Medicaid Budget Reductions".

Relation to Performance Measures:
HCPF Performance Measure 4: Contain Health Care Costs: The initiatives contained in this request ensure care is both necessary and appropriate without sacrificing the integrity of clients' health.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
The Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per 25.5-4-401 (1) (a), C.R.S. (2011).

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CHIPRA Bonus Payment True-up

Priority Number: S-6

Dept. Approval by: John Bartholomew 12/21/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	**$91,156,720**	**$0**	**$91,156,720**	**$0**	**$0**
	FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	GF	**$66,146,615**	**($5,633,177)**	**$60,127,929**	**$0**	**$0**
	GFE	**$0**	**$0**	**$0**	**$0**	**$0**
	CF	**$0**	**$0**	**$0**	**$0**	**$0**
	RF	**$0**	**$0**	**$0**	**$0**	**$0**
	FF	**$25,010,105**	**$5,633,177**	**$31,028,791**	**$0**	**$0**
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$91,156,720	$0	$91,156,720	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	($5,633,177)	$60,127,929	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$5,633,177	$31,028,791	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-6
CHIPRA Bonus Payment True-up

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	$0	($5,633,177)	0.0

Request Summary:
The Department requests a reduction to the General Fund appropriation to the Medicaid Modernization Act of 2003 State Contribution Payment (MMA) line item in the amount of $5,633,177 in FY 2011-12 with corresponding increases in the federal funds appropriation. The requested change is the result of updated calculations for the State's projected CHIPRA bonus payments for FFY 2010 forward. The Department requested to adjust the FY 2012-13 appropriation for the CHIPRA bonus payment in its November 1, 2011 FY 2012-13 R-11, and any FY 2012-13 amount presented in this request is for informational purposes only. Please note that the Department's estimate for the FFY 2011 CHIPRA bonus payment have been updated from that included in its November 1, 2011 FY 2012-13 R-11 due to new information provided by the Centers for Medicare and Medicaid Services.

As discussed in the Department's November 1, 2010 DI-6 "Cash Fund Insolvency Financing" and February 15, 2011 "Cash Fund Insolvency True-Up," under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities. Five of eight outreach and retention policies must be in place for at least half of the federal fiscal year for a state to qualify to receive a bonus. Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target.

The CHIPRA bonuses are made in two distinct payments- an initial payment in the December following the end of the federal fiscal year for which the bonus payment is being made, and a second payment in approximately the following August. The second payment is made in order to allow for retroactive enrollments or disenrollments to occur, which makes the enrollment number used to calculate the payment more comparable to the baseline enrollment level.

The Department received notification that Colorado qualified for the FFY 2010 payment on December 23, 2010, and the Department received the first payment of $13,671,043 in late December 2010. The Department received an award letter for the second payment in the amount of $4,532,230 on August 10, 2011.

The Department's MMA line item was appropriated $25,010,105 federal funds in FY 2011-12 for the initial FFY 2011 CHIPRA bonus payment, with a corresponding decrease in the General Fund appropriation. This request is to

adjust this appropriation for two factors. First, the Department did not receive an appropriation for the second FFY 2010 payment, which was received in FY 2011-12. Second, the Department is adjusting the projected CHIPRA bonus payments for FFY 2011 forward to account for the revised Medicaid caseload forecast that is included in the Department's November 1, 2011 Budget Request.

Please note that the Department's request for FY 2011-12 includes a reduction of $30,000 from the full amount of the second FFY 2010 payment. Pursuant to HB 10-1264, the Department submitted an IDEA application to reward 11 Department employees for the extraordinary effort that went into ensuring that the State qualified for the FFY 2010 bonus payment. In accordance with 24-50-903 et seq. C.R.S. (2011), this application was approved by the Executive Director of the Department, the savings were reviewed and verified by the State Auditor, and the State Auditor presented these findings to the Legislative Audit Committee on July 11, 2011. As such, the Department has been granted authority to reduce the federal award by $30,000: $25,000 in discretionary funds for the Department and $5,000 to be equally distributed among the 11 Department employees on the team that won the award. This amount will be placed in a non-appropriated line item by the Office of the State Controller for disbursement.

Assumptions for Calculations:
The projected bonus payments for FFY 2011 forward are based on formulas set in federal law at 42 U.S.C. 1397ee(a)(3), and have been updated for the revised Medicaid caseload forecast that is included in the Department's November 1, 2011 Budget Request. Please see Attachment A for details assumptions, and calculations regarding the calculation of this request.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
42 U.S.C. 1397ee(a)(3) Performance bonus payment to offset additional Medicaid and CHIP child enrollment costs resulting from enrollment and retention efforts

(A) In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

Attachment A
CHIPRA Bonus Payment True-up

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities.

Bonus payments were made available beginning in federal fiscal year (FFY) 2009. For each year, bonuses will be paid by December 31st following the end of the federal fiscal year (e.g., FFY 2011 bonuses will be paid by December 31, 2011). Five of the eight policies must be in place for at least half of the federal fiscal year for a state to qualify to receive a bonus. The qualifying policies are shown in Table 1, along with Colorado's status. Colorado received approval for a Medicaid State Plan Amendment in FY 2010-11 that will clarified that Colorado's Medicaid Health Insurance Buy-In program meets all of the requirements for the Premium Assistance Subsidy provisions set forth in CHIPRA. This State Plan Amendment qualified Colorado to receive the CHIPRA bonus payment beginning in FFY 2010.

The CHIPRA bonuses are made in two distinct payments- an initial payment in the December following the end of the federal fiscal year for which the bonus payment is being made, and a second payment in approximately the following summer. The second payment is made in order to allow for retroactive enrollments or disenrollments to occur, which makes the enrollment number used to calculate the payment more comparable to the baseline enrollment level. The Department has assumed that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17% based on enrollment data from the Medicaid Management Information System (MMIS) for January through December 2009 as well as the FFY 2010 final retroactive adjustment, though this percent is not known at this time.

Table 1: 8 Enrollment and Retention Provisions

Provision	Description	Medicaid	CHP+
12-Month Continuous Eligibility under Title XIX and Title XXI *	Establishment of a 12-month continuous eligibility period for children under age 19 in the Medicaid and/or CHIP State Plans.		✓
Elimination of Asset Test under Title XIX and Title XXI*	The State has liberalized asset test requirements for determining eligibility of children for Medicaid or CHIP by either removing asset/resource tests or reducing the documentation requirements for eligibility.	✓	✓
Elimination of In-Person Interview under Title XIX and Title XXI*	The State has eliminated in-person interview requirements for applying for Medicaid or CHIP (with exception for circumstances that justify a face-to-face interview).	✓	✓
Joint Application	The State has established a joint application and verification process for initial enrollment into Medicaid or CHIP and renewals of enrollment.	✓	✓
Auto Renewal under Title XIX and Title XXI	The State's Medicaid or CHIP program utilizes a renewal form with pre-printed eligibility information that is sent to the parent/caretaker relative of the child with notice that the child's eligibility will be automatically renewed unless other information is provided to the State that affects the child's continued eligibility.		
Presumptive Eligibility under Title XIX and Title XXI*	The State has implemented presumptive eligibility for children under the Medicaid and/or CHIP State Plans.	✓	✓
Express Lane under Title XIX and Title XXI*	The State is implementing the option to utilize express lane agencies under the Medicaid and CHIP State Plans.		
Premium Assistance Subsidy under Title XIX and Title XXI	The State has implemented the option of providing premium assistance subsidies under the Medicaid and/or CHIP State Plans.	✓	✓
* Both Medicaid and CHIP must implement these provisions.			

Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target. The enrollment target will be set each year by applying the formula set out in CHIPRA to state enrollment data. Specifically, the Centers for Medicare and Medicaid Services will calculate the target for each state, which is based on the state's child enrollment in Medicaid in 2007 adjusted each year by the state's child population growth and a standard enrollment growth factor that changes over time as specified in CHIPRA. The standard enrollment growth factor, which is the same for all states, is based on national projected caseload growth. Because of the recession, it is pegged at a fairly high rate. The rate starts at 4% but drops to 3.5%, 3%, and ultimately to 2%.

The CHIPRA bonus payment is equal to a percentage of the state's share of the average per capita cost of a Medicaid child, applied to the number of Medicaid children that exceed the enrollment target. The percentage depends on how much enrollment exceeds the enrollment target. A state with enrollment between the target level and 110% of the target level (Tier 1 enrollment) would receive a bonus payment equal to 15% of the state's share of the average per capita cost of a Medicaid child, multiplied by the number of children above the target. The percentage would rise to 62.5% of the state's share of the average cost per child for enrollment above 110% of the target (Tier 2 enrollment).

Table 2a: CHIPRA Bonus Caseload Calculations- Initial Payment

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Baseline Enrollment	263,497	276,400	288,230	300,912
Estimated Child Population Growth Factor[1]	4.90%	4.50%	4.40%	4.07%
Tier 1 Bonus Target Enrollment Estimate[2]	276,400	288,834	300,912	313,159
Tier 2 Bonus Target Enrollment Estimate[3]	304,040	317,717	331,003	344,475
Projected Enrollment	313,759	342,341	368,568	381,204
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 2 Bonus Enrollment	9,719	24,624	37,565	36,729

[1] Estimated Child population growth equals estimated population growth for age 0-18. The FFY 2010 estimate is provided by the Centers for Medicare and Medicaid Services, and future growth rates are estimates from the U.S. Census Bureau plus 3.5% in FFY 2011 through FFY 2012, and 3.0% in FFY 2013 thereafter.
[2] Tier 1 Bonus target is the Baseline Enrollment increased by the Estimated Child Population Growth Factor.
[3] Tier 2 Bonus target is 10% above the Tier 2 Bonus Enrollment target.

Table 2b: CHIPRA Bonus Per Capita Calculations

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Kaiser State Health Facts CO Child Medicaid Cost[4]	$2,478.75	$2,650.89	$2,887.39	$3,116.32
Estimated Increase in National Health Expenditures	7.93%	6.96%	7.93%	7.93%
State FMAP Rate	50.00%	50.00%	50.00%	50.00%
Applicable Per Capita	$1,337.64	$1,325.45	$1,558.16	$1,681.70

[4] Per capita costs used to calculate the bonus payment is the average cost of a non-SSI, non-waiver child in Medicaid including retroactivity. Because the Department does not report a similar per capita cost in its budget, the Kaiser State Health Facts CO Child Medicaid Cost is used as the closest available proxy to that used by the Centers for Medicare and Medicaid Services to calculate the payment.

Table 2c: CHIPRA Bonus Payment Calculation- Initial Payment

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 1 Per Capita Bonus[5]	$200.64	$198.82	$233.72	$252.26
Projected Tier 1 Bonus Payment	**$5,545,765**	**$5,742,446**	**$7,032,869**	**$7,899,774**
Projected Tier 2 Bonus Enrollment	9,719	24,624	37,565	36,729
Projected Tier 2 Per Capita Bonus[5]	$836.02	$828.41	$973.85	$1,051.06
Projected Tier 2 Bonus Payment	**$8,125,278**	**$20,398,606**	**$36,582,763**	**$38,604,278**
Projected Total Initial CHIPRA Bonus Payment	**$13,671,043**	**$26,141,052**	**$43,615,632**	**$46,504,052**

[5] Projected Tier 1 Bonus Per Capita is equal to the estimated base per capita cost for Medicaid children multiplied by the State's FMAP rate multiplied by 15%. Projected Tier 1 Bonus Per Capita is equal to the estimated base per capita cost for Medicaid children multiplied by the State's FMAP rate multiplied by 62.5%.

Table 2d: CHIPRA Bonus Payment Calculation- Final Caseload Projections				
Projected Enrollment with Retroactivity[6]	319,961	346,346	372,880	385,664
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 2 Bonus Enrollment	15,921	28,629	41,877	41,189
Applicable Per Capita	$1,291.35	$1,393.74	$1,504.24	$1,623.50

[6] Based on enrollment data from the MMIS for January through December 2009 as well as the FFY 2010 final retroactive adjustment, the Department estimates that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17%.

