MEMORANDUM

JOINT BUDGET COMMITTEE

TO	Joint Budget Committee
FROM	Eric Kurtz, JBC Staff (303-866-4952)
DATE	3/8/2017
SUBJECT	Health Care Policy Financing additional figure setting issues: • Cash fund for repayment due to the transitional Medicaid system error • Contingency planning for the Children's Basic Health Plan • CU School of Medicine Supplemental Payment

This memo addresses some additional issues the JBC needs to make decisions on for the Department of Health Care Policy and Financing, including:

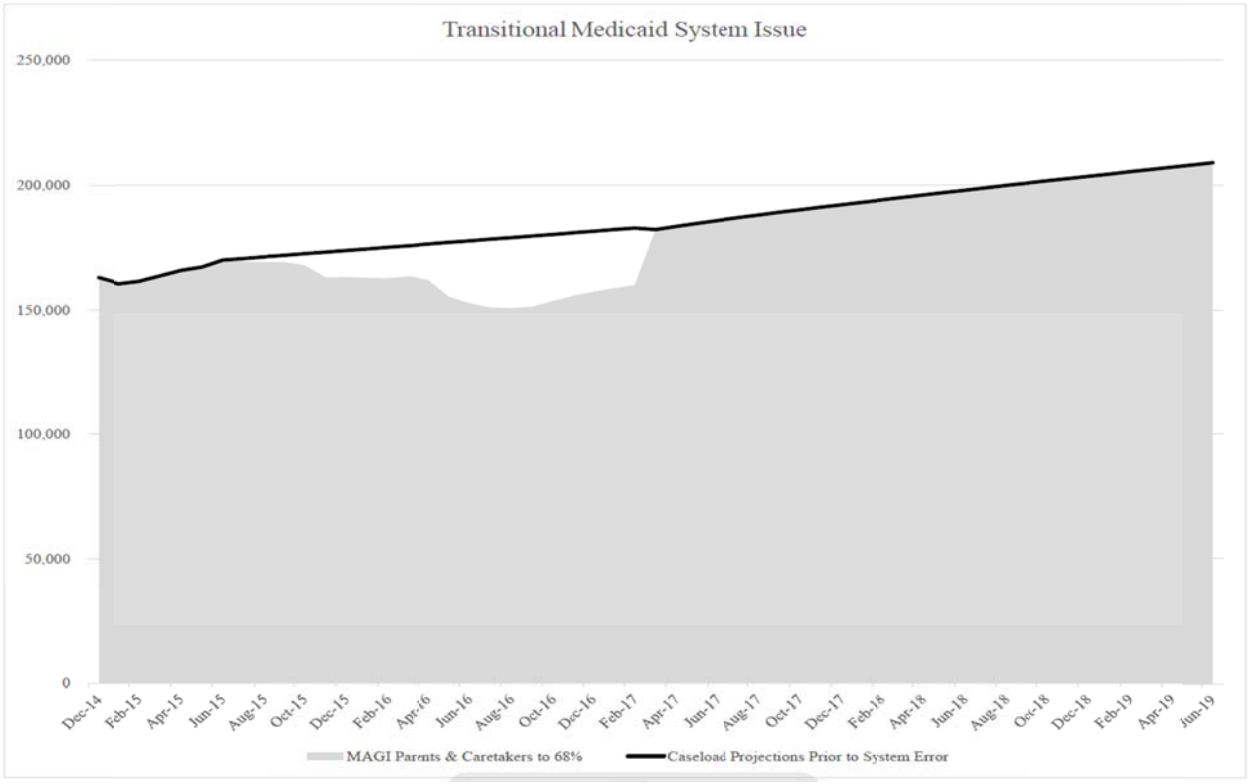
- Cash fund for repayment due to the transitional Medicaid system error
- Contingency planning for the Children's Basic Health Plan
- CU School of Medicine Supplemental Payments

➔ CASH FUND FOR REPAYMENT DUE TO TRANSITIONAL MEDICAID SYSTEM ERROR

REQUEST: On February 15, 2017, the Governor's Office of State Planning and Budgeting submitted a letter asking the JBC to create a new cash fund to hold $25.0 million General Fund in FY 2016-17 for a possible repayment to the federal government due to a system error that erroneously categorized some services as eligible for the enhanced federal match that applies to expansion populations when those services should have been categorized as eligible for the standard 50 percent federal match rate. The letter accompanied the Department's February forecast update, which is not an "official" request and is not accounted for in the Governor's budget balancing. Although the information came after the budget request deadlines, it represents the most current data available about potential Medicaid costs.

The system error is causing parents and caretakers with income that rises above 68 percent of the federal poverty guidelines (FPL) to be categorized as eligible for the enhanced match that applies to ACA expansion populations. 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 system error will be fixed as of March and the Department adjusted the forecast for FY 2016-17 and FY 2017-18 to account for the expected change in the federal match when the error is fixed. However, the forecast does not account for a possible repayment to the federal government as a result of the system error causing too high of a claim on federal funds for the period from FY 2015-16 to March of 2017.

In the table below the grey area shows the actual enrollment attributed in the Department's systems to parents and caretakers to 68 percent of the federal poverty guidelines and what the Department expects to happen when the system error is fixed. The black line represents the Department's projection based on the trends in place prior to the system error. The gap represents an estimate of the population that was incorrectly categorized as eligible for the enhanced federal map during the existence of the system error.



The Department has projected an upper and lower bound on what might be owed to the federal government of between $43.4 million and $21.8 million.

Potential Repayment for Transitional Medicaid Error			
	GENERAL FUND	Adult Dental Fund	Total
Upper Bound Estimate	$43,362,101	$2,474,792	$45,836,893
Lower Bound Estimate	$21,819,324	$1,245,288	$23,064,612

However, there is room for negotiation with the federal government on the size and timing of any repayment. According to the Department, the previous federal administration showed some leniency with unintentional and technical issues states encountered with implementing the new federal eligibility criteria associated with the Affordable Care Act. It is not known if that pattern will continue with the current federal administration. There is disagreement among the Department and OSPB staff about likely outcomes of negotiations with the federal government with opinions ranging from optimism that the full error will be forgiven to incredulity at the idea that the federal government would require anything less than full repayment, and views in between.

Because of uncertainty about the amount and timing of any repayment, the Governor is proposing creating a cash fund to hold $25 million until it is needed. Compared to the Governor's November request, the Department's February forecast for Medical Services Premiums is $30.6 million General Fund lower. Rather than reducing the FY 2016-17 appropriation to match the February forecast, the Governor proposes setting aside $25.0 million General Fund in a cash fund for a potential

repayment to the federal government for the transitional Medicaid system error. Putting the money in a cash fund would require a bill.

RECOMMENDATION: The JBC staff does not recommend the creation of a cash fund. Any unused General Fund for Medical Services Premiums in FY 2016-17 will increase the size of the beginning balance in the General Fund reserve for FY 2017-18. A cash fund is not necessary to move General Fund for this purpose from FY 2016-17 to FY 2017-18.

Instead, the JBC staff recommends an increase to FY 2017-18 appropriations for Medical Services Premiums of $25.0 million General Fund for the potential repayment for the transitional Medicaid system error. In the figure setting document the JBC recommended adjustments to both FY 2016-17 and FY 2017-18 to match the Department's forecast of expenditures. This included an adjustment for the expected effect of the fix to the transitional Medicaid system error going forward, beginning in March 2017. It did not include a potential repayment for incorrect billings to the federal government that occurred from July 2015 through February 2017. The $25.0 million General Fund for the potential repayment of those overbillings is on top of what the JBC staff recommended in the figure setting document.

➔ CONTINGENCY PLANNING FOR THE CHILDREN'S BASIC HEALTH PLAN

REQUEST: The Department did not submit a request, but has identified a possibility that federal funding for the Children's Basic Health Plan (CHP+) could run out during FY 2017-18, when the legislature is not in session to address the issue. The federal statutory authorization for the program runs through September 30, 2019, but the federal budget currently only includes money through September 30, 2017. The federal money is appropriated in blocks to states and the Department is projecting that Colorado will not use the entire block by September 30. Assuming that Congress doesn't take action to sweep the remaining block funds, then the Department estimates that Colorado could keep drawing federal funds at current consumption rates until December 2017. The Department has identified three possible federal funding scenarios and estimated costs for potential legislative responses.

FEDERAL FUNDING IS CONTINUED AT THE ENHANCED 88.0 PERCENT MATCH RATE

The Department considers this the most likely outcome and it is the federal funding scenario assumed in the Department's February forecast. No changes would be needed from the appropriation recommended by the JBC staff and no changes would be needed to state statutes.

FEDERAL FUNDING IS CONTINUED AT THE PRE-ACA 65.0 PERCENT MATCH RATE

Prior to the Affordable Care Act the federal match rate for CHP+ was 65.0 percent. Under this federal funding scenario the Department projects the General Assembly would need to appropriate $47.5 million more General Fund in FY 2017-18 to backfill lost federal funds. Some of the fiscal impact is for populations on Medicaid that receive the CHP+ match rate. It is unclear if the General Assembly could reduce eligibility or benefits in lieu of increased General Fund expenditures, because federal law contains a maintenance of effort requirement for children on Medicaid and CHP+ through October 1, 2019.

Federal Funding Continued at 65% Match

Item	Total Funds	General Fund	CBHP Trust	Hospital Provider Fee	Federal Funds
FY 2017-18	$0	$47,484,508	$15,143,031	$14,113,578	($76,741,117)
FY 2018-19	$0	$68,588,338	($2,250,727)	$15,311,667	($81,649,278)

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

FEDERAL FUNDING ENDS SEPTEMBER 30, 2017

As noted above, the Department estimates it could continue servicing children and pregnant women on CHP+ until December 2017. At that point, the Department identified three possible responses.

1 *END THE PROGRAM DECEMBER 2017:* In this scenario the Department would eliminate eligibility and benefits for the estimated 69,011 children and 792 pregnant women on CHP+. People in the income eligibility range for CHP+ meet the income qualifications for federal tax credits through Connect for Health Colorado. The Department has received direction from the federal Centers for Medicare and Medicaid Services that the federal maintenance of effort requirement for children would not apply for CHP+ if federal funding is not continued. However, the maintenance of effort would apply for children on Medicaid who currently receive the CHP+ match rate. These populations would be converted to the standard 50 percent federal match rate, increasing projected FY 2017-18 General Fund costs by $19.3 million. The Department estimates there would be a sufficient unused balance in the CHP+ Trust Fund that could be used to offset the increased General Fund cost for Medicaid to get through FY 2017-18. A change might be necessary to the CHP+ Trust Fund authorizing statute to allow it to be used for Medicaid, depending on how narrowly the General Assembly interprets the statutory purposes of the CHP+ Trust Fund, but that could be addressed during the 2018 session. There would be some costs to change eligibility determination systems to reflect the new eligibility criteria, but the Department has not estimated those costs and assumes they would be addressed in a supplemental.

End the Program December 2017

Item	Total Funds	General Fund	CHP+ Trust	Hospital Provider Fee	Federal Funds
Current Department Request	$333,657,026	$17,093,051	$16,178,615	$8,604,997	$291,780,363
Est. Cost through June 30, 2018	$228,916,393	$36,352,959	$8,089,310	$4,302,500	$180,171,624
Incremental Need	**($104,740,633)**	**$19,259,908**	**($8,089,305)**	**($4,302,497)**	**($111,608,739)**
Offset General Fund with CHP+ Trust Balance	$0	($19,259,908)	$19,259,908	$0	$0
Incremental Need	**($104,740,633)**	**$0**	**$11,170,603**	**($4,302,497)**	**($111,608,739)**

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

2 *EXTEND THE PROGRAM UNTIL FEBRUARY 2018:* In this scenario the General Assembly would pass legislation during the 2017 session to authorize an extension of the program, using state funds, until February 2018, perhaps contingent on JBC approval during the interim, to allow time for the General Assembly to reconvene in 2018 and potentially pass legislation to adapt to whatever Congress has approved. In this scenario the Department assumes the General Assembly would also authorize Hospital Provider Fee revenues designated for the CHP+ program to be used to offset the General Fund cost.

End the Program February 2017

Item	Total Funds	General Fund	CHP+ Trust	Hospital Provider Fee	Federal Funds
Current Department Request	$333,657,026	$17,093,051	$16,178,615	$8,604,997	$291,780,363
Est. Cost through February 28, 2018	$263,829,937	$49,853,164	$10,785,746	$5,736,666	$197,454,361
Incremental Need	**($69,827,089)**	**$32,760,113**	**($5,392,869)**	**($2,868,331)**	**($94,326,002)**
Offset General Fund with CHP+ Trust Balance	$0	($20,897,618)	$20,897,618	$0	$0
Incremental Need	**($69,827,089)**	**$11,862,495**	**$15,504,749**	**($2,868,331)**	**($94,326,002)**
Offset General Fund with Hospital Provider Fee	$0	($2,868,331)	$0	$2,868,331	$0
Incremental Need	**($69,827,089)**	**$8,994,164**	**$15,504,749**	**$0**	**($94,326,002)**

Note: CBHP Trust fund balance includes the Colorado Immunization Fund and Health Care Expansion Fund.

The Department also estimated the cost of running the program through FY 207-18, but the General Fund cost was $91.5 million. If federal funding for the program is discontinued, the JBC staff assumes the General Assembly would want to revisit the CHP+ program before committing to spending that much.

RECOMMENDATION: The contingencies the Department identified if Congress does not renew federal funding for the CHP+ program do not change the JBC staff recommendations for CHP+ or Medicaid. The JBC staff recommended funding for CHP+ is sufficient if federal funding is renewed. If federal funding is renewed at a lower match rate, the resulting General Fund cost will need to be addressed in a supplemental. If federal funding is not renewed, the JBC staff assumes the Department would discontinue eligibility and benefits for CHP+ in December 2017 as described above.

It is hard for the General Assembly to have a debate about whether to continue the CHP+ program without federal funding until it is known that federal funding is being discontinued. For this reason, running legislation to allow a continuation of the program until February, if federal funding is not renewed, might have value.

However, if federal funding is discontinued, it would be a major expense to extend CHP+ using General Fund. The largely mandatory additional General Fund cost in FY 2018-19 just for the people on Medicaid who would lose the CHP+ match rate is $74.1 million compared to the Department's current forecast. To continue CHP+ with General Fund would add another $191.6 million General Fund on top of that amount. That would be such a tough cost for the budget to absorb that the JBC staff sees little value in delaying the end of CHP+ for a potential miracle solution in the first two months of the 2018 session. If the Department had a miracle solution for how CHP+ could be continued with General Fund, then the JBC staff would be more open to recommending contingency legislation.

➔ CU SCHOOL OF MEDICINE SUPPLEMENTAL PAYMENT

REQUEST: With the November budget the Department included an "informational request" estimating how funding would need to change to create a supplemental payment for physicians of the University of Colorado School of Medicine. When asked what an "informational request" means, staff for the Office of State Planning and Budgeting 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 led the JBC staff to assume that a formal request would be submitted at a later date, but nothing additional has been submitted.

The concept is that funding for the University of Colorado Health Sciences Center would be transferred to the Department of Health Care Policy and Financing, where it would be used to match federal funds and make a supplemental payment to enhance Medicaid reimbursement rates for physicians who are faculty of the School of Medicine and provide clinical care at the University of Colorado Hospital and Children's Hospital. Then University Physicians, Inc., a component of unit of the University of Colorado that is responsible for physician billing, would take a portion of the supplemental payments and give them back to the University of Colorado Health Sciences Center to hold education program harmless. The remainder of the supplemental payments would be distributed to the physicians. A small portion of the funds would come off the top for administrative costs at the Department of Health Care Policy and Financing and to pay for three additional family residency training placements.

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**

House Bill 16-1408 made a change to the higher education statutes to allow this type of payment by adding the following section:

> *23-18-304. Funding for specialty education programs – area vocational schools – local district junior colleges. (1) (c) Specialty education services provided by the health sciences center campus at the university of Colorado as authorized by paragraph (a) of this subsection (1) [higher education fee-for-service payments] includes care provided by the faculty of the health sciences center campus at the university of Colorado that are eligible for payment pursuant to section 25.5-4-401, C.R.S. [Medicaid provider payments]*

The federal government allows supplemental payments to faculty at public medical schools up to an upper payment limit and CU testified to the JBC that approximately 30 states already make similar payments, which includes some states that make payments to broader groups that include public medical school faculty. When asked if any of those other states have removed direct state funding for their medical schools and replaced it with indirect funding from a separate nonprofit physician organization, the departments replied that they did not know.

The Department estimates that the supplemental payments would increase Medicaid reimbursements to University Physicians, Inc. by 72 percent.

Supplemental Payments to UPI, Inc. under Proposal	$ 123,042,864
Less Funds Transferred from Department of Higher Education to Department of Health Care Policy and Financing	$ 61,900,000
Net New Funding to UPI, Inc. from Proposed Supplemental Funding Mechanism	$ 61,142,864
FY 2015-16 Medicaid claims payments to UPI, Inc.	$ 84,346,644
Percentage Increase to UPI, Inc.	72%

The Department submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services on September 30, 2016, seeking federal approval for the supplemental payments. The SPA requests retroactive approval to July 1, 2016. The Department anticipates the SPA could be approved by July 1, 2017, allowing supplemental payments to begin in FY 2017-18 based on FY 2016-17 claims data.

RECOMMENDATION: The JBC staff does not recommend any funding in the Long Bill for the supplemental payments to the University of Colorado School of Medicine physicians. The supplemental payments would provide a significant financial advantage to University of Colorado School of Medicine physicians compared to other providers. The Department's policy case for why these providers should receive preferential treatment is not robust, and the JBC views the primary rationale for the targeted payments as being that this financing option is not available to providers who are not employed by the School of Medicine.

The JBC staff can envision other ways to take advantage of the special financing opportunity that the University of Colorado has identified that don't provide preferential treatment to a special class of providers. For example, instead of transferring the current level of General Fund for the University of Colorado School of Medicine to the Department of Health Care Policy and Financing, the General Assembly could reduce the General Fund for the University of Colorado and then make up the difference with the federal matching funds through the supplemental payments. This would free up General Fund to address other state budget needs without any negative impact on the School of Medicine. Alternatively, the JBC could transfer the full current level of General Fund for the University of Colorado School of Medicine, send the supplemental payment to UPI, and then ask UPI to not only pay for the School of Medicine, but also for nursing programs at community colleges. This would free up General Fund that would otherwise be appropriated for the nursing programs. If UPI can make a private payment for the Medical School, why not a private payment for nursing programs at community colleges? The extra General Fund made available by either of these strategies could be used for Medicaid financing in an environment of reduced federal funding, applied for a completely different purpose such as K12 funding, or saved in the General Fund.

The proposed supplemental payments for the employees of the School of Medicine have not been reviewed or recommended by the Medicaid Provider Rate Review Advisory Committee. A significant focus of the proposed supplemental payments is expanding access to specialty care for Medicaid patients, but the Medicaid Provider Rate Review Advisory Committee's Rate Review Analysis Report indicates that Medicaid patients are not more or less likely to access specialty care than privately insured Coloradoans. It is not clear to the JBC staff that the Medicaid Provider Rate

Review Advisory Committee would identify issues with access to care for Medicaid clients that would need to be addressed through a targeted rate increase.

According to the Proposed Use of Additional Funds submitted to the JBC, the majority of the additional money would be used to expand patient volume and expand access and enhance care using a medical home model. The success of these initiatives would be measured based on CU School of Medicine physicians seeing an additional 10,000 Medicaid patients and providing them 56,000 services. The Department assumes that the majority of this would be new utilization. However, the JBC staff is concerned that a more likely result is a transfer of utilization from other providers that will not be as aggressive in pursuing Medicaid patients due to less favorable reimbursement rates. This could actually be counter-productive for Medicaid clients as they would be funneled to narrower group of providers.

One of the proposed uses of the funds is to expand targeted rural patient access, to be measured by the hiring of 10 FTE pediatric and adult subspecialists. The JBC staff sees this as a very large investment to get only 10 FTE targeted at rural patient access. Furthermore, the additional 10 FTE should not be viewed as being located in rural communities. According to the Department: "Due to the size and populations of rural communities it is more likely that FTE would not permanently reside in these locations. To enable the CUSOM to provide as much care as possible in rural areas, additional outreach clinic services would be set up or expanded throughout the state."

Everything else the Department is proposing to do with provider rates has a significant focus on performance payments. It is not clear to the JBC staff that the supplemental payments would be based on performance. The supplemental payments would go to only one provider.

If the General Assembly is going to authorize a 72 percent increase in payments for UPI, there should be a high return on the investment. The JBC staff believes the departments should be able to show a greater benefit for the Medicaid program and the state budget as whole than what has been proposed so far. In particular, the JBC staff would like to see a net General Fund savings and higher performance expectations than what has been described to the JBC so far.

JOINT BUDGET COMMITTEE

STAFF FIGURE SETTING
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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MARCH 8, 2017

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HOW TO USE THIS DOCUMENT

The Department Overview contains a table summarizing the staff recommended incremental changes followed by brief explanations of each incremental change. A similar overview table is provided for each division, but the description of incremental changes is not repeated, since it is available under the Department Overview. More details about the incremental changes are provided in the sections following the Department Overview and the division summary tables.

Decision items, both department-requested items and staff-initiated items, are discussed either in the Decision Items Affecting Multiple Divisions or at the beginning of the most relevant division. Within a section, decision items are listed in the requested priority order, if applicable.

DEPARTMENT OVERVIEW

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

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

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

SUMMARY OF STAFF RECOMMENDATIONS

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)	$7,781,062,016	$2,163,886,443	$964,723,620	$11,561,599	$4,640,890,354	397.5
Other Legislation	56,973,679	(6,186,893)	27,386,412	0	35,774,160	2.8
SB 17-162 (Supplemental Bill)	156,804,477	23,832,957	9,332,285	3,826,150	119,813,085	0.0
Long Bill supplemental	(142,520,755)	(31,652,171)	(5,373,081)	0	(105,495,503)	0.0
TOTAL	**$7,852,319,417**	**$2,149,880,336**	**$996,069,236**	**$15,387,749**	**$4,690,982,096**	**400.3**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$7,852,319,417	$2,149,880,336	$996,069,236	$15,387,749	$4,690,982,096	400.3
R1 Medical Services Premiums	641,554,433	111,659,372	164,816,795	(71,665)	365,149,931	0.0
R3 Childrens Basic Health Plan	13,763,634	(1,880,340)	(1,167,848)	0	16,811,822	0.0
R4 Medicare Modernization Act	17,222,134	17,222,134	0	0	0	0.0
R6 Delivery system and payment reform	45,370,739	14,735,125	903,427	0	29,732,187	0.0
R7 Oversight of state resources	409,346	(1,927,951)	(206,126)	0	2,543,423	11.4
R8 MMIS Operations	23,499,620	(572,612)	2,953,578	(275,978)	21,394,632	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	621,676	73,518	0	0	548,158	0.0
R11 Vendor transitions	2,598,458	929,629	369,600	0	1,299,229	0.0
R12 Local Public Health Agency partnerships	0	0	0	0	0	0.0
R13 Quality of care and performance improvement projects	708,339	315,420	0	0	392,919	0.0
BA9 Pueblo Regional Center corrective action plan	296,240	148,120	0	0	148,120	0.0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
BA10 Regional Center cost reporting	0	0	0	0	0	0.0
BA13 Connect for Health Colorado	0	0	0	0	0	0.0
BA14 Public School Health Services	1,025,015	0	748,947	0	276,068	0.0
NP OIT CBMS	73,522	(930,212)	757,510	(2,349)	248,573	0.0
Standard federal match	774,463	8,743,939	1,346,331	6,020	(9,321,827)	0.0
ACA "Newly eligible" federal match	0	0	46,060,326	0	(46,060,326)	0.0
Transfers to other state agencies	1,430,126	507,431	0	0	922,695	0.0
Centrally appropriated line items	1,308,522	431,137	96,045	21,801	759,539	0.0
Tobacco forecast adjustment	498,584	7,750	490,834	0	0	0.0
Indirect cost adjustment	215,804	(215,804)	32,729	327,295	71,584	0.0
Annualize prior year budget actions	(98,192,664)	660,013	(27,998,431)	6,702	(70,860,948)	0.3
SUBTOTAL	**$8,506,527,976**	**$2,300,044,649**	**$1,185,263,734**	**$15,399,575**	**$5,005,820,018**	**413.8**
Legislation and Set Asides						
R1 Restrict Hospital Provider Fee revenue	(390,000,000)	0	(195,000,000)	0	(195,000,000)	0.0
R1 Set-aside for SB 17-091	2,211,530	1,025,567	18,216	0	1,167,747	0.0
Performance Payments/ACC	555,097	27,549	250,000	0	277,548	0.9
TOTAL	**$8,119,294,603**	**$2,301,097,765**	**$990,531,950**	**$15,399,575**	**$4,812,265,313**	**414.7**
INCREASE/(DECREASE)	**$266,975,186**	**$151,217,429**	**($5,537,286)**	**$11,826**	**$121,283,217**	**14.4**
Percentage Change	3.4%	7.0%	(0.6%)	0.1%	2.6%	3.6%
FY 2017-18 EXECUTIVE REQUEST	**$8,218,022,192**	**$2,307,281,981**	**$986,609,051**	**$15,183,771**	**$4,908,947,389**	**415.6**
Request Above/(Below) Recommendation	$98,727,589	$6,184,216	($3,922,899)	($215,804)	$96,682,076	0.9

DESCRIPTION OF INCREMENTAL CHANGES

FY 2016-17

LONG BILL SUPPLEMENTAL: Staff recommends a supplemental based on enrollment and utilization trends identified in the Department's February forecast. See the descriptions of *R1 Medical Services Premiums*, *R3 Children's Basic Health Plan*, and *R4 Medicare Modernization Act* for more information.

FY 2017-18

R1 Medical Services Premiums: Staff recommends an increase of $641.6 million total funds, including $111.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item.

R3 Children's Basic Health Plan: Staff recommends an increase of $13.8 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: Staff recommends an increase of $17.2 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.

R6 DELIVERY SYSTEM AND PAYMENT REFORM: Staff recommends a net increase of $18.7 million total funds, including $7.5 million General Fund, for continuing the primary care rate bump, adjusting vaccine stock pricing, and offsetting reductions due to a federally required change in behavioral health capitation rates and the timing of hospital outpatient payments. Some of the change affects the Behavioral Health division and is not displayed in the summary table. In a companion recommendation the JBC staff proposes legislation to authorize performance payments and the Accountable Care Collaborative.

R7 OVERSIGHT OF STATE RESOURCES: Staff recommends a net increase of $0.4 million total funds, including a decrease of $1.9 million General Fund, and an increase of 11.4 FTE for a number of initiatives related to the oversight of state resources.

R7 Oversight of State Resources					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Electronic verification of assets	$429,183	$214,592	$0	$214,591	0.0
Consumer directed care evaluation	422,000	211,000	0	211,000	0.0
Audit database	0	0	0	0	0.0
Project management staff	164,009	71,756	0	92,253	3.0
Audits of Community Mental Health Centers	204,000	102,000	0	102,000	0.0
Investigate fraud and abuse	(471,888)	(53,796)	(86,696)	(331,396)	5.5
Investigators	*390,547*	*195,276*	*0*	*195,271*	*5.5*
Anticipated cost savings	*(862,435)*	*(249,072)*	*(86,696)*	*(526,667)*	*0.0*
Native American health services	268,359	(2,180,169)	(133,388)	2,581,916	3.7
HCPF staff	*134,179*	*67,090*	*0*	*67,089*	*1.9*
Other department staff	*134,180*	*134,180*	*0*	*0*	*1.8*
Anticipated General Fund savings	*0*	*(2,381,439)*	*(133,388)*	*2,514,827*	*0.0*
Hospital Provider Fee model resources	67,993	0	33,997	33,996	1.0
Office-administered drugs	(540,130)	(159,154)	(20,039)	(360,937)	0.0
Recalibrate rates	*39,320*	*11,586*	*1,459*	*26,275*	*0.0*
Anticipated cost savings	*(579,450)*	*(170,740)*	*(21,498)*	*(387,212)*	*0.0*
TOTAL	**$543,526**	**($1,793,771)**	**($206,126)**	**$2,543,423**	**13.2**
Human Services	67,090	67,090	0	0	0.9
Office of the Governor	67,090	67,090	0	0	0.9
Health Care Policy and Financing	409,346	(1,927,951)	(206,126)	2,543,423	11.4

R8 MMIS Operations: Staff recommends an increase of $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.

R9 Long-term care utilization management: Staff recommends 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 staff presentation includes $922,801 total funds, including $224,066 General Fund, and 1.8 FTE based on the Governor's request to implement the recommendations of the Regional Center Task Force. The staff recommendation is pending and will be addressed during figure setting for the Office of Community Living.

R11 Vendor transitions: Staff recommends $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: Staff recommends no funding, based on the JBC's actions during figure setting for the Department of Public Health and Environment, for the requested initiative to improve coordination between the Accountable Care Collaborative and Local Public Health Agencies.

R13 Quality of care and performance improvement projects: Staff recommends $708,339 total funds, including $315,420 General Fund, to conduct member satisfaction surveys aimed at

improving quality of care, and to validate performance improvement projects by managed care organizations.

BA9 Pueblo Regional Center corrective action plan: The staff presentation includes $296,240 total funds, including $148,120 General Fund, based on the based on the Governor's request for the Pueblo Regional Center corrective action plan. The staff recommendation is pending and will be addressed during figure setting for the Office of Community Living.

BA10 REGIONAL CENTER COST REPORTING: Staff recommends continuation of funding (no net change in costs) for the Regional Center cost reporting, based on the JBC's supplemental action.

BA13 CONNECT FOR HEALTH COLORADO: Staff recommends continuation of funding (no net change in costs) to pay Connect for Health Colorado for eligibility determination assistance provided to Medicaid and CHP+ clients, based on the JBC's supplemental action.

BA14 PUBLIC SCHOOL HEALTH SERVICES: Staff recommends $1.0 million total funds, including $0.7 million certified public expenditures, for projected changes in caseload and utilization for the Public School Health Services program.

NP OIT CBMS: Staff recommends $73,522 total funds, including a decrease of $930,212 for the Colorado Benefits Management System based on the JBC's actions during figure setting for the Governor's Office of Information Technology.

STANDARD FEDERAL MATCH: Staff recommends an increase of $774,463 total funds, including $8.7 million General Fund, based on changes in the standard federal match rates for Medicaid and CHP+.

ACA "NEWLY ELIGIBLE" FEDERAL MATCH: Staff recommends an increase of $46.31 million cash funds from the Hospital Provider Fee and a corresponding decrease in federal funds for changes in the federal match rate for the Medicaid expansion populations.

TRANSFERS TO OTHER STATE AGENCIES: Staff recommends $1.4 million total funds, including $0.5 million General Fund, based on the JBC's decisions during figure setting for other departments that receive transfers from Medicaid. Some of the JBC's decisions are pending and so this total is a mix of JBC actions and the Governor's request.

CENTRALLY APPROPRIATED LINE ITEMS: Staff recommends an increase of $1.3 million total funds, including $431,137 General Fund, for changes to centrally appropriated line items based on JBC common policies.

Tobacco forecast adjustment: Staff recommends an increase of $98,584, including $7,750 General Fund, based on changes to the forecast of tobacco settlement and tobacco tax moneys used to finance programs in the Department.

INDIRECT COST ADJUSTMENT: Staff recommends a net increase of $215,804, including a decrease of $215,804 General Fund, based on changes to the statewide indirect cost assessment on the Department.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: Staff recommends adjustments for out-year impacts of prior year legislation and budget actions. 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.

LEGISLATION AND SET ASIDES

R1 RESTRICT HOSPITAL PROVIDER FEE REVENUE: Staff recommends the requested $195.0 million restriction on Hospital Provider Fee revenues, but staff recommends that the JBC sponsor legislation to implement the restriction. In addition, the JBC staff recommends eliminating the statutory prioritization of the uses of the Hospital Provider Fee so that a bill is not required in future years to modify the allowable revenues from the Hospital Provider Fee.

R1 SET-ASIDE FOR S.B. 17-091: Staff recommends that the JBC set aside $2.2 million total funds, including $1.0 million General Fund, for S.B. 17-091 to implement a federally mandated change in where clients can receive home health services.

PERFORMANCE PAYMENTS/ACC: Staff recommends that the JBC sponsor legislation to authorize performance payments and phase II of the Accountable Care Collaborative. Most of the costs associated with the legislation are in FY 2018-19.

MAJOR DIFFERENCES FROM THE REQUEST

The largest differences between the request and the JBC staff recommendation are due to the JBC staff using the Department's February 2017 forecast of expenditures for Medical Services Premiums, the Children's Basic Health Plan, and the Medicare Modernization Act

DECISION ITEMS AFFECTING MULTIPLE DIVISIONS

➔ R14 FEDERAL MATCH RATE

REQUEST: The Department requests adjustments to account for changes in the federal match rate for Medicaid and the Children's Basic Health Plan (CHP+). These are changes mandated by federal law and not a discretionary choice for the state.

The change in the standard federal match rate is the result of improved per capita income in Colorado relative to the national average. The standard Medicaid federal match rate, or Federal Medical Assistance Percentage (FMAP), is calculated each federal fiscal year for each state according to a formula[1] that takes into account each state's per capita income compared to the national average. Federal law provides for a minimum match rate of 50 percent and a maximum of 83 percent. A state with per capita income equal to the national average would get a 55 percent Medicaid match and states get a larger or smaller match based on having per capita income below or above the national average. The federal match rates for CHP+ and some subsets of Medicaid services, such as breast and cervical cancer treatment, are calculated as derivatives of the FMAP, so the federal match rates for these programs also change when the standard Medicaid FMAP changes.

In addition to the changes in the standard Medicaid federal match rate, there will be changes in FY 2017-18 to the federal match rate for services to adults defined as "Newly Eligible" pursuant to the federal Affordable Care Act (ACA). The federal match rate for the "Newly Eligible" is calculated on a different basis than the standard Medicaid FMAP. It is not dependent on a state's per capita income relative to the national average, nor does it change with the federal fiscal year. The federal match for the "Newly Eligible" steps down each calendar year in increments until it reaches 90 percent in calendar year 2020.

The tables below show the changes in the standard federal match rate, the ACA "Newly Eligible" federal match, and the CHP+ federal match rate. The tables provide the applicable federal match for each quarter of the state fiscal year and calculate an average federal match for the state fiscal year.

Standard Medicaid Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	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	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	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

[1] The FMAP = 1 – (a three-year average of the state's per capita income)^2 / (a three-year average of the national per capita income)^2 * 0.45.

CHP+ 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	65.00	65.00	65.00	65.00	65.00
FY 14-15	65.53	65.00	65.71	65.71	65.71
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	88.14	88.50	88.01	88.01	88.01
FY 17-18	88.00	88.01	*88.00*	*88.00*	*88.00*
FY 18-19	*88.00*	*88.01*	*88.00*	*88.00*	*88.00*

Italicized figures are projections.

The Department requested funding for these changes in the federal match rate in several places. In R14 the Department requested funding for line items where the Department did not submit a separate forecast adjustment. For Medical Services Premiums, Behavioral Health, the Children's Basic Health Plan, the Medicare Modernization Act, and the Office of Community Living the effects of the changes to the federal match rate were included in the requested forecast adjustments (R1 through R5).

RECOMMENDATION: Staff recommends appropriation adjustments based on the new federal match rates, which is consistent with the Department's request. The change in federal match rates is something that will happen in FY 2017-18 based on federal policy and is not something that can be altered through a discretionary decision by the General Assembly.

However, there is a difference in the way the JBC staff is presenting the change as compared with the Department's request. As noted above, the Department requested the change attributable to the new federal match rates in several places, including burying some of the change in the forecast adjustments (R1 through R5). The JBC staff takes the change attributable to the new FMAP out of the forecast adjustments and shows the total change to the base under *R14 Federal match rate*. The estimated costs of new recommendations to increase or decrease funding are presented at the new federal match rates. The staff presentations for Behavioral Health and the Office of Community Living follow a similar format. Because of the difference in presentation, comparing the dollars requested by the Department in R14 to the dollars recommended by the JBC staff would be comparing apples and oranges.

The difference in presentation does not represent a difference in the total dollars recommended for the Department. It is just a difference in how much of the dollar change is attributed to the change in the federal match rates versus the forecast adjustments.

The primary reason for the difference in presentation is that the JBC staff is trying to isolate the increase in General Fund due to the change in the federal match rates from the increases that are due to changes in the forecasted enrollment and per capita costs. The JBC staff also wants to make sure that the estimated costs for new policies that increase or decrease funding are shown using the new match rates, so that if the JBC or General Assembly decides to do something different than the JBC staff recommendation there is not a compounding dollar change due to the new match rates that is missing from the decision.

In the summary tables the JBC staff has separate rows to show the change attributable to the decrease in the standard federal match rate and the change attributable to the step down in the

federal match rate for the "Newly Eligible" pursuant to the ACA. The Department included the dollar impact of the later in R1 Medical Services Premiums and R2 Behavioral Health. The step down in the federal match rate for the "Newly Eligible" is a relatively high profile change in financing for the expansion populations, and so the JBC staff decided to show it separately from forecast adjustments for enrollment and utilization trends.

Most health services provided by the Department qualify for the federal match rates described above while administrative costs are typically reimbursed with a 50 percent federal match. However, there are a myriad of special match rates for certain populations, services, and administrative expenses. The table below summarizes special match rates currently applicable in Colorado. There are other enhanced match rates that Colorado could qualify for in the future if certain program changes are implemented, such as home health services for people with chronic disabilities for the first 8 quarters the benefit is in place. Some of the special match rates for certain populations and services are indexed to the standard Medicaid FMAP, and so the dollar effect of those changes is included by the JBC staff in *R14 Federal match rate*. The administrative match rates are not changing in FY 2017-18.

Special Match Rates	
Activity/Population	Rate
Breast and Cervical Cancer Treatment	CHP+ rate-23 percentage points
Medicaid services to children and pregnant adults formerly on CHP+ (SB 11-008 Children 107% - 147% FPL and SB 11-250 Pregnant Adults to 142% FPL)	CHP+ rate
Clinical Preventive Services for Adults	FMAP + 1%
Family Planning Services	90%
Money Follows the Person Rebalancing Demonstration	FMAP+25% in rebalancing fund
Services provided through Indian Health Service and Tribal Facilities	100%
Administrative Match Rates	
Adoption and use of electronic health record (EHR) technology	100%
Immigration status verification	100%
Citizenship verification	90%
Medicaid health information technology planning	90%
Design, development, and installation of MMIS and citizenship verification systems	90%
Management and operation of MMIS and citizenship verification systems	75%
Eligibility software, operations, maintenance, and staff	75%
Independent external reviews of managed care plans	75%
Medical and utilization review	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel	75%
State fraud and abuse control unit activities	75%
State survey and certification	75%
Translation and interpretation services for children	75%
Other program administration activities	50%

➔ R6 DELIVERY SYSTEM AND PAYMENT REFORM

REQUEST: In the November 1 request the Department asked for a net increase of $3.2 million total funds, including a reduction of $200,342 General Fund, for a number of changes that the Department characterizes as delivery system and payment reforms. However, the JBC has already approved a reduction of $15.4 million total funds, including $7.7 million General Fund, in the FY 2016-17 supplemental for this initiative. From the lower FY 2016-17 base the incremental change

required to get to the Department's FY 2017-18 request is a net increase of $18.7 million total funds, including $7.5 million General Fund.

The request can be divided into performance based payments, the Accountable Care Collaborative, vaccine stock rates, and offsetting rate changes. The table below summarizes changes to the budget associated with the request, as proposed by the Governor. Descriptions of each component follow the table. Some of the policy changes are budget neutral and some don't impact expenditures until out years, and so in several cases the policy changes are more complex than the dollar changes reflected in the table.

