JOINT BUDGET COMMITTEE

SUPPLEMENTAL BUDGET REQUESTS FY 2016-17 AND FY 2015-16

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

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JANUARY 25, 2017

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CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

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

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

SUMMARY: FY 2015-16 APPROPRIATION AND RECOMMENDATION

REQUEST/RECOMMENDATION DESCRIPTIONS

S15 RELEASE OVER-EXPENDITURE RESTRICTION: The Department requests and the JBC staff recommends the release of restrictions on the FY 2016-17 appropriations imposed by the State Controller due to over-expenditures in prior years. Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided with unlimited over-expenditure authority as long as the over-expenditures are consistent with the statutory provisions of the Medicaid program (Section 24-75-109, C.R.S.). However, the State Controller restricts the current fiscal year's appropriation until the General Assembly approves a supplemental for the prior year over-expenditure. Releasing the over-expenditure restriction requires increasing the FY 2015-16 appropriation by $11,542,129 total funds, including $405,525 General Fund.

SUMMARY: FY 2016-17 APPROPRIATION AND RECOMMENDATION

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING: RECOMMENDED CHANGES FOR FY 2016-17						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	7,781,062,016	2,163,886,443	964,723,620	11,561,599	4,640,890,354	397.5
Other Legislation	56,973,679	(6,186,893)	27,386,412	0	35,774,160	2.8
CURRENT FY 2016-17 APPROPRIATION	**$7,838,035,695**	**$2,157,699,550**	**$992,110,032**	**$11,561,599**	**$4,676,664,514**	**400.3**
RECOMMENDED CHANGES						
Current FY 2016-17 Appropriation	$7,838,035,695	2,157,699,550	$992,110,032	$11,561,599	$4,676,664,514	400.3
S1 Medical Services Premiums	141,694,902	32,217,993	1,650,193	3,861,816	103,964,900	0.0
S3 Children's Basic Health Plan	15,610,893	1,515	1,914,824	0	13,694,554	0.0
S4 Medicare Modernization Act	1,369,323	1,369,323	0	0	0	0.0
S6 Delivery system and payment reform	(15,440,295)	(7,720,148)	0	0	(7,720,147)	0.0
S7 Oversight of state resources	200,000	50,000	50,000	0	100,000	0.0
S8 MMIS Operations	0	0	0	0	0	0.0
S12 SB 16-19 PACE rollforward	0	0	0	0	0	0.0
S13 Connect for Health Colorado	0	0	0	0	0	0.0
S14 Public School Health Services	9,393,330	0	4,754,691	0	4,638,639	0.0
RECOMMENDED FY 2016-17 APPROPRIATION	**$7,990,863,848**	**$2,183,618,233**	**$1,000,479,740**	**$15,423,415**	**$4,791,342,460**	**400.3**
RECOMMENDED INCREASE/(DECREASE)	**$152,828,153**	**$25,918,683**	**$8,369,708**	**$3,861,816**	**$114,677,946**	**0.0**
Percentage Change	1.9%	1.2%	0.8%	33.4%	2.5%	0.0%
FY 2016-17 EXECUTIVE REQUEST	**$7,994,512,576**	**$2,185,376,141**	**$999,941,935**	**$15,154,021**	**$4,794,040,479**	**400.3**
Request Above/(Below) Recommendation	$3,648,728	$1,757,908	($537,805)	($269,394)	$2,698,019	0.0

REQUEST/RECOMMENDATION DESCRIPTIONS

S1 MEDICAL SERVICES PREMIUMS: The Department requests and the JBC staff recommends an adjustment for projected changes in caseload, per capita expenditures, and fund sources.

S3 CHILDREN'S BASIC HEALTH PLAN: The Department requests and the JBC staff recommends an adjustment for projected changes in caseload, per capita expenditures, and fund sources.

S4 Medicare Modernization Act: The Department requests and the JBC staff recommends and adjustment for projected changes in caseload, per capita expenditures, and fund sources.

S6 Delivery system and payment reform: The Department requests and the JBC staff recommends an adjustment to account for a change in the timing of hospital outpatient payments. Total payments to the hospitals will not change. The old hospital reimbursement method generated a significant initial overpayment that was corrected through reconciliations that sometimes took as long as four to five years to complete. The new reimbursement method generates an initial payment that is much closer to the correct rate from the start, so that going forward the Department expects reconciliations to decrease. However, in the short term the Department is still receiving reconciliations for payments in prior years at the old inflated initial payments, resulting in a short-duration savings over the next few years until those reconciliations are all resolved.

S7 Oversight of state resources: The Department requests and the JBC staff recommends funding for the electronic verification of assets and for resources to help with the development of the Hospital Provider Fee model.

S8 MMIS Operations: The JBC staff recommends delaying a decision on the Department's requested changes to the multi-year reprocurement of the Medicaid Management Information System (MMIS) project. The changes account for a delay in implementation, changes in estimated costs for certain components, new federally required features, and revised estimates of fund sources and federal financial participation levels. The Department's request would reduce FY 2016-17 expenditures by $1,495,480 total funds, including $32,549 General Fund.

S12 PACE rollfoward: The Department requests and the JBC staff recommends roll-forward authority of $225,000 cash funds donated to the Health Care Policy and Financing Cash Fund by providers of the Program for All-inclusive Care for the Elderly (PACE) to implement S.B. 16-199. The bill requires the Department, contingent on receiving sufficient donations, to develop an alternate payment method for providers of the PACE program.

S13 Connect for Health Colorado: The JBC staff does not recommend the Department's request for $5,114,208 total funds, including $1,790,457 General Fund to reimburse Connect for Health Colorado (C4HCO) for activities related to determining eligibility for Medicaid and the Children's Basic Health Plan (CHP+).

S14 Public School Health Services: The Department requests and the JBC staff recommends an adjustment for projected changes in certified public expenditures by local school districts and boards of cooperative education services.

PRIORITIZED SUPPLEMENTAL REQUESTS

S1 MEDICAL SERVICES PREMIUMS

	REQUEST	RECOMMENDATION
TOTAL	**$141,694,902**	**$141,694,902**
General Fund	32,217,993	32,217,993
Cash Funds	1,650,193	1,650,193
Reappropriated Funds	3,861,816	3,861,816
Federal Funds	103,964,900	103,964,900

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.

DEPARTMENT REQUEST: The Department requests a net increase in funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2016-17 appropriation incorporated trend data through December 2015 while the latest forecast used for this supplemental request incorporates data through June 2016. The Department will submit a new forecast in February that uses data through December 2016. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The FY 2016-17 revised projection of expenditures is $141.7 million, or 2.1 percent, higher than the appropriation in total. The revised projection of General Fund is $32.2 million, or 1.7 percent, higher than the appropriation.

The Medical Services Premiums line item pays for physical health and most long-term services and supports for clients eligible for the Medicaid program.

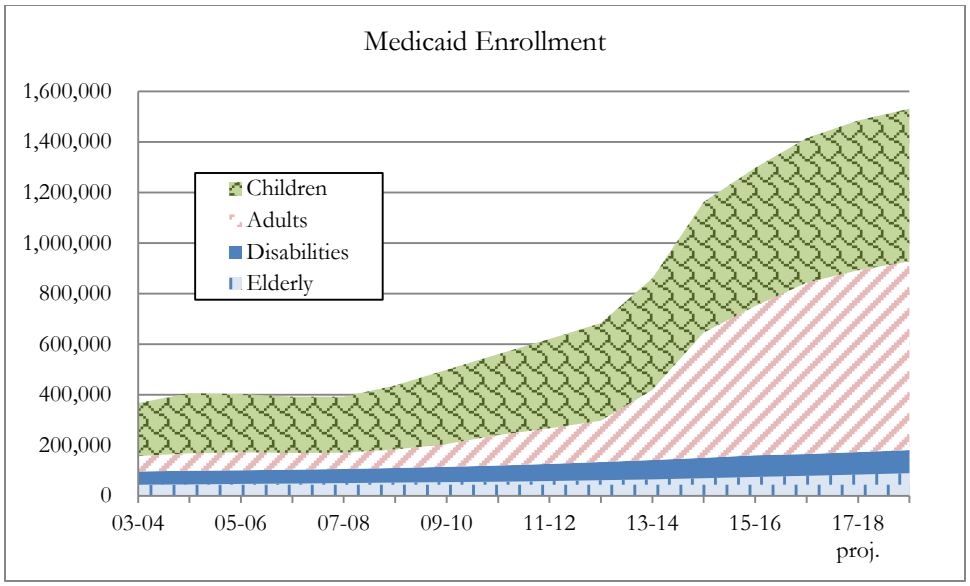
STAFF RECOMMENDATION: Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law. There is significant uncertainty about the future of the Medicaid program at the federal level, but unless and until changes are actually implemented the budget must be balanced to current law and policy. If the February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

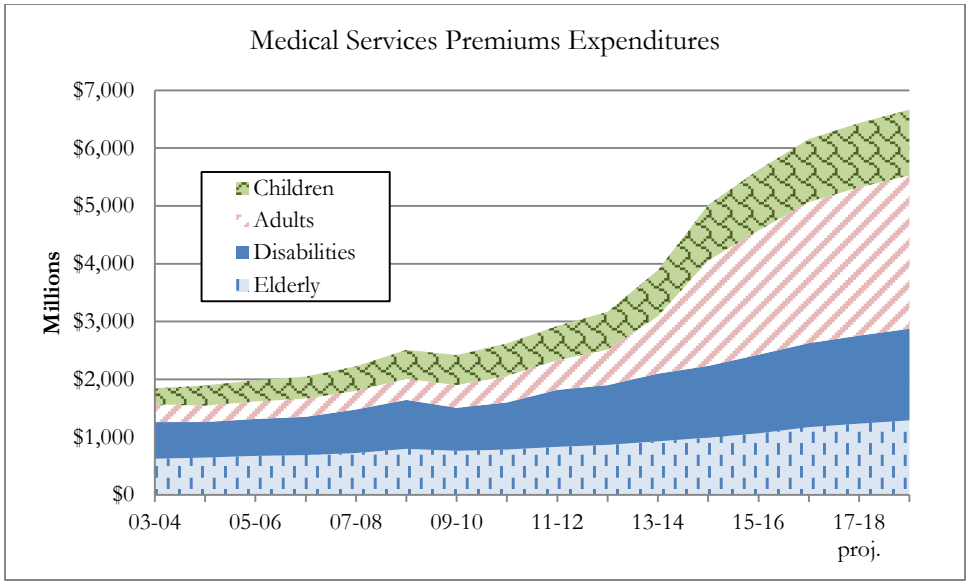
The table below summarizes major changes to the assumptions used for the forecast.