Table 2e: CHIPRA Bonus Payment Calculation- Final Payment				
	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 1 Per Capita Bonus	$193.70	$192.96	$225.64	$243.53
Projected Tier 1 Bonus Payment	**$5,353,937**	**$5,573,267**	**$6,789,613**	**$7,626,229**
Projected Tier 2 Bonus Enrollment	15,921	28,629	41,877	41,189
Projected Tier 2 Per Capita Bonus	$807.09	$804.00	$940.15	$1,014.69
Projected Tier 2 Bonus Payment	**$12,849,336**	**$23,017,729**	**$39,370,662**	**$41,793,963**
Projected Total CHIPRA Bonus Payment	**$18,203,273**	**$28,590,996**	**$46,160,275**	**$49,420,192**
Projected Second Payment	**$4,532,230**	**$2,449,944**	**$2,544,643**	**$2,916,140**

Table 3: CHIPRA Bonus Payments by State Fiscal Year					
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Projected Initial Bonus Payment (December of Respective State Fiscal Year)	$13,671,043	$26,141,052	$43,615,632	$46,504,052	$0
Projected Second Bonus Payment (August of Following State Fiscal Year)*	$0	$4,502,230	$2,449,944	$2,544,643	$2,916,140
Projected Total Bonus Payments by State Fiscal Year	**$13,671,043**	**$30,643,282**	**$46,065,576**	**$49,048,695**	**$2,916,140**

* The amount appropriated from the second payment from FFY 2010 is reduced by $30,000 for IDEA awards. Please see narrative for details.

Table 4: Estimated/Requested Appropriation Adjustments for CHIPRA Bonus Payments				
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Projected Total Bonus Payments by State Fiscal Year	$13,671,043	$30,643,282	$46,065,576	$49,048,695
Appropriation/Base Request	$13,671,043	$25,010,105	$31,028,791	$0
Estimated/Requested Incremental Increase in Federal Funds Appropriation (Corresponding Decrease in General Fund Appropriation)	**$0**	**$5,633,177**	**$15,036,785**	**$49,048,695**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Hospital Provider Fee Administrative True-up

Priority Number: S-7

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$96,766,237	$3,920,338	$98,483,655	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$27,485,261	$0	$27,272,835	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$9,809,945	$2,023,541	$11,183,319	$0	$0
	RF	$121,320	$0	$121,810	$0	$0
	FF	$59,349,711	$1,896,797	$59,905,691	$0	$0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects[a]	**Total**	$6,596,052	($120,000)	$6,410,052	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,430,918	$0	$1,487,168	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$721,750	($60,000)	$497,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,443,384	($60,000)	$4,425,384	$0	$0
(1) Executive Director's Office; (C) Information Technology Contracts, Centralized Eligibility Vendor Contract Project[b]	**Total**	$2,221,482	$2,230,940	$4,584,648	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$964,169	$1,246,853	$2,129,467	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,257,313	$984,087	$2,455,181	$0	$0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards[c]	**Total**	$120,000	$9,240	$120,000	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$59,203	$0	$59,203	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$4,620	$0	$0	$0
	RF	$1,593	$0	$1,593	$0	$0
	FF	$59,204	$4,620	$59,204	$0	$0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration[d]	**Total**	$33,547,878	($2,361,502)	$34,008,773	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$10,300,790	$0	$10,373,188	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$6,513,282	($1,180,751)	$6,671,332	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$16,733,806	($1,180,751)	$16,964,253	$0	$0

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration *(new line item)* [e]	Total	$0	$2,361,502	$0	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$1,180,751	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$1,180,751	$0	$0	$0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach [f]	Total	$5,213,157	$90,506	$4,895,961	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,550,470	$0	$2,376,649	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$56,109	$45,253	$71,333	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,606,578	$45,253	$2,447,979	$0	$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts [g]	Total	$7,670,839	$243,612	$7,801,722	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,100,370	$0	$2,100,370	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$60,537	$53,795	$100,654	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,509,932	$189,817	$5,600,698	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System [h]	Total	$8,983,839	$1,466,040	$8,895,282	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	$0	$4,416,786	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$733,020	$14,520	$0	$0
	RF	$19,399	$0	$19,889	$0	$0
	FF	$4,488,403	$733,020	$4,444,087	$0	$0

Letternote Text Revision Required? **Yes:** ☑ **No:** ☐ **If yes, describe the Letternote Text Revision:**

a Of this amount, ~~$2,545,858~~ $2,485,858 shall be from the Hospital Provider Fee Cash Fund...

b Of this amount, ~~$964,169~~ $2,211,022 shall be from the Hospital Provider Fee Cash Fund...

c Of this amount $4,620 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

d Of this amount, ~~$1,180,751~~ $0 shall be from the Hospital Provider Fee Cash Fund...

e Of this amount, $1,180,751 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

f Of this amount, ~~$56,109~~ $101,362 shall be from the Hospital Provider Fee Cash Fund...

g Of this amount ~~$60,537~~ $114,332 shall be from the Hospital Provider Fee Cash Fund...

h Of this amount. $733,020 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A); FF: Title XIX, Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? **Yes:** ☐ **No:** ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services, Governor's Office of Information Technology

Other Information: N/A.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Governor's Office of Information Technology
Request Title: Hospital Provider Fee Administrative True-up
Priority Number: HCPF S-12

Dept. Approval by: _____ Date

OSPB Approval by: _____ 12/29/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 6 Continuation Amount FY 2013-14
Total of All Line Items	Total	19,007,729	1,466,040	19,127,288	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	1,466,040	19,127,288	-	-
	FF	-	-	-	-	-
(5) Office of Information Technology, (E) Colorado Benefits Management System, Operating Expenses	Total	19,007,729	1,466,040	19,127,288	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	1,466,040	19,127,288	-	-
	FF	-	-	-	-	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: COFRS Fund 613 (IT Revolving Fund)
Reappropriated Funds Source, by Department and Line Item Name: User charges
Approval by OIT? Yes: ☑ No: ☐ Not Required: ☐
Schedule 13s from Affected Departments: Departments of Health Care Policy & Financing
Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2011-12 Supplemental Request
January 3, 2012

Department Priority: S-7
Request Title: Hospital Provider Fee Administrative True-up

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Request	$3,920,338	$0	0.0

Request Summary:
The Department requests an increase of $3,920,338 total funds, comprised of $2,023,541 hospital provider fee cash funds and $1,896,797 federal funds in FY 2011-12, in order to true-up appropriations with actual need for hospital provider fee administration.

To date, appropriations for hospital provider fee administration have for the most part been directly from the original fiscal note developed for HB 09-1293. Since then however, implementation dates of programs have changed and caseload forecasts have begun to deviate from those originally estimated, requiring a true-up to bring the appropriations in line with actual need based on the current caseload and program implementation dates. This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals and that the fees collected for administration are being allocated accurately.

HB 09-1293 authorized the Department to collect a hospital provider fee for the purpose of obtaining federal financial participation, and to use the combined funds to increase reimbursement to hospitals that provide medical care under the State Medical Assistance Program and the Colorado Indigent Care Program (CICP), increase the number of persons covered by public medical assistance, and to pay the administrative costs of the Department in implementing and administering the program. This request is to true-up the hospital provider fee appropriations to administrative lines that are required in the implementation and administration of the program. All adjustments to medical, mental health, and dental costs due to updated caseload forecasts for Medicaid and Children's Basic Health Plan (CHP+) expansions under the hospital provider fee are incorporated in the Department's November 1, 2011 R-1, R-2, and R-3.

Anticipated Outcomes:
This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals and that the fees collected for administration are being allocated accurately.

Assumptions for Calculations:
To estimate the adjustments required to individual line items, the most recent caseload forecasts for FY 2011-12 and FY 2012-13 are used with the goal of equalizing the hospital provider fee spending authority with the proportion of the expansion populations funded under the hospital provider fee relative to the appropriate total caseload. Each line item is adjusted to reflect the proportion of the relevant expansion caseload to the total caseload. Appendix A outlines which proportions are used to adjust each line item in this request, along with

justifications for each adjustment. Please refer to Table B.1 in Appendix B for the calculations of the different percentages used to adjust the various line items in the request.

Consequences if not Funded:
If this request is not approved, funding would be appropriated to the administrative functions of the hospital provider fee program in a disproportionate and inadequate manner. These appropriations would be for the most part directly from the original fiscal note, which was developed more than two years ago. Since then, the need for administrative appropriations has deviated due to adjusted expansion population implementation dates and updated caseload forecasts. This results in inefficiencies in the hospital provider fee model, and may result in over-collection of provider fee or the need to request spending authority at a later date.

Impact to Other State Government Agency:
There would be impacts to the Department of Human Services and to the Governor's Office of Information Technology.

See Attachment A for financial impacts.

Cash Fund Projections:
Cash Funds used in this request are exclusively from the Hospital Provider Fee Cash Fund, which is created at 25.5-4-402.3 C.R.S. (2011). Revenue into the fund is from provider fees collected from hospitals, which is modeled to match projected expenditures. For more detail, please refer to the Colorado Health Care Affordability Act Update included in the Department's November 1, 2011 Budget Request.

Cash Fund Name	Hospital Provider Fee Cash Fund
Cash Fund Number	24A
FY 2010-11 Expenditures	$426,069,052
FY 2010-11 End of Year Cash Balance	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
25.5-4-402.3 C.R.S. (2011) establishes the Hospital Provider Fee and authorizes the Department to charge and collect hospital provider fees.

25.5-4-402.3 (3) (a) (I) (III) C.R.S. (2011) and 25.5-4-402.3 (4) (b) (VI) C.R.S. (2011) allow the provider fee and federal matching funds collected to be used to pay the administrative costs of the Department in implementing and administering the Hospital Provider Fee.

General Administration, Legal Services and Third Party Recovery Legal Services and Administrative Law Judge Services

These lines are for legal services provided by the Department of Law and administrative law judges and paralegals from the Office of Administrative Courts. The services cover the Department as a whole, and will be adjusted to be proportionate with all of the expansions funded under the Hospital Provider fee relative to Medicaid and the Children's Basic Health Plan (CHP+) in total. This adjustment, however, is not being done through this request; rather, it will be done through the Common Policy adjustments toward the end of FY 2011-12. At that time, the Department will collaborate with the affected Departments to ensure that the FY 2011-12 and FY 2012-13 appropriations from the hospital provider fee are brought in line with the proportion of all expansion populations relative to total caseload in Medicaid and CHP+.

General Administration, General Professional Services and Special Projects

The appropriation to this line item is used to fund some of the contracts required to implement and administer the hospital provider fee. These contracted activities include assisting the Department in responding to questions from the Centers for Medicare and Medicaid Services (CMS) after submission of the provider fee model each year, reviewing the Department's upper payment limit calculations and recommending any necessary changes, assisting in development of benefit packages and cost-effective rates for the Disabled Buy-In and the Adults without Dependent Children (AwDC) programs, and assistance in the development of hospital quality incentive payments. The original fiscal note for HB 09-1293 also included funding of $120,000 for a project manager for the significant and complex information technology work required to implement the bill. Since the implementation of HB 09-1293 however, the Department has been able to perform this function internally, and therefore the Department requests to reduce this appropriation by $120,000 in FY 2011-12.

Information Technology Contracts and Projects, Information Technology Contracts

This line contains funding for the Medicaid Management Information System (MMIS), which is a system of hardware and software used to process Medicaid claims and manage information about Medicaid and CHP+ beneficiaries and services. In addition to the FY 2011-12 Long Bill appropriation of $4,402,843, the Department also received rollforward authority in the amount of $1,087,619 for hospital provider fee projects that were not completed in FY 2010-11, resulting in total FY 2011-12 spending authority of $5,490,462. The Department is adjusting the MMIS appropriation for hospital provider fee projects in its FY 2012-13 BA-6 "MMIS Technical Adjustments."

Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project

This line has a FY 2011-12 appropriation of $2,221,482. The Department did not expend any of the appropriation to this line item in FY 2009-10 or FY 2010-11 because the volume triggers included in the Department's contract with Maximus, the CHP+ eligibility and enrollment vendor, were not reached. As such, the funding was not needed. However, effective FY 2011-12, the Department has executed a contract amendment with Maximus in the amount of $843,877 due to increased call volume per the terms of the eligibility and enrollment contract. The Department is requesting to adjust the FY 2011-12 appropriation to the amounts shown in Table A.1 below. The updated estimates are based on the actual contract amendment for the CHP+ expansion, updated caseload estimates for the Disabled Buy-In and AwDC expansions, and the Department's implementation of a waitlist for the AwDC population, which the Centralized Eligibility Vendor will manage.