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					
Performance payments					
Primary care	54,085,240	18,846,157	936,326	34,302,757	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	0	0	0	0	
Subtotal - Performance payments	*$54,085,240*	*$18,846,157*	*$936,326*	*$34,302,757*	
Accountable Care Collaborative (ACC)	$0	$0	$0	$0	
Vaccine stock rates	($994,353)	($250,958)	($32,899)	($710,496)	
Offsetting rate changes					
Behavioral health capitation rates	(26,717,069)	(7,215,319)	(1,090,836)	(18,410,914)	
Hospital outpatient payment timing	(23,160,443)	(11,580,222)	0	(11,580,221)	
Subtotal - Offsetting rate changes	*($49,877,512)*	*($18,795,541)*	*($1,090,836)*	*($29,991,135)*	
TOTAL FY 2017-18	**$3,213,375**	**($200,342)**	**($187,409)**	**$3,601,126**	**0.0**
FY 2018-19					
Performance payments					
Contract performance evaluator	225,000	112,500	0	112,500	
Rate analyst	74,975	37,487	0	37,488	0.9
Primary care	60,413,683	21,051,321	1,199,912	38,162,450	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	26,717,069	7,215,319	1,090,836	18,410,914	
Subtotal - Performance payments	*$87,430,727*	*$28,416,627*	*$2,290,748*	*$56,723,352*	*0.9*
Accountable Care Collaborative (ACC)					
Administrative staff	327,767	163,884	0	163,883	3.7
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	
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	*($68,656,847)*	*($21,939,157)*	*($2,398,552)*	*($44,319,138)*	*3.7*
Vaccine stock rates	($1,022,420)	($255,171)	($39,016)	($728,233)	
Offsetting rate changes					
Behavioral health capitation rates	(28,131,120)	(7,503,004)	(1,306,187)	(19,321,929)	
Hospital outpatient payment timing	(23,160,443)	(9,769,075)	0	(13,391,368)	
Subtotal - Offsetting rate changes	*($51,291,563)*	*($17,272,079)*	*($1,306,187)*	*($32,713,297)*	
TOTAL FY 2018-19	**($33,540,103)**	**($11,049,780)**	**($1,453,007)**	**($21,037,316)**	**4.6**

R6 Delivery System and Payment Reform					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2019-20					
Performance payments					
Contract performance evaluator	150,000	75,000	0	75,000	
Rate analyst	81,074	40,537	0	40,537	1.0
Primary care	59,055,014	20,577,889	1,492,346	36,984,779	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	28,131,120	7,503,004	1,306,187	19,321,929	
Subtotal - Behavioral health	*$87,417,208*	*$28,196,430*	*$2,798,533*	*$56,422,245*	*1.0*
Accountable Care Collaborative (ACC)					
Administrative staff	329,047	164,524	0	164,523	4.0
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	
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	*($180,365,147)*	*($60,321,156)*	*($7,489,299)*	*($112,554,692)*	**4.0**
Vaccine stock rates	($1,048,261)	($262,303)	($49,379)	($736,579)	
Offsetting rate changes					
Behavioral health capitation rates	(28,536,463)	(7,609,325)	(1,569,344)	(19,357,794)	
Hospital outpatient payment timing	(23,160,443)	(7,645,263)	0	(15,515,180)	
Subtotal - Offsetting rate changes	*($51,696,906)*	*($15,254,588)*	*($1,569,344)*	*($34,872,974)*	
TOTAL FY 2018-19	**($145,693,106)**	**($47,641,617)**	**($6,309,489)**	**($91,742,000)**	**10.0**
Incremental Change by Fiscal Year					
FY 2016-17 (approved in supplemental)	($15,440,295)	($7,720,148)	$0	($7,720,147)	0.0
FY 2017-18	$18,653,670	$7,519,806	($187,409)	$11,321,273	0.0
FY 2018-19	($36,753,478)	($10,849,438)	($1,265,598)	($24,638,442)	4.6
FY 2019-20	($112,153,003)	($36,591,837)	($4,856,482)	($70,704,684)	5.4

PERFORMANCE PAYMENTS: 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. For all of the proposed performance payments the Department would begin measuring performance in FY 2017-18 and make payments based on that performance in FY 2018-19.

- *PRIMARY CARE:* The Department requests extending, through FY 2017-18, some FY 2016-17 increases in primary care rates that were authorized by H.B. 16-1408, and then converting the so-called primary care rate bump[2], plus some of the base primary care rates, to performance payments over time, beginning in FY 2018-19. In H.B. 16-1408 the primary care rate bump was financed with a one-time cash fund transfer of tobacco settlement moneys. To extend the rate

[2] The rate bump began in January 2013 when the federal Affordable Care Act (ACA) required states to temporarily increase Medicaid primary care rates to match Medicare rates in order to ensure an adequate number of primary care providers for the Medicaid expansion. The rate bump was fully funded with federal funds for two years from January 2013 through December 2014. Colorado extended the rate bump, with modifications, for another 1.5 years (through June 2016) using the General Fund savings from a short-term increase in the federal match rate for Medicaid that occurred as a result of the downturn in Colorado's economy. In FY 2016-17 the estimated General Fund cost of continuing the full rate bump was $49.5 million, but the General Assembly instead approved a one-time cash funds transfer (in H.B. 16-1408) of $20 million from tobacco settlement money to continue a portion of the rate bump. It is this reduced funding level that the Department proposes extending.

bump in FY 2017-18 the Department requests $54.1 million total funds, including $18.8 million General Fund. The amount of payments based on performance is being negotiated and may change, but the Department is considering beginning at 4.0 percent and increasing over time to 9.0 percent, which is similar to the way performance funding is being implemented for Medicare. The Department estimates the primary care rate bump represents approximately 7.0 percent of payments, so 4.0 percent performance payments would be less than the primary care rate bump and 9.0 percent performance payments would require converting additional fee-for-service payments beyond the primary care rate bump to performance.

As an alternative to performance payments, some primary care providers would be given an option to enter a partial capitation agreement. In a partial capitation agreement a portion of a provider's reimbursement would be based on fee-for-service and a portion based on the number of members per month for which the provider serves as the medical home, regardless of whether the members receive services in the month. As an example, the Department offered that 60 percent of payments could be based on fee-for-service and 40 percent on a per-member per-month (PMPM) basis. A partial capitation agreement would offer financial flexibility for providers to experiment with alternative delivery mechanisms that might not be adequately reimbursed through the fee-for-service system otherwise. This option would only be available to providers with the capacity to meet reporting requirements designed to ensure that providers aren't rationing care and are achieving positive health outcomes. The partial capitation agreements are anticipated to be budget neutral and were not included in the narrative for R6, but were described in communications to the JBC staff as being part of the initiative.

To help implement the changes to primary care reimbursement the Department requests one new rate analyst (0.9 FTE in the first year), beginning in FY 2018-19. The rate analyst would be responsible for transitioning from a single fee schedule to a payment model that adjusts based on the performance of the specific provider, and for monitoring that payments remain in budget and are achieving the intended changes in practice.

- *FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS):* Performance incentives for FQHCs would be financed by reducing Colorado's current rates for FQHCs to amounts closer to the federal minimum. The Department assumes the aggregate amount earned in performance payments would match the aggregate reduction in rates, and both the performance payments and rate reductions would occur in FY 2018-19, so there would be no net change in appropriations. Similar to non-FQHC primary care, the Department is considering starting with 4.0 percent of payments based on performance and increasing the percentage over time, although the maximum FQHC payments the Department can convert to performance is constrained by the federal minimum required payments.

  As an alternative to performance payments, FQHCs could convert their current payment each time a patient is seen by a doctor to a payment based on the number of members per month for which the provider serves as the medical home. This would allow FQHCs to get paid for treatment that doesn't require face to face contact with a doctor, such as group therapy, telemedicine, or nurse help lines. Reporting requirements and clawback provisions in the contracts would ensure that FQHCs converting to this payment method don't ration care and achieve positive health outcomes.

- *BEHAVIORAL HEALTH:* Beginning in FY 2018-19, the Department requests spending $26.7 million total funds, including $7.2 million General Fund, on performance payments for behavioral health. The amount is based on the expected savings from a federally required change in the way behavioral health capitation rates are set. The proposed performance payment is approximately 3.8 percent of projected FY 2018-19 capitation payments. The federally required reduction in capitation payments takes effect in FY 2017-18, but the performance based payments would not begin until FY 2018-19, resulting in a delay of payment for behavioral health providers.

The Department reports that many different entities, both public and private, are moving toward performance payments and emphasizes the importance of aligning with those performance initiatives to ensure providers are not pulled in different directions, and that the financial incentives from all payers are sufficient to drive change. The request specifically mentions that performance payments will be aligned with the Comprehensive Primary Care Initiative/Comprehensive Primary Care Plus (public and private insurers that agree to a shared set of value payments), the Accountable Care Collaborative, the State Innovation Model (federal grant-funded multi-payer practice transformation, with Colorado's efforts focused on integrating behavioral and physical health), and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

ACCOUNTABLE CARE COLLABORATIVE (ACC): In the reprocurement of the Accountable Care Collaborative (ACC), the Department has identified the following areas with increased costs or savings: mandatory enrollment; a $1 increase in the per member per month reimbursement; additional administrative staff; and the integration of physical and behavioral health. The ACC pays for a regional administrative structure charged with coordinating care. The Regional Accountable Entities (RAEs) are responsible for developing the provider network, connecting Medicaid clients to providers, and ensuring that Medicaid clients receive coordinated care. Each of the cost drivers in the reprocurement is summarized in the bullets below: Additional costs for the ACC do not begin until FY 2018-19.

- *ADMINISTRATIVE STAFF:* The Department requests $327,767, including $163,884 General Fund, for four new staff to help administer the ACC (3.7 FTE in the first year). The additional staff would measure and evaluate performance and quality outcomes of the new initiatives in phase II of the ACC and provide recommendations for improvements, manage contracts, perform outreach and communication, and address complaints and provide enhanced liaison services for vulnerable populations.

- *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. The Department estimates that mandatory enrollment will add 167,080 to the ACC, including 60,064 elderly and people with disabilities, 84,256 adults, and 22,760 children. Paying the RAEs the per member per month fee for the additional enrollment will cost $29.1 million, including $11.3 million General Fund in FY 2018-19. The Department is projecting savings of $55.6 million, including $24.1 million General Fund, as a result of more people receiving coordinated care. The net result is a savings of $26.5 million, including $12.8 million General Fund.

- *INCREASE PMPM BY $1:* The Department proposes increasing the per member per month fee to the RAEs by $1 to account for their increased responsibilities, particularly related to behavioral health. The department estimates the FY 2018-19 cost will be $16.3 million, including $6.3 million General Fund.

- *INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH:* The Department projects that in FY 2018-19 integrating physical and behavioral health will save $58.8 million, including $15.6 million General Fund. The savings estimates are based on studies of the cost of treating clients with serious and persistent mental illness (SPMI) or substance use disorder (SUD) in an integrated setting vs a general medicine clinic.

VACCINE STOCK RATES: The Department proposes updating rates for vaccines annually to the retail rates published by the Centers for Disease Control to save $994,353 total funds, including $250,958 General Fund. 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 as the rates for some vaccines increase. Currently, rates are set when new vaccines are introduced and then generally not changed from one year to the next. As a result, many of the Department's vaccine rates are out of date.

OFFSETTING RATE CHANGES: The Department included in the request two changes to rates that partially offset the costs of the other initiatives in the request. First, the Department included short-duration savings from a change in the timing of Medicaid payments for hospital outpatient services. The old hospital reimbursement method generated a significant initial overpayment that was corrected through reconciliations that sometimes took as long as four to five years to complete. The new reimbursement method generates an initial payment that is much closer to the correct rate from the start, so that going forward the Department expects reconciliations to decrease. However, in the short term the Department is still receiving reconciliations for payments in prior years at the old inflated initial payments, resulting in a short-duration savings over the next few years until those reconciliations are all resolved. Second, new federal regulations regarding managed care are expected to decrease capitated payments to behavioral health providers by approximately 4 percent. The old regulations allowed rates to be set within a range identified as actuarially sound to cover costs. The new regulations narrow the range to essentially a point that is actuarially sound.

The savings from the two rate changes are tangentially related to the other initiatives in the request, but will occur regardless of whether the JBC approves the rest of the request. The JBC staff would characterize these changes as forecast adjustments rather than payment reforms. The adjustment to the timing of hospital payments is not a new policy that the JBC is being asked to approve, because it has already been implemented. Similarly, the change to behavioral health capitation rates is not discretionary, since it is mandated by federal regulation.

RECOMMENDATION: The JBC staff recommends the requested funding in FY 2017-18, but recommends that the JBC sponsor legislation to authorize the expenditures that begin in FY 2018-19 for performance payments and the Accountable Care Collaborative.

FY 2017-18 RECOMMENDED FUNDING

For FY 2017-18 the biggest dollar decision is whether to spend $18.8 million General Fund to continue the primary care rate bump at the level funded in H.B. 16-1408. Last year an independent

third-party analysis commissioned by the Department did not show a correlation between the primary care rate bump and provider participation in Medicaid. However, the results of the analysis conflicted with communications the JBC received from providers that the rate bump was critical to the financial feasibility of their continued participation in the Medicaid program. The JBC identified an alternative fund source to continue the rate bump at a reduced level. Based on the JBC's actions last year, the JBC staff assumes that the JBC wants to continue the rate bump, if it fits the overall budget. However, if the JBC needs a large sum to balance the budget, the JBC staff would strongly encourage the JBC to consider eliminating the $18.8 million for the rate bump, based on the results of the third-party analysis that found no effect on provider participation, and the one-time nature of the funding provided in FY 2016-17.

The other FY 2017-18 funding policy option is whether to annually update vaccine stock rates to match retail rates. This reform is projected to result in a net savings, does not include any performance component, and would make the pricing of vaccines more consistent with the pricing of other pharmaceuticals. The change was not reviewed or recommended by the Medicaid Provider Rate Review Advisory Committee, but the JBC staff is comfortable recommending the change because it is a net savings, and because the resulting pricing will cover at least costs, so there is no threat to provider retention or access.

As noted previously, the JBC staff considers the offsetting rate changes to be forecast adjustments, rather than discretionary policy decisions. The changes to behavioral health capitation rates and hospital outpatient payment timing, which together save $49.9 million, including $18.8 million General Fund, will happen will happen with or without JBC approval, based on current policy.

Because the JBC has already approved a reduction of $15.4 million total funds, including $7.7 million General Fund, in the FY 2016-17 supplemental for the Hospital outpatient payment timing, the incremental change required to get to the Department's FY 2017-18 request is a net increase of $18.7 million total funds, including $7.5 million General Fund. This is the amount shown in the summary tables for the staff recommendation.

RECOMMENDED LEGISLATION AUTHORIZING PERFORMANCE PAYMENTS AND THE ACC

Communicating the JBC's recommendations on the request to the rest of the legislature presents challenges that the JBC staff believes are best addressed by introducing legislation to authorize the policy initiatives that the Department proposes. The Department wants to make major changes to the way it pays primary care and behavioral health providers to convert significant amounts of the current financing from fee-for-service payments to performance-based payments. In addition, the Department is proposing major changes to the Accountable Care Collaborative, including integrating physical and behavioral health and implementing mandatory enrollment. These changes will have profound effects on providers, the delivery system, and expenditures, but no fiscal impact in FY 2017-18 whatsoever. As a result, there would be nothing in the Long Bill to indicate whether the JBC recommends the new policy direction proposed by the Department or not. If, somehow, a legislator outside of the JBC learned of the JBC's intent and didn't agree with the policy direction, there would be nothing in the Long Bill for the legislator to amend.

A potential solution would be to include a footnote or footnotes in the Long Bill describing the assumptions regarding the performance based payments and the Accountable Care Collaborative that were used to make the appropriation. This would communicate the policy changes to legislators outside of the JBC and provide something for legislators who disagreed with the policy direction to

amend. However, footnotes cannot make substantive law and cannot administer the appropriation. The Department's authority to implement the performance based payments and Accountable Care Collaborative derives from current law, rather than from a footnote or footnotes in the Long Bill, and any amendment to a footnote or footnotes that the executive branch viewed as overly prescriptive might get vetoed or ignored.

The JBC staff believes that a better approach would be to authorize the performance based payments and Accountable Care Collaborative in substantive legislation that is separate from the Long Bill. The Department has broad statutory authority that could be used to implement both performance payments and the ACC, and so legislation authorizing the initiatives is not strictly necessary. However, specific authorizing legislation would provide the best vehicle for the General Assembly to debate the merits of the Department's proposed policies and to offer any feedback or guidance. If legislators want to stop the implementation, or direct that it occur in a different manner, the best way to do so would be through a bill. The JBC staff recommendation for legislation is about trying to offer the legislature the best vehicle for debate of the policies.

The JBC staff recommends that the legislation describe broadly the goals and objectives of the performance payments and the ACC, and include reporting requirements related to each. The JBC may also want to consider including procedures for involving stakeholders and approving changes. However, the Department has expressed anxiety that statutory procedures might conflict with stakeholder engagement that has already been done and cause the Department to have to replow seeded ground.

Initially, the JBC staff's biggest concern regarding procedures was that changes to payments be approved by the Medical Services Board to ensure accountability to an oversight entity. The Medical Services Board has the expertise to review the complicated clinical ramifications of the Department's proposals and the General Assembly has at least some influence over the Board through the confirmation process. The Department has convinced the JBC staff that current statutes are sufficient to ensure that the performance payments will be approved by the Medical Services Board. If the JBC approves a bill, the JBC staff would work with Legislative Legal Services to review whether statutory clarification is needed to ensure oversight by the Medical Services Board of the ACC.

The Department reports that draft performance payments have been well received by stakeholders and the Department has received praise for coordinating with other public and private initiatives that are also measuring performance to ensure that goals for providers are consistent across payers. However, the JBC staff sees a number of potential risks with performance payments. For example:

- The Department could implement performance based payments in a manner that increases overall expenditures.
- The Department could implement performance based payments that are so hard to achieve that providers lose needed funding.
- The Department could choose the wrong performance indicators that don't improve outcomes and cause providers to waste money chasing ineffective objectives.
- The performance payments could be too small to influence provider behavior.
- The performance payments could be too large, putting providers in financial jeopardy.

- The Department could manipulate performance payments to finance pet projects or reward favored providers.
- Providers may make practice decisions based on criteria independent of the performance payments.
- The performance objectives could change too frequently to provide meaningful incentives.
- There could be too few performance objectives, rewarding only particular providers.
- There could be too many performance objectives such that there is no focus.
- Measuring performance to make the payments could significantly increase the administrative burden on the Department and on providers.
- Tying payments to performance could encourage fraudulent reporting of performance and lead to policy decisions based on bad data.

An on-going statutory reporting requirement is a more than reasonable minimum expectation for the Department to help the General Assembly monitor the implementation of the performance payments.

Regarding the ACC, the JBC staff has concerns about whether the projected savings will actually be achieved, and believes that close monitoring is essential to ensure that the General Assembly is not building budgets based on assumptions about avoided costs that do not 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.

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 rather 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 in the first year of the ACC. If there is currently not much integration of physical and behavioral health services, then seeing 75 percent of SPMI and SUD clients in an integrated clinic in the first year of the ACC seems like an optimistic projection of the rate of practice transformation. If there is already a high degree of integration of physical and behavioral health services, or a movement toward integration, then that should be captured in the Department's forecast and the incremental change the Department attributes to the ACC may be overly generous.

The primary current reporting mechanism on the performance of the ACC is a request for information submitted by the JBC to the Governor. Requests for information are non-statutory and the Governor agrees or disagrees to submit the information voluntarily.

> 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.*

In addition to the annual Legislative Request for Information, there is a requirement in Section 25.5-5-417(2), C.R.S, that the Department provide an update on the ACC's influence on fraud, waste, and abuse to the committees of reference as part of the SMART Act hearings. This requirement led the Department to include one slide in the SMART Act presentation with "HB 13-1196: Reducing waste through the Accountable Care Collaborative" written on it, and that appears to be the extent of the written materials provided during the current legislative session.

The JBC staff proposes codifying the Legislative Request for Information in statute and merging the language in the Legislative Request for Information with the statutory report on the ACC and fraud, waste, and abuse, to create one comprehensive report.

In addition to providing authorization for the performance payments and the ACC, the JBC staff recommends that the legislation provide specific authorization for Delivery System Reform Incentive Payments (DSRIP) to hospitals and include $500,000 total funds, including $250,000 from the Hospital Provider Fee, for contract services to help design the demonstration waiver that would be necessary to implement them. This is a type of performance payment that the Department requested in R7 Oversight of state resources. The JBC staff believes the proposed DSRIP to hospitals conflicts with the existing statutory uses for the Hospital Provider Fee. The JBC staff is also recommending a bill related to the Hospital Provider Fee that could authorize the DSRIP, but DSRIP fits better with performance payments. See the recommendation on R7 for more detail.

Also, the JBC staff recommends that the legislation merge reporting requirements related to fraud that are in statute and a legislative request for information to request one comprehensive annual report on program integrity efforts. An argument could be made that this is ancillary to performance payments and the ACC, and therefore should be done in a separate bill, but the JBC staff assumes that the title of a performance payments/ACC bill will need to be broad and could probably be crafted to accommodate this otherwise fairly technical change. See the recommendation on R7 for more detail.

Finally, the JBC staff recommends that the legislation include $55,097, including $27,549 General Fund, for one new staff position to design differential payments for office-administered drugs that encourage utilization of high value drugs that are currently underutilized. This is a type of performance payment that the Department requested in R7 Oversight of state resources. See the recommendation on R7 for more detail.

If the JBC approves the staff recommendation, the JBC staff expects the fiscal note will show approximately the following costs:

Performance Payments/Accountable Care Collaborative Legislation					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2017-18					
DSRIP	$500,000	$0	$250,000	$250,000	
Office-administered drugs	55,097	27,549	0	27,548	0.9
TOTAL FY 2017-18	**$555,097**	**$27,549**	**$250,000**	**$277,548**	**0.9**
FY 2018-19					
Performance payments					
Contract performance evaluator	225,000	112,500	0	112,500	
Rate analyst	74,975	37,487	0	37,488	0.9
Primary care	60,413,683	21,051,321	1,199,912	38,162,450	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	26,717,069	7,215,319	1,090,836	18,410,914	
Subtotal - Performance payments	*$87,430,727*	*$28,416,627*	*$2,290,748*	*$56,723,352*	*0.9*
Accountable Care Collaborative (ACC)					
Administrative staff	327,767	163,884	0	163,883	3.7
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	
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	*($68,656,847)*	*($21,939,157)*	*($2,398,552)*	*($44,319,138)*	*3.7*
DSRIP	500,000	0	250,000	250,000	
Office-administered drugs	50,394	25,197	0	25,197	1.0
TOTAL FY 2018-19	**$19,324,274**	**$6,502,667**	**$142,196**	**$12,679,411**	**5.6**

The bill would not include the requested changes to vaccine stock rates or the offsetting rate changes in behavioral health capitation rates and hospital outpatient payment timing, as those costs would be accounted for in the Long Bill. These amounts could change based on specific language included in the bill by the JBC, or differences in forecasting by Legislative Council Staff Fiscal Notes. One side benefit of running a bill, although not a primary reason for the staff recommendation, is that another legislative budget analyst would review the Department's cost and savings assumptions. This might be particularly beneficial in looking at the savings assumptions for mandatory enrollment and the integration of physical and behavioral health.

➔ R7 OVERSIGHT OF STATE RESOURCES

REQUEST: The Department requests a net increase of $1.4 million total funds, including a decrease of $1.6 million General Fund, and an increase of 14.1 FTE for a number of initiatives the Department characterizes as related to the oversight of state resources. This is the total requested for the initiatives after funds already approved in the supplemental and includes $80,628 General Fund and 0.9 FTE for the Department of Human Services. The net General Fund savings is primarily due to an increase in the federal match for coordinating services to Native Americans and the anticipated savings from a proposed change to pricing for office-administered drugs.

RECOMMENDATION: The JBC staff recommends portions of the request for a net increase of $543,526 total funds, including a decrease of $1,793,771 General Fund, and 13.2 FTE. This is the total for all departments and includes FTE and operating expenses for the Department of Human

Services and the Office of the Governor. The table below summarizes the staff recommendation. Each component of the staff recommendation is discussed below the table.

R7 Oversight of State Resources					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Electronic verification of assets	$429,183	$214,592	$0	$214,591	0.0
Consumer directed care evaluation	422,000	211,000	0	211,000	0.0
Audit database	0	0	0	0	0.0
Project management staff	164,009	71,756	0	92,253	3.0
Audits of Community Mental Health Centers	204,000	102,000	0	102,000	0.0
Investigate fraud and abuse	(471,888)	(53,796)	(86,696)	(331,396)	5.5
Investigators	*390,547*	*195,276*	*0*	*195,271*	*5.5*
Anticipated cost savings	*(862,435)*	*(249,072)*	*(86,696)*	*(526,667)*	*0.0*
Native American health services	268,359	(2,180,169)	(133,388)	2,581,916	3.7
HCPF staff	*134,179*	*67,090*	*0*	*67,089*	*1.9*
Other department staff	*134,180*	*134,180*	*0*	*0*	*1.8*
Anticipated General Fund savings	*0*	*(2,381,439)*	*(133,388)*	*2,514,827*	*0.0*
Hospital Provider Fee model resources	67,993	0	33,997	33,996	1.0
Office-administered drugs	(540,130)	(159,154)	(20,039)	(360,937)	0.0
Recalibrate rates	*39,320*	*11,586*	*1,459*	*26,275*	*0.0*
Anticipated cost savings	*(579,450)*	*(170,740)*	*(21,498)*	*(387,212)*	*0.0*
TOTAL	**$543,526**	**($1,793,771)**	**($206,126)**	**$2,543,423**	**13.2**
Human Services	67,090	67,090	0	0	0.9
Office of the Governor	67,090	67,090	0	0	0.9
Health Care Policy and Financing	409,346	(1,927,951)	(206,126)	2,543,423	11.4

ELECTRONIC VERIFICATION OF ASSETS: The Department requests and the JBC staff recommends $429,183 total funds, including $214,592 General Fund, to design, build, and operate a system for the electronic verification of assets for aged, blind, and disabled applicants for Medicaid as required by federal regulation. The electronic verification of assets will reduce the need for applicants to provide paper verification, thereby simplifying the application process and reducing errors and incomplete verifications. The Department expects the system to be fully operational by January 2018 and ongoing annual electronic verification costs would be $858,366 total funds, including $429,183 General Fund. This is a continuation of the request approved by the JBC during the supplemental.

CONSUMER DIRECTED CARE EVALUATION: The Department requests and the JBC staff recommends $422,000 total funds, including $211,000 General Fund, for a one-year study of Consumer Directed Attendant Support Services (CDASS) and In-home Support Services (IHSS). The study would use survey tools to quantify the impact of CDASS and IHSS on health outcomes, quality of life, member independence, and service satisfaction relative to other care options.

Both CDASS and IHSS allow clients to direct and manage attendants who provide personal care, homemaker, and health maintenance services. In CDASS attendants work directly for the client while in IHSS the attendants work through a home health agency. The CDASS and IHSS programs are offered under some, but not all, Home and Community Based Services waivers. Recently, CDASS was expanded to the Supported Living Services waiver for people with intellectual and developmental disabilities. There have been discussions about expanding consumer directed care to other Medicaid benefits, such as respite care.

In a May 2015 report[3] the State Auditor recommended a comprehensive analysis of CDASS, noting that program costs were 58-86 percent higher than other service delivery options. The Auditor cited inadequate data to evaluate the effectiveness of the program in the areas of client acuity, health outcomes, and cost drivers. The State Auditor's Office concluded, "Although we recognize that a comprehensive analysis of Program cost-effectiveness will require resources, based on the Department's initial analysis and our review of Program costs, which appear significantly higher than alternative options, additional analysis appears warranted."

The State Auditor's recommendation was made in May 2015 and the Department agreed to "investigate the possibility of requesting funding through the state's Budget process" with a targeted implementation date of July 2016, but the Department did not submit a budget request for FY 2016-17 due to overall constraints on the budget and where this study fit in the Governor's priorities. The current request is consistent with the recommendation of the State Auditor and the JBC staff recommends approval.

AUDIT DATABASE: The Department requests, but the JBC staff does not recommend, $70,182 total funds, including $35,091 General Fund, for a new audit database. The Department uses the audit database to track compliance with findings of the State Auditor (like the one on consumer directed care noted above), the Office of the Inspector General, the Centers for Medicare and Medicaid Services, and the General Accountability Office. The Department's current audit database uses outdated technology and certain reporting functions are inoperable.

The Department submitted a similar request last year, but the JBC approved a staff recommendation that the Department instead work with the Governor's Office of Information Technology to use pool funds allocated to that agency for miscellaneous projects of this nature. The Department describes a Catch 22 where the JBC has directed that the project be funded with OIT pool funds, but OIT is putting a low priority on the project in part because it does not have a dedicated fund source from the General Assembly. Other factors in the low OIT priority ranking for the project include the limited statewide impact and the presence of other more critical projects in the queue.

The JBC staff position on this request has not changed from last year. To the JBC staff, a specialized database solution to the Department's needs feels like technology overkill. The Department reports there are currently 18 active audits and each audit has multiple recommendations. If there are 200 active recommendations (11 per active audit), or even if there are twice that many, it seems like the Department could track the status of the recommendations in a spreadsheet. If the Department wants a little bit more in the way of search functions, date tracking, or delegation functions, then maybe project management software or a database might provide benefits, but there are off-the-shelf options that don't require trained IT staff to configure for relatively simple needs. These off-the-shelf options are purchasable within the Department's existing resources. The Department says it wants the database to include follow-up responses, so if there is staff turnover the information is in a central, easily retrievable location. To the JBC staff this seems like it could be addressed with a good filing system. For the second year in a row the JBC staff feels that the Department has not presented sufficient justification of the need for a database and the low priority ranking of this project by OIT serves to confirm the staff impression.

[3] http://leg.colorado.gov/sites/default/files/documents/audits/1413p_-_cdass_performance_audit_may_2015.pdf

PROJECT MANAGEMENT STAFF: The Department requests and the JBC staff recommends, with modifications, 3.0 FTE project management staff. The JBC staff modification is to apply the JBC's common policies regarding benefits for new FTE to reduce the total cost from the requested $202,436 total funds, including $88,578 General Fund, to $164,009, including $71,767 General Fund.

The FTE would help the Department with large, multi-year projects that involve multiple program areas. The Department believes project management staff would help ensure these large scale activities are completed on time and on budget with the minimum disruption to normal work flow. Typical activities for the project management staff would include identifying tasks that are dependent on the completion of other tasks and developing work plans and timelines to sequence tasks accordingly, assigning tasks and preventing duplication of effort, tracking progress and new issues, monitoring budgets related to the work plan, facilitating communication between programs and with management to resolve problems, and verifying completion of milestones.

The Department hopes to establish a project management office in house to assist with future projects, such as changes to the Medicaid Management Information System, the State Innovation Model that uses federal grant funds to coordinate physical and behavioral health, the consolidation of Home- and Community-Based Services (HCBS) waivers, and the implementation of the Community Living Advisory Group recommendations. The Department has previously employed temporary contract project management staff for several efforts, including the Accountable Care Collaborative Phase II, vendor transitions, and the reprocurement of the Medicaid Management Information System (MMIS). The Department believes these activities have progressed more smoothly as a result of the involvement of professional project management staff.

An in-house project management office would be familiar with the Department and presumably operate more efficiently than contracted staff that work on one project and then leave without being able to apply lessons learned to other initiatives. The Department also notes that federal regulations require the application of some specific project management principals and techniques to receive enhanced federal matching funds of between 75 and 90 percent for information technology development and maintenance. An in house project management office would know the specific principals and techniques required to comply with federal regulations.

The Department regularly engages in a sufficient number of large and complex projects that would benefit from project management staff to justify an in-house project management office. Without in-house staff, the Department would need to contract for services on a project by project basis. This might be more cost effective if there was a small volume of projects that would benefit from project management services, or if there were gaps between projects. The last few years, the Department has had multiple projects every year that would benefit from project management services, and the JBC staff anticipates that this pattern will continue. If changes to the Medicaid program being discussed at the federal level are implemented, there might be a spike in business transformation projects the Department is engaged in that would benefit from project management services. The Department would be better prepared to handle a spike in projects, whether caused by a change in federal policies or other factors, with an in-house project management office.

AUDITS OF COMMUNITY MENTAL HEALTH CENTERS: The Department requests and the JBC staff recommends $204,000 total funds, including $102,000 General Fund, to perform annual audits of cost reports submitted by Community Mental Health Centers. The cost reports are one of the inputs used to set rates for the Behavioral Health Organizations that subcontract with the

Community Mental Health Centers. The Department recently conducted an audit of the cost reports from the four largest Community Mental Health Centers, using money provided by the JBC in FY 2015-16 to do sampling audits of managed care organizations on a rotating basis. Based on the findings from that audit, the Department believes it would be in the state's interest to audit all of the cost reports from the Community Mental Health Centers on an annual basis, rather than doing sampling audits every few years. The Department's audit identified $12 million in incorrectly reported costs for the four largest Community Mental Health Centers, which resulted in inflated rates paid to the Behavioral Health Organizations. The relationship between the incorrectly reported costs and the rates paid is not one for one, as other factors play into the rates, such as trend and utilization data, risk corridors, and medical loss ratios. Calculations of recoupments for FY 15-16 are not complete, and so the Department was unable to identify the total overpayment. The Department estimates that subcontracts from the Behavioral Health Organizations to the Community Mental Health Centers total approximately $370 million annually and notes that the Community Mental Health Centers also contract with the Office of Behavioral Health in the Department of Human Services.

Although the JBC staff is recommending the request, the JBC staff has concerns about the administrative burden on the Community Mental Health Centers of cooperating with annual audits, and wonders if periodic random auditing might be a more cost effective approach for improving reporting accuracy. After consulting with the JBC analyst for the Office of Behavioral Health, the JBC staff was convinced there would be cross-over benefits for the Office of Behavioral Health, where there have been major issues with determining what is appropriately charged to Medicaid vs the Office of Behavioral Health. More accurate cost reports would also help with policy analysis of the adequacy of the behavioral health delivery system. These cross-over benefits convinced the JBC staff to recommend the request.

INVESTIGATE FRAUD AND ABUSE: The Department requests $470,675 total funds, including $235,340 General Fund, for six investigators of fraud and abuse (5.5 FTE in the first year), but the JBC staff recommends $390,547, including $195,276 General Fund, after application of the JBC's common policies regarding benefits for new FTE. The Department anticipates the new staff will more than pay for themselves in avoided expenditures for fraudulent and inappropriate billing. The Department estimates savings in the first year, when the new hires are in training, of $862,435 total funds, including $249,072 General Fund. In out years the Department estimates savings of $1,724,870 total funds, including $498,144 General Fund. In addition, the JBC staff recommends a statutory change to merge an annual legislative request for information from the JBC with a statutory reporting requirement, and improve the requested information to get a more comprehensive picture of program integrity efforts. This recommendation only applies if the JBC decides to carry the legislation recommended in R6, and the title of the bill is sufficiently broad to include the merging of the reports. Otherwise, the JBC staff would recommend continuing the separate reports.

Some specific areas of need identified by the Department include: smaller improper claims that don't meet the threshold for fraud and where, as a result, there is no financial incentive for counties to investigate; fraud that crosses county boundaries; cases that involve opioids or durable medical equipment that tend to be more complex and difficult to investigate; and complex cases where assistance has been requested by counties, law enforcement, the US Drug Enforcement Agency, district attorneys, the Attorney General, and/or the US Assistant Attorney.

The Department assumes that the average recoveries per new staff person in the program integrity division are equal to the current average recoveries per staff person. By this logic, the JBC could keep adding new resources for fraud investigations to achieve more savings, which is clearly not the case. At some point there are diminishing returns from adding new resources to investigate fraud. In FY 2015-16 the JBC added a request for information asking the Department to report on the cost effectiveness of fraud detection efforts. The JBC staff assumes the purpose of the request for information was to introduce some accountability to ensure that the Department was achieving the expected return on investment, and that the frequent requests from the Department for additional funding for fraud investigations were not resulting in diminishing returns.

The text of the request for information is:

> 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.*

The Department has interpreted the legislative request for information as applying only to the prepayment analytics intended to prevent inappropriate payments before they occur, because the request was added in conjunction with JBC approval of new resources for prepayment analytics. The JBC staff would note that nothing in the language of the request suggests that it should be limited to just prepayment analytics. Regarding prepayment analytics, the Department reported that it is still developing and evaluating the technology and that new post-payment predictive analytic software included as part of the new MMIS is a necessary prerequisite to design the prepayment predictive analytics program. The Department also reported that other states with prepayment 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 that information. The funding provided to develop prepayment predictive analytics has been used to inform the design of the MMIS to accommodate the technology. The Department also reported that it is researching opportunities for additional federal funding. This response from the Department suggests that a new request for resources related to prepayment predictive analytics might be forthcoming in a future year.

In addition to the report in response to the legislative request for information, the Department submits an annual report[4] in response to Section 25.51-115.5, C.R.S., on the amount of fraud and trends in methods used to commit fraud. The statutory requirement doesn't specifically address cost effectiveness. The Department has interpreted this statutory report as applying to county fraud investigations, since it was added by S.B. 12-060 (Roberts/Gerou) that concerned cost sharing with counties of fraud recoveries. The report identified $1.1 million in recoveries self-reported by counties. It did not include the $2.6 million in recoveries the Department attributed in R7 to current program integrity staff. Nor did it include recoveries by the Department's contractors. In response to a separate question by the JBC staff, the Department estimated that recoveries including recoveries by contractors totaled $13.4 million in FY 2015-16.

Rather than having two separate reports with the Department interpreting each as being very narrow in scope, the JBC staff would like to see one report that provides a more comprehensive look at the Department's efforts to improve program integrity, and the overall cost effectiveness of those

[4] https://www.colorado.gov/pacific/sites/default/files/Improving%20Medicaid%20Fraud%20Prosecution%20Report.pdf

efforts. If this recommendation is approved, the JBC staff would work with the Department to develop appropriate language that the Department will interpret as seeking a comprehensive review of program integrity efforts.

NATIVE AMERICAN HEALTH SERVICES: The Department requests, and the JBC staff recommends, with modifications, four new staff (3.7 FTE in the first year) to better coordinate health services for Native Americans. The first modification is to put the funding for one of the FTE in the Lt. Governor's Office and the second modification is to apply the JBC's common policies regarding benefits for new FTE and correct a minor calculation error by the Department to reduce the total cost from the requested $322,508 total funds, including $241,884 General Fund, to $268,359, including $201,270 General Fund. With the additional staff, the Department anticipates some Medicaid services will qualify for a 100 percent federal match, resulting in a savings of $2,381,439 General Fund that offsets the General Fund cost of the new FTE.

In February 2016 the Centers for Medicare and Medicaid Services (CMS) issued new guidance expanding the health services to Native Americans that are eligible for a 100 percent federal match to include services coordinated by an IHS facility as well as those delivered by an IHS facility. The additional staff requested would develop policies and procedures for documenting coordination with IHS facilities to claim the 100 percent federal match and perform outreach to eligible members and stakeholders.

The Department hopes improving coordination with IHS facilities will help address issues with Native Americans having to travel long distances to receive affordable care at an IHS facility, and issues where a lack of coordination of care between IHS facilities and outside providers has resulted in Native Americans paying more for care or foregoing costly care. These issues were identified in a recent study by the Department and the Colorado Commission on Indian Affairs.

Of the new positions, two would be at the Department of Health Care Policy and Financing to coordinate health care issues between Medicaid providers and federal Indian Health Services (IHS) and tribal governments, one would be in the Lieutenant Governor's Office for the Commission of Indian Affairs to lead the initiative, and one would be located in the Department of Human Services in the Office of Behavioral Health to train and provide technical assistance to behavioral health providers. The Governor requested that the position for the Commission of Indian Affairs be appropriated in the Department of Health Care Policy and Financing, but work through a memorandum of understanding for the Commission. The JBC staff recommends just appropriating the FTE to the Lt. Governor's Office.

Of the FTE, the two at the Department of Health Care Policy and Financing represent the minimum necessary to earn the enhanced federal match that generates the General Fund savings. The other two positions are more focused on outreach and improving services and could potentially be eliminated, if the JBC is concerned about adding new FTE. The JBC staff is recommending the outreach positions based on the access to care issues for Native Americans identified in the request.

HOSPITAL PROVIDER FEE MODEL RESOURCES: The Department requests and the JBC staff recommends, with modifications, additional resources, including 1.0 FTE, to help administer the Hospital Provider Fee model. The first modification is to remove $500,000 in contractor funding and put it in the recommended bill authorizing performance payments that is discussed under R6 above. The second modification is to apply the JBC's common policies regarding benefits for new

FTE. The two modifications combined reduce the cost from the requested $581,612 total funds, including $290,808 cash funds from the Hospital Provider Fee, to $67,993, including $33,997 from the Hospital Provider Fee. This is the net remaining after accounting for $100,000 total funds that the JBC approved in the supplemental.

