JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2017-18

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

PREPARED BY:
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DECEMBER 5, 2016

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CONTENTS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

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

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, administering grants such as the Primary Care and Preventive Care Grant Program, and housing the Commission on Family Medicine Residency Training Programs.

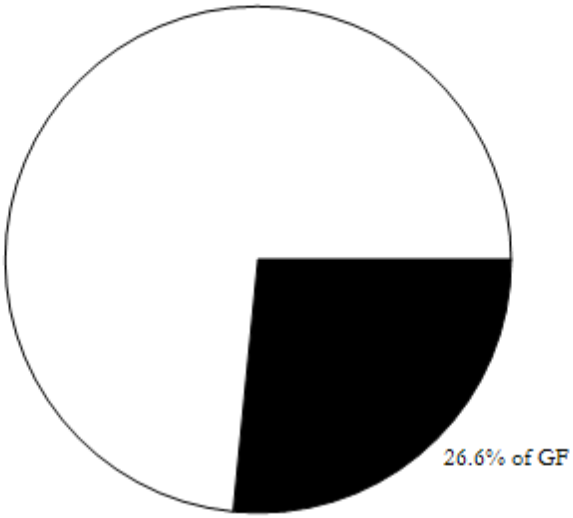
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

FUNDING SOURCE	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18*
General Fund	$2,352,933,836	$2,500,140,061	$2,654,394,214	$2,797,230,737
Cash Funds	902,103,342	1,156,297,382	1,012,485,521	1,020,139,119
Reappropriated Funds	6,104,791	17,003,651	12,406,599	16,069,145
Federal Funds	4,675,575,363	5,438,943,180	5,437,594,544	5,656,948,374
TOTAL FUNDS	**$7,936,717,332**	**$9,112,384,274**	**$9,116,880,878**	**$9,490,387,375**
Full Time Equiv. Staff	390.9	422.2	435.8	452.9

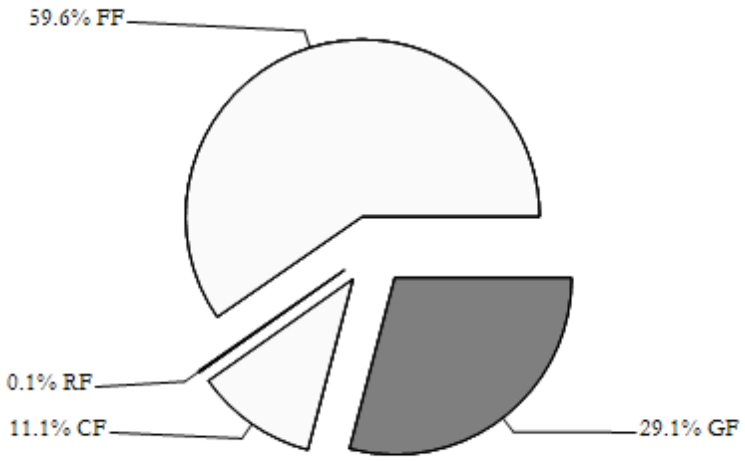
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

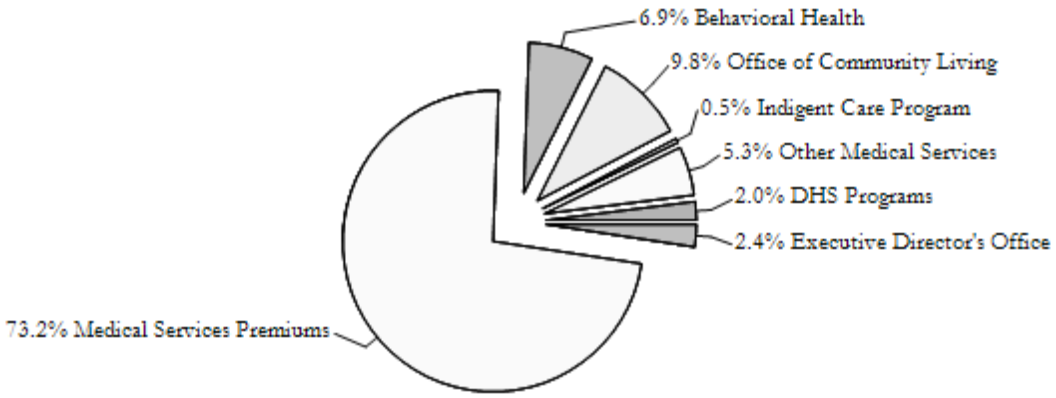


Department Funding Sources

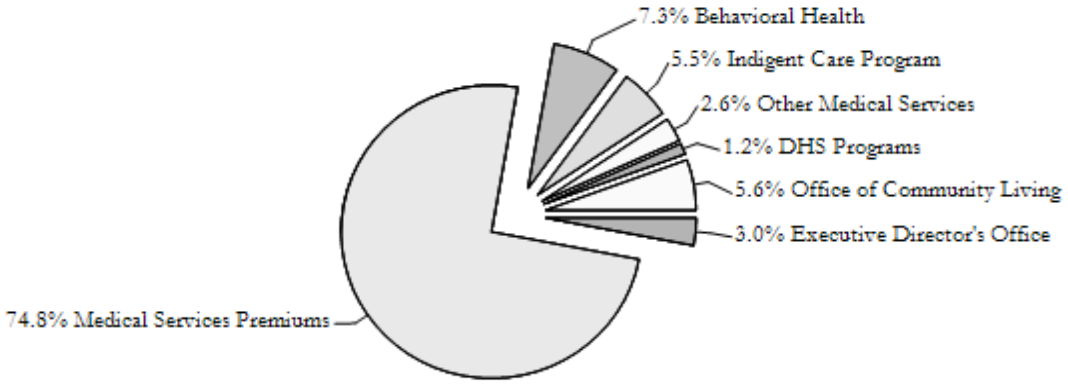


All charts are based on the FY 2016-17 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2016-17 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

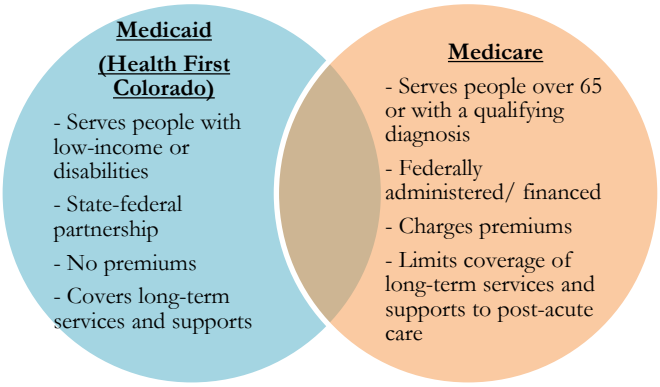
Funding for this department consists of 29.1 percent General Fund, 11.1 percent cash funds, 0.1 percent reappropriated funds, and 59.6 percent federal funds. The major sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) recoveries and recoupments; (4) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; (5) local government funds (certified public expenditures); and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

MEDICAID

Medicaid (marketed by the Department as Health First Colorado) provides health insurance to people with low income and to people needing long-term care. Participants generally do not pay annual premiums[1] and copayments at the time of service are either nominal or not required. The financing, administration, and policy-making responsibilities for the program are shared between the federal and state governments.

Medi**caid** should not be confused with the similarly named Medi**care** that provides insurance for people who are elderly or have a specific eligible diagnosis regardless of income. Medicare is federally administered and financed with a combination of federal funds and annual premiums charged to participants. While the two programs are distinct, they do interact with each other as some people are eligible for both Medicaid, due to their income, and Medicare, due to their age. For these people (called "dual eligible"), Medicaid pays the Medicare premiums and may assist with copayments, depending on the person's income. Also, there are some differences in the coverage provided by Medicaid and Medicare. Most notably from a budgeting perspective, Medicaid covers long-term services and supports (LTSS) while Medicare coverage for LTSS is limited to post-acute care.

[1] The exception where participants would pay a premium is the voluntary "buy-in" program for people with disabilities whose income is above the standard Medicaid eligibility criteria but below 400 percent of the federal poverty guidelines.



The federal government matches state expenditures for the Medicaid program. The federal match rate, called the Federal Medical Assistance Percentage (FMAP), can vary based on economic conditions in the state, the type of services being provided, and the population receiving services. For state fiscal year 2016-17 the average FMAP for the majority of Colorado Medicaid expenditures is 50.2 percent. For adults "newly eligible" pursuant to the federal Affordable Care Act, Colorado will receive a 100 percent federal match in calendar year 2016 and a 95 percent federal match for calendar year 2017, and the federal match is scheduled to step down in increments annually until it reaches 90 percent in calendar year 2020.

Standard Medicaid Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 13-14	50.00	50.00	50.00	50.00	50.00
FY 14-15	50.76	50.00	51.01	51.01	51.01
FY 15-16	50.79	51.01	50.72	50.72	50.72
FY 16-17	50.20	50.72	50.02	50.02	50.02
FY 17-18	*50.00*	50.02	*50.00*	*50.00*	*50.00*
FY 18-19	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*

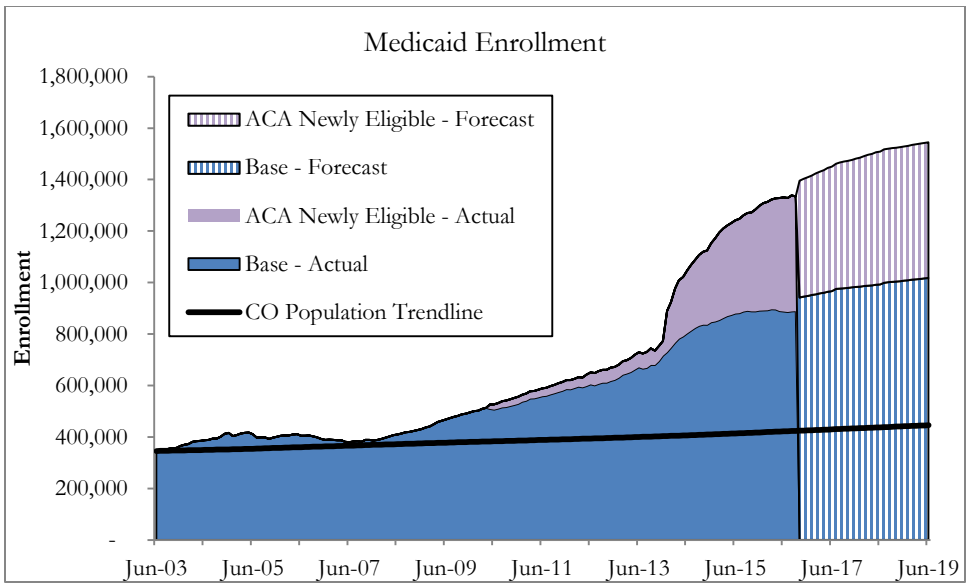
Italicized figures are projections.

ACA "Newly Eligible" Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 14-15	NA	NA	NA	100.00	100.00
FY 15-16	100.00	100.00	100.00	100.00	100.00
FY 16-17	97.50	100.00	100.00	95.00	95.00
FY 17-18	94.50	95.00	95.00	94.00	94.00
FY 18-19	93.50	94.00	94.00	93.00	93.00
FY 19-20	91.50	93.00	93.00	90.00	90.00
FY 20-21	90.00	90.00	90.00	90.00	90.00

Medicaid generally operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits. As a result, if the eligible population and/or the eligible services utilized are greater than expected, then the state and federal government must pay the resulting higher cost, regardless of the initial appropriation. There are exceptions where federal waivers allow enrollment and/or expenditure caps for expansion populations and services. In the event that the

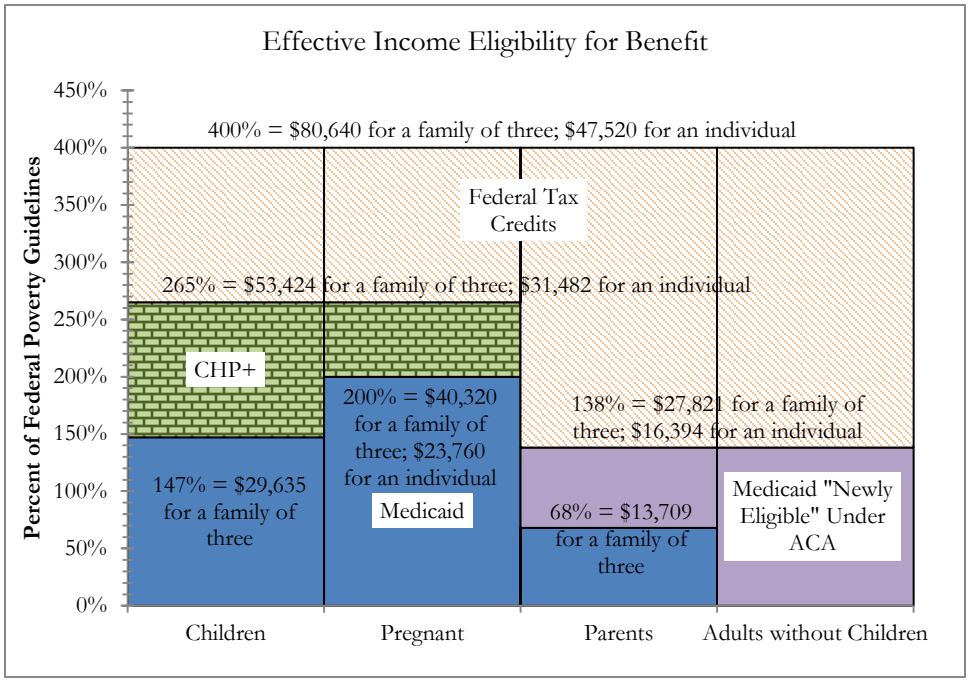
State's Medicaid obligation is greater than anticipated, the Department has statutory authority to overexpend the Medicaid appropriation.[2]

The most significant factor affecting Medicaid expenditures is enrollment. Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. The following chart shows the actual and forecasted Colorado Medicaid population. The chart highlights the population that is "newly eligible" pursuant to the federal Affordable Care Act and therefore qualifies for the enhanced federal match. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 2003.



The next tables summarize the effective income eligibility criteria for Medicaid and other publicly-financed health care programs for people with low income. The eligibility for these programs is usually expressed as a percentage of the federal poverty level (FPL) guidelines, but some populations qualify based on other criteria, such as their eligibility for federal supplemental security income (SSI). The effective income eligibility criteria listed in the next table will be higher than the thresholds listed in state statute due to the way the federally mandated formula for calculating eligibility disregards some sources of income.

[2] See Section 24-75-109 (1) (a), C. R. S.



Special Medicaid Eligibility Categories	
Category	Eligibility Standard
Adults 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities (not otherwise qualified)	450% FPL = may "buy in" to Medicaid with premiums on a sliding scale based on income
Nursing home level of care	300% of SSI income threshold
Breast or cervical cancer	250% of FPL
Former foster children	To age 26 regardless of income
Non-citizens	If otherwise qualified for Medicaid = emergency services only

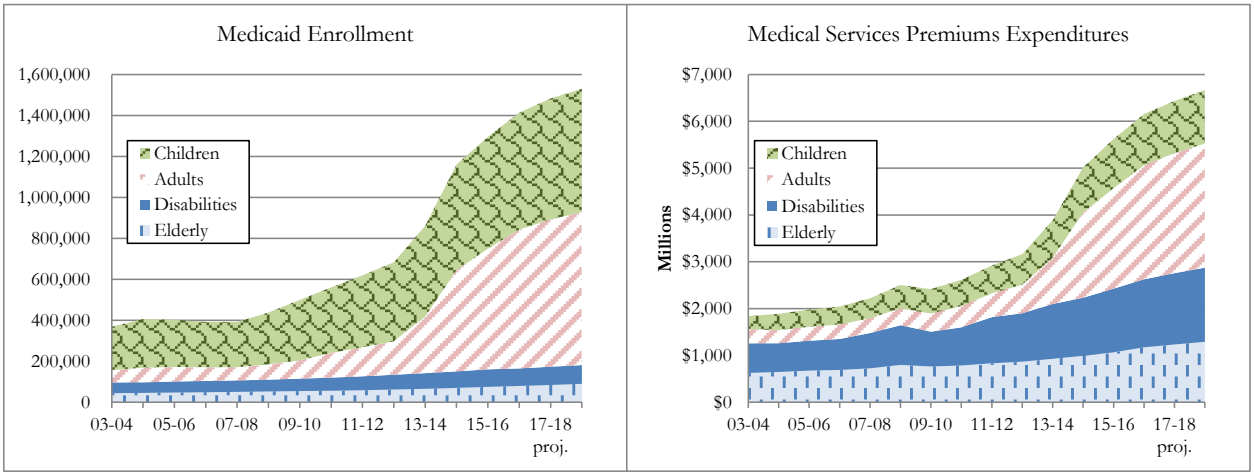
Family Size	Federal Poverty Guideline - 2017	SSI Annual Income Limit
1	$11,880	$8,820
2	$16,020	$13,236
3	$20,160	
4	$24,300	
More	add $4,140 each	

Appropriations for Medicaid are divided into six main components, not including administration: (1) Medical Services Premiums; (2) Behavioral Health Community Programs; (3) the Office of Community Living; (4) the Indigent Care Program; (5) the Medicare Modernization Act State Contribution; and (6) programs administered by other departments. Each of these is discussed in more detail below.

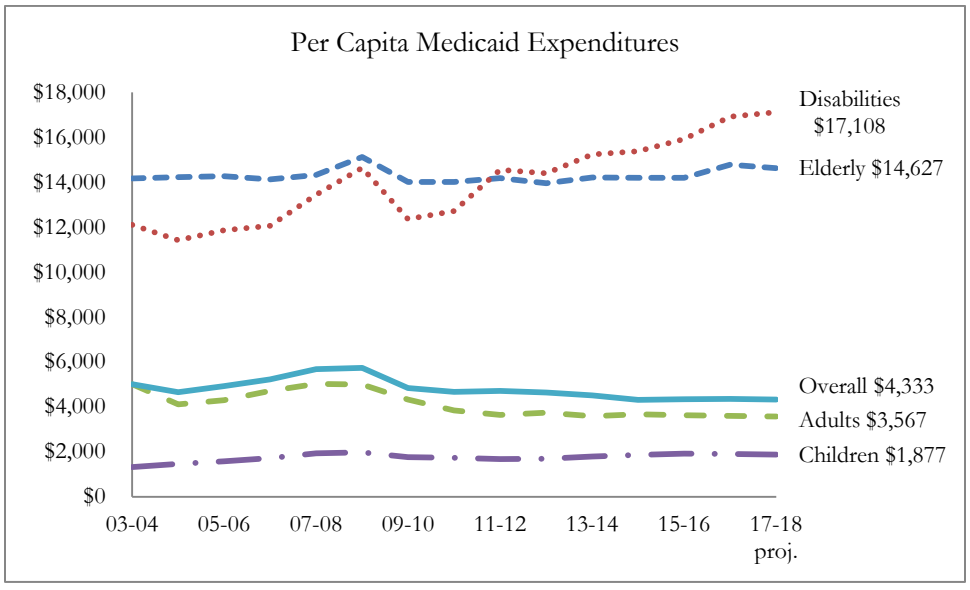
(1) Medical Services Premiums

Medical Services Premiums is a subset of Medicaid expenditures that pays for physical health care and long-term services and supports. Expenditures for Medical Service Premiums are driven by the

number of clients, the costs of providing health care services, and the utilization of health care services. The two charts below illustrate recent changes in Medicaid enrollment and expenditures by broad eligibility category. The expenditures in these charts don't include supplemental payments to hospitals and nursing homes that are financed with provider fees. In FY 2016-17, the elderly and people with disabilities are projected to account for approximately 12 percent of enrollment, but 43 percent of expenditures.

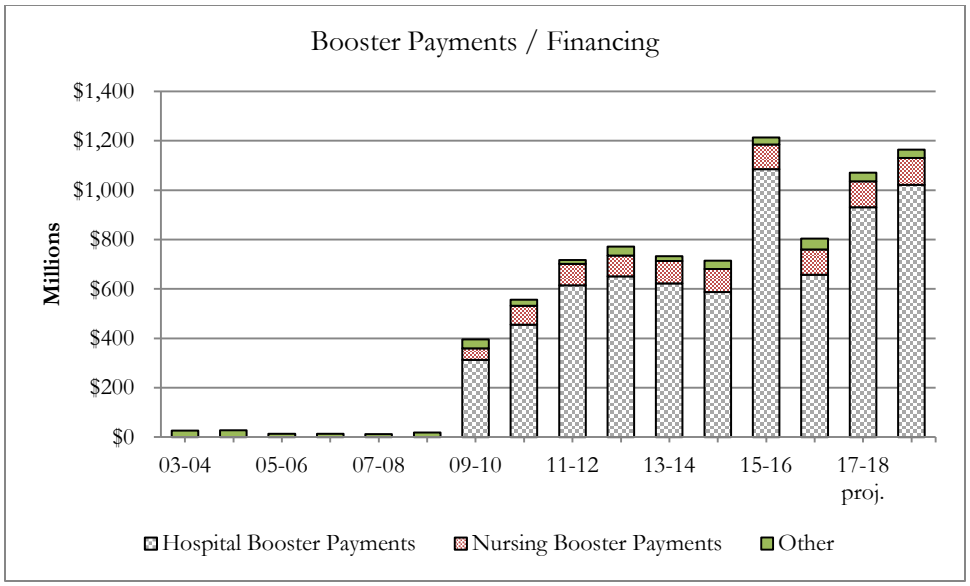


As illustrated in the following chart, per capita costs for the elderly and people with disabilities are much higher than for children and adults. Changes in per capita costs for the elderly are dampened by Medicare absorbing a portion of the costs for the subset of the population that is dually eligible for both Medicare and Medicaid.



The charts above track direct payments for physical health services and for long-term services and supports, but the Medical Services Premiums section also includes indirect financing for hospitals and nursing homes through provider fees. A portion of the Hospital Provider Fee is collected for

the purpose of matching federal funds and making payments back to hospitals based on the amount of services they provide to low-income clients. All of the Nursing Facility Fee is used in this way. The annual expenditures for these supplemental payments (referred to in this document as "booster payments" to avoid confusion with supplemental bills) do not always move in concert with Medicaid enrollment and utilization patterns, as they tend to be influenced more by federal and state policies regarding allowable collections from the provider fees. The table below shows actual and projected expenditures on hospital and nursing home booster payments. The FY 2016-17 total reflects the General Assembly's decision to restrict hospital provider fee revenues by $73.1. The FY 2017-18 projection is before the Governor's proposed restriction of $195.0 million.



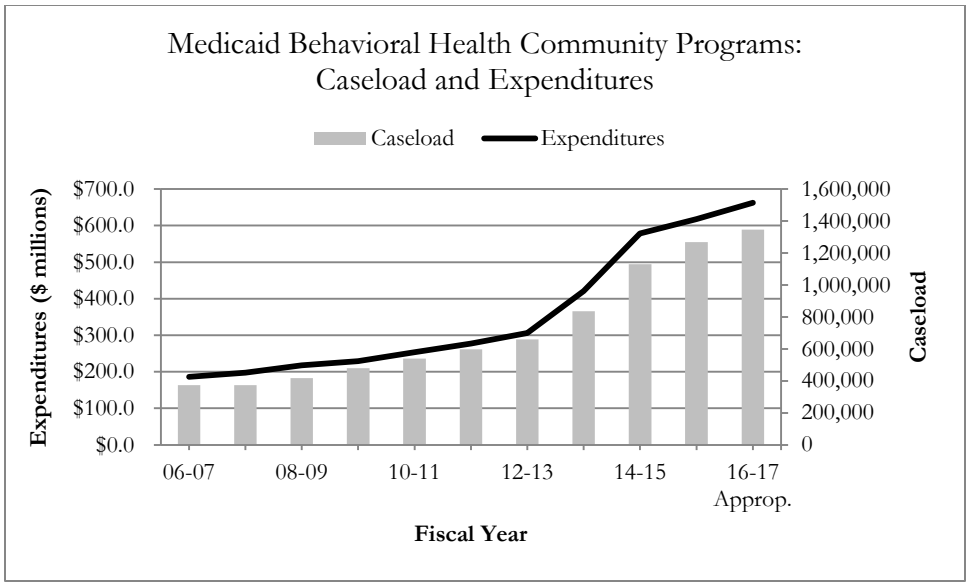
(2) BEHAVIORAL HEALTH CAPITATION PAYMENTS

Behavioral health services include both mental health and substance use-related services. With a few exceptions (e.g., non-citizens), Medicaid clients are eligible for behavioral health services. Behavioral health services are provided to Medicaid clients through a statewide managed care or "capitated" program. Under capitation, the Department contracts with regional entities known as behavioral health organizations (BHOs) to provide or arrange for behavioral health services for clients within their geographic region who are enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary. Each BHO receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its region. The "per-member-per-month" rates paid to a BHO are unique for each Medicaid eligibility category in each geographic region. These rates are periodically adjusted based on clients' actual utilization of behavioral health services and the associated expenditures.

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals

eligible within each category. The State's share of expenditures is also affected by changes in the federal match rate for various eligibility categories.

The following chart depicts recent caseload and expenditure trends for Medicaid behavioral health community programs. The caseload and expenditure increases that began in FY 2013-14 reflect the expansion of Medicaid eligibility in January 2014. Generally, adult clients are more expensive than children. Thus, as Medicaid eligibility has been expanded to include more adults, the average annual expenditure per eligible client has increased (from $457 in FY 2012-13 to an estimated $485 in FY 2016-17).



(3) OFFICE OF COMMUNITY LIVING

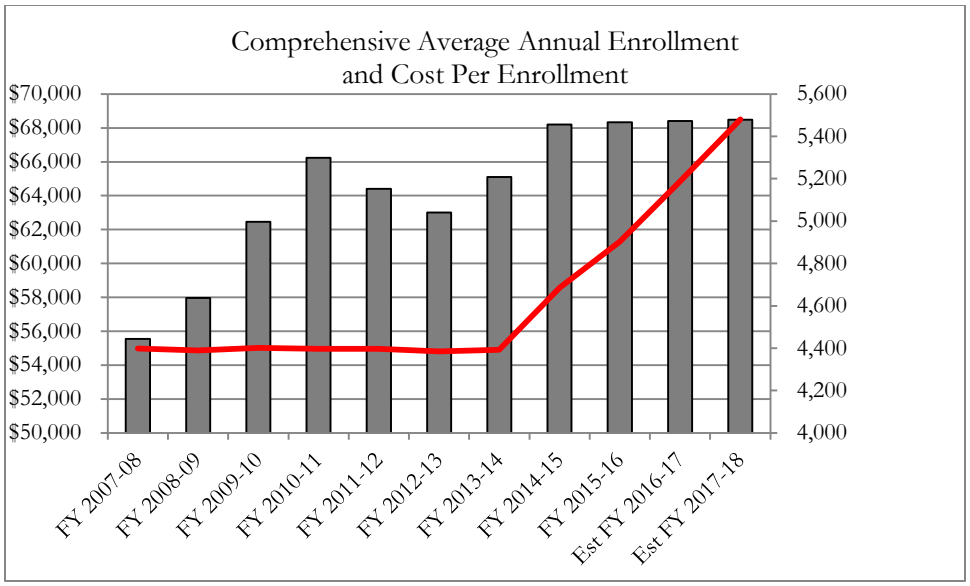
Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. Instead, these services are provided under a Medicaid waiver program. As part of the waiver, Colorado is allowed to limit the number of waiver program participants which has resulted in a large number of individuals being unable to immediately access the services they need. Colorado has three Medicaid waivers for individuals who qualify for intellectual and developmental disability services:

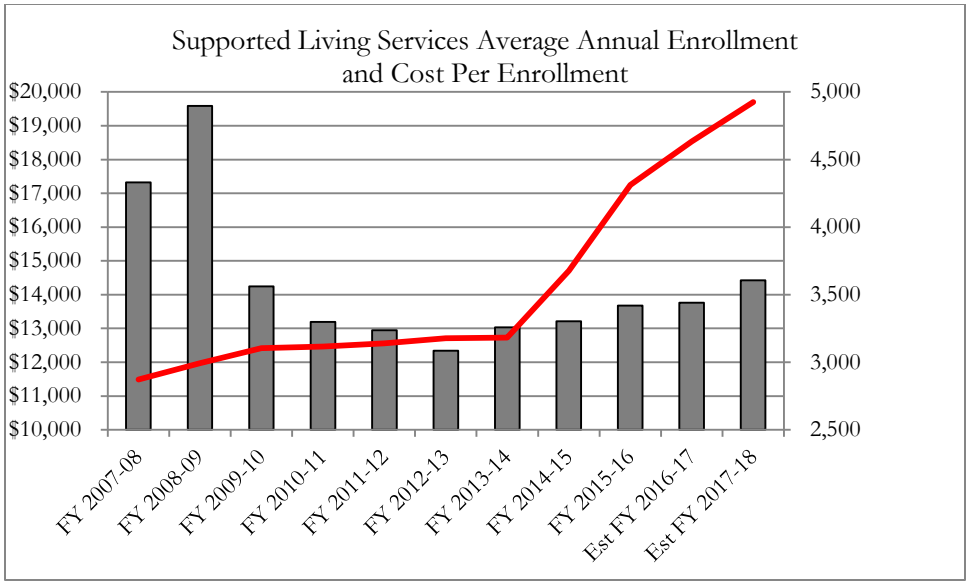
Adult Comprehensive waiver (also called the Comprehensive or Comp waiver) is for individuals over the age of eighteen who require residential and daily support services to live in the community.

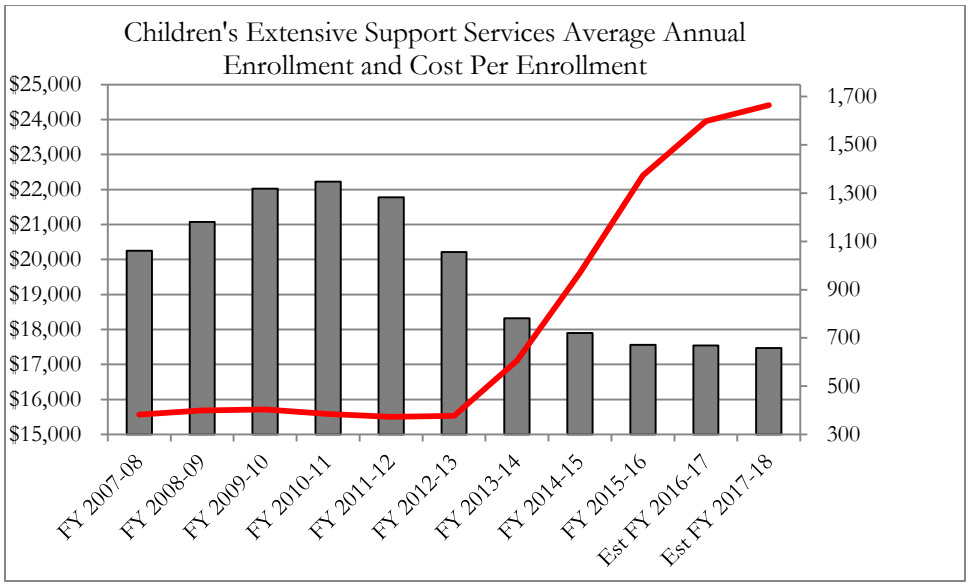
Supported Living Services waiver (SLS waiver) is for individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.

Children's Extensive Services waiver (also called the CES waiver or children's waiver) is for youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.

New enrollments are funded for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and to service all individuals eligible for the Supported Living Services (SLS) and Children's Extensive Services (CES) waivers. The following graphs illustrate the growth in adult and children enrollments respectively.







(4) Indigent Care Program

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Funding for this program is based on policy decisions at the state and federal levels and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding is from federal sources. State funds for the program come from the Hospital Provider Fee, certifying public expenditures at hospitals, and the General Fund.

Colorado Indigent Care Program					
	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation
Safety Net Provider Payments	$299,175,424	$309,976,756	$309,470,584	$310,125,957	$311,296,186
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
Pediatric Specialty Hospital	11,799,938	11,799,938	13,455,012	13,455,012	13,455,012
TOTAL	**317,095,122**	**327,896,454**	**329,045,356**	**329,700,729**	**330,870,958**
General Fund	8,959,849	8,959,849	9,639,107	9,632,256	9,748,236
Cash Funds	149,587,712	154,988,378	152,391,319	152,556,889	155,073,238
Federal Funds	158,547,561	163,948,227	167,014,930	167,511,584	166,049,484
Total Funds Change		**$10,801,332**	**$1,148,902**	**$655,373**	**$1,170,229**
Percent Change		3.4%	0.4%	0.6%	0.0%

(5) Medicare Modernization Act

The federal Medicare Modernization Act requires states to reimburse 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 federal costs the federal legislation required 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 payment is sometimes referred to as the "clawback." In recent years, in order to offset General Fund costs,

Colorado has applied bonus payments received from the federal government for meeting performance goals in CHP+ toward this obligation. The table below summarizes Colorado's payments to the federal government.

Medicare Modernization Act				
Fiscal Year	Total Funds	General Fund	Federal Funds	Total 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
FY 2013-14	106,376,992	68,306,130	38,070,862	4,559,137
FY 2014-15	107,620,224	107,190,799	429,425	1,243,232
FY 2015-16	114,014,334	114,014,334	0	6,394,110
FY 2016-17 proj.	132,037,056	132,037,056	0	18,022,722
FY 2017-18 proj.	150,341,733	150,341,733	0	18,304,677
FY 2018-19 proj.	163,907,186	163,907,186	0	13,565,453

(6) Programs Administered By Other Departments

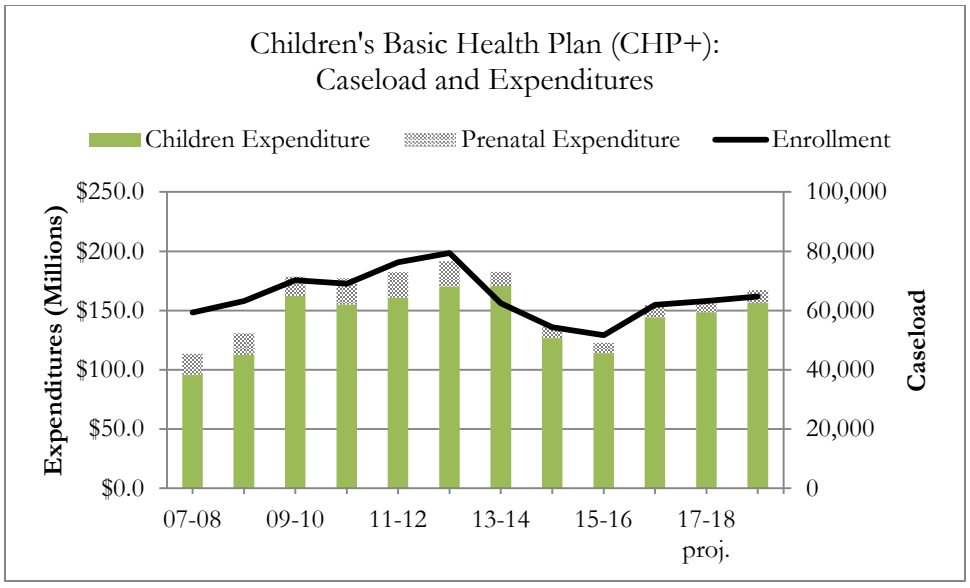
The Department of Health Care Policy and Financing (HCPF) transfers Medicaid money to several other departments. The Medicaid funds are first appropriated to HCPF and then transferred to the administering departments to comply with federal regulations that one state agency receives all federal Medicaid funding. The cost drivers for these programs are described in more detail in the "General Factors Driving the Budget" for the receiving departments, but the table below summarizes some of the larger transfers.

Department of Human Services Medicaid-funded Programs FY 2016-17				
	Total	General Fund	Cash Funds	Federal Funds
Executive Director's Office	$16,109,873	$8,054,937	$0	8,054,936
Information Technology	647,220	322,316	0	324,904
Operations	5,656,943	2,817,321	0	2,839,622
Child Welfare	15,340,342	7,639,776	0	7,700,566
Early Childhood	6,563,353	3,268,550	0	3,294,803
Self Sufficiency	25,799	0	0	25,799
Behavioral Health	8,833,660	4,399,995	0	4,433,665
Services for People with Disabilities	54,337,724	25,187,543	1,866,142	27,284,039
Adult Assistance Programs	1,800	900	0	900
Youth Corrections	1,452,654	723,422	0	729,232
Other	500,000	0	0	500,000
TOTAL	**$109,469,368**	**$52,414,760**	**$1,866,142**	**55,188,466**

CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than Medicaid eligibility criteria allow. Annual membership premiums are variable based on income, with an example being $75 to enroll one child in a family earning 205 percent of the federal poverty guidelines. Coinsurance costs are nominal. Federal funds pay approximately 88.0 percent of the program costs not covered by member contributions, and state funds pay the remaining 12.0 percent as a match. CHP+ typically receives roughly $28 million in revenue from the tobacco master settlement agreement, and any remaining state match comes from the General Fund.

Enrollment in CHP+ is highly changeable, in part because eligibility for the program is sandwiched between an upper income limit and a lower income limit below which an applicant is eligible for Medicaid and not eligible for CHP+. In addition, the program has experienced frequent adjustments to state and federal eligibility criteria and to administrative procedures for handling eligibility determinations that have impacted enrollment.



SUMMARY: FY 2016-17 APPROPRIATION & FY 2017-18 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION:						
HB 16-1405 (Long Bill)	9,059,846,783	2,660,581,107	985,068,901	12,406,599	5,401,790,176	432.0
Other Legislation	57,034,095	(6,186,893)	27,416,620	0	35,804,368	3.8
TOTAL	**$9,116,880,878**	**$2,654,394,214**	**$1,012,485,521**	**$12,406,599**	**$5,437,594,544**	**435.8**
FY 2017-18 APPROPRIATION:						
FY 2016-17 Appropriation	$9,116,880,878	2,654,394,214	$1,012,485,521	$12,406,599	$5,437,594,544	435.8
R1 Medical Services Premiums	361,396,284	124,330,802	10,348,553	3,790,151	222,926,778	0.0
R2 Behavioral Health	20,962,544	(406,491)	11,420,458	0	9,948,577	0.0
R3 Children's Basic Health Plan	18,510,002	(1,878,825)	1,665,246	0	18,723,581	0.0
R4 Medicare Modernization Act	19,674,000	19,674,000	0	0	0	0.0
R5 Office of Community Living	9,869,672	(2,025,296)	8,427,248	0	3,467,720	0.0
R6 Delivery system and payment reform	3,213,375	(200,342)	(187,409)	0	3,601,126	0.0
R7 Oversight of state resources	1,486,941	(1,658,036)	100,685	0	3,044,292	13.2
R8 MMIS Operations	23,524,339	(566,430)	2,953,578	(275,978)	21,413,169	1.8
R9 Long-term care utilization management	1,030,568	257,644	(9,219)	0	782,143	0.0
R10 Regional Center task force	922,801	224,066	0	0	698,735	1.8
R11 Vendor transitions	2,598,458	929,629	369,600	0	1,299,229	0.0
R12 Local Public Health Agency partnerships	711,000	355,500	0	0	355,500	0.0
R13 Quality of care and performance improvement projects	639,237	280,869	0	0	358,368	0.0
R14 Federal match rate	0	253,832	574,855	6,020	(834,707)	0.0
Human Services programs	2,302,088	1,151,047	0	0	1,151,041	0.0
Centrally appropriated line items	1,348,670	487,423	102,151	22,581	736,515	0.0
Non-prioritized requests	861,753	403,591	28,663	0	429,499	0.0
Transfers to other state agencies	832,997	208,866	0	0	624,131	0.0
Indirect cost adjustment	215,804	0	32,729	111,491	71,584	0.0
Annualize prior year budget actions	(96,594,036)	1,014,674	(28,173,540)	8,281	(69,443,451)	0.3
TOTAL	**$9,490,387,375**	**$2,797,230,737**	**$1,020,139,119**	**$16,069,145**	**$5,656,948,374**	**452.9**
INCREASE/(DECREASE)	$373,506,497	$142,836,523	$7,653,598	$3,662,546	$219,353,830	17.1
Percentage Change	4.1%	5.4%	0.8%	29.5%	4.0%	3.9%

DESCRIPTION OF INCREMENTAL CHANGES

R1 Medical Services Premiums: The Department requests a net increase of $361.4 million total funds, including $124.3 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item. The projection includes an increase of $93.3 million total funds, including $22.2 million General Fund, for Hepatitis C treatments resulting from a change in prior authorization criteria that was implemented by the Department in October 2016. The projection for cash funds and federal funds reflects the Governor's proposed $195.0 million restriction on Hospital Provider Fee revenues, which reduces the General Fund obligation for a TABOR refund by $195.0 million from the Office of State Planning and Budgeting forecast. *See the issue brief "Forecast Trends" for more information.*

R2 Behavioral Health Programs: The Department requests a net increase of $21.0 million total funds, including a decrease of $0.4 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services. *See the 12/13/16 briefing on Behavioral Health Community Programs for more information.*

R3 Children's Basic Health Plan: The Department requests a net increase of $18.5 million total funds, including a decrease of $1.9 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan.

R4 Medicare Modernization Act: The Department requests an increase of $19.7 million General Fund for the projected state obligation pursuant to the federal Medicare Modernization Act to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare.

R5 Office of Community Living: The Department requests a net increase of $9.9 million total funds, including a decrease of $2.0 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for services for people with intellectual and developmental disabilities. *See the 12/19/16 briefing on the Office of Community Living for more information.*

R6 DELIVERY SYSTEM AND PAYMENT REFORM: The Department requests a net increase of $3.2 million total funds, including a decrease of $200,342 General Fund, for a number of changes that the Department characterizes as delivery system and payment reforms.

The Department proposes taking a portion of the money currently paid to certain providers and transforming it into incentive payments based on health outcomes and performance:

- *Primary Care:* The Department requests General Fund for the state share of costs to continue an increase in primary care rates (referred to as the primary care rate bump) that was financed with one-time tobacco settlement moneys by H.B. 16-1408 and is set to expire at the end of FY 2016-17. The Department would negotiate with stakeholders over the course of the year so that beginning in FY 2018-19 an unspecified portion of the primary care rate bump would be paid based on performance metrics, which would be aligned with the performance metrics of the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
- *Behavioral Health:* Behavioral health incentive payments would be financed using the savings from a federally required change in the way behavioral health capitation rates are set, although there would be a delay between when capitated rates are reduced and incentive payments are disbursed, resulting in a one-time savings in FY 2017-18.
- *Federally Qualified Health Centers (FQHCs):* An unspecified amount of performance incentives for FQHCs would be financed by reducing monthly base payments to the FQHCs.

In addition to implementing the new incentive payments described above, the Department requests funding to implement Phase II of the Accountable Care Collaborative, which features the coordination of physical and behavioral health and mandatory enrollment. Phase II is projected to result in net savings from avoided high cost care. The expenditures and savings associated with Phase II won't occur until FY 2018-19.

The Department also proposes adjusting Medicaid rates for vaccines annually to match private sector prices reported by the Centers for Disease Control. Annually updating vaccine rates will capture decreases in price that often occur when patents expire and generics are introduced, leading the Department to believe that the policy change will result in a net savings, even if the rates for some vaccines increase.

Finally, the request accounts for expected short-duration savings from a change in the timing of Medicaid payments for hospital outpatient services. This partially offsets the first year General Fund cost of continuing the primary care rate bump (the rest of the first year offset comes from the delay in funding behavioral health incentive payments and the change to vaccine stock rates). Although the Governor's official supplemental request is not due until January 2017, this request notes that the savings from changing the timing of payments for hospital outpatient services are projected to reduce FY 2016-17 expenditures by $15.4 million total funds, including a decrease of $7.7 million General Fund, in addition to the fiscal impact in FY 2017-18.

See the issue brief "Accountable Care Collaborative and Related Reforms (R6)" for more information.

R7 OVERSIGHT OF STATE RESOURCES: The Department requests a net increase of $1.5 million total funds, including a decrease of $1.7 million General Fund, and an increase of 13.2 FTE for a number of initiatives the Department characterizes as related to the oversight of state resources, including:

1. Implementing electronic verification of assets for enrollment, as required by federal regulation
2. Evaluating consumer directed care in response to recommendations from the State Auditor
3. Developing a new audit database to track audit findings and mitigation efforts
4. Renewing expiring funds for project management staff and making the staff available for other initiatives
5. Performing audits of annual cost reports from Community Mental Health Centers for rate setting
6. Hiring additional staff to investigate fraud and abuse, resulting in projected savings
7. Better coordinating services to Native Americans to qualify for an increased federal match
8. Increasing administrative resources for the annual Hospital Provider Fee model and associated incentive payments, including a proposed new demonstration waiver for performance payments *[see the issue brief "Hospital Payments (R1 and R7)" for more information]*
9. Updating pricing for office-administered drugs on a periodic basis to encourage more providers in cost-effective settings to offer services, as recommended by the Medicaid Provider Rate Review Advisory Committee, resulting in projected savings [*see the issue brief "Medicaid Provider Rate Review (R7)" for more information*]

The net General Fund savings is primarily due to an increase in the federal match for coordinating services to Native Americans (item 7) and the change to pricing for office-administered drugs (item 9).

Although the Governor's official supplemental request is not due until January 2017, this request assumes expenditures for the electronic verification of assets and the hospital provider fee resources (1 and 8) would begin in FY 2016-17 at a cost of $200,000 total funds, including $50,000 General Fund.

R8 MMIS Operations: The Department requests $23.5 million total funds, including a reduction of $0.6 million General Fund, and an increase of 1.8 FTE for updated estimates of the costs and federal match rates associated with the new Medicare Management Information System (MMIS). Some of the changes include adjustments related to: a delay in the projected launch date from October 31, 2016, to March 1, 2017; revised estimates of available federal funds and cash funds based on the type of work being done and the populations served; a newly identified technology requirement to comply with a federal limit on client copayments; and revised estimates of ongoing maintenance needs. The Governor's official supplemental request is not due until January 2017, but this request assumes a net increase in expenditures for the MMIS in FY 2016-17 of $1.5 million total funds, including a decrease of $1.2 million General Fund.

R9 Long-term care utilization management: The Department requests an increase of $1.0 million total funds, including $257,644 General Fund to contract with a quality improvement organization and thereby qualify for an enhanced federal match for services. Except as noted, the functions of the quality improvement organization identified below are either being shifted from Department staff to the contractor, thereby freeing up the Department staff to focus on policy and strategic issues, or the functions are new. The quality improvement organization would:

1. Perform acuity assessments for brain injury services, removing a conflict of interest when providers currently perform this function
2. Monitor critical incident reports, including validating what occurred, elevating high priority events that require immediate follow-up, and tracking outcomes
3. Conduct over cost containment reviews that examine treatment plans above pre-determined cost thresholds to: ensure authorized services are appropriate and would stand up to appeal; prevent duplication of services; and, document that the average annual cost of waiver services are less than care in an institutional setting
4. Score applications for performance funding from the nursing facility provider fee in place of the current contractor who performs this function
5. Review claimed deductions to nursing home client income for incurred medical expenses for appropriateness and to ensure clients are not charged for benefits covered by Medicaid
6. Sample a statistically valid subset of Home- and Community-Based Service payments to ensure services were rendered appropriately and in a manner consistent with the bill and service plan
7. Recommend standard criteria on service limits to improve consistency across waivers and between case management agencies, and to periodically review utilization trends to ensure compliance with the service limits
8. Review under- and over-utilization of services and ensure that service plans are being updated appropriately when client circumstances change
9. Audit case management activities of Community Centered Boards and Single Entry Point agencies

10 Review applications for the Children's Extensive Support waiver

R10 Regional Center task force: The Department requests $922,801 total funds, including $224,066 General Fund, and 1.8 FTE to: (1) provide intensive case management to people with intellectual and developmental disabilities who are transitioning from an Intermediate Care Facility or Regional Center to the community, and continue that service for one year after their transition; and (2) provide staff for the Department to continue working on implementation of the recommendations of the Regional Center Task Force. *See the 12/19/16 briefing on the Office of Community Living for more information.*

R11 Vendor transitions: The Department requests $2.6 million total funds, including $929,629 General Fund, in one-time funding to allow overlap between outgoing and new vendors, in order to minimize service disruptions. Vendor services being reprocured in FY 2017-18 include the Accountable Care Collaborative, the enrollment broker that provides information to newly eligible Medicaid clients regarding their plan choices, and the Medicaid managed care ombudsman that assists members with complaints.