Table A.1: Revised Centralized Eligibility Vendor Costs			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Eligibility and Enrollment Vendor Cost for CHP+- Eligibility	**$843,877**	**$843,877**	**$843,877**
State Costs (Provider Fee)	$406,749	$406,749	$406,749
Federal Funds	$437,128	$437,128	$437,128
Estimated Eligibility and Enrollment Vendor Cost for Disabled Buy-In and AwDC	**$3,608,545**	**$4,254,910**	**$5,306,068**
State Costs (Provider Fee)	$1,804,273	$2,127,455	$2,653,034
Federal Funds	$1,804,272	$2,127,455	$2,653,034
Total	**$4,452,422**	**$5,098,787**	**$6,149,945**
State Costs (Provider Fee)	$2,211,022	$2,534,204	$3,059,783
Federal Funds	$2,241,400	$2,564,583	$3,090,162

Medical Identification Cards
Currently, this line does not have a hospital provider fee appropriation as total funding to this line has historically exceeded overall need. Going forward however, with the growing and upcoming expansions funded under the hospital provider fee, the Department is requesting to include a hospital provider fee appropriation in proportion with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. Based on the most recent caseload estimates, the Department is requesting total funds appropriations to this line item of $9,240 in FY 2011-12.

Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations
This line has a FY 2011-12 appropriation of $5,602,536. This funding was for two separate items: $3,074,400 for Hospital Outstationing and $2,528,136 for disability determinations for the Disabled Buy-In population. In FY 2010-11, the Department was working to develop a model to distribute the Hospital Outstationing funding and the expansions to the Disabled Buy-In populations were delayed, both of which contributed to the Department not expending any of this appropriation. For FY 2011-12, the Department will implement the model to pay the $3,074,400 appropriated for Hospital Outstationing. Further, the Disabled Buy-In populations for which money was appropriated for disability determinations will be implemented in FY 2011-12, creating the need for the disability determination portion of the appropriation. In addition to the Disabled Buy-In populations for which the Department originally anticipated the need for disability determination funding, the Department has subsequently learned that there will be funding needs for two other types of disability determinations. First, a portion of the AwDC population will require a disability determinations due to federal requirements prohibiting individuals that are deemed "medically frail" from being enrolled in a benchmark benefit package. Second, some Disabled Buy-in clients may require extra services through Consumer Directed Attendant Support Services (CDASS), which will require a separate disability determination. These costs were not included in the fiscal note for HB 09-1293, and thus are not built into the appropriation. Policy decisions still need to be made in these areas, and estimates of costs are still unknown. Due to these unknown factors, the Department is not requesting to change the appropriation for disability determinations at this time. If the anticipated costs for disability determinations differ from the appropriation once these policy decisions are made, the Department will request an adjustment to this appropriation through the normal budget process.

Eligibility Determinations and Client Services, County Administration and Eligibility Determinations and Client Services, Hospital Provider Fee County Administration *(new line item)*
The County Administration line item has a FY 2011-12 hospital provider fee related appropriation of $2,361,502 total funds. Currently, the funding for the County Administration line item as a whole is composed of General Fund, cash funds, and federal funds, with the cash funds portion consisting of both

the hospital provider fee and a local match from the counties. The Department reimburses local county departments of social/human services for processing Medicaid applications and on-going case management according to the methodology agreed upon by the Department and the Department of Human Services, which is based on actual costs incurred by the county and a random moment time study. The Hospital Provider Fee appropriation however, contains no local match, and the Department is currently developing an alternate methodology to the random moment time study mentioned above to distribute these funds to the counties to ensure that expenditures are appropriately aligned with actual workloads related to the hospital provider fee expansions. Because of these factors, the Department requests to move the hospital provider fee funding for county administration to a new line item, Eligibility Determinations and Client Services, Hospital Provider Fee County Administration. The movement of the hospital provider fee funding to this new line item will make the budget more transparent, allow for easier tracking of hospital provider fee funds, and separate funding sources that are allocated based on differing methodologies. The Department will work with the counties to develop an allocation methodology for these funds that more accurately reflects hospital provider fee related expenditures.

While the Centralized Eligibility Vendor discussed above is intended to complete eligibility determinations and provide on-going case management services for the CHP+ expansion to 250% FPL, Disabled Buy-In, and AwDC, clients would still have the option of applying for assistance at a county office. The Department does anticipate that some of these expansion clients will apply at local county departments of social/human services, but the number of applications for these expansion populations, time allocated to them, and the cost associated with the initial processing are all unknown at this time. The Department will reimburse counties for the costs associated with the initial intake of any such application through a methodology to be developed and agreed upon by the Department and counties based on actual costs incurred by the county. Because these factors are currently unknown, the Department is not requesting to adjust this appropriation amount at this time.

Eligibility Determinations and Client Services, Customer Outreach

This line contains the funding for both the S.B. 97-05 Enrollment Broker, which is contracted to provide information on health plan choices and Medicaid benefits offered through the plans, and the administrative cost to provide outreach and case management for the federally required Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) program. The Enrollment Broker appropriation includes 3.7% hospital provider fee and federal matching funds for FY 2011-12. Since the services provided are to Medicaid populations only, the Department requests to bring this budget line's hospital provider fee funding in proportion with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. This results in the hospital provider fee appropriation being increased to 7.15% of the total appropriation for FY 2011-12. This increase is due to the inclusion of the Disabled Buy-In and AwDC populations. In the original fiscal note for HB 09-1293, the Department had assumed that enrollment broker functions for these populations would be performed by the Centralized Eligibility Vendor, similar to the current process in CHP+. However, because these clients will be enrolled in traditional Medicaid, the Department has determined that the Medicaid enrollment broker must be used for these functions. For the EPSDT program, the appropriation includes 0.44% hospital provider fee and federal matching funds for FY 2011-12. However, because Continuous Eligibility for Medicaid Children is not currently scheduled to be implemented in FY 2011-12, the Department is eliminating the hospital provider fee appropriation to this line item at this time.

Utilization and Quality Review Contracts, Professional Services Contracts

This line contains funding for external quality review, acute care utilization review, and drug utilization review. External quality review funds performance improvement projects and calculation of required

quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); acute care utilization review funds prospective and retrospective reviews of specified services to ensure proper coverage and medical necessity, and; drug utilization review is federally required to ensure appropriate use of drug therapy through prospective and retrospective reviews. The appropriation to this line item includes 3.33% hospital provider fee and federal matching funds for FY 2011-12. As these services are for the Medicaid program only, the Department requests that this line's hospital provider fee funding be brought in line with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. This results in the hospital provider fee appropriation being increased to 7.15% of the total appropriation for FY 2011-12.

Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System

This line contains funding for the Colorado Benefits Management System (CBMS), which tracks clients, data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. The Department's hospital provider fee appropriation to this line item in FY 2011-12 is $228,864 total funds. In addition, the Department of Human Services has a Hospital Provider Fee appropriation of $368,616 total funds, for a total appropriation between the two departments of $597,480. However, due to the delayed implementation of the Disabled Buy-In and AwDC expansion populations, this funding is inadequate to complete systems development. The Department requests an increase of $1,466,040 to the appropriation to have sufficient funds to complete the system development work within CBMS to implement the Working Adults Buy-in and AwDC on March 1, 2012 and the Children's Buy-in 4 to 6 months later. The purpose of this request is only to true-up the amount of funding needed for system development. If the Department's FY 2012-13 S-12, BA-5 "CBMS Technical Adjustment for HB 09-1293 and HCPF Only Projects" is approved, the Department requests that the incremental appropriations from both this request and the Department's FY 2012-13 R-12 "Hospital Provider Fee Administrative True-up" be made to the new line item, "Colorado Benefits Management System Projects HCPF Only."

Please note that the FY 2011-12 request includes $187,800 for correspondence costs. Of this amount, $87,800 is for those clients that the Department anticipates to enroll in FY 2011-12, and assumes three mailings per year at a cost of $0.63 each for an annual average of 46,455 clients. An additional $100,000 is also being requested for correspondence costs for those individuals that will be placed on the waitlist for AwDC and those that may apply and be denied for the expansion populations. This $100,000 would allow for approximately 52,910 individuals on the waitlist to receive three mailing a year at $0.63 each. This funding would also cover the cost of the mailings for those who apply for the program and are denied. Many individuals applying may not know their income level, so there may be many denials resulting solely from applicants being over the income limit for AwDC. The Department expects the largest influx of applicants to occur in FY 2011-12, with FY 2012-13 only having the costs associated with churn in the waitlist and a reduced number of applicants applying and being denied compared to FY 2011-12. Please see Table A.2 below for the CBMS costs for FY 2011-12.

Table A.2: FY 2011-12 CBMS Need

	Hours	Cost per Hour	Total Cost
AwDC Development	5,159	$108	$557,172
Working Adults Buy-in Development	7,239	$108	$781,812
Children's Buy-in Development	4,068	$108	$439,344
Waitlist Development	624	$108	$67,392
CBMS Correspondence	-	-	$187,800
Pipeline Expansion	-	-	$30,000
Total	17,090		$2,063,520

Appendix B: Tables and Calculations

Table B.1: Calculations of Medicaid/CHP+ Percentages		
Row		FY 2012-13
1	FY 2012-13 Total Medicaid Caseload Projection	673,956
2	FY 2012-13 Total CHP+ Caseload Projection	79,257
3	FY 2012-13 Total Medicaid and CHP + Caseload Projection (Row 1 + Row 2)	753,213
4	FY 2012-13 Expansion Adults to 100% Caseload Projection	36,083
5	FY 2012-13 Adults Without Dependent Children (AwDC) Caseload Projection	10,000
6	FY 2012-13 Disabled Buy-In Caseload Projection	2,126
7	FY 2012-13 Medicaid Expansion Projections (Row 4 + Row 5 + Row 6)	48,209
8	FY 2012-13 CHP+ Expansion to 250% Caseload Projection (Children + Prenatal)	11,436
9	FY 2012-13 Medicaid and CHP + Expansion Projections (Row 7 + Row 8)	59,645
10	**Expansion Adults to 100% as % of Medicaid Caseload (Row 4 / Row 1)**	**5.35%**
11	**All Medicaid Expansions as % of Medicaid (Row 7 / Row 1)**	**7.15%**
12	**All Expansions as % of Medicaid and CHP+ (Row 9 / Row 3)**	**7.92%**

Table B.2: Summary of Incremental Request FY 2011-12				
	Total Funds	**General Fund**	**Cash Funds (Provider Fee)**	**Federal Funds**
Total Request	**$3,920,338**	**$0**	**$2,023,541**	**$1,896,797**
(A) General Administration, General Professional Services and Special Projects	($120,000)	$0	($60,000)	($60,000)
(C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$2,230,940	$0	$1,246,853	$984,087
(D) Medical Identification Cards	$9,240	$0	$4,620	$4,620
(D) Eligibility Determinations and Client Services, County Administration	($2,361,502)	$0	($1,180,751)	($1,180,751)
(D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration (*new line item*)	$2,361,502	$0	$1,180,751	$1,180,751
(D) Eligibility Determinations and Client Services, Customer Outreach	$90,506	$0	$45,253	$45,253
(E) Utilization and Quality Review Contracts, Professional Services Contracts	$243,612	$0	$53,795	$189,817
(6) (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$1,466,040	$0	$733,020	$733,020

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Cost Sharing for CHP+

Priority Number: S-8

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$213,086,149	($264,453)	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	($138,601)	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$136,133	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	($261,985)	$122,048,467	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**Total**	$213,086,149	($264,453)	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	($138,601)	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$136,133	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	($261,985)	$122,048,467	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ If yes, describe the Letternote Text Revision:

Of this amount, ~~$28,727,097~~ $28,865,698 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,389,580~~ $12,387,112 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Children's Basic Health Plan Trust Fund (11G); FF: Title XXI.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-8
Request Title: Cost Sharing for CHP+

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Cost Sharing for CHP+	($264,453)	($138,601)	0.0

Request Summary:
The Department requests a reduction of $264,453 total funds, $138,601 General Fund in FY 2011-12 from increased cost sharing for the Child Health Plan *Plus* (CHP+). In its November 1, 2011 FY 2012-13 Budget Request R-7 "Cost-sharing for Medicaid and CHP+," the Department outlines its plan to increase cost-sharing in CHP+ by increasing co-payments and tripling annual enrollment fees for certain CHP+ families. While the increased co-payments would take effect in FY 2012-13, the increased enrollment fees would become effective in January 2012.