As requested, the money would be used to: (1) hire a more qualified contractor to score hospital performance for the Hospital Quality Incentive Payments (HQIP) program; (2) provide additional support for the preparation, development, maintenance, and modifications to the model that distributes the Hospital Provider Fee booster payments; and (3) help develop the application for a Section 1115 demonstration waiver that would make a larger portion of hospital reimbursements dependent on performance. The Department indicates there have been issues with the accuracy and timeliness of both the HQIP scoring and the distribution model for the booster payments. These have required some large end-of-year reconciliations and led to $8 million in disallowances identified by the Centers for Medicare and Medicaid services that hospitals have had to pay. The Department also reports complaints by legislators about a lack of transparency for the Hospital Provider Fee model that the Department attributes in part to inadequate resources.

The $500,000 in contract services that the JBC staff recommends including in the legislation authorizing performance payments is for Delivery System Reform Incentive Payments (DSRIP) that would convert a portion of existing Hospital Provider Fee booster payments to performance-based payments. In addition to the general recommendations about authorizing performance payments in legislation, as discussed under R6 above, in this particular case the JBC staff has concerns that the proposed DSRIP payments conflict with existing statute. The Hospital Provider Fee statutes make a distinction between payments to "maximize the inpatient and outpatient hospital reimbursements" and "quality incentive payments". The quality incentive payments are specifically capped in statute at no more than 7 percent of the Hospital Provider Fee payments. The proposed DSRIP would cause more than 7 percent of Hospital Provider Fee payments to be awarded based on quality, and so the JBC staff believes a statutory change is necessary. The Department disagrees and argues that DSRIP is different than HQIP and only HQIP is capped at 7 percent. The Department believes DSRIP could fit within payments to "maximize the inpatient and outpatient hospital reimbursements". The JBC staff believes that argument is a stretch and the JBC staff is already recommending legislation to authorize performance payments, so the JBC staff recommends making the statutory change and the appropriation in that legislation.

OFFICE-ADMINISTERED DRUGS: The Department requests and the JBC staff recommends, with modifications, periodically updating the pricing for office-administered drugs to encourage more providers in cost-effective settings to offer services, as recommended by the Medicaid Provider Rate Review Advisory Committee. The modification is to separate $67,538, including $33,772 General Fund, for 1.0 FTE from the rest of the request, apply the JBC's common policies regarding benefits for new FTE, and then put the remaining funding in the recommended bill authorizing performance payments discussed under R6 above. The result of the modification is to reduce the amount included in the Long Bill from the requested $106,858 total funds, including $45,.58 General Fund, and 0.9 FTE to $39,320 total funds, including $11,586 General Fund, and no FTE. The Department projects that repricing office-administered drugs will result in a net savings of $579,450 total funds, including $170,740 General Fund. The projected savings come from people migrating from receiving these drugs in more expensive settings, such as hospitals, to receiving them during a physician visit. There may also be an increase in utilization that results in savings as these long-acting

drugs are more effective at controlling symptoms that can result in hospitalizations than alternatives, but the Department did not attempt to estimate this impact.

The Department proposes that rates would be increased to an average of 2.5 percent over average sales price. The margin is to account for administrative costs of stocking the medicine and is similar to how the Department pays pharmacies for administrative expenses in addition to drug expenses. However, the Department requests flexibility to set the rates for some drugs at higher than 2.5 percent over average sales price and other drugs at lower than 2.5 percent. The purpose of differentiating the pricing is to encourage increased utilization of drugs the Department believes are especially effective and currently underutilized. In other words, the purpose is to encourage improved performance through differentiated pricing. The JBC staff assumes that repricing to 2.5% above the published average sales price is a simple task that could be accomplished without additional FTE and that the requested FTE is to differentiate the pricing for some drugs above or below the 2.5% target to encourage performance and to track the results and make modifications over time. The JBC staff believes an FTE to implement performance funding for office-administered drugs would be better placed in the recommended bill authorizing performance funding than in the Long Bill.

➔ R10 REGIONAL CENTER TASK FORCE

REQUEST: 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.

RECOMMENDATION: The staff recommendation will be handled during figure setting for the Office of Community Living. Amounts associated with this decision item appear in some of the summary tables because there are line items in the Executive Director's Office that are affected by the request, but these amounts are just the Department's request and do not represent the final staff recommendation.

➔ R11 VENDOR TRANSITIONS

REQUEST: 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.

RECOMMENDATION: Staff recommends approval of the request. The General Assembly has provided one-time funding in prior years of a similar nature for other contracts that were being reprocured in order to ensure a smooth transition to the new vendor. Of the request, $2.1 million total funds, including $680,400 General Fund is attributable to the reporcurement of the Accountable Care Collaborative (ACC). The JBC staff considered recommending that this be

included in the legislation recommended in the discussion of R6 above, but decided that there would be costs regardless of whether the Department implemented the proposed new initiatives in Phase II of the ACC. The complexity of the initiatives proposed in Phase II of the ACC causes the Department to estimate a slightly higher transition cost than it would if the Department was reprocuring the exact same program, but it would be difficult to separate the marginal difference for inclusion in the proposed legislation.

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. The sources of cash funds and reappropriated funds reflect the Department's financing as a whole and the programs supported by the FTE in the division. The largest source of cash funds for the division is the Hospital Provider Fee.

EXECUTIVE DIRECTOR'S OFFICE						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 Appropriation						
HB 16-1405 (Long Bill)	$272,118,432	$63,269,353	$31,588,960	$3,828,984	$173,431,135	397.5
Other Legislation	1,524,631	343,067	381,040	0	800,524	2.8
SB 17-162 (Supplemental Bill)	4,176,324	(2,035,726)	1,012,577	(35,666)	5,235,139	0.0
TOTAL	**$277,819,387**	**$61,576,694**	**$32,982,577**	**$3,793,318**	**$179,466,798**	**400.3**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$277,819,387	$61,576,694	$32,982,577	$3,793,318	$179,466,798	400.3
R7 Oversight of state resources	1,811,911	861,714	33,997	0	916,200	11.4
R8 MMIS Operations	23,499,620	(572,612)	2,953,578	(275,978)	21,394,632	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	621,676	73,518	0	0	548,158	0.0
R11 Vendor transitions	498,458	249,229	0	0	249,229	0.0
R12 Local Public Health Agency partnerships	0	0	0	0	0	0.0
R13 Quality of care and performance improvement projects	708,339	315,420	0	0	392,919	0.0
BA9 Pueblo Regional Center corrective action plan	296,240	148,120	0	0	148,120	0.0
BA10 Regional Center cost reporting	0	0	0	0	0	0.0
BA13 Connect for Health Colorado	0	0	0	0	0	0.0
NP OIT CBMS	73,522	(930,212)	757,510	(2,349)	248,573	0.0
Transfers to other state agencies	1,430,126	507,431	0	0	922,695	0.0
Centrally appropriated line items	1,308,522	431,137	96,045	21,801	759,539	0.0
Indirect cost adjustment	215,804	(215,804)	32,729	327,295	71,584	0.0
Standard federal match	0	0	0	6,020	(6,020)	0.0
Annualize prior year budget actions	(32,821,181)	(1,900,500)	(1,122,584)	6,702	(29,804,799)	0.3
TOTAL	**$276,492,992**	**$60,801,779**	**$35,724,633**	**$3,876,809**	**$176,089,771**	**413.8**
INCREASE/(DECREASE)	**($1,326,395)**	**($774,915)**	**$2,742,056**	**$83,491**	**($3,377,027)**	**13.5**
Percentage Change	(0.5%)	(1.3%)	8.3%	2.2%	(1.9%)	3.4%
FY 2017-18 EXECUTIVE REQUEST	**$278,374,533**	**$63,540,333**	**$34,219,670**	**$3,661,005**	**$176,953,525**	**415.6**
Request Above/(Below) Recommendation	$1,881,541	$2,738,554	($1,504,963)	($215,804)	$863,754	1.8

DECISION ITEMS - EXECUTIVE DIRECTOR'S OFFICE

➔ R8 MMIS OPERATIONS

REQUEST: The Department requests changes to the multi-year reprocurement of the Medicaid Management Information System (MMIS) project. In FY 2017-18 and on-going total estimated expenditures are higher, but the General Fund share of costs is lower. This request affects FY 2016-17 as well as FY 2017-18 and beyond. The requested changes are to account for a delay in implementation, changes in estimated costs for certain components, new federally required features, and revised estimates of fund sources and federal financial participation levels. The table below summarizes projected changes by fiscal year.

S8/R8 MMIS Operations				
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Total	($1,495,480)	$23,524,339	$5,707,012	5,707,012
FTE	0.0	1.8	2.0	2.0
General Fund	(32,549)	(566,430)	(1,641,310)	(1,656,576)
Cash Funds	(537,805)	2,953,578	2,253,604	2,286,321
Reappropriated Funds	(269,394)	(275,978)	(281,168)	(281,146)
Federal Funds	(655,732)	21,413,169	5,375,886	5,358,413

RECOMMENDATION: Staff recommends approval of the request, which includes a change to FY 2016-17, except with a modification to apply the JBC's common policies related to benefits for new FTE, which reduces the FY 2017-18 cost by $24,719, including $6,182 General Fund.

ANALYSIS: The request includes several changes in assumed match rates. The Department's updated funds source estimates are influenced by an increase in the federal financial participation rate for the Children's Basic Health Plan, higher enrollment from populations financed with the Hospital Provider Fee, and lower enrollment from populations financed with the Old Age Pension Health and Medical Care Program. Revised projections indicate costs for commercial off-the-shelf software products that receive a 75 percent federal match are lower than originally anticipated, but system development costs that receive a 90 percent federal match rate are higher than expected. This causes changes in the estimated costs by both line item and fund source.

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

Also, the MMIS will take over some functions previously performed by contractors financed through other line items, and so the Department is requesting a budget true up to match the services provided by different contractors.

The table below summarizes key factors driving the increase in overall costs. The table reflects the JBC staff recommendation to apply the JBC's common policies regarding benefits for new FTE.

S8/R8 MMIS Operations				
	FY 16-17	FY 17-18	FY 18-19	FY 19-20
Implementation delay	($4,282,319)	$4,282,319	$0	0
Call Center	94,345	188,690	0	0
Case management	1,383,762	5,881,998	941,368	941,368
Federal regulations	211,164	4,633,488	633,488	633,488
Breaking the system into modules	*0*	*4,000,000*	*0*	*0*
Co-payment notifications	*211,164*	*633,488*	*633,488*	*633,488*
Issues identified in development	4,906,382	4,597,889	0	0
Transfer from Medical Services Premiums	0	3,000,000	3,000,000	3,000,000
Commercial off-the-shelf products	1,971,973	806,832	996,664	996,664
Contract administrators	0	108,404	135,492	135,492
Denied enhanced match	(6,203,115)	0	0	0
TOTAL	**($1,495,480)**	**$23,499,620**	**$5,707,012**	**5,707,012**
FTE	0.0	1.8	2.0	2.0
General Fund	(32,549)	(572,612)	(1,641,310)	(1,656,576)
Cash Funds	(537,805)	2,953,578	2,253,604	2,286,321
Reappropriated Funds	(269,394)	(275,978)	(281,168)	(281,146)
Federal Funds	(655,732)	21,394,632	5,375,886	5,358,413

- *IMPLEMENTATION DELAY:* The implementation of the MMIS was originally scheduled for October 31, 2016, but was postponed four months to March 1, 2017. Provider enrollment and revalidation took longer than expected and provider training was delayed. In addition, the Department had concerns that testing was insufficient to assure that the launch would be free of major errors that could result in improper or delayed payments. As a result of the delay, the Department expects $4.3 million in expenses for some development activities that were expected to occur after the go live date will shift from FY 2016-17 into FY 2017-18.
- *CALL CENTER:* The Department 10 additional temporary staff to handle expected increased call volume during the transition to the new system.
- *CASE MANAGEMENT:* One of the larger factors driving the increase in overall costs is the development of the module that supports case management for services for people with intellectual and developmental disabilities. The request includes for this component an additional $1.4 million in FY 2016-17, $5.9 million in FY 2017-18, and $941,368 ongoing. The Department assumed 200 licenses and potential simultaneous users based on the number of offices, rather than the number of case managers. The revised cost estimate assumes initial configuration for 3,500 licenses and potential simultaneous users, including security upgrades for a more public-facing interface. The legacy systems are antiquated, presenting significant data transition challenges. When the original estimates for this module were made the services for people with intellectual and developmental disabilities and their associated information technology systems were housed at the Department of Human Services, contributing to the Department's misunderstanding of the scope of the project.

  FEDERAL REGULATIONS: The request includes $4.0 million total funds to break the system into independent modules in response to a new federal regulation. The regulation requires that pieces of the system be severable so that in the future states don't have to spend several years planning and procuring monolithic systems and being beholden to the success or failure of a single key contractor. The new regulation applies to future requests for federal funding, but the regulation reflects best practice recommendations and the Department believes this upfront investment will make compliance in the future with the new regulation more achievable. The Department has already pulled the single MMIS contract apart into three different contracts with different

vendors and the requested funding would make technical changes to further divide the system into manageable modules. In addition, the request includes $211,164 in FY 2016-17 and $633,488 in FY 2017-18 and beyond for costs to notify clients and providers when a client reaches federal limits on annual copayments. This is required by existing federal regulation, but the previous MMIS did not have the capacity to generate the notifications.

- *ISSUES IDENTIFIED IN DEVELOPMENT*: The request includes $6.4 million in FY 2016-17 and $4.4 million in FY 2017-18 to address a backlog of change requests identified during development. These are primarily functions the Department didn't anticipate needing, but users identified as essential to business practices once they began working with and testing the new system. It also includes a few miscellaneous one-time programming or software costs that the Department didn't fully anticipate.
- *TRANSFER FROM MEDICAL SERVICES PREMIUMS:* The request includes a transfer of $3.0 million from the Medical Services Premiums line item for the Statewide Data Analytics Contractor who tracks performance metrics for the Accountable Care Collaborative. There is a corresponding decrease to the Medical Services Premiums line item built into the Department's forecast request R1 Medical Services Premiums. The work was previously done by a separate contractor, but the new MMIS will include the necessary data analysis tools.
- *COMMERCIAL OFF-THE-SHELF PRODUCTS:* The request reflects a number of updated estimates for the costs associated with commercial off-the-shelf products.
- *CONTRACT ADMINISTRATORS:* The request includes $133,123 for two contract administrators (1.8 FTE in the first year) to deal with the increasing complexity of the MMIS-related contracts, to hold contractors accountable for performance, and to work with contractors to quickly complete any future needed amendments.
- *DENIED ENHANCED MATCH:* The Department received direction from the federal Centers for Medicare and Medicaid Services (CMS) that some contract services would be financed at a 50 percent federal match rate, rather than the 90 percent federal match rate assumed in the original plan. This caused the Department to reevaluate the need for contract services and reduce planned utilization for these activities to stay within the total General Fund appropriation.

➔ R9 LONG-TERM CARE UTILIZATION MANAGEMENT

REQUEST: 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. The Department assumes it would complete the procurement process and enter the contract by April 1, 2018. The annualized cost of the contract in FY 2018-19 is estimated at $4.0 million total funds, including $958,901 General Fund. 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:

11 Perform acuity assessments for brain injury services, removing a conflict of interest when providers currently perform this function

12 Monitor critical incident reports, including validating what occurred, elevating high priority events that require immediate follow-up, and tracking outcomes

13 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

14 Score applications for performance funding from the nursing facility provider fee in place of the current contractor who performs this function

15 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

16 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

17 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

18 Review under- and over-utilization of services and ensure that service plans are being updated appropriately when client circumstances change

19 Audit case management activities of Community Centered Boards and Single Entry Point agencies

20 Review increased applications for the Children's Extensive Support waiver as a result of removing the wait list for services

RECOMMENDATION: Staff recommends approval of the request to address a number of deficiencies in the Department's management of long-term services and supports, and to take advantage of enhanced federal funding to minimize the General Fund cost. Each of the proposed contract services addresses a deficiency in protecting client safety, compliance with federal regulations, best practices, or ensuring financial accountability. Some of the services that the Department proposes outsourcing might be better performed in-house, but claiming the enhanced federal match would require a level of time tracking that would make it impractical. Since outsourcing gains the enhanced federal match the General Fund cost is lower.

R9 Long-term care utilization management				
	TOTAL	GF	CF	FF
FY 2017-18				
Brain Injury Acuity Assessments	$14,985	$3,747	$0	$11,238
Critical Incidents	306,085	76,522	0	229,563
Over Cost Containment	39,100	9,775	0	29,325
Nursing Facility Pay for Performance	36,875	0	9,219	27,656
Nursing Home Client Income Deductions	88,400	22,100	0	66,300
HCBS Payment Review	133,875	33,469	0	100,406
Service Limits Review	35,063	8,766	0	26,297
Under- and Over-Utilization of Services Review	81,120	20,280	0	60,840
Audit Case Management by CCBs and SEPs	162,240	40,560	0	121,680
Children's Extensive Support Services Applications	169,700	42,425	0	127,275
TOTAL	**$1,067,443**	**$257,644**	**$9,219**	**$800,580**

R9 Long-term care utilization management				
	TOTAL	GF	CF	FF
FY 2018-19				
Brain Injury Acuity Assessments	$59,940	$14,985	$0	$44,955
Critical Incidents	1,224,340	306,085	0	918,255
Over Cost Containment	156,400	39,100	0	117,300
Nursing Facility Pay for Performance	147,500	0	36,875	110,625
Nursing Home Client Income Deductions	353,600	88,400	0	265,200
HCBS Payment Review	535,500	133,875	0	401,625
Service Limits Review	351,645	87,912	0	263,733
Under- and Over-Utilization of Services Review	324,480	81,120	0	243,360
Audit Case Management by CCBs and SEPs	648,960	162,240	0	486,720
Children's Extensive Support Services Applications	180,735	45,184	0	135,551
TOTAL	**$3,983,100**	**$958,901**	**$36,875**	**$2,987,324**

➔ R12 LOCAL PUBLIC HEALTH AGENCY PARTNERSHIPS

REQUEST: 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.

RECOMMENDATION: Staff recommends no funding based on the JBC's actions during figure setting for the Department of Public Health and Environment. If the JBC approves a comeback on the Department of Public Health and Environment's request, then a corresponding adjustment will be made to the appropriation for the Department of Health Care Policy and Environment.

➔ R13 QUALITY OF CARE AND PERFORMANCE IMPROVEMENT PROJECTS

REQUEST: 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. This would allow the Department to address complaints with the providers. 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 the elderly and people with disabilities and expand the frequency and depth of the survey of people with intellectual and developmental disabilities. The surveys of the elderly, people with disabilities, and people with intellectual and developmental disabilities address health outcomes, protection of patient rights, staff stability and

competency, community integration, and family outcomes and the results can be compared to other participating states. Expanding the surveys as proposed would allow the Department to use the surveys toward meeting federally requirements around a Quality Improvement Strategy. Currently, data on member satisfaction is missing from the QIS. The Department views the reports as valuable in assessing system performance. 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.

RECOMMENDATION: Staff recommends approval of the request. The possible actions the Department can take based on issues identified in the CAHPS survey are severely limited without provider-specific information. The surveys of the elderly, people with disabilities, and people with intellectual and developmental disabilities provide metrics to help the Department improve the performance of one of the more expensive parts of the delivery system, and to monitor quality issues for vulnerable populations. The program improvement projects are required by federal regulation.

The Department received short duration federal funds to pilot the survey of the elderly and people with disabilities. That portion of the request, estimated to cost $250,500, including $131,500 General Fund, could be viewed as backfilling federal funds. However, the JBC staff believes the Department would have developed a survey of this type to fill a gap in the federally required Quality Improvement System regardless of whether the federal funding for the pilot had been provided. The JBC staff views the federal funds as offsetting the development costs for a necessary and appropriate survey, rather than creating demand for a program that didn't exist and then expecting the state to pick up the cost.

➔ BA9 PUEBLO REGIONAL CENTER CORRECTIVE ACTION PLAN

REQUEST: The Department requests funding to comply with a federal corrective action plan related to the Pueblo Regional Center.

RECOMMENDATION: The staff recommendation will be handled during figure setting for the Office of Community Living. Amounts associated with this decision item appear in some of the summary tables because there are line items in the Executive Director's Office that are affected by the request, but these amounts are just the Department's request and do not represent the final staff recommendation.

➔ BA10 REGIONAL CENTER COST REPORTING

REQUEST: The Department requests $75,000 total funds, including $37,500 General Fund, to hire a contractor to audit Colorado's regional centers and calculate their rates to ensure the Regional Centers are being properly compensated for the services they provide.

RECOMMENDATION: Staff recommends approval of the request based on the JBC's actions during the supplemental for the Office of Community Living. In the summary tables this amount appears

as a net zero, because the funding was already added in FY 2016-17 and is just continuing at the same level for FY 2017-18.

➔ BA13 CONNECT FOR HEALTH COLORADO

REQUEST: The Department requests $5.1 million, including $1.8 million General Fund, to reimburse Connect for Health Colorado (C4HCO) for activities related to determining eligibility for Medicaid and the Children's Basic Health Plan (CHP+).

RECOMMENDATION: Staff recommends approval of the total funds, but with the state share coming from certified public expenditures, rather than the General Fund, based on the JBC's actions during the supplemental for the Executive Director's Office. In the summary tables this amount appears as a net zero, because the funding was already added in FY 2016-17 and it is just continuing at the same level for FY 2017-18.

LINE ITEM DETAIL — EXECUTIVE DIRECTOR'S OFFICE

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, employee-related expenses and benefits, operating expenses, and general contract services. This subdivision also contains funding for all of the centrally appropriated line items in the Department.

STATUTORY AUTHORITY: Section 25.5-1-104 et. seq., C.R.S.

LINE ITEMS SET BY JBC COMMON POLICY

The majority of line items in this subdivision are centralized appropriations that the JBC sets through common policies. In most cases the common policy allocates costs to agencies for a centralized service based on prior year actual utilization of that service by the department. Rather than discussing the staff recommendation for each line item individually, this section deals with all the line items set through JBC common policies at once. Line items that are not set by common policy are discussed individually following this section. This grouping of the staff recommendations on line items that are set through common policies is intended to simplify the narrative, but it does cause the descriptions of some line items to appear in an order that is different than the order in the numbers pages and in the Long Bill.

REQUEST: The Department requests:

- Annualizations of prior year bills and budget actions
- Application of the OSPB common policies
- Benefits associated with the new FTE requested in *R7 Oversight of state resources* and *R8 MMIS operations*

RECOMMENDATION: Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below, including the way benefits for new FTE are handled.

Note that the JBC's common policy was pending for some of the line items at the time this document was prepared. The amounts included in the numbers pages and department and division summary tables for the pending items are based on the request and will be updated to reflect the JBC's actions.

Health, Life, and Dental	
Short-term Disability	
Amortization Equalization Disbursement	
Supplemental AED	
Salary Survey	
Merit Pay	
Workers' Compensation	
Legal Services	Pending
Administrative Law Judge Services	
CORE Operations	
Payment to Risk Management and Property	
Capitol Complex Leased Space	
Payments to OIT	Pending

PERSONAL SERVICES

This line item contains all of the personal services for the Department's employees, including employee salaries and the employer contributions to PERA and Medicare taxes. The line item also includes funding for temporary employees, employee buy-outs, and some contract services. However, most of the Department's professional contract service costs are contained in separate line items.

REQUEST: The Department requests:

- R7 Oversight of state resources
- R8 Medicaid Management information System operations
- R11 Vendor transitions
- Annualizations of prior year bills and budget actions

STAFF RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. In addition to the items requested by the Department, the JBC staff recommendation includes an adjustment to the fund sources to account for the increase in statewide indirect cost recoveries available to offset the need for General Fund for the line item.

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, PERSONAL SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$29,515,964	$10,173,953	$2,936,203	$1,564,801	$14,841,007	397.5
Other Legislation	$191,257	$37,495	$58,134	$0	$95,628	2.8
TOTAL	**$29,707,221**	**$10,211,448**	**$2,994,337**	**$1,564,801**	**$14,936,635**	**400.3**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$29,707,221	$10,211,448	$2,994,337	$1,564,801	$14,936,635	400.3
R7 Oversight of state resources	702,239	309,928	31,170	0	361,141	11.4
R8 MMIS Operations	97,098	24,275	0	0	72,823	1.8
R11 Vendor transitions	26,448	13,224	0	0	13,224	0.0
Annualize prior year budget actions	43,602	128,487	(48,330)	898	(37,453)	0.3
Indirect cost adjustment	0	(215,804)	0	215,804	0	0.0
TOTAL	**$30,576,608**	**$10,471,558**	**$2,977,177**	**$1,781,503**	**$15,346,370**	**413.8**
INCREASE/(DECREASE)	**$869,387**	**$260,110**	**($17,160)**	**$216,702**	**$409,735**	**13.5**
Percentage Change	2.9%	2.5%	(0.6%)	13.8%	2.7%	3.4%
FY 2017-18 EXECUTIVE REQUEST	**$30,706,680**	**$10,792,716**	**$2,977,177**	**$1,565,699**	**$15,371,088**	**415.6**
Request Above/(Below) Recommendation	$130,072	$321,158	$0	($215,804)	$24,718	1.8

OPERATING EXPENSES

This line item pays for operating expenses associated with the staff at the Department. Examples of the expenditures include software/licenses, office supplies, office equipment, utilities, printing, and travel.

Request: The Department requests:

- R7 Oversight of state resources
- R8 Medicaid Management information System operations
- Annualizations of prior year bills and budget actions

STAFF RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$2,045,965	$930,064	$65,869	$10,449	$1,039,583	0.0
Other Legislation	$12,573	$635	$5,653	$0	$6,285	0.0
TOTAL	**$2,058,538**	**$930,699**	**$71,522**	**$10,449**	**$1,045,868**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$2,058,538	$930,699	$71,522	$10,449	$1,045,868	0.0
R7 Oversight of state resources	54,489	24,194	2,827	0	27,468	0.0
R8 MMIS Operations	11,306	2,827	0	0	8,479	0.0
Annualize prior year budget actions	(22,964)	(6,736)	(4,083)	0	(12,145)	0.0
TOTAL	**$2,101,369**	**$950,984**	**$70,266**	**$10,449**	**$1,069,670**	**0.0**

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
INCREASE/(DECREASE)	**$42,831**	**$20,285**	**($1,256)**	**$0**	**$23,802**	**0.0**
Percentage Change	2.1%	2.2%	(1.8%)	0.0%	2.3%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$2,107,022**	**$953,810**	**$70,266**	**$10,449**	**$1,072,497**	**0.0**
Request Above/(Below) Recommendation	$5,653	$2,826	$0	$0	$2,827	0.0

LEASE SPACE

This line item pays for the Department's leased space at 225 E. 16th Street and 303 E. 17th Ave.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding based on the lease costs.

SCHOLARSHIPS FOR RESEARCH USING THE ALL-PAYER CLAIMS DATABASE

This line item provides scholarships for nonprofit and governmental entities to defray the cost of access to the All-Payer Claims Database to conduct research.

REQUEST: The Department requests continuation funding of $500,000.

RECOMMENDATION: Staff recommends the requested continuation funding. This line item was added by the General Assembly in FY 2014-15 and the JBC staff assumes the intent was to provide on-going funding.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility Fee, Nursing Home Penalties, and the IDD Services Cash Fund. The federal match rate varies based on the specific contracts.

REQUEST: The Department requests:

- R7 Oversight of state resources
- R8 Medicaid Management Information System operations
- R9 Long-term care utilization management
- R13 Quality of care and performance improvement projects
- BA9 Pueblo Regional Center corrective action plan

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. The amount for the *BA9 Pueblo Regional Center*

corrective action plan is pending figure setting for the Office of Community Living and the amount table reflects the Governor's request, rather than the staff recommendation.

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION					
HB 16-1405 (Long Bill)	$6,625,237	$1,947,261	$1,227,500	$3,450,476	0.0
Other Legislation	$575,000	$100,000	$300,000	$175,000	0.0
SB 17-162 (Supplemental Bill)	$200,000	$50,000	$50,000	$100,000	0.0
TOTAL	**$7,400,237**	**$2,097,261**	**$1,577,500**	**$3,725,476**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION					
FY 2016-17 Appropriation	$7,400,237	$2,097,261	$1,577,500	$3,725,476	0.0
R7 Oversight of state resources	851,183	425,592	0	425,591	0.0
R8 MMIS Operations	(750,000)	(187,500)	0	(562,500)	0.0
R9 Long-term care utilization management	(36,875)	0	(18,438)	(18,437)	0.0
R13 Quality of care and performance improvement projects	708,339	315,420	0	392,919	0.0
BA9 Pueblo Regional Center corrective action plan	267,864	133,932	0	133,932	0.0
Annualize prior year budget actions	555,240	465,120	(300,000)	390,120	0.0
TOTAL	**$8,995,988**	**$3,249,825**	**$1,259,062**	**$4,487,101**	**0.0**
INCREASE/(DECREASE)	**$1,595,751**	**$1,152,564**	**($318,438)**	**$761,625**	**0.0**
Percentage Change	21.6%	55.0%	(20.2%)	20.4%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$9,566,170**	**$3,284,916**	**$1,509,062**	**$4,772,192**	**0.0**
Request Above/(Below) Recommendation	$570,182	$35,091	$250,000	$285,091	0.0

(B) TRANSFERS TO OTHER DEPARTMENTS

PUBLIC HEALTH AND ENVIRONMENT

FACILITY SURVEY AND CERTIFICATION

This line item pays the Department of Public Health and Environment to monitor a variety of long-term care providers for safety and compliance with Medicaid regulations, including nursing homes, hospices, home health agencies, alternative care facilities, personal care/homemaking agencies, and adult day services. This monitoring is performed as part of the Department of Public Health and Environment's larger function of establishing and enforcing standards of operation for health care facilities. Financing for the Medicaid-related regulation is provided as follows:

Minimum Data Set resident assessment (used to determine nursing home patient acuity, which is a consideration in the nursing home reimbursement formula)	100% General Fund
In-the-field surveys and inspections	75% federal match
Office time preparing reports and administering the program	50% federal match

REQUEST: The Department requests annualizations of prior year budget decisions and nonprioritized adjustments for decision items submitted by the Department of Public Health and

Environment related to health facility inspection staff and to IDD provider and facility inspection staff.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

PRENATAL STATISTICAL INFORMATION

This line item pays the Department of Public Health and Environment to collect and analyze data, through the Vital Statistics office, on the effectiveness of the Enhanced Prenatal Care program, more commonly known as Prenatal Plus. This program provides case management, nutrition, and mental health counseling for women assessed as at-risk for delivering low birth weight infants. The services address lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect pregnancy. Services are paid for in the Medical Services Premiums line item. This appropriation covers only the data collection and evaluation performed by the Department of Public Health and Environment. The federal match rate is 50 percent.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding based on the JBC's decisions during figure setting for the Department of Public Health and Environment.

LOCAL PUBLIC HEALTH AGENCIES

This is a new line item being requested as part of *R12 Local Public Health Agency partnerships*.

REQUEST: The Department requests creation of the line item in *R12 Local Public Health Agency partnerships*.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

HUMAN SERVICES

NURSE HOME VISITOR PROGRAM

This line item pays a portion of the cost for nurses to visit first-time mothers in families with incomes up to 200 percent of the federal poverty guidelines to provide education on nutrition and general child care and to promote the health and development of children. Funding for the program is appropriated to the Department of Human Services and then a portion is transferred to the Department of Health Care Policy and Financing to match federal funds for Medicaid-eligible clients. The original source of funding is Tobacco Master Settlement Agreement moneys. Although the Department of Human Services is the lead agency for financing, the program is actually

administered by the University of Colorado Health Sciences Center. The federal match rate is at the standard FMAP for Medicaid services.

STATUTORY AUTHORITY: Section 25-31-102, C.R.S.

REQUEST: The Department requests adjustments to account for the change in the FMAP rate.

Recommendation: Staff recommends the requested total funding and the adjustment to the fund sources for the change in the FMAP. Based on prior year actual expenditures, this is probably more spending authority than the line item needs, but if fewer Medicaid-eligible clients are served, then the Department of Human Services will transfer less to the Department of Health Care Policy and Financing and use the tobacco settlement monies instead to serve clients who are not eligible for Medicaid.

REGULATORY AGENCIES

NURSE AIDE CERTIFICATION

This line item pays for the Department of Regulatory Agencies to certify nurse aides working in facilities with Medicaid patients. The Department of Regulatory Agencies also receives payments from Medicare. The reappropriated funds are fees for background checks transferred from the Department of Regulatory Affairs. Only non-certified nurses are required to pay the fees. The federal match rate is 50 percent.

STATUTORY AUTHORITY: Section 12-38.1-101 et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding based on the JBC's actions during figure setting for the Department of Regulatory Agencies. The money is transferred to the Division of Registrations in the Department of Regulatory Agencies.

REVIEWS

This line item pays the Department of Regulatory Affairs to conduct sunset reviews of programs administered by the Department of Health Care Policy and Financing. The federal match rate depends on the program being reviewed.

STATUTORY AUTHORITY: Section 24-34-104, et seq., C.R.S.

REQUEST: The Department requests funding for two reviews, each projected to cost $5,000.

RECOMMENDATION: Staff recommends a total of $5,120 based on the number of sunset reviews scheduled for FY 2017-18.

REGULATION OF MEDICAID TRANSPORTATION PROVIDERS

This line item pays for limited regulation permits of Medicaid non-emergency transportation providers pursuant to H.B. 16-1097 (Coram & Moreno/Scott). Vehicle inspection costs are eligible

for a 50 percent federal match, but other costs are 100 percent General Fund. The money received by the Public Utilities Commission is continuously appropriated.

STATUTORY AUTHORITY: Section 40-10.1-302(2)(b)(II), C.R.S.

REQUEST: The Department requests annualization of the appropriation provided in H.B. 16-1097.

RECOMMENDATION: Staff recommends the requested funding to annualize H.B. 16-1097.

EDUCATION

PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION
This line item offsets costs of the Department of Education for the Public School Health Services program. The program is jointly administered by the Department of Health Care Policy and Financing and the Department of Education. Pursuant to statute, up to 10 percent of the federal funds received for the program may be retained for administration and these moneys are allocated between the two departments according to an interagency agreement. The source of funding used to match the federal funds is certified public expenditures by school districts. Please see the line item "Public School Health Services" in the Other Medical Services division for a discussion of the projected certified public expenditures and a description of program costs.

STATUTORY AUTHORITY: Section 25.5-5-318, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Education. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the Department of Education funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

LOCAL AFFAIRS

HOME MODIFICATIONS BENEFIT ADMINISTRATION AND HOUSING ASSISTANCE PAYMENTS
This appropriation pays the Department of Local Affairs to administer the existing Medicaid home modifications benefit. In addition, the Department of Local Affairs assists clients of the Colorado Choice Transitions (CCT) program in acquiring housing. The federal match rate is 50 percent for administration.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Local Affairs. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the Department of Local Affairs funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

This line item pays for maintenance of the Medicaid Management Information System (MMIS) and the Web Portal. MMIS processes Medicaid claims, performs electronic prior authorization reviews for certain medical services, transmits data so that payments can be made to providers, and manages information about Medicaid beneficiaries and services. The Web Portal provides a front-end interface for providers to submit electronic information to MMIS, the Colorado Benefits Management System, and the Benefits Utilization System in a format that complies with the confidentiality standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives an 88 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

STATUTORY AUTHORITY: Section 25.5-4-204, C.R.S.

REQUEST: The Department requests:

- R8 MMIS operations
- R10 Regional center task force
- Annualizations of prior year budget requests.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. The amount for *R10 Regional center task force* is pending figure setting for the Office of Community Living and the amount table reflects the Governor's request, rather than the staff recommendation.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$35,263,793	$7,198,178	$2,209,009	$293,350	$25,563,256	0.0
Other Legislation	$301,027	$12,850	$17,253	$0	$270,924	0.0
SB 17-162 (Supplemental Bill)	$0	$0	$0	$0	$0	0.0
TOTAL	**$35,564,820**	**$7,211,028**	**$2,226,262**	**$293,350**	**$25,834,180**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$35,564,820	$7,211,028	$2,226,262	$293,350	$25,834,180	0.0
R8 MMIS Operations	5,501,405	(1,526,183)	2,078,236	(281,542)	5,230,894	0.0
R10 Regional Center task force	593,300	59,330	0	0	533,970	0.0
Annualize prior year budget actions	(124,067)	173,924	(34,454)	0	(263,537)	0.0

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
TOTAL	**$41,535,458**	**$5,918,099**	**$4,270,044**	**$11,808**	**$31,335,507**	**0.0**
INCREASE/(DECREASE)	**$5,970,638**	**($1,292,929)**	**$2,043,782**	**($281,542)**	**$5,501,327**	**0.0**
Percentage Change	16.8%	(17.9%)	91.8%	(96.0%)	21.3%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$41,535,458**	**$5,918,099**	**$4,270,044**	**$11,808**	**$31,335,507**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REPROCUREMENT CONTRACTED STAFF

This line items pays for contracted staff for the renewal of the Department's claims processing hardware and software.

STATUTORY AUTHORITY: Section 25.5-4-204, C.R.S.

REQUEST: The Department annualizations of prior year budget decisions to eliminate this line item as the work need for the contracted staff is complete.

RECOMMENDATION: Staff recommends the request based on the procurement schedule and expected expenditures for the contracts.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MMIS REPROCUREMENT CONTRACTED STAFF						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$5,145,018	$431,304	$134,757	$0	$4,578,957	0.0
SB 17-162 (Supplemental Bill)	$0	$0	$0	$0	$0	0.0
TOTAL	**$5,145,018**	**$431,304**	**$134,757**	**$0**	**$4,578,957**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$5,145,018	$431,304	$134,757	$0	$4,578,957	0.0
Annualize prior year budget actions	(5,145,018)	(431,304)	(134,757)	0	(4,578,957)	0.0
TOTAL	**$0**	**$0**	**$0**	**$0**	**$0**	**0.0**
INCREASE/(DECREASE)	**($5,145,018)**	**($431,304)**	**($134,757)**	**$0**	**($4,578,957)**	**0.0**
Percentage Change	(100.0%)	(100.0%)	(100.0%)	0.0%	(100.0%)	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$0**	**$0**	**$0**	**$0**	**$0**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTS

This line items pays for reprocruement contracts for the renewal of the Department's claims processing hardware and software.

REQUEST: The Department requests R8 MMIS Operations and annualizations of prior year budget decisions.

RECOMMENDATION: Staff recommends the request based on the procurement schedule and expected expenditures for the contracts.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MMIS REPROCUREMENT CONTRACTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$26,916,597	$2,615,317	$701,879	$0	$23,599,401	0.0
SB 17-162 (Supplemental Bill)	$0	$0	$0	$0	$0	0.0
TOTAL	**$26,916,597**	**$2,615,317**	**$701,879**	**$0**	**$23,599,401**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$26,916,597	$2,615,317	$701,879	$0	$23,599,401	0.0
R8 MMIS Operations	18,546,779	1,034,108	875,342	5,564	16,631,765	0.0
Annualize prior year budget actions	(26,916,597)	(2,615,317)	(701,879)	0	(23,599,401)	0.0
TOTAL	**$18,546,779**	**$1,034,108**	**$875,342**	**$5,564**	**$16,631,765**	**0.0**
INCREASE/(DECREASE)	**($8,369,818)**	**($1,581,209)**	**$173,463**	**$5,564**	**($6,967,636)**	**0.0**
Percentage Change	(31.1%)	(60.5%)	24.7%	0.0%	(29.5%)	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$18,546,779**	**$1,034,108**	**$875,342**	**$5,564**	**$16,631,765**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

FRAUD DETECTION SOFTWARE CONTRACT

This line item pays for maintenance and upgrades of software that detects payment, utilization, and referral patterns that may be indicators of fraud, waste, or abuse. It also monitors compliance issues and statistics related to fraud investigative costs.

STATUTORY AUTHORITY: Section 25.5-4-301, C.R.S.

REQUEST: The Department requests R8 MMIS Operations

RECOMMENDATION: Staff recommends the requested funding, consistent with the recommendation on R8 and the ongoing contract.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, FRAUD DETECTION SOFTWARE CONTRACT				
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION				
HB 16-1405 (Long Bill)	$250,000	$62,500	$187,500	0.0
TOTAL	**$250,000**	**$62,500**	**$187,500**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION				
FY 2016-17 Appropriation	$250,000	$62,500	$187,500	0.0
R8 MMIS Operations	(135,000)	(34,155)	(100,845)	0.0
TOTAL	**$115,000**	**$28,345**	**$86,655**	**0.0**
INCREASE/(DECREASE)	**($135,000)**	**($34,155)**	**($100,845)**	**0.0**
Percentage Change	(54.0%)	(54.6%)	(53.8%)	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$115,000**	**$28,345**	**$86,655**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	0.0

CBMS OPERATING AND CONTRACT EXPENSES

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

REQUEST: The Department requests NP OIT CBMS and annualizations of prior year budget actions.

