COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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

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December 2, 2014

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Department Overview

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

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

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

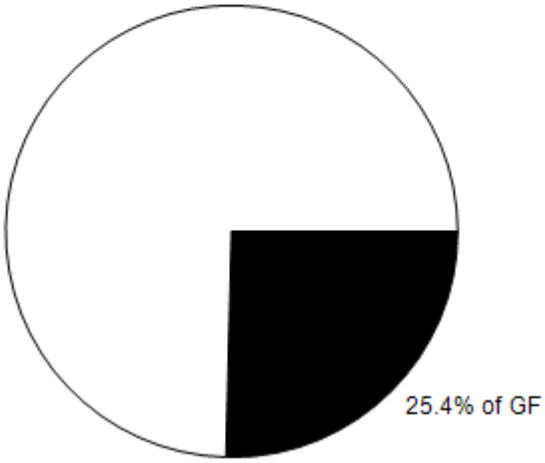
Department Budget: Recent Appropriations

Funding Source	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16 *
General Fund	$1,853,401,062	$2,067,258,413	$2,264,471,263	$2,481,588,376
Cash Funds	936,836,405	986,463,698	952,277,490	1,006,274,704
Reappropriated Funds	7,174,145	10,483,522	7,782,578	7,913,669
Federal Funds	2,804,733,050	3,592,923,500	4,652,324,132	5,136,537,937
Total Funds	**$5,602,144,662**	**$6,657,129,133**	**$7,876,855,463**	**$8,632,314,686**
Full Time Equiv. Staff	327.1	358.3	390.9	412.8

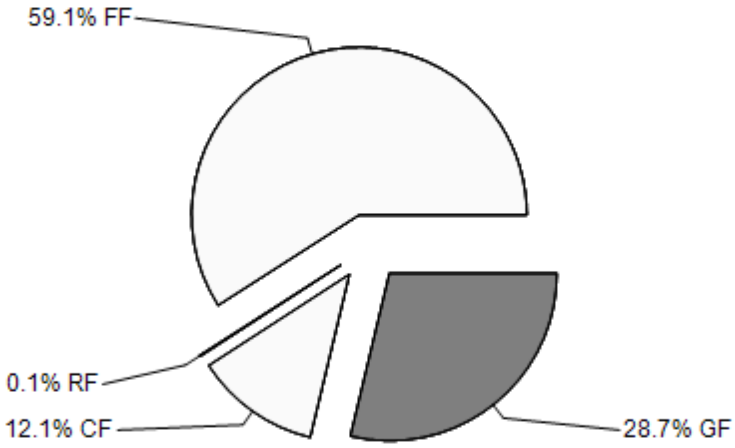
*Requested appropriation.

Department Budget: Graphic Overview

Department's Share of Statewide General Fund

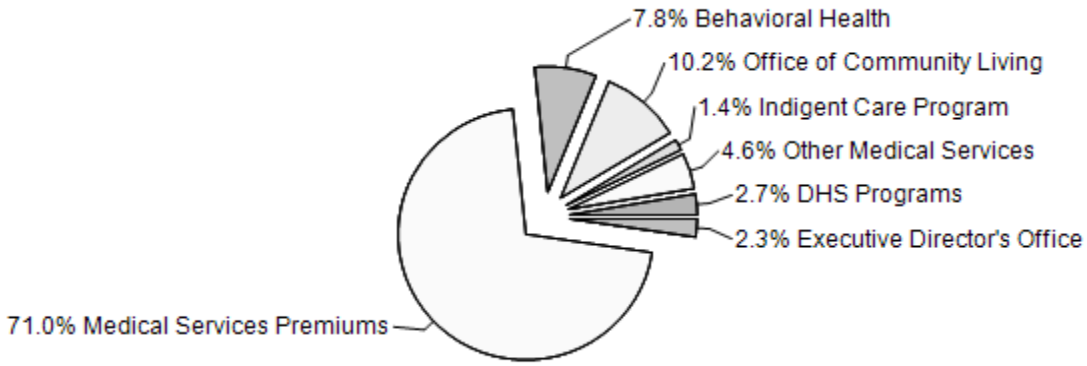


Department Funding Sources

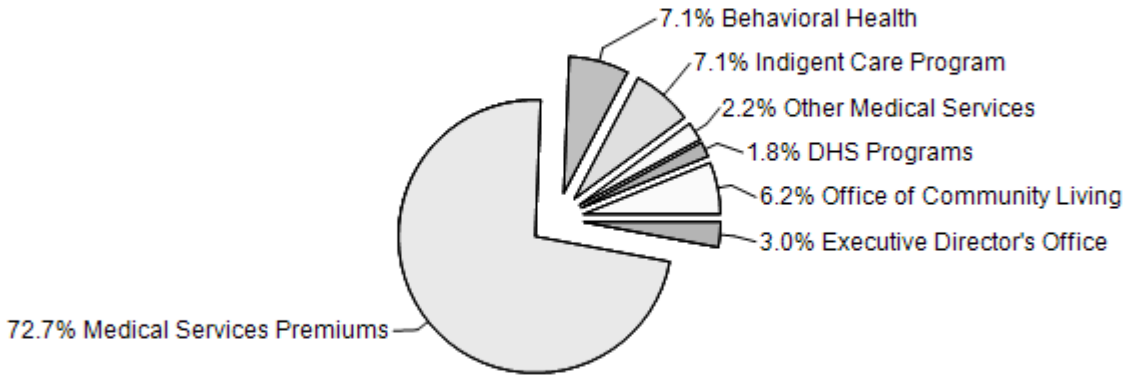


All charts are based on the FY 2014-15 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2014-15 appropriation.

General Factors Driving the Budget

Total funding to the Department of Health Care Policy and Financing in FY 2014-15 is about $7.9 billion, of which 28.7 percent is General Fund, 59.1 percent is federal funds, 12.1 percent is cash funds, and 0.1 percent is reappropriated funds. The major sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; and (5) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. Federal Funds are appropriated as matching funds to the Medicaid program (through Title XIX of the Social Security Administration Act) and as matching funds to the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). Some of the most important factors driving the budget are reviewed below.

MEDICAID

Medicaid provides health insurance to people with low income and to people needing long-term care. Participants generally do not pay annual premiums[1] and copayments at the time of service are either nominal or not required. Administration and policy making responsibilities for the program are shared between the federal and state governments. The federal government matches state expenditures for the program. The federal match rate, called the Federal Medical Assistance Percentage (FMAP), can vary based on economic conditions in the state, the type of service being provided, and the population receiving services. For federal fiscal year 2014-15 the FMAP for the majority of Colorado Medicaid expenditures is 51.01 percent.

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

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

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

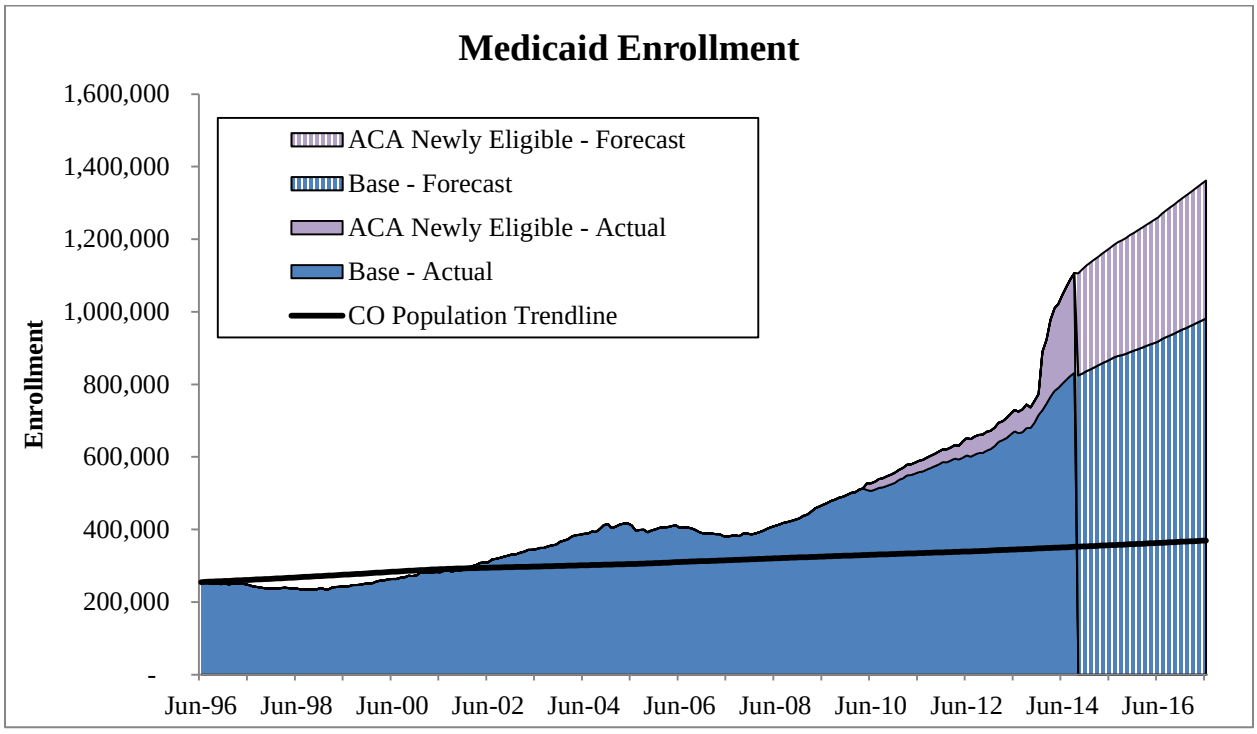
event that the State's Medicaid obligation is greater than anticipated, the Department has statutory authority[2] to overexpend the Medicaid appropriation.

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

(1) Medical Service Premiums

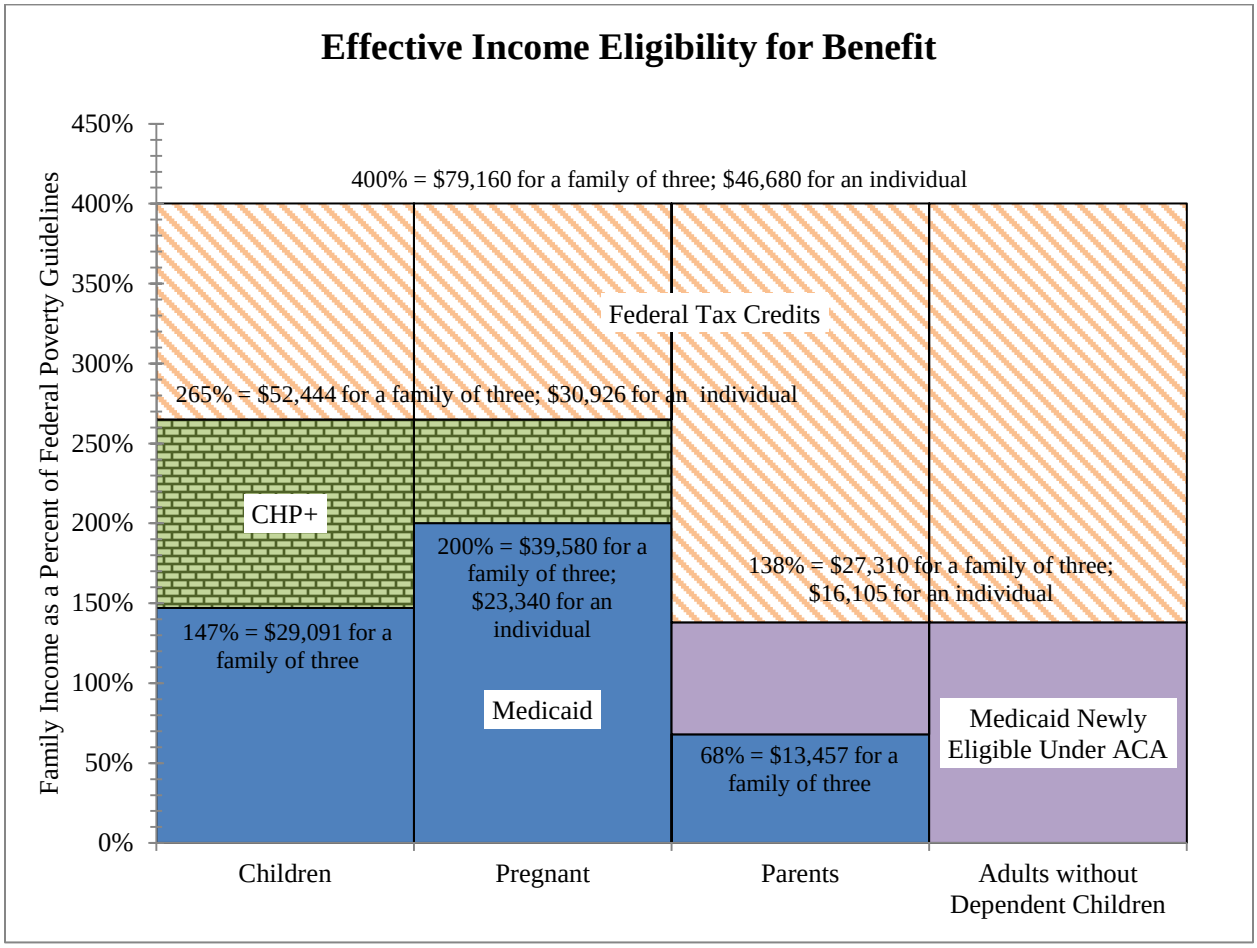
Medical Service Premiums pay for physical health care and long-term services and supports. Expenditures for Medical Service Premiums are driven by the number of clients, the amount of services each client uses, and the cost per unit of service.

Medicaid enrollment has increased significantly in recent years, due to increases in the state population, economic conditions that impact the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. The federal Affordable Care Act provides an enhanced match for newly eligible adults. In 2014 the federal match is 100 percent, but beginning in 2017 it decreases in increments until it reaches 90 percent in 2020. The following chart shows the actual and forecasted Colorado Medicaid population with the newly eligible adults highlighted in purple. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 1996.



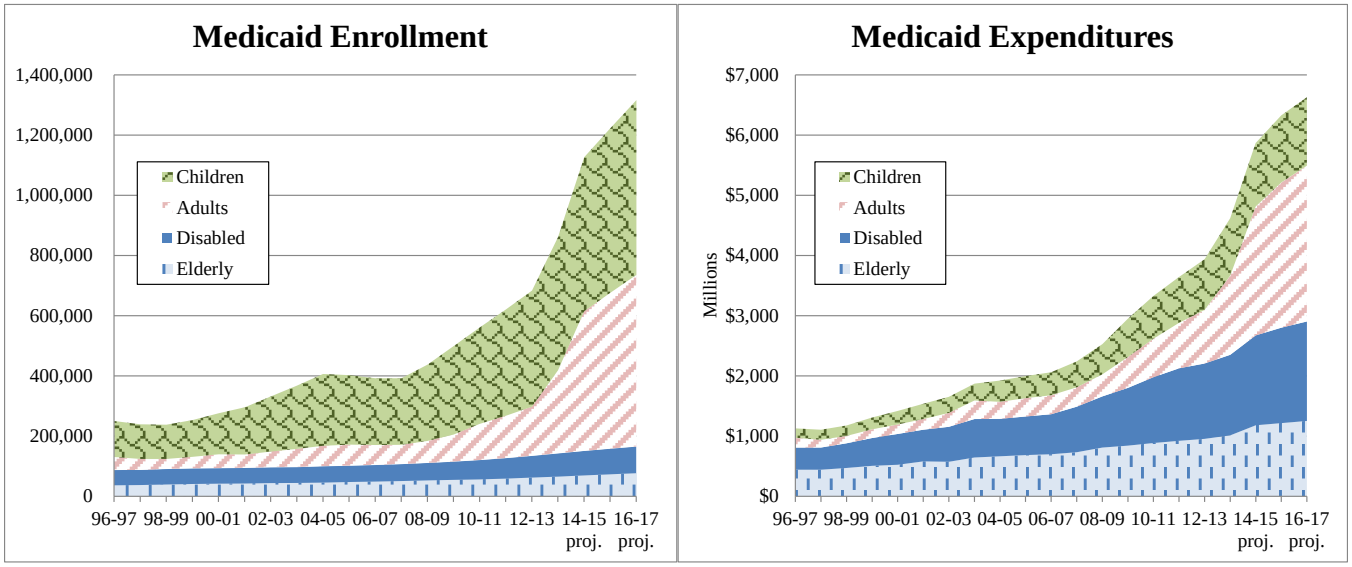
[2] See Section 24-75-109 (1) (a), C.R.S.

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

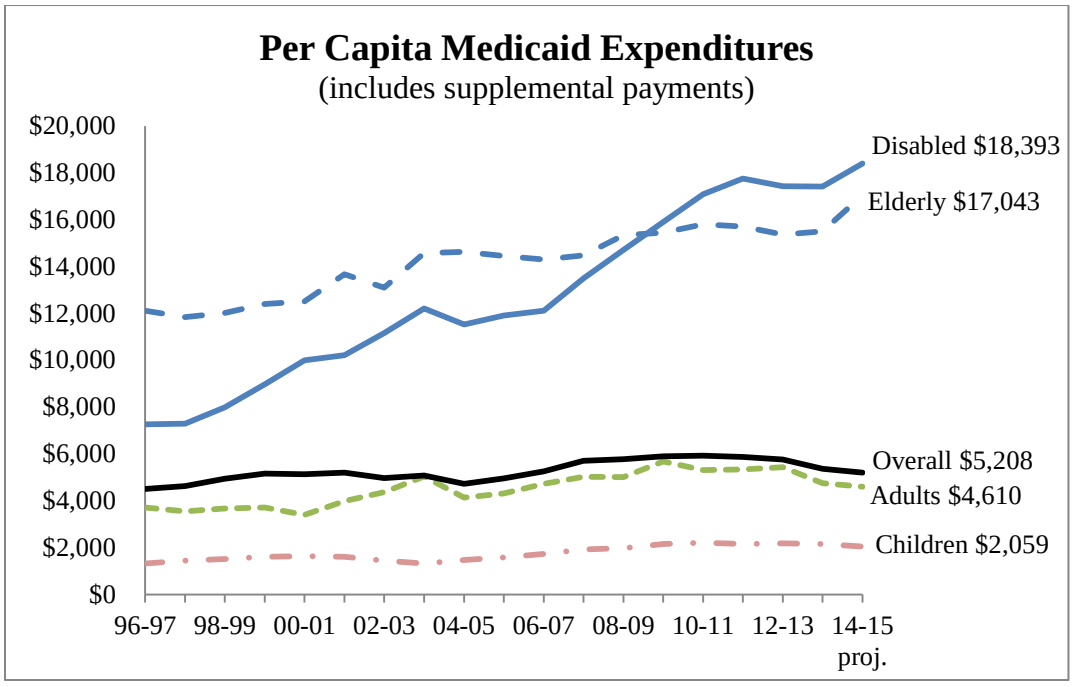


Special Medicaid Eligibility Categories	
Category	**Eligibility Standard**
Elderly 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities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

In addition to costs due to Medicaid enrollment growth, the Medicaid budget also fluctuates as a result of changes in medical costs and utilization of medical services. The two charts below illustrate recent changes in Medicaid enrollment and expenditures by eligibility category. In FY 2014-15, the elderly and people with disabilities are projected to account for approximately 13 percent of enrollment, but 46 percent of expenditures.



As illustrated in the following chart, per capita costs for the elderly and people with disabilities are much higher than for children and adults, and they have increased at a faster rate.



(2) Behavioral Health Community Programs

Behavioral health services include both mental health and substance use-related services. With a few exceptions (*e.g.*, non-citizens), Medicaid clients are eligible for behavioral health services. Behavioral health services are provided to Medicaid clients through a statewide managed care or "capitated" program. Under capitation, the Department contracts with regional entities known as behavioral health organizations (BHOs) to provide or arrange for behavioral health services for clients within their geographic region who are enrolled in the Medicaid program. In order to receive services through a BHO, a client must have a covered diagnosis and receive a covered service or procedure that is medically necessary. The Department pays a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within a BHO's geographic area. The "per-member-per-month" rates paid to a BHO are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on historical rate experience and recent encounter data (*i.e.*, statewide average costs by diagnosis category).

Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. The State's share of expenditures is also affected by changes in the federal match rate for various eligibility categories. The following table provides recent expenditure and caseload trend information for the Medicaid behavioral health capitation program.

Medicaid Behavioral Health Capitation Payments					
	FY 2011-12 Actual	**FY 2012-13 Actual**	**FY 2013-14 Actual**	**FY 2014-15 Estimate**	**FY 2015-16 Request**
Capitation Payments	**$273,376,614**	**$301,303,046**	**$415,933,333**	**$541,853,355**	**$616,257,535**
Annual Dollar Change	$24,023,949	$27,926,432	$114,630,287	$125,920,022	$74,404,180
Annual Dollar % Change	*9.6%*	*10.2%*	*38.0%*	*30.3%*	*13.7%*
Caseload	**598,322**	**659,104**	**860,956**	**1,096,397**	**1,189,338**
Annual Caseload Change	57,866	60,782	201,852	235,441	92,941
Annual Caseload % Change	*10.7%*	*10.2%*	*30.6%*	*27.3%*	*8.5%*
Average Cost Per Case	**$457**	**$457**	**$483**	**$494**	**$518**

As indicated in the above table, the rate of caseload growth outpaced the rate of expenditure growth in FY 2011-12. In FY 2012-13 this trend began to reverse, resulting in an increasing average cost per case. This trend reversal is due to: (a) an increase in the proportion of adults within the overall caseload; (b) the implementation of an enhanced substance use disorder benefit as part of this program effective January 1, 2014; and (c) general increases in rates over time.

(3) Office of Community Living

Overview of services. Services for individuals with intellectual and development disabilities (IDD) are funded through one of three State Medicaid waivers which enable the State to contract with providers for specific services that are in greater amounts and for longer time periods than would be allowed under the Medicaid State Plan. These services fall into three main categories for individuals with IDD:

- 24--hour comprehensive services for individuals over the age of 18 who require residential and daily support services to remain in the community. These services are collectively called the Intellectual and Developmental Disability Comprehensive Waiver.
- Daily support services for individuals over the age of 19 who do not require residential services but do require daily support services to remain in the community. These services are collectively called the Supported Living Services Waiver (or the SLS waiver).
- Daily support services for children from ages 3 to 18 who do not require residential services but who do require and/or their families require additional supports to enable the children to remain in their own homes. These services are collectively called the Children's Extensive Support Services Waiver.

Colorado has delegated the responsibility of providing community based services and coordinating care for individuals receiving community-based services to nonprofit Community Centered Boards. There are twenty Community Centers Boards, each with unique catchment areas across the State.

Approximately 300 adults with more severe medical and behavioral issues are served at one of the state-operated Regional Centers located in Wheat Ridge, Grand Junction and Pueblo. The Regional Centers are operated by the Department of Human Services.

Population, Services and Cost of Services. The Division of Intellectual and Developmental Disabilities oversees the financial and programmatic aspects of services for more than 14,900 children and adults with IDD. Prior to FY 2013-14 the Department of Human Services was responsible for the programmatic aspects of services but this responsibility was transferred via legislation to the Department of Health Care Policy and Financing.

Services provided to both residential and non-residential individuals include day services (activities provided outside of the residence), transportation, personal care, respite care for providers, and home and vehicle modifications. The range of needs across the population of individuals with IDD ranges from nonverbal individuals who require assistance with personal care to adults capable of working in the community and living independently with minimal assistance.

The average cost per enrollment varies by waiver; comprehensive services cost on average three times as much as the supported living services and children's services waiver. The following table summarizes the enrollment and expenditures associated with each waiver.

FY 2014-15 Appropriations for IDD Waivers			
Waiver	**Enrollment**	**Total Appropriation**	**Cost Per Enrollment**
Adult Comprehensive	4,820	$310,561,572	$64,431.86
Support Living Services			
General Fund Only	692	8,118,728	11,732.27
Medicaid	5,541	62,529,725	11,284.92
Children's Extensive Support	1,204	24,610,892	20,440.94
Case Management			
General Fund Only	692	2,356,106	3,404.78
Medicaid	11,281	26,944,627	2,388.50
Total*	**12,257**	**$435,121,650**	

*Total enrollments do not include case management numbers.

Factors driving the budget - Funding for transitions and emergency enrollments. Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. As part of the waiver, Colorado is allowed to limit the number of waiver program participants which has resulted in a large number of individuals being unable to immediately access the services they need. The General Assembly is not required to appropriate funds for services for individuals waiting for services, but has made the policy decision to provide additional funds for waiver services in past years. These funds have been used for individuals who experience emergency situations (*e.g.*, the death of their care giver or loss of a home) or are waiting for services.

Youth with IDD receive services through the Children's Extensive Support (CES) waiver or the child welfare system, which can include the Children's Habilitation Residential Program (CHRP) waiver. Funding for adult services for these youth when they age out of their current services is not required, but the General Assembly has made the decision that once an individual receives services they should continue to receive those services regardless of age. The CES waiver provides services to youth under age 18 who are able to remain in their home. Upon turning 18, youth receiving CES services are transitioned to the adult supported living waiver because of the youth's existing residential support structure.

The child welfare system provides services to youth with an IDD through age 21. Upon turning 21, a youth will no longer qualify for child welfare services. Most youth do not have an existing support structure to access, and the General Assembly has made it a policy to provide funding for these youth with IDD to transition to the adult comprehensive waiver starting at age 18.

(4) Indigent Care Program

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Funding for this program is based on policy decisions at the state and federal levels and is not directly dependent on the number of individuals served or the cost of the services provided. The majority of the funding is from federal sources. State funds for the program come from the Hospital Provider Fee, certifying public expenditures at hospitals, and the General Fund. Providers that participate agree to accept reduced payments for medical services on a sliding scale based on income up to 250 percent of

the federal poverty guidelines. The following table summarizes recent expenditures for this program.

Colorado Indigent Care Program	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation
Safety Net Provider Payments	$288,633,447	$299,175,424	$309,976,756	$311,296,186
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760
Pediatric Specialty Hospital	11,799,938	11,799,938	11,799,938	13,455,012
TOTAL	**$306,553,145**	**$317,095,122**	**$327,896,454**	**$330,870,958**
General Fund	8,959,849	8,959,849	8,959,849	9,639,107
Cash Funds	144,316,724	149,587,712	154,988,378	153,307,474
Federal Funds	153,276,572	158,547,561	163,948,227	167,924,377
Annual Total Funds Change		$10,541,977	$10,801,332	$2,974,504
Annual Percent Change		*3.4%*	*3.4%*	*0.9%*

(5) Programs Administered by Other Departments

The Department of Health Care Policy and Financing (HCPF) transfers Medicaid money to several other departments. The Medicaid funds are first appropriated to HCPF and then transferred to the administering departments to comply with federal regulations that one state agency receives all federal Medicaid funding. The cost drivers for these programs are described in more detail in the "General Factors Driving the Budget" for the receiving departments, but the table below summarizes some of the larger transfers. In FY 2014-15 the administration of community-based services for people with IDD was transferred from the Department of Human Services to the HCPF, and so the transfer of Medicaid funds to the Department of Human Services is now limited to the amount necessary for the state-operated Regional Centers for people with IDD.

Major Medicaid-funded Programs Administered by Other Departments					
Program	**Department**	**FY 2011-12 Actual**	**FY 2012-13 Actual**	**FY 2013-14 Actual**	**FY 2014-15 Approp.**
Information Technology, Maintenance, and Administration	Human Services	$27,092,121	$48,833,821	$45,172,314	$45,172,314
Child Welfare	Human Services	11,066,417	8,561,389	8,069,034	15,080,921
Office of Early Childhood	Human Services	0	0	3,407,528	5,268,899
Mental Health Institutes	Human Services	6,370,737	3,289,608	2,527,843	6,988,514
People with Disabilities	Human Services	377,031,150	380,102,701	402,400,310	49,917,540
Youth Corrections	Human Services	1,501,271	1,503,985	1,682,431	1,556,021
Regulation of long-term care facilities	Public Health and Environment	4,671,998	4,672,189	4,426,141	6,105,822
	TOTAL	**$427,733,694**	**$446,963,693**	**$467,685,601**	**$130,090,031**

CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than the Medicaid eligibility criteria allows. Annual membership premiums are variable based on income, with an example being $75 to enroll one child in a family earning 206 percent of the federal poverty level (FPL) guidelines. Coinsurance costs are nominal. In federal fiscal year 2014-15, federal funds pay 65.71 percent of the program costs not covered by member contributions and state funds pay the remaining 34.29 percent. In federal fiscal year 2015-16 the federal match rate is scheduled to increase 23 percentage points to a little more than 88 percent, but federal funding for the program has not yet been approved by Congress. CHP+ typically receives approximately $28 million in revenue from the tobacco master settlement agreement and the remaining state match comes from the General Fund.

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

	Children's Basic Health Plan					
	FY 11-12 Actual	FY 12-13 Actual*	FY 13-14 Actual*	FY 14-15 Proj.	FY 15-16 Proj.	FY 16-17 Proj.
Expenditures						
Children Medical	$148,628,670	$129,856,417	$154,221,552	$155,129,756	$172,004,422	$189,659,998
Children Dental	$12,414,377	$13,335,077	$13,817,690	$16,938,839	$20,413,377	$23,126,120
Prenatal	$21,411,076	$16,652,330	$12,009,028	$11,804,483	$12,038,464	$13,909,201
TOTAL	$182,454,123	$159,843,825	$180,048,270	$183,873,078	$204,456,263	$226,695,319
Enrollment						
Children	74,266	77,835	61,554	66,667	76,519	81,699
Prenatal	2,064	1,611	953	854	960	1,040
TOTAL	76,330	79,446	62,507	67,521	77,479	82,739
Per Capita						
Children Medical	$2,001.30	$1,668.36	$2,505.47	$2,326.93	$2,247.87	$2,321.45
Children Dental	$167.16	$171.32	$224.48	$254.08	$266.78	$283.06
Prenatal	$10,373.16	$10,336.64	$12,601.29	$13,822.58	$12,540.07	$13,374.23

* Expenditures in these years have been adjusted to remove overpayments that occurred due to a computer error. The overpayments were recovered in the following fiscal year.

MEDICARE MODERNIZATION ACT STATE CONTRIBUTION

The federal Medicare Modernization Act requires states to reimburse the federal government for a portion of prescription drug costs for people who are dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This payment is sometimes referred to as the "clawback". In recent years, in order to offset General Fund costs, Colorado has applied toward this obligation bonus payments received from the federal government for meeting performance goals in CHP+. The table below summarizes Colorado's payments.

Medicare Modernization Act				
	FY 2011-12 Actual	**FY 2012-13 Actual**	**FY 2013-14 Appropriation**	**FY 2014-15 Appropriation**
State Contribution	$93,582,494	$101,817,855	$105,091,301	$104,007,505
General Fund	62,939,212	52,136,848	67,020,439	99,304,985
Federal Funds	30,643,282	49,681,007	38,070,862	4,702,520
State Contribution change		$8,235,361	$3,273,446	($1,083,796)
Annual Percent Change		*8.8%*	*3.2%*	*(1.0%)*
General Fund change		($10,802,364)	$14,883,591	$32,284,546
Annual Percent Change		*(17.2%)*	*28.6%*	*48.2%*

Summary: FY 2014-15 Appropriation & FY 2015-16 Request

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$7,855,593,433	$2,259,525,686	$946,748,434	$7,782,578	$4,641,536,735	389.1
Other legislation	21,262,030	4,945,577	5,529,056	0	10,787,397	1.8
TOTAL	**$7,876,855,463**	**$2,264,471,263**	**$952,277,490**	**$7,782,578**	**$4,652,324,132**	**390.9**
FY 2015-16 Requested Appropriation						
FY 2014-15 Appropriation	$7,876,855,463	2,264,471,263	$952,277,490	$7,782,578	$4,652,324,132	390.9
R1 Medical Services Premiums	557,958,547	130,769,564	54,975,173	0	372,213,810	0.0
R2 Behavioral Health Programs	77,148,072	21,340,878	467,470	0	55,339,724	0.0
R3 Children's Basic Health Plan	(15,392,141)	(21,502,903)	(12,922,721)	0	19,033,483	0.0
R4 Medicare Modernization Act	15,613,436	20,315,956	0	0	(4,702,520)	0.0
R5 Office of Community Living	22,459,283	11,002,803	0	0	11,456,480	0.0
R6 Enrollment simplification	1,050,191	147,729	213,004	0	689,458	0.0
R7 Participant directed programs	1,708,633	816,371	0	0	892,262	0.9
R8 Children with autism waiver	10,616,568	367,564	4,840,203	0	5,408,801	0.0
R9 Personal health records	772,570	122,257	0	0	650,313	0.0
R10 Customer service center	2,077,065	674,424	364,111	0	1,038,530	20.8
R11 Public health and Medicaid alignment	1,400,000	495,740	190,120	0	714,140	0.0
R12 Provider rates	32,910,761	11,389,124	716,803	0	20,804,834	0.0
R13 ACC reprocurement preparation	250,000	125,000	0	0	125,000	0.0
R14 Primary Care Fund audit	0	0	0	0	0	0.0
R15 Managed care organization audits	300,000	150,000	0	0	150,000	0.0
R16 Comprehensive primary care	84,952	42,476	0	0	42,476	0.0
R17 School-based early intervention and prevention	4,216,324	1,999,674	0	0	2,216,650	0.0
R18 DDDWeb stabilization	205,260	102,629	0	0	102,631	0.0
R19 Public school health services	5,476,888	0	2,683,127	0	2,793,761	0.0
Annualize prior year budget decisions*	32,933,996	37,201,699	2,303,306	(7,600)	(6,563,409)	0.2
Centrally appropriated line items	3,112,363	1,438,617	167,071	138,691	1,367,984	0.0
Human Services programs	556,455	117,511	(453)	0	439,397	0.0
TOTAL*	**$8,632,314,686**	**$2,481,588,376**	**$1,006,274,704**	**$7,913,669**	**$5,136,537,937**	**412.8**
Increase/(Decrease)	$755,459,223	$217,117,113	$53,997,214	$131,091	$484,213,805	21.9
Percentage Change	9.6%	9.6%	5.7%	1.7%	10.4%	5.6%

** Includes a reduction of $1,950,000 General Fund for the annualization of S.B. 14-215 (Disposition of Legal Marijuana Related Revenue) that was not included in the Governor's November 1, 2014 submission. OSPB indicates the omission was a technical error, and so including the annualization better reflects the Governor's request.*

DESCRIPTION OF REQUESTED CHANGES

R1 Medical Service Premiums: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing.

R2 Behavioral Health Programs: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing. *See the briefing on Behavioral Health Community Programs for more information.*

R3 Children's Basic Health Plan: The Department requests a net decrease for projected changes in caseload, per capita expenditures, and financing.

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

R5 Office of Community Living: The Department requests an increase for projected changes in caseload, per capita expenditures, and financing for services for people with intellectual and developmental disabilities. *See the briefing on the Office of Community Living for more information.*

R6 Enrollment simplification: The Department requests:
1. $900,191, including $72,729 General Fund, to provide a one-month grace period to pay the annual CHP+ enrollment fee, rather than requiring up-front payment of the enrollment fee before coverage begins
2. $150,000, including $75,000 General Fund, to study the potential impact of implementing continuous eligibility for Medicaid adults and other policies that could reduce the number of people who experience changes in eligibility based on changes in income (churn)
3. Approval in the FY 2015-16 budget process for expenses projected to begin in FY 2016-17 of $12,281,696, including $1,410,508 General Fund, to modify the income calculation process for Medicaid and CHP+ to use annualized income, rather than monthly income, in order to reduce churn, which the Department indicates is a particular problem for seasonal workers

R7 Participant directed programs: The Department requests funding to manage the Colorado First Choice (CFC) implementation process and to allow individuals receiving services on the Supported Living Services (SLS) waiver for individuals with intellectual and developmental disabilities to utilize Consumer Directed Attendant Support Services (CDASS).

R7 Participant Directed Programs Expansion		
	FY 15-16	FY 16-17
Administration of CFC	$326,627	$328,262
FTE	0.9	1.0
General Fund	163,316	164,132
Federal Funds	163,311	164,130
CDASS for SLS	$1,382,006	$2,441,573
General Fund	653,055	1,196,127
Federal Funds	728,951	1,245,446
TOTAL	$1,708,633	$2,769,835
FTE	0.9	1.0
General Fund	816,371	1,360,259
Federal Funds	892,262	1,409,576

R8 Children with autism waiver: The Department requests that the JBC sponsor legislation to expand and modify the Children with Autism (CWA) waiver. Specifically, the Department proposes eliminating the enrollment cap of 75, expanding eligibility to add children ages 6 to 8, allowing children who begin receiving services before age 8 to receive a full three years of services (and no more than three years), increasing the $25,000 annual expenditure cap to $30,000, allowing the annual expenditure cap to be adjusted in future years through the budget process rather than requiring a statutory change, and providing for an annual independent evaluation of the effectiveness of services for people with autism. Based on the implementation schedule and the availability of a fund balance in the Autism Treatment Cash Fund, the projected General Fund costs in the first year are significantly lower than expected costs in future years.

R8 Children with Autism Waiver Expansion		
	FY 2015-16	FY 2016-17
Total	$10,616,568	$19,042,713
General Fund	367,564	8,830,589
Cash Funds	4,840,203	508,566
Federal Funds	5,408,801	9,703,558

R9 Personal health records: The Department proposes creating a secure, centralized web portal through which Medicaid clients could (1) access online health education materials and (2) view their personal health records and communicate securely with their providers. A vendor would develop and maintain an online health article repository and tools to assist clients in shared decision making with their providers, such as videos, articles, and interactive questionnaires to guide them through treatment options. The ability to view personal health records and communicate with providers would occur through the Health Information Exchange (HIE). The HIE is managed by the Colorado Regional Health Information Organization (CORHIO) and provides for the sharing of electronic health records between providers. This request would add new functionality by allowing Medicaid clients who go through the web portal to view their aggregated electronic health records from the HIE and communicate with their providers. Development costs, which the Department expects to be eligible for a 90 percent federal match rate, are spread over four years and total $2,140,697, including $214,070 General

Fund. When fully implemented the ongoing operational and maintenance costs are expected to be $950,139 per year, including $475,070 General Fund.

R10 Customer service center: The Department requests 25.0 FTE (20.8 in the first year) and associated operating costs to address an increase in call volume experienced by the customer service center.

R11 Public health and Medicaid alignment: The Department requests funding to connect direct health care and population based health initiatives of local public health agencies (LPHAs). The Department would distribute an average of $200,000 to each Regional Care Collaborative Organization (RCCO) responsible for coordinating the Medicaid health delivery system within the Accountable Care Collaborative (ACC). The RCCOs would then give grants to LPHAs, which the Department estimates would total about $30,000 each, to better connect Medicaid clients with LPHA programs like diabetes management and obesity intervention.

R12 Provider rates: The Department proposes an increase for provider rates equal to 1.0 percent of estimated eligible expenditures. The Department would use this money to increase all discretionary rates by 0.5 percent across-the-board and the remaining funds would be used for targeted rate increases not yet identified. The Department indicates the targeted rate increases will be detailed in a separate submission to the JBC by February 15, 2015, and the Department requests a hearing with the JBC in February specifically to address the targeted rate increases.

R13 ACC reprocurement preparation: The Department requests consulting services to prepare for the reprocurement in FY 2016-17 of contracts with Regional Care Collaborative Organizations (RCCOs) that are essential to the operation of the Accountable Care Collaborative. The RCCOs are responsible for developing a network of providers for Medicaid clients, assisting providers in navigating the Medicaid program and improving quality of care for Medicaid clients, coordinating care for Medicaid clients (e.g. ensuring smooth handoffs between providers, performing outreach to ensure clients follow home care recommendations, and helping clients address nonmedical needs with bearing on their health), and reporting. The requested consulting services would assist with stakeholder engagement, financial analysis, and program/policy assessment. Regarding stakeholder engagement, the Department highlights in particular the need to discuss the potential integration of behavioral health services with the ACC. The financial analysis would focus on payment methods for purchasing quality, rather than volume. The program/policy assessment would evaluate the strengths and weaknesses of the current program and identify best practices from other public and private care coordination efforts nationally. In addition to the FY 2015-16 cost there would be a cost of $100,000 total funds, including $50,000 General Fund, for ongoing stakeholder engagement in FY 2016-17 up until the new contracts take effect July 1, 2017.

R14 Primary Care Fund audit: The Department requests reallocating a total of $126,056 cash funds from the Primary Care Fund Program line item with $50,000 going to the Professional Audit Contract line item and $76,056 to the Personal Services line item. The Primary Care Fund Program takes tobacco tax dollars and grants them to primary care providers with qualified programs for serving indigent clients. The audit funds would ensure applicants are reporting data consistently for use in the formula allocation of the grant funds. The reallocation of funding

to personal services is to more accurately reflect the portion of administrative costs devoted to this program.

R15 Managed care organization audits: The Department requests funding to evaluate applying medical loss ratios (MLRs) to managed care contracts and to audit the financial and encounter data submitted by managed care providers to ensure accuracy and consistency. A MLR is the portion of total expenditures on client services versus other expenditures such as administration and profit. The request is based on indicators from CMS that they may require MLRs as part of managed care contracts in the future and a recent recommendation from the Government Accountability Office (GAO) that state Medicaid plans perform audits of managed care contracts. The Department is interested in exploring MLR requirements that could change based on achieving improved health outcomes.

R16 Comprehensive primary care: The Department requests funding for Medicaid's allocated share of the Comprehensive Primary Care initiative (CPCi). The CPCi aggregates data from multiple payers about patients within a practice with the goal of helping providers make better-informed decisions. The Department explains that this is different than the Health Information Exchange (HIE) in that the HIE focusses on sharing data between providers while the CPCi shares data from multiple payers within a single practice. Medicaid participation in the CPCi is not mandatory, but it is a high priority for the Department.

R17 School-based early intervention and prevention: The Department request funding to continue paying behavioral health organizations for school-based substance abuse prevention and intervention programs, as authorized through S.B. 14-215. This request is calculated based on paying an additional $7.89 per month for each Medicaid-eligible child.

R18 DDDWeb stabilization: The Department requests funding to address security and stability issues with the case management system for clients with intellectual and developmental disabilities. When the administration of services for people with intellectual and developmental disabilities was transferred from the Department of Human Services to the Department of Health Care Policy and Financing there were known issues with the age and reliability of servers supporting the DDDWeb, but it was believed that upgrades to DDDWeb could be avoided by replacing it with functionality in the new Medicaid Management Information System (MMIS) in November 2016. Replacing DDDWeb with MMIS is still the plan, but the Department believes the security and stability issues are too critical to ignore until November 2016. The proposed solution would move DDDWeb to the virtual server environment operated by the Governor's Office of Information Technology until the new MMIS functionality is available.

R19 Public school health services: The Department requests an increase in spending authority for public school health services based on projected increases in enrollment and school district participation. The public school health services program calculates money spent by school districts on services for Medicaid children and certifies it as public expenditures eligible for federal matching funds. The federal funds are then distributed to the school districts. Expenditures are based on the amount of certified public expenditures, which are a function of enrollment, utilization, and the amount of participation in the program by school districts and boards of cooperative education.

Annualize prior year budget decisions: The Department's request includes annualizations of the following prior year budget decisions:

Annualize Prior Year Budget Decisions						
	TOTAL	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 14-15 BA 10 FMAP change	$43,718,716	$39,042,661	$5,521,213	($7,600)	($837,558)	0.0
SB 13-200 Medicaid eligibility expansion	20,704,042	986,188	1,941,515	0	17,776,339	0.0
FY 14-15 R11 Provider rate increase	7,222,552	2,399,275	90,097	0	4,733,180	0.0
FY 14-15 Removal of 5-year bar	6,850,358	856,150	557,153	0	5,437,055	0.0
FY 14-15 R5 Medicaid health information exchange	3,967,250	396,725	0	0	3,570,525	0.0
FY 14-15 R7 SLS funding	3,122,439	1,561,220	0	0	1,561,219	0.0
SB 14-180 Dental health seniors	2,967,800	2,967,800	0	0	0	0.2
FY 14-15 R8 New IDD enrollments	2,941,443	1,421,157	0	0	1,520,286	0.0
SB 14-130 Personal care allowance nursing facility	1,588,240	778,079	0	0	810,161	0.0
FY 14-15 BA11 Alignment of CHP+ oral health benefits to CHIPRA	1,178,100	(1,334,347)	599,171	0	1,913,276	0.0
FY 14-15 Provider rate increase (IDD)	1,007,227	518,929	0	0	488,298	0.0
HB 14-1357 In home support services	893,956	437,949	0	0	456,007	0.0
HB 14-1213 Pharmacy benefit manager	189,164	9,838	0	0	179,326	0.0
FY 14-15 R9 Medicaid community living initiative	8,203	3,109	0	0	5,094	0.0
HB 14-1211 Complex rehab	764	191	0	0	573	0.0
FY 14-15 One-time CBMS Phase 2 funding	(25,041,089)	(6,259,805)	(1,270,547)	0	(17,510,737)	0.0
FY 14-15 BA12 Enroll dual eligibles in ACC	(10,959,812)	140,692	0	0	(11,100,504)	0.0
SB 14-215 Disposition of legal marijuana related revenue	(6,363,807)	(4,000,000)	0	0	(2,363,807)	0.0
HB 14-1368 Child foster care transitions	(5,746,227)	0	(2,829,586)	0	(2,916,641)	0.0
FY 14-15 R12 Administrative contract reprocurements	(4,296,940)	(1,134,165)	(991,260)	0	(2,171,515)	0.0
HB 14-1045 BCCP reauthorization	(3,621,882)	0	(1,254,454)	0	(2,367,428)	0.0
FY 14-15 R6 Eligibility determination enhanced match	(2,536,068)	0	0	0	(2,536,068)	0.0
FY 14-15 S6 BA6 Leased space	(1,154,948)	(596,619)	19,145	0	(577,474)	0.0
FY 13-14 R5	(1,033,939)	(92,349)	(18,798)	0	(922,792)	0.0
HB 08-1373 Breast & Cervical Cancer Fund	(834,968)	(287,793)	0	0	(547,175)	0.0
FY 14-15 R10 Primary care specialty collaboration	(711,484)	(270,277)	(6,707)	0	(434,500)	0.0
FY 14-15 BA13 Disability determinations contract reprocurement	(293,406)	(146,703)	0	0	(146,703)	0.0
FY 12-13 R12	(200,000)	0	(50,000)	0	(150,000)	0.0
FY 12-13 BA8	(200,000)	(17,863)	(3,636)	0	(178,501)	0.0
FY 14-15 Rate setting study	(150,000)	(75,000)	0	0	(75,000)	0.0
FY 14-15 R15 LTSS for individuals with complex medical conditions	(125,000)	(62,500)	0	0	(62,500)	0.0
SB 14-144 Family medicine residency training in rural areas	(75,000)	0	0	0	(75,000)	0.0
FY 14-15 OIT	(53,104)	(26,551)	0	0	(26,553)	0.0
FY 14-15 BA13 Disability determinations contract reprocurement	(28,584)	(14,292)	0	0	(14,292)	0.0
TOTAL	$32,933,996	$37,201,699	$2,303,306	($7,600)	($6,563,409)	0.2

Centrally appropriated line items: The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; merit pay; salary survey; short-term disability; supplemental state contributions to the Public Employees'

Retirement Association (PERA) pension fund; shift differential; vehicle lease payments; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; and Capitol complex leased space.

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

Issue: Forecast trends

This issue brief provides a brief overview of forecast trends in enrollment and expenditures for Medical Service Premiums, the Children's Basic Health Plan, and the Medicare Modernization Act State Contribution Payment.

SUMMARY:

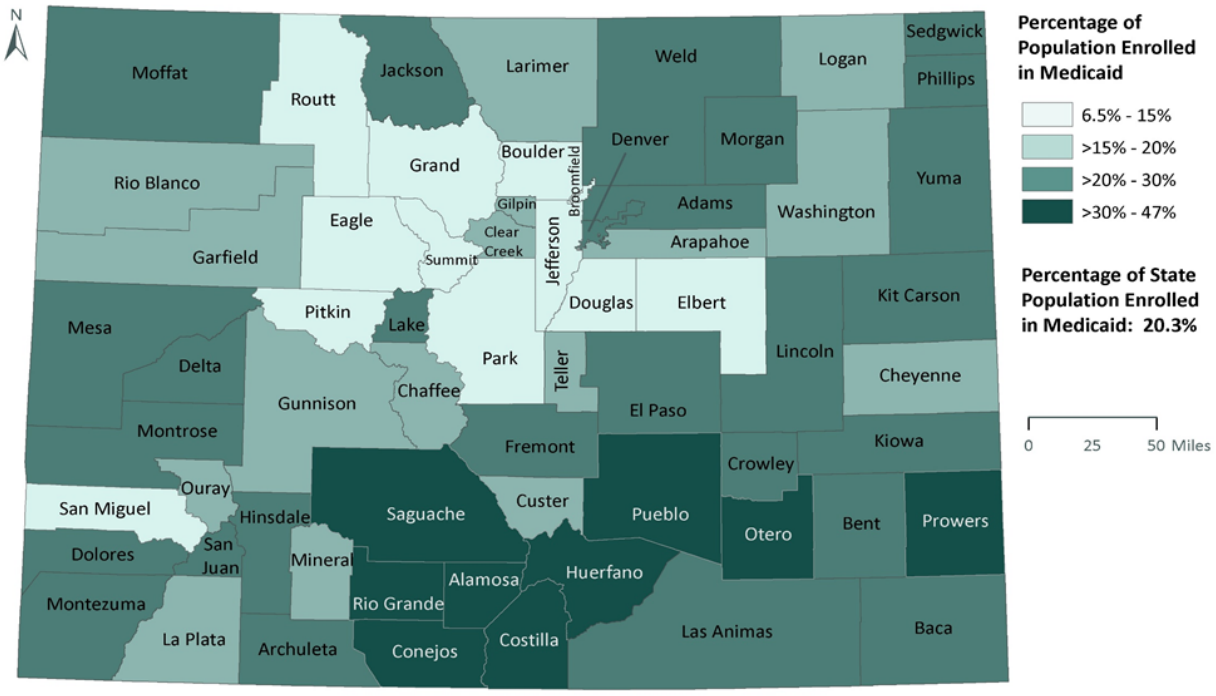
- Medicaid covers an estimated 1 in 5 Colorado residents, but the proportion of the population covered by Medicaid varies significantly by county.
- Medicaid covers 41 percent of births in Colorado.
- Nationally Medicaid covers about 40 percent of the cost of long term supports and services.
- Key trends behind the forecasted changes are discussed.

DISCUSSION:

Medicaid highlights

Medicaid is the largest health insurer in Colorado, covering an estimated 1 in 5 residents. This is up from 1 in 7 just prior to the S.B. 13-200 expansion that took effect in January 2014. However, the proportion of the population insured by Medicaid varies considerably by county from less than 7 percent in Pitkin and Douglas counties to almost 47 percent in Costilla County.

Percentage of Population Enrolled in Medicaid, by County, Colorado, August 2014



Map prepared September 25, 2014
by the Colorado Health Institute.

Source: Colorado Department of Health Care Policy and Financing, August 2014 Medicaid Caseload Report. Colorado State Demographer's Office.

While Medicaid covers 20 percent of the population statewide, it covers a higher proportion of pregnancy care, paying for 41 percent of calendar year 2013 births in Colorado. In part this is due to a higher income qualifying threshold for pregnant women (an effective limit of 200 percent of FPL).

Although the Department did not identify any recent Colorado-specific studies, nationally Medicaid consistently ranks as the largest payer for long term supports and services (LTSS), representing an estimated 40 percent of national expenditures in 2012.[3] The next largest payer is Medicare at 20 percent, but Medicare coverage of LTSS is limited, generally to post-acute services such as surgery recovery.

Costs for Medicaid, as with private insurance, are driven by a relatively small number of very expensive cases. Medicaid appears to follow the Pareto principle with 20 percent of utilizers accounting for 80 percent of costs in FY 2013-14. The top 1 percent of utilizers accounted for 25 percent of expenditures. Pharmacy and hospitalization expenditures are particularly concentrated among a few high cost clients. For example, the Department indicates that some drugs for treating hemophilia can cost $800,000 per year. Part of the cost for these particular drugs is due to the time required to produce them, as they are biologicals made from cell lines in sources such as Chinese hamster ovaries (Advate), human plasma (Feiba), and baby hamster kidneys (NovoSeven). In FY 2013-14 the Department spent $1.5 million on one client who received both Feiba and NovoSeven for the treatment of hemophilia.

Medical Service Premiums forecast

The Department's R1 provides the forecast of expenditures for Medical Service Premiums. The Request is expressed in terms of the change from the FY 2014-15 appropriations, but a portion of the increase will actually occur in FY 2014-15, for which the Department will submit a supplemental request in January. The table below shows the portion of R1 attributable to reforecasting FY 2014-15 and the portion attributable to FY 2015-16.

Medical Services Premiums Forecast by Fiscal Year				
	Total	General Fund	Cash Funds	Federal Funds
FY 14-15 Appropriation	$5,724,352,770	$1,608,812,454	$622,898,368	$3,492,641,948
FY 14-15 Revised projection	5,866,244,550	1,692,495,876	648,065,968	3,525,682,706
Difference	**141,891,780**	**83,683,422**	**25,167,600**	**33,040,758**
Percent	2.5%	5.2%	4.0%	0.9%
FY 14-15 Revised projection	5,866,244,550	1,692,495,876	648,065,968	3,525,682,706
Annualizations	44,215,455	45,772,169	5,806,981	(7,363,695)
FY 15-16 Base	5,910,460,005	1,738,268,045	653,872,949	3,518,319,011
FY 15-16 Projection	6,326,526,772	1,785,354,187	683,680,522	3,857,492,063
Difference	**416,066,767**	**47,086,142**	**29,807,573**	**339,173,052**
Percent	7.0%	2.7%	4.6%	9.6%
TOTAL R1	**$557,958,547**	**$130,769,564**	**$54,975,173**	**$372,213,810**

[3] http://kaiserfamilyfoundation.files.wordpress.com/2014/07/8617-medicaid-and-long-term-services-and-supports_a-primer.pdf

The FY 2014-15 revised projection of expenditures is 2.5 percent higher than the appropriation in total, but 5.2 percent higher in General Fund. This raises the question of what happened to cause such a revision in the forecast. A complete answer requires tracking the effect of hundreds of little changes, many offsetting each other, that compound to result in the net change to the forecast. But, there are a few changes that are worth noting for their size or for being different than the usual tweaking that happens to the forecast every year.

- Welcome mat effect underestimated – The Department believes that national publicity and outreach efforts associated with the Medicaid expansion, along with the individual mandate of the ACA, created a "welcome mat" that resulted in higher enrollment rates from among the potentially eligible than observed in prior years. The Department anticipated a welcome mat effect in the forecast used for the appropriation, but the Department believes the actual effect has been greater than anticipated. This is particularly true for parents/caretakers to 68 percent of the FPL and children. The Department increased enrollment projections by approximately 30,000 for parents/caretakers to 68 percent of the FPL and approximately 8,000 for children based on actual enrollment through June 2014. Similarly, the Department believes it underestimated the success counties and the Department of Human Services would have in outreach efforts to former foster children ages 21 to 26 who became eligible under provisions of the ACA. The Department increased the projection for foster children by approximately 2,300.
- Per capita costs of clients responding to the welcome mat effect – In the forecast used for the appropriation the Department assumed that people eligible but not enrolled (EBNE) who responded to the welcome mat effect would have per capita costs below those of the standard enrolled population. The assumption was that this population would have sought enrollment before the welcome mat effect if they had pressing health issues. However, there was significant uncertainty about the per capita cost assumptions, because the Department had no history with these clients. Based on actual expenditure patterns, for children the Department has revised per capita cost assumptions upward about $55, and for parents and caretakers to 68 percent of the FPL the Department has revised per capita cost assumptions downward about $370. The change for parents/caretakers is not entirely attributable to welcome mat effect enrollment, but includes an adjustment for lower-than-expected per capita costs in FY 2013-14, too.
- Continuous eligibility – The Department believes continuous eligibility may be responsible for an increase in enrollment from the expectation for children eligible through S.B. 11-008. The Department revised the enrollment projection for this population upward by approximately 25,000. Senate Bill 11-008 granted Medicaid eligibility to children 6-19 with family income between 100 percent and 133 percent of the FPL. This population was previously eligible for CHP+ and remains eligible for the CHP+ match rate while on Medicaid. Pursuant to statute, continuous eligibility for children is supposed to be financed with the Hospital Provider Fee (HPF), but the Department has assumed General Fund for the larger than expected S.B. 11-008 population. The Department explains that the speculation that the increase in population is attributable to continuous eligibility for children is just a speculation and that practically speaking there is no way to determine which children are eligible due to continuous eligibility. As a result, the Department did not change the estimate

of the amount of funding from the HPF for continuous eligibility in FY 2014-15. In FY 2015-16 the Department's request assumes that all of the financing for continuous eligibility will come from the General Fund. The Department explains that this is based on negotiated agreements when the Hospital Provider Fee was adopted. The JBC staff does not know whether the assumption that the Hospital Provider Fee would support continuous eligibility only through FY 2014-15 was understood by legislators when the Hospital Provider Fee was passed, but the specific language approved by the General Assembly does not support financing from the General Fund. If the JBC wants to finance continuous eligibility from the General Fund in FY 2015-16 legislation would be needed.

- Federal standardization of eligibility determinations – The ACA required changes in the way states determine income for purposes of Medicaid and CHP+ eligibility. The changes can either increase or decrease a client's income compared to the old eligibility standard, depending on individual circumstances. The Department believes the new eligibility standards caused some movements between eligibility categories that changed financing in ways not anticipated in the appropriation, particularly with how family size is calculated. The new federal standards have also caused some people to move from federally funded adult and parent categories to the state matched pregnant category. In addition, for children the new method for determining income results in a higher effective income eligibility threshold.
- Nursing bed days and rates – The Department increased the projection of both nursing bed days and rates based on higher than expected FY 2013-14 actuals.
- Program of All-inclusive Care for the Elderly (PACE) – The Department had originally anticipated that a one-time coding issue that resulted in an underestimate of PACE expenditures would be resolved in FY 2013-14, but the Department has now included those costs in FY 2014-15.

The projection for FY 2015-16 is largely just the result of the flow through of the FY 2014-15 changes noted above and enrollment and per capita trends.

Children's Basic Health Plan (CHP+) forecast

The Department's R3 provides the forecast of expenditures for the Children's Basic Health Plan (CHP+). The table below summarizes the portions of the request attributable to FY 2014-15 and FY 2015-16.

Children's Basic Health Plan (CHP+) Forecast by Fiscal Year				
	Total	General Fund	Cash Funds	Federal Funds
FY 14-15 Appropriation	$199,832,216	$22,299,001	$48,226,542	$129,306,673
FY 14-15 Revised projection	183,909,178	17,537,575	48,464,456	117,907,147
Difference	**(15,923,038)**	**(4,761,426)**	**237,914**	**(11,399,526)**
Percent	-8.0%	-21.4%	0.5%	-8.8%
FY 14-15 Revised projection	183,909,178	17,537,575	48,464,456	117,907,147
Annualizations	20,016,188	(796,098)	780,168	20,032,118
FY 15-16 Base	203,925,366	16,741,477	49,244,624	137,939,265
FY 15-16 Projection	204,456,263	0	36,083,989	168,372,274
Difference	**530,897**	**(16,741,477)**	**(13,160,635)**	**30,433,009**

Percent	0.3%	-100.0%	-26.7%	22.1%
TOTAL R3	**($15,392,141)**	**($21,502,903)**	**($12,922,721)**	**$19,033,483**

Major factors contributing to the decrease in the projection for FY 2014-15 include:

- Actual average monthly caseloads for children and prenatal adults were more than 5 percent lower than expected in FY 2013-14.
- The Department had projected an increase in rates for prenatal clients, but rates were unchanged. CHP+ is a capitated managed care program, the rates must meet an actuarial sound standard, and so the rates are set annually by a process outside the General Assembly's process for discretionary rates.
- The actual increase in dental rates was lower than expected for new services approved by the General Assembly to comply with the CHIPRA legislation of 2009.
- The General Assembly approved funding to remove the five-year bar on legal immigrant children and pregnant women in FY 2014-15, but the Department is now estimating implementation will not occur until FY 2015-16.

In FY 2015-16 the projected shift in financing from the General Fund and cash funds to federal funds is attributable to a change in the federal match rate. The request assumes that in October 2015 the federal match rate will increase by 23 percentage points. See the issue brief on the federal medical assistance percentage for more information.

Medicare Modernization Act State Contribution Payment forecast

The Department's R4 provides the forecast of the state's obligation under the Medicare Modernization Act for pharmacy expenses that were shifted from Medicaid to Medicare.

Medicare Modernization Act Forecast by Fiscal Year			
	Total	General Fund	Federal Funds
FY 14-15 Appropriation	$104,007,505	$99,304,985	$4,702,520
FY 14-15 Revised projection	109,773,087	109,343,662	429,425
Difference	**5,765,582**	**10,038,677**	**(4,273,095)**
Percent	5.5%	10.1%	-90.9%
FY 14-15 Revised projection	109,773,087	109,343,662	429,425
Annualizations	0	0	0
FY 15-16 Base	109,773,087	109,343,662	429,425
FY 15-16 Projection	119,620,941	119,620,941	0
Difference	**9,847,854**	**10,277,279**	**(429,425)**
Percent	9.0%	9.4%	-100.0%
TOTAL R4	**$15,613,436**	**$20,315,956**	**($4,702,520)**

The projected increase in expenditures in both years is primarily the result of caseload growth, although the Department is also projecting an increase in the per member per month cost according to the federal formula. The shift in financing from federal fund to the General Fund is due to a portion of federal bonus payments for meeting performance objectives for serving low

income children being applied to offset the need for General Fund for this program. This line item is normally a 100 percent General Fund obligation, but for the last few years the General Assembly has used the federal bonus payments to offset the need for General Fund. In FY 2014-15 the Department's forecast decreases the projection of available federal bonus payments by $4.3 million and increases the estimated General Fund payments by a like amount. These bonus payments are for a time-limited duration and in FY 2014-15 the available funding begins to run out, so the Department is not projecting any available federal funds in FY 2015-16.

Issue: Affordable Care Act Expansion (and R10 Call Center)

This issue brief discusses the Affordable Care Act implementations impact on the state and some of the effects on the Department's workload, including the Department's request for new FTE to address call center volume.

SUMMARY:

- The population that is "newly eligible" under the Affordable Care Act (ACA) definition in Colorado includes parents and caretakers from an effective income limit of 69 percent to 138 percent of the federal poverty guidelines (FPL) and adults without dependent children from an effective income limit of 0 percent to 138 percent of the FPL.
- For FY 2014-15, the Department significantly underestimated the "newly eligible" population that would enroll in Medicaid, but due to an overestimate of the cost per capita the revised forecast of expenditures is almost unchanged.
- If the state had to pay 10 percent of the share of the costs for the "newly eligible" population in FY 2015-16 the projected cost would be $151.1 million. Pursuant to statute, the state share of costs for this population will come from the Hospital Provider Fee.
- Enrollment of the "newly eligible" is concentrated in more urban counties of the state, but relative to the size of the population the ACA is having a bigger impact in some rural counties.
- A demographic profile of the "newly eligible" population is provided.
- In addition to increases in enrollment, the ACA implementation has resulted in an increase in call volume, leading to the Department's R10 request for 25.0 FTE for the call center.

DISCUSSION:

States choosing to implement the Medicaid eligibility expansion authorized by the Affordable Care Act (ACA) started from different eligibility standards, so the exact population gaining eligibility as a result of the ACA varies by state. The ACA allowed states to expand Medicaid eligibility to 133 percent of the federal poverty guidelines (FPL). In addition, the ACA changed the way income is calculated for purposes of determining Medicaid eligibility, resulting in an effective income eligibility standard of 138 percent of the FPL.

In Colorado, the federally defined "newly eligible" under the ACA include parents and caretakers from an effective limit of 69 percent of FPL to 138 percent of FPL and adults without dependent children from an effective limit of 0 percent of FPL to 138 percent of FPL. This is the population that is eligible for the enhanced federal match of 100 percent through 2016, stepping down to 90 percent by 2020.

However, being "newly eligible" under the ACA is not the same as being newly eligible because of the ACA. This is because (1) there are some populations in Colorado that meet the federal definition of "newly eligible" that Colorado would have covered with or without the ACA, and (2) there are populations that Colorado is now covering as a result of the ACA that do not meet the federal definition of "newly eligible" and do not qualify for an enhanced federal match.

The populations Colorado would have expanded to cover with or without the ACA include parents and caretakers from 61 percent to 100 percent of FPL and adults without dependent children from 0 percent to 100 percent of FPL. House Bill 09-1293 authorized a Medicaid expansion to cover these populations *before the ACA was adopted* using financing from the Hospital Provider Fee.[4] Colorado completed the ACA expansion with the passage of S.B. 13-200 that took the income limits for parents and caretakers and for adults without dependent children from 100 percent to 133 percent of FPL and the implementation of the new federal standards for determining income that brought the effective income limit to 138 percent of the FPL. Although the H.B. 09-1293 expansions were authorized before the ACA, they were not implemented until after the ACA cutoff to qualify as "newly eligible."[5] So, while these H.B. 09-1293 expansion adults are "newly eligible" under the ACA definition, Colorado arguably would have covered them absent the ACA.

Populations Colorado is covering to comply with the ACA that do not meet the federal definition of "newly eligible" include former foster children between the ages of 20 and 26 and people eligible as a result of ACA-mandated changes in the way income is determined. In addition, there are a number of people who have signed up for Medicaid as a result of the individual mandate contained in the ACA and/or publicity and outreach efforts associated with the ACA. While this population would have been eligible without the ACA, they arguably went to the effort to sign up because of the ACA. So, there are increases in the Colorado Medicaid population that can be attributed to the ACA that are not part of the federally defined "newly eligible" under the ACA.

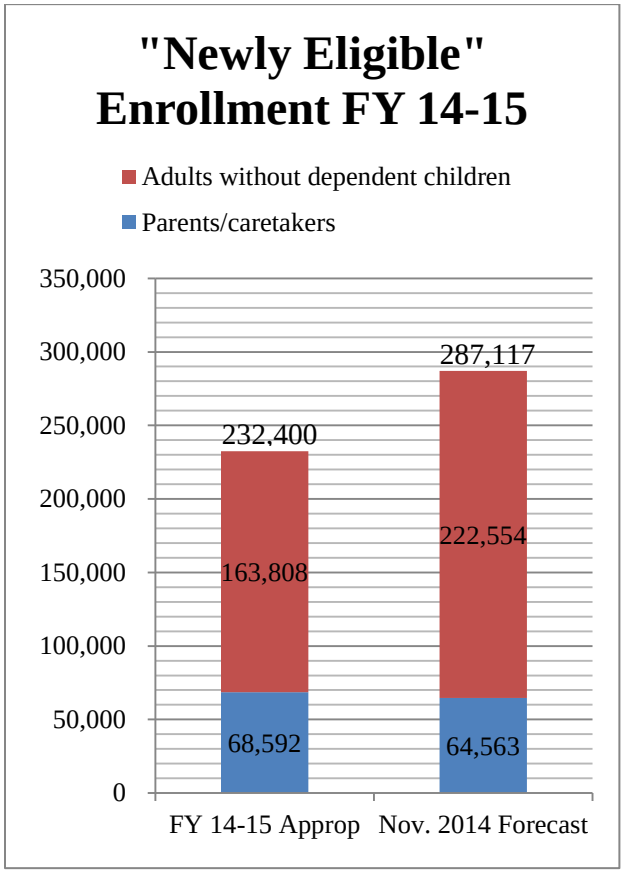
The difference between people who are "newly eligible" under the ACA and people who are newly eligible because of the ACA is a distinction that will likely be lost in many forums of debate, but it is a nuance that may be relevant to certain lines of questions and policy analysis by the JBC. For example, if the JBC wanted to know the cost of repealing the ACA in Colorado it would be important to understand if the repeal was of the "newly eligible" under the ACA or of just the population added in S.B. 13-200.

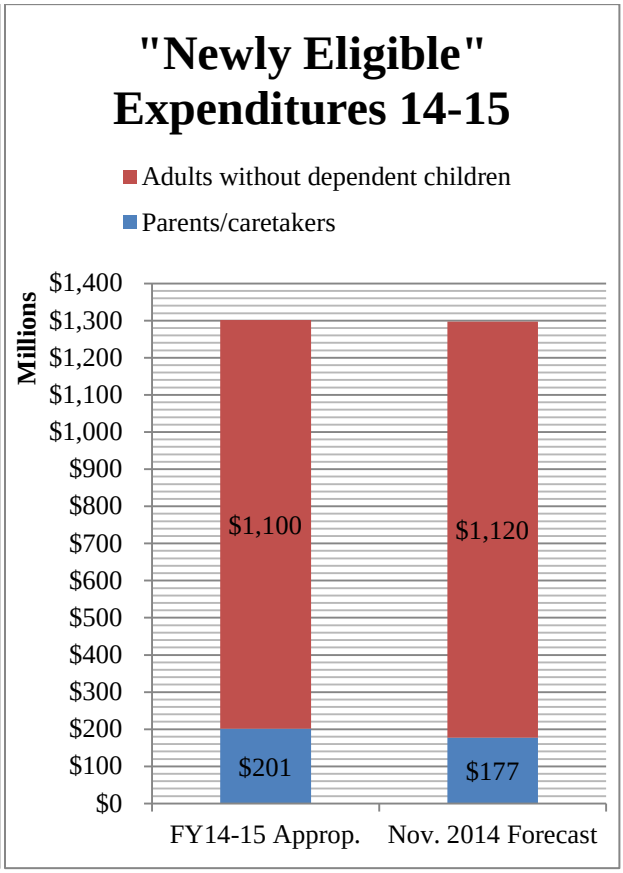
[4] These are the H.B. 09-1293 expansions that are relevant to this issue brief, but H.B. 09-1293 also authorized expanding the Children's Basic Health Plan from 205 percent to 250 percent of the FPL, continuous eligibility for children, and an option for people with disabilities with income up to 450 percent of the FPL to "buy in" to Medicaid.

[5] To further complicate things, the H.B. 09-1293 expansions were only partially implemented before S.B. 13-200, so part of the costs identified in the fiscal note for S.B. 13-200 were associated with the completion of the implementation of H.B. 09-1293.

Forecast of "Newly Eligible"

The charts below show the difference in the forecast of the "newly eligible" for FY 2014-15 that was used for the appropriation versus the forecast submitted with the November 2014 budget request. The JBC staff has received a number of questions about how the reality of the ACA implementation compares to the forecast, with the implied assumption that the forecast grossly underestimated the impact. Although enrollment is trending much higher than the Department forecast, per capita expenditures are trending lower. As a result, the Department significantly increased the forecast of the "newly eligible" enrollment for FY 2014-15, but decreased per capita assumptions, resulting in almost no net change in projected expenditures.





Predicting per capita expenditures for an expansion population can be difficult, because there may be pent up need, but it may also take time for new clients to establish relationships with providers. It often takes a few years before per capita expenditures for an expansion population to stabilize. The Department had selected higher per capita assumptions for the "newly eligible" than the non-expansion parents on Medicaid to account for pent up need. Over time the Department expects the per capita expenditure patterns to converge.

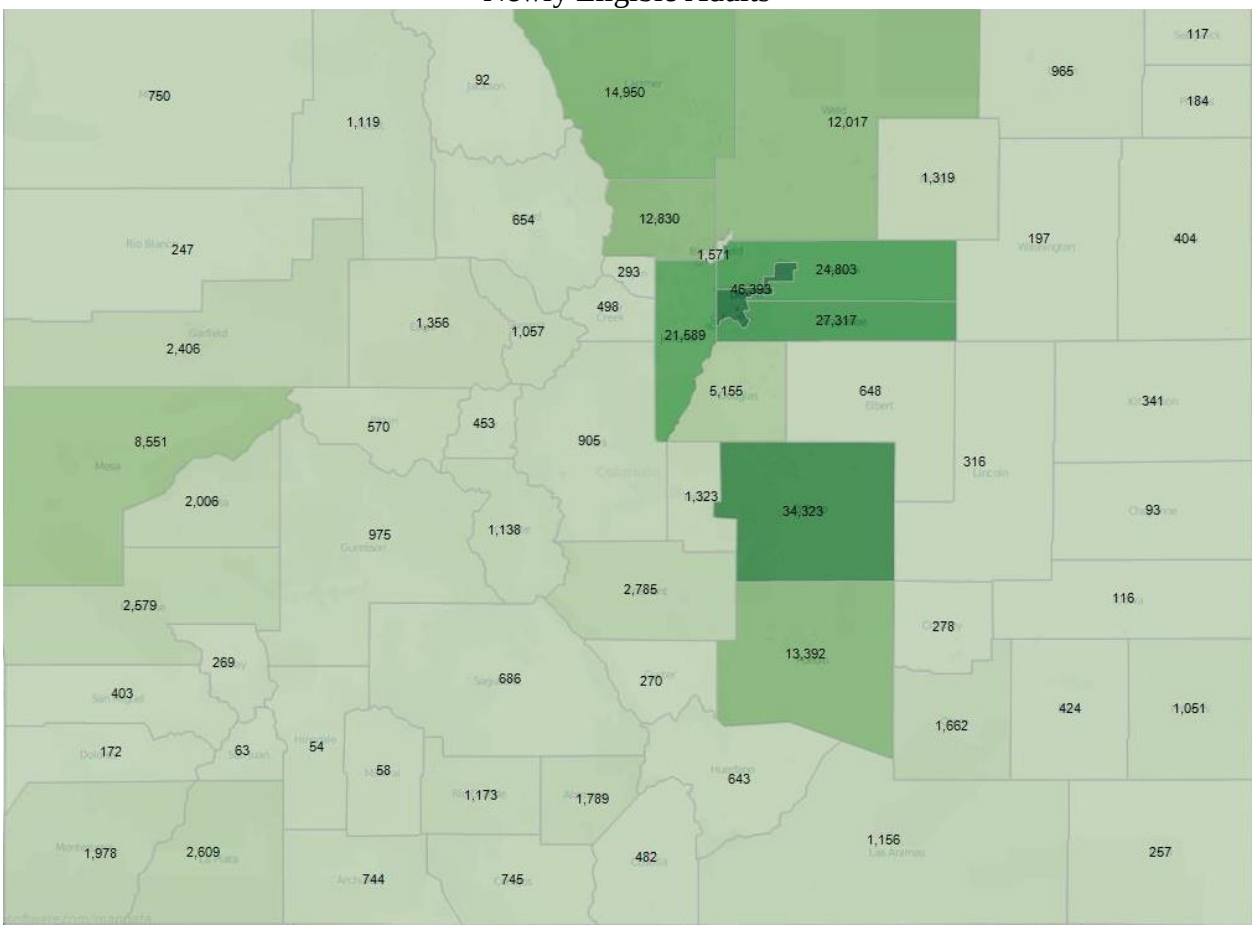
Beginning in 2017 the 100 percent federal match rate for the "newly eligible" population begins to decrease in small increments until it reaches 90 percent in 2020, and the JBC staff has received several questions about the impact on the state budget when the state has to pay 10 percent of the cost for the "newly eligible" population. Rather than trying to make a forecast of expenditures in 2020, staff focused on what the state costs would be in FY 2015-16 if the 10 percent requirement were in place. The JBC staff focused on FY 2015-16 because the Department projects that most of the ramp up in enrollment will be complete by then. For FY 2015-16 the Department expects to spend a total of $1,531,458,906 on medical services and behavioral health for the "newly eligible" population. If Colorado had to provide a 10 percent match for the "newly eligible" under the ACA in FY 2015-16, as states will be required to do in 2020, the projected cost would be $153.1 million.

When the state has to begin providing a match for the "newly eligible" population, statutes stipulate that the Hospital Provider Fee (HPF) will cover the costs. The Hospital Provider Fee is an assessment per occupied bed per day. The revenue is used to make supplemental payments to hospitals and to finance expansion populations. In 2020 more of the HPF will need to be used to finance expansion populations and less will be available for supplemental payments. The proportion of care provided to expansion populations that is attributable to hospitals will presumably remain the same. So, the net benefit to hospitals from the provider fee will decrease compared to today, but it will still be significantly more than scenarios with no expansion and/or no hospital provider fee.

Demographics

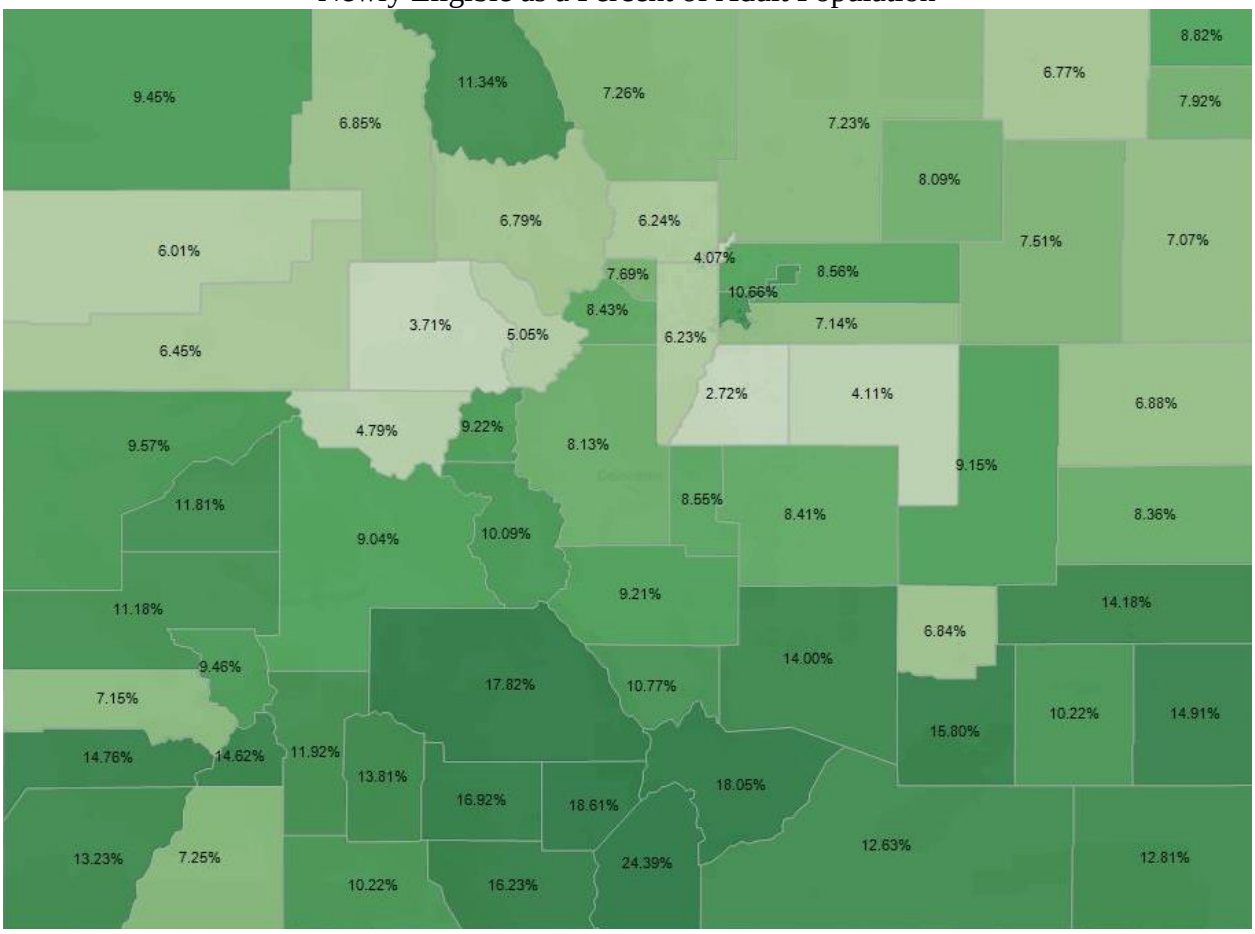
The map below shows the distribution of "newly eligible" adults by county. This map explores where the ACA expansion is having the biggest impact in raw numbers. Not surprisingly, the map reveals a concentration of enrollments in the urban centers along the front range and in Mesa County.

Newly Eligible Adults



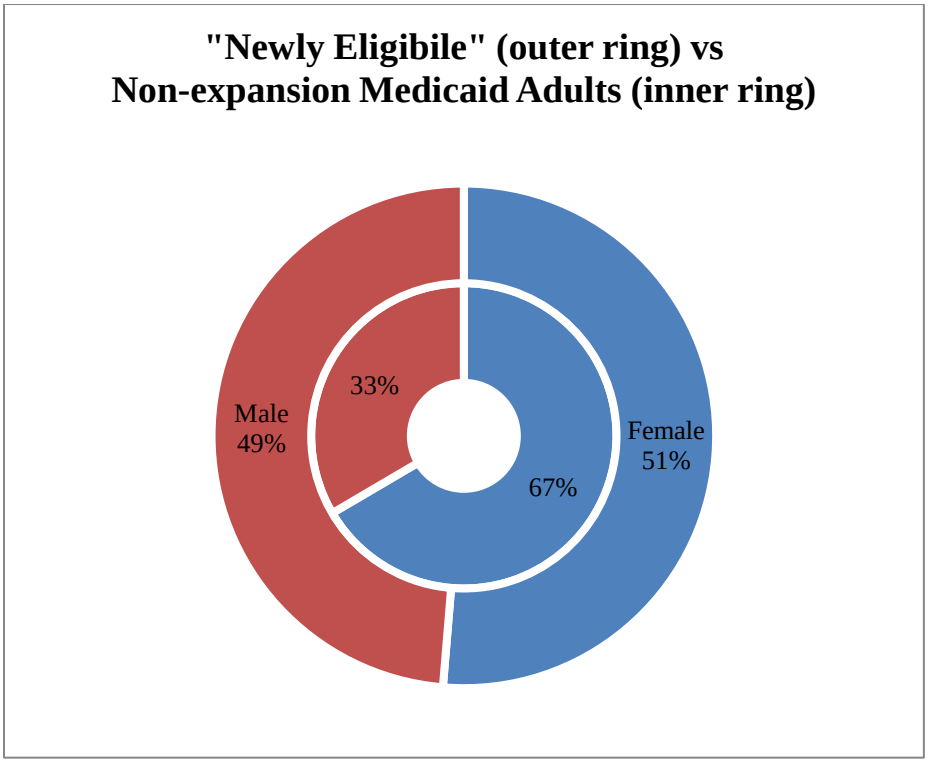
The next map shows the newly eligible enrollment as a percentage of adults 19-64 in each county. This map explores the impact of the ACA expansion relative to the adult population.

Newly Eligible as a Percent of Adult Population

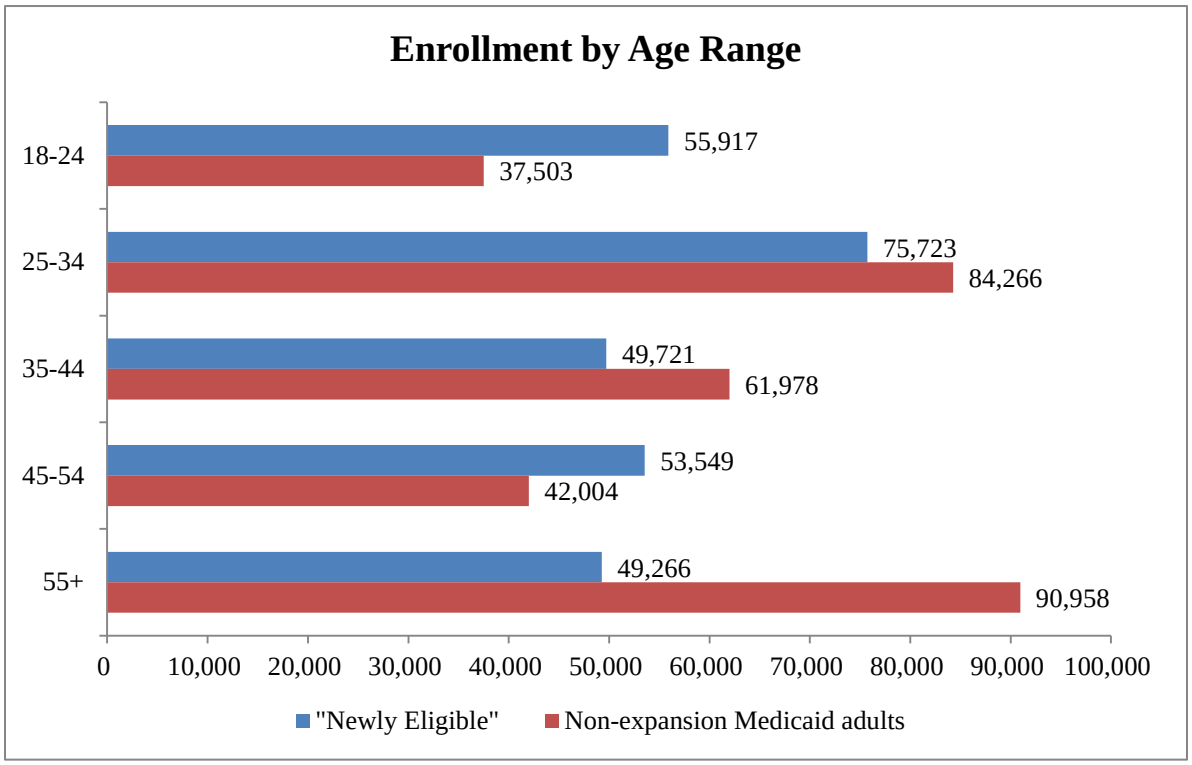


After normalizing for differences in population size, the next logical step would be to normalize for differences in income to show the impact of the ACA relative to the need in each county. This could reveal information about successful and problematic outreach efforts. The Department attempted to look at the newly eligible as a percent of the potentially eligible, using estimates of the potentially eligible prepared by the Colorado Health Institute, but the analysis showed that in several counties the newly eligible exceeded the potentially eligible. The Department thinks that the explanation has to do with the estimate of the potentially eligible not fully taking into account the new federal requirements for how to calculate income for purposes of determining eligibility. There could be other contributing factors, too. For example, the newly eligible may include some people who are migrating from private insurance to Medicaid. Both the Colorado Health Institute and the Department are doing further analysis on the regional impact of the newly eligible and the Colorado Health Institute is targeting a report sometime after the first of the year.

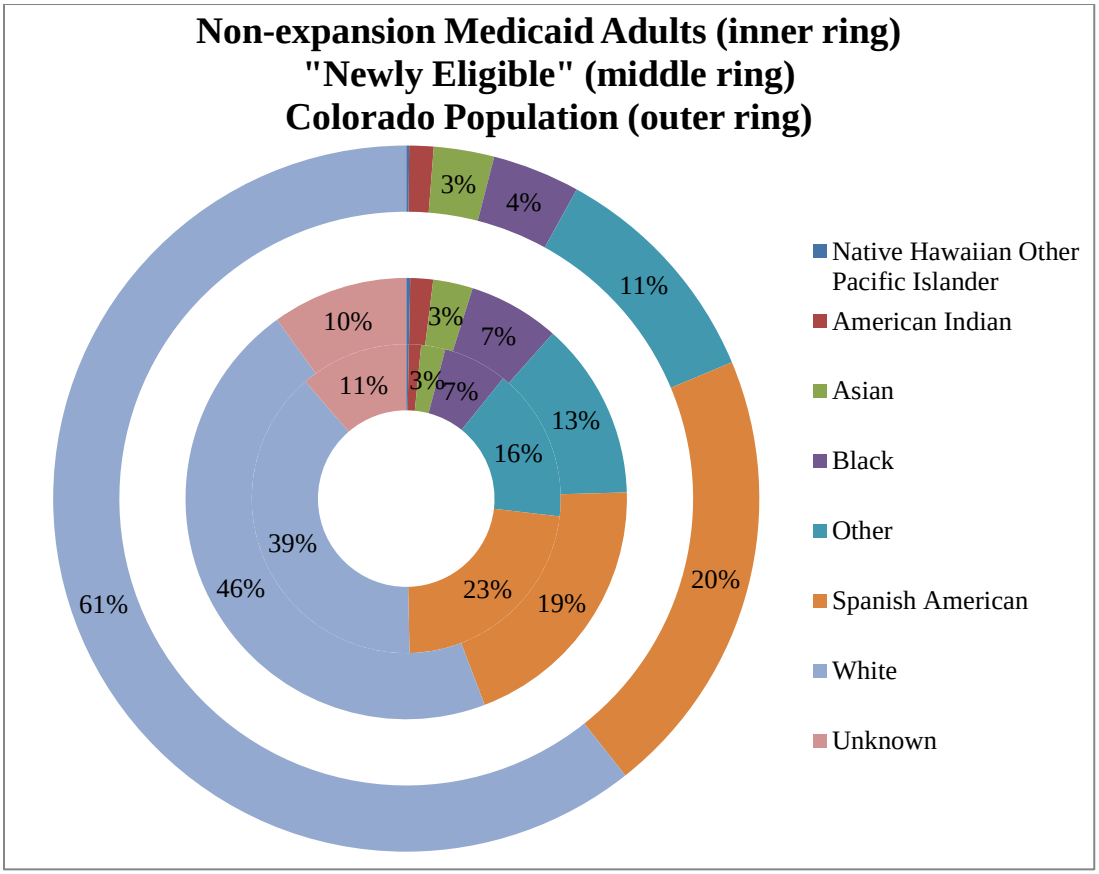
The "newly eligible" population includes slightly more females than males, but looks much closer to Colorado's 50-50 split than the non-expansion Medicaid adults, which are skewed heavily toward females.



The next chart shows some differences in the age distribution between the "newly eligible" and the non-expansion Medicaid adults. These differences are probably attributable to the non-expansion Medicaid adults being limited to parents, people with disabilities, and the elderly.



The next chart shows enrollment by race. It is hard to draw firm conclusions about how the "newly eligible" population compares to the Colorado population because of the relatively large "unknown" category for Medicaid clients. It appears that "black" and "other" are slightly overrepresented among the "newly eligible" population. This is self-reported data, and so "other" includes any case where a person doesn't feel they fit the alternative options. For example, it might include a person of Mexican descent who considers themselves Mexican rather than Spanish American, or a person of Korean descent who considers themselves Korean rather than Asian.



The next table focuses on the primary language of Medicaid adults. The "newly eligible" population looks similar to the non-expansion adults. Both include fewer non-English speakers than the Colorado population. This might reflect an outreach issue, or it could just reflect the subset of the Colorado population that is eligible for Medicaid.

Populations by Language						
	"Newly Eligible"		Non-expansion Adults		CO Population	
Language	Client Count	Percent	Client Count	Percent	Client Count	Percent
English	266,853	93.9%	304,875	93.4%	3,912,773	83.2%
Spanish	12,732	4.5%	16,440	5.0%	557,825	11.9%
Other	4,591	1.6%	5,178	1.6%	231,426	4.9%
Total	284,176	100.0%	326,493	100.0%	4,702,024	100.0%

Call volume (R10)

Another area where the implementation of the ACA has impacted the Department is call volume to the customer service center (CSC). The increase in call volume is not all due to the expansion of Medicaid. It is also attributable to the individual mandate and the requirement that an applicant for health insurance tax credits through the health exchange must demonstrate that they are ineligible for Medicaid. The Department reports that call volume increased from 10,471 in May 2013 to 97,775 in May 2014. The Department experienced a peak in January 2014 of 97,775 calls. The Department is able to answer only about half the calls to the CSC within five minutes.

To address the increase in call volume, the Department's R10 requests 25.0 FTE and $2,077,065 total funds, including $674,424 General Fund, for the Customer Service Center. Previous supplementals and budget amendments approved by the JBC have allowed the Department to upgrade the technology used by the CSC to make the staff more efficient in handling the call volume as well as flexible contingency funds for contract services to deal with ACA implementation issues. The Department has also received some temporary federal funding for the surge in call volume. The Department believes a long-term solution is necessary.

The requested number of FTE is based on an industry standard calculator. The calculator uses data about average call duration, average wrap up time, and hourly call volume to estimate call answering time and the number of staff necessary to meet the Department's target of 80 percent of calls answered within five minutes. Including temporary contractors the Department currently has 22 staff in the CSC including 19 customer facing staff and 3 providing system and management support, but this staffing level will drop to 10 state FTE when the short-term funding for contract services expires. Of the contract positions, 7 are being financed with ACA implementation contingency funds approved by the General Assembly and 5 are from temporary federal funding. The Department expects it will exhaust the funding for temporary staff from the state-approved ACA implementation contingency funds in December 2014 and the federal funding for temporary staff in December 2015.

The Department indicates that it does not have plans to submit a supplemental request, despite the fact that the request describes an urgent need. Some of the funding for the temporary staff the Department has cobbled together will be exhausted in December 2014, during open enrollment for plans offered through health exchange, when call volume would be expected to peak.

The request makes five arguments for using in-house staff versus outsourcing the call center: (1) the Department has trouble retaining temporary staff; 2) experience and research "confirms that agents have the greatest impact on customer satisfaction"; (3) Medicaid is complex; (4) in-house staff can receive consistent training and a better team environment; (5) in-house staff offer flexibility to shift staff based on the type and number of calls. The Department did not estimate the cost of outsourcing, but the Department did indicate that it spends $3,750,000 for a contract to serve CHP+ clients. The CHP+ contractor is responsible for hosting, maintaining and updating the CHP+ website, CHP+ eligibility and enrollment and customer service which includes basic applicant and client questions and enrollment fee processing. The CHP+

contractor's duties are not exactly equivalent to the CSC, but enrollment in CHP+ is slightly more than 62,000 versus over a million in Medicaid.

Issue: Federal medical assistance percentage (FMAP)

This issue brief discusses changes in the federal match rates for Medicaid and the Children's Basic Health Plan (CHP+).

SUMMARY:

- Based on recent guidance from the Centers for Medicare and Medicaid Services (CMS), the decrease in the federal match rate for Medicaid and the Children's Basic Health Plan (CHP+) will cost approximately $28 million less than the contingency set aside in the Governor's November 1, 2014 request.
- The federal match rate is calculated based on state per capita income compared to the national average. The decrease in the match rate for Colorado is due to per capita income exceeding the national average.
- A separate provision of the Affordable Care Act (ACA) increases the match rate for the Children's Basic Health Plan (CHP+) by 23 percentage points beginning October 2015, eliminating the need for a General Fund subsidy of the program in FY 2015-16.
- Federal funding for the increased match rate for CHP+ has not yet been approved, and so the JBC may want to consider legislation to develop a contingency plan.
- If federal funding is reauthorized, the JBC may want to reexamine the statutory distribution of tobacco settlement moneys to CHP+, as the current transfer is projected to be more than the need for the next few years.

DISCUSSION:

The Governor's November 1, 2014 budget request included a set aside of $40.0 million General Fund as a contingency for a potential decrease in the federal match rates for Medicaid and CHP+. Since the Governor's request was submitted the Department has received "preliminary" federal match rates from the Centers for Medicare and Medicaid Services (CMS). Based on these figures, the JBC staff estimates the General Fund cost of the change in federal match rates is approximately $12 million, or $28 million less than the Governor's set aside.

It is important to note that this is a rough estimate based on the assumptions used in the Governor's request. In January the JBC will receive an official supplemental request for the change in the federal match rate and then in February the Department will submit a revised forecast that incorporates the change in the federal match rate. Also, changes by the General Assembly to the Governor's request would change the estimated fiscal impact of the new federal match rates.

The federal match rate for Medicaid, known as the Federal Medical Assistance Percentage (FMAP), is calculated for each state annually according to a formula[6] that takes into account each state's per capita income compared to the national average. Federal law provides for a

[6] 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.

minimum match rate of 50 percent and a maximum of 83 percent. The match rate for CHP+ is then calculated as a derivative of the Medicaid FMAP[7]. 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.

For federal fiscal year 2015-16 the preliminary federal guidance indicates the Medicaid FMAP will be 50.72 percent compared to 51.01 percent for federal fiscal year 2014-15. Based on the way the state fiscal year and federal fiscal year line up, each state fiscal year includes one quarter at the old FMAP rate and three quarters at the new FMAP rate. The average FMAP for state fiscal year 2015-16 will actually increase slightly over state fiscal year 2014-15.

Medicaid Federal Medical Assistance Percentage (FMAP)					
State Fiscal Year	Ave. FMAP	FMAP by Quarter			
		Q1	Q2	Q3	Q4
FY 12-13	50.00	50.00	50.00	50.00	50.00
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

While the change in FMAP will increase the General Fund obligation for Medicaid, it is because per capita income in Colorado is growing faster than the nation. The General Fund revenue projections reflect that per capita income trend.

Generally, the activities that qualify for the standard Medicaid FMAP rate described above are health services while administrative costs are typically reimbursed with a 50 percent federal match. However, there are a myriad of special match rates for a 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.

Special Match Rates	
Activity/Population	Rate
Breast and Cervical Cancer Treatment	CHIP 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%
Primary care physician evaluation and management and vaccinations through December 31, 2014	100%
"Newly eligible" under ACA	100%
Administrative Match Rates	
Adoption and use of electronic health record (EHR) technology	100%
Immigration status verification	100%

[7] The enhanced FMAP (eFMAP) for CHP+ is seventy percent of the standard Medicaid FMAP + 30 percentage points, up to a maximum of 85 percent. Beginning in October 2015 through September 2019 the ACA adds 23 percentage points to the eFMAP.

Special Match Rates	
Activity/Population	Rate
Citizenship verification	90%
Medicaid health information technology planning	90%
Upgrading eligibility and enrollment systems through December 31, 2015	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%

Special provisions related to the Children's Basic Health Plan (CHP+)

A provision of the Affordable Care Act (ACA) adds 23 percentage points to the match rate for CHP+ from October 1, 2015 through September 30, 2019. So, the CHP+ match rate will be influenced by both the change in the Medicaid match rate and the ACA provision. However, reauthorization of federal funding for CHP+ has not yet occurred. That would happen in a separate budget bill. There is some risk that federal funding might not be reauthorized, but the Department believes this is unlikely based on the level of support the program has received at the national level in prior years.

If federal funding for CHP+ was not reauthorized, Colorado would have a few months before funding ran out. This is because federal funding for CHP+ is provided in block grants. If Colorado doesn't use the entire block grant in a fiscal year, then the spending authority rolls forward to the next year. For several years the federal formula for determining Colorado's block grant has resulted in an over allocation compared to Colorado's need. The Department anticipates that roll over block grant funding would allow continued operation of CHP+ until approximately December 2015 or January of 2016. The JBC may want to consider legislation to develop a contingency plan for CHP+ if federal funding is not reauthorized, since service could be interrupted before the 2015 legislative session.

Because of the change in the federal match rate for CHP+, the Department is projecting that the General Fund subsidy can be eliminated in FY 2015-16 and there will still be a surplus in the CHP+ Trust Fund at the end of the year of $18.1 million. By FY 2016-17, when there is a full year at the higher federal match rate, the Department projects a need for expenditures from the CHP+ Trust Fund of $16.9 million compared to revenues of $29.8 million. The majority of the revenue to the CHP+ Trust Fund is an annual statutory transfer of tobacco settlement moneys, projected by the Department to be $28.2 million in FY 2015-16 and FY 2016-17. In addition, the CHP+ Trust Fund is projected to receive $1.5 million in enrollment fees and a nominal amount of interest. If federal funding for CHP+ is reauthorized, the JBC may want to reexamine the statutory distribution of tobacco settlement moneys to CHP+, as the current transfer is projected to be more than the need for the next few years.

Provider Rate Setting Process (R12, RFI #1, and RFI #2)

This issue brief discusses the Department's request for rate increases for FY 2015-16 and a plan the Department submitted for how an annual rate review process could be implemented for future years.

SUMMARY:

- The Department requests a provider rate increase equal to 1.0 percent of eligible expenditures. Half of the funding would be allocated for a 0.5 percent across-the-board increase and the other half would be used for targeted rate increases.
- In response to a JBC request, the Department submitted a plan for an annual rate review process, but did not request funding in FY 2015-16.

DISCUSSION:

Requested funding for provider rate increases (R12)

The Department's R12 requests funding for provider rate increases in an amount equal to 1.0 percent of estimated eligible expenditures. This is a total of $32.9 million, including $11.4 million General Fund. The Department would use half the money to increase all discretionary rates by 0.5 percent across-the-board and the remaining funds would be used for targeted rate increases not yet identified. The Department indicates the targeted rate increases will be detailed in a separate submission to the JBC by February 15, 2015, and the Department requests a hearing with the JBC in February specifically to address the targeted rate increases.

Not all services would be eligible for the across-the-board or targeted rate increases. For some services rates are set according to an external method governed by state statute or federal regulation. Examples include nursing home services where state statutes prescribe the rate setting method and capitated payments such as those to health maintenance organizations that must meet an actuarially sound standard pursuant to federal regulation. The costs to set these rates according to their external method are included in the Department's forecast requests R1 through R5.

In the February submission the Department may request a reallocation of the increases by line item, depending on the rates selected for targeted increases. The November request shows the increases as 1.0 percent per eligible rate in each line item, but in February the Department might, for example, request more of an increase for Medical Service Premiums and less for the Office of Community Living for services for people with developmental disabilities, or vice versa.

The case for targeted rate increases

The Department argues that targeted rate increases are necessary because there are dramatic variations in the adequacy of current rates. According to the Department, some rates are so low that Medicaid clients have trouble accessing services. In these cases, an across-the-board increase would not be sufficient to change provider behavior to increase access. Targeted rate

increases allow for larger changes for select providers that are sufficient to address access issues and therefore more cost-effective than an across-the-board increase.

When rates for a service are first established the Department goes through a detailed analysis to determine an appropriate amount for the rate, but once the rate is set it generally does not change without action by the General Assembly, unless federal or state laws and regulations require adjustments. This can create problems when provider costs change more quickly than adjustments by the General Assembly. It also limits the Department's ability to try to use rates to drive greater utilization of services known to improve health outcomes and reduce costs in other areas.

The need for an annual rate setting review process

The Department's requested process for targeted provider rate increases is similar to the process ultimately used by the JBC and the Department last year, but the JBC asked the Department in the annual Request for Information (RFI) letter to look at ways to improve the process and gave the Department $150,000 for consulting services to ensure a thorough examination of the issue. The JBC included the following two RFI's in the annual letter:

1. Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects – The Department is requested to submit a plan to the Joint Budget Committee by November 1, 2014 for an ongoing annual process to address disparities in Medicaid rates that limit client access to cost-effective care. The proposed process must include opportunities for legislative input and modification. The proposed process must provide actions that can be taken to improve or preserve client access and quality of care in years when state funding for rates is flat or declining as well as years when funding increases. The Department is also requested to report on rate setting procedures used by other public and private insurers and evaluate the applicability of those processes to addressing rate disparities in Colorado. The plan should include an estimate of administrative costs and any statutory changes that may be necessary for implementation.

2. Department of Health Care Policy and Financing, Executive Director's Office, Personal Services -- The Department is requested to submit a report to the Joint Budget Committee, by November 1, 2014, identifying when clients may be experiencing difficulty accessing cost-effective care. As part of the report, the Department is requested to submit a plan for improving the metrics with a dual goal of developing and implementing intervention procedures where appropriate and providing quantifiable data to support rate setting decisions.

In recommending the RFIs, the JBC staff identified a number of weaknesses in the Department's process for targeting rate increases:

- A lack of standardized metrics to prioritize rate increases (the Department made a compelling case that the rates targeted for increases needed attention, but struggled to show that they were a higher priority than other rates)
- Limited evidence that the proposed increases were the right size to address the identified access issues and change provider behavior
- No concrete explanation of how the Department would measure whether the rate changes succeeded in changing provider behavior
- The late submission after the November 1 deadline for budget requests left inadequate time for the question, answer, and refinement process typical of other budget requests

An annual formal rate review process could provide objective criteria for evaluating requests for rate increases, leading to more equitable and timely adjustments for problematic rates. However, it could also identify issues and raise expectations for funding that are beyond the capacity of the budget to address.

Criteria for prioritizing rates

The RFIs focus on Medicaid client access to care and quality of care. These are the gold standards for measuring the adequacy of rates in federal statute. Pursuant to 42 U.S.C. sec. 1396a (a) (30) (A) state Medicaid plans must:

> *assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*

The federal expectation is not that Medicaid rates match private rates, or necessarily that Medicaid rates cover costs in all cases, but that they be designed for Medicaid clients to have access to the same services as the general population and be consistent with quality of care. Because of the wording of the RFIs and the federal guidance on how to determine the adequacy of rates, the Department focused on access and quality of care in the responses to the RFIs.

In retrospect, though, the JBC staff wonders if the focus in the RFIs on access and quality of care is sufficient to address all of the concerns of state legislators. With the increase in Medicaid's share of the insurance market, to the point that it now covers an estimated one in five people in Colorado, it becomes increasingly important that Medicaid pay providers a fair rate. Judging the fairness of Medicaid rates on access and quality of care may not capture all cases where there are problems with Medicaid rates. For example, staff has heard arguments from anesthesiologists that the way their practices are currently set up they see all the clients who need their services and they don't have an ability to turn down referrals of Medicaid clients based on the payer. Staff is not making a value statement about the adequacy of anesthesia rates, but this is the type of situation where a prioritization of rates for targeted increases based on access and quality of care would not identify a problem if it exists. Maybe anesthesiologists could change their business models in a way that would allow them to throttle their Medicaid caseload, thereby creating an access issue, but staff is not sure that the Medicaid rate prioritization process should encourage that approach. Maybe legislative review of the Department's rate setting priorities is sufficient to correct any blind spots in a prioritization based on access and quality of care, but

staff wanted to raise the issue in case there are other criteria in addition to access and quality of care that the JBC would like to direct the Department to use in prioritizing rates.

Key considerations for an annual rate review process

With the funding provided, the Department hired the Public Consulting Group (PCG) to help design a potential annual rate review process. After receiving the recommendations from PCG, the Department emphasized three key considerations for an annual rate review process:

1. The rate review process should complement and not conflict with forthcoming federal regulations from the Centers for Medicare and Medicaid Services (CMS) regarding rates.
2. The JBC should consider making any targeted rate increases approved through an annual rate review process effective January 1, rather than the start of the fiscal year.
3. The Department estimates it would need $567,572, including $283,786 General Fund and 4.0 FTE, to provide the necessary administrative support for the annual rate review process recommended by PCG.

The Department's response to RFI #1 indicates that the Department supports "a more consistent and data-driven manner" for changing reimbursement rates, but the Department did not request the necessary administrative funding in FY 2015-16 to implement the process recommended by PCG. Two factors contributed to the Department's decision not to request funding: (1) the limited time between the completion of the initial PCG report and the due date for the Governor's request; and (2) a desire to wait until the new CMS regulations regarding rates were finalized. The Department did not commit to submitting a budget amendment to implement an annual rate review process. The Department did indicate that it will likely need resources to implement the new CMS regulations, if funding is not provided for a state process that synchronizes with the federal requirements, but the Department says it is premature to estimate those costs until the federal regulations are finalized.

The Department's recommendation to change the assumed implementation date for targeted rate increases to January is to allow time for CMS approval. The Department has had trouble getting some targeted rate increases approved by CMS before the start of the fiscal year. In those cases where CMS approval has been delayed the Department has made the rate increases retroactive to the earliest date in the fiscal year allowed by CMS. According to the Department, retroactive payments have been administratively burdensome for both the Department and providers. Also, not knowing if CMS will approve retroactive payments creates uncertainty and confusion for providers. The Department believes assuming a January start date for targeted rate increases will allow sufficient time for CMS approval, even if the General Assembly provides guidance for targeted rate increases that differ from the Department's request.

The Department did not assume that the targeted rate increases proposed for FY 2015-16 would be implemented in January. According to the Department, changing the assumed start date is a consideration for future years. For FY 2015-16 the Department is proposing a process as similar to last year as possible.

Assuming a January start date for targeted rate increases would ameliorate an implementation challenge, but it could have consequences for the budget setting process. A rate increase that

starts in January will cost approximately half as much in the first year, potentially making it easier to adopt, but the full-year cost will be the same and will need to be financed by the General Assembly in the next year.

PCG recommendations

The PCG recommendations are largely based on the consensus findings of the Medicaid and CHIP Payment Access Commission (MACPAC) about how to measure the adequacy of rates in providing access. PCG worked with the MACPAC, and so is very familiar with their deliberations. The MACPAC recommendations formed the basis for a proposed CMS rule issued in May 2011 that would clarify state obligations for payment policies that allow Medicaid clients equal access to care as the general population. The PCG report expected a final version of the CMS rule to be issued imminently.

In the proposed CMS rule, states would be required to look at a subset of rates every year and every service category at least once every five years, similar to the Medicare standard. States would also need to do an analysis of rates before any rate reduction. In the analysis of rates states would be required to look at enrollee needs, provider availability, and service utilization, though states would have some flexibility in choosing which metrics to use. States would also need to compare Medicaid rates to average customer charges and at least one of the following three: Medicare rates, average commercial rates, or the applicable Medicaid allowable cost of services. If access issues are identified, states could be required to submit a remediation plan. All required aspects of the proposed rule are incorporated in the PCG recommendations for Colorado's rate review process, but the requirements of the final rule may differ from those of the proposed rule.

The PCG, "did not identify any state currently performing the type of systematic Medicaid fee-for-service rate review of interest to Colorado." The PCG did find that California and New Hampshire prepare regular reports on access, Virginia is moving toward a regular report, and several other states have performed one-time or infrequent access reviews. Some of these access reviews have included recommendations for rate increases to improve provider participation, but they aren't systematic studies of rates, and they only address access without consideration for quality of care.

For Colorado, PCG recommends a process that would begin with an evaluation of access to care. The access to care evaluation would include analysis of:

- Enrollee needs -- demographic information collected from the MMIS, enrollee satisfaction survey results, beneficiary requests for assistance, Medicaid beneficiaries reporting difficulties finding care, and areas of complaints
- Provider ability – provider to population ratio, time and distance from client to provider, number of providers participating in Medicaid, number of providers entering and exiting the network, providers accepting new patients
- Service utilization – usual source of care for enrollees, percentage of enrollees receiving particular services, rates of use of preventative services, potentially preventable events,

adequacy of prenatal and postpartum care, emergency department visits, benefit restriction analysis

For each area the PCG report recommends comparing the data collected for the Medicaid population with data for the general population, data over time, and data across geographic regions.

The next step in the process would be a rate review. The evaluation of access would inform decisions about the order in which rates are reviewed. The prioritization order would also favor high volume services. PCG recommends a flexible schedule that allows rates to be reviewed out of sequence when budget circumstances or anticipated fluctuations in provider networks dictate.

The rate review would include the proposed CMS rule comparisons of Medicaid rates to average customer charges and at least one of the following three: Medicare rates, average commercial rates, or the applicable Medicaid allowable cost of services. For rates paid to practitioners, PCG recommends a five-year comparison to peer benchmarks. The appropriate peers will vary by service, but may include Medicare, average commercial rates, and/or other state Medicaid rates. For hospitals and nursing homes PCG recommends a five-year comparison of the ratio of Medicaid rates to actual costs, since detailed cost reports are available. The five-year trend data would be used for analysis of associations between changes in rates and provider participation.

The rate review would include a policy analysis component that would consider alternative options to rate changes for addressing access and utilization issues as well as overall budget constraints. Alternative options could include things like changes to administrative rules, interventions through the Accountable Care Collaborative, and gainsharing incentives.

The PCG recommendations include a stakeholder engagement process overlapping the access evaluation and rate review. However, the PCG report does not detail how the stakeholder process would work.

The PCG plan would produce a list of prioritized rates by June for incorporation in the Governor's November request and then consideration by the General Assembly. The JBC staff believes there might be advantages to adjusting this timing to allow OSPB to be part of the policy analysis phase of the rate review. OSPB is in a better position to take into account overall budget constraints than the Department. On the other hand, a report due with the November budget request might be viewed as politically biased. It might be better to have an independent report and then let the Governor explain funding decisions.

Remaining PCG deliverables

In addition to the report already submitted, PCG is going to go through the recommended rate review process for a subset of the Department's rates. The goal is to provide a "proof of concept." PCG will then present refined recommendations for how the Department could operationalize a robust annual rate review. If there are actionable items from the PCG rate review the Department will present them to the JBC, but the Department indicates the focus of the PCG rate review is on evaluating the process, rather than achieving specific recommendations for rate changes at this time.

Determining income and other eligibility calculations (R6)

This issue brief discusses the effect of the Affordable Care Act (ACA) on income determinations for eligibility purposes and the Department's R6 request for additional changes to the eligibility criteria.

SUMMARY:

- The Affordable Care Act (ACA) required states to use a new federal standard for determining income for purposes of eligibility.
- The new standards create higher effective income eligibility standards than implied by the statutes.
- For FY 2015-16 the Department proposes some additional changes to the eligibility calculation, including annualizing income for adults, studying the feasibility of continuous eligibility for adults, and providing a one-month grace period for people to pay the enrollment fees for the Children's Basic Health Plan (CHP+).

DISCUSSION:

Modified Adjusted Gross Income (MAGI)

Part of the Affordable Care Act (ACA) required states to adopt a new federal standard for most populations for determining income for purposes of Medicaid and CHP+ eligibility. The new standard, called Modified Adjusted Gross Income (MAGI), results in a higher effective maximum income than implied by the statutory limits on eligibility.

State statute stipulates the maximum income for different eligibility categories, but it largely delegates the process for determining income to the Department. State statute also gives the Department authority to comply with federal requirements for participation in Medicaid.

The new federal standards eliminate a large number of sate-specific income disregards. These disregards were for things like child care expenses, child support payments, veterans' benefits, and work-related expenses. In the new federal formula there are still adjustments to gross income, but these adjustments are standardized across states according to the federal formula.

A separate provision of the ACA required states to maintain at least the income eligibility criteria they had before the ACA for children and pregnant women through 2019. To ensure compliance, Colorado used a CMS formula to determine the average income disregard as a percentage of the FPL that was in place prior to the ACA for each population subject to the maintenance of effort requirement and then applied this as a standard income disregard in the post-ACA environment. The maintenance of effort adjustment results in an effective income limit that is higher than the statute, but in theory nobody is gaining eligibility compared to the pre-ACA environment.

Another component of the new ACA standard is a flat five percent income disregard for all populations. The five percent disregard is often described as in lieu of the old state-specific income disregards. That is a reasonable description of the impact for the newly eligible populations. However, for the populations subject to the maintenance of effort requirement the Department explains that the five percent income disregard is being applied after the maintenance of effort is satisfied. In these cases, the five percent disregard is not in lieu of anything. It is a straight increase in eligibility.

The table below summarizes the effect of the maintenance of effort requirement and the MAGI five percent income disregard on the effective income eligibility limits for different populations.

Effective Income Eligibility					
	Children	Pregnant Adults	Adult Parents	Adults without Dependent Children	CHP+
Income eligibility limit in statute	133%	185%	133%	133%	250%
Maintenance of effort of prior state income disregards	9%	10%	NA	NA	10%
Additional MAGI 5.0 percent income disregard	5%	5%	5%	5%	5%
Effective income eligibility limit	147%	200%	138%	138%	265%

Annualizing income

As part of R6 the Department proposes another change to the income calculation process to allow the use of annualized income, rather than monthly income, to determine Medicaid and CHP+ eligibility. Using annualized income would be more consistent with the way eligibility is determined for health insurance tax credits available through the Health Exchange. The purpose of the request is to reduce churn, where clients gain or lose Medicaid eligibility based on fluctuating income, and in particular the request highlights seasonal workers as vulnerable to churn.

According to the Department, transitional Medicaid is not sufficient to address the needs of clients who would be helped by an option to annualize income. Transitional Medicaid is a federally required eligibility category that allows clients to continue receiving services for up to a year after an increase in income from employment. However, the Department reports that transitional Medicaid has some eligibility requirements that may not apply to people who would be helped by annualized income. Specifically, the Department noted that to qualify for transitional Medicaid an applicant must have been eligible for Medicaid in three of the last six months. Also, the Department noted that the federal authorization for transitional Medicaid has been year to year, creating uncertainty about the future.

If the annualized income option is approved, a Medicaid client who is already enrolled (not a new applicant) could request the use of annualized income. They would need to provide a clear indicator, such as a signed contract or history of fluctuating income. The eligibility system would then make a projection of their income for the rest of the year. Clients who disagree with the projection could appeal. Federal regulations allow annualizing income for the remainder of the year, which is not quite the same as annualizing income for the entire year. Clients are responsible for reporting variances between their actual and estimated income. For employment

income the Department receives monthly reports that verify income. A variance that doesn't meet rules for reasonable compatibility and reasonable explanation would require a redetermination and could result in a loss of benefits.

The Department estimates allowing the use of annualized income would cost $12,281,696, including $1,410,508 General Fund, beginning in FY 2016-17. The change is expected to impact 20,430 clients who would receive an average of 3.48 months more of Medicaid services in a year.

Three other states, California, Vermont, and Michigan, have implemented annualized income for adults.

There are no costs projected for FY 2015-16. Implementing the annualized income option will require changes to CBMS that the Department indicates can be accomplished within existing resources, but not soon enough to implement the policy before FY 2016-17.

The Department says that they requested the option to use annualized income as part of the package of requests in R6 that also includes a one-month grace period to pay the annual CHP+ enrollment fee and a study of the feasibility of implementing continuous eligibility for adults. If R6 is approved, the Department would treat the cost of creating an option to use annualized income as an annualization in the FY 2016-17 budget process.

Staff believes the Department's proposal for how to handle annualized income through the budget process is problematic. Because there are no costs in FY 2015-16, it may not be transparent to legislators voting on the Long Bill that they are approving a change to the income determination process that will drive expenditures in FY 2016-17. This lack of transparency could be addressed through a footnote, but because this is a change in eligibility that will result in more people qualifying for Medicaid, it could be viewed as substantive law, which can't be made through a footnote. The Department might argue that this is merely a change in the way income is calculated for purposes of determining eligibility and within the delegated authority of the Department. Another argument could be made, however, that this is analogous to presumptive eligibility or continuous eligibility where an individual is given access to benefits when they might not otherwise meet the income qualifications. In the cases where the Department uses presumptive eligibility and continuous eligibility the authority is provided in state statute. Like annualizing income, presumptive eligibility and continuous eligibility are options under federal guidelines, but none of these options are required for state participation in Medicaid, and so arguably not part of the Department's broad authority to comply with federal Medicaid regulations. Authorizing an annualized income option through the Long Bill implies a broader interpretation of the Department's authority to implement federally optional eligibility changes than authorizing it through a bill. Legislative Legal Services was not definitive on whether this change could be accomplished through the budget process or whether it would require a bill, but the JBC staff believes that the best approach, if the JBC supports this policy, would be to authorize it in a bill.

Continuous eligibility

Another component of the R6 request is $150,000 total funds, including $75,000 General Fund, to study ways to ameliorate the negative impacts of churn, including the feasibility of implementing continuous eligibility for adults. Continuous eligibility means that once a person has been deemed eligible they remain eligible for a calendar year, even if they have a change in income.

Continuous eligibility for children is optional under federal regulations and has been authorized in state statute and implemented by the Department, but continuous eligibility for adults would require a waiver. To date, no other state has implemented continuous eligibility for adults, but several states are exploring it.

To qualify for a waiver to implement continuous eligibility the state would need to demonstrate to CMS that the policy is cost neutral to the federal government. The job of the contractor would be to see if a case could be made that the continuity of care provided by continuous eligibility saves money in the long run by avoiding preventable health costs for people who churn on and off Medicaid.

One-month grace period for annual enrollment fee for CHP+

The remaining element of R6 that hasn't been discussed is a proposal to allow CHP+ applicants a one-month grace period to pay the annual enrollment fee. Several states have grace periods of varying length for applicants to pay annual enrollment fees. In calendar year 2013 there were 5,383 clients in Colorado who applied and met the income qualifications for CHP+ but were deemed ineligible for failure to pay the enrollment fee. The Department assumes that if provided a one-month grace period to pay the annual enrollment fee that 90 percent of this population would follow through. This is based on a large portion of clients who reapply within a short period of time and pay the annual enrollment fee. The remaining 10 percent would be eligible for services for one month and then be denied services.

In addition to the benefit for the applicant, this policy would help the Department satisfy court-mandated timely processing requirements. Currently, the time between when an application is submitted and when the enrollment fee is paid is viewed by the courts as a delay in processing.

The table below summarizes the enrollment fees for CHP+. Children below 157% FPL and pregnant women are exempt from paying the enrollment fee.

CHP+ Enrollment Fees	Children 157%-205%	Children 206%-260%
Fee to enroll one child	$25	$75
Fee to enroll more than one child	$35	$105

The JBC staff is skeptical about the Department's assumption that 90 percent of the people who currently don't pay will suddenly decide to pay if offered a one-month grace period. Being denied access to services seems a greater incentive to pay than being given access to services. If the goal is to decrease the number of people who meet the eligibility criteria but don't pay, the

JBC staff wonders if improved outreach and education about the value of enrollment would be a better investment than a one-month grace period.

It is possible that some clients with an urgent care need will apply for CHP+, receive services during the one-month grace period, and then never pay the enrollment fee and let their coverage lapse. However, an urgent care episode may also reinforce the value of insurance for a client who was struggling to pay the fee.

This is another area where the JBC might want to consider authorizing the change through legislation, should the JBC decide to support the request, but the JBC staff has fewer concerns about this request than the request to implement annualized income. With this request there are costs in FY 2015-16, and so it would be transparent to legislators voting on the Long Bill that they were approving a change in policy. In this case there is no question that the applicants meet the statutory income eligibility criteria. The issue is whether they have paid the enrollment fee. Medicaid does not have enrollment fees, and so the risk of a broad interpretation of the Department's authority to set policies governing enrollment fees is limited to CHP+. Enrollment fees are a relatively small portion of the revenue supporting CHP+, as they are expected to generate approximately $1.5 million in FY 2015-16. In FY 2011-12 the JBC sponsored legislation to make changes to the CHP+ enrollment fees, but then when that bills was vetoed by the Governor the JBC authorized more modest changes to the enrollment fees in the FY 2012-13 budget process.

In the Department's proposal, people who apply but do not pay the enrollment fee would not be eligible for continuous enrollment. The Department also indicates that it would implement systems and rules to prevent people from applying over and over again and qualifying for the grace period without ever paying the enrollment fee.

Children with Autism Waiver Expansion (R8)

This issue brief discusses the Department's R8 request for the JBC to sponsor legislation to expand and modify the Children with Autism waiver.

SUMMARY:

- The Department requests that the JBC sponsor legislation to expand and modify the Children with Autism waiver.
- In addition to a waitlist for services of 320 compared to an enrollment cap of 75, there are several aspects of the current structure of the Children with Autism waiver that make it function less than optimally even for the people who make it off the wait list.

DISCUSSION:

The Department requests that the JBC sponsor legislation to expand and modify the Children with Autism (CWA) waiver. Specifically, the Department proposes eliminating the enrollment cap of 75, expanding eligibility to add children ages 6 to 8, allowing children who begin receiving services before age 8 to receive a full three years of services (and no more than three years), increasing the $25,000 annual expenditure cap to $30,000, allowing the annual expenditure cap to be adjusted in future years through the budget process rather than requiring a statutory change, and providing for an annual independent evaluation of the effectiveness of services for people with autism. Based on the implementation schedule and the availability of a fund balance in the Autism Treatment Cash Fund, the projected General Fund costs in the first year are significantly lower than expected costs in future years.

R8 Children with Autism Waiver Expansion		
	FY 2015-16	FY 2016-17
Total	$10,616,568	$19,042,713
General Fund	367,564	8,830,589
Cash Funds	4,840,203	508,566
Federal Funds	5,408,801	9,703,558

The source of revenue to the Autism Treatment Cash Fund is a $1.0 million annual statutory transfer from tobacco settlement moneys.

Currently, to qualify for the autism waiver a child must be eligible for Medicaid, be under the age of 6, have a diagnosis of autism, be at risk of institutionalization, and not in another waiver program. Once qualified, a child must wait until there is room on the waiver before receiving services. Enrollment on the waiver is capped at 75. Pursuant to statute, children on the wait list are prioritized for services based on imminent need. Because the children are at risk of institutionalization, they are considered a family of one and parent income is not considered.

There are a number of challenges with the current structure of the waiver program.

- **Large waitlist** -- The waitlist for services is four times the size of the enrollment cap of 75. As of the budget request the number of people on the waitlist for services was 320, the average time on the waitlist before receiving services was 2.5 years, and in the last three years 95 clients on the waitlist aged out of eligibility before receiving services. The Department believes many more people have not signed up for the waitlist due to low expectations that they will receive services and assumes that if the enrollment cap were removed an additional 161 clients more than the 320 on the waitlist would enroll in the first year.
- **Length of services too short** -- Once people get off the wait list the average length of time they are eligible for services before aging out of the waiver is less than a year. According to the Department, intensive behavior therapies should be provided for three years to have the greatest impact for children with autism.
- **Age limits don't match window when services are effective** -- The current age cap for the waiver is shorter than the window of time when research indicates services are most effective. The Department cites guidance from the Lovass Institute that behavioral treatment should be received by age 12 and is most effective between the ages of 2 and 8.
- **Annual expenditure limit doesn't allow provide rate increases** -- The annual expenditure limit of $25,000 has meant no provider rate increases for autism services for several years. If autism service rates were to increase it would diminish the buying power of clients within the annual expenditure limit.
- **Medicaid coverage is less than required by state statute for private insurance plans issued in Colorado** – Section 10-16-104 (1.4), C.R.S., referred to as the Health Insurance Mandated Autism Treatment (HIMAT), requires health plans issued or renewed in Colorado to include coverage of autism services, but Medicaid clients do not have access to these services unless there is room under the enrollment cap. The HIMAT does not apply to self-funded plans governed by the Employee Retirement Income Security Act (ERISA) or plans issued in other states, which is a significant portion of the Colorado insurance market.

It is possible that a number of people who qualify for the Children with Autism waiver have private insurance. The way the waiver is structured, only the child's income, and not the income of parents/caretakers, is considered for purposes of determining Medicaid eligibility. The Department does not have data about the income of the parents/caretakers of children on the waiver. If the parents/caretakers do not qualify for public health insurance, they would need to purchase private insurance to satisfy the individual mandate of the ACA. Medicaid is the payer of last resort, and so there is no risk of Medicaid paying for services that are already covered by private insurance. Rather, this is of interest because if people with private insurance can qualify for Medicaid coverage of autism services, then that may influence the decisions of private insurance providers about whether to cover autism services.

Expanding Medicaid coverage for autism services may create a disincentive for private insurance to cover these services. According to the Department, private insurance coverage of behavioral services for children with autism has increased in recent years. However, not all private insurance covers autism services. The HIMAT requires health plans issued or renewed in Colorado to include coverage of autism services, but it does not apply to self-funded plans governed by ERISA or plans issued in other states, which is a significant portion of the Colorado

insurance market. If Medicaid covers autism services, then that may reduce the need for private insurance plans that are not subject to the HIMAT to cover autism. Of course, health plans that are issued out of state to people in Colorado are often insuring people in many states, and so their decisions about what services to cover will not be driven solely by the coverage offered by Colorado's Medicaid. Also, 37 states have adopted specific coverage requirements for autism services that require varying degrees of coverage.

Hospital Provider Fee TABOR impact

This issue brief discusses the interaction of the Hospital Provider Fee and TABOR.

SUMMARY:

- Growth in revenue to the Hospital Provider Fee is contributing to a larger projected General Fund refund under TABOR.
- Estimating the effect of converting the Hospital Provider Fee to an enterprise is dependent on assumptions about the future growth rate of the Hospital Provider Fee.

DISCUSSION:

Growth in revenue from the Hospital Provider Fee is contributing to a larger projected General Fund refund under TABOR. The revenues subject to the TABOR limit include cash funds, but the mechanisms for refunding excess TABOR revenues focuses on payments from the General Fund. As a result, if a cash fund grows faster than the TABOR limit it can crowd out the amount of General Fund that the state is allowed to retain. The reverse is also true, where a cash fund growing slower than the TABOR limit would allow the state to retain more General Fund that it otherwise would be allowed.

The Hospital Provider Fee is an assessment per occupied bed per day. The revenue is used to match federal funds and then make supplemental payments to hospitals and to finance expansion populations. An increase in revenue from the Hospital Provider Fee generally benefits hospitals, because it increases the amount of matching federal funds. However, some of the Hospital Provider Fee is spent for administration and not all of the services for expansion populations are attributable to hospitals, so not all of the benefit from a higher Hospital Provider Fee goes back to hospitals.

The Hospital Provider Fee is set by the Medical Services Board with input from the Hospital Provider Fee Advisory Committee. There are two federal limits on how much revenue can be raised from the HPF. First, the Hospital Provider Fee cannot exceed six percent of net patient revenues for the hospitals. Second, the Department cannot use the Hospital Provider Fee to pay more than the Medicaid Upper Payment Limit (UPL) to the hospitals. There are nuances to how the UPL is calculated, but it can be thought of as the amount Medicare would have paid for the same services as Medicaid.

In FY 2014-15 the Department projects a significant increase in revenue from the Hospital Provider fee, primarily due to the Medicaid expansion's impact on the Upper Payment Limit. The table below summarizes projected revenues.

Hospital Provider Fee Revenue				
	FY 13-14 Actual	FY 14-15 est.	FY 15-16 est.	FY 16-17 est.
Amount	$566,716,385	$622,865,266	$643,362,741	$682,911,664
Dollar Change		$56,148,881	$20,497,475	$39,548,923
Percent Change		9.9%	3.3%	6.1%

The increase in revenue from the Hospital Provider Fee has led some to speculate whether it could/should be converted to an enterprise with revenue exempt from the TABOR limit. To qualify as an enterprise a government entity must be a government-owned business, have authority to issue bonds, and receive less than 10 percent of annual revenue from state and local government grants. Staff is not sure how the Hospital Provider Fee could be modified to meet the enterprise criteria.

If an entity gains or loses enterprise status, TABOR provides that the TABOR limit be adjusted so that there is not a financial windfall or penalty to the state. However, there still might be a long-term impact on the revenue that the state can maintain under TABOR if revenues to an enterprise are growing faster or slower than the TABOR limit.

Legislative Council Staff (LCS) recently shared a preliminary estimate of the impact of making the Hospital Provider Fee an enterprise with the JBC staff. LCS estimates that making the Hospital Provider Fee an enterprise and adjusting the TABOR base would reduce the TABOR refund by $84.2 million in FY 2015-16 and $29.1 million in FY 2016-17. It is important to note, however, that the LCS projection of Hospital Provider Fee revenue is significantly different than the Department's estimate.

The JBC staff has also heard speculation that the TABOR base should not be modified if the Hospital Provider Fee were structured as an enterprise due to the timing of the adoption of Referendum C and the adoption of the Hospital Provider Fee. The JBC staff is not familiar with the legal arguments behind this position.

If the Hospital Provider Fee were converted to an enterprise and the TABOR limit was not adjusted, the state would have experience a one-time increase in the amount of General Fund it could retain under the TABOR limit, in addition to the ongoing impact of the difference in the growth rate of the enterprise and the TABOR limit. In this scenario, LCS estimates the TABOR refunds of $121.5 million in FY 2015-16 and $392.6 million in FY 2016-17 would be eliminated. In addition, the state would be $541 million below the TABOR limit in FY 2015-16 and $238.5 million below the TABOR limit in FY 2016-17.

It should be noted that whether the TABOR limit is adjusted or not, the effect to the state budget is not as straight forward as the simple change in the TABOR refund. This is due to the impact on the statutory transfers to the Highway Users Tax Fund and the Capital Construction Fund.

To evaluate the effect of a change to enterprise status for the Hospital Provider Fee requires a long-range forecast of Hospital Provider Fee revenues. The Department did not provide a long-term forecast of Hospital Provider Fee revenues for this briefing. There are a number of unknowns about future Hospital Provider Fee revenue. The Medicaid expansion had a dramatic impact on the Upper Payment Limit. The other limitation on Hospital Provider Fee revenue is net patient revenues. Net patient revenues have also been impacted by the expansion and the individual mandate of the ACA. Net patient revenues are not reported until up to two years after the fact. This leads to significant uncertainty about future Hospital Provider Fee revenues. Different assumptions about the future growth rate of the Hospital Provider Fee could have a

significant effect on the projected impact of converting the Hospital Provider Fee to an enterprise.

Appendix A: Number Pages

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Personal Services	22,338,943	25,782,006	26,037,911	28,000,068	*
FTE	315.9	363.7	360.4	382.3	
General Fund	8,062,731	8,477,796	8,796,787	9,514,670	
Cash Funds	1,922,374	2,564,595	2,676,189	2,938,818	
Reappropriated Funds	1,176,645	1,613,082	1,885,519	1,920,262	
Federal Funds	11,177,193	13,126,533	12,679,416	13,626,318	
Health, Life, and Dental	2,216,793	2,322,449	2,476,612	2,962,649	*
General Fund	796,479	748,152	896,868	1,023,393	
Cash Funds	174,652	227,867	166,066	263,616	
Reappropriated Funds	111,821	72,376	129,013	179,602	
Federal Funds	1,133,841	1,274,054	1,284,665	1,496,038	
Short-term Disability	33,497	42,151	64,185	61,393	*
General Fund	12,334	13,671	21,082	22,202	
Cash Funds	2,503	3,764	4,955	4,751	
Reappropriated Funds	1,309	802	1,915	2,663	
Federal Funds	17,351	23,914	36,233	31,777	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	730,633	850,598	1,235,106	1,317,068	*
General Fund	283,141	273,870	405,144	476,107	
Cash Funds	53,468	76,148	96,428	101,903	
Reappropriated Funds	37,574	16,232	36,801	57,301	
Federal Funds	356,450	484,348	696,733	681,757	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	627,713	767,027	1,157,972	1,272,168	*
General Fund	242,160	246,370	379,822	459,876	
Cash Funds	45,949	68,744	90,431	98,429	
Reappropriated Funds	33,280	14,654	34,501	55,348	
Federal Funds	306,324	437,259	653,218	658,515	
Salary Survey	0	669,740	831,265	321,383	
General Fund	0	199,437	272,365	115,474	
Cash Funds	0	53,484	64,811	24,853	
Reappropriated Funds	0	10,800	24,814	14,235	
Federal Funds	0	406,019	469,275	166,821	
Merit Pay	0	372,361	265,923	317,662	
General Fund	0	119,442	94,487	111,192	
Cash Funds	0	28,027	19,363	26,760	
Reappropriated Funds	0	9,889	9,333	15,675	
Federal Funds	0	215,003	142,740	164,035	
Worker's Compensation	30,844	47,286	52,712	43,207	
General Fund	15,422	23,643	26,356	21,604	
Federal Funds	15,422	23,643	26,356	21,603	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Operating Expenses	1,503,436	2,497,422	3,350,622	2,216,745	*
General Fund	663,213	1,141,931	1,582,459	1,006,296	
Cash Funds	43,601	121,029	62,577	77,778	
Reappropriated Funds	64,796	1,382	23,910	23,910	
Federal Funds	731,826	1,233,080	1,681,676	1,108,761	
Legal and Third Party Recovery Legal Services	896,802	979,454	1,426,338	1,361,512	
General Fund	284,349	346,973	461,512	440,536	
Cash Funds	162,313	153,671	251,658	240,220	
Reappropriated Funds	0	0	0	0	
Federal Funds	450,140	478,810	713,168	680,756	
Administrative Law Judge Services	510,597	538,016	365,007	570,872	
General Fund	211,949	219,941	141,828	221,820	
Cash Funds	43,350	49,067	40,675	63,616	
Federal Funds	255,298	269,008	182,504	285,436	
Purchase of Services from Computer Center	1,001,906	882,219	0	0	
General Fund	496,907	436,917	0	0	
Reappropriated Funds	4,046	4,193	0	0	
Federal Funds	500,953	441,109	0	0	
Multiuse Network Payments	245,162	139,002	0	0	
General Fund	122,581	69,501	0	0	
Federal Funds	122,581	69,501	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
COFRS Modernization	569,048	504,637	950,660	950,660	
General Fund	329,397	331,447	329,397	329,397	
Cash Funds	173,190	173,190	173,190	173,190	
Reappropriated Funds	2,052	0	2,052	2,052	
Federal Funds	64,409	0	446,021	446,021	
Information Technology Security	0	11,374	0	0	
General Fund	0	5,687	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	5,687	0	0	
Management and Administration of OIT	0	72,130	0	0	
General Fund	0	36,065	0	0	
Federal Funds	0	36,065	0	0	
Payment to Risk Management and Property Funds	123,841	131,604	166,889	112,673	
General Fund	61,921	65,802	83,445	56,337	
Federal Funds	61,920	65,802	83,444	56,336	
Vehicle Lease Payments	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Leased Space	659,770	747,035	1,472,104	1,787,968	*
General Fund	216,966	195,437	593,298	721,520	
Cash Funds	99,625	138,874	142,754	172,464	
Federal Funds	343,179	412,724	736,052	893,984	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Capitol Complex Leased Space	394,599	496,658	386,909	599,833	
General Fund	197,300	248,329	193,455	299,917	
Federal Funds	197,299	248,329	193,454	299,916	
Payments to OIT	0	201,448	1,571,743	3,319,062	*
General Fund	0	100,724	777,190	1,649,384	
Cash Funds	0	0	4,805	10,147	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	100,724	789,748	1,659,531	
Scholarships for research using the All-Payer Claims Database	0	0	500,000	500,000	
General Fund	0	0	500,000	500,000	
General Professional Services and Special Projects	3,350,149	7,145,144	5,986,808	7,064,495	*
General Fund	1,353,401	2,048,401	2,225,315	2,523,649	
Cash Funds	354,610	442,324	562,500	913,609	
Federal Funds	1,642,138	4,654,419	3,198,993	3,627,237	
SUBTOTAL - (A) General Administration	35,233,733	45,199,761	48,298,766	52,779,418	9.3%
FTE	315.9	363.7	360.4	382.3	6.1%
General Fund	13,350,251	15,349,536	17,780,810	19,493,374	9.6%
Cash Funds	3,075,635	4,100,784	4,356,402	5,110,154	17.3%
Reappropriated Funds	1,431,523	1,743,410	2,147,858	2,271,048	5.7%
Federal Funds	17,376,324	24,006,031	24,013,696	25,904,842	7.9%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,672,189	4,426,141	6,105,822	6,105,822	
General Fund	1,383,261	1,257,350	1,895,914	1,895,914	
Cash Funds	0	0	110,000	110,000	
Federal Funds	3,288,928	3,168,791	4,099,908	4,099,908	
Life Safety Code Inspections for Health Facilities, Transfer to Department of Public Safety	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Nurse Home Visitor Program, Transfer from the Department of Human Services	964,536	930,166	3,010,000	3,010,000	
General Fund	0	(11,847)	0	0	
Reappropriated Funds	481,337	465,083	1,482,199	1,474,599	
Federal Funds	483,199	476,930	1,527,801	1,535,401	
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	5,887	5,886	5,887	5,887	
General Fund	2,943	2,943	2,944	2,944	
Federal Funds	2,944	2,943	2,943	2,943	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,041	324,041	324,041	
General Fund	147,369	147,369	147,369	147,369	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,020	162,020	162,020	162,020	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Reviews, Transfer to the Department of Regulatory Agencies	4,818	4,160	10,000	10,000	
General Fund	2,409	2,080	5,000	5,000	
Federal Funds	2,409	2,080	5,000	5,000	
Public School Health Services Administration, Transfer to the Department of Education	145,640	143,721	160,335	160,335	
Reappropriated Funds	0	143,721	160,335	160,335	
Federal Funds	145,640	0	0	0	
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	0	0	205,146	206,185	
General Fund	0	0	102,573	103,092	
Federal Funds	0	0	102,573	103,093	
Enhanced Prenatal Care Training, Transfer to the Department of Public Health and Environment	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (B) Transfers to Other Departments	6,117,111	5,834,115	9,821,231	9,822,270	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,535,982	1,397,895	2,153,800	2,154,319	0.0%
Cash Funds	0	0	110,000	110,000	0.0%
Reappropriated Funds	495,989	623,456	1,657,186	1,649,586	(0.5%)
Federal Funds	4,085,140	3,812,764	5,900,245	5,908,365	0.1%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(C) Information Technology Contracts and Projects					
Medicaid Management Information System Maintenance and Projects	28,115,228	30,637,273	29,913,030	29,587,830	*
General Fund	6,273,361	6,594,356	6,141,964	6,142,801	
Cash Funds	1,254,472	1,181,953	1,696,376	1,642,740	
Reappropriated Funds	100,328	293,350	293,350	293,350	
Federal Funds	20,487,067	22,567,614	21,781,340	21,508,939	
MMIS Reprocurement Contracts	0	9,933,790	30,177,141	29,143,202	
General Fund	0	967,847	2,736,240	2,643,891	
Cash Funds	0	100,036	552,209	533,411	
Federal Funds	0	8,865,907	26,888,692	25,965,900	
MMIS Reprocurement Contracted Staff	0	920,936	3,000,435	3,000,435	
General Fund	0	89,321	273,730	273,730	
Cash Funds	0	20,954	55,049	55,049	
Federal Funds	0	810,661	2,671,656	2,671,656	
Fraud Detection Software Contract	144,054	144,565	250,000	250,000	
General Fund	36,419	38,938	62,500	62,500	
Federal Funds	107,635	105,627	187,500	187,500	
Centralized Eligibility Vendor Contract Project	4,695,409	6,875,044	8,342,477	9,133,612	
Cash Funds	2,335,093	2,816,997	3,053,888	3,145,326	
Federal Funds	2,360,316	4,058,047	5,288,589	5,988,286	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
CBMS Modernization Project	0	789,500	1,150,000	1,150,000	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	789,500	1,150,000	1,150,000	
Federal Funds	0	0	0	0	
Health Information Exchange Maintenance and Projects	0	0	8,228,926	12,968,746	*
General Fund	0	0	1,302,893	1,821,875	
Federal Funds	0	0	6,926,033	11,146,871	
SUBTOTAL - (C) Information Technology Contracts and Projects	32,954,691	49,301,108	81,062,009	85,233,825	5.1%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	6,309,780	7,690,462	10,517,327	10,944,797	4.1%
Cash Funds	3,589,565	4,119,940	5,357,522	5,376,526	0.4%
Reappropriated Funds	100,328	1,082,850	1,443,350	1,443,350	0.0%
Federal Funds	22,955,018	36,407,856	63,743,810	67,469,152	5.8%
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	117,011	140,257	158,247	164,720	
General Fund	53,532	59,400	60,370	60,718	
Cash Funds	4,177	9,932	17,957	20,844	
Reappropriated Funds	1,593	1,593	1,593	1,593	
Federal Funds	57,709	69,332	78,327	81,565	
Contracts for Special Eligibility Determinations	3,800,160	6,017,314	11,695,703	11,402,297	
General Fund	826,993	945,228	1,116,459	969,756	
Cash Funds	827,925	1,763,845	4,343,468	4,343,468	
Federal Funds	2,145,242	3,308,241	6,235,776	6,089,073	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
County Administration	25,338,161	34,733,208	41,718,342	39,536,478	
General Fund	9,894,404	8,558,486	10,572,620	11,114,448	
Cash Funds	0	4,460,662	5,707,810	5,859,623	
Federal Funds	15,443,757	21,714,060	25,437,912	22,562,407	
Hospital Provider Fee County Administration	2,029,164	4,654,643	9,723,802	11,104,684	
Cash Funds	1,014,582	1,752,329	3,208,371	3,585,446	
Federal Funds	1,014,582	2,902,314	6,515,431	7,519,238	
Administrative Case Management	1,866,788	1,648,048	869,744	869,744	
General Fund	933,394	824,024	434,872	434,872	
Federal Funds	933,394	824,024	434,872	434,872	
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	0	862,471	986,436	0	
General Fund	0	268,702	314,109	0	
Federal Funds	0	593,769	672,327	0	
Medical Assistance Sites	0	0	1,152,000	1,452,000	
General Fund	0	0	0	0	
Cash Funds	0	0	288,000	363,000	
Federal Funds	0	0	864,000	1,089,000	
Customer Outreach	4,917,340	4,943,170	6,924,550	6,194,093	
General Fund	2,371,809	2,384,724	2,860,895	2,686,447	
Cash Funds	86,861	86,861	336,621	336,621	
Federal Funds	2,458,670	2,471,585	3,727,034	3,171,025	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
SUBTOTAL - (D) Eligibility Determinations and Client Services	38,068,624	52,999,111	73,228,824	70,724,016	(3.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	14,080,132	13,040,564	15,359,325	15,266,241	(0.6%)
Cash Funds	1,933,545	8,073,629	13,902,227	14,509,002	4.4%
Reappropriated Funds	1,593	1,593	1,593	1,593	0.0%
Federal Funds	22,053,354	31,883,325	43,965,679	40,947,180	(6.9%)
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	6,435,636	6,121,625	11,856,020	11,881,984	
General Fund	1,799,872	1,784,427	3,152,257	3,183,748	
Cash Funds	103,638	93,766	461,089	461,089	
Federal Funds	4,532,126	4,243,432	8,242,674	8,237,147	
SUBTOTAL - (E) Utilization and Quality Review Contracts	6,435,636	6,121,625	11,856,020	11,881,984	0.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,799,872	1,784,427	3,152,257	3,183,748	1.0%
Cash Funds	103,638	93,766	461,089	461,089	0.0%
Federal Funds	4,532,126	4,243,432	8,242,674	8,237,147	(0.1%)
(F) Provider Audits and Services					
Professional Audit Contracts	2,207,726	2,382,760	2,463,406	2,813,406 *	
General Fund	891,703	1,066,015	969,283	1,119,283	
Cash Funds	0	204,210	262,420	312,420	
Reappropriated Funds	212,160	0	0	0	
Federal Funds	1,103,863	1,112,535	1,231,703	1,381,703	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
SUBTOTAL - (F) Provider Audits and Services	2,207,726	2,382,760	2,463,406	2,813,406	14.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	891,703	1,066,015	969,283	1,119,283	15.5%
Cash Funds	0	204,210	262,420	312,420	19.1%
Reappropriated Funds	212,160	0	0	0	0.0%
Federal Funds	1,103,863	1,112,535	1,231,703	1,381,703	12.2%
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	531,346	564,482	700,000	700,000	
Cash Funds	265,673	282,241	350,000	350,000	
Federal Funds	265,673	282,241	350,000	350,000	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	531,346	564,482	700,000	700,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds	265,673	282,241	350,000	350,000	0.0%
Federal Funds	265,673	282,241	350,000	350,000	0.0%
State of Health Projects					
Transfer from General Fund to State of Health Cash Fund	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
State of Health Projects	0	0	0	0	
Cash Funds	0	0	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Pain Management Capacity Program	0	0	500,000	500,000	
General Fund	0	0	246,212	246,212	
Federal Funds	0	0	253,788	253,788	
Dental Provider Network Adequacy	0	0	5,000,000	0	
General Fund	0	0	2,500,000	0	
Federal Funds	0	0	2,500,000	0	
SUBTOTAL - State of Health Projects	0	0	5,500,000	500,000	(90.9%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	2,746,212	246,212	(91.0%)
Cash Funds	0	0	0	0	0.0%
Federal Funds	0	0	2,753,788	253,788	(90.8%)
(H) Indirect Cost Assessment					
Indirect Cost Assessment	0	452,913	663,489	635,877	
Cash Funds	0	121,193	122,479	145,818	
Reappropriated Funds	0	0	21,941	37,442	
Federal Funds	0	331,720	519,069	452,617	
SUBTOTAL - (H) Indirect Cost Assessment	0	452,913	663,489	635,877	(4.2%)
FTE	0.0	0.0	0.0	0.0	0.0%
Cash Funds	0	121,193	122,479	145,818	19.1%
Reappropriated Funds	0	0	21,941	37,442	70.6%
Federal Funds	0	331,720	519,069	452,617	(12.8%)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
TOTAL - (1) Executive Director's Office	121,548,867	162,855,875	233,593,745	235,090,796	0.6%
FTE	315.9	363.7	360.4	382.3	6.1%
General Fund	37,967,720	40,328,899	52,679,014	52,407,974	(0.5%)
Cash Funds	8,968,056	16,995,763	24,922,139	26,375,009	5.8%
Reappropriated Funds	2,241,593	3,451,309	5,271,928	5,403,019	2.5%
Federal Funds	72,371,498	102,079,904	150,720,664	150,904,794	0.1%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,937,400,734	4,618,770,195	5,724,517,770	6,364,672,466	*
General Fund	847,647,042	926,160,050	897,976,497	1,083,541,119	
General Fund Exempt	507,235,957	642,235,957	710,835,957	710,835,957	
Cash Funds	639,607,454	567,267,338	623,063,368	689,090,663	
Reappropriated Funds	2,936,892	2,936,892	0	0	
Federal Funds	1,939,973,389	2,480,169,958	3,492,641,948	3,881,204,727	
TOTAL - (2) Medical Services Premiums	3,937,400,734	4,618,770,195	5,724,517,770	6,364,672,466	11.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	847,647,042	926,160,050	897,976,497	1,083,541,119	20.7%
General Fund Exempt	507,235,957	642,235,957	710,835,957	710,835,957	0.0%
Cash Funds	639,607,454	567,267,338	623,063,368	689,090,663	10.6%
Reappropriated Funds	2,936,892	2,936,892	0	0	0.0%
Federal Funds	1,939,973,389	2,480,169,958	3,492,641,948	3,881,204,727	11.1%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
This division 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. The division 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 division is mainly General Fund and federal 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	301,303,046	415,933,333	543,737,807	620,621,342	*
General Fund	136,833,502	151,532,141	169,004,720	190,757,194	
Cash Funds	13,513,748	12,402,378	4,534,586	4,884,884	
Reappropriated Funds	0	0	0	0	
Federal Funds	150,955,796	251,998,814	370,198,501	424,979,264	
School-based Prevention and Intervention Substance Use Disorder Services	0	0	4,363,807	4,216,324	*
General Fund	0	0	2,000,000	1,999,674	
Federal Funds	0	0	2,363,807	2,216,650	
Behavioral Health Fee-for-service Payments	4,569,198	5,295,835	7,107,049	7,917,221	*
General Fund	2,253,518	2,475,020	3,499,689	2,576,708	
Cash Funds	0	6,385	0	84,197	
Federal Funds	2,315,680	2,814,430	3,607,360	5,256,316	
School-based Substance Abuse Prevention and Intervention Grant Program	0	0	1,950,000	0	
General Fund	0	0	1,950,000	0	
Contract Reprocurement	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
TOTAL - (3) Behavioral Health Community Programs	305,872,244	421,229,168	557,158,663	632,754,887	13.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	139,087,020	154,007,161	176,454,409	195,333,576	10.7%
Cash Funds	13,513,748	12,408,763	4,534,586	4,969,081	9.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	153,271,476	254,813,244	376,169,668	432,452,230	15.0%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	0	517,386	2,575,884	2,648,939	
FTE	0.0	0.0	30.5	30.5	
General Fund	0	250,167	1,369,423	1,405,951	
Cash Funds	0	0	38,730	38,730	
Federal Funds	0	267,219	1,167,731	1,204,258	
Operating Expenses	0	57,981	292,036	292,036	
General Fund	0	28,991	144,899	144,899	
Federal Funds	0	28,990	147,137	147,137	
Community and Contract Management System	0	54,700	137,480	137,480	
General Fund	0	36,851	89,362	89,362	
Federal Funds	0	17,849	48,118	48,118	
Support Level Administration	0	32,490	57,368	57,368	
General Fund	0	16,245	28,684	28,684	
Federal Funds	0	16,245	28,684	28,684	
System Capacity	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Appropriation from General Fund to Disabilities Services Cash Fund	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL -	0	662,557	3,062,768	3,135,823	2.4%
FTE	0.0	0.0	30.5	30.5	(0.0%)
General Fund	0	332,254	1,632,368	1,668,896	2.2%
Cash Funds	0	0	38,730	38,730	0.0%
Federal Funds	0	330,303	1,391,670	1,428,197	2.6%
(ii) Program Costs					
Adult Comprehensive Services	0	0	347,106,514	360,790,069	*
General Fund	0	0	152,632,855	161,195,688	
Cash Funds	0	0	33,628,301	31,134,998	
Federal Funds	0	0	160,845,358	168,459,383	
Adult Supported Living Services	0	1,976,615	70,648,433	89,818,758	*
General Fund	0	1,976,615	38,709,948	48,036,081	
Federal Funds	0	0	31,938,485	41,782,677	
Children's Extensive Support Services	0	0	24,610,892	22,411,675	*
General Fund	0	0	12,080,413	10,955,485	
Federal Funds	0	0	12,530,479	11,456,190	
Case Management	0	734,516	29,300,733	31,738,956	*
General Fund	0	734,516	15,594,596	16,736,705	
Federal Funds	0	0	13,706,137	15,002,251	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Family Support Services	0	838,100	6,828,718	6,912,298	*
General Fund	0	838,100	6,828,718	6,912,298	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Preventive Dental Hygiene	0	30,892	65,754	66,534	*
General Fund	0	30,892	62,112	62,856	
Cash Funds	0	0	3,642	3,678	
Federal Funds	0	0	0	0	
Eligibility Determination and Waiting List Management	0	81,661	3,062,117	3,099,596	*
General Fund	0	81,661	3,041,968	3,079,101	
Cash Funds	0	0	0	0	
Federal Funds	0	0	20,149	20,495	
Regional Center Adult Comprehensive Services	0	0	0	21,525,353	*
General Fund	0	0	0	10,545,270	
Federal Funds	0	0	0	10,980,083	
SUBTOTAL -	0	3,661,784	481,623,161	536,363,239	11.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	3,661,784	228,950,610	257,523,484	12.5%
Cash Funds	0	0	33,631,943	31,138,676	(7.4%)
Federal Funds	0	0	219,040,608	247,701,079	13.1%
TOTAL - (4) Office of Community Living	0	4,324,341	484,685,929	539,499,062	11.3%
FTE	0.0	0.0	30.5	30.5	(0.0%)
General Fund	0	3,994,038	230,582,978	259,192,380	12.4%
Cash Funds	0	0	33,670,673	31,177,406	(7.4%)
Federal Funds	0	330,303	220,432,278	249,129,276	13.0%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(5) INDIGENT CARE PROGRAM					
Primary functions: Provides assistance to hospitals and clinics serving a disproportionate share of uninsured or underinsured populations, provides health insurance to qualifying children and pregnant women ineligible for Medicaid, and provides grants to providers to improve access to primary and preventative care for the indigent population.					
Safety Net Provider Payments	299,175,424	309,976,756	311,296,186	311,296,186	
Cash Funds	149,587,712	154,988,378	153,307,474	152,527,268	
Federal Funds	149,587,712	154,988,378	157,988,712	158,768,918	
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	
General Fund	3,059,880	3,059,880	3,013,523	2,998,071	
Federal Funds	3,059,880	3,059,880	3,106,237	3,121,689	
Health Care Services Fund Programs	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Pediatric Specialty Hospital	11,799,938	11,799,938	13,455,012	13,455,012	
General Fund	5,899,969	5,899,969	6,625,584	6,595,789	
Federal Funds	5,899,969	5,899,969	6,829,428	6,859,223	
General Fund Appropriation to Pediatric Specialty Hospital	0	0	0	0	
General Fund	0	0	0	0	
General Fund Exempt	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Appropriation from Tobacco Tax Fund to the General Fund	429,812	421,610	423,600	423,600	
Cash Funds	429,812	421,610	423,600	423,600	
Primary Care Fund	27,258,545	26,679,334	26,828,000	26,701,944	*
Cash Funds	27,258,545	26,679,334	26,828,000	26,701,944	
Primary Care Grant Program Special Distribution	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Administration	4,245,129	4,013,739	5,127,772	5,033,274	
General Fund	0	0	0	0	
Cash Funds	1,883,715	1,502,836	2,404,035	2,363,824	
Federal Funds	2,361,414	2,510,903	2,723,737	2,669,450	
Children's Basic Health Plan Medical and Dental Costs	191,570,458	182,753,054	199,832,216	205,356,454	*
General Fund	29,398,182	12,114,378	21,875,401	72,729	
General Fund Exempt	441,600	438,300	423,600	0	
Cash Funds	37,761,085	72,640,720	48,226,542	36,296,993	
Federal Funds	123,969,591	97,559,656	129,306,673	168,986,732	
Comprehensive Primary and Preventive Care Grants	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Hospice Supplemental Payment	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Trust	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Premium Costs (Children & Pregnant Adults)	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Dental Costs	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
HB 09-1293 Childless Adult	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
TOTAL - (4) Indigent Care Program	540,599,066	541,764,191	563,082,546	568,386,230	0.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	38,358,031	21,074,227	31,514,508	9,666,589	(69.3%)
General Fund Exempt	441,600	438,300	423,600	0	(100.0%)
Cash Funds	216,920,869	256,232,878	231,189,651	218,313,629	(5.6%)
Federal Funds	284,878,566	264,018,786	299,954,787	340,406,012	13.5%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(6) OTHER MEDICAL SERVICES					
Primary functions: This division provides funding for the following three state-only Medical programs: (1) Old Age Pension Medical Program, (2) the Medicare Modernization Act State Contribution Payment, and (3) the Colorado Cares RX Program. This division also contains funding for programs that eligible for Medicaid funding but are not part of the Medical Services Premiums or Mental Health Programs.					
Old Age Pension State Medical	9,675,508	6,581,973	4,504,973	7,593,031	
General Fund	0	0	0	2,962,510	
Cash Funds	9,675,508	6,581,973	4,504,973	4,630,521	
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	1,741,077	3,371,077	5,476,843	5,401,843	
General Fund	870,538	1,685,538	2,660,002	2,651,490	
Federal Funds	870,539	1,685,539	2,816,841	2,750,353	
State University Teaching Hospitals Denver Health and Hospital Authority	1,831,714	1,831,714	2,804,714	2,804,714	
General Fund	915,857	915,857	1,381,112	1,376,487	
Federal Funds	915,857	915,857	1,423,602	1,428,227	
State University Teaching Hospitals University of Colorado Hospital	633,314	633,314	633,314	633,314	
General Fund	316,657	316,657	311,860	310,261	
Federal Funds	316,657	316,657	321,454	323,053	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Medicare Modernization Act State Contribution Payment	101,817,855	106,376,992	104,007,505	119,620,941 *	
General Fund	52,136,848	68,306,130	99,304,985	119,620,941	
Reappropriated Funds	0	0	0	0	
Federal Funds	49,681,007	38,070,862	4,702,520	0	
Public School Health Services Contract Administration	811,941	812,550	2,491,722	2,491,722	
Reappropriated Funds	0	812,550	2,491,722	2,491,722	
Federal Funds	811,941	0	0	0	
Public School Health Services	49,784,091	43,494,624	54,353,956	59,830,844 *	
Cash Funds	24,887,311	21,747,312	26,919,482	29,516,777	
Federal Funds	24,896,780	21,747,312	27,434,474	30,314,067	
TOTAL - (5) Other Medical Services	166,295,500	163,102,244	174,273,027	198,376,409	13.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	54,239,900	71,224,182	103,657,959	126,921,689	22.4%
Cash Funds	34,562,819	28,329,285	31,424,455	34,147,298	8.7%
Reappropriated Funds	0	812,550	2,491,722	2,491,722	0.0%
Federal Funds	77,492,781	62,736,227	36,698,891	34,815,700	(5.1%)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
Primary functions: This division reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this division 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					
Executive Director's Office - Medicaid Funding	14,543,801	16,549,747	18,085,504	16,621,789 *	
General Fund	7,271,901	8,274,874	9,042,753	8,394,983	
Federal Funds	7,271,900	8,274,873	9,042,751	8,226,806	
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	14,543,801	16,549,747	18,085,504	16,621,789	(8.1%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	7,271,901	8,274,874	9,042,753	8,394,983	(7.2%)
Federal Funds	7,271,900	8,274,873	9,042,751	8,226,806	(9.0%)
(B) Office of Information Technology Services - Medicaid Funding					
Colorado Benefits Management System	10,006,971	19,045,031	8,513,990	8,461,557	
General Fund	4,249,653	5,454,849	4,226,710	4,201,013	
Cash Funds	8,092	23,928	14,595	14,142	
Reappropriated Funds	37,834	13,499	18,809	18,809	
Federal Funds	5,711,392	13,552,755	4,253,876	4,227,593	
CBMS SAS-70 Audit	46,554	24,859	55,204	55,204	
General Fund	23,164	12,393	27,416	27,416	
Cash Funds	25	15	89	89	
Reappropriated Funds	155	31	119	119	
Federal Funds	23,210	12,420	27,580	27,580	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Colorado Benefits Management System, HCPF Only	0	578,146	611,520	611,520	
Cash Funds	0	289,073	305,760	305,760	
Federal Funds	0	289,073	305,760	305,760	
CBMS Modernization Project, Phase I	0	9,388,569	564,113	572,563	
General Fund	0	1,896,821	282,058	286,283	
Cash Funds	0	43,902	0	0	
Reappropriated Funds	0	18,003	0	0	
Federal Funds	0	7,429,843	282,055	286,280	
CBMS Modernization Project, Phase II	0	0	26,770,806	1,729,717	
General Fund	0	0	7,102,544	842,739	
Cash Funds	0	0	1,286,032	15,485	
Federal Funds	0	0	18,382,230	871,493	
Other Office of Information Technology Services line items	500,820	572,373	615,989	583,932	
General Fund	250,410	286,187	303,328	285,930	
Federal Funds	250,410	286,186	312,661	298,002	
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	10,554,345	29,608,978	37,131,622	12,014,493	(67.6%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	4,523,227	7,650,250	11,942,056	5,643,381	(52.7%)
Cash Funds	8,117	356,918	1,606,476	335,476	(79.1%)
Reappropriated Funds	37,989	31,533	18,928	18,928	0.0%
Federal Funds	5,985,012	21,570,277	23,564,162	6,016,708	(74.5%)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request		Request vs. Appropriation
(C) Office of Operations - Medicaid Funding						
Office of Operations - Medicaid Funding	4,069,739	3,941,460	4,979,011	4,945,311	*	
General Fund	2,034,870	1,970,730	2,451,789	2,422,676		
Federal Funds	2,034,869	1,970,730	2,527,222	2,522,635		
SUBTOTAL - (C) Office of Operations - Medicaid Funding	4,069,739	3,941,460	4,979,011	4,945,311		(0.7%)
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	2,034,870	1,970,730	2,451,789	2,422,676		(1.2%)
Federal Funds	2,034,869	1,970,730	2,527,222	2,522,635		(0.2%)
(D) Division of Child Welfare - Medicaid Funding						
Administration	132,899	133,069	137,306	140,806		
General Fund	66,449	66,535	68,653	70,403		
Federal Funds	66,450	66,534	68,653	70,403		
Child Welfare Services	8,428,490	7,935,965	14,943,615	15,093,051	*	
General Fund	4,214,245	3,960,443	7,358,611	7,396,517		
Federal Funds	4,214,245	3,975,522	7,585,004	7,696,534		
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	8,561,389	8,069,034	15,080,921	15,233,857		1.0%
FTE	0.0	0.0	0.0	0.0		0.0%
General Fund	4,280,694	4,026,978	7,427,264	7,466,920		0.5%
Federal Funds	4,280,695	4,042,056	7,653,657	7,766,937		1.5%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(D.5) Office of Early Childhood - Medicaid Funding					
Division of Community and Family Support, Early Intervention Services	3,407,528	5,268,899	5,610,792 *		
General Fund	1,703,764	2,594,539	2,750,211		
Federal Funds	1,703,764	2,674,360	2,860,581		
SUBTOTAL - (D.5) Office of Early Childhood - Medicaid Funding	3,407,528	5,268,899	5,610,792	6.5%	
FTE	0.0	0.0	0.0	0.0%	
General Fund	1,703,764	2,594,539	2,750,211	6.0%	
Federal Funds	1,703,764	2,674,360	2,860,581	7.0%	
(E) Office of Self Sufficiency - Medicaid Funding					
Systematic Alien Verification for Eligibility	26,338	33,951	33,951	34,505	
General Fund	0	0	0	0	
Federal Funds	26,338	33,951	33,951	34,505	
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	26,338	33,951	33,951	34,505	1.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Federal Funds	26,338	33,951	33,951	34,505	1.6%
(F) Behavioral Health Services - Medicaid Funding					
Community Behavioral Health Administration	293,274	318,262	404,350	416,056	
General Fund	146,637	159,131	199,112	203,944	
Federal Funds	146,637	159,131	205,238	212,112	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Mental Health Treatment Services for Youth (H.B. 99-1116)	44,226	20,624	121,558	122,774 *	
General Fund	22,113	10,312	59,858	60,147	
Federal Funds	22,113	10,312	61,700	62,627	
High Risk Pregnant Women Program	1,052,270	1,138,015	1,464,861	1,479,510 *	
General Fund	526,135	569,008	721,334	724,811	
Federal Funds	526,135	569,007	743,527	754,699	
Mental Health Institutes	1,899,838	1,050,942	4,997,745	4,997,745	
General Fund	947,761	516,910	2,461,015	2,447,272	
Federal Funds	952,077	534,032	2,536,730	2,550,473	
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	3,289,608	2,527,843	6,988,514	7,016,085	0.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,642,646	1,255,361	3,441,319	3,436,174	(0.1%)
Federal Funds	1,646,962	1,272,482	3,547,195	3,579,911	0.9%
(G) Services for People with Disabilities - Medicaid Funding					
Regional Centers	48,571,244	47,397,999	48,974,477	28,794,652 *	
General Fund	20,499,769	21,805,812	22,215,109	12,218,455	
Cash Funds	3,785,853	1,866,142	1,866,142	1,866,142	
Reappropriated Funds	0	0	0	0	
Federal Funds	24,285,622	23,726,045	24,893,226	14,710,055	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
Regional Center Depreciation and Annual Adjustments	1,187,826	1,187,825	943,063	932,429	*
General Fund	593,913	593,913	464,388	456,797	
Federal Funds	593,913	593,912	478,675	475,632	
Community Services for People with Developmental Disabilities, Administration	2,356,594	2,017,844	0	0	
General Fund	1,178,297	1,008,922	0	0	
Federal Funds	1,178,297	1,008,922	0	0	
Community Services for People with Developmental Disabilities, Program Costs	327,987,037	351,796,642	0	0	
General Fund	163,993,519	175,890,710	0	0	
Cash Funds	0	0	0	0	
Federal Funds	163,993,518	175,905,932	0	0	
Community Services for People with Developmental Disabilities, Early Intervention Services	0	0	0	0	
General Fund	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	380,102,701	402,400,310	49,917,540	29,727,081	(40.4%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	186,265,498	199,299,357	22,679,497	12,675,252	(44.1%)
Cash Funds	3,785,853	1,866,142	1,866,142	1,866,142	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	190,051,350	201,234,811	25,371,901	15,185,687	(40.1%)

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding					
Community Services for the Elderly	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	
Federal Funds	900	900	900	900	
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,800	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	900	900	900	900	0.0%
Federal Funds	900	900	900	900	0.0%
(I) Division of Youth Corrections - Medicaid Funding					
Division of Youth Corrections - Medicaid Funding	1,503,985	1,682,431	1,556,021	1,829,123 *	
General Fund	751,992	841,216	766,224	898,595	
Federal Funds	751,993	841,215	789,797	930,528	
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	1,503,985	1,682,431	1,556,021	1,829,123	17.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	751,992	841,216	766,224	898,595	17.3%
Federal Funds	751,993	841,215	789,797	930,528	17.8%

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	Request vs. Appropriation
(J) Other					
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	500,000	500,000	500,000		
General Fund	0	0	0		
Federal Funds	500,000	500,000	500,000		
SUBTOTAL - (J) Other	500,000	500,000	500,000	0.0%	
FTE	0.0	0.0	0.0	0.0%	
General Fund	0	0	0	0.0%	
Federal Funds	500,000	500,000	500,000	0.0%	
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	422,653,706	468,723,082	139,543,783	93,534,836	(33.0%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	206,771,728	225,023,430	60,346,341	43,689,092	(27.6%)
Cash Funds	3,793,970	2,223,060	3,472,618	2,201,618	(36.6%)
Reappropriated Funds	37,989	31,533	18,928	18,928	0.0%
Federal Funds	212,050,019	241,445,059	75,705,896	47,625,198	(37.1%)
TOTAL - Department of Health Care Policy and Financing	5,494,370,117	6,380,769,096	7,876,855,463	8,632,314,686	9.6%
FTE	315.9	363.7	390.9	412.8	5.6%
General Fund	1,324,071,441	1,441,811,987	1,553,211,706	1,770,752,419	14.0%
General Fund Exempt	507,677,557	642,674,257	711,259,557	710,835,957	(0.1%)
Cash Funds	917,366,916	883,457,087	952,277,490	1,006,274,704	5.7%
Reappropriated Funds	5,216,474	7,232,284	7,782,578	7,913,669	1.7%
Federal Funds	2,740,037,729	3,405,593,481	4,652,324,132	5,136,537,937	10.4%

Appendix B: Recent Legislation Affecting Department Budget

2013 Session Bills

SB 13-166 (Medical Clean Claims): Extends deadlines for development and implementation of recommendations from the Medical Clean Claims Task Force for standardizing claim submissions and edits to facilitate prompt payment. Provides $100,000 General Fund in FY 2013-14 to support the work of the Task Force.

S.B. 13-167 (Individuals with Intellectual Disabilities): Makes changes to the provider fee for intermediate care facilities for individuals with intellectual disabilities, including transferring responsibility for administering the fee from the Department of Human Services to the Department of Health Care Policy and Financing. Provides $1,867,133 total funds, including a reduction of $932,575 General Fund to the Department for FY 2013-14. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

S.B. 13-200 (Expand Medicaid Eligibility): Expands Medicaid eligibility for adults to 133 percent of the federal poverty level (FPL). The newly eligible populations affected by this change include adults without dependent children with income from 11 percent through 133 percent of the FPL and parents with income from 101 percent through 133 percent of the FPL. Pursuant to the provisions of the federal Affordable Care Act, Colorado is eligible for an enhanced federal match rate for certain populations as a result of the eligibility expansion authorized in S.B. 13-200. For Colorado the enhanced federal match rate applies to adults without dependent children with income from 0 percent through 133 percent of the federal poverty level and to parents with income from 61 percent through 133 percent of the FPL. The enhanced federal match rate is 100 percent from 2014 through 2016 and then it reduces in increments until it reaches 90 percent in 2020. Senate Bill 13-200 authorizes the Hospital Provider Fee to pay the state share of costs for the newly eligible populations when the enhanced federal match rate is reduced. Makes the following appropriations for FY 2013-14:

SB 13-200 Appropriations by Department

Department	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Health Care Policy and Financing	$315,141,256	($123,209)	($154,578,421)	$0	$469,842,886	19.0
Corrections	(2,471,751)	(2,471,751)	0	0	0	0.4
Human Services	(651,875)	(651,875)	0	0	0	0.0
Law	24,910	0	0	24,910	0	0.0
Personnel	12,122	0	0	12,122	0	0.0
Total	$312,054,662	($3,246,835)	($154,578,421)	$37,032	$469,842,886	19.4

S.B. 13-230 (Long Bill): General appropriations act for FY 2013-14.

S.B. 13-232 (Continue Tobacco Tax Medicaid Management Transfers): Eliminates the repeal of a transfer of $2.0 million from the Prevention, Early Detection, and Treatment Fund to the Department of Health Care Policy and Financing for disease management programs. Refinances $2.0 million General Fund appropriations with transfers from the fund.

S.B. 13-242 (Medicaid Adult Dental Benefit): Adds a dental benefit for adults on Medicaid. Requires the Department of Health Care Policy and Financing to design the benefit with input from stakeholders and implement it by April 1, 2014. Transfers money from the Unclaimed Property Trust Fund to the newly created Adult Dental Fund to pay for the benefit. Appropriates $33.9 million total funds and 1.3 FTE to the Department of Health Care Policy and Financing in FY 2013-14, including a reduction of $0.7 million General Fund, an increase of $11.2 million cash funds, and an increase of $23.4 million federal funds.

S.B. 13-264 (Rural Family Medicine): Requires the Commission on Family Medicine to support the development of rural family medicine residency programs and appropriates $1,000,000 to support this purpose, including $500,000 General Fund and $500,000 federal funds, to the Department of Health Care Policy and Financing in FY 2013-14.

S.B. 13-276 (Disability Investigational and Pilot Support): Renames the Coordinated Care for People with Disabilities Fund the Disability Investigational and Pilot Support Fund. Repurposes the fund to support grants and loans to projects that study or pilot new and innovative initiatives to improve the quality of life and independence of people with disabilities. Transfers administration of the fund from the Department of Health Care Policy and Financing to the Department of Personnel. In FY 2013-14 reduces appropriations to the Department of Health Care Policy and Financing by $163,649 total funds, including $80,593 cash funds and $82,696 federal funds, increases appropriations to the Department of Personnel by $1,173,976 cash funds, and increases appropriations to the Governor - Lieutenant Governor - State Planning and Budgeting by $300,000 cash funds.

H.B. 13-1117 (Alignment of Child Development Programs): Makes changes to the Early Childhood Leadership Council, including transferring administration from the Governor's Office to the Department of Human Services and makes corresponding adjustments to appropriations. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

H.B. 13-1152 (Nursing Facility Per Diem): Adjusts the formula for calculating the per diem rate paid to nursing facilities and reduces appropriations for the Department of Health Care Policy and Financing for FY 2013-14 by $9.7 million total funds, including $4.8 million General Fund and $4.8 million federal funds.

H.B. 13-1314 (Transfer Development Disabilities to HCPF): Transfers the powers, duties, and functions of the Department of Human Services relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the Department of Health Care Policy and Financing. For more information see the "Recent Legislation" section at the end of the Department of Human Services section of this report.

2014 Session Bills

S.B. 14-012 (Aid to the Needy Disabled): Requires the Department of Human Services to increase the monthly benefit amount for the Aid to the Needy and Disabled program by 8.0 percent in FY 2014-15. From FY 2015-16 to FY 2018-19, subject to available appropriations, the Department is encouraged to increase the monthly award until it is equal to the award level in FY 2006-07, and then to increase the award to account for cost of living in future years. Appropriates $4,697 total funds, including $2,301 General Fund, to the Department of Health Care Policy and Financing for FY 2014-15, and reappropriates these moneys to the Department of Human Services to contract with the Governor's Office of Information Technology to make changes to the Colorado Benefits Management System (CBMS). For more information on S.B. 14-012, please see the "Recent Legislation" section in the Department of Human Services section of this document.

S.B. 14-014 (Heat Fuel Grants): Makes changes to the Property Tax, Rent, and Heat Rebate Program to increase the maximum property tax and rent rebate for income-eligible claimants, establish a flat rate rebate for both the property tax and rent rebate and the heat rebate in an expanded range of income eligibility, and implements various recommendations of the August 2013 legislative audit of the program. Appropriates $1,397 total funds, including $684 General Fund, to the Department of Health Care Policy and Financing for FY 2014-15, and reappropriates these moneys to the Department of Human Services to contract with the Governor's Office of Information Technology to make changes to the Colorado Benefits Management System (CBMS). For more information on S.B. 14-014, please see the "Recent Legislation" section in the Department of Revenue section of this document.

S.B. 14-130 (Nursing Personal Care Allowance): Increases from $50 to $75 per month the personal needs allowance for Medicaid recipients in nursing facilities and inflates this amount by the increase in nursing facility rates in future years. Makes the appropriations contained in the table below to implement the act and, in addition, reduces General Fund appropriations to the Controlled Maintenance Trust Fund by $532,412.

Cost of Implementing S.B. 14-130					
Line Item	**TOTAL**	**GF**	**CF**	**RF**	**FF**
Health Care Policy and Financing					
Medical Service Premiums					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	$1,057,300	$517,971	$0	$0	$539,329
Department of Human Services Medicaid-funded programs					
Office of Information Technology Services - Medicaid Funding					
Colorado Benefits Management System	2,289	1,138	9	0	1,142
Services for People with Disabilities					
Regional Centers	22,345	10,947	0	0	11,398
Human Services					
Office of Information Technology Services					

Cost of Implementing S.B. 14-130					
Line Item	**TOTAL**	**GF**	**CF**	**RF**	**FF**
Colorado Benefits Management System					
Colorado Benefits Management System, Operating Expenses	6,203	2,356	215	2,289	1,343
Services for People with Disabilities -- Medicaid Funding					
Regional Centers for People with Developmental Disabilities					
Wheat Ridge Regional Center Personal Services	0	0	(9,216)	9,216	0
Grand Junction Regional Center Personal Services	0	0	(7,111)	7,111	0
Pueblo Regional Center Personal Services	0	0	(6,018)	6,018	0
Governor - Lieutenant Governor - State Planning and Budgeting					
Office of Information Technology					
Applications					
Colorado Benefits Management System	6,203	0	0	6,203	0
TOTAL	**$1,094,340**	**$532,412**	**($22,121)**	**$30,837**	**$553,212**

S.B. 14-144 (Family Medicine Residency Training in Rural Areas): Expands the responsibilities of the Commission on Family Medicine regarding family medicine residency training programs in rural and underserved areas and appropriates a net $75,000 federal funds to the Commission for this purpose in FY 2014-15.

S.B. 14-151 (Nursing Home Innovations): Modifies the Nursing Home Innovation Grant Program, including establishing minimum annual grants based on the balance in the Nursing Home Penalty Cash Fund, and appropriates $165,000 from the Nursing Home Penalty Cash Fund to the Department of Health Care Policy and Financing for FY 2014-15 for an increase in grant awards.

S.B. 14-159 (Medical Clean Claims): Modifies procedures and deadlines for the Medical Clean Claims Task Force responsible for developing standardized payment rules and edits for payers and providers for undisputed claims, and appropriates $128,688 General Fund to the Department of Health Care Policy and Financing in FY 2014-15 for the Task Force's new duties.

S.B. 14-180 (Transfer Senior Dental Program to HCPF): Transfers the Dental Assistance Program for Seniors, also known as the Old Age Pension (OAP) Dental Program, from the Department of Public Health and Environment (DPHE) to the Department of Health Care Policy and Financing (HCPF) as of July 1, 2015. Renames the Program the Colorado Dental Health Care Program for Low-Income Seniors and modifies the eligibility criteria to align with other dental benefits for seniors and to target services to economically disadvantaged seniors as defined in rule. Provides funds to qualified grantees, including Area Agencies on Aging, community organizations, Local Public Health Agencies, federally qualified health centers, and private dental practices. Requires HCPF to award grants to qualified grantees on or after July 1, 2015, and to establish rates for dental services under the program. Grantees are required to provide outreach, identify eligible seniors and dental care providers, and pay claims for services.

Creates the Senior Dental Advisory Committee. Reduces the appropriation in the DPHE by $55,000 General Fund and increases the appropriation in HCPF by $55,000 General Fund and 0.8 FTE for FY 2014-15.

S.B. 14-215 (Disposition of Legal Marijuana Related Revenue): Creates the Marijuana Tax Cash Fund (MTCF) and directs that all sales tax moneys collected by the state starting in FY 2014-15 from retail and medical marijuana be deposited in the MTCF instead of the Marijuana Cash Fund. Specifies permissible uses of moneys in the MTCF, including increasing the availability of school-based prevention, early intervention, and health care services and programs to reduce the risk of marijuana and other substance use and abuse by school-aged children. Creates the School-based Substance Abuse Prevention and Intervention grant program in the Department of Health Care Policy and Financing (HCPF) to award competitive grants to entities to provide school-based prevention and intervention programs for youth, primarily focused on reducing marijuana use, but including strategies and efforts to reduce alcohol use and prescription drug misuse. Appropriates a total of $6,363,807 to HCPF for FY 2014-15, including $2,000,000 General Fund for the newly created grant program, and $4,363,807 (including $2,000,000 General Fund and $2,363,807 federal Medicaid funds) for school-based prevention and intervention substance use disorder services to be provided by behavioral health organizations. Directs the State Treasurer to transfer $4,260,000 from the MTCF to the General Fund to offset the General Fund appropriations to HCPF. For more information see the "Recent Legislation" section at the end of the Department of Revenue section of this report.

H.B. 14-1045 (Breast and Cervical Cancer Prevention): Reauthorizes and modifies the Breast and Cervical Cancer Prevention Program in the Department of Health Care Policy and Financing and for FY 2014-15: (1) decreases appropriations from tobacco tax money in the Prevention, Early Detection, and Treatment Fund to the Department of Public Health and Environment for transfer to the Department of Health Care Policy and Financing for breast and cervical cancer treatment by $936,892 and increases appropriations to the Department of Public Health and Environment by the same amount for breast and cervical cancer screening; and (2) provides a total of $7,006,802 and 1.0 FTE, including $2,424,017 cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund and $4,582,785 from federal funds, to the Department of Health Care Policy and Financing for the reauthorized Breast and Cervical Cancer Prevention program.

H.B. 14-1211 (Complex Rehabilitation Technology in Medicaid): Modifies the Medicaid benefit for Complex Rehabilitation Technology designed and configured to meet a client's unique medical, physical, and functional needs, such as manual wheelchair systems, alternate positioning systems, standing frames, and gait trainers. Appropriates $51,133 to the Department of Health Care Policy and Financing in FY 2014-15 for implementation of the benefit modifications, including $16,533 General Fund and $34,600 federal funds, and reduces appropriations to the Controlled Maintenance Trust Fund by $16,533 General Fund.

H.B. 14-1213 (Pharmacy Benefit Manager): Changes regulations for pharmacy benefit managers and appropriates, in FY 2014-15, $129,831 to the Department of Health Care Policy and Financing, including $44,519 General Fund and $85,312 federal funds, for increased costs of

the Children's Basic Health Plan associated with the new regulations. Reduces appropriations to the Controlled Maintenance Trust Fund by $44,519 General Fund.

H.B. 14-1236 (Supplemental Bill): Supplemental appropriation to the Department of Health Care Policy and Financing to modify appropriations for FY 2012-13 and FY 2013-14.

H.B. 14-1252 (Intellectual and Development Disabilities Services System Capacity): Amends the Intellectual and Developmental Disabilities Cash Fund (fund) to allow moneys in the fund to be used for administrative expenses relating to Medicaid waiver renewal and redesign and for increasing system capacity for home- and community-based services for persons with intellectual and developmental disabilities. Requires the Department, on or before April 1, 2014, to report to the Joint Budget Committee the plan for the distribution of moneys appropriated for increases in system capacity, and requires the Department to distribute the moneys by April 15, 2014 for increases in system capacity. Requires each community-centered board or provider that receives moneys for increases in system capacity shall report to the department on the use of the funds by October 1, 2014. Appropriates the following in FY 2013-14:

- Makes FY 2013-14 supplemental adjustments to the waivers;
- $4,500,000 General Fund to the Fund;
- $13,852 total funds and 0.2 FTE to the Department for administrative expenses for waiver renewal;
- $400,000 total funds, of which $200,000 is cash funds from the Fund and $200,000 is matching federal funds, for waiver renewal and redesign; and
- $4,293,074 cash funds from the Fund for system capacity improvements.

H.B. 14-1317 (Colorado Child Care Assistance Program Changes): Makes changes to the Colorado Child Care Assistance Program in the Department of Human Services. Includes an appropriation of $44,529 total funds, of which $21,813 is General Fund, to the Department for FY 2014-15. See the "Recent Legislation" section for the Department of Human Services for additional information.

H.B. 14-1336 (Long Bill): General appropriations act for FY 2014-15. Includes provisions modifying appropriations to the Department of Health Care Policy and Financing for FY 2012-13 and FY 2013-14.

H.B. 14-1357 (In-home Support Services in Medicaid): Modifies the Medicaid benefit for in-home support services, such as household and personal care services, for clients who would otherwise require care in a nursing facility, and appropriates $297,985 to the Department of Health Care Policy and Financing in FY 2014-15, including $145,983 General Fund and $152,002 federal funds, for implementation of the benefit modifications. Also, reduces appropriations to the Controlled Maintenance Trust Fund by $145,983 General Fund.

H.B. 14-1360 (Sunset Review Licensure of Home Care Agencies): Continues the regulation of home care agencies and home care placement agencies until September 1, 2019, and implements the recommendations of the sunset report. Allows HCPF-certified community-

centered boards or services agencies (CCBs) that provide in-home personal care services to obtain a home care agency license, prohibits the Department from conducting inspections related to a home care agency license renewal, or from assessing fees for a new or renewal home care agency license, for certified CCBs until July 1, 2016. Until that date, requires the Department and HCPF to establish a work group with CCBs and recipients of Medicaid Home- and Community-Based Services (HCBS) waivers to identify gaps or conflicts between home care agency license requirements and HCBS provider requirements. Requires the work group to submit recommendations for resolving gaps or conflicts to the State Board of Health and the Medical Services Board, and requires the boards to adopt rules regarding the gaps and conflicts by July 1, 2016. Requires the departments to report on the progress of these requirements during the 2014 and 2015 annual SMART Act presentations to the joint committees of reference. Appropriates $110,000 cash funds to the Department which is reappropriated to the Department of Public Health and Environment for FY 2014-15.

H.B. 14-1368 (Transition Youth Developmental Disabilities to Adult Services): Establishes a plan and appropriates funds to transfer youth into adult services for persons with IDD under Medicaid Home- and Community-Based Services (HCBS) in the Department of Health Care Policy and Financing (HCPF). The bill sets forth criteria for transition planning and instructs the State Board of Human Services and the Medical Services Board to promulgate any rules necessary to guide the transition. Creates the Child Welfare Transition Cash Fund (Fund). Appropriates a total of $5,746,227 total funds, including $2,829,586 cash funds and $2,916,641 federal funds to the Department for FY 2014-15.

Appendix C:
Update on Long Bill Footnotes & Requests for Information

LONG BILL FOOTNOTES

9 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: The Department is using the funding in compliance with the footnote.

10 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects – This appropriation includes $150,000 for the purpose of consulting services and stakeholder outreach to assist the Department in developing a plan for addressing disparities in Medicaid rates that limit client access to cost-effective care.

Comment: The Department is using the funding in compliance with the footnote. See the issue brief *Provider Rate Setting Process* for more detail.

11 Department of Health Care Policy and Financing, Medical Services Premiums - The appropriations in this division assume the following caseload and cost estimates:

Description	TOTAL	Children	Adults	Elderly	Disabled
Enrollment	1,003,612	476,585	376,910	68,239	81,878
Per Capita	$4,886.20	$1,643.27	$4,684.62	$15,053.77	$15,823.54
Medical Services	$4,871,689,966	$783,158,744	$1,765,682,145	$1,027,254,291	$1,295,594,786
Supplemental Payments	$843,823,028				
TOTAL	$5,715,512,994				

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

12 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes $15 million from an intergovernmental transfer from Denver Health, the purpose of which is to finance an amendment to the state plan to provide nursing home services for chronically acute, long-stay patients.

Comment: The Department is still working with the Centers for Medicare and Medicaid Services to get approval. The JBC may want to request an update for the hearing.

13 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes $1,015,383 total funds, including $500,000 General Fund and $515,383 federal funds for the purpose of increasing the current $10,000 lifetime cap on

home modifications by an amount projected to be feasible within this level of funding, up to a maximum lifetime cap of $20,000.

Comment: The Department estimates that the funding provided would allow an increase in the cap to $12,500 and has a proposed rule pending before the Medical Services Board.

14 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes $26,737,869 total funds, including $5,926,144 from the Adult Dental Fund created in Section 25.5-5.207 (4) (a), C.R.S., $87,874 from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., and $20,723,851 federal funds, for the purpose of adding coverage for full dentures with prior authorization as part of the limited adult dental benefit authorized in Section 25.5-5-202 (1) (w), C.R.S.

Comment: The Department implemented coverage for full dentures with prior authorization effective July 1, 2014.

15 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation assumes that the Department will allow primary care providers to receive reimbursement for providing oral health risk assessments and applying fluoride varnishes up to three times per year for children five years and older.

Comment: __

15a Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Administrative Costs -- It is the intent of the General Assembly that the Division use the administrative costs to ensure that in FY 2014-15 at least 4,820 individuals are enrolled in and receiving adult comprehensive services, at least 6,010 individuals are enrolled in and receiving adult supported living services, and at least 1,204 children are enrolled in and receiving children's extensive support services.

Comment: See the briefing for the Office of Community Living for more detail.

16 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs -- The appropriations in this subdivision assume the following caseload and cost estimates for clients:

Waiver	Enrollment	Full Program Equivalent (FPE)	Cost Per FPE
Comprehensive	4,820	4,728.19	$65,682.97
Supported Living Services			
General Fund	692	692.00	$11,732.27
Medicaid	5,318	4,267.50	$14,652.54
Children's Extensive Support	1,204	1,200.13	$20,506.86
Case Management			

Waiver	Enrollment	Full Program Equivalent (FPE)	Cost Per FPE
General Fund	692	692.00	$3,404.78
Medicaid	11,342	10,195.82	$2,642.71

Comment: See the briefing for the Office of Community Living for more detail.

17 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: See the briefing for the Office of Community Living for more detail.

18 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 developmental disabilities.

Comment: See the briefing for the Office of Community Living for more detail.

19 Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs -- This appropriation assumes the following: (1) A total children's caseload of 69,966 at an average medical per capita cost of $2,351.85 per year; and (2) a total adult prenatal caseload of 789 at an average medical per capita cost of $13,344.72 per year.

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

20 Department of Health Care Policy and Financing, Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs -- This appropriation assumes an average cost of $267.94 per child per year for the dental benefit.

Comment: This footnote describes caseload and cost assumptions used to develop the appropriation and requires no action by the Department.

21 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 line items in the division Department of Human Services Medicaid-Funded Programs.

REQUESTS FOR INFORMATION

Department of Health Care Policy and Financing

1. Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects – The Department is requested to submit a plan to the Joint Budget Committee by November 1, 2014 for an ongoing annual process to address disparities in Medicaid rates that limit client access to cost-effective care. The proposed process must include opportunities for legislative input and modification. The proposed process must provide actions that can be taken to improve or preserve client access and quality of care in years when state funding for rates is flat or declining as well as years when funding increases. The Department is also requested to report on rate setting procedures used by other public and private insurers and evaluate the applicability of those processes to addressing rate disparities in Colorado. The plan should include an estimate of administrative costs and any statutory changes that may be necessary for implementation.

   Comment: The Department submitted the report as requested. See the issue brief titled Provider Rate Setting Process for more information.

2. Department of Health Care Policy and Financing, Executive Director's Office, Personal Services -- The Department is requested to submit a report to the Joint Budget Committee, by November 1, 2014, identifying when clients may be experiencing difficulty accessing cost-effective care. As part of the report, the Department is requested to submit a plan for improving the metrics with a dual goal of developing and implementing intervention procedures where appropriate and providing quantifiable data to support rate setting decisions.

   Comment: The Department submitted the report as requested. See the issue brief titled Provider Rate Setting Process for more information.

3. 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, mental 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.

Comment: The Department is submitting the monthly information as requested.

4. Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit a report by November 1, 2014, to the Joint Budget Committee, providing information on the implementation of the Accountable Care Collaborative Organization project. In the report, the Department is requested to inform the Committee on how many Medicaid clients are enrolled in the pilot program, the current administrative fees and costs for the program, and performance results with an emphasis on the fiscal impact.

Comment: The department submitted the report as requested.

Background

The Accountable Care Collaborative (ACC) pays for care coordination with a component of the compensation tied to improved health outcomes. Within the ACC there are seven Regional Care Collaborative Organizations (RCCOs) that are paid a per member per month fee to manage care, develop a network of providers, provide support services to those providers, and perform state reporting functions. The RCCOs create formal contracts with providers to be Primary Care Medical Providers (PCMPs) and informal relationships with specialists and ancillary providers to assist with referrals. The support given to providers by the RCCOs includes analytical tools to identify effective interventions, client materials, administrative assistance, and ideas for clinical practice redesign to improve outcomes.

The PCMPs function as medical homes for clients and also receive a per member per month fee to coordinate care that includes a payment component based on achieving improved health outcomes. Part of the care coordination provided by RCCOs and PCMPs includes looking beyond health needs to connect clients with wraparound services such as housing assistance, long-term services and supports, behavioral health care, child care, transportation, food assistance, and other community services.

To assist with care coordination and the performance funding the Statewide Data Analytics Contractor (SDAC) collects information and disseminates it to ACC providers and the Department. The client level data helps identify high needs clients and potentially effective interventions. At a population level the data helps identify high performing PCMPs and RCCOs and best practices. Access to the information is monitored based on role-based security protocols and protected under federal health privacy laws.

Enrollment

At the end of FY 2013-14 609,051 clients, or 58 percent of the clients on Medicaid, were enrolled in the ACC. This is a significant increase from the 352,236 clients enrolled last year.

Administrative fees and costs

The table below summarizes actual administrative costs for the program in FY 2012-13 and FY 2014-15 and projected costs through FY 201-16. These figures are from the Department's narrative for R1 and include incentive payments paid in one year that were earned in another year, and so they differ slightly from the costs identified in the report that are based on when the payments are earned.

Accountable Care Collaborative Administrative Expenses				
	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Regional Care Collaborative Organizations	$27,696,161	$52,945,462	$100,514,838	$105,255,449
Primary Care Medical Providers	6,130,270	12,674,868	28,305,947	33,055,279
Statewide Data Analytics Contractor	2,902,500	2,950,000	3,467,498	3,350,000
Administration	$36,728,931	$68,570,330	$132,288,283	$141,660,728

The RCCOs earn per member per month fees between $8.93 and $9.30 and the PCMPs $3.00, with an additional $1.00 in incentive payments available to each if they meet performance goals for improved health outcomes.

Performance/savings

The Department's financial modeling estimates FY 2013-14 ACC activities resulted in savings of between $98.4 and $102.1 million. Because the budget is based on cash accounting the estimated savings assumed in the budget request are slightly different.

Accountable Care Collaborative Estimated Savings				
	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Administration	$36,728,931	$68,570,330	$132,288,283	$141,660,728
Estimated Savings	(43,647,968)	(81,781,107)	(140,673,766)	(166,266,952)
Net Impact	($6,919,037)	($13,210,777)	($8,385,483)	($24,606,224)

When looking at subsets of the population the Department finds that the majority of net savings were generated in ACC services to people with disabilities. The Department projects that the ACC did not generate savings for expansion adults or children. To calculate savings, the Department's modeling compares per capita expenditures for the ACC population to a benchmark assumption about per capita expenditures for people not enrolled in the ACC. In looking at the results for people with disabilities, the JBC staff wonders if there is a selection bias in the analysis, where people with less severe disabilities are more likely to participate in the ACC. Given the incredibly high cost of service for the most expensive clients with disabilities, even a small selection bias could make the savings look larger. For children, it is important to note that the comparison of per capita expenditures is to a benchmark assumption for the same age group and it does not account for potential savings later in life that result from addressing health issues at a young age.

5. Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities - The Department is request to submit a report to the Joint Budget Committee on November 1, 2014 regarding the status of the distribution of the full program equivalents for the developmental disabilities waivers. The report is requested to identify any current or possible future issues which would prevent the distribution and enrollment of all full program equivalents noted in the FY 2014-15 Long Bill.

   Comment: See the briefing for the Office of Community Living for more information.

6. 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: This report is not due until February 1.

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

   Comment: The Department submitted the report as requested. The program pays for medically necessary services that are part of a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Examples of covered services include direct medical services, rehabilitative therapies, and Early and Periodic Screening, Diagnostic and Treatment Services. Medical necessity is determined through the federally and state regulated IEP or IFSP process. In FY 2013-14 the program served 16,500 children. Due to delays in the way the eligible costs are determined and the funds are distributed the Department reported FY 2012-13 total federal funds matched with certified public expenditures, rather than FY 2013-14 funds. The total federal funds distributed were $20,174,776 and this amount was distributed to 52 school health services program providers.

Appendix D: Indirect Cost Assessment Methodology

The Department does not have a traditional departmental indirect cost recovery plan. All of the funding for the Department's FTE is currently provided in one line item. The amounts from various fund sources that are used to support the FTE are calculated individually, rather than through an indirect cost allocation plan. The only indirect assessments that appear in the Indirect Cost Recoveries line item are related to the statewide indirect plan.

Appendix E: SMART Act Annual Performance Report

Pursuant to Section 2-7-205 (1) (b), C.R.S., the Department of Health Care Policy and Financing is required to publish an Annual Performance Report by November 1 of each year. This report is to include a summary of the Department's performance plan and most recent performance evaluation. The report dated November 1, 2014 is attached for consideration by the Joint Budget Committee in prioritizing the Department's budget requests.

COLORADO

Department of Health Care Policy and Financing
Annual Performance Report

Strategic Policy Initiatives

The Department of Health Care Policy and Financing has identified several strategic policy initiatives for FY 2014-15 and beyond. For this evaluation report, the Department selected a few initiatives that best capture some of the Department's strategic and operational priorities and reflect the overall direction as identified by Department leadership. The initiatives also provide context for much of the day-to-day work, which is highlighted in the measures section of the report. Additional detail for these, and other, strategic policy initiatives is available in the Department's Performance Plan, which may be accessed here.

Customer – Improve health outcomes, client experience and lower per capita costs

The Department is committed to delivering a customer-focused Medicaid program that improves health outcomes and client experience while delivering services in a cost-effective manner. Central to this initiative is the establishment of an integrated delivery system through the Accountable Care Collaborative (ACC), which holds providers accountable for health outcomes. This shifts financial incentives away from volume of services to efficacy. The ACC focuses on the needs of its members and leverages local resources to best meet those needs. Medicaid members in the ACC receive the regular Medicaid benefit package and belong to a Regional Care Collaborative Organization. They choose a Primary Care Medical Provider as a medical home, who coordinates and manages their health needs across specialties and along the continuum of care. In addition to the ACC, the Department is working to improve eligibility and enrollment systems for members, expand member access to medical providers, reduce waiting lists for waiver services, and enhance long term services and supports.

Technology – Provide exceptional service through technological innovation

The Department is encouraging the adoption of electronic health records (EHRs) for Medicaid members through a federally-funded incentive program. Creating a personal EHR will allow Medicaid clients and their providers to see individual claims, service utilization, costs compared to similar clients, and monitor personal wellness needs. Linking this data to the Statewide Data and Analytics Contractor for the Accountable Care Collaborative will allow Medicaid providers access to a broader picture of member resource needs. Providers who meet defined eligibility criteria can qualify for limited-time incentive payments to help offset the costs of adopting EHR. Providers must demonstrate "Meaningful Use" or declare that their services meet core measures to receive incentive payments.

Process – Enhance efficiency and effectiveness through process improvement

The Department established a Lean Community for process improvement in 2012. The Lean Community empowers employees to eliminate waste and maximize value in their daily work activities, and fosters a culture of continuous improvement through training and project management. The Department is using training, coaching, global projects and rapid improvement sessions called "Quick Hits" to deploy Lean throughout the Department, and to create a Lean culture that is customer-centric, and focused on continuous improvement and data-driven decision-making.

Financing – Ensure sound stewardship of financial resources

The Department's "Financing" initiative is intertwined with its "Customer" initiative in that it contains costs through many of the same programs designed to improve health outcomes. This is because medical costs decrease when overall population health improves: members engage in prevention and wellness programs, they experience better management of chronic diseases, and have fewer acute care episodes. Costs are also controlled by shifting payment systems from outdated "pay and chase" models that drive volume of services to new systems that pay for value and improved health. In addition, the Department is focused on financing efforts to prevent fraud, waste and abuse; expand the use of performance-based contracts; and seek grant funding to further strategic goals not funded through the regular budget process.

Operational Measures

Customer – Improve health outcomes, client experience and lower per capita costs
Process – Increase enrollment of Medicaid recipients into the ACC

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of ACC enrollees of total Medicaid population	13.2%	34.4%	52.2%	64.8%	71.3%

Counts are based upon annual average of monthly enrollment.

Process – Attribute ACC clients to primary care providers in RCCO network

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of ACC enrollees with a Primary Care Medical Provider	N/A	76.4%	70.9%	69.6%	75.0%

Counts are based upon annual average of monthly enrollment.

Process – Increase timely eligibility determinations

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of eligibility applications processed within various state and federal timeline requirements	81.0%	89.9%	91.8%	94.0%	95.8%

Process – Enroll new Medicaid providers

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Number of Colorado providers serving Medicaid	36,537	39,821	43,867	44,996	50,845

Process – Increase enrollment for Children's Extensive Support (CES) Waiver

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of CES eligible individuals in need of immediate services enrolled	N/A	44.7%	71.9%	100%	100%

Process – Place appropriate Long Term Services and Supports (LTSS) Members in nursing facilities

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of LTSS Members in nursing facilities	22.3%	21.1%	20.7%	18.1%	17.0%

Process – Provide waiver services to appropriate LTSS Members

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of LTSS Members receiving HCBS waiver services	72.9%	73.5%	74.4%	76.3%	76.6%

Process – Provide PACE services to appropriate LTSS Members

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of LTSS Members enrolled in PACE	4.8%	5.3%	4.9%	5.7%	6.5%

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of Medicaid Providers receiving EHR-MU incentive payments	N/A	N/A	57.4%	56.8%	78.6%

Process – Enhance efficiency and effectiveness through process improvement
Process – Promote a Lean culture throughout the Department

Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Percentage of Favorable survey responses to "Work Done > Efficiently with < Waste"	43.0%	N/A	49.0%	60.0%	75.0%

Data source is DPA statewide employee survey, which is conducted biennially. Survey question did not exist in 2013.

Financing – Ensure sound stewardship of financial resources
Process – Achieve ACC net savings targets

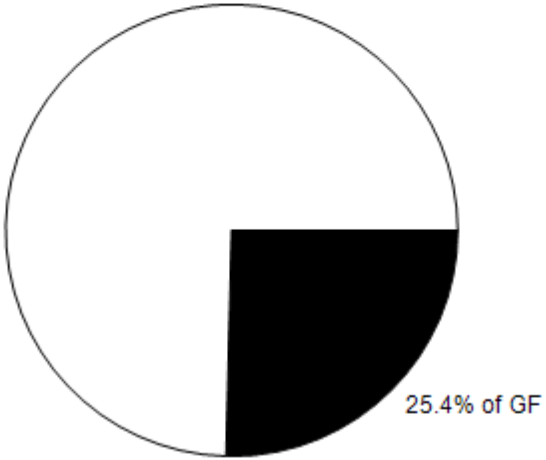
Measure	FY12 Actual	FY13 Actual	FY14 Actual	1-Year Goal	3-Year Goal
Dollar amount of ACC net savings (range minimum)	($2,708,711)	($6,930,854)	($13,210,777)	($20,143,291)	($23,386,336)

JBC Staff Briefing
Department of Health Care Policy and Financing

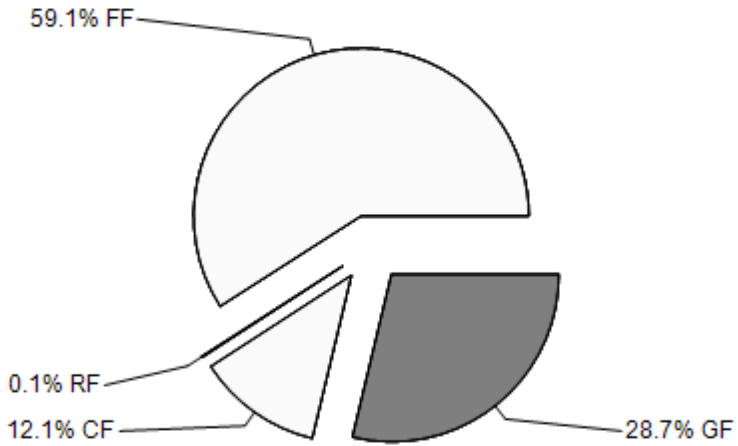
Presented by:

Eric Kurtz, JBC Staff
December 2, 2014

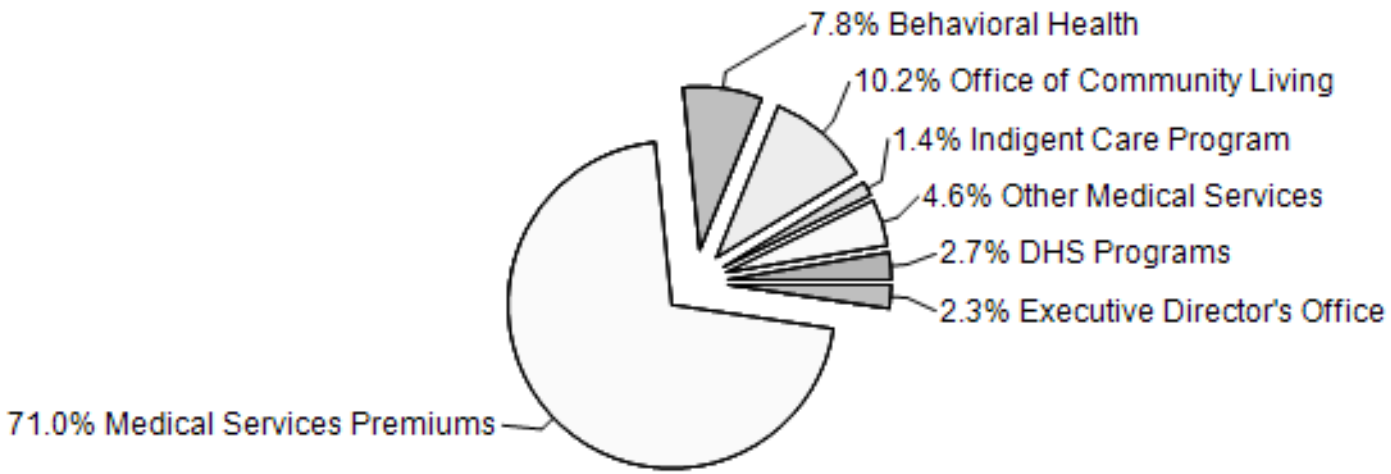
Department's Share of Statewide General Fund

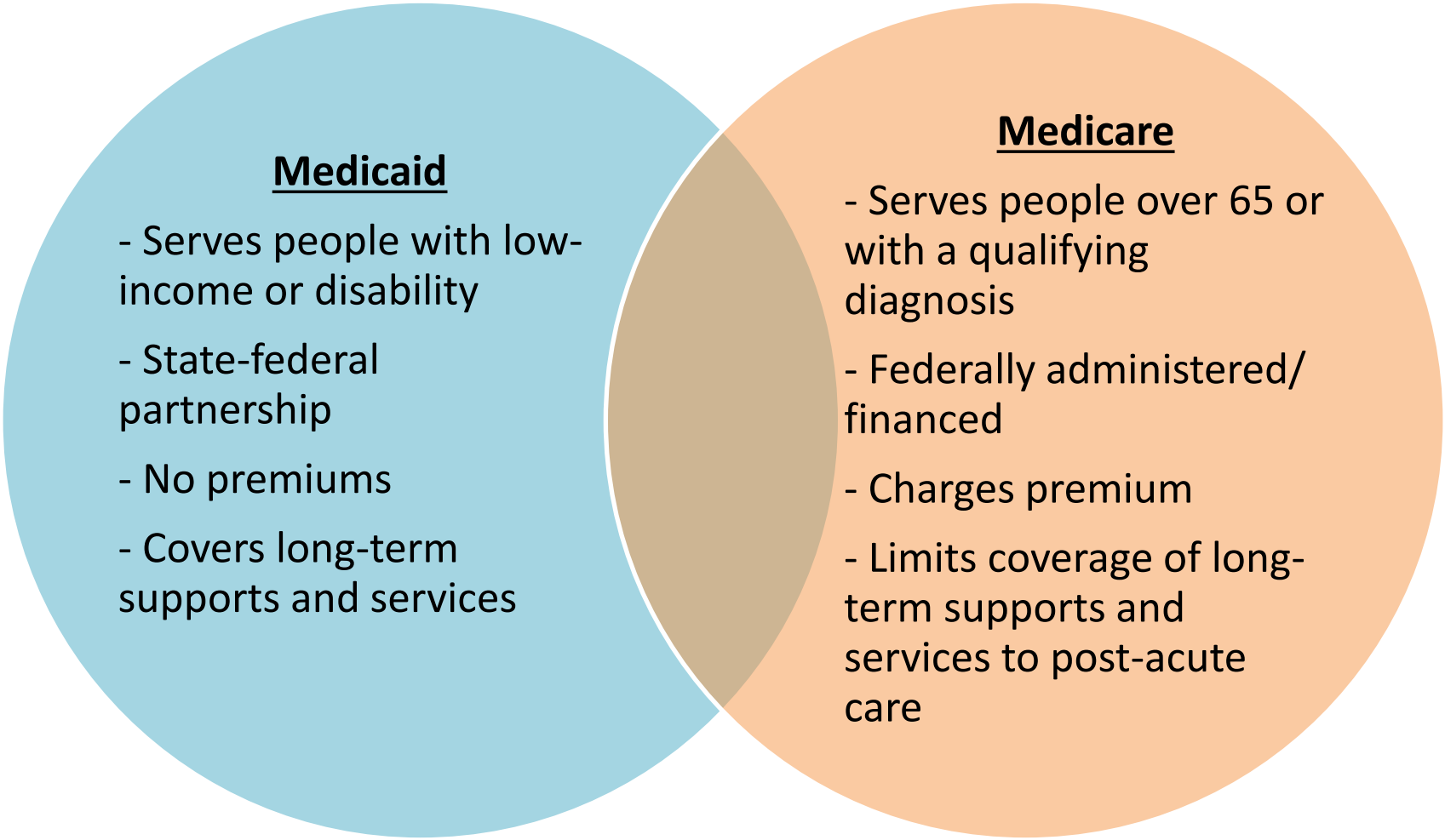


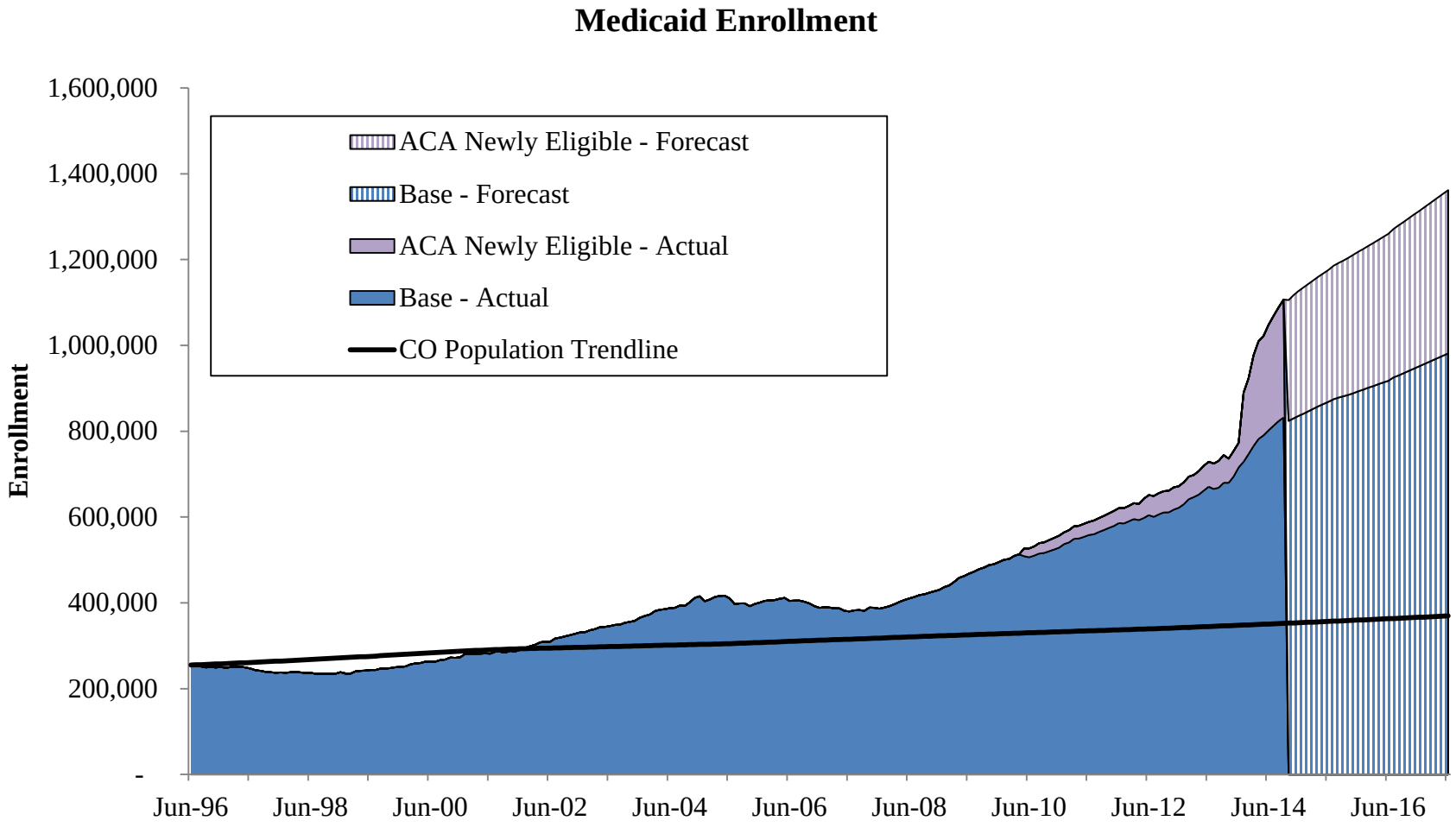
Department Funding Sources

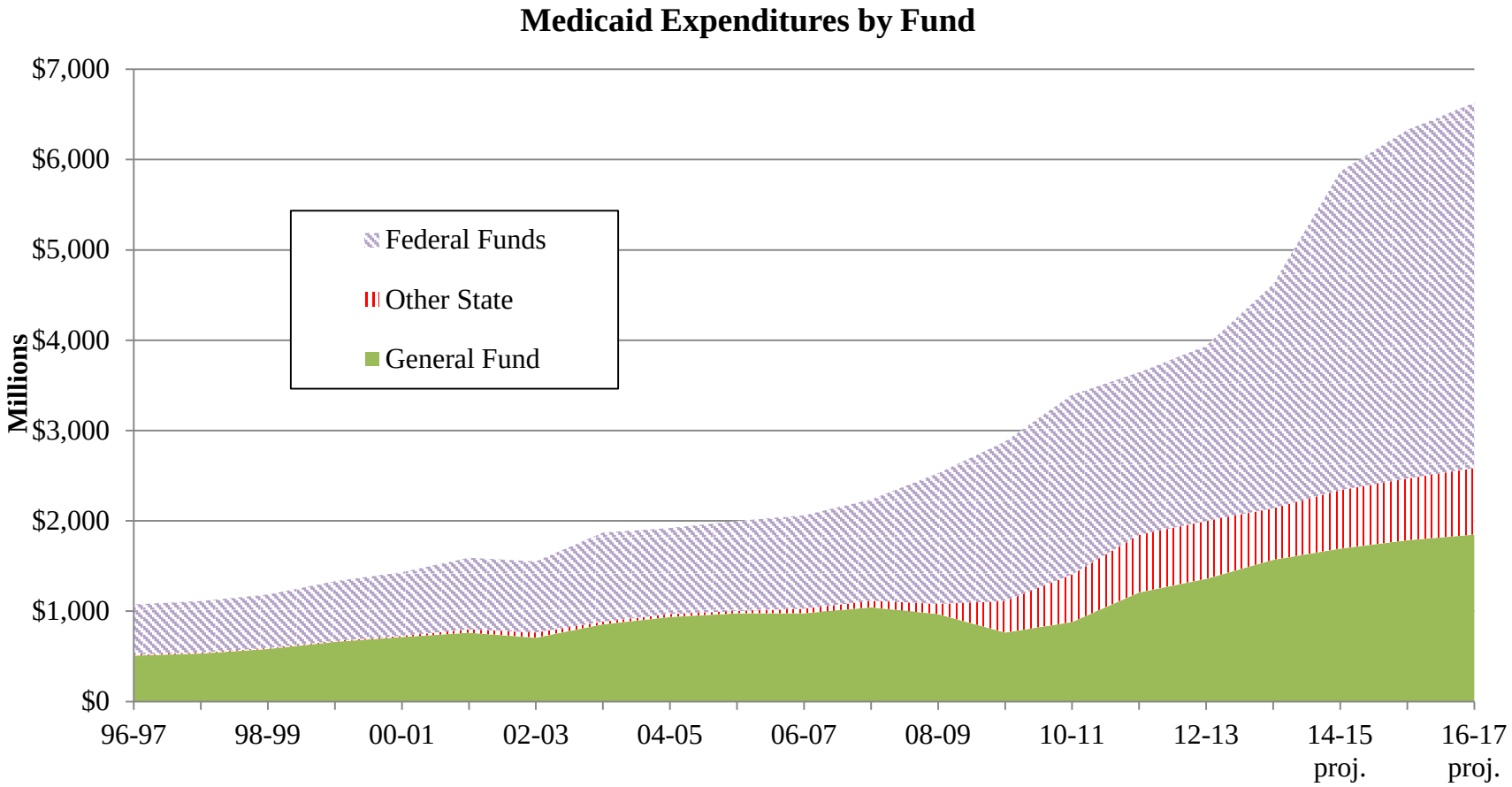


Distribution of General Fund by Division

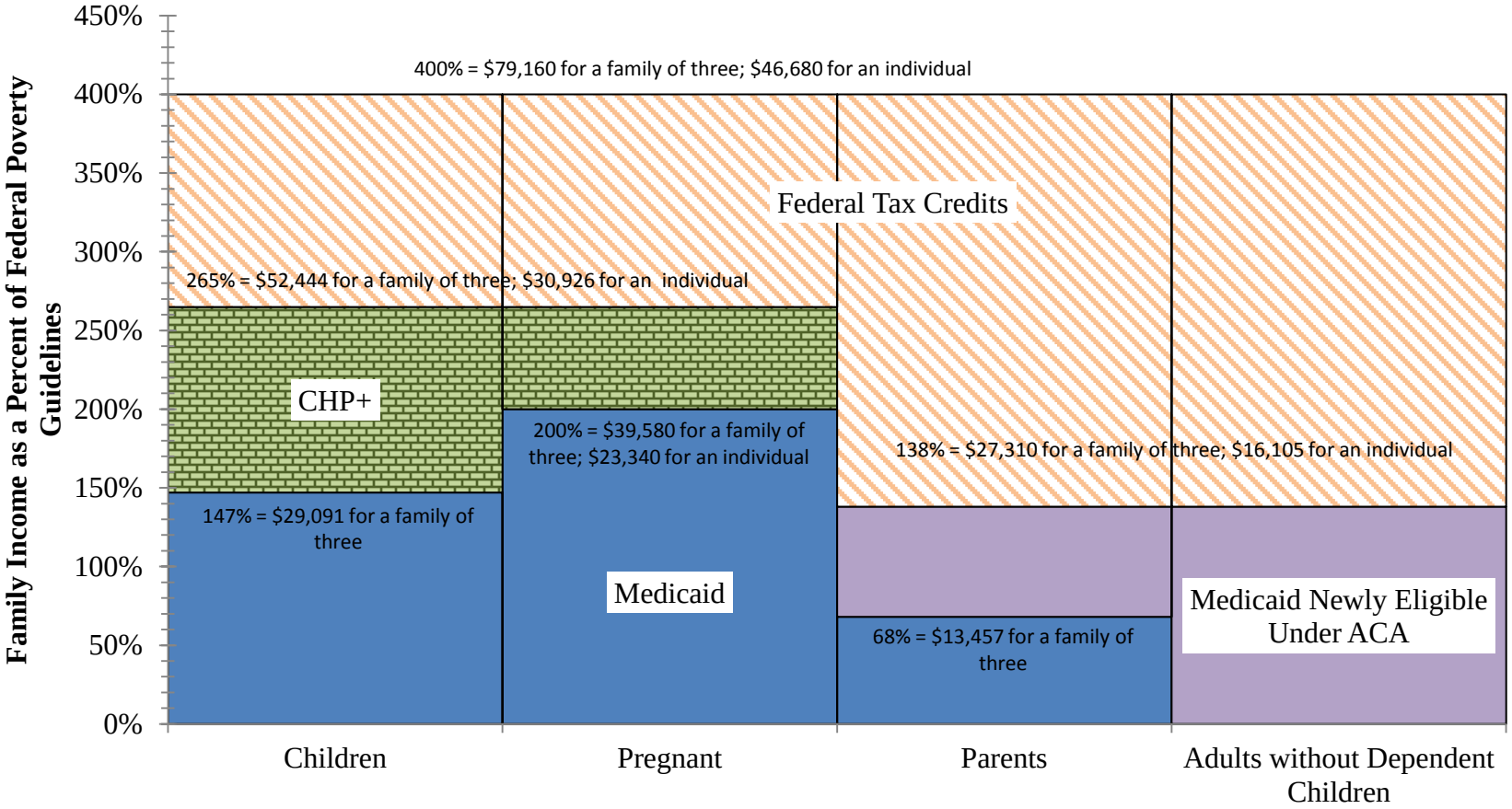



Medicaid
- Serves people with low-income or disability
- State-federal partnership
- No premiums
- Covers long-term supports and services
Medicare
- Serves people over 65 or with a qualifying diagnosis
- Federally administered/ financed
- Charges premium
- Limits coverage of long-term supports and services to post-acute care

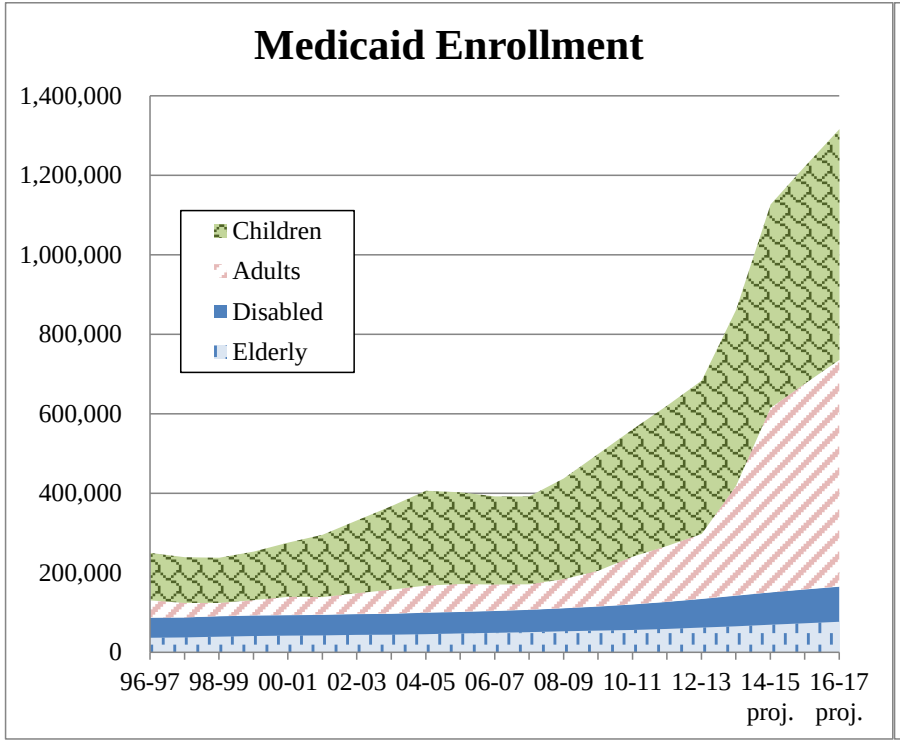

Medicaid Enrollment
Enrollment
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
-
ACA Newly Eligible - Forecast
Base - Forecast
ACA Newly Eligible - Actual
Base - Actual
CO Population Trendline
Jun-96
Jun-98
Jun-00
Jun-02
Jun-04
Jun-06
Jun-08
Jun-10
Jun-12
Jun-14
Jun-16

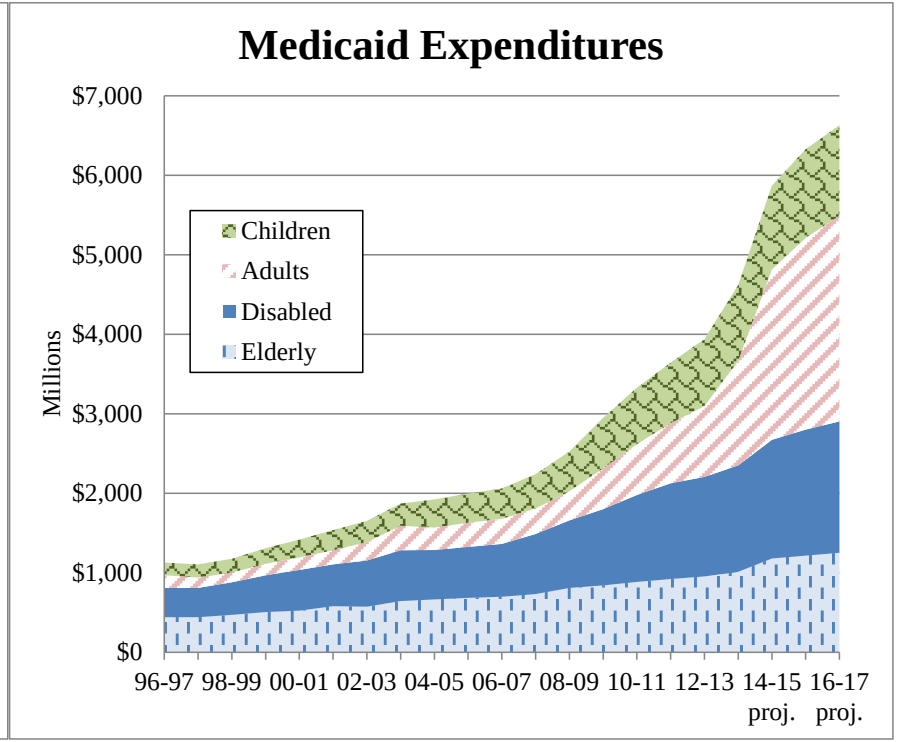

Medicaid Expenditures by Fund
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Millions
Federal Funds
Other State
General Fund
96-97
98-99
00-01
02-03
04-05
06-07
08-09
10-11
12-13
14-15 proj.
16-17 proj.

Effective Income Eligibility for Benefit

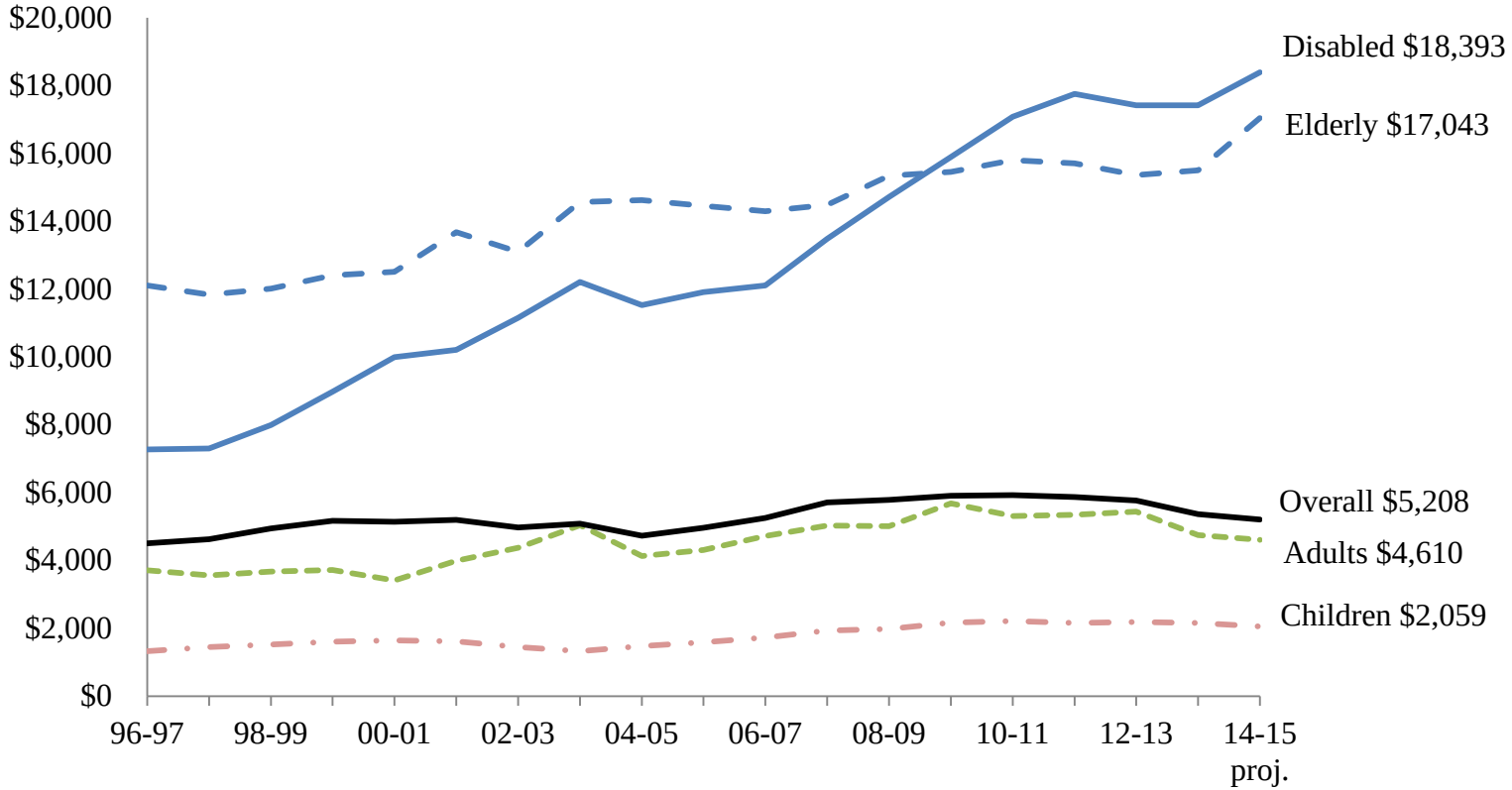


Special Medicaid Eligibility Categories	
Category	**Eligibility Standard**
Elderly 65+ years	Qualify for federal Supplemental Security Income (SSI) = standard Medicaid benefit 100% FPL = assistance with Medicare premiums and coinsurance 135% FPL = assistance with Medicare premiums
People with disabilities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

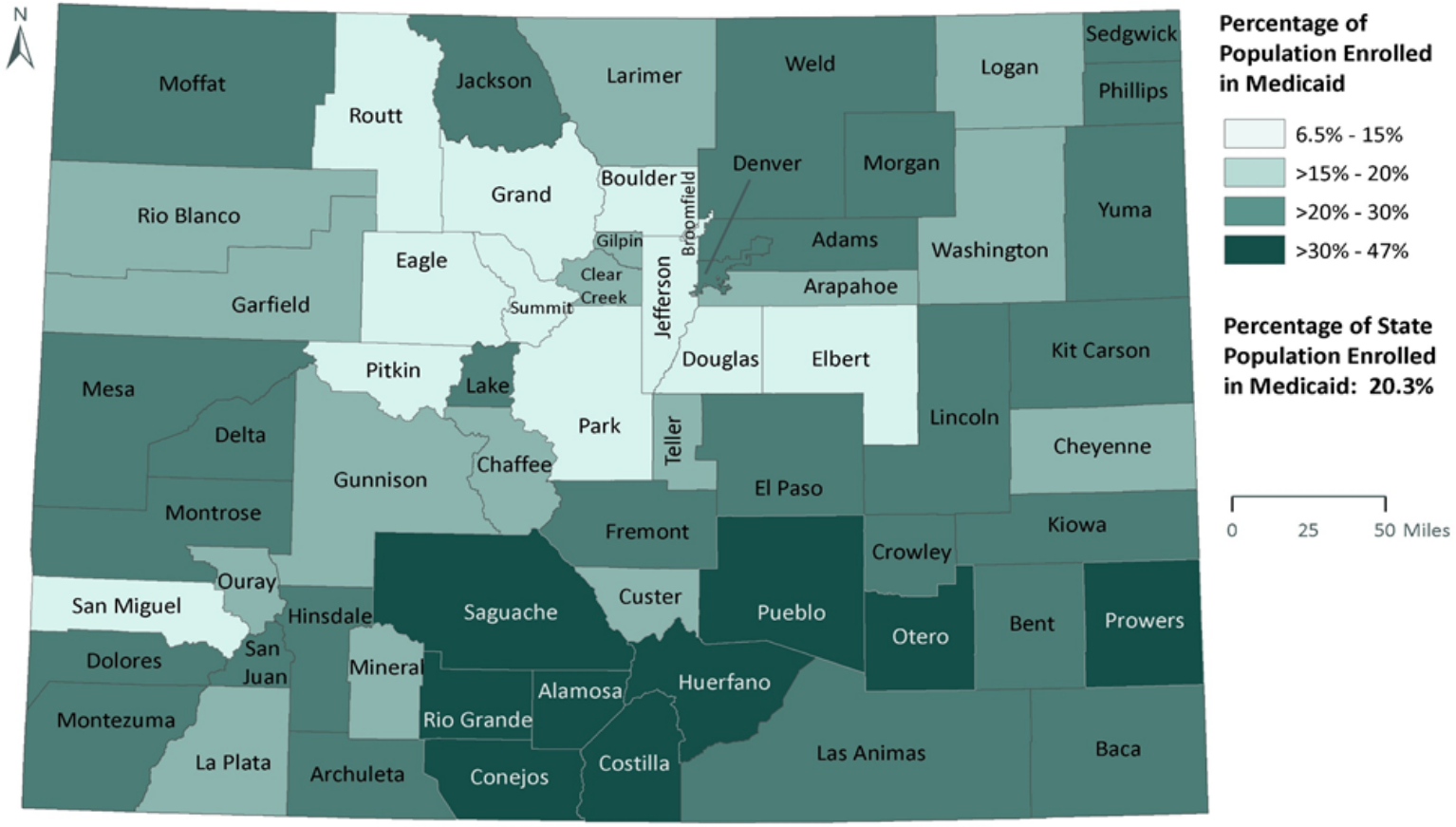

Medicaid Enrollment
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Children
Adults
Disabled
Elderly
96-97
98-99
00-01
02-03
04-05
06-07
08-09
10-11
12-13
14-15 proj.
16-17 proj.


Medicaid Expenditures
Millions
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Children
Adults
Disabled
Elderly
96-97
98-99
00-01
02-03
04-05
06-07
08-09
10-11
12-13
14-15 proj.
16-17 proj.

Per Capita Medicaid Expenditures
(includes supplemental payments)



Percentage of Population Enrolled in Medicaid, by County, Colorado, August 2014

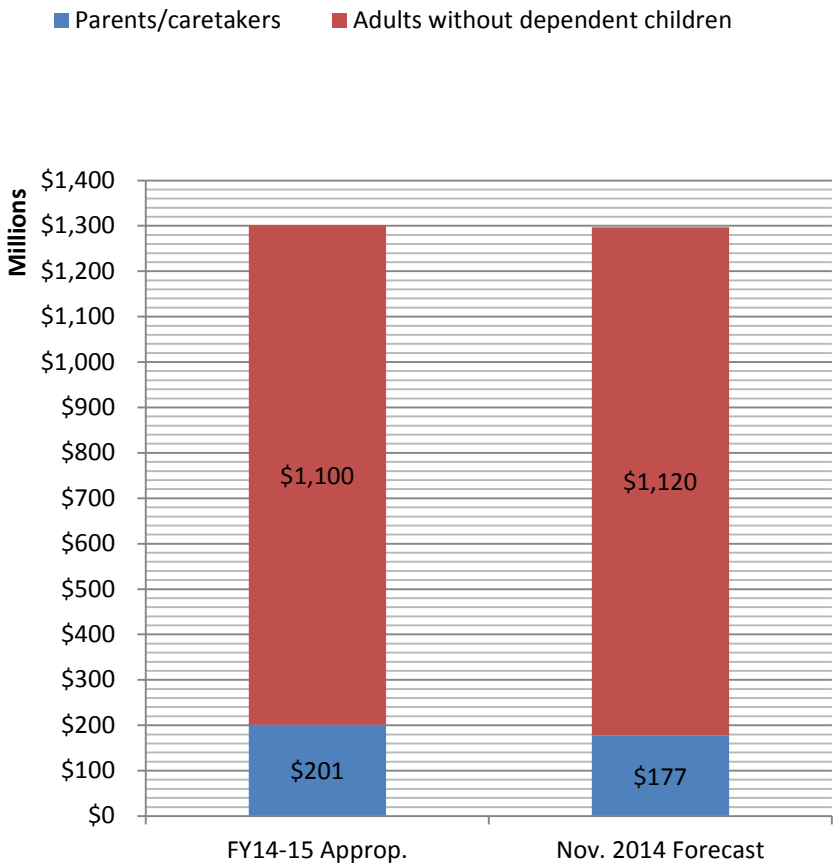


Map prepared September 25, 2014
by the Colorado Health Institute.

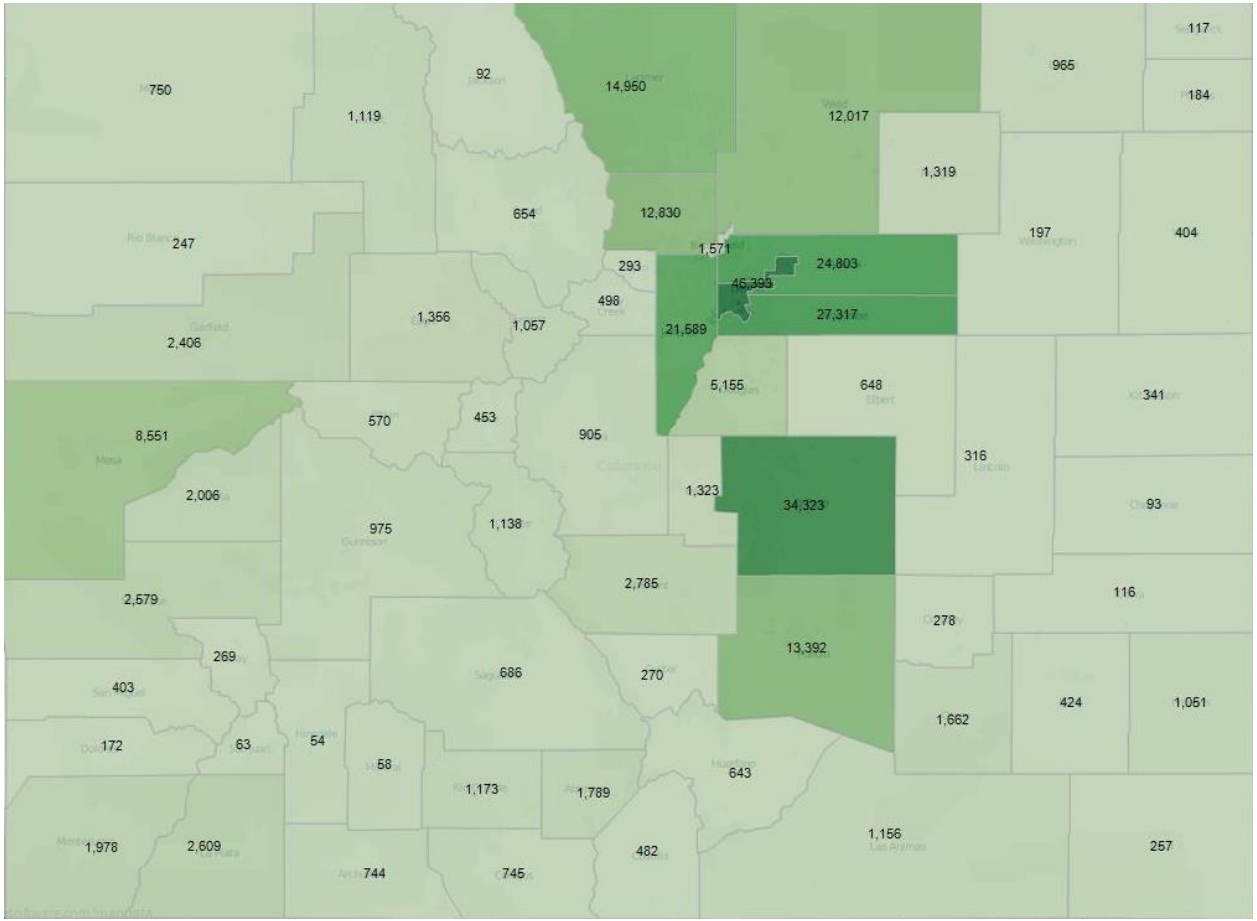
Source: Colorado Department of Health Care Policy and Financing, August 2014 Medicaid Caseload Report. Colorado State Demographer's Office.

"Newly Eligible" Enrollment FY 14-15

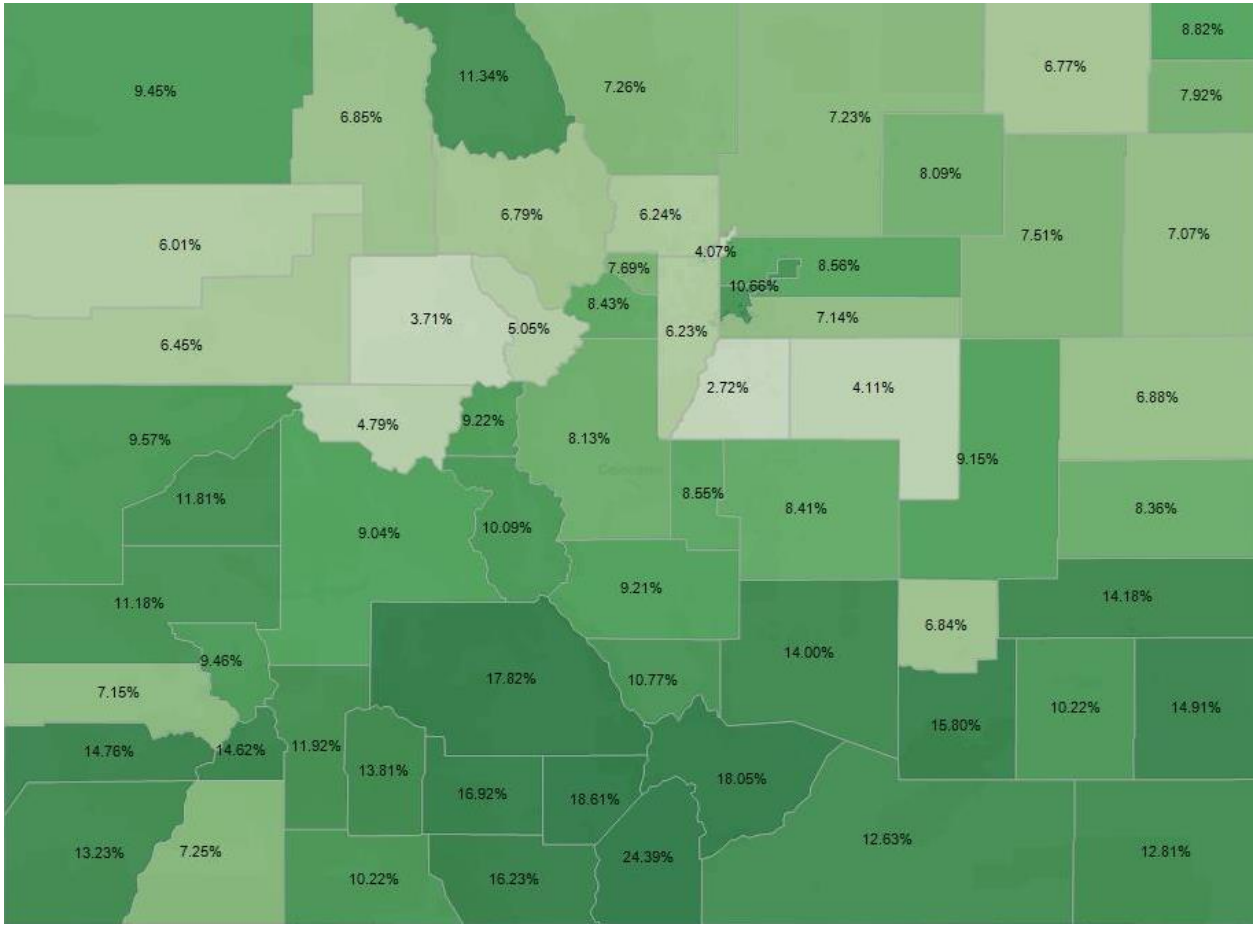
"Newly Eligible" Expenditures 14-15



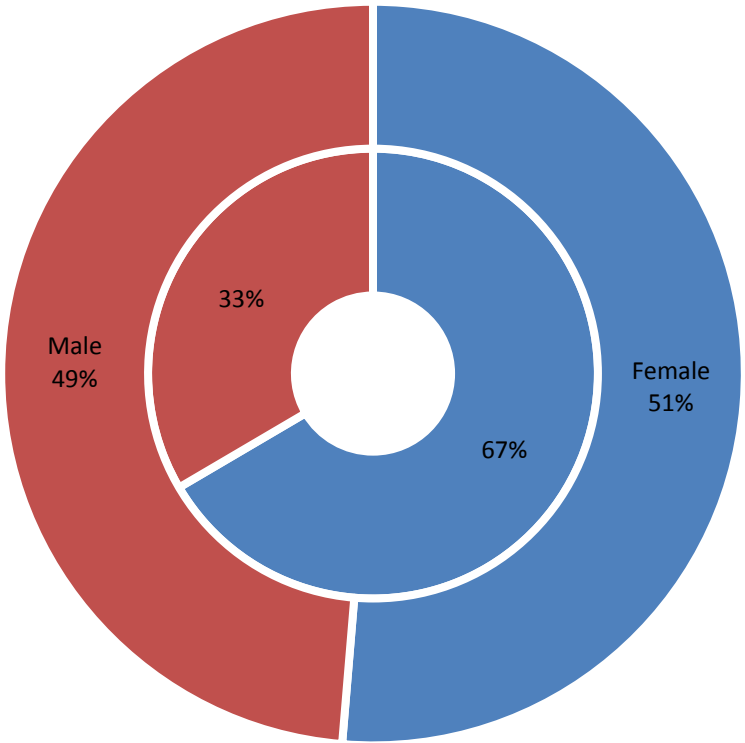
Newly Eligible Adults

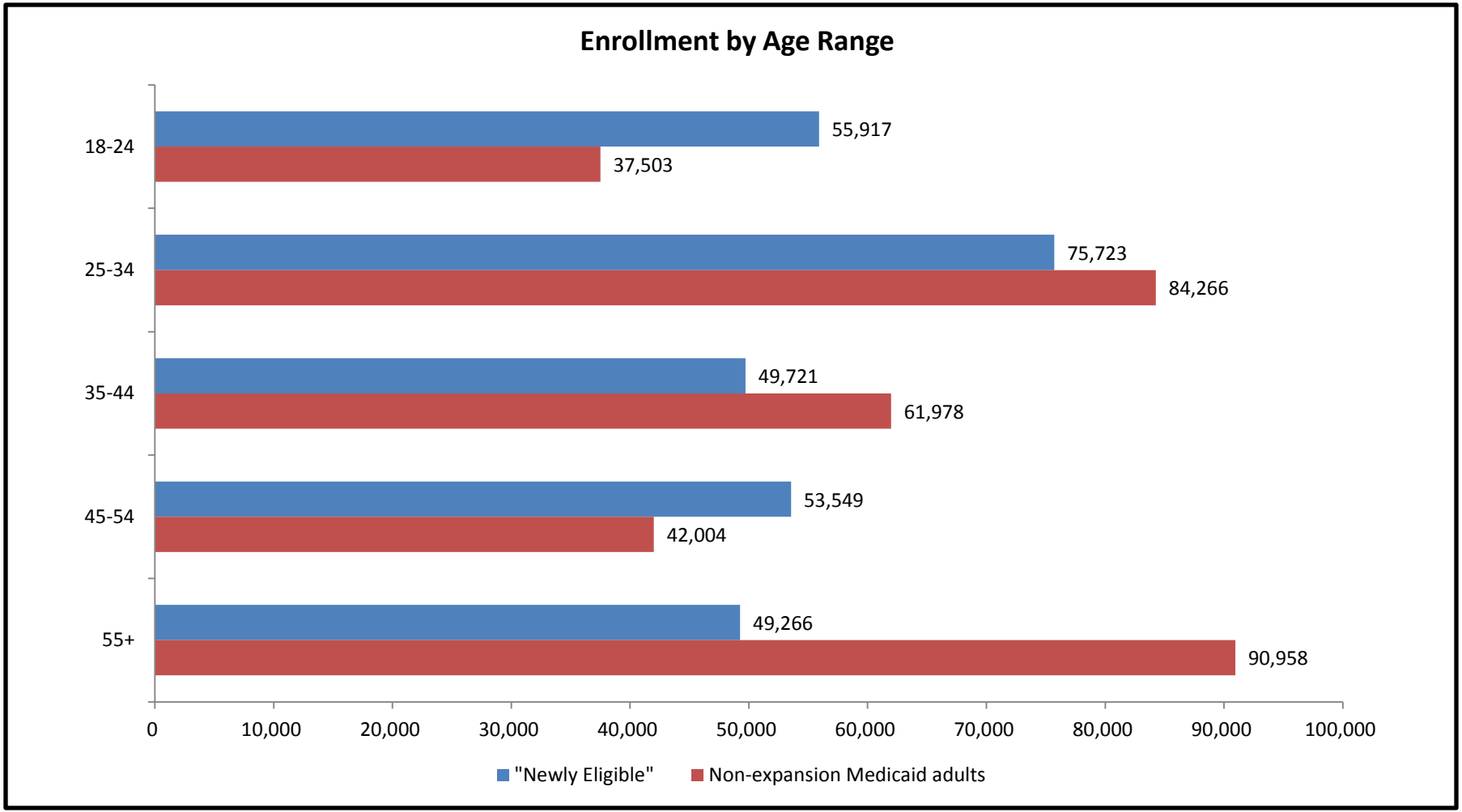


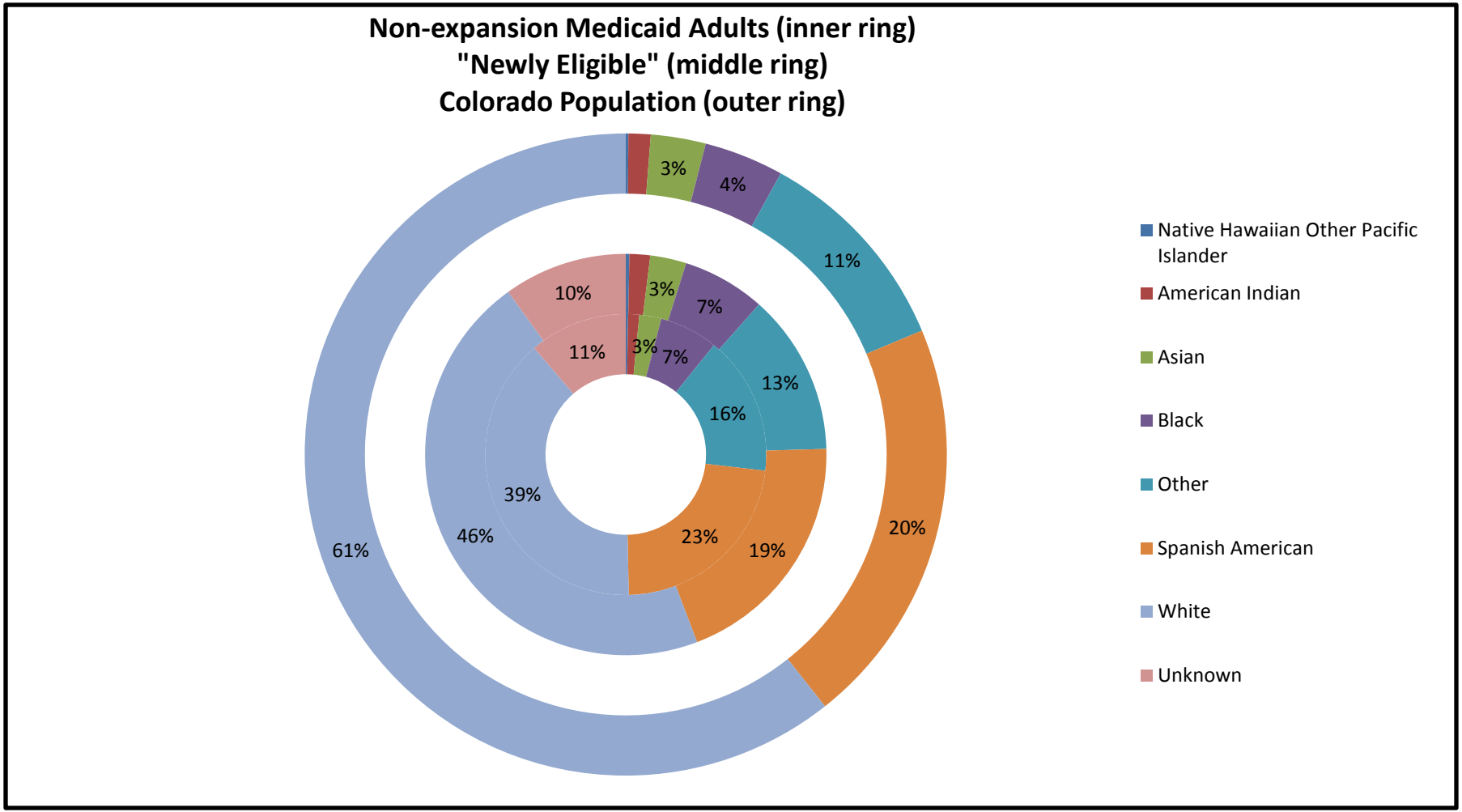
Newly Eligible as a Percent of Adult Population



"Newly Eligibile" (outer ring) vs Non-expansion Medicaid Adults (inner ring)




Enrollment by Age Range
18-24
25-34
35-44
45-54
55+
55,917
37,503
75,723
84,266
49,721
61,978
53,549
42,004
49,266
90,958
0
10,000
20,000
30,000
40,000
50,000
60,000
70,000
80,000
90,000
100,000
"Newly Eligible"
Non-expansion Medicaid adults


Non-expansion Medicaid Adults (inner ring)
"Newly Eligible" (middle ring)
Colorado Population (outer ring)
3%
4%
11%
20%
19%
23%
46%
61%
10%
11%
3%
7%
3%
7%
13%
16%
39%
Native Hawaiian Other Pacific Islander
American Indian
Asian
Black
Other
Spanish American
White
Unknown