Thus, this supplemental request reflects six months of estimated savings realized in FY 2011-12 from tripling the current annual enrollment fees for CHP+ families with incomes above 205% of the Federal Poverty Level (FPL). The Department currently requires these families to pay an enrollment fee of $25 for one child or $35 for 2 or more children; these enrollment fees would be increased to $75 and $105, respectively. The Department estimates this would result in savings of $264,453 total funds, $138,601 General Fund in FY 2011-12. Please see the Department's budget request cited above for further details.

The Department has actively engaged stakeholders to determine what level of increases to CHP+ cost sharing would result in the lowest attrition of clients and maintain affordability for families while still increasing clients' responsibility in their personal and family health care while realizing savings to the State.

Anticipated Outcomes:
The Department anticipates that the higher CHP+ enrollment fees for clients in higher income brackets would ease some financial burden from the Department while moderately increasing costs for the families that are best able to absorb them.

Assumptions for Calculations:
Please see the Department's November 1, 2011 FY 2012-13 Budget Request, R-7 "Cost-sharing for Medicaid and CHP+."

Consequences if not Funded:
If this request is not funded, the Department would not be able to realize the proposed savings and mitigate long-term cost growth by requiring clients to be more financially involved in their health care decisions.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. This request will increase clients' responsibility for their health care and reduce costs to the Department.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
Sections 25.5-8-107 (1)(b) and (c), C.R.S. (2011) authorize the Department to implement a cost sharing structure for the Children's Basic Health Plan that includes an annual enrollment fee based on a sliding fee scale and co-payments. Families with incomes below 151% FPL and pregnant women are exempt from paying enrollment fees.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Smoking Cessation Quitline for Medicaid Clients

Priority Number: S-9, BA-3 (CDPHE NP-R-16)

Dept. Approval by: John Bartholomew TB 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$3,543,863,749	$577,316	$3,559,795,929	$1,373,470	$1,281,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$288,658	$534,529,617	$686,735	$640,520
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$288,658	$1,756,668,882	$686,735	$640,520
(2) Medical Services Premiums						
	Total	$3,543,863,749	$577,316	$3,559,795,929	$1,373,470	$1,281,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$288,658	$534,529,617	$686,735	$640,520
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$288,658	$1,756,668,882	$686,735	$640,520

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2011-12: (2) Medical Services Premiums: ...and $288,658 shall be from the Tobacco Education Cash Fund created in Section 24-22-117 (2) (c) (I), C.R.S.

FY 2012-13: (2) Medical Services Premiums: ...and ~~$288,658~~ $686,735 shall be from the Tobacco Education Cash Fund created in Section 24-22-117 (2) (c) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Tobacco Education Program Fund (18M)

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Public Health and Environment

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental and Budget Amendment

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-9, BA-3 (CDPHE NP-R-16)
Request Title: Smoking Cessation Quitline for Medicaid Clients

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Impact	**$865,974**	**$0**	**0.0**
Department of Health Care Policy and Financing	$577,316	$0	0.0
Department of Public Health and Environment	$288,658	$0	0.0
Summary of Incremental Funding Change for FY 2012-13	**Total Funds**	**General Fund**	**FTE**
Total Impact	**$2,060,205**	**$0**	**0.0**
Department of Health Care Policy and Financing	$1,373,470	$0	0.0
Department of Public Health and Environment	$686,735	$0	0.0

Request Summary:

The Department requests a transfer of spending authority from the Colorado Department of Public Health and Environment (CDPHE) to increase available funding for Medicaid client utilization of the smoking cessation QuitLine. Pursuant to recent federal guidance, the Department would be able to obtain federal matching funds for QuitLine expenditure for Medicaid clients. The Department estimates this request would have a total funds impact of $865,974 in FY 2011-12, $2,060,205 in FY 2012-13 and $1,921,560 in FY 2013-14. The Department would, however, like to note that the total funds impact reflects the funding transfer as an increase to reappropriated funds. The increase in federal funds as a result of the transfer in FY 2011-12 is $288,658, for FY 2012-13 the federal funds impact is $686,735 and the FY 2013 federal funds impact is $640,520.

The smoking cessation QuitLine has been administered through CDPHE and National Jewish Health since 2002 and provides Colorado residents over the age of 15 with a free telephone based smoking cessation coaching program and nicotine replacement therapy. The Department does not currently pay for QuitLine Services for Medicaid clients, although approximately 18% of the clients served in FY 2010-11 were Medicaid clients.

Section 4107 of the Affordable Care Act (ACA) requires states to provide smoking cessation benefits to pregnant women. In a State Medicaid Director (SMD) letter[1] on June 24, 2011, the Centers for Medicare and Medicaid Services (CMS) issued guidance on implementing the section 4107 and offered an additional provision stating that tobacco QuitLine services provided to Medicaid clients are eligible for federal matching funds. CMS will also provide matching funds for QuitLine marketing and evaluation targeted at Medicaid clients. The guidance allows the Department to claim expenditure beginning June 24, 2011 and does not require a state plan amendment.

In order to receive federal funds, the Department must ensure that payments for QuitLine services

[1] The State Medicaid Director Letter can be found at https://www.cms.gov/SMDL/SMD/list.asp

are compliant with the Office of Management and Budget (OMB) Circular A-87 (2 CFR 225). The Circular requires the Department to create a written cost allocation plan and to ensure payments are not duplicate costs that have been, or should have been, paid through another source. The departments would include a written cost allocation plan in an interagency agreement and would create regular reports with client information to ensure Medicaid eligibility and payment for exclusively Medicaid clients.

To finance QuitLine administration, the Department would enter into an interagency agreement with CDPHE to transfer funding for Medicaid Quitline services. Federal regulations at 42 CFR § 431.10 requires a single state agency to administer the Medicaid program and CMS requires funds to be appropriated directly to that agency. Given that the Department of Health Care Policy and Financing serves as the single state agency, the Department is requesting an appropriation from the Tobacco Education Programs Cash Fund in order to draw federal funds to pay for Medicaid client QuitLine administration. The Department would then transfer the cash funds and matching federal funds to CDPHE as reappropriated funds. Concurrently, the Department requests a corresponding change in CDPHE's appropriation for Tobacco Education, Prevention, and Cessation Grants.

Anticipated Outcomes:
This request would enable the Department to receive federal funds for QuitLine services offered through CDPHE and National Jewish Health provided to Medicaid clients. The Department anticipates this request would free up funding for CDPHE by requiring less funding for Medicaid clients utilizing the QuitLine. This would allow CDPHE to serve more Coloradoans through the QuitLine.

Assumptions for Calculations:
The Department's calculations are contained in Appendix A. To calculate estimated expenditure, the Department obtained historical Quitline data from CDPHE. The Department took the average total expenditure per client and trended utilization and costs to determine the fiscal impact of the transfer. Additionally, this request assumes the full level of funding from the tobacco excise revenue. If fiscal emergency is declared and the amount of money available to the program is reduced, the amount of spending authority needed may change accordingly.

Consequences if not Funded:
If this request is not funded, the Department would not be able to take advantage of the federal funding available to reimburse for the smoking cessation QuitLine. CDPHE would continue to pay for Medicaid client using the QuitLine which would restrict available funding for other Colorado residents to utilize the program.

Impact to Other State Government Agency:
This request will impact CDPHE through a transfer of spending authority from the Tobacco Education Programs Cash Fund. See table 1.1 through 1.3 for the impact by line item and fiscal year. In the event that the Department is not able to obtain a federal match on the full amount, or Medicaid utilization is less than expected, the Department will still transfer the full appropriation from the Tobacco Education Programs Cash Fund to CDPHE.

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. By obtaining federal funds for Medicaid clients using the QuitLine program, the state is able to offer more Coloradoans smoking cessation counseling and pharmacotherapy.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
This request qualifies as a supplemental and budget amendment as it is a result of new data changing funding needs. The SMD letter from CMS was issued in June 2011 which did not allow the Department to request funding prior to the beginning of FY 2011-12.

Current Statutory Authority or Needed Statutory Change:
Effective June 24, 2011, CMS has indicated that states may consider administration of a smoking cessation Quitline for Medicaid clients is necessary for the "proper and efficient" administration of the State plan under its authority under section 1903(a)(7) of the Social Security Act.

Table 1.1 - FY 2011-12 Impact by Department						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Estimate	**$865,974**	**$0**	**$0**	**$577,316**	**$288,658**	
Health Care Policy and Financing	$577,316	$0	$288,658	$0	$288,658	Table 3.1
Public Health and Environment	$288,658	$0	($288,658)	$577,316	$0	Table 2.1

Table 1.2 - FY 2012-13 Impact by Department						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Request	**$2,060,205**	**$0**	**$0**	**$1,373,470**	**$686,735**	
Health Care Policy and Financing	$1,373,470	$0	$686,735	$0	$686,735	Table 3.2
Public Health and Environment	$686,735	$0	($686,735)	$1,373,470	$0	Table 2.2

Table 1.3 - FY 2013-14 Impact by Department						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Request	**$1,921,560**	**$0**	**$0**	**$1,281,040**	**$640,520**	
Health Care Policy and Financing	$1,281,040	$0	$640,520	$0	$640,520	Table 3.3
Public Health and Environment	$640,520	$0	($640,520)	$1,281,040	$0	Table 2.3

Table 2.1 - FY 2011-12 Summary of Request for Health Care Policy and Financing Department						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$577,316**	**$0**	**$288,658**	**$0**	**$288,658**	**0.0**
(2) Medical Services Premiums	$577,316	$0	$288,658	$0	$288,658	0.0

Table 2.2 - FY 2012-13 Summary of Request for Health Care Policy and Financing Department						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$1,373,470**	**$0**	**$686,735**	**$0**	**$686,735**	**0.0**
(2) Medical Services Premiums	$1,373,470	$0	$686,735	$0	$686,735	0.0

Table 2.3 - FY 2013-14 Summary of Request for Health Care Policy and Financing Department						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$1,281,040**	**$0**	**$640,520**	**$0**	**$640,520**	**0.0**
(2) Medical Services Premiums	$1,281,040	$0	$640,520	$0	$640,520	0.0

Table 3.1 - FY 2011-12 Summary of Request for Department of Public Health and Environment						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$288,658**	**$0**	**($288,658)**	**$577,316**	**$0**	**0.0**
(9) Prevention Services; (A) Prevention Programs; (5) Tobacco Education, Prevention, and Cessation Program Administration	$288,658	$0	($288,658)	$577,316	$0	0.0

Table 3.2 - FY 2012-13 Summary of Request for Department of Public Health and Environment						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$686,735**	**$0**	**($686,735)**	**$1,373,470**	**$0**	**0.0**
(9) Prevention Services; (A) Prevention Programs; (5) Tobacco Education, Prevention, and Cessation Program Administration	$686,735	$0	($686,735)	$1,373,470	$0	0.0

Table 3.3 - FY 2013-14 Summary of Request for Department of Public Health and Environment						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$640,520**	**$0**	**($640,520)**	**$1,281,040**	**$0**	**0.0**
(9) Prevention Services; (A) Prevention Programs; (5) Tobacco Education, Prevention, and Cessation Program Administration	$640,520	$0	($640,520)	$1,281,040	$0	0.0

Table 4.1 - FY 2011-12 Summary of Request for Health Care Policy and Financing Department								
Row	**Item**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Medicaid Clients Growth Rate	-	-	-	4.32%	4.32%	4.32%	Average Growth Rate in Medicaid Client Utilization from FY 2008-09 to FY 2010-11
B	Estimated Medicaid Client Calls	3,995	2,112	3,290	5,038	11,040	11,040	Estimate[2]
C	Percentage of Clients with more than 6 Calls	10.32%	10.32%	10.32%	10.32%	10.32%	10.32%	Data from National Jewish
D	Total Medicaid Calls Eligible for Federal Match [1]	3,583	1,894	2,950	4,518	9,901	9,901	Row B * (1 - Row A)

[1] As mentioned in a question and answer session with CMS, the Department is not able to reimburse for more than 6 counseling calls.

[2] CDPHE estimates that with additional funding, provided through federal funds, the Quitline would be able to serve Medicaid clients at the same level as before budget cuts beginning in FY 2008-09. In addition, targeted outreach directed at Medicaid clients would likely increase the number of QuitLine utilizers.