RECOMMENDATION: Staff recommends the requested adjustments based on the JBC's decisions during figure setting for the Governor's Office of Information Technology.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING AND CONTRACT EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$23,132,658	$7,691,683	$3,319,100	$87,981	$12,033,894	0.0
SB 17-162 (Supplemental Bill)	(1,276,246)	(2,135,711)	(832,685)	(34,760)	1,726,910	0.0
TOTAL	**$21,856,412**	**$5,555,972**	**$2,486,415**	**$53,221**	**$13,760,804**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$21,856,412	$5,555,972	$2,486,415	$53,221	$13,760,804	0.0
NP OIT CBMS	70,509	(930,917)	756,715	(2,357)	247,068	0.0
Annualize prior year budget actions	1,622,219	594,629	210,805	6,702	810,083	0.0
TOTAL	**$23,549,140**	**$5,219,684**	**$3,453,935**	**$57,566**	**$14,817,955**	**0.0**
INCREASE/(DECREASE)	**$1,692,728**	**($336,288)**	**$967,520**	**$4,345**	**$1,057,151**	**0.0**
Percentage Change	7.7%	(6.1%)	38.9%	8.2%	7.7%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$23,549,140**	**$5,219,684**	**$3,453,935**	**$57,566**	**$14,817,955**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

CBMS HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

REQUEST: The Department requests NP OIT CBMS.

RECOMMENDATION: Staff recommends the request based on the JBC's decisions during figure setting for the Governor's Office of Information Technology.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION						
HB 16-1405 (Long Bill)	$648,441	$232,139	$90,321	$2,617	$323,364	0.0
SB 17-162 (Supplemental Bill)	$33,362	$12,485	$4,805	($906)	$16,978	0.0
TOTAL	**$681,803**	**$244,624**	**$95,126**	**$1,711**	**$340,342**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$681,803	$244,624	$95,126	$1,711	$340,342	0.0
NP OIT CBMS	3,013	705	795	8	1,505	0.0
TOTAL	**$684,816**	**$245,329**	**$95,921**	**$1,719**	**$341,847**	**0.0**
INCREASE/(DECREASE)	**$3,013**	**$705**	**$795**	**$8**	**$1,505**	**0.0**
Percentage Change	0.4%	0.3%	0.8%	0.5%	0.4%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$684,816**	**$245,329**	**$95,921**	**$1,719**	**$341,847**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS

This line item funds Medicaid's participation in the Health Information Exchange (HIE) network that allows the sharing of health data between providers.

Request: The Department requests annualizations of prior year budget decisions

Recommendation: Staff recommends the requested funding based on the previously approved development and maintenance schedule for the Health Information Exchange.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS				
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION				
HB 16-1405 (Long Bill)	$10,622,455	$2,046,246	$8,576,209	0.0
TOTAL	**$10,622,455**	**$2,046,246**	**$8,576,209**	**0.0**

FY 2017-18 RECOMMENDED APPROPRIATION				
FY 2016-17 Appropriation	$10,622,455	$2,046,246	$8,576,209	0.0
Annualize prior year budget actions	(2,550,000)	(155,000)	(2,395,000)	0.0
TOTAL	**$8,072,455**	**$1,891,246**	**$6,181,209**	**0.0**
INCREASE/(DECREASE)	**($2,550,000)**	**($155,000)**	**($2,395,000)**	**0.0**
Percentage Change	(24.0%)	(7.6%)	(27.9%)	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$8,072,455**	**$1,891,246**	**$6,181,209**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	0.0

CONNECT FOR HEALTH COLORADO SYSTEMS

This was a new line item added during the supplemental to reimburse Connect for Health for eligibility determination assistance provided to applicants for Medicaid and the Children's Basic Health Plan.

REQUEST: The Department requests BA13 Connect for Health Colorado to continue the additional funding provided in the Supplemental.

RECOMMENDATION: The JBC staff recommends the same total funds as the request, but with the state share of costs coming from certified public expenditures, consistent with the JBC's actions during the supplemental.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

Funding in this line item pays for production of authorization cards for Medicaid and the Old Age Pension State Medical Program. The source of cash funds is the Hospital Provider Fee. The source of reappropriated funds is a transfer from the Old Age Pension Medical Program in the Other Medical Services division. The federal match rate is 50.0 percent for Medicaid cards. There is no federal match for the Old Age Pension State Medical Program.

STATUTORY AUTHORITY: Section 25.5-4-102, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding. The number of cards required each year is dependent not only on caseload, but also turnover. Periodically the Department will submit requests to update the estimate based on changing patterns in the number of cards needed, but not typically every year.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission

and resident assessments are also required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital. The sources of cash funds are the Hospital Provider Fee and Colorado Autism Treatment Cash Fund.

STATUTORY AUTHORITY: Sections 25.5-4-105, 25.5-6-104, 25.5-4-205, and 25.5-4-402.3, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding based on the ongoing eligibility determination requirements and outstationing costs.

COUNTY ADMINISTRATION

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. At one point there was an expectation that counties contribute 20 percent toward the total, but over the years the legislature has approved initiatives without requiring an increase in county matching funds and the federal government has increased the federal match rate so that in FY 2015-16 county funds represent just under 13 percent of the appropriation. The traditional federal match was 50 percent, but a recent reinterpretation by the Centers for Medicare and Medicaid Services (CMS) expanded the activities eligible for a 75 percent match as maintenance and operations of eligibility determination systems. There are no matching federal funds for eligibility determinations for the Old Age Pension State Medical Program.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding for this on-going need.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item was created to separate the funding for eligibility determinations for expansion populations authorized through the Health Care Affordability Act (H.B. 09-1293) from the funding for other populations. The state match for eligibility determinations for the expansion populations authorized by H.B. 09-1293 is funded entirely with the Hospital Provider Fee with no local county match.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding for this on-going need.

ADMINISTRATIVE CASE MANAGEMENT

This line item provides Medicaid funding for qualifying expenditures associated with state supervision and county administration of programs that protect and care for children (out-of-home placement, subsidized adoptions, child care, and burial reimbursements). The primary activity reimbursed through this line item is completing, or assisting a child or family in the child welfare system to complete, a Medicaid application. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

MEDICAL ASSISTANCE SITES

This line item pays Medical Assistance sites for their work in processing applications.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CUSTOMER OUTREACH

This line item provides funding for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program provides outreach and case management services to promote access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and regulations. The source of cash funds is the Hospital Provider Fee. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-5-102 (1) (g) and 25.5-5-406 (1) (a) (II), C.R.S.

REQUEST: The Department requests R11 Vendor transitions and annualizations of prior year budget actions.

RECOMMENDATION: Staff recommends the requested funding. See the recommendation on R11 for more detail.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT

This line item pays a contractor to process applications and determine eligibility for the Children's Basic Health Plan (CHP+). It also includes money for determining Medicaid eligibility for adults without dependent children and the Medicaid buy-in for people with disabilities. The source of cash

funds is the Hospital Provider Fee. The federal match rate varies based on the type of work and the population served. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. For populations that are "newly eligible" pursuant to the ACA the match rate is higher.

STATUTORY AUTHORITY: Section 25.5-4-102, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CONNECT FOR HEALTH COLORADO ELIGIBILITY DETERMINATIONS

This was a new line item added during the supplemental to reimburse Connect for Health for eligibility determination assistance provided to applicants for Medicaid and the Children's Basic Health Plan.

REQUEST: The Department requests *BA13 Connect for Health* to continue the supplemental S13 by the same name.

RECOMMENDATION: Staff recommends the requested total funds, but the state share from certified public expenditures, rather than the General Fund, consistent with the JBC's action on the supplemental.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

This line item contains the professional contracts related to reviewing acute care utilization, long-term care utilization, external quality review, drug utilization review, and mental health quality review. These contracts ensure that the benefits and services provided to Medicaid clients are medically necessary and appropriate.

Acute care utilization performs prior authorization review for services such as transplants, out-of-state elective admissions, inpatient mental health services, inpatient substance abuse rehabilitation, durable medical equipment, non-emergent medical transportation, home health service reviews, and physical and occupational therapy. It also includes retrospective reviews of inpatient hospital claims to ensure care was medically necessary, required an acute level of care, and was coded and billed correctly. The federal match rate is 75.0 percent.

Long-term care utilization review includes prior authorization reviews to determine medical necessity, level of care, and target population determinations. It also includes periodic reevaluations of services. The federal match for the majority of services is 75.0 percent.

External quality review handles provider credentialing, including activities such as verifying licensure and certification information, validating Healthcare Effectiveness Data and Information Set

(HEDIS) measures, and reviewing provider performance improvement projects. The federal match rate is 75.0 percent.

Mental health external quality review is very similar to the external quality review, but for mental health providers. The federal match rate is 75.0 percent.

Drug utilization review performs prior authorization reviews, retrospective reviews, and provider education to ensure appropriate drug therapy according to explicit predetermined standards.

STATUTORY AUTHORITY: Sections 25.5-5-405, 506, and 411, C.R.S.

REQUEST: The Department requests R8 MMIS operations, R9 Long-term care utilization management, and annualizations of prior year budget decisions.

RECOMMENDATION: Staff recommends the requested funding. See the discussion of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, UTILIZATION AND QUALITY REVIEW CONTRACTS, PROFESSIONAL SERVICE CONTRACTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION					
HB 16-1405 (Long Bill)	$11,985,007	$3,452,759	$461,089	$8,071,159	0.0
Other Legislation	$202,856	$50,714	$0	$152,142	0.0
TOTAL	**$12,187,863**	**$3,503,473**	**$461,089**	**$8,223,301**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION					
FY 2016-17 Appropriation	$12,187,863	$3,503,473	$461,089	$8,223,301	0.0
R9 Long-term care utilization management	905,203	217,084	9,219	678,900	0.0
Annualize prior year budget actions	119,999	30,000	0	89,999	0.0
R8 MMIS Operations	(96,968)	(48,484)	0	(48,484)	0.0
TOTAL	**$13,116,097**	**$3,702,073**	**$470,308**	**$8,943,716**	**0.0**
INCREASE/(DECREASE)	**$928,234**	**$198,600**	**$9,219**	**$720,415**	**0.0**
Percentage Change	7.6%	5.7%	2.0%	8.8%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$13,116,097**	**$3,702,073**	**$470,308**	**$8,943,716**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	0.0

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.

- Hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Centers -- These federally-required audits focus on costs and rate data and serve as the basis for reimbursement. Most of the audits are completed from the Medicare cost report and tailored to Medicaid requirements.
- Single Entry Point Agencies -- Cost reports for all 23 Single Entry Point agencies are reviewed, and on-site audits are conducted to the extent possible within the appropriation.
- Payment Error Rate Measurement Project -- Each state must estimate the number of Medicaid payments that should not have been made or that were made in an incorrect amount, including underpayments and overpayments, every three years according to a staggered schedule set up by the federal government.
- Nursing facility appraisals -- Every four years this audit determines the fair rental value (depreciated cost of replacement) for nursing facilities for use in the rate setting process. The next appraisal will occur in FY 2014-15.
- Colorado Indigent Care Program -- These audits are similar to the Medicaid audits of hospitals, FQHCs and RHCs, but for the indigent care program, rather than the Medicaid program.
- Disproportionate Share Hospital Audits -- This federally-required audit looks at qualifying expenditures for Disproportionate Share Hospital (DSH) payments. These payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients.
- Primary Care Program – These audits improve performance and ensure sound fiscal management of the Primary Care Program.

The sources of cash funds are the Hospital Provider Fee, Nursing Facility Fee, CHP+ Trust, and Primary Care Fund. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-6-201 and 202, 25.5-4-401 (1) (a), 25.5-4-402, 25.5-5-408 (1) (d), 25.5-6-106, 25.5-6-107, 25.5-4-105, and 25.5-4-402.3 (3) (a), C.R.S.

REQUEST: The Department requests R10 Oversight of state resources, R9 Long-term care utilization management, BA10 Regional Center cost reporting, to add to the entities audited. The Department also requests annualizations of prior year budget actions.

RECOMMENDATION: Staff recommends the request, consistent with the recommendations on the decisions items.

EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION					
HB 16-1405 (Long Bill)	$3,401,907	$1,266,408	$415,408	$1,720,091	0.0
SB 17-162 (Supplemental Bill)	$75,000	$37,500	$0	$37,500	0.0
TOTAL	**$3,476,907**	**$1,303,908**	**$415,408**	**$1,757,591**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION					
FY 2016-17 Appropriation	$3,476,907	$1,303,908	$415,408	$1,757,591	0.0
R7 Oversight of state resources	204,000	102,000	0	102,000	0.0
R9 Long-term care utilization	162,240	40,560	0	121,680	0.0

EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
management					
BA10 Regional Center cost reporting	0	0	0	0	0.0
Annualize prior year budget actions	(588,501)	(147,125)	(102,988)	(338,388)	0.0
TOTAL	**$3,254,646**	**$1,299,343**	**$312,420**	**$1,642,883**	**0.0**
INCREASE/(DECREASE)	**($222,261)**	**($4,565)**	**($102,988)**	**($114,708)**	**0.0**
Percentage Change	(6.4%)	(0.4%)	(24.8%)	(6.5%)	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$3,254,646**	**$1,299,343**	**$312,420**	**$1,642,883**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	0.0

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The program pursues recoveries from estates and places liens on property held by Medicaid clients in nursing facilities or clients over the age of 55. The contractor works on a contingency fee basis. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

STATUTORY AUTHORITY: Section 25.5-4-301, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

(H) INDIRECT COSTS

STATEWIDE INDIRECT COST ASSESSMENT

This line item finances the Department's indirect cost assessment according to the state plan. The state plan takes costs associated with agencies such as the Governor's Office, the Department of Personnel, and the Department of Treasury that are not directly billed and allocates these costs to each state department. The departments are then responsible for collecting the money from the various sources of revenue that support their activities. Pursuant to JBC policy, the money collected is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The indirect cost assessment on a department can change from year to year based on changes in the total statewide indirect cost pool or based on changes in the allocation of costs. The allocation of costs complies with criteria of the Government Accounting Standards Bureau (GASB).

REQUEST: The Department requests an indirect cost adjustment based on OSPB's common policies.

RECOMMENDATION: Staff recommends the request based on the indirect cost plan approved by the JBC.

(2) MEDICAL SERVICES PREMIUMS

This division provides funding for physical health and most long-term services and supports for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term services and supports for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. There is only one line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

MEDICAL SERVICES PREMIUMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 Appropriation						
HB 16-1405 (Long Bill)	$6,762,815,547	$1,948,969,728	$678,702,748	$5,240,893	$4,129,902,178	0.0
Other Legislation	55,449,048	(6,529,960)	27,005,372	0	34,973,636	0.0
SB 17-162 (Supplemental Bill)	126,254,607	24,497,845	1,650,193	3,861,816	96,244,753	0.0
Long Bill supplemental	(150,381,550)	(30,568,837)	(8,451,937)	0	(111,360,776)	0.0
TOTAL	**$6,794,137,652**	**$1,936,368,776**	**$698,906,376**	**$9,102,709**	**$4,149,759,791**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$6,794,137,652	$1,936,368,776	$698,906,376	$9,102,709	$4,149,759,791	0.0
R1 Medical Services Premiums	641,554,433	111,659,372	164,816,795	(71,665)	365,149,931	0.0
R6 Delivery system and payment reform	45,370,739	14,735,125	903,427	0	29,732,187	0.0
R7 Oversight of state resources	(1,402,565)	(2,789,665)	(240,123)	0	1,627,223	0.0
R11 Vendor transitions	2,100,000	680,400	369,600	0	1,050,000	0.0
Standard federal match	0	7,907,160	555,023	0	(8,462,183)	0.0
ACA "Newly eligible" federal match	0	0	46,060,326	0	(46,060,326)	0.0
Annualize prior year budget actions	(65,371,483)	2,560,513	(26,875,847)	0	(41,056,149)	0.0
SUBTOTAL - LONG BILL	**$7,416,388,776**	**$2,071,121,681**	**$884,495,577**	**$9,031,044**	**$4,451,740,474**	**0.0**
R1 Restrict Hosptial Provider Fee revenue	(390,000,000)	0	(195,000,000)	0	(195,000,000)	0.0
Set-aside for SB 17-091	2,211,530	1,025,567	18,216	0	1,167,747	0.0
TOTAL ALL LEGISLATION	**$7,028,600,306**	**$2,072,147,248**	**$689,513,793**	**$9,031,044**	**$4,257,908,221**	**0.0**
INCREASE/(DECREASE)	**$234,462,654**	**$135,778,472**	**($9,392,583)**	**($71,665)**	**$108,148,430**	**0.0**
Percentage Change	3.5%	7.0%	(1.3%)	(0.8%)	2.6%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$7,144,917,275**	**$2,074,236,795**	**$690,213,730**	**$9,031,044**	**$4,371,435,706**	**0.0**
Request Above/(Below) Recommendation	$116,316,969	$2,089,547	$699,937	$0	$113,527,485	0.0

DECISION ITEMS - MEDICAL SERVICES PREMIUMS

➔ R1 MEDICAL SERVICES PREMIUMS

REQUEST: This part of R1 requests a change to the Medical Services Premiums appropriation for both FY 2016-17 and FY 2017-18 based on a new forecast of caseload and expenditures under current law and policy. There are two other parts to the R1 request that the JBC staff has named *R1 Restrict Hospital Provider Fee revenue* and *R1 Home health services in community* respectively that will be discussed separately in the next arrowed items, because the JBC staff is recommending legislation to implement them. Also, consistent with the recommendation on *R14 Federal match rate* above, the JBC staff has separated the impact of changes to the FMAP from the rest of the request for purposes of the summary tables.

This part of R1 is presented as a request by the Department, but it is not really discretionary, because it is what the Department expects to spend absent a change to current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109(1)(a), C.R.S., to overexpend the Medicaid appropriation, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria or plan benefits.

On February 15, 2017, the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2017 forecast is lower than the forecast used for the Governor's request by $150.4 million, including $30.6 million General Fund, in FY 2016-17 and $116.3 million, including $2.1 million General Fund, in FY 2017-18. The table below compares the projected expenditures under the forecast used for the Governor's November request with the updated February 2017 forecast.

Medical Services Premiums November vs February Forecast				
	November Forecast	February Forecast	Difference	Percent Difference
FY 16-17	$6,959,959,497	$6,809,577,947	($150,381,550)	-2.2%
General Fund	1,974,657,761	1,944,088,924	(30,568,837)	-1.5%
Cash Funds	707,358,313	698,906,376	(8,451,937)	-1.2%
Reappropriated Funds	9,102,709	9,102,709	0	0.0%
Federal Funds	4,268,840,714	4,157,479,938	(111,360,776)	-2.6%
Enrollment	1,414,916	1,352,514	(62,402)	-4.4%
FY 17-18	$7,114,289,396	$6,997,972,427	($116,316,969)	-1.6%
General Fund	2,069,331,083	2,067,241,536	(2,089,547)	-0.1%
Cash Funds	689,180,826	688,480,889	(699,937)	-0.1%
Reappropriated Funds	9,031,044	9,031,044	0	0.0%
Federal Funds	4,346,746,443	4,233,218,958	(113,527,485)	-2.6%
Enrollment	1,484,636	1,416,675	(67,961)	-4.6%

RECOMMENDATION: Staff recommends using the Department's February 2017 forecast of enrollment and expenditures to modify both the FY 2016-17 and FY 2017-18 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the February forecast is lower than the November forecast by $150.4 million, including $30.6 million General Fund in FY 2016-17 and $116.3 million, including $2.1 million General Fund, in FY 2017-18, so the staff recommendation is lower than the Governor's request by these amounts.

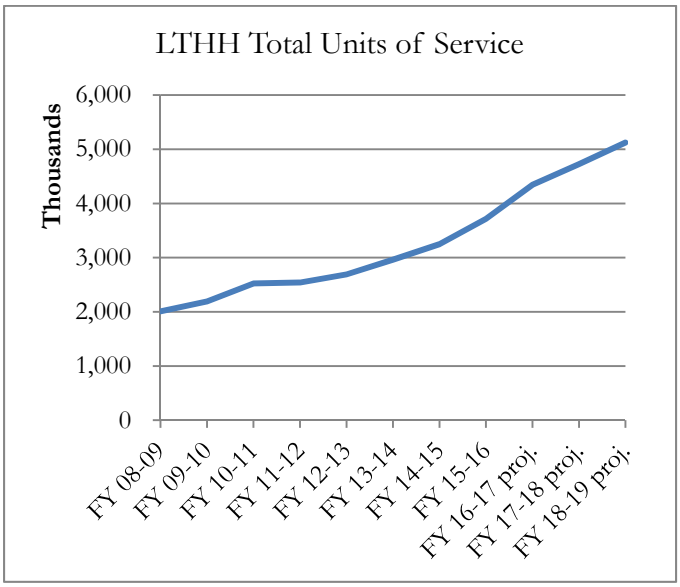
ANALYSIS: The following subsections highlight major factors driving the forecast changes.

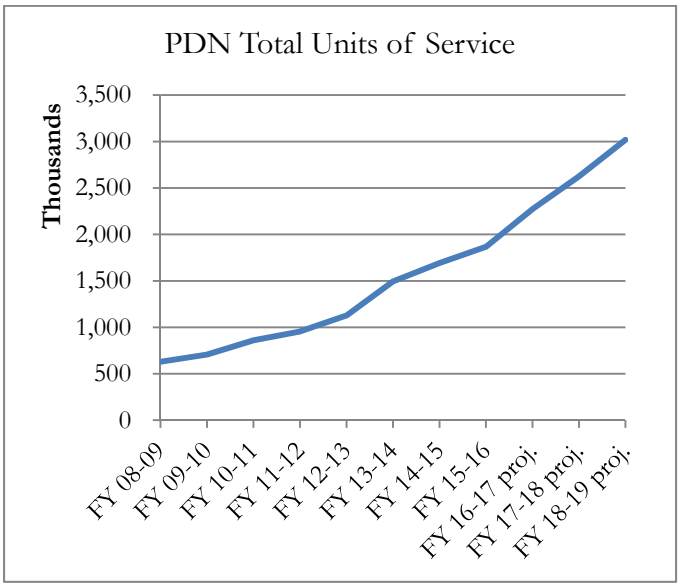
FY 2016-17

The next table shows the most significant factors driving the change in the Department's forecast for FY 2016-17, followed by brief bulleted descriptions of each item. Note that this table displays changes from the appropriation and not changes from FY 2015-16. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2016-17 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
Medicaid Caseload				
Elderly and People with Disabilities	($8,442,229)	($4,917,166)	$712,936	($4,237,999)
Children	(24,276,062)	(11,181,570)	0	(13,094,492)
Non-Expansion Adults	(56,166,617)	(24,639,428)	(2,933,702)	(28,593,487)
Expansion Adults	(21,217,155)	0	(530,428)	(20,686,727)
Subtotal - Caseload	*(110,102,063)*	*(40,738,164)*	*(2,751,194)*	*(66,612,705)*
Per Capita Trends Acute Care	8,050,545	21,199,141	(3,380,810)	(9,767,786)
Long-term Services and Supports				
Nursing Homes	7,785,544	3,299,907	(10,015)	4,495,652
HCBS waivers	(4,520,727)	(2,239,800)	1,042	(2,281,969)
Long-Term Home Health	23,811,775	11,633,336	109,821	12,068,618
Private Duty Nursing	7,313,328	3,572,955	33,729	3,706,644
PACE	2,723,618	1,356,362	0	1,367,256
Hospice	1,447,312	509,564	266,707	671,041
Subtotal - LTSS	*38,560,850*	*18,132,324*	*401,284*	*20,027,242*
Transitional Medicaid System Error				
Reduce Non-Expansion Adults Caseload	(50,466,937)	(23,737,403)	(1,354,758)	(25,374,776)
Funding Shift with Fix in March	0	9,712,854	(487,593)	(9,225,261)
Subtotal - Transitional Medicaid	*(50,466,937)*	*(14,024,549)*	*(1,842,351)*	*(34,600,037)*
Tobacco Tax Revenues	0	(3,125,649)	3,125,649	0
Autism Behavioral Therapy Benefit	(16,170,122)	(2,778,534)	(5,274,187)	(8,117,401)
Medicare Insurance Premiums	(13,435,502)	(6,690,880)	0	(6,744,622)
Denver Health Enrollment Activities	(8,582,121)	(2,399,972)	(862,529)	(5,319,620)
Other	1,763,800	(142,554)	2,132,201	(225,847)
TOTAL FY 2016-17 Changes	**($150,381,550)**	**($30,568,837)**	**($8,451,937)**	**($111,360,776)**

- *MEDICAID CASELOAD* – Changes in caseload projections decrease the forecast by $110.1 million total funds, including $40.7 million General Fund. The rate of enrollment growth is slowing and the Department attributes this in part to improving economic conditions and in part to actual enrollment approaching the maximum potentially eligible population based on income.
- *PER CAPITA TRENDS ACUTE CARE* – Changes in per capita assumptions increase the forecast by a net $8.1 million total funds, including $21.2 million General Fund. Most of the General Fund increase is attributable to per capita expenditures for children. This might be a result of improved economic conditions causing higher income children to leave Medicaid and skewing the remaining Medicaid population toward poorer children that tend to have higher per capita costs, but the Department is investigating further.
- *LONG-TERM SERVICES AND SUPPORTS* – The revised forecast estimates that expenditures for long-term services and supports will exceed the appropriation by $38.6 million total funds, including $18.1 million General Fund. Utilization of long-term home health and private duty nursing has been significantly higher than expected. Long-term home health (LTHH) includes services such as: assistance with bathing, dressing, and hygiene provided by a certified nurse or higher; physical, occupational, and speech and language therapies; and nursing visits. LTHH is for chronic needs rather than acute rehabilitation. Private duty nursing (PDN) pays for extensive in-home nursing services, mainly for children who are dependent on medical equipment, such as a ventilator. For both LTHH and PDN the Department describes the growth in both the average utilizers per month and the units per utilizer as "unprecedented". The overall increase for long-term services and supports also reflects higher nursing home costs based on where increased utilization is occurring, higher enrollment in the Program for All-Inclusive Care for the Elderly, and greater utilization of hospice, offset by somewhat lower-than-expected utilization in the Home and Community-Based Service (HCBS) waivers. The graphics below show trends in the total units of service for LTHH and PDN.





- *TRANSITIONAL MEDICAID SYSTEM ERROR* – The Department 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 erroneously categorized as eligible for the enhanced match that applies to ACA expansion populations. 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. In November the Department forecasted the expenditures for non-expansion adults based on the trends prior to the emergence of the system error in July 2015. For the February forecast the Department has lowered the estimate based on actual year-to-date caseload and projects an upper bound of the impact of the system issue of $50.5 million total funds, including $23.7 million General Fund. The system error will be fixed as of March and the Department projects that the correction of the error will cause $19.5 million total funds to shift from the Expansion Adults to Non-Expansion Adults, causing a shift in financing from federal funds and cash funds to the General Fund of $9.7 million. In a letter accompanying the February forecast the Governor proposed legislation (discussed in more detail below) to create a cash fund to hold $25 million General Fund for a possible repayment to the federal government as a result of the system error causing too high of a claim on federal funds.

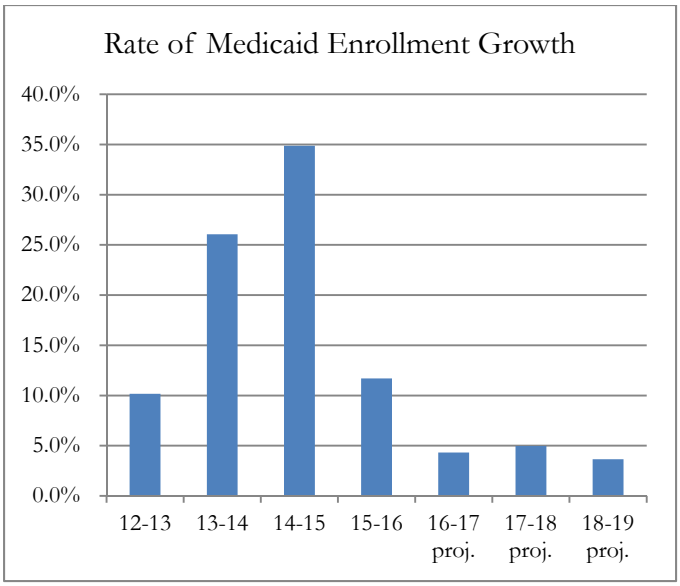
- *TOBACCO TAX REVENUES* – The Department's projection reflects an increase in the Legislative Council Staff's forecast of the Tobacco Tax revenues that will be deposited in the Health Care Expansion Fund and become available to offset the need for General Fund. This increase also incorporates an additional reserve amount from FY 2015-16 that can offset General Fund in FY 2016-17.
- *AUTISM BEHAVIORAL THERAPY BENEFIT* – The FY 16-17 budget included funding for additional behavioral therapy services for children with autism to comply with new federal guidance on required services, but utilization of the newly available services has been lower than expected. The Department has not lowered the overall projected cost of the new services, but has shifted $16.2 million in expected FY 16-17 expenditures to FY 17-18 to account for the slower adoption rate.
- *MEDICARE INSURANCE PREMIUMS* – Congressional action set 2017 Medicare insurance premiums at an amount lower than the recommendation of the federal Medicare trustees report, driving a decrease in projected Medicaid expenditures for FY 2016-17 of $13.4 million total funds, including $6.7 million General Fund. Medicaid pays the Medicare premiums for people who qualify for both Medicaid and Medicare.
- *DENVER HEALTH ENROLLMENT ACTIVITIES* – Hospitals are eligible for reimbursement for assistance provided to clients enrolling in Medicaid or CHP+. In FY 16-17 the General Assembly approved changing the source of state funding for the enrollment activities of Denver Health from certified public expenditures to the General Fund, but delays in federal approval are causing expenditures to shift to FY 17-18.

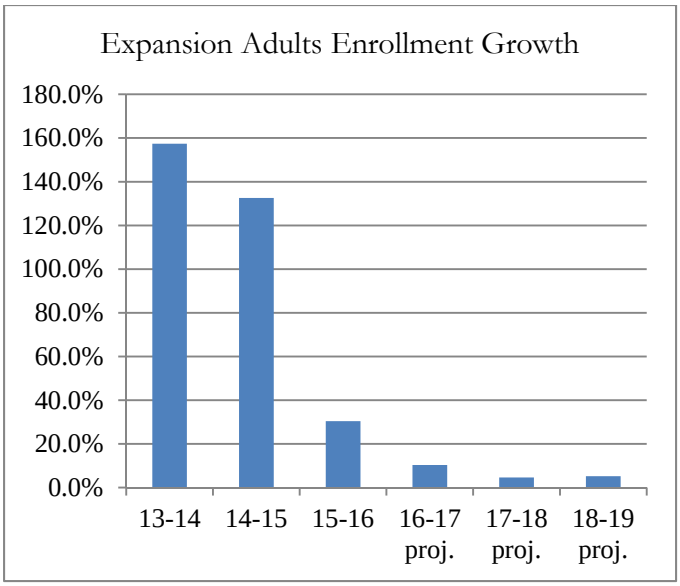
FY 2017-18

The next table shows the most significant factors driving the forecasted change in expenditures from FY 2016-17 to FY 2017-18, followed by brief bulleted descriptions of each item. The table addresses only the remaining change after removing the parts of the Department's R1 request that the JBC staff is addressing separately, such as the Hospital Provider Fee restriction, the set-aside for S.B. 17-091, and the change in the federal match rate.

FY 2017-18 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
Medicaid Caseload				
Elderly and People with Disabilities	$25,346,963	$8,727,079	$3,946,402	$12,673,482
Children	18,263,875	6,217,094	0	12,046,781
Non-Expansion Adults	79,447,187	38,512,780	1,282,927	39,651,480
Expansion Adults	81,673,209	0	5,670,163	76,003,046
Subtotal - Caseload	*204,731,234*	*53,456,953*	*10,899,492*	*140,374,789*
Per Capita Trends Acute Care	(12,787,320)	(7,898,133)	3,169,848	(8,059,035)
Long-term Services and Supports				
Nursing Homes	23,606,407	11,734,429	8,939	11,863,039
HCBS waivers	35,238,179	17,426,048	127,472	17,684,659
Long-Term Home Health	24,152,922	11,864,451	114,407	12,174,064
Private Duty Nursing	14,427,921	7,087,315	68,342	7,272,264
PACE	17,685,992	8,842,995	0	8,842,997
Hospice	2,293,550	839,341	244,089	1,210,120
Subtotal - LTSS	*117,404,971*	*57,794,579*	*563,249*	*59,047,143*
Hospital Provider Fee (unrestricted growth)	273,495,333	0	138,061,558	135,433,775
Annualize Hepatitis C Criteria Change	27,217,614	6,496,367	918,447	19,802,800
Autism Behavioral Therapy Benefit	16,170,122	2,459,631	5,630,158	8,080,333
Medicare Insurance Premiums	6,638,824	3,314,022	0	3,324,802
Nursing Facility Provider Fee	3,704,369	0	2,058,441	1,645,928
Denver Health Enrollment Activities	(892,138)	1,551,101	(2,698,421)	255,182
Tobacco Tax Revenues	0	2,979,530	(2,979,530)	0
Other	5,943,089	(8,494,678)	9,121,888	5,244,214
TOTAL FY 2017-18 Changes	**$641,626,098**	**$111,659,372**	**$164,745,130**	**$365,149,931**

- *MEDICAID CASELOAD* – Caseload growth is projected to increase total expenditures by $204.7 million, including $53.5 million General Fund at FY 2016-17 projected average per capita costs. The General Fund increase is primarily attributable to non-expansion adults and includes $39.9 million ($19.9 million General Fund) related to correcting the Transitional Medicaid System Error described above. Except for the correction of the Transitional Medicaid System Error, the forecast projects a significantly slower rate of enrollment growth for both the overall Medicaid population and the expansion adults than in prior years, in part due to improving economic conditions and in part due to actual enrollment approaching the maximum potentially eligible population based on income.



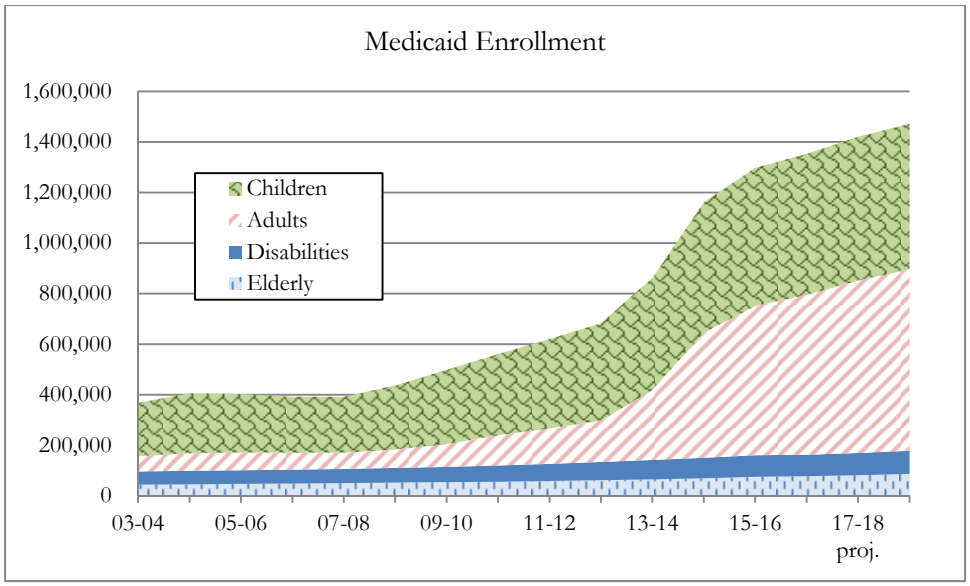


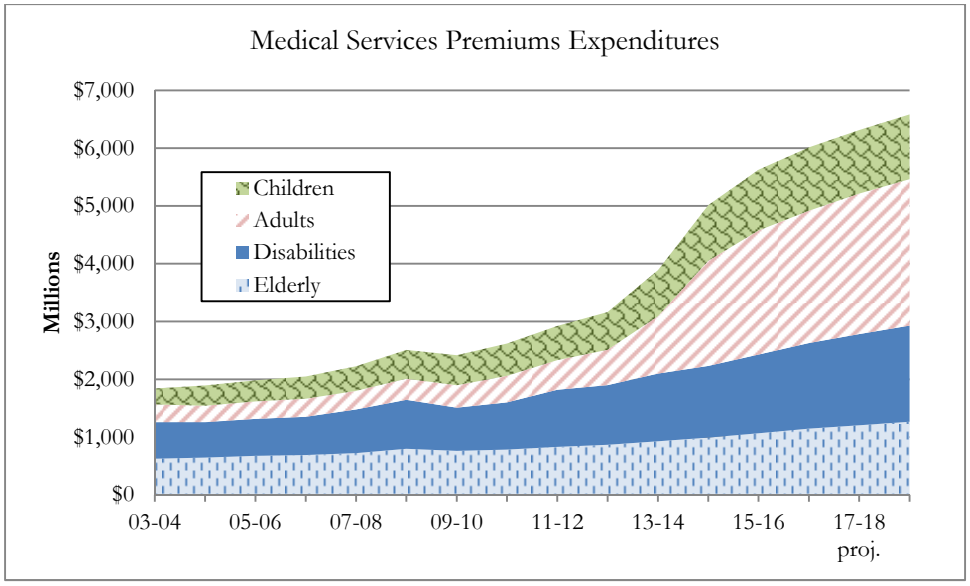
- *Per Capita Trends Acute Care* – The Department is projecting a net decrease in per capita costs of $12.8 million, including $7.9 million General Fund. For most populations the Department is projecting little change in acute care per capita expenses, but for parents and caretakers to 68 percent of the federal poverty guidelines the per capita expenses are running lower in FY 2016-17 and the Department assumes the trend will continue in FY 2017-18. The increase in cash funds is attributable to increased utilization of the adult dental benefit that is funded with unclaimed property tax cash funds.
- *Long-term Services and Supports* – The Department expects expenditures for long-term services and supports will increase $117.4 million, including $57.8 million General Fund. Of the General Fund increase, $17.4 million is attributable to Home and Community Based Services (HCBS) waivers, mostly for increases in enrollment and utilization of the Elderly, Blind and Disabled waiver. The Department projects continued rapid growth, based on the trends in FY 2016-17, in the number of utilizers and the units per utilizer for both Long-Term Home Health and Private Duty Nursing and combined these two services account for $19.0 million of the General Fund increase. Nursing home payments account for $11.7 million of the General Fund increase, primarily due to the statutory 3.0 percent inflation in nursing home rates. The Program for All-inclusive Care for the Elderly (PACE) accounts for $8.8 million of the General Fund increase, primarily due to expected continued strong enrollment growth.
- *Hospital Provider Fee* – The Department projects an increase of $273.5 million total funds, including $138.1 million from the Hospital Provider Fee, in payments to increase hospital reimbursements, referred to in this document as booster payments. This is the projected growth if Hospital Provider Fee revenues are not restricted. The Governor proposes a $195.0 million restriction on Hospital Provider Fee revenues that would decrease booster payments by $390.0 million total funds that is discussed in more detail below.
- *Annualize Hepatitis C Criteria Change* – In FY 2016-17 the Department expanded Hepatitis C drug criteria. The incremental cost to annualize the FY 2016-17 policy change in FY 2017-18 is $27.2 million, including $6.5 million General Fund. The total full-year cost for the criteria change is $93.3 million total funds, including $22.2 million General Fund.

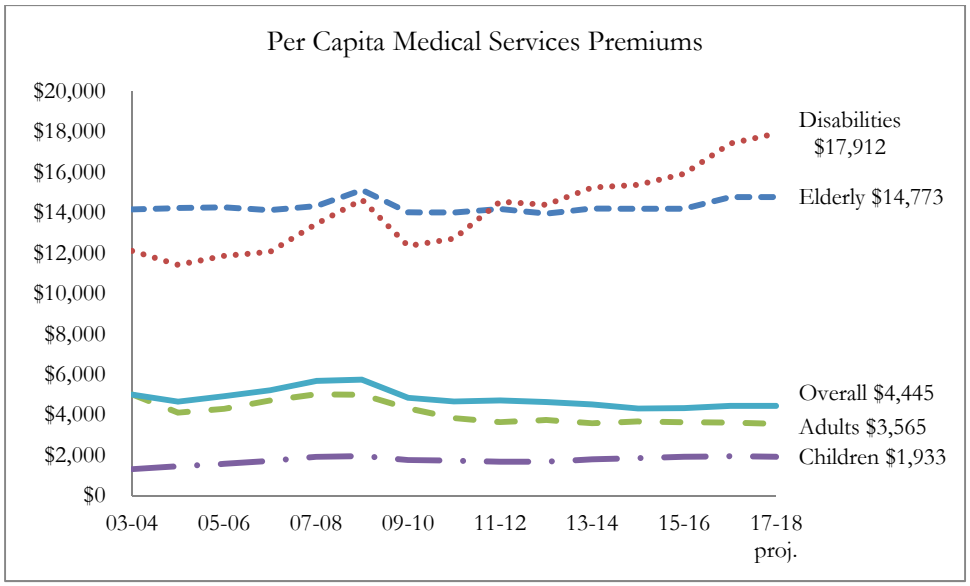
- *AUTISM BEHAVIORAL THERAPY BENEFIT* – The FY 16-17 budget included funding for additional behavioral therapy services for children with autism to comply with new federal guidance on required services, but utilization of the newly available services has been lower than expected. The Department has not lowered the overall projected cost of the new services, but has shifted $16.2 million in expected FY 16-17 expenditures to FY 17-18 to account for the slower adoption rate.
- *MEDICARE INSURANCE PREMIUMS* – The Department projects an increase of $6.6 million, including $3.3 million General Fund, based on the most recent recommendations of the federal Medicare trustees report on Medicare insurance premiums. Medicaid pays the Medicare premiums for people who qualify for both Medicaid and Medicare.
- *NURSING FACILITY PROVIDER FEE* – Statue allows the nursing provider fee to fill in costs not covered by nursing rate increases up to the 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.
- *DENVER HEALTH ENROLLMENT ACTIVITIES* - Hospitals are eligible for reimbursement for assistance provided to clients enrolling in Medicaid or CHP+. In FY 16-17 the General Assembly approved changing the source of state funding for the enrollment activities of Denver Health from certified public expenditures to the General Fund, but delays in federal approval are causing expenditures to shift to FY 17-18. In addition, the Department is implementing a new method for estimating reimbursable costs that preliminary projections indicate will result in lower reimbursable costs than estimated under the old method.
- *TOBACCO TAX REVENUES* –The Department's projection reflects a decrease in the Legislative Council Staff's forecast of the Tobacco Tax revenues that will be deposited in the Health Care Expansion Fund and become available to offset the need for General Fund, as well as the removal of the reserve amount available in FY 16-17.

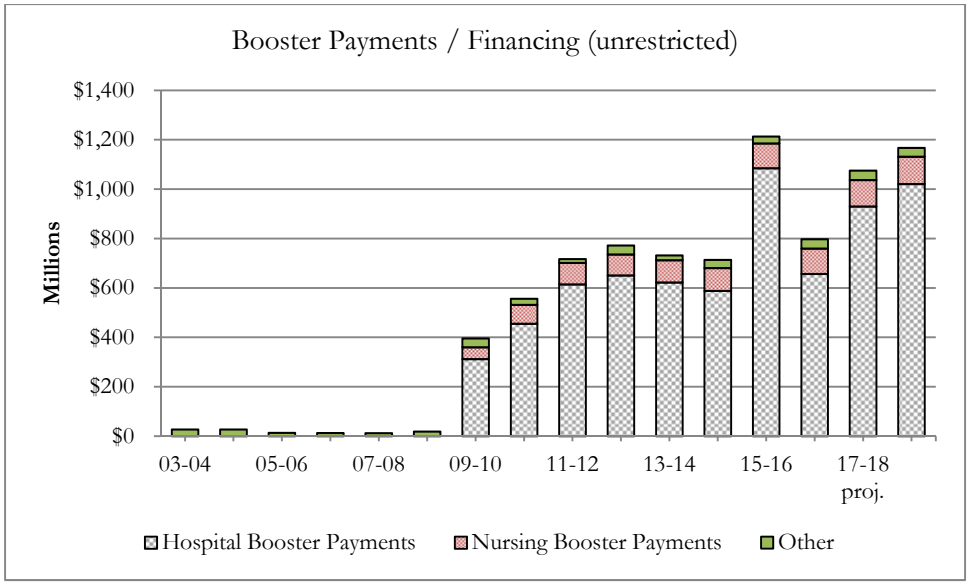
LONG-TERM TRENDS

The next series of graphs summarize longer term trends in Medicaid enrollment and expenditures. In the graphs the booster payments and miscellaneous other financing are shown separately from other costs, because the factors that drive changes in these expenditures are related more to policies of the General Assembly than enrollment and including them with medical services would obscure the trends in medical costs.


Medicaid Enrollment
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Children
Adults
Disabilities
Elderly
03-04
05-06
07-08
09-10
11-12
13-14
15-16
17-18 proj.


Medical Services Premiums Expenditures
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Millions
Children
Adults
Disabilities
Elderly
03-04
05-06
07-08
09-10
11-12
13-14
15-16
17-18 proj.





➔ R1 RESTRICT HOSPITAL PROVIDER FEE REVENUE

REQUEST: As part of R1 the Department included a proposed $195.0 million restriction on Hospital Provider Fee revenues. The restriction would limit the ability of the Department to draw matching federal funds and the Governor describes the effect as reducing payments to hospitals by a total of $390.0 million. The purpose of the restriction is to reduce expenditures subject to the limit in Article X, Section 20 of the Colorado Constitution (TABOR) and thereby reduce the General Fund obligation for a TABOR refund.

The JBC staff is addressing this component of the request separately from the rest of R1, because it is a discretionary policy rather than a forecast change, and because the JBC staff is recommending a statutory change to implement it.

The Governor's proposed strategy for saving General Fund only works if there is a TABOR refund that can be reduced that is at least as large as the Hospital Provider Fee restriction. If the March revenue forecast shows that there is not a large enough TABOR refund that can be reduced, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then this strategy may not produce General Fund savings.

In the Governor's request, the reduction in Hospital Provider Fee revenues would result in lower booster payments paid from the Medical Services Premiums line item. The other major purpose of the Hospital Provider Fee is to pay for Medicaid expansion populations and the Governor is NOT requesting any reduction to Medicaid eligibility or benefits as a result of the restriction on Hospital Provider Fee revenues.

RECOMMENDATION: Staff recommends that the JBC sponsor legislation to restrict Hospital Provider Fee revenues by the $195.0 million proposed by the Governor and eliminate the statutory prioritization of the uses of the Hospital Provider Fee. The staff recommendation assumes that the March revenue forecast will show at least a $195 million General Fund obligation for a TABOR refund. In December the Legislative Council Staff projected a TABOR refund obligation of $279.4 million and the Office of State Planning and Budgeting projected a TABOR refund obligation of $247.7 million. If the March revenue forecast shows less than a $195.0 million General Fund obligation for a TABOR refund, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then the recommended restriction on Hospital Provider Fee revenues may not be as beneficial to the budget and would need to be revisited.

The JBC staff is recommending legislation because the statutes prioritize the uses of the Hospital Provider Fee in a manner that potentially conflicts with the Governor's proposal. If revenues are insufficient, the statutory priority order places the financing of the Medicaid expansion populations last, and the Governor is not proposing a reduction in Medicaid eligibility or benefits. One of the statutory priorities before Medicaid eligibility expansions is to "maximize" inpatient and outpatient hospital revenues up to the upper payment limit, which could be in jeopardy if revenues were reduced. If there are insufficient revenues to "fully fund" all of the prioritized uses of the Hospital Provider Fee, the Medical Services Board is required to adopt rules for reducing Medicaid eligibility or benefits. These rules have to be approved by the JBC before they could take effect, but if the JBC doesn't like the rules, then the JBC has to propose rules for limiting eligibility or benefits.

Senate Bill 13-200 and the federal Affordable Care Act protect some of the expansion populations from reductions in eligibility or benefits. Senate Bill 13-200 included provisions protecting the Medicaid expansion populations required to receive the ACA's enhanced federal match from reductions due to insufficient hospital provider fee revenues. The ACA included a maintenance of effort requirement for eligibility for children until October 2019. The remaining eligibility criteria and benefits that are financed from the Hospital Provider Fee that could potentially be reduced if there are insufficient revenues would be the disabled buy-in program, services for pregnant adults on CHP+, and continuous eligibility for children.[5]

[5] The ACA maintenance of effort requirement for children applies to eligibility standards as of the passage of the ACA and so it does not apply to Colorado's continuous eligibility for children, which was implemented after the ACA.

If the intent were to reduce eligibility or benefits for the disabled buy-in, services for pregnant adults on CHP+, and continuous eligibility for children, then implanting a restriction on the Hospital Provider Fee through the Long Bill would be appropriate. However, if the intent is to reduce the booster payments without reducing Medicaid eligibility or benefits, as proposed by the Governor, then the statutory priority order does not reflect the actual priorities of the General Assembly and should be changed or eliminated.

During debate on the FY 2016-17 budget the JBC received an opinion from Legislative Legal Services, dated December 7, 2015, that reducing Hospital Provider Fee revenues without reducing Medicaid eligibility or benefits would require legislation, due to the way the statutes prioritize expenditures from the Hospital Provider Fee when revenues are insufficient. Despite the legal opinion, the JBC implemented a $73.2 million restriction on Hospital Provider Fee revenues through the FY 16-17 Long Bill. The Colorado Hospital Association lobbied against a separate bill to implement the restriction, arguing that the magnitude of the proposed restriction fell within potential interpretations of what it means to "maximize" inpatient and outpatient revenues and "fully fund" all of the prioritized uses of the Hospital Provider Fee. The JBC's decision last year was not challenged, but had there been a successful legal challenge the Department and the JBC potentially would have had to restrict eligibility and benefits. The magnitude of the proposed restriction this year is larger than last year, which might increase the risk of a legal challenge.

ALTERNATIVE – REPLACE HOSPITAL BOOSTER PAYMENTS WITH A PROVIDER RATE INCREASE

If legislators want to mitigate the effect on hospitals of the staff recommendation, a possible alternative would be to replace hospital booster payments with a provider rate increase. When the Hospital Provider Fee booster payments were created, they allowed the state to increase reimbursements to hospitals with no cost to the General Fund. Hospitals paid the state a dollar to get two dollars in return for a net benefit of $1. However, in a TABOR refund environment, booster payments are an inefficient way to deliver increased funding to hospitals. This is because the revenue from the Hospital Provider Fee increases the General Fund obligation for a TABOR refund. To give the hospitals a net benefit of $1 costs the General Fund $1 in increased TABOR refunds. It is as if the General Assembly made a direct General Fund payment to the hospitals with no matching federal funds. If the same net benefit of $1 was provided through a rate increase for the hospitals, it would only cost the General Fund $0.50 at the standard federal match rate. However, because some of the populations and treatments provided by the hospitals are eligible for enhanced federal matching funds, the cost to the General Fund would be even less. Based on the mix of populations and treatments that the Department projects hospitals will provide in FY 2017-18, the average General Fund match rate for fee-for-service payments to hospitals is expected to be 27.9 percent.

If the JBC wanted to replace $10 million from the Hospital Provider Fee with a rate increase, it would cost $2.8 million General Fund to hold the hospitals harmless in aggregate, and the General Fund would pay $10 million less in TABOR refunds, resulting in a net savings to the General Fund of $7.2. This example, summarized in the table below, is scalable, so if the JBC wanted to replace the entire $195.0 million reduction to the Hospital Provider Fee that is recommended by the JBC staff with a rate increase to hold hospitals harmless, the net savings to the General Fund would be $140.7 million. This is less than the $195.0 million savings to the General Fund under the JBC staff recommendation, but it is still a considerable savings. If the JBC wanted to achieve the same $195.0 million of General Fund savings recommended by the JBC staff, it could do so by replacing $270.3 million from the Hospital Provider Fee with a provider rate increase.

Restrict Hospital Provider Fee (HPF) revenue	($10,000,000)
Effect on hospitals	
Net loss in HPF booster payments	($10,000,000)
Provider rate increase	$10,000,000
Net benefit to hospitals	$0
Effect on the General Fund	
TABOR Refund (not appropriated)	($10,000,000)
GF cost of rate increase	$2,786,965
Net benefit to General Fund	($7,213,035)

There are a some limits on how much General Fund savings the JBC could achieve by replacing Hospital Provider Fee booster payments with a provider rate increase. First, the cut to the Hospital Provider Fee cannot exceed the booster payments. The projected Hospital Provider Fee expenditure in FY 2017-18 from the Medical Services Premiums line item for hospital booster payments is $465.2 million. Potentially, the General Assembly could also replace booster payments from the Safety Net Provider Payments line item with rate increases, but that would require a reimagining of the Colorado Indigent Care Program. Second, the cut to the Hospital Provider Fee cannot exceed the TABOR refund, because the General Fund savings from this strategy is dependent on reducing the General Fund obligation for a TABOR refund. The March revenue forecast will provide a new estimate of the TABOR refund. The actual TABOR refund will be dependent on actual revenues. In December the Legislative Council Staff projected a TABOR refund obligation of $279.4 million and the Office of State Planning and Budgeting projected a TABOR refund obligation of $247.7 million.

While replacing Hospital Provider Fee revenues with a rate increase could hold hospitals harmless in aggregate, it would most likely result in a reallocation of resources between hospitals. The larger the change in financing the greater the distortion will be from the status quo distribution by hospital. The Department could potentially make adjustments to the distribution formula for any remaining Hospital Provider Fee booster payments to minimize the change in funding by hospital, if this was a policy goal, but it is unlikely that a new distribution formula plus a rate increase could exactly duplicate the current allocation of funds by hospital.

Reducing Hospital Provider Fee revenues and increasing provider rates would require federal approval from the Centers for Medicare and Medicaid Services (CMS). The size of the change in financing might influence the level of CMS scrutiny and the time required to receive approval. The Department has accounted for the time required to get CMS approval for a change in the Hospital Provider Fee revenues in the request. A reduction in revenues may not be evenly distributed through the state fiscal year, but the Department believes a reduction in revenues to a specific dollar amount identified by the General Assembly is achievable within the fiscal year. Similarly, a rate increase might not be approved by CMS by July 1, but upon CMS approval it could be implemented retroactively to July 1.

The JBC staff is not recommending this alternative in part because it may have unintended consequences. As noted above, replacing the Hospital Provider Fee with a rate increase will likely change the distribution of funding among hospitals and that could have negative consequences for the delivery system, but it is unknown whether and how the Department might change the distribution formula for the remaining booster payments and what the final result would be by

hospital. One factor in the distribution of the Hospital Provider Fee is quality of care, but that is not a consideration in the current fee-for-service rates. Also, if hospital provider rates are increased, then the effect on the budget of future changes in the utilization of hospital services is magnified.

Another consideration is that the Governor's request is for a temporary reduction to the Hospital Provider Fee, while a provider rate increase for the hospitals would be perceived as permanent. The JBC staff is uncomfortable recommending a rate increase for a specific provider, particularly if it is a large increase, that hasn't been through the S.B. 15-228 rate review process or a similar vetting. It could be that increasing rates for a different provider turns out to be more important for the delivery system than backfilling lost revenue to the hospitals from the Hospital Provider Fee. While it may be unrealistic to assume that the budget environment will be significantly better next year such that restoring the Hospital Provider Fee will be easy, there might be more clarity about where Medicaid provider rates are causing the most issues with access and where backfilling lost revenue from the Hospital Provider Fee falls among the Department's priorities.

Another consideration is that the net benefit to hospitals from the Hospital Provider Fee has been significantly greater than originally expected. When the Hospital Provider Fee was created it was not expected that the expansion populations would receive an enhanced federal match pursuant to the ACA. That match for FY 2017-18 is 94.5 percent. The enhanced federal match reduces the amount of Hospital Provider Fee revenue that goes to providers other than hospitals for services to expansion populations and increases the proportion of the Hospital Provider Fee that directly benefits the hospitals. Also, when the Hospital Provider Fee was created the effect of the Medicaid expansion on increasing the federal limits on the Hospital Provider Fee was not fully understood.

The booster payments have not always been in place and during their existence there have been frequent variations in funding levels, including large diversions from the booster payments to offset the need for General Fund as follows:

- $46.3 million in FY 2009-10
- $53.5 million in FY 2010-11
- $50.0 million in FY 2011-12
- $25.0 million in FY 2012-13
- $73.1 million in FY 2016-17

ALTERNATIVE – DESIGNATE THE HOSPITAL PROVIDER FEE AS AN ENTERPRISE

In prior years the Governor has proposed that rather than limiting the Hospital Provider Fee revenue, the General Assembly designate the Hospital Provider Fee as part of an enterprise, which would make the revenue exempt from TABOR. The Governor then goes one step further and argues that doing so would not require an adjustment to the TABOR base. Designating the Hospital Provider Fee as an enterprise would remove roughly $870 million in projected revenue attributable to the Hospital Provider Fee from the calculation of whether a TABOR refund is due. This does not mean that there would be $870 million more General Fund available for the budget. The amount of General Fund savings would be dependent on the size of the TABOR refund absent a change in policy.

In addition to saving General Fund that would otherwise be needed for a TABOR refund, designating the Hospital Provider Fee as an enterprise would remove the budget balancing reason to implement the Governor's proposed restriction on Hospital Provider Fee revenues.

There would be some secondary effects from designating the Hospital Provider Fee as an enterprise. First, the conservation easement tax credit would remain non-refundable. Pursuant to Section 39-22-522 (5) (b), C.R.S., a portion of the tax credit becomes refundable if a TABOR surplus is due. Second, the General Assembly would be allowed to eliminate tax expenditures without prior voter approval in FY 2017-18, if it wanted, which could increase General Fund revenues. The conclusion that limiting tax expenditures without prior voter approval is allowable when it doesn't cause a TABOR refund is based on the Colorado Supreme Court's decision in Mesa County Bd. of County Comm'rs v. State.

The two main downsides to designating the Hospital Provider Fee as an enterprise are that: (1) it may not be constitutional; and (2) it eliminates projected TABOR refunds taxpayers could otherwise expect to receive. There could be legal costs if a designation of the Hospital Provider Fee as an enterprise is challenged. If it is found unconstitutional, the state would owe a refund for money retained illegally through the policy for up to four full fiscal years prior to the date a suit is filed, plus 10 percent annual simple interest.

The dollar risk of designating the Hospital Provider Fee as an enterprise and subsequently receiving a court determination that it is unconstitutional is dependent on when a law suit is filed and resolved and on how much revenue is retained. It is important to note that the Governor's budget, including budget amendments, was balanced in January assuming $195 million in savings from restricting Hospital Provider Fee revenues. So, when looking at what designating the Hospital Provider Fee as an enterprise would save compared to the Governor's request, the total savings from the enterprise designation needs to be reduced by the $195 million that the Governor was already counting on achieving through a different policy action.

➔ R1 SET ASIDE FOR S.B. 17-091

REQUEST: The Department included in both R1 and the February forecast update the anticipated additional cost associated with a new federal regulation that people be permitted to access home health services in the community as well as in the home. The Department has broad statutory authority to comply with federal regulations, but in this case a state statute specifically conflicts with the federal regulation and S.B. 17-091 (Crowder & Moreno/Ginal) has been introduced to resolve the conflict.

RECOMMENDATION: Since S.B. 17-091 will make changes to state statute to implement the new federal regulation, the JBC staff recommends that the associated change in expenditures be included in that bill. The JBC staff recommends that the JBC create a set aside in the budget package for the estimated cost of S.B. 17-091 of $2,211,530 total funds, including $1,025,567 General Fund. The new federal regulation expands the locations where people can receive home health services and this is expected to result in a modest increase in utilization. For example, people may choose to utilize pool therapy or home health services in a work setting.

LINE ITEM DETAIL

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

This line item provides funding for physical health and most long-term care services for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term care services for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. This is the only line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

STATUTORY AUTHORITY: Section 25.5-5-101 et seq., C.R.S.

REQUEST: The Department requests:

- R1 Medical Services Premiums
- R6 Delivery system and payment reforms
- R7 Oversight of state resources
- R11 Vendor transitions
- Annualizations of prior year budget decisions

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

MEDICAL SERVICES PREMIUMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 Appropriation						
HB 16-1405 (Long Bill)	$6,762,815,547	$1,948,969,728	$678,702,748	$5,240,893	$4,129,902,178	0.0
Other Legislation	55,449,048	(6,529,960)	27,005,372	0	34,973,636	0.0
SB 17-162 (Supplemental Bill)	126,254,607	24,497,845	1,650,193	3,861,816	96,244,753	0.0
Long Bill supplemental	(150,381,550)	(30,568,837)	(8,451,937)	0	(111,360,776)	0.0
TOTAL	**$6,794,137,652**	**$1,936,368,776**	**$698,906,376**	**$9,102,709**	**$4,149,759,791**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$6,794,137,652	$1,936,368,776	$698,906,376	$9,102,709	$4,149,759,791	0.0
R1 Medical Services Premiums	641,554,433	111,659,372	164,816,795	(71,665)	365,149,931	0.0
R6 Delivery system and payment reform	45,370,739	14,735,125	903,427	0	29,732,187	0.0
R7 Oversight of state resources	(1,402,565)	(2,789,665)	(240,123)	0	1,627,223	0.0
R11 Vendor transitions	2,100,000	680,400	369,600	0	1,050,000	0.0
Standard federal match	0	7,907,160	555,023	0	(8,462,183)	0.0
ACA "Newly eligible" federal match	0	0	46,060,326	0	(46,060,326)	0.0
Annualize prior year budget actions	(65,371,483)	2,560,513	(26,875,847)	0	(41,056,149)	0.0
SUBTOTAL - LONG BILL	**$7,416,388,776**	**$2,071,121,681**	**$884,495,577**	**$9,031,044**	**$4,451,740,474**	**0.0**

MEDICAL SERVICES PREMIUMS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
R1 Restrict Hosptial Provider Fee revenue	(390,000,000)	0	(195,000,000)	0	(195,000,000)	0.0
Set-aside for SB 17-091	2,211,530	1,025,567	18,216	0	1,167,747	0.0
TOTAL ALL LEGISLATION	**$7,028,600,306**	**$2,072,147,248**	**$689,513,793**	**$9,031,044**	**$4,257,908,221**	**0.0**
INCREASE/(DECREASE)	**$234,462,654**	**$135,778,472**	**($9,392,583)**	**($71,665)**	**$108,148,430**	**0.0**
Percentage Change	3.5%	7.0%	(1.3%)	(0.8%)	2.6%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$7,144,917,275**	**$2,074,236,795**	**$690,213,730**	**$9,031,044**	**$4,371,435,706**	**0.0**
Request Above/(Below) Recommendation	$116,316,969	$2,089,547	$699,937	$0	$113,527,485	0.0

(5) INDIGENT CARE PROGRAM

This division contains funding for the following programs: (1) Colorado Indigent Care Program (CICP), which partially reimburses providers for medical services to uninsured individuals with incomes up to 250 percent of the federal poverty level; (2) Children's Basic Health Plan; and (3) the Primary Care Grant Program. The sources of cash funds are the Hospital Provider Fee, tobacco tax money, tobacco settlement money, enrollment fees for the Children's Basic Health Plan, and recoveries and recoupments. The tobacco tax money primarily goes through the Primary Care Fund to provide primary care grants. The tobacco settlement money primarily goes through the Children's Basic Health Plan Trust.

INDIGENT CARE PROGRAM					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 Appropriation					
HB 16-1405 (Long Bill)	$505,068,224	$12,248,677	$202,679,964	$290,139,583	0.0
SB 17-162 (Supplemental Bill)	15,610,893	1,515	1,914,824	13,694,554	0.0
Long Bill supplemental	8,944,129	0	3,078,856	5,865,273	0.0
TOTAL	**$529,623,246**	**$12,250,192**	**$207,673,644**	**$309,699,410**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION					
FY 2016-17 Appropriation	$529,623,246	$12,250,192	$207,673,644	$309,699,410	0.0
R3 Children's Basic Health Plan	13,763,634	(1,880,340)	(1,167,848)	16,811,822	0.0
Tobacco forecast adjustment	498,584	7,750	490,834	0	0.0
Standard federal match	0	39,150	791,308	(830,458)	0.0
TOTAL	**$543,885,464**	**$10,416,752**	**$207,787,938**	**$325,680,774**	**0.0**
INCREASE/(DECREASE)	**$14,262,218**	**($1,833,440)**	**$114,294**	**$15,981,364**	**0.0**
Percentage Change	2.7%	(15.0%)	0.1%	5.2%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$523,578,226**	**$10,409,002**	**$204,920,065**	**$308,249,159**	**0.0**
Request Above/(Below) Recommendation	($20,307,238)	($7,750)	($2,867,873)	($17,431,615)	0.0

DECISION ITEMS - INDIGENT CARE PROGRAM

➔ R3 CHILDREN'S BASIC HEALTH PLAN

REQUEST: The Department requests a change to the appropriation for the Children's Basic Health Plan (CHP+) based on a new forecast of caseload and expenditures under current law and policy. R3 represents the Department's forecast of expenditures based on the eligibility criteria and plan benefits in current law and policy and proposed changes to the eligibility criteria or plan benefits are contained in other requests.

On February 15, 2017 the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2017 forecast is higher than the forecast used for the Governor's request in total funds by $8.9 million in FY 2016-17 and $19.8 million in FY 2017-

18. The General Fund is unchanged. The table below compares the projected expenditures under the forecast used for the Governor's request with the updated February 2017 forecast.

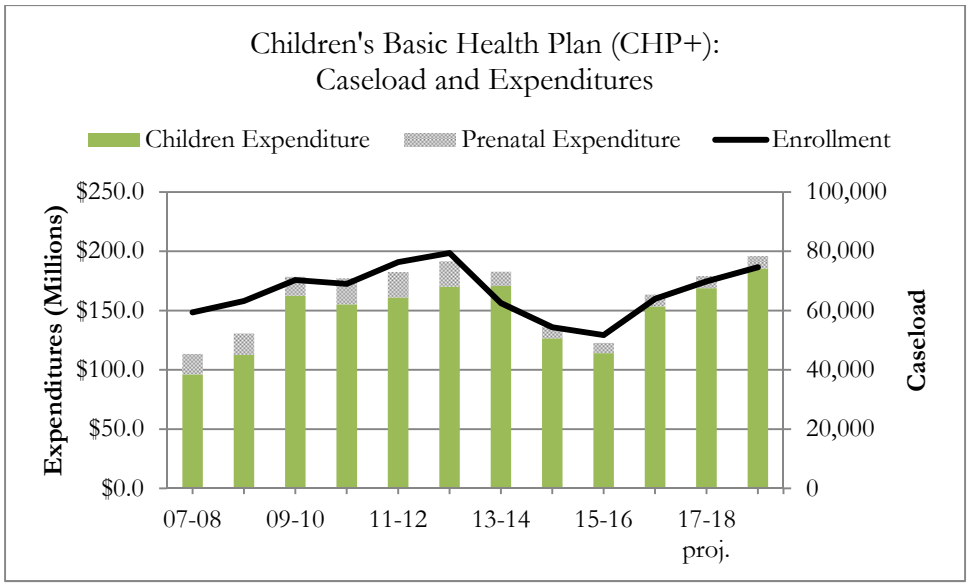
Children's Basic Health Plan Under Current Law/Policy				
	Governor's Request	Feb-17 Forecast	Difference	Percent Difference
FY 16-17	$157,065,937	$166,010,066	$8,944,129	5.7%
General Fund	2,501,956	2,501,956	0	0.0%
Cash Funds	21,215,152	24,294,008	3,078,856	14.5%
Federal Funds	133,348,829	139,214,102	5,865,273	4.4%
Enrollment	63,257	63,922	665	1.1%
FY 17-18	$159,965,046	$179,773,700	$19,808,654	12.4%
General Fund	621,616	621,616	0	0.0%
Cash Funds	20,959,031	23,336,070	2,377,039	11.3%
Federal Funds	138,384,399	155,816,014	17,431,615	12.6%
Enrollment	64,733	69,803	5,070	7.8%

The forecasted General Fund is to reimburse the federal government for disallowed payments in prior years. The majority of the cash funds come from the Children's Basic Health Plan (CHP+) Trust, which receives revenue from the tobacco master settlement, enrollment fees, and interest. The CHP+ program also receives money from the Hospital Provider Fee for children and pregnant adults with income from 206 percent to 260 percent of the federal poverty guidelines. Small amounts of the cash funds are from the Colorado Immunization Fund (originally tobacco settlement money), and the Health Care Expansion Fund (originally tobacco tax money). The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. The average federal match rate for FY 2016-17 is 88.13 percent and for FY 2017-18 it is projected to be at the federal minimum of 88.0 percent.

Last year, in H.B. 16-1408, the General Assembly significantly reduced the amount of tobacco settlement moneys annually allocated to the Children's Basic Health Plan Trust, based on projected needs for the program over the next few years. The table below summarizes the projected cash flow for the Children's Basic Health Plan Trust.

Children's Basic Health Plan Trust					
	FY 14-15	FY 15-16	FY 16-17	FY 17-18	FY 18-19
Beginning Fund Balance	$13,937,178	$18,291,567	$32,152,034	$16,066,151	$15,504,749
Revenue	$31,840,037	$28,795,070	$17,974,966	$15,255,495	$15,189,891
Fees	896,127	1,123,899	661,836	677,759	699,546
Tobacco Settlement	27,889,272	27,459,195	17,202,838	14,468,096	14,400,000
Interest	195,419	205,351	110,292	109,640	90,345
Recoveries	2,859,220	6,625	0	0	0
Expenses	$27,485,649	$14,934,603	$34,060,849	$15,816,897	$17,106,758
Net Cash Flow	$4,354,389	$13,860,467	($16,085,883)	($561,402)	($1,916,867)
Ending Fund Balance	$18,291,567	$32,152,034	$16,066,151	$15,504,749	$13,587,882

RECOMMENDATION: Staff recommends using the Department's February 2017 forecast of enrollment and expenditures to modify both the FY 2016-17 and FY 2017-18 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the February forecast is higher than the November forecast by $8.9 million in FY 2016-17 and $19.8 million in FY 2017-18, so the staff recommendation is higher than the Governor's request by these amounts. The recommended General Fund is the same as the Governor's request. The graph below illustrates trends in CHP+ enrollment and expenditures.



As described under the discussion of *R14 Federal match rate*, the JBC staff separates the portion of the forecast requests attributable to changes in the federal match rate from the rest of the forecast adjustment for the division and line item summary tables. For CHP+ medical and dental costs the change in the standard federal match rate increases the projected cash funds by $209,910 and decreases the projected federal funds by a like amount. For the CHP+ administration the change in the federal match increases the cash funds by $6,543 and decreases the federal funds by a like amount. The staff modification is a difference in presentation and not a material difference in the total recommended funding.

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION					
HB 16-1405 (Long Bill)	$141,455,044	$2,500,441	$17,533,954	$121,420,649	0.0
SB 17-162 (Supplemental Bill)	$15,610,893	$1,515	$3,681,198	$11,928,180	0.0
Long Bill supplemental	$8,944,129	$0	$3,078,856	$5,865,273	0.0
TOTAL	**$166,010,066**	**$2,501,956**	**$24,294,008**	**$139,214,102**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION					
FY 2016-17 Appropriation	$166,010,066	$2,501,956	$24,294,008	$139,214,102	0.0
R3 Children's Basic Health Plan	13,763,634	(1,880,340)	(1,167,848)	16,811,822	0.0
Tobacco forecast adjustment	0	7,750	(7,750)	0	0.0
Standard federal match	0	0	209,910	(209,910)	0.0
TOTAL	**$179,773,700**	**$629,366**	**$23,328,320**	**$155,816,014**	**0.0**

INCREASE/(DECREASE)	**$13,763,634**	**($1,872,590)**	**($965,688)**	**$16,601,912**	**0.0**
Percentage Change	8.3%	(74.8%)	(4.0%)	11.9%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$159,965,046**	**$621,616**	**$20,959,031**	**$138,384,399**	**0.0**
Request Above/(Below) Recommendation	($19,808,654)	($7,750)	($2,369,289)	($17,431,615)	0.0

LINE ITEM DETAIL – INDIGENT CARE PROGRAM

SAFETY NET PROVIDER PAYMENTS

This line item provides funding to partially reimburse hospitals for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to adults and emancipated minors with income to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services beyond emergency care that they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

The source of cash funds is the Hospital Provider Fee and the federal match rate is at the standard Medicaid FMAP. Colorado draws the federal funds for Safety Net Provider Payments through two different methods. First, Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds, if the local match is provided. Second, Colorado receives a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. Federal DSH allotments are required to decrease in aggregate with the implementation of the Affordable Care Act and the expected decrease in the uninsured population.

The Medicaid expansion authorized by S.B. 13-200 significantly reduced the number of people eligible for the CICP, but there is still a population with income above the effective Medicaid eligibility threshold for adults of 138 percent and the CICP eligibility income limit of 250 percent. Also, non-pregnant adult legal immigrants who have been in the United States for less than five years do not qualify for Medicaid, but do qualify for the CICP. Many people eligible for the CICP would also qualify for federal tax credits to purchase insurance through Connect for Health Colorado, but may not be able to meet out-of-pocket expenses.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests continuation funding, except for an increase of $574,855 cash funds and a corresponding decrease in federal funds in *R14 Federal match rate* to account for the change in the FMAP. A small portion of the line item for administration receives a 50 percent federal match.

RECOMMENDATION: Staff recommends the requested continuation funding based on the expected allocations through the CICP.

CLINIC BASED INDIGENT CARE

This line item is similar in purpose to the Safety Net Provider Payments line item, except that instead of funding hospitals it partially reimburses clinics for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to people with income up to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

Since clinics are not eligible for UPL or DSH financing, the federal funds for this line item are drawn through the UPL for Children's Hospital. The hospital then contracts with the clinics to distribute the money, retaining approximately $60,000 from the total appropriation to cover administrative costs. The clinics are not necessarily affiliated with Children's other than through the contract that allows them to receive the supplemental payments.

The available CICP funding is distributed based on each clinic's share of estimated write-off costs compared to all clinics.

Unlike the Safety Net Provider Payments line item, the state participation for this line item comes from the General Fund. This line item existed prior to H.B. 09-1293, and so using the Hospital Provider Fee to match the federal funds might be viewed as supplanting existing General Fund, which is prohibited in Section 25.5-4-402.3 (5) (a) (I), C.R.S. Also, these are not hospitals, and the hospitals are already giving up a share of their UPL to allow the clinics to receive these supplemental payments. The match rate is at the standard Medicaid FMAP.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests continuation funding, except for an increase of $12,240 General Fund and a corresponding decrease in federal funds in *R14 Federal match rate* to account for the change in the FMAP.

RECOMMENDATION: Staff recommends the request to continue the historic total distributions to clinics. This program is discretionary, rather than a required component of Medicaid. This program has not traditionally been included in the community provider rate common policy.

PEDIATRIC SPECIALTY HOSPITAL

The line item provides supplemental payments to Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The line item also provides funding for the Children's Hospital Kids Street and Medical Day Treatment programs, which are not eligible for Medicaid fee-for-service reimbursement, but do qualify for this supplemental payment.

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of

hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

The Medical Day Treatment program serves children and adolescents aged 7 to 21 years of age with chronic illnesses or medical conditions requiring ongoing medical monitoring. Patients are served five days a week at The Children's Hospital's campus in Aurora. Aurora Public Schools provides educational staff and instruction on site. Individual education plans are developed and maintained for the patients. The services reduce hospitalizations and provide psycho-social supports to patients' families.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests continuation funding, except for an increase of $26,910 General Fund and a corresponding decrease in federal funds in *R14 Federal match rate* to account for the change in the FMAP.

RECOMMENDATION: Staff recommends the requested funding to continue the historic level of support for the program. This program is discretionary, rather than a required component of Medicaid. This program has not traditionally been included in the community provider rate common policy.

APPROPRIATION FROM TOBACCO TAX FUND TO GENERAL FUND

Section 24-22-117(1)(c)(I)(A), C.R.S. requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund. Section 24-22-117(1)(c)(I)(B.5), C.R.S. requires that 50 percent of those revenues appropriated to the General Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

STATUTORY AUTHORITY: Section 24-22-117(1)(c)(I)(A), C.R.S.; Section 24-22-117(1)(c)(I)(B.5), C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends an increase of $7,750 based on the Legislative Council Staff's December forecast of tobacco tax revenue. The JBC provided authority during the figure setting for tobacco programs to adjust this amount, if necessary, based on the March revenue forecast.

PRIMARY CARE FUND

Through this line item tobacco tax funds are distributed to providers who:

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;

- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

Awards are based on the percentage of medically indigent clients the provider serves. The Primary Care Fund receives 19 percent of tobacco tax collections annually.

STATUTORY AUTHORITY: Section 25.5-3-301 through 303, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends an increase of $490,834 based on the Legislative Council Staff's December forecast of tobacco tax revenue. The JBC provided authority during the figure setting for tobacco programs to adjust this amount, if necessary, based on the March revenue forecast.

CHILDREN'S BASIC HEALTH PLAN (CHP+) ADMINISTRATION

This line item provides funding for private contracts for administrative services associated with the Children's Basic Health Plan. There is a separate appropriation in the Executive Director's Office for the centralized eligibility vendor for CHP+ expansion populations funded from the Hospital Provider Fee. There are also appropriations in the Executive Director's Office for internal administrative costs, including personal services, operating expenses, and the Medicaid Management Information System.

The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee.

Prior to FY 2016-17 the federal match for this line item was based on a time allocation between Medicaid and CHP+. In order to qualify for CHP+ an applicant must first be determined ineligible for Medicaid. Beginning in FY 2016-17 the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for a new time allocation plan that attributes all of the work of this contractor to the CHP+ match rate.

STATUTORY AUTHORITY: Section 25.5-8-111 and 107, C.R.S.

REQUEST: The Department requests continuation funding, except for an increase of $6,543 General Fund and a corresponding decrease in federal funds in *R3 Children's Basic Health Plan* to account for the change in the FMAP.

RECOMMENDATION: Staff recommends the requested funding based on the ongoing contracts for administration of CHP+. Consistent with the recommendation on *R14 Federal match rate*, in the summary tables the JBC staff attributes the portion of *R3 Children's Basic Health Plan* that is related to the change in the federal match rate to *R14 Federal match rate.*

CHILDREN'S BASIC HEALTH PLAN (CHP+) MEDICAL AND DENTAL COSTS

This line item contains the medical costs associated with serving the eligible children and pregnant women on the CHP+ program and the dental costs for the children. Children are served by both managed care organizations and the Department's self-insured network. The pregnant women on the program are served in the self-insured network.

If actual expenditures run higher than the forecast based on the eligibility criteria and plan benefits, the budget is usually adjusted. However, states have more options and flexibility under CHP+ rules to keep costs within the budget than under Medicaid rules. Correspondingly, the statutes provide less overexpenditure authority for CHP+ than for Medicaid. Pursuant to Section 24-75-109(1)(a.5), C.R.S. the Department can make unlimited overexpenditures from cash fund sources, including the CHP+ Trust Fund, but annual overexpenditures from the General Fund are capped at $250,000.

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid. The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, the Health Care Expansion Fund, and recoveries and reocupments. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. The projected average federal match rate for state FY 2017-18 is 88.0 percent.

STATUTORY AUTHORITY: Section 25.5-8-107 et seq., C.R.S.

REQUEST: The Department requests *R3 Children's Basic Health Plan* to update the appropriation for a more recent forecast.

RECOMMENDATION: Staff recommends updating the appropriation based on the Department's February 2017 forecast, which is more recent than the November forecast used for the budget request. See the discussion of *R3 Children's Basic Health Plan* for more detail. In addition, the JBC staff recommends an adjustment to the fund sources to account for the Legislative Council Staff December forecast of available revenue from the Tobacco Tax Cash Fund that is appropriated to the General Fund and then to support CHP+ pursuant to Section 24-22-117(1)(c)(I)(A), C.R.S. and Section 24-22-117(1)(c)(I)(B.5), C.R.S.. The staff recommendation for the line item is summarized in the table below.