Medical Services Premiums FY 2016-17 Changes				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
Medicaid Caseload				
Elderly and People with Disabilities	($10,717,410)	($5,302,655)	($34,614)	($5,380,141)
Children	(9,504,179)	(5,217,656)	0	(4,286,523)
Non-Expansion Adults	23,775,976	10,197,339	577,835	13,000,802
Expansion Adults	97,117,122	0	2,427,928	94,689,194
Subtotal - Caseload	*100,671,509*	*(322,972)*	*2,971,149*	*98,023,332*
Per Capita Trends	(27,115,965)	18,135,285	1,223,395	(46,474,645)
Hepatitis C Drug Criteria Change	66,099,921	15,713,791	1,215,017	49,171,113
Certified Public Expenditures	16,414,112	(867,484)	8,606,760	8,674,836
Medicare Insurance Premiums	16,607,810	4,567,492	0	12,040,318
Nursing Provider Fee Booster Payments	5,153,056	2,566,222	0	2,586,834
Elderly, Blind and Disabled Waiver	4,609,746	2,295,654	0	2,314,092
Long-term Home Health	2,391,122	1,190,779	0	1,200,343
Brain Injury Waiver	1,559,086	776,425	0	782,661
Single Entry Points	1,558,925	776,345	0	782,580
Mental Health Supports Waiver	1,142,836	569,132	0	573,704
Hospital Provider Fee Booster Payments	(22,054,503)	0	(9,541,143)	(12,513,360)
Nursing Homes	(11,886,639)	(5,913,074)	21,536	(5,995,101)
Program of All-inclusive Care for the Elderly	(8,732,244)	(4,348,658)	0	(4,383,586)
Private Duty Nursing	(3,425,446)	(1,705,872)	0	(1,719,574)
Hospice	(2,402,054)	(1,196,223)	0	(1,205,831)
Physical Therapy/Occupational Therapy Cap	(2,224,371)	2,386,258	(40,613)	(4,570,016)
Other	3,328,001	(2,405,107)	1,055,908	4,677,200
TOTAL	**$141,694,902**	**$32,217,993**	**$5,512,009**	**$103,964,900**

As illustrated in the table, the lion's share of the General Fund changes in the supplemental are attributable to assumptions about per capita trends and a Hepatitis C Drug Criteria Change. The Hepatitis C Drug Criteria Change is discussed in more detail under a separate subheading below. The change in assumptions about per capita trends is primarily a result of actual FY 2015-16 expenditures for people with disabilities being higher than expected, causing the Department to increase the forecast for FY 2016-17. Per capita costs for parents and adults without dependent children are trending lower than originally expected, but this primarily affects the federal funds, rather than the General Fund.

The next two graphs show longer term trends in enrollment and expenditures.





While the supplemental forecast is based on current law, it reflects two changes in policy that are worth further discussion. The Department expanded its coverage of medications for treating Hepatitis C and thereby increased projected expenditures by a significant amount, raising important questions about the role, or lack thereof, of the General Assembly in the decision. Also, the Department implemented a change in coverage limits for physical therapy and occupational therapy that was approved by the General Assembly in 2011-12, but delayed in implementation until this year.

HEPATITIS C DRUG CRITERIA CHANGE

COVERAGE EXPANDED TO FIBROSIS OF F2, PEOPLE IN REHABILITATION, AND PREGNANT ADULTS

As of October 1, 2016, the Department expanded coverage criteria for Hepatitis C medications. The Department covers Hepatitis C medications, but requires that clients receive prior authorization from the Department that the patient meets certain criteria before Medicaid will pay. The Department changed the prior authorization criteria to provide coverage for patients with a fibrosis score of F2 (the previous cut-off was F3), patients in a substance abuse rehabilitation program (eliminating requirements that the patient be substance free for a designated time), and patients who are pregnant.

CRITERIA EXPANSION ESTIMATED TO COST $22.2 MILLION GENERAL FUND ANNUALLY

The Department estimates that the expansion of the Hepatitis C drug criteria will cost $93.3 million total funds, including $22.2 million General Fund, annually. The partial year cost in FY 2016-17 is $66.7 million total funds, including $15.7 million General Fund. The high estimated cost of expanding the coverage criteria is due to the expense of the medications per client. The Department can't report rebates on specific drugs, but using average rebates the Department's estimates indicate an average net treatment cost per client after drug rebates of almost $46,000.

The Department estimates there are 14,451 Medicaid clients with a Hepatitis C diagnosis and providing drug treatment to all of them, regardless of fibrosis score, would cost another $550.6 million total funds, including $131.4 million General Fund, after estimated drug rebates.

DEPARTMENT ACTED WITHIN ITS AUTHORITY IN EXPANDING THE HEPATITIS C DRUG CRITERIA

The Department acted within its authority in approving the change to the Hepatitis C drug criteria. Legislative Legal Services (LLS) agrees with this assessment. Pursuant to federal law, pharmacy is an optional benefit under Medicaid, but states that elect to provide a pharmacy benefit must do so in compliance with federal guidelines. States may put limits on drug coverage in the form of prior authorization criteria, but that also must be done within federal regulations.[1] Those federal guidelines require, among other things, that standards of care be reasonable and comparable.[2] The plaintiffs in a recent law suit against the state (Cunningham v. Birch, U.S. District Court for District of Colorado) cite case law in arguing that states must cover treatment that is "medically necessary".

In state statute the General Assembly has given authority to the Department to establish prior authorization criteria for pharmaceuticals. In general the Medical Services Board may by rule limit coverage of services that are optional under Medicaid, including pharmacy, to stay within the appropriation, provided the services are sufficient in amount, duration, and scope to achieve the purposes required by federal law or regulation.[3] Specific to pharmacy, the Department is required to implement a drug utilization review process and, "The state department shall implement drug utilization mechanisms, including, but not limited to, prior authorization, to control costs in the medical assistance program associated with prescribed drugs."[4]

[1] 42 U.S..C. 1396r-8(d)(5)
[2] 42 U.S.C. § 1396a (10); 42 U.S..C. 1396a (17)
[3] Section 25.5-5-202(3), C.R.S.
[4] Section 25.5-5-506, C.R.S.

The Department initially implemented prior authorization criteria for Hepatitis C drugs without first consulting the General Assembly based on the information available about the drugs at the time. In October the Department loosened the prior authorization criteria in order to stay within federal guidelines with the current information available about the drugs.

RATIONALE FOR THE CHANGE

The Department's original Hepatitis C drug criteria took into account cost, the slow progression/low mortality of the disease, and safety concerns about new drugs due to a lack of long-term studies. In a December 1, 2015, report to the General Assembly the Department noted that only a small number of people infected with Hepatitis C progress to liver failure and in 2013 the mortality rate for Hepatitis C was 5/100,000. Also, the Department indicated it is fairly standard practice for the Department to implement prior authorization criteria for drugs newly released to market, due to limited long-term safety studies. The Department also described a need to balance public health concerns with the high cost of treatment and a responsibility to the taxpayers. The Department's solution was to treat members with the most advanced disease who were likely to respond to treatment.

More recently, according to the Department, new data has emerged questioning the degree of accuracy of fibrosis scores as an indicator of liver damage and Hepatitis C disease progression. Washington State's Medicaid program recently faced an injunction from a federal judge against implementing that state's Hepatitis C drug prior authorization criteria, which were based in part on fibrosis scores. Under the Department's new prior authorization criteria as of October 1, 2016, more people will be able to access Hepatitis C medications, but there will still be limits based on fibrosis score.