Table 5.1 - FY 2011-12 Summary of Request for Health Care Policy and Financing Department					
Row	**Item**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Actual Quitline Expenditure per Utilizer for FY 2010-11	$89.49	$89.49	$89.49	Actual per Utilizer Expenditure for FY 2010-11
B	Estimated Utilization	4,518	9,901	9,901	Table 4.1, Row D
C	Administrative Costs	$173,000	$487,430	$395,000	Table 6.1 Row C
D	Estimated Quitline Total Cost	$577,316	$1,373,470	$1,281,040	(Row A * Row B) + Row C

Table 6.1 Estimated Quitline Additional Administrative Costs					
Row	**Item**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Marketing costs[(1)]	$173,000	$345,000	$345,000	Estimate
B	Evaluation	$0	$142,430	$50,000	Estimate
C	Total Administrative Costs	$173,000	$487,430	$395,000	Row A + Row B

[(1)] Marketing costs include brochures, posters, direct mailing and closed circuit television commercials. In addition, personnel/agency costs to put together promotional material targeting Medicaid clients are included in the marketing costs line. This includes activities such developing content for partner and state websites, newsletters and eligibility notifications.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Utilize Supplemental Payments for General Fund Relief
Priority Number: S-10, BA-4

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$3,853,688,855	($9,634,148)	$3,869,621,035	($10,527,400)	($10,527,400)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($614,990)	$981,320,305	$400,246	$400,246
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$763,229,728	($5,306,633)	$689,442,170	($5,946,273)	($5,946,273)
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,901,056,618	($3,712,525)	$1,911,581,435	($4,981,373)	($4,981,373)
(2) Medical Services Premiums[a]	Total	$3,543,863,749	$6,262,092	$3,559,795,929	($10,527,400)	($10,527,400)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($614,990)	$981,320,305	$400,246	$400,246
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$2,641,487	$534,529,617	($5,946,273)	($5,946,273)
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$4,235,595	$1,756,668,882	($4,981,373)	($4,981,373)
(4) Indigent Care Program; Safety Net Provider Payments[b]	Total	$309,825,106	($15,896,240)	$309,825,106	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$154,912,553	($7,948,120)	$154,912,553	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$154,912,553	($7,948,120)	$154,912,553	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2011-12

[a] Of this amount, ~~$7,629,150~~ $10,271,637 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program...

[b] Of this amount, $144,686,653 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4) C.R.S., and $10~~,225,900~~ $3,277,780 shall be from public funds certified as representing expenditures by hospitals that are eligible for federal financial participation under the Medicaid upper payment limit and the Medicaid Disproportionate Share Payments to Hospitals program.

FY 2012-13

[a] Of this amount, ~~$7,732,438~~ $1,776,165 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program...

Cash or Federal Fund Name and COFRS Fund Number: Certified Public Expenditure.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request and FY 2012-13 Budget Amendment
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-10, BA-4
Request Title: Utilize Supplemental Payments for General Fund Relief

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Request	($9,634,148)	($614,990)	0.0

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Request	($10,527,400)	$400,246	0.0

Request Summary:
The Department requests to use $614,990 federal funds in FY 2011-12 to provide General Fund relief to the Medical Services Premiums line item. Similarly, the Department requests to use $606,506 federal funds in FY 2012-13, to true-up estimates included in the Department's FY 2012-13 R-10 "Utilize Supplemental Payments for General Fund Relief." These General Fund savings would be achieved by a reduction to certain certified public expenditure (CPE) based supplemental payments in the Medical Services Premiums line item. The Department also requests to move the inpatient high volume CPE supplemental payment currently in the Safety Net Provider Payments line to the Medical Services Premiums line item.

Currently, the Safety Net Programs Section of the Department manages and calculates several payments utilizing the CPE methodology, and is continuously working on new and innovative ways to increase payments to providers in order to reduce the uncompensated costs of providing care to under and uninsured Coloradans. However, due to the increasing strain on the state's General Fund, the Department is requesting to withhold 10% of the federal funds drawn under some of these payments in order to offset General Fund costs in the Department. Specifically, the Department requests to withhold 10% of the federal funds drawn under the physician supplemental payment and the inpatient high volume CPE supplemental payment currently in the Safety Net Provider Payments line item as authorized pursuant to the Department's FY 2011-12 DI-7 "Maximize Reimbursement for High Volume Medicaid and CICP Hospitals." Please see Table 2 in Appendix A below for more detailed information on these individual payments and the withholding calculations. Similar withholding of federal funds is already being done with some of the CPE based payments within the Medical Services Premiums line item, particularly the Home Health and Nursing Facility payments made under the Upper Payment Limit (UPL).

For FY 2011-12, the Department projects the federal funds drawn under these payments at a base Federal Medical Assistance Percentage (FMAP) of 50% to equal $6,149,897, resulting in General Fund relief in the amount of $614,990 after 10% of these funds are withheld. These payments will be eligible for the enhanced federal match provided through the American Recovery and Reinvestment Act (ARRA) as the

uncompensated costs being certified were incurred in 2010. The 10% withholding is calculated on the base FMAP, as the incremental federal funds from the enhanced FMAP will already be withheld by the State for General Fund relief.

The physician supplemental payment applies to Denver Health Medical Center and Memorial Hospital in Colorado Springs. The inpatient high volume CPE supplemental payment will be made only to Memorial Hospital. Denver Health Medical Center, which is also a High Volume Medicaid and CICP Hospital, has its hospital-specific UPL maximized under the Hospital Provider Fee supplemental payments, so would not receive any additional inpatient high volume CPE supplemental payments pursuant to the Department's FY 2011-12 DI-7.

In addition to the requested General Fund savings, the Department also requests to move the inpatient high volume CPE supplemental payment in the Safety Net Provider Payments line item to the Medical Services Premiums line item to place it with the other payments made under the Upper Payment Limit. This action will make both lines more transparent and limit the purpose of the Safety Net Provider Payment line item to only Hospital Provider Fee payments. First, the Department requests a reduction of $9,019,158 total funds in FY 2011-12, composed of $5,306,633 cash funds and $3,712,525 federal funds to align the appropriation with the new payment estimates. After this reduction is made, the Department requests to transfer the appropriation for this payment to the Medical Services Premiums line item. The withholding will take place after the reduction and transfer discussed above. Please see Table 1 in Appendix A for more detail on this transfer, and Table 4 for a comparison of this request to the Department's FY 2012-13 R-10 "Utilize Supplemental Payments for General Fund Relief."

Anticipated Outcomes:
If this request is approved, the Department anticipates savings in the amount of $614,990 General Fund in FY 2011-12 and $606,506 General Fund in FY 2012-13.

Assumptions for Calculations:
Assumptions used in this request include the approval of a State Plan Amendment (SPA) by the Centers for Medicare and Medicaid Services (CMS), which would allow the Department to implement the inpatient high volume CPE supplemental payment. The Department expects approval of this SPA by March 1, 2012. The Department also assumes that it will have received the data from all hospitals to calculate the payments, and that the data support payments in the amounts budgeted. Please see Appendix A for detailed calculations for this request.

Consequences if not Funded:
If this request is not approved, the Department will forego General Fund relief in the amount of $614,990 in FY 2011-12 and $606,506 in FY 2012-13. This process of retaining a portion of the federal funds distributed to providers has already been approved by CMS, and not approving this would limit the Department's ability to reduce its overall General Fund need.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
There are no federal regulations that prohibit the State from retaining all or a portion of the federal funds it earns through the CPE methodology. Indeed, Colorado already retains all federal funds from the Public Nursing Facility Supplemental Payment and the Public Home Health Agency Supplemental Payment. While the intent of the text of State Plan Amendments is not to address State retention of federal funds, the State must notify CMS if it intends to do so in its response to standard funding questions that are submitted with any proposed State Plan Amendment that modifies provider reimbursement methodologies or amounts.

Appendix A: Tables and Calculations

Table 1: Transfer of Inpatient High Volume Supplemental Payment			
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds
(4) Safety Net Provider Payments	($6,877,082)	($2,641,487)	($4,235,595)
(2) Medical Services Premiums	$6,877,082	$2,641,487	$4,235,595
Net Transfer Request	$0	$0	$0

Table 2: Payments and Withholding Calculations				
FY 2011-12				
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds (50% FMAP)	Withholding for General Fund
Physician Supplemental Payment	$5,422,712	$2,711,356	$2,711,356	($271,136)
Inpatient High Volume CPE Supplemental Payment	$6,877,082	$3,438,541	$3,438,541	($343,854)
Total	$12,299,794	$6,149,897	$6,149,897	($614,990)
FY 2012-13				
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds (50% FMAP)	Withholding for General Fund
Physician Supplemental Payment	$7,161,512	$3,580,756	$3,580,756	($358,076)
Inpatient High Volume CPE Supplemental Payment	$4,968,594	$2,484,297	$2,484,297	($248,430)
Total	$12,130,106	$6,065,053	$6,065,053	($606,506)

Table 3: Inpatient High Volume CPE Supplemental Payment Adjustment			
FY 2011-12			
	Total Funds	Certified Public Expenditures	Federal Funds
Appropriated Inpatient High Volume CPE Supplemental Payment	$15,896,240	$7,948,120	$7,948,120
Needed Inpatient High Volume CPE Supplemental Payment	$6,877,082	$2,641,487	$4,235,595
Net Inpatient High Volume CPE Supplemental Payment	($9,019,158)	($5,306,633)	($3,712,525)
FY 2012-13			
	Total Funds	Certified Public Expenditures	Federal Funds
Appropriated Inpatient High Volume CPE Supplemental Payment	$15,896,240	$7,948,120	$7,948,120
Needed Inpatient High Volume CPE Supplemental Payment	$4,968,594	$2,001,847	$2,966,747
Net Inpatient High Volume CPE Supplemental Payment	($10,927,646)	($5,946,273)	($4,981,373)

Table 4: R-10 and S-10, BA-4 Request Comparison				
FY 2011-12				
	Total Funds	General Fund	Certified Public Expenditures	Federal Funds
R-10	$0	$0	$0	$0
S-10, BA-4	($9,634,148)	($614,990)	($5,306,663)	($3,712,525)
Net Request	($9,634,148)	($614,990)	($5,306,663)	($3,712,525)
FY 2012-13				
	Total Funds	General Fund	Certified Public Expenditures	Federal Funds
R-10	($1,006,752)	($1,006,752)	$0	$0
S-10, BA-4	($11,534,152)	($606,506)	($5,946,273)	($4,981,373)
Net Request	($10,527,400)	$400,246	($5,946,273)	($4,981,373)

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Federally Mandated CHP+ PPS Payments to FQHCs and RHCs

Priority Number: S-11

Dept. Approval by: John Bartholomew 12/20/11 (Date)

OSPB Approval by: 12/27/11 (Date)

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$213,086,149	$1,650,176	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$577,562	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$1,072,614	$122,048,467	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$213,086,149	$1,650,176	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$577,562	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$1,072,614	$122,048,467	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

Of this amount, ~~$28,727,097~~ $29,266,985 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,389,580~~ $12,427,254 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Children's Basic Health Plan Trust Fund (11G); FF: Title XXI.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-11
Request Title: Federally Mandated CHP+ PPS payments for FQHCs and RHCs

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Federally Mandated CHP+ PPS Payments	$1,650,176	$0	0

Request Summary:
The Department is requesting to increase funding to the Children's Basic Health Plan Medical and Dental Costs line item in FY 2011-12 in order to comply with federal regulations requiring that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) receive certain reimbursement for services provided to CHP+ clients. The Department is requesting one-time funding of $1,650,176 total funds in FY 2011-12, of which $539,888 is cash funds from the CHP+ Trust Fund, $37,674 is cash funds from the Hospital Provider Fee and $1,072,614 is federal funds. This funding is necessary to make the required retroactive payments back to the effective date of the federal regulation. Beginning in FY 2012-13, the Department will implement a budget neutral reimbursement methodology that complies with federal requirements.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) created a new section 1902(bb) in the Social Security Act that requires Medicaid programs to make payments for FQHC and RHC services in an amount calculated on a per-visit basis. This reimbursement methodology is called a prospective payment system (PPS) and requires reimbursement to be set at 100% of the clinic's average cost of providing covered services during certain "base years." These rates are then adjusted annually by a health care costs index. States may also implement an alternative payment system that reimburses FQHCs and RHCs at or above the PPS rate specified in BIPA.

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended section 2107(e)(1) of the Social Security Act to make section 1902(bb) applicable to CHIP effective October 1, 2009. The Department is thus required to pay FQHCs and RHCs the BIPA PPS rate (or an agreed-upon alternative payment system) for CHP+ services provided from October 1, 2009 forward.