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 APPROPRIATION					
HB 16-1405 (Long Bill)	$141,455,044	$2,500,441	$17,533,954	$121,420,649	0.0
SB 17-162 (Supplemental Bill)	$15,610,893	$1,515	$3,681,198	$11,928,180	0.0
Long Bill supplemental	$8,944,129	$0	$3,078,856	$5,865,273	0.0
TOTAL	**$166,010,066**	**$2,501,956**	**$24,294,008**	**$139,214,102**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION					
FY 2016-17 Appropriation	$166,010,066	$2,501,956	$24,294,008	$139,214,102	0.0
R3 Childrens Basic Health Plan	13,763,634	(1,880,340)	(1,167,848)	16,811,822	0.0

CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Tobacco forecast adjustment	0	7,750	(7,750)	0	0.0
Standard federal match	0	0	209,910	(209,910)	0.0
TOTAL	**$179,773,700**	**$629,366**	**$23,328,320**	**$155,816,014**	**0.0**
INCREASE/(DECREASE)	**$13,763,634**	**($1,872,590)**	**($965,688)**	**$16,601,912**	**0.0**
Percentage Change	8.3%	(74.8%)	(4.0%)	11.9%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$159,965,046**	**$621,616**	**$20,959,031**	**$138,384,399**	**0.0**
Request Above/(Below) Recommendation	($19,808,654)	($7,750)	($2,369,289)	($17,431,615)	0.0

(6) OTHER MEDICAL SERVICES

This division contains the funding for:

- The state's obligation under the Medicare Modernization Act for prescription drug benefits for people dually eligible for Medicare and Medicaid;
- The Old Age Pension State-Only Medical Program;
- Health training programs, including the Commission on Family Medicine and the University Teaching Hospitals; and
- Public School Health Services.

The sources of cash funds include certified public expenditures by school districts, the Old Age Pension Health and Medical Fund, and the Marijuana Tax Cash Fund. The source of reappropriated funds is transfers within the division from the Public School Health Services line item.

OTHER MEDICAL SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2016-17 Appropriation						
HB 16-1405 (Long Bill)	$241,059,813	$139,398,685	$51,751,948	$2,491,722	$47,417,458	0.0
SB 17-162 (Supplemental Bill)	10,762,653	1,369,323	4,754,691	0	4,638,639	0.0
Long Bill supplemental	(1,083,334)	(1,083,334)	0	0	0	0.0
TOTAL	**$250,739,132**	**$139,684,674**	**$56,506,639**	**$2,491,722**	**$52,056,097**	**0.0**
FY 2017-18 RECOMMENDED APPROPRIATION						
FY 2016-17 Appropriation	$250,739,132	$139,684,674	$56,506,639	$2,491,722	$52,056,097	0.0
BA14 Public School Health Services	1,025,015	0	748,947	0	276,068	0.0
Standard federal match	774,463	797,629	0	0	(23,166)	0.0
R4 Medicare Modernization Act	17,222,134	17,222,134	0	0	0	0.0
TOTAL	**$269,760,744**	**$157,704,437**	**$57,255,586**	**$2,491,722**	**$52,308,999**	**0.0**
INCREASE/(DECREASE)	**$19,021,612**	**$18,019,763**	**$748,947**	**$0**	**$252,902**	**0.0**
Percentage Change	7.6%	12.9%	1.3%	0.0%	0.5%	0.0%
FY 2017-18 EXECUTIVE REQUEST	**$271,152,158**	**$159,095,851**	**$57,255,586**	**$2,491,722**	**$52,308,999**	**0.0**
Request Above/(Below) Recommendation	$1,391,414	$1,391,414	$0	$0	$0	0.0

DECISION ITEMS – OTHER MEDICAL SERVICES

➔ R4 MEDICARE MODERNIZATION ACT

REQUEST: The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act. The Medicare Modernization Act (MMA) 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 the 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 is often referred to colloquially as the "clawback." The size of the state's obligation under the federal formula is influenced by changes in

the population that is dually eligible for Medicaid and Medicare, their utilization of prescription drugs, and prescription drug prices.

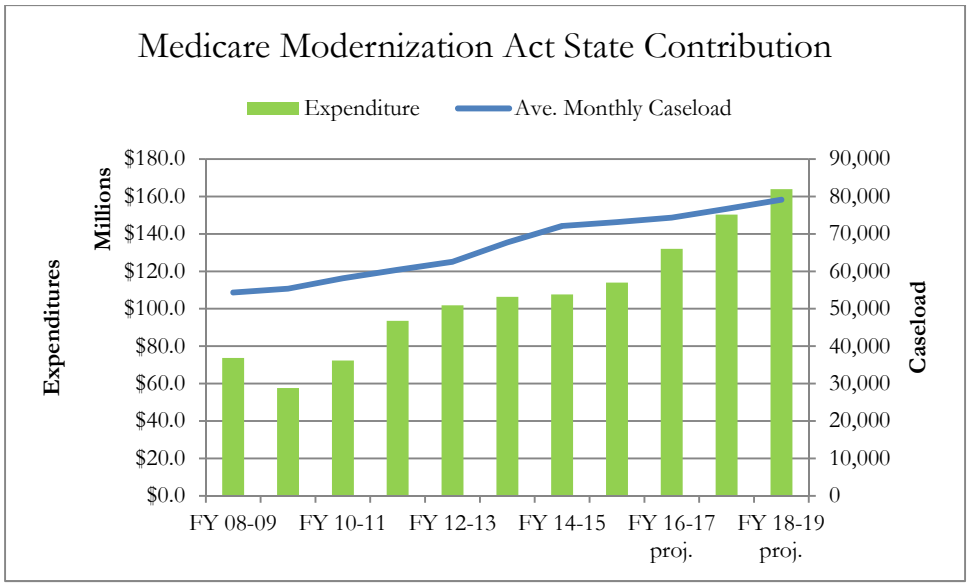
On February 15, 2017, the Department submitted an update to the R4 Medicare Modernization Act forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2017 forecast is lower than the forecast used for the Governor's request in total funds by $1.1 million General Fund in FY 2016-17 and $1.4 million General Fund in FY 2017-18.

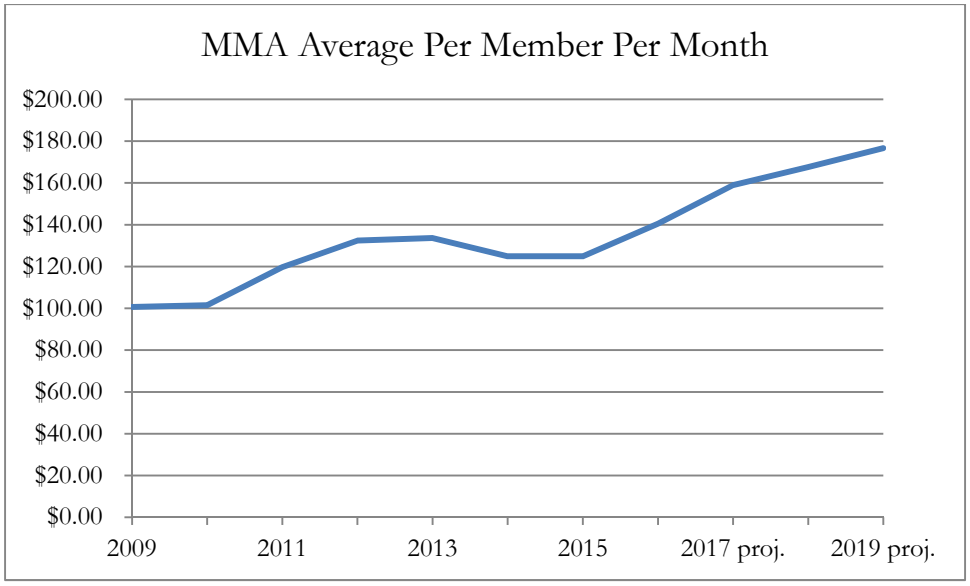
MMA November Request vs February Forecast				
	Governor's Request	February 2017 Forecast	Difference	Percent Difference
FY 16-17	$132,037,056	$130,953,722	($1,083,334)	-0.8%
FY 17-18	$150,341,733	$148,950,319	($1,391,414)	-0.9%

RECOMMENDATION: Staff recommends using the Department's February 2017 forecast of enrollment and expenditures to modify both the FY 2016-17 and FY 2017-18 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the February 2017 forecast is lower than the forecast used for the Governor's request in total funds by $1.1 million General Fund in FY 2016-17 and $1.4 million General Fund in FY 2017-18.

Consistent with the recommendation on *R14 Federal match rate*, the JBC staff broke out the portion of the request attributable to the change in the federal match rate. Although there is no federal match for this line item, the federal match rate for a state affects the federal formula that calculates the state obligation. Of the total projected increase for the line item, $774,463 General Fund is attributable to the change in the standard federal match rate. This is the only place in the budget where the change in the federal match rate results in a net positive increase in expenditures, rather than an increase in General Fund that is offset by a decrease in federal funds.

Most of the variation in expenditures for this obligation has been due to changes in the per capita drug expenditures estimated by the federal formula, which may not match actual drug expenditures. The growth rate for the population subject to the Medicare Modernization Act has been relatively stable. Changes in the FMAP rate also change the state obligation. The graphs below illustrate trends in the average monthly caseload subject to the Medicare Modernization Act, the total obligation, and the per member per month (PMPM) rate assessed by the federal formula. Note that the PMPM is on a calendar year, while all the other charts show figures by state fiscal year.





Recent increases in per capita Medicare drug expenditures were unusually high due to the availability of several new classifications of prescription drugs, including a new high cost drug treatment for Hepatitis C. The Department expects the rate of growth to slow somewhat in coming years.

This is a 100 percent state obligation with no matching federal funds. However, in some years, in order to offset General Fund costs, Colorado has applied bonus payments received from the federal government for meeting performance goals for enrolling and retaining children in Medicaid and CHP+ toward this obligation. The table below summarizes recent expenditures for the Medicare Modernization Act. The large increase in FY 2016-17 was primarily due to the availability of the new classifications of prescription drugs noted above.

Medicare Modernization Act					
Fiscal Year	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	Total Change	Percent Change
FY 08-09	$73,720,837	$73,720,837	$0		
FY 09-10	57,624,126	57,624,126	0	(16,096,711)	-21.8%
FY 10-11	72,377,768	72,377,768	0	14,753,642	25.6%
FY 11-12	93,582,494	93,582,494	0	21,204,726	29.3%
FY 12-13	101,817,855	52,136,848	49,681,007	8,235,361	8.8%
FY 13-14	106,376,992	68,306,130	38,070,862	4,559,137	4.5%
FY 14-15	107,620,224	107,190,799	429,425	1,243,232	1.2%
FY 15-16	114,014,334	114,014,334	0	6,394,110	5.9%
FY 16-17 proj.	132,037,056	132,037,056	0	18,022,722	15.8%
FY 17-18 proj.	150,341,733	150,341,733	0	18,304,677	13.9%
FY 18-19 proj.	163,907,186	163,907,186	0	13,565,453	9.0%

➔ BA14 PUBLIC SCHOOL HEALTH SERVICES

REQUEST: The Department requests two changes to the Public School Health Services line item that the JBC staff has combined into one. First, the Department requests a decrease of $0.9 million total funds, including $445,046 certified public expenditures, in BA14 Public School Health Services to continue and annualize supplemental S14 Public School Health Services. Second, the Department requests an increase of $1,933,578, including $1,193,993 certified public expenditures to annualize prior year budget actions. The prior year budget action that is being annualized is really just a forecast adjustment, and so the JBC staff has combined them to show the net effect, which is an increase of $1.0 million, including $748,947 certified public expenditures.

Through the Public School Health Services program school districts and Boards of Cooperative Education Services (BOCES) are allowed to identify their expenses in support of Medicaid eligible children with an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP) and claim federal Medicaid matching funds for these costs. Participating school districts and BOCES report their expenses to the Department according to a federally-approved methodology and the Department submits them as certified public expenditures to claim the federal matching funds. The federal matching funds are then disbursed to the school districts and BOCES and may be used to offset their costs of providing services, or to expand services for low-income, under- or uninsured children and to improve coordination of care between school districts and health providers.

Utilization of the program has increased dramatically in recent years due to a variety of factors, including growth in the number of eligible children in Medicaid, outreach efforts, school districts and BOCES becoming more familiar and comfortable with the required reporting, and the efforts of school districts and BOCES to maximize revenues from all sources to help address tight budgets.

RECOMMENDATION: Staff recommends approval of the request. This request is driven by the amount of expenditures by school districts and BOCES that can be claimed for a federal match. The Department needs the spending authority to distribute the federal funds to the school districts. The certified public expenditures by the school districts and BOCES are not included in the State's calculation of spending that is subject to the limitations in Article X, Section 20 of the Colorado Constitution (TABOR). Approval of this request will not result in any increase in state expenditures.

LINE ITEM DETAIL – OTHER MEDICAL SERVICES

OLD AGE PENSION STATE MEDICAL PROGRAM

This line item funds health care services to persons who qualify to receive old age pensions and who are not a patient in an institution for the treatment of tuberculous or mental diseases using a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund. In addition, the line item pays for grants to dental providers to serve low-income seniors who do not otherwise have access to dental care through Medicaid, the Old Age Pension Health and Medical Program, or private insurance. The grants for dental services through the Colorado Dental Program for Low-income Seniors are financed with General Fund ($2,962,510 in FY 2016-17).

With the expansion of Medicaid that was authorized in S.B. 13-200, a large portion of the people eligible for an old age pension are also eligible for Medicaid. All $10.0 million of the constitutional allocation of sales tax is appropriated in this line item to ensure the funds are available to serve eligible people who do not qualify for Medicaid. Any funds left over are reappropriated to the Medical Services Premiums line item to offset the need for General Fund in that line item for people who are dually eligible for Medicaid and the Old Age Pension Health and Medical Program. For FY 2017-18 the Department is projecting $9.0 million will be available to offset General Fund in the Medical Services Premiums line item. If that forecast is off, the Medical Services Premiums line item has statutory authority to overexpend the appropriation.

The Department pays providers for the Old Age Pension Health and Medical Program based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation. With most of the clients now dually eligible for both Medicaid and the Old Age Pension Health and Medical Program, the Department has been able to pay for services at 100 percent of the Medicaid rates.

STATUTORY AUTHORITY: Article XXIV, Section 7, Colorado Constitution; Section 25.5-2-101, C.R.S.; Section 25.5-3-401 et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding. The portion of the line item that pays for physical health services is required by the Colorado Constitution. The portion related to dental services is discretionary.

For the dental program, the Department submits an annual statutory report[6] on the effectiveness of the program. According to the most recent report, in FY 2015-16 grants were awarded to 21 recipients that spent $2,776,729 to serve 2,828 seniors, or $982 per senior. Administrative costs were $82,575 at the state level and $161,159 at the grantee level. Of the services, 32 percent were provided by Federally Qualified Health Centers or safety net clinics and another 29 percent were provided by community based organizations or foundations. The remainder went to Area Agencies on Aging, local public health agencies, Pueblo Community College, and the University of Colorado School of Dental Medicine. The table below summarizes where the majority of services were provided by county.

[6] http://www.leg.state.co.us/library/reports.nsf/ReportsDoc.xsp?documentId=08FAC22F71C4AC4F87257CF400700363

OAP Dental		
County	Served	Percent
El Paso	670	23.7%
Denver	379	13.4%
Adams	293	10.4%
Pueblo	217	7.7%
Mesa	199	7.0%
Larimer	175	6.2%
Jefferson	171	6.0%
Boulder	154	5.4%
Arapahoe	149	5.3%
All Other	421	14.9%
TOTAL	**2,828**	**100.0%**

COMMISSION ON FAMILY MEDICINE

This line item provides payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians (University Hospital's payments are in a separate line item). The funding in this line item goes directly to the residency programs, with the exception of funds to support and develop rural family medicine residency programs pursuant to S.B 14-144. Federal regulations allow Medicaid financial participation for the payments to the hospitals enrolled in the program.

STATUTORY AUTHORITY: Section 25-1-901 et seq., C.R.S.

REQUEST: The Department requests R14 Federal match rate to increase the General Fund by $12,345 and decrease the federal funds by a like amount to account for the change in the FMAP rate.

RECOMMENDATION: Staff recommends the requested funding. Traditionally this line item has received periodic rate adjustments rather than the community provider rate common policy adjustment. No rate adjustment was requested for FY 2017-18.

STATE UNIVERSITY TEACHING HOSPITALS – DENVER HEALTH AND HOSPITAL AUTHORITY UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

These two line items provide funding for the Denver Health and Hospital Authority and the University of Colorado Hospital Authority respectively for Graduate Medical Education (GME). Expenses incurred when graduate students see Medicaid patients were previously appropriated in the Medical Service Premiums line item. Separating them in this line item helps to better track these costs and clarify the status of Denver Health and Hospital Authority as a "Unit of Government" with activity the state can certify as public expenditures to match federal funds. The certified public expenditures appear in the Medical Services Premiums line item.

STATUTORY AUTHORITY: Section 25.5-4-106, C.R.S.

REQUEST: The Department requests R14 Federal match rate to increase the General Fund by $10,821 and decrease the federal funds by a like amount for the two line items combined to account for the change in the FMAP rate.

RECOMMENDATION: Staff recommends the requested funding. Traditionally these line items have received periodic rate adjustments rather than the community provider rate common policy adjustment. No rate adjustment was requested for FY 2017-18.

MEDICARE MODERNIZATION ACT

This line item pays the state's obligation under the Medicare Modernization Act (MMA) 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 the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

This is a 100 percent state obligation and there is no federal match. However, in some prior years the General Assembly applied federal bonus payments received for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

STATUTORY AUTHORITY: Section 25.5-4-105, C.R.S.

REQUEST: The Department requests R4 Medicare Modernization Act to update the appropriation to match the forecasted state obligation. Although there is no federal match for this line item, the federal match rate for a state affects the federal formula that calculates the state obligation. The effect of the change in the federal match rate is accounted for in the Department's R4.

RECOMMENDATION: Staff recommends adjusting both the FY 2016-17 and FY 2017-18 appropriations based on the updated February 2017 forecast. See the recommendation on R4 Medicare Modernization Act for more detail. In the line item and division summary tables the JBC staff broke out the portion of R4 attributable to the change in the federal match rate from the rest of the forecast changes.

OTHER MEDICAL SERVICES, MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT		
	TOTAL FUNDS	GENERAL FUND
FY 2016-17 APPROPRIATION		
HB 16-1405 (Long Bill)	$130,667,733	$130,667,733
SB 17-162 (Supplemental Bill)	1,369,323	1,369,323
Long Bill supplemental	(1,083,334)	(1,083,334)
TOTAL	**$130,953,722**	**$130,953,722**
FY 2017-18 RECOMMENDED APPROPRIATION		
FY 2016-17 Appropriation	$130,953,722	$130,953,722
R4 Medicare Modernization Act	17,222,134	17,222,134
Standard federal match	774,463	774,463
TOTAL	**$148,950,319**	**$148,950,319**
INCREASE/(DECREASE)	**$17,996,597**	**$17,996,597**
Percentage Change	13.7%	13.7%
FY 2017-18 EXECUTIVE REQUEST	**$150,341,733**	**$150,341,733**
Request Above/(Below) Recommendation	$1,391,414	$1,391,414

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION; AND PUBLIC SCHOOL HEALTH SERVICES

When local school districts, Boards of Cooperative Education Services, or the Colorado School for the Deaf and Blind provide health care services to children with disabilities who are eligible for Medicaid, the cost of services covered by Medicaid and some administrative expenses can be certified as public expenditures to match federal funds. The Department allocates the federal financial participation back to the school providers, minus administrative costs, and the school providers use the money to increase access to primary and preventative care programs to low-income, under-, or uninsured children, and to improve the coordination of care between schools and health care providers. Participation by school providers is voluntary.

The source of cash funds is certified public expenditures. The Department retains some of the federal funds for administrative costs up to a maximum of 10 percent pursuant to Section 25.5-5-318 (8) (b), C.R.S. The majority of the federal funds retained by the Department for administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts. The Public School Health Services line item represents the payments to the school districts and boards of cooperative education services.

STATUTORY AUTHORITY: Section 25.5-5-318 et seq., C.R.S.

REQUEST: The Department requests BA14 Public school health services to make adjustments based on projected certified public expenditures by schools. The Department also requests an annualization of a prior year forecast adjustment.

RECOMMENDATION: Staff recommends the request, based on the expected certified public expenditures. As noted in the discussion of BA14 above, the JBC staff combined the forecast adjustment in BA14 and the forecast adjustment in the annualization into one issue for purposes of the division summary table.

There have been dramatic increases in recent expenditures, but predicting the increases has proven difficult. The Department attributes the increases to a combination of outreach efforts by the Department, school districts needing to pursue new revenue streams due to the economy, and an increase in Medicaid eligible students. The Department makes an initial payment during the fiscal year, but then makes a reconciliation payment in the next fiscal year. Some of the data points for that reconciliation payment are not available until the spring after the fiscal year when the service was provided, which is after the General Assembly's supplemental process.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TRAINING GRANT PROGRAM

This line item pays for grants to organizations to provide evidence-based training for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The source of cash funds is the Marijuana Tax Cash Fund.

STATUTORY AUTHORITY: Sections 25.5-5-208 and 39-28.8-501(2)(b)(IV)(C), C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends continuation funding. This is a discretionary expenditure and the JBC could choose to allocate the Marijuana Tax Cash Fund to a different purpose. In FY 2015-16 the Department was appropriated $500,000 for this program, but due to the procurement timeline awarded only $134,100 in that year. The funding trained 468 providers. In FY 2016-17 the General Assembly increased the funding to $750,000. The JBC staff assumes the intent was to continue funding at this higher level. For FY 2016-17 the Department expects to award all the funds. The Department is also working with the training provider to coordinate with the Regional Care Collaborative Organizations to improve outreach.

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

Staff recommends **CONTINUING AND MODIFYING** the following 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. The first report submitted with this funding and expanded scope will be June 1, 2017. The JBC staff assumes the intent is to continue the funding and that is consistent with the staff recommendation on the General Professional Services line item.

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	$105,879

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. The JBC staff will update the figures in the footnote based on the JBC's actions to reflect the approrpaited funds for the State Demonstration to Improve Care for Medicare-Medicaid Enrollees Implementation Support grant.

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.

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.

Staff recommends DISCONTINUING the following footnotes:

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 provided one-time roll forward authority that is no longer needed for a limited portion of the appropriations for the Colorado Benefits Management System.

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 explained the assumptions related to funding for the Program for All-inclusive Care for the Elderly (PACE) that were used to create the appropriation. Senator Steadman added the footnote during JBC comebacks and explained the purpose as increasing transparency. The JBC doesn't typically describe the assumptions for other programs in this detail. The JBC staff recommendation for the Medical Services Premiums line item is based on the Department's February forecast and the assumptions regarding the PACE program are detailed in that forecast, which is available to the public from the Department's web site. The annual rates for PACE are set through the process in Section 25.5-5-412(12)(a), C.R.S.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUING AND MODIFYING** the following requests for information:

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: These reports provide helpful information on expenditure and caseload trends between forecasts, and the JBC is not the only consumer of the reports as research organizations such as the Colorado Health Institute also use the data.

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 provides helpful information on the Colorado Indigent Care Program.

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: There are frequent questions about the various programs that fund health services in public schools and this report provides useful information to address questions about Medicaid funding and the little understood certified public expenditure financing.

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: This request for information is addressed in the figure setting for the Office of Community Living.

Staff recommends **DISCONTINUING** The following 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: Consistent with the recommendation on R7, the JBC staff recommends eliminating this request for information and putting a more comprehensive request related to fraud detection efforts in statute.

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 staff recommendation is to codify this request for information in statute. See the recommendation on R6 for more information.

STATUTORY REPORTS

Statute Cite	Bill	Name	Submitted
25.5-1-113.5	07-186	Access to Quality of Care for Children on Medicaid and CHP **Sandoval-Frangass**	1/3/2017
https://www.colorado.gov/pacific/sites/default/files/2017%20HCPF%20Access%20to%20Quality%20of%20Care%20for%20Children.pdf			
25.5-6-1206	08-1210	In-Home Support Services Implementation **Riesberg-Williams**	1/3/2017
https://www.colorado.gov/pacific/sites/default/files/2017%20HCPF%20In-Home%20Support%20Services.pdf			
25.5-6-409.3	15-1318	Consolidate Intellectual and Dev. Disability Waivers **Young/Grantham**	1/17/2017
https://www.colorado.gov/pacific/sites/default/files/Waiver%20Redesign%20Quarterly%20Update.pdf			
25.5-4-211	13-1281	MMIS Roll-forward Authority **Gerou-Hodge**	1/3/2017
https://www.colorado.gov/pacific/sites/default/files/2017%20MMIS%20Roll-Forward%20Authority.pdf			
24-76.5-103(9)	06S-1023	Verification of Lawful Presence **Romanoff/Fitz-Gerald**	1/17/2017
https://www.colorado.gov/pacific/sites/default/files/CICP%202017%20Lawful%20Presence%20Report.pdf			
25.5-4-402.3(IX)(f)	09-1293	Hospital Provider Fee **Riesberg-Keller**	1/17/2017
https://www.colorado.gov/pacific/sites/default/files/2017%20OAB%20Annual%20Report.pdf			
25.5-1-115.5	12-060	Improving Medicaid Fraud Prosecution **Roberts-Gerou**	1/17/2017
https://www.colorado.gov/pacific/sites/default/files/Improving%20Medicaid%20Fraud%20Prosecution%20Report.pdf			
25.5-1-123	07-130	Medical Homes for Children **Boyd-Carrol M.**	1/30/2017
https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Medical%20Homes%20for%20Children%20Report.pdf			
25.5-3-107	2003	Colorado Indigent Care Program	2/1/2017
https://www.colorado.gov/pacific/sites/default/files/HCPF_2017%20CICP%20Annual%20Report_25.5-3-107.pdf			
25.5-6-409.3	15-1318	Consolidate Intellectual and Dev. Disability Waivers **Young/Grantham**	Not yet submitted
25.5-5-415	12-1281	Medicaid Payment Reform Pilot: Part IV **Young, Gerou-Steadman**	Not yet submitted
25.5-4-401.5	15-228	Medicaid Provider Rate Review **Steadman/Rankin**	Not yet submitted
25.5-6-806	12-159	Changes Children w/ Autism Waiver **Hudak-Kerr J**	Not yet submitted

Statute Cite	Bill	Name	Submitted
25.5-6-412	14-1368	Cross-system Response Pilot Intellectual Dev Disab **YOUNG--GRANTHAM**	Not yet submitted
25.5-6-409.3	15-1318	Consolidate Intellectual and Dev. Disability Waivers **Young/Grantham**	Not yet submitted
25-1-107.5	09-1196	Nursing Home Penalty Cash Fund Report **Gerou-Boyd**	Not yet submitted
25.5-6-409.3	15-1318	Consolidate Intellectual and Dev. Disability Waivers **Young/Grantham**	10/3/2016
https://www.colorado.gov/pacific/sites/default/files/Waiver%20Redesign%20Quarterly%20Update.pdf			
25.5-10-207.5	14-1051	IDD Waitlist **Shafer-Kefalas**	11/1/2016
https://www.colorado.gov/pacific/sites/default/files/HCPF%202016%20HB14-1051%20Strategic%20Plan%20Update.pdf			
25.5-1-206	14-215	School-based Substance Abuse Prevention and Intervention Program **Steadman-Duran and Gerou**	11/1/2016
https://www.colorado.gov/pacific/sites/default/files/HCPF%202016%20Senior%20Dental%20Report.pdf			
25.5-3-405(2)	14-180	Dental Program for Older Coloradans **Kefalas-Swalm**	11/1/2016
2-7-203 (4)	12-1008	Regulatory Agenda **Acree-Jahn**	11/1/2016
https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Regulatory%20Agenda%20and%202016%20Regulatory%20Agenda%20Report.pdf			
25.5-4-401.5	15-228	Medicaid Provider Rate Review **Steadman/Rankin**	11/1/2016
https://www.colorado.gov/pacific/sites/default/files/HCPF%202016%20Medicaid%20Provider%20Rate%20Review%20Recommendation%20Report.pdf			

Appendix A: Number Pages

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
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	30,576,608	*
FTE	360.4	388.0	400.3	415.6	413.8	
General Fund	8,982,621	9,828,325	10,211,448	10,792,716	10,471,558	
Cash Funds	2,676,189	2,849,157	2,994,337	2,977,177	2,977,177	
Reappropriated Funds	1,524,777	574,169	1,564,801	1,565,699	1,781,503	
Federal Funds	14,883,299	13,975,325	14,936,635	15,371,088	15,346,370	
Health, Life, and Dental	2,476,612	3,139,489	3,434,070	3,787,740	3,668,834	*
General Fund	928,931	1,137,726	1,230,952	1,371,673	1,321,630	
Cash Funds	166,066	277,707	337,577	348,096	344,132	
Reappropriated Funds	64,887	88,133	104,755	103,855	103,855	
Federal Funds	1,316,728	1,635,923	1,760,786	1,964,116	1,899,217	
Short-term Disability	64,185	61,246	55,072	59,902	58,459	*
General Fund	21,358	22,736	20,569	22,407	21,794	
Cash Funds	4,955	4,746	4,588	4,849	4,796	
Reappropriated Funds	1,363	1,457	1,393	1,365	1,365	
Federal Funds	36,509	32,307	28,522	31,281	30,504	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
S.B. 04-257 Amortization Equalization Disbursement	1,235,106	1,314,119	1,434,489	1,664,004	1,625,975 *
General Fund	409,819	488,354	535,695	622,238	606,153
Cash Funds	96,428	101,814	119,586	134,856	133,459
Reappropriated Funds	27,452	30,035	36,269	37,816	37,816
Federal Funds	701,407	693,916	742,939	869,094	848,547
S.B. 06-235 Supplemental Amortization Equalization Disbursement	1,157,972	1,269,320	1,419,546	1,663,979	1,625,950 *
General Fund	384,601	472,426	530,115	622,238	606,153
Cash Funds	90,431	98,344	118,340	134,856	133,459
Reappropriated Funds	24,943	27,570	35,891	37,791	37,791
Federal Funds	657,997	670,980	735,200	869,094	848,547
Salary Survey	831,265	321,383	56,903	877,186	877,186
General Fund	283,209	121,695	19,245	326,644	326,644
Cash Funds	64,811	24,853	6,898	72,622	72,622
Reappropriated Funds	3,127	1,794	898	19,282	19,282
Federal Funds	480,118	173,041	29,862	458,638	458,638
Worker's Compensation	52,712	43,712	54,318	67,591	65,937
General Fund	26,356	21,856	27,159	33,796	32,968
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	26,356	21,856	27,159	33,795	32,969

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Operating Expenses	2,967,212	1,930,861	2,058,538	2,107,022	2,101,369	*
General Fund	1,426,580	907,377	930,699	953,810	950,984	
Cash Funds	37,759	3,365	71,522	70,266	70,266	
Reappropriated Funds	0	0	10,449	10,449	10,449	
Federal Funds	1,502,873	1,020,119	1,045,868	1,072,497	1,069,670	
Legal and Third Party Recovery Legal Services	1,151,606	932,995	1,369,290	1,429,940	1,429,940	
General Fund	443,159	442,869	443,055	462,680	462,680	
Cash Funds	166,747	23,677	241,591	252,292	252,292	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	541,700	466,449	684,644	714,968	714,968	
Administrative Law Judge Services	376,861	568,419	697,852	656,743	647,622	*
General Fund	146,434	220,867	271,159	255,187	251,642	
Cash Funds	41,996	63,343	77,767	73,185	72,169	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	188,431	284,209	348,926	328,371	323,811	
CORE Operations	2,717,568	1,598,167	1,417,701	1,499,911	1,252,236	
General Fund	1,297,165	544,698	465,081	493,926	352,493	
Cash Funds	679,257	285,501	243,770	257,906	230,239	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	741,146	767,968	708,850	748,079	669,504	
Payment to Risk Management and Property Funds	166,890	166,912	176,936	134,486	128,274	*
General Fund	83,445	83,456	88,468	67,244	64,137	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	83,445	83,456	88,468	67,242	64,137	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Leased Space	1,480,251	1,848,260	2,514,035	2,514,035	2,514,035	
General Fund	578,965	852,378	1,009,653	1,009,653	1,009,653	
Cash Funds	124,924	71,752	247,365	247,365	247,365	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	776,362	924,130	1,257,017	1,257,017	1,257,017	
Capitol Complex Leased Space	386,910	549,237	572,466	664,902	666,217	
General Fund	193,455	274,619	286,233	332,451	333,108	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	193,455	274,618	286,233	332,451	333,109	
Payments to OIT	1,578,757	2,702,092	4,703,675	4,979,059	4,979,059	*
General Fund	784,642	1,518,550	1,974,295	2,115,392	2,115,392	
Cash Funds	4,736	11,360	377,545	373,641	373,641	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	789,379	1,172,182	2,351,835	2,490,026	2,490,026	
Scholarships for research using the All-Payer Claims Database	500,000	475,050	500,000	500,000	500,000	
General Fund	500,000	475,050	500,000	500,000	500,000	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
General Professional Services and Special Projects	5,584,179	7,993,989	7,400,237	9,566,170	8,995,988 *
General Fund	2,037,349	2,980,993	2,097,261	3,284,916	3,249,825
Cash Funds	511,089	731,075	1,577,500	1,509,062	1,259,062
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,035,741	4,281,921	3,725,476	4,772,192	4,487,101
Merit Pay	265,923	317,662	0	0	0
General Fund	98,565	118,042	0	0	0
Cash Funds	19,363	26,760	0	0	0
Reappropriated Funds	1,176	1,975	0	0	0
Federal Funds	146,819	170,885	0	0	0
SUBTOTAL - (A) General Administration	51,060,895	52,459,889	57,572,349	62,879,350	61,713,689
FTE	360.4	388.0	400.3	415.6	413.8
General Fund	18,626,654	20,512,017	20,641,087	23,266,971	22,676,814
Cash Funds	4,684,751	4,573,454	6,418,386	6,456,173	6,170,679
Reappropriated Funds	1,647,725	725,133	1,754,456	1,776,257	1,992,061
Federal Funds	26,101,765	26,649,285	28,758,420	31,379,949	30,874,135
(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	7,819,645 *
General Fund	1,477,142	1,918,370	2,469,927	2,974,455	2,974,455
Cash Funds	110,000	110,000	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,189,817	3,697,411	3,928,667	4,845,190	4,845,190

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Nurse Home Visitor Program, Transfer from the Department of Human Services	1,028,130	946,528	3,010,000	3,010,000	3,010,000	*
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	478,806	428,921	1,498,980	1,505,000	1,505,000	
Federal Funds	549,324	517,607	1,511,020	1,505,000	1,505,000	
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	5,888	5,887	5,887	5,887	5,887	
General Fund	2,944	2,943	2,944	2,944	2,944	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,944	2,944	2,943	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,042	324,041	324,041	324,041	
General Fund	147,368	147,369	147,369	147,369	147,369	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652	
Federal Funds	162,021	162,021	162,020	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	3,852	5,036	10,000	35,175	5,120	
General Fund	1,926	2,518	5,000	11,425	2,560	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,926	2,518	5,000	23,750	2,560	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Transfer to the Department of Regulatory Agencie						
for Regulation of Medicaid Transportation Providers	0	0	78,328	78,328	103,503	
General Fund	0	0	59,578	59,578	66,003	
Federal Funds	0	0	18,750	18,750	37,500	
Public School Health Services Administration,						
Transfer to the Department of Education	160,335	153,845	170,979	170,979	170,979	
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	160,335	153,845	170,979	170,979	170,979	
Federal Funds	0	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	219,356	
General Fund	102,573	107,978	109,678	109,678	109,678	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	102,573	107,977	109,678	109,678	109,678	
Local Public Health Agencies, Transfer to the						
Department of Public Health and Environment	0	0	0	711,000	0	*
General Fund	0	0	0	355,500	0	
Federal Funds	0	0	0	355,500	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
SUBTOTAL - (B) Transfers to Other Departments	6,504,351	7,377,074	10,217,185	12,374,411	11,658,531	
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	3,303,009	
Cash Funds	110,000	110,000	0	0	0	
Reappropriated Funds	653,793	597,418	1,684,611	1,690,631	1,690,631	
Federal Funds	4,008,605	4,490,478	5,738,078	7,022,831	6,664,891	
(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	41,535,458	*
General Fund	5,655,519	6,823,650	7,211,028	5,918,099	5,918,099	
Cash Funds	934,073	3,099,843	2,226,262	4,270,044	4,270,044	
Reappropriated Funds	293,350	293,350	293,350	11,808	11,808	
Federal Funds	17,832,836	24,148,454	25,834,180	31,335,507	31,335,507	
MMIS Reprocurement Contracts	26,955,910	41,437,857	26,916,597	18,546,779	18,546,779	*
General Fund	2,657,672	4,164,679	2,615,317	1,034,108	1,034,108	
Cash Funds	539,548	1,177,899	701,879	875,342	875,342	
Reappropriated Funds	23,758,690	0	0	5,564	5,564	
Federal Funds	0	36,095,279	23,599,401	16,631,765	16,631,765	
MMIS Reprocurement Contracted Staff	407,681	4,448,524	5,145,018	0	0	
General Fund	4,017	353,814	431,304	0	0	
Cash Funds	64,139	131,360	134,757	0	0	
Reappropriated Funds	339,525	0	0	0	0	
Federal Funds	0	3,963,350	4,578,957	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Fraud Detection Software Contract	135,000	164,143	250,000	115,000	115,000	*
General Fund	34,136	62,500	62,500	28,345	28,345	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	100,864	101,643	187,500	86,655	86,655	
Health Information Exchange Maintenance and Projects	3,746,881	14,168,748	10,622,455	8,072,455	8,072,455	
General Fund	524,667	2,321,876	2,046,246	1,891,246	1,891,246	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	3,222,214	11,846,872	8,576,209	6,181,209	6,181,209	
Colorado Benefits Management Systems, Operating and Contract Expenses	0	13,324,222	21,856,412	23,549,140	23,549,140	*
General Fund	0	4,578,401	5,555,972	5,219,684	5,219,684	
Cash Funds	0	2,086,971	2,486,415	3,453,935	3,453,935	
Reappropriated Funds	0	42,532	53,221	57,566	57,566	
Federal Funds	0	6,616,318	13,760,804	14,817,955	14,817,955	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	0	0	681,803	684,816	684,816	*
General Fund	0	0	244,624	245,329	245,329	
Cash Funds	0	0	95,126	95,921	95,921	
Reappropriated Funds	0	0	1,711	1,719	1,719	
Federal Funds	0	0	340,342	341,847	341,847	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
Connect for Health Colorado Systems	0	0	669,757	669,757	669,757 *
General Fund	0	0	0	122,690	0
Cash Funds	0	0	122,690	0	122,690
Federal Funds	0	0	547,067	547,067	547,067
Centralized Eligibility Vendor Contract Project	6,824,419	2,275,016	0	0	0
General Fund	0	0	0	0	0
Cash Funds	2,281,751	1,137,508	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,542,668	1,137,508	0	0	0
SUBTOTAL - (C) Information Technology Contracts and Projects	62,785,669	110,183,807	101,706,862	93,173,405	93,173,405
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	8,876,011	18,304,920	18,166,991	14,459,501	14,336,811
Cash Funds	3,819,511	7,633,581	5,767,129	8,695,242	8,817,932
Reappropriated Funds	24,391,565	335,882	348,282	76,657	76,657
Federal Funds	25,698,582	83,909,424	77,424,460	69,942,005	69,942,005
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	247,001	182,775	278,974	278,974	278,974
General Fund	63,966	61,681	90,988	90,988	90,988
Cash Funds	58,738	30,109	44,587	44,587	44,587
Reappropriated Funds	1,593	19	28	28	28
Federal Funds	122,704	90,966	143,371	143,371	143,371

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
Contracts for Special Eligibility Determinations	6,623,800	8,095,340	11,402,297	11,402,297	11,402,297
General Fund	664,131	904,553	969,756	969,756	969,756
Cash Funds	2,290,311	2,763,760	4,343,468	4,343,468	4,343,468
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,669,358	4,427,027	6,089,073	6,089,073	6,089,073
County Administration	36,730,383	43,358,806	45,998,063	45,998,063	45,998,063
General Fund	10,572,620	11,114,448	11,114,448	11,114,448	11,114,448
Cash Funds	0	5,859,623	5,859,623	5,859,623	5,859,623
Reappropriated Funds	0	0	0	0	0
Federal Funds	26,157,763	26,384,735	29,023,992	29,023,992	29,023,992
Hospital Provider Fee County Administration	10,038,778	14,485,439	15,748,868	15,748,868	15,748,868
General Fund	0	0	0	0	0
Cash Funds	3,208,371	4,945,446	4,945,446	4,945,446	4,945,446
Reappropriated Funds	0	0	0	0	0
Federal Funds	6,830,407	9,539,993	10,803,422	10,803,422	10,803,422
Administrative Case Management	1,514,868	869,744	869,744	869,744	869,744
General Fund	757,434	434,872	434,872	434,872	434,872
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	757,434	434,872	434,872	434,872	434,872
Medical Assistance Sites	78,000	709,730	1,531,968	1,531,968	1,531,968
General Fund	0	0	0	0	0
Cash Funds	39,000	184,347	402,984	402,984	402,984
Reappropriated Funds	0	0	0	0	0
Federal Funds	39,000	525,383	1,128,984	1,128,984	1,128,984

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Customer Outreach	5,079,676	5,309,698	5,904,846	6,607,445	6,607,445	*
General Fund	2,203,298	2,215,113	2,556,675	2,873,665	2,873,665	
Cash Funds	336,621	336,620	336,621	336,621	336,621	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,539,757	2,757,965	3,011,550	3,397,159	3,397,159	
Centralized Eligibility Vendor Contract Project	0	0	5,053,644	5,053,644	5,053,644	
Cash Funds	0	0	1,745,342	1,745,342	1,745,342	
Federal Funds	0	0	3,308,302	3,308,302	3,308,302	
Connect for Health Colorado Eligibility Determination	0	0	4,474,451	4,474,451	4,474,451	*
General Fund	0	0	0	1,667,767	0	
Cash Funds	0	0	1,667,767	0	1,667,767	
Federal Funds	0	0	2,806,684	2,806,684	2,806,684	
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	774,366	0	0	0	0	
General Fund	74,945	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	699,421	0	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
SUBTOTAL - (D) Eligibility Determinations and Client Services	61,086,872	73,011,532	91,262,855	91,965,454	91,965,454	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	14,336,394	14,730,667	15,166,739	17,151,496	15,483,729	
Cash Funds	5,933,041	14,119,905	19,345,838	17,678,071	19,345,838	
Reappropriated Funds	1,593	19	28	28	28	
Federal Funds	40,815,844	44,160,941	56,750,250	57,135,859	57,135,859	
(E) Utilization and Quality Review Contracts						
Professional Service Contracts	8,825,726	9,726,242	12,187,863	13,116,097	13,116,097	*
General Fund	2,514,723	2,877,507	3,503,473	3,702,073	3,702,073	
Cash Funds	329,807	342,739	461,089	470,308	470,308	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	5,981,196	6,505,996	8,223,301	8,943,716	8,943,716	
SUBTOTAL - (E) Utilization and Quality Review Contracts	8,825,726	9,726,242	12,187,863	13,116,097	13,116,097	
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	3,702,073	
Cash Funds	329,807	342,739	461,089	470,308	470,308	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	5,981,196	6,505,996	8,223,301	8,943,716	8,943,716	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
(F) Provider Audits and Services					
Professional Audit Contracts	2,108,454	2,454,646	3,476,907	3,254,646	3,254,646 *
General Fund	947,607	1,042,243	1,303,908	1,299,343	1,299,343
Cash Funds	106,620	191,893	415,408	312,420	312,420
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,054,227	1,220,510	1,757,591	1,642,883	1,642,883
SUBTOTAL - (F) Provider Audits and Services	2,108,454	2,454,646	3,476,907	3,254,646	3,254,646
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	947,607	1,042,243	1,303,908	1,299,343	1,299,343
Cash Funds	106,620	191,893	415,408	312,420	312,420
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,054,227	1,220,510	1,757,591	1,642,883	1,642,883
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	844,170	673,182	700,000	700,000	700,000
General Fund	0	0	0	0	0
Cash Funds	422,085	336,591	350,000	350,000	350,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	422,085	336,591	350,000	350,000	350,000
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	844,170	673,182	700,000	700,000	700,000
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Cash Funds	422,085	336,591	350,000	350,000	350,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	422,085	336,591	350,000	350,000	350,000

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
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	
FTE	0.0	0.0	0.0	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	
(H) Indirect Cost Assessment					
Indirect Cost Assessment	245,511	567,546	695,366	911,170	911,170
General Fund	0	0	0	0	0
Cash Funds	141,654	178,540	224,727	257,456	257,456
Reappropriated Funds	2,766	0	5,941	117,432	117,432
Federal Funds	101,091	389,006	464,698	536,282	536,282
SUBTOTAL - (H) Indirect Cost Assessment	245,511	567,546	695,366	911,170	911,170
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Cash Funds	141,654	178,540	224,727	257,456	257,456
Reappropriated Funds	2,766	0	5,941	117,432	117,432
Federal Funds	101,091	389,006	464,698	536,282	536,282

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
TOTAL - (1) Executive Director's Office	193,953,648	256,939,982	277,819,387	278,374,533	276,492,992
FTE	360.4	388.0	400.3	415.6	413.8
General Fund	47,279,342	59,889,564	61,576,694	63,540,333	60,801,779
Cash Funds	15,547,469	27,486,703	32,982,577	34,219,670	35,724,633
Reappropriated Funds	26,697,442	1,658,452	3,793,318	3,661,005	3,876,809
Federal Funds	104,429,395	167,905,263	179,466,798	176,953,525	176,089,771

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(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	6,794,137,652	7,144,917,275	7,416,388,776	*
General Fund	882,758,797	1,029,604,779	1,062,533,776	1,200,401,795	1,197,286,681	
General Fund Exempt	813,135,957	809,024,467	873,835,000	873,835,000	873,835,000	
Cash Funds	549,810,900	822,942,823	698,906,376	690,213,730	884,495,577	
Reappropriated Funds	0	9,214,192	9,102,709	9,031,044	9,031,044	
Federal Funds	3,482,402,881	4,168,502,891	4,149,759,791	4,371,435,706	4,451,740,474	
TOTAL - (2) Medical Services Premiums	5,728,108,535	6,839,289,152	6,794,137,652	7,144,917,275	7,416,388,776	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	882,758,797	1,029,604,779	1,062,533,776	1,200,401,795	1,197,286,681	
General Fund Exempt	813,135,957	809,024,467	873,835,000	873,835,000	873,835,000	
Cash Funds	549,810,900	822,942,823	698,906,376	690,213,730	884,495,577	
Reappropriated Funds	0	9,214,192	9,102,709	9,031,044	9,031,044	
Federal Funds	3,482,402,881	4,168,502,891	4,149,759,791	4,371,435,706	4,451,740,474	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(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	605,844,642	647,630,305	616,836,053	*
General Fund	173,415,971	166,102,477	168,584,973	173,967,178	172,509,947	
Cash Funds	5,333,335	9,773,437	17,918,141	26,612,883	25,816,287	
Federal Funds	386,670,933	427,342,755	419,341,528	447,050,244	418,509,819	
Behavioral Health Fee-for-service Payments	7,525,423	8,086,839	8,438,052	9,241,145	8,847,038	*
General Fund	2,946,662	1,881,329	1,838,697	2,010,180	1,911,520	
Cash Funds	20,963	71,017	214,571	382,610	369,467	
Federal Funds	4,557,798	6,134,493	6,384,784	6,848,355	6,566,051	
School-based Prevention and Intervention Substance Use Disorder Services	4,540,153	0	0	0	0	
General Fund	2,132,374	0	0	0	0	
Federal Funds	2,407,779	0	0	0	0	
School-based Substance Abuse Prevention and Intervention Grant Program	795,909	0	0	0	0	
General Fund	795,909	0	0	0	0	
Contract Reprocurement	203,752	0	0	0	0	
General Fund	101,876	0	0	0	0	
Federal Funds	101,876	0	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
TOTAL - (3) Behavioral Health Community Programs	578,485,476	611,305,508	614,282,694	656,871,450	625,683,091
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	179,392,792	167,983,806	170,423,670	175,977,358	174,421,467
Cash Funds	5,354,298	9,844,454	18,132,712	26,995,493	26,185,754
Federal Funds	393,738,386	433,477,248	425,726,312	453,898,599	425,075,870

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(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	3,360,575	3,360,575	*
FTE	30.5	34.2	35.5	39.1	39.1	
General Fund	1,241,132	1,405,951	1,431,598	1,572,568	1,572,568	
Cash Funds	0	259,564	257,080	262,556	337,556	
Reappropriated Funds	0	0	0	1,579	(73,421)	
Federal Funds	1,356,924	1,425,092	1,375,304	1,523,872	1,523,872	
Operating Expenses	250,603	2,027,063	301,489	248,858	(520,192)	*
General Fund	126,325	144,899	144,899	120,935	120,935	
Cash Funds	0	567,513	5,201	2,850	3,800	
Reappropriated Funds	0	0	0	0	(770,000)	
Federal Funds	124,278	1,314,651	151,389	125,073	125,073	
Community and Contract Management System	106,864	137,480	137,480	137,480	137,480	
General Fund	68,839	89,362	89,362	89,362	89,362	
Federal Funds	38,025	48,118	48,118	48,118	48,118	
Support Level Administration	39,498	57,368	57,368	1,319,037	1,319,037	
General Fund	19,749	28,684	28,684	659,171	659,171	
Cash Funds	0	0	0	221	221	
Federal Funds	19,749	28,684	28,684	659,645	659,645	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Cross-system Response for behavioral Health Crises						
Pilot Program	0	3,390,000	1,690,000	1,075,776	1,075,776	*
FTE	0.0	0.0	0.0	0.0	0.0	
Cash Funds	0	1,695,000	1,690,000	1,075,776	1,075,776	
Reappropriated Funds	0	1,695,000	0	0	0	
Cross-System Response Pilot Program Services	0	0	1,050,215	0	1,050,215	
Cash Funds	0	0	741,986	0	741,986	
Reappropriated Funds	0	0	308,229	0	308,229	
SUBTOTAL - (i) Administrative Costs	2,995,021	8,702,518	6,300,534	6,141,726	6,422,891	
FTE	30.5	34.2	35.5	39.1	39.1	
General Fund	1,456,045	1,668,896	1,694,543	2,442,036	2,442,036	
Cash Funds	0	2,522,077	2,694,267	1,341,403	2,159,339	
Reappropriated Funds	0	1,695,000	308,229	1,579	(535,192)	
Federal Funds	1,538,976	2,816,545	1,603,495	2,356,708	2,356,708	
(ii) Program Costs						
Adult Comprehensive Services	316,670,767	375,465,768	362,346,433	369,815,964	369,815,964	*
General Fund	156,848,877	169,373,036	180,448,523	176,446,775	176,446,775	
Cash Funds	1	31,281,613	1	8,461,207	8,461,207	
Federal Funds	159,821,889	174,811,119	181,897,909	184,907,982	184,907,982	
Adult Supported Living Services	56,136,806	62,872,177	74,382,391	71,296,103	75,997,103	*
General Fund	33,457,241	34,961,826	38,677,034	39,398,224	39,398,224	
Cash Funds	0	0	4,701,000	209,815	4,910,815	
Federal Funds	22,679,565	27,910,351	31,004,357	31,688,064	31,688,064	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Children's Extensive Support Services	15,985,596	22,544,937	26,310,826	26,774,458	26,774,458	*
General Fund	8,389,564	11,094,363	13,102,791	13,387,229	13,387,229	
Federal Funds	7,596,032	11,450,574	13,208,035	13,387,229	13,387,229	
Case Management	26,970,379	30,139,104	32,255,501	32,795,233	32,795,233	*
General Fund	14,302,452	15,404,955	16,605,002	17,400,076	17,400,076	
Cash Funds	0	0	0	40,923	40,923	
Federal Funds	12,667,927	14,734,149	15,650,499	15,354,234	15,354,234	
Family Support Services	7,828,718	6,960,204	6,960,460	6,960,460	6,960,460	
General Fund	6,828,718	6,960,204	6,960,460	6,960,460	6,960,460	
Cash Funds	1,000,000	0	0	0	0	
Preventive Dental Hygiene	0	67,012	63,311	63,311	63,311	
General Fund	0	63,308	63,311	63,311	63,311	
Cash Funds	0	3,704	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Eligibility Determination and Waiting List Management	3,001,454	3,121,079	3,121,194	3,121,194	3,121,194	
General Fund	2,986,287	3,100,442	3,100,556	3,100,556	3,100,556	
Federal Funds	15,167	20,637	20,638	20,638	20,638	
Waiver Enrollment	1,633,428	1,586,987	0	0	0	
Cash Funds	1,633,428	1,586,987	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
SUBTOTAL - (ii) Program Costs	428,227,148	502,757,268	505,440,116	510,826,723	515,527,723
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	256,756,631
Cash Funds	2,633,429	32,872,304	4,701,001	8,711,945	13,412,945
Reappropriated Funds	0	0	0	0	0
Federal Funds	202,780,580	228,926,830	241,781,438	245,358,147	245,358,147
TOTAL - (4) Office of Community Living	431,222,169	511,459,786	511,740,650	516,968,449	521,950,614
FTE	30.5	34.2	35.5	39.1	39.1
General Fund	224,269,184	242,627,030	260,652,220	259,198,667	259,198,667
Cash Funds	2,633,429	35,394,381	7,395,268	10,053,348	15,572,284
Reappropriated Funds	0	1,695,000	308,229	1,579	(535,192)
Federal Funds	204,319,556	231,743,375	243,384,933	247,714,855	247,714,855

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(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	311,296,186	*
General Fund	0	0	0	0	0	
Cash Funds	152,391,319	152,556,889	155,073,238	155,648,093	155,648,093	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	157,079,265	157,569,068	156,222,948	155,648,093	155,648,093	
Clinic Based Indigent Care	6,119,760	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	3,059,880	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	3,106,237	3,108,226	3,072,120	3,059,880	3,059,880	
Pediatric Specialty Hospital	13,455,012	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	6,727,506	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	6,829,428	6,833,800	6,754,416	6,727,506	6,727,506	
Appropriation from Tobacco Tax Fund to the General Fund	423,600	427,593	432,590	432,590	440,340	
General Fund	0	0	0	0	0	
Cash Funds	423,600	427,593	432,590	432,590	440,340	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Primary Care Fund	26,828,000	26,778,000	27,276,358	27,276,358	27,767,192	
General Fund	0	0	0	0	0	
Cash Funds	26,828,000	26,778,000	27,276,358	27,276,358	27,767,192	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Children's Basic Health Plan Administration	3,653,692	1,771,063	5,033,274	5,033,274	5,033,274	*
General Fund	0	0	0	0	0	
Cash Funds	1,214,777	231,115	597,450	603,993	603,993	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,438,915	1,539,948	4,435,824	4,429,281	4,429,281	
Children's Basic Health Plan Medical and Dental Costs	130,538,362	126,415,423	166,010,066	159,965,046	179,773,700	*
General Fund	6,003,180	2,098,125	2,069,366	189,026	217,686	
General Fund Exempt	0	427,593	432,590	432,590	411,680	
Cash Funds	48,154,315	26,137,685	24,294,008	20,959,031	23,328,320	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	76,380,867	97,752,020	139,214,102	138,384,399	155,816,014	
TOTAL - (4) Indigent Care Program	490,489,010	485,092,808	529,623,246	523,578,226	543,885,464	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	15,642,287	11,730,871	11,817,602	9,976,412	10,005,072	
General Fund Exempt	0	427,593	432,590	432,590	411,680	
Cash Funds	229,012,011	206,131,282	207,673,644	204,920,065	207,787,938	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	245,834,712	266,803,062	309,699,410	308,249,159	325,680,774	

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

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Medicare Modernization Act State Contribution Payment	107,776,447	114,014,334	130,953,722	150,341,733	148,950,319	*
General Fund	107,360,512	114,014,334	130,953,722	150,341,733	148,950,319	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	415,935	0	0	0	0	
Public School Health Services Contract Administration	854,207	923,345	2,491,722	2,491,722	2,491,722	
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	854,207	923,345	2,491,722	2,491,722	2,491,722	
Federal Funds	0	0	0	0	0	
Public School Health Services	62,716,218	78,309,241	91,997,962	93,022,977	93,022,977	*
General Fund	0	0	0	0	0	
Cash Funds	31,449,659	38,606,226	45,756,639	46,505,586	46,505,586	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	31,266,559	39,703,015	46,241,323	46,517,391	46,517,391	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	0	134,100	750,000	750,000	750,000	
General Fund	0	500,000	0	0	0	
Cash Funds	0	(365,900)	750,000	750,000	750,000	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
TOTAL - (5) Other Medical Services	180,617,743	208,546,787	250,739,132	271,152,158	269,760,744
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	111,705,833	123,157,131	139,684,674	159,095,851	157,704,437
Cash Funds	31,880,659	38,885,308	56,506,639	57,255,586	57,255,586
Reappropriated Funds	854,207	923,345	2,491,722	2,491,722	2,491,722
Federal Funds	36,177,044	45,581,003	52,056,097	52,308,999	52,308,999

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(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.						
(A) Executive Director's Office - Medicaid Funding						
DHS Previous Structure						
Executive Director's Office - Medicaid Funding	13,036,103	30,324,971	0	0	0	
General Fund	6,436,271	15,148,287	0	0	0	
Federal Funds	6,599,832	15,176,684	0	0	0	
SUBTOTAL - DHS Previous Structure	13,036,103	30,324,971	0	0	0	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	6,436,271	15,148,287	0	0	0	
Federal Funds	6,599,832	15,176,684	0	0	0	
(1) DHS General Administration						
Personal Services	0	0	193,073	39	39	
General Fund	0	0	96,537	20	19	
Federal Funds	0	0	96,536	19	20	
Health, Life, and Dental	0	0	6,585,648	6,883,095	6,883,095	*
General Fund	0	0	3,218,895	3,441,547	3,441,547	
Federal Funds	0	0	3,366,753	3,441,548	3,441,548	
Short-term Disability	0	0	65,634	62,117	62,117	
General Fund	0	0	33,780	31,058	31,058	
Federal Funds	0	0	31,854	31,059	31,059	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
S.B. 04-257 Amortization Equalization Disbursement	0	0	1,791,572	1,627,283	1,627,283	
General Fund	0	0	912,063	813,642	813,642	
Federal Funds	0	0	879,509	813,641	813,641	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	0	0	1,776,931	1,647,240	1,647,240	
General Fund	0	0	904,137	823,620	823,620	
Federal Funds	0	0	872,794	823,620	823,620	
Salary Survey	0	0	140,012	1,076,968	1,076,968	
General Fund	0	0	77,538	538,484	538,484	
Federal Funds	0	0	62,474	538,484	538,484	
Shift Differential	0	0	1,855,670	2,313,487	2,313,487	
General Fund	0	0	947,354	1,156,744	1,156,744	
Federal Funds	0	0	908,316	1,156,743	1,156,743	
Workers' Compensation	0	0	2,557,448	2,398,448	2,398,448	
General Fund	0	0	1,278,724	1,199,224	1,199,224	
Federal Funds	0	0	1,278,724	1,199,224	1,199,224	
Operating Expenses	0	0	106,183	0	0	
General Fund	0	0	53,091	0	0	
Federal Funds	0	0	53,092	0	0	
Payment to Risk Management and Property Funds	0	0	178,070	257,834	257,834	*
General Fund	0	0	89,034	128,917	128,917	
Federal Funds	0	0	89,036	128,917	128,917	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
Injury Prevention Program	0	0	76,417	76,418	76,418
General Fund	0	0	38,209	38,209	38,209
Federal Funds	0	0	38,208	38,209	38,209
Merit Pay	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
SUBTOTAL - (1) DHS General Administration	0	0	15,326,658	16,342,929	16,342,929
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	7,649,362	8,171,465	8,171,464
Federal Funds	0	0	7,677,296	8,171,464	8,171,465
(2) DHS Special Purpose					
Employment and Regulatory Affairs	0	0	722,954	723,981	723,981
General Fund	0	0	361,477	361,991	361,991
Federal Funds	0	0	361,477	361,990	361,990
Health Insurance portability and Accountability Act of 1996 – Security Remediation	0	0	60,261	60,261	60,261
General Fund	0	0	44,098	30,131	30,131
Federal Funds	0	0	16,163	30,130	30,130
SUBTOTAL - (2) DHS Special Purpose	0	0	783,215	784,242	784,242
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	405,575	392,122	392,122
Federal Funds	0	0	377,640	392,120	392,120

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	13,036,103	30,324,971	16,109,873	17,127,171	17,127,171
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	6,436,271	15,148,287	8,054,937	8,563,587	8,563,586
Federal Funds	6,599,832	15,176,684	8,054,936	8,563,584	8,563,585
(B) Office of Information Technology Services - Medicaid Funding					
DHS Previous Structure					
Colorado Benefits Management System	11,146,358	624,648	0	0	
General Fund	4,192,880	223,621	0	0	
Cash Funds	1,393,789	87,072	0	0	
Reappropriated Funds	0	2,521	0	0	
Federal Funds	5,559,689	311,434	0	0	
Other Office of Information Technology Services line items	615,988	647,220	0	0	
General Fund	303,328	318,950	0	0	
Federal Funds	312,660	328,270	0	0	
CBMS SAS-70 Audit	30,349	0	0	0	
General Fund	15,193	0	0	0	
Federal Funds	15,156	0	0	0	
Colorado Benefits Management System, HCPF Only	611,520	0	0	0	
Cash Funds	305,760	0	0	0	
Federal Funds	305,760	0	0	0	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
CBMS Modernization Project Personal Services, Operating Expenses, and Centrally Appropriated Expenses	580,580	0	0	0		
General Fund	217,110	0	0	0		
Cash Funds	73,180	0	0	0		
Federal Funds	290,290	0	0	0		
CBMS Modernization Project, Phase II	12,018,067	0	0	0		
General Fund	1,165,344	0	0	0		
Cash Funds	968,100	0	0	0		
Federal Funds	9,884,623	0	0	0		
SUBTOTAL - DHS Previous Structure	25,002,862	1,271,868	0	0		
FTE	0.0	0.0	0.0	0.0		
General Fund	5,893,855	542,571	0	0		
Cash Funds	2,740,829	87,072	0	0		
Reappropriated Funds	0	2,521	0	0		
Federal Funds	16,368,178	639,704	0	0		
(1) DHS Information Technology						
Payments to OIT	0	0	647,220	736,283	736,283	*
General Fund	0	0	322,316	368,142	368,142	
Federal Funds	0	0	324,904	368,141	368,141	
SUBTOTAL - (1) DHS Information Technology	0	0	647,220	736,283	736,283	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	322,316	368,142	368,142	
Federal Funds	0	0	324,904	368,141	368,141	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	25,002,862	1,271,868	647,220	736,283	736,283	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	5,893,855	542,571	322,316	368,142	368,142	
Cash Funds	2,740,829	87,072	0	0	0	
Reappropriated Funds	0	2,521	0	0	0	
Federal Funds	16,368,178	639,704	324,904	368,141	368,141	
(C) Office of Operations - Medicaid Funding						
DHS Previous Structure						
Office of Operations - Medicaid Funding	4,228,581	5,566,028	5,627,443	0	5,627,443	*
General Fund	2,093,656	2,742,584	2,802,571	0	2,802,571	
Federal Funds	2,134,925	2,823,444	2,824,872	0	2,824,872	
SUBTOTAL - DHS Previous Structure	4,228,581	5,566,028	5,627,443	0	5,627,443	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,093,656	2,742,584	2,802,571	0	2,802,571	
Federal Funds	2,134,925	2,823,444	2,824,872	0	2,824,872	
(1) DHS Administration						
Personal Services	0	0	0	3,924,327	69,544	*
General Fund	0	0	0	1,962,164	42,319	
Federal Funds	0	0	0	1,962,163	27,225	
Vehicle Lease Payments	0	0	0	256,192	0	
General Fund	0	0	0	128,096	512	
Federal Funds	0	0	0	128,096	(512)	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Utilities	0	0	0	1,545,968	0	*
General Fund	0	0	0	772,984	3,092	
Federal Funds	0	0	0	772,984	(3,092)	
SUBTOTAL - (1) DHS Administration	0	0	0	5,726,487	69,544	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	0	2,863,244	45,923	
Federal Funds	0	0	0	2,863,243	23,621	
SUBTOTAL - (C) Office of Operations - Medicaid Funding	4,228,581	5,566,028	5,627,443	5,726,487	5,696,987	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,093,656	2,742,584	2,802,571	2,863,244	2,848,494	
Federal Funds	2,134,925	2,823,444	2,824,872	2,863,243	2,848,493	
(D) Division of Child Welfare - Medicaid Funding						
Administration	128,550	122,128	142,640	143,008	143,008	
General Fund	64,274	61,061	71,320	71,504	71,504	
Federal Funds	64,276	61,067	71,320	71,504	71,504	
Child Welfare Services	6,814,876	15,213,328	15,197,702	15,197,702	15,197,702	*
General Fund	3,346,566	7,481,767	7,568,456	7,598,851	7,598,851	
Federal Funds	3,468,310	7,731,561	7,629,246	7,598,851	7,598,851	
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	6,943,426	15,335,456	15,340,342	15,340,710	15,340,710	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	3,410,840	7,542,828	7,639,776	7,670,355	7,670,355	
Federal Funds	3,532,586	7,792,628	7,700,566	7,670,355	7,670,355	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
(D.5) Office of Early Childhood - Medicaid Funding					
Division of Community and Family Support, Early Intervention Services	4,002,321	3,617,689	6,563,353	6,563,353	6,563,353 *
General Fund	1,969,640	1,779,075	3,268,550	3,282,308	3,281,677
Federal Funds	2,032,681	1,838,614	3,294,803	3,281,045	3,281,676
SUBTOTAL - (D.5) Office of Early Childhood - Medicaid Funding	4,002,321	3,617,689	6,563,353	6,563,353	6,563,353
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,969,640	1,779,075	3,268,550	3,282,308	3,281,677
Federal Funds	2,032,681	1,838,614	3,294,803	3,281,045	3,281,676
(E) Office of Self Sufficiency - Medicaid Funding					
(1) DHS Special Purpose Welfare Programs					
Systematic Alien Verification for Eligibility	15,887	34,505	25,799	25,799	25,799
Federal Funds	15,887	34,505	25,799	25,799	25,799
SUBTOTAL - (1) DHS Special Purpose Welfare Programs	15,887	34,505	25,799	25,799	25,799
FTE	0.0	0.0	0.0	0.0	0.0
Federal Funds	15,887	34,505	25,799	25,799	25,799
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	15,887	34,505	25,799	25,799	25,799
FTE	0.0	0.0	0.0	0.0	0.0
Federal Funds	15,887	34,505	25,799	25,799	25,799

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
(F) Behavioral Health Services - Medicaid Funding					
DHS Previous Structure					
Mental Health Institutes	4,444,254	6,693,980	0	0	0
General Fund	1,995,085	3,294,108	0	0	0
Federal Funds	2,449,169	3,399,872	0	0	0
Community Behavioral Health Administration	323,369	416,056	0	0	0
General Fund	161,684	208,028	0	0	0
Federal Funds	161,685	208,028	0	0	0
SUBTOTAL - DHS Previous Structure	4,767,623	7,110,036	0	0	0
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	2,156,769	3,502,136	0	0	0
Federal Funds	2,610,854	3,607,900	0	0	0
(1) DHS Community Behavioral Health Administration					
Personal Services	0	317,990	403,830	406,126	406,126
General Fund	0	158,994	201,915	203,063	203,063
Federal Funds	0	158,996	201,915	203,063	203,063
Operating Expenses	0	12,226	12,226	12,226	12,226
General Fund	0	6,113	6,113	6,113	6,113
Federal Funds	0	6,113	6,113	6,113	6,113
SUBTOTAL - (1) DHS Community Behavioral Health Administration	0	330,216	416,056	418,352	418,352
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	165,107	208,028	209,176	209,176
Federal Funds	0	165,109	208,028	209,176	209,176

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(2) DHS Mental Health Community Programs						
Mental Health Treatment Services for Youth (H.B. 99-1116)	8,677	8,133	123,624	123,624	123,624	*
General Fund	4,284	4,008	61,565	61,812	61,812	
Federal Funds	4,393	4,125	62,059	61,812	61,812	
SUBTOTAL - (2) DHS Mental Health Community Programs	8,677	8,133	123,624	123,624	123,624	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	4,284	4,008	61,565	61,812	61,812	
Federal Funds	4,393	4,125	62,059	61,812	61,812	
(3) DHS Substance Use Treatment and Prevention						
High Risk Pregnant Women Program	969,806	735,467	1,600,000	1,600,000	1,600,000	*
General Fund	478,103	361,798	796,800	800,000	800,000	
Federal Funds	491,703	373,669	803,200	800,000	800,000	
SUBTOTAL - (3) DHS Substance Use Treatment and Prevention	969,806	735,467	1,600,000	1,600,000	1,600,000	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	478,103	361,798	796,800	800,000	800,000	
Federal Funds	491,703	373,669	803,200	800,000	800,000	
(4) DHS Mental Health Institutes						
Personal Services	0	0	14,490	14,490	14,490	*
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	7,216	7,245	7,245	
Federal Funds	0	0	7,274	7,245	7,245	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Operating Expenses	0	0	13,524	13,524	13,524	*
General Fund	0	0	6,735	6,762	6,762	
Federal Funds	0	0	6,789	6,762	6,762	
Pharmaceuticals	0	0	10,178	10,178	10,178	*
General Fund	0	0	5,069	5,089	5,089	
Federal Funds	0	0	5,109	5,089	5,089	
SUBTOTAL - (4) DHS Mental Health Institutes	0	0	38,192	38,192	38,192	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	19,020	19,096	19,096	
Federal Funds	0	0	19,172	19,096	19,096	
(4) DHS Mental Health Institutes						
Personal Services	0	7,176,701	6,016,870	6,016,871	6,016,871	*
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	3,249,703	2,996,401	3,004,715	3,008,435	
Federal Funds	0	3,926,998	3,020,469	3,012,156	3,008,436	
Operating Expenses	0	0	393,098	393,097	393,097	*
General Fund	0	0	195,763	198,332	196,548	
Federal Funds	0	0	197,335	194,765	196,549	
Pharmaceuticals	0	0	366,691	366,691	366,691	*
General Fund	0	0	182,612	185,221	183,346	
Federal Funds	0	0	184,079	181,470	183,345	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
Circle Program	0	0	17,321	17,321	17,321 *
General Fund	0	0	8,626	8,722	8,661
Federal Funds	0	0	8,695	8,599	8,660
SUBTOTAL - (4) DHS Mental Health Institutes	0	7,176,701	6,793,980	6,793,980	6,793,980
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	3,249,703	3,383,402	3,396,990	3,396,990
Federal Funds	0	3,926,998	3,410,578	3,396,990	3,396,990
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	5,746,106	15,360,553	8,971,852	8,974,148	8,974,148
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	2,639,156	7,282,752	4,468,815	4,487,074	4,487,074
Federal Funds	3,106,950	8,077,801	4,503,037	4,487,074	4,487,074
(G) Services for People with Disabilities - Medicaid Funding					
DHS Previous Structure					
Regional Centers	39,525,715	52,774,028	0	0	0
General Fund	17,309,840	24,029,264	0	0	0
Cash Funds	1,866,142	1,866,142	0	0	0
Federal Funds	20,349,733	26,878,622	0	0	0
Regional Center Depreciation and Annual Adjustments	943,063	1,044,544	0	0	0
General Fund	464,388	514,020	0	0	10,911
Federal Funds	478,675	530,524	0	0	(10,911)

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
SUBTOTAL - DHS Previous Structure	40,468,778	53,818,572	0	0	0	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	17,774,228	24,543,284	0	0	10,911	
Cash Funds	1,866,142	1,866,142	0	0	0	
Federal Funds	20,828,408	27,409,146	0	0	(10,911)	
(1) DHS Regional Centers for People with Developmental Disabilities						
Wheat Ridge Regional Center Intermediate Care Facility	0	0	25,382,498	23,978,321	23,978,321	*
General Fund	0	0	11,697,180	11,757,781	11,757,781	
Federal Funds	0	0	13,685,318	12,220,540	12,220,540	
Wheat Ridge Regional Center Provider Fee	0	0	1,412,851	2,848,463	2,848,463	*
Cash Funds	0	0	1,412,851	1,412,851	1,412,851	
Federal Funds	0	0	0	1,435,612	1,435,612	
Wheat Ridge Regional Center Depreciation	0	0	150,000	150,000	150,000	*
General Fund	0	0	74,700	75,885	75,885	
Federal Funds	0	0	75,300	74,115	74,115	
SUBTOTAL - (1) DHS Regional Centers for People with Developmental Disabilities	0	0	26,945,349	26,976,784	26,976,784	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	11,771,880	11,833,666	11,833,666	
Cash Funds	0	0	1,412,851	1,412,851	1,412,851	
Federal Funds	0	0	13,760,618	13,730,267	13,730,267	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
(1) DHS Regional Centers for People with Developmental Disabilities						
Grand Junction Regional Center Intermediate Care Facility	0	0	6,025,810	5,583,993	5,583,993	*
General Fund	0	0	3,000,853	3,019,549	3,019,549	
Federal Funds	0	0	3,024,957	2,564,444	2,564,444	
Grand Junction Regional Center Provider Fee	0	0	453,291	906,582	906,582	*
Cash Funds	0	0	453,291	453,291	453,291	
Federal Funds	0	0	0	453,291	453,291	
Grand Junction Regional Center Waiver Services	0	0	9,653,449	9,670,390	9,670,390	*
General Fund	0	0	4,807,418	4,835,195	4,835,195	
Federal Funds	0	0	4,846,031	4,835,195	4,835,195	
Grand Junction Regional Center Depreciation	0	0	515,997	515,997	515,997	*
General Fund	0	0	256,967	261,044	261,044	
Federal Funds	0	0	259,030	254,953	254,953	
SUBTOTAL - (1) DHS Regional Centers for People with Developmental Disabilities	0	0	16,648,547	16,676,962	16,676,962	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	8,065,238	8,115,788	8,115,788	
Cash Funds	0	0	453,291	453,291	453,291	
Federal Funds	0	0	8,130,018	8,107,883	8,107,883	
(1) DHS Regional Centers for People with Developmental Disabilities						
Pueblo Regional Center Waiver Services	0	0	10,232,792	10,432,048	10,357,048	*
General Fund	0	0	5,095,780	5,224,732	5,187,232	
Federal Funds	0	0	5,137,012	5,207,316	5,169,816	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Pueblo Regional Center Depreciation	0	0	436,036	436,036	436,036	*
General Fund	0	0	217,145	220,590	220,590	
Federal Funds	0	0	218,891	215,446	215,446	
SUBTOTAL - (1) DHS Regional Centers for People with Developmental Disabilities	0	0	10,668,828	10,868,084	10,793,084	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	5,312,925	5,445,322	5,407,822	
Federal Funds	0	0	5,355,903	5,422,762	5,385,262	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	40,468,778	53,818,572	54,262,724	54,521,830	54,446,830	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	17,774,228	24,543,284	25,150,043	25,394,776	25,368,187	
Cash Funds	1,866,142	1,866,142	1,866,142	1,866,142	1,866,142	
Federal Funds	20,828,408	27,409,146	27,246,539	27,260,912	27,212,501	
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding						
(1) DHS Community Services for the Elderly						
State Ombudsman Program	1,800	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	900	
Federal Funds	900	900	900	900	900	
State Funding for Senior Services	0	0	0	1,000,000	1,000,000	*
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	0	500,000	500,000	
Federal Funds	0	0	0	500,000	500,000	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
SUBTOTAL - (1) DHS Community Services for the Elderly	1,800	1,800	1,800	1,001,800	1,001,800	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	900	900	900	500,900	500,900	
Federal Funds	900	900	900	500,900	500,900	
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,001,800	1,001,800	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	900	900	900	500,900	500,900	
Federal Funds	900	900	900	500,900	500,900	
(I) Division of Youth Corrections - Medicaid Funding						
DHS Previous Structure						
Division of Youth Corrections - Medicaid Funding	1,413,139	1,582,081	0	0		
General Fund	696,590	778,787	0	0		
Federal Funds	716,549	803,294	0	0		
SUBTOTAL - DHS Previous Structure	1,413,139	1,582,081	0	0		
FTE	0.0	0.0	0.0	0.0		
General Fund	696,590	778,787	0	0		
Federal Funds	716,549	803,294	0	0		
(1) DHS Community Programs						
Personal Services	0	0	305,768	305,768	305,768	*
General Fund	0	0	152,273	152,883	152,883	
Federal Funds	0	0	153,495	152,885	152,885	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation	
Operating Expenses	0	0	11,306	11,306	11,306	*
General Fund	0	0	5,630	5,653	5,653	
Federal Funds	0	0	5,676	5,653	5,653	
Purchase of Contract Placements	0	0	911,433	763,739	574,844	*
General Fund	0	0	453,895	381,870	287,801	
Federal Funds	0	0	457,538	381,869	287,043	
Managed Care Project	0	0	35,252	35,252	35,252	*
General Fund	0	0	17,555	17,626	17,626	
Federal Funds	0	0	17,697	17,626	17,626	
SUBTOTAL - (1) DHS Community Programs	0	0	1,263,759	1,116,065	927,170	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	629,353	558,032	463,963	
Federal Funds	0	0	634,406	558,033	463,207	
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	1,413,139	1,582,081	1,263,759	1,116,065	927,170	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	696,590	778,787	629,353	558,032	463,963	
Federal Funds	716,549	803,294	634,406	558,033	463,207	
(J) Other						
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	500,000	500,000	500,000	500,000	500,000	
Federal Funds	500,000	500,000	500,000	500,000	500,000	

	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Appropriation	FY 2017-18 Request	FY 2017-18 Recommendation
SUBTOTAL - (J) Other	500,000	500,000	500,000	500,000	500,000
FTE	0.0	0.0	0.0	0.0	0.0
Federal Funds	500,000	500,000	500,000	500,000	500,000
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	101,359,003	127,413,523	109,314,165	111,633,646	111,340,251
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	40,915,136	60,361,068	52,337,261	53,688,418	53,552,378
Cash Funds	4,606,971	1,953,214	1,866,142	1,866,142	1,866,142
Reappropriated Funds	0	2,521	0	0	0
Federal Funds	55,836,896	65,096,720	55,110,762	56,079,086	55,921,731
TOTAL - Department of Health Care Policy and Financing	7,704,235,584	9,040,047,546	9,087,656,926	9,503,495,737	9,765,501,932
FTE	390.9	422.2	435.8	454.7	452.9
General Fund	1,501,963,371	1,695,354,249	1,759,025,897	1,921,878,834	1,912,970,481
General Fund Exempt	813,135,957	809,452,060	874,267,590	874,267,590	874,246,680
Cash Funds	838,845,737	1,142,638,165	1,023,463,358	1,025,524,034	1,228,887,914
Reappropriated Funds	27,551,649	13,493,510	15,695,978	15,185,350	14,864,383
Federal Funds	4,522,738,870	5,379,109,562	5,415,204,103	5,666,639,929	5,734,532,474

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LEGAL MEMORANDUM

TO: The Joint Budget Committee

FROM: Office of Legislative Legal Services

DATE: December 7, 2015

SUBJECT: Reduction in hospital provider fee revenue[1]

Legal Questions and Short Answers

1. Governor Hickenlooper's proposed budget for fiscal year 2016-17 (budget) proposes a $100 million dollar decrease in hospital provider fee (HPF) revenue. Would decreasing HPF revenue by $100 million dollars require additional legislation?

Short Answer: No. Under current law, the Medical Services Board (state board) in the Department of Health Care Policy and Financing (department) is required to set the amount of the HPF approximately equal to the General Assembly's appropriation specified for the fee. If the General Assembly reduces the HPF cash fund appropriation in the annual general appropriation act, the state board should reduce the HPF, thereby reducing HPF revenue to match the appropriation.

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[1] This legal memorandum results from a request made to the Office of Legislative Legal Services (OLLS), a staff agency of the General Assembly. OLLS legal memoranda do not represent an official legal position of the General Assembly or the State of Colorado and do not bind the members of the General Assembly. They are intended for use in the legislative process and as information to assist the members in the performance of their legislative duties.

2. Governor Hickenlooper's budget proposes reducing HPF revenue by $100 million dollars without any reduction in medical benefits or eligibility. Under current law, could HPF revenues be reduced by $100 million dollars without any reduction in medical benefits or eligibility?