R12 Local Public Health Agency partnerships: The Department requests $711,000 total funds, including $355,500 General Fund, to improve coordination between the Accountable Care Collaborative and Local Public Health Agencies. There is a corresponding request in the Department of Public Health and Environment for a decrease in General Fund to offset the increase in the Department of Health Care Policy and Financing. The net effect of both requests is to increase federal financing for Local Public Health Agencies by $355,500 with no change in statewide General Fund. *See the 11/28/16 briefing for the Department of Public Health and Environment for more information.*

R13 Quality of care and performance improvement projects: The Department requests $639,237 total funds, including $280,869 General Fund, to conduct member satisfaction surveys aimed at improving quality of care, and to validate performance improvement projects by managed care organizations. The Department currently conducts a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that looks at member satisfaction with treatment, but the survey is done at a regional level and funding is only sufficient to survey adults or children, but not both, each year. The Department would like to extend the annual survey to collect data at a provider level and to cover both adults and children. In addition to the CAHPS survey, the Department conducts surveys of the elderly, people with disabilities, and people with intellectual and developmental disabilities who are receiving long-term services and supports, but federal funding to pilot and test the components of the survey related to the elderly and people with disabilities is expiring, and for the component focused on people with intellectual and developmental disabilities the available funding limits the scope of the survey to one snap shot per year. The Department would like to continue surveying adults and people with disabilities and expand the frequency and depth of the survey of people with intellectual and developmental disabilities. Finally, pursuant to federal regulation the Department requires managed care organizations to engage in performance improvement projects that collect data to identify weaknesses in service delivery and implement improvements, but funding for the Department to validate the performance improvement projects is limited. The Department requests additional funding for validations to ensure compliance with

federal regulations, and to hold Regional Care Collaborative Organizations to the same standards as managed care organizations.

R14 Federal match rate: The Department requests an increase in General Fund and cash funds and a corresponding decrease in federal funds based on a projected decrease in the federal match rate for Medicaid. The Department expects per capita income in Colorado will grow faster than the national average, leading to a formula decrease in the Federal Medical Assistance Percentage (FMAP) for Medicaid. This request is just for the line items where the Department did not submit a forecast adjustment. For Medical Services Premiums, Behavioral Health, the Children's Basic Health Plan, and the Office of Community Living the effect of the change in the FMAP is included in the requested forecast adjustments (R1 through R5).

Human Services programs: The Department's request reflects adjustments for several programs that are financed with Medicaid funds, but operated by the Department of Human Services. *See the briefings for the Department of Human Services for more information.*

Centrally appropriated line items: The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; short-term disability; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; salary survey; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; Capitol complex leased space; payments to the Governor's Office of Information Technology (OIT); and CORE operations.

Non-prioritized requests: The Department requests $861,997 total funds, including $403,591 General Fund, to reflect the impact on the Department of Health Care Policy and Financing from requests submitted by other departments. These include requests from: the Department of Public Health And Environment for staffing related to services for people with intellectual and developmental disabilities, and for resources for health surveys; the Governor's Office of Information Technology for Deskside and for Secure Colorado resources; and the Department of Personnel and Administration for administrative courts.

Transfers to other state agencies: The Department requests $832,997 total funds, including $208,866 General Fund, for transfers to programs administered by other departments. All of the requested changes are related to centrally appropriated line items and indirect cost recoveries in the Department of Public Health and Environment for the Facility Survey and Certification program.

Indirect cost adjustment: The appropriation includes a net increase in the Department's indirect cost assessment.

Annualize prior year budget decisions: The request includes adjustments for out-year impacts of prior year legislation and budget actions. All of the annualizations included in the Department's request are summarized in the table below. The titles of the annualizations begin with either a bill number or the fiscal year when a budget decision was made in the Long Bill. For budget decisions made in the Long Bill, a reference to the priority numbering the Department used in that year for the initiative is provided, if relevant.

The largest annualization is for H.B. 16-1408 (Tobacco/Marijuana allocations). The bill provided one-time funding from tobacco settlement moneys in the Children's Basic Health Plan Trust to support one more year of higher primary care reimbursement rates, referred to as the primary care rate bump. The bill also spent down a fund balance of tobacco settlement moneys in the Autism Treatment Fund to provide a one-year offset to the cost of behavioral therapy services for children with autism, which must be backfilled with General Fund in FY 2017-18 to continue the federally mandated behavioral therapy services.

The second largest annualization is for FY 13-14 R5 MMIS Reprocurement, which was an action in the FY 13-14 Long Bill to fund the Department's fifth budget priority for resources related to the replacement and modernization of the Medicaid Management Information System (MMIS) that processes provider claims. The largely federally-funded development stage of that project is winding down and the new MMIS is scheduled to begin operation March 1, 2017.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 16-17 BA14 Public School Health Services	$1,933,578	$0	$1,193,993	$0	$739,585	0.0
SB 16-192 Needs assessment for LTSS	1,671,363	916,388	(137,837)	0	892,812	0.2
FY 16-17 NP CBMS-PEAK	1,601,147	573,206	221,852	6,460	799,629	0.0
FY 15-16 R7 Participant directed programs	1,011,619	505,683	0	0	505,936	0.0
SB 16-120 Medicaid explanation of benefits	659,921	231,219	80,498	0	348,204	0.5
FY 16-17 BA10 Medicaid-Medicare grant true-up	633,403	282,959	0	0	350,444	0.0
SB 16-077 Employment for people with disabilities	228,838	23,298	0	0	205,540	0.0
FY 16-17 NP CO Benefits Management System	59,843	21,423	8,339	242	29,839	0.0
SB 16-038 Community-centered Board transparency	6,249	0	3,125	0	3,124	0.0
FY 16-17 BA7 Fed reg for managed care	3,092	1,546	0	0	1,546	0.0
FY 16-17 BA9 Provider enrollment fee	2,663	0	2,663	0	0	0.0
HUM - SB 14-130 Personal needs allowance	2,001	1,001	0	0	1,000	0.0
FY 16-17 BA6 Fed reg for assuring access	1,591	796	0	0	795	0.0
Prior year salary survey	1,579	0	0	1,579	0	0.0
HB 16-1408 Tobacco/Marijuana allocations	(55,694,236)	6,451,471	(27,008,330)	0	(35,137,377)	0.0
FY 13-14 R5 MMIS Reprocurement	(23,991,872)	(2,180,270)	(439,445)	0	(21,372,157)	0.0
FY 14-15 BA7 MMIS Adjustments final test	(9,410,459)	(1,105,267)	(497,477)	0	(7,807,715)	0.0
FY 14-15 BA10 Primary care rate bump	(7,748,597)	(3,169,176)	0	0	(4,579,421)	0.0
FY 14-15 R5 Medicaid health info technology	(2,235,000)	(223,500)	0	0	(2,011,500)	0.0
SB 16-027 Mail delivery pharmacy	(1,737,180)	(528,579)	(43,239)	0	(1,165,362)	0.0
HB 15-1368 Cross-system response	(1,690,000)	0	(1,690,000)	0	0	0.0
FY 07-08 S5 Fed reg for payment error	(588,501)	(147,125)	(102,988)	0	(338,388)	0.0
FY 15-16 R9 Personal health records	(315,000)	68,500	0	0	(383,500)	0.0
SB 16-199 PACE Rate methodology	(225,000)	0	(225,000)	0	0	0.0
HB 16-1097 PUC permit Medicaid transportation	(209,317)	(61,016)	(8,561)	0	(139,740)	0.0
FY 15-16 R16 Comprehensive Primary Care	(194,760)	(97,380)	0	0	(97,380)	0.0
FY 14-15 BA10 Enhanced FMAP	(150,000)	(75,000)	0	0	(75,000)	0.0
FY 15-16 R13 ACC Reprocurement	(100,000)	(50,000)	0	0	(50,000)	0.0
SB 11-177 Teen pregnancy/dropout prevention	(40,562)	1,970	0	0	(42,532)	(0.4)
FY 16-17 Cervical cancer eligibility	(38,771)	0	(19,084)	0	(19,687)	0.0
HB 16-1277 Medicaid appeals process	(25,000)	(2,500)	0	0	(22,500)	0.0
FY 15-16 BA8 HCBS Settings	(13,955)	(5,343)	0	0	(8,612)	0.0
HB 16-1321 Medicaid buy-in eligibility	(2,713)	(419,630)	487,951	0	(71,034)	0.0
TOTAL	**($96,594,036)**	**1,014,674**	**($28,173,540)**	**$8,281**	**($69,443,451)**	**0.3**

OTHER ISSUES IN THE GOVERNOR'S REQUEST

Restrict Hospital Provider Fee revenue: The Governor proposes restricting Hospital Provider Fee revenues by $195.0 million from projected maximum collections for FY 2017-18. This reduces projected cash fund and federal fund expenditures in the Department of Health Care Policy and Financing by $195.0 million each, and that effect is included in R1 Medical Services Premiums. However, the main purpose of the proposed restriction is to reduce TABOR revenues and thereby reduce the projected General Fund obligation for a TABOR refund by $195.0 million. The General Fund obligation for the TABOR refund is not appropriated in the Long Bill, so the only place to see the effect of the Hospital Provider Fee restriction on the TABOR refund is the General Fund overview. *See the issue brief Hospital Payments (R1 and R7) for more information.*

Set aside for supplementals: The Governor's budget letter includes a set aside in FY 2016-17 of $23.95 million General Fund for potential supplementals for the Department of Health Care Policy and Financing. Although the Governor's official supplemental request is not due until January 2017, the budget request for the Department includes projected FY 2016-17 impacts associated with several requests, adding to $10.8 million. This leaves $13.2 million of the requested $23.95 million mentioned in the Governor's budget letter unallocated. When asked about the unallocated set aside, OSPB staff explained that those funds are a contingency above the needs explicitly identified by the Department in order to be conservative.

FY 2016-17 Fiscal Impact Associated with Health Care Policy and Financing Requests

	Total	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
R1 Medical Services Premiums	$141,694,902	$32,217,993	$1,650,193	$3,861,816	103,964,900
R2 Behavioral Health	(56,448,298)	(6,379,746)	569,523	0	(50,638,075)
R3 Children's Basic Health Plan	15,610,893	1,515	3,681,198	0	11,928,180
R4 Medicare Modernization Act	1,369,323	1,369,323	0	0	0
R5 Office of Community Living	(18,626,814)	(8,707,629)	0	0	(9,919,185)
R6 Delivery system and payment reform	(15,440,295)	(7,720,148)	0	0	(7,720,147)
R7 Oversight of state resources	200,000	50,000	50,000	0	100,000
R8 MMIS Operations	(1,495,480)	(32,549)	(537,805)	(269,394)	(655,732)
TOTAL	**$66,864,231**	**$10,798,759**	**$5,413,109**	**$3,592,422**	**47,059,941**
Set-aside in Governor's Budget Letter		$23,950,000			
Unallocated set-aside		$13,151,241			

Repayment of CHIPRA bonuses: The Governor's request includes a $19.0 million General Fund set aside for a potential repayment to the federal government of bonuses the Department received through the federal Children's Health Insurance Program Reauthorization Act (CHIPRA). The bonuses were paid for meeting performance goals related to the enrollment and retention of children in Medicaid and CHP+. A September federal audit found that Colorado incorrectly included blind and disabled children when calculating its eligibility for the bonus payments. The audit identified overpayments of $38,373,386 from federal fiscal year 2010 through 2013. The Department believes it followed the letter of the federal regulation and disputes the audit finding. Because of uncertainties about whether the Department will need to repay the funds, how much might be due after negotiations with the federal government, and when any repayment would be required, the Governor's requested set aside is for roughly half of the total disputed funds.

Information on eliminating the wait list for Adult Comprehensive Services: As part of the Department's response to H.B. 14-1051 that requires a comprehensive strategic plan to eliminate wait lists by July 1, 2020, for services for people with developmental disabilities, the Department included an estimate of the cost to eliminate the wait list for Adult Comprehensive Services. This was provided for informational purposes only and is not part of the Governor's request. A separate response specifically addressing the requirements of H.B. 14-1051 will be submitted to the committees of reference. The Department estimates it would need the following to eliminate the enrollment cap by July 1, 2020:

Eliminate the Wait List for Adult Comprehensive Services for People with Intellectual and Developmental Disabilities				
	Total Funds	General Fund	Federal Funds	FTE
FY 2017-18	$29,301,994	$14,648,078	$14,653,916	0.9
FY 2018-19	$93,407,513	$46,703,760	$46,703,753	1.0
FY 2019-20	$160,697,025	$80,348,515	$80,348,510	1.0
FY 2020-21	$190,383,350	$95,191,678	$95,191,672	1.0

See the 12/19/16 briefing on the Office of Community Living for more information.

Information on making a supplemental payment to the University of Colorado School of Medicine: In response to a statutory change in H.B. 16-1408, sponsored by the JBC, that allows Medicaid funding for the University of Colorado School of Medicine, the Department included an estimate of how funding would change. This was provided for informational purposes only and is not part of the Governor's request. However, OSPB staff explained that the information was provided, "to demonstrate the commitment to increasing the cash fund allocations for [the University of Colorado School of Medicine] while waiting approval from [the Centers for Medicare and Medicaid Services]. The departments will continue to work together to complete an acceptable interagency agreement." This explanation suggests that a formal request might be forthcoming at a later date. The Department's estimate assumes there would be a reappropriated funds transfer from the Department of Higher Education of $61.9 million that would be matched with federal Medicaid funds. The resulting $123.8 million would be used to pay for administrative costs of $824,863 and 6.0 FTE at the Department of Health Care Policy and Financing, for two new residency placements through the family medicine residency training program at a cost of $300,000, and for a supplemental payment to the University of Colorado School of Medicine of $122.7 million. The additional federal funds through Medicaid would nearly double the government support for the Colorado School of Medicine.

Supplemental Payment to the University of Colorado School of Medicine Pursuant to H.B. 16-1408				
	Total Funds	Reappropriated Funds	Federal Funds	FTE
HCPF Administrative Costs	$824,863	$412,432	$412,431	6.0
Family Medicine Residency Training	$300,000	$150,000	$150,000	0.0
CU School of Medicine Supplemental Payment	$122,675,137	$61,337,568	$61,337,569	0.0
TOTAL	**$123,800,000**	**$61,900,000**	**$61,900,000**	**6.0**

See the 12/13/16 briefing on the Department of Higher Education for more information.

ISSUE: FORECAST TRENDS

This issue brief discusses the forecast trends that are driving the majority of the projected increase in expenditures for the Department.

SUMMARY

- Medicaid and the Children's Basic Health Plan (CHP+) cover approximately 1 in 4 Colorado residents.

- The majority of total funds expenditures are for physical health services, but when focusing on just the General Fund the expenditures for long-term services and supports are almost as significant.

- The biggest driver of physical health care costs is enrollment growth. Other major factors affecting FY 2017-18 General Fund expenditures include a change in prior authorization review criteria for Hepatitis C medications, a proposed extension of the primary care rate bump, and increased prescription drug costs for clients dually eligible for Medicaid and Medicare.

- For long-term services and supports the Department is projecting not only increased enrollment, but also increased utilization of services by the eligible population and increases in the cost of services. The utilization of nursing homes (which represent 32.3 percent of total LTSS costs) continues to increase at a slower rate than enrollment of the elderly and people with disabilities. The next largest expenditure for LTSS is for services for people with intellectual and developmental disabilities.

RECOMMENDATION

The primary purpose of this issue brief is to highlight trends influencing the expenditure forecast, but it does contain a recommendation that the JBC discuss contingency plans with the Department at the hearing in case federal funding for the Children's Basic Health Plan (CHP+) is not reauthorized, or is reauthorized at a lower level.

DISCUSSION

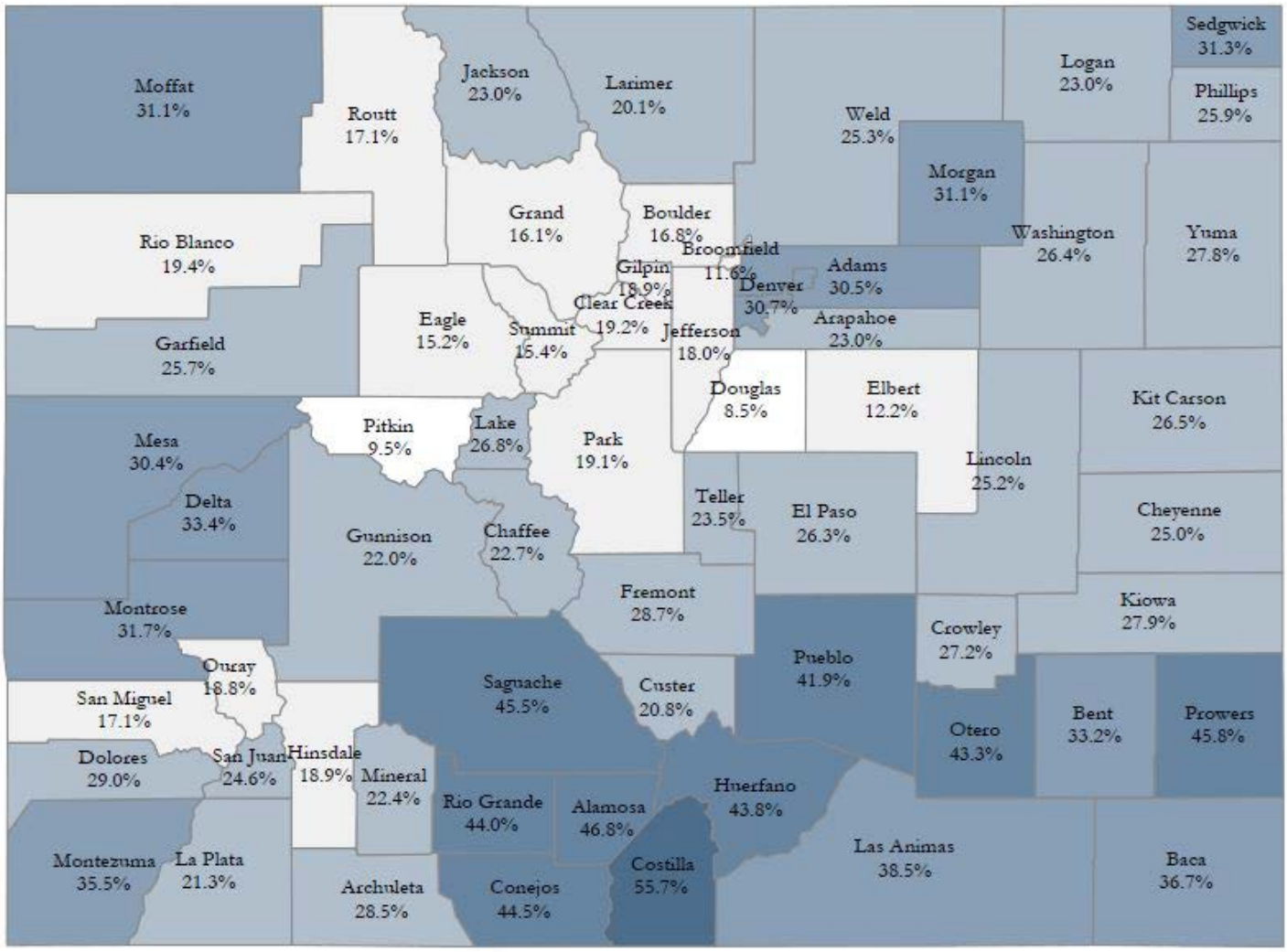
OVERVIEW

MEDICAID AS AN INSURER

Medicaid is an important health insurer in Colorado, covering almost 1 in 4 residents. The Department of Health Care Policy and Financing reports Medicaid enrollment in October 2016 was 1,332,134, or 23.7 percent of Colorado's estimated population. Enrollment in the Children's Basic Health Plan (CHP+) in October 2016 was 61,386, bringing the combined Medicaid and CHP+ enrollment to 1,393,520, or 24.8 percent of Colorado's estimated population.

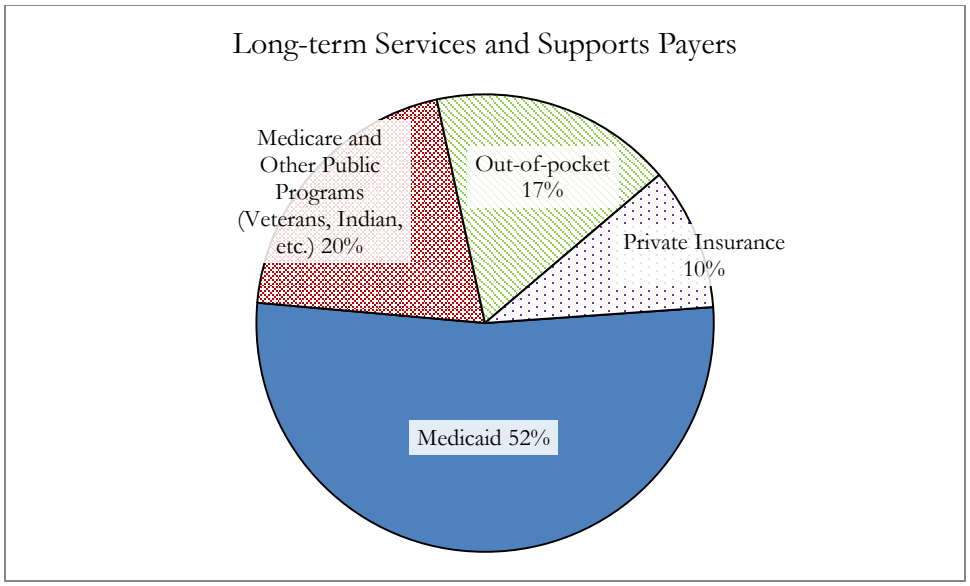
There can be significant variation in the importance of Medicaid and CHP+ as insurers across different regions of the state. There are two counties (Pitkin and Douglas) where Medicaid and CHP+ insure less than 10 percent of the estimated population and nine counties where Medicaid and CHP+ insure more than 40 percent of the estimated population (Costilla, Alamosa, Prowers, Saguache, Conejos, Rio Grande, Huerfano, Otero, and Pueblo).

Medicaid and CHP+ Enrollment as a Percentage of the Population



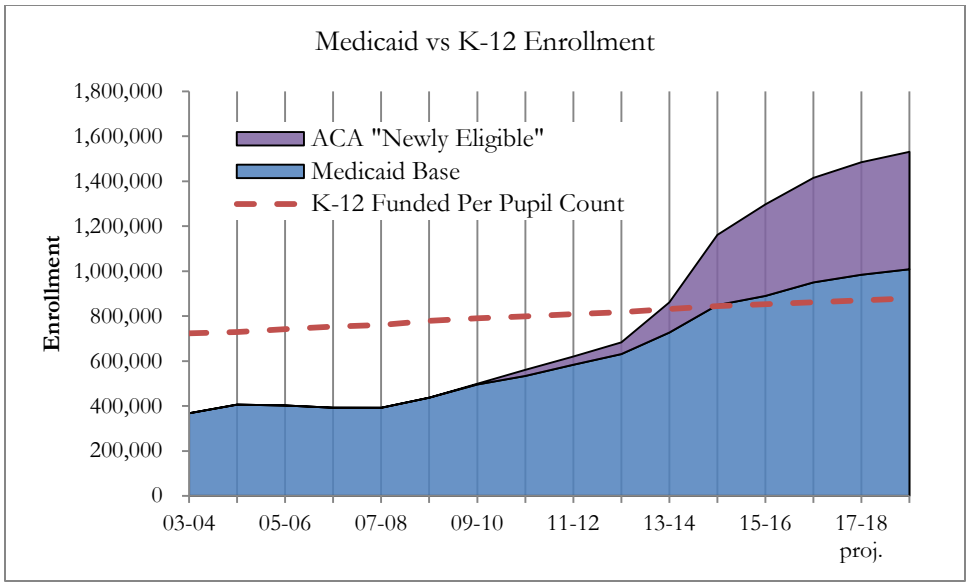
There can also be significant variation in the importance of Medicaid and CHP+ as insurers by type of service. For example, while Medicaid covers approximately 1 in 4 residents, in calendar year 2015 Medicaid and CHP+ paid for 45 percent of Colorado births (29,269 Medicaid births and 375 CHP+ births out of 66,566 total births). In part this is due to Medicaid covering pregnant adults to 200 percent of the federal poverty guidelines compared to 138 percent of the federal poverty guidelines for non-pregnant adults.

As another example, Medicaid is the primary payer for long-term services and supports (LTSS). The next largest payer is Medicare, but Medicare coverage of LTSS is limited, generally to post-acute services such as surgery recovery and home health for qualifying beneficiaries who are home bound. Nationally Medicaid accounted for an estimated 52 percent of payments for LTSS in 2014 (the JBC staff is not aware of any Colorado-specific estimates).

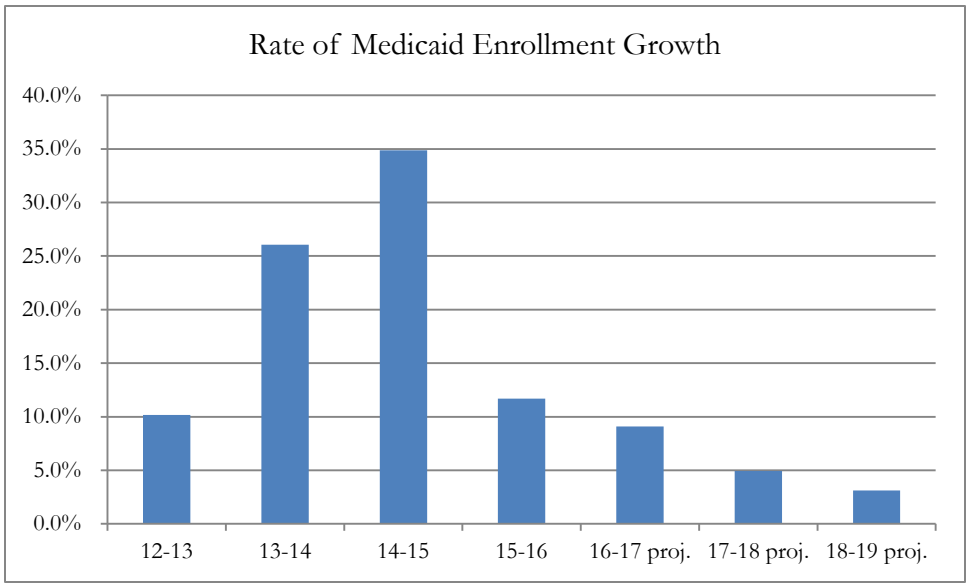


MEDICAID ENROLLMENT GROWTH

Medicaid enrollment has been growing quickly. In FY 2013-14 Medicaid enrollment eclipsed K-12 enrollment. Even if the Medicaid expansion populations were excluded (the ACA "Newly Eligible" in the chart below) Medicaid enrollment would still exceed K-12 enrollment. In December 2013, just prior to the Medicaid expansion authorized by S.B. 13-200 and the implementation of the individual mandate of the federal Affordable Care Act (ACA), Medicaid enrollment was 772,954, providing coverage to approximately 14.5 percent of Colorado's estimated population, compared to today's Medicaid enrollment of 1,332,134, or 23.7 percent of Colorado's estimated population.



The rate of Medicaid enrollment growth has decreased sharply in FY 2015-16 and through the first part of FY 2016-17 and the Department expects that trend to continue as Medicaid moves beyond the expansion ramp-up period.

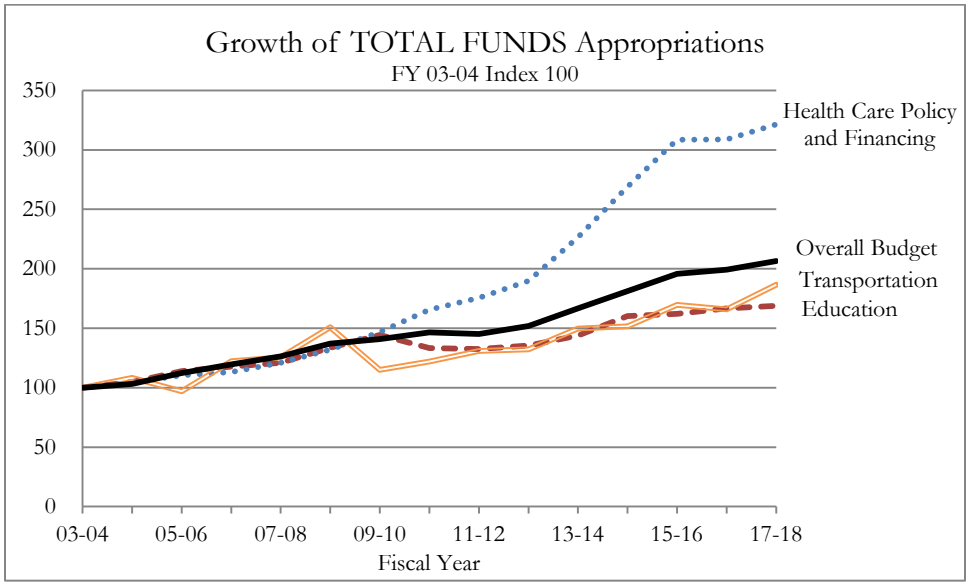


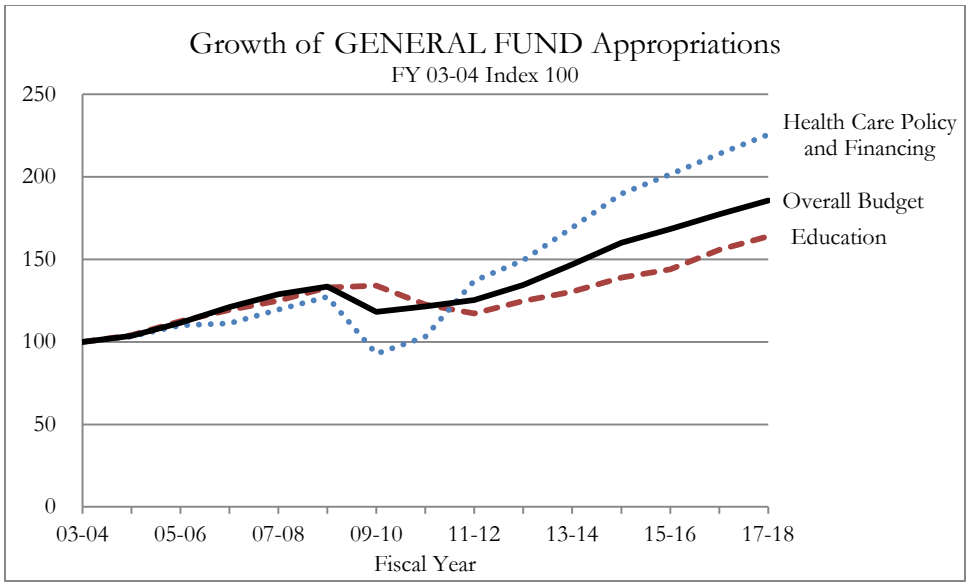
Part of the projected slower rate of enrollment growth is informed by estimates from other parties that suggest Medicaid is approaching a saturation point where all potentially eligible people are enrolled. Medicaid enrollment already exceeds estimates from the Colorado Health Institute of the potentially eligible adults and children. The American Community Survey makes estimates of the population below poverty bands that don't align exactly with Medicaid and CHP+ eligibility criteria, but are close enough to suggest that Medicaid and CHP+ enrollment is very near or over an estimate of the potentially eligible population of adults and children using the American Community Survey income estimates.

Third Party Estimates of the Potentially Eligible Adults and Children Compared to the Medicaid Enrollment Forecast				
	FY 2015-16		FY 2016-17	
	Enrollment	Percent	Enrollment	Percent
Forecast Above/(Below) estimate of potentially eligible from:				
Colorado Health Institute				
Adults - Nondisabled, nonpregnant	24,124	4.4%	101,279	18.2%
Children - Medicaid	26,478	4.9%	41,045	7.5%
American Community Survey by Poverty Level				
Adults to 150% of poverty guidelines	(11,004)	-1.65%	66,924	9.8%
Children to 250% of poverty guidelines	13,451	2.24%	36,970	6.1%
Children to 300% of poverty guidelines	(94,381)	-13.34%	(72,756)	-10.1%

MEDICAID EXPENDITURE GROWTH

Over the last few years, appropriations for the Department of Health Care Policy and Financing have grown faster than the overall budget when looking at both total funds and General Fund. The growth in appropriations for the Department of Health Care Policy and Financing is often compared to the growth in appropriations for Education and Transportation, so those departments are included in the graphs below for reference, although it should be noted that the Department of Health Care Policy and Financing is not the only department growing faster than the overall budget.





DECOMPOSING THE REQUEST

For FY 2017-18 the Governor is requesting an increase of $373.5 million total funds (4.1 percent), including $142.8 million General Fund (5.4 percent), for the Department. Most of the increase is for projected expenditures based on current law and policy, rather than for new discretionary requests. The forecast requests, R1 through R5, and annualizations of prior year budget actions account for $333.8 million total funds, including $140.7 million General Fund, while all other requests account for $39.7 million total funds, including only $2.1 million General Fund. As a result, the summary of the Department's request on page 15 and the accompanying descriptions of the incremental changes may leave readers frustrating when trying to understand what is driving the request. This issue brief disaggregates the request in a different way to provide an alternative approach for understanding the request. In doing so, this issue brief will blur the boundaries between some divisions, line items, and requests to look at the Department as a whole.

The tables below divide Department expenditures into four broad categories of administration, physical health, long-term services and supports (LTSS), and behavioral health. Some of the Governor's request is attributable to a reforcast of FY 2016-17 expenditures, so the tables divide the request into components related to FY 2016-17 and FY 2017-18. The sum of the FY 2016-17 and FY 2017-18 changes is the total change requested by the Governor. While total fund expenditures are dominated by physical health, it is worth noting that when looking at the General Fund the expenditures for LTSS are almost as significant.

Total Funds							
	FY 16-17 Appropriation	FY 16-17 Change		FY 16-17 Projection	FY 17-18 Change		FY 17-18 Request
		Dollars	Percent		Dollars	Percent	
Administration	$302,576,468	($1,295,480)	-0.4%	$301,280,988	$2,603,220	0.9%	$303,884,208
Physical Health	5,773,210,351	152,136,219	2.6%	5,925,346,570	117,041,522	2.0%	6,042,388,092
Long-term Services & Supports	2,352,850,073	(27,528,210)	-1.2%	2,325,321,863	136,292,442	5.9%	2,461,614,305
Behavioral Health	688,243,986	(56,448,298)	-8.2%	631,795,688	50,705,082	8.0%	682,500,770
TOTAL	**$9,116,880,878**	**$66,864,231**	**0.7%**	**$9,183,745,109**	**$306,642,266**	**3.3%**	**$9,490,387,375**

General Fund							
	FY 16-17 Appropriation	FY 16-17 Change		FY 16-17 Projection	FY 17-18 Change		FY 17-18 Request
		Dollars	Percent		Dollars	Percent	
Administration	$76,501,537	$17,451	0.0%	$76,518,988	$2,293,468	3.0%	$78,812,456
Physical Health	1,264,932,022	30,270,395	2.4%	1,295,202,417	72,284,542	5.6%	1,367,486,959
Long-term Services & Supports	1,116,569,778	(13,109,341)	-1.2%	1,103,460,437	58,678,867	5.3%	1,162,139,304
Behavioral Health	196,390,877	(6,379,746)	-3.2%	190,011,131	(1,219,113)	-0.6%	188,792,018
TOTAL	**$2,654,394,214**	**$10,798,759**	**0.4%**	**$2,665,192,973**	**$132,037,764**	**5.0%**	**$2,797,230,737**

ADMINISTRATION

The changes to administration are primarily for centrally appropriated line items and the staffing and information technology components of the Department's discretionary requests.

PHYSICAL HEALTH

For physical health, the tables below summarize the projected changes for FY 2016-17 and FY 2017-18.

Physical Health 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 Criteria Change	66,099,921	15,713,791	1,215,017	49,171,113
Medicare insurance premiums	16,607,810	4,567,492	0	12,040,318
Children's Basic Health Plan	15,610,893	1,515	3,681,198	11,928,180
Hospital payment timing (in R6)	(15,440,295)	(7,720,148)	0	(7,720,147)
Limit Physical Therapy/Occupational Therapy	(2,224,371)	2,386,258	(40,613)	(4,570,016)
Other	(2,073,283)	(2,490,826)	(2,425,493)	2,843,036
TOTAL FY 2016-17 Changes	**$152,136,219**	**$30,270,395**	**$6,624,653**	**$115,241,171**

Physical Health FY 2017-18 Changes				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
Medicaid Caseload				
Elderly and People with Disabilities	$26,572,108	$10,271,711	$3,014,342	$13,286,055
Children	30,511,976	11,793,473	0	18,718,503
Non-Expansion Adults	18,573,541	9,695,694	(445,699)	9,323,546
Expansion Adults	118,728,452	0	6,530,065	112,198,387
Subtotal - Caseload	*194,386,077*	*31,760,878*	*9,098,708*	*153,526,491*
Per Capita Trends	705,853	(1,685,439)	362,942	2,028,350
R6 Delivery system and payment reform	53,090,887	18,595,199	903,427	33,592,261
Annualize Hepatitis C Criteria Change	27,217,614	6,496,366	918,447	19,802,801
Medicare Modernization Act	18,304,677	18,304,677	0	0
Medicare insurance premiums	8,397,467	4,534,632	0	3,862,835
Children's Basic Health Plan	2,899,109	(1,880,340)	(256,121)	5,035,570
R11 Vendor transitions	2,100,000	680,400	369,600	1,050,000
Annualize HB 16-1408 Autism Treatment	0	4,991,726	(4,991,726)	0
FMAP Change (Standard and ACA)	0	4,632,278	47,149,559	(51,781,837)
Hospital Provider Fee				
Unrestricted Growth	273,495,333	0	138,061,558	135,433,775
Proposed Restriction	(390,000,000)	0	(195,000,000)	(195,000,000)
Subtotal - Hospital Provider Fee	*(116,504,667)*	*0*	*(56,938,442)*	*(59,566,225)*
Annualize HB 16-1408 Primary Care Rate Bump	(51,053,050)	0	(18,583,013)	(32,470,037)
Annualize Hospital payment timing (in R6)	(7,720,148)	(3,860,074)	0	(3,860,074)
R7 Oversight of state resources	(1,402,565)	(2,789,665)	(240,123)	1,627,223
Other	(13,379,732)	(7,496,096)	2,225,972	(8,109,608)
TOTAL FY 2017-18 Changes	**$117,041,522**	**$72,284,542**	**($19,980,770)**	**$64,737,750**

FY 2016-17

- Caseload – Changes in caseload projections increase the forecast by a net $100.7 million total funds, but the General Fund remains largely unchanged. The fiscal impact of an increase in projected adult enrollment is offset by decreases in projected enrollment for the elderly and people with disabilities and for children. The total funds increase is driven by a projected increase in enrollment of expansion adults.
- Per capita trends – Changes in per capita assumptions decrease the forecast by $27.1 million total funds, but increase the General Fund forecast by $18.1 million. The increase in General Fund is primarily because FY 2015-16 actual per capita expenditures for people with disabilities were higher than expected, causing the Department to increase the forecast for this population for FY 2016-17. The decrease in federal funds is primarily due to per capita expenditures for expansion adults trending lower than expected, but the decrease in per capita expenditures for expansion adults is not as great as the increase in costs due to higher enrollment by this population.
- Hepatitis C Criteria Change – A change in prior authorization review criteria for Hepatitis C drug treatments increased the forecast by $66.1 million, including $15.7 million General Fund. As of October 1, 2016, the Department changed the prior authorization review criteria to provide coverage to 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. When annualized, this change is projected to increase expenditures by $93.3 million total funds, including $22.2 million General Fund. According to the Department, new data has emerged questioning the accuracy of fibrosis scores as an indicator of disease progression. Washington State's Medicaid program recently

faced an injunction from a federal judge against implementing prior authorization review criteria for Hepatitis C drug benefits based on fibrosis scores. A similar law suit was recently filed against Colorado and several other states. The Department estimates that providing drug coverage to all patients with a Hepatitis C diagnosis would cost another $550.6 million total funds, including $131.4 million General Fund, after drug rebates.

- Medicare insurance premiums – An updated estimate of Medicare insurance premiums increased the projection $16.6 million, including $4.6 million. The most recent report of the federal Medicare trustees report recommends a significant increase in Medicare premiums for 2007, driving an increase in projected Medicaid expenditures for both FY 2016-17 and FY 2017-18. Medicaid pays the Medicare premiums for people who qualify for both Medicaid and Medicare. Last year, the Commission recommended an even larger increase, but Congress took action to limit the growth in Medicare premiums.
- Children's Basic Health Plan – The Department raised the forecast for the Children's Basic Health Plan by $15.6 million total funds, with almost no change in the General Fund. The increase 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.
- Hospital payment timing (in R6) – A change in the timing of hospital outpatient payments is expected to result in short-duration savings of $15.4 million total funds, including $7.7 million General Fund. Total payments to the hospitals will not change. The old 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, but it is not a new policy that the JBC is being asked to approve, because it has already been implemented.
- Limit Physical Therapy/Occupational Therapy – The Department decreased the projection by $2.2 million total funds, but increased the General Fund by $2.4 million, for implementing a 12 hour per year limit on physical and occupational therapy as of July 1, 2016. This was a policy change approved by the General Assembly and the Centers for Medicare and Medicaid Services (CMS) as a budget control 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.

FY 2017-18

- Caseload – Caseload growth is projected to increase total expenditures by $194.4 million, including $31.8 million General Fund at FY 2016-17 projected average per capita costs. The General Fund increase is attributable to growth in the elderly, people with disabilities, children, and non-expansion adults. The General Fund caseload increase is 44 percent of the total General Fund increase for FY 2017-18.
- Per Capita Trends – The Department is adjusting numerous assumptions about per capita costs, but in net these adjustments have a negligible impact on the change in expenditures for FY 2017-18.
- R6 Delivery system and payment reform – This decision item increases projected physical health costs by $53.1 million, including $18.6 million, mostly due to continuing the primary care rate bump and replacing the tobacco financing authorized in HB 16-1408 for the rate bump with General Fund. This cost is offset in the request by changes in hospital payment timing and in behavioral health capitation rates that are shown separately.
- Annualize Hepatitis C Criteria Change – As described under the FY 2016-17 changes above, the Department expanded Hepatitis C treatment criteria. This is the cost to annualize the FY 2016-17 policy change. The total full-year cost for the criteria change is $93.3 million total funds, including $22.2 million General Fund.
- Medicare Modernization Act – Payments through the Medicare Modernization Act to reimburse the federal government for a portion of the cost of paying for prescription drugs for people dually eligible for Medicaid and Medicare are expected to increase by $18.3 million General Fund. The increase is primarily attributable to increased prescription drug costs for Medicare, but also affected by increased drug utilization by seniors.
- Medicare insurance premiums – This $8.4 million total funds increase, including $4.5 million General Fund, is a continuation of the increase described under the FY 2016-17 changes above in Medicare insurance premiums for calendar year 2017.
- Children's Basic Health plan – The Department projects CHP+ expenditures will increase $2.9 million total funds, including a decrease of $1.9 million General Fund. This is a result of enrollment increases seen in FY 2016-17 beginning to taper in FY 2017-18 and the end of General Fund reconciliation payment to the federal government for overcharges in prior years.
- R11 Vendor transitions – In this decision item the Department requests a temporary increase of $2.1 million, including $0.7 million General Fund, for transition costs associated with a new Accountable Care Collaborative vendor.
- Annualize HB 16-1408 Autism Treatment – House Bill 16-1408 provided one-time General Fund relief in FY 2016-17 by spending down a balance of tobacco settlement moneys in the Autism Treatment Fund, but that spending from the fund balance must be replaced with $5.0 million General Fund in FY 2017-18 to continue federally-mandated behavioral therapy services for children with autism.
- FMAP Change (Standard and ACA) – The average standard federal match rates for the fiscal year for both Medicaid and CHP+ are decreasing from 50.2 percent to 50.0 and from 88.14 percent to 88.0 percent respectively, due to improving per capita income in Colorado relative to the national average. This requires an increase in General Fund of $4.6 million and a corresponding decrease in federal funds. In addition, the average federal match rate for the fiscal year for ACA expansion adults is decreasing from 97.5 percent to 94.5 percent. Most of the

increase in other state funds and remaining decrease in federal funds is for the Hospital Provider Fee covering the increased state share for expansion adults.

- Hospital Provider Fee – The Department projects a net decrease of $116.5 million total funds, including $56.9 million from the Hospital Provider Fee, in payments to increase hospital reimbursements, referred to in this document as booster payments. Absent any restriction on Hospital Provider Fee revenues, the Department projects that booster payments would increase $273.5 million total funds, including $138.1 from the Hospital Provider Fee. However, the Governor is proposing a $195.0 million restriction on Hospital Provider Fee revenues that will decrease booster payments by $390.0 million total funds. The combination of the projected unrestricted growth and the Governor's proposed restriction results in the net change.
- Annualize HB 16-1408 Primary Care Rate Bump – The Department expects a reduction of $51.1 million, including $18.6 million tobacco settlement funds, from the end of a one-time transfer that supported an increase in primary care provider rates that is referred to as the primary care rate bump. As described above, in *R6 Delivery system and payment reform* the Department is requesting General Fund to continue the primary care rate bump and transform it over time to a performance-based payment.
- Annualize Hospital payment timing (in R6) – As described above under FY 2016-17 the Department changed the timing of hospital outpatient payments resulting in a short-duration savings. This is the incremental difference in savings for FY 2017-18.
- R7 Oversight of state resources – This request proposes a lot changes to administrative expenses, but a few of the changes have ramifications for the Department's projection of physical health care costs, including an increased federal match due to coordinating services for Native Americans, fraud prevention efforts, and changes to rates for office administered drugs.

LONG-TERM SERVICES AND SUPPORTS

For long-term services and supports (LTSS), the table below summarizes the projected changes for FY 2016-17 and FY 2017-18. The table eliminates all the fund source detail shown in the tables for physical health, because the financing for LTSS is much simpler. Almost all of the expenditures for LTSS are at a 50 percent federal match rate. Alternative cash funds financing accounts for only 2.9 percent of expenditures, and almost all of that financing is from the Nursing Provider Fee. So, for all the rows in the table except the Nursing Provider Fee row, the General Fund impact is going to be approximately half of the total funds.

Long-term Services and Supports							
	FY 16-17	FY 16-17 Change		FY 16-17	FY 17-18 Change		FY 17-18
	Appropriation	Dollars	Percent	Projection	Dollars	Percent	Request
Nursing Homes	$661,130,031	($11,886,639)	-1.8%	$649,243,392	$23,417,777	3.6%	$672,661,169
Services for people with IDD	560,112,619	(19,194,411)	-3.4%	540,918,208	29,011,212	5.4%	569,929,420
Elderly, Blind and Disabled Waiver	363,084,880	4,609,746	1.3%	367,694,626	29,055,493	7.9%	396,750,119
Long-term Home Health	253,310,658	2,391,122	0.9%	255,701,780	15,183,688	5.9%	270,885,468
PACE	156,026,037	(8,732,244)	-5.6%	147,293,793	17,232,759	11.7%	164,526,552
Nursing Provider Fee	97,869,540	5,153,056	5.3%	103,022,596	2,801,608	2.7%	105,824,204
Private Duty Nursing	85,995,159	(3,425,446)	-4.0%	82,569,713	9,471,649	11.5%	92,041,362
Hospice	55,870,038	(2,402,054)	-4.3%	53,467,984	2,491,360	4.7%	55,959,344
Mental Health Supports Waiver	40,652,035	1,142,836	2.8%	41,794,871	3,393,879	8.1%	45,188,750
Single Entry Points	31,461,008	1,558,925	5.0%	33,019,933	1,340,609	4.1%	34,360,542
Brain Injury Waiver	19,774,938	1,559,086	7.9%	21,334,024	600,062	2.8%	21,934,086
Disabled Children's Waiver	14,417,668	216,801	1.5%	14,634,469	1,416,268	9.7%	16,050,737
Human Services programs	6,590,952	0	0.0%	6,590,952	1,000,000	15.2%	7,590,952
Other	6,554,510	1,481,012	22.6%	8,035,522	(123,922)	-1.5%	7,911,600
TOTAL LTSS	**$2,352,850,073**	**($27,528,210)**	**-1.2%**	**$2,325,321,863**	**$136,292,442**	**5.9%**	**2,461,614,305**

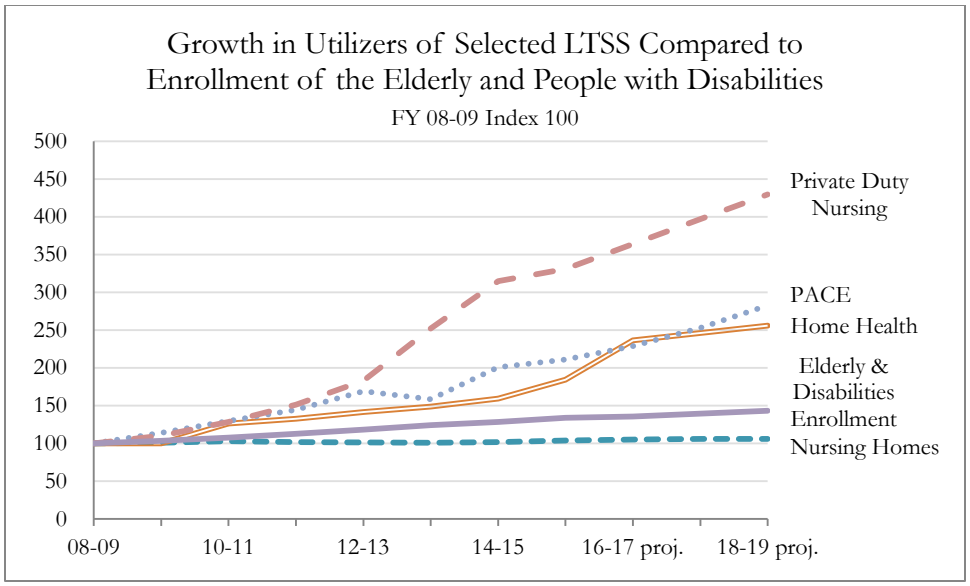
The items listed in the table as a "Waiver" are programs where the Department has received federal permission to offer non-standard services designed to prevent institutionalization to specific qualifying populations. Some of the typical benefits offered through the waivers include adult day services, alternative care facilities (assisted living), homemaker services, personal care, home modifications, and respite care. Specific services offered and utilization limits may vary depending on the target population for the waiver.

- Nursing Homes – The $11.9 million decrease in FY 2016-17 is due to a lower patient day estimate based on FY 2015-16 actuals. The $23.4 million increase in FY 2017-18 is primarily due to the annual statutory inflation in nursing home rates, plus a relatively small projected increase in patient days. Nursing home rates are calculated using a complicated statutory formula that seeks to keep aggregate General Fund increases to the lesser of the growth in actual nursing home costs or three percent. Nursing home utilization is increasing at a slower rate than overall enrollment of the elderly and people with disabilities. When direct payments for nursing homes are combined with financing from the Nursing Provider Fee, expenditures for nursing homes represent 32.3 percent of LTSS costs.
- Services for people with IDD – Services for people with intellectual and developmental disabilities (IDD) will be discussed in detail during the 12/19/16 briefing on the Office of Community Living, but the changes are mostly driven by the Adult Comprehensive Services and Supported Living Services waivers. The totals in this table include the regional centers. Including the regional centers, services for people with intellectual and developmental disabilities represent 23.3 percent of all expenditures for LTSS.
- Elderly, Blind and Disabled Waiver – The $29.1 million increase in FY 2017-18 is nearly equal parts attributable to increases in enrollment and per enrollee costs. Both enrollment and per enrollee costs are projected to grow 3.9 percent, compounding to produce the projected overall 7.9 percent rate of growth. Increases in the utilization of consumer directed services, personal care, and homemaker services contributed significantly to the change in per enrollee cost assumptions.
- Long-term home health – The $15.2 million increase is a function of increases in both the number of people utilizing home health and the amount of services they are using within the

benefit. The long-term home health benefit includes physical therapy, occupational therapy, speech therapy, nursing visits, and home health aid visits.

- PACE – The $8.7 million decrease in FY 2016-17 for the Program for All-inclusive Care for the Elderly (PACE) is a correction to the forecast to account for patient payments. The increase $17.2 million increase for FY 2017-18 is primarily attributable to a 10.6 percent projected increase in enrollment. The number of PACE facilities operating in the state and the number of Medicaid recipients enrolling in the PACE program have both increased dramatically in recent years. PACE provides clients with a continuum of care from home- and community-based services to nursing home services. Providers receive a capitated payment based on expected utilization and accept risk if utilization of the higher cost nursing home services is higher than expected
- Nursing Provider Fee – The $5.2 million increase in FY 2016-17 is a correction for FY 2015-16 actuals being higher than expected and the $2.8 million increase for FY 2017-18 is based on the statutory formula that allows the nursing provider fee to fill in costs not covered by nursing rate increases up to federal upper payment limits. The mechanics of the Nursing Provider Fee are very similar to the Hospital Provider Fee, but the statutory uses and scale are different.
- Private Duty Nursing – The $3.4 million decrease in FY 2016-17 is a correction for the number of utilizers trending lower than expected, but the average growth in utilizers per year is still very high, explaining the projected $9.5 million increase for FY 2017-18. The private duty nursing benefit pays for nursing services for clients with high needs. Typically the clients are technology dependent and require round the clock care, as opposed to the brief nursing visits covered through the long-term home health benefit.
- Hospice – The $2.4 million decrease in FY 2016-17 is due to the net projected fiscal impact of a federally mandated restructuring of rates. The new rates pay a higher amount for the first 60 days of services and a lower amount thereafter. The $2.5 million increase in FY 2017-18 is due to projected enrollment plus inflation in the portion of hospice rates that is connected to nursing home rates.
- Mental Health Supports Waiver – The $3.4 million FY 20171-8 increase is due to an expected 4.7 percent increase in enrollment and 3.7 percent increase in cost per enrollee.
- Single Entry Points – The contracts with the SEPs are based on waiver enrollment, so changes in total waiver enrollment change the expenditures for the SEPs.
- Brain Injury Waiver – Both the FY 2016-17 correction and FY 2017-18 increase are driven by enrollment.
- Disabled Children's Waiver – The $1.4 million increase in FY 2017-18 is primarily attributable to enrollment.

The table below highlights some LTSS where utilization is growing significantly faster or slower than overall enrollment of the elderly and people with disabilities.



BEHAVIORAL HEALTH

Behavioral health services will be discussed in detail during the 12/13/16 briefing on Behavioral Health Community Programs. Most behavioral health services are paid for based on a capitated rate per eligible enrollee that must by federal regulation be actuarially sound to cover costs. The decrease for behavioral health in FY 2016-17 is primarily a function of capitated rates coming in lower than expected. The increase in FY 2017-18 is mostly attributable to enrollment growth and the end of some reconciliations that were lowering expenditures in prior years.

The net change in FY 2017-18 includes a reduction of $26.7 million total funds, including $7.2 million General Fund, for a federally mandated modification to the way capitated rates are calculated. Rather than allowing states to set capitated rates within a range determined by a third party to be actuarially sound to cover costs, the new federal policy requires states to set capitated rates at a specific point determined to be actuarially sound. For behavioral health, the Department expects this point under the new federal policy will be lower than the current rates, resulting in a savings that is accounted for in *R6 Delivery system and payment reform*. As part of that decision item, the Department proposes a new supplemental payment to allow behavioral health providers to earn back the lost revenue if they meet performance objectives. However, the Department assumes that the new supplemental payments would not begin until FY 2018-19, after performance data from FY 2017-18 is collected and evaluated, resulting in the one-time savings in FY 2017-18.

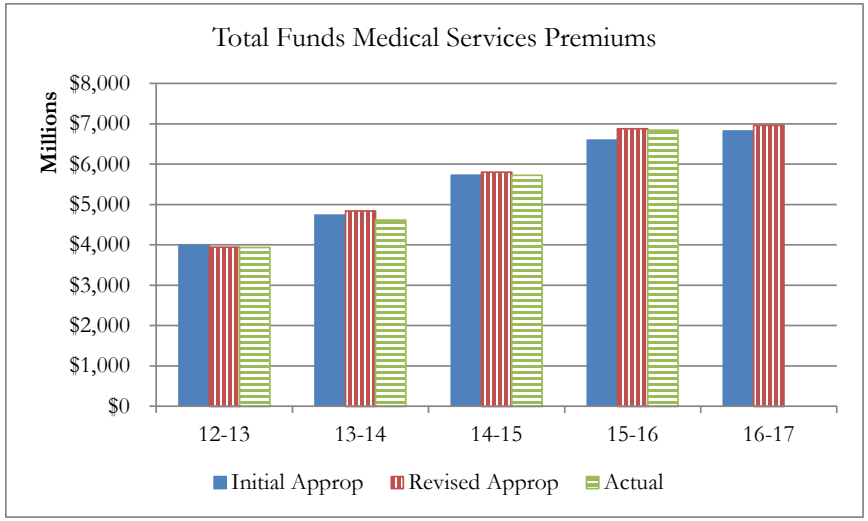
ACCURACY OF THE FORECAST

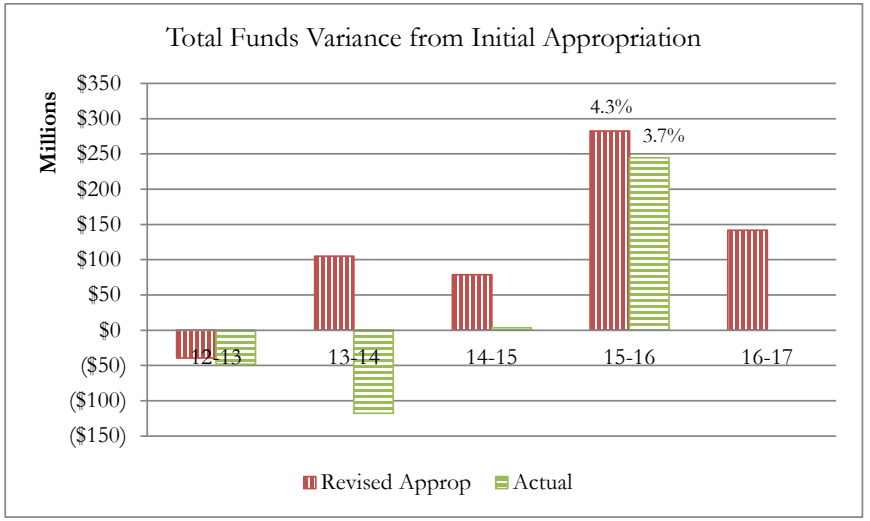
With so much of the funding for the Department based on forecasted enrollment and expenditures under current law, it begs the question of how accurate the Department is in forecasting. This is a surprisingly difficult question to answer because it is challenging to disentangle the effects of policy decisions by the General Assembly from what the Department could reasonably be expected to project. Every year the Department includes with the request a comparison of prior year forecasts to actuals, but it doesn't account for policy changes of the General Assembly. For example, the comparison shows that in FY 2013-14 the revised forecast increased $551.4 million from the initial forecast, suggesting a significant forecast error, until considering that the revised forecast took into

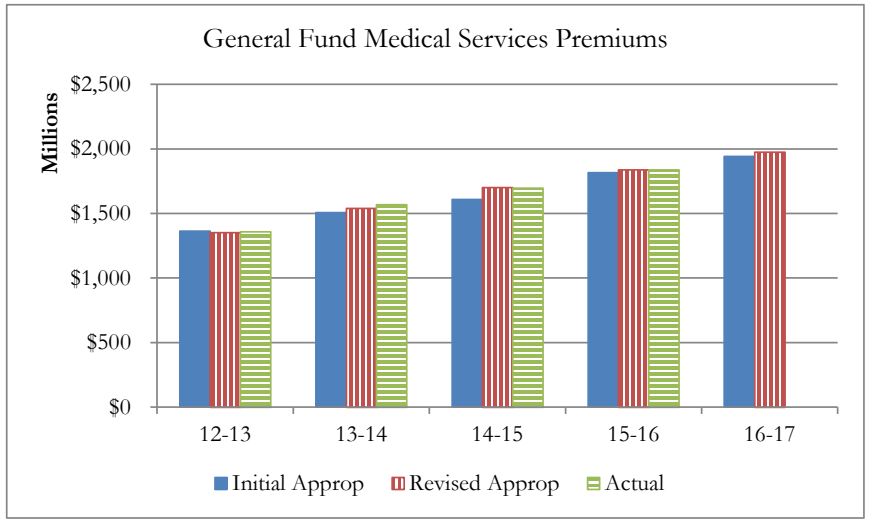
account the Medicaid expansion authorized by S.B. 13-200. The Department's comparison also focuses on total funds, when much of the forecast errors in recent years have been due to misjudgment of the financing leading to the need for General Fund adjustments. To address these weaknesses in the Department's comparison, the JBC looked at the appropriations, which reflect a combination of the Department's base forecast and the predicted impact of policy actions of the General Assembly. This means that some of the forecast error will be attributable to assumptions of the JBC staff and Legislative Council Staff, but the Department works very closely with the JBC staff and Legislative Council Staff in estimating the impact of policy actions of the General Assembly and disagreements of a large magnitude are infrequent. To further minimize the skewing by policy actions of the General Assembly, the JBC staff limited the analysis to the Medical Services Premiums line item. Finally, the JBC staff did not go back further than FY 2012-13, because prior to that year the JBC staff prepared a competing forecast of expenditures that the JBC sometimes selected for the appropriation.

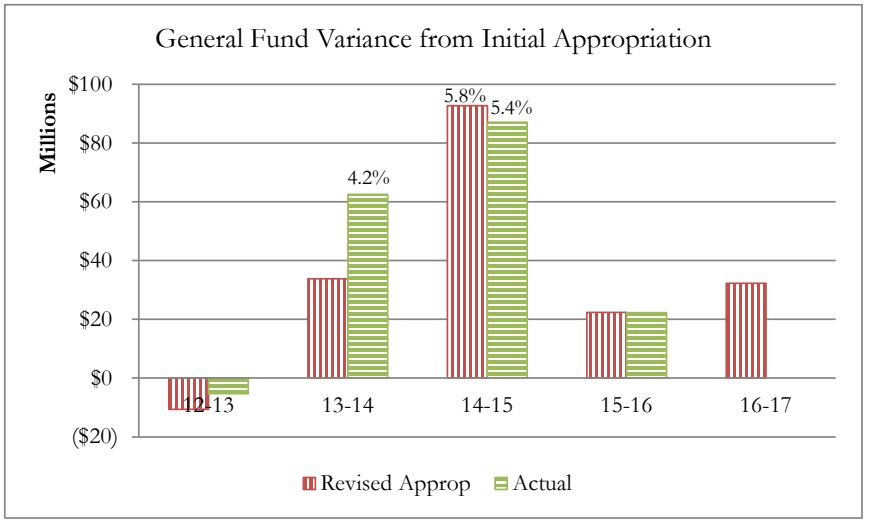
The tables on the next page compare the initial appropriation, the revised appropriation after supplementals, and the actual expenditures. Due to the scale of the graphs on the left of the page, it can be difficult to judge the magnitude of variations. The graphs on the right show just the variations from the initial appropriation. So, for example, in FY 2013-14 the revised appropriation, or supplemental, increased total funds by $105.1 million from the initial appropriation, but the actual expenditure ended up being $118.1 million below the initial appropriation. Places where the revised appropriation or actual varied by more than three percent from the initial appropriation are highlighted.

During this period the implementation of the Affordable Care Act (ACA) in 2014 introduced significant uncertainty to the forecast. The Department began serving a large new population it had never served before where both the likely enrollment and expenditures per capita were unknown. The combination of outreach efforts and publicity associated with the expansion and the individual mandated caused increased enrollment from people previously eligible but not enrolled. And, the ACA changed the way income was calculated for eligibility determination purposes in ways that caused restated income to switch between eligibility bands that have significantly different financing. With such significant changes to the Medicaid program a higher than typical forecast error could be expected.


Total Funds Medical Services Premiums
Millions
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
12-13
13-14
14-15
15-16
16-17
Initial Approp
Revised Approp
Actual


Total Funds Variance from Initial Appropriation
Millions
$350
$300
$250
$200
$150
$100
$50
$0
($50)
($100)
($150)
4.3%
3.7%
12-13
13-14
14-15
15-16
16-17
Revised Approp
Actual


General Fund Medical Services Premiums
Millions
$2,500
$2,000
$1,500
$1,000
$500
$0
12-13
13-14
14-15
15-16
16-17
Initial Approp
Revised Approp
Actual


General Fund Variance from Initial Appropriation
Millions
$100
$80
$60
$40
$20
$0
($20)
4.2%
5.8%
5.4%
12-13
13-14
14-15
15-16
16-17
Revised Approp
Actual

FACTORS NOT ACCOUNTED FOR IN THE FORECAST

PARENTS AND CARETAKERS WITH INCOME THAT RISES ABOVE 68 PERCENT

The Department has identified a systems error that is causing parents and caretakers with income that rises above 68 percent of the federal poverty guidelines (FPL) to be categorized as eligible for federal funding at the enhanced rate for expansion populations that applies to parents and caretakers with income between 69 percent and 138 percent of the FPL. However, prior to the ACA expansion this population would have entered a status called transitional Medicaid and remained eligible for one year. Therefore, the population should be financed at the standard non-expansion federal match rate of 50 percent. The Department is in the process of fixing the systems error and determining how much overbilling to the federal government occurred. The forecast for both FY 2016-17 and FY 2017-18 corrects for the systems error when estimating the General Fund needed. However, the Department does not yet have enough information to estimate the size of overbillings from FY 2015-16 when it is believed that the systems error first emerged. There is also room for negotiations with the federal government on the size and timing of repayments.

A preliminary estimate from the Department identified a range for the overbilling of the federal government that occurred in FY 2015-16 and might need to be repaid of between $20.7 million and $30.0 million. A small portion of the repayment would be from the Hospital Provider Fee, but the lion's share of the burden would be from the General Fund.

The potential cost of this repayment is not specifically accounted for in the Governor's budget, but as noted previously the Governor included a set aside for potential supplementals related to the Department of Health Care Policy and Financing. The unallocated portion of that set aside is $13.2 million General Fund.

CHILDREN'S BASIC HEALTH PLAN (CHP+)

The Department's request assumes federal funding for CHP+ will continue at an 88 percent federal match for state FY 2017-18, but federal funding is currently only appropriated through September 2017. The federal statutory authorization for the CHP+ program extends through September 2019, as do federal maintenance of effort requirements that don't allow the state to reduce eligibility for children served through Medicaid and CHP+. However, the federal funding for CHP+ has only been approved through September 2017. A similar scenario played out last year and the Department's instinct that federal funding for CHP+ would be extended proved correct. With the change in federal administration, the Department is less certain about the prospects for an extension of federal funding for CHP+ this year. The JBC may want to ask the Department to discuss contingency plans at the hearing if federal funding is not reauthorized, or reauthorized at a significantly lower rate. It is possible that the Department would not know the federal funding status of CHP+ until the Colorado legislature is out of session.

The Department currently projects direct costs for the CHP+ program (not including administration) of $160.0 million in FY 2017-18 and expects to receive $138.4 million federal funds for the program. This would serve an estimated 64,733 children and pregnant women. Children qualify for CHP+ with an effective family income from 147 percent to 265 percent of the federal poverty guidelines (FPL). Pregnant women qualify for CHP+ with a family income from 201 percent to 265 percent of FPL.

ISSUE: ACCOUNTABLE CARE COLLABORATIVE AND RELATED PAYMENT REFORMS (R6)

This issue brief discusses the Department's plans and expected costs and savings for Phase II of the Accountable Care Collaborative as well as related payment reforms.

SUMMARY

- The Accountable Care Collaborative (ACC) pays regional organizations to develop the provider network, connect clients to providers, and ensure clients receive coordinated care. The ACC also increases payments to primary care medical providers to coordinate care at the practice level. A relatively small portion of ACC funding is distributed based on performance.

- The Department estimates that after accounting for administrative costs the ACC resulted in a net savings of $61.9 million total funds in FY 2015-16 through avoiding unnecessary high cost care. However, there are significant variations in the success of the ACC in changing expenditure patterns for different populations.

- Phase II of the ACC focuses on integration of the physical and behavioral health delivery systems, increased participation in the ACC through mandatory enrollment, promoting team-based care that involves specialists and health neighborhoods that extend beyond traditional health providers, and new standards for engaging and activating clients in treatment plans.

- Related to the implementation of Phase II of the ACC, the Department proposes performance-based payments for primary care, behavioral health, and Federally Qualified Health Centers as part of *R6 Delivery system and payment reform*.

RECOMMENDATION

The issue brief suggests that the JBC may want to discuss the governance structure and approval process for Phase II of the ACC and the related performance payment reforms with the Department at the hearing.

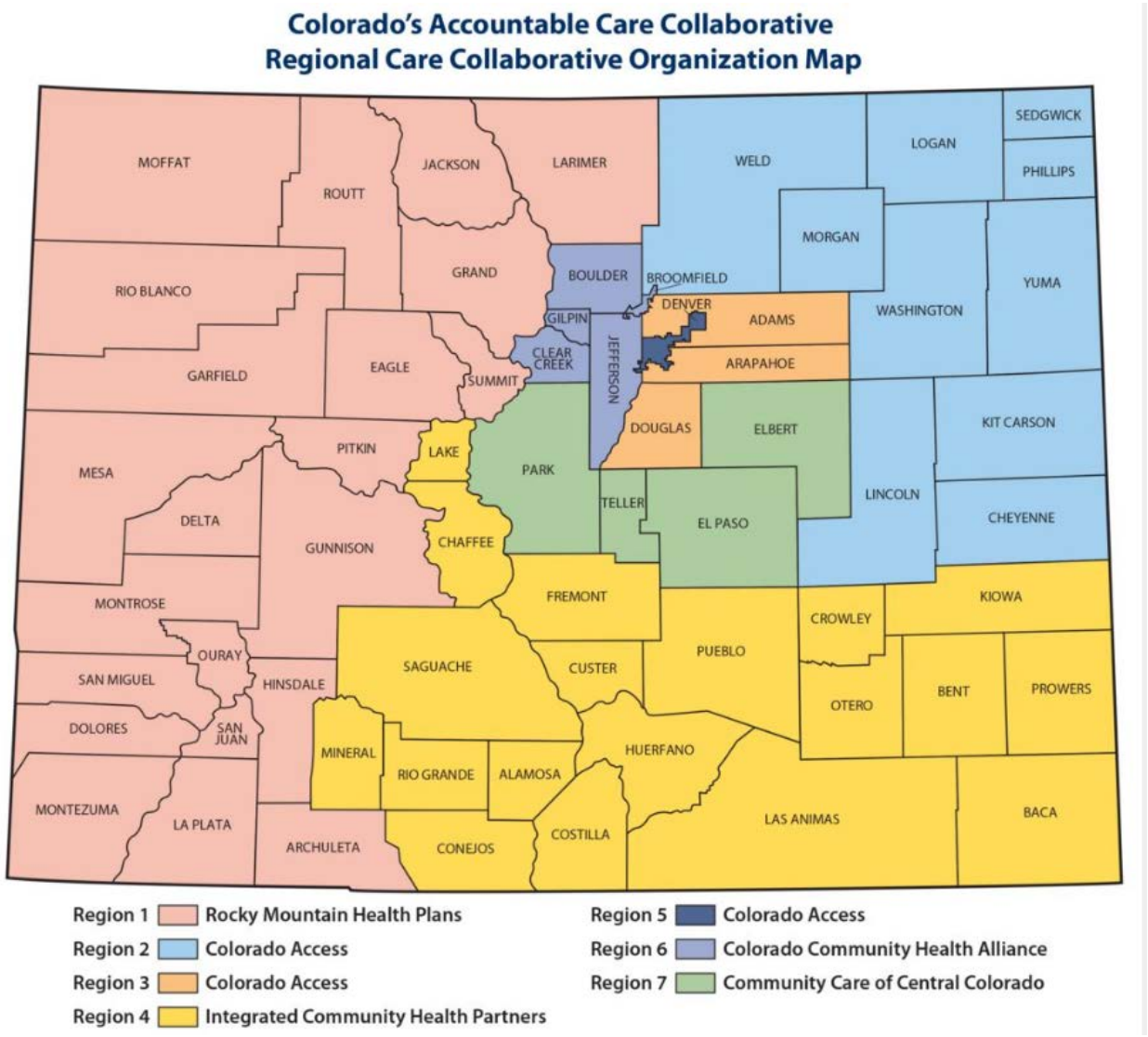
The issue brief also raises questions about the probability of the projected increases in cost avoidance with the implementation of Phase II of the ACC that may be worth discussing with the Department at the hearing.

DISCUSSION

In FY 2015-16 the Department spent approximately $143.2 million, including $50.1 million General Fund, on the Accountable Care Collaborative (ACC) to coordinate care and pay for performance, and thereby improve health outcomes and reduce costs. In *R6 Delivery system and payment reform* the Department proposes several new performance payments that build on the principles of the ACC and describes projected costs and savings associated with Phase II of the ACC.

STRUCTURE AND COSTS OF THE ACCOUNTABLE CARE COLLABORATIVE

The ACC created a new regional administrative structure to coordinate care that did not exist for physical health before. In FY 2015-16 the Department spent $107.1 million, or 75 percent of the total for the ACC, on seven regional organizations. These organizations are currently referred to as Regional Care Collaborative Organizations (RCCOs), but will be renamed Regional Accountable Entities (RAEs) in Phase II of the ACC to acknowledge changes in the scope of their responsibilities. They are administrative organizations that do not directly deliver services. The map below shows the current ACC regions.



The regional organizations are responsible for developing the provider network, connecting Medicaid clients to providers, and ensuring that Medicaid clients receive coordinated care. Developing the network includes recruiting providers, maintaining referral lists of specialists accepting Medicaid, and working with providers to transform their practices to improve quality of care. Connecting clients to providers includes not only ensuring that Medicaid clients have a medical

home, but also working to make sure clients follow up on referrals and post-treatment care. Ensuring that clients receive coordinated care includes tracking data to identify clients who might benefit from preventive or follow-up care, working with providers to deliver the care to clients, and developing programs such as classes and electronic consults to assist providers in getting appropriate care to Medicaid clients.

Of the payments to the regional organizations $96.7 million, or 90 percent, was distributed as a per member per month (PMPM) payment. The remaining $10.5 million, or 10 percent, was distributed based on meeting performance goals set by the Department.

The second core component of the ACC is payments to primary care medical providers (PCMPs), which received $32.7 million, or 23 percent of total ACC payments, in FY 2015-16. The PCMPs are responsible for coordinating care at the practice level. Of the payments to the PCMPs, $26.2 million, or 80 percent, was distributed as a PMPM payment and $6.5 million, or 20 percent, was disbursed based on performance.

The last component of the ACC is a payment to the State Data Analytics Coordinator (SDAC) responsible for tracking data to help the regional organizations and PCMPs improve care coordination, and to help the Department determine performance payments. The SDAC received $3.4 million, or 2.4 percent, of total ACC payments in FY 2015-16.

Overall, the amount paid through the ACC based on performance was relatively small in FY 2015-16. The total combined performance payments to the RCCOs and PCMPs was only $17.0 million, or 11.9 percent of the cost of the ACC.

Currently, new Medicaid clients are passively enrolled in the ACC and can opt out if they don't want to participate. The Department indicates 4.6 percent of those passively enrolled opt out. Clients are attributed to a PCMP based on claims history. People receiving their physical health care through a managed care program that is not part of the ACC are exempted from passive enrollment, which includes clients that are in the Program for All-inclusive Care for the Elderly (PACE) and the Denver Health managed care plan. The Department also currently exempts clients with a nursing home claim in the last 12 months and clients in a Medicare Advantage Plan. For clients dually eligible for Medicare and Medicaid the Department has an agreement with the federal government to share in any cost savings that accrue to the Medicare program. This population was only recently added to the ACC and the evaluation of cost savings to Medicare is not complete. Clients who are eligible to receive assistance with Medicare premiums, but not eligible for full Medicaid benefits are not enrolled in the ACC.

SAVINGS AND PERFORMANCE OF THE ACCOUNTABLE CARE COLLABORATIVE

The Department estimates the ACC saved the state Medicaid program $61.9 million in FY 2015-16 through avoiding unnecessary and high cost care. When the ACC was first implemented it was relatively easy to estimate the cost savings by comparing the expenditures associated with people enrolled in the ACC with those who were not, and early evaluations of the ACC documented savings by this method. Now, with over 80 percent of the Medicaid population enrolled in the ACC, the Department's contract evaluator must make a projection of what costs would have been absent the ACC. The ACC began in FY 2011-12, so to find expenditure trends that don't include the ACC

the contract evaluator must go back several years. Small errors in the contractor's assumptions, or changes in expenditure patterns that are exogenous to the ACC, could result in inaccurate savings projections.

To the extent the projections are accurate, the ACC appears to result in significantly different costs/(savings) based on the population served. Using the average financing rates for the affected populations suggests that the ACC actually results in a net increase in General Fund expenditures.

Avoided Costs			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
People with Disabilities	($134,027,494)	($65,954,930)	(68,072,564)
Expansion Adults	(131,157,637)	0	(131,157,637)
Non-expansion Adults	69,771,146	34,157,701	35,613,445
Children	(9,702,559)	(4,418,545)	(5,284,014)
Performance Payments	NA		
SDAC	NA		
TOTAL	**($205,116,544)**	**($36,215,774)**	**($168,900,770)**

Administrative Costs			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
People with Disabilities	$7,707,725	$3,792,972	3,914,753
Expansion Adults	37,414,646	0	37,414,646
Non-expansion Adults	20,190,399	9,880,601	10,309,798
Children	57,543,412	26,205,270	31,338,142
Performance Payments	17,001,155	8,500,577	8,500,578
SDAC	3,375,525	1,687,762	1,687,763
TOTAL	**$143,232,862**	**$50,067,182**	**$93,165,680**

Net Cost/(Savings)			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
People with Disabilities	($126,319,769)	($62,161,958)	($64,157,811)
Expansion Adults	(93,742,991)	0	(93,742,991)
Non-expansion Adults	89,961,545	44,038,302	45,923,243
Children	47,840,853	21,786,725	26,054,128
Performance Payments	17,001,155	8,500,577	8,500,578
SDAC	3,375,525	1,687,762	1,687,763
TOTAL	**($61,883,682)**	**$13,851,408**	**($75,735,090)**

There are several possible reasons for the net cost to serve non-expansion adults and children and the resulting increase in net General Fund expenditures. There is a risk adjustment to the calculation that takes into account the health of the population. However, if the ACC is improving overall health, the risk adjustment may cause an understatement of the savings from the ACC. The Department notes that non-expansion adults had a lower per capita cost in FY 2015-16 than in FY 2014-15, especially in the area of hospital costs, suggesting that the projected net value of the ACC may not accurately be capturing the savings. The Department also noted that the utilization of long-term services and supports by this population increased, suggesting that the population is aging, which would be a factor not captured in the projection of the net value of the ACC. For children, most utilization is preventive care that generates savings later in life. There can also be benefits from improved health care for children that show up in areas outside of the health arena, such as school

performance. As a result, the Department has concerns about using the estimated net cost/(savings) by population to estimate the impact of the ACC on General Fund expenditures.

Some of the key performance indicators noted in the Department's annual report on the ACC are summarized in the table below. For these indicators the experiences of clients enrolled in the ACC 0-6 months is compared with the experience of clients enrolled 7-11 months. The expectation if the ACC is working is that performance on these metrics will improve as clients are enrolled in the ACC longer.

Selected Performance Metrics of the ACC		
	0-6 months	7-11 months
Primary care follow-up within 30 days of hospital discharge		
Standard ACC	43.8%	48.3%
Medicare- Medicaid ACC	48.8%	62.9%
Depression Screening		
Standard ACC	1.9%	4.0%
Medicare- Medicaid ACC	1.9%	3.4%
Well-child visits ages 3-9		
Standard ACC	27.4%	45.0%
Prenatal care (at least one visit)		
Standard ACC	59.2%	65.5%
Postpartum care		
Standard ACC	66.3%	72.9%
Chlamydia Screening		
Standard ACC	42.3%	48.1%
Emergency room visits per 1,000 members		
Standard ACC	782.5	782.7
Medicare- Medicaid ACC	1,493.4	1,333.7
Hospital readmissions within 30 days per 1,000 members		
Standard ACC	8.5	7.0
Medicare- Medicaid ACC	170.5	99.2
Imaging per 1,000 members		
Standard ACC	314.0	285.4
Medicare- Medicaid ACC	1,461.1	1,165.1
Potentially preventable hospital admissions per 1,000 members		
Medicare- Medicaid ACC	81.2	60.8

The statistics on emergency room visits speak to the need for a program like the ACC. The Colorado Health Institute reports Medicaid clients are more than twice as likely as the privately insured population to access care through the emergency room.[3] While the risk characteristics of the privately insured population are very different from Medicaid, this degree of difference in the usage patterns suggests that there is more at work than just risk profiles and there should be opportunities for managed care to change behavior patterns and accepted norms for how to access services.

The Department's Rate Review Analysis Report also provided some statistics relevant to the ACC. According to the Rate Review Analysis Report, the percentage of Medicaid clients reporting a usual source of care decreased two percentage points between 2013 and 2015 to 84 percent, although the Department notes this is not a statistically significant change and the overall number reporting a usual source of care increased. Creating a medical home for Medicaid clients is a prime objective of the ACC. According to the report, Medicaid clients are less likely to have a usual source of care than

[3] http://www.coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf

other insured Coloradans with 89 percent of those privately insured reporting a usual source of care. Medicaid clients are also less likely to have a preventive care visit than other insured Coloradans (63 percent compared to 68 percent of the privately insured). The percentage of Medicaid clients with a preventive care visit increased a percentage point between 2013 and 2015, but this was not a statistically significant increase. The absolute number of Medicaid clients with a preventive care visit increased. There was a statistically significant increase in specialist visits for Medicaid clients from 2013 to 2015 of 7%. In 2015 Medicaid clients were no more or less likely to access specialists than privately insured Coloradoans.

WHAT'S NEW IN PHASE II?

Phase II of the ACC is being designed through the Request for Proposals (RFP) process. The Department issued a draft RFP November 4, 2016, and public comments are due by January 13, 2017. The Department anticipates the final RFP will be issued in Spring 2017 and contracts will be awarded for the RAEs in the Fall of 2017. The full implementation of Phase II will be in FY 2018-19.

Some key changes to the ACC in Phase II include:

1. Integrating physical and behavioral health – Functions of the Behavioral Health Organizations (BHOs) and the RCCOs will be merged into the new RAEs. New performance incentives will reward increased behavioral health screening and the colocation of physical health and behavioral health services. Requirements that a patient have a covered diagnosis to receive behavioral health services will be relaxed to allow clients to receive limited therapies in a physical health setting.
2. Mandatory enrollment – All full-benefit Medicaid members who are not already part of a Medicaid managed care plan will be enrolled in the ACC. Currently, enrollment in the ACC is voluntary. As of June 2016, 1,025,176 were enrolled in the ACC, or about 80 percent of Medicaid members.
3. An increased emphasis on team-based care and health neighborhoods – There are a number of new requirements for RAEs and PCMPs to work with specialists and non-health community supports. For example, RAEs will be required to maintain electronic tools for specialists and primary care providers to communicate on care coordination issues for doctors that don't already have the technology. A new performance indicator is contemplated measuring the extent RAEs assist with connecting patients referred for specialty care to specialty providers. The Department is considering requiring formal agreements between primary care and specialty providers on who takes the lead in treating episodes of care, and new requirements for communication between primary care and hospital providers. A proposed new performance indicator on obesity would measure the involvement of RAEs with non-health resources such as recreation centers.
4. New standards for promoting member choice and engagement – For example, RAEs would be required to perform an initial screen of needs and work with clients and care givers to develop a health promotion plan.

5 Increased latitude for RAEs to work with PCMPs – Rather than the Department paying PCMPs, the money would go to the RAEs and the RAEs would negotiate with the PCMPs. A minimum of 30 percent of the base payment to RAEs would need to be passed on to PCMPs, but the RAEs could choose to package and target those payments differently.

6 Increased reimbursement – To acknowledge the changing role of the regional organizations, the Department proposes a $1 increase in the PMPM payment to RAEs.

7 Realigning regions – Elbert County would move from Region 7 with El Paso, Teller, and Park counties to Region 3 with Douglas, Arapahoe, and Adams counties. Behavioral health services for Larimer County would move to Region 1 with all the western counties. Clients would be attributed to RAEs based on the location of their primary care provider, rather than their own address, to reduce the number of RAEs that a primary care provider might need to contract with.

R6 DELIVERY SYSTEM AND PAYMENT REFORMS

The projected new costs and savings associated with Phase II of the ACC are described in *R6 Delivery system and payment reforms*. Although the costs and savings do not begin until FY 2018-19, the lead time required to launch Phase II is such that the Department needed a way to communicate with the General Assembly on the expected expenditures and get approval. The Department elected to use this request as the means for that communication.

In addition to describing the projected costs and savings associated with the ACC, *R6 Delivery system and payment reforms* proposes some new ways to pay for performance that build on the principles of the ACC, but that the Department considers as separate from the ACC. The table below summarizes the elements of *R6 Delivery system and payment reforms* by fiscal year. The projections go out to FY 2019-20 to show a full year of savings from the ACC. The Department assumes that the ACC savings lag the implementation of the new Phase II policies by six months. The bullets below the table highlight key elements of the request.

R6 Delivery System and Payment Reform	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2016-17					
Hospital outpatient payment timing	($15,440,295)	($7,720,148)	$0	($7,720,147)	
TOTAL FY 2016-17	**($15,440,295)**	**($7,720,148)**	**$0**	**($7,720,147)**	**0.0**
FY 2017-18					
Primary care rate bump	54,085,240	18,846,157	936,326	34,302,757	
Behavioral health capitation rates	(26,717,069)	(7,215,319)	(1,090,836)	(18,410,914)	
Federally Qualified Health Center Payments	0	0	0	0	
Vaccine stock rates	(994,353)	(250,958)	(32,899)	(710,496)	
Hospital outpatient payment timing	(23,160,443)	(11,580,222)	0	(11,580,221)	
TOTAL FY 2017-18	**$3,213,375**	**($200,342)**	**($187,409)**	**$3,601,126**	**0.0**
FY 2018-19					
Primary care rate bump					
Contract performance evaluator	225,000	112,500	0	112,500	
Payment incentives	60,413,683	21,051,321	1,199,912	38,162,450	
Subtotal - Primary care rate bump	*60,638,683*	*21,163,821*	*1,199,912*	*38,274,950*	
Behavioral health					
Behavioral health incentive payments	26,717,069	7,215,319	1,090,836	18,410,914	
Behavioral health capitation rates	(28,131,120)	(7,503,004)	(1,306,187)	(19,321,929)	
Subtotal - Behavioral health	*(1,414,051)*	*(287,685)*	*(215,351)*	*(911,015)*	
Federally Qualified Health Center Payments	0	0	0	0	
Accountable Care Collaborative (ACC)					
Mandatory enrollment	29,071,971	11,284,115	1,140,906	16,646,950	
Increase PMPM by $1	16,271,367	6,315,635	638,557	9,317,175	
Administrative staff	402,742	201,371	0	201,371	4.6
Savings - Mandatory enrollment	(55,567,996)	(24,079,004)	(2,248,634)	(29,240,358)	
Savings - Physical-behavioral health	(58,759,956)	(15,623,787)	(1,929,381)	(41,206,788)	
Subtotal – ACC	*(68,581,872)*	*(21,901,670)*	*(2,398,552)*	*(44,281,650)*	
Vaccine stock rates	(1,022,420)	(255,171)	(39,016)	(728,233)	
Hospital outpatient payment timing	(23,160,443)	(9,769,075)	0	(13,391,368)	
TOTAL FY 2018-19	**(33,540,103)**	**(11,049,780)**	**(1,453,007)**	**(21,037,316)**	**4.6**
FY 2019-20					
Primary care rate bump					
Contract performance evaluator	150,000	75,000	0	75,000	
Payment incentives	59,055,014	20,577,889	1,492,346	36,984,779	
Subtotal - Primary care rate bump	*59,205,014*	*20,652,889*	*1,492,346*	*37,059,779*	
Behavioral health					
Behavioral health incentive payments	28,131,120	7,503,004	1,306,187	19,321,929	
Behavioral health capitation rates	(28,536,463)	(7,609,325)	(1,569,344)	(19,357,794)	
Subtotal - Behavioral health	*(405,343)*	*(106,321)*	*(263,157)*	*(35,865)*	
Federally Qualified Health Center Payments	0	0	0	0	
Accountable Care Collaborative (ACC)					
Mandatory enrollment	27,439,753	10,586,593	1,153,232	15,699,928	
Increase PMPM by $1	16,654,557	6,425,532	699,954	9,529,071	
Administrative staff	410,121	205,061	0	205,060	5.0
Savings - Mandatory enrollment	(105,604,954)	(45,807,852)	(4,349,813)	(55,447,289)	
Savings - Physical-behavioral health	(119,183,550)	(31,689,953)	(4,992,672)	(82,500,925)	
Subtotal – ACC	*(180,284,073)*	*(60,280,619)*	*(7,489,299)*	*(112,514,155)*	
Vaccine stock rates	(1,048,261)	(262,303)	(49,379)	(736,579)	
Hospital outpatient payment timing	(23,160,443)	(7,645,263)	0	(15,515,180)	
TOTAL FY 2018-19	**(145,693,106)**	**(47,641,617)**	**(6,309,489)**	**(91,742,000)**	**5.0**

- Hospital outpatient payment timing – The Department decided to account for a change in the timing of hospital outpatient payments in R6, rather than in the forecast adjustment *R1 Medical*

Services Premiums. The savings from the change in the timing of hospital outpatient payments offsets some of the General Fund costs of R6. The change in timing has already been implemented and affects projected FY 2016-17 expenditures. Total payments to the hospitals will not change, but the shift in the timing of payments results in a short duration savings for the Department. 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 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 for the Department over the next few years until those reconciliations are all resolved.

- Primary care rate bump – The Department proposes continuing the primary care rate bump with General Fund and negotiating with providers over the course of the year so that beginning in FY 2018-19 an unspecified portion of the rate bump would be awarded based on performance. This change would require contract resources beginning in FY 2018-19 to help design and measure the performance criteria. The primary care rate bump was initially federally required and funded in 2013 and 2014 through the Affordable Care Act (ACA). It raised Medicaid reimbursement for primary care to the equivalent Medicare rate as an incentive for primary care providers to accept newly eligible Medicaid patients. The primary care rate bump was continued with some modifications in 2015 through June 2016 using the General Fund savings from a short-duration increase in the federal match rate for Medicaid. State and federal evaluations of the primary care rate bump raised questions about whether it successfully affected access, but the JBC heard from providers that it made a significant difference in their ability and willingness to see Medicaid patients. For FY 2016-17, H.B. 16-1408, sponsored by the JBC, provided a one-time transfer from tobacco moneys in the CHP+ Trust Fund to continue the primary care rate bump, but at a significantly reduced total. The Department's request is based on the H.B. 16-1408 funding level.
- Behavioral health – The Department estimates that a federally mandated change in the way capitated rates are calculated will reduce reimbursement for behavioral health organizations by about four percent. Rather than allowing states to set capitated rates within a range determined by a third party to be actuarially sound to cover costs, the new federal policy requires states to set capitated rates at a specific point determined to be actuarially sound. The Department proposes a new supplemental payment to allow behavioral health providers to earn back the lost revenue if they meet performance objectives. However, the Department assumes that the new supplemental payments would not begin until FY 2018-19, after performance data from FY 2017-18 is collected and evaluated, resulting in a one-time savings in FY 2017-18.
- Federally Qualified Health Center Payments – The Department proposes reducing monthly payments to FQHCs by an unspecified amount to finance new performance incentives that the Department anticipates the FQHCs would earn back in aggregate, although there would likely be redistributions between FQHCs based on performance.
- Vaccine stock rates – The Department proposes adjusting Medicaid rates for vaccines annually to match private sector prices reported by the Centers for Disease Control. Annually updating vaccine rates will capture decreases in price that often occur when patents expire and generics are introduced, leading the Department to believe that the policy change will result in a net savings, even if the rates for some vaccines increase.
- Accountable Care Collaborative – The Department anticipates that implementation of Phase II of the ACC will drive new costs and savings. Cost drivers include an increase in PMPM payments as a result of mandatory enrollment, a $1 increase in the PMPM for the expanded role

of the regional organizations, and a proposed 5.0 FTE to manage Phase II and the associated payment reforms. Of the proposed 5.0 FTE: 3.0 are for program oversight and performance monitoring of the behavioral health integration; 1.0 is for managing client and provider complaints and addressing special populations, such as people receiving long-term services and supports, children in child welfare, people with criminal justice involvement, and people experiencing housing insecurity; and 1.0 FTE is for implementing performance payments for primary care. Savings drivers include increased participation in the ACC as a result of mandatory enrollment and the integration of physical and behavioral health.

GOVERNANCE OF THE PAYMENT REFORMS AND ACC

The JBC may want to discuss with the Department at the hearing the appropriate governance structure and procedures for adopting the proposed payment reforms and the ACC.

The JBC staff anticipates that negotiations on the proposed performance payments will likely be contentious, with providers seeking to ensure that the performance payments are as easy to earn as possible and the Department attempting to purchase as much performance as possible. Previous attempts by the Department to target rate increases in order to provide incentives to providers for offering high value services have drawn criticism for not prioritizing the providers with the greatest needs. This type of criticism was part of the impetus for S.B. 15-228 and the creation of the Medicaid Provider Rate Review Advisory Committee (MPRRAC) that ensures a systematic review of the adequacy of all provider rates. The Department's current proposal is somewhat different than previous targeted rate proposals in that it seeks to convert existing payments to performance, rather than offering new funding, but the JBC staff can imagine similar kinds of criticism arising about where the Department is targeting resources. A strong governance structure and formal public process for designing the performance payments could ease the adoption of the reforms.

In a traditional capitated managed care program, providers receive bundled payments and accept risks and rewards based on how well they adhere to the bottom line. This type of arrangement often draws criticism for creating perverse incentives, such as for providers to enroll only the healthiest clients or to ration care for short term gains. However, traditional capitated managed care arrangements allow the providers, who are closest to the clients, significant flexibility to innovate and redesign services as they see best to improve care.

With the ACC model and the related proposed payment reforms, the Department, rather than the provider, will set the practice transformation goals. There is some risk that the Department will select the wrong performance criteria and pay for practice transformations that don't ultimately reduce costs. It might also be possible for an administration to design performance criteria to fund pet projects or funnel money to preferred providers. There is significant risk that some providers will not agree with the performance criteria adopted by the Department. Careful design of the procedures for developing the performance criteria and a governance structure that provides for meaningful public input could increase public confidence in the outcome.

There might be benefits to authorizing the payment reforms and Phase II of the ACC in statute. The ACC was originally developed and approved through the budget process. There are broad state and federal statutes authorizing managed care that permit the ACC, but as noted above the ACC is a little bit of a different animal than traditional capitated managed care. In contrast to the ACC, the

much smaller payment reform pilot program authorized by H.B. 12-1281 is specifically created in statute. The design of the H.B. 12-1281 pilot program is very flexible, but the statute establishes some minimum procedures and criteria for selecting pilot projects and implements reporting requirements. The primary reporting requirement for the ACC is an annual legislative request for information sent to the Governor. Over the last year the JBC has asked the Department for frequent updates on the implementation of Phase II and emphasized to the Department the importance of engaging the committees of reference in the design of Phase II of the ACC. Legislation to codify the ACC and/or the payment reforms in statute could provide an avenue for involvement of the committees of reference.

EVALUATING THE PROJECTING ACC SAVINGS

A key consideration in evaluating the request for Phase II of the ACC is whether the projected savings are likely to materialize. For all changes due to Phase II of the ACC the Department assumed a six month delay before any savings would materialize.

To estimate the effect of increased participation in the ACC as a result of mandatory enrollment, the Department looked at the current estimated ACC savings for different populations and assumed that for the people added through mandatory enrollment the Department would experience a similar savings rate. The Department expects that when fully annualized the implementation of mandatory enrollment will save $106.6 million, including $45.8 million General Fund.

The JBC staff has some questions about the assumption that the ACC will achieve the current savings rate per member for the new people enrolled through mandatory enrollment. Some of the people affected by mandatory enrollment will be those who previously opted out of the program. A client that takes the necessary steps to opt out of the ACC might be a client who is already highly engaged in their care where the potential for savings from adding care coordination resources is minimal. Another population affected by mandatory enrollment is people in nursing homes. On the one hand, the nursing home population tends to use a lot of high cost care, so small changes in utilization from coordinating care could reap large rewards. On the other hand, the population is in institutions that presumably already take measures to ensure that their clients engage in preventive practices and that they follow up on treatment plans or referrals to specialists, because this is a population that by definition needs assistance with activities of daily living. Another population affected by mandatory enrollment is people who churn on and off Medicaid before they complete the currently rather slow passive enrollment process for the ACC to become attributed to a primary care provider. By enrolling them in the ACC more quickly the Department will incur more PMPM costs, but the prospects for avoiding costs of a churning population seem minimal. Another population affected by mandatory enrollment is people enrolled in a Medicare Advantage Plan. Since this population is already receiving managed care through Medicare, it is unclear how the ACC will increase care coordination and avoided costs. The JBC may want to ask the Department to expand on who will be enrolled through mandatory enrollment, their health characteristics, and how the ACC will help the mandatory enrollment population avoid costs.

To estimate the savings from integrating physical and behavioral health the Department looked at evidence from a number of national studies and then discounted the savings to be conservative. For clients with a serious and persistent mental illness (SPMI), the Department referenced a 2001 study that estimated these patients cost $1,533 less when served in an integrated care setting than a general

medicine clinic, although the study was rated "fair" in literature reviews due to a large loss to follow up. The Department also referenced a 2010 study that observed the same changes in care patterns identified in the 2001 study, but did not attempt to estimate the resulting cost savings. The Department identified $1,079 as the net savings in the 2001 study from avoided inpatient costs and increased primary care costs and ignored the remaining estimated savings due to a lack of specificity in the study. The Department then assumed only half that savings rate due to the age and small sample size of the study. For clients with a substance use disorder (SUD) the Department referenced a 2003 study rated "good" in the literature review that estimated cost savings from delivering care in an integrated setting of $231.09 to $343.67 for clients with substance abuse-related medical conditions, medical conditions in addition to a substance use disorder, or psychiatric conditions, compared to clients with similar characteristics who were treated in a non-integrated setting. The Department used one third of the bottom end of the savings range to be conservative. The Department was also conservative in estimating the population that would achieve these savings rates. The Department used actual FY 2014-15 clients with SPMI and SUD and projected growth in the number of clients with these diagnoses at half the caseload trend and then discounted for the penetration rate of the ACC and an assumption that 75 percent of these clients would receive care in an integrated setting.

The JBC staff has questions about the assumption that 75 percent of SPMI and SUD clients would receive care in an integrated setting. The JBC may want to ask the Department to describe the current integrated care capacity and whether providing integrated care in 75 percent of practices by FY 2018-19 is realistic.