When this federal regulation was passed, the Department received a grant from the Centers for Medicare and Medicaid Services to develop an alternative payment system that would have included incentive payments for FQHCs and RHCs based on health outcomes. After multiple discussions, the Department was unable to reach an agreement with FQHCs and RHCs on an incentive-based alternative payment system. Consequently, the Department is implementing the BIPA PPS rates for FQHCs and RHCs.

Due to the various agreed upon reimbursement levels currently in place between the CHP+ Managed Care Organizations (MCOs) and the FQHCs and RHCs, some of which are above the BIPA PPS rate and some of which are below, the Department anticipates that the future prospective payment methodology would have no net impact on the CHP+ budget. The Department will

implement the BIPA PPS rates going forward beginning in FY 2012-13, and all necessary changes resulting from this new reimbursement methodology will be incorporated into the FY 2012-13 rate setting and contracting processes.

The Department is requesting funding in FY 2011-12 to make retroactive payments to FQHCs and RHCs for services provided between October 1, 2009 and June 30, 2012. Because the Department cannot adjust reimbursement policy for services provided during this retroactive period, the Department has no way of making the retroactive reimbursement budget neutral- this can only be done by decreasing payments where the encounter rate exceeds the BIPA PPS in order to increase those where the payment is less than the BIPA PPS minimum.

The Department has estimated the retroactive payments based on newly available data on FQHC and RHC services. The Department estimates that the total aggregate retroactive payments due to FQHCs and RHCs are $1,650,176 total funds. Once the retroactive payments are made, the Department does not anticipate a need for any additional funding resulting from this request.

Anticipated Outcomes:
The approval of this proposal would result in reimbursement to FQHCs and RHCs for CHP+ services that complies with existing federal regulations.

Assumptions for Calculations:
Please see Appendix A for the Department's assumptions and calculations for this request.

Consequences if not Funded:
This request is for funding to implement federally mandated changes. If this request is not funded, federal financial participation in CHP+ will be at risk. The Department's FY 2011-12 appropriation includes $141,179,458 federal funds for CHP+.

Relation to Performance Measures:
Federal mandate.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data on FQHC and RHC services provided in CHP+ has become available which allows the Department to estimate the retroactive payments from paying BIPA PPS rates on a per-encounter basis since October 1, 2009.

Current Statutory Authority or Needed Statutory Changes:
The federal Children's Health Insurance Program is established in the Social Security Act, Title XXI (42 U.S.C. 1397aa et seq.) and amended by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

42 U.S.C. 1397GG (e)(1)(E) applies Medicaid law at 42 U.S.C. 1396a (bb) relating to payment for services provided by Federally-qualified health centers and rural health clinics to CHP+.

25.5-8-101 C.R.S. (2011) et seq. authorizes the Children's Basic Health Plan.

Appendix A: Assumptions and Calculations for this Request

Detailed Background

Prior to 2001, federal law required State Medicaid programs to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) based on reasonable costs. States were allowed to establish their own definition of "reasonable costs" based on Medicare regulations and cost reports. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) changed the payment requirements for FQHCs and RHCs. Section 702 of BIPA ("New Prospective Payment System For Federally-Qualified Health Centers and Rural Health Clinics") created section 1902(bb) in the Social Security Act (the Act). This section requires Medicaid programs to make payments for FQHC and RHC services using a prospective payment system (PPS). Unlike a cost-based reimbursement system, a PPS establishes a provider's payment rate for a service before the service is delivered; the rate is not dependent on the provider's actual costs or the amount charged for the service. The Medicaid PPS specified in section 1902(bb) is determined separately for each individual FQHC or RHC (calculated on a per-visit basis) using 1999 and 2000 as the baseline period. These rates do not include any adjustment factors other than a growth rate to account for inflation (Medicare Economic Index) and any change in the scope of services furnished during that fiscal year. Medicaid programs may also develop an alternative payment methodology that reimburses at least at the BIPA PPS rates for FQHC and RHC services.

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended section 2107(e)(1) of the Act to make section 1902(bb) of the Act applicable to CHIP in the same manner as it applies to Medicaid. This payment provision became effective October 1, 2009. As outlined in State Health Official Letter #11-004 released by the Centers for Medicare and Medicaid Services (CMS) on February 4, 2010, any States that did not implement this payment methodology by its effective date must make retroactive payments to FQHCs and RHCs based on the BIPA PPS rates back to that date.

When this regulation was passed, the Department considered it an opportunity to implement an alternative payment system that would improve the quality of health care provided by FQHCs and RHCs and contain costs for services provided in CHP+. The Department received a grant from CMS to develop an alternative payment system that would have included incentive payments for FQHCs and RHCs based on health outcomes. After multiple discussions, the Department was unable to reach an agreement with the FQHCs and RHCs on an incentive-based alternative payment system. Consequently, the Department is implementing the BIPA PPS rates for FQHCs and RHCs in CHP+.

The Department does not contract directly with FQHCs and RHCs for CHP+, rather it contracts with several managed care organizations (MCOs) which subcontract with providers, including FQHCs and RHCs, to provide services to clients. The Department is currently in the process of coordinating with these MCOs to implement the BIPA PPS rate for each of their subcontracted FQHCs and RHCs going forward. The Department will implement contractual arrangements to ensure these rates are paid to FQHCs and RHCs beginning on July 1, 2012 so that retroactive payments will not be necessary after FY 2011-12.

Retroactive Payments to Providers

With newly available data, the Department's contracted actuary has calculated the number of encounters and the payments received by FQHCs and RHCs for these encounters. Due to varying payment

arrangements between MCOs and FQHCs and RHCs, some payments for individual encounters were below the BIPA PPS rate for that FQHC or RHC, while others were above the rate. Per the federal regulations in section 1902(bb) of the Act described above, the Department must ensure that FQHCs and RHCs receive *at least* the BIPA PPS rate for each encounter. As a result, for the retroactive payments, the Department has omitted from its calculations any encounters for which FQHCs and RHCs received a payment greater than the BIPA PPS rate. Table 1 below summarizes the data provided by the CHP+ actuary.

Table 1- Data for Payments Below the BIPA PPS Rate				
Number of FQHCs and RHCs	Total Number of Encounters	Total Paid to FQHCs and RHCs	Total BIPA PPS Encounter Payments	Net Due to Providers
46	16,054	$1,921,316	$2,697,695	$776,379

While the available data includes some encounters through October 2011, it is not a complete list of all FQHC and RHC encounters through that date. The Department has taken this into account in its projection of the total retroactive payments for services provided through June 30, 2012. The Department assumes that the utilization and payment patterns in the data would not change significantly by June 30, 2012. Table 2 below summarizes the Department's estimated retroactive payments by year.

Table 2- Retroactive Payments due to FQHCs and RHCs			
FY 2009-10*	FY 2010-11	FY 2011-12	TOTAL
$449,150	$600,514	$600,512	$1,650,176
* Includes 9 months of payments as the regulation is effective October 1, 2009.			

The Department is thus requesting $1,650,176 total funds to make retroactive payments to FQHCs and RHCs for services provided up to FY 2012-13, when the Department will implement BIPA PPS rates going forward. The Department will receive the same 65% federal financial participation it receives for all other CHP+ premiums expenditures to make these retroactive payments. Thus, $1,072,614 of the total funds requested would be federal funds. Since CHP+ families with incomes between 206% of the Federal Poverty Level (FPL) and 250% FPL are funded through the Hospital Provider Fee implemented in May 2010 pursuant to HB 09-1293, the Department assumes that a proportion of these retroactive payments would have the same funding source. Using historical caseload data and the caseload forecast from its November 1, 2011 FY 2012-13 Budget Request, R-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," the Department estimates that 6.5% of the total CHP+ caseload is between 205% and 250% FPL for the retroactive period of October 2009 through June 2012. Hence, the Department assumes that 6.5% of the state's share of retroactive payments, or $37,674, would be funded through the Hospital Provider Fee. Since CHP+ families with incomes below 206% FPL are funded through the CHP+ Trust Fund, the Department assumes that the remaining portion of the state's share of retroactive payments, $539,888, would also be from the CHP+ Trust Fund.

Implementation of BIPA PPS Going Forward

While the Department pays each CHP+ MCO a monthly capitation for enrolled clients, it does not control the level of reimbursement from MCOs to each provider. MCOs may reimburse different providers, including different FQHCs and RHCs, varying rates for the same services. According to the data from the Department's actuary, actual reimbursement amounts calculated on an encounter basis vary widely. In fact, the total reimbursement received by FQHCs and RHCs for all encounters (including reimbursements above the BIPA PPS rate) is significantly higher than what it would be if BIPA PPS rates were paid for all encounters. When all encounter and payment data available from the CHP+ actuary for services provided

by FQHCs and RHCs from October 2009 through October 2011 is aggregated, FQHCs and RHCs were actually reimbursed an estimated $1,000,000 above the BIPA PPS rates. Since the available data is not an exhaustive account of all encounters over this time period, the actual aggregated payments for this two year time period may be even greater than this initial estimate. This suggests that the capitation payments the Department has made to MCOs have allowed them, on average, to reimburse FQHCs and RHCs at a rate above the BIPA PPS rate. As a result, the Department is working towards a budget neutral implementation of BIPA PPS rates going forward.

Since CHP+ is a separate state CHIP program rather than a Medicaid expansion or combination program, the Department has additional flexibility in implementing BIPA PPS rates. Federal CHIP regulations, for example, do not define "encounters" nor include a definition of the scope of services for FQHCs and RHCs. In order to implement its payment methodology going forward, the Department will amend its contracts with MCOs to ensure that each FQHC and RHC receives the BIPA PPS rate at the time of service. At the same time, the Department will work with its CHP+ actuary so that capitation rates for FY 2012-13 forward reflect the BIPA PPS rates. The Department has been in continued conversations with the CHP+ MCOs and FQHCs and RHCs regarding the implementation of BIPA PPS rates going forward beginning in FY 2012-13. Once implemented, the Department would provide FQHCs and RHCs and MCOs with a list of BIPA PPS rates for CHP+ services on an annual basis, adjusted by the Medicare Economic Index as specified in 1902(bb)(3)(A) of the Act.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects

Priority Number: S-12, BA-5

Dept. Approval by: John Bartholomew JB 12/20/11 Date

OSPB Approval by: 12/28/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$8,983,839	$511,406	$8,895,282	$296,486	$296,486
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	($42,022)	$4,416,786	($149,482)	($149,482)
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$298,257	$14,520	$298,257	$298,257
	RF	$19,399	($650)	$19,889	($650)	($650)
	FF	$4,488,403	$255,821	$4,444,087	$148,361	$148,361
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	$8,983,839	($300,994)	$8,895,282	($300,994)	($300,994)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	($149,482)	$4,416,786	($149,482)	($149,482)
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	($483)	$14,520	($483)	($483)
	RF	$19,399	($650)	$19,889	($650)	($650)
	FF	$4,488,403	($150,379)	$4,444,087	($150,379)	($150,379)
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System Projects - HCPF Only (new line item)	Total	$0	$812,400	$0	$597,480	$597,480
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$107,460	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$298,740	$0	$298,740	$298,740
	RF	$0	$0	$0	$0	$0
	FF	$0	$406,200	$0	$298,740	$298,740

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** For Colorado Benefits Management System Projects HCPF Only line: $298,740 Cash Funds shall be from the Hospital Provider Fee Cash Fund.

Cash or Federal Fund Name and COFRS Fund Number: CF: $14,520 from Children's Basic Health Plan Trust Fund 11G, $19,889 from Old Age Pension Fund managed by Department of Human Services, $298,740 from Hospital Provider Fee Cash Fund 24A. FF: Title XXI and Title XIX.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2011-12, Supplemental Request
January 3, 2012

Department Priority: S-12, BA-5
CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects

Summary of FY 2011-12 Incremental Funding Change	Total Funds	General Fund	FTE
Department of Human Services	$0	($199,322)	0.0
Department of Health Care Policy and Financing	$511,406	($42,022)	0.0

Request Summary:
The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Human Services (DHS) request a technical correction to funding for the Colorado Benefits Management System (CBMS). The combined impact for all Departments is an overall total funds increase of $511,406, but an overall decrease of $241,344 General Fund. Note that the total fund figure double counts reappropriated funds. The request represents no net change to CBMS total funding. HCPF and DHS share funding for CBMS. The Governor's Office of Information Technology (GOIT) would not be impacted because total funding for the CBMS vendor would not change.