> **Short Answer:** No. If HPF revenues and federal matching funds are insufficient to fully fund all of the purposes for the HPF, the HPF statute requires HPF revenue to be used first to fully fund hospital reimbursement and incentive payments and certain administrative expenses relating to the fee, with any remaining HPF revenue used to fund the expansion of medical benefits or eligibility. Without legislation amending the HPF statute, the state board is required to adopt rules, to be approved by the Joint Budget Committee, that reduce medical benefits or eligibility to match available HPF revenue.

3. Any state board rules that reduce medical benefits or eligibility pursuant to the requirement in the HPF statute must comply with the requirement in the "State Administrative Procedure Act"[2] that agency rules not conflict with other provisions of law. Would state board rules adopted pursuant to the HPF statute that reduce medical benefits or eligibility conflict with other provisions of law?

> **Short Answer:** Partly, yes. State and federal law enacted subsequent to the enactment of the HPF statute limits, in part, the state board's authority to reduce medical benefits or eligibility pursuant to the HPF statute.

4. State TABOR[3] revenue for FY 2016-17 is forecast to exceed the state spending limit by over $250 million.[4] Governor Hickenlooper's budget proposes reducing HPF revenue by $100 million, which would reduce the forecasted TABOR refund by $100 million and make $100 million of additional general fund money available for expenditure. By increasing available general fund money, does the proposal convert the HPF from a fee into a tax and trigger TABOR voter approval requirements?

> **Short Answer:** No. Based on relevant Colorado Supreme Court precedents, the HPF currently satisfies all legal requirements for classification under TABOR as a fee rather than a tax. Reducing the amount of HPF revenue collected as

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[2] Section 24-4-101, C.R.S., et seq.

[3] *The Taxpayer's Bill of Rights,* Colo. Const., art X, sec. 20.

[4] Colorado Legislative Council Staff Economics Section, *Focus Colorado: Economic and Revenue Forecast,* September 21, 2015.

proposed does not convert the HPF from a fee to a tax and does not trigger TABOR voter approval requirements.

Discussion

1. The HPF statute requires the state board to establish the HPF approximately equal to the General Assembly's appropriations specified for the fee.

The state board has the authority to establish the amount of the HPF and the rules governing the fee.[5] However, the state board's authority to establish the amount of the HPF is tied to the General Assembly's power to appropriate HPF cash funds. All money in the HPF cash fund is "subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly . . . " for the purposes set forth in the HPF statute.[6] Section 25.5-4-402.3 (3) (b), C.R.S., reads in part:

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (3) (b) The provider fees shall be assessed pursuant to rules adopted by the state board, pursuant to section 24-4-103, C.R.S. **The amount of the fee shall be established by rule of the state board** but shall not exceed the federal limit for such fees. **In establishing the amount of the fee** and in promulgating the rules governing the fee, **the state board shall:**
>
> (III) **Establish the amount of the provider fee** so that the amount collected from the fee is **approximately equal to or less than the amount of the appropriation specified for the fee in the general appropriation act** or any supplemental appropriation act. (**emphasis added**)

Pursuant to section 25.5-4-402.3 (3) (b), C.R.S., if the General Assembly were to reduce its appropriation of HPF cash funds in the annual general appropriations act from the amount appropriated in the previous year, the state board would be required to adopt rules for the assessment of the fee that result in HPF revenue that approximates the General Assembly's reduced appropriation. Therefore, without additional legislation, a $100 million dollar reduction in the General Assembly's appropriation of HPF cash funds should result in a reduction in the HPF and the collection of approximately $100 million dollars less in HPF revenue.

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[5] Section 25.5-4-402.3 (3) (b), C.R.S.

[6] Section 25.5-4-402.3 (4) (b), C.R.S.

2. The HPF statute contemplates that HPF revenue may be insufficient to fully fund all of the statutory purposes for the HPF.

2.1. The HPF statute prioritizes the use of HPF revenue when revenue is insufficient to fully fund all of the statutory purposes for the HPF.

The statutory purposes for the HPF are set forth in section 25.5-4-402.3 (4) (b), C.R.S. That section reads in part:[7]

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (4) (b) **All moneys in the fund shall be subject to** federal matching as authorized under federal law and subject to **annual appropriation by the general assembly for the following purposes:**
>
> (I) To **maximize** the **inpatient and outpatient hospital reimbursements to up to the upper payment limits** as defined in 42 CFR 447.272 and 42 CFR 447.321;
>
> (II) To **increase hospital reimbursements under the Colorado indigent care program** to up to one hundred percent of the hospital's costs of providing medical care under the program;
>
> (III) To **pay the quality incentive payments** provided in section 25.5-4-402 (3);
>
> (IV) **Subject to available revenue from the provider fee and federal matching funds,** to **expand eligibility for public medical assistance by:**
>
> (A) Increasing the eligibility level for **parents and caretaker relatives** of children who are eligible for medical assistance, pursuant to section 25.5-5-201 (1) (m), from sixty-one percent to **one hundred thirty-three percent** of the federal poverty line;
>
> (B) Increasing the eligibility level for **children and pregnant women** under the **children's basic health plan** to up to **two hundred fifty percent** of the federal poverty line;
>
> (C) Providing eligibility under the state medical assistance program for a **childless adult** or an adult without a dependent child in the home, pursuant to section 25.5-5-201 (1) (p), who earns up to **one hundred thirty-three percent** of the federal poverty line;
>
> (D) Providing **a buy-in program** in the state medical assistance program for **disabled adults and children** whose families have income of up to **four hundred fifty percent** of the federal poverty line;
>
> (V) To provide **continuous eligibility for twelve months for children** enrolled in the state medical assistance program;

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[7] Details of the state department's actual administrative costs and repealed provisions have been omitted.

(VI) To pay the **state department's actual administrative costs** of implementing and administering this section, including but not limited to the following costs:

[. . .]

(VII) To offset the loss of any federal matching funds due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008. (**emphasis added**)

While HPF revenue may be used for all of the enumerated purposes, in the event revenue is insufficient to fully fund all of the purposes, the HPF statute prioritizes the use of the existing HPF revenue. Section 25.5-4-402.3 (5) (b), C.R.S., reads in part:

25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal. (5) (b) If the revenue from the provider fee **is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section:**

(II) The **hospital provider reimbursement** and **quality incentive payment increases** described in **subparagraphs (I) to (III) of paragraph (b) of subsection (4)** of this section and the **costs** described in **subparagraphs (VI) and (VII) of paragraph (b) of subsection (4)** of this section **shall be fully funded** using revenue from the provider fee and federal matching funds **before any eligibility expansion is funded;** and (**emphasis added**)

Pursuant to section 25.5-4-402.3 (5) (b) (II), C.R.S., in the event there is insufficient revenue to fully fund all of the enumerated purposes, the hospital reimbursements and payments described in subparagraphs (4) (b) (I) to (4) (b) (III) must be "**fully funded using revenue from the provider fee** . . . **before any eligibility expansion is funded**". This includes maximizing the inpatient and outpatient hospital provider reimbursements up to the upper payment limits, increasing hospital reimbursements under the Colorado Indigent Care Program up to one hundred percent, and making quality incentive payments. In addition, fully funding the department's administrative costs and offsetting the loss of federal matching funds in certain circumstances pursuant to subparagraphs (4) (b) (VI) and (4) (b) (VII) take priority over funding any expanded medical benefits or eligibility.

Statutory language further supports the elevation of subparagraphs (4) (b) (I) to (4) (b) (III), (4) (b) (VI), and (4) (b) (VII) over the expansion of medical benefits or eligibility. Subparagraph (4) (b) (IV), which lists expansions in medical benefits and eligibility criteria, begins with the introductory phrase "[s]ubject to available revenue from the provider fee". No such limiting language introduces the other statutory purposes for the HPF enumerated in paragraph (4) (b). Therefore, HPF revenue must first be used to accomplish the goals described in subparagraphs (4) (b) (I) to (4) (b) (III), (4) (b)

(VI), and (4) (b) (VII) before any remaining "available" revenue is used for expanded medical benefits or eligibility pursuant to subparagraph (4) (b) (IV).

Further, while the phrase "to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limit" in subparagraph (4) (b) (I) is not defined in statute, the language of section 25.5-4-402.3, C.R.S., taken as a whole, provides some basis for discerning legislative intent. Given the entire statutory scheme creating the HPF and the numerous references to "fully" funding hospital reimbursements before "any" revenue is used to fund the expansion of medical benefits or eligibility, the phrase "to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limit" in subparagraph (4) (b) (I) may fairly be interpreted to mean fully funding hospital reimbursements by increasing reimbursements to the highest practicable level allowed by federal guidelines governing the upper payment limit and by the General Assembly's appropriation.

2.2. When revenue is insufficient to fully fund all of the statutory purposes for the HPF, the state board must adopt rules reducing medical benefits or eligibility to the level of available HPF revenue.

The HPF statute specifically contemplates that HPF revenue may be insufficient to fully fund all of the statute's purposes. If medical benefits or eligibility has already been expanded pursuant to subparagraph (4) (b) (IV), in the event HPF revenue is insufficient, the state board, with the approval of the Joint Budget Committee, must reduce medical benefits or eligibility to the level necessary to match available HPF revenue. Section 25.5-4-402.3 (5) (b) (III), C.R.S., reads in part:

> **25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal.** (5) (b) If the revenue from the provider fee is insufficient to fully fund all of the purposes described in paragraph (b) of subsection (4) of this section:
>
> (III) (A) **If the state board promulgates rules that expand eligibility for medical assistance to be paid for pursuant to subparagraph (IV) of paragraph (b) of subsection (4)** of this section, and the state department thereafter notifies the advisory board that **the revenue available from the provider fee** and the federal matching funds **will not be sufficient to pay for all or part of the expanded eligibility,** the advisory board **shall recommend** to the state board **reductions in medical benefits or eligibility** so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. **After receiving the recommendations of the advisory board, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue shall be sufficient and shall forward any**

adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), C.R.S., following the adoption of rules pursuant to this sub-subparagraph (A), the state board shall not submit the rules to the attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to sub-subparagraph (B) of this subparagraph (III).

(B) **The joint budget committee shall promptly consider any rules adopted by the state board** pursuant to sub-subparagraph (A) of this subparagraph (III). The joint budget committee shall promptly notify the state department, the state board, and the advisory board of any action on such rules. **If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that the revenue from the provider fee and the matching federal funds will be sufficient to pay for the reduced benefits or eligibility.** After approving the rules pursuant to this sub-subparagraph (B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, C.R.S., extend the rules as provided for in section 24-4-103 (8), C.R.S., unless the committee on legal services finds after review that the rules do not conform with section 24-4-103 (8) (a), C.R.S. (**emphasis added**)

Therefore, in the event that HPF revenue is insufficient to fully fund all of the statute's enumerated purposes, HPF revenue must be used first to fully fund hospital reimbursements and incentive payments and administrative costs and, subject to the limitations discussed in section 3 of this memo, the state board must adopt rules reducing medical benefits or eligibility to match the remaining HPF revenue.

3. Without statutory changes or other state action, the state board's ability to adopt rules reducing medical benefits and eligibility in response to insufficient HPF revenue is limited, in part, by other state and federal law.

Except as provided in section 25.5-4-402.3 (5) (b) (III), C.R.S., relating to delayed filing of the rules, the state board's rules reducing medical benefits or eligibility in response to reduced HPF revenue must comply with the "State Administrative Procedure Act".[8] Section 24-4-103 (4) (b), C.R.S., prohibits the adoption of rules that conflict with other provisions of law.

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[8] Section 24-4-101, C.R.S., et seq.

Subsequent to the enactment of the HPF statute in 2009, Congress passed the Affordable Care Act[9] (ACA) in 2010. The ACA made numerous changes to the Medicaid program, including increasing income eligibility levels for existing eligibility groups and expanding eligibility to childless adults. Colorado elected to participate in the ACA's expanded Medicaid eligibility for childless adults. In 2013, the General Assembly enacted S.B. 13-200, which amended section 25.5-5-201, C.R.S, relating to optional Medicaid groups. In S.B. 13-200, the General Assembly removed language in section 25.5-5-201 (1) (m) and (1) (p), C.R.S., that specifically permitted the state board to use the mechanism set forth in the HPF statute to reduce income and eligibility levels for parents and caretaker relatives and childless adults in the event HPF revenue is insufficient to fully fund all of the purposes for the HPF. Further, until 2019, the ACA prohibits Colorado from reducing income eligibility for children under the Medicaid program and the Children's Basic Health Plan.[10]

With respect to the expanded medical benefits or eligibility that may be reduced by rule of the state board, state and federal law do not appear to limit the ability of the state board to reduce certain medical benefits or eligibility described in section 25.5-4-402.3 (4) (b) (IV), C.R.S. These medical benefits or eligibility include the Medicaid buy-in program for adults and children with disabilities, continuous eligibility for children enrolled in the Medicaid program, and income eligibility for pregnant women under the Children's Basic Health Plan. However, eliminating these programs may not result in a reduction of $100 million dollars in services.

Therefore, if HPF revenue is reduced by $100 million dollars as proposed in the Governor's budget, absent changes to state law and state action relating to Colorado's Medicaid program and the Children's Basic Health Plan, state and federal law enacted subsequent to the enactment of the HPF statute limits some, but not all, of the state board's authority to adopt rules reducing medical benefits and eligibility in response to a reduction in HPF revenue.

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[9] Patient Protection and Affordable Care Act, 42 U.S.C. sec 18001 et seq.

[10] Section 25.5-8-101, C.R.S., et seq.

4. The HPF currently satisfies all legal requirements for classification under TABOR as a fee rather than a tax, and reducing the amount of HPF revenue collected as proposed does not convert it into a fee or require voter approval under TABOR.

4.1. As currently imposed, the HPF is a fee, not a tax, for purposes of TABOR.

Section (4) (a) of TABOR requires "voter approval in advance" for "any new tax, tax rate increase, . . . extension of an expiring tax, or . . . tax policy change directly causing a net tax revenue gain," but does not require such voter approval for increases in other government-imposed charges, such as fees, fines, and penalties, that do not increase tax revenue. TABOR does not define the term "tax", but the Office of Legislative Legal Services has developed a sequential series of tests, based upon Colorado judicial decisions, for the purpose of determining whether a charge is a "tax" for purposes of TABOR. Applying the tests in order, to the extent necessary, to the HPF establishes that the HPF is a fee, not a tax.

The first test is whether the charge being examined is imposed by legislative authority to raise money for a public purpose. If so, it may be a tax. Because the HPF is imposed pursuant to statute and raises money that is used to fund state medical assistance program and Colorado indigent care program services, it satisfies the first test.

The second test requires a determination as to whether the HPF is a type of governmental charge that is not a tax, such as a fee, fine, or penalty. Colorado Supreme Court decisions indicate that while a tax is imposed for the purpose of raising revenue to defray general expenses of government,[11] a fee is a charge that: (1) Is imposed to defray the cost of a particular governmental service; (2) Is imposed in an amount that is reasonably related to the overall cost of the service, even though mathematical exactitude is not required; and (3) At the time it is first imposed, is not made primarily for the purpose of raising revenue for general public purposes.[12]

The General Assembly originally imposed and has continued to impose the HPF not to defray general expenses of government, but instead for the limited purpose of "obtaining federal financial participation under the state medical assistance program . . . and the Colorado indigent care program . . ." so that it can increase reimbursement to

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[11] For example, the vast majority of revenue generated by the state income tax and the state sales and use taxes is credited to the general fund and accounts for over 96% of general fund revenue.

[12] *See Tabor Foundation v. Colorado Bridge Enterprise,* 2014 COA 106, PP 21-44; *Barber v. Ritter,* 196 P.3d 238, 248-49 (Colo. 2008); *Bloom v. City of Fort Collins,* 784 P.2d 304, 308 (Colo. 1989).

hospitals for services provided under the state medical assistance program and the Colorado indigent care program, cover more people with public medical assistance, and defray its own administrative costs of implementing and administering the HPF program.[13] In addition, the requirement that HPF-funded services be limited or prioritized, as detailed in section 2 of this memorandum, when HPF revenue is insufficient to fund hospital reimbursements to the upper payment limit supports the conclusion that the HPF is imposed at a level that is reasonably related to the cost of the HPF program. Because the HPF therefore meets the requirements of a fee, it is not a tax for purposes of TABOR.

4.2. Reducing HPF revenue by $100 million would not convert the HPF from a fee into a tax and would not trigger TABOR voter approval requirements.

HPF revenue is included in state fiscal year spending (TABOR revenue) and counts against the state fiscal year spending limit (limit). For a fiscal year in which TABOR revenue exceeds the limit, reducing HPF revenue reduces TABOR revenue and thereby also reduces the amount of the TABOR refund, which is paid from the general fund, on a dollar for dollar basis until TABOR revenue no longer exceeds the limit. Because such a reduction in the amount that must be refunded from the general fund makes more general fund money available for expenditure, it has been suggested that reducing HPF revenue converts the HPF from a fee into a tax and requires voter approval. But Colorado Supreme Court precedent establishes that such a conversion does not occur.

Between 2001 and 2004, in order to increase the amount of general fund money available to fund various state programs and services during and following an economic downturn, the general assembly enacted legislation that transferred a total amount of over $442 million from various cash funds to the general fund. The money transferred from the cash funds had originally been generated by various state-imposed fees, surcharges, and special assessments, and had, like HPF revenue, been counted as TABOR revenue when first received by the state.

In a lawsuit filed against the state, fee and surcharge paying plaintiffs alleged that "the transfers from the special funds to the general fund represented a tax policy change directly causing a net tax revenue gain, a new tax, or a tax rate increase, without voter approval in violation of [TABOR] because the transferred monies, which [plaintiffs alleged] became general tax dollars as a result of the transfer, would be expended to defray general governmental expenses unrelated to the respective purposes for which

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[13] Section 25.5-5-402.3 (3) (a), C.R.S.

the cash funds were created.[14] The Colorado Supreme Court rejected the claim, stating that "the primary purpose for which the legislature originally imposes a charge is the dispositive criteria in determining whether that charge is a fee or a tax," that "[i]t is undisputed here that, while the monies resided in the special cash funds, they were fees," that "[t]he fact that the fees were eventually transferred to the general fund does not alter their essential character as fees because the transfer does not change the fact that the primary object for which they were collected was not to defray the general cost of government," and that "[a]t most, the transfer of fees to a general fund where, as here, the statutes authorizing assessment of those fees do not contemplate the generation of revenue for general use, incidentally makes funds available to defray the general cost of government," and "does not transform a fee into a tax."[15] Here, the HPF as currently imposed satisfies the tests for classification as a fee for TABOR purposes, and the relevant judicial precedent establishes that even a direct transfer of HPF fees to the general fund would not convert the HPF into a tax. Accordingly, the proposed reduction of HPF revenue, which does not transfer any HPF revenue or cause HPF revenue to be used for any purpose for which it is not already used, clearly would not effect such a conversion and, since TABOR voter approval requirements do not apply to fees, would not require voter approval.

Conclusion

Under current law, the General Assembly may trigger a reduction in the HPF and the resulting revenue by reducing HPF cash fund appropriations by $100 million dollars. If the resulting HPF revenue is insufficient to fully fund all of the purposes for the HPF, the existing HPF revenue would be allocated pursuant to the prioritization in the HPF statute. Under current law, HPF revenue and the federal matching funds must be used first to fully fund hospital reimbursements and incentive payments and the department's administrative costs, before any remaining available revenue is used to fund the expansion of medical benefits or eligibility. The state board is directed to adopt rules reducing medical benefits or eligibility to match available HPF revenue. However, absent changes to state law and state action relating to Colorado's Medicaid program and the Children's Basic Health Plan, state and federal law enacted subsequent to the enactment of the HPF statute limits some, but not all, of the state board's authority to adopt rules reducing medical benefits and eligibility in response to

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[14] *Barber,* 196 P.3d at 244 (internal quotations omitted).

[15] *Id.,* at 249-50 and 249 n.13 (internal citations omitted).

insufficient HPF revenue. Finally, the General Assembly may act to reduce HPF revenue without voter approval.

Hospital	County	Rural Hospital	Critical Access Hospital	$669.3M HPF Budget Limit			$864.4M HPF			Net Reimbursement Change
				SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	
				A	B	C = B-A	D	E	F = E-D	= C-F
Children's Hospital Colorado	Adams			$ 23,059,383	$ 28,972,854	$ 5,913,471	$ 29,782,222	$ 42,687,141	$ 12,904,920	$ (6,991,449)
HealthOne North Suburban Medical Center	Adams			$ 14,841,489	$ 26,064,411	$ 11,222,922	$ 19,168,445	$ 38,401,988	$ 19,233,543	$ (8,010,621)
HealthOne Spalding Rehabilitation Hospital	Adams			$ -	$ (10,950)	$ (10,950)	$ -	$ -	$ -	$ (10,950)
Kindred Hospital Aurora	Adams			$ -	$ 296,904	$ 296,904	$ -	$ 363,852	$ 363,852	$ (66,948)
Platte Valley Medical Center	Adams			$ 5,185,530	$ 11,366,862	$ 6,181,332	$ 6,697,343	$ 16,747,361	$ 10,050,018	$ (3,868,686)
University of Colorado Hospital	Adams			$ 52,274,571	$ 58,662,075	$ 6,387,504	$ 67,514,940	$ 86,429,741	$ 18,914,802	$ (12,527,298)
Vibra Long Term Acute Care Hospital	Adams			$ -	$ (19,725)	$ (19,725)	$ -	$ -	$ -	$ (19,725)
San Luis Valley Regional Medical Center	Alamosa	✓		$ 2,331,645	$ 5,039,661	$ 2,708,016	$ 3,011,424	$ 7,425,182	$ 4,413,759	$ (1,705,743)
Centura Health - Littleton Adventist Hospital	Arapahoe			$ 16,285,854	$ 9,652,278	$ (6,633,576)	$ 21,033,907	$ 14,221,179	$ (6,812,727)	$ 179,151
Craig Hospital	Arapahoe			$ -	$ (59,460)	$ (59,460)	$ -	$ -	$ -	$ (59,460)
HealthOne Medical Center of Aurora	Arapahoe			$ 26,649,360	$ 20,695,914	$ (5,953,446)	$ 34,418,837	$ 30,492,315	$ (3,926,522)	$ (2,026,924)
HealthOne Swedish Medical Center	Arapahoe			$ 38,737,929	$ 40,481,319	$ 1,743,390	$ 50,031,763	$ 59,643,133	$ 9,611,370	$ (7,867,980)
HealthSouth Rehabilitation Hospital - Denver	Arapahoe			$ -	$ 341,961	$ 341,961	$ -	$ 430,236	$ 430,236	$ (88,275)
Pagosa Mountain Hospital	Archuleta	✓	✓	$ 472,212	$ 1,589,136	$ 1,116,924	$ 609,883	$ 2,341,353	$ 1,731,470	$ (614,546)
Southeast Colorado Hospital	Baca	✓	✓	$ 212,766	$ 912,186	$ 699,420	$ 274,797	$ 1,343,969	$ 1,069,172	$ (369,752)
Boulder Community Hospital	Boulder			$ 14,756,817	$ 12,447,027	$ (2,309,790)	$ 19,059,087	$ 18,338,822	$ (720,266)	$ (1,589,524)
Centennial Peaks Hospital	Boulder			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Centura Health - Avista Adventist Hospital	Boulder			$ 5,522,835	$ 7,391,628	$ 1,868,793	$ 7,132,988	$ 10,890,452	$ 3,757,464	$ (1,888,671)
Centura Health - Longmont United Hospital	Boulder			$ 10,616,175	$ 12,553,413	$ 1,937,238	$ 13,711,263	$ 18,495,565	$ 4,784,302	$ (2,847,064)
Good Samaritan Medical Center	Boulder			$ 14,712,456	$ 7,762,491	$ (6,949,965)	$ 19,001,793	$ 11,436,863	$ (7,564,931)	$ 614,966
Centura Health - Saint Anthony North Hospital	Broomfield			$ 10,596,612	$ 12,946,650	$ 2,350,038	$ 13,685,997	$ 19,074,941	$ 5,388,944	$ (3,038,906)
Heart of the Rockies Regional Medical Center	Chaffee	✓	✓	$ 1,232,676	$ 3,705,321	$ 2,472,645	$ 1,592,056	$ 5,459,233	$ 3,867,177	$ (1,394,532)
Keefe Memorial Hospital	Cheyenne	✓		$ 88,872	$ 489,498	$ 400,626	$ 114,782	$ 721,202	$ 606,420	$ (205,794)
Conejos County Hospital	Conejos	✓	✓	$ 117,402	$ 531,021	$ 413,619	$ 151,630	$ 782,380	$ 630,750	$ (217,131)
Delta County Memorial Hospital	Delta	✓		$ 3,117,420	$ 3,499,470	$ 382,050	$ 4,026,287	$ 5,155,943	$ 1,129,656	$ (747,606)
Centura Health - Porter Adventist Hospital	Denver			$ 16,861,284	$ 10,945,947	$ (5,915,337)	$ 21,777,100	$ 16,127,206	$ (5,649,894)	$ (265,443)
Colorado Acute Long Term Hospital	Denver			$ -	$ (5,673)	$ (5,673)	$ -	$ -	$ -	$ (5,673)
Colorado Mental Health Institute-Ft Logan	Denver			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Denver Health Medical Center	Denver			$ 23,363,463	$ 41,581,098	$ 18,217,635	$ 30,174,954	$ 61,263,492	$ 31,088,537	$ (12,870,902)
Eating Recovery Center	Denver			$ -	$ -	$ -	$ -	$ -	$ -	$ -
HealthOne Presbyterian/St. Luke's Medical Center	Denver			$ 25,987,617	$ 37,393,962	$ 11,406,345	$ 33,564,166	$ 55,094,377	$ 21,530,210	$ (10,123,865)
HealthOne Rose Medical Center	Denver			$ 19,024,830	$ 19,795,680	$ 770,850	$ 24,571,416	$ 29,165,956	$ 4,594,540	$ (3,823,690)
Kindred Hospital	Denver			$ -	$ (4,089)	$ (4,089)	$ -	$ -	$ -	$ (4,089)
National Jewish Health	Denver			$ 1,637,130	$ 5,773,419	$ 4,136,289	$ 2,114,426	$ 8,506,264	$ 6,391,838	$ (2,255,549)

Hospital	County	Rural Hospital	Critical Access Hospital	$669.3M HPF Budget Limit			$864.4M HPF			Net Reimbursement Change
				SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	
				A	B	C = B-A	D	E	F = E-D	= C-F
Saint Joseph Hospital	Denver			$ 22,410,306	$ 38,385,684	$ 15,975,378	$ 28,943,910	$ 56,555,530	$ 27,611,620	$ (11,636,242)
Select Specialty Hospital - Denver	Denver			$ -	$ 17,070	$ 17,070	$ -	$ 25,150	$ 25,150	$ (8,080)
Centura Health - Castle Rock Adventist Hospital	Douglas			$ 1,921,065	$ 2,392,539	$ 471,474	$ 2,481,141	$ 3,525,046	$ 1,043,905	$ (572,431)
Centura Health - Parker Adventist Hospital	Douglas			$ 10,673,988	$ 6,450,255	$ (4,223,733)	$ 13,785,932	$ 9,503,480	$ (4,282,451)	$ 58,718
HealthOne Sky Ridge Medical Center	Douglas			$ 17,133,714	$ 5,216,196	$ (11,917,518)	$ 22,128,956	$ 7,685,280	$ (14,443,676)	$ 2,526,158
Highlands Behavioral Health System	Douglas			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vail Valley Medical Center	Eagle	✓		$ 3,007,245	$ 4,246,425	$ 1,239,180	$ 3,883,991	$ 6,256,468	$ 2,372,477	$ (1,133,297)
Cedar Springs Behavior Health System	El Paso			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Centura Health - Penrose -St. Francis Health Services	El Paso			$ 35,919,096	$ 41,022,120	$ 5,103,024	$ 46,391,114	$ 60,439,922	$ 14,048,807	$ (8,945,783)
HealthSouth Rehabilitation Hospital - Colorado Springs	El Paso			$ -	$ 175,899	$ 175,899	$ -	$ 259,161	$ 259,161	$ (83,262)
Kindred Hospital Colorado Springs	El Paso			$ -	$ 11,118	$ 11,118	$ -	$ 16,381	$ 16,381	$ (5,263)
Memorial Hospital	El Paso			$ 24,614,289	$ 31,898,760	$ 7,284,471	$ 31,790,452	$ 46,998,023	$ 15,207,571	$ (7,923,100)
Peak View Behavioral Health	El Paso			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Centura Health - St. Thomas More Hospital	Fremont	✓		$ 1,653,378	$ 4,533,495	$ 2,880,117	$ 2,135,411	$ 6,679,423	$ 4,544,011	$ (1,663,894)
Grand River Medical Center	Garfield	✓	✓	$ 952,491	$ 3,057,345	$ 2,104,854	$ 1,230,185	$ 4,504,538	$ 3,274,353	$ (1,169,499)
Valley View Hospital	Garfield	✓		$ 5,099,301	$ 11,139,639	$ 6,040,338	$ 6,585,975	$ 16,412,582	$ 9,826,607	$ (3,786,269)
Kremmling Memorial Hospital	Grand	✓	✓	$ 301,140	$ 1,811,073	$ 1,509,933	$ 388,936	$ 2,668,344	$ 2,279,408	$ (769,475)
Gunnison Valley Hospital	Gunnison	✓	✓	$ 643,719	$ 1,971,801	$ 1,328,082	$ 831,392	$ 2,905,152	$ 2,073,760	$ (745,678)
Spanish Peaks Regional Health Center	Huerfano	✓	✓	$ 224,028	$ 876,561	$ 652,533	$ 289,342	$ 1,291,481	$ 1,002,139	$ (349,606)
Centura Health - Ortho Colorado	Jefferson			$ 1,186,926	$ -	$ (1,186,926)	$ 1,532,968	$ -	$ (1,532,968)	$ 346,042
Centura Health - Saint Anthony Central Hospital	Jefferson			$ 21,161,205	$ 20,829,753	$ (331,452)	$ 27,330,640	$ 30,689,507	$ 3,358,867	$ (3,690,319)
Lutheran Medical Center	Jefferson			$ 23,222,628	$ 17,643,096	$ (5,579,532)	$ 29,993,060	$ 25,994,447	$ (3,998,612)	$ (1,580,920)
SCL Health Community Hospital - Westminster	Jefferson			$ 369,192	$ 880,740	$ 511,548	$ 476,828	$ 1,297,638	$ 820,810	$ (309,262)
UCHealth Broomfield Hospital	Jefferson			$ 4,122,801	$ 4,387,674	$ 264,873	$ 5,324,781	$ 6,464,577	$ 1,139,796	$ (874,923)
Weisbrod Memorial County Hospital	Kiowa	✓	✓	$ 67,425	$ 564,804	$ 497,379	$ 87,082	$ 832,154	$ 745,071	$ (247,692)
Kit Carson County Memorial Hospital	Kit Carson	✓	✓	$ 323,904	$ 1,221,303	$ 897,399	$ 418,336	$ 1,799,406	$ 1,381,070	$ (483,671)
Animas Surgical Hospital	La Plata	✓		$ 913,113	$ 1,094,826	$ 181,713	$ 1,179,326	$ 1,613,061	$ 433,735	$ (252,022)
Centura Health - Mercy Medical Center	La Plata	✓		$ 6,504,303	$ 12,560,604	$ 6,056,301	$ 8,400,597	$ 18,506,160	$ 10,105,563	$ (4,049,262)
St. Vincent General Hospital District	Lake	✓	✓	$ 114,387	$ 931,593	$ 817,206	$ 147,736	$ 1,372,562	$ 1,224,826	$ (407,620)
Banner Health Fort Collins	Larimer			$ 347,952	$ 6,137,211	$ 5,789,259	$ 449,396	$ 9,042,257	$ 8,592,861	$ (2,803,602)
Estes Park Medical Center	Larimer		✓	$ 482,520	$ 1,662,045	$ 1,179,525	$ 623,196	$ 2,448,773	$ 1,825,577	$ (646,052)
McKee Medical Center	Larimer			$ 5,666,397	$ 11,991,360	$ 6,324,963	$ 7,318,404	$ 17,667,465	$ 10,349,060	$ (4,024,097)
Medical Center of the Rockies	Larimer			$ 19,077,171	$ 31,055,613	$ 11,978,442	$ 24,639,017	$ 45,755,773	$ 21,116,756	$ (9,138,314)
Northern Colorado Long Term Acute Care Hospital	Larimer			$ -	$ 6,729	$ 6,729	$ -	$ 9,914	$ 9,914	$ (3,185)

Hospital	County	Rural Hospital	Critical Access Hospital	$669.3M HPF Budget Limit			$864.4M HPF			Net Reimbursement Change
				SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	
				A	B	C = B-A	D	E	F = E-D	= C-F
Poudre Valley Hospital	Larimer			$ 20,588,238	$ 21,568,584	$ 980,346	$ 26,590,628	$ 31,778,063	$ 5,187,436	$ (4,207,090)
Mount San Rafael Hospital	Las Animas	✓	✓	$ 921,342	$ 1,461,336	$ 539,994	$ 1,189,954	$ 2,153,059	$ 963,104	$ (423,110)
Lincoln Community Hospital and Nursing Home	Lincoln	✓	✓	$ 211,023	$ 599,931	$ 388,908	$ 272,546	$ 883,908	$ 611,362	$ (222,454)
Sterling Regional Medical Center	Logan	✓		$ 1,120,545	$ 5,232,900	$ 4,112,355	$ 1,447,234	$ 7,709,891	$ 6,262,657	$ (2,150,302)
Colorado West Psychiatric Hospital Inc	Mesa			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Community Hospital	Mesa			$ 3,351,681	$ 3,793,245	$ 441,564	$ 4,328,845	$ 5,588,776	$ 1,259,930	$ (818,366)
Family Health West Hospital	Mesa		✓	$ 667,842	$ 934,302	$ 266,460	$ 862,548	$ 1,376,553	$ 514,006	$ (247,546)
St. Mary's Hospital and Medical Center	Mesa			$ 23,773,752	$ 28,376,268	$ 4,602,516	$ 30,704,861	$ 41,808,161	$ 11,103,300	$ (6,500,784)
The Memorial Hospital	Moffat	✓	✓	$ 747,237	$ 5,146,077	$ 4,398,840	$ 965,090	$ 7,581,970	$ 6,616,880	$ (2,218,040)
Southwest Memorial Hospital	Montezuma	✓	✓	$ 1,063,872	$ 3,227,079	$ 2,163,207	$ 1,374,038	$ 4,754,615	$ 3,380,577	$ (1,217,370)
Montrose Memorial Hospital	Montrose	✓		$ 4,823,964	$ 4,922,262	$ 98,298	$ 6,230,365	$ 7,252,212	$ 1,021,848	$ (923,550)
Colorado Plains Medical Center	Morgan	✓		$ 3,907,365	$ 4,627,920	$ 720,555	$ 5,046,536	$ 6,818,544	$ 1,772,008	$ (1,051,453)
East Morgan County Hospital	Morgan	✓	✓	$ 485,238	$ 972,681	$ 487,443	$ 626,707	$ 1,433,099	$ 806,393	$ (318,950)
Arkansas Valley Regional Medical Center	Otero	✓	✓	$ 1,911,591	$ 3,439,638	$ 1,528,047	$ 2,468,905	$ 5,067,789	$ 2,598,884	$ (1,070,837)
Haxtun Hospital	Phillips	✓	✓	$ 60,408	$ 497,826	$ 437,418	$ 78,020	$ 733,472	$ 655,452	$ (218,034)
Melissa Memorial Hospital	Phillips	✓	✓	$ 137,325	$ 593,796	$ 456,471	$ 177,361	$ 874,869	$ 697,508	$ (241,037)
Aspen Valley Hospital	Pitkin	✓	✓	$ 1,187,205	$ 1,692,480	$ 505,275	$ 1,533,328	$ 2,493,615	$ 960,286	$ (455,011)
Prowers Medical Center	Prowers	✓	✓	$ 626,079	$ 2,911,530	$ 2,285,451	$ 808,609	$ 4,289,701	$ 3,481,092	$ (1,195,641)
Centura Health - St. Mary-Corwin Medical Center	Pueblo			$ 12,527,946	$ 24,606,342	$ 12,078,396	$ 16,180,401	$ 36,253,743	$ 20,073,342	$ (7,994,946)
Colorado Mental Health Institute-Pueblo	Pueblo			$ -	$ -	$ -	$ -	$ -	$ -	$ -
Parkview Medical Center	Pueblo			$ 31,180,752	$ 42,080,304	$ 10,899,552	$ 40,271,332	$ 61,998,997	$ 21,727,665	$ (10,828,113)
Pioneers Hospital	Rio Blanco	✓	✓	$ 144,684	$ 510,993	$ 366,309	$ 186,866	$ 752,871	$ 566,005	$ (199,696)
Rangely District Hospital	Rio Blanco	✓	✓	$ 78,609	$ 972,357	$ 893,748	$ 101,527	$ 1,432,622	$ 1,331,095	$ (437,347)
Rio Grande Hospital	Rio Grande	✓	✓	$ 414,882	$ 1,387,197	$ 972,315	$ 535,839	$ 2,043,826	$ 1,507,987	$ (535,672)
Yampa Valley Medical Center	Routt	✓		$ 1,900,245	$ 6,008,205	$ 4,107,960	$ 2,454,251	$ 8,852,186	$ 6,397,935	$ (2,289,975)
Sedgwick County Memorial Hospital	Sedgwick	✓	✓	$ 149,565	$ 474,432	$ 324,867	$ 193,170	$ 699,004	$ 505,834	$ (180,967)
Centura Health - Saint Anthony Summit Hospital	Summit	✓		$ 1,684,971	$ 2,496,159	$ 811,188	$ 2,176,215	$ 3,677,715	$ 1,501,500	$ (690,312)
Pikes Peak Regional Hospital	Teller	✓	✓	$ 620,643	$ 1,211,640	$ 590,997	$ 801,588	$ 1,785,169	$ 983,581	$ (392,584)
North Colorado Medical Center	Weld			$ 18,600,579	$ 7,987,032	$ (10,613,547)	$ 24,023,477	$ 11,767,690	$ (12,255,787)	$ 1,642,240
Northern Colorado Rehabilitation Hospital	Weld			$ -	$ 24,546	$ 24,546	$ -	$ 36,165	$ 36,165	$ (11,619)
Wray Community District Hospital	Yuma	✓	✓	$ 250,785	$ 805,899	$ 555,114	$ 323,900	$ 1,187,371	$ 863,471	$ (308,357)
Yuma District Hospital	Yuma	✓	✓	$ 337,773	$ 1,075,068	$ 737,295	$ 436,249	$ 1,583,951	$ 1,147,702	$ (410,407)
				$ 669,276,153	**$ 824,603,649**	**$ 155,327,496**	**$ 864,400,000**	**$ 1,214,929,408**	**$ 350,529,408**	**$ (195,201,912)**

Hospital	County	Rural Hospital	Critical Access Hospital	$669.3M HPF Budget Limit			$864.4M HPF			Net Reimbursement Change
				SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	SFY 2017-18 Provider Fee	SFY 2017-18 Supplemental Payment	Net Reimbursement	
				A	B	C = B-A	D	E	F = E-D	= C-F
Rural Hospital				$ 50,162,778	$ 110,043,168	$ 59,880,390	$ 64,787,465	$ 162,132,051	$ 97,344,586	$ (37,464,196)
Non Rural Hospitals				$ 619,113,375	$ 714,560,481	$ 95,447,106	$ 799,612,535	$ 1,052,797,357	$ 253,184,822	$ (157,737,716)
Total				**$ 669,276,153**	**$ 824,603,649**	**$ 155,327,496**	**$ 864,400,000**	**$ 1,214,929,408**	**$ 350,529,408**	**$ (195,201,912)**

Assumptions:

FMAP for SFY 2017-18 of 50.01%

Fees and Payments distributed under fully funded model the same as restricted model

Definitions:

Rural hospital is a hospital not located within a Metropolitan Statistical Area (MSA) or is located within an outlying county of a MSA as designated by the United States Office of Management & Budget.

Note: A Rural hospital is a hospital not located in Boulder, El Paso, Adams, Arapahoe, Broomfield, Denver, Douglas, Jefferson, Larimer, Mesa, Weld, or Pueblo county.

Critical Access Hospital (CAH) is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP. Some of the requirements for CAH certification include having no more than 25 inpatient beds; maintaining an annual average length of stay of no more than 96 hours for acute inpatient care; offering 24-hour, 7-day-a-week emergency care; and at least 35 miles drive away from any other hospital or CAH (fewer in some circumstances).
(https://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/critical.html)