ROLE OF THE GENERAL ASSEMBLY

It is disconcerting that the Department can change drug prior authorization criteria without consulting the legislature and thereby drive expenditures of this magnitude. To the extent the Department must cover "medically necessary' pharmacy, the identification of what is "medically necessary" is based on context and a very large and real part of that context is the budget. What is considered "medically necessary" in the United States is very different from standards in England, or China, or Uganda. Some of those differences may be due to factors such as culture or geography, but the differences can largely be traced back to economic resources. There is no magical and pure definition of "medically necessary" that exists outside of the budgetary context, and so it would be ridiculous not to consider the budget when evaluating what is "medically necessary".[5]

On the other hand, it would be challenging for the General Assembly to consistently weigh in on changes to the Department's drug utilization criteria. The General Assembly does not have staff with the clinical and regulatory expertise or time to analyze drug utilization criteria. In FY 2012-13 the Department asked the General Assembly to approve changes to prior authorization criteria for multiple specific services and drugs as part of a package of initiatives designed to reduce expenditures in a difficult budget year. At the time, several members of the JBC expressed

[5] In the case law cited by the plaintiffs in Cunningham versus Birch, the "medically necessary" standard appears to derive in large part, although not exclusively, from 42 U.S.C. § 1396-1 that describes the purpose of federal appropriations for Medicaid as, "enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance [to those persons] whose income and resources are insufficient to meet the costs of necessary medical services." While the courts have given significant attention to "necessary medical services", the statement begins with, "as far as practicable under the conditions in such State," which seems to acknowledge that local conditions, presumably including the budget, should inform the interpretation of "necessary medical services".

discomfort and even anger at being asked to vote on changes to very specific coverage policies when they knew nothing about the presenting ailments, typical treatments, or potential complications and risks for the patients.

This makes it challenging to identify the appropriate role and process for the legislature to provide input on decisions like prior authorization criteria for Hepatitis C medications in order to preserves the General Assembly's power over the budget, but not put the General Assembly in a position of playing doctor. The JBC staff does not have an answer to this conundrum, but would argue that size and materiality matters.

Most of the individual changes the Department makes to the prior authorization criteria for drugs have a relatively small fiscal impact. Also, most of the changes reduce rather than increase costs. Often when the Department implements new prior authorization criteria, the new criteria is focused on drugs entering the market. In these circumstances the effect of the new prior authorization criteria is to reduce expectations about medical inflation that would otherwise occur, rather than to change existing baseline expenditure assumptions.

The Department's decision on the Hepatitis C drug criteria had a fiscal impact several orders of magnitude larger than anything the Department had previously done; it increased costs rather than saved money; and it changed baseline assumptions rather than containing future medical inflation. What was considered acceptable executive branch practice when the Department was making changes to drug authorization criteria with relatively small fiscal impacts to save money may not apply to the Hepatitis C criteria change. The JBC staff believes the Department made an error in judgement in not consulting with the General Assembly before implementing a change with a fiscal impact of the magnitude of the Hepatitis C drug criteria change.

OPTIONS FOR THE JBC

It is important to note that the Department is not asking the JBC to vote to approve or deny the change to the Hepatitis C drug criteria. The change has already been implemented under the Department's authority to design drug utilization criteria. The Department is asking the JBC to approve funding based on the new forecast of Medicaid expenditures and the Department is explaining that the change to the Hepatitis C drug criteria is one of the factors influencing the higher forecast. A vote for the supplemental is not an endorsement of the Department's Hepatitis C criteria, but it does acknowledge that the Department made this change within their authority and that the change has budget consequences.

Since the Department acted within its authority in approving the change, the JBC staff recommendation treats the Department's decision to expand the Hepatitis C drug criteria as a must pay bill. However, as noted above, the JBC staff has concerns about the lack of consultation with the General Assembly for a decision of this magnitude, and about the best process to use for decisions like this one.

If the JBC wants to send a message to the Department to revert to the old Hepatitis C drug criteria, the JBC could choose not to fund that portion of the supplemental request. The JBC staff is not sure how the Department would respond. The Department has statutory authority to overexpend the Medicaid appropriation and doesn't necessarily need the General Assembly to approve a supplemental. The Department could continue its current Hepatitis C drug criteria, although that sort of brinksmanship and torching of relations with the JBC would not serve the Department well

in the long run. Also, the Governor's Office would likely have concerns if by continuing current policy the Department would cause the budget to be out of balance. If the JBC wanted to be more certain that the Department would revert to the old Hepatitis C drug criteria, a bill would be necessary.

If the JBC convinced the Department to revert to the old Hepatitis C drug criteria, whether through a budget action or a bill, it could put the state in an awkward position relative to the pending law suit. The plaintiffs in the law suit could call on experts from the Department to help argue that coverage to a fibrosis score of F2 is "medically necessary" and that the legislature chose not to fund that level of coverage.

The JBC staff does not recommend defunding the pharmaceutical budget or legislation aimed at getting the Department to change the Hepatitis C drug criteria. However, the JBC may want to discuss with the Department appropriate procedures for involving the legislature prior to a decision of the magnitude of the Hepatitis C criteria change in the future. Informing the legislature after the policy is implemented doesn't provide an opportunity for meaningful legislative input.

An informal consultation process might be better than spelling out procedures in law or a footnote. Based on prior interactions between the JBC and the Department, the JBC staff assumes that JBC members would not want to be consulted on every change to pharmacy criteria. Simply sending a notification to the JBC when changes to pharmacy criteria are being considered would be insufficient to generate meaningful participation, because the JBC is bombarded with too many responsibilities to attend meetings on pharmacy criteria that might or might not have a significant budgetary impact. The Department needs to curate the information for the JBC and let the JBC know when decisions with a significant budget impact are pending. Triggers could be put in statute or a footnote that require notification of the JBC based on the size or direction (positive or negative) of a the budgetary impact of a pharmacy criteria decision, but it is possible that medium or small changes to pharmacy criteria that are negative might be more controversial that large changes. The best approach might be to communicate to the Department that the JBC wants to be consulted on major prior authorization criteria decisions, but leave some discretion to the Department in identifying what is "major".

HANDLING OF DRUG AUTHORIZATION CRITERIA CHANGES IN THE BUDGET REQUEST

The Department has been inconsistent in the way it handles changes to drug authorization criteria with regard to the budget. In some years, the Department has not called attention to changes in drug authorization criteria, but has selected trend assumptions for the forecast that are influenced by the Department's ongoing efforts to contain prescription drug costs. In other instances, the Department has included changes to drug authorization criteria as a specifically identified adjustment within the forecast or as part of a decision item. The table below summarizes changes since 2008 that were identified as a specific adjustment in the budget request.

PHARMACY CHANGES IN BUDGET		
ITEM	BUDGET REQUEST	AMOUNT
Implement preferred drug list	FY 2008-09 S-9 Implement Preferred Drug List	($1,606,818)
Implementation of automatic PAR system and using state maximum allowable cost structure	FY 2009-10 BRI-1 Pharmacy Technical and Pricing Efficiencies	($2,133,886)
Add anti-convulsant pharmaceuticals to prior authorization requirements and/or preferred drug list	FY 2009-10 BA-33 Provider Volume and Rate Reductions	($960,000)
Reduction to Synagis recommended dosage	FY 2010-11 DI-1 Medical Services Premiums - Bottom Line Impact	($1,259,131)
Expand preferred drug list and subject more pharmacy expenditure to new or additional restrictions	FY 2010-11 ES-2 Medicaid Program Reductions	($5,558,030)
Increase review of prior authorizations for Synagis to ensure only appropriate dosages are utilized	FY 2012-13 R-6 Medicaid Budget Reductions	($419,772)
Implemented policies to prevent utilization of Seroquel for off label use	FY 2012-13 R-6 Medicaid Budget Reductions	($1,931,172)

From 2003 through 2015 the Department submitted an annual report[6] on drug utilization policies to the health committees of each chamber and the Joint Budget Committee, pursuant to Section 25.5-5-506(3)(b), C.R.S.:

> *(b) The state department shall report to the Health and Human Services Committees for the House of Representatives and the Senate, or any successor committees, and the Joint Budget Committee no later than December 1, 2003, and each December 1 thereafter, on plan utilization mechanisms that have been implemented or that will be implemented by the state department, the time frames for implementation, the expected savings associated with each utilization mechanism, and any other information deemed appropriate by the health and human services committees, or any successor committees, or the Joint Budget Committee.*

The Department did not submit a report in 2016 because H.B. 16-1081 (Representatives Ransom & Esgar/Senators Lundberg & Newell) eliminated the section of statute as an obsolete reporting requirement. The Department continues to submit publicly available annual reports to the federal government on drug utilization policies[7], although the federal reports provide significantly less detail than the old state reports.

The JBC staff does not have any specific recommended for handling changes to drug criteria in the budget process. The JBC could consider reinstating the reporting requirement, but a reporting requirement does not provide the General Assembly with an opportunity to influence prior authorization criteria before implementation.

EXECUTIVE PROCESS USED TO MAKE THE CHANGE

In making the change to the Hepatitis C drug criteria the Department indicates it followed established executive branch procedures. To comply with federal guidelines, the Department has a Pharmacy and Therapeutics (P&T) Committee that advises the Medical Director on the preferred drug list and a Drug Utilization Review (DUR) Board that advises the Medical Director on prior authorization criteria that limit coverage. The P&T Committee meets quarterly to review the safety and efficacy of products, to collect stakeholder input, and to provide recommendations to the Department. After the Department makes decisions about the preferred drug list the DUR Board uses the findings of the P&T Committee and additional stakeholder input to inform recommendations on prior authorization review criteria. The members of both of these advisory

[6] http://www.leg.state.co.us/library/reports.nsf/ReportsDoc.xsp?documentId=4BEB92A82861DADE872576CE006B6F5E

[7] https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/annual-reports/index.html

entities are appointed by the executive director of the Department. With the input of these advisory entities the Department's Medical Director, made a clinical-based decision to change the Hepatitis C drug criteria to cover treatment for a broader range of people. The Medical Services Board, with members appointed by the General Assembly and confirmed by the Senate, and the federal Centers for Medicare and Medicaid Services (CMS) had roles in approving the process the Department uses to develop prior authorization criteria, but neither is involved in specific changes to drug prior authorization criteria such as the change to the Hepatitis C criteria.

The JBC staff does not have any recommend changes to the executive process for approving drug criteria. The JBC could consider legislation to change the process the executive branch uses to approve pharmacy criteria to include elected officials, or people appointed or approved by the General Assembly.

OCCUPATIONAL AND PHYSICAL THERAPY LIMITS

The second policy change included in the Department's forecast that the JBC staff wants to highlight is a new annual limit of 12 hours per client on occupational and physical therapy rehabilitation services. The limit is a hard cap for adults. Children may receive additional hours with prior authorization. Adults eligible through the Affordable Care Act may receive an additional 12 hours of habilitative services on top of rehabilitative services per year pursuant to federal law. According to CMS, habilitative services help people attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The OT/PT rehabilitative service limit was a policy change approved by the General Assembly and the Centers for Medicare and Medicaid Services (CMS) in FY 2011-12, but information technology issues prevented the Department from implementing it until FY 2016-17. Overall the policy is projected to save $2.2 million, but in FY 2016-17 it is expected to cost $2.4 million General Fund as the Department repays the federal government for years where it allowed overutilization of PT and OT in violation of the Department's coverage plan. In future years the policy is expected to save roughly $500,000 General Fund each year.

Advocates argue that there should be exceptions to the limit, with prior authorization, for special circumstances, like a client with two events that require rehabilitation in one year. According to the Department, that was essentially the policy prior to the hard cap, except that there were separate limits for physical and occupational therapy of 6 hours each. Therefore, if the Department were to allow prior authorization of exceptions to the cap, the Department assumes all of the savings would go away. The estimated cost would be $2,321,083 total funds, including $468,510 General Fund, in FY 2017-18. The Department would need to submit a State Plan Amendment to CMS for approval, and so the JBC staff assumes there would be no change in policy in FY 2016-17. Reversing direction on the cap going forward would not change the repayment due to the federal government for the years when the Department paid for hours of service in excess of the coverage defined in the state plan.

S3 CHILDREN'S BASIC HEALTH PLAN

	REQUEST	RECOMMENDATION
TOTAL	**$15,610,893**	**$15,610,893**
General Fund	1,515	1,515
Cash Funds	1,914,824	1,914,824
Federal Funds	13,694,554	13,694,554

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.

DEPARTMENT REQUEST: The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2016-17 appropriation incorporated trend data through December 2015 while the latest forecast used for this supplemental request incorporates data through June 2016. The Department will submit a new forecast in February that uses data through December 2016. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The FY 2016-17 revised projection of expenditures is $15.6 million, or 11.0 percent, higher than the appropriation in total. The revised projection of General Fund is $1,515 million, or 0.7 percent, higher than the appropriation.

In addition to the change for the new forecast of medical and dental costs, the request includes an update of fund sources for the administration of the program.

The Children's Basic Health Plan pays for physical health services for eligible children and pregnant women and for dental services for children.

STAFF RECOMMENDATION: Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law. If the February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

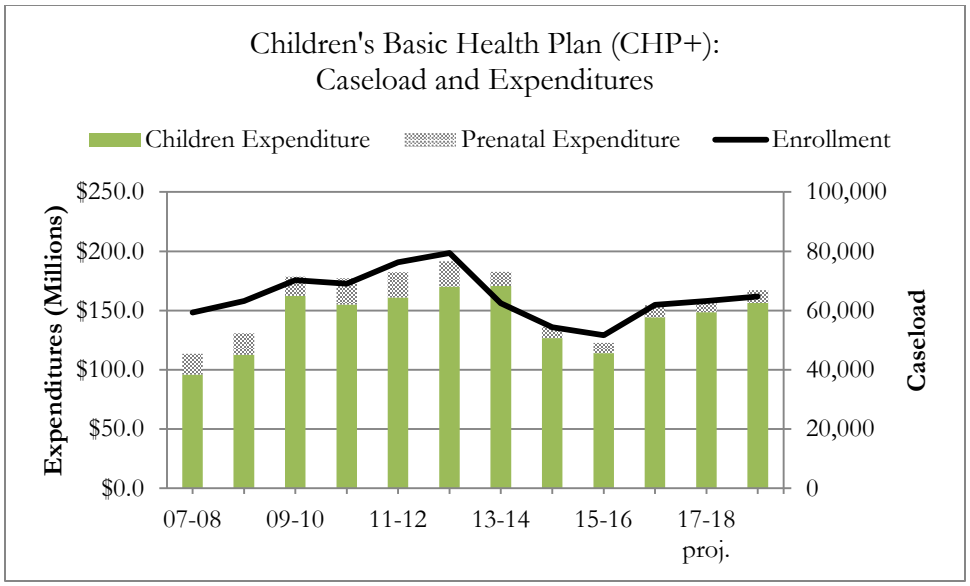
The increase in the forecast is due to both caseload trending higher than expected and final capitation rates being higher than expected. The revised caseload projection is partly due to correcting a system issue that caused the Department to under forecast enrollment. The change in capitation rates is mostly due to higher prescription drug costs than expected. CHP+ is financed with 88 percent federal funds and the increase in the state share of costs is being shouldered by the CHP+ Trust Fund that receives an annual allocation from tobacco settlement moneys. The small increase in General Fund is due to a change in the estimated repayment of a federal disallowance from prior years.

The tables and chart below summarize caseload and expenditures for the CHP+ program in recent years. The table of expenditures does not include payments for disallowances, so the total will be not match the appropriation by the amount of the disallowance payments.

Enrollment				
	Children	Prenatal	TOTAL	% Change
FY 07-08	$57,796	$1,571	$59,367	
FY 08-09	61,582	1,665	63,247	6.5%
FY 09-10	68,725	1,561	70,286	11.1%
FY 10-11	67,266	1,742	69,008	-1.8%
FY 11-12	74,266	2,064	76,330	10.6%
FY 12-13	77,835	1,611	79,446	4.1%
FY 13-14	61,554	953	62,507	-21.3%
FY 14-15	53,699	687	54,386	-13.0%
FY 15-16	51,041	668	51,709	-4.9%
FY 16-17 proj.	61,119	833	61,952	19.8%
FY 17-18 proj.	62,422	835	63,257	2.1%
FY 18-19 proj.	63,899	834	64,733	2.3%

Expenditures				
	Children	Prenatal	TOTAL	% Change
FY 07-08	$96,038,557	$17,361,986	$113,400,543	
FY 08-09	112,599,454	18,086,904	130,686,358	15.2%
FY 09-10	162,471,143	16,023,878	178,495,021	36.6%
FY 10-11	155,207,326	22,076,574	177,283,899	-0.7%
FY 11-12	161,043,047	21,411,076	182,454,123	2.9%
FY 12-13	170,136,500	21,433,958	191,570,458	5.0%
FY 13-14	170,744,026	12,009,028	182,753,054	-4.6%
FY 14-15	126,621,571	9,580,452	136,202,023	-25.5%
FY 15-16	114,115,567	8,544,303	122,659,870	-9.9%
FY 16-17 proj.	144,208,767	10,355,214	154,563,981	26.0%
FY 17-18 proj.	148,717,620	10,625,810	159,343,430	3.1%
FY 18-19 proj.	156,446,006	10,800,857	167,246,863	5.0%

Per Capita Expenditures				
	Children	Prenatal	TOTAL	% Change
FY 07-08	$1,662	$11,052	$1,910	
FY 08-09	1,828	10,863	2,066	8.2%
FY 09-10	2,364	10,265	2,540	22.9%
FY 10-11	2,307	12,673	2,569	1.2%
FY 11-12	2,168	10,374	2,390	-7.0%
FY 12-13	2,186	13,305	2,411	0.9%
FY 13-14	2,774	12,601	2,924	21.2%
FY 14-15	2,358	13,945	2,504	-14.3%
FY 15-16	2,236	12,791	2,372	-5.3%
FY 16-17 proj.	2,359	12,431	2,495	5.2%
FY 17-18 proj.	2,382	12,726	2,519	1.0%
FY 18-19 proj.	2,448	12,951	2,584	2.6%



S4 MEDICARE MODERNIZATION ACT

	REQUEST	RECOMMENDATION
TOTAL	**$1,369,323**	**$1,369,323**
General Fund	1,369,323	1,369,323

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.

DEPARTMENT REQUEST: The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2016-17 appropriation incorporated trend data through December 2015 while the latest forecast used for this supplemental request incorporates data through June 2016. The Department will submit a new forecast in February that uses data through December 2016.

The FY 2016-17 revised projection of expenditures is $1.4 million General Fund, or 1.0 percent, higher than the appropriation.

The Medicare Modernization Act line item reimburses the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This is a 100 percent state obligation and there is no federal match. However, in some prior years the General Assembly applied federal bonus

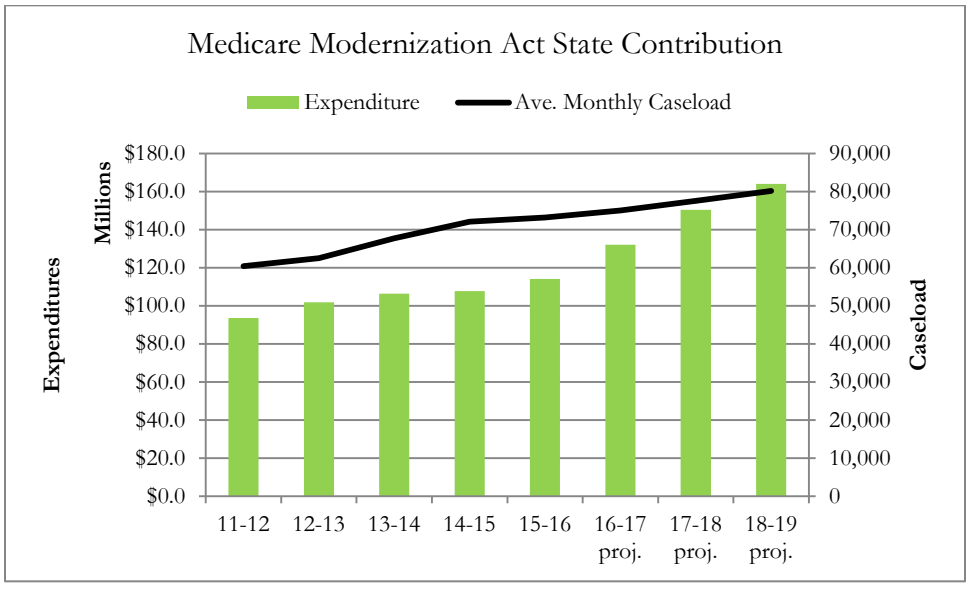
payments received for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

STAFF RECOMMENDATION: Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. The is an obligation to the federal government that is calculated based on a federal formula and over which the General Assembly has no control. If the February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The federal formula takes into account the annual percentage increase in average per capita Medicare drug expenditures. Recent increases in per capita Medicare drug expenditures were unusually high due to the availability of several new classifications of prescription drugs, including a new high cost drug treatment for Hepatitis C. The double digit percentage increases in expenditures for the Medicare Modernization Act projected for FY 2016-17 and FY 2017-18 are primarily attributable to this large increase in Medicare prescription drug costs. This supplemental is making a relatively minor adjustment to the overall projected increase for FY 2016-17 based on more recent information about enrollment and expenditures.

The table and chart below summarize recent expenditures for the Medicare Modernization Act. The Department expects the rate of growth to regress somewhat toward the mean in coming years.

Medicare Modernization Act					
Fiscal Year	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	Total Change	Percent Change
FY 2011-12	$93,582,494	$62,939,212	$30,643,282		
FY 2012-13	101,817,855	52,136,848	49,681,007	8,235,361	8.8%
FY 2013-14	106,376,992	68,306,130	38,070,862	4,559,137	4.5%
FY 2014-15	107,620,224	107,190,799	429,425	1,243,232	1.2%
FY 2015-16	114,014,334	114,014,334	0	6,394,110	5.9%
FY 2016-17 proj.	132,037,056	132,037,056	0	18,022,722	15.8%
FY 2017-18 proj.	150,341,733	150,341,733	0	18,304,677	13.9%
FY 2018-19 proj.	163,907,186	163,907,186	0	13,565,453	9.0%



S6 DELIVERY SYSTEM AND PAYMENT REFORM

	REQUEST	RECOMMENDATION
TOTAL	**($15,440,295)**	**($15,440,295)**
General Fund	(7,720,148)	(7,720,148)
Federal Funds	(7,720,147)	(7,720,147)

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of a technical error in calculating the original appropriation. The Department made a cost neutral change to the way it pays hospitals, but the Department's budget staff initially overlooked how the change shifts some payments from one fiscal year to the next, resulting in a short-duration savings.

DEPARTMENT REQUEST: The Department requests an adjustment to account for a change in the timing of hospital outpatient payments. Total payments to the hospitals will not change. The old hospital reimbursement method generated a significant initial overpayment that was corrected through reconciliations that sometimes took as long as four to five years to complete. The new reimbursement method generates an initial payment that is much closer to the correct rate from the start, so that going forward the Department expects reconciliations to decrease. However, in the short term the Department is still receiving reconciliations for payments in prior years at the old inflated initial payments, resulting in a short-duration savings over the next few years until those reconciliations are all resolved. This savings is accounted for in *R6 Delivery system and payment reform* and partially offsets the General Fund cost in that request of continuing the primary care rate bump.

STAFF RECOMMENDATION: Staff recommends approval of the request. The change in hospital payments has already been implemented so this savings will occur. The savings was not accounted for in last year's expenditure forecast due to an oversight. This supplemental corrects for that oversight.

To be consistent with the Department's request, the JBC has presented this issue separately from the forecast adjustment to Medical Services Premiums in S1, but for presentation to the rest of the General Assembly the JBC staff will combine it with forecast adjustment.

S7 OVERSIGHT OF STATE RESOURCES

	REQUEST	RECOMMENDATION
TOTAL	**$200,000**	**$200,000**
General Fund	50,000	50,000
Cash Funds	50,000	50,000
Federal Funds	100,000	100,000

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of data that was not available with the original appropriation was made.

DEPARTMENT REQUEST: The Department requests funding for the electronic verification of assets and for resources to help with the development of the Hospital Provider Fee model. These are part of a larger package of initiatives requested by the Department in R7 that all relate to the oversight of state resources. These two components of the package the Department would like to begin in FY 2016-17.

Federal regulations adopted in 2008 required states to implement a system for the electronic verification of assets for aged, blind, and disabled applicants for Medicaid. The current asset verification process in Colorado is paper-based and manual. Although the federal requirement for an electronic asset verification program was put in place in 2008, the Department indicates that states encountered initial technical difficulties, and the federal Centers for Medicare and Medicaid Services (CMS) directed all states to prioritize changes to eligibility procedures necessary to implement the Affordable Care Act. In June 2016 the Department received a letter from CMS indicating that Colorado was one of several states that had not made a good faith effort to comply with the federal regulation and without action from Colorado CMS would implement a corrective plan and could reduce federal financial participation. To avoid a federal corrective plan, the Department requests funding to hire a contractor to design a system, integrate it with the Department's existing enrollment processing systems, and begin enrolling financial institutions. The Department expects the system to be fully operational by January 2018 and ongoing annual electronic verification costs would be $858,366 total funds, including $429,183 General Fund.

The Department indicates inadequate funding from the Hospital Provider Fee is preventing the Department from hiring a qualified contractor to score hospital performance for the Hospital Quality Incentive Payments (HQIP) program. The HQIP program is authorized in statute and is one of the allowable distribution methods for the Hospital Provider Fee. Up to 7 percent of the Hospital Provider Fee is distributed through the HQIP program each year. The department currently has $50,000 per year for a contractor to gather and validate the HQIP performance data and calculate the associated payments, but there have been numerous scoring errors requiring correction by the Department's staff and causing delays in payments to hospitals. To correct this problem the Department requests an additional $100,000 total funds, including $50,000 cash funds from the Hospital Provider Fee, to procure a more qualified contractor. In R7 the Department requests some additional FY 2017-18 resources for the Hospital Provider Fee program beyond the amount for the HQIP contractor, but those FY 2017-18 resources are severable from the supplemental request, and so the JBC staff will address them during figure setting. Approving the supplemental would not

change the projected revenue from the Hospital Provider Fee, or any associated TABOR refund, because the revenue projection is based on available room under the federal Upper Payment Limit for hospitals. If the supplemental is approved, it will increase the portion of the Hospital Provider Fee spent on administration and decrease the amount available for distribution to hospitals. According to the Department, the hospitals are aware of the request and supportive of it.

The tale below summarizes the two components of the Department's request.

S7 Oversight of State Resources			
	FY 16-17	FY 17-18	FY 18-19
Electronic verification of assets			
Project Planning	14,400	0	0
Integration with State Systems	59,680	100,000	0
Enroll Financial Institutions	25,920	0	0
Verification Costs - Ongoing	0	429,183	858,366
Subtotal - Electronic verification	*100,000*	*529,183*	*858,366*
Hospital Quality Improvement Payments	100,000	100,000	100,000
TOTAL	**$200,000**	**$629,183**	**958,366**
General Fund	50,000	264,591	429,183
Hospital Provider Fee	50,000	50,000	50,000
Federal Funds	100,000	314,592	479,183

STAFF RECOMMENDATION: Staff recommends that the Committee approve the request. The electronic verification of assets is required to comply with federal regulation and for most applicants it will simplify the application process and improve the experience of the applicants. The CMS threat to implement corrective action is new information justifying supplemental action. The current funding for the Hospital Quality Improvement Payments (HQIP) program is proving inadequate to hire a qualified contractor. The failure of the current contractor is new information that must be addressed to continue the HQIP program, and so the JBC staff is convinced it is reasonable for a supplemental, although the JBC staff suspects the Department could muddle through on a short-term basis if necessary.

S8 MMIS OPERATIONS

	REQUEST	RECOMMENDATION
TOTAL	**($1,495,480)**	**$0**
General Fund	(32,549)	0
Cash Funds	(537,805)	0
Reappropriated Funds	(269,394)	0
Federal Funds	(655,732)	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of unforeseen contingencies.

DEPARTMENT REQUEST: The Department requests changes to the multi-year reprocurement of the Medicaid Management Information System (MMIS) project to account for a delay in implementation, changes in estimated costs for certain components, new federally required features, and revised estimates of fund sources and federal financial participation levels. The table below summarizes projected changes by fiscal year. In FY 2017-18 and on-going total estimated expenditures are higher, but the General Fund share of costs is lower.

S1/R1 MMIS Operations				
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Total	($1,495,480)	$23,524,339	$5,707,012	5,707,012
FTE	0.0	1.8	2.0	2.0
General Fund	(32,549)	(566,430)	(1,641,310)	(1,656,576)
Cash Funds	(537,805)	2,953,578	2,253,604	2,286,321
Reappropriated Funds	(269,394)	(275,978)	(281,168)	(281,146)
Federal Funds	(655,732)	21,413,169	5,375,886	5,358,413

The implementation of the MMIS was originally scheduled for October 31, 2016, but has been postponed four months to March 1, 2017. Provider enrollment and revalidation has taken longer than originally expected and provider training has been delayed. In addition, the Department was concerned that testing was insufficient to assure that the launch would be free of major errors that could result in improper or delayed payments. Part of the request is to extend the time the Department is paying for the old systems as well as development of the new system. The delay also shifts expenses for some development activities that were expected to occur after the go live date from FY 2016-17 into FY 2017-18.

Part of the request is to move money between line items. The Department received direction from CMS that some contract services will be financed at a 50 percent federal match rate, rather than the 90 percent federal match rate assumed in the original plan. This caused the Department to reevaluate the need for contract services and reduce planned utilization for these activities to stay within the total General Fund. At the same time, revised projections indicate costs for commercial off-the-shelf software products that receive a 75 percent federal match are lower than originally anticipated, but system development costs that receive a 90 percent federal match rate are higher than expected. This causes changes in the estimated costs by both line item and fund source. Also, the MMIS will take over some functions previously performed by contractors financed through other line items, and so the Department is requesting a budget true up to match the services provided by different contractors.

The request includes several changes in assumed match rates. The Department's updated funds source estimates are influenced by an increase in the federal financial participation rate for the Children's Basic Health Plan, higher enrollment from populations financed with the Hospital Provider Fee, and lower enrollment from populations financed with the Old Age Pension Health and Medical Care Program.

Some of the request is for necessary functions that were not anticipated in the original design. Federal law limits copays by a Medicaid household to 5 percent of the family's monthly income and the Department is required to provide a variety of notifications to clients regarding copays. The Department's current MMIS does not address these requirements, but the new system must perform these functions and the Department did not anticipate this cost.

STAFF RECOMMENDATION: Staff recommends delaying a decision on this supplemental request until figure setting. The supplemental and the request for FY 2017-18 are so integrated that it would be better to deal with them as a whole. Originally, the JBC staff anticipated tackling both the supplemental and the FY 2017-18 request during the supplemental presentation, but the JBC staff is still working with the Department to get clarification on some components of the request. The JBC staff has not identified any concerns or red flags with the request, but there are pieces of the request that the Department has not adequately explained. This is a very complex request with a lot of moving parts and the JBC staff hopes that with additional time and discussion with the Department the key components can be summarized succinctly to help the JBC make a good policy decision.

Delaying a decision should not negatively impact the Department. Overall for FY 2016-17 the Department expects expenditures to decrease. There are some important shifts in funding between line items and between fund sources that need to be authorized in a supplemental, but as long as these changes are authorized before the end of the fiscal year the Department's operations should not be impinged.

S12 SB 16-199 PACE ROLLFORWARD

	REQUEST	RECOMMENDATION
TOTAL	**$0**	**$0**
Cash Funds	0	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of an unforeseen contingency that the procurement process would delay a portion of expenditures into FY 2017-18.

DEPARTMENT REQUEST: The Department requests roll-forward authority of $225,000 cash funds donated to the Health Care Policy and Financing Cash Fund by providers of the Program for All-inclusive Care for the Elderly (PACE) to implement S.B. 16-199. The bill requires the Department, contingent on receiving sufficient donations, to develop an alternate payment method for providers of the PACE program. According to the Department, in the current method for determining PACE rates the trends in some of the key variables are expected to exert downward pressure on rates in coming years. The alternate payment method required by the bill must feature specific characteristics described in the bill. Nothing in the bill requires the Department to implement the alternate payment method. The process of procuring an actuary to help develop the new payment methodology took longer than the Department expected, and so the Department now anticipates that some of the expenditures will occur in FY 2017-18, rather than FY 2016-17.

STAFF RECOMMENDATION: Staff recommends approval of the request. The Department is proceeding with the work as required by S.B. 16-199 and the total estimated cost has not changed, but an unknown portion of the payments are now expected to occur in FY 2017-18 rather than FY

2016-17. The requested roll-forward authority will allow the Department to spend the already appropriated cash funds when the bills for contractual services are due.

S13 CONNECT FOR HEALTH COLORADO

	REQUEST	RECOMMENDATION
TOTAL	**$5,144,208**	**$0**
General Fund	1,790,457	0
Federal Funds	3,353,751	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **NO**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: The Department argues that the request is the result of new information about an agreement in principal with the federal Centers for Medicare and Medicaid Services for how application assistance activities of Connect for Health Colorado could be reimbursed by Medicaid and CHP+, but the JBC staff believes the potential for an agreement with CMS was known when the bill authorizing Connect for Health Colorado was passed, and so this is not new information.

DEPARTMENT REQUEST: The Department requests funding to reimburse Connect for Health Colorado (C4HCO) for activities related to determining eligibility for Medicaid and the Children's Basic Health Plan (CHP+). In order to qualify for an income-based federal tax credit to help pay for health insurance purchased through C4HCO, an applicant must first be determined ineligible for Medicaid or CHP+. To minimize duplicate data entry, C4HCO and the Department electronically share information about applicants that is relevant to both the determination of eligibility for tax credits and the determination of eligibility for Medicaid and CHP+. In addition, C4HCO provides assistance to people in completing their Medicaid and CHP+ applications, from answering technical assistance calls to in-person meetings at a computer to guide the applicant through the on-line process. The electronic sharing of information and the application assistance activities are potentially eligible for federal matching funds, but to receive federal funding there must be a cost allocation plan approved by the federal Centers for Medicare and Medicaid Services (CMS) that calculates the portion of C4HCO's activities that are attributable to Medicaid and CHP+ eligibility determinations.

The Department did not request funding through the regular budget process because initially C4HCO did not have the necessary time tracking procedures in place to claim federal matching funds. As C4HCO has worked to develop appropriate time tracking procedures, the Department has been communicating with CMS on potential cost allocation plans. In the Fall of 2016 the Department received communication from CMS that the general framework of a draft cost allocation plan submitted by the Department was acceptable. If the Department can get funding from the General Assembly for the state match, the Department anticipates CMS will approve a final cost allocation plan by March 31, 2017, that would allow the Department to reimburse C4HCO for eligibility determination activities retroactive to the beginning of FY 2016-17. If the Department does not receive funding from the General Assembly, it will withdraw the request for approval of the cost allocation plan.

The estimated portion of C4HCO activities eligible for reimbursement from Medicaid and CHP+ is based on a random moment time sample and the Department emphasizes that the point in time used for this supplemental request was not during an open enrollment period. It is possible that eligible activities by C4HCO during open enrollment might be different, and that the proportion of eligible activities may evolve over time as the health exchange matures and patterns of use stabilize.

Based on the random moment time sample, the Department estimates that approximately 12.9 percent of C4HCO's overall expenditures are attributable to eligibility determinations activities that are reimbursable through Medicaid and CHP+. Of the 94,932 applications processed by C4HCO in the first six months of FY 2016-17 (July-December), 7,933 were eligible for Medicaid or CHP+. The Department's cost allocation methodology estimates 25 percent of C4HCO's call volume is attributable to Medicaid and CHP+. Applying that estimate to the 489,862 calls C4HCO received in calendar year 2016 suggests C4HCO handles approximately 122,466 calls per year related to Medicaid and CHP+.

STAFF RECOMMENDATION: Staff does not recommend approval of the request because (1) there is a statutory prohibition on the use of General Fund for the activities of C4HCO and (2) because the request does not meet the JBC's supplemental criteria. It appears that denying the request would have no negative effect on the application assistance services available to Medicaid and CHP+ applicants. It is mutually beneficial for C4HCO and for Medicaid and CHP+ when C4HCO provides application assistance services. Also, when C4HCO begins helping people it is unknown if the assistance C4HCO provides will be reimbursable by Medicaid or CHP+ until an eligibility determination is made and so, as a practical matter, C4HCO could not prescreen people and refuse to help Medicaid and CHP+ clients due to a lack of financing from the state, even if it wanted that outcome. According to the Department, if the request is not financed, "C4HCO would continue to inappropriately absorb these costs within its existing revenue."

Since C4HCO would continue providing application assistance services for Medicaid and CHP+ clients, the consequence of not funding the supplemental request would be that C4HCO's fees to insurance agencies would need to remain high enough to cover application assistance costs. There would be no relief from the General Fund and federal funds that might otherwise put downward pressure on C4HCO's fees. Since C4HCO is already providing and paying for the application assistance services from the fees, a denial of this supplemental request would not be the cause of any increase in C4HCO fees.

STATUTORY PROHIBITION ON GENERAL FUND FOR C4HCO

Part of the reason the JBC staff recommends denying the request is that the bill[8] that created C4HCO specifically stated, "Moneys form the general fund shall not be used for the implementation of this article".[9] The intent of the prohibition appears clear that C4HCO be self-sufficient from the fees it raises, and the supplemental request runs counter to that goal.

The Department addressed the General Fund prohibition in the request and argued that other federal and state statutes allow the Department to pay for medical assistance programs, including eligibility determination services, and to use the General Fund for that purpose. The Department argues that under federal law it is the single state agency responsible for completing eligibility

[8] S.B. 11-200 (Boyd/Stephens)

[9] Section 10-22-108, C.R.S.

determinations, that pursuant to Section 25.5-1-120(2) it may use General Fund for the cost of administering medical assistance programs, and that pursuant to Section 25.5-4-106 the Department is responsible for administering the delivery of medical assistance by counties or any other public or private entities. The Department says it received informal guidance from the Attorney General's Office that the Department has authority to pay C4HCO for costs of administering the Medicaid program, and that these costs are not for the "implementation" of the health care exchange.

However, Legislative Legal Services (LLS), without taking a formal position, indicated to the JBC staff that the prohibition on using General Fund is problematic for funding the supplemental request. The prohibition is both more recent and more specific than the statutory authority cited by the Department. The language is not convoluted or suggestive of ambiguity. The limitation on General Fund applies to the implementation of Article 22. There is no statutory authority for C4HCO to provide application assistance or otherwise administer the Medicaid program separate from the authority granted in Article 22. LLS advised that the best approach if the JBC wants to use General Fund for the requested purpose would be to sponsor legislation to either remove the prohibition or create an exception to it.

REQUEST DOES NOT MEET THE JBC'S SUPPLEMENTAL CRITERIA

Another reason the JBC staff recommends denying the request is that it does not meet the JBC's supplemental criteria. The Department argues that the request is the result of new information about the availability of matching federal funds for the eligibility determination activities of C4HCO, which would meet the JBC's supplemental criteria of either data that was not available when the original appropriation was made or an unforeseen contingency. However, when the bill creating C4HCO passed it was known that Medicaid and CHP+ could pay for eligibility determination services provided by third parties with approval from CMS, and that C4HCO would be engaging in eligibility determination activities related to Medicaid and CHP+, since applicants for tax credits through C4HCO have to demonstrate that they do not qualify for Medicaid or CHP+. Rather than assuming that the Department would pursue approval from CMS to pay C4HCO, the bill specifically prohibited the use of General Fund for C4HCO. The possibility of an agreement with CMS was known, though the general framework of an agreement was not in hand, and the General Assembly chose a different financing mechanism for C4HCO. The JBC staff is not seeing any new information in the request about potential financing options or changes in the work that needs to be done from what would have been considered when the bill was passed.

Financing eligible activities of C4HCO with Medicaid and CHP+ funds would leverage federal funding and reduce the need for fees from insurance providers. However, it creates a burden on the General Fund and comes at the expense of other state programs that need General Fund. The JBC staff assumes the General Assembly considered this trade off when passing the C4HCO authorizing legislation and intentionally decided that the appropriate source of revenue for C4HCO's activities was fees on insurance providers, rather than the General Fund.

S14 PUBLIC SCHOOL HEALTH SERVICES

	REQUEST	RECOMMENDATION
TOTAL	**$9,393,330**	**$9,393,330**
Cash Funds	4,754,691	4,754,691
Federal Funds	4,638,639	4,638,639

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of data that was not available with the original appropriation was made regarding certified public expenditures by local school districts and boards of cooperative education servies.

DEPARTMENT REQUEST: The Department requests funding based on a projected increase in certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES). Through the School Health Services Program school districts and BOCES are allowed to identify their expenses in support of Medicaid eligible children with an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP) and claim federal Medicaid matching funds for these costs. Participating school districts and BOCES report their expenses to the Department according to a federally-approved methodology and the Department submits them as certified public expenditures to claim the federal matching funds. The federal matching funds are then disbursed to the school districts and BOCES and may be used to offset their costs of providing services or to expand services for low-income, under or uninsured children and to improve coordination of care between school districts and health providers. Utilization of the program has increased dramatically in recent years due to a variety of factors, including outreach efforts, school districts and BOCES becoming more familiar and comfortable with the required reporting, the efforts of school districts and BOCES to maximize revenues from all sources to help address tight budgets, and increases in enrollment of children in Medicaid.

STAFF RECOMMENDATION: Staff recommends approval of the request. This request is driven by an increase in the amount of expenditures by school districts and BOCES that can be claimed for a federal match. The actual amount of certified public expenditures are not in the direct control of the Department, and the availability of data to forecast the expenditures is limited, so this is a line item that frequently receives mid-year adjustments. The Department needs this increase in spending authority to distribute the federal funds to the school districts. Approval of this request will not result in any increase in state expenditures.

S15 RELEASE OVER-EXPENDITURE RESTRICTIONS

	REQUEST (FY 2015-16)	RECOMMENDATION (FY 2015-16)
TOTAL	**$5,233,207**	**$11,542,129**
General Fund	405,525	405,525
Cash Funds	4,759,008	11,067,930
Rappropriated Funds	68,674	68,674
Federal Funds	0	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

[An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]

Explanation: JBC staff and the Department agree that this request is the result of **data that was not available** when the original appropriation was made regarding actual expenditures for Medicaid.

DEPARTMENT REQUEST: The Department requests the release of restrictions on the FY 2016-17 appropriations imposed by the State Controller due to over-expenditures in prior years. Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided with unlimited over-expenditure authority as long as the over-expenditures are consistent with the statutory provisions of the Medicaid program (Section 24-75-109, C.R.S.). However, the State Controller restricts the current fiscal year's appropriation until the General Assembly approves a supplemental for the prior year over-expenditure. This restriction allows the JBC an opportunity to review the reasons for over expenditures and to decide if the over-expenditures could have been avoided with better management of the appropriation or if the over-expenditures occurred as a result of an unforeseen event or forecast error.

The FY 2015-16 overexpenditures were primarily of cash funds with the largest overexpenditure for certified public expenditures by publicly financed hospitals. These are expenditures by local governments that can be claimed as part of the state match for Medicaid to draw additional federal funds. The overexpenditure is due to a forecast error where the Department did not accurately predict how much eligible local government expenditures would occur.

Mechanically, the release of the restrictions on the FY 2016-17 appropriations is accomplished by amending the FY 2015-16 appropriations.

STAFF RECOMMENDATION: Staff recommends releasing the overexpenditures, but the total cash funds change recommended by the JBC staff differs from the Department's request. This is because the Department requested some decreases in cash funds spending authority to match actual expenditures. These decreases are not necessary to release overexpenditure restrictions, and so staff is not recommending the requested decreases. The tables below summarize the release of overexpenditures by line item and fund source.

Recommended Changes to FY 15-16 to Release Over-expenditure Restrictions in FY 16-17					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Medical Services Premiums	$10,003,127	$0	$9,934,453	$68,674	$0
Behavioral Health Fee-for-service Payments	251,317	251,317	0	0	0
Children's Basic Health Plan Medical and Dental Costs	1,133,477	0	1,133,477	0	0
Medicare Modernization Act State Contribution Payment	154,208	154,208	0	0	0
TOTAL	**$11,542,129**	**$405,525**	**$11,067,930**	**$68,674**	**$0**

Cash and Reappropriated Fund Sources	
	TOTAL
Medical Services Premiums Cash Funds	$9,934,453
Breast and Cervical Cancer Treatment and Prevention Fund	105,237
Hospital Provider Fee Cash Fund	1,758,407
Nursing Facility Cash Fund	2,608,457
Certified Public Expenditure	5,462,352
Children's Basic Health Plan Cash Funds	
Recoveries	1,133,477
Medical Services Premiums Reappropriated Funds	
Old Age Pension Health and Medical Program	68,674

STATEWIDE COMMON POLICY SUPPLEMENTAL REQUESTS

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

DEPARTMENT'S PORTION OF STATEWIDE SUPPLEMENTAL REQUEST	TOTAL	GENERAL FUND	CASH FUNDS	REAPPROP. FUNDS	FEDERAL FUNDS
OIT CBMS	($1,242,884)	($2,123,226)	($827,880)	($35,666)	$1,743,888
DPA Fleet	(29,500)	(14,750)	0	0	(14,750)
Property Fund Supplemental	42,471	21,236	0	0	21,235
DEPARTMENT'S TOTAL STATEWIDE SUPPLEMENTAL REQUESTS	**($1,229,913)**	**($2,116,740)**	**($827,880)**	**($35,666)**	**$1,750,373**

STAFF RECOMMENDATION: The staff recommendation for these requests is pending Committee action on common policy supplementals. Staff asks permission to include the corresponding appropriations in the Department's supplemental bill when the Committee acts on common policy supplementals. If staff believes there is reason to deviate from the common policy, staff will appear before the Committee at a later date to present the relevant analysis.

Appendix A: Number Pages

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
S1 Medical Services Premiums					
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	6,839,289,152	6,818,264,595	141,694,902	141,694,902	6,959,959,497
General Fund	1,029,604,779	1,068,604,768	32,217,993	32,217,993	1,100,822,761
General Fund Exempt	809,024,467	873,835,000	0	0	873,835,000
Cash Funds	822,942,823	705,708,120	1,650,193	1,650,193	707,358,313
Reappropriated Funds	9,214,192	5,240,893	3,861,816	3,861,816	9,102,709
Federal Funds	4,168,502,891	4,164,875,814	103,964,900	103,964,900	4,268,840,714
Total for S1 Medical Services Premiums	6,839,289,152	6,818,264,595	141,694,902	141,694,902	6,959,959,497
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	1,029,604,779	1,068,604,768	32,217,993	32,217,993	1,100,822,761
General Fund Exempt	809,024,467	873,835,000	0	0	873,835,000
Cash Funds	822,942,823	705,708,120	1,650,193	1,650,193	707,358,313
Reappropriated Funds	9,214,192	5,240,893	3,861,816	3,861,816	9,102,709
Federal Funds	4,168,502,891	4,164,875,814	103,964,900	103,964,900	4,268,840,714

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S3 Childrens Basic Health Plan					
(4) INDIGENT CARE PROGRAM					
Children's Basic Health Plan Administration	1,771,063	5,033,274	0	0	5,033,274
General Fund	0	0	0	0	0
Cash Funds	231,115	2,363,824	(1,766,374)	(1,766,374)	597,450
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,539,948	2,669,450	1,766,374	1,766,374	4,435,824
Children's Basic Health Plan Medical and Dental Costs	126,415,423	141,455,044	15,610,893	15,610,893	157,065,937
General Fund	2,098,125	2,067,851	1,515	1,515	2,069,366
General Fund Exempt	427,593	432,590	0	0	432,590
Cash Funds	26,137,685	17,533,954	3,681,198	3,681,198	21,215,152
Reappropriated Funds	0	0	0	0	0
Federal Funds	97,752,020	121,420,649	11,928,180	11,928,180	133,348,829
Total for S3 Childrens Basic Health Plan	128,186,486	146,488,318	15,610,893	15,610,893	162,099,211
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	2,098,125	2,067,851	1,515	1,515	2,069,366
General Fund Exempt	427,593	432,590	0	0	432,590
Cash Funds	26,368,800	19,897,778	1,914,824	1,914,824	21,812,602
Reappropriated Funds	0	0	0	0	0
Federal Funds	99,291,968	124,090,099	13,694,554	13,694,554	137,784,653

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S4 Medicare Modernization Act					
(5) OTHER MEDICAL SERVICES					
Medicare Modernization Act State Contribution Payment	114,014,334	130,667,733	1,369,323	1,369,323	132,037,056
General Fund	114,014,334	130,667,733	1,369,323	1,369,323	132,037,056
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Total for S4 Medicare Modernization Act	114,014,334	130,667,733	1,369,323	1,369,323	132,037,056
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	114,014,334	130,667,733	1,369,323	1,369,323	132,037,056
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S6 Delivery system and payment reform					
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	6,839,289,152	6,818,264,595	(15,440,295)	(15,440,295)	6,802,824,300
General Fund	1,029,604,779	1,068,604,768	(7,720,148)	(7,720,148)	1,060,884,620
General Fund Exempt	809,024,467	873,835,000	0	0	873,835,000
Cash Funds	822,942,823	705,708,120	0	0	705,708,120
Reappropriated Funds	9,214,192	5,240,893	0	0	5,240,893
Federal Funds	4,168,502,891	4,164,875,814	(7,720,147)	(7,720,147)	4,157,155,667
Total for S6 Delivery system and payment reform	6,839,289,152	6,818,264,595	(15,440,295)	(15,440,295)	6,802,824,300
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	1,029,604,779	1,068,604,768	(7,720,148)	(7,720,148)	1,060,884,620
General Fund Exempt	809,024,467	873,835,000	0	0	873,835,000
Cash Funds	822,942,823	705,708,120	0	0	705,708,120
Reappropriated Funds	9,214,192	5,240,893	0	0	5,240,893
Federal Funds	4,168,502,891	4,164,875,814	(7,720,147)	(7,720,147)	4,157,155,667

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S7 Oversight of state resources					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
General Professional Services and Special Projects	7,993,989	7,200,237	200,000	200,000	7,400,237
General Fund	2,980,993	2,047,261	50,000	50,000	2,097,261
Cash Funds	731,075	1,527,500	50,000	50,000	1,577,500
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,281,921	3,625,476	100,000	100,000	3,725,476
Total for S7 Oversight of state resources	7,993,989	7,200,237	200,000	200,000	7,400,237
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	2,980,993	2,047,261	50,000	50,000	2,097,261
Cash Funds	731,075	1,527,500	50,000	50,000	1,577,500
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,281,921	3,625,476	100,000	100,000	3,725,476

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S8 MMIS Operations					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(C) Information Technology Contracts and Projects					
Medicaid Management Information System					
Maintenance and Projects	34,365,297	35,564,820	1,716,274	0	35,564,820
General Fund	6,823,650	7,211,028	1,267,940	0	7,211,028
Cash Funds	3,099,843	2,226,262	(306,876)	0	2,226,262
Reappropriated Funds	293,350	293,350	(279,984)	0	293,350
Federal Funds	24,148,454	25,834,180	1,035,194	0	25,834,180
MMIS Reprocurement Contracts	41,437,857	26,916,597	1,463,574	0	26,916,597
General Fund	4,164,679	2,615,317	(1,240,267)	0	2,615,317
Cash Funds	1,177,899	701,879	(193,865)	0	701,879
Reappropriated Funds	0	0	9,675	0	0
Federal Funds	36,095,279	23,599,401	2,888,031	0	23,599,401
MMIS Reprocurement Contracted Staff	4,448,524	5,145,018	(4,675,328)	0	5,145,018
General Fund	353,814	431,304	(60,222)	0	431,304
Cash Funds	131,360	134,757	(37,064)	0	134,757
Reappropriated Funds	0	0	915	0	0
Federal Funds	3,963,350	4,578,957	(4,578,957)	0	4,578,957
Total for S8 MMIS Operations	80,251,678	67,626,435	(1,495,480)	0	67,626,435
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	11,342,143	10,257,649	(32,549)	0	10,257,649
Cash Funds	4,409,102	3,062,898	(537,805)	0	3,062,898
Reappropriated Funds	293,350	293,350	(269,394)	0	293,350
Federal Funds	64,207,083	54,012,538	(655,732)	0	54,012,538

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S12 SB 16-19 PACE rollforward					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
General Professional Services and Special Projects	7,993,989	7,200,237	0	0	7,200,237
General Fund	2,980,993	2,047,261	0	0	2,047,261
Cash Funds	731,075	1,527,500	0	0	1,527,500
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,281,921	3,625,476	0	0	3,625,476
Total for S12 SB 16-19 PACE rollforward	7,993,989	7,200,237	0	0	7,200,237
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	2,980,993	2,047,261	0	0	2,047,261
Cash Funds	731,075	1,527,500	0	0	1,527,500
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,281,921	3,625,476	0	0	3,625,476

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S13 Connect for Health Colorado					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(C) Information Technology Contracts and Projects					
Connect for Health Colorado Systems	0	0	669,757	0	0
General Fund	0	0	122,690	0	0
Federal Funds	0	0	547,067	0	0
(1) EXECUTIVE DIRECTOR'S OFFICE					
(D) Eligibility Determinations and Client Services					
Connect for Health Colorado Eligibility Determination	0	0	4,474,451	0	0
General Fund	0	0	1,667,767	0	0
Federal Funds	0	0	2,806,684	0	0
Total for S13 Connect for Health Colorado	0	0	5,144,208	0	0
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	0	0	1,790,457	0	0
Federal Funds	0	0	3,353,751	0	0

	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2016-17 Requested Change	FY 2016-17 Rec'd Change	FY 2016-17 Total w/Rec'd Change
S14 Public School Health Services					
(5) OTHER MEDICAL SERVICES					
Public School Health Services	78,309,241	82,604,632	9,393,330	9,393,330	91,997,962
General Fund	0	0	0	0	0
Cash Funds	38,606,226	41,001,948	4,754,691	4,754,691	45,756,639
Reappropriated Funds	0	0	0	0	0
Federal Funds	39,703,015	41,602,684	4,638,639	4,638,639	46,241,323
Total for S14 Public School Health Services	78,309,241	82,604,632	9,393,330	9,393,330	91,997,962
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	0	0	0	0	0
Cash Funds	38,606,226	41,001,948	4,754,691	4,754,691	45,756,639
Reappropriated Funds	0	0	0	0	0
Federal Funds	39,703,015	41,602,684	4,638,639	4,638,639	46,241,323
Totals Excluding Pending Items HEALTH CARE POLICY AND FINANCING					
TOTALS for ALL Departmental line items	9,040,413,446	9,116,880,878	156,476,881	152,828,153	9,269,709,031
FTE	422.2	435.8	0 .0	0 .0	435.8
General Fund	1,695,354,249	1,780,126,624	27,676,591	25,918,683	1,806,045,307
General Fund Exempt	809,452,060	874,267,590	0	0	874,267,590
Cash Funds	1,143,004,065	1,012,485,521	7,831,903	8,369,708	1,020,855,229
Reappropriated Funds	13,493,510	12,406,599	3,592,422	3,861,816	16,268,415
Federal Funds	5,379,109,562	5,437,594,544	117,375,965	114,677,946	5,552,272,490