In the FY 2011-12 Long Bill (SB 11-209) funding for CBMS changes related to HB 09-1293 "Colorado Health Care Affordability Act" was appropriated using fund splits expected to result from the Random Moment Sampling rather than from the Hospital Provider Fee Cash Fund. This has resulted in the use of more General Fund than is appropriate for HB 09-1293 related CBMS changes.

Currently, the bulk of CBMS funding is allocated by Random Moment Sampling. The methodology is based on the assumption that all programs at HCPF and DHS will contribute to the funding for all CBMS projects. For example, at DHS, Temporary Aid for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP or Food Stamps), Title IV-E Foster Care, Title XX Adult Protective Services, and Old Age Pension all contribute portions of the total funding for CBMS projects. Likewise, at HCPF, Medicaid, the Children's Basic Health Plan, and Old Age Pension State Medical programs all may contribute to portions of funding for CBMS projects. The problems with this approach are two-fold. This methodology is only appropriate for maintenance and operations funding and CBMS changes that impact all programs. However, not all CBMS projects impact all assistance programs. By using Random Moment Sampling for all projects, funding is forced into arbitrary fund splits that do not appropriately reflect the impacted programs.

To create better transparency for the funding of CBMS projects that disproportionately impact HCPF programs, the Department proposes establishing a separate line item for those CBMS projects that benefit HCPF programs only. This line item, called "Colorado Benefit Management System Projects - HCPF Only", would appear in both the HCPF and DHS budgets. Note that it would still be necessary to appropriate the funding to both HCPF and DHS because both Departments have a long-standing agreement that

DHS handles CBMS payment requests from the Governor's Office of Information Technology.

At this time, it is anticipated that funding for two projects would be transferred into the new line item. Those two projects are: 1) the HB 09-1293 Hospital Provider Fee project that covers adding expansion populations into Medicaid, and 2) FY 2011-12 DI-5 "CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements" that was submitted on November 1, 2010 and included in the FY 2011-12 Long Bill, SB 11-209.

For future fiscal years, it is requested that this new line item continue because it is anticipated that HCPF only projects will exist every year. Projects will change from year to year as they are completed and rotate out of the line and new projects begin and rotate into the new line. For example, the funding for HB 09-1293 Hospital Provider Fee would continue into FY 2012-13, but the DI-5 project will complete in FY 2011-12.

In addition to transferring part of the existing appropriation into the new line item, HCPF requests that the incremental requests from S-7 and R-12 (both Hospital Provider Fee requests) also be incorporated into the new line item if the request is approved. Request S-7 includes $1,466,040 additional Hospital Provider Fee Cash Funds for CBMS, and Request R-12 includes $14,040 additional Hospital Provider Fee Cash Fund for CBMS.

Anticipated Outcomes:
If approved, the Departments anticipate greater transparency of funding related to projects that relate only to HCPF programs. Approval of the request would free up General Fund that was inadvertently appropriated for CBMS changes related to the Colorado Health Care Affordability Act (HB 09-1293).

Assumptions for Calculations:
The Departments assume that the costs associated with projects related to the new "Colorado Benefits Management System Projects - HCPF Only" line will no longer be included in the Random Moment Sampling process.

Furthermore, HCPF assumes that funding within this new line item would remain as appropriated, except for the requested technical correction to the funding related to the Colorado Health Care Affordability Act:

- HB 09-1293 projects would use the Hospital Provider Fee Cash Fund for the state share of 50%, joined with federal Medicaid funding of 50%.
- CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements funding would use standard Medicaid funding of 50% General Fund and 50% federal funds as appropriated in Long Bill, SB 11-209.

Both Departments assume that the Random Moment Sampling allocation process will continue to be used for joint undertakings with the following adjustments:

- The DHS Colorado Benefits Management System Operating Expenses line has been adjusted for the removal of the HCPF Only projects from this line item, and the standard allocations have been reapplied to account for the correction and removal of the Colorado Health Care Affordability Act funding. .
- The FY 2011-12 RMS percentages of 62.95% for DHS and 37.05% for HCPF, as used in the Long Bill, SB 09-209, will continue to apply for the adjustments.

See Appendix 1 for detailed calculations.

Consequences if not Funded:
If this request is not approved, distortion of funding splits is likely to continue in the RMS allocation process that may also result in failure to claim the appropriate amount of dollars from each of various federal partners for the Departments. If not approved, $168,996 General Fund that could be refinanced using non-General Fund sources will remain appropriated for CBMS changes related to HB 09-1293.

Impact to Other State Government Agency:
There would be impacts to the Department of Human Services.

Cash Fund Projections:
The Old Age Pension Fund, managed by DHS, and the Children's Basic Health Plan Trust Fund, managed by HCPF, and the Hospital Provider Fee Cash Fund would be impacted by this request.

The Old Age Pension Fund, created in Article XXIV of the State Constitution, does not have a specific balance but is managed by the State Controller to have the amount needed for programs for eligible Old Age Pension clients.

The Children's Basic Health Plan Trust Fund projection is below.

Cash Fund Name	Children's Basic Health Plan Trust Fund
Cash Fund Number	11G
FY 2010-11 Expenditures	$43,062,875
FY 2010-11 End of Year Cash Balance	$7,745,026
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096
FY 2012-13 End of Year Cash Balance Estimate	$8,028,945
FY 2013-14 End of Year Cash Balance Estimate	$6,908,297

The Hospital Provider Fee Cash Fund projection is below.

Cash Fund Name	Hospital Provider Fee Cash Fund
Cash Fund Number	24A
FY 2010-11 Expenditures	$426,069,052
FY 2010-11 End of Year Cash Balance	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436

Relation to Performance Measures:
This request is a technical correction and does not relate specifically to a performance measure.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
This request meets the Supplemental Request and Budget Amendment criteria since it is a technical correction.

Current Statutory Authority or Needed Statutory Change:
Statutory authority is under 25.5.4-106 (3), C.R.S. (2011) and 25.5-4-204 (1), C.R.S. (2011). No changes to statutes are needed.

Table 1
Technical Adjustments

Current Total Funding at DHS for Colorado Benefits Management System Operating Expenses	$18,858,730
1) HB 09-1293 Hospital Provider Fee Project Inadvertently Appropriated Incorrectly	($597,480)
2) Low Income Subsidy and Disability Determination Services Federal Requirements	($214,920)
Total Funding Needing to be Separated from RMS Determined Fund Splits	**($812,400)**
Revised Funding for DHS Colorado Benefits Management System Operating Expenses (Echoed in GOIT Funding for CBMS)	$18,046,330

Table 2
Creation of new "Colorado Benefits Management System Projects - HCPF Only" line

Component 1: HB 09-1293 Hospital Provider Fee Project (50% CF & 50% FF)	$597,480
Component 2: Low Income Subsidy (LIS) and Disability Determination Project (50% GF & 50% FF)	$214,920
Create New Line Item: Colorado Benefits Management System Projects HCPF Only	**$812,400**

Table 2A
Fund Splits for "Colorado Benefits Management System Projects - HCPF Only"

Fund splits calculated based on corrected HB 09-1293 funding source and LIS funding appropriated through SB 11-209. (New Line Item to DHS and HCPF.)

	TF	GF	CF	RF	FF
HCPF	$812,400	$107,460	$298,740	$0	$406,200
DHS	$812,400	$0	$0	$812,400	$0

Table 3
New Fund Splits Based on RMS Estimates for DHS
"Colorado Benefits Management System Operating Expenses" line

	TF	GF	CF	RF	FF
DHS Current	$18,858,730	$4,585,647	$1,034,792	$6,924,731	$6,313,560
Remove 1293 & LIS	($812,400)	($199,322)	($37,655)	($300,994)	($274,429)
New Amount	**$18,046,330**	**$4,386,325**	**$997,137**	**$6,623,737**	**$6,039,131**

Table 4
New Fund Splits Based on RMS Estimates for HCPF
"Colorado Benefits Management System" line

	TF	GF	CF	RF	FF
HCPF Current	$8,983,839	$4,461,609	$14,428	$19,399	$4,488,403
Remove 1293 & LIS	($300,994)	($149,482)	($483)	($650)	($150,379)
New Amount	**$8,682,845**	**$4,312,127**	**$13,945**	**$18,749**	**$4,338,024**

Table 5
Incremental Adjustments for All Line Items in Request

Department of Human Services				
Colorado Benefits Management System Operating Expenses				
TF	GF	CF	RF	FF
($812,400)	($199,322)	($37,655)	($300,994)	($274,429)
Colorado Benefits Management System Projects - HCPF Only (New Line)				
TF	GF	CF	RF	FF
$812,400	$0	$0	$812,400	$0
Health Care Policy and Financing				
Colorado Benefits Management System				
TF	GF	CF	RF	FF
($300,994)	($149,482)	($483)	($650)	($150,379)
Colorado Benefits Management System Projects - HCPF Only (New Line)				
TF	GF	CF	RF	FF
$812,400	$107,460	$298,740	$0	$406,200

Table 6
Combined Adjustments for Each Department

	TF	GF	CF	RF	FF
DHS	$0	($199,322)	($37,655)	$511,406	($274,429)
HCPF	$511,406	($42,022)	$298,257	($650)	$255,821
Total	**$511,406**	**($241,344)**	**$260,602**	**$510,756**	**($18,608)**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Commission on Family Medicine Residency Training Program Adjustment

Priority Number: S-13

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$1,391,077	$350,000	$1,391,077	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$695,538	$175,000	$695,538	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$695,539	$175,000	$695,539	$0	$0
(5) Other Medical Services; Commission on Family Medicine Residency Training Programs	Total	$1,391,077	$350,000	$1,391,077	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$695,538	$175,000	$695,538	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$695,539	$175,000	$695,539	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ If yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Commission on Family Medicine

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-13
Request Title: Commission on Family Medicine Residency Training Program Adjustment

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Commission on Family Medicine Residency Training Program Adjustment	$350,000	$175,000	0.0

Request Summary:
The Department is requesting an increase of $350,000 total funds, of which $175,000 is General Fund and the remainder is federal funds, to the Commission on Family Medicine Residency Training Program in FY 2011-12. This increased appropriation reflects a technical adjustment to comply with current state law.

During the 2011 legislative session, Colorado's General Assembly passed SB 11-184, "Concerning Tax Reporting," which adds section 39-21-202 to state statute. Section 39-21-202 (1) C.R.S. (2011) creates the Tax Amnesty cash fund (the Fund), which receives funds from the taxpayer amnesty program authorized at 39-21-201 C.R.S. (2011). Further, section 39-21-202 (2) C.R.S. (2011) mandates the following:

"(b) The state treasurer shall transfer the balance of the fund as of December 31, 2011, minus one million dollars, as follows:

(I) One hundred seventy-five thousand dollars shall be transferred to the general fund. If such transfer occurs, 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."

The Department assumes that the balance in the Fund will be sufficient for the transfer of $175,000 to occur per 39-21-202 (2)(b)(I) C.R.S. (2011). As a result, the Department is requesting a corresponding one-time increase to its FY 2011-12 appropriation. Since the Commission on Family Medicine Residency Training Program receives a 50% federal financial participation rate, the Department's total fund request of $350,000 is comprised of $175,000 General Fund and $175,000 federal funds.

Impact to Other State Government Agency:
The Colorado Family Medicine Residency Training Program is administered by the Advisory Commission on Family Medicine in the Department of Higher Education, Health Sciences Center.

Relation to Performance Measures:
State mandated increase.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
Technical adjustment to abide by current law.

Current Statutory Authority or Needed Statutory Change:
39-21-202 (2) C.R.S. (2011) mandates the transfer and specifies the intent to include a supplemental appropriation to the Department.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: MMIS Technical Adjustments

Priority Number: BA-6

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/28/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☐ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$32,412,990	$0	$31,767,217	$1,065,358	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,581,901	$0	$6,459,471	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,479,670	$0	$1,698,513	$225,140	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$24,251,091	$0	$23,508,905	$840,218	$0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts[a]	Total	$32,412,990	$0	$31,767,217	$1,065,358	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,581,901	$0	$6,459,471	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,479,670	$0	$1,698,513	$225,140	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$24,251,091	$0	$23,508,905	$840,218	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**
FY 2012-13

[a] Of this amount, ~~$1,449,800~~ $1,674,940 shall be from the Hospital Provider Fee Cash Fund...