ISSUE: HOSPITAL PAYMENTS (R1 AND R7)

This issue brief explores hospital payments, cost shifting, and the impact of the Governor's proposed provider rate reduction.

SUMMARY

- The Department estimates that hospitals receive 32.6 percent of total Medicaid payments to providers, including booster payments financed with the Hospital Provider Fee.

- The primary purpose of the Hospital Provider Fee is to increase reimbursements to hospitals and reduce cost shifting. Costs to fund the expansion populations represent 21 percent of expenditures.

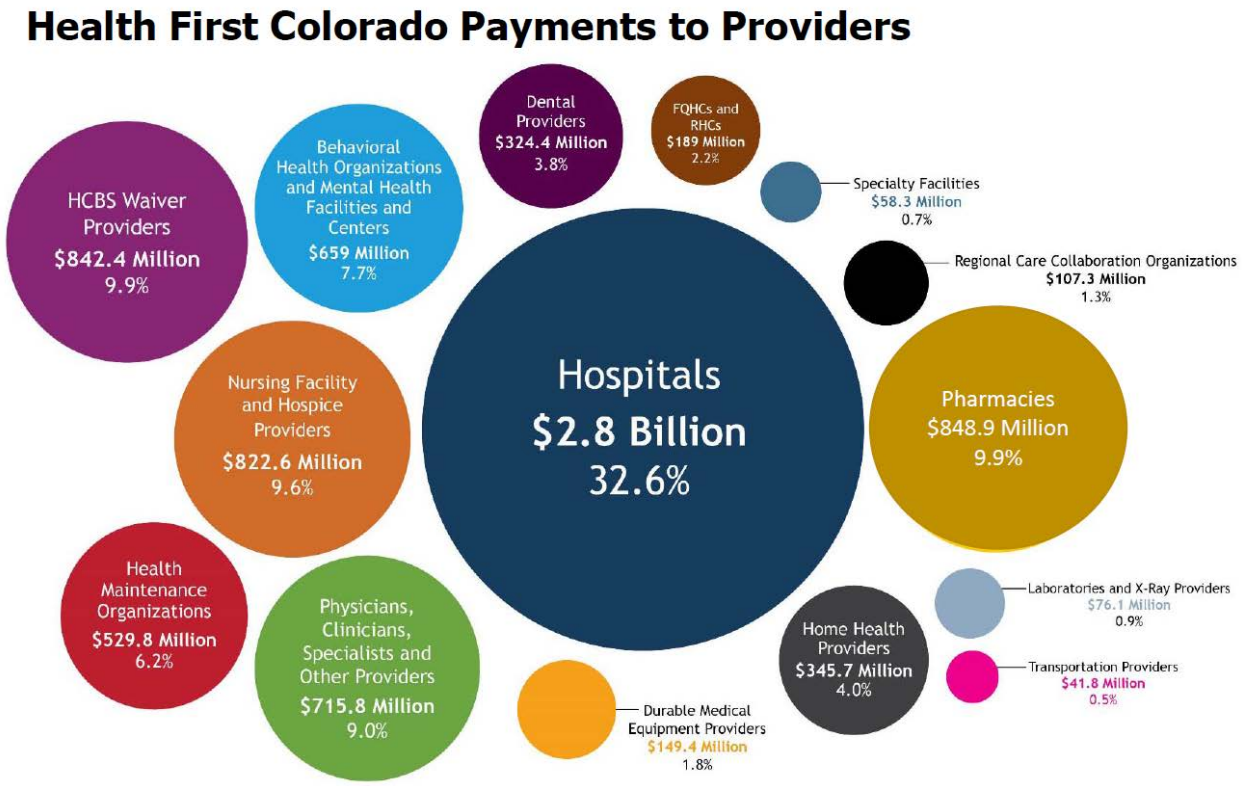
- The Governor proposes a $195.0 million restriction on Hospital Provider Fee revenue from the unrestricted projection. This reduces the General Fund obligation for a TABOR refund by $195.0 million from the OSPB forecast. It reduces booster payments that increase hospital reimbursements by $56.4 million, or 11.7 percent, from the projection for FY 2016-17.

- The proposed restriction could increase cost shifting to private insurance, but it could also be absorbed by reducing the overall payment less cost per patient with no impact on private insurance.

- Recent studies of hospital costs have identified significant variations in cost per member, utilization per 1,000 members, cost per service unit, and administrative overhead to total costs, giving the impression that there are opportunities for improvement in hospital practices to contain costs.

DISCUSSION

Hospitals are an important provider for Medicaid. The Department estimates that payments to hospitals, including payments financed with the Hospital Provider Fee, represent 32.6 percent of total payments to providers.



An analysis by the Division of Insurance estimates that for private insurers the payments to hospitals represent an even larger share of total payments at roughly 42 percent in 2015. The greater reliance of private insurance on hospitals is probably a result of private insurance not covering long-term services and supports or financing institutional care to the extent of Medicaid.

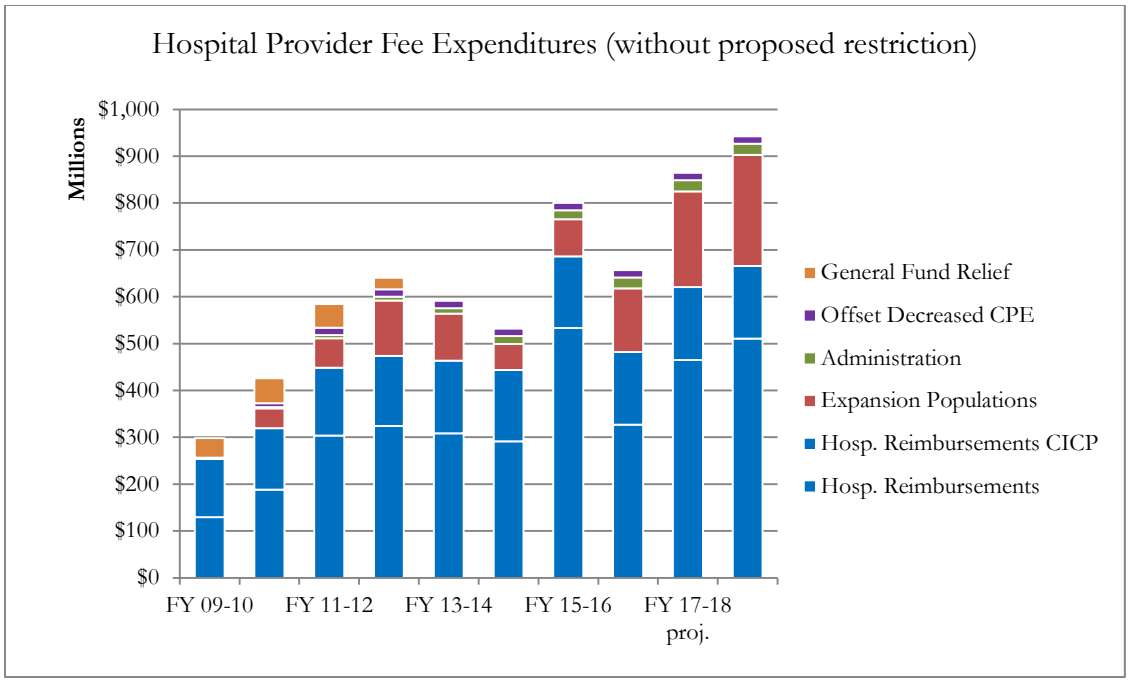
The Department's Hospital Provider Fee annual report estimates that prior to the Hospital Provider Fee, Medicaid reimbursement rates to hospitals covered on average $0.54 for every dollar of costs, resulting in a significant cost shift to other payers. When the Hospital Provider Fee was created it offered a way to increase Medicaid reimbursements to the hospitals without costing the General Fund. In addition, it offered a way to finance the expansion of Medicaid eligibility.

For FY 2017-18 the Office of State Planning and Budgeting is projecting a TABOR surplus and as a result the General Fund's relationship to the Hospital Provider Fee has changed. To the extent money collected though the Hospital Provider Fee drives a TABOR surplus, the Hospital Provider Fee increases the General Fund obligation for a TABOR refund.

Hospital Provider Fee Overview

The Hospital Provider Fee is an assessment on hospitals that is primarily used to match federal funds and make payments back to hospitals to increase hospital reimbursements. In FY 2016-17 an estimated 73 percent of the Hospital Provider Fee will be used for payments to increase reimbursements to hospitals, referred to in this document as booster payments. Secondarily, the Hospital Provider Fee is used to finance the state share of costs for Medicaid expansion populations. Projections for FY 2016-17 estimate that 21 percent of the Hospital Provider Fee will be used for

expansion populations. The remainder of the Hospital Provider Fee is used for administrative costs and, in certain limited circumstances, to offset the need for General Fund.



Over time the state share of costs for the expansion populations is scheduled to increase, until it reaches 10 percent in 2020, and the amount required from the Hospital Provider Fee to subsidize the expansion populations will increase accordingly. However, if the Hospital Provider Fee had to pay the full 10 percent for expansion populations in FY 2016-17, the share of the Hospital Provider Fee devoted to expansion populations would still only be 40 percent compared to 55 percent for booster payments. Also, federal limits on the amount of Hospital Provider Fee revenue that can be collected for booster payments are projected to increase over time.

It is also important to note that by financing the expansion populations the Hospital Provider Fee benefits hospitals. The increases in Medicaid and CHP+ enrollment reduces the number of uninsured and decreases the uncompensated care provided by hospitals.

A common misconception is that the Hospital Provider Fee increases charges to patients. Hospitals get the money to pay the Hospital Provider Fee from cash on hand for future obligations, such as payroll or leased space. The Hospital Provider Fee is collected monthly and then matched with federal funds and distributed back to the hospitals electronically almost as quickly as the money is collected, typically in a matter of minutes or hours, rather than days. The Hospital Provider Fee transaction is complete before hospitals need the money for the other obligations. There is no need for hospitals to increase charges on patients to pay the Hospital Provider Fee and hospitals are explicitly prohibited in statute from putting a line item on patient bills for the Hospital Provider Fee.

One of the stated purposes of the Hospital Provider Fee is to reduce bills for privately insured customers by decreasing the amount of cost shifting that occurs when hospitals see patients who are uninsured or treat Medicaid patients for rates that are below cost. The tables below from the

Department's Hospital Provider Fee annual report[4] provide an estimate of the amount of cost shifting that occurs from Medicaid to other providers.

Table 4	Payment Less Cost per Patient by Payer Group					
Payer Group	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**
Medicare	($2,853)	($3,361)	($3,097)	($3,886)	($5,318)	($4,706)
Medicaid	($4,480)	($2,586)	($2,488)	($2,465)	($2,418)	($3,665)
Insurance	$6,820	$6,518	$7,358	$7,746	$7,717	$8,838
CICP/Self Pay/ Other	($4,563)	($2,897)	($3,920)	($4,013)	($2,070)	($860)
Overall	$542	$701	$918	$903	$747	$1,039

Table 5	Payment to Cost Ratio by Payer Group					
Payer Group	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**
Medicare	0.78	0.76	0.77	0.74	0.66	0.71
Medicaid	0.54	0.74	0.76	0.79	0.80	0.72
Insurance	1.55	1.49	1.54	1.54	1.52	1.59
CICP/Self Pay/ Other	0.52	0.72	0.65	0.67	0.84	0.93
Overall	1.05	1.06	1.07	1.07	1.05	1.07

Table 6	Bad Debt and Charity Care					
Bad Debt and Charity Care Overall	**CY 2009**	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**
Bad Debt	$844,900,497	$777,753,964	$682,111,289	$743,972,504	$952,008,803	$570,925,681
Charity Care	$1,451,755,203	$1,430,777,552	$1,656,589,009	$1,678,545,772	$1,657,809,286	$679,903,960
Total	$2,296,655,700	$2,208,531,516	$2,338,700,298	$2,422,518,276	$2,609,818,089	$1,250,829,641

The next Hospital Provider Fee annual report will be issued in January with CY 2015 information.

GOVERNOR'S PROPOSED RESTRICTION ON HOSPITAL PROVIDER FEE REVENUE

The Governor proposes restricting revenue from the Hospital Provider Fee by $195.0 million in order to reduce TABOR revenues by a like amount and eliminate the projected General Fund obligation for a TABOR refund. The Office of State Planning and Budgeting projects that General Fund revenues subject to the TABOR limit will increase 5.1 percent in FY 2017-18, compared to the TABOR allowed growth of 4.5 percent. Meanwhile, Hospital Provider Fee revenues are projected to grow 31.8 percent in FY 2017-18 without the Governor's proposed restriction, resulting in a crowd out of General Fund. Hospital Provider Fee revenues are the second largest non-General Fund revenue source subject to Tabor after the HUTF.

If the proposed restriction is implemented Hospital Provider Fee revenues are still projected to grow by $13.2 million, or 2.0 percent, instead of $208.2 million, or 31.8 percent, without the restriction. In the Governor's proposal the decrease in revenue due to the restriction would cause a decrease in booster payments. The net benefit to hospitals from the booster payments, after accounting for the cost of paying the Hospital Provider Fee, would decrease compared to FY 2016-17 by $56.4 million or 11.7 percent, versus increasing by $138.6 million or 28.7 percent without the restriction.

[4] https://www.colorado.gov/pacific/sites/default/files/2016%20Annual%20Report_1.pdf

To put the proposed Hospital Provider Fee restriction in context, backup documents used for the Department's annual Hospital Provider Fee report estimate net hospital payments from all payers in calendar year 2014 totaled 12.9 billion. The Governor's proposed restriction would be 1.5 percent of this amount. Estimated calendar year 2014 net hospital payments from Medicaid were 1.7 billion. The Governor's proposed restriction would be 11.4 percent of the estimated 2014 Medicaid net hospital payments.

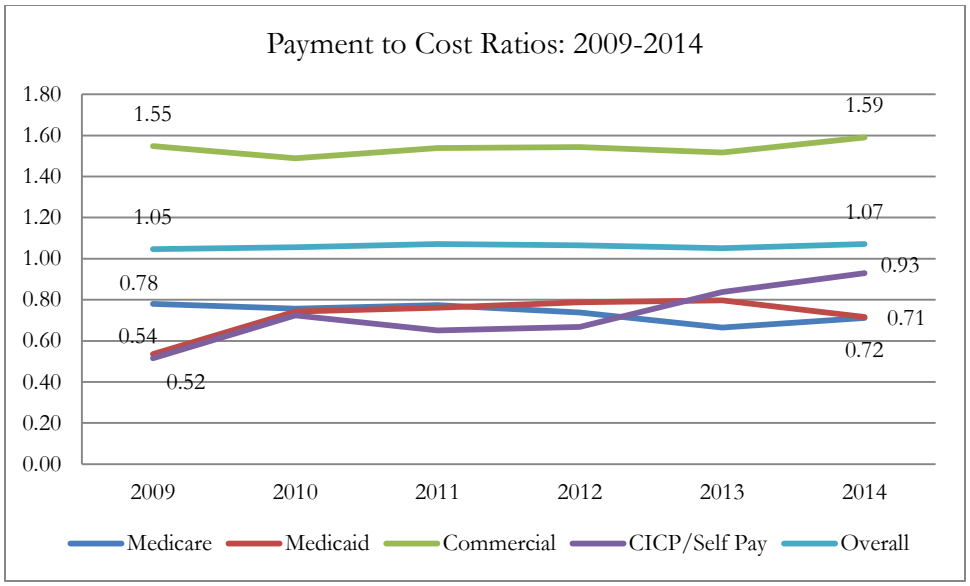
COST SHIFTING

If the Governor's proposed restriction had been in place in CY 2014, and the decrease in Medicaid payments were absorbed entirely by increases in private insurance payments, then the payment less cost per patient for private insurance would have increased $630. The payment to cost ratio for private insurance would have increased from 1.59 to 1.63. In the tables below this is Scenario A. However, it is worth noting that for calendar year 2014 the overall payments less cost per patient was $1,039 with a payment to cost ratio of 1.07. The entire restriction proposed by the Governor could have been absorbed by reducing the overall margin to a payment less cost per patient of $801 and a payment to cost ratio of 1.05. In the tables below this is Scenario B.

Payment Less Cost per Patient by Payer Group			
Payer Group	**CY 2014**	**Scenario A**	**Scenario B**
Medicare	($4,706)	($4,706)	($4,706)
Medicaid	($3,665)	($4,711)	($4,711)
Insurance	$8,838	$9,468	$8,838
CICP/Self Pay/ Other	($860)	($860)	($860)
Overall	$1,039	$1,039	$801

Payment to Cost Ratio by Payer Group			
Payer Group	**CY 2014**	**Scenario A**	**Scenario B**
Medicare	0.71	0.71	0.71
Medicaid	0.72	0.63	0.63
Insurance	1.59	1.63	1.59
CICP/Self Pay/ Other	0.93	0.93	0.93
Overall	1.07	1.07	1.05

This analysis raises an interesting question about why the overall payment less cost per patient is positive and the payment to cost ratio is greater than one. There is only one for profit hospital operating in Colorado, but the Department's Hospital Provider Fee annual report shows a consistent positive payment less cost per patient and a payment to cost ratio of greater than one for every year covered by the report.



CONTAINING HOSPITAL COSTS

The Hospital Provider Fee causes hospital reimbursements to be cost based. Base Medicaid reimbursements change with utilization, but the base rates do not increase without a provider rate increase from the General Assembly. However, the Hospital Provider Fee booster payments fill the gap between base Medicaid rates and what is known as the federal Upper Payment Limit (UPL). The UPL is determined through a complicated formula with many nuances, but it can be thought of as what Medicare would have paid for the same service. Medicare hospital rates are set primarily on costs. Thus, the combined base payments plus the Hospital Provider Fee booster payments results in reimbursement for the hospitals at a UPL rate that is intended to mirror costs. However, since half of the money for the Hospital Provider Fee booster payments comes from the hospitals themselves, the net benefit to the hospitals is still less than total costs as determined by the UPL. As hospital costs increase, though, Hospital Provider Fee booster payments increase.

Cost-based reimbursements are potentially problematic, because they minimize incentives for providers to contain costs. Hospitals might argue that there is plenty of incentive to contain costs for Medicaid patients, because the UPL is not accurately capturing costs, and because half of the funds to close the gap between Medicaid base rates and the UPL is coming from hospitals in the form of their contribution to the Hospital Provider Fee booster payments.

Recent analysis by the Division of Insurance that was focused on identifying cost drivers behind increases in private insurance rates in the western region, identified some concerning variations in hospital costs. The table below is from the report "Colorado Total Health Cost and Geographic Areas 2016 Study". The yellow highlighting identifies services where the cost or utilization in the western region is twice the average for the rest of the state.

		2014					
		Total Cost per Member per Year		Units per 1,000 Members per Year		Cost per Unit	
High Level	Category	All Regions	Region 9	All Regions	Region 9	All Regions	Region 9
IP	Delivery/Newborn	$148	$148	18.0	13.0	$8,216	$11,327
IP	Inpatient Surgery	$471	$692	12.0	15.0	$39,151	$46,116
IP	Mental Health Inpatient	$10	$5	1.8	0.8	$5,750	$6,527
IP	Inpatient Medical	$259	$317	16.3	20.4	$15,949	$15,563
IP	**Total**	$889	$1,163	48.1	49.3	$18,478	$23,603
OP	Emergency Room	$326	$306	149.8	134.3	$2,177	$2,282
OP	Outpatient Surgery	$409	$852	96.8	124.9	$4,221	$6,821
OP	Observation	$15	$32	6.9	11.4	$2,151	$2,789
OP	Advanced Imaging	$47	$185	20.6	65.4	$2,299	$2,829
OP	Imaging	$87	$203	129.5	278.3	$675	$730
OP	Lab/Pathology	$66	$195	115.1	371.7	$572	$525
OP	Therapy (PT/OT/ST)	$19	$48	43.6	67.7	$443	$716
OP	DME/Prosthetics/Supplies (OP)	$2	$3	0.8	1.3	$2,269	$1,998
OP	Mental Health Outpatient	$5	$3	6.8	1.5	$744	$1,649
OP	Other Outpatient	$98	$192	99.9	89.2	$980	$2,155
OP Total	**Total**	$1,074	$2,019	669.8	1,145.7	$1,604	$1,762
Professional	Ambulance - Air	$4	$29	0.1	0.7	$33,121	$40,896
Professional	Ambulance - Land	$19	$33	8.1	12.7	$2,324	$2,622
Professional	Mental Health Professional	$48	$37	55.6	32.4	$866	$1,149
Professional	DME/Prosthetics/Supplies (P)	$109	$191	91.7	102.4	$1,187	$1,865
Professional	Facility Surgical Visit	$236	$442	140.9	190.7	$1,675	$2,319
Professional	Office Surgical Visit	$194	$158	198.6	180.7	$978	$874
Professional	Facility Visit	$665	$539	1923.6	1417.6	$346	$380
Professional	Office Visit	$200	$181	600.0	501.8	$334	$360
Professional	Other Professional	$86	$50	418.1	224.0	$205	$223
Professional Total	**Total**	$1,561	$1,660	3,436.7	2,663.1	$454	$623
Pharmacy	Generic	$336	$196	10771.6	6665.1	$31	$29
Pharmacy	Brand	$409	$302	1788.8	1279.8	$229	$236
Pharmacy	Specialty	$301	$188	131.5	59.5	$2,290	$3,168
Pharmacy Total	**Total**	$1,046	$686	12,691.8	8,004.4	$82	$86
Combined	**Total**	$4,571	$5,527				

The Department of Health Care Policy and Financing has also been looking at variations in hospital costs and has identified significant variations in administrative and capital costs. According to the Department's analysis of federally required hospital cost reports, these administrative overhead expenditures for Colorado hospitals range from a low of 17 percent of costs to a high of 43 percent of costs. Wide variations in administrative overhead costs can be seen both across and within regions, both across and within hospital systems, and both across and within urban versus rural hospitals, and both across and within hospitals of different sizes.

The JBC staff does not know the reasons behind these variations in administrative overhead. It is possible that hospitals with high administrative costs are actually more efficient, because they are investing in managing care. It is possible that hospitals are not filling out the federally required cost reports consistently and mischaracterizing expenditures. There are many possible explanations for the variations in reported administrative overhead, but the JBC believes the degree of variation warrants further investigation.

Overall, the variations in cost per member, utilization per 1,000 members, cost per service unit, and administrative overhead to total costs, gives the impression that there might be significant opportunities for improvements in hospital practices to contain costs.

One component of the Department's *R7 Oversight of state resources* is for additional resources for the Hospital Provider Fee model. The added staff and resources would focus on hospital quality incentive payments authorized through the Hospital Provider Fee and an effort for a federal waiver to allow a greater portion of Hospital Provider Fee payments to be distributed based on performance. The waiver would allow Delivery System Reform Incentive Payments (DSRIP) for

efforts to integrate care and perform care interventions in conjunction with the Accountable Care Collaborative. The table below summarizes the requested funding for this component of R7.

Hospital Provider Fee Model Support in R7				
	TOTAL FUNDS	Hospital Provider Fee	FEDERAL FUNDS	FTE
FTE Costs	$75,959	$37,981	$37,978	1.0
FTE Operating Costs	950	475	475	0.0
Contractor Costs	600,000	300,000	300,000	0.0
TOTAL	**$676,909**	**$338,456**	**$338,453**	**1.0**

REPLACING THE HOSPITAL PROVIDER FEE WITH A RATE INCREASE

In an environment where a TABOR refund is due, the Hospital Provider Fee is an inefficient way to deliver funding to hospitals. The net benefit to hospitals of collecting $100 million through the Hospital Provider Fee is $100 million. The cost to the General Fund is an increase in the TABOR refund of $100 million. So, indirectly the General Assembly is spending $100 million General Fund to give the hospitals $100 million. This is equivalent to giving the hospitals a direct General Fund appropriation with no federal match. Compare this to if the General Assembly did away with $100 million in Hospital Provider Fee revenues and instead spent $100 million General Fund on a rate increase for the hospitals. At the standard federal match rate of 50 percent, $100 million General Fund would match $100 million federal funds to provide a net benefit to the hospitals of $200 million. The hospitals would not have to pay $100 million through the Hospital Provider Fee to get the rate increase. Already, this is a more efficient way to deliver funding to the hospitals with the same amount of General Fund, but in reality the state could get a much higher federal match. Enhanced federal matching funds are available for hospital rates based on the population served and in some cases the services provided. The largest example is hospital rates for services to people newly eligible for Medicaid under the Affordable Care Act, which are eligible for a 95 percent match for calendar year 2017. As a result, a scenario could be designed that achieves almost the same General Fund savings contemplated by the Governor with no decrease in the net benefit to hospitals by replacing the Hospital Provider Fee with a provider rate increase. The effectiveness of this type of scenario is highly dependent on small changes in the revenue forecast.

MAKING THE HOSPITAL PROVIDER FEE AN ENTERPRISE

Rather than restricting Hospital Provider Fee revenues, the General Assembly could achieve the same $195.0 million General Fund benefit contemplated by the Governor's office by designating the Hospital Provider Fee as an enterprise. The size of the General Fund benefit from designating the Hospital Provider Fee as an enterprise is roughly equivalent to the size of the General Fund obligation for a TABOR refund.

To be an enterprise under TABOR an entity must:

1. Be a government-owned business
2. Have authority to issue revenue bonds
3. Receive less than 10 percent of annual revenue from state and local governments

The argument for the Hospital Provider Fee being a government-owned business is that the Department employees working on the Hospital Provider Fee are acting as brokers between the hospitals and the federal government. It may or may not be relevant to the strength of this argument that only state governments can perform this particular type of intermediary service in the Medicaid program. House Bill 15-1389 would have granted authority to issue revenue bonds to address the second enterprise criteria. No General Fund is used to support the Hospital Provider Fee, and so the last of the enterprise criteria is not difficult to satisfy. Whether the Hospital Provider Fee meets the TABOR enterprise most likely hinges on whether it is viewed as a government-owned business.

Meeting the TABOR enterprise criteria doesn't provide a General Fund windfall by itself, because TABOR requires that the base be adjusted when an entity qualifies as an enterprise. Referendum C has a similar requirement. The way this is done administratively is by removing the contribution of the entity qualifying as an enterprise from the prior year base and then applying the adjustments for population and inflation to determine the cap for the year the entity qualifies as an enterprise.

The Office of State Planning and Budgeting argues that the Hospital Provider Fee made no contribution to the prior year base, and so the adjustment to the base would be $0. This argument stems from the way Referendum C changed the allowable revenue under TABOR. Referendum C allowed the state to retain revenue based on the highest revenue from FY 2005-06 through FY 2009-10, adjusted annually for inflation, population, any voter-approved debt service, and the qualification or disqualification of enterprises (see the definition of the Excess State Revenues Cap in Section 24-77-103.6 (6) (b) (I) (B), C.R.S.). There is no ratchet down under Referendum C if actual revenue in a given year is less than the Excess State Revenues Cap (Ref. C Cap), so the Hospital Provider Fee is not propping up the Ref C Cap in low revenue years. The year with the highest state revenue that established the Ref. C Cap was FY 2007-08. The state did not generate revenue from the Hospital Provider Fee until FY 2009-10. Revenue from the Hospital Provider Fee did not contribute to the initial establishment of the Ref. C Cap and the Ref. C Cap adjusts annually for inflation and population growth independent of however much or little revenue is generated from the Hospital Provider Fee. Therefore, the argument goes, if the Ref. C Cap is adjusted for the contribution of the Hospital Provider Fee, then the adjustment is $0.

ISSUE: MEDICAID PROVIDER RATE REVIEW (R7)

This issue brief discusses the findings from the first cycle of rate reviews that were required by S.B. 15-228 and the ramifications of Amendment 70 to increase Colorado's minimum wage.

SUMMARY

- The first rate review cycle of S.B. 15-228 examined 2,314 procedure codes out of approximately 13,770 codes that will eventually be reviewed.

- The only area where the Department is recommending a rate change is for physician-administered drugs as part of *R7 Oversight of state resources*.

- Based on the Department's findings and the discussions of the Medicaid Provider Rate Review Advisory Committee, the JBC staff predicts that the areas where the JBC is most likely to hear concerns relate to home health and emergency medical transportation services.

- Non-emergent medical transportation continues to be a service area with fragmented delivery and inconsistent or incomplete data issues, but the Department is not recommending any rate changes at this time.

- Providers of homemaker and personal care services indicate that they employ many people at or near the minimum wage and thus their costs will be affected by the implementation of Amendment 70. Increasing their rates in FY 2017-18 to match the percentage change in the minimum wage would require an estimated $45.9 million total funds, including $23.0 million General Fund. Increasing their hourly rates by the dollar increase in the minimum wage would require an estimated $23.2 million total funds, including $11.6 million General Fund.

DISCUSSION

In response to S.B. 15-228, sponsored by the JBC, the Department of Health Care Policy and Financing completed the first year of a five-year Medicaid rate review cycle and recommends changing the reimbursement rates for physician-administered drugs, but no other changes to rates reviewed in this cycle. The Department reviewed rates for 2,314 medical procedure codes, out of approximately 13,770 codes that will eventually be reviewed through S.B. 15-228. The rates reviewed this year fall into six broad categories:

- Laboratory and pathology services
- Home health services
- Private duty nursing
- Non-emergent medical transportation
- Emergency medical transportation
- Physician-administered drugs

BACKGROUND

The JBC sponsored S.B. 15-228 to assist the legislature in evaluating rate change proposals. Medicaid is becoming an increasingly important payer for medical services with nearly 25 percent of Colorado's population now covered by Medicaid. JBC members frequently hear complaints from providers about the insufficiency of Medicaid reimbursement rates. The Department has brought forth several proposals in recent years to target certain rates for increases, but not others. The process established by S.B. 15-228 is intended to address these issues by providing data to support rate setting decisions, and by establishing formal procedures for the Department to engage with providers regarding rate setting priorities.

Some of the key features of S.B. 15-228 include:

- Five-year review cycle – The requirement that rates be reviewed at least once every five years ensures that all rates covered by S.B. 15-228 get a day in the sun, while spreading the workload out for the Department and the advisory committee.
- Annual reports – The bill requires an analysis report[5] by May 1 each year that provides information for the rates under review on the level of access, service, quality, and utilization provided, as well as comparisons of the rates with available benchmarks, including Medicare and usual and customary rates paid by private payers. The report must assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. A second recommendation report[6], due by November 1 each year, explains the Department's recommendations on the rates. If a rate is identified as needing adjustment, but the budget does not support a change, the annual reports ensure the data and analysis remain available to inform decision making in future years.
- Medicaid Provider Rate Review Advisory Committee (MPRRAC) – This 24 member advisory committee, appointed by the House and Senate leadership and composed of providers and stakeholders, reviews the Department's May 1 report and helps the Department devise strategies for responding to the findings, including non-fiscal approaches or rebalancing of rates. The Advisory Committee also holds meetings with the Department to solicit public comment on the rates under review. The MPRRAC also may direct the Department to change the rate review schedule and make recommendations to the General Assembly for how to improve the rate review process.

Concurrent with the passage of S.B. 15-228 the federal government issued new rules requiring states to conduct periodic rate reviews. The federal rules require states to review certain rates at least once every three years. There is overlap between the rate reviews required by federal regulation and those required by S.B. 15-228, but some rates are covered by S.B. 15-228 that are not covered by the federal regulation and vice versa. The federal rules emphasis regional variations in access, and so the Department has incorporated a discussion of regional access in the S.B. 15-228 process. Significantly, the federal rule requires any reduction in Medicaid rates be accompanied by an analysis of the expected effect on member access to services, which could potentially result in a rate

[5] https://www.colorado.gov/pacific/sites/default/files/2016%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report.pdf

[6] https://www.colorado.gov/pacific/sites/default/files/2016%20Medicaid%20Provider%20Rate%20Review%20Recommendation%20Report.pdf

reduction implemented by the General Assembly to balance the budget, or for other purposes, being denied or delayed.

RATES REVIEWED IN THIS CYCLE

LABORATORY AND PATHOLOGY SERVICES

Laboratory and pathology providers analyze bodily fluids and specimens to assist in the screening and treatment of diseases and disorders. Where Medicaid rates could be compared to Medicare, the Department estimates that Medicaid paid 88.0 percent of what Medicare paid. This resulted in a difference in payment of roughly $12.9 million total funds, including $3.5 million General Fund.

The Department's recommendation report describes a general impression of the MPRRAC that laboratory service rates may be too high. The report mentions a study by the federal Office of the Inspector General that concluded Medicare rates may be higher than rates paid by other insurers, and a new federal rule requiring laboratories to report rates from other payers and base Medicare rates on other payers' average rates.

The Department concluded that current rates for laboratory and pathology services are sufficient to provide for provider retention and client access and the Department does not recommend any changes in rates at this time. The Department will reevaluate Medicaid rates after Medicare rates are updated in November 2017 based on the new federal rule.

HOME HEALTH SERVICES

Home health services pay for periodic or intermittent nursing care and for physical, occupational and speech therapy. Services may be provided during recovery from an acute condition or episode, such as post-surgical care, or on a long-term basis with prior authorization review for clients that need services beyond 60 days. The Department believes Medicaid's coverage of home health services is sufficiently different from private insurance or Medicare that the best available benchmark is other states. The Department compared Colorado's rates to six states with recent and readily available data and then expressed Colorado's rates as a percentage of the comparison state's, for rates where a comparison could be made:

- Nebraska 72.5%
- Illinois 108.6%
- North Carolina 109.8%
- Idaho 114.5%
- Ohio 154.4%
- Louisiana 197.1%

If Colorado had reimbursed at Nebraska's rates in FY 2014-15, the Department estimates it would have cost an additional $95.7 million, including $45.3 million General Fund. Conversely, if Colorado lowered reimbursement to Louisiana's rates, it would have saved $124.2 million total funds, including $58.8 million General Fund.

According to the Department's recommendation report, the general impression of the MPRRAC is that home health rates are below market and that the Department should index rates to 90 percent of Medicare's Low-Utilization Payment Adjustment (LUPA) rate. The MPPRAC recommended

spreading increases over three years to achieve 90 percent of the LUPA rate. Finally, the MPRRAC recommended investigating a time-based payment method rather than a visit-based payment method. Testimony during MPRRAC meetings identified issues with recruiting and retaining staff and competition with hospitals that offer better wages and benefit packages. The testimony also identified differences in transportation costs and quality of care as issues that may not be appropriately addressed by visit-based reimbursements.

The Department disagreed with the MPPRAC's general impression about the adequacy of rates, concluding that current rates for home health services are sufficient to provide for provider retention and client access, and recommending no changes in rates at this time. The Department noted that providers accommodated an increase in utilization from FY 2013-14 through FY 2014-15, arguing this would not have happened if reimbursement was insufficient.

The Department does not believe Medicare's LUPA rate is an appropriate index for Medicaid. Medicare pays the LUPA rate for clients confined to the home to receive care, which is a higher acuity standard than home health services covered by Medicaid. The Department notes that 57 percent of Medicaid utilizers of home health services were also eligible for Medicare, but received coverage through Medicaid because they did not meet the criteria for Medicare coverage of home health services. Medicare's LUPA rate applies only to elderly populations while Medicaid covers a broader population that includes children and adults and thus a different range of health needs. For example, the most common principle diagnosis for Medicaid long-term home health coverage in FY 2014-15 was infantile cerebral palsy, which is a condition not covered by Medicare. Finally, Medicaid has tiered payments based on visit type that are not comparable to Medicare's LUPA reimbursement structure.

In response to the issues home health agencies reported with hiring and retaining staff, the Department noted that there is evidence of a statewide nursing shortage and raised doubts that a Medicaid-specific rate increase for home health would provide relief. Regarding competition with hospitals for employees, the Department noted there are differences beyond wages in the types of services provided, employee travel requirements, and work schedules. Also, the Department noted that it does not control, and would have difficulty measuring, whether an increase in rates translated to an increase in wages.

The Department provided the following estimate of the additional costs to increase Medicaid home health rates to 90 percent of the Medicare LUPA rates over three years, as suggested by the MPRRAC.

Home Health Rates to 90% of Medicare LUPA				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
FY 2017-18	$26,691,430	$12,785,520	$185,070	$13,720,840
FY 2018-19	$64,605,748	$30,947,214	$465,483	$33,193,051
FY 2019-20	$113,751,807	$54,488,983	$850,920	$58,411,904

PRIVATE DUTY NURSING

Private duty nursing pays for skilled nursing for clients dependent on medical technology who need more care than is available through home health services. Private duty nursing is an optional benefit of the Medicaid program and not a standard covered service for Medicare or private insurance, so

the Department believes the best benchmark comparison is other state Medicaid programs. The Department selected six states with publicly available and recently published data and then expressed Colorado's rates as a percentage of the comparison state's, for rates where a comparison could be made:

- North Carolina 111.8%
- Nebraska 112.4%
- Ohio 125.7%
- Louisiana 135.5%
- Illinois 141.8%
- Idaho 144.7%

The Department's recommendation report indicates that the MPRRAC had similar concerns about provider difficulties recruiting and retaining staff and competition with hospitals as were expressed for the home health services benefit. Some members of the MPRRAC suggested that if rates for Licensed Practical Nurse (LPN) services were increased the use of more expensive Registered Nurse (RN) services might decrease. The MPRRAC recommended the Department gather more information about LPN reimbursement rates from hospitals and long-term acute care facilities to evaluate appropriate funding, and maintain adequate RN reimbursement rates over time.

The Department does not recommend a change in rates, concluding that current rates are sufficient to provide for provider retention and client access. In response to the recommendation from the MPRRAC the Department will survey hospitals and long-term acute care facilities and investigate if other states that have increased LPN rates have experienced a substitution of LPN services for RN services. The Department also plans to collect more information about differences in client populations, facility costs, and types of services provided in facility settings versus home settings to determine if the comparison of LPN wages for facility and home settings is appropriate.

NON-EMERGENT MEDICAL TRANSPORTATION

Non-emergent medical transportation pays to move clients to and from medically necessary services for clients with no other means of transportation. The majority of utilizers and people with disabilities. The Department estimates Colorado's reimbursement rates are 28.2 percent of a rate comparison benchmark based on Medicaid fee schedules from Alabama, Alaska, Arkansas, California, Connecticut, Montana, Nebraska, New Mexico, North Dakota, and Wisconsin.

The Department's recommendation report describes a general impression of the MPRRAC that rates for non-emergent medial transportation are significantly below surrounding state rates. The MPRRAC recommended that the Department collect data on surrounding state rates and strive for parity.

Inconsistent and incomplete data from providers made it impossible for the Department to draw a conclusion on whether rates are sufficient to allow for provider retention and access. Therefore, the Department is not recommending any changes to rates at this time. The Department is working outside the rate process to reduce fragmentation in the administration of the non-emergent medical transportation benefit and improve the consistency and completeness of utilization data. The Department is cooperating with the Public Utilities Commission to implement H.B. 16-1097, which makes permitting for Medicaid providers easier to obtain. Also, the Department reports that it is

continuing to implement reforms outlined in the response to FY 2015-16 legislative request for information #5.

EMERGENCY MEDICAL TRANSPORTATION

Emergency Medical Transportation (EMT) pays for emergency ground and air transportation to and from a hospital. The Department estimates Colorado Medicaid reimbursements are 30.7 percent of the benchmark based on Medicare's ambulance fee schedule and Medicaid fee schedules for Alabama, Alaska, Arkansas, California, Connecticut, Montana, Nebraska, New Mexico, North Dakota, and Wisconsin. The Department estimates that bringing EMT and non-emergent medical transportation rates combined to 100 percent of the benchmark would cost $74.1 million total funds, including $25.2 million General Fund.

The MPRRAC emphasized that EMT services must be available around-the-clock, and that EMT services are only reimbursed if a patient is taken to a hospital. The later may provide an incentive for EMT providers to transport patients when it is not warranted. The MPRRAC also discussed challenges providers face with recruiting, training, and retaining staff and a need to analyze ground and air transportation separately in future studies. The MPRRAC recommends initially surveying surrounding state rates and increasing Colorado Medicaid rates to achieve parity. Over time, the MPRRAC recommends moving to parity with Medicare rates. The MPRRAC also recommended that the Department investigate reimbursing for "treat and release" and "supplies used" codes, and reimbursing for alternative transportation vehicles.

The Department concluded that EMT rates are sufficient to allow for client access and provider retention because providers cannot refuse service to clients, but noted that despite access sufficiency the rates may not reflect appropriate reimbursement for high-value services. The Department does not recommend a change in rates at this time, but in response to the MPRRAC recommendations will:

- Gather information on surrounding state rates
- Investigate supplemental funding (similar to the Hospital Provider Fee or Nursing Provider Fee) for EMT services
- Calculate the fiscal impact of opening "treat and release" codes
- Investigate if changes to regulations could lesson potentially-avoidable utilization of EMT services
- Gather more information from EMT providers on the rate components they consider inadequate
- Forecast budgetary impacts of a rate increase for existing EMT services.

PHYSICIAN-ADMINISTERED DRUGS

Physician-administered drugs covers medications and devices that must be delivered in an office under medical supervision. The Department estimates that in aggregate rates are 100.7 percent of the benchmark, but significant variation exists on a drug by drug basis.

The MPRRAC heard testimony that recommended moving long-acting, anti-psychotic injectables from the physician services benefit to the pharmacy benefit to allow for more frequent price updating. The recommendation report describes a general impression of the MPRRAC that current rates are not adjusted frequently enough to keep pace with changes in drug prices both up and

down. The MPRRAC recommended indexing rates to the average sales price of the drugs and measures to update pricing more frequently.

The Department concluded that current rates are sufficient to allow for provider retention and client access, but recommends a change to address the inconsistencies on a drug by drug basis identified by the MPPRAC. This is the only component of this year's rate analysis that resulted in a recommended change to the budget. The recommendation is contained in *R7 Oversight of state resources*.

The Department proposes indexing physician-administered drugs to an average of 2.5 percent above the average sales price for the drugs and updating rates periodically to provide an incentive for more providers to administer the drugs. The Department believes this will result in some cost avoidance by reducing trips to hospitals to receive the drugs, where the billing to Medicaid would be higher. Also, it may result in patients accessing drugs that are more effective for them, such as an injected anti-psychotic that lasts thirty days instead of a daily oral pill. That 2.5 percent premium above the average sales price is intended to encourage more providers to offer this high-value service. The Department requests flexibility to pay more for some especially useful drugs and balance that with lower payments for other drugs to maintain a 2.5 percent average premium above average sales price.

The Department estimates that implementing the proposed change to physician-administered drug pricing would require an FTE to develop the rates and track the avoided costs. The table below summarizes the projected costs and savings associated with this component of R7.

Physician-Administered Drugs in R7					
	Total Fund	General Fund	Cash Funds	Federal Funds	FTE
FTE Costs	$66,796	$33,400	$0	$33,396	1.0
FTE Operating Costs	950	475	0	475	0.0
Cost Avoidance	(1,205,488)	(355,098)	(49,057)	(801,333)	0.0
Rate Impact	2,164,801	637,679	88,097	1,439,025	0.0
TOTAL	**$1,027,059**	**$316,456**	**$39,040**	**$671,563**	**1.0**

Minimum Wage

Independent of the Department's work to assess the adequacy of provider rates, voters approved Amendment 70 to increase Colorado's minimum wage from $8.31 to $12.00 per hour by calendar year 2020 and adjust the minimum wage thereafter for the cost of living. This initiative has bearing on the adequacy of provider rates, because it may force some providers to increase employee compensation. In particular, providers of personal care and homemaker services frequently describe to the JBC that a large percentage of their employees work at or near the minimum wage. The table below compares hourly rates paid by Medicaid with the minimum wage and shows the increases in rates that would be necessary to keep pace with the percentage increases in the minimum wage mandated by Amendment 70. This is a larger increase in the hourly rates than an increase based on

the dollar value change in the minimum wage. The hourly Medicaid rates are already approximately twice the minimum wage. The difference presumably goes to benefits, taxes, and other overhead costs of the provider agency.

Personal Care and Homemaker Rates and the Minimum Wage							
	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22
Personal Care (Waivers)	$17.00	$17.00	$19.95	$21.79	$23.63	$24.82	$25.36
Homemaker (Waivers)	$17.00	$17.00	$19.95	$21.79	$23.63	$24.82	$25.36
Homemaker Enhanced (Waivers)	$24.52	$24.52	$28.77	$31.42	$34.08	$35.80	$36.58
IHSS Homemaker	$17.00	$17.00	$19.95	$21.79	$23.63	$24.82	$25.36
IHSS Personal Care	$17.00	$17.00	$19.95	$21.79	$23.63	$24.82	$25.36
CDASS Homemaker[1]	$15.44	$15.44	$18.12	$19.79	$21.46	$22.54	$23.04
CDASS Personal Care[1]	$15.44	$15.44	$18.12	$19.79	$21.46	$22.54	$23.04
Averaged Minimum Wage Rate	$8.31	$8.31	$9.75	$10.65	$11.55	$12.13	$12.40

[1] These CDASS Rates are estimates based on the Department's Rate and Fee Schedule and are not fixed.

The next table estimates the incremental cost above the Department's current forecast to increase rates at the same pace as the percentage increase in the minimum wage.

Increase Rates with percentage Change in Minimum Wage					
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Personal Care (Waivers)	$23,453,804	$38,773,157	$54,845,741	$65,644,292	$70,792,445
Homemaker (Waivers)	5,313,206	8,837,310	12,615,485	15,186,244	16,427,188
Homemaker Enhanced (Waivers)	449,412	762,844	1,098,028	1,326,661	1,439,634
IHSS Homemaker	274,899	474,654	685,999	819,588	878,551
IHSS Personal Care	280,046	466,065	667,466	807,123	874,046
CDASS Homemaker	5,210,433	8,620,456	12,242,394	14,723,465	15,902,551
CDASS Personal Care	10,964,206	18,139,846	25,761,415	30,982,280	33,463,408
TOTAL	**$45,946,005**	**$76,074,331**	**$107,916,528**	**$129,489,654**	**$139,777,824**
General Fund	22,973,002	38,037,166	53,958,264	64,744,827	69,888,912
Federal Funds	22,973,003	38,037,165	53,958,264	64,744,827	69,888,912

The next table shows the incremental cost above the Department's current forecast if instead hourly rates were increased by the dollar increase in the minimum wage.

Increase Rates with Dollar Change in Minimum Wage					
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Personal Care (Waivers)	$11,464,771	$18,979,607	$26,909,225	$32,268,129	$34,839,888
Homemaker (Waivers)	2,597,220	4,328,003	6,198,695	7,481,189	8,105,463
Homemaker Enhanced (Waivers)	152,309	259,727	375,769	455,754	495,911
IHSS Homemaker	134,377	233,137	338,280	404,515	433,549
IHSS Personal Care	136,893	228,262	328,102	398,039	431,788
CDASS Homemaker	2,804,320	4,645,684	6,613,982	7,972,688	8,621,783
CDASS Personal Care	5,901,072	9,775,815	13,917,665	16,776,762	18,142,639
TOTAL	**$23,190,962**	**$38,450,234**	**$54,681,718**	**$65,757,076**	**$71,071,021**
General Fund	11,595,481	19,225,117	27,340,859	32,878,538	35,535,510
Federal Funds	11,595,481	19,225,117	27,340,859	32,878,538	35,535,511

The JBC staff also asked the Department if it was aware of any other Medicaid services where the primary providers are likely paid at or near minimum wage and the Department did not identify any services. In looking over the services provided by the Department, the JBC wonders if Non-emergent Medical Transportation might be another area impacted by the minimum wage requirement, but has not had an opportunity to survey providers. The Department did not provide an estimate of the cost to increase rates for Non-emergent Medical Transportation to keep pace with the minimum wage.

Appendix A: Number Pages

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(1) EXECUTIVE DIRECTOR'S OFFICE					
Primary functions: Provides all of the administrative, audit and oversight functions for the Department.					
(A) General Administration					
Personal Services	28,066,886	27,226,976	29,707,221	30,706,680	*
FTE	360.4	388.0	400.3	415.6	
General Fund	8,982,621	9,828,325	10,211,448	10,792,716	
Cash Funds	2,676,189	2,849,157	2,994,337	2,977,177	
Reappropriated Funds	1,524,777	574,169	1,564,801	1,565,699	
Federal Funds	14,883,299	13,975,325	14,936,635	15,371,088	
Health, Life, and Dental	2,476,612	3,139,489	3,434,070	3,808,218	*
General Fund	928,931	1,137,726	1,230,952	1,374,476	
Cash Funds	166,066	277,707	337,577	353,742	
Reappropriated Funds	64,887	88,133	104,755	104,635	
Federal Funds	1,316,728	1,635,923	1,760,786	1,975,365	
Short-term Disability	64,185	61,246	55,072	59,668	*
General Fund	21,358	22,736	20,569	22,290	
Cash Funds	4,955	4,746	4,588	4,849	
Reappropriated Funds	1,363	1,457	1,393	1,365	
Federal Funds	36,509	32,307	28,522	31,164	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	1,235,106	1,314,119	1,434,489	1,657,860	*
General Fund	409,819	488,354	535,695	619,166	
Cash Funds	96,428	101,814	119,586	134,856	
Reappropriated Funds	27,452	30,035	36,269	37,816	
Federal Funds	701,407	693,916	742,939	866,022	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	1,157,972	1,269,320	1,419,546	1,657,835	*
General Fund	384,601	472,426	530,115	619,166	
Cash Funds	90,431	98,344	118,340	134,856	
Reappropriated Funds	24,943	27,570	35,891	37,791	
Federal Funds	657,997	670,980	735,200	866,022	
Salary Survey	831,265	321,383	56,903	877,626	
General Fund	283,209	121,695	19,245	326,644	
Cash Funds	64,811	24,853	6,898	73,062	
Reappropriated Funds	3,127	1,794	898	19,282	
Federal Funds	480,118	173,041	29,862	458,638	
Worker's Compensation	52,712	43,712	54,318	67,591	
General Fund	26,356	21,856	27,159	33,796	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	26,356	21,856	27,159	33,795	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Operating Expenses	2,967,212	1,930,861	2,058,538	2,107,022	*
General Fund	1,426,580	907,377	930,699	953,810	
Cash Funds	37,759	3,365	71,522	70,266	
Reappropriated Funds	0	0	10,449	10,449	
Federal Funds	1,502,873	1,020,119	1,045,868	1,072,497	
Legal and Third Party Recovery Legal Services	1,151,606	932,995	1,369,290	1,429,940	
General Fund	443,159	442,869	443,055	462,680	
Cash Funds	166,747	23,677	241,591	252,292	
Reappropriated Funds	0	0	0	0	
Federal Funds	541,700	466,449	684,644	714,968	
Administrative Law Judge Services	376,861	568,419	697,852	656,743	*
General Fund	146,434	220,867	271,159	255,187	
Cash Funds	41,996	63,343	77,767	73,185	
Reappropriated Funds	0	0	0	0	
Federal Funds	188,431	284,209	348,926	328,371	
CORE Operations	2,717,568	1,598,167	1,417,701	1,499,911	
General Fund	1,297,165	544,698	465,081	493,926	
Cash Funds	679,257	285,501	243,770	257,906	
Reappropriated Funds	0	0	0	0	
Federal Funds	741,146	767,968	708,850	748,079	
Payment to Risk Management and Property Funds	166,890	166,912	176,936	134,259	
General Fund	83,445	83,456	88,468	67,130	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	83,445	83,456	88,468	67,129	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Leased Space	1,480,251	1,848,260	2,514,035	2,514,035	
General Fund	578,965	852,378	1,009,653	1,009,653	
Cash Funds	124,924	71,752	247,365	247,365	
Reappropriated Funds	0	0	0	0	
Federal Funds	776,362	924,130	1,257,017	1,257,017	
Capitol Complex Leased Space	386,910	549,237	572,466	664,902	
General Fund	193,455	274,619	286,233	332,451	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	193,455	274,618	286,233	332,451	
Payments to OIT	1,578,757	2,702,092	4,703,675	4,979,059	*
General Fund	784,642	1,518,550	1,974,295	2,115,392	
Cash Funds	4,736	11,360	377,545	373,641	
Reappropriated Funds	0	0	0	0	
Federal Funds	789,379	1,172,182	2,351,835	2,490,026	
Scholarships for research using the All-Payer Claims Database	500,000	475,050	500,000	500,000	
General Fund	500,000	475,050	500,000	500,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
General Professional Services and Special Projects	5,584,179	7,993,989	7,200,237	9,298,306 *	
General Fund	2,037,349	2,980,993	2,047,261	3,150,984	
Cash Funds	511,089	731,075	1,527,500	1,509,062	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,035,741	4,281,921	3,625,476	4,638,260	
Merit Pay	265,923	317,662	0	0	
General Fund	98,565	118,042	0	0	
Cash Funds	19,363	26,760	0	0	
Reappropriated Funds	1,176	1,975	0	0	
Federal Funds	146,819	170,885	0	0	
SUBTOTAL - (A) General Administration	51,060,895	52,459,889	57,372,349	62,619,655	9.1%
FTE	360.4	388.0	400.3	415.6	3.8%
General Fund	18,626,654	20,512,017	20,591,087	23,129,467	12.3%
Cash Funds	4,684,751	4,573,454	6,368,386	6,462,259	1.5%
Reappropriated Funds	1,647,725	725,133	1,754,456	1,777,037	1.3%
Federal Funds	26,101,765	26,649,285	28,658,420	31,250,892	9.0%
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,776,959	5,725,781	6,398,594	7,819,645 *	
General Fund	1,477,142	1,918,370	2,469,927	2,974,455	
Cash Funds	110,000	110,000	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,189,817	3,697,411	3,928,667	4,845,190	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Nurse Home Visitor Program, Transfer from the Department of Human Services	1,028,130	946,528	3,010,000	3,010,000	*
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	478,806	428,921	1,498,980	1,505,000	
Federal Funds	549,324	517,607	1,511,020	1,505,000	
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	5,888	5,887	5,887	5,887	
General Fund	2,944	2,943	2,944	2,944	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,944	2,944	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,042	324,041	324,041	
General Fund	147,368	147,369	147,369	147,369	
Cash Funds	0	0	0	0	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,021	162,021	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	3,852	5,036	10,000	35,175	
General Fund	1,926	2,518	5,000	11,425	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,926	2,518	5,000	23,750	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Transfer to the Department of Regulatory Agencie for Regulation of Medicaid Transportation Providers	0	0	78,328	78,328	
General Fund	0	0	59,578	59,578	
Federal Funds	0	0	18,750	18,750	
Public School Health Services Administration, Transfer to the Department of Education	160,335	153,845	170,979	170,979	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	160,335	153,845	170,979	170,979	
Federal Funds	0	0	0	0	
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	205,146	215,955	219,356	219,356	
General Fund	102,573	107,978	109,678	109,678	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	102,573	107,977	109,678	109,678	
Local Public Health Agencies, Transfer to the Department of Public Health and Environment	0	0	0	711,000	*
General Fund	0	0	0	355,500	
Federal Funds	0	0	0	355,500	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation	
SUBTOTAL - (B) Transfers to Other Departments	6,504,351	7,377,074	10,217,185	12,374,411	21.1%	
FTE	0.0	0.0	0.0	0.0	0.0%	
General Fund	1,731,953	2,179,178	2,794,496	3,660,949	31.0%	
Cash Funds	110,000	110,000	0	0	0.0%	
Reappropriated Funds	653,793	597,418	1,684,611	1,690,631	0.4%	
Federal Funds	4,008,605	4,490,478	5,738,078	7,022,831	22.4%	
(C) Information Technology Contracts and Projects						
Medicaid Management Information System Maintenance and Projects	24,715,778	34,365,297	35,564,820	41,535,458	*	
General Fund	5,655,519	6,823,650	7,211,028	5,918,099		
Cash Funds	934,073	3,099,843	2,226,262	4,270,044		
Reappropriated Funds	293,350	293,350	293,350	11,808		
Federal Funds	17,832,836	24,148,454	25,834,180	31,335,507		
MMIS Reprocurement Contracts	26,955,910	41,437,857	26,916,597	18,546,779	*	
General Fund	2,657,672	4,164,679	2,615,317	1,034,108		
Cash Funds	539,548	1,177,899	701,879	875,342		
Reappropriated Funds	23,758,690	0	0	5,564		
Federal Funds	0	36,095,279	23,599,401	16,631,765		
MMIS Reprocurement Contracted Staff	407,681	4,448,524	5,145,018	0		
General Fund	4,017	353,814	431,304	0		
Cash Funds	64,139	131,360	134,757	0		
Reappropriated Funds	339,525	0	0	0		
Federal Funds	0	3,963,350	4,578,957	0		

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Fraud Detection Software Contract	135,000	164,143	250,000	115,000	*
General Fund	34,136	62,500	62,500	28,345	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	100,864	101,643	187,500	86,655	
Health Information Exchange Maintenance and Projects	3,746,881	14,168,748	10,622,455	8,072,455	
General Fund	524,667	2,321,876	2,046,246	1,891,246	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,222,214	11,846,872	8,576,209	6,181,209	
Colorado Benefits Management Systems, Operating and Contract Expenses	0	13,324,222	23,132,658	24,754,877	
General Fund	0	4,578,401	7,691,683	8,286,312	
Cash Funds	0	2,086,971	3,319,100	3,529,905	
Reappropriated Funds	0	42,532	87,981	94,683	
Federal Funds	0	6,616,318	12,033,894	12,843,977	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	0	0	648,441	648,441	
General Fund	0	0	232,139	232,139	
Cash Funds	0	0	90,321	90,321	
Reappropriated Funds	0	0	2,617	2,617	
Federal Funds	0	0	323,364	323,364	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Centralized Eligibility Vendor Contract Project	6,824,419	2,275,016	0	0	
General Fund	0	0	0	0	
Cash Funds	2,281,751	1,137,508	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,542,668	1,137,508	0	0	
SUBTOTAL - (C) Information Technology Contracts and Projects	62,785,669	110,183,807	102,279,989	93,673,010	(8.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	8,876,011	18,304,920	20,290,217	17,390,249	(14.3%)
Cash Funds	3,819,511	7,633,581	6,472,319	8,765,612	35.4%
Reappropriated Funds	24,391,565	335,882	383,948	114,672	(70.1%)
Federal Funds	25,698,582	83,909,424	75,133,505	67,402,477	(10.3%)
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	247,001	182,775	278,974	278,974	
General Fund	63,966	61,681	90,988	90,988	
Cash Funds	58,738	30,109	44,587	44,587	
Reappropriated Funds	1,593	19	28	28	
Federal Funds	122,704	90,966	143,371	143,371	
Contracts for Special Eligibility Determinations	6,623,800	8,095,340	11,402,297	11,402,297	
General Fund	664,131	904,553	969,756	969,756	
Cash Funds	2,290,311	2,763,760	4,343,468	4,343,468	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,669,358	4,427,027	6,089,073	6,089,073	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
County Administration	36,730,383	43,358,806	45,998,063	45,998,063	
General Fund	10,572,620	11,114,448	11,114,448	11,114,448	
Cash Funds	0	5,859,623	5,859,623	5,859,623	
Reappropriated Funds	0	0	0	0	
Federal Funds	26,157,763	26,384,735	29,023,992	29,023,992	
Hospital Provider Fee County Administration	10,038,778	14,485,439	15,748,868	15,748,868	
General Fund	0	0	0	0	
Cash Funds	3,208,371	4,945,446	4,945,446	4,945,446	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,830,407	9,539,993	10,803,422	10,803,422	
Administrative Case Management	1,514,868	869,744	869,744	869,744	
General Fund	757,434	434,872	434,872	434,872	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	757,434	434,872	434,872	434,872	
Medical Assistance Sites	78,000	709,730	1,531,968	1,531,968	
General Fund	0	0	0	0	
Cash Funds	39,000	184,347	402,984	402,984	
Reappropriated Funds	0	0	0	0	
Federal Funds	39,000	525,383	1,128,984	1,128,984	
Customer Outreach	5,079,676	5,309,698	5,904,846	6,607,445	*
General Fund	2,203,298	2,215,113	2,556,675	2,873,665	
Cash Funds	336,621	336,620	336,621	336,621	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,539,757	2,757,965	3,011,550	3,397,159	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Centralized Eligibility Vendor Contract Project	0	0	5,053,644	5,053,644	
Cash Funds	0	0	1,745,342	1,745,342	
Federal Funds	0	0	3,308,302	3,308,302	
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	774,366	0	0	0	
General Fund	74,945	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	699,421	0	0	0	
SUBTOTAL - (D) Eligibility Determinations and Client Services	61,086,872	73,011,532	86,788,404	87,491,003	0.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	14,336,394	14,730,667	15,166,739	15,483,729	2.1%
Cash Funds	5,933,041	14,119,905	17,678,071	17,678,071	0.0%
Reappropriated Funds	1,593	19	28	28	0.0%
Federal Funds	40,815,844	44,160,941	53,943,566	54,329,175	0.7%
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	8,825,726	9,726,242	12,187,863	13,116,097 *	
General Fund	2,514,723	2,877,507	3,503,473	3,702,073	
Cash Funds	329,807	342,739	461,089	470,308	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,981,196	6,505,996	8,223,301	8,943,716	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
SUBTOTAL - (E) Utilization and Quality Review Contracts	8,825,726	9,726,242	12,187,863	13,116,097	7.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	2,514,723	2,877,507	3,503,473	3,702,073	5.7%
Cash Funds	329,807	342,739	461,089	470,308	2.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	5,981,196	6,505,996	8,223,301	8,943,716	8.8%
(F) Provider Audits and Services					
Professional Audit Contracts	2,108,454	2,454,646	3,401,907	3,179,646 *	
General Fund	947,607	1,042,243	1,266,408	1,261,843	
Cash Funds	106,620	191,893	415,408	312,420	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,054,227	1,220,510	1,720,091	1,605,383	
SUBTOTAL - (F) Provider Audits and Services	2,108,454	2,454,646	3,401,907	3,179,646	(6.5%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	947,607	1,042,243	1,266,408	1,261,843	(0.4%)
Cash Funds	106,620	191,893	415,408	312,420	(24.8%)
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,054,227	1,220,510	1,720,091	1,605,383	(6.7%)
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	844,170	673,182	700,000	700,000	
General Fund	0	0	0	0	
Cash Funds	422,085	336,591	350,000	350,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	422,085	336,591	350,000	350,000	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
SUBTOTAL - (G) Recoveries and Recoupment					
Contract Costs	844,170	673,182	700,000	700,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	422,085	336,591	350,000	350,000	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	422,085	336,591	350,000	350,000	0.0%
State of Health Projects					
Pain Management Capacity Program	492,000	486,064	0	0	
General Fund	246,000	243,032	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	246,000	243,032	0	0	
SUBTOTAL - State of Health Projects	492,000	486,064	0	0	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	246,000	243,032	0	0	0.0%
Cash Funds	0	0	0	0	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	246,000	243,032	0	0	0.0%
(H) Indirect Cost Assessment					
Indirect Cost Assessment	245,511	567,546	695,366	911,170	
General Fund	0	0	0	0	
Cash Funds	141,654	178,540	224,727	257,456	
Reappropriated Funds	2,766	0	5,941	117,432	
Federal Funds	101,091	389,006	464,698	536,282	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
SUBTOTAL - (H) Indirect Cost Assessment	245,511	567,546	695,366	911,170	31.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	141,654	178,540	224,727	257,456	14.6%
Reappropriated Funds	2,766	0	5,941	117,432	1876.6%
Federal Funds	101,091	389,006	464,698	536,282	15.4%
TOTAL - (1) Executive Director's Office	193,953,648	256,939,982	273,643,063	274,064,992	0.2%
FTE	360.4	388.0	400.3	415.6	3.8%
General Fund	47,279,342	59,889,564	63,612,420	64,628,310	1.6%
Cash Funds	15,547,469	27,486,703	31,970,000	34,296,126	7.3%
Reappropriated Funds	26,697,442	1,658,452	3,828,984	3,699,800	(3.4%)
Federal Funds	104,429,395	167,905,263	174,231,659	171,440,756	(1.6%)

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	5,728,108,535	6,839,289,152	6,818,264,595	7,144,917,275 *	
General Fund	882,758,797	1,029,604,779	1,068,604,768	1,200,401,795	
General Fund Exempt	813,135,957	809,024,467	873,835,000	873,835,000	
Cash Funds	549,810,900	822,942,823	705,708,120	690,213,730	
Reappropriated Funds	0	9,214,192	5,240,893	9,031,044	
Federal Funds	3,482,402,881	4,168,502,891	4,164,875,814	4,371,435,706	
TOTAL - (2) Medical Services Premiums	5,728,108,535	6,839,289,152	6,818,264,595	7,144,917,275	4.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	882,758,797	1,029,604,779	1,068,604,768	1,200,401,795	12.3%
General Fund Exempt	813,135,957	809,024,467	873,835,000	873,835,000	0.0%
Cash Funds	549,810,900	822,942,823	705,708,120	690,213,730	(2.2%)
Reappropriated Funds	0	9,214,192	5,240,893	9,031,044	72.3%
Federal Funds	3,482,402,881	4,168,502,891	4,164,875,814	4,371,435,706	5.0%

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
This section provides for behavioral health services through the purchase of services from five regional behavioral health organizations (BHOs), which manage mental health and substance use disorder services for eligible Medicaid recipients in a capitated, risk-based model. This section also contains funding for Medicaid behavioral health fee-for-service programs for those services not covered within the capitation contracts and rates. The funding for this section is primarily from the General Fund and federal Medicaid funds. Cash fund sources include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.					
Behavioral Health Capitation Payments	565,420,239	603,218,669	653,650,029	647,630,305 *	
General Fund	173,415,971	166,102,477	181,949,404	173,967,178	
Cash Funds	5,333,335	9,773,437	16,383,180	26,612,883	
Federal Funds	386,670,933	427,342,755	455,317,445	447,050,244	
Behavioral Health Fee-for-service Payments	7,525,423	8,086,839	8,967,301	9,241,145 *	
General Fund	2,946,662	1,881,329	1,678,280	2,010,180	
Cash Funds	20,963	71,017	249,835	382,610	
Federal Funds	4,557,798	6,134,493	7,039,186	6,848,355	
TOTAL - (3) Behavioral Health Community Programs	572,945,662	611,305,508	662,617,330	656,871,450	(0.9%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	176,362,633	167,983,806	183,627,684	175,977,358	(4.2%)
Cash Funds	5,354,298	9,844,454	16,633,015	26,995,493	62.3%
Federal Funds	391,228,731	433,477,248	462,356,631	453,898,599	(1.8%)

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	2,598,056	3,090,607	3,063,982	3,223,462	*
FTE	30.5	34.2	35.5	37.3	
General Fund	1,241,132	1,405,951	1,431,598	1,504,011	
Cash Funds	0	259,564	182,080	187,556	
Reappropriated Funds	0	0	75,000	76,579	
Federal Funds	1,356,924	1,425,092	1,375,304	1,455,316	
Operating Expenses	250,603	2,027,063	1,070,539	1,007,882	*
General Fund	126,325	144,899	144,899	115,922	
Cash Funds	0	567,513	4,251	1,900	
Reappropriated Funds	0	0	770,000	770,000	
Federal Funds	124,278	1,314,651	151,389	120,060	
Community and Contract Management System	106,864	137,480	137,480	137,480	
General Fund	68,839	89,362	89,362	89,362	
Federal Funds	38,025	48,118	48,118	48,118	
Support Level Administration	39,498	57,368	57,368	1,319,037	
General Fund	19,749	28,684	28,684	659,171	
Cash Funds	0	0	0	221	
Federal Funds	19,749	28,684	28,684	659,645	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation	
Cross-system Response for behavioral Health Crises Pilot Program	0	3,390,000	1,690,000	0		
FTE	0.0	0.0	0.0	0.0		
Cash Funds	0	1,695,000	1,690,000	0		
Reappropriated Funds	0	1,695,000	0	0		
SUBTOTAL -	2,995,021	8,702,518	6,019,369	5,687,861	(5.5%)	
FTE	30.5	34.2	35.5	37.3	5.1%	
General Fund	1,456,045	1,668,896	1,694,543	2,368,466	39.8%	
Cash Funds	0	2,522,077	1,876,331	189,677	(89.9%)	
Reappropriated Funds	0	1,695,000	845,000	846,579	0.2%	
Federal Funds	1,538,976	2,816,545	1,603,495	2,283,139	42.4%	
(ii) Program Costs						
Adult Comprehensive Services	316,670,767	375,465,768	362,346,433	369,815,964	*	
General Fund	156,848,877	169,373,036	180,448,523	176,446,775		
Cash Funds	1	31,281,613	1	8,461,207		
Federal Funds	159,821,889	174,811,119	181,897,909	184,907,982		
Adult Supported Living Services	56,136,806	62,872,177	69,681,391	71,296,103	*	
General Fund	33,457,241	34,961,826	38,677,034	39,398,224		
Cash Funds	0	0	0	209,815		
Federal Funds	22,679,565	27,910,351	31,004,357	31,688,064		
Children's Extensive Support Services	15,985,596	22,544,937	26,310,826	26,774,458	*	
General Fund	8,389,564	11,094,363	13,102,791	13,387,229		
Federal Funds	7,596,032	11,450,574	13,208,035	13,387,229		

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Case Management	26,970,379	30,139,104	32,255,501	32,795,233	*
General Fund	14,302,452	15,404,955	16,605,002	17,400,076	
Cash Funds	0	0	0	40,923	
Federal Funds	12,667,927	14,734,149	15,650,499	15,354,234	
Family Support Services	7,828,718	6,960,204	6,960,460	6,960,460	
General Fund	6,828,718	6,960,204	6,960,460	6,960,460	
Cash Funds	1,000,000	0	0	0	
Preventive Dental Hygiene	0	67,012	63,311	63,311	
General Fund	0	63,308	63,311	63,311	
Cash Funds	0	3,704	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Eligibility Determination and Waiting List Management	3,001,454	3,121,079	3,121,194	3,121,194	
General Fund	2,986,287	3,100,442	3,100,556	3,100,556	
Federal Funds	15,167	20,637	20,638	20,638	
Waiver Enrollment	1,633,428	1,586,987	0	0	
Cash Funds	1,633,428	1,586,987	0	0	
SUBTOTAL -	428,227,148	502,757,268	500,739,116	510,826,723	2.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	222,813,139	240,958,134	258,957,677	256,756,631	(0.8%)
Cash Funds	2,633,429	32,872,304	1	8,711,945	871194400.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	202,780,580	228,926,830	241,781,438	245,358,147	1.5%

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
TOTAL - (4) Office of Community Living	431,222,169	511,459,786	506,758,485	516,514,584	1.9%
FTE	30.5	34.2	35.5	37.3	5.1%
General Fund	224,269,184	242,627,030	260,652,220	259,125,097	(0.6%)
Cash Funds	2,633,429	35,394,381	1,876,332	8,901,622	374.4%
Reappropriated Funds	0	1,695,000	845,000	846,579	0.2%
Federal Funds	204,319,556	231,743,375	243,384,933	247,641,286	1.7%

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
providers to improve access to primary and preventative care for the indigent population.					
Safety Net Provider Payments	309,470,584	310,125,957	311,296,186	311,296,186	*
General Fund	0	0	0	0	
Cash Funds	152,391,319	152,556,889	155,073,238	155,648,093	
Reappropriated Funds	0	0	0	0	
Federal Funds	157,079,265	157,569,068	156,222,948	155,648,093	
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	*
General Fund	3,013,523	3,011,534	3,047,640	3,059,880	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,106,237	3,108,226	3,072,120	3,059,880	
Pediatric Specialty Hospital	13,455,012	13,455,012	13,455,012	13,455,012	*
General Fund	6,625,584	6,621,212	6,700,596	6,727,506	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,829,428	6,833,800	6,754,416	6,727,506	
Appropriation from Tobacco Tax Fund to the General Fund	423,600	427,593	432,590	432,590	
General Fund	0	0	0	0	
Cash Funds	423,600	427,593	432,590	432,590	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Primary Care Fund	26,828,000	26,778,000	27,276,358	27,276,358	
General Fund	0	0	0	0	
Cash Funds	26,828,000	26,778,000	27,276,358	27,276,358	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Administration	3,653,692	1,771,063	5,033,274	5,033,274	*
General Fund	0	0	0	0	
Cash Funds	1,214,777	231,115	2,363,824	603,993	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,438,915	1,539,948	2,669,450	4,429,281	
Children's Basic Health Plan Medical and Dental Costs	130,538,362	126,415,423	141,455,044	159,965,046	*
General Fund	6,003,180	2,098,125	2,067,851	189,026	
General Fund Exempt	0	427,593	432,590	432,590	
Cash Funds	48,154,315	26,137,685	17,533,954	20,959,031	
Reappropriated Funds	0	0	0	0	
Federal Funds	76,380,867	97,752,020	121,420,649	138,384,399	
TOTAL - (4) Indigent Care Program	490,489,010	485,092,808	505,068,224	523,578,226	3.7%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	15,642,287	11,730,871	11,816,087	9,976,412	(15.6%)
General Fund Exempt	0	427,593	432,590	432,590	0.0%
Cash Funds	229,012,011	206,131,282	202,679,964	204,920,065	1.1%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	245,834,712	266,803,062	290,139,583	308,249,159	6.2%

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
of the other divisions.					
Old Age Pension State Medical	431,000	3,582,551	12,962,510	12,962,510	
General Fund	0	2,937,569	2,962,510	2,962,510	
Cash Funds	431,000	644,982	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	5,401,843	7,597,298	7,597,298	7,597,298	*
General Fund	2,652,350	3,743,374	3,786,304	3,798,649	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,749,493	3,853,924	3,810,994	3,798,649	
State University Teaching Hospitals Denver Health and Hospital Authority	2,804,714	2,804,714	2,804,714	2,804,714	*
General Fund	1,381,111	1,380,200	1,396,748	1,402,357	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,423,603	1,424,514	1,407,966	1,402,357	
State University Teaching Hospitals University of Colorado Hospital	633,314	1,181,204	1,181,204	1,181,204	*
General Fund	311,860	581,654	585,390	590,602	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	321,454	599,550	595,814	590,602	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
Medicare Modernization Act State Contribution Payment	107,776,447	114,014,334	130,667,733	150,341,733	*
General Fund	107,360,512	114,014,334	130,667,733	150,341,733	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	415,935	0	0	0	
Public School Health Services Contract Administration	854,207	923,345	2,491,722	2,491,722	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	854,207	923,345	2,491,722	2,491,722	
Federal Funds	0	0	0	0	
Public School Health Services	62,716,218	78,309,241	82,604,632	84,538,210	
General Fund	0	0	0	0	
Cash Funds	31,449,659	38,606,226	41,001,948	42,195,941	
Reappropriated Funds	0	0	0	0	
Federal Funds	31,266,559	39,703,015	41,602,684	42,342,269	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	0	500,000	750,000	750,000	
General Fund	0	500,000	0	0	
Cash Funds	0	0	750,000	750,000	
TOTAL - (5) Other Medical Services	180,617,743	208,912,687	241,059,813	262,667,391	9.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	111,705,833	123,157,131	139,398,685	159,095,851	14.1%
Cash Funds	31,880,659	39,251,208	51,751,948	52,945,941	2.3%
Reappropriated Funds	854,207	923,345	2,491,722	2,491,722	0.0%
Federal Funds	36,177,044	45,581,003	47,417,458	48,133,877	1.5%

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	Request vs. Appropriation
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
This section reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this section and then transferred to the Department of Human Services. See the Department of Human Services for additional details about the line items contained in this division.					
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	101,359,003	127,413,523	109,469,368	111,773,457	2.1%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	40,915,136	60,361,068	52,414,760	53,758,324	2.6%
Cash Funds	4,606,971	1,953,214	1,866,142	1,866,142	0.0%
Reappropriated Funds	0	2,521	0	0	0.0%
Federal Funds	55,836,896	65,096,720	55,188,466	56,148,991	1.7%
TOTAL - Department of Health Care Policy and Financing	7,698,695,770	9,040,413,446	9,116,880,878	9,490,387,375	4.1%
FTE	390.9	422.2	435.8	452.9	3.9%
General Fund	1,498,933,212	1,695,354,249	1,780,126,624	1,922,963,147	8.0%
General Fund Exempt	813,135,957	809,452,060	874,267,590	874,267,590	0.0%
Cash Funds	838,845,737	1,143,004,065	1,012,485,521	1,020,139,119	0.8%
Reappropriated Funds	27,551,649	13,493,510	12,406,599	16,069,145	29.5%
Federal Funds	4,520,229,215	5,379,109,562	5,437,594,544	5,656,948,374	4.0%

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2015 SESSION BILLS

S.B. 15-011 (SPINAL CORD INJURY ALTERNATIVE MEDICINE PILOT PROGRAM): Continues and changes the Medicaid Spinal Cord Injury Alternative Medicine Pilot Program. Provides $362,649 total funds, including $179,347 General Fund and $183,302 federal funds, and 0.8 FTE to the Department of Health Care Policy and Financing for the program.

S.B. 15-228 (MEDICAID PROVIDER RATE REVIEW): Establishes an annual process for the Department of Health Care Policy and Financing to review Medicaid provider rates, creates an advisory committee, and requires reporting to the Joint Budget Committee. Provides $539,823 total funds, including $269,912 General Fund and $269,911 federal funds, and 4.0 FTE to implement the rate review process.

S.B. 15-234 (LONG BILL): General appropriations act for FY 2015-16. Includes provisions modifying appropriations to the Department of Health Care Policy and Financing for FY 2013-14 and FY 2014-15.

H.B. 15-1186 (SERVICES FOR CHILDREN WITH AUTISM): For the Children with Autism waiver program the bill:

1. Expands eligibility to add children ages 6 to 8
2. Allows children who begin receiving services before age 8 to receive a full three years of services, and no more than three years
3. Allows General Fund support and thereby eliminates the current enrollment cap of 75 children
4. Eliminates the annual statutory $25,000 per child expenditure cap on services and allows the cap to be adjusted through the budget process

Provides for an annual evaluation of the effectiveness of services for people with autism

To implement these changes, the bill provides $10.6 million, including $367,564 General Fund, to the Department of Health Care Policy and Financing in FY 2015-16. The table below summarizes the projected costs over the next three years. The source of cash funds is tobacco settlement moneys deposited in the Autism Treatment Cash Fund.

CHILDREN WITH AUTISM WAIVER EXPANSION			
	FY 15-16	FY 16-17	FY 17-18
Total	$10,616,568	$19,042,713	$22,726,738
General Fund	367,564	8,830,589	10,567,929
Cash Funds	4,840,203	508,566	577,333
Federal Funds	5,408,801	9,703,558	11,581,476

H.B. 15-1309 (PROTECTIVE RESTORATIONS BY DENTAL HYGIENISTS): Allows dental hygienists to receive a permit from the Colorado Dental Board to perform interim therapeutic restorations. The Department must establish an advisory committee to develop standards for interim therapeutic restorations. The bill places various restrictions on dental hygienists performing interim therapeutic restorations, including prohibiting the use of local anesthesia and requiring that a dentist first provide the diagnosis, treatment plan, and instruction for the dental hygienist to perform the restoration. Appropriations include $37,940 cash funds from the Division of Professions and Occupations Cash Funds to the Department of Regulatory Affairs for FY 2015-16, including $30,514 for personal services and $7,426 for the purchase of legal services from the Department of Law. The bill also appropriates $37,606 to the Department of Health Care Policy and Financing for FY 2015-16, including $10,815 General Fund and $833 cash funds from various cash funds. This provision also anticipates that the Department of Health Care Policy and Financing will receive $25,958 federal funds to implement the act.

H.B. 15-1318 (CONSOLIDATE INTELLECTUAL AND DEVELOPMENTAL DISABILITY WAIVERS): Requires the Department of Health Care Policy and Financing (Department) to consolidate the two existing home- and community-based waivers for adults with intellectual and developmental disabilities into a single waiver by July 1, 2016 or as soon as the Department receives approval from the Centers for Medicare and Medicaid. Requires the redesigned waiver to include flexible service definitions, provide access to services and supports when and where they are needed, offer services and supports based on the individual's needs and preferences, and incorporate the following principles (which are drawn from the Community Living Advisory Report):

1. Freedom of choice over living arrangements and social, community, and recreational opportunities;
2. Individual authority over supports and services;
3. Support to organize resources in ways that are meaningful to the individual receiving services;
4. Health and safety assurances;
5. Opportunity for community contribution; and
6. Responsible use of public dollars.

Requires the use of a needs assessment tool that aligns with the Community Living Advisory Group recommendations and one that is fully integrated with the assessment processes for other long-term services. The tool must ensure an individual's voice and needs are accounted for when determining what services the individual needs. The bill requires the payment system for services to be efficient, transparent, and equitable and to ensure the fair distribution of available resources. Requires the Department to submit to the JBC as part of the FY 2016-17 Governor's budget request a justification for the continued use of the Supports Intensity Scale (SIS) assessment. If the JBC concludes the justification is insufficient, the Department shall present a transition plan to a different assessment tool for the redesigned waiver.

Requires the Department to develop a plan by July 1, 2016 for the delivery of conflict-free case management services that comply with federal requirements related to person-centered planning. The Department is required to report back to the Joint Budget Committee during the FY 2016-17 budget process regarding plan development and any required statutory changes. The Department is required to get input from Community Centered Boards, Single Entry Points and other stakeholders

on the development of the plan. Appropriates $2,176,695 total funds, including $788,347 cash funds and 2.7 FTE to the Department for FY 2015-16.

H.B. 15-1368 (CROSS-SYSTEM RESPONSE PILOT INTELLECTUAL AND DEVELOPMENTAL DISABILITIES): Establishes the Cross-system Response for Behavioral Health Crises Pilot Program (Pilot Program) to provide crisis intervention, stabilization, and follow-up services to individuals who:

Have both an intellectual or developmental disability and a mental health or behavioral disorder;
Require services not available through an existing Medicaid waiver; and
Are not covered under the Colorado behavioral health care system.

Requires the Pilot Program to begin on or before March 1, 2016 and consist of multiple sites that represent different geographic areas of the state. The Pilot Program must provide access to intensive coordinated psychiatric, behavioral, and mental health services as an alternative to emergency department care or in-patient hospitalization; offer community-based, mobile supports to individuals with dual diagnoses and their families; offer follow-up supports to individuals with dual diagnoses, their families, and their caregivers to reduce the likelihood of future crises; provide education and training for families and service agencies; provide data about the cost in Colorado of providing such services throughout the state; and provide data to inform changes to existing regulatory or procedural barriers to the authorized use of public funds across systems, including the Medicaid state plan, home- and community-based service Medicaid waivers, and the capitated mental health system.

Requires the Department of Health Care Policy and Financing (Department) to conduct a cost-analysis study related to the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system. Also, requires the Department to provide recommendations for eliminating the service gap. Authorizes the Departments of Human Services and Health Care Policy and Financing to examine the feasibility of allowing a Community Centered-Board to use a vacant Regional Center group home for the Pilot Program. Appropriates $1,695,000 cash funds from the Intellectual and Developmental Disabilities Services Cash Fund to the Cross-system Response for Behavioral Health Crises Pilot Program Fund and reappropriates this money for the pilots in the Department of Health Care Policy and Financing for FY 2015-16.

2016 SESSION BILLS

S.B. 16-027 (MEDICAID OPTION FOR PRESCRIBED DRUGS BY MAIL): Authorizes the Department of Health Care Policy and Financing to allow all Medicaid recipients, rather than just those with a hardship or third party insurance, to receive maintenance medication through the mail, up to a three month supply, and details associated procedures with the new benefit. The bill is expected to reduce dispensing fees and cause some pharmacy costs to shift from one fiscal year to the next. For FY 2016-17 the bill reduces appropriations by $29,917 total funds ($9,084 General Fund, $409 cash funds from the Hospital Provider Fee, and $20,424 federal funds). The table below summarizes expected future year savings under the bill.

S.B. 16-027			
	FY 16-17	FY 17-18	FY 18-19
Dispensing Fee Savings	($658,026)	($2,069,622)	($2,169,792)
Cost Shift – Current Year Increase	628,108	930,634	1,034,203
Cost Shift – Next Year Savings	0	(628,108)	(930,634)
TOTAL	**($29,918)**	**($1,767,096)**	**($2,066,223)**

S.B. 16-038 (TRANSPARENCY OF COMMUNITY-CENTERED BOARDS): Requires a Community-Centered Board (CCB) that receives more than 75.0 percent of its annual funding from federal, state, or local governments, or any combination thereof, to be subject to the Colorado Local Government Audit Act. The Office of the State Auditor must conduct a performance audit of any CCB that exceeds the 75 percent government threshold to determine if the CCB is effectively and efficiently fulfilling its statutory obligations. Audits of CCBs are to occur in the five-year period following the effective date of the bill and as requested by the Office of the State Auditor thereafter. This bill also requires each CCB to post information on its website related to the board of directors and their meetings, financial statements, annual budgets and other CCB business related information. Appropriates $60,416 total funds, of which $30,208 is cash funds from the Intellectual and Developmental Disability Services Cash Fund and $30,208 is federal funds, and 1.0 FTE to the Department of Health Care Policy and Financing for FY 2016-17.

S.B. 16-120 (REVIEW BY MEDICAID CLIENT FOR BILLING FRAUD): Requires the Department of Health Care Policy and Financing to provide explanation of benefits statements to Medicaid clients and describes minimum standards for the frequency, distribution method, and content of the statements. For FY 2016-17 the bill appropriates $188,000 total funds ($35,350 General Fund, $3,450 cash funds from the Hospital Provider Fee, and $149,200 federal funds) for information technology system modifications and form development. Costs are expected to rise in future years to include personal services, mailing expenses, and vendor costs. These costs may be offset by increased cost recoveries, but potential savings were not estimated in the Legislative Council Staff Fiscal Note. The table below summarizes projected future costs.

S.B. 16-120			
	FY 16-17	FY 17-18	FY 18-19
Personal Services	$0	$24,268	$24,268
FTE	0.0 FTE	0.5 FTE	0.5 FTE
Operating Expenses and Capital Outlay Costs	0	5,178	475
Information Technology System Modifications	138,000	0	0
Form Development Costs	50,000	0	0
EOB Statement Mailing Costs	0	524,700	524,700
Ongoing Vendor Costs	0	293,775	305,775
TOTAL	**$188,000**	**$847,921**	**$855,218**
General Fund	35,350	266,569	266,467
Cash Funds	3,450	83,948	84,698
Federal Funds	149,200	497,404	504,053

S.B. 16-192 (Assessment Tool Intellectual and Developmental Disabilities): Requires the Department of Health Care Policy and Financing, by July 1, 2018, and pursuant to the ongoing stakeholder process relating to eligibility determination for long-term services and supports, to select a needs assessment tool for persons receiving long-term services and supports, including persons with intellectual and developmental disabilities. The Department must have stakeholder involvement in the needs assessment tool selection process. The selected needs assessment tool must include a reassessment process that can be completed within thirty days after the reassessment is requested.

Once the tool is selected, the Department must report to the applicable House and Senate committees of reference and the Joint Budget Committee the needs assessment tool that was selected and the level of stakeholder involvement during the selection process. Appropriates $277,573 total funds, of which $138,787 is cash funds from the Intellectual and Developmental Disability Services Cash Fund and $138,786 is federal funds, and 1.8 FTE to the Department of Health Care Policy and Financing for FY 2016-17.

S.B. 16-199 (PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY): Establishes a Program of All-inclusive Care for the Elderly (PACE) ombudsman office in the long-term care ombudsman office to set forth statewide policies and procedures to identify, investigate, and seek resolution of referral of complaints made by or on behalf of a PACE participant. Appropriates $225,000 cash funds for FY 2016-17 to the Department of Health Care Policy and Financing for general professional services related to the rate-setting process for Medicaid participants in the PACE program. Additionally, appropriates $81,675 cash funds and 1.0 FTE for FY 2016-17 to the Department of Human Services for use by the state ombudsman program.

H.B. 16-1097 (PUC PERMIT FOR MEDICAID TRANSPORTATION PROVIDERS): Allows providers of non-emergency transportation services for Medicaid clients to operate under a limited regulation permit from the Public Utilities Commission (PUC), rather than a certificate of public convenience and necessity, and establishes parameters for the limited regulation permits. For FY 2016-17 the bill is expected to increase state revenue from permit fees by $7,450, of which $5,725 is subject to the TABOR limit, and it makes the following appropriations:

H.B. 16-1097						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
Health Care Policy and Financing	($136,943)	($9,827)	($2,549)	$0	($124,567)	0.0
Transfer to Regulatory Agencies	78,328	59,578	0	$0	18,750	0.0
Medical Services Premiums	(215,271)	($69,405)	(2,549)	$0	(143,317)	0.0
Public Safety						
Colorado Crime Information Center	2,636	0	2,636	0	0	0.0
Law						
Legal Services to State Agencies	23,753	0	0	23,753	0	0.1
Office of the Governor						
Office of Information Technology	8,755	0	0	8,755	0	0.0
TOTAL	**($101,799)**	**($9,827)**	**$87**	**$32,508**	**($124,567)**	**0.1**

H.B. 16-1240 (SUPPLEMENTAL BILL): Supplemental appropriation to the Department of Health Care Policy and Financing to modify appropriations for FY 2015-16. Includes provisions modifying appropriations to the Department for FY 2013-14 and FY 2014-15.

H.B. 16-1277 (APPEAL PROCESS FOR CHANGES TO MEDICAID BENEFITS): Makes changes to the Department of Health Care Policy and Financing's dispute resolution process, including requiring the Department to give Medicaid clients at least 10 days advance notice prior to suspending, terminating, or modifying a client's medical assistance benefits and extending the time for a client to appeal the action. For FY 2016-17 the bill appropriates $25,000 total funds, including $2,500 General Fund and $22,500 federal funds, to the Department of Health Care Policy and Financing for associated changes to information technology systems.

H.B. 16-1321 (MEDICAID BUY-IN CERTAIN MEDICAID WAIVERS): Requires the Department of Health Care Policy and Financing to pursue federal authorization to extend the Medicaid buy-in program to people eligible for the Supported Living Services Medicaid waiver, the Brain Injury waiver, and the Spinal Cord Injury waiver pilot program. For FY 2016-17 the bill appropriates $138,027 total funds, including $13,803 cash funds from the Hospital Provider Fee and $124,224 federal funds, to the Department of Health Care Policy and Financing for associated information technology changes.

H.B. 16-1405 (LONG BILL): General appropriations act for FY 2016-17. Includes provisions modifying appropriations to the Department of Health Care Policy and Financing for FY 2015-16.

H.B. 16-1407 (EXTEND MEDICAID PAYMENT REFORM & INNOVATION PILOT): Extends the Medicaid Payment Reform and Innovation Pilot Program (established through H.B. 12-1281) that allows contractors to work with providers and managed care entities to develop a payment reform project and submit a proposal to the Department. Removes statutory dates concerning the selection of and completion of payment reform projects, allowing projects that have been approved to continue beyond June 30, 2016, and allowing the Department to continue selecting new projects for the Pilot Program. Amends associated evaluation and reporting requirements. Appropriates $245,639 General Fund to the Department of Health Care Policy and Financing for FY 2016-17, and states that the appropriation is based on the assumptions that the Department will require an additional 1.0 FTE and that the Department will receive $347,064 federal funds to implement the act. This funding essentially reinstates full funding for the Department to evaluate proposals that are submitted, validate and certify provider rates, review managed care contracts, evaluate the payment reform projects that are approved, and prepare the required reports.

H.B. 16-1408 (CASH FUND ALLOCATIONS FOR HEALTH-RELATED PROGRAMS): Establishes a new formula for the allocation of the annual payment received by the state as part of the Tobacco Master Settlement Agreement (Tobacco MSA). The new formula allocates all Tobacco MSA revenue by percentage shares, rather than the hybrid scheme of fixed dollar amounts and capped percentage shares in multiple tiers. The bill creates a new Primary Care Provider Sustainability Fund in the Department of Health Care Policy and Financing to fund increased access to primary care office visits, immunization administration, health screening services, and newborn care, including neonatal critical care and transfers $20.0 million from the Children's Basic Health Plan Trust to this new fund on July 1, 2016. For the Department of Health Care Policy and Financing for FY 2016-17 the bill increases funding by $55,694,236 total funds, including a decrease of $6,451,471 General Fund, an increase of $6,451,471 cash funds from the Colorado Autism Treatment Fund, an increase of $20,000,000 cash funds from the Primary Care Provider Sustainability Fund, an increase of $556,859 cash funds from the Hospital Provider Fee, and an increase of $35,137,377 federal funds. For more information about the bill, see the description under the Department of Public Health and Environment.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

10 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, Scholarships for Research Using the All-Payer Claims Database -- The purpose of this appropriation is to provide scholarships for nonprofit and governmental entities to defray the cost of access to the All-Payer Claims Database to conduct research.

Comment: This footnote explains the purpose of the appropriation. The Department is using the money as intended.

11 Department of Health Care Policy and Financing, Executive Director's Office, General Professional Services and Special Projects -- This line item includes $62,000 total funds, including $31,000 General Fund, the purpose of which is the autism waiver program evaluation required by Section 25.5-6-806 (2) (c) (I), C.R.S. It is the General Assembly's intent that the Department also use the $62,000 total funds to evaluate the new behavioral therapy benefit through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Comment: This footnote explains the purpose of the appropriation. The Department is using the money as intended.

12 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects; Eligibility Determinations and Client Services, Customer Outreach; Utilization and Quality Review Contracts, Professional Services Contracts; Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- For line items with this footnote the limitation on the appropriation from the "(M)" notation does not apply to federal funds from the State Demonstration to Improve Care for Medicare-Medicaid Enrollees Implementation Support grant. The following line items include the listed amounts that are assumed to come from federal funds for the State Demonstration to Improve Care for Medicare-Medicaid Enrollees Implementation Support grant:

Line Item	Federal Funds
Medicaid Management Information System Maintenance and Projects	$207,500
Customer Outreach	$131,138
Professional Services Contracts	$105879

Comment: This footnote makes exceptions from the "(M)" notation restriction for certain specified federal funds. The "(M)" notation restriction requires that if federal funding increases or decreases from the appropriation for a line item the General Fund be reduced by a like amount.

13 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses -- Of this appropriation, $9,625,475 remains available through June 30, 2018.

Comment: This footnote allows roll forward authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is in compliance with the footnote.

14 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses and Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department is authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote. The Department is also authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote to line item appropriations within the Department of Human Services, Office of Information Technology Services, Colorado Benefits Management System subsection.

Comment: This footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is in compliance with the footnote.

15 Department of Health Care Policy and Financing, Medical Services Premiums -- Of the appropriation for this division an estimated $156,026,037 is for the Program for All-inclusive Care for the Elderly (PACE), based on the assumptions in Exhibit H of the Department of Health Care Policy and Financing's February 2016 forecast of Medicaid enrollment and expenditures, including an expected average enrollment in PACE of 3,170 enrollees and an average annual cost per PACE enrollee of $49,219.57; except that expenditures for PACE will be based on the monthly capitated rate for the contracted services as negotiated by the Department pursuant to Section 25.5-5-412 (12) (a), C.R.S., and actual enrollment.

Comment: This footnote explains the assumptions related to funding for the Program for All-inclusive Care for the Elderly (PACE) that were used to create the appropriation.

16 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs -- It is the intent of the General Assembly that expenditures for these services be recorded only against the Long Bill group total for Program Costs.

Comment: This footnote provides flexibility for the Department to move money between line items within the division. The Department is in compliance with the footnote.

17 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs, Preventive Dental Hygiene -- It is the intent of the General Assembly that this appropriation be used to provide special dental services for persons with intellectual and developmental disabilities.

Comment: This footnote explains the purpose of the appropriation to provide special dental services for persons with intellectual and developmental disabilities. The Department is in compliance with the footnote.

18 Department of Health Care Policy and Financing, Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program -- It is the General Assembly's intent that this appropriation be used to sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse that is authorized in Section 25.5-5-208, C.R.S., through:

- Training for health professionals statewide that is evidence-based and that may be either in person or web based;
- Consultation and technical assistance to providers, healthcare organizations, and stakeholders;
- Outreach, communication, and education of providers and patients;
- Coordination with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; and
- Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce the stigma of treatment.

Comment: This footnote explains the purpose of the appropriation. The Department is in compliance with the footnote.

19 Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with the headnotes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is hereby authorized to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This footnote authorizes transfers between specified line items. The Department is in compliance with the footnote.

UPDATE ON REQUESTS FOR INFORMATION

1. Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit a report by November 1 each year estimating the total savings, total cost, and net cost effectiveness of fraud detection efforts.

   Comment: The Department submitted the report as requested. According to the report, the Department is still evaluating pre-payment predictive analytics to prevent fraud. The Department will be implementing new post-payment predictive analytic software in Spring 2017. Based on a review of other states, the Department believes this software is necessary to design pre-payment predictive analytics program. The Department also reports that other states with pre-payment predictive analytics programs have experienced staffing issues where not all flagged claims can be reviewed before prompt payment deadlines and the Department is considering how to proceed based on this information. Funding provided to develop pre-payment predictive analytics has been used to inform the design of the Medicaid Management Information System (MMIS). The Department also reports that it is researching opportunities for additional federal funding for this initiative.

2. Department of Health Care Policy and Financing, Executive Director's Office -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, behavioral health capitation, and the intellectual and developmental disabilities line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report. The Department is also requested to include in the report the number of applications and the number of approvals for new intermediate care facilities for individuals with intellectual disabilities, including the number of beds and the cost of those beds.

   Comment: The Department continues to submit the monthly expenditure and caseload reports as requested.

3. Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit a report by November 1 each year to the Joint Budget Committee providing information on the implementation of the Accountable Care Collaborative project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the program, the current administrative fees and costs for the program, and performance results with an emphasis on the fiscal impact.

   Comment: The Department submitted the report as requested. See the issue brief "Accountable Care Collaborative and Related Payment Reforms (R6)" for information on enrollment, costs, and performance results.

4. Department of Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payments -- The Department is requested to submit a report by February 1 of each year to the Joint Budget Committee estimating the disbursement to each hospital from the Safety Net Provider Payments line item.

   Comment: The requested report is not due until February.

5. Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

   Comment: The Department submitted the report as requested.

6. Department of Health Care Policy and Financing, Office of Community Living -- The Department is requested to provide by November 1, 2016, a written report detailing the continued implementation of the recommendations made by the Community Living Advisory Group, Colorado's Community Living Plan developed to comply with the United States Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 14 581 (1999), and the final federal rule setting forth requirements for home- and community-based services, 79 FR 2947. The report shall include: an update on the detailed project plan which includes the timeline for implementing the recommendations and requirements, an explanation of any recommendations or requirements not included in the plan, and an explanation of how outcome measures will be tracked in the future to better understand how changes impact clients. The Department is also requested to provide a financial analysis of the costs of implementing recommendations. Additionally, the report shall include a description of any FY 2017-18 budget requests that align with the plan.

   Comment: The Department submitted the report as requested. *See the 12/19/16 briefing on the Office of Community Living for an analysis of the report.*

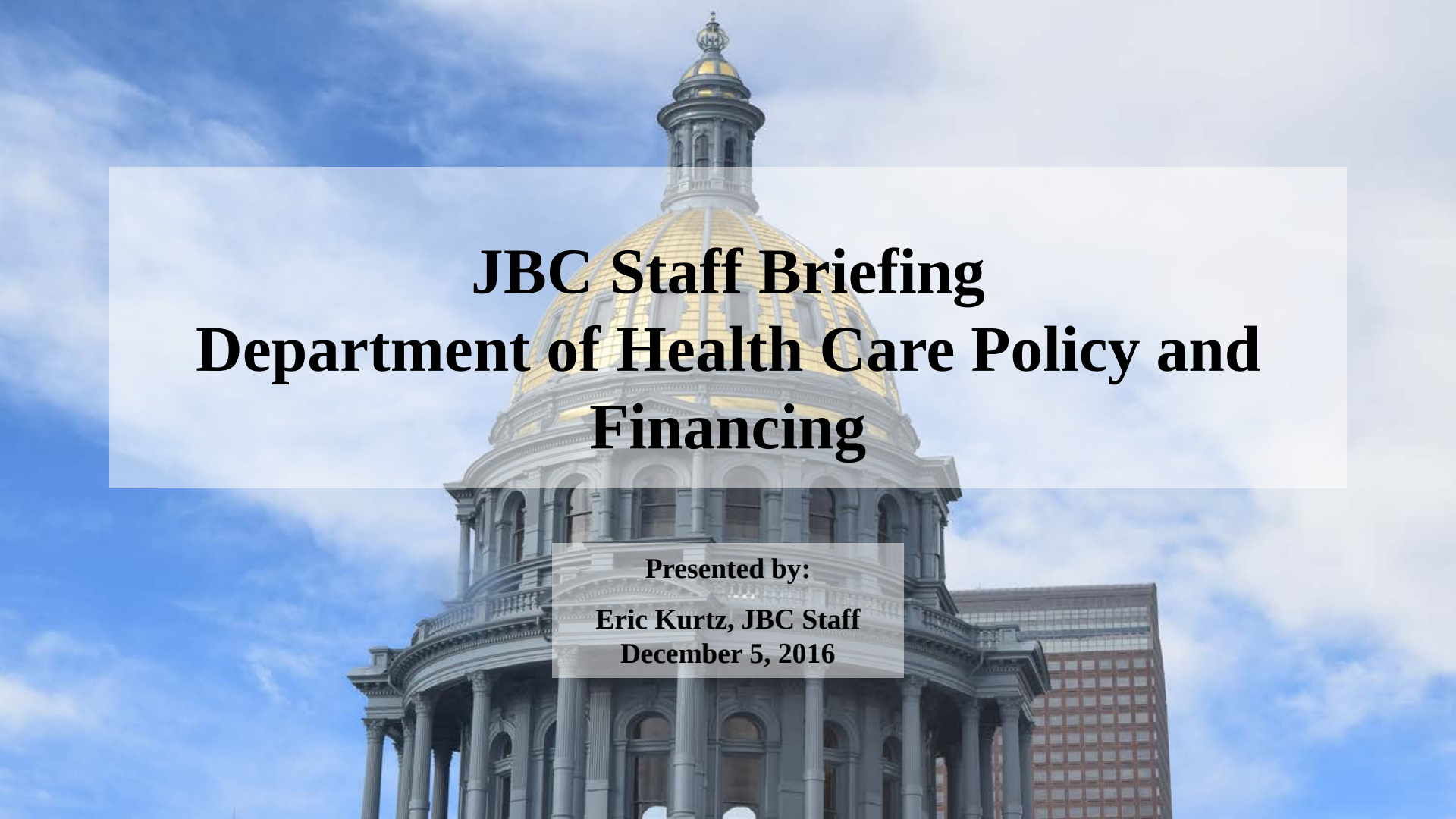
APPENDIX D
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1) (a) (I), C.R.S., the Office of State Planning and Budgeting is required to publish an Annual Performance Report for the Department of Health Care Policy and Financing by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2016-17 report dated October 2016 can be found at the following link:

https://sites.google.com/a/state.co.us/colorado-performance-management/department-performance-plans/health-care-policy-and-financing/fy-2016-17-performance-plan-and-evaluation-reports

Pursuant to Section 2-7-204 (3) (a) (I), C.R.S., the Department of Health Care Policy and Financing is required to develop a performance plan and submit that plan to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year. For consideration by the Joint Budget Committee in prioritizing the Department's budget request, the FY 2016-17 plan can be found at the following link:

https://sites.google.com/a/state.co.us/colorado-performance-management/department-performance-plans/health-care-policy-and-financing/fy-2016-17-performance-plan-and-evaluation-reports



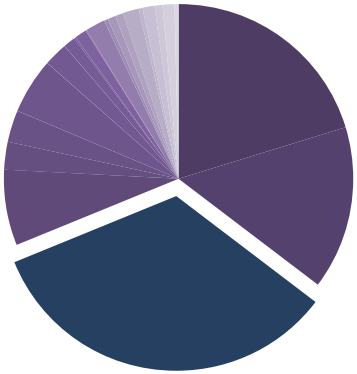
JBC Staff Briefing
Department of Health Care Policy and Financing

Presented by:

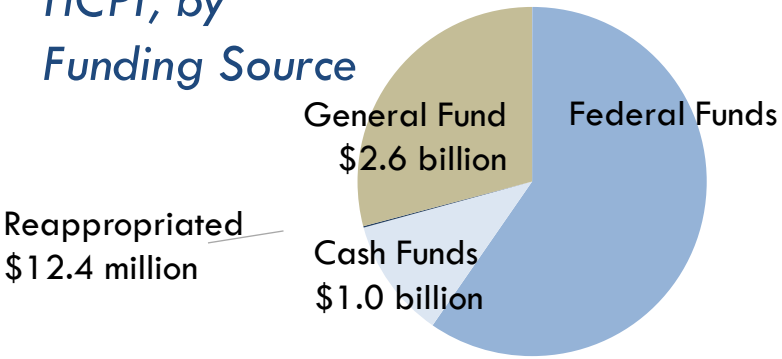
Eric Kurtz, JBC Staff
December 5, 2016

Health Care Policy and Financing

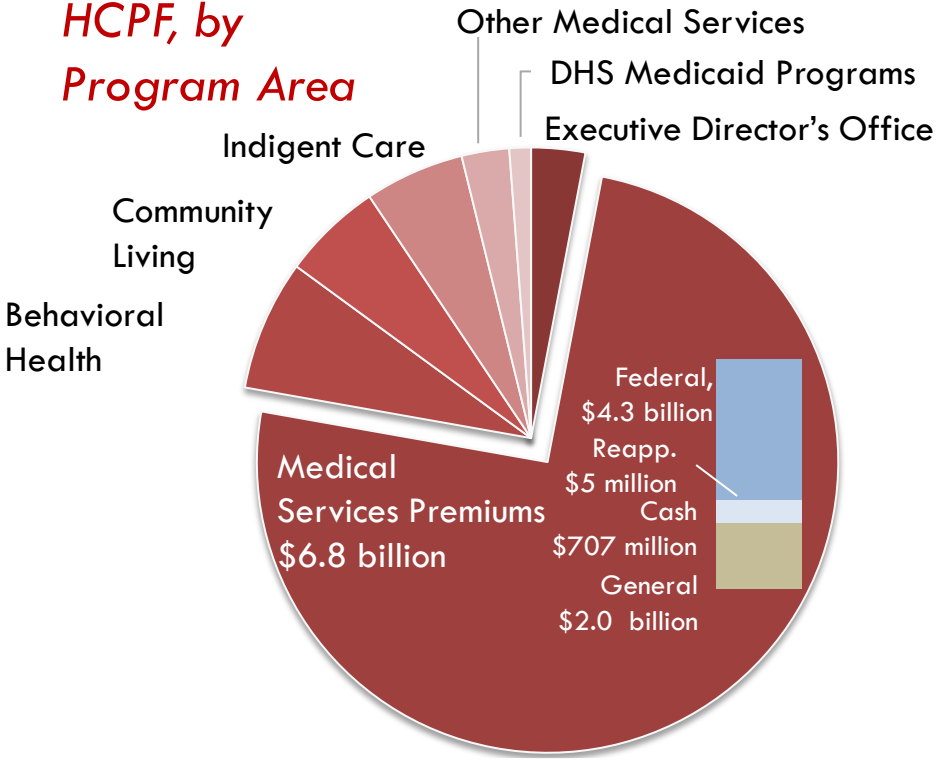
$9.1 Billion
33.6% of Total
26.6% of GF
435.8 FTE

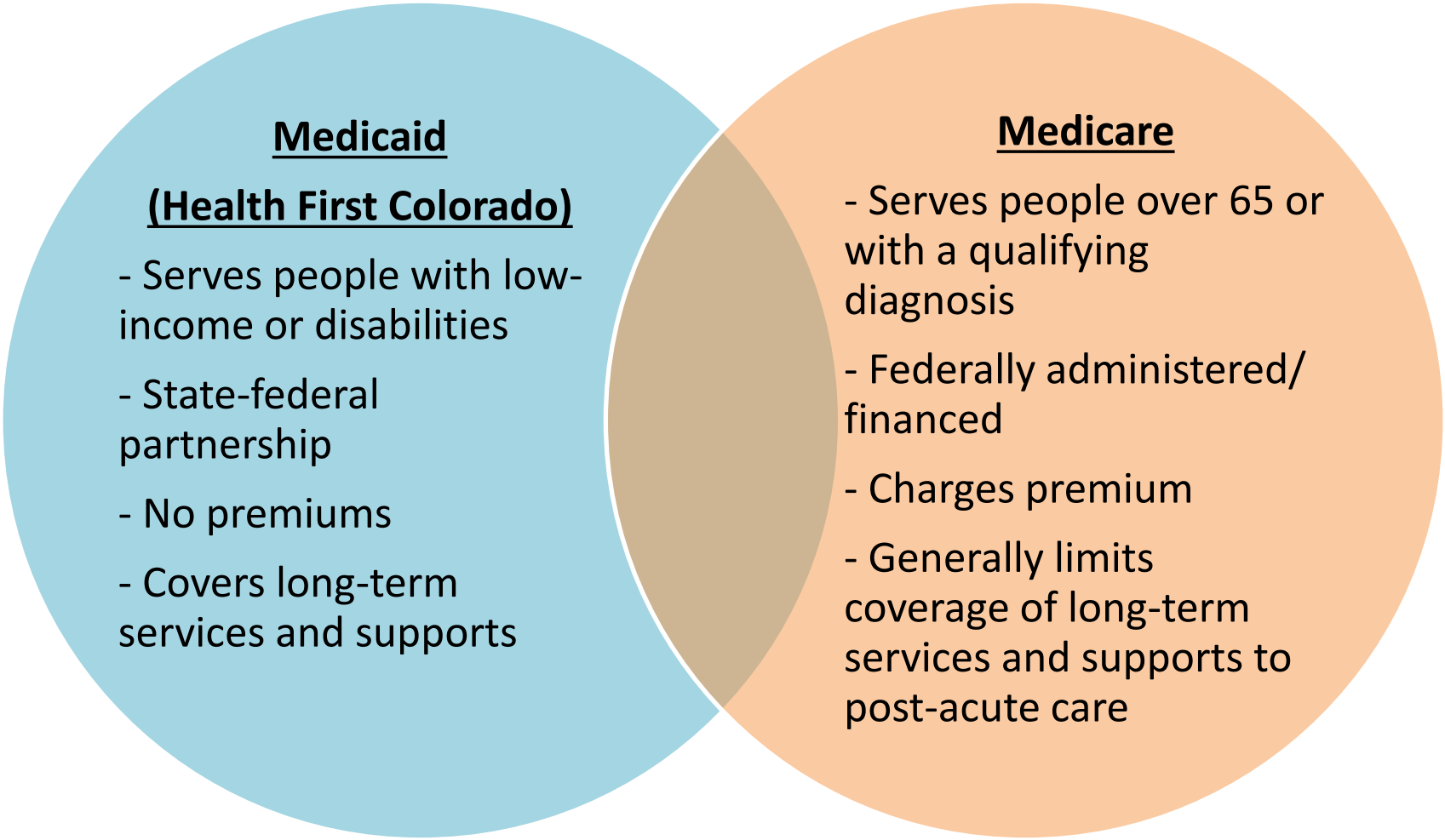


HCPF, by Funding Source



HCPF, by Program Area

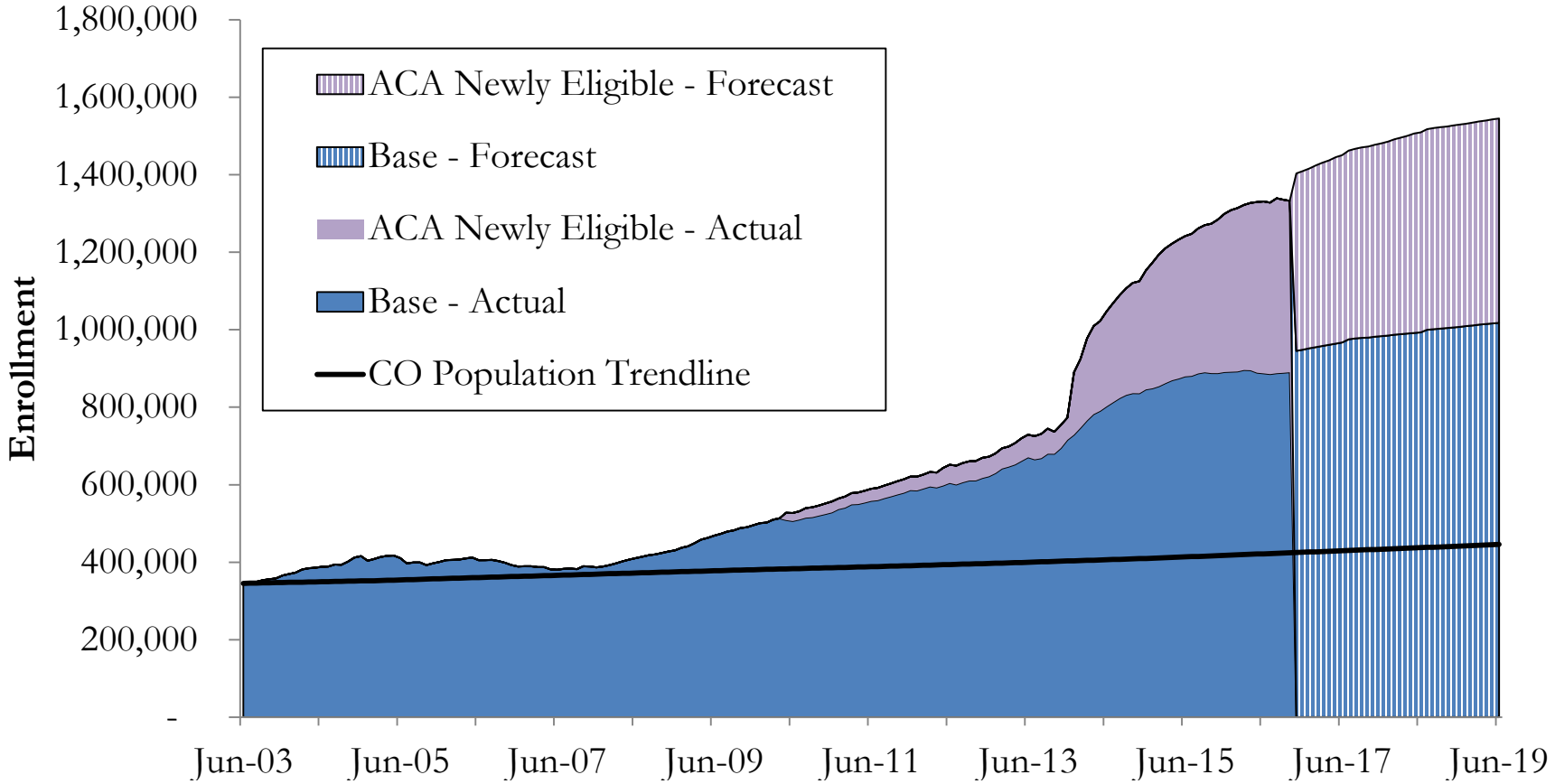



Medicaid
(Health First Colorado)
- Serves people with low-income or disabilities
- State-federal partnership
- No premiums
- Covers long-term services and supports
Medicare
- Serves people over 65 or with a qualifying diagnosis
- Federally administered/ financed
- Charges premium
- Generally limits coverage of long-term services and supports to post-acute care

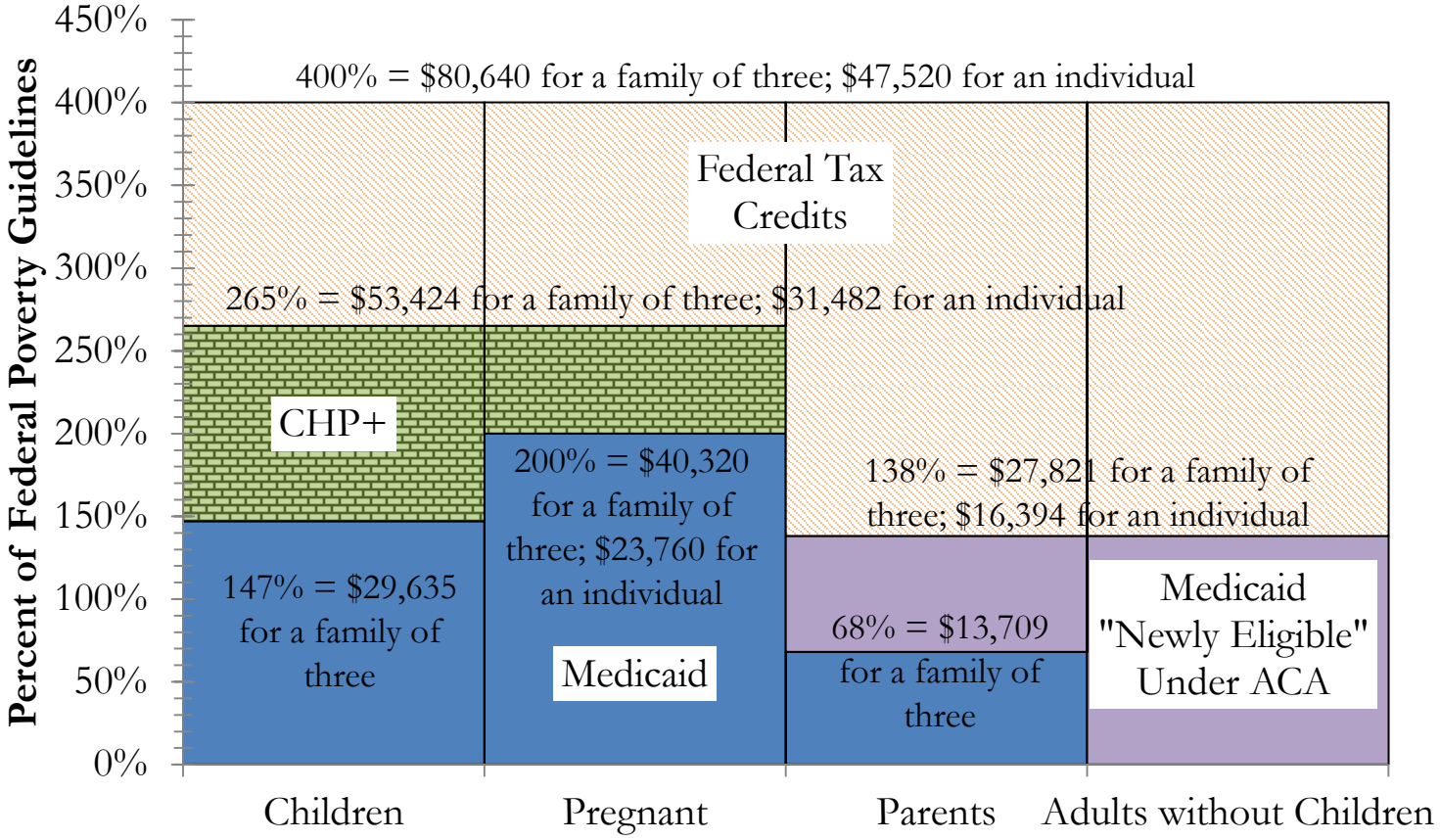
FY 17-18 Match Rates

	State Share	Federal Share
Standard Medicaid	50%	50%
"Newly Eligible" Adults	5.5%	94.5%
Children's Basic Health Plan	12%	88%

Medicaid Enrollment

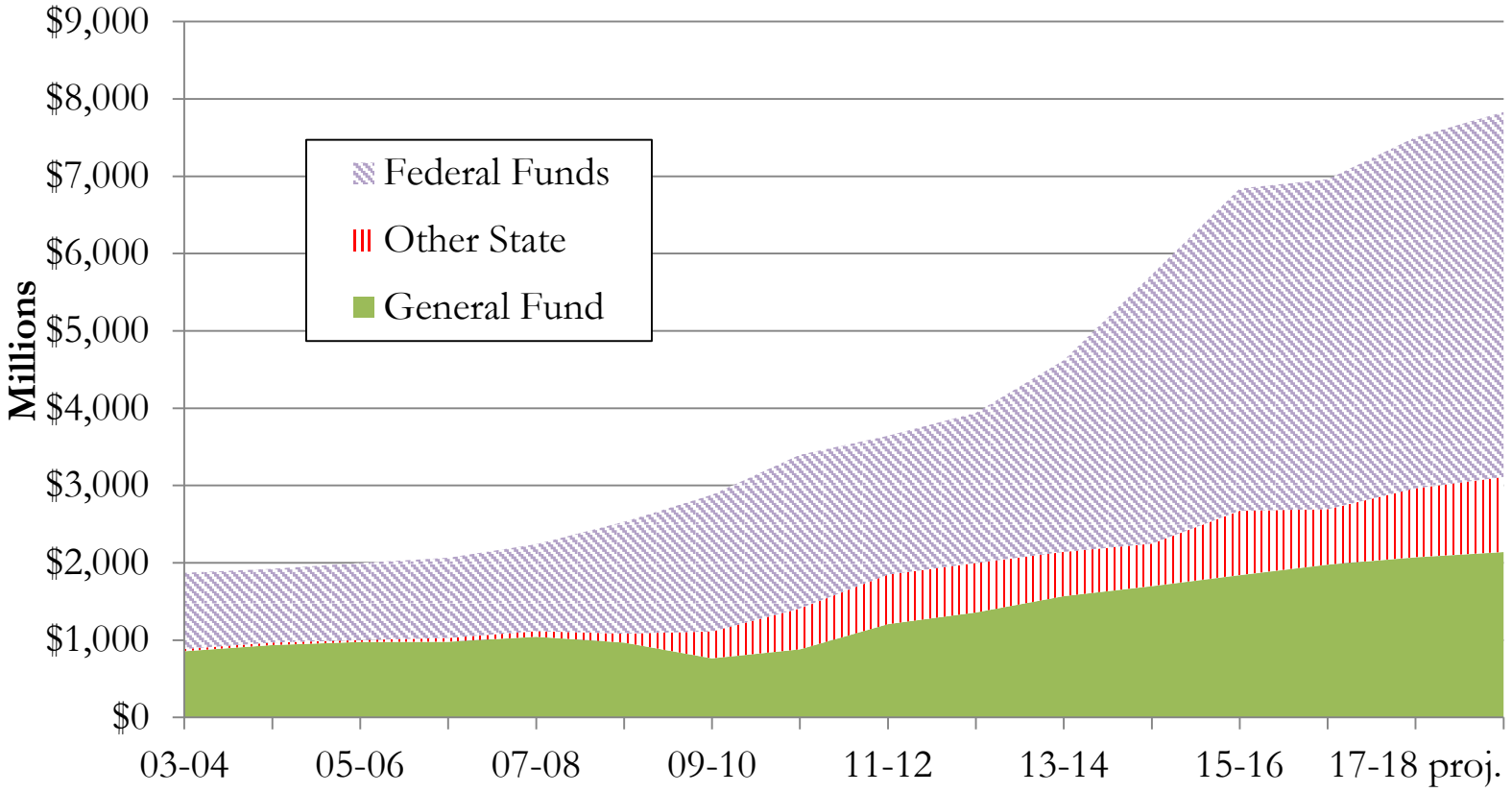


Effective Income Eligibility for Benefit

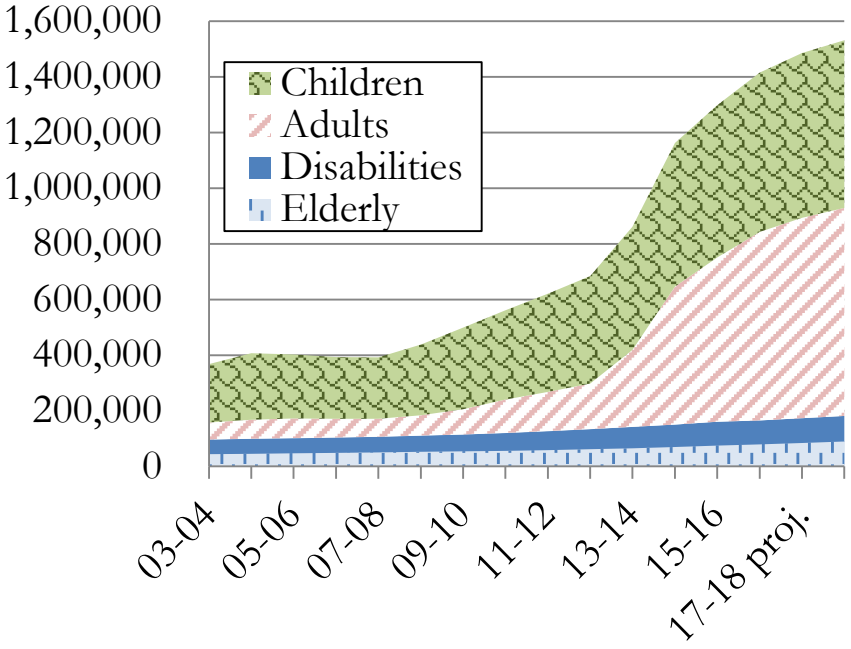


Special Medicaid Eligibility Categories	
Category	**Eligibility Standard**
Elderly 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities (not otherwise qualified)	450% FPL = may "buy in" to Medicaid (with premium on sliding scale based on income)
Nursing home level of care	300% of SSI income threshold
Breast or cervical cancer	250% of FPL
Former foster children	To age 26 regardless of income
Non-citizens	If otherwise qualified for Medicaid = emergency services only

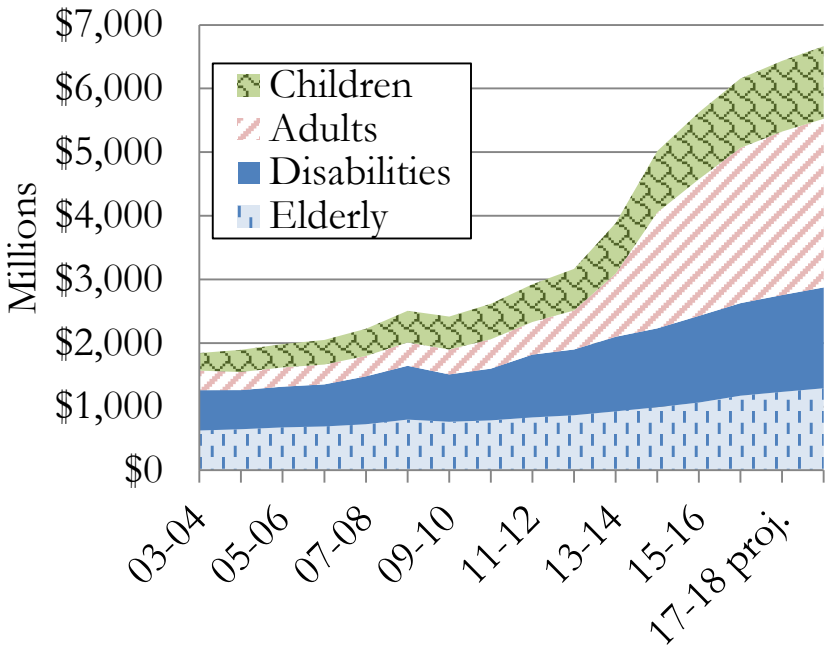
Medicaid Expenditures by Fund



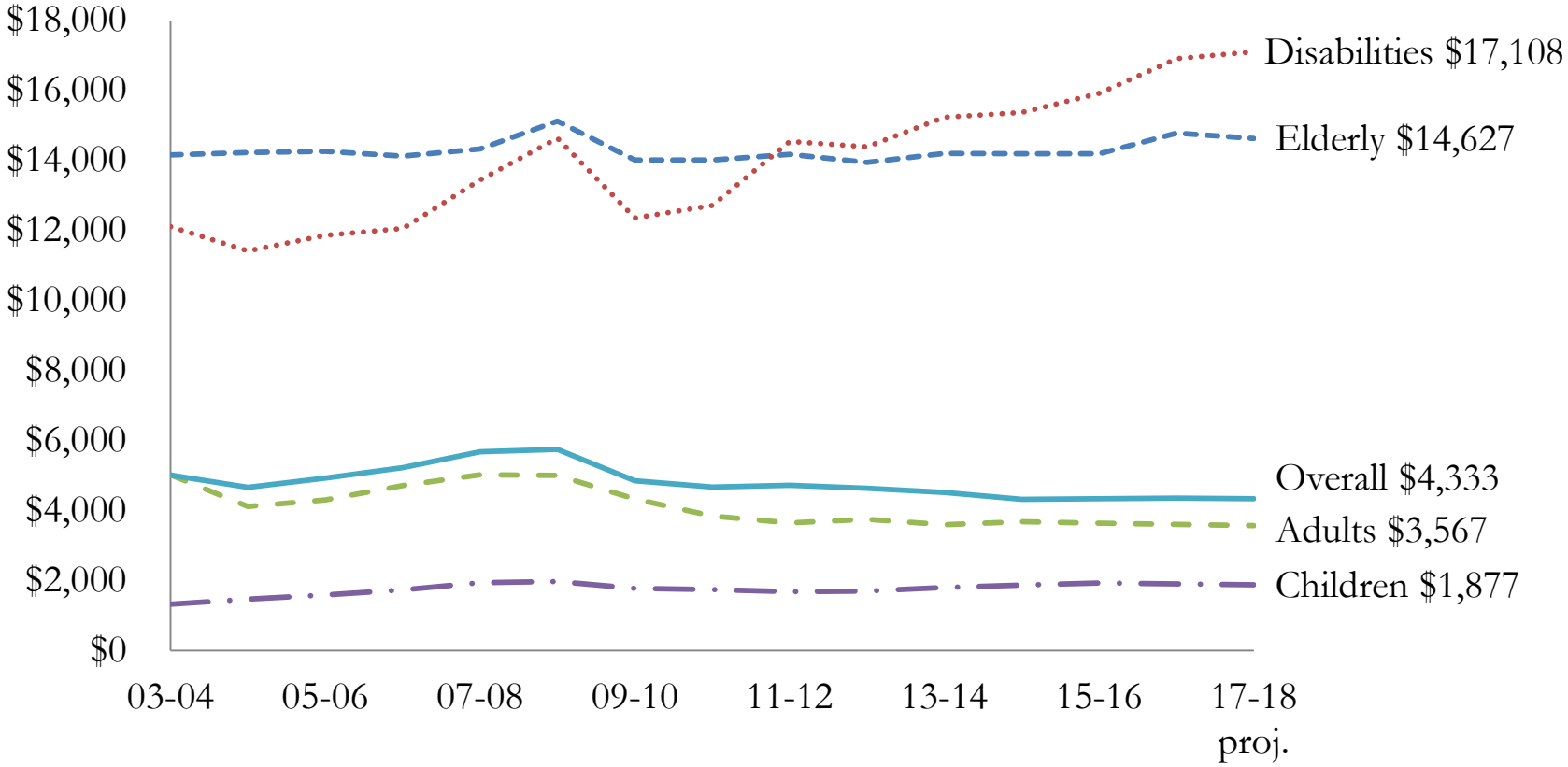
Medicaid Enrollment



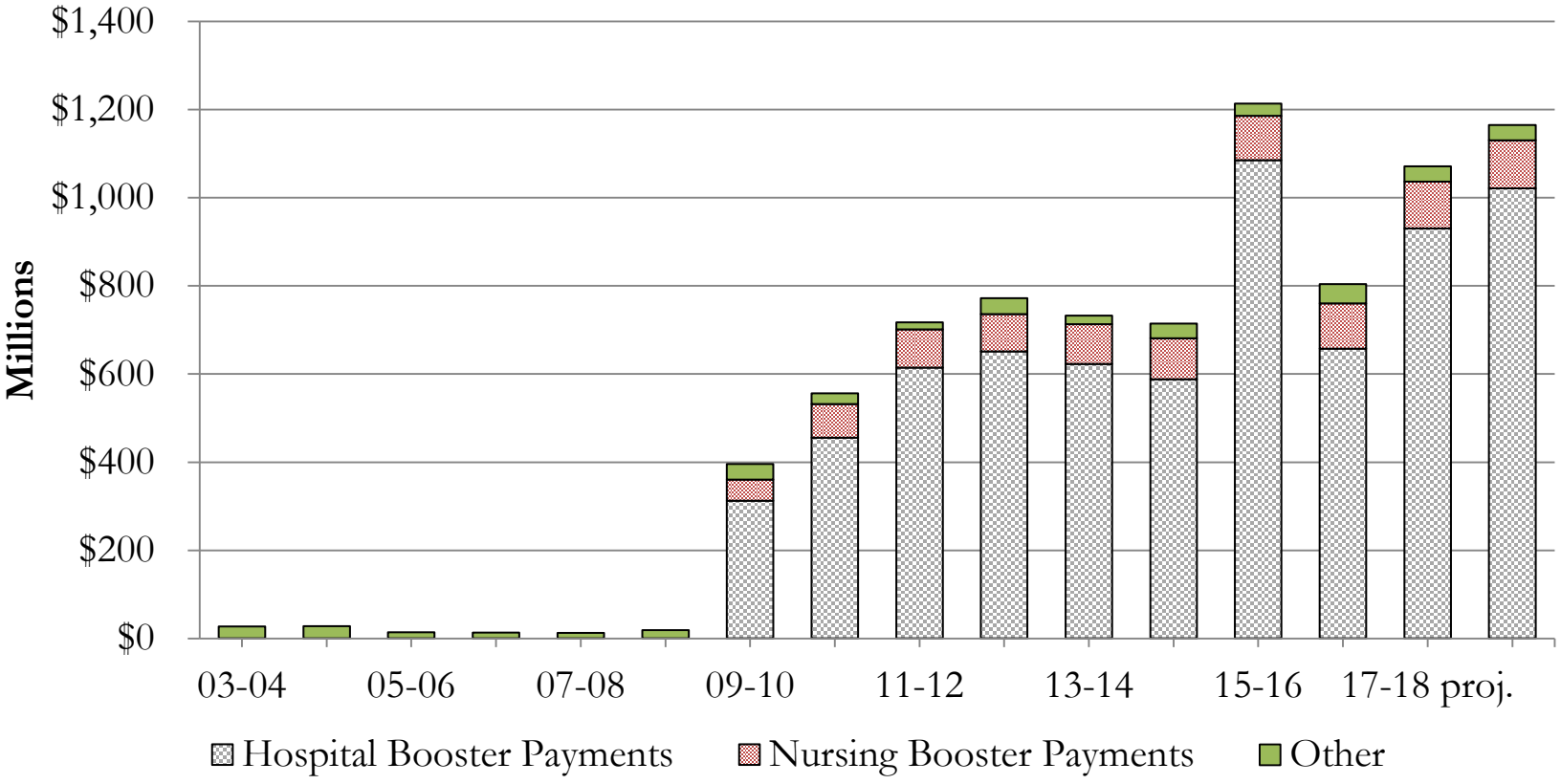
Medical Services Expenditures



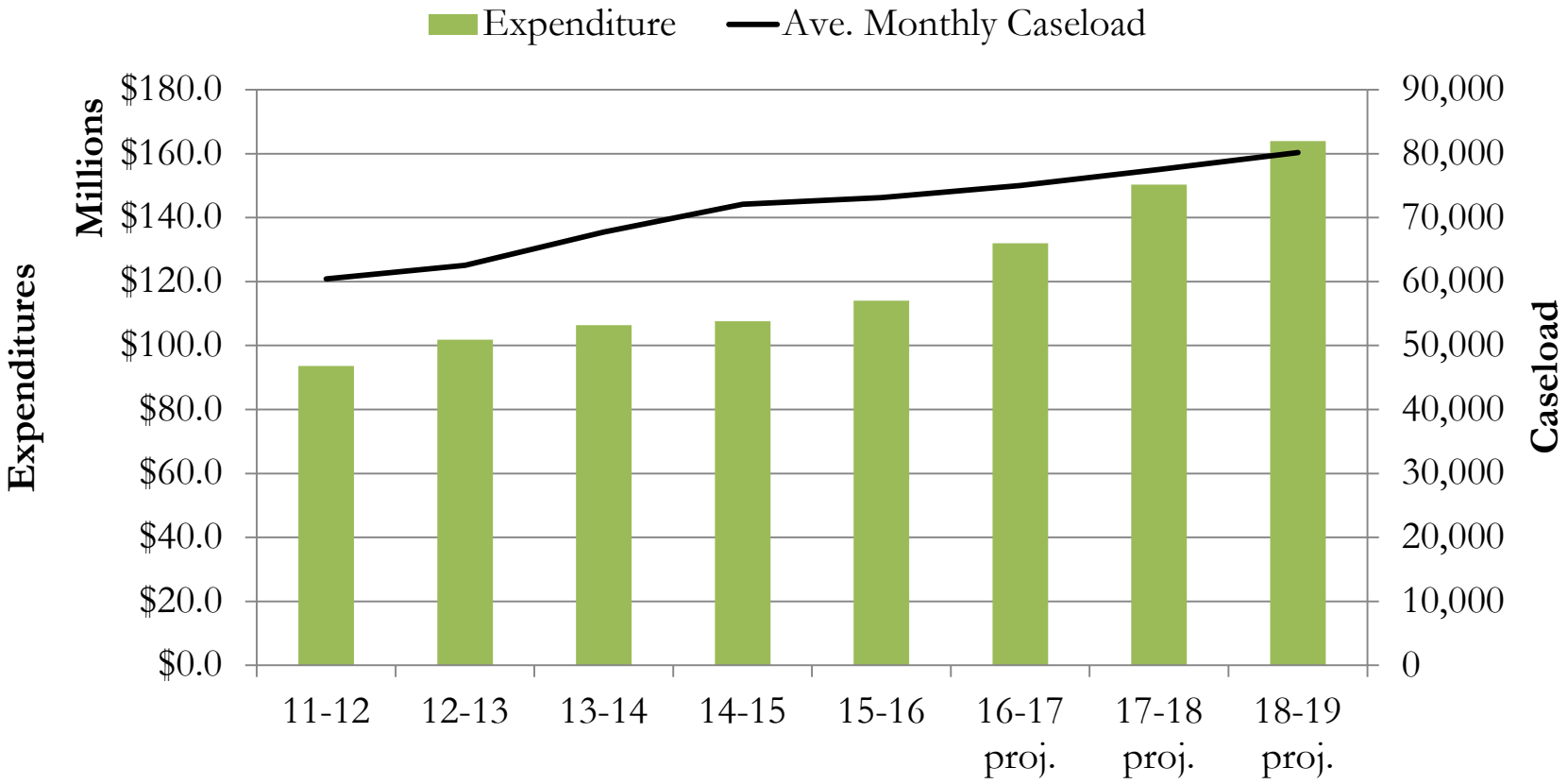
Per Capita Medicaid Expenditures



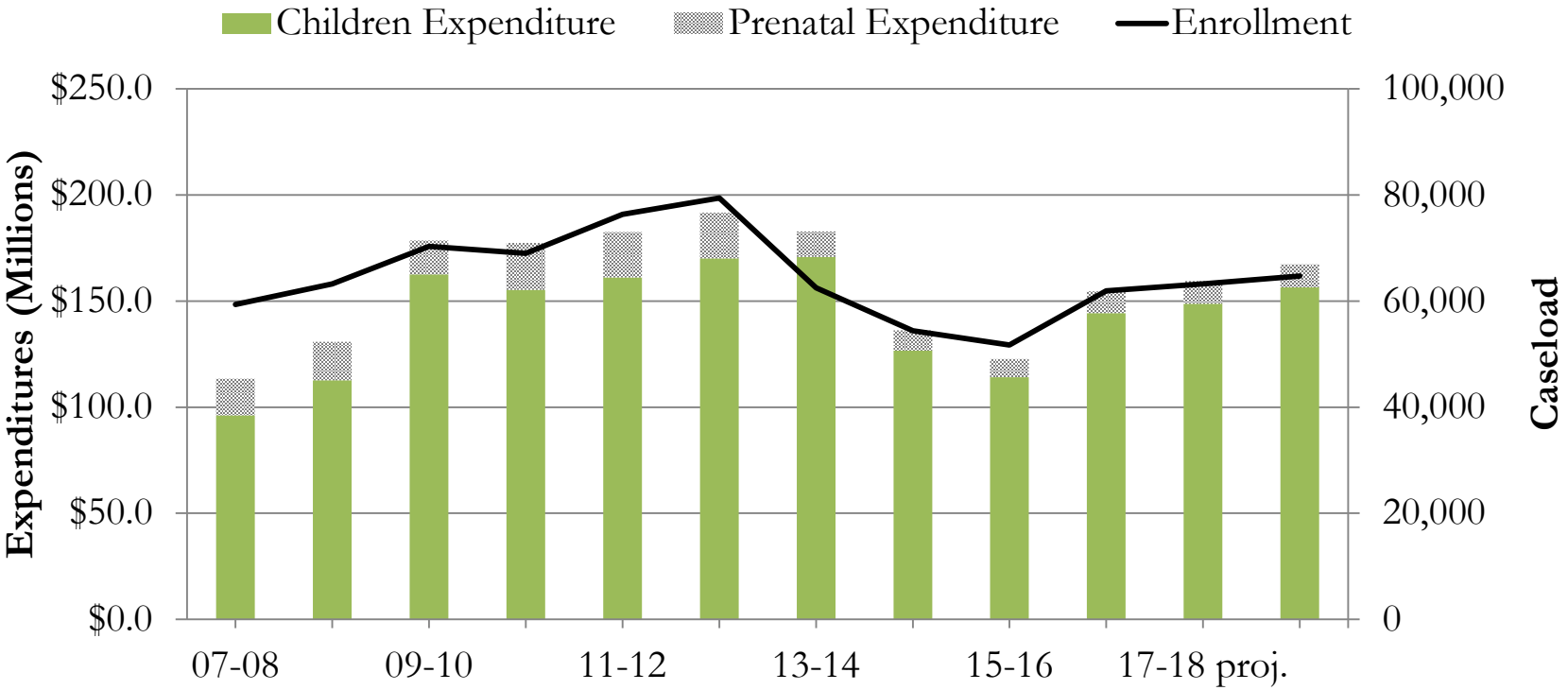
Booster Payments / Financing



Medicare Modernization Act State Contribution



Children's Basic Health Plan (CHP+): Caseload and Expenditures



FY 17-18 Request Highlights

- Forecast adjustments of $333.8 million total funds ($140.7 million General Fund) in R1-R5 and the annualizations

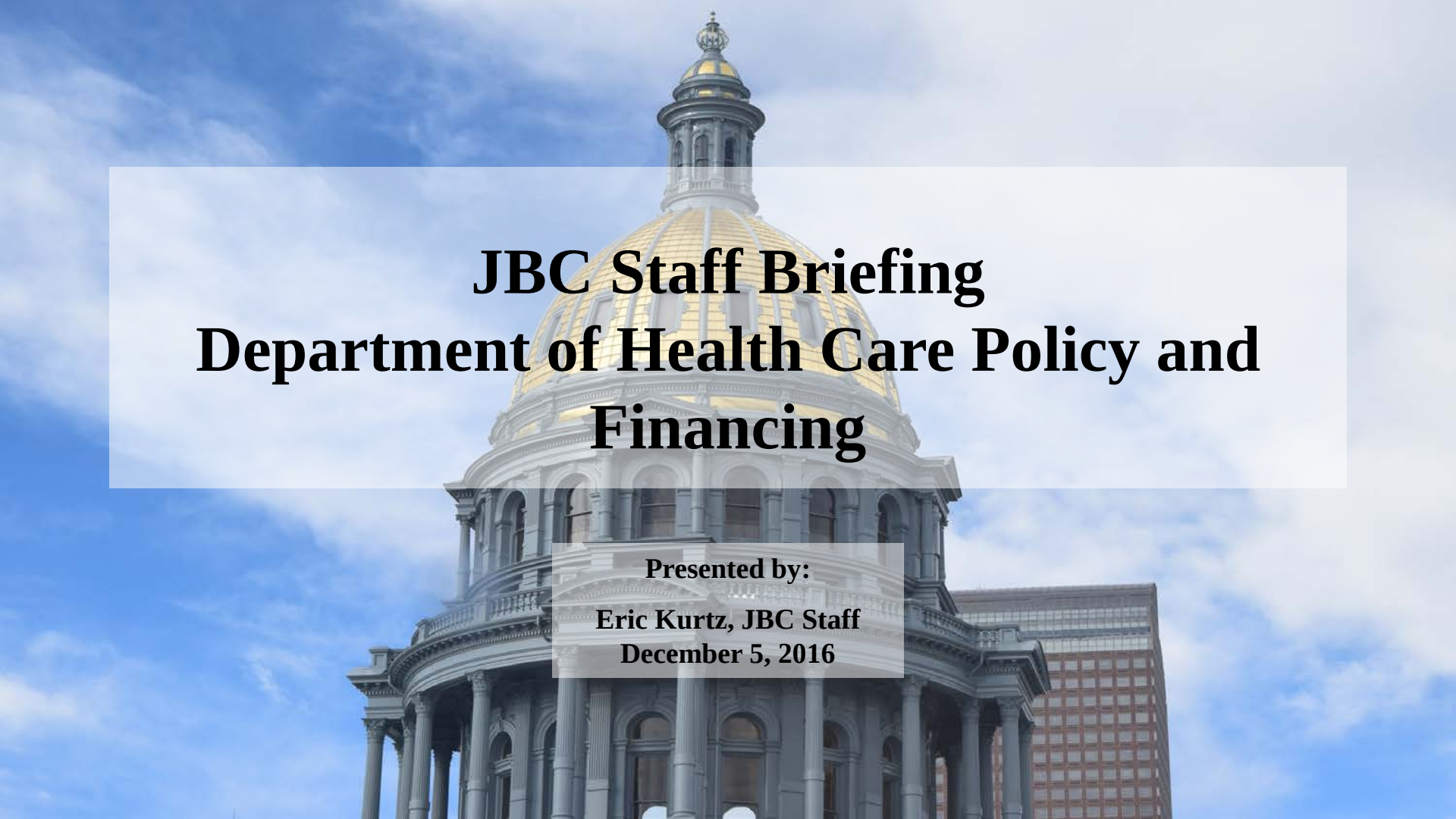
- *R6 Delivery system and payment reform* $3.2 million total funds (decrease of $200,342 General Fund) for performance payments and Phase II of the ACC

- *R7 Oversight of state resources* $1.5 million total funds (decrease of $1.7 million General Fund) and 13.2 FTE for nine initiatives to improve oversight

- *R8 MMIS Operations* $23.5 million total funds (decrease of $566,430 General Fund) and 1.8 FTE for updated costs, match rates, and timing of the new Medicaid Management Information System

FY 17-18 Other Issues In the Request

- Restrict Hospital Provider Fee Revenue by $195.0 million to reduce General Fund obligation of TABOR refund by $195.0 million
- Set-aside for supplementals of $23.95 million General Fund
- Set-aside of $19.0 million General Fund for possible repayment of CHIPRA bonuses
- Information on eliminating the wait list for services for people with IDD
- Information on making a supplemental payment to CU School of Medicine



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Department of Health Care Policy and Financing

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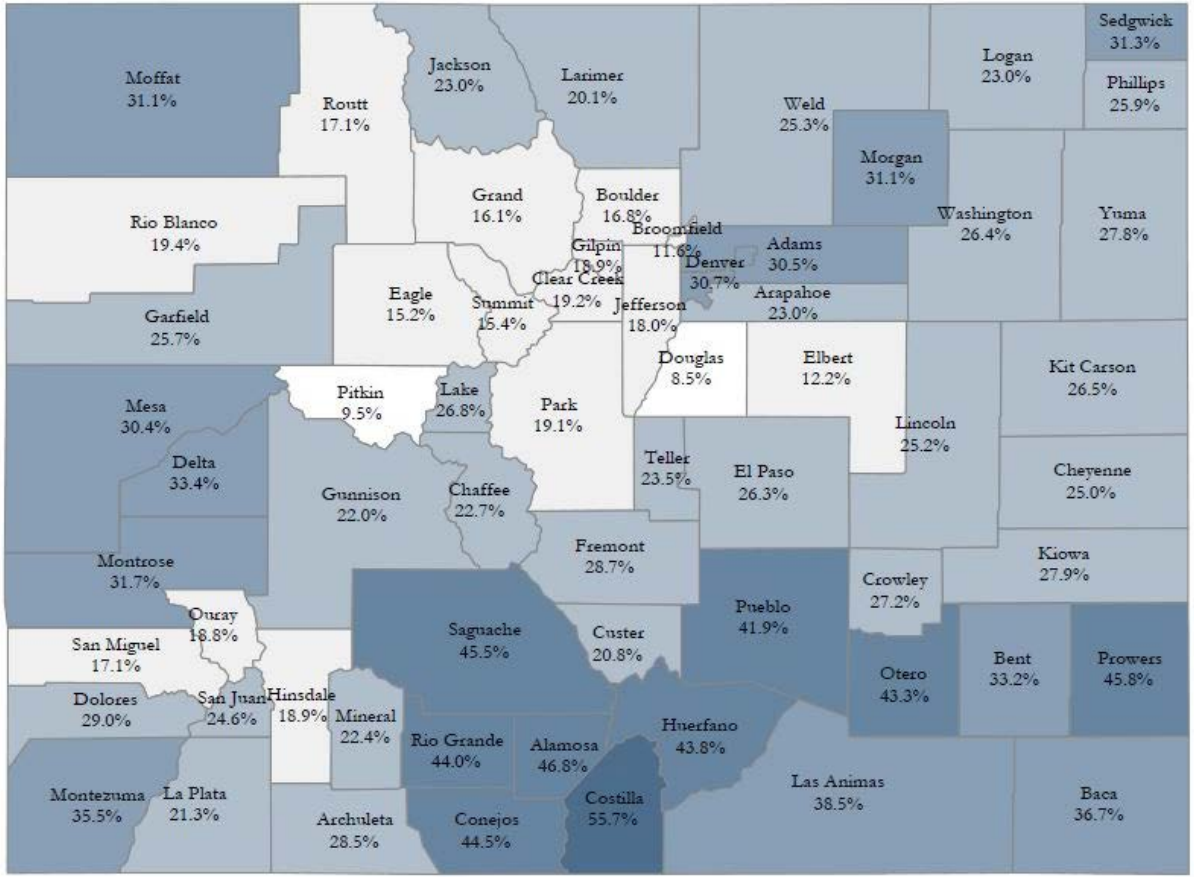
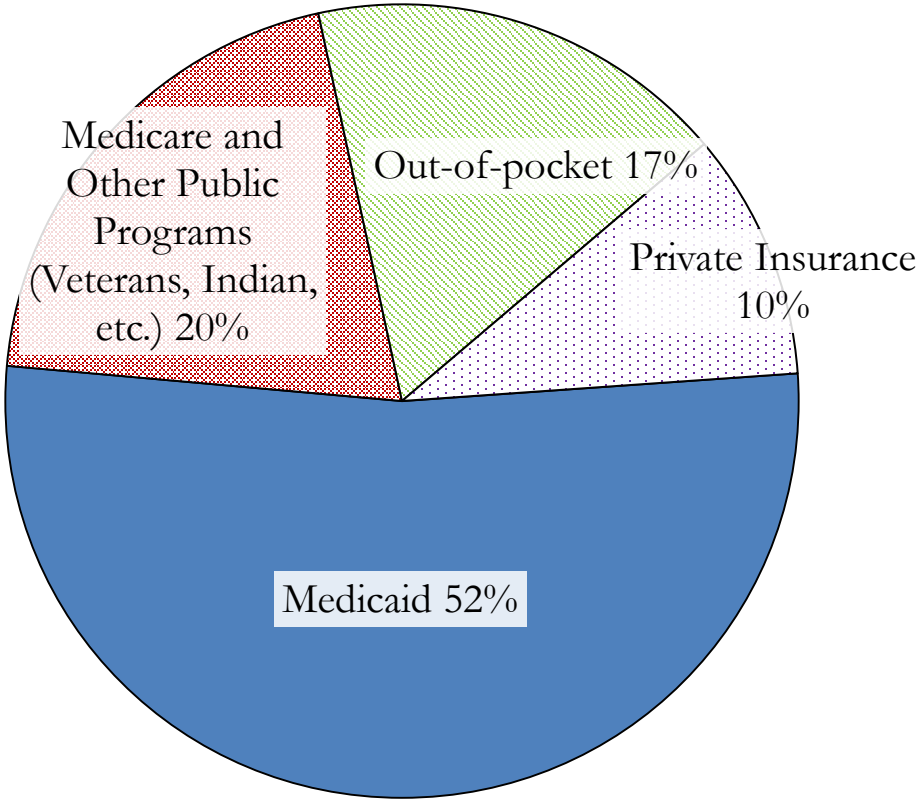
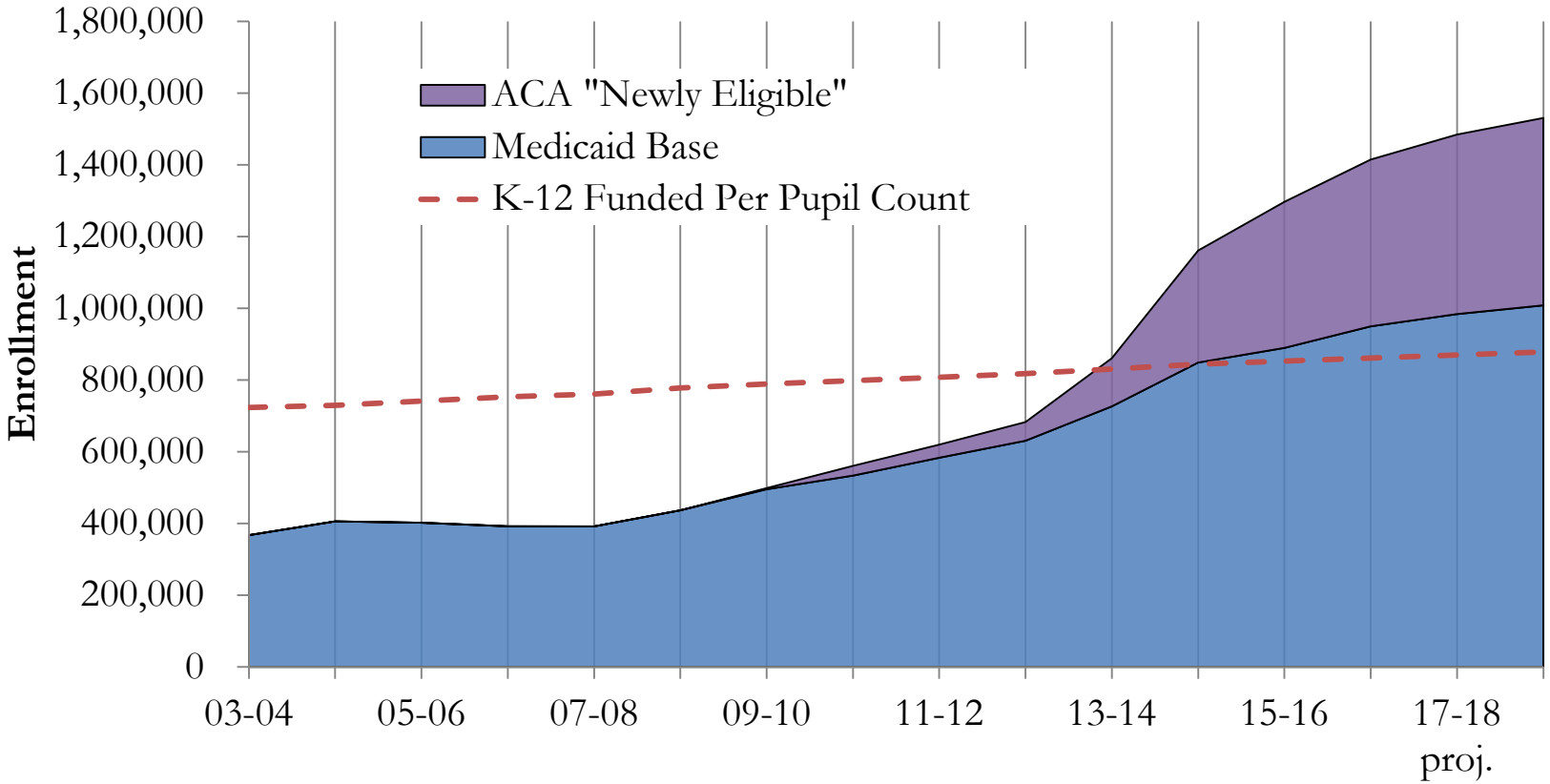
December 5, 2016


Moffat
31.1%
Routt
17.1%
Jackson
23.0%
Larimer
20.1%
Weld
25.3%
Logan
23.0%
Sedgwick
31.3%
Phillips
25.9%
Morgan
31.1%
Washington
26.4%
Yuma
27.8%
Rio Blanco
19.4%
Grand
16.1%
Boulder
16.8%
Broomfield
11.6%
Gilpin
18.9%
Clear Creek
19.2%
Denver
30.7%
Adams
30.5%
Arapahoe
23.0%
Jefferson
18.0%
Garfield
25.7%
Eagle
15.2%
Summit
15.4%
Douglas
8.5%
Elbert
12.2%
Kit Carson
26.5%
Pitkin
9.5%
Lake
26.8%
Park
19.1%
Mesa
30.4%
Lincoln
25.2%
Delta
33.4%
Teller
23.5%
El Paso
26.3%
Cheyenne
25.0%
Gunnison
22.0%
Chaffee
22.7%
Fremont
28.7%
Kiowa
27.9%
Montrose
31.7%
Crowley
27.2%
Ouray
18.8%
Pueblo
41.9%
San Miguel
17.1%
Saguache
45.5%
Custer
20.8%
Bent
33.2%
Prowers
45.8%
Otero
43.3%
Dolores
29.0%
San Juan
24.6%
Hinsdale
18.9%
Mineral
22.4%
Huerfano
43.8%
Rio Grande
44.0%
Alamosa
46.8%
Las Animas
38.5%
Baca
36.7%
Montezuma
35.5%
La Plata
21.3%
Archuleta
28.5%
Conejos
44.5%
Costilla
55.7%
Percentage of total state population enrolled in Medicaid and CHP+: 24.8%
0.0%
60.0%

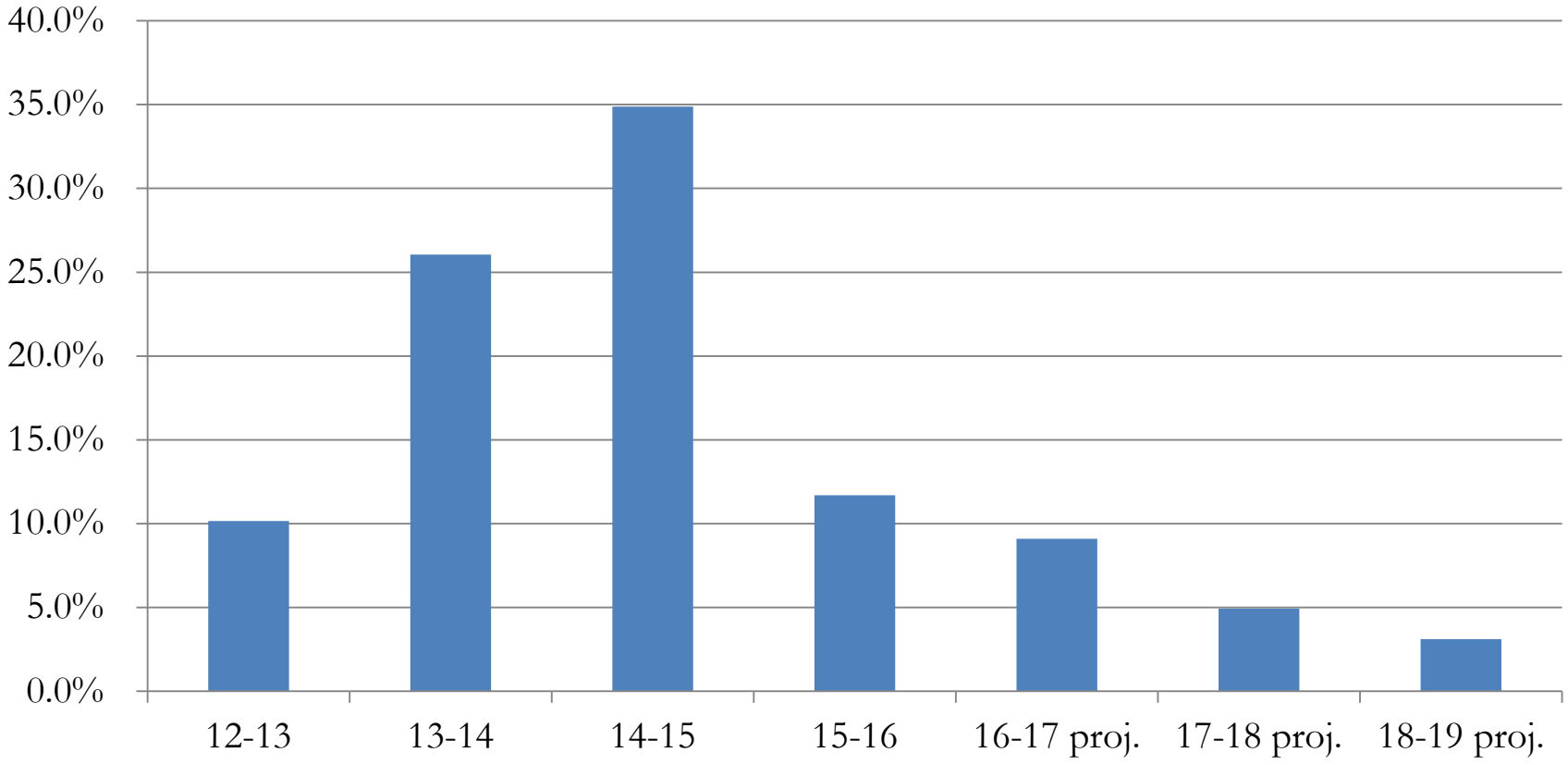
Long-term Services and Supports Payers



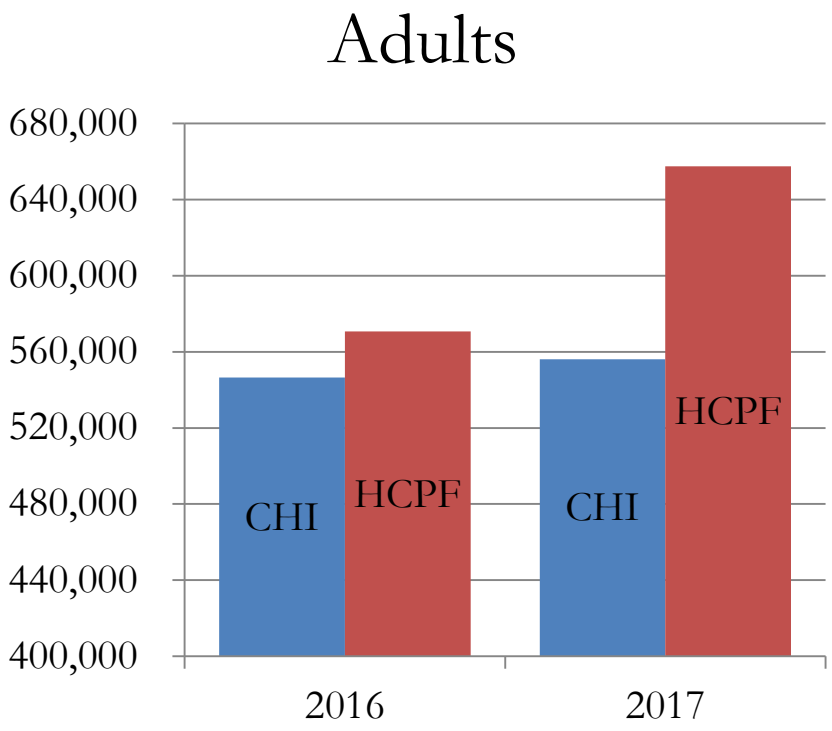
Medicaid vs K-12 Enrollment

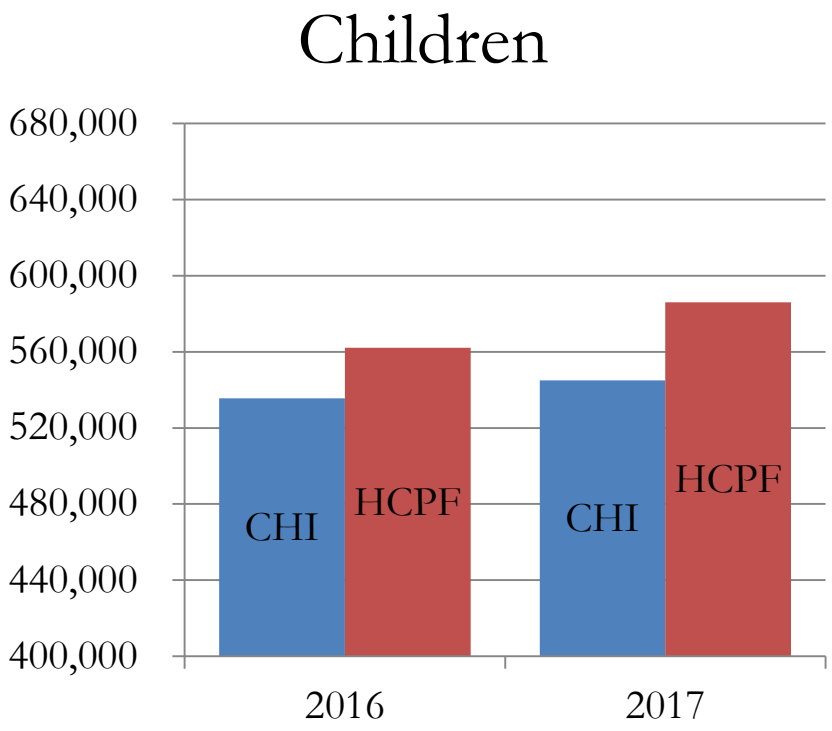


Rate of Medicaid Enrollment Growth



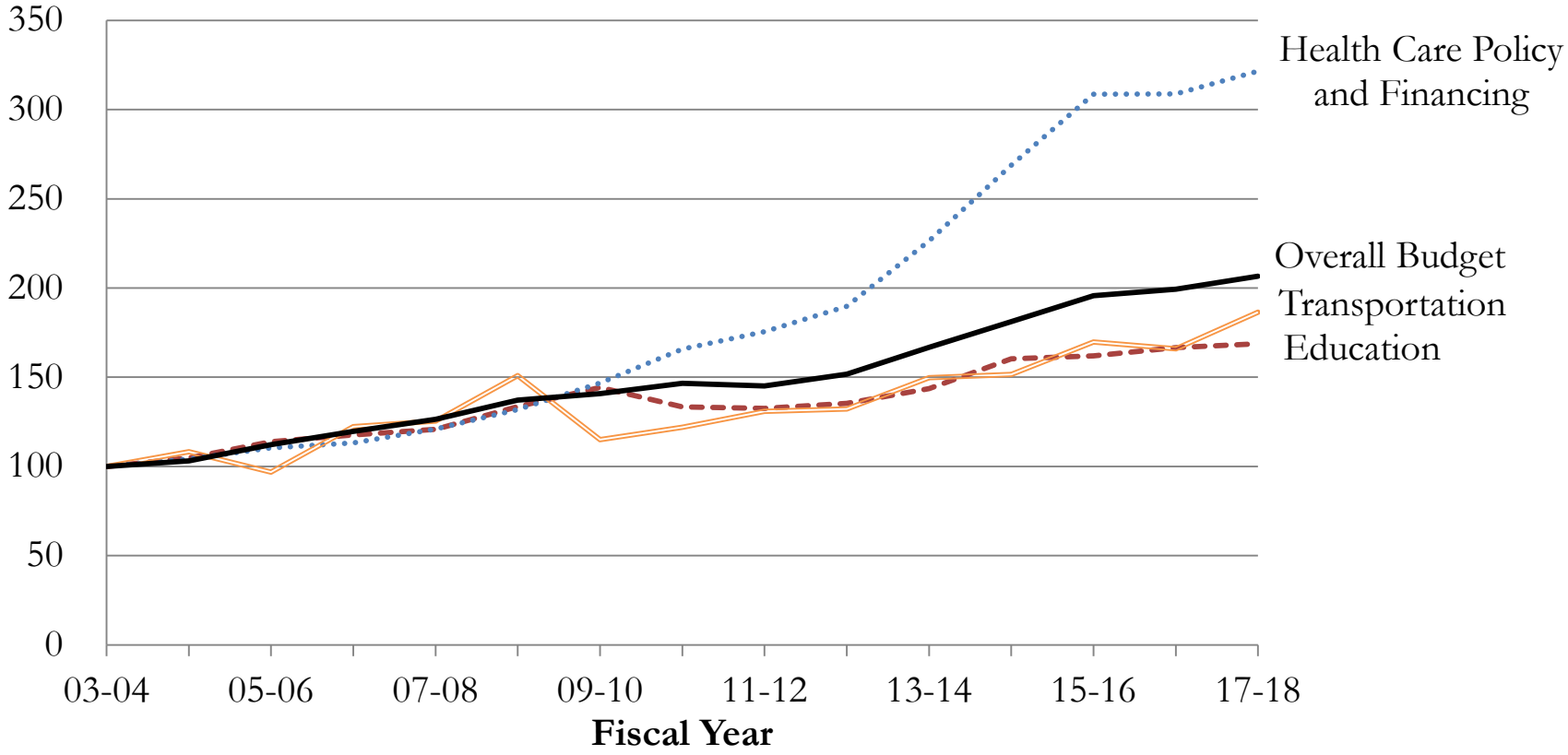
Colorado Health Institute's estimate of the potentially eligible population versus the 2016 Actual Enrollment and HCPF's 2017 Projected Enrollment





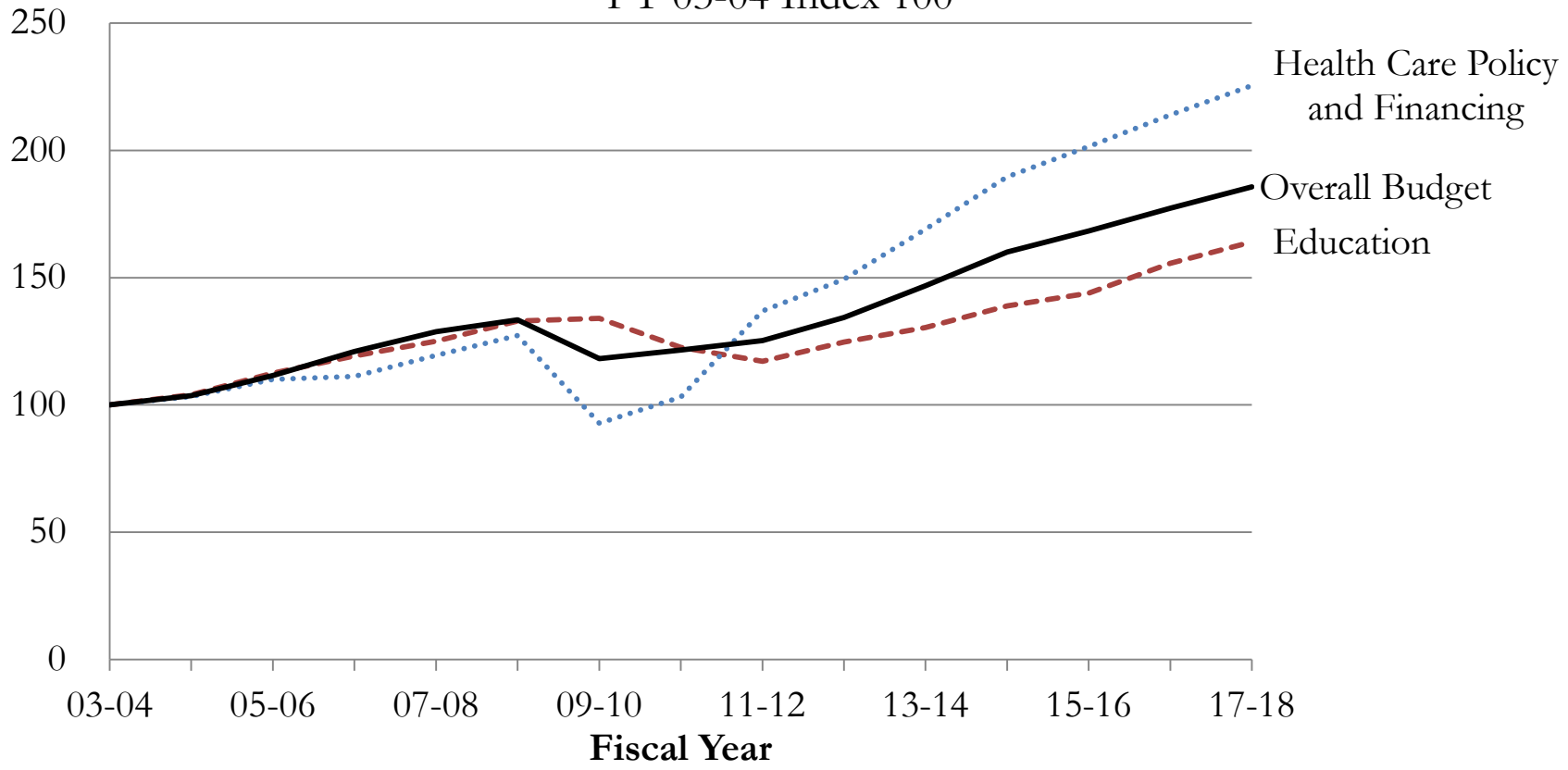
Growth of TOTAL FUNDS Appropriations

FY 03-04 Index 100



Growth of GENERAL FUND Appropriations

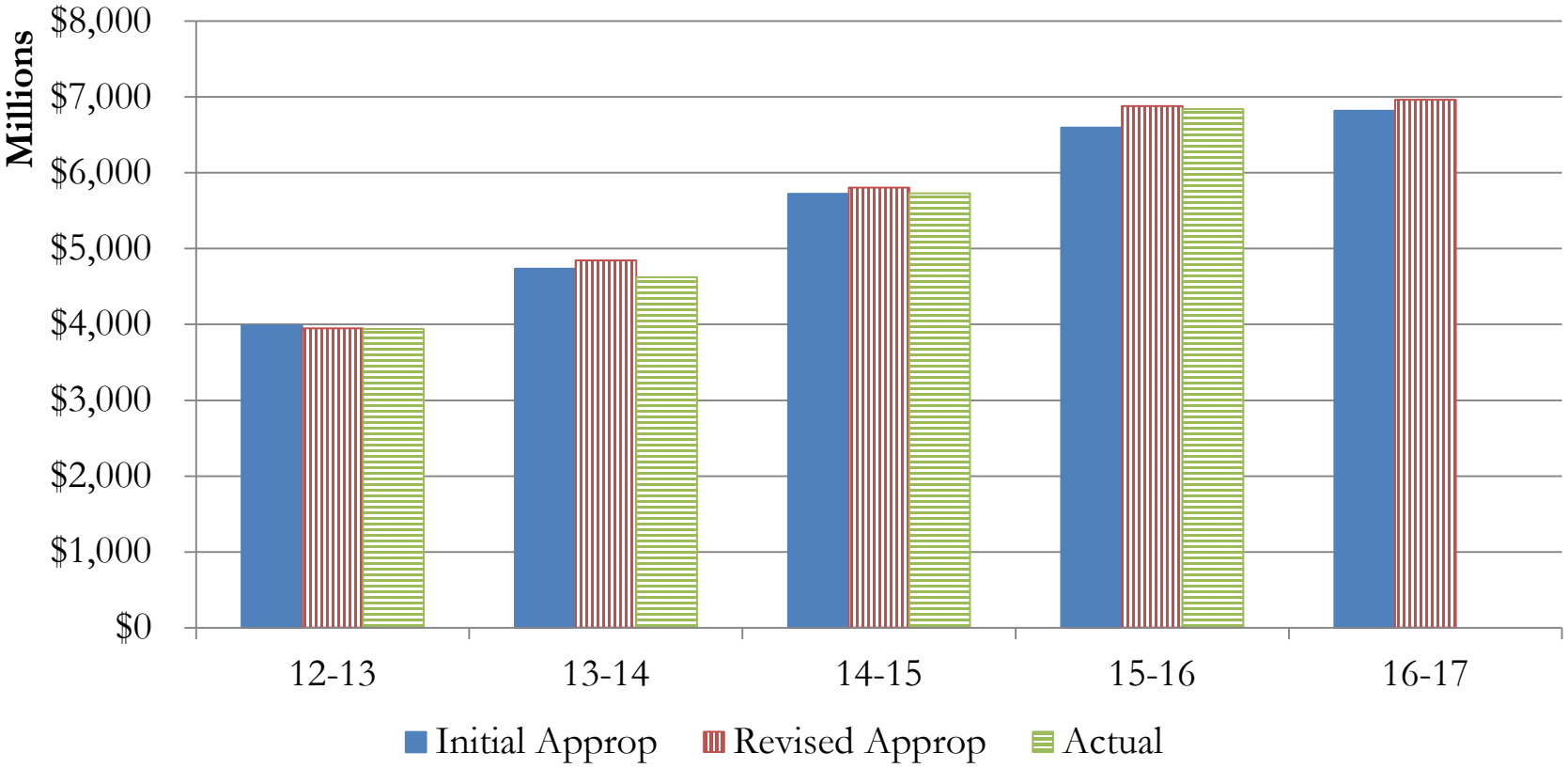
FY 03-04 Index 100



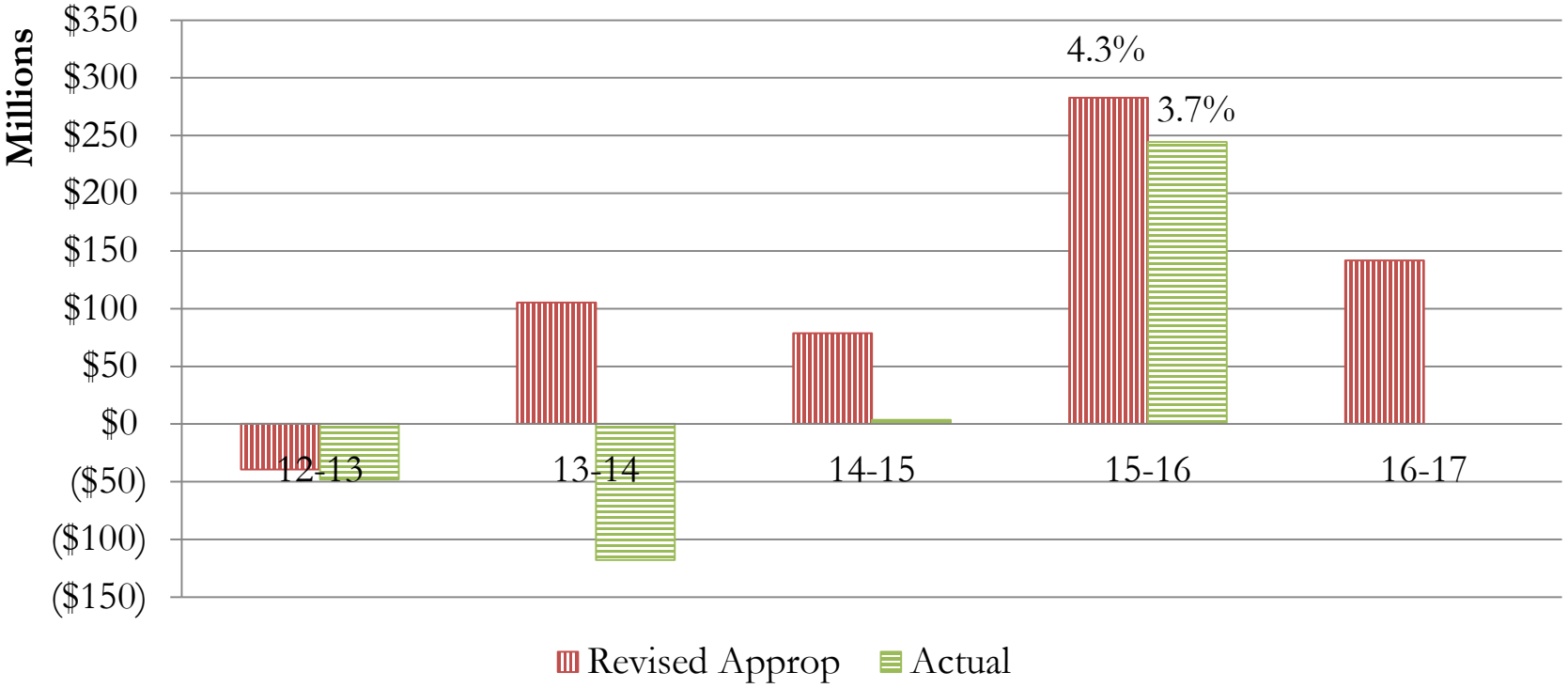
Total Funds							
	FY 16-17 Appropriation	FY 16-17 Change		FY 16-17 Projection	FY 17-18 Change		FY 17-18 Request
		Dollars	%		Dollars	%	
Admin.	$302,576,468	($1,295,480)	-0.4%	$301,280,988	$2,603,220	0.9%	$303,884,208
Physical Health	5,773,210,351	152,136,219	2.6%	5,925,346,570	117,041,522	2.0%	6,042,388,092
Long-term Services & Supports	2,352,850,073	(27,528,210)	-1.2%	2,325,321,863	136,292,442	5.9%	2,461,614,305
Behavioral Health	688,243,986	(56,448,298)	-8.2%	631,795,688	50,705,082	8.0%	682,500,770
TOTAL	$9,116,880,878	$66,864,231	0.7%	$9,183,745,109	$306,642,266	3.3%	$9,490,387,375

General Fund							
	FY 16-17 Appropriation	FY 16-17 Change		FY 16-17 Projection	FY 17-18 Change		FY 17-18 Request
		Dollars	%		Dollars	%	
Admin.	$76,501,537	$17,451	0.0%	$76,518,988	$2,293,468	3.0%	$78,812,456
Physical Health	1,264,932,022	30,270,395	2.4%	1,295,202,417	72,284,542	5.6%	1,367,486,959
Long-term Services & Supports	1,116,569,778	(13,109,341)	-1.2%	1,103,460,437	58,678,867	5.3%	1,162,139,304
Behavioral Health	196,390,877	(6,379,746)	-3.2%	190,011,131	(1,219,113)	-0.6%	188,792,018
TOTAL	$2,654,394,214	$10,798,759	0.4%	$2,665,192,973	$132,037,764	5.0%	$2,797,230,737

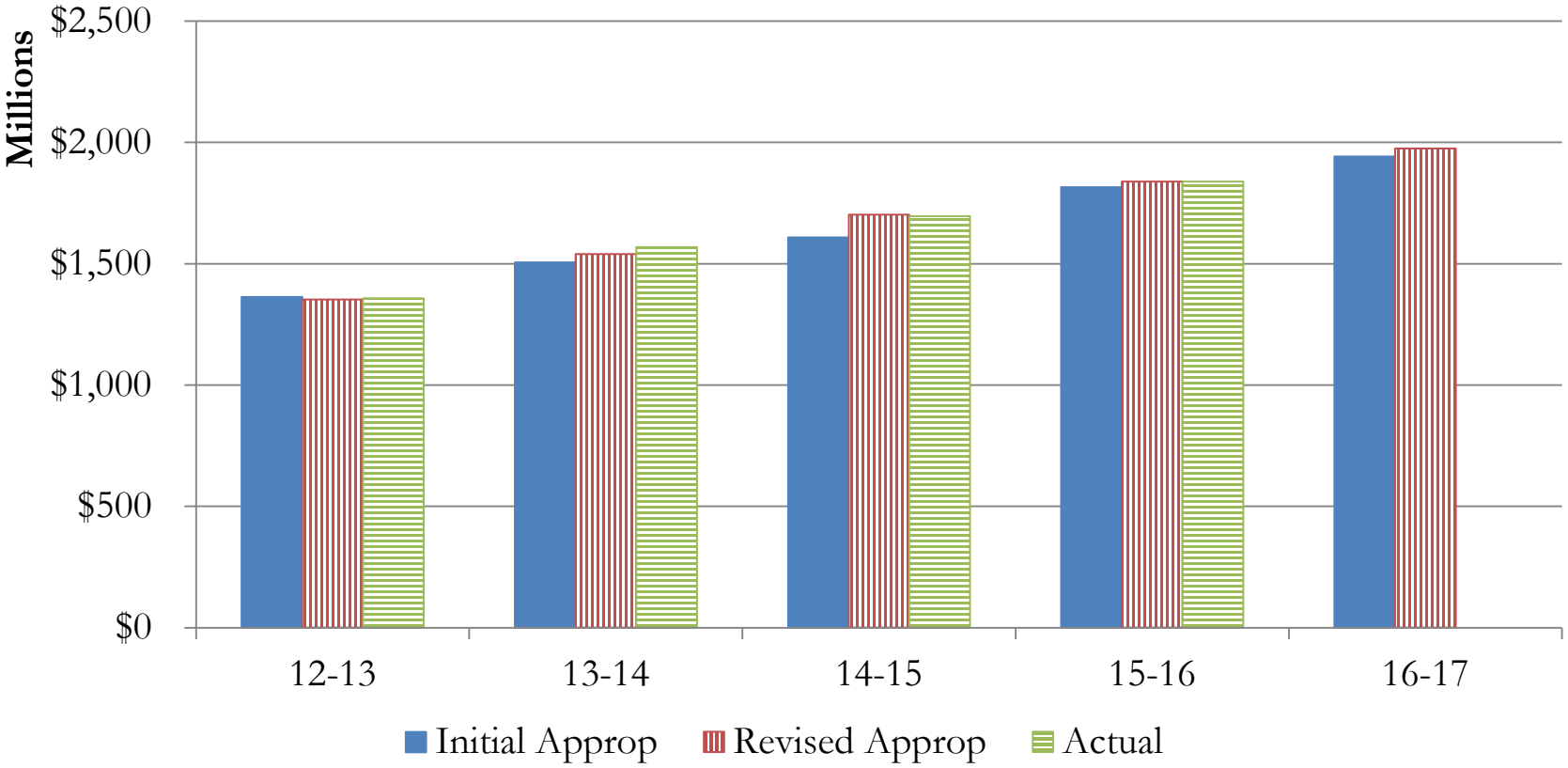
Total Funds Medical Services Premiums



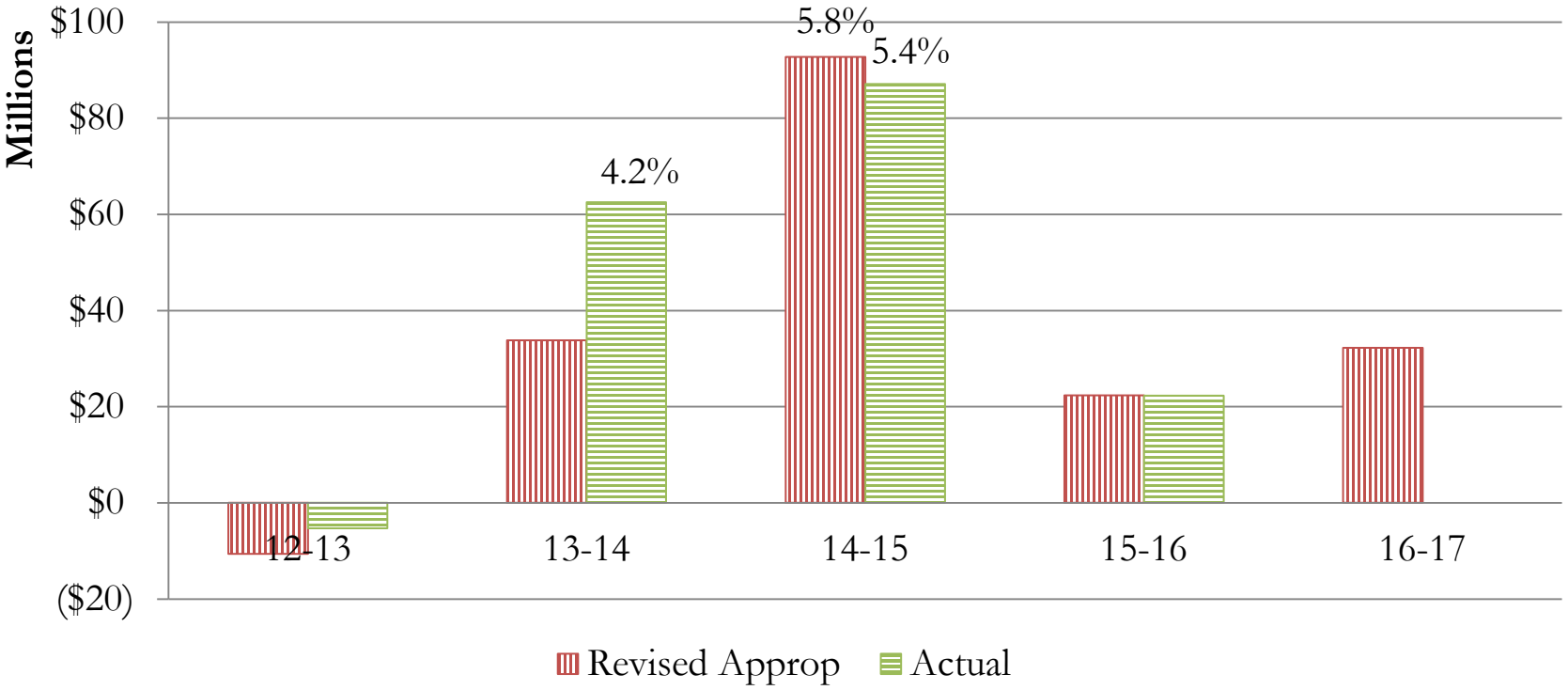
Total Funds Variance from Initial Appropriation

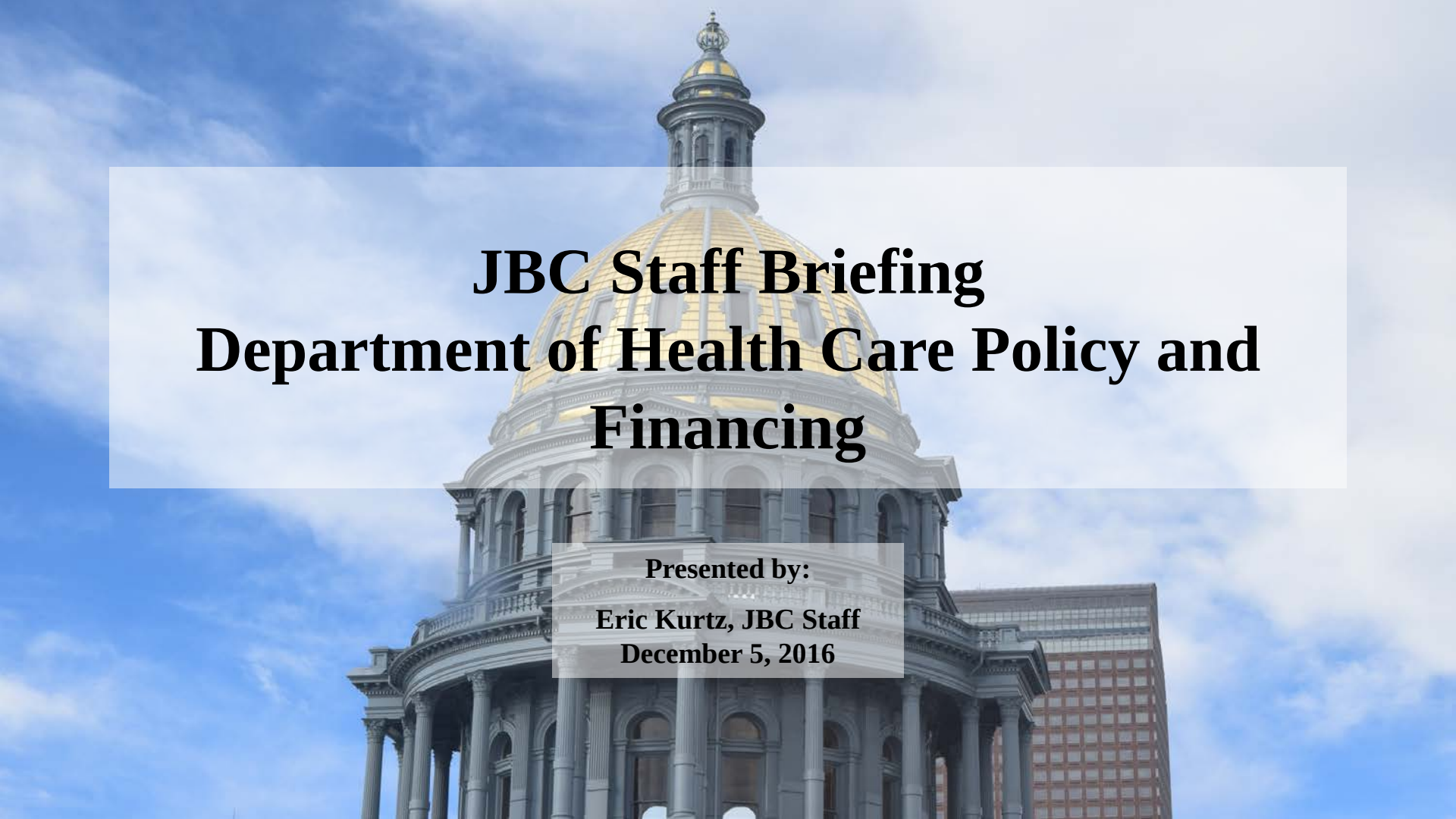


General Fund Medical Services Premiums



General Fund Variance from Initial Appropriation





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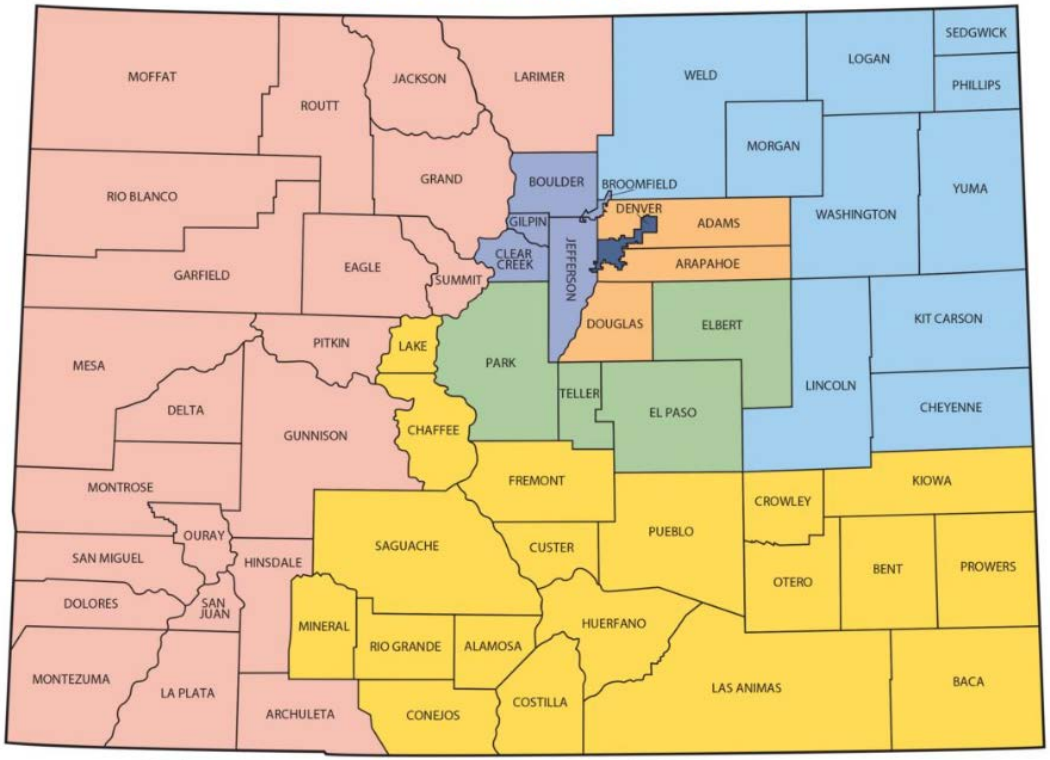
Department of Health Care Policy and Financing

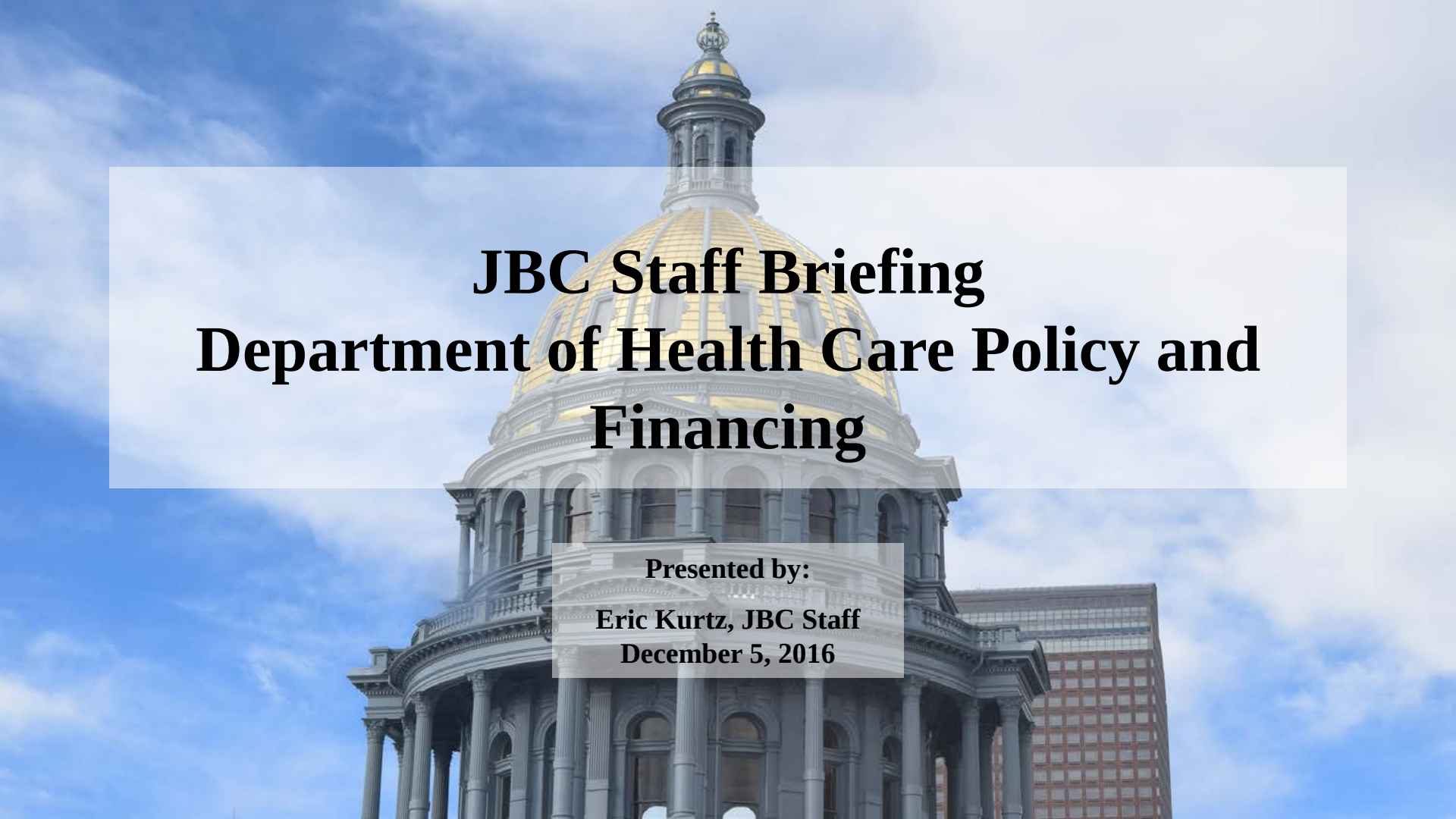
Presented by:

Eric Kurtz, JBC Staff
December 5, 2016

Colorado's Accountable Care Collaborative
Regional Care Collaborative Organization Map



Region 1 Rocky Mountain Health Plans
Region 2 Colorado Access
Region 3 Colorado Access
Region 4 Integrated Community Health Partners
Region 5 Colorado Access
Region 6 Colorado Community Health Alliance
Region 7 Community Care of Central Colorado



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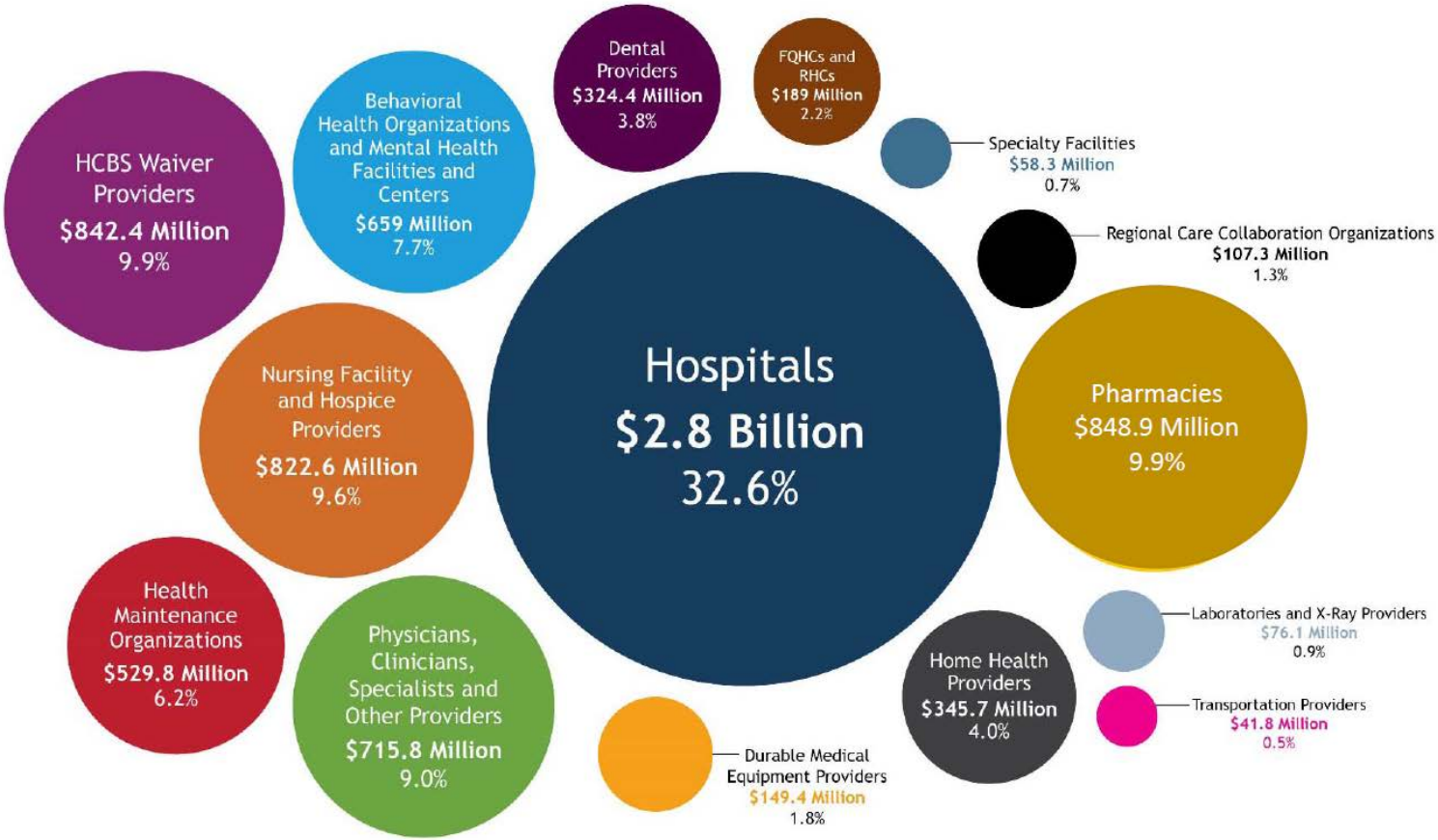
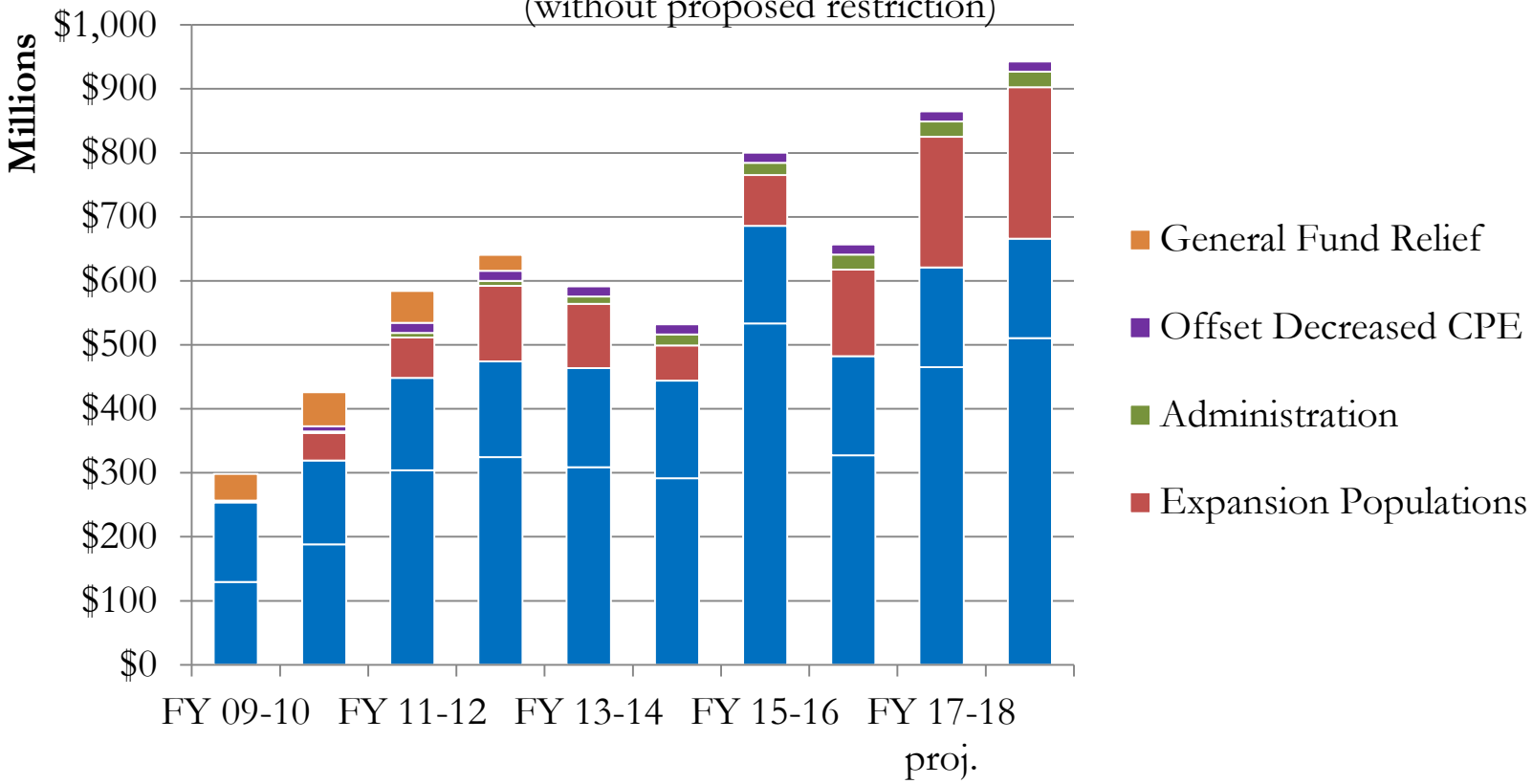
Health First Colorado Payments to Providers



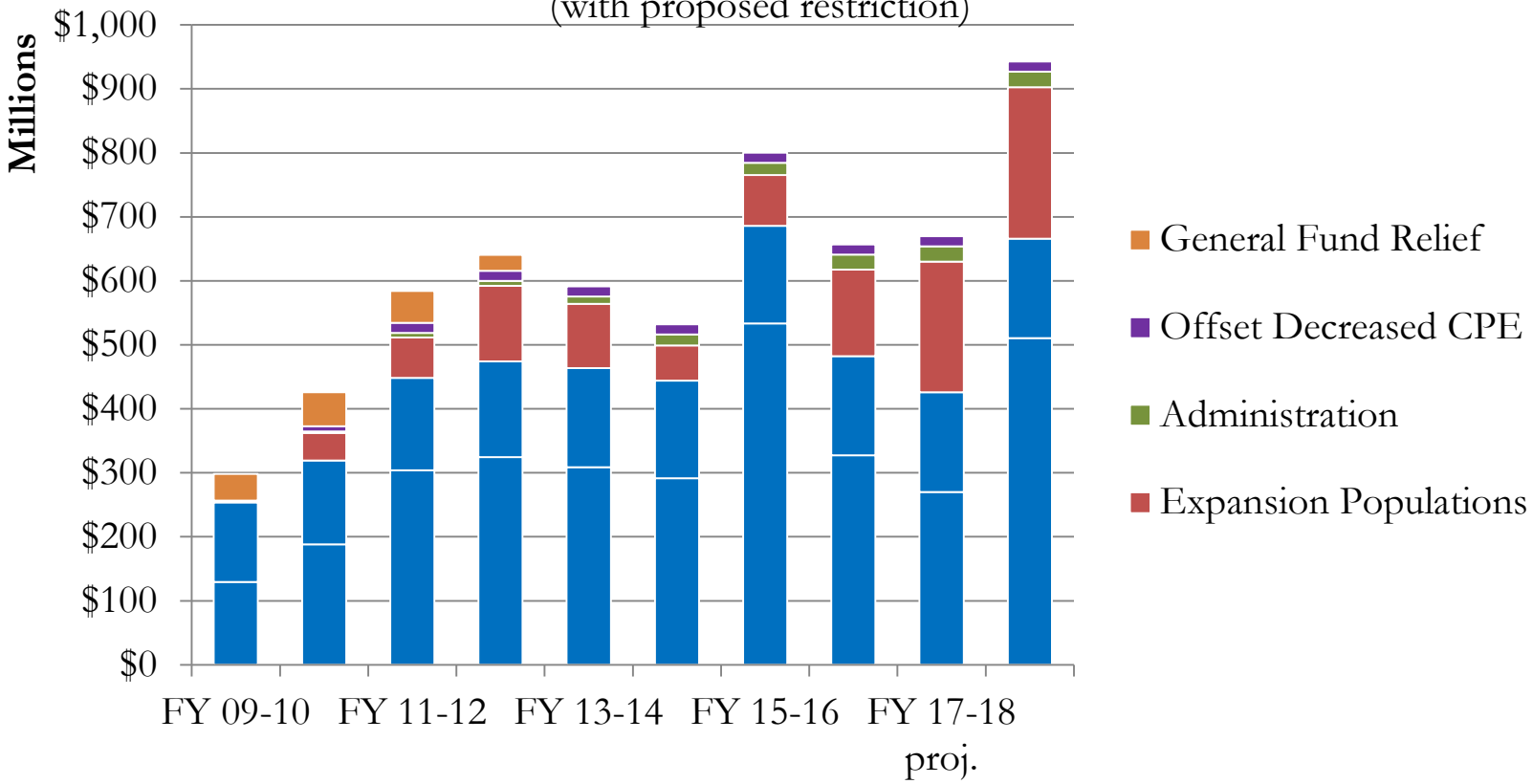
Hospital Provider Fee Expenditures

(without proposed restriction)

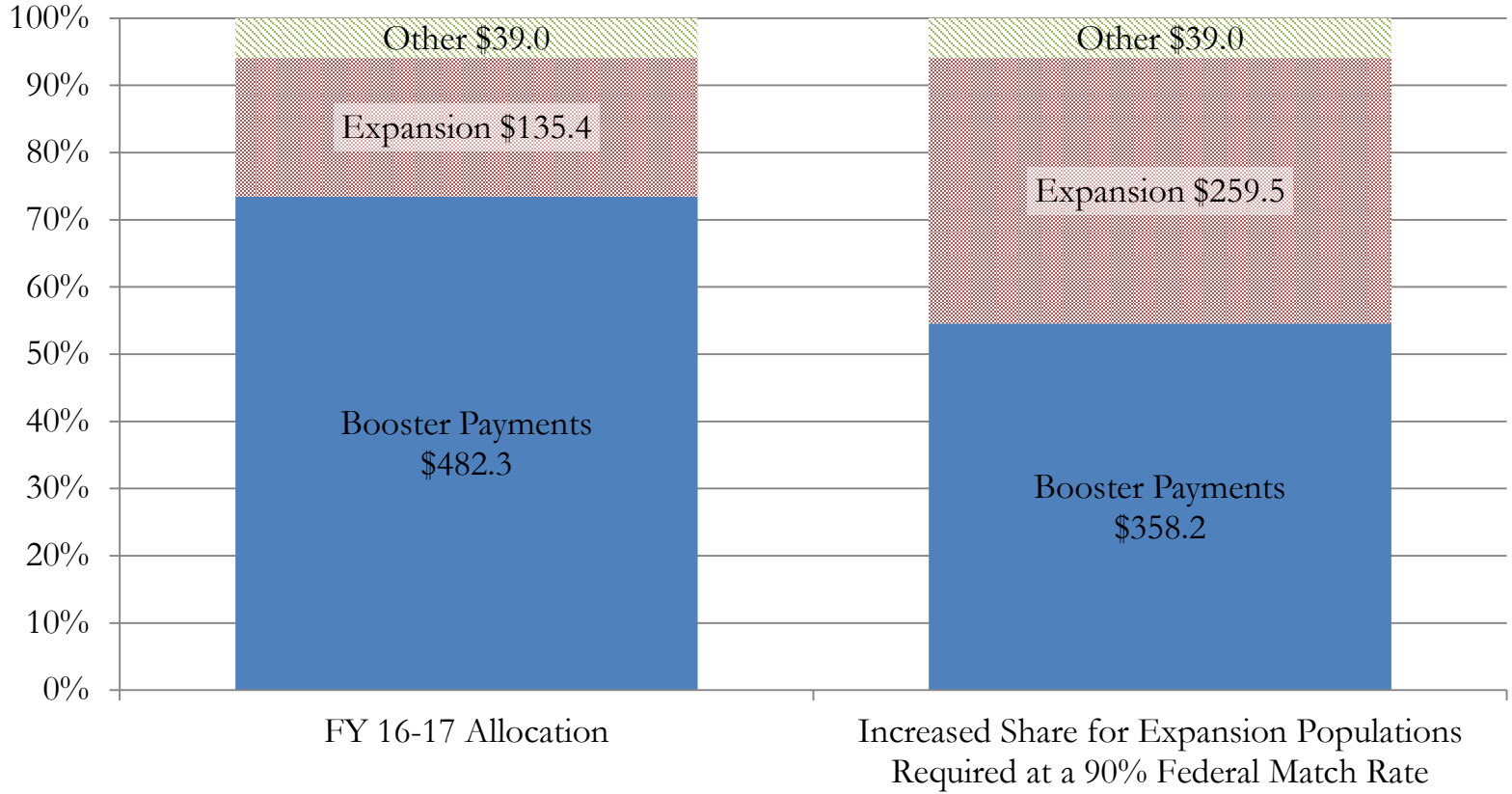


Hospital Provider Fee Expenditures

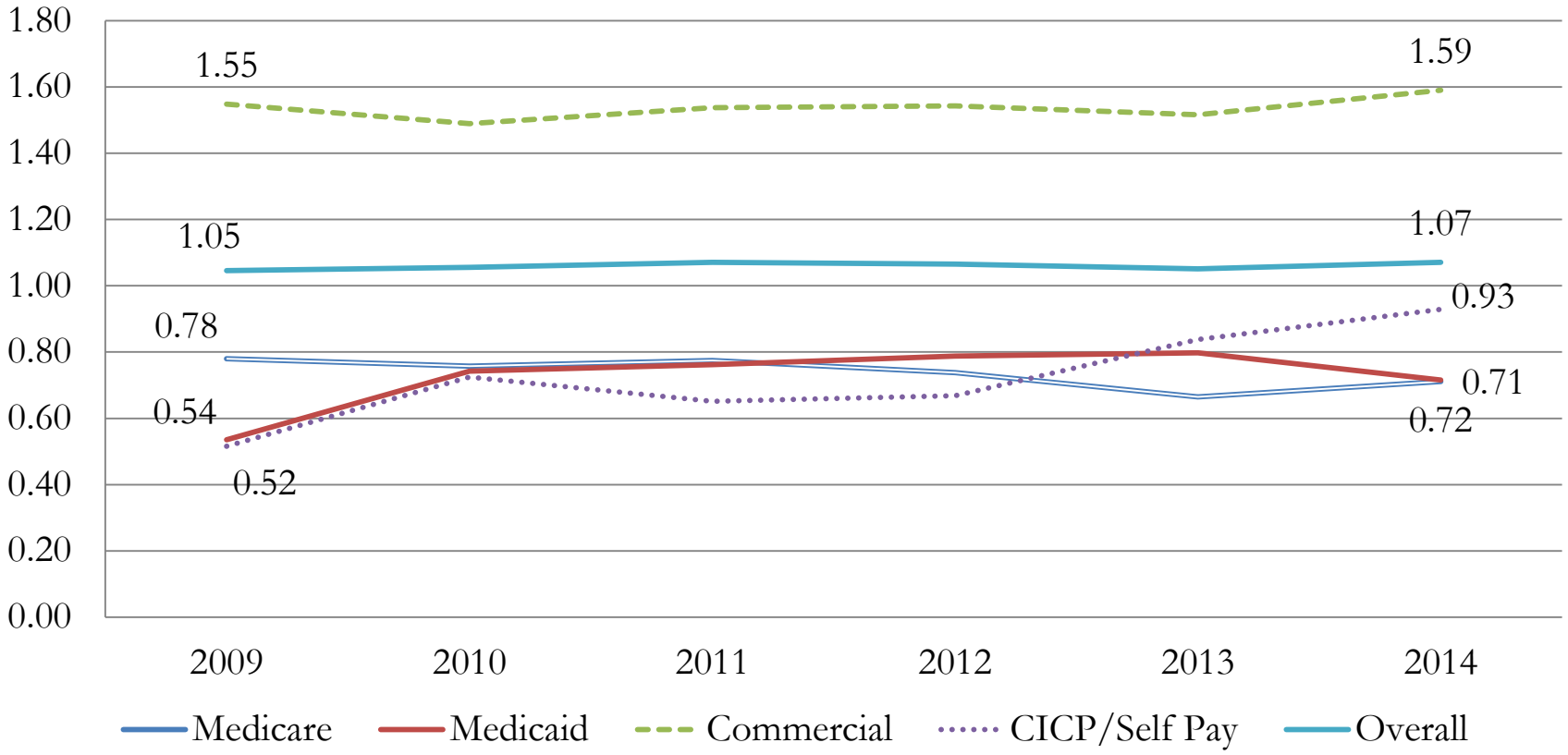
(with proposed restriction)



Hospital Provider Fee Uses



Payment to Cost Ratios: 2009-2014

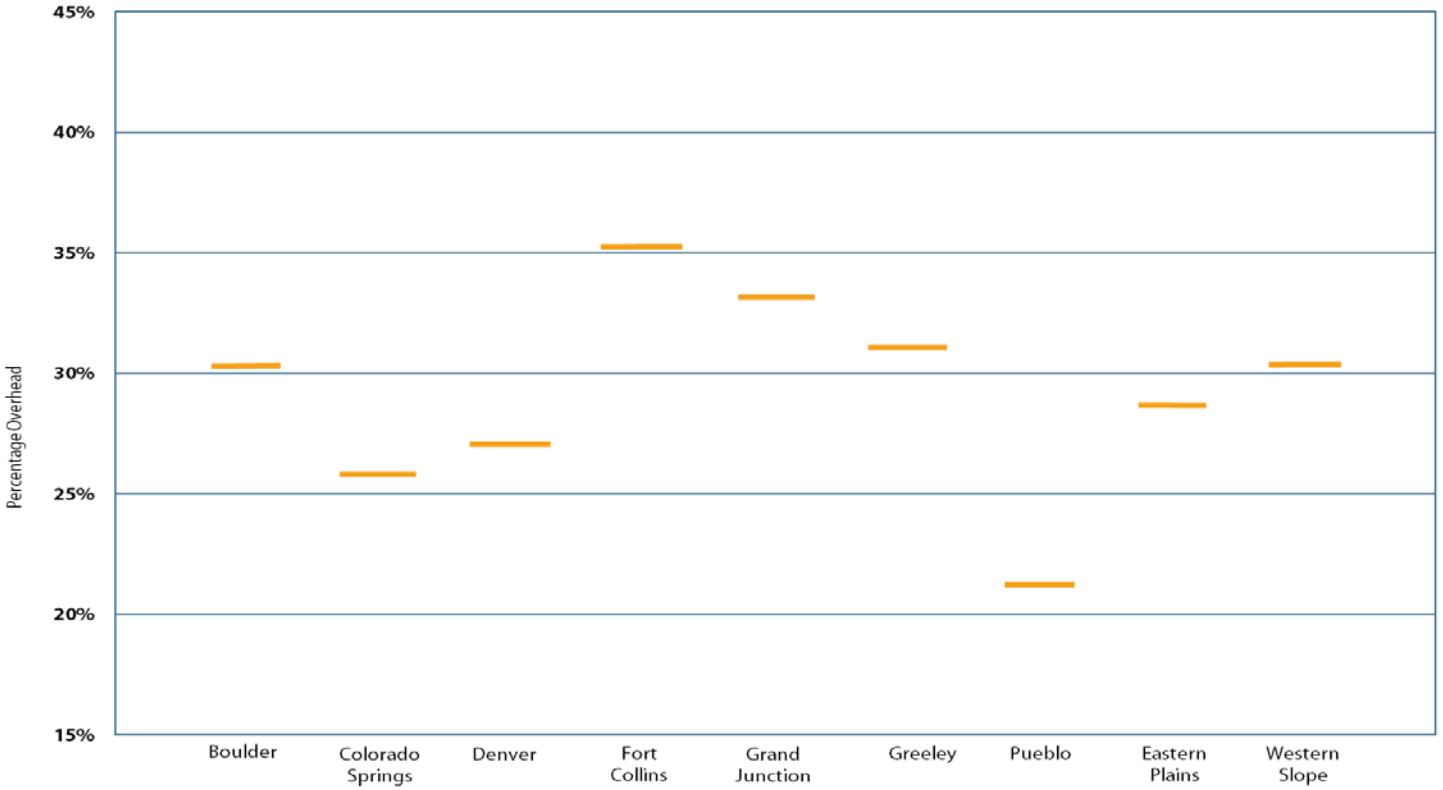


Payment Less Cost per Patient by Payer Group			
Payer Group	**CY 2014**	**Scenario A**	**Scenario B**
Medicare	($4,706)	($4,706)	($4,706)
Medicaid	($3,665)	($4,711)	($4,711)
Insurance	$8,838	$9,468	$8,838
CICP/Self Pay/ Other	($860)	($860)	($860)
Overall	$1,039	$1,039	$801

Payment to Cost Ratio by Payer Group			
Payer Group	**CY 2014**	**Scenario A**	**Scenario B**
Medicare	0.71	0.71	0.71
Medicaid	0.72	0.63	0.63
Insurance	1.59	1.63	1.59
CICP/Self Pay/ Other	0.93	0.93	0.93
Overall	1.07	1.07	1.05

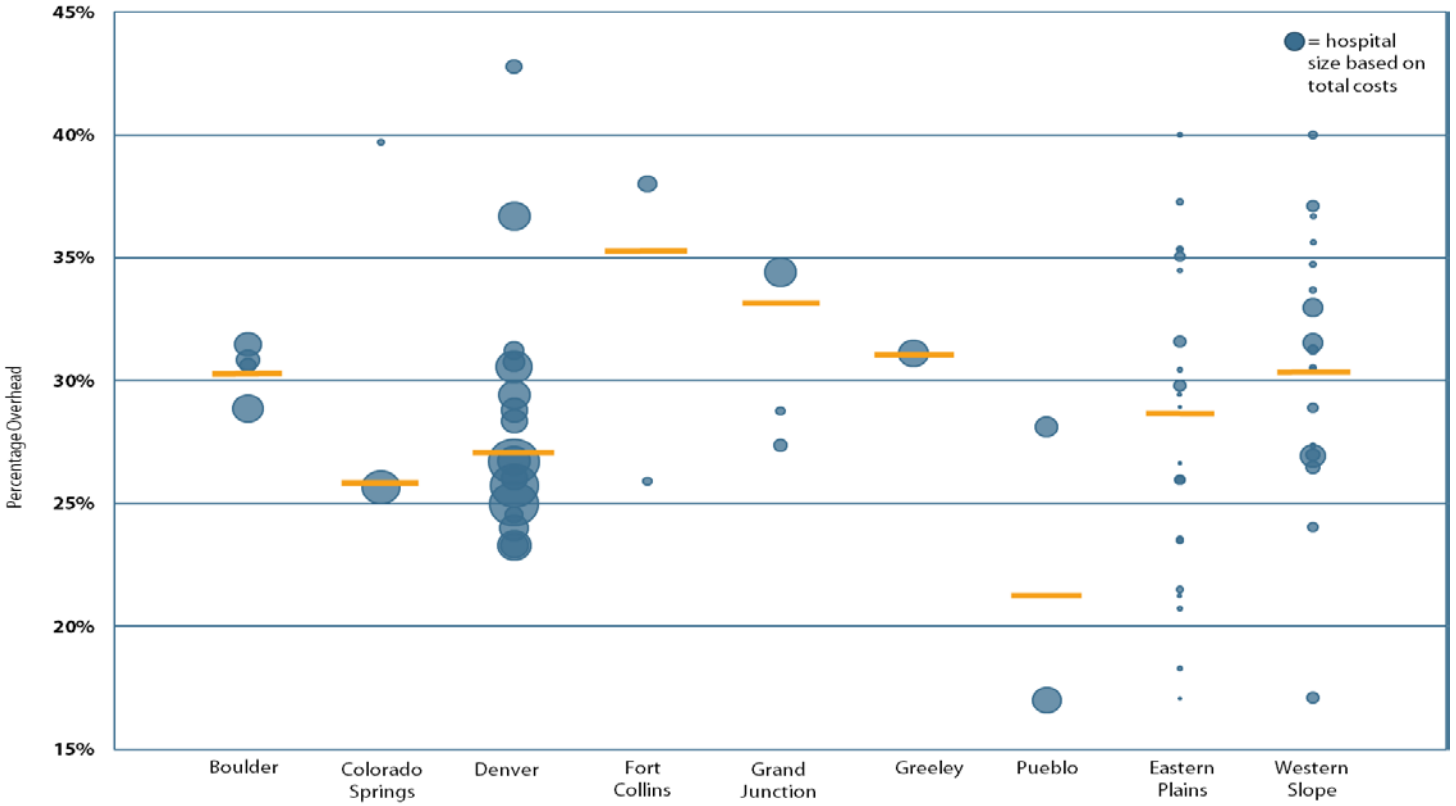
Hospital Overhead Costs by Insurance Rating Region

Rates Vary Widely Across Regions



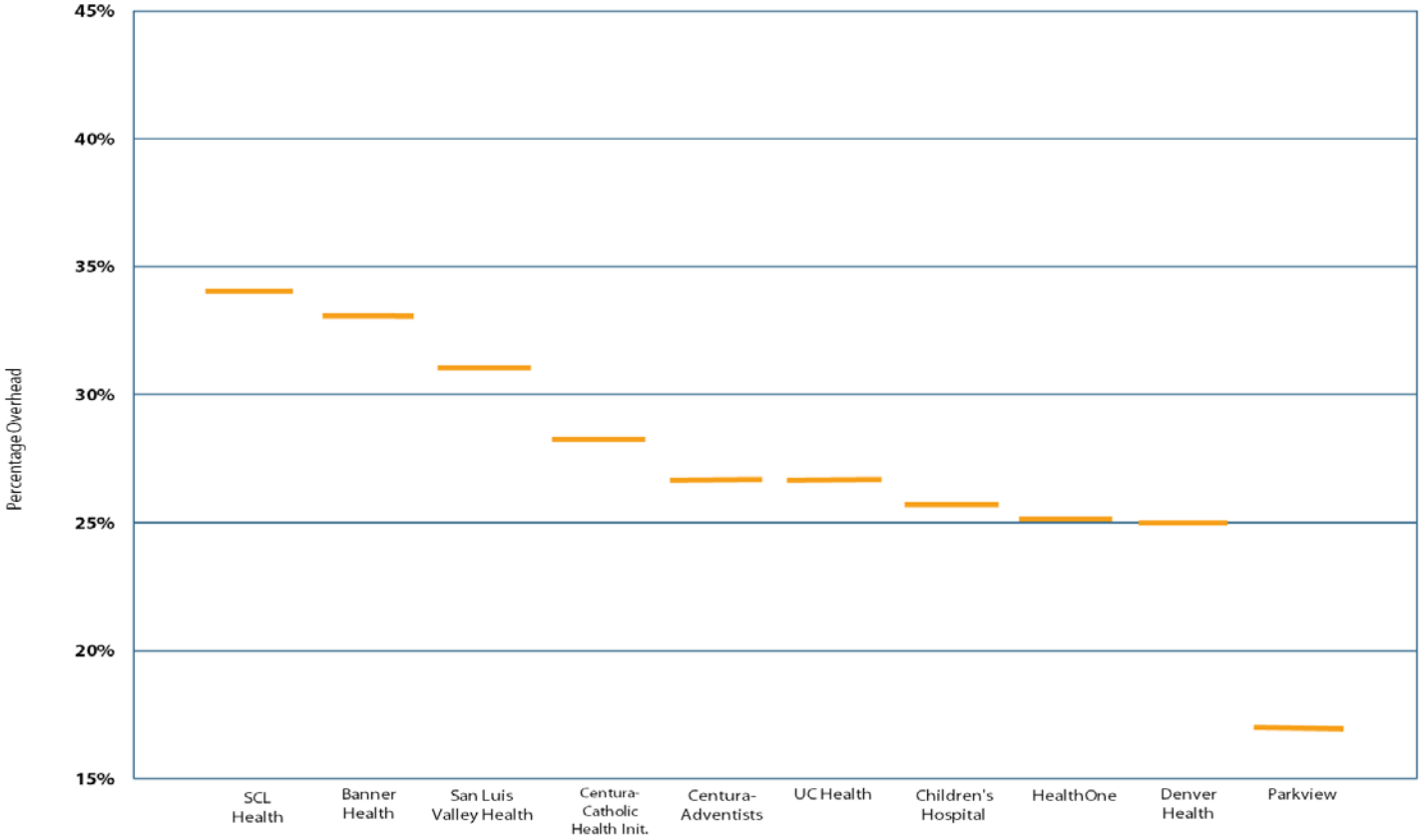
Hospital Overhead Costs by Insurance Rating Region

Rates Vary Widely Across Regions – and Within Regions



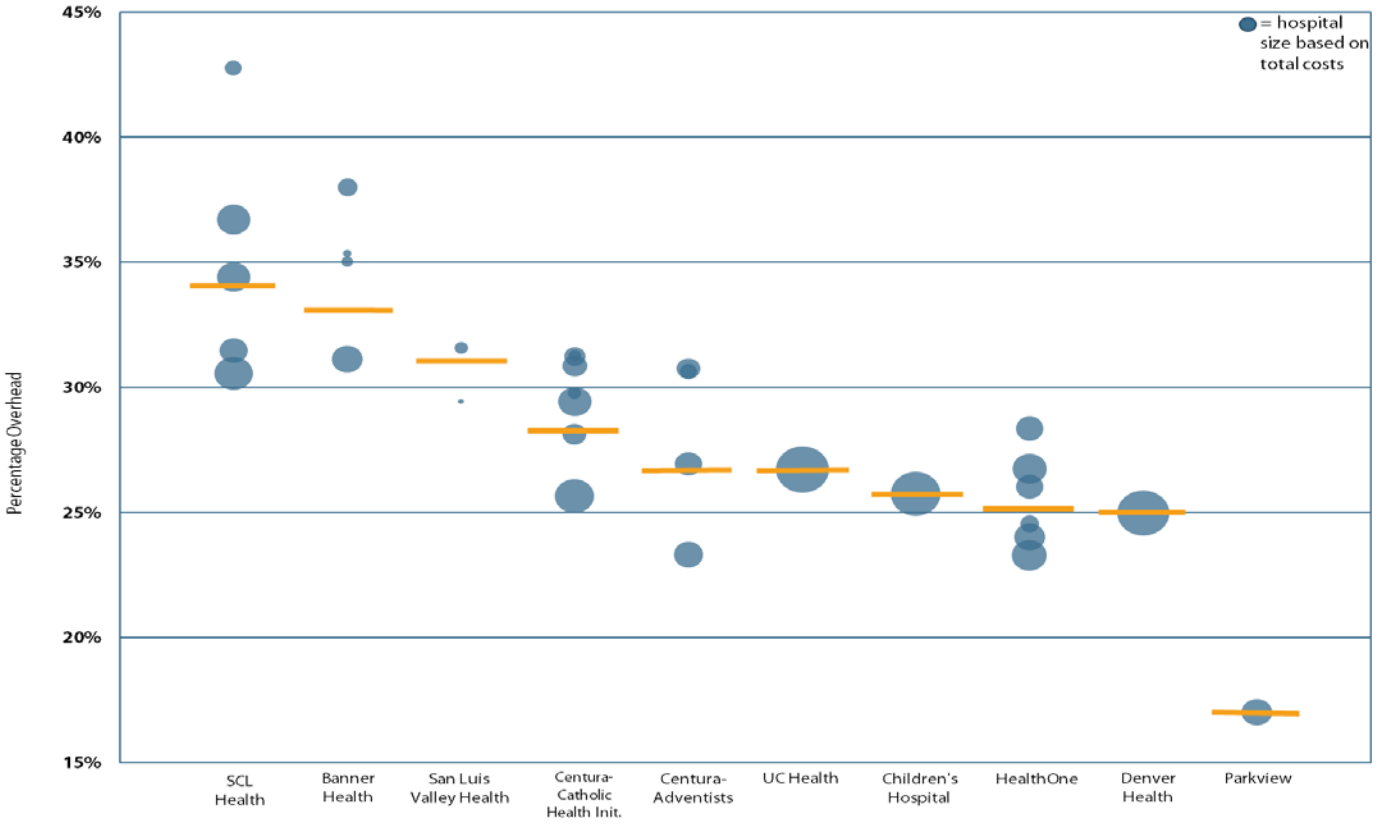
Hospital Overhead Costs by Hospitals and Systems

Rates Vary Widely Across Systems



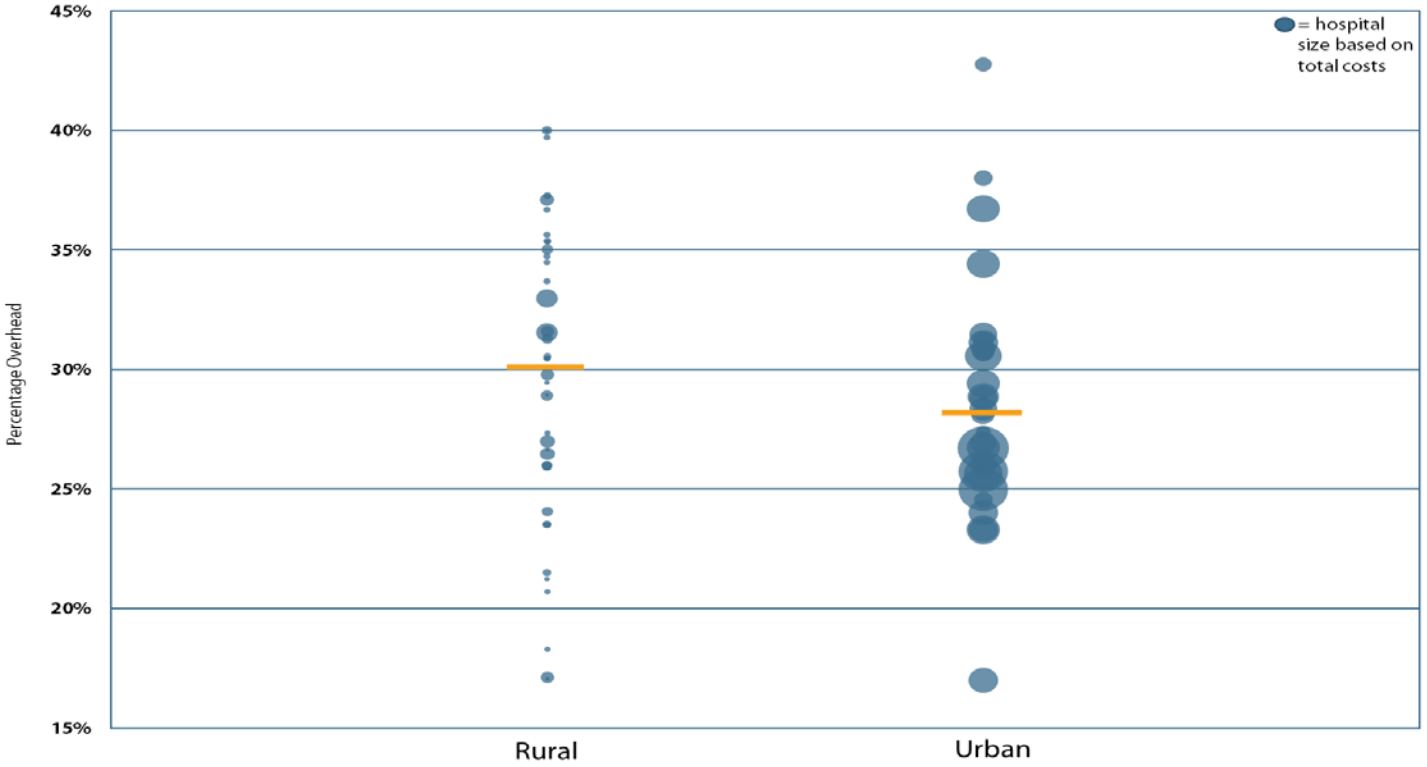
Hospital Overhead Costs by Hospitals and Systems

Rates Vary Widely Across Systems – and Within Systems



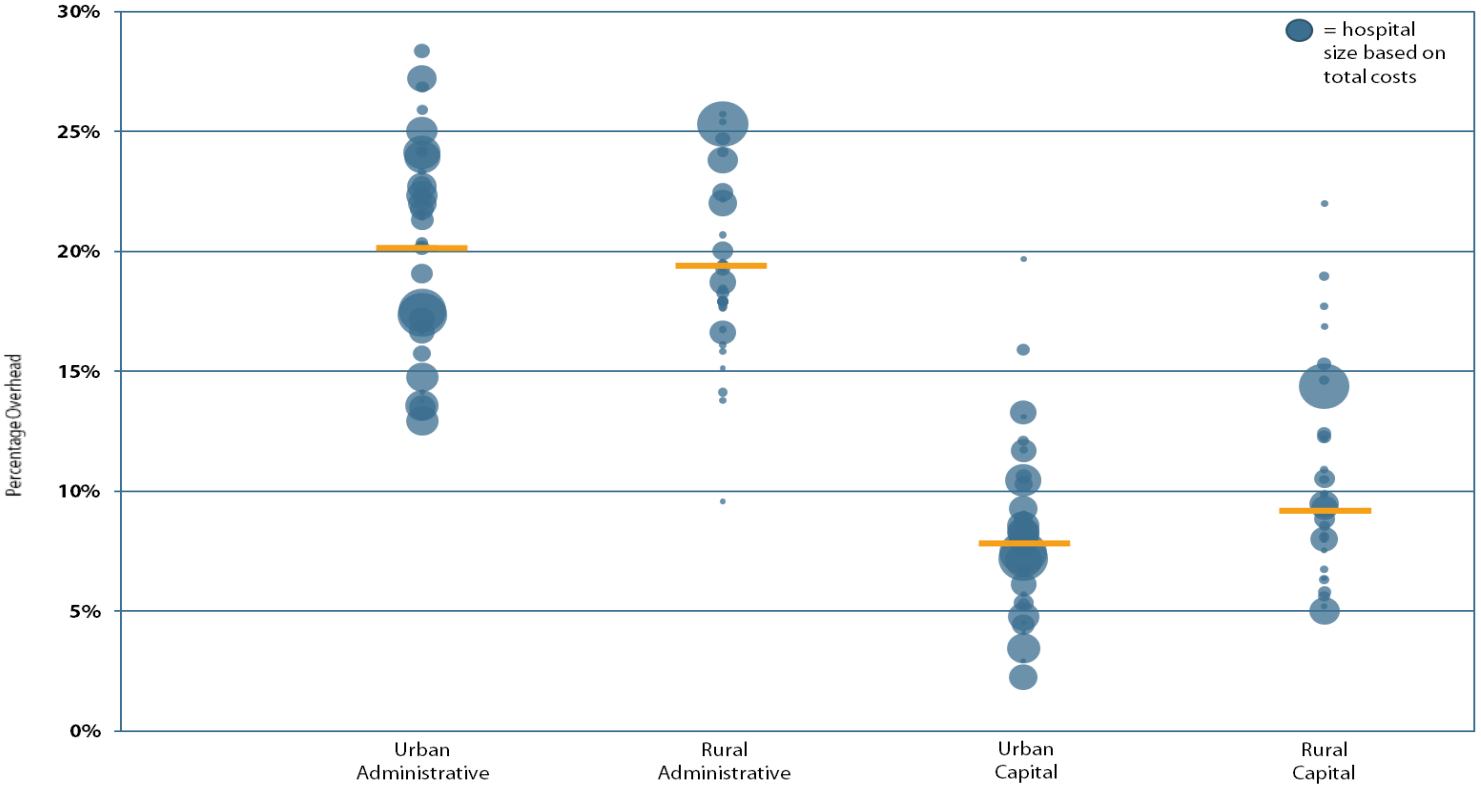
Urban and Rural Hospital Overhead Costs

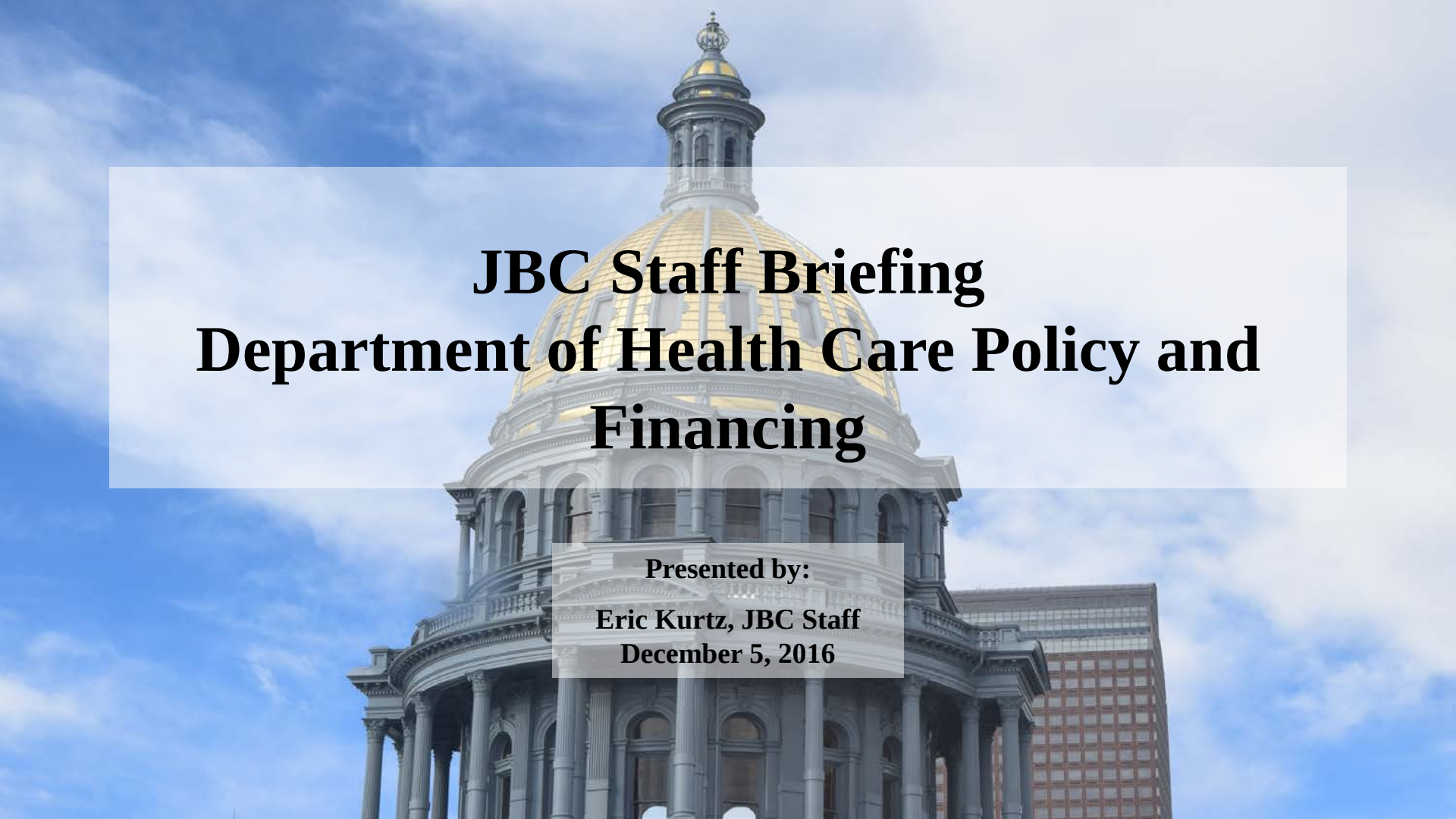
Rates Vary Widely Within Rural and Urban Regions and Within Size Categories



Administrative and Capital Costs: A Breakdown

Rates Vary Widely Across Regions and Within Categories





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