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A); FF: Title XIX, Title XXI

Reappropriated Funds Source, by Department and Line Item Name: None

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: None

Other Information: None

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Budget Amendment
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: BA-6
Request Title: MMIS Technical Adjustments

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Request	$1,065,358	$0	0.0

Request Summary:
The Department requests an increase of $1,065,358 total funds in FY 2012-13, comprised of $225,140 hospital provider fee cash funds and $840,218 federal funds. The Department also requests roll forward authority for any unused FY 2011-12 General Fund appropriated for the Medicaid Management Information System (MMIS) system development projects. The Department makes these requests in order to true up appropriated funding with actual need for MMIS system development projects.

For many MMIS system development projects, timelines and costs have changed since the original estimates were made. These changes require flexibility in funding for MMIS system development projects in order to shift funding between fiscal years and reorganize funding from development projects that cost less than the original estimate to development projects that cost more than the original estimate.

The MMIS system development projects affected by this request include Reimbursement Reporting and the All Patient Refined Diagnosis Related Groups (APR-DRG) inpatient hospital rate reform system development projects funded under HB 09-1293. The Department is requesting to update the appropriations provided under HB 09-1293 for these projects to reflect updated estimates. The Department is also refinancing General Fund appropriated to several system-wide projects to hospital provider fee cash fund.

It has been the Department's experience that many initial cost and timeline estimates for MMIS system development projects prove to be inaccurate relative to the final cost and time required to complete the project. This occurs because the Department is often required to request funding based on high-level estimates due to the State budgeting process, and more refined estimates are developed as the Department and its fiscal agent complete detailed business requirements for these development projects. Two major examples of this experience are the Adults without Dependent Children (AwDC) and Buy-In Programs for Individuals with Disabilities (Buy-In) expansions system development under HB 09-1293 and the federally-mandated Health Insurance Portability and Accountability Act (HIPAA) version 5010/D.0 system development as outlined in the Department's FY 2010-11 BA-15.

For AwDC and Buy-In expansions system development costs, the Department received an original estimate of $4,335,912 total funds, spanning three fiscal years with 79% of the cost in FY 2010-11. However, the most recent cost estimate for this system development is $601,650, with all work to be completed in FY 2011-12. This represents an 87% decrease in cost and

roughly a one year delay from the original estimate.

For HIPAA v5010/D.0 system development costs, the Department received an original estimate of $1,665,598 total funds, to be completed by January 2012. However, the most recent cost estimate for this system development is $3,546,245, to be completed by July 2012. This represents a 112% increase in cost and a six month delay from the original estimate.

Due to the volatile nature of MMIS system development cost and timeline estimates, the Department requests roll forward authority for any unused General Fund in FY 2011-12 to be applied toward any MMIS system development costs in FY 2012-13 due to updated timelines and cost estimates.

Anticipated Outcomes:
This request would allow the Department to have appropriately allocated funding for numerous MMIS system development projects by truing up hospital provider fee cash funds with actual need as well as allowing any unused General Fund to be rolled forward from FY 2011-12 to cover development costs in FY 2012-13 due to changing timelines and cost estimates.

Assumptions for Calculations:
In order to calculate funding needs for MMIS system development projects, the Department used the latest cost estimates and timelines from the Department's fiscal agent. See Appendix A for detailed costs for HB 09-1293 development projects in FY 2012-13.

Consequences if not Funded:
If this request is not approved, hospital provider fee funding for MMIS system development projects will be inadequate to complete all necessary systems development projects. Without General Fund roll forward authority for FY 2011-12, the Department may need to request additional General Fund in FY 2012-13 in order to adequately fund and meet federally-mandated implementation deadlines for a number of development projects with shifting timelines and cost estimates.

Cash Fund Projections:

Cash Fund Name	Hospital Provider Fee Cash Fund
Cash Fund Number	24A
FY 2010-11 Expenditures	$426,069,052
FY 2010-11 End of Year Cash Balance	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
The Department is the single state Medicaid agency and has authority to administer the MMIS through 25.5-4-204 (3), C.R.S. (2011) and §1903 (a) of the Social Security Act [42 U.S.C. 1396b].

Appendix A: Calculations for HB 09-1293 MMIS Projects

FY 2012-13 Hospital Provider Fee Need

Table A.1 contains a detailed breakdown of FY 2012-13 hospital provider fee need for MMIS. The total funds amount needed is $5,336,610, comprised of $1,317,953 hospital provider fee cash funds and $4,018,657 federal funds. This amount includes $4,071,252 total funds for MMIS ongoing operating costs and development project costs of $924,839 total funds for APR-DRG rate reform implementation, Reimbursement Reporting, and any unforeseen development needs as requested in the Department's November 1, 2011 FY 2012-13 R-12, "Hospital Provider Fee Administrative True-up." Also included are $340,519 total funds to refinance 7.92% of General Fund appropriations for a number of system-wide MMIS development projects. This refinance applies to HIPAA v5010/D.0 and International Classification of Diseases, 10th Revision (ICD-10) changes, Medicaid Information Technology Architecture (MITA) and MMIS reprocurement projects, and the implementation of the National Correct Coding Initiative (NCCI.) This refinance is done with the goal of equalizing the hospital provider fee allocation with the proportion of the expansion populations funded under the hospital provider fee relative to the total Medicaid caseload. Because these development projects are system-wide, the department believes it is appropriate to refinance these projects with hospital provider fee cash funds. Please see the Department's January 3, 2012 S-7, "Hospital Provider Fee Administrative True-up" for details regarding the cost allocation methodology used for refinancing.

Table A.1: FY 2012-13 MMIS Hospital Provider Fee Cash Funds Need

	Total Funds	Cash Funds (Hospital Provider Fee)	Federal Funds
Ongoing Operations			
Claims Processing	$3,971,252	$992,813	$2,978,439
Postage	$100,000	$50,000	$50,000
Subtotal: Ongoing Operations	$4,071,252	$1,042,813	$3,028,439
Development Projects			
APR-DRG	$475,146	$118,786	$356,360
Reimbursement Reporting	$249,693	$62,423	$187,270
Additional Need	$200,000	$50,000	$150,000
Subtotal: Development Projects	$924,839	$231,209	$693,630
Hospital Provider Fee Refinancing			
HIPAA v5010/D.0 and ICD-10 Refinance	$265,909	$28,526	$237,383
NCCI Refinance	$52,965	$13,241	$39,724
MITA and Reprocurement Refinance	$21,645	$2,164	$19,481
Subtotal: Hospital Provider Fee Refinance	$340,519	$43,931	$296,588
Total FY 2012-13 Need	**$5,336,610**	**$1,317,953**	**$4,018,657**

FY 2012-13 Incremental Request

Table A.2 shows the calculations used to obtain the incremental amount included in this request. For hospital provider fee operations and development, the Department's FY 2012-13 base request is $4,885,226 total funds. The Department requested a reduction of $613,974 total funds in its November 1, 2011 FY 2012-13, "Hospital Provider Fee Administrative True-up" for reduced postage costs, for a total year-to-date FY 2012-13 request of $4,271,252 total funds. The FY 2012-13 incremental request is an increase of $1,065,358 total funds, comprised of $225,140 provider fee cash funds, and $840,218 federal funds. Please note that the reduction of $356,987 in provider fee cash funds requested in the Department's November 1, 2011 FY 2012-13 R-12, "Hospital Provider Fee Administrative True-up" for reduced postage costs and the increase of $225,140 in provider fee cash funds in this request for development projects results in a the net reduction of $131,847 in provider fee cash funds for FY 2012-13.

Table A.2: FY 2012-13 MMIS Hospital Provider Fee Cash Funds Incremental Request			
	Total Funds	**Cash Funds (Hospital Provider Fee)**	**Federal Funds**
FY 2012-13 Base Request	$4,885,226	$1,449,800	$3,435,426
November 1, 2011 FY 2012-13 R-12	($613,974)	($356,987)	($256,987)
Year-to-Date FY 2012-13 Request	**$4,271,252**	**$1,092,813**	**$3,178,439**
Total FY 2012-13 Need (See Table A.2)	$5,336,610	$1,317,953	$4,018,657
Incremental Request	**$1,065,358**	**$225,140**	**$840,218**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Additional Federal Funds for Medicaid Facility Survey and Certification

Priority Number: NP-S1 (See CDPHE S-10)

Dept. Approval by: John Bartholomew PM for JB 12/28/11 (Date)

OSPB Approval by: 12/28/11 (Date)

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$4,945,441	$217,047	$5,232,683	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,539,788	$0	$1,572,708	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,405,653	$217,047	$3,659,975	$0	$0
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Public Health and Environment Facility for Survey and Certification	Total	$4,945,441	$217,047	$5,232,683	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,539,788	$0	$1,572,708	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,405,653	$217,047	$3,659,975	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Colorado Department of Public Health and Environment

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Utilities Funding Request

Priority Number: NP-S2, NP-BA1

Dept. Approval by: John Bartholomew JAP for JB 12/19/11 Date

OSPB Approval by: [signature] 12/19/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	($350,000)	$5,184,971	($350,000)	($350,000)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($175,000)	$2,592,486	($175,000)	($175,000)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($175,000)	$2,592,485	($175,000)	($175,000)
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	($350,000)	$5,184,971	($350,000)	($350,000)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($175,000)	$2,592,486	($175,000)	($175,000)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($175,000)	$2,592,485	($175,000)	($175,000)

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Colorado Mental Health Institutes Revenue Adjustment

Priority Number: NP-S3, NP-BA2

Dept. Approval by: John Bartholomew 12/13/11 Date

OSPB Approval by: 12/18/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$4,129,919	$1,125,866	$4,196,912	$1,125,866	$1,125,866
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,064,959	$562,933	$2,098,456	$562,933	$562,933
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,064,960	$562,933	$2,098,456	$562,933	$562,933
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Mental Health Institutes	**Total**	$4,129,919	$1,125,866	$4,196,912	$1,125,866	$1,125,866
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,064,959	$562,933	$2,098,456	$562,933	$562,933
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,064,960	$562,933	$2,098,456	$562,933	$562,933

Letternote Text Revision Required? Yes: ☐ No: ☑ If yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Suspension of ICF/ID Provider Fee

Priority Number: NP-S4

Dept. Approval by: John Bartholomew 12/15/11 Date

OSPB Approval by: 12/21/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$46,829,800	($1,867,655)	$47,801,815	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,547,245	$933,828	$22,033,253	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,867,655	($1,867,655)	$1,867,655	$0	$0
	FF	$23,414,900	($933,828)	$23,900,907	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Regional Centers	**Total**	$46,829,800	($1,867,655)	$47,801,815	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,547,245	$933,828	$22,033,253	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,867,655	($1,867,655)	$1,867,655	$0	$0
	FF	$23,414,900	($933,828)	$23,900,907	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Common Policy True-up for CCLS and ALJ

Priority Number: NP-S5

Dept. Approval by: John Bartholomew 12/29/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$820,758	$39,104	$979,109	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$385,681	$19,552	$444,056	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$24,698	$0	$45,499	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$410,379	$19,552	$489,554	$0	$0
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	**Total**	$422,830	$26,297	$536,111	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$186,717	$13,148	$222,557	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$24,698	$0	$45,499	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$211,415	$13,149	$268,055	$0	$0
(1) Executive Director's Office; (A) General Administration, Capital Complex Leased Space	**Total**	$397,928	$12,807	$442,998	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$198,964	$6,404	$221,499	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$198,964	$6,403	$221,499	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF - Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Personnel and Administration

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Annual Fleet True-Up

Priority Number: NP-S6

Dept. Approval by: John Bartholomew TP for JB 12/23/11 Date

OSPB Approval by: 12/23/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	($15,765)	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($7,882)	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($7,883)	$2,592,485	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	($15,765)	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($7,882)	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($7,883)	$2,592,485	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - FY 2011-12 Common Policy Allocation True-Up

Priority Number: NP-S7

Dept. Approval by: John Bartholomew for SB 12/22/11 Date

OSPB Approval by: [signature] 12/23/11 Date

- Decision Item FY 2012-13
- Base Reduction Item FY 2012-13
- Supplemental FY 2011-12
- Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	$1,272	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	$636	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	$636	$2,592,485	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	$1,272	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	$636	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	$636	$2,592,485	$0	$0

Letternote Text Revision Required? Yes: No: If yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: No: Not Required:

Schedule 13s from Affected Departments: Department of Human Services

Other Information: