

This PDF includes:

1. Technical comebacks – This two page memo presented 3/15/16 corrects a few errors identified in the main figure setting recommendations.
2. Figure setting recommendations for the Department of Health Care Policy and financing, Executive Director's Office, Medical Services premiums, Indigent Care Programs, and Other Medical Programs.

MEMORANDUM

TO: Joint Budget Committee

FROM: Eric Kurtz, JBC Staff (303-866-4952)

SUBJECT: Comebacks, Department of **Health Care Policy and Financing**
Regarding:

- Old Age Pension State Medical Program
- Children's Basic Health Plan

DATE: March 15, 2016

1. The JBC staff recommends that for the Medical Services Premiums line item \$5,240,893 identified in the figure setting document as coming from cash funds should instead be identified as coming from reappropriated funds. This is money that the Department projected in the February 2016 forecast would come from the Old Age Pension Health and Medical Care Fund, but it should be from a reappropriated funds transfer from the Old Age Pension State Medical Program line item to be consistent with the JBC's action on the supplemental. The JBC staff intended to recommend this modification from the Department's February 2016 forecast, but failed to include it in the original figure setting document due to a technical error.
2. The JBC staff recommends reducing the FY 2015-16 appropriation for the Children's Basic Health Plan (CHP+) Medical and Dental Costs from the amount recommended in the figure setting document. The reduction is \$3,519,701 total funds, including \$1,213,241 cash funds from the Children's Basic Health Plan Trust and \$2,306,460 federal funds. In the Department's February 2016 forecast the Department made a technical error in not accounting for an offset to expenditures from recoveries and recoupments.
3. Page 76 of the figure setting document featured a table showing the projected balance in the CHP+ Trust that needs to be updated. First, the table needs to be corrected for the technical error identified in item 2 above. Second, the JBC staff responsible for the Tobacco Settlement distribution identified a technical error in the forecast of the distribution to the CHP+ Trust for FY 2017-18 and FY 2018-19. Correcting the table does not change any of the JBC staff recommendations, but it may be relevant if the JBC is considering changes to the distribution of tobacco settlement moneys or actions to reduce the fund balance in the CHP+ Trust. Below is a revised version of the table.

Comebacks, Department of Health Care Policy and Financing

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March 15, 2016

Children's Basic Health Plan Trust					
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Beginning Fund Balance	\$13,937,178	\$18,291,567	\$29,317,340	\$41,546,387	\$53,102,408
Revenue	<u>\$31,840,037</u>	<u>\$28,858,086</u>	<u>\$27,041,381</u>	<u>\$26,957,239</u>	<u>\$22,582,583</u>
Fees	896,127	1,205,499	1,299,858	1,376,216	1,470,499
Tobacco Settlement	27,889,272	27,459,195	25,548,832	25,390,434	20,921,495
Interest	195,419	193,392	192,691	190,589	190,589
Recoveries	2,859,220	0	0	0	0
Expenses	\$27,485,649	\$17,832,313	\$14,812,334	\$15,401,218	\$16,028,872
Net Cash Flow	\$4,354,389	\$11,025,773	\$12,229,047	\$11,556,021	\$6,553,711
Ending Fund Balance	\$18,291,567	\$29,317,340	\$41,546,387	\$53,102,408	\$59,656,119

**COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE**



FY 2016-17 STAFF FIGURE SETTING

**DEPARTMENT OF HEALTH CARE POLICY AND
FINANCING**

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

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

**Prepared By:
Eric Kurtz, JBC Staff
March 15, 2016**

For Further Information Contact:

Joint Budget Committee Staff
200 E. 14th Avenue, 3rd Floor
Denver, Colorado 80203
Telephone: (303) 866-2061
TDD: (303) 866-3472

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How to Use this Document

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

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

Department Overview

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

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

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

SUMMARY OF STAFF RECOMMENDATIONS

Department of Health Care Policy and Financing						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	\$7,591,382,066	\$2,014,406,882	\$980,559,608	\$6,110,549	\$4,590,305,027	383.2
Other legislation	11,760,974	1,182,788	4,841,036	0	5,737,150	4.8
HB 16-1240 (Supplemental)	213,516,502	33,182,655	117,698,459	9,195,581	53,439,807	0.0
Recommended Long Bill Supplemental	<u>59,242,613</u>	<u>(13,413,417)</u>	<u>6,796,973</u>	<u>0</u>	<u>65,859,057</u>	<u>0.0</u>
TOTAL	\$7,875,902,155	\$2,035,358,908	\$1,109,896,076	\$15,306,130	\$4,715,341,041	388.0
FY 2016-17 Recommended Appropriation						
FY 2015-16 Appropriation	\$7,875,902,155	\$2,035,358,908	\$1,109,896,076	\$15,306,130	\$4,715,341,041	388.0
Enrollment/utilization trends						
R1 Medical Services Premiums	138,777,450	129,493,645	(103,134,682)	(9,145,518)	121,564,005	0.0
R3 Children's Basic Health Plan	5,964,870	(25,277)	(1,820,368)	0	7,810,515	0.0
R4 Medicare Modernization Act	<u>16,273,413</u>	<u>16,273,413</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0.0</u>

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Department of Health Care Policy and Financing						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
<i>Subtotal - Enrollment/utilization trends</i>	<i>161,015,733</i>	<i>145,741,781</i>	<i>(104,955,050)</i>	<i>(9,145,518)</i>	<i>129,374,520</i>	<i>0.0</i>
Eligibility/benefit changes						
NP Cervical cancer eligibility	275,016	0	101,387	0	173,629	0.0
Annualize HB 15-1186 children with autism/Behavioral therapy benefit	<u>18,480,411</u>	<u>9,203,138</u>	<u>0</u>	<u>0</u>	<u>9,277,273</u>	<u>0.0</u>
<i>Subtotal - Eligibility/benefit changes</i>	<i>18,755,427</i>	<i>9,203,138</i>	<i>101,387</i>	<i>0</i>	<i>9,450,902</i>	<i>0.0</i>
Provider rate changes						
R12 Provider rates	0	0	0	0	0	0.0
Annualize primary care rate bump	<u>(145,075,634)</u>	<u>(49,519,402)</u>	<u>(1,642,057)</u>	<u>0</u>	<u>(93,914,175)</u>	<u>0.0</u>
<i>Subtotal - Provider rate changes</i>	<i>(145,075,634)</i>	<i>(49,519,402)</i>	<i>(1,642,057)</i>	<i>0</i>	<i>(93,914,175)</i>	<i>0.0</i>
Federal match rate						
R11/BA16 Standard federal match	534,194	17,612,305	(3,326,229)	17,759	(13,769,641)	0.0
ACA "Newly eligible" federal match	<u>0</u>	<u>0</u>	<u>38,431,390</u>	<u>0</u>	<u>(38,431,390)</u>	<u>0.0</u>
<i>Subtotal - Federal match rate</i>	<i>534,194</i>	<i>17,612,305</i>	<i>35,105,161</i>	<i>17,759</i>	<i>(52,201,031)</i>	<i>0.0</i>
R7 County administration funding	0	0	0	0	0	0.0
R9/BA13 Old Age Pension Medical	0	0	0	0	0	0.0
BA6 Fed reg for assuring access	460,913	230,457	0	0	230,456	3.0
BA7 Fed reg for managed care	665,066	332,533	0	0	332,533	4.0
BA8 HCBS settings final rule	1,166,571	583,286	0	0	583,285	0.9
BA9 Provider enrollment fee	(1,061,183)	0	(1,061,183)	0	0	0.0
BA10 Medicaid-Medicare grant true up	(6,120,881)	(6,656)	0	0	(6,114,225)	0.0
BA11 Technical adjustments	0	0	0	0	0	0.0
BA12 External quality review	0	0	0	0	0	0.0
BA14 Public school health services	(2,035,791)	0	(778,066)	0	(1,257,725)	0.0
NP CO Benefits Management System	12,857,067	4,152,953	1,804,179	0	6,899,935	0.0
Annualize prior year budget decisions	13,365,942	3,296,259	2,727,908	0	7,341,775	3.0
Indirect cost adjustment	59,489	(59,489)	46,187	60,710	12,081	0.0
Transfers to other departments	14,045	1,701	0	10,644	1,700	0.0
Tobacco tax forecast	47,937	0	47,937	0	0	0.0
Centrally appropriated line items	<u>(785,286)</u>	<u>(484,606)</u>	<u>71,154</u>	<u>31,921</u>	<u>(403,755)</u>	<u>0.0</u>
SUBTOTAL Long Bill	\$7,929,765,764	\$2,166,443,168	\$1,041,363,633	\$6,281,646	\$4,715,677,317	398.9
R1 Restrict Hospital Provider Fee revenue	<u>(202,217,646)</u>	<u>0</u>	<u>(100,000,000)</u>	<u>0</u>	<u>(102,217,646)</u>	<u>0.0</u>
TOTAL	\$7,727,548,118	\$2,166,443,168	\$941,363,633	\$6,281,646	\$4,613,459,671	398.9
Increase/(Decrease)	(\$148,354,037)	\$131,084,260	(\$168,532,443)	(\$9,024,484)	(\$101,881,370)	10.9
Percentage Change	(1.9%)	6.4%	(15.2%)	(59.0%)	(2.2%)	2.8%
FY 2016-17 Executive Request	\$7,593,320,044	\$2,157,652,143	\$946,101,698	\$6,219,464	\$4,483,346,739	398.9
Request Above/(Below) Recommendation	(\$134,228,074)	(\$8,791,025)	\$4,738,065	(\$62,182)	(\$130,112,932)	0.0

Description of Incremental Changes

FY 2015-16

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

FY 2016-17

Enrollment/utilization trends: Staff recommends a net increase of \$161.0 million, including \$145.7 million General Fund, based on enrollment and utilization trends in the Department's February 2016 forecast. See the descriptions of *R1 Medical Services Premiums*, *R3 Children's Basic Health Plan*, and *R4 Medicare Modernization Act* for more information.

Eligibility/benefit changes: Staff recommends the requested increase of \$18.8 million, including \$9.2 million General Fund, for two changes in the benefits under Medicaid. Of the total, \$18.5 million, including \$9.2 million General Fund, is for a federally mandated behavioral therapy benefit for children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Most of the users of this new benefit are expected to be children with autism. The remaining \$275,016 is to expand the age of women eligible for cervical cancer screenings through the Breast and Cervical Cancer Program from the current 40 to 64 years old to 21 to 64 years old.

Provider rate changes: Staff recommends the requested decrease of \$145.1 million, including \$49.5 million General Fund, for the end of a rate bump that temporarily raised Medicaid primary care rates to the equivalent Medicare rates.

Federal match rate: Staff recommends the requested changes in financing based on new federal match rates. Due to a decrease in the standard federal match rates for Medicaid and CHP+, General Fund expenditures are expected to increase \$17.6 million. Due to a decrease in the federal match rate for the "newly eligible" pursuant to the Affordable Care Act the Hospital Provider Fee expenditures are expected to increase \$38.4 million.

R7 County administration: Staff recommends the requested continuation of a supplemental increase in federal funds for reimbursements to counties for eligibility determination services and reconfiguration of line items related to eligibility determinations. A higher-than-anticipated portion of county activities are eligible for an enhanced federal match rate for populations newly eligible for Medicaid.

R9/BA13 Old Age Pension Medical: Staff does not recommend the requested decrease in cash funds from the Old Age Pension Health and Medical Care Fund and instead recommends continuing a restructuring of appropriations approved by the JBC during supplementals.

BA6 Fed reg for assuring access: Staff recommends the requested increase (with some technical modifications) of 3.0 FTE to implement a new federal regulation regarding assuring access to providers.

BA7 Fed reg for managed care: Staff recommends the requested increase (with some technical modifications) of 4.0 FTE to implement a new federal regulation regarding managed care.

BA8 HCBS settings final rule: The staff recommendation is pending figure setting for the Office of Community Living and the figures in the summary table reflect the Department's request as a placeholder.

BA9 Provider enrollment fee: Staff recommends the requested spending authority for a federally mandated provider enrollment fee, but from an existing cash fund, rather than creating a new cash fund as proposed by the Department.

BA10 Medicaid-Medicare grant true up: Staff recommends the requested modifications to reflect changes in the amount, scope, and timing of the federal grant.

BA11 Technical adjustments: Staff recommends annualizing the portions of the technical adjustments approved by the JBC during supplementals. This results in transfers between line items, but no net change in total funding.

BA12 External quality review: Staff recommends the requested continuation of the fund source adjustment that was approved during supplementals. Because the fund source adjustment is already in the base from the supplemental, no further change is needed and the adjustment that appears in the department and division summary tables for this request is \$0.

BA14 Public school health services: Staff recommends the requested adjustment based on projected certified public expenditures by school districts for school health services that are eligible for a federal match.

NP CO Benefits Management System: The staff recommendation is pending figure setting for the Governor's Office of Information Technology and the figures in the summary table reflect the Department's request as a placeholder.

Annualize prior year budget decisions: Staff recommends the requested annualizations of prior year budget decisions.

Indirect cost adjustment: Staff recommends the requested indirect cost adjustment based on the statewide indirect plan approved by the JBC.

Transfers to other departments: Staff recommends some increase in the transfers to other departments based on the JBC's actions during figure setting for the receiving departments.

Tobacco tax forecast: The staff recommendation includes truing up appropriations for the Children's Basic Health Plan and Primary Care Grant Program based on the most recent Legislative Council Staff forecast of tobacco tax revenue.

Centrally appropriated line items: Staff recommends adjustments to centrally appropriated line items based on the JBC's common policies.

Major Differences from the Request

The difference between the staff recommendation and the Governor's request is primarily attributable to two factors. First, the JBC staff used the Department's more recent February 2016 forecast of enrollment and utilization trends for *R1 Medical Services Premiums*, *R3 Children's Basic Health Plan*, and *R4 Medicare Modernization Act*, adding \$92.8 million total funds, including a decrease of \$1.2 million General Fund. Second, the JBC staff did not recommend *R12 Provider rates*, adding \$30.4 million total funds, including \$10.3 million General Fund. The JBC staff is recommending a larger decrease in the Hospital Provider Fee than would be indicated by the February 2016 forecast, but equal to the restriction requested in the Governor's November request.

Decision Items Affecting Multiple Divisions

➔ R11/BA16 Standard federal match rate

AND

➔ ACA "Newly eligible" federal match rate

Request: The Department requests adjustments to account for changes in the federal match rate for Medicaid and the Children's Basic Health Plan (CHP+). The change in the standard federal match rate is the result of a decrease in the ratio of estimated per capita income in Colorado to the national average.

The standard Medicaid federal match rate, or Federal Medical Assistance Percentage (FMAP), is calculated each federal fiscal year for each state according to a formula¹ that takes into account each state's per capita income compared to the national average. Federal law provides for a minimum match rate of 50 percent and a maximum of 83 percent. A state with per capita income equal to the national average would get a 55 percent Medicaid match and states get a larger or smaller match based on having per capita income below or above the national average. The federal match rates for CHP+ and some subsets of Medicaid services, such as breast and cervical cancer treatment, are calculated as derivatives of the FMAP, so the federal match rates for these programs also change when the standard Medicaid FMAP changes.

In addition to the changes in the standard Medicaid federal match rate, there will be changes in FY 2016-17 to the federal match rate for services to adults defined as "Newly Eligible" pursuant to the federal Affordable Care Act (ACA). The federal match rate for the "Newly Eligible" is calculated on a different basis than the standard Medicaid FMAP. It is not dependent on the state's per capita income relative to the national average, nor does it change with the federal fiscal year. The federal match for the "Newly Eligible" steps down from 100 percent to 95 percent beginning in calendar year 2017. It continues stepping down each calendar year thereafter in increments until it reaches 90 percent in calendar year 2020.

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

¹ The FMAP = $1 - (a \text{ three-year average of the state's per capita income})^2 / (a \text{ three-year average of the national per capita income})^2 * 0.45$.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Standard Medicaid Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 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
FY 16-17	50.20	50.72	50.02	50.02	50.02
FY 17-18	<i>50.01</i>	50.02	<i>50.00</i>	<i>50.00</i>	<i>50.00</i>

Italicized figures are projections.

CHP+ Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 12-13	65.00	65.00	65.00	65.00	65.00
FY 13-14	65.00	65.00	65.00	65.00	65.00
FY 14-15	65.53	65.00	65.71	65.71	65.71
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	88.14	88.50	88.01	88.01	88.01
FY 17-18	<i>88.00</i>	88.01	<i>88.00</i>	<i>88.00</i>	<i>88.00</i>

Italicized figures are projections.

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

The Department requested funding for these changes in the federal match rate in several places. In R11 the Department requested funding for line items where the Department did not submit a separate forecast adjustment. For Medical Services Premiums, Behavioral Health, the Children's Basic Health Plan, the Medicare Modernization Act, and the Office of Community Living the effects of the changes to the federal match rate were included in the requested forecast adjustments (R1 through R5). In BA16 the Department revised the estimated funding needs for all line items based on new information received November 6, 2015, about the official federal match rates for federal fiscal year 2016-17. Also in BA16 are revisions to all requests for new funding for FY 2016-17 to reflect the new federal match rate.

Recommendation: Staff recommends appropriation adjustments based on the new federal match rates, which is consistent with the Department's request. The change in federal match rates is something that will happen in FY 2016-17 based on federal policy and is not something that can be altered through a discretionary decision by the General Assembly.

However, there is a difference in the way the JBC staff is presenting the change as compared with the Department's request. As noted above, the Department requested the change attributable to the new federal match rates in several places, including burying some of the change in the forecast adjustments (R1 through R5). The JBC staff takes the change attributable to the new FMAP out of the forecast adjustments and shows the total change to the base under "R11/BA16 Standard federal match rate". The estimated costs of new recommendations to increase or decrease funding are presented at the new federal match rates. The staff presentations for Behavioral Health and the Office of Community Living follow a similar format. Because of the difference in presentation, comparing the dollars requested by the Department in R11/BA16 to the dollars recommended by the JBC staff would be comparing apples and oranges.

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

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

In addition to showing the change in the FMAP, the JBC staff has added a row in the summary tables to show the increase in Hospital Provider Fee and decrease in federal funds due to the step down in the federal match rate for the "Newly Eligible" pursuant to the ACA. The Department included this dollar impact in R1 Medical Services Premiums and R2 Behavioral Health. This is a relatively high profile change in financing for the expansion populations, and so the JBC staff decided to show it separately from forecast adjustments for enrollment and utilization trends.

Most health services provided by the Department qualify for the federal match rates described above while administrative costs are typically reimbursed with a 50 percent federal match. However, there are a myriad of special match rates for certain populations, services, and administrative expenses. The table below summarizes special match rates currently applicable in Colorado. There are other enhanced match rates that Colorado could qualify for in the future if certain program changes are implemented, such as home health services for people with chronic disabilities for the first 8 quarters the benefit is in place. Some of the special match rates for certain populations and services are indexed to the standard Medicaid FMAP, and so the dollar effect of those changes is included by the JBC staff in "R11/BA16 Standard federal match rate". The administrative match rates are not changing in FY 2016-17.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Special Match Rates	
Activity/Population	Rate
Breast and Cervical Cancer Treatment	CHP+ rate -23 percentage points
Medicaid services to children and pregnant adults formerly on CHP+ (SB 11-008 Children 107% - 147% FPL and SB 11-250 Pregnant Adults to 142% FPL)	CHP+ rate
Clinical Preventive Services for Adults	FMAP + 1%
Family Planning Services	90%
Money Follows the Person Rebalancing Demonstration	FMAP + 25% in rebalancing fund
Services provided through Indian Health Service and Tribal Facilities	100%
Administrative Match Rates	
Adoption and use of electronic health record (EHR) technology	100%
Immigration status verification	100%
Citizenship verification	90%
Medicaid health information technology planning	90%
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%

➔ BA10 Medicaid-Medicare grant true up

Request: The Department requests adjustments to several line items to continue and annualize the supplemental *S10 Medicaid-Medicare grant true up*, which modified appropriations for a demonstration grant. The demonstration grant is to coordinate care for people eligible for both Medicaid and Medicare. The modifications are to match an increase in the federal grant, changes to the implementation timeline, and changes to the allocation of expenditures by line item. The supplemental also added a footnote for line items with an "(M)" headnote identifying that the demonstration grant funds are not part of the money used to calculate compliance with the "(M)" headnote and the Department requests continuation of this footnote.

Recommendation: Staff recommends the requested adjustments and exemption from the "(M)" headnote to reflect the new information about the timing and scope of the demonstration project.

Calculations: The table below summarizes the changes to FY 2015-16 approved by the JBC in *S10 Medicaid-Medicare grant true up*, the changes to FY 2016-17 requested in *BA 10 Medicaid-Medicare grant true up* and the net change from FY 2015-16 to FY 2016-17 required to implement the request.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

BA10 Medicaid-Medicare Grant True Up			
	FY 15-16	FY 16-17	Net
	S10	BA10	Change
Personal Services	<u>\$307,446</u>	<u>\$287,904</u>	<u>(\$19,542)</u>
General Fund	(39,060)	(42,080)	(3,020)
Federal Funds	346,506	329,984	(16,522)
Operating Expenses	<u>\$500</u>	<u>\$4,618</u>	<u>\$4,118</u>
General Fund	(5,163)	(5,512)	(349)
Federal Funds	5,663	10,130	4,467
General Professional Services	<u>(\$146,800)</u>	<u>(\$121,800)</u>	<u>\$25,000</u>
General Fund	(51,925)	(60,900)	(8,975)
Federal Funds	(94,875)	(60,900)	33,975
MMIS Maintenance and Projects	<u>\$400,000</u>	<u>\$207,500</u>	<u>(\$192,500)</u>
General Fund	0	0	0
Federal Funds	400,000	207,500	(192,500)
Customer Outreach	<u>(\$363,268)</u>	<u>(\$130,679)</u>	<u>\$232,589</u>
General Fund	(142,655)	(124,467)	18,188
Federal Funds	(220,613)	(6,212)	214,401
Utilization and Quality Review	<u>\$102,425</u>	<u>\$5,879</u>	<u>(\$96,546)</u>
General Fund	(37,500)	(50,000)	(12,500)
Federal Funds	139,925	55,879	(84,046)
Medical Services Premiums	<u>\$6,074,000</u>	<u>\$0</u>	<u>(\$6,074,000)</u>
General Fund	0	0	0
Federal Funds	6,074,000	0	(6,074,000)
TOTAL	<u>\$6,374,303</u>	<u>\$253,422</u>	<u>(\$6,120,881)</u>
General Fund	(276,303)	(282,959)	(6,656)
Federal Funds	6,650,606	536,381	(6,114,225)

➔ BA11 Technical adjustments

Request: In *BA11 Technical adjustments* the Department requests continuing and annualizing the supplemental *S11 Technical adjustments*, which made several corrections to the FY 2015-16 appropriation.

Recommendation: Staff recommends approval of the components of *BA11 Technical adjustments* that were approved by the JBC as part of *S11 Technical adjustments*. The net effect of BA11 is shown in the department and division summary tables as \$0. Most of the changes requested in BA11 are already in the base from the supplemental, and so no further change is required. Some of the changes in BA11 were related to county administration and those pieces are discussed with *R7 County administration* in the Executive Director's Office. The remaining piece of BA11 that is not already in the base or related to county administration is a net \$0 transfer of \$1,688,243, including \$658,013 General Fund, from the General Professional Services line item to the Payments to OIT line item to better reflect who is responsible for the Department's customer service technology.

➔ NP Cervical cancer eligibility

Request: This request is for the Department of Health Care Policy and Financing's costs associated with a request submitted by the Department of Public Health and Environment, titled *R4 Cervical cancer eligibility expansion*. The proposal from the Department of Public Health and Environment would expand the age of women eligible for cervical cancer screenings through the Breast and Cervical Cancer Program from the current 40 to 64 years old to 21 to 64 years old. With the increase in screening a projected 54 more women are expected to be found eligible for Medicaid services and in need of treatment, and so there are increased costs in the Department of Health Care Policy and Financing. Some of the costs are for modifications to the Colorado Benefits Management System to increase the age range of people eligible for the benefit and some of the costs are for services.

Recommendation: Staff recommends approval of the request based on the JBC's action during figure setting for the Department of Public Health and Environment. For more information on this request, see the Department of Public Health and Environment figure setting dated February 23, 2016. The table below summarizes the recommendation by line item. The source of cash funds is the Breast and Cervical Cancer Prevention and Treatment Fund that receives money from specialty license plates and a small amount of money from interest accrued by the Tobacco Litigation Settlement Trust Fund.

NP Cervical cancer eligibility		
	FY 16-17	FY 17-18
Colorado Benefits Management System	<u>\$38,771</u>	<u>\$0</u>
Breast & Cervical Cancer Prev./Treat. Fund	19,386	0
Federal Funds	19,385	0
Medical Services Premiums	<u>\$236,245</u>	<u>\$236,245</u>
Breast & Cervical Cancer Prev./Treat. Fund	82,001	82,284
Federal Funds	154,244	153,961
Behavioral Health Capitation Payments	<u>\$16,512</u>	<u>\$16,512</u>
Breast & Cervical Cancer Prev./Treat. Fund	5,732	5,751
Federal Funds	10,780	10,761
TOTAL	<u>\$291,528</u>	<u>\$252,757</u>
Breast & Cervical Cancer Prev./Treat. Fund	107,119	88,035
Federal Funds	184,409	164,722
<i>Medicaid Enrollment</i>	<i>54</i>	<i>54</i>

➔ NP CO Benefits Management System

Request: The Departments of Health Care Policy and Financing and Human Services, along with the Governor's Office of Information Technology, request an increase of \$23,074,827 total funds, including \$15,348,082 General Fund, spread across the departments for FY 2016-17 and future fiscal years for the projected costs associated with ongoing system operations and maintenance for the Colorado Benefits Management System (CBMS). Additionally, the agencies

seek roll-forward authority for the moneys requested, as well as the ability to transfer up to five percent of the moneys between agencies.

Recommendation: The staff recommendation for this item is covered in the figure setting for the Governor's Office of Information Technology, dated 3/10/16. At the time this document was prepared the JBC action was pending, so the department and division summary tables reflect the Governor's request as a placeholder.

➔ Annualize HB 15-1186 Children with autism / Behavioral therapy benefit

Request: The Department requests an annualization of H.B. 15-1186, sponsored by the JBC, which sought to expand the eligibility and benefits under the Children with Autism waiver. However, what the Department is really requesting is more accurately described as funding for a federally-mandated behavioral therapy benefit, which is how the JBC staff would label this policy change for the Long Bill Narrative, if the JBC approves funding.

To comply with H.B. 15-1186 the Department submitted a request to the federal Centers for Medicare and Medicaid Services (CMS) to expand the Children with Autism waiver, but CMS denied the expansion. Instead, CMS indicated that most of the services provided through the proposed expansion of the Children with Autism waiver should be covered under the federally mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Thus, CMS required the Department to provide the services, but in a different format than originally anticipated in the bill.

The new benefit that must be made available through EPSDT is behavioral therapy. The Department is not yet sure how the costs of providing behavioral therapy through EPSDT may differ from the original plan to expand the Children with Autism waiver, so the Department requested funding for the behavioral therapy benefit based on the assumptions in the original bill.

On February 16, 2016, the Department submitted an updated forecast for Medical Services Premiums that adjusted the expected expenditures for the new behavioral therapy benefit through EPSDT. This updated forecast is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. In the February 2016 forecast the Department assumed no expenditures for behavioral therapy through EPSDT in FY 2015-16, due to the time required to define the new behavioral therapy benefit and recruit providers. For FY 2016-17 the February 2016 forecast assumed approximately the same total expenditures for behavioral therapy through EPSDT that the fiscal note for H.B. 15-1186 projected would have been spent on the Children with Autism waiver expansion², but with changes in financing. In the fiscal note for H.B. 15-1186 it was assumed that \$508,566 of the state share of costs for FY 2016-17 for the Children with Autism waiver expansion would come from the Colorado Autism Treatment Fund, but the February 2016 forecast assumed that all the state share for the behavioral therapy benefit would come from the General Fund. The Colorado

² The actual total included in the February forecast for behavioral therapy is \$446,566 less than assumed in the fiscal note for H.B. 15-1186, but this is due to a technical error rather than an intentional decision to reduce the projected expenditures.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Autism Treatment Fund receives an annual distribution of \$1,000,000 from the Tobacco Master Settlement and the statutory uses of the fund are restricted to paying for the Children with Autism waiver. In addition, the Department updated assumptions about the federal match rate based on the new FMAP. The table below compares the assumptions in the February 2016 forecast for the behavioral therapy benefit with the fiscal note for H.B. 15-1186.

	Behavioral Therapy Benefit					
	HB 15-1186 Fiscal Note		February 2016 Forecast		Difference	
	FY 15-16	FY 16-17	FY 15-16	FY 16-17	FY 15-16	FY 16-17
Enrollment/waitlist management	53,736	0	53,736	0	0	0
Waiver effectiveness study	<u>62,000</u>	<u>62,000</u>	<u>62,000</u>	<u>62,000</u>	<u>0</u>	<u>0</u>
Executive Director's Office	\$115,736	\$62,000	\$115,736	\$62,000	\$0	\$0
<i>General Fund</i>	57,868	31,000	57,868	31,000	0	0
<i>Federal Funds</i>	57,868	31,000	57,868	31,000	0	0
Case management and utilization review	548,634	941,035	0	0	(548,634)	(941,035)
Waiver services	8,836,477	15,240,715	0	0	(8,836,477)	(15,240,715)
State plan services	<u>820,049</u>	<u>2,052,892</u>	<u>0</u>	<u>18,534,147</u>	<u>(820,049)</u>	<u>16,481,255</u>
Medical Services Premiums	\$10,205,160	\$18,234,642	\$0	\$18,534,147	(\$10,205,160)	\$299,505
<i>General Fund</i>	164,846	8,434,089	0	9,230,006	(164,846)	795,917
<i>CF - Autism Treatment Fund</i>	4,840,203	508,566	0	0	(4,840,203)	(508,566)
<i>Federal Funds</i>	5,200,111	9,291,987	0	9,304,141	(5,200,111)	12,154
Behavioral Health	\$295,672	\$746,071	\$0	\$0	(\$295,672)	(\$746,071)
<i>General Fund</i>	144,850	365,500	0	0	(144,850)	(365,500)
<i>Federal Funds</i>	150,822	380,571	0	0	(150,822)	(380,571)
Total	\$10,616,568	\$19,042,713	\$115,736	\$18,596,147	(\$10,500,832)	(\$446,566)
<i>General Fund</i>	367,564	8,830,589	57,868	9,261,006	(309,696)	430,417
<i>CF - Autism Treatment Fund</i>	4,840,203	508,566	0	0	(4,840,203)	(508,566)
<i>Federal Funds</i>	5,408,801	9,703,558	57,868	9,335,141	(5,350,933)	(368,417)

There are several factors contributing to the uncertainty about expenditures in FY 2016-17. The expansion of the Children with Autism waiver included age limits, caps on expenditures, and constraints on the duration of services that do not apply to the behavioral therapy benefit. The Department has established prior authorization review (PAR) criteria for the behavioral therapy benefit to ensure that it is medically necessary for clients, but CMS has raised concerns about some of the PAR criteria, and so the PAR criteria may need to be revised. Examples of the current PAR criteria include: the safety of the client or others must be at risk; other therapies, such as occupational therapy or speech therapy, must have been tried and not effective; the client must have exhibited persistent and pronounced social communication and social interactive deficits for 3 months; and measurable functional improvement must be expected and progress cannot have plateaued in the previous six months. The Department assumes that there is pent up demand for the behavioral therapy benefit, but providers must be recruited and enrolled, and so the speed of the ramp up in expenditures is unknown. The Department assumes that the majority of users of the behavioral therapy benefit will be children with autism, but the behavioral therapy benefit will be available for any condition for which the services are recognized (i.e. evidence-based or evidence-informed) as therapeutically appropriate. With all these variables in play, the

Department decided to use the fiscal note for H.B. 15-1186 as a placeholder for what the new benefit will cost and revisit the issue in next November's forecast.

In addition to the cost for the new behavioral therapy benefit, the Department expects expenditures for the Children with Autism waiver, as it existed prior to the proposed expansion in H.B. 15-1186, to continue in FY 2016-17. In the February 2016 forecast the Department estimated expenditures of \$668,920, with the state share of \$333,122 from the Colorado Autism Treatment Fund, for the continuation of the Children with Autism waiver. The Department indicates that it is exploring whether the current Children with Autism waiver should be modified or phased out based on the availability of behavioral therapy services through EPSDT. The current federal authority for the waiver expires 12/31/18.

Recommendation: Staff recommends funding for the behavioral therapy benefit based on the February 2016 forecast. The behavioral therapy benefit is being mandated by CMS.

In addition, the JBC staff recommends a statutory change to make a one-time transfer of the balance in the Colorado Autism Treatment Fund to the General Fund at the beginning of FY 2016-17 (approximately \$5.1 million), and eliminate future transfers to the Colorado Autism Treatment Fund from the Tobacco Litigation Settlement Cash Fund beginning in FY 2016-17. This would require backfilling appropriations from the Colorado Autism Treatment Fund with General Fund, which would cost approximately \$389,131, based on the JBC staff recommendations. The staff recommendation would simplify financing for Medicaid and free up money in both the General Fund and Tobacco Litigation Settlement Cash Fund.

An alternative approach to spend down the fund balance that has accumulated in the Colorado Autism Treatment Fund would be to expand the allowable uses of the fund to include financing the behavioral therapy benefit. However, the historic \$1,000,000 annual transfer from the Tobacco Litigation Settlement Cash Fund is not nearly enough to cover the projected costs of the behavioral therapy benefit on an ongoing basis. Also, CMS has directed that the behavioral therapy benefit is a federally-mandated core service of Medicaid, and therefore the JBC staff believes it is most appropriately financed with the General Fund.

Finally, the JBC staff recommends adding the following footnote to the General Professional Services line item:

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

When CMS denied the expansion of the Children with Autism waiver the scope of the evaluation required by Section 25.5-6-806 (c) (I), C.R.S., changed dramatically. The JBC staff recommendation is to ask the Department to use the funding to also evaluate the behavioral

therapy benefit. An alternative approach would be to make a statutory change to eliminate the evaluation and save \$31,000 General Fund.

➔ Indirect Cost Adjustment

Request: The Department requests a net increase in the indirect cost assessment of \$59,489. This increases the reappropriated funds available to offset the need for General Fund in the Personal Services line item by a like amount.

Recommendation: Staff recommends the requested indirect cost adjustment based on changes in the statewide indirect cost plan.

(1) Executive Director's Office

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

Executive Director's Office						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	\$266,518,407	\$60,696,819	\$29,669,200	\$3,618,827	\$172,533,561	383.2
Other legislation	792,861	390,132	0	0	402,729	4.8
HB 16-1240 (Supplemental)	<u>10,496,328</u>	<u>407,742</u>	<u>1,674,300</u>	<u>50,063</u>	<u>8,364,223</u>	<u>0.0</u>
TOTAL	\$277,807,596	\$61,494,693	\$31,343,500	\$3,668,890	\$181,300,513	388.0
FY 2016-17 Recommended Appropriation						
FY 2015-16 Appropriation	\$277,807,596	\$61,494,693	\$31,343,500	\$3,668,890	\$181,300,513	388.0
R7 County administration funding	0	0	0	0	0	0.0
R11/BA16 Standard federal match	0	0	0	17,759	(17,759)	0.0
BA6 Fed reg for assuring access	460,913	230,457	0	0	230,456	3.0
BA7 Fed reg for managed care	665,066	332,533	0	0	332,533	4.0
BA8 HCBS settings final rule	1,166,571	583,286	0	0	583,285	0.9
BA9 Provider enrollment fee	(1,061,183)	0	(1,061,183)	0	0	0.0
BA10 Medicaid-Medicare grant true up	(46,881)	(6,656)	0	0	(40,225)	0.0
BA11 Technical adjustments	0	0	0	0	0	0.0
BA12 External quality review federal match	0	0	0	0	0	0.0
NP Cervical cancer eligibility	38,771	0	19,386	0	19,385	0.0
NP CO Benefits Management System	12,857,067	4,152,953	1,804,179	0	6,899,935	0.0
Annualize HB 15-1186 children with autism	(53,736)	(26,868)	0	0	(26,868)	0.0
Annualize prior year budget decisions	(16,423,507)	(1,998,727)	(207,752)	0	(14,217,028)	3.0
Indirect cost adjustment	59,489	(59,489)	46,187	60,710	12,081	0.0
Transfers to other departments	14,045	1,701	0	10,644	1,700	0.0
Centrally appropriated line items	<u>(785,286)</u>	<u>(484,606)</u>	<u>71,154</u>	<u>31,921</u>	<u>(403,755)</u>	<u>0.0</u>
TOTAL	\$274,698,925	\$64,219,277	\$32,015,471	\$3,789,924	\$174,674,253	398.9

Executive Director's Office						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Increase/(Decrease)	(\$3,108,671)	\$2,724,584	\$671,971	\$121,034	(\$6,626,260)	10.9
Percentage Change	(1.1%)	4.4%	2.1%	3.3%	(3.7%)	2.8%
FY 2016-17 Executive Request:	\$272,211,393	\$63,476,458	\$31,499,165	\$3,738,386	\$173,497,384	398.9
Request Above/(Below) Recommendation	(\$2,487,532)	(\$742,819)	(\$516,306)	(\$51,538)	(\$1,176,869)	0.0

DECISION ITEMS - EXECUTIVE DIRECTOR'S OFFICE

➔ BA6 Fed reg for assuring access

Request: The Department requests \$505,986 total funds, including \$252,994 General Fund, for 3.0 FTE and contract actuarial services to implement a new federal rule regarding assuring access to providers for Medicaid clients. The new rule requires the Department to assess Medicaid client access to care and the relationship between provider rates and access to care. The Department is concerned that failure to comply with the new federal rule could affect the Department's ability to implement proposed provider rate reductions in FY 2016-17.

The JBC first considered this request during supplementals as part *S6 Fed reg for assuring access*. The JBC staff recommended approval of the supplemental, but the JBC denied the request. The Governor's office submitted a comeback, but the JBC continued to deny the request. There have been no changes in the circumstances that precipitated the request, but the Department did submit some new information in response to questions from JBC members.

Recommendation: The JBC staff continues to recommend approval of the request, with modifications to account for a later hire date and to comply with the JBC's common policies on new FTE. The main JBC staff concern is that failing to fund the request could make it difficult for the Department to do a thorough analysis of access to care to satisfy the requirements of the new federal regulation, and that might increase the likelihood that the federal Centers for Medicare and Medicaid Services (CMS) would deny a rate reduction. In that scenario, failing to fund the request would be penny wise and pound foolish. However, there are no guarantees that funding the request will lead to CMS approval of a rate reduction or that failure to fund the request will lead to CMS denial of a rate reduction.

If the JBC is able to maintain the common policy decision for no across-the-board decrease in community provider rates, then that would alleviate some of the JBC staff concern. Under the new federal regulation the Department would have to submit an analysis of access to care with every rate reduction, and monitor access for three years after the implementation of a rate reduction. If the JBC adopted the one percent across-the-board decrease proposed by the Governor in *R12 Provider rates* (see the Medical Services Premiums division), then the Department would be doing this for every discretionary rate beginning immediately. If the JBC does not implement an across-the-board decrease, then the Department will have more time to

come into compliance with the new federal regulation and there is more opportunity for the rate review process started by S.B. 15-228 to inform compliance with the new federal regulation.

However, even without an across-the-board rate reduction, compliance with the new federal rule will require additional work by the Department. There are two other proposed rate reductions in the Governor's request that would require, if implemented, an analysis of access to care and three years of monitoring under the new federal regulation. These include the end of the primary care rate bump and the proposed legislation to limit the Hospital Provider Fee. With the end of the primary care rate bump the Department has already procured and received a relatively in-depth third party analysis, but there is no similar baseline analysis completed on how limiting the Hospital Provider Fee would affect access. There are also requirements of the new federal rule that differ from the work the Department was funded to complete in S.B. 15-228 (see the analysis section below) that would still lead the JBC staff to recommend the request.

Analysis: The bullets below highlight key differences between the new federal rule and the requirements of S.B. 15-228 that were identified by the Department as driving the need for the new resources. For S.B. 15-228 the Department received \$539,823, including \$269,912 General Fund, for 4.0 FTE and contract actuarial services.

- Regional analysis of access – The new federal rule requires states to describe the characteristics of Medicaid clients by geographic area, assess local access needs, and track changes in Medicaid client utilization by region over time. It also requires procedures for collecting regional provider and beneficiary feedback. Pursuant to S.B. 15-228 the Department's rate review is required to include analysis of access, service, quality, and utilization, as well as collect public input, but the bill does not require regional analysis and regional feedback.
- Three-year review cycle – The new federal rule requires analysis of provider rates at least once every three years for primary care services, physical specialist services, behavioral health services, pre- and post-natal obstetric services, and home health services. In S.B. 15-228 the Department was required to review rates on a 5-year cycle. Also, S.B. 15-228 allowed the Department to propose exemptions from review for rates that are adjusted on a periodic basis as a result of state or federal laws or regulations, but the new federal rule does not include similar exemptions. Some examples of rates that will need to be reviewed under the federal rule that were exempted under S.B. 15-228 include rates for behavioral health services, Federally Qualified Health Centers, and pre-and post-natal care at hospitals.
- Services receiving access complaints – The new federal rule requires separate analysis of services with a high volume of complaints. This is not a requirement of S.B. 15-228. It is not clear how many rates might require this special review, but the Department will need to demonstrate that it has a process for tracking access complaints across all communication mediums and evaluating the merits of complaints to determine what requires additional review.
- Assessment of access to care with State Plan Amendment – Pursuant to the new federal rule, for any rate reduction or restructure that requires a State Plan Amendment, the Department must submit an assessment of how access to care would be affected, collect feedback from stakeholders, and submit analysis of the feedback. The Department must also monitor the

effect on access for three years after the rate reduction or restructure is implemented. The Governor's request for FY 2016-17 included several rate reductions that the Department anticipates would be subject to the requirement, including the 1.0 percent across-the-board community provider rate reduction, the end of the primary care rate bump, and restricting hospital provider fee revenue. If the General Assembly approves these rate reductions, it will require the Department to do rate reviews before they are scheduled to occur pursuant to S.B. 15-228, and require three years of monitoring above and beyond the requirements of S.B. 15-228.

- Remediation of rate deficiencies – If any of the procedures described above identify issues with access to care, the Department must submit a plan within 90 days with specific steps and timelines to remediate the deficiencies. There is no remediation requirement in S.B. 15-228.

The JBC could sponsor legislation to better align the requirements of S.B. 15-228 with the new federal regulation to reduce costs, but this would mean that several rates that are currently part of the S.B. 15-228 five-year review process would not get a periodic review, because they are not part of the three-year review cycle required under the federal regulation. Some examples of these rates include emergency and non-emergency transportation, anesthesia, dialysis, home- and community-based waiver services, and private duty nursing. The federal regulation would only require a review of these rates if the state tries to implement a decrease. For the excluded rates there would be no data collected in advance to inform a legislative decision about whether a rate change, up or down, is appropriate. Therefore, the JBC staff is not recommending a change to the S.B. 15-228 requirements.

The Department estimates it needs \$253,750 for roughly 1,250 hours of actuarial services to assist with comparing Colorado Medicaid rates to available benchmarks. This is based on the Department's experience responding to Legislative Request for Information #1 that asked for a comparison of Colorado Medicaid rates to Medicare or usual and customary rates. The Department anticipates the data will need to be updated and regionalized to satisfy the new federal rule for the rates the Governor proposes reducing in FY 2016-17, and then periodically recalculated for each rate as it comes up for review in the three-year cycle.

In addition, the Department requests 3.0 FTE as follows:

- 1.0 FTE access data analyst to develop and implement a methodology for using data to monitor access to care by geographic region and predict the effects of rate changes on access.
- 1.0 FTE rate benchmarking analyst to obtain, compile, and validate data to be used by the actuary, to oversee and interpret the benchmarking work of the actuary, and make cost estimates based on the analysis. This position would also be heavily involved in the access monitoring plan.
- 1.0 FTE client access specialist to develop new procedures for soliciting, tracking and trending feedback on client access from all sources. This position would also be involved in access monitoring and any remediation plans.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

JBC Questions: During the discussion of the supplemental request, the JBC raised several questions related to who has responsibility for setting provider rates. The Department raised these questions with CMS and paraphrased the response they received. According to the Department, CMS views rate setting as a shared responsibility between states and the federal government. States have the same responsibilities to set rates as before the new regulation and CMS must still ensure that the rates set by states comply with the requirement in Section 1902 (a) (30) (A) of the Social Security Act (42 USC 1396a), "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." Prior to the federal regulation state practices varied significantly and CMS collected very little in the way of data to evaluate provider rates. The new regulation is intended to ensure that states and CMS have procedures and data to ensure compliance with this provision of federal law.

The Department also consulted with the Attorney General, per the request of some JBC members, and received guidance that CMS acted within its authority in issuing the new federal regulation.

The Department also put together some illustrations and a table to highlight where S.B. 15-228 and the new federal regulation differ and overlap and to show how different rates are reviewed and set. See Appendix A at the end of this document for the Department's responses to the JBC's questions.

Calculations: In the supplemental the Department proposed that the new staff start June 1, but since the JBC rejected the supplemental the JBC staff assumes the new staff would not start until July 1 and has adjusted the recommended appropriation accordingly. The later start date means that there would be 11 months of salary costs in FY 2016-17 as a result of the pay date shift, rather than the requested 12 months. Also, one-time start-up operating costs would occur in FY 2016-17 instead of the requested FY 2015-16. Based on the JBC's common policies regarding new FTE, the JBC staff is not recommending funding in the first year for centrally appropriated items for Health, Life, and Dental, Short-term Disability, Amortization Equalization Disbursement, or Supplemental Amortization Equalization Disbursement. The table below summarizes the staff calculation of the costs and the recommendation by line item.

BA6 Fed Reg for Assuring Access					
	Units	Rate	FY 2016-17		
			Amount	FTE	
<u>Personal Services</u>					
Access Data Analyst - Statistical Analyst III	11 months	\$5,372	\$59,092	1.0	
Rate Benchmarking Analyst - Rate/Financial Analyst III	11 months	\$5,215	\$57,365	1.0	
Client Access Specialist - General Professional IV	11 months	\$4,907	<u>\$53,977</u>	<u>1.0</u>	
Subtotal			\$170,434	3.0	
PERA		10.15%	\$17,299		
Medicare		1.45%	<u>\$2,471</u>	-	
Personal Services			\$190,204	3.0	
<u>Operating</u>					

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BA6 Fed Reg for Assuring Access			FY 2016-17	
	Units	Rate	Amount	FTE
Ongoing				
Regular FTE Operating Expenses	3	\$500	\$1,500	
Telephone Expenses	3	\$450	\$1,350	
One-time start-up costs				
PC, One-Time	3	\$1,230	\$3,690	
Office Furniture, One-Time	3	\$3,473	<u>\$10,419</u>	
Operating Expenses			\$16,959	
<u>General Professional Services</u>				
Actuarial Analysis	1,250 hours	\$203	\$253,750	
TOTAL			<u>\$460,913</u>	3.0
General Fund			\$230,457	
Federal Funds			\$230,456	
Not recommended, per JBC common policy:				
Health, Life, Dental			\$23,781	
Short-term disability			\$353	
Amortization Equalization Disbursement (AED)			\$8,924	
Supplemental AED			\$8,832	

➔ R7 County administration funding

Request: Most of the changes originally requested in R7 were already voted on in the supplemental as part of *S11 Technical adjustments* and the only remaining piece that the JBC has not yet considered is moving the Centralized Eligibility Vendor Contract Project line item from the Information Technology Contracts and Projects subdivision to the Eligibility Determinations and Client Services subdivision and taking \$79,968 from the line item and giving it to the Medical Assistance Sites line item for costs related to implementing the Random Moment Sampling process required to claim federal matching funds.

The Department's original request included:

- An increase in federal funds to increase reimbursements for county eligibility determination services, based on a higher-than-anticipated portion of county activities qualifying for an enhanced federal match rate for populations newly eligible for Medicaid;
- Removing the "(M)" headnote on the County Administration line item to allow increased funding if additional federal funds are available, which was rejected by the JBC in the supplemental; and
- Moving money between line items to reflect changes in the contract with the centralized eligibility vendor and the duties performed by this provider versus the duties performed by counties and medical assistance sites.

The Department also indicates that it plans to use some of the increase in federal funding for county administration for the county incentive and grant program to allow payments for activities other than eligibility determinations that may help improve health outcomes. Examples of the non-eligibility determination activities cited by the Department that would be encouraged

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through grant funding include: using shared Customer Relationship Management and Interactive Voice Response systems so counties use the same knowledge library; increasing training on programs and new policies; connecting clients with the Regional Care Collaborative Organizations and Behavioral Health Organizations; implementing the Colorado Opportunity Project; and collaborating with the No Wrong Door Long Term Support Services redesign project.

Recommendation: Staff recommends approval of the remaining portion of the request that hasn't been acted on by the JBC and annualization of the JBC's supplemental decisions regarding county administration. Moving the Centralized Eligibility Vendor Contract Project line item and separating some of the money out for the Medical Assistance Sites will better reflect the responsibilities of the contract vendors.

R7 County Administration				
	TOTAL	CF - HPF	CF - CHP+	FF
<u>Portions of R7 that are in the base because they were approved as part of the S11</u>				
Transfer from Centralized Eligibility Vendor to counties	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Centralized Eligibility Vendor Contract Project	(4,000,000)	(1,360,000)	0	(2,640,000)
Hospital Provider Fee County Administration	4,000,000	1,360,000	0	2,640,000
Fund source correction				
Centralized Eligibility Vendor Contract Project	\$0	\$991,235	(\$991,235)	\$0
County Administration federal funding	<u>\$7,105,769</u>	<u>\$0</u>	<u>\$0</u>	<u>\$7,105,769</u>
County Administration	6,461,585	0	0	6,461,585
Hospital Provider Fee County Administration	644,184	0	0	644,184
County Administration remove "(M)" headnote	Not Approved			
County Administration add "(I)" headnote	Approved			
Subtotal - Approved Changes in Base	\$7,105,769	\$991,235	(\$991,235)	\$7,105,769
<u>Remaining changes requested in R7 that have not yet been approved</u>				
Relocate Centralized Eligibility Vendor line item	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Information Technology subdivision	(5,133,612)	(1,785,326)	0	(3,348,286)
Eligibility Determination subdivision	5,133,612	1,785,326	0	3,348,286
Medical Assistance Sites for Random Moment Sampling	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Centralized Eligibility Vendor Contract Project	(79,968)	(39,984)	0	(39,984)
Medical Assistance Sites	79,968	39,984	0	39,984
Subtotal - Remaining Changes Not Yet Approved	\$0	\$0	\$0	\$0

➔ BA7 Fed reg for managed care

Request: The Department requests \$722,809 total funds, including \$361,405 General Fund, for 4.0 new FTE and to expand the scope of actuarial and quality review contracts to implement a proposed new federal rule by the Centers for Medicare and Medicaid Services (CMS) regarding

managed care and program quality. The Department indicates that the scope of changes in the proposed rule is unusually large and would require significant new resources to implement.

The JBC first considered this request during supplementals as part *S7 Fed reg for managed care*. The JBC staff did not recommended approval of the supplemental, and the JBC denied the request. The Governor's office did not submit a comeback. However, since the JBC considered the supplemental there is new information that has changed the staff recommendation.

Recommendation: The JBC staff recommends approval of the request, with modifications to account for a later hire date and to comply with the JBC's common policies on new FTE. When the JBC staff recommended against the supplemental request this was a proposed rule and the JBC staff was concerned that based on the scope of the changes, the number of stakeholder comments, and the pattern of CMS with previous proposed rules, it might take years for CMS to finalize rule, and that the final rule could potentially differ significantly from the proposed rule. Since the supplemental request, the Department reports that CMS has sent a version of the rule to the Office of Management and Budget (OMB) for a review that can take up to 90 days before the rule is finalized. The fact that a version of the rule was sent to OMB for finalization suggests that the rule will be finalized much more quickly than the JBC staff originally anticipated.

It is still unknown if the rule sent to OMB matches the proposed rule that was issued June 1, 2015, or if OMB is likely to make changes to the rule. So, the exact requirements for Colorado to comply with the new federal rule are unknown. However, given the relatively short turn around between the publication of the proposed rule and the submission of a rule to OMB for finalization, it seems reasonable to assume that the final rule will resemble the proposed rule. Waiting until the final rule is published to take action might put the Department in the position of needing to request an emergency interim supplemental. Also, due to the lead time required to hire and train new staff it would leave the Department temporarily short-staffed.

Another factor in the staff recommendation is that some aspects of the proposed rule appear to align with and extend program improvement initiatives the General Assembly has instructed the Department to pursue in recent years. For example, one of the provisions of the new federal regulation is that states must have plans for continuous quality improvement. This aligns with the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act, but according to the Department the federal regulation requires a greater level of detail and tracking, and the potential consequence of failure to comply is a loss of federal matching funds. Other provisions of the new federal regulation are aimed at combatting fraud and abuse, such as requiring standard medical loss ratios (MLRs) that establish minimum percentages of payments that must be used for services versus administration and overhead, or requiring detailed and timely encounter data so that the state knows what services are provided for the bundled payments made to managed care organizations. The General Assembly has adopted bills and budget actions to combat Medicaid fraud and abuse in recent years. Detailed encounter data is also a prerequisite for designing and implementing many of the payment reforms the state has encouraged the Department to pursue to reimburse providers based on quality and health outcomes rather than the quantity of services. Ultimately, the Department has no choice but to comply with the federal regulation, but through compliance the Department will gather data and

take actions that will help further state policy goals regarding performance, reducing fraud and abuse, and reforming payments to reward outcomes.

Analysis: The proposed rule is wide ranging, but mostly concerned with managed care and overall Medicaid program quality. Managed care payments offer flexibility for providers to change their practices and procedures to improve health outcomes and efficiency in ways that might be discouraged by a rigid fee-for-service system that pays for volume in certain procedures rather than health outcomes. Also, managed care may encourage the development of medical homes, more proactive outreach and engagement with clients, and greater utilization of preventive care. However, to enter a risk-based managed care agreement the state must pay a premium to providers to transfer risk that the state is arguably big enough to absorb on its own. In fact, in many cases the state is transferring risk to a provider that has a smaller risk pool than the state. Some managed care programs have been accused of rationing care to the detriment of beneficiaries. Also, traditionally the state has received less data about how managed care payments are used, making it harder to identify trends for forecasting, developing payment reforms, and spotting fraud and abuse. The new federal regulation includes provisions that appear designed to address the potential downsides of managed care arrangements.

Many states are much more heavily invested in managed care than Colorado, but Colorado's investment is not small. In FY 2014-15 the Department spent just under \$1 billion on full risk managed care contracts for behavioral health, Rocky Mountain Health Plan, Denver Health, and CHP+. In addition, the Department expects a large portion of the proposed new rule would apply to contracts through the Accountable Care Collaborative, which the Department is in the process of reprocurring. The tables below summarize the Department's managed care contracts.

FY 2014-15 Expenditure and Average Enrollment by Full-Risk Managed Care Plan		
Managed Care Plan	Expenditure	Average Enrollment
Medicaid		
<i>Behavioral Health Organizations</i>		
Access Behavioral Care Northeast	\$64,723,895	181,205
Access Behavioral Care Denver	\$89,357,350	140,902
Behavioral Healthcare Inc.	\$127,572,765	273,924
Colorado Health Partnerships	\$195,890,203	389,459
Foothills Behavioral Health Partners	\$92,609,291	139,497
Subtotal: Behavioral Health Organizations	\$570,153,504	1,124,987
<i>Physical Health Managed Care Plans</i>		
Rocky Mountain Health Plan (RMHP Prime)	\$130,526,394	20,921
Denver Health	\$162,333,678	66,453
Subtotal: Physical Health Managed Care Plans	\$292,860,072	87,374
CHP+		

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FY 2014-15 Expenditure and Average Enrollment by Full-Risk Managed Care Plan		
Managed Care Plan	Expenditure	Average Enrollment
Colorado Choice	\$2,717,662	1,913
Rocky Mountain Health Plans	\$14,860,469	32,168
Denver Health	\$7,491,492	1,376
Kaiser Permanente	\$13,571,652	4,192
Colorado Access	\$49,200,340	7,264
Colorado Access or State Managed Care Network (SMCN)	\$31,024,648	7,474
Subtotal: CHP+	\$118,866,263	54,387
Grand Total: Medicaid and CHP+¹	\$981,879,839	

¹ Total average enrollment is not presented as a client can be enrolled in both a behavioral health organization and a physical health managed care plan.

FY 2014-15 Expenditure and Average Enrollment for Accountable Care Collaborative		
Regional Care Collaborative Organization (RCCO)	Expenditure	Average Enrollment
RCCO 1 Rocky Mountain Health Plans	\$12,024,913	106,991
RCCO 2 Colorado Access	\$7,314,299	62,336
RCCO 3 Colorado Access	\$22,335,186	208,863
RCCO 4 Integrated Community Health Partners	\$11,015,496	93,205
RCCO 5 Colorado Access	\$6,573,645	59,306
RCCO 6 Colorado Community Health Alliance	\$11,046,237	104,278
RCCO 7 Community Care	\$13,918,841	123,682
Total: Accountable Care Collaborative	\$84,228,616	758,661

As examples of the changes in the proposed new rule, the Department identified the following:

- State Comprehensive Quality Strategy -- The proposed new rule would require a comprehensive quality strategy for all programs (not just managed care) that includes measurable goals and objectives for continuous quality improvement. The rule requires public input and tribal consultation on the quality strategy.
- Actuarially sound Capitation Rates for Medicaid Managed Care Programs -- The proposed new rule would require an actuarially sound rate for each rating cohort. Current rules allow the use of an actuarially sound rate range, rather than requiring certification of individual rates.
- Encounter Data and Health Information Systems -- The proposed new rule would require all encounter data submitted by managed care plans to be audited for accuracy, completeness,

and timeliness. All the Department's managed care contracts would need to be amended to add this requirement and to be monitored by the Department.

- Medical Loss Ratio -- The proposed new rule would establish a standard Medical Loss Ratio (MLR) for all managed care contracts. The MLR defines the allowable premium revenue to medical costs and the remainder that can be used for administration and profit. The Department would be involved in the calculation of the standard MLR and all of the Department's managed care contracts would need to be modified and monitored for compliance.

The Department indicates these are just examples of the scope of change and that there are many other proposed requirements around external quality review, technical reporting, performance assessments for primary care, periodic review of managed care plans using standards similar to accrediting organizations, improved client and provider materials, and program integrity.

To comply with the proposed new rule, the Department requests 4.0 FTE with estimated ongoing costs beginning in FY 2016-17 of \$321,309 total funds, including \$295,655 General Fund, as follows:

- 2.0 FTE program management specialists to work with CMS to understand the proposed new rule and develop guidelines for the Department's implementation. The positions would monitor implementation and ensure all contract requirements are met. The positions would also be responsible for provisions of the proposed new rule related to beneficiary protections, beneficiary support systems, and enrollment processes. Also, these positions would ensure encounter data and health information systems are in compliance.
- 1.0 quality and health improvement specialist to oversee the creation of the state comprehensive quality strategy and rating system, including the solicitation of public input, and ongoing implementation of the strategy and rating system, including annual publication of the results.
- 1.0 FTE program integrity analyst to implement provisions of the proposed new rule and related regulations to combat fraud, waste, and abuse in managed care programs.

In addition to the new FTE, the Department requests \$300,000 total funds, including \$150,000 General Fund, beginning in FY 2016-17 for the External Quality Review vendor to assist the Department with performance measures, developing the framework for ranking plans, collecting provider level data, and enhanced oversight of communications to clients. The requested funding is intended to allow the Department to validate six of the Department's 13 full risk managed care contracts per year and validate three performance improvement projects per entity. It is unknown how quickly and frequently the Department would need to perform these validations.

Finally, the Department anticipates it would need, beginning in FY 2016-17, \$101,500 total funds, including \$50,750 General Fund, for 500 hours additional actuarial services for more detailed rate certifications and the establishment of MLRs.

Calculations: In the supplemental the Department proposed that the new staff start June 1, but since the JBC rejected the supplemental the JBC staff assumes the new staff would not start until

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July 1 and has adjusted the recommended appropriation accordingly. The later start date means that there would be 11 months of salary costs in FY 2016-17 as a result of the pay date shift, rather than the requested 12 months. Also, one-time start-up operating costs would occur in FY 2016-17 instead of the requested FY 2015-16. Based on the JBC's common policies regarding new FTE, the JBC staff is not recommending funding in the first year for centrally appropriated items for Health, Life, and Dental, Short-term Disability, Amortization Equalization Disbursement, or Supplemental Amortization Equalization Disbursement. The table below summarizes the staff calculation of the costs and the recommendation by line item.

BA7 Fed Reg for Managed Care				FY 2016-17	
	Units	Rate	Amount	FTE	
<u>Personal Services</u>					
Program Management Specialist - General Professional IV	11 months	\$4,907	\$53,977	1.0	
Program Management Specialist - General Professional IV	11 months	\$4,907	\$53,977	1.0	
Quality and Health Improvement Specialist - GP IV	11 months	\$4,907	\$53,977	1.0	
Program Integrity Analyst - General Professional IV	11 months	\$4,907	<u>\$53,977</u>	<u>1.0</u>	
Subtotal			\$215,908	4.0	
PERA		10.15%	\$21,915		
Medicare		1.45%	<u>\$3,131</u>	-	
Personal Services			\$240,954	4.0	
<u>Operating</u>					
Ongoing					
Regular FTE Operating Expenses	4	\$500	\$2,000		
Telephone Expenses	4	\$450	\$1,800		
One-time start-up costs					
PC, One-Time	4	\$1,230	\$4,920		
Office Furniture, One-Time	4	\$3,473	<u>\$13,892</u>		
Operating Expenses			\$22,612		
<u>General Professional Services</u>					
Actuarial Analysis	500 hours	\$203	\$101,500		
<u>Utilization and Quality Review Contracts</u>					
Managed care plan validations per year	6	\$40,000	\$240,000		
Performance Improvement Projects per year	12	\$5,000	<u>\$60,000</u>		
Utilization and Quality Review Contracts			\$300,000		
TOTAL			<u>\$665,066</u>	4.0	
General Fund			\$332,533		
Federal Funds			\$332,533		
Not recommended, per JBC common policy:					
Health, Life, Dental			\$31,709		
Short-term disability			\$448		
Amortization Equalization Disbursement (AED)			\$11,306		
Supplemental AED			\$11,188		

➔ BA8 HCBS settings final rule

Request: The Department requests \$1,179,660, including \$589,832 General Fund, and 0.9 FTE for implementation of a federal rule regarding home and community based settings.

Recommendation: The staff recommendation for this request will be handled during figure setting for the Office of Community Living. The amounts in the department and division summary tables reflect the Department's request as a placeholder until the JBC makes a decision.

➔ BA9 Provider enrollment fee

Request: The Department requests cash funds spending authority to continue and annualize the supplemental *S9 Provider enrollment fee*, which proposed legislation to create a new cash fund for federally required provider enrollment fees. The revenue from the fees is used to offset administrative costs related to screening providers. The supplemental provided \$1,180,463 cash funds and the net change to the requested FY 2016-17 funding level in BA9 is a decrease of \$1,061,183 cash funds.

Recommendation: Staff recommends the requested decrease in cash funds spending authority based on the projected enrollment fees that will be collected, but the spending authority will be from the Department of Health Care Policy and Financing Cash Fund to be consistent with the JBC's action on the supplemental request. The Department expects revenue and expenditures from the provider enrollment fee will spike in FY 2015-16 when all providers are required to revalidate, but it will be minimal in subsequent years until 2021 when providers are again required to revalidate on the five-year cycle.

BA9 Provider Enrollment Fee			
	FY 15-16	FY 16-17	Net
	S9	BA9	Change
MMIS Maintenance and Projects			
Cash Funds	\$1,180,463	\$119,280	(\$1,061,183)

➔ BA12 External quality review federal match

Request: The Department requests adjustments to fund sources to continue and annualize the supplemental *S12 External quality review federal match*, which increased General Fund and decreased federal funds for the External Quality Review after the Department received notification from the federal Centers for Medicare and Medicaid Services (CMS) that certain activities of the vendor are eligible for a 50 percent federal match, rather than the 75 percent federal match rate originally assumed.

Recommendation: Staff recommends the requested continuation of the fund source adjustment that was approved during supplementals. Because the fund source adjustment is already in the base from the supplemental, no further change is needed and the adjustment that appears in the department and division summary tables for this request is \$0.

Analysis: The External Quality Review vendor evaluates quality, timeliness, and access for managed care contracts and prepaid inpatient health plans. Among the duties of the External

Quality Review vendor is analysis of the Accountable Care Collaborative (ACC), including Healthcare Effectiveness Data and Information Set compliance audits and reports, site reviews of Regional Care Collaborative Organizations (RCCOs), RCCO performance improvement projects, and Colorado Health Assessment and Planning System (CHAPS) surveys to evaluate members' experience of care. The federal CMS determined that the ACC does not fit the federal definition of a managed care organization or prepaid inpatient health plan, and so the evaluation activities are eligible for a 50 percent match instead of a 75 percent match. The evaluation activities External Quality Review vendor are essential to the function of the ACC, but are not required by the federal government.

LINE ITEM DETAIL – EXECUTIVE DIRECTOR'S OFFICE

(A) General Administration

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

Statutory Authority: Section 25.5-1-104 et. seq., C.R.S.

Line items set by JBC common policy

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

Request: The Department requests:

- Annualizations of prior year bills and budget actions
- Application of the OSPB common policies
- Benefits associated with the new FTE requested in *BA6 Fed reg for assuring access*, *BA7 Fed reg for managed care*, and *BA8 HCBS settings*

Recommendation: Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below. Note that the JBC's common policy was pending for several of the line items at the time this document was prepared. The amounts included in the numbers pages and department and division summary tables for the pending items are based on the request and will be updated to reflect the JBC's actions.

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

Personal Services

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

Request: The Department requests:

- BA6 Fed reg for assuring access
- BA7 Fed reg for managed care
- BA8 HCBS settings final rule
- BA10 Medicaid-Medicare grant true up
- BA11 Technical adjustments
- Annualize HB 15-1186 children with autism
- Annualize prior year budget decisions
- Indirect cost adjustment

Recommendation: The staff recommended changes are summarized in the table below.

Executive Director's Office, General Administration, Personal Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	\$27,865,140	\$9,681,391	\$2,860,502	\$1,501,543	\$13,821,704	383.2
Other legislation	433,986	216,994	0	0	216,992	4.8
HB 16-1240 (Supplemental)	<u>245,446</u>	<u>(70,060)</u>	<u>0</u>	<u>0</u>	<u>315,506</u>	<u>0.0</u>
TOTAL	\$28,544,572	\$9,828,325	\$2,860,502	\$1,501,543	\$14,354,202	388.0
FY 2016-17 Recommended Appropriation						

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Executive Director's Office, General Administration, Personal Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation	\$28,544,572	\$9,828,325	\$2,860,502	\$1,501,543	\$14,354,202	388.0
Annualize prior year budget decisions	649,471	237,405	75,701	3,769	332,596	3.0
BA7 Fed reg for managed care	240,954	120,477	0	0	120,477	4.0
BA6 Fed reg for assuring access	190,204	95,102	0	0	95,102	3.0
BA8 HCBS settings final rule	59,143	29,572	0	0	29,571	0.9
BA11 Technical adjustments	0	0	0	0	0	0.0
Indirect cost adjustment	0	(59,489)	0	59,489	0	0.0
Annualize HB 15-1186 children with autism	(53,736)	(26,868)	0	0	(26,868)	0.0
BA10 Medicaid-Medicare grant true up	<u>(19,542)</u>	<u>(3,020)</u>	<u>0</u>	<u>0</u>	<u>(16,522)</u>	<u>0.0</u>
TOTAL	\$29,611,066	\$10,221,504	\$2,936,203	\$1,564,801	\$14,888,558	398.9
Increase/(Decrease)	\$1,066,494	\$393,179	\$75,701	\$63,258	\$534,356	10.9
Percentage Change	3.7%	4.0%	2.6%	4.2%	3.7%	2.8%
FY 2016-17 Executive Request:	\$29,650,262	\$10,241,102	\$2,936,203	\$1,564,801	\$14,908,156	398.9
Request Above/(Below) Recommendation	\$39,196	\$19,598	\$0	\$0	\$19,598	0.0

Operating Expenses

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

Request: The Department requests

- BA6 Fed reg for assuring access
- BA7 Fed reg for managed care
- BA8 HCBS settings final rule
- BA10 Medicaid-Medicare grant true up
- Annualize prior year budget decisions

Recommendation: The staff recommended changes are summarized in the table below.

Executive Director's Office, General Administration, Operating Expenses						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	\$2,099,434	\$951,018	\$78,907	\$10,449	\$1,059,060	0.0
Other legislation	28,675	14,338	0	0	14,337	0.0
HB 16-1240 (Supplemental)	<u>500</u>	<u>(5,163)</u>	<u>0</u>	<u>0</u>	<u>5,663</u>	<u>0.0</u>

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Executive Director's Office, General Administration, Operating Expenses						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
TOTAL	\$2,128,609	\$960,193	\$78,907	\$10,449	\$1,079,060	0.0
FY 2016-17 Recommended Appropriation						
FY 2015-16 Appropriation	\$2,128,609	\$960,193	\$78,907	\$10,449	\$1,079,060	0.0
BA7 Fed reg for managed care	22,612	11,306	0	0	11,306	0.0
BA6 Fed reg for assuring access	16,959	8,480	0	0	8,479	0.0
BA8 HCBS settings final rule	5,558	2,779	0	0	2,779	0.0
BA10 Medicaid-Medicare grant true up	4,118	(349)	0	0	4,467	0.0
Annualize prior year budget decisions	<u>(123,412)</u>	<u>(48,105)</u>	<u>(13,038)</u>	<u>0</u>	<u>(62,269)</u>	<u>0.0</u>
TOTAL	\$2,054,444	\$934,304	\$65,869	\$10,449	\$1,043,822	0.0
Increase/(Decrease)	(\$74,165)	(\$25,889)	(\$13,038)	\$0	(\$35,238)	0.0
Percentage Change	(3.5%)	(2.7%)	(16.5%)	0.0%	(3.3%)	0.0%
FY 2016-17 Executive Request:	\$2,021,523	\$917,843	\$65,869	\$10,449	\$1,027,362	0.0
Request Above/(Below) Recommendation	(\$32,921)	(\$16,461)	\$0	\$0	(\$16,460)	0.0

Leased Space

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

Request: The Department requests annualizations of prior year budget decisions.

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

Executive Director's Office, General Administration, Leased Space					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	<u>\$2,203,793</u>	<u>\$885,015</u>	<u>\$216,881</u>	<u>\$1,101,897</u>	<u>0.0</u>
TOTAL	\$2,203,793	\$885,015	\$216,881	\$1,101,897	0.0
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$2,203,793	\$885,015	\$216,881	\$1,101,897	0.0
Annualize prior year budget decisions	<u>310,242</u>	<u>124,638</u>	<u>30,484</u>	<u>155,120</u>	<u>0.0</u>
TOTAL	\$2,514,035	\$1,009,653	\$247,365	\$1,257,017	0.0
Increase/(Decrease)	\$310,242	\$124,638	\$30,484	\$155,120	0.0
Percentage Change	14.1%	14.1%	14.1%	14.1%	0.0%

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Executive Director's Office, General Administration, Leased Space					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2016-17 Executive Request:	\$2,514,035	\$1,009,653	\$247,365	\$1,257,017	0.0
Request Above/(Below) Recommendation	\$0	\$0	\$0	\$0	0.0

All-Payer Claims Database

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

Request: The Department requests continuation funding.

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

General Professional Services

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

Request: The Department requests:

- BA6 Fed reg for assuring access
- BA7 Fed reg for managed care
- BA8 HCBS settings final rule
- BA10 Medicaid-Medicare grant true up
- BA11 Technical adjustments
- Annualize prior year budget decisions

Recommendation: The staff recommended changes are summarized in the table below.

Executive Director's Office, General Administration, General Professional Services and Special Projects					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	\$9,046,970	\$2,964,887	\$1,463,609	\$4,618,474	0.0
Other legislation	305,000	152,500	0	152,500	0.0
HB 16-1240 (Supplemental)	<u>(84,800)</u>	<u>(20,925)</u>	<u>0</u>	<u>(63,875)</u>	<u>0.0</u>
TOTAL	\$9,267,170	\$3,096,462	\$1,463,609	\$4,707,099	0.0

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Executive Director's Office, General Administration, General Professional Services and Special Projects					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$9,267,170	\$3,096,462	\$1,463,609	\$4,707,099	0.0
BA8 HCBS settings final rule	1,101,870	550,935	0	550,935	0.0
BA6 Fed reg for assuring access	253,750	126,875	0	126,875	0.0
BA7 Fed reg for managed care	101,500	50,750	0	50,750	0.0
BA10 Medicaid-Medicare grant true up	25,000	(8,975)	0	33,975	0.0
BA11 Technical adjustments	(1,688,243)	(658,013)	(186,109)	(844,121)	0.0
Annualize prior year budget decisions	<u>(1,386,615)</u>	<u>(686,176)</u>	<u>(50,000)</u>	<u>(650,439)</u>	<u>0.0</u>
TOTAL	\$7,674,432	\$2,471,858	\$1,227,500	\$3,975,074	0.0
Increase/(Decrease)	(\$1,592,738)	(\$624,604)	(\$236,109)	(\$732,025)	0.0
Percentage Change	(17.2%)	(20.2%)	(16.1%)	(15.6%)	0.0%
FY 2016-17 Executive Request:	\$7,674,432	\$2,471,858	\$1,227,500	\$3,975,074	0.0
Request Above/(Below) Recommendation	\$0	\$0	\$0	\$0	0.0

(B) Transfers to Other Departments

This subsection funds programs administered or financed by departments other than the Department of Health Care Policy and Financing, except for programs administered by the Department of Human Services, which are appropriated in Division 6.

Public Health and Environment

Facility Survey and Certification

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

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

Statutory Authority: Section 25-1.5-103, C.R.S.

Request: The Department requests continuation funding.

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

Prenatal Statistical Information

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

Request: The Department requests continuation funding.

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

Human Services

Nurse Home Visitor Program

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

Statutory Authority: Section 25-31-102, C.R.S.

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

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

Regulatory Agencies

Nurse Aide Certification

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

Statutory Authority: Section 12-38.1-101 et seq., C.R.S.

Request: The Department requests continuation funding.

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

Reviews

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

Statutory Authority: Section 24-34-104, et seq., C.R.S.

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

Recommendation: Staff recommends the request based on the statutory sunset reviews required. The money is transferred to the Executive Director's Office of the Department of Regulatory Agencies.

Education

Public School Health Services Administration

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

Statutory Authority: Section 25.5-5-318, C.R.S.

Request: The Department requests continuation funding.

Recommendation: Staff recommends an increase of \$10,644 reappropriated funds based on the JBC's decisions during figure setting for the Department of Education. The increase is for common policy adjustments to salaries, benefits, and operating expenses.

Local Affairs

Home Modifications Benefit administration and Housing Assistance Payments

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

Request: The Department requests continuation funding.

Recommendation: Staff recommends an increase of \$3,401, including \$1,701 General Fund, based on the JBC's decisions during figure setting for the Department of Local Affairs. The increase is for common policy adjustments to salaries, benefits, and operating expenses.

(C) Information Technology Contracts and Projects

Medicaid Management Information System Maintenance and Projects

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

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives a 65 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

Statutory Authority: Section 25.5-4-204, C.R.S.

Request: The Department requests:

- *BA9 Provider enrollment fee*
- *BA10 Medicaid-Medicare grant true up*
- *Annualizations of prior year budget decisions*

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Recommendation: The staff recommended changes are summarized in the table below.

Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	\$32,759,633	\$6,817,349	\$1,919,380	\$293,350	\$23,729,554	0.0
HB 16-1240 (Supplemental)	1,580,463	0	1,180,463	0	400,000	0.0
Other legislation	<u>25,200</u>	<u>6,300</u>	<u>0</u>	<u>0</u>	<u>18,900</u>	<u>0.0</u>
TOTAL	\$34,365,296	\$6,823,649	\$3,099,843	\$293,350	\$24,148,454	0.0
FY 2016-17 Recommended Appropriation						
FY 2015-16 Appropriation	\$34,365,296	\$6,823,649	\$3,099,843	\$293,350	\$24,148,454	0.0
Annualize prior year budget decisions	2,152,180	374,529	170,349	0	1,607,302	0.0
BA9 Provider enrollment fee	(1,061,183)	0	(1,061,183)	0	0	0.0
BA10 Medicaid-Medicare grant true up	<u>(192,500)</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>(192,500)</u>	<u>0.0</u>
TOTAL	\$35,263,793	\$7,198,178	\$2,209,009	\$293,350	\$25,563,256	0.0
Increase/(Decrease)	\$898,497	\$374,529	(\$890,834)	\$0	\$1,414,802	0.0
Percentage Change	2.6%	5.5%	(28.7%)	0.0%	5.9%	0.0%
FY 2016-17 Executive Request:	\$35,263,793	\$7,198,178	\$2,209,009	\$293,350	\$25,563,256	0.0
Request Above/(Below) Recommendation	\$0	\$0	\$0	\$0	\$0	0.0

Medicaid Management Information System (MMIS) Reprocurement Contracted Staff
Medicaid Management Information System Reprocurement Contracts

These two line items pay for the renewal of the Department's claims processing hardware and software.

Statutory Authority: Section 25.5-4-204, C.R.S.

Request: The Department requests annualizations of prior year budget decisions.

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

Fraud Detection Software Contract

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

Statutory Authority: Section 25.5-4-301, C.R.S.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding based on the ongoing maintenance contract.

Centralized Eligibility Vendor Contract

This line item pays a contractor to process applications and determine eligibility for the Children's Basic Health Plan (CHP+). It also includes money for determining Medicaid eligibility for adults without dependent children and the Medicaid buy-in for people with disabilities. The source of cash funds is the Hospital Provider Fee. The federal match rate varies based on the type of work and the population served. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. For populations that are "newly eligible" pursuant to the ACA the match rate is higher.

Statutory Authority: Section 25.5-4-102, C.R.S.

Request: The Department requests *R7 County administration* to shift some of the funding to counties based on a new contract that reduced the responsibilities of the vendor, and to transfer the line item to the Eligibility Determinations and Client Services subdivision.

Recommendation: Staff recommends the requested shift in funding and transfer of the line item consistent with the recommendation on *R7 County administration*.

CBMS Modernization Project

This line item pays for a modernization of the Colorado Benefits Management System (CBMS).

Request: The Department requests *NP Colorado benefits management system* and *NP Cervical cancer eligibility*.

Recommendation: Staff recommends adjusting this line item based on the JBC's decisions during figure setting for the Governor's Office of Information Technology, which were pending at the time this document was prepared. In addition, staff recommends the requested adjustment for NP Cervical cancer eligibility based on the JBC's actions during figure setting for the Department of Public Health and Environment.

Health Information Exchange Maintenance and Projects

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

Request: The Department requests annualizations of prior year budget decisions

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

(D) Eligibility Determinations and Client Services

Medical Identification Cards

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

Statutory Authority: Section 25.5-4-102, C.R.S.

Request: The Department *BA11 Technical adjustments.*

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

Contracts for Special Eligibility Determinations

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

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

Request: The Department requests continuation funding.

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

County Administration

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. At one point there was an expectation that counties contribute 20 percent toward the total, but over the years the legislature has approved initiatives without requiring an increase in county matching funds and the federal government has increased the federal match rate so that in FY 2015-16 county funds represent just under 13 percent of the appropriation. The traditional federal match was 50 percent, but a

recent reinterpretation by the Centers for Medicare and Medicaid Services (CMS) expanded the activities eligible for a 75 percent match as maintenance and operations of eligibility determination systems. There are no matching federal funds for eligibility determinations for the Old Age Pension State Medical Program.

Statutory Authority: Sections 25.5-1-120 through 122, C.R.S.

Request: The Department requests *R7 County administration*.

Recommendation: Staff recommends the requested funding consistent with the staff recommendation on *R7 County administration*.

Hospital Provider Fee County Administration

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

Statutory Authority: Sections 25.5-1-120 through 122, C.R.S.

Request: The Department requests *R7 County administration*.

Recommendation: Staff recommends the requested funding consistent with the staff recommendation on *R7 County administration*.

Administrative Case Management

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

Statutory Authority: Sections 25.5-1-120 through 122, C.R.S.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency

This line item was added as a result of the JBC's action on an interim supplemental dealing with the enhanced match for eligibility determination services.

Statutory Authority: Cite the relevant statute or statutes.

Request: The Department requests no funding, as this was a short-duration investment.

Recommendation: Staff recommends no funding, consistent with the request.

Medical Assistance Sites

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

Request: The Department requests *R7 County administration* to shift money from the Centralized Eligibility Vendor to this line item.

Recommendation: Staff recommends the request consistent with the staff recommendation on *R7 County administration*.

Customer Outreach

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

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

Request: The Department requests *BA10 Medicaid-Medicare grant true up* and annualizations of prior year budget actions.

Recommendation: Staff recommends the requested funding.

(E) Utilization and Quality Review Contracts

Professional Services Contracts

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

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

*JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision*

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

External quality review handles provider credentialing, including activities such as verifying licensure and certification information, validating Healthcare Effectiveness Data and Information Set (HEDIS) measures, and reviewing provider performance improvement projects. The federal match rate is 75.0 percent.

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

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

Statutory Authority: Sections 25.5-5-405, 506, and 411, C.R.S.

Request: The Department requests *BA7 Fed reg for managed care, BA10 Medicaid-Medicare grant true up, BA12 External quality review*, and annualizations of prior year budget actions.

Recommendation: The staff recommendations are summarized in the table below.

Executive Director's Office, Utilization and Quality Review Contracts, Professional Service Contracts					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	\$11,881,984	\$3,183,748	\$461,089	\$8,237,147	0.0
HB 16-1240 (Supplemental)	<u>102,425</u>	<u>169,725</u>	<u>0</u>	<u>(67,300)</u>	<u>0.0</u>
TOTAL	\$11,984,409	\$3,353,473	\$461,089	\$8,169,847	0.0
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$11,984,409	\$3,353,473	\$461,089	\$8,169,847	0.0
BA7 Fed reg for managed care	300,000	150,000	0	150,000	0.0
BA12 External quality review federal match	0	0	0	0	0.0
Annualize prior year budget decisions	(202,856)	(38,214)	0	(164,642)	0.0
BA10 Medicaid-Medicare grant true up	<u>(96,546)</u>	<u>(12,500)</u>	<u>0</u>	<u>(84,046)</u>	<u>0.0</u>
TOTAL	\$11,985,007	\$3,452,759	\$461,089	\$8,071,159	0.0
Increase/(Decrease)	\$598	\$99,286	\$0	(\$98,688)	0.0
Percentage Change	0.0%	3.0%	0.0%	(1.2%)	0.0%
FY 2016-17 Executive Request:	\$11,985,007	\$3,452,759	\$461,089	\$8,071,159	0.0

Executive Director's Office, Utilization and Quality Review Contracts, Professional Service Contracts	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Request Above/(Below) Recommendation	\$0	\$0	\$0	\$0	0.0

(F) Provider Audits and Services

Professional Audit Contracts

This line item pays for contract audits of the following:

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

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

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

Request: The Department requests annualizations of prior year budget actions.

Recommendation: Staff recommends the request the request based on the ongoing audit requirements.

(G) Recoveries and Recoupment Contract Costs

Estate Recovery

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

Statutory Authority: Section 25.5-4-301, C.R.S.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

(G.5) State of Health Projects

Pain Management Capacity Program

This line item provides training and builds the capacity of physicians to deal with clients requiring pain management. It was created with savings from the change in the FMAP rate in FY 2014-15. A 2013 study by the National Survey on Drug Use and Health found Colorado had the second highest rate of drug abuse in the country. In response to a small-scale Department survey 78 percent of primary care providers who responded identified pain management as the most difficult specialty to access. The Department also indicates that the complications of dealing with patients who misuse prescription drugs can significantly impact provider job satisfaction and willingness to treat Medicaid patients.

Request: The Department requests no funding. This program received six months of funding in FY 2015-16 and then phased out in the second half of the fiscal year. There was a technical error in the Governor's request that showed a slight positive General Fund and negative federal funds amount for this program, but the Department confirms that the intent was to zero out the program.

Recommendation: Staff recommends no funding.

(H) Indirect costs

Statewide Indirect Cost Assessment

This line item finances the Department's indirect cost assessment according to the state plan. The state plan takes costs associated with agencies such as the Governor's Office, the Department of Personnel, and the Department of Treasury that are not directly billed and allocates these costs to each state department. The departments are then responsible for collecting the money from the various sources of revenue that support their activities. Pursuant

to JBC policy, the money collected is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The indirect cost assessment on a department can change from year to year based on changes in the total statewide indirect cost pool or based on changes in the allocation of costs. The allocation of costs complies with criteria of the Government Accounting Standards Bureau (GASB).

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

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

(2) Medical Services Premiums

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

Medical Services Premiums					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	\$6,584,363,560	\$1,816,067,112	\$698,756,395	\$0	\$4,069,540,053
Other legislation	10,466,924	292,656	4,840,893	0	5,333,375
HB 16-1240 (Supplemental)	213,234,125	34,093,714	110,294,265	9,145,518	59,700,628
Recommended Long Bill Supplemental	<u>69,360,066</u>	<u>(11,775,595)</u>	<u>5,425,739</u>	<u>0</u>	<u>75,709,922</u>
TOTAL	\$6,877,424,675	\$1,838,677,887	\$819,317,292	\$9,145,518	\$4,210,283,978
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$6,877,424,675	\$1,838,677,887	\$819,317,292	\$9,145,518	\$4,210,283,978
Enrollment/utilization trends					
R1 Medical Services Premiums	138,777,450	129,493,645	(103,134,682)	(9,145,518)	121,564,005
Eligibility/benefit changes					
NP Cervical cancer eligibility	236,245	0	82,001	0	154,244
Annualize HB 15-1186 children with autism/Behavioral therapy benefit	18,534,147	9,230,006	0	0	9,304,141
Provider rate changes					
Annualize primary care rate bump	(145,075,634)	(49,519,402)	(1,642,057)	0	(93,914,175)
R12 Provider rates	0	0	0	0	0
R11/BA16 Standard federal match	0	16,899,407	2,103,578	0	(19,002,985)
ACA "Newly eligible" federal match	0	0	38,431,390	0	(38,431,390)
BA10 Medicaid-Medicare grant true up	(6,074,000)	0	0	0	(6,074,000)
Annualize prior year budget decisions	<u>25,821,337</u>	<u>5,794,986</u>	<u>464,146</u>	<u>0</u>	<u>19,562,205</u>
SUBTOTAL Long Bill	\$6,762,950,647	\$1,950,576,529	\$755,621,668	\$0	\$4,203,446,023
R1 Restrict Hospital Provider Fee revenue	<u>(146,693,573)</u>	<u>0</u>	<u>(100,000,000)</u>	<u>0</u>	<u>(102,217,646)</u>

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Medical Services Premiums					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
TOTAL	\$6,707,426,574	\$1,950,576,529	\$655,621,668	\$0	\$4,101,228,377
Increase/(Decrease)	(\$169,998,101)	\$111,898,642	(\$163,695,624)	(\$9,145,518)	(\$109,055,601)
Percentage Change	(2.5%)	6.1%	(20.0%)	(100.0%)	(2.6%)
FY 2016-17 Executive Request:	\$6,573,594,996	\$1,938,479,615	\$669,472,084	\$0	\$3,965,643,297
Request Above/(Below) Recommendation	(\$133,831,578)	(\$12,096,914)	\$13,850,416	\$0	(\$135,585,080)

The difference between the staff recommendation and the Governor's request is attributable to two factors. First, the JBC staff used the Department's more recent February 2016 forecast of enrollment and utilization trends for *R1 Medical Services Premiums*, adding \$103.5 million total funds, including \$1.8 million General Fund. Second, the JBC staff did not recommend *R12 Provider rates*, adding \$30.4 million total funds, including \$10.3 million General Fund. The JBC staff is recommending a larger decrease in the Hospital Provider Fee than would be indicated by the February 2016 forecast, but equal to the restriction requested in the Governor's November request.

DECISION ITEMS – MEDICAL SERVICES PREMIUMS

R1 Medical Services Premiums

Request: This part of R1 requests a change to the Medical Services Premiums appropriation for both FY 2015-16 and FY 2016-17 based on a new forecast of caseload and expenditures under current law and policy. There is a second part to the R1 request that the JBC staff has named *R1 Restrict Hospital Provider Fee revenue* that will be discussed separately in the next arrowed item, because it involves proposed legislation.

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

On February 16, 2016 the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2016 forecast is higher than the forecast used for the Governor's request in total funds for both FY 2015-16 and FY 2016-17. The General Fund is \$11.8 million lower in FY 2015-16 and \$10.6 million higher in FY 2016-

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17. The table below compares the projected expenditures under the forecast used for the Governor's request with the updated February 2016 forecast.

Total Projected Medical Services Premiums Under Current Law/Policy*				
	Governor's Request**	February 2016 Forecast	Difference	Percent Difference
FY 15-16***	<u>\$6,808,064,609</u>	<u>\$6,877,424,675</u>	<u>\$69,360,066</u>	1.0%
General Fund	1,850,453,482	1,838,677,887	(11,775,595)	-0.6%
Cash Funds	813,891,553	819,317,292	5,425,739	0.7%
Reappropriated Funds	9,145,518	9,145,518	0	0.0%
Federal Funds	4,134,574,056	4,210,283,978	75,709,922	1.8%
Enrollment	<i>1,289,644</i>	<i>1,303,080</i>	<i>13,436</i>	1.0%
FY 16-17	<u>\$6,805,952,194</u>	<u>\$6,909,407,975</u>	<u>\$103,455,781</u>	1.5%
General Fund	1,948,779,785	1,950,576,529	1,796,744	0.1%
Cash Funds	770,020,745	755,539,667	(14,481,078)	-1.9%
Reappropriated Funds	0	0	0	NA
Federal Funds	4,087,151,664	4,203,291,779	116,140,115	2.8%
Enrollment	<i>1,352,005</i>	<i>1,342,326</i>	<i>(9,679)</i>	-0.7%

* *Compares the forecasts excluding the proposed restriction on the Hospital Provider Fee.*

** *Includes FMAP changes*

*** *Includes JBC-approved supplementals.*

The next table shows the incremental change needed by fiscal year based on the February 2016 forecast.

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February 2016 Forecast for Medical Services Premiums - Changes by Fiscal Year						
	Total	GF	CF	RF	FF	Enrollment
<u>FY 15-16</u>						
FY 15-16 Appropriation	\$6,808,064,609	\$1,850,453,482	\$813,891,553	\$9,145,518	\$4,134,574,056	1,289,644
FY 15-16 February 2016 Forecast	\$6,871,350,675	\$1,842,453,926	\$824,686,771	\$0	\$4,204,209,978	1,303,080
Approved Supplementals	<u>\$6,074,000</u>	<u>(\$3,776,039)</u>	<u>(\$5,369,479)</u>	<u>\$9,145,518</u>	<u>\$6,074,000</u>	<u>0</u>
FY 15-16 Total Projected Expenditure	\$6,877,424,675	\$1,838,677,887	\$819,317,292	\$9,145,518	\$4,210,283,978	1,303,080
Difference	\$69,360,066	(\$11,775,595)	\$5,425,739	\$0	\$75,709,922	13,436
Percent	1.0%	-0.6%	0.7%	0.0%	1.8%	1.0%
<u>FY 16-17</u>						
FY 15-16 Total	\$6,877,424,675	\$1,838,677,887	\$819,317,292	\$9,145,518	\$4,210,283,978	1,303,080
Annualize primary care rate bump	(\$145,075,634)	(\$49,519,402)	(\$1,642,057)	\$0	(\$93,914,175)	0
Annualize children with autism	\$18,534,147	\$9,230,006	\$0	\$0	\$9,304,141	0
Other annualizations	\$19,747,337	\$5,794,986	\$464,146	\$0	\$13,488,205	0
Federal match changes	<u>\$0</u>	<u>\$16,899,407</u>	<u>\$40,534,968</u>	<u>\$0</u>	<u>(\$57,434,375)</u>	<u>0</u>
FY 16-17 Base	\$6,770,630,525	\$1,821,082,884	\$858,674,349	\$9,145,518	\$4,081,727,774	1,303,080
FY 16-17 February 2016 Forecast*	\$6,909,407,975	\$1,950,576,529	\$755,539,667	\$0	\$4,203,291,779	1,342,326
Difference	\$138,777,450	\$129,493,645	(\$103,134,682)	(\$9,145,518)	\$121,564,005	39,246
Percent	2.0%	7.0%	-12.6%	-100.0%	2.9%	3.0%

* This is the forecast under current law/policy without the Governor's proposed restriction on Hospital Provider Fee revenue.

Recommendation: Staff recommends using the Department's February forecast of enrollment and expenditures to modify both the FY 2015-16 and FY 2016-17 appropriations. This is the best estimate available of what the actual costs will be for the Medicaid program based on current law and policy. The following subsections highlight major factors driving the forecast changes.

FY 2015-16

The change in the forecast is the result of numerous changes to assumptions, many offsetting each other, but some of the changes that caused the largest dollar differences include:

- **Enrollment among adults without dependent children and among parents/caretakers with income from 69% to 138% of the federal poverty guidelines (FPL)** - Enrollment projections for these federally-funded populations increased 27,262, or 7.3 percent, based on actual enrollment over the last six months. The cost of the increase in the caseload projections is somewhat offset by a decrease in projected per capita costs for adults without dependent children, but this increase in the enrollment projections is the largest factor behind the higher total funds and federal funds projection for FY 2015-16. Projected FY 15-16 expenditures for these two populations are up \$78.2 million federal funds. The rate of enrollment growth for these populations is expected to taper off dramatically in coming years (see the discussion below of FY 2016-17 services for more information).
- **Nursing home utilization** – Projected FY 15-16 expenditures for nursing homes are up \$29.7 million, including \$14.6 million General Fund, primarily due to higher than expected utilization of nursing bed days in the last six months.

- **Adult dental benefit** – Projected FY 2015-16 expenditures for the adult dental benefit that is financed with the Unclaimed Property Trust Fund are up \$14.9 million, or 31.6 percent, based on higher than expected per capita expenditures in the last six months. The adult benefit is capped at \$1,000 annually to help control costs. In the February forecast the estimated per capita costs increased \$11.12, or 30.4 percent, to \$47.64.
- **Medicare premiums and coinsurance** – Federal increases in Medicare premiums and coinsurance were higher than expected, resulting in an increase in the FY 2015-16 projection of \$8.6 million total funds, including \$3.0 million General Fund, for this cost.
- **Enrollment among General Fund populations** – The increases above are somewhat offset by modest decreases in enrollment projections for some key populations financed with General Fund, including parents and caretakers to 68% FPL, children, pregnant adults, and noncitizen emergency services. Per capita expenditure assumptions were also lowered for all of these populations except the pregnant adults.
- **Community based long-term care** – Projected expenditures for community-based long-term care have been reduced \$13.4 million, including \$6.6 million General Fund, largely due to lower enrollment in the elderly, blind, and disabled waiver, decreased utilization of nurses, and delays in implementing rate increases approved last year by the General Assembly. Overall the Department is still projecting an increase in the cost of community based long-term care, but the February forecast is lower than the appropriated increase.

FY 2016-17

The projected change in expenditures for Medical Service Premiums for FY 2016-17 can be divided into two components for (1) services and for (2) booster payments/financing. The services include expenditures for medical services and long term services and supports (LTSS), except for the LTSS related to people with intellectual and developmental disabilities, which are financed in the Office of Community Living. The booster payments/financing are composed primarily of payments that increase reimbursements to hospitals and nursing homes using the Hospital Provider Fee and Nursing Facility Provider Fee to draw additional federal funds within the relevant Medicaid upper payment limit. Also in the booster payments/financing category are miscellaneous other mechanisms to increase the federal funding for Medicaid or offset the need for General Fund, such as certified public expenditures by local government entities, recoveries from other health insurance providers and estates, and financing from the Health Care Expansion Fund and other cash funds. The trends for services and for booster payments/financing are discussed separately below.

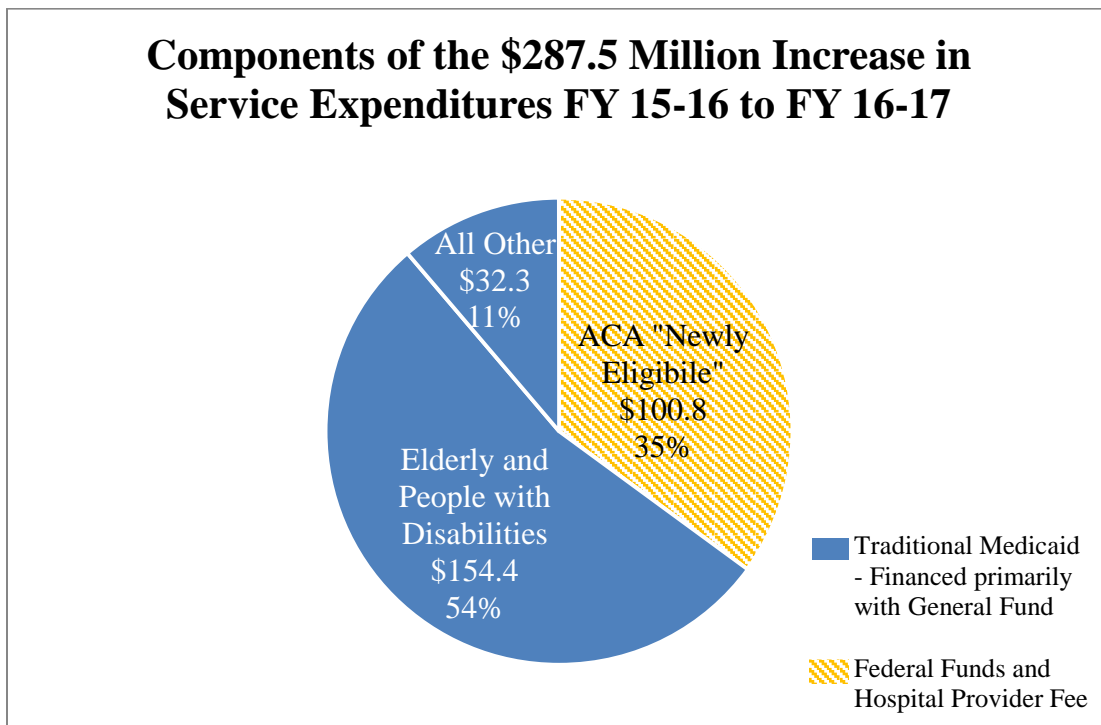
Services

The net projected changes in services cause an increase in the expected expenditures for Medical Services Premiums of \$287.5 million total funds, including \$87.7 million General Fund. Expenditures for services are driven by the number of clients, the amount of services each client uses, and the cost per unit of service.

The increase in total expenditures for services from FY 2015-16 to FY 2016-17 is being driven primarily by the elderly and people with disabilities and by the Medicaid expansion to the "Newly Eligible" under the Affordable Care Act (ACA). The ACA "Newly Eligible" includes parents and caretakers with income from 69 percent to 138 percent of the federal poverty

guidelines (FPL) and adults without dependent children with income to 138 percent of the FPL. The increase in General Fund expenditures for services is being driven primarily by the elderly and people with disabilities.

In the pie chart below the traditional Medicaid populations, shown in solid blue, are financed primarily at the standard federal match rate (50.20 percent in FY 2016-17) with most of the state share of expenses coming from the General Fund. There are exceptions where subsets of the population or specific services get a higher match rate or special cash funds financing, such as from the Adult Dental Fund. The ACA "Newly Eligible" populations, shown in striped yellow, receive the enhanced federal match rate (97.50 percent in FY 2016-17) with the state share of expenses coming from the Hospital Provider Fee.



For the elderly and people with disabilities there are several important stories explaining the projected increase in expenditures.

- **Community Based Long-term Care (CBLTC)** – The projection is for a \$67.6 million increase in CBLTC, due to a 4.95 percent increases in enrollment in home- and community-based service (HCBS) waivers and a 12.06 percent increase in expenditures per enrollee.
- **Private Duty Nursing & Long-term Home Health** – The projection is for \$26.4 million, or 10.7 percent, increase in expenditures, mostly due to large expected increases in utilization.
- **Nursing Homes** – The projection is for \$32.1 million increase in expenditures for nursing facilities, mostly based on the statutory formula for increasing provider rates.
- **Program for All-inclusive Care for the Elderly (PACE)** – The projection is for \$20.3 million increase, or 15 percent. This is a function of projected strong growth in both utilization and per capita costs. PACE providers are paid a capitated rate per client and

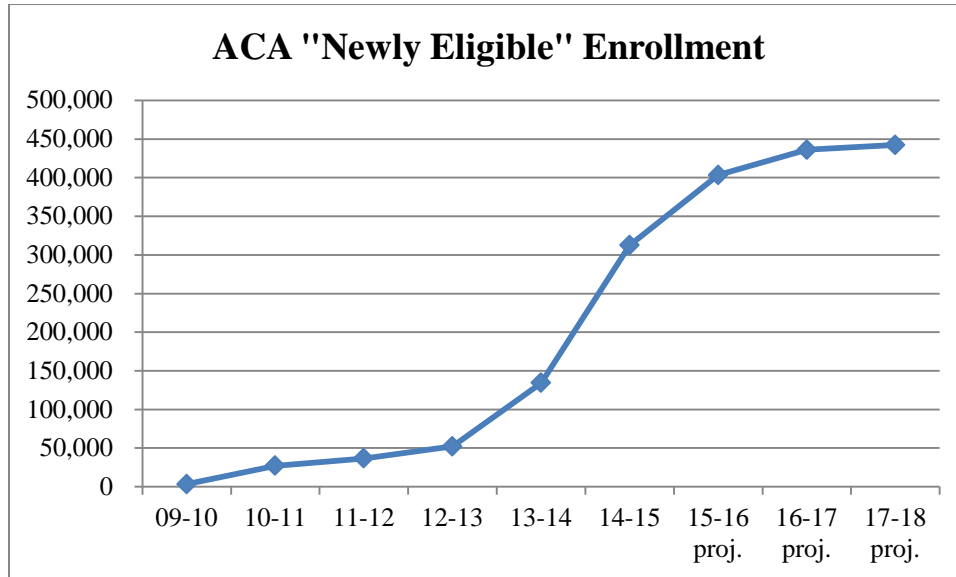
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accept the risk if actual costs are higher than anticipated. Because of the capitated and risk-based nature of the payment, federal Medicaid rules require that the rates meet a standard of actuarial soundness. The Department changes rates annually based on the actuarial analysis rather than discretionary policies of the General Assembly.

- **Medicare premiums and coinsurance** – The projection is for an \$19.0 million increase, or 12.1 percent, largely based on a change in federal policy that increased premiums and coinsurance requirements, coupled with strong enrollment growth.

Projected Medical Services Premiums Expenditures for the Elderly and People with Disabilities				
	FY 15-16	FY 16-17	Difference	% Change
Acute Care	\$758,139,179	\$738,373,694	(\$19,765,485)	-2.6%
Community Based Long-Term Care (CBLTC)				
Base CBLTC	388,235,963	455,872,762	67,636,799	17.4%
Hospice	47,847,386	50,378,169	2,530,783	5.3%
Private Duty Nursing & Long-Term Home Health	<u>246,164,801</u>	<u>272,515,245</u>	<u>26,350,444</u>	10.7%
Subtotal CBLTC	682,248,150	778,766,176	96,518,026	14.1%
Long-Term Care				
Class I Nursing Facilities	622,564,443	654,714,048	32,149,605	5.2%
Class II Nursing Facilities	4,764,670	5,035,779	271,109	5.7%
Program for All-inclusive Care for the Elderly (PACE)	<u>135,691,161</u>	<u>156,026,037</u>	<u>20,334,876</u>	15.0%
Subtotal Long-Term Care	763,020,274	815,775,864	52,755,590	6.9%
Insurance				
Supplemental Medicare Insurance Benefit	156,746,424	175,706,238	18,959,814	12.1%
Health Insurance Buy-In	<u>1,357,617</u>	<u>1,661,749</u>	<u>304,132</u>	22.4%
Subtotal Insurance	158,104,041	177,367,987	19,263,946	12.2%
Service Management				
Single Entry Points	31,461,008	33,019,933	1,558,925	5.0%
Disease Management	184,233	187,305	3,072	1.7%
ACC and PIHP Administration	<u>11,884,529</u>	<u>15,941,391</u>	<u>4,056,862</u>	34.1%
Subtotal Service Management	43,529,770	49,148,629	5,618,859	12.9%
Medical Services Total	\$2,405,041,414	\$2,559,432,350	\$154,390,936	6.4%

For the ACA "Newly Eligible" the projected increase is mostly due to enrollment growth of 32,895, or 8.2 percent. The effect on expenditures of the increase in enrollment is somewhat offset by a projected decrease in per capita costs, largely due to the end of the primary care rate bump. Although the projected enrollment growth in FY 2016-17 is still strong at 8.2 percent, it is dramatically lower than the 29.1 percent enrollment growth experienced in FY 2015-16 and the rate of enrollment growth is expected to continue to decrease in FY 2017-18 to only 1.4 percent. Based on data from the Colorado Health Institute and other sources, the Department believes enrollment from these income ranges is approaching saturation of Colorado's population that meets the eligibility criteria. The graph below shows how the rate of enrollment growth for the ACA "Newly Eligible" is expected to decline.



Increases in expenditures for the All Other category in the original pie chart above are being repressed by the end of the primary care rate bump. The All Other category includes services for children, low-income parents/caretakers with resources below the ACA "Newly Eligible" income threshold, and pregnant adults, among others. These populations are high utilizers of primary care services. The end of the primary care rate bump is expected to reduce expenditures by \$145.1 million and the Department estimates roughly \$73.3 million, or over half that amount, will come from services for children, low-income parents, and pregnant adults. The projected decrease in expenditures from the end of the primary care rate bump is offsetting a substantial portion of the projected increases in expenditures from enrollment growth among children and low-income parents.

The tables below show the projected year over year changes by detailed enrollment category.

Category	Enrollment			
	FY 15-16	FY 16-17	Difference	Percent
Adults 65+ to SSI	42,235	42,831	596	1.4%
Adults with Disabilities 60 to 64	10,541	11,058	517	4.9%
Individuals with Disabilities to 59	69,387	70,731	1,344	1.9%
Disabled Buy-In to 450% FPL	6,122	5,858	(264)	-4.3%
Parents / Caretakers to 68% FPL	169,718	185,519	15,801	9.3%
Breast & Cervical Cancer to 250% FPL	293	154	(139)	-47.4%
Children to 107% FPL	470,946	494,148	23,202	4.9%
SB 11-008 Children 107% to 147% FPL	59,725	64,623	4,898	8.2%
Foster Care to 26 years	19,796	19,806	10	0.1%
Pregnant Adults to 142% FPL	14,370	14,459	89	0.6%
SB 11-250 Pregnant 142% to 200% FPL	1,678	1,700	22	1.3%
Non-Citizens - Emergency Services	2,689	2,746	57	2.1%
Adults 65+ SSI to 135% FPL-Medicare premiums	<u>32,330</u>	<u>36,113</u>	<u>3,783</u>	11.7%
Subtotal - Traditional Medicaid	899,830	949,746	49,916	5.5%

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Enrollment				
Category	FY 15-16	FY 16-17	Difference	Percent
<u>ACA "Newly Eligible"</u>				
Parents / Caretakers 69% to 138% FPL	85,399	90,649	5,250	6.1%
Adults w/out Dependent Children to 138% FPL	<u>317,851</u>	<u>345,496</u>	<u>27,645</u>	8.7%
Subtotal - ACA "Newly Eligible"	403,250	436,145	32,895	8.2%
TOTAL	1,303,080	1,385,891	82,811	6.4%

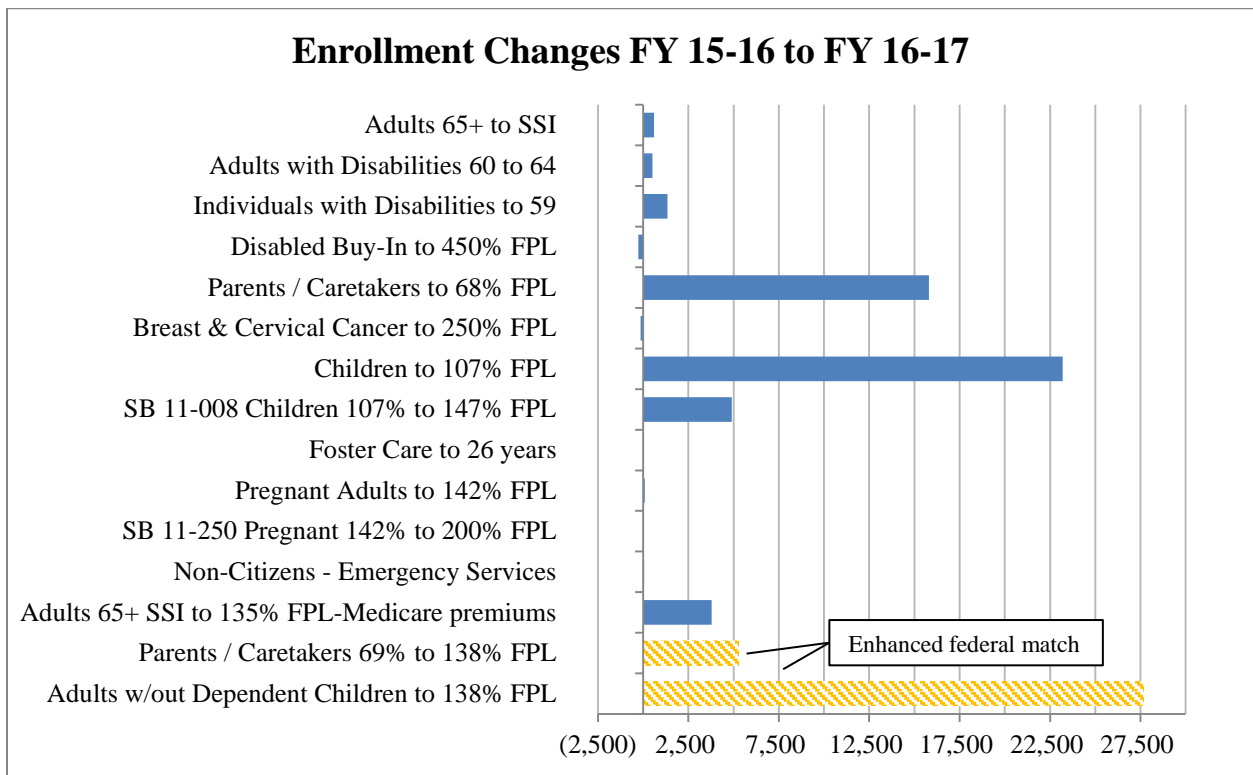
Expenditures				
Category	FY 15-16	FY 16-17	Difference	Percent
Adults 65+ to SSI	\$1,041,516,111	\$1,111,060,470	\$69,544,359	6.7%
Adults with Disabilities 60 to 64	203,649,655	214,949,498	11,299,843	5.5%
Individuals with Disabilities to 59	1,082,916,479	1,146,282,209	63,365,730	5.9%
Disabled Buy-In to 450% FPL	33,580,394	34,829,398	1,249,004	3.7%
Parents / Caretakers to 68% FPL	505,829,821	519,009,553	13,179,732	2.6%
Breast & Cervical Cancer to 250% FPL	3,743,934	1,936,016	(1,807,918)	-48.3%
Children to 107% FPL	890,598,315	901,962,860	11,364,545	1.3%
SB 11-008 Children 107% to 147% FPL	95,109,855	100,716,518	5,606,663	5.9%
Foster Care to 26 years	87,513,714	90,232,097	2,718,383	3.1%
Pregnant Adults to 142% FPL	154,535,053	155,092,294	557,241	0.4%
SB 11-250 Pregnant 142% to 200% FPL	16,185,345	16,380,860	195,515	1.2%
Non-Citizens - Emergency Services	38,215,597	38,690,531	474,934	1.2%
Adults 65+ SSI to 135% FPL-Medicare premiums	<u>43,378,775</u>	<u>52,310,775</u>	<u>8,932,000</u>	20.6%
Subtotal - Traditional Medicaid	\$4,196,773,048	\$4,383,453,079	\$186,680,031	4.4%
<u>ACA "Newly Eligible"</u>				
Parents / Caretakers 69% to 138% FPL	217,180,511	227,317,845	10,137,334	4.7%
Adults w/out Dependent Children to 138% FPL	1,256,638,190	1,347,295,324	90,657,134	7.2%
Subtotal - ACA "Newly Eligible"	\$1,473,818,701	\$1,574,613,169	\$100,794,468	6.8%
Services Subtotal	\$5,670,591,749	\$5,958,066,248	\$287,474,499	5.1%
Booster Payments / Financing	1,200,758,926	804,648,154	(396,110,772)	-33.0%
TOTAL	\$6,871,350,675	\$6,762,714,402	(\$108,636,273)	-1.6%

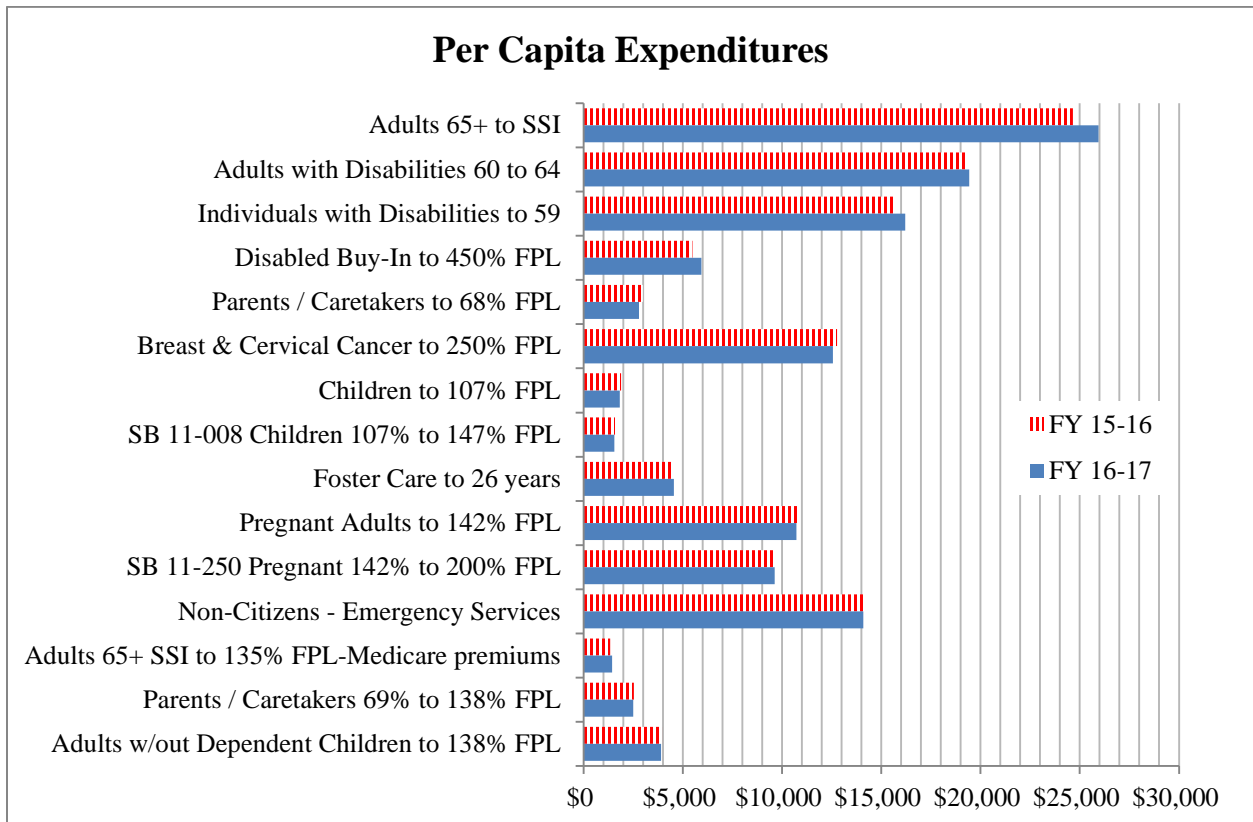
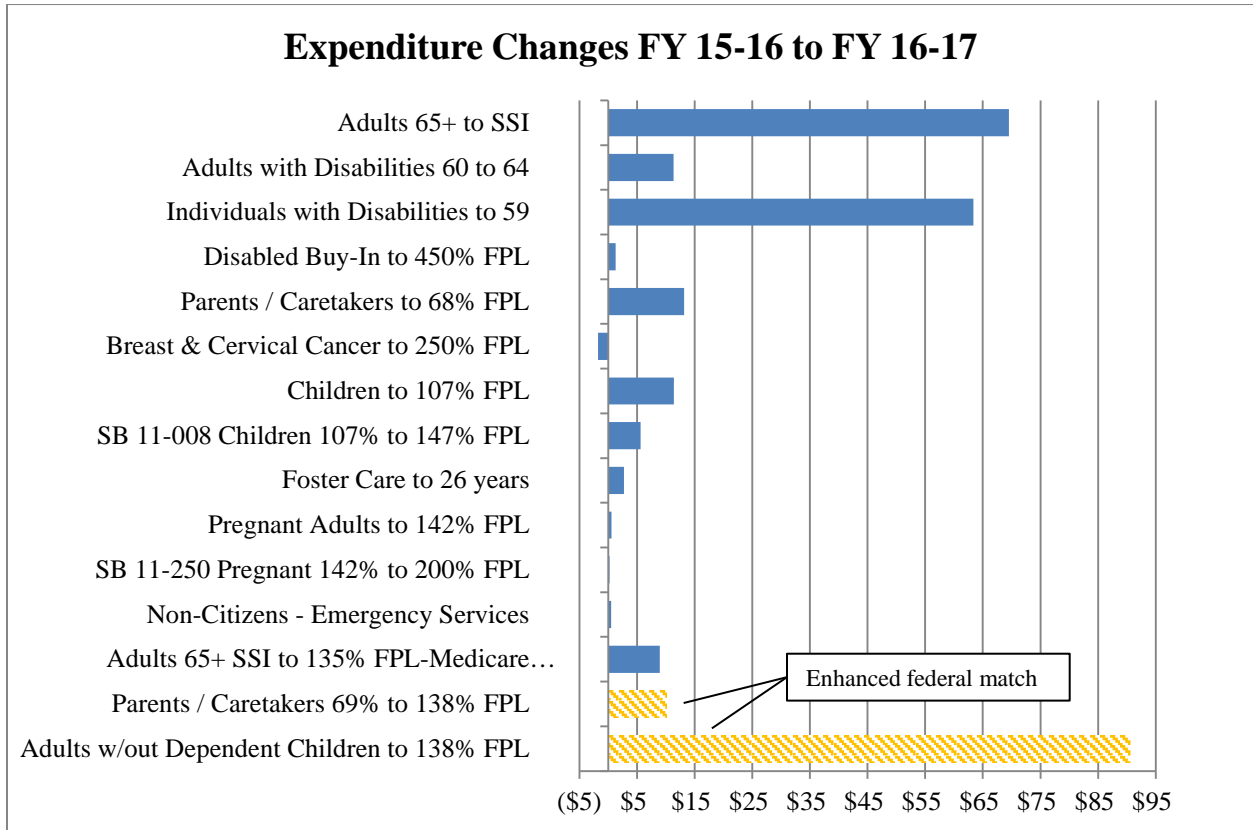
Per Capita Expenditures				
Category	FY 15-16	FY 16-17	Difference	Percent
Adults 65+ to SSI	\$24,660.02	\$25,940.57	\$1,280.54	5.2%
Adults with Disabilities 60 to 64	\$19,319.77	\$19,438.37	\$118.60	0.6%
Individuals with Disabilities to 59	\$15,606.91	\$16,206.22	\$599.31	3.8%
Disabled Buy-In to 450% FPL	\$5,485.20	\$5,945.61	\$460.41	8.4%
Parents / Caretakers to 68% FPL	\$2,980.41	\$2,797.61	(\$182.80)	-6.1%
Breast & Cervical Cancer to 250% FPL	\$12,777.93	\$12,571.53	(\$206.40)	-1.6%
Children to 107% FPL	\$1,891.08	\$1,825.29	(\$65.79)	-3.5%
SB 11-008 Children 107% to 147% FPL	\$1,592.46	\$1,558.52	(\$33.94)	-2.1%
Foster Care to 26 years	\$4,420.78	\$4,555.80	\$135.02	3.1%
Pregnant Adults to 142% FPL	\$10,754.01	\$10,726.35	(\$27.66)	-0.3%
SB 11-250 Pregnant 142% to 200% FPL	\$9,645.62	\$9,635.80	(\$9.82)	-0.1%
Non-Citizens - Emergency Services	\$14,211.82	\$14,089.78	(\$122.05)	-0.9%

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Per Capita Expenditures					
Category	FY 15-16	FY 16-17	Difference	Percent	
Adults 65+ SSI to 135% FPL-Medicare premiums	\$1,341.75	\$1,448.53	\$106.78	8.0%	
<u>ACA "Newly Eligible"</u>					
Parents / Caretakers 69% to 138% FPL	\$2,543.13	\$2,507.67	(\$35.46)	-1.4%	
Adults w/out Dependent Children to 138% FPL	\$3,953.54	\$3,899.60	(\$53.95)	-1.4%	
TOTAL (without booster payments/financing)	\$4,351.68	\$4,299.09	(\$52.60)	-1.2%	

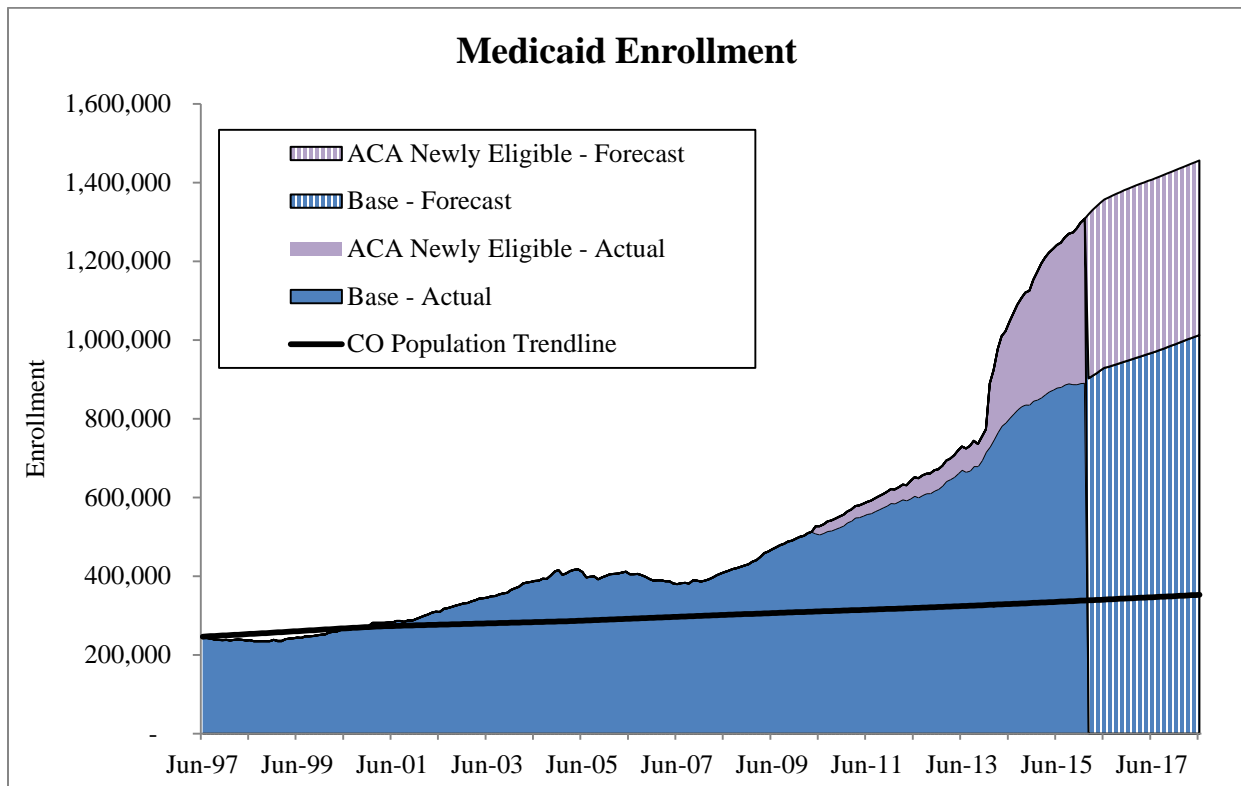
The next series of graphs present the same information in a pictorial format to highlight the year over year changes in enrollment, expenditures, and per capita expenditures.



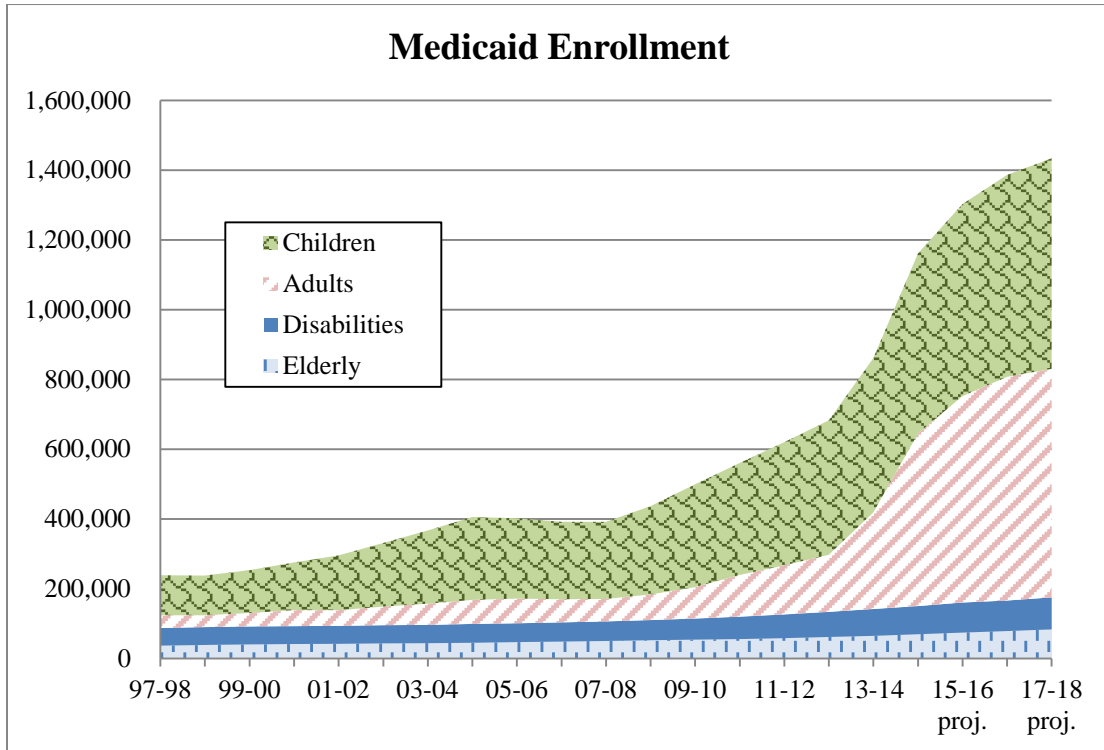


Rather than focusing on the year over year changes, the next several graphs focus on long-term trends and aggregate the data at a higher level.

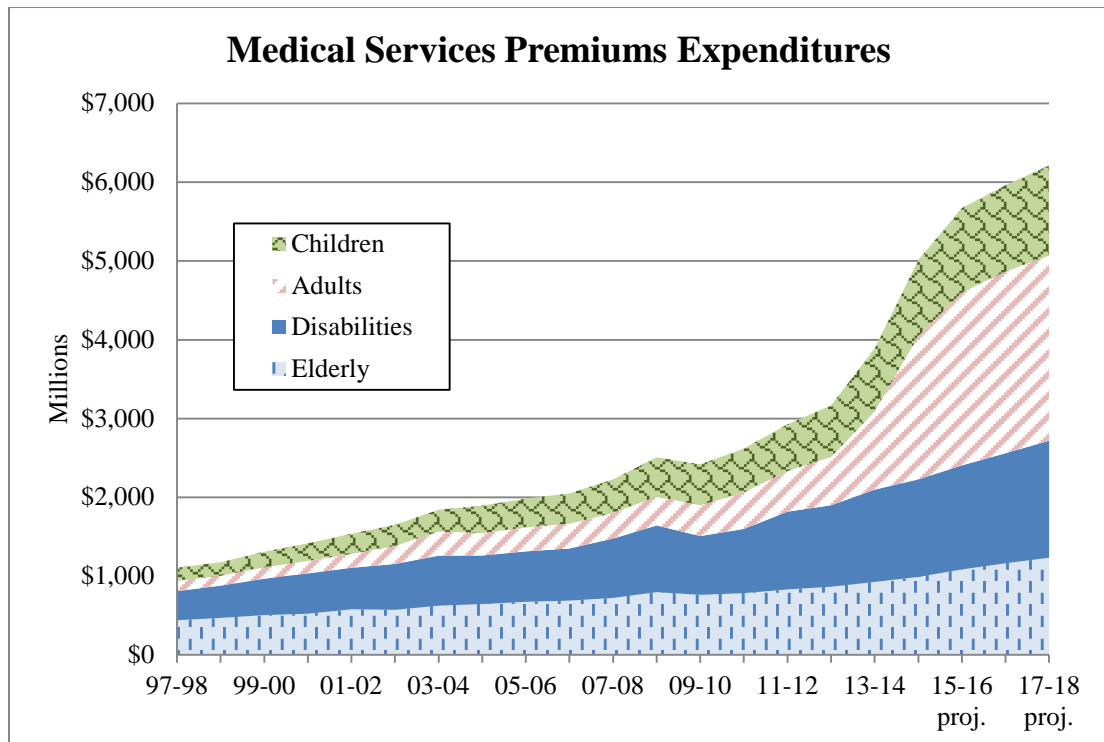
The graph below summarizes projected changes in Medicaid enrollment, highlighting the population that is defined as "newly eligible" pursuant to the ACA and therefore eligible for an enhanced federal match. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 1997. Medicaid currently covers an estimated 20 percent of Colorado's population and HCPF is projecting that it will cover almost 25 percent by the end of FY 2016-17.



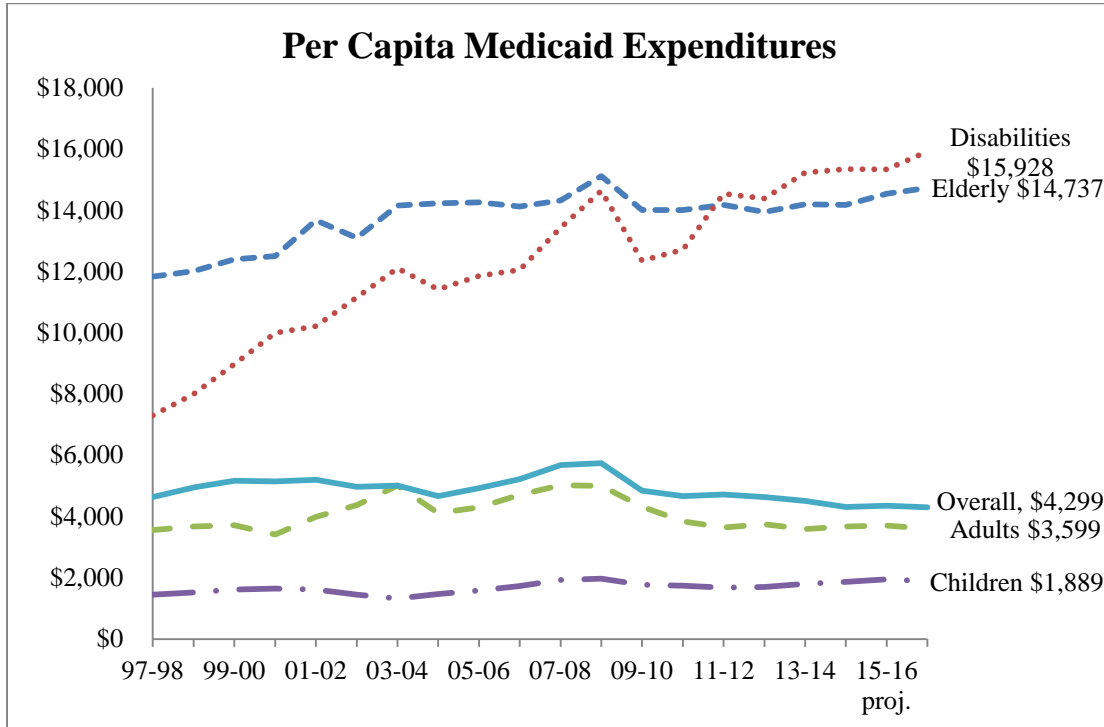
The next graph breaks the Medicaid enrollment into broad categories of children, adults, people with disabilities, and the elderly. Historically, most of the variability in enrollment trends is among children and adults. These populations are sensitive to changes in the economy. The recent growth is primarily due to the Medicaid expansion authorized in S.B. 13-200. In addition to new eligibility criteria, there has been increased enrollment from among people previously eligible but not enrolled (EBNE). The Department describes this as a "welcome mat" effect due to national attention on the ACA implementation and the individual mandate.



The next graph shows trends in expenditures for the same four broad eligibility categories. Compared to the previous graph, For FY 2016-17 the elderly and disabled represent 12 percent of the projected enrollment, but 43 percent of the projected expenditures.



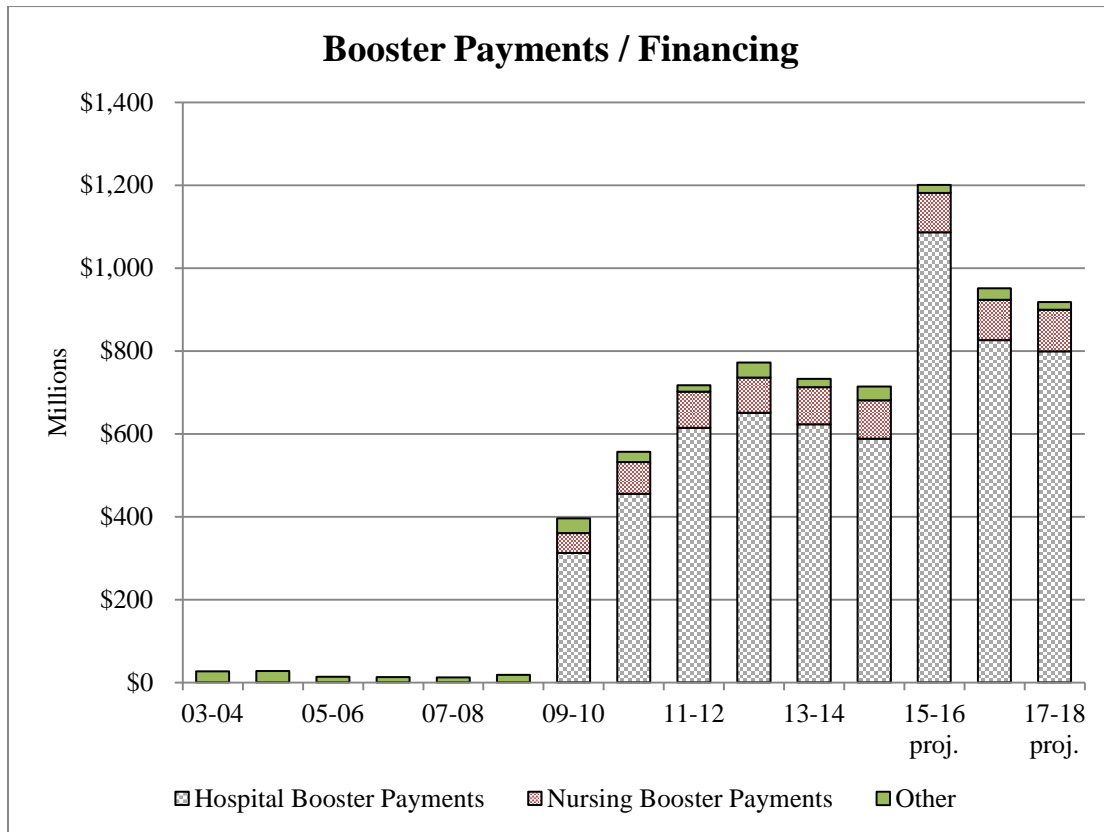
The next graph provides projected changes in per capita expenditures by enrollment category, not including booster payments / financing.



Booster Payments/Financing

Although this expenditure category includes some miscellaneous other financing mechanisms, it is primarily composed of booster payments to hospitals and nursing facilities. The Department refers to these as supplemental payments, but the JBC staff describes them as booster payments to avoid potential confusion caused by the term "supplemental" that has a very specific meaning in the legislative budget process. The net change in booster payments/financing drives a decrease in expected expenditures for Medical Services Premiums of \$396.1 million total funds and an increase of \$3.6 million General Fund.

The table below summarizes the trends in booster payments/financing under current law. This does not include the Governor's proposed statutory restriction on hospital provider fee revenue, which is discussed in the next arrowed item.



Most of the variability in this expenditure category is attributable to the hospital booster payments. The Medicaid expansion caused a level shift in the amount of revenue Colorado could collect through the Hospital Provider Fee within federal limits on this type of financing. Much of that level shift was expected to occur in FY 2014-15, but due to delays in federal approval the revenue and expenditures were pushed to FY 2015-16. The projected decrease in expenditures in FY 2016-17 is due to Hospital Provider Fee revenues returning to the expected post-expansion norm.

➔ R1 Restrict Hospital Provider Fee revenue

Description: The Department requests legislation to restrict hospital provider fee revenue for FY 2016-17 and FY 2017-18. This was originally described by the executive branch as a \$100 million restriction, but in the February 2016 forecast the Department lowered the projected maximum revenue that could be collected from the Hospital Provider Fee without lowering the requested total revenue from the Hospital Provider Fee with the Governor's restriction, so it is now better described as an approximately \$73.1 million restriction on the Hospital Provider Fee revenue. The Department explains that the Governor's budget was balanced to a specific total revenue from the Hospital Provider Fee, rather than a specific restriction on the revenue.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

	Governor's Request	February 2016 Forecast
Maximum HPF under federal limits	\$756,254,120	\$729,403,848
Requested HPF	<u>\$656,254,120</u>	<u>\$656,254,120</u>
Required restriction on HPF	(\$100,000,000)	(\$73,149,728)

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

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

The Governor proposed that the restriction on the Hospital Provider Fee revenue be accomplished through a statutory change. The JBC received an opinion from Legislative Legal Services, dated December 7, 2015, that reducing Hospital Provider Fee revenues without reducing Medicaid eligibility or benefits would require legislation, due to the way the statutes prioritize expenditures from the Hospital Provider Fee when revenues are insufficient.

The Department provided an estimate of the change in net payments by hospital as a result of the proposed restriction. The estimate can be found in Appendix B at the end of this document.

Recommendation: Staff recommends that the JBC sponsor legislation to restrict Hospital Provider Fee revenues by \$100 million for FY 2016-17 and FY 2017-18. This is a greater restriction than currently requested by the Department. As described previously, the Department originally proposed a \$100 million restriction on revenue, but with the revised February 2016 forecast, the effective restriction in the Governor's request is approximately \$73.1 million.

The staff recommendation assumes that the March revenue forecast will show at least a \$100 million General Fund obligation for a TABOR refund. If the March revenue forecast shows less than a \$100 million General Fund obligation for a TABOR refund, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then the JBC staff does not believe a \$100 million reduction in Hospital Provider Fee revenues would be beneficial to the budget and would not recommend the restriction.

The Hospital Provider Fee booster payments can be thought of as filling a gap between Medicaid rates and hospital costs and the JBC staff recommendation is to maintain expectations about how much of the gap will remain unfilled. The booster payments raise hospital reimbursement to the

federal Upper Payment Limit (UPL), and the UPL is based on what Medicare would have paid for equivalent services, and Medicare rates are nominally based on cost, and so the Hospital Provider Fee is closing a gap between Medicaid rates and hospital costs. It could be argued whether the UPL formula accurately describes what Medicare would have paid, and whether Medicare rates accurately reflect costs, but these are the policy objectives that guide the calculations. The booster payments do not fully fill the gap between Medicaid rates and cost, because half the money to make the booster payments comes from the hospitals themselves. The Governor's request established an expectation of how much of the gap would go unfilled. Based on the February 2016 forecast, the size of the gap is smaller than originally assumed, so the same total revenue from the Hospital Provider Fee could fill more of the gap. However, the staff recommendation is to maintain expectations about how much of the gap will go unfilled. Relative to the most recent information about actual hospital costs for Medicaid clients, the JBC staff recommends the same shortfall in funding as originally proposed by the Governor.

Both the JBC staff recommendation and the Governor's request would reduce the TABOR refund due to taxpayers. The loss of TABOR refunds is one objection sometimes raised to designating the Hospital Provider Fee as an enterprise, and so the JBC staff wants to make sure that legislators understand that this staff recommendation would have a similar effect on TABOR refunds, although the magnitude might be different.

Adopting the JBC staff recommendation could affect statutory transfers to the Highway Users Tax Fund and Capital Construction, including whether the transfers are made and the size of the transfers. The purpose of the staff recommendation is to provide budget relief and not to direct a specific allocation of that relief to another budget priority. The JBC staff recommendation assumes the JBC will explore any potential transfers from the General Fund and the size of those transfers as a separate issue.

The staff recommendation is for a temporary reduction in Hospital Provider Fee revenue for FY 2016-17 and FY 2017-18, consistent with the temporary restriction proposed by the Governor.

Alternative – Replace hospital booster payments with a provider rate increase

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

Department projects hospitals will provide in FY 2016-17, the average General Fund match rate for fee-for-service payments to hospitals is expected to be 28.4 percent.

If the JBC wanted to replace \$10 million from the Hospital Provider Fee with a rate increase, it would cost \$2.9 million General Fund to hold the hospitals harmless in aggregate, and the General Fund would pay \$10 million less in TABOR refunds, resulting in a net savings to the General Fund of \$7.1. This example, summarized in the table below, is scalable, so if the JBC wanted to replace the entire \$100 million reduction to the Hospital Provider Fee that is recommended by the JBC staff with a rate increase to hold hospitals harmless, the net savings to the General Fund would be \$71 million. This is less than the \$100 million savings to the General Fund under the JBC staff recommendation, but it is still a considerable savings. If the JBC wanted to achieve the same \$100 million of General Fund savings recommended by the JBC staff, it could do so by replacing \$140.2 million from the Hospital Provider Fee with a provider rate increase.

Restrict Hospital Provider Fee (HPF) revenue	(\$10,000,000)
<u>Effect on hospitals</u>	
Net loss in HPF booster payments	(\$10,080,321)
Provider rate increase	<u>\$10,080,321</u>
Net benefit/(loss) to hospitals	\$0
<u>Effect on the General Fund</u>	
TABOR Refund (not appropriated)	(\$10,000,000)
GF cost of rate increase	<u>\$2,867,207</u>
Net benefit to General Fund	(\$7,132,793)

There are a some limits on how much General Fund savings the JBC could achieve by replacing Hospital Provider Fee booster payments with a provider rate increase. First, the cut to the Hospital Provider Fee cannot exceed the booster payments. The FY 2016-17 projected Hospital Provider Fee expenditure from the Medical Services Premiums line item for hospital booster payments is \$409.8 million. Potentially, the General Assembly could also replace booster payments from the Safety Net Provider Payments line item with rate increases, but this would require a reimagining of the Colorado Indigent Care Program. Second, the cut to the Hospital Provider Fee cannot exceed the TABOR refund, because the General Fund savings from this strategy is dependent on reducing the General Fund obligation for a TABOR refund. The March revenue forecast will provide a new estimate of the TABOR refund. The actual TABOR refund will be dependent on actual revenues.

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

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

If Hospital Provider Fee revenues were replaced with a provider rate increase, it might reduce the potential for a challenge by CMS based on the new federal regulation regarding assuring access (see the discussion of *BA6 Fed reg for assuring access* for more background on this regulation).

The JBC staff is not recommending this alternative in part because it may have unintended consequences. As noted above, replacing the Hospital Provider Fee with a rate increase will likely change the distribution of funding among hospitals and that could have negative consequences for the delivery system, but it is unknown whether and how the Department might change the distribution formula for the remaining booster payments and what the final result would be by hospital. One factor in the distribution of the Hospital Provider Fee is quality of care, but that is not a consideration in the current fee-for-service rates. Also, if hospital provider rates are increased, then the effect on the budget of future changes in the utilization of hospital services is magnified.

Another consideration is that both the Governor's request and the JBC staff recommendation are for temporary reductions to the Hospital Provider Fee, while a provider rate increase for the hospitals would be perceived as permanent. The JBC staff is uncomfortable recommending a rate increase for the hospitals, particularly if it is a large increase, before the S.B. 15-228 rate review process has had a chance to do even one review cycle. It could be that increasing rates for a different provider turns out to be more important for the delivery system than backfilling lost revenue to the hospitals from the Hospital Provider Fee. While it may be unrealistic to assume that the budget environment will be significantly better in two years such that restoring the Hospital Provider Fee will be easy, there might be more clarity in two years about where Medicaid provider rates are causing the most issues with access and where backfilling lost revenue from the Hospital Provider Fee falls among the Department's priorities.

Another consideration is that the net benefit to hospitals from the Hospital Provider Fee has been significantly greater than originally expected. When the Hospital Provider Fee was created it was not expected that the expansion populations would receive an enhanced federal match pursuant to the ACA. That match for FY 201617 is 97.5 percent. The enhanced federal match reduces the amount of Hospital Provider Fee revenue that goes to providers other than hospitals for services to expansion populations and increases the proportion of the Hospital Provider Fee that directly benefits the hospitals. Also, when the Hospital Provider Fee was created the effect of the Medicaid expansion on increasing the federal limits on the Hospital Provider Fee was not fully understood.

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

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

Alternative – Designate the Hospital Provider Fee as an enterprise

Last year the Governor proposed that rather than limiting the Hospital Provider Fee revenue, the General Assembly designate the Hospital Provider Fee as part of an enterprise, which would make the revenue exempt from TABOR. He then went one step further and argued that doing so would not require an adjustment to the TABOR base. House Bill 15-1389 (Hullinghorst & Court / Steadman) was introduced to implement the idea, but it was postponed indefinitely in the Senate's State, Veterans, and Military Affairs Committee. If something similar to H.B. 15-1389 was implemented in FY 2016-17, it would remove approximately \$730 million in projected revenue attributable to the Hospital Provider Fee from the calculation of whether a TABOR refund is due. This does not mean that there would be \$730 million more General Fund available for the budget. The amount of General Fund savings would be dependent on the size of the TABOR refund absent a change in policy.

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

There would be some secondary effects from designating the Hospital Provider Fee as an enterprise. First, the conservation easement tax credit would remain non-refundable. Pursuant to Section 39-22-522 (5) (b), C.R.S., a portion of the tax credit becomes refundable if a TABOR surplus is due. In November the Legislative Council Staff estimated that this would increase General Fund revenue projections by approximately \$5.2 million in FY 2016-17 and \$10.5 million in FY 2017-18. These figures might need to be updated after the March revenue forecast. Second, the General Assembly would be allowed to eliminate tax expenditures without prior voter approval in FY 2016-17, if it wanted, which could increase General Fund revenues. The conclusion that limiting tax expenditures without prior voter approval is allowable when it doesn't cause a TABOR refund is based on the Colorado Supreme Court's decision in *Mesa County Bd. of County Comm'rs v. State*.

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

The dollar risk of designating the Hospital Provider Fee as an enterprise and subsequently receiving a court determination that it is unconstitutional is dependent on when a law suit is filed and resolved and on how much revenue is retained. It is important to note that the Governor's budget, including budget amendments, was balanced in January assuming \$100 million in savings from restricting Hospital Provider Fee revenues. So, when looking at what designating the Hospital Provider Fee as an enterprise would save compared to the Governor's request, the total savings from the enterprise designation needs to be reduced by the \$100 million that the Governor was already counting on achieving through a different policy action.

➔ R12 Provider rates

Request: The Department requests a 1.0 percent across-the-board reduction to certain discretionary community provider rates. The only affected division that is covered in this presentation is Medical Services Premiums, but the request also affects Behavioral Health Community Programs and the Office of Community Living.

For the Medical Services Premiums division the requested reduction is projected to save \$30.4 million, including \$10.3 million General Fund. The Governor proposed excluding from the reduction physician services and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, because the providers of these services will be significantly affected by the scheduled expiration of the primary care rate bump. Also, the proposed reduction does not apply to non-discretionary rates traditionally excluded from across-the-board adjustments because they are capitated rates, cost-based rates, or rates that are based on a methodology defined in statute. The traditionally excluded rates are for pharmacy reimbursements, rural health centers, federally qualified health centers, home- and community-based services for children with autism, hospice care in nursing facilities, nursing reimbursements, disease management, and administrative contracts.

Recommendation: Staff recommends no across-the-board reduction, based on the JBC's common policy regarding community provider rates.

➔ Annualize Primary Care Rate Bump

Request: The Governor's request does not extend an increase in primary care rates that was originally put in place January 2013 and is scheduled to expire June 2016. The Department estimates this saves \$145.1 million total funds, including \$49.5 million General Fund.

Recommendation: Staff recommends the Governor's request. The funding for the primary care rate bump, as it is called, was tied by both the Governor and the legislature to a temporary increase in the federal match rate for Colorado Medicaid that is no longer available. Also, a third-party analysis commissioned by the Department does not show a correlation between the primary care rate bump and provider participation in Medicaid. After the analysis section there is a discussion of options the JBC could consider if the Committee wants to continue funding for primary care rates at a reduced level.

Analysis: The primary care rate bump was originally implemented to comply with Section 1202 of the Affordable Care Act that required states to increase Medicaid rates for certain primary

care services and immunizations performed by primary care providers to at least match the equivalent Medicare Part B rates. The ACA provided a 100 percent federal match for the primary care rate bump from January 2013 through the end of calendar year 2014. The purpose of the federally-mandated primary care rate bump was to ensure there would be a sufficient pool of primary care providers willing to see people newly eligible for Medicaid as a result of the expansion.

During the state FY 2014-15 budget cycle, the General Assembly decided to extend the primary care rate bump with some modifications. Colorado was one of 15 states to fully or partially extend the rate bump. The decision to extend the rate bump was made following unexpected news that the federal match rate, called the federal medical assistance percentage (FMAP), was going to increase for Colorado in federal fiscal year 2014-15 from 50.00 percent to 51.01 percent. The Governor submitted a budget amendment connecting the enhanced primary care rates to the General Fund savings from the increase in the FMAP rate. The Governor proposed that the elevated primary care rates continue an additional 18 months from January 2015 through June 2016.

Part of the rationale for a time-limited extension was that the source of funding financing the extension was expected to have a short-duration. The increase in the FMAP was due to Colorado's per capita personal income falling relative to other states during the economic downturn. As the economy improved, the Department anticipated the FMAP would approach the federal minimum of 50% that Colorado had received each year for at least the preceding decade. The FMAP has decreased as predicted. The FMAP for federal fiscal year 2016-17 will be 50.02 percent and the Department projects it will drop to 50 percent for federal fiscal year 2017-18.

The second reason for the time-limited extension was that the Department had only anecdotal evidence about whether the change in primary care rates was effective in improving client access to services. As part of the extension of the enhanced primary care rates the Department requested and received funding to study the effect of the rates on access. The Department indicated that the extension would allow time to collect data to inform a decision about whether to request continued funding in future years.

The state extension of the rate bump made some modifications intended to improve the effectiveness of the policy as an incentive for access. First, the state extension removed a requirement that providers self-attest that they meet the federal eligibility qualifications or operate under the personal supervision of a provider meeting the eligibility qualifications. Instead, the state extension paid based on the type of service provided. The Department indicated the self-attestation requirement was administratively burdensome for providers, potentially causing them to not claim the enhanced rate. The change also allowed some new providers to benefit from the enhanced rates, such as independent advanced practice nurses, school based health clinics, nephrologists, or HIV doctors, who often act as the medical home for clients. Second, the Department began paying the enhanced rate on a per claim basis, rather than quarterly as a supplemental payment. This made the enhanced rates more transparent to providers and got the money in the hands of the providers more quickly. The changes also made the payments significantly easier for the Department to administer.

The effect of the rate bump on payments varied widely by code from a 1.1 percent to 69.4 percent increase, so it is hard to say the exact percentage reduction that will be caused by the end of the rate bump. The effect by provider will vary based on the codes most frequently used by the provider. According to HCPF, more than half of the rate increases from the rate bump were between 10% and 30%. Overall expenditures for eligible codes increased 23.2% due to the rate bump.

The Department contracted for a study of the effect of the primary care rate bump on access. An initial report with analysis of data through June 2014 was shared with the JBC during the briefing. A final report that includes analysis of data through June 2015 is in editing and will be published in March, but the Department was able to share a draft with the JBC staff. The final report includes analysis of the effect of the Colorado modifications to the primary care rate bump, including removing the attestation requirement. The draft of the final report indicates there were no major differences in the key findings from the initial report. As indicators of access the study looked at client outcomes and at provider behavior, using claims data.

If the rate bump increased access, then the report expected client outcomes to improve. The client outcomes measured were:

- The number of emergency department visits for ambulatory care sensitive conditions per 10,000 adult Medicaid clients. Ambulatory care sensitive conditions are those that are potentially preventable with good primary care, such as visits for diabetes, as opposed to visits for accidents such as a broken arm.
- The percentage of adults having at least one primary care visit in the prior 12 months
- The percentage of children having at least one primary care visit in the prior 12 months
- The percentage of bump-eligible visits with usual care providers, which measures continuity of care

If the rate bump increased access, then the report expected the following provider behaviors to increase:

- Number of providers with bump-eligible visits
- Number of bump-eligible visits in a month

The report had three main findings:

- During a period of significant enrollment growth, client-based access to care measures remained stable and the number of providers of primary care services to Medicaid clients increased with enrollment.
- Graphical and time-series regression analysis of the claims data suggest that the rate bump did not significantly alter the time trends of the client outcomes and provider behaviors measured.
- Statistical modeling suggests providers delivered an additional two to five bump-eligible visits per month to Medicaid clients in months when the provider was attested. The modeling of the Colorado extension of the primary care rate bump, which removed the attestation requirement, does not show an impact on the number of bump-eligible visits.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Options: Some JBC members have expressed an interest in trying to maintain a portion of the primary care rate bump at a reduced funding level.

One way to reduce costs would be to prioritize certain rates over others. The Department broke the codes out into some categories and identified two areas of concern. First, when Colorado extended the primary care rate bump and switched from a supplemental payment to a per claim payment, some of the rate increases ended up getting applied to evaluation and management codes used for emergency room visits. Funding evaluation and management in an emergency room setting may not be what legislators had in mind when trying to increase resources for primary care services. Second, the Department noted that some of the largest gaps between Medicaid and Medicare reimbursement for primary care are related to immunization administration, and so this might be an area to prioritize for funding.

Primary Care Rate Bump by Code Group				
Code Group	Total Funds	General Fund	Cash Funds	Federal Funds
Counseling and Health Risk Assessments	\$198,744	\$55,319	\$2,666	\$140,758
Critical Care Visit	4,763,812	1,703,417	60,399	2,999,995
Emergency Department Visit	29,462,705	8,995,271	338,657	20,128,777
Home Visit	165,138	75,545	1,411	88,182
Immunization Administration	6,247,766	2,817,432	13,285	3,417,048
Inpatient/facility Visit	20,323,467	6,779,537	296,333	13,247,597
Newborn	1,702,933	823,858	2,533	876,542
Office Visit	70,139,341	23,366,191	871,058	45,902,092
Preventive Medicine visits	11,722,786	4,772,177	51,621	6,898,987
Prolonged visits	348,204	130,389	4,090	213,725
Standby, Warfarin, Interdisciplinary conference	<u>739</u>	<u>264</u>	<u>5</u>	<u>470</u>
Total	\$145,075,634	\$49,519,402	\$1,642,057	\$93,914,175

Another way to reduce costs would be to target some minimum percentage of Medicare rates that the JBC doesn't want to fall below. In this scenario primary care rates would be reduced to the greater of their pre-primary care rate bump level or a specified percentage of the equivalent Medicare rate. The table below summarizes the cost of bringing the primary care rates to a few different percentages of the Medicare rates. This particular table excludes emergency department visits, but the same could be done including emergency department visits, if the JBC wants.

Primary Care to a Minimum Percent of Medicare (Excluding Emergency Department Visits)				
	Total Funds	General Fund	Cash Funds	Federal Funds
90% of Medicare	\$76,368,277	\$26,926,222	\$841,709	\$48,600,347
85% of Medicare	\$56,761,514	\$20,134,517	\$610,874	\$36,016,123
80% of Medicare	\$37,214,463	\$13,365,381	\$380,652	\$23,468,431
75% of Medicare	\$18,507,594	\$6,904,060	\$160,101	\$11,443,434
70% of Medicare	\$5,622,569	\$2,361,125	\$22,195	\$3,239,249

LINE ITEM DETAIL – MEDICAL SERVICES PREMIUMS

Medical and Long-term Care Services for Medicaid Eligible Individuals

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

Statutory Authority: Section 25.5-5-101 et seq., C.R.S.

Request: The Department requests:

- R1 Medical Services Premiums
- BA10 Medicaid-Medicare grant true up
- R11/BA16 standard federal match
- R12 Provider rates
- NP Cervical cancer eligibility
- Annualize HB 15-1186 children with autism/Behavioral therapy benefit
- Annualize primary care rate bump
- Annualizations of other prior year budget decisions

Included in R1 was a request for legislation to limit revenue from the Hospital Provider Fee.

Recommendation: For a summary of the staff recommendations see the summary table for the division.

(5) Indigent Care Program

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

Indigent Care Program					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	\$529,831,660	\$12,158,464	\$211,881,900	\$305,791,296	0.0
Other legislation	1,189	0	143	1,046	0.0
HB 16-1240 (Supplemental)	(22,754,546)	0	(3,785,168)	(18,969,378)	0.0
Recommended Long Bill Supplemental	<u>(8,479,631)</u>	<u>0</u>	<u>1,371,234</u>	<u>(9,850,865)</u>	<u>0.0</u>
TOTAL	\$498,598,672	\$12,158,464	\$209,468,109	\$276,972,099	0.0
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$498,598,672	\$12,158,464	\$209,468,109	\$276,972,099	0.0
Tobacco tax forecast	47,937	0	47,937	0	0.0
R3 Childrens Basic Health Plan	5,964,870	(25,277)	(1,820,368)	7,810,515	0.0
R11/BA16 Standard federal match	0	115,490	(5,471,292)	5,355,802	0.0
Annualize prior year budget decisions	<u>1,327</u>	<u>0</u>	<u>160</u>	<u>1,167</u>	<u>0.0</u>
TOTAL	\$504,612,806	\$12,248,677	\$202,224,546	\$290,139,583	0.0
Increase/(Decrease)	\$6,014,134	\$90,213	(\$7,243,563)	\$13,167,484	0.0
Percentage Change	1.2%	0.7%	(3.5%)	4.8%	0.0%
FY 2016-17 Executive Request:	\$512,229,160	\$12,248,677	\$203,191,883	\$296,788,600	0.0
Request Above/(Below) Recommendation	\$7,616,354	\$0	\$967,337	\$6,649,017	0.0

DECISION ITEMS – INDIGENT CARE PROGRAM

➔ R3 Children's Basic Health Plan

Request: The Department requests a change to the appropriation for the Children's Basic Health Plan (CHP+) based on a new forecast of caseload and expenditures under current law and policy.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

R3 represents the Department's forecast of expenditures based on the eligibility criteria and plan benefits in current law and policy and proposed changes to the eligibility criteria or plan benefits are contained in other requests.

On February 16, 2016 the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2016 forecast is lower than the forecast used for the Governor's request in total funds by \$8.5 million in FY 2015-16 and \$7.7 million in FY 2016-17. The General Fund is unchanged. The table below compares the projected expenditures under the forecast used for the Governor's request with the updated February 2016 forecast.

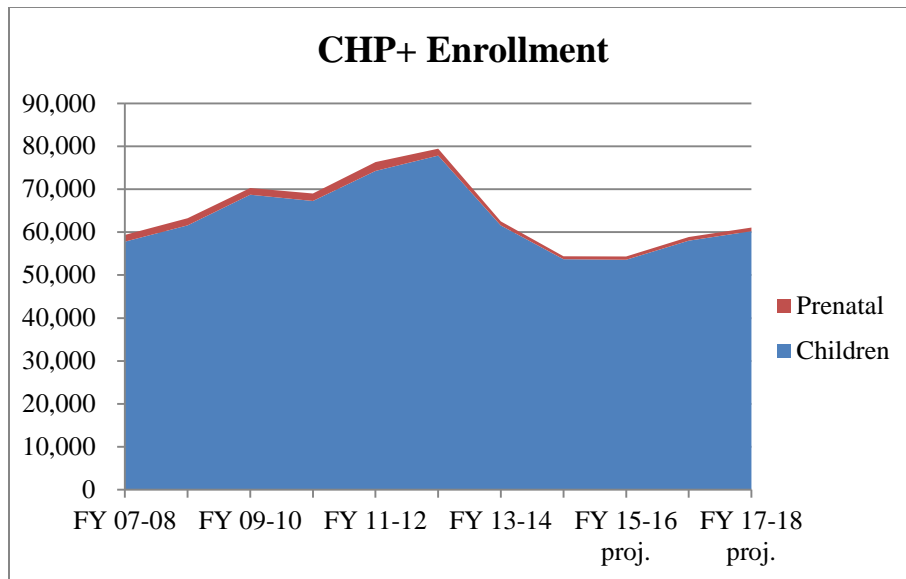
Total Projected Children's Basic Health Plan Under Current Law/Policy				
	Governor's Request	February 2016 Forecast	Difference	Percent Difference
FY 15-16	<u>\$143,968,478</u>	<u>\$135,488,847</u>	<u>(\$8,479,631)</u>	-5.9%
General Fund	\$2,525,718	2,525,718	0	0.0%
Cash Funds	\$25,326,308	26,697,542	1,371,234	5.4%
Federal Funds	\$116,116,452	106,265,587	(9,850,865)	-8.5%
Enrollment	58,471	54,337	(4,134)	-7.1%
FY 16-17	<u>\$149,119,335</u>	<u>\$141,455,044</u>	<u>(\$7,664,291)</u>	-5.1%
General Fund	2,500,441	2,500,441	0	0.0%
Cash Funds	18,011,548	17,533,954	(477,594)	-2.7%
Federal Funds	128,607,346	121,420,649	(7,186,697)	-5.6%
Enrollment	60,639	58,870	(1,769)	-2.9%

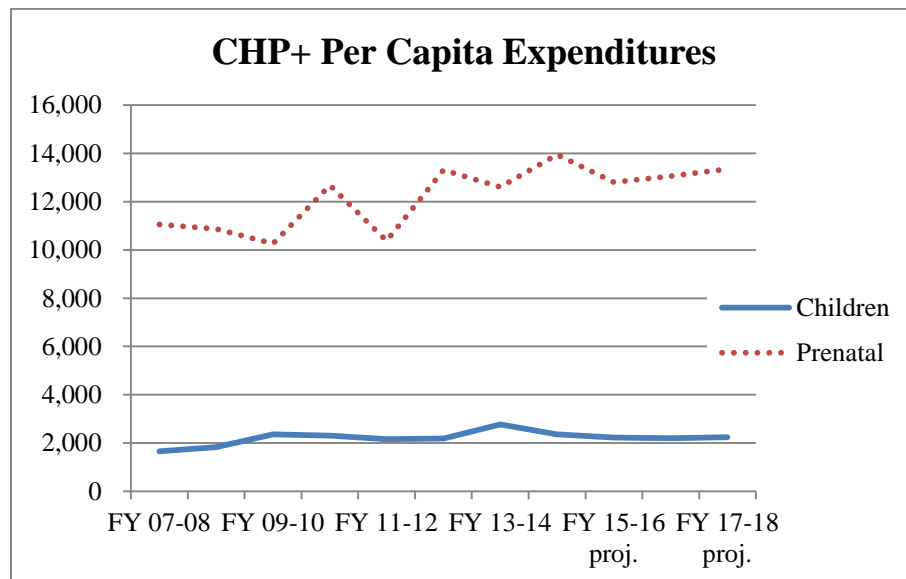
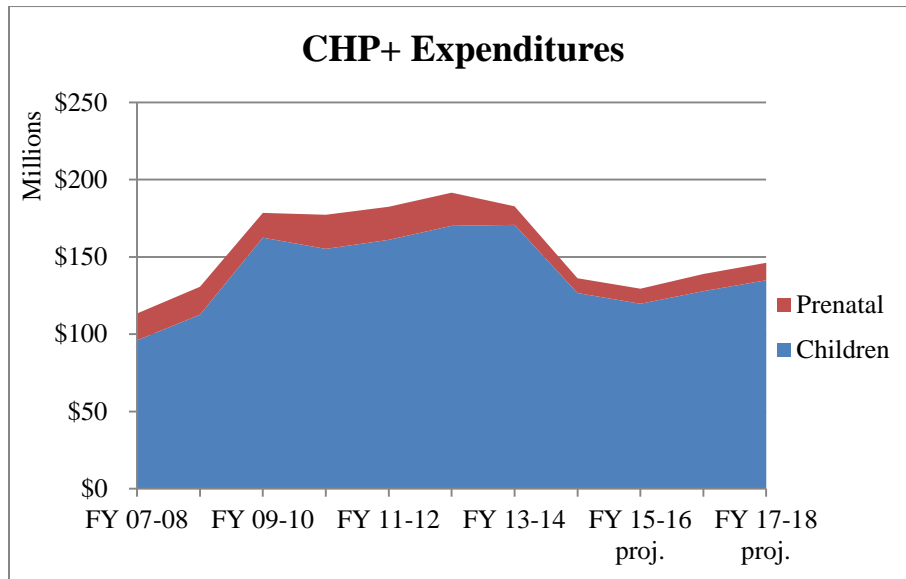
The table below summarizes the changes in expenditure projected in the February 2016 forecast compared to the appropriation.

February 2016 Forecast for Children's Basic Health Plan - Changes by Fiscal Year					
	Total	GF	CF	FF	Enrollment
<u>FY 15-16</u>					
FY 15-16 Appropriation	\$143,968,478	\$2,525,718	\$25,326,308	\$116,116,452	58,471
FY 15-16 February 2016 Forecast	\$135,488,847	\$2,525,718	\$26,697,542	\$106,265,587	54,337
Difference	(\$8,479,631)	\$0	\$1,371,234	(\$9,850,865)	(4,134)
Percent	-5.9%	0.0%	5.4%	-8.5%	-7.1%
<u>FY 16-17</u>					
FY 15-16 Total	\$135,488,847	\$2,525,718	\$26,697,542	\$106,265,587	54,337
Annualizations	\$1,327	\$0	\$160	\$1,167	0
Federal match changes	<u>\$0</u>	<u>\$0</u>	<u>(\$7,343,380)</u>	<u>\$7,343,380</u>	<u>0</u>
FY 16-17 Base	\$135,490,174	\$2,525,718	\$19,354,322	\$113,610,134	54,337
FY 16-17 February 2016 Forecast	\$141,455,044	\$2,500,441	\$17,533,954	\$121,420,649	58,870
Difference	\$5,964,870	(\$25,277)	(\$1,820,368)	\$7,810,515	4,533
Percent	4.4%	-1.0%	-6.8%	7.3%	8.3%

The forecasted General Fund is to reimburse the federal government for disallowed payments in prior years. The majority of the cash funds come from the Children's Basic Health Plan (CHP+) Trust, which receives revenue from the tobacco master settlement, enrollment fees, and interest. The CHP+ program also receives money from the Hospital Provider Fee for children and pregnant adults with income from 206 percent to 260 percent of the federal poverty guidelines. Small amounts of the cash funds are from the Colorado Immunization Fund (originally tobacco settlement money), and the Health Care Expansion Fund (originally tobacco tax money). The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. In October 2015 the enhanced FMAP for CHP+ increased by 23 percentage points and so there is an annualization of that increase in FY 2016-17. This is why the adjustment for the change in the federal match rate results in a decrease in the state share and increase in the federal share while the opposite is happening for all other line items. The average federal match for CHP+ for state FY 3016-17 is 88.14 percent.

Recommendation: Staff recommends using the Department's February 2016 forecast of enrollment and expenditures to modify both the FY 2015-16 and FY 2016-17 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. The graphs below illustrate trends in CHP+ enrollment and expenditures.





Projected revenues for the CHP+ Trust exceed projected expenditures for the time period the program is authorized at the federal level. The projected surplus in the CHP+ Trust is primarily the result of two factors: (1) bills that made some of the population traditionally served by CHP+ eligible for Medicaid (S.B. 11-008 and S.B. 11-250); and (2) the 23 percentage point increase in the federal match rate that occurred October 2015.

Based on the projections, the JBC could consider using money in the CHP+ Trust to help balance the budget. There are three ways the CHP+ Trust could be used to help balance the budget:

- Reduce the allocation from the tobacco master settlement agreement:** The JBC is already considering a bill to make changes to the distribution of the tobacco master settlement and this could be part of the bill. The CHP+ program currently receives 25.0

percent of the Tier 1 distributions plus 14.5 percent of the Tier 2 distributions, which has historically provided roughly \$27 million per year. Reducing this annual transfer by somewhere in the neighborhood of \$10 million would bring revenues for the CHP+ program more in line with projected expenditures for the forecast horizon. A larger reduction in the transfer would create a negative cash flow and spend down the fund balance, but would not be sustainable if the fund balance is depleted before FY 2018-19, or if the CHP+ program continues beyond FY 2018-19. A reduction in the transfer would free up money from the tobacco master settlement agreement for other purposes.

- **Transfer money from the CHP+ Trust to the General Fund.:** This would take a bill. The JBC staff is projecting a fund balance at the end of FY 2015-16 of \$28.1 million. A transfer would provide one-time funding and so would be best reserved for one-time needs, such as bridging a mid-year budget shortfall or financing a capital construction project.
- **Offset the need for General Fund in the Medical Services Premiums line item:** The Office of Legislative Legal Services has reviewed the CHP+ Trust statutes and provided guidance that the CHP+ Trust could be used to pay costs for the children eligible for Medicaid pursuant to S.B. 11-008 without a change in statute. This would reduce the amount of General Fund required for the Medical Services Premiums line item. For FY 2016-17 the Department is projecting General Fund expenditures of \$11.9 million for the S.B. 11-008 children that could be offset with money from the CHP+ Trust.

The JBC could potentially use some combination of all three strategies, as long as the combined effect stayed within whatever level of funding the JBC targets for the CHP+ Trust. The table below provides an updated projection of the revenues, expenditures, and fund balance for the CHP+ Trust based on the December Legislative Council Staff forecast of revenue from the tobacco master settlement agreement and the February 2016 forecast by the Department of expenditures for the CHP+ program.

	Children's Basic Health Plan Trust				
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Beginning Fund Balance	\$13,937,178	\$18,291,567	\$28,104,099	\$40,333,146	\$53,604,209
Revenue	<u>\$31,840,037</u>	<u>\$28,858,086</u>	<u>\$27,041,381</u>	<u>\$28,672,281</u>	<u>\$23,957,481</u>
Fees	896,127	1,205,499	1,299,858	1,376,216	1,470,499
Tobacco Settlement	27,889,272	27,459,195	25,548,832	27,105,476	22,296,393
Interest	195,419	193,392	192,691	190,589	190,589
Recoveries	2,859,220	0	0	0	0
Expenses	\$27,485,649	\$19,045,554	\$14,812,334	\$15,401,218	\$16,028,872
Net Cash Flow	\$4,354,389	\$9,812,532	\$12,229,047	\$13,271,063	\$7,928,609
Ending Fund Balance	\$18,291,567	\$28,104,099	\$40,333,146	\$53,604,209	\$61,532,818

The JBC staff is not recommending any specific action to reduce the CHP+ Trust at this time. The JBC is already considering a bill to change the distribution of the tobacco master settlement agreement and the JBC staff does not know how much of a change, if any, the JBC expects to make to the transfer for the CHP+ Trust.

A factor to consider before reducing the CHP+ Trust is that the future federal authority for the program is uncertain. Federal authority for the program expires October 2019. It is not clear whether the program is likely to be reauthorized, or if federal policy makers will decide that the population served by CHP+ can get access to insurance through the health care exchange. If the program is not reauthorized at the federal level, or it is reauthorized at a less advantageous federal match rate, then Colorado will need to decide whether to continue the program and, if so, how to finance it with less federal funds. Carrying a balance in the CHP+ Trust might provide funding for a transition to whatever comes next.

Another consideration is that keeping a balance in the CHP+ Trust could minimize General Fund costs in the event a mid-year adjustment to funding is required due to a forecast error. CHP+ expenditures have historically been difficult to predict, as there is both an upper and lower bound on income eligibility. Expenditures for CHP+ can move counter to the economy, as people who were eligible for Medicaid gain income and become eligible for CHP+. Also, the new guidance from LLS indicates that the CHP+ Trust can be used for Medicaid for the children eligible pursuant S.B. 11-008. So, the CHP+ Trust could potentially be used to offset the General Fund cost of a mid-year adjustment to Medicaid as well as CHP+.

LINE ITEM DETAIL – INDIGENT CARE PROGRAM

Safety Net Provider Payments

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

The source of cash funds is the Hospital Provider Fee and the federal match rate is at the standard Medicaid FMAP. Colorado draws the federal funds for Safety Net Provider Payments through two different methods. First, Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds, if the local match is provided. Second, Colorado receives a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. Federal DSH allotments are required to decrease in aggregate with the implementation of the Affordable Care Act and the expected decrease in the uninsured population, but federal legislation has delayed the decrease until federal fiscal year 2016-17 and the specific effect on Colorado is not yet known.

The Medicaid expansion authorized by S.B. 13-200 significantly reduced the number of people eligible for the CICP, but there is still a population with income above the effective Medicaid eligibility threshold for adults of 138 percent and the CICP eligibility income limit of 250

percent. Also, non-pregnant adult legal immigrants who have been in the United States for less than five years do not qualify for Medicaid but do qualify for the CICIP. Many people eligible for the CICIP would also qualify for federal tax credits to purchase insurance through Connect for Health Colorado, but may not be able to meet out-of-pocket expenses.

Statutory Authority: Section 25.5-3-104, C.R.S.

Request: The Department requests *R11/BA16 Standard federal match rate* and annualizations to account for the change in the FMAP rate. A small portion of the line item for administration receives a 50 percent federal match.

Recommendation: Staff recommends the requested funding based on the expected allocations through the CICIP.

Clinic Based Indigent Care

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

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

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

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

Statutory Authority: Section 25.5-3-104, C.R.S.

Request: The Department requests *R11/BA16 Standard federal match rate* and annualizations to account for the change in the FMAP rate.

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

Pediatric Specialty Hospital

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

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

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

Statutory Authority: Section 24-22-117, C.R.S.

Request: The Department requests *R11/BA16 Standard federal match rate* and annualizations to account for the change in the FMAP rate.

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

Appropriation from Tobacco Tax Fund to General Fund

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

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

Request: The Department requests continuation funding.

Recommendation: Staff recommends a decrease of \$3,963 based on the Legislative Council Staff's December forecast of tobacco tax revenue. The JBC provided authority during the figure setting for tobacco programs to adjust this amount, if necessary, based on the March revenue forecast.

Primary Care Fund

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

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

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

Statutory Authority: Section 25.5-3-301-303, C.R.S.

Request: The Department requests continuation funding.

Recommendation: Staff recommends a decrease of \$250,990 based on the Legislative Council Staff's December forecast of tobacco tax revenue. The JBC provided authority during the figure setting for tobacco programs to adjust this amount, if necessary, based on the March revenue forecast.

Children's Basic Health Plan (CHP+) Administration

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

The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee. Much of the activities of the contractor are actually related to the Medicaid program, because children may not enroll in CHP+ unless determined ineligible for Medicaid, and so a portion of the activities are financed at the Medicaid match rate instead of the CHP+ match rate.

Statutory Authority: Section 25.5-8-111 and 107, C.R.S.

Request: The Department requests continuation funding. This line item receives federal match rates based on administration that are not affected by the changes in the federal match rates for services.

Recommendation: Staff recommends the requested funding based on the ongoing contracts for administration of CHP+.

Children's Basic Health Plan (CHP+) Medical and Dental Costs

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

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

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid.

The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, and the Health Care Expansion Fund. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. In October 2015 the enhanced FMAP for CHP+ increased by 23 percentage points.

CHP+ Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 12-13	65.00	65.00	65.00	65.00	65.00
FY 13-14	65.00	65.00	65.00	65.00	65.00
FY 14-15	65.53	65.00	65.71	65.71	65.71
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	88.14	88.50	88.01	88.01	88.01
FY 17-18	<i>88.00</i>	88.01	<i>88.00</i>	<i>88.00</i>	<i>88.00</i>

Italicized figures are projections.

Statutory Authority: Section 25.5-8-107 et seq., C.R.S.

Request: The Department requests

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

- *R3 Children's Basic Health Plan*
- *R11/BA16 Standard federal match*
- Annualizations of prior year budget decisions.

Recommendation: The staff recommendation is summarized in the table below.

Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs					
	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	\$166,721,835	\$2,525,718	\$29,111,333	\$135,084,784	0.0
Other legislation	1,189	0	143	1,046	0.0
HB 16-1240 (Supplemental)	(22,754,546)	0	(3,785,168)	(18,969,378)	0.0
Recommended Long Bill Supplemental	<u>(8,479,631)</u>	<u>0</u>	<u>1,371,234</u>	<u>(9,850,865)</u>	<u>0.0</u>
TOTAL	\$135,488,847	\$2,525,718	\$26,697,542	\$106,265,587	0.0
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$135,488,847	\$2,525,718	\$26,697,542	\$106,265,587	0.0
R3 Children's Basic Health Plan	5,964,870	(25,277)	(1,820,368)	7,810,515	0.0
Annualize prior year budget decisions	1,327	0	160	1,167	0.0
Tobacco tax forecast	0	0	0	0	0.0
R11/BA16 Standard federal match	<u>0</u>	<u>0</u>	<u>(7,343,380)</u>	<u>7,343,380</u>	<u>0.0</u>
TOTAL	\$141,455,044	\$2,500,441	\$17,533,954	\$121,420,649	0.0
Increase/(Decrease)	\$5,966,197	(\$25,277)	(\$9,163,588)	\$15,155,062	0.0
Percentage Change	4.4%	(1.0%)	(34.3%)	14.3%	0.0%
FY 2016-17 Executive Request:	\$149,119,335	\$2,500,441	\$18,549,228	\$128,069,666	0.0
Request Above/(Below) Recommendation	\$7,664,291	\$0	\$1,015,274	\$6,649,017	0.0

(6) Other Medical Services

This division contains the funding for:

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

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

Other Medical Services						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	\$210,668,439	\$125,484,487	\$40,252,113	\$2,491,722	\$42,440,117	0.0
Other legislation	500,000	500,000	0	0	0	0.0
HB 16-1240 (Supplemental)	12,540,595	(1,318,801)	9,515,062	0	4,344,334	0.0
Recommended Long Bill Supplemental	<u>(1,637,822)</u>	<u>(1,637,822)</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0.0</u>
TOTAL	\$222,071,212	\$123,027,864	\$49,767,175	\$2,491,722	\$46,784,451	0.0
FY 2016-17 Recommended Appropriation						
FY 2015-16 Appropriation	\$222,071,212	\$123,027,864	\$49,767,175	\$2,491,722	\$46,784,451	0.0
R4 Medicare Modernization Act	16,273,413	16,273,413	0	0	0	0.0
R9/BA13 Old Age Pension Medical	0	0	0	0	0	0.0
R11/BA16 Standard federal match	534,194	597,408	41,485	0	(104,699)	0.0
BA11 Technical adjustments	0	0	0	0	0	0.0
BA14 Public school health services	(2,035,791)	0	(778,066)	0	(1,257,725)	0.0
Annualize prior year budget decisions	<u>3,966,785</u>	<u>(500,000)</u>	<u>2,471,354</u>	<u>0</u>	<u>1,995,431</u>	<u>0.0</u>
TOTAL	\$240,809,813	\$139,398,685	\$51,501,948	\$2,491,722	\$47,417,458	0.0
Increase/(Decrease)	\$18,738,601	\$16,370,821	\$1,734,773	\$0	\$633,007	0.0
Percentage Change	8.4%	13.3%	3.5%	0.0%	1.4%	0.0%
FY 2016-17 Executive Request:	\$235,284,495	\$143,447,393	\$41,938,566	\$2,481,078	\$47,417,458	0.0
Request Above/(Below) Recommendation	(\$5,525,318)	\$4,048,708	(\$9,563,382)	(\$10,644)	\$0	0.0

DECISION ITEMS – OTHER MEDICAL SERVICES

➔ R4 Medicare Modernization Act

Request: The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act. The Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. The size of the state's obligation under the federal formula is influenced by changes in the population that is dually eligible for Medicaid and Medicare, their utilization of prescription drugs, and prescription drug prices.

On February 16, 2016 the Department submitted an update to the forecast. Although the update is not an "official" request to change the appropriation and it was submitted after the General Assembly's budget request deadlines, it represents the most current forecast available. Compared to the November request the February forecast is \$1.6 million General Fund lower in FY 2015-16 and \$3.0 million General Fund lower in FY 2016-17.

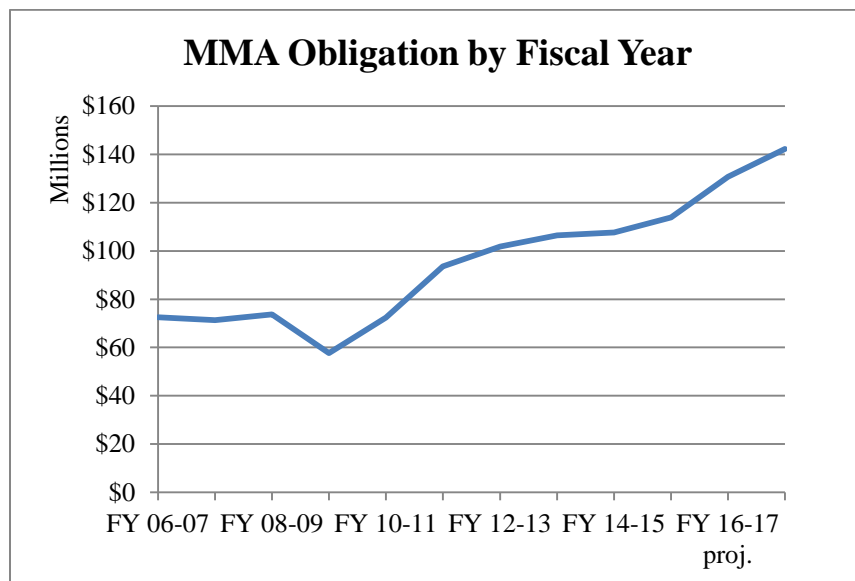
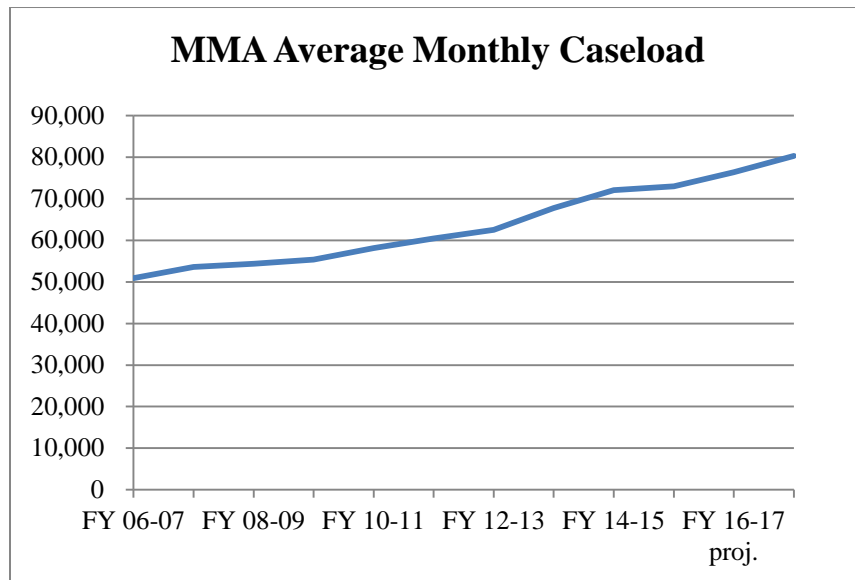
	Total Projected Under Current Law/Policy			Percent Difference
	Governor's Request	February 2016 Forecast	Difference	
FY 15-16	\$115,497,948	\$113,860,126	(\$1,637,822)	-1.4%
FY 16-17	\$133,682,247	\$130,667,733	(\$3,014,514)	-2.3%

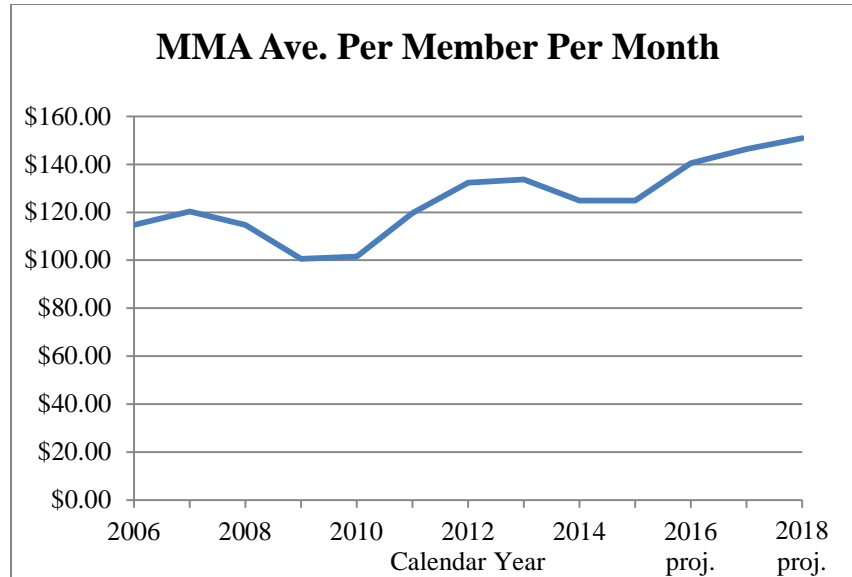
The table below summarizes the February 2016 estimate of the state obligation by fiscal year.

R4 Medicare Modernization Act	
GF	
<u>FY 15-16</u>	
FY 15-16 Appropriation	115,497,948
FY 15-16 February 2016 Forecast	113,860,126
Difference	(1,637,822)
Percent	-1.4%
<u>FY 16-17</u>	
FY 15-16 Total	113,860,126
Federal match changes	<u>534,193</u>
FY 16-17 Base	114,394,319
FY 16-17 February 2016 Forecast	130,667,733
Difference	16,273,414
Percent	12.5%

Recommendation: Staff recommends using the Department's February 2016 forecast of enrollment and expenditures to modify both the FY 2015-16 and FY 2016-17 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

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





➔ R9/BA13 Old Age Pension Medical Program

Request: The Department requests a decrease in cash funds from the Old Age Pension Health and Medical Care Fund to the Old Age Pension Medical Program to reflect a more recent projection of expenditures for the people requiring services. The Old Age Pension Medical Program serves people who qualify to receive an old age pension, do not reside in an institution for tuberculosis or mental disease, and do not qualify for Medicaid. The Department projects a decline in expenditures because of an increase in old age pensioners who qualify for Medicaid as a result of the Medicaid expansion.

Recommendation: Staff does not recommend the requested decrease in order to ensure that the full \$10 million allocated by Colorado' Constitution for the Old Age Pension Medical Program is available for people who qualify for services. The JBC already approved this approach when it adopted the staff recommendation on supplemental request S13.

R9/BA13 Old Age Pension Medical Program Recommendation v. Request		
	Total	CF - OAP
JBC staff recommendation	\$0	\$0
R9	(3,939,225)	(3,939,225)
BA13	265,815	265,815
Less amount already in base from S13	<u>(5,388,407)</u>	<u>(5,388,407)</u>
Remaining Department request	(\$9,061,817)	(\$9,061,817)
Request Above/(Below) Rec.	(\$9,061,817)	(\$9,061,817)

Based on the Department's projected expenditures, the JBC staff recommendation will result in more money appropriated for the Old Age Pension Medical Program than the expected costs, but a related JBC staff recommendation ensures that the money is not needlessly tied up. As part of the staff recommendation on R1 Medical Services Premiums, the JBC staff recommends

providing reappropriated funds spending authority in the Medical Services Premiums line item to allow the Department to transfer unused money from the Old Age Pension Medical Program to the Medical Services Premiums line item to offset the need for General Fund. For more information on the projected allocation of the Old age Pension Health and Medical Care Fund, see the line item description for the Old Age Pension Medical Program.

➔ BA14 Public School Health Services

Request: The Department requests a decrease of \$2.0 million total funds, including \$778,066 certified public expenditures, to continue and annualize supplemental *S14 Public School Health Services* that provided an increase in spending authority based on a projected increase in certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES). Although the change for this budget amendment is negative, the Department is projecting overall expenditures for the line item to increase \$1.9 million, including \$1.2 million certified public expenditures, with the annualizations of prior year budget actions. Through the School Health Services program school districts and BOCES are allowed to identify their expenses in support of Medicaid eligible children with an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP) and claim federal Medicaid matching funds for these costs. Participating school districts and BOCES report their expenses to the Department according to a federally-approved methodology and the Department submits them as certified public expenditures to claim the federal matching funds. The federal matching funds are then disbursed to the school districts and BOCES and may be used to offset their costs of providing services or to expand services for low-income, under or uninsured children and to improve coordination of care between school districts and health providers. Utilization of the program has increased dramatically in recent years due to a variety of factors, including outreach efforts, school districts and BOCES becoming more familiar and comfortable with the required reporting, and the efforts of school districts and BOCES to maximize revenues from all sources to help address tight budgets. In addition to those factors, the Department expects an increase due to an increase in the number of children enrolled in Medicaid as a result of the "welcome mat effect" of the ACA expansion and the implementation of continuous eligibility for children.

Recommendation: Staff recommends approval of the request. This request is driven by the amount of expenditures by school districts and BOCES that can be claimed for a federal match. The Department needs the spending authority to distribute the federal funds to the school districts. Approval of this request will not result in any increase in state expenditures.

LINE ITEM DETAIL – OTHER MEDICAL SERVICES

Old Age Pension State Medical Program

This line item funds health care services to persons who qualify to receive old age pensions and who are not a patient in an institution for the treatment of tuberculous or mental diseases. Physical health services are financed with a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund. Dental services through the Colorado Dental Program for Low-income Seniors are financed with General Fund.

With the expansion of Medicaid authorized in S.B. 13-200 a large portion of the people eligible for an old age pension are also eligible for Medicaid, and so a portion of the funds are reappropriated to offset the need for General Fund in the Medical Services Premiums line item.

The Department pays providers based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation.

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

Request: The Department requests adjustments for *R9/BA13 Old Age Pension Medical Program* and *BA11 Technical adjustments*.

Recommendation: Staff recommends continuation funding, consistent with the JBC's decision during supplementals to change the way the financing for this program works. See the recommendations on *R9/BA13 Old Age Pension Medical Program* and *BA11 Technical adjustments* for more information.

In the new budgeting format all \$10 million from the Old Age Pension Health and Medical Care Fund is appropriated to the Old Age Pension State Medical Program to ensure that it is available for people who qualify for services and do not qualify for Medicaid. An estimate is made of how much will not be needed for this purpose and that remainder is reappropriated for administration expenses in the Executive Director's Office and to offset the need for General Fund in the Medical Services Premiums line item. If the estimate of the unused funding available to offset the need for General Fund is incorrect, the Department has separate statutory authority to overexpend the Medical Services Premiums line item.

Commission on Family Medicine

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

Statutory Authority: Section 25-1-901 et seq., C.R.S.

Request: The Department requests *R11/BA16 Standard federal match rate* and annualizations to account for the change in the FMAP rate. The Department also requests *BA11 Technical adjustments* to continue a supplemental transfer of \$1,565 to the State University Teaching Hospitals University of Colorado Hospital line item for a new residency position that was awarded to the University.

Recommendation: Staff recommends the requested funding. Traditionally this line item has received periodic rate adjustments rather than the community provider rate common policy adjustment. No rate adjustment was requested for FY 2016-17.

State University Teaching Hospitals -- Denver Health and Hospital Authority

State University Teaching Hospitals -- University of Colorado Hospital Authority

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

Statutory Authority: Section 25.5-4-106, C.R.S.

Request: The Department requests *R11/BA16 Standard federal match rate* and annualizations to account for the change in the FMAP rate. The Department also requests *BA11 Technical adjustments* to continue a supplemental transfer of \$1,565 from the Commission on Family Medicine line item to the State University Teaching Hospitals University of Colorado Hospital line item for a new residency position that was awarded to the University.

Recommendation: Staff recommends the requested funding. Traditionally these line items have received periodic rate adjustments rather than the community provider rate common policy adjustment. No rate adjustment was requested for FY 2016-17.

Medicare Modernization Act

This line item pays the state's obligation under the Medicare Modernization Act (MMA) to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

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

Statutory Authority: Section 25.5-4-105, C.R.S.

Request: The Department requests *R4 Medicare Modernization Act* to update the appropriation to match the forecasted state obligation and *R11/BA16 Standard federal match rate* to account for the change in the FMAP rate. Although there is no federal match for this line item, the federal match rate for a state affects the federal formula that calculates the state obligation.

Recommendation: Staff recommends adjusting both the FY 2015-16 and FY 2016-17 appropriations based on the updated February 2016 forecast. See the recommendation on *R4*

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

Medicare Modernization Act for more detail. The staff recommended changes are summarized in the table below.

Other Medical Services, Medicare Modernization Act State Contribution Payment					
	Total Funds	General Fund	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation					
SB 15-234 (Long Bill)	\$116,816,749	\$116,816,749	\$0	\$0	0.0
HB 16-1240 (Supplemental)	(1,318,801)	(1,318,801)	0	0	0.0
Recommended Long Bill Supplemental	<u>(1,637,822)</u>	<u>(1,637,822)</u>	<u>0</u>	<u>0</u>	<u>0.0</u>
TOTAL	\$113,860,126	\$113,860,126	\$0	\$0	0.0
FY 2016-17 Recommended Appropriation					
FY 2015-16 Appropriation	\$113,860,126	\$113,860,126	\$0	\$0	0.0
R4 Medicare Modernization Act	16,273,413	16,273,413	0	0	0.0
R11/BA16 Standard federal match	<u>534,194</u>	<u>534,194</u>	<u>0</u>	<u>0</u>	<u>0.0</u>
TOTAL	\$130,667,733	\$130,667,733	\$0	\$0	0.0
Increase/(Decrease)	\$16,807,607	\$16,807,607	\$0	\$0	0.0
Percentage Change	14.8%	14.8%	0.0%	0.0%	0.0%
FY 2016-17 Executive Request:	\$134,216,441	\$134,216,441	\$0	\$0	0.0
Request Above/(Below) Recommendation	\$3,548,708	\$3,548,708	\$0	\$0	0.0

**Public School Health Services Contract Administration; and
Public School Health Services**

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

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

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual

qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts.

Statutory Authority: Section 25.5-5-318 et seq., C.R.S.

Request: The Department requests *BA14 Public school health services* to make adjustments based on a projected increase in certified public expenditures by schools. The Department also requests annualizations to account for the change in the FMAP rate. Finally, the Department requests *BA11 Technical adjustments* to true up administrative expenses. These reimbursements are based on actual allowable costs and certified public expenditures, and so no additional community provider rate common policy adjustment was requested.

Recommendation: Staff recommends the request, based on the expected certified public expenditures, except that the recommendation does not include a reduction of \$10,644 reappropriated funds for administration that was denied by the JBC during supplementals. See the recommendation on *BA11 Technical adjustments* for more information on this difference.

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training Grant Program

This line item pays for grants to organizations to provide evidence-based training for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The line item first received funding in FY 2015-16 pursuant to H.B. 15-1367, contingent on voter approval of Proposition AA. Pursuant to Sections 39-28.8-501 (4) (b) and 39-28.8-604, C.R.S., money was transferred from the Marijuana Tax Cash Fund to the Proposition AA account in the General Fund. The appropriation for the SBIRT training grant program was made from the Proposition AA refund account in the General Fund.

Statutory Authority: Sections 25.5-5-208 and 39-28.8-501 (2) (b) (II), C.R.S.

Request: The Department request continuation funding from the General Fund.

Recommendation: Staff recommends continuation funding, but from the Marijuana Tax Cash Fund. There is no statutory transfer from the Marijuana Tax Cash Fund to the General Fund in FY 2016-17. Funding the SBIRT training grant program fits the allowable uses of the Marijuana Tax Cash Fund. There are no matching federal funds for the SBIRT training grant program that could conceivably be put in jeopardy by using the Marijuana Tax Cash Fund as the state match.

Long Bill Footnotes and Requests for Information

LONG BILL FOOTNOTES

Staff recommends the following **new** footnotes:

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

Comment: See the recommendation on Annualize H.B. 15-1186 Children with autism/Behavioral therapy benefit for a discussion of the rationale for this footnote.

Staff recommends **continuing** the following footnotes, with modifications in struck type and small caps:

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

Comment: This footnote explains the purpose of the line item.

10c Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects; Eligibility Determinations and Client Services, Customer Outreach; Utilization and Quality Review Contracts, Professional Services Contracts; Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals – For line items with this footnote the limitation on the appropriation from the "(M)" notation does not apply to federal funds from the State Demonstration to Improve Care for Medicare-Medicaid Enrollees Implementation Support grant. The following line items include the listed amounts that are assumed to come from federal funds for the State Demonstration to Improve Care for Medicare-Medicaid Enrollees Implementation Support grant:

<u>Line Item</u>	<u>Federal Funds</u>
Medicaid Management Information System Maintenance and Projects	\$400,000
Customer Outreach	\$70,000
Professional Services Contracts	\$202,425
Medical and Long-term care Services for Medicaid Eligible Individuals	\$6,074,000

Comment: See the recommendation on BA10 Medicaid-Medicare grant true up for the rationale for continuing this footnote. The JBC staff will update the amounts in the table based on the JBC's figure setting decisions.

- 16 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.

Staff recommends **discontinuing** the following footnotes:

- 11 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses – It is the General Assembly's intent that necessary changes be made to the Colorado Benefits Management System to allow, beginning in FY 2016-17, the use of annualized income for purposes of determining Medicaid eligibility for adults who present evidence of fluctuating income. Allowing the use of annualized income in FY 2016-17 is projected to effect 20,430 clients who would receive an average of 3.48 months more of Medicaid services in a year at a cost of \$12,281,696 total funds, including \$1,410,508 General Fund.

Comment: The Department indicates that it is on pace for a July 1 implementation of the change in eligibility determination policy.

- 12 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes \$1 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 has submitted the state plan amendment. The Department cannot implement the program until authorized by the Centers for Medicare and Medicaid Services.

- 13 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes \$711,238 total funds, including \$350,000 General Fund and \$361,238 federal funds for the purpose of increasing the current \$12,500 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 received federal approval to implement the increase in the lifetime cap.

REQUESTS FOR INFORMATION

Staff recommends **continuing** the following requests for information, with modifications in struck type and small caps:

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

Comment: This is worded as an ongoing request.

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

Comment: This is worded as an ongoing request.

Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit a report by November 1, ~~2015~~, EACH YEAR 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 Accountable Care Collaborative is the core cost containment initiative of the Department and so the JBC staff recommends modifications to make this an annual ongoing report.

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 is worded as an ongoing request.

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: This is worded as an ongoing request.

Staff recommends **discontinuing** the following requests for information:

Department of Health Care Policy and Financing, Executive Director's Office – The Department of Health Care Policy and Financing is requested to submit a report to the Joint Budget Committee, by November 1, 2015, comparing Medicaid reimbursement rates for services to Medicare. For codes without a comparable Medicare rate, the Department shall find and identify a data source that will estimate the usual and customary rate paid in a commercial health plan. The Department shall include the reasoning behind the selection of data sources used to estimate the usual and customary rate. The report shall be submitted in a format that provides the ability to estimate the cost of bringing Medicaid rates to a variable percentage of the applicable Medicare rate or usual and customary rate. For codes unique to the Medicaid program, the Department is requested to collect comparable data from other states' Medicaid programs when and if available. For any codes for which the Department cannot find a comparison rate, the Department shall list the codes, the current Medicaid rate, and the reason the Department was unable to find a comparison. Capitated rates, cost-based rates, and rates that are based on a methodology defined in statute shall not be included in the report, except that the Department will estimate the portion of total expenditures paid through each of these methods.

Comment: The Department submitted the report as requested.

Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit a report to the Joint Budget Committee by June 30, 2015, on how the Department plans to improve the allocation of administrative expenses by cash fund, either using the Public Assistance Cost Allocation Plan (PACAP) technology, or some other method, for the FY 2016-17 budget cycle.

Comment: The Department submitted the report as requested.

Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit a report to the Joint Budget Committee by November 1, 2015, on performance and policy issues associated with emergency and non-emergency transportation services. Regarding non-emergency transportation, the report should include, but not be limited to, the time to complete a request for transportation, the wait time for a same-day request for transportation (e.g. for a hospital discharge), and a discussion of performance variations by region. Regarding emergency transportation, the report should discuss whether providers are appropriately compensated if they provide services on site and the patient declines transportation. If the information requested is not available, the Department is requested to provide as much relevant information as possible.

Comment: The Department submitted the report as requested.

Department of Health Care Policy and Financing, Executive Director's Office – The Department of Health Care Policy and Financing is requested to submit a report to the Joint Budget Committee, by November 1, 2015, on the performance of the Medicare Savings Program. The report should discuss enrollment trends, obstacles to enrollment, previous and current marketing and outreach efforts, and future implementation strategies. The report should also discuss the effect of the program on health outcomes.

Comment: The Department submitted the report as requested.

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

Appendix A: Number Pages

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING Sue Birch, Executive Director

(1) EXECUTIVE DIRECTOR'S OFFICE

Primary functions: Provides all of the administrative, audit and oversight functions for the Department.

(A) General Administration

Personal Services	<u>25,782,006</u>	<u>28,066,886</u>	<u>28,544,572</u>	<u>29,650,262</u>	<u>29,611,066</u> *
FTE	363.7	360.4	388.0	398.9	398.9
General Fund	8,477,796	8,982,621	9,828,325	10,241,102	10,221,504
Cash Funds	2,564,595	2,676,189	2,860,502	2,936,203	2,936,203
Reappropriated Funds	1,613,082	1,524,777	1,501,543	1,564,801	1,564,801
Federal Funds	13,126,533	14,883,299	14,354,202	14,908,156	14,888,558
Health, Life, and Dental	<u>2,322,449</u>	<u>2,476,612</u>	<u>3,139,489</u>	<u>3,497,487</u>	<u>3,434,070</u> *
General Fund	748,152	928,931	1,137,726	1,262,662	1,230,952
Cash Funds	227,867	166,066	277,707	337,577	337,577
Reappropriated Funds	72,376	64,887	88,133	104,755	104,755
Federal Funds	1,274,054	1,316,728	1,635,923	1,792,493	1,760,786
Short-term Disability	<u>42,151</u>	<u>64,185</u>	<u>61,246</u>	<u>55,974</u>	<u>55,072</u> *
General Fund	13,671	21,358	22,736	21,021	20,569
Cash Funds	3,764	4,955	4,746	4,588	4,588
Reappropriated Funds	802	1,363	1,457	1,393	1,393
Federal Funds	23,914	36,509	32,307	28,972	28,522

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
S.B. 04-257 Amortization Equalization					
Disbursement	<u>850,598</u>	<u>1,235,106</u>	<u>1,314,119</u>	<u>1,457,263</u>	<u>1,434,399</u> *
General Fund	273,870	409,819	488,354	547,082	535,695
Cash Funds	76,148	96,428	101,814	119,586	119,586
Reappropriated Funds	16,232	27,452	30,035	36,269	36,179
Federal Funds	484,348	701,407	693,916	754,326	742,939
S.B. 06-235 Supplemental Amortization					
Equalization Disbursement	<u>767,027</u>	<u>1,157,972</u>	<u>1,269,320</u>	<u>1,442,083</u>	<u>1,419,546</u> *
General Fund	246,370	384,601	472,426	541,384	530,115
Cash Funds	68,744	90,431	98,344	118,340	118,340
Reappropriated Funds	14,654	24,943	27,570	35,891	35,891
Federal Funds	437,259	657,997	670,980	746,468	735,200
Salary Survey					
General Fund	<u>669,740</u>	<u>831,265</u>	<u>321,383</u>	<u>56,903</u>	<u>56,903</u>
Cash Funds	199,437	283,209	121,695	19,245	19,245
Reappropriated Funds	53,484	64,811	24,853	6,898	6,898
Federal Funds	10,800	3,127	1,794	898	898
Federal Funds	406,019	480,118	173,041	29,862	29,862
Merit Pay					
General Fund	<u>372,361</u>	<u>265,923</u>	<u>317,662</u>	<u>0</u>	<u>0</u>
Cash Funds	119,442	98,565	118,042	0	0
Reappropriated Funds	28,027	19,363	26,760	0	0
Federal Funds	9,889	1,176	1,975	0	0
Federal Funds	215,003	146,819	170,885	0	0

JBC Staff Staff Figure Setting - FY 2016-17
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	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Worker's Compensation	<u>47,286</u>	<u>52,712</u>	<u>43,712</u>	<u>58,296</u>	<u>54,318</u> *
General Fund	23,643	26,356	21,856	29,148	27,159
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	23,643	26,356	21,856	29,148	27,159
Operating Expenses	<u>2,497,422</u>	<u>2,967,212</u>	<u>2,128,609</u>	<u>2,021,523</u>	<u>2,054,444</u> *
General Fund	1,141,931	1,426,580	960,193	917,843	934,304
Cash Funds	121,029	37,759	78,907	65,869	65,869
Reappropriated Funds	1,382	0	10,449	10,449	10,449
Federal Funds	1,233,080	1,502,873	1,079,060	1,027,362	1,043,822
Legal and Third Party Recovery Legal Services	<u>979,454</u>	<u>1,151,606</u>	<u>1,368,714</u>	<u>1,368,714</u>	<u>1,368,714</u>
General Fund	346,973	443,159	442,869	442,869	442,869
Cash Funds	153,671	166,747	241,489	241,489	241,489
Reappropriated Funds	0	0	0	0	0
Federal Funds	478,810	541,700	684,356	684,356	684,356
Administrative Law Judge Services	<u>538,016</u>	<u>376,861</u>	<u>568,419</u>	<u>688,283</u>	<u>697,852</u> *
General Fund	219,941	146,434	220,867	267,441	271,159
Cash Funds	49,067	41,996	63,343	76,701	77,767
Reappropriated Funds	0	0	0	0	0
Federal Funds	269,008	188,431	284,209	344,141	348,926
CORE Operations	<u>504,637</u>	<u>2,717,568</u>	<u>1,598,167</u>	<u>1,446,417</u>	<u>1,414,701</u>
General Fund	331,447	1,297,165	544,698	474,501	465,081
Cash Funds	173,190	679,257	285,501	248,708	240,770
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	741,146	767,968	723,208	708,850

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Payment to Risk Management and Property Funds	<u>131,604</u>	<u>166,890</u>	<u>166,912</u>	<u>189,629</u>	<u>176,936</u>
General Fund	65,802	83,445	83,456	94,815	88,468
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	65,802	83,445	83,456	94,814	88,468
Leased Space	<u>747,035</u>	<u>1,480,251</u>	<u>2,203,793</u>	<u>2,514,035</u>	<u>2,514,035</u>
General Fund	195,437	578,965	885,015	1,009,653	1,009,653
Cash Funds	138,874	124,924	216,881	247,365	247,365
Reappropriated Funds	0	0	0	0	0
Federal Funds	412,724	776,362	1,101,897	1,257,017	1,257,017
Capitol Complex Leased Space	<u>496,658</u>	<u>386,910</u>	<u>549,237</u>	<u>558,783</u>	<u>572,466</u>
General Fund	248,329	193,455	274,619	279,392	286,233
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	248,329	193,455	274,618	279,391	286,233
Payments to OIT	<u>201,448</u>	<u>1,578,757</u>	<u>3,059,824</u>	<u>3,778,381</u>	<u>3,778,381</u> *
General Fund	100,724	784,642	1,518,550	1,694,640	1,694,640
Cash Funds	0	4,736	11,360	194,552	194,552
Reappropriated Funds	0	0	0	0	0
Federal Funds	100,724	789,379	1,529,914	1,889,189	1,889,189

JBC Staff Staff Figure Setting - FY 2016-17
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	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Scholarships for research using the All-Payer					
Claims Database	<u>0</u>	<u>500,000</u>	<u>500,000</u>	<u>500,000</u>	<u>500,000</u>
General Fund	0	500,000	500,000	500,000	500,000
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
General Professional Services and Special Projects	<u>7,145,144</u>	<u>5,584,179</u>	<u>9,267,170</u>	<u>7,674,432</u>	<u>7,674,432</u> *
General Fund	2,048,401	2,037,349	3,096,462	2,471,858	2,471,858
Cash Funds	442,324	511,089	1,463,609	1,227,500	1,227,500
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,654,419	3,035,741	4,707,099	3,975,074	3,975,074
Purchase of Services from Computer Center	<u>882,219</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	436,917	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	4,193	0	0	0	0
Federal Funds	441,109	0	0	0	0
Multiuse Network Payments	<u>139,002</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	69,501	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	69,501	0	0	0	0

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Information Technology Security	<u>11,374</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	5,687	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	5,687	0	0	0	0
Management and Administration of OIT	<u>72,130</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	36,065	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	36,065	0	0	0	0
SUBTOTAL - (A) General Administration	45,199,761	51,060,895	56,422,348	56,958,465	56,817,335
<i>FTE</i>	<u>363.7</u>	<u>360.4</u>	<u>388.0</u>	<u>398.9</u>	<u>398.9</u>
General Fund	15,349,536	18,626,654	20,737,889	20,814,656	20,749,504
Cash Funds	4,100,784	4,684,751	5,755,816	5,825,376	5,818,504
Reappropriated Funds	1,743,410	1,647,725	1,662,956	1,754,456	1,754,366
Federal Funds	24,006,031	26,101,765	28,265,687	28,563,977	28,494,961

(B) Transfers to Other Departments

Facility Survey and Certification, Transfer to the Department of Public Health and Environment	<u>4,426,141</u>	<u>4,776,959</u>	<u>6,240,010</u>	<u>6,130,010</u>	<u>6,240,010</u>
General Fund	1,257,350	1,477,142	2,315,772	2,315,772	2,315,772
Cash Funds	0	110,000	110,000	0	110,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,168,791	3,189,817	3,814,238	3,814,238	3,814,238

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Nurse Home Visitor Program, Transfer from the Department of Human Services	<u>930,166</u>	<u>1,028,130</u>	<u>3,010,000</u>	<u>3,010,000</u>	<u>3,010,000</u> *
General Fund	(11,847)	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	465,083	478,806	1,481,221	1,498,980	1,498,980
Federal Funds	476,930	549,324	1,528,779	1,511,020	1,511,020
 Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	 <u>5,886</u>	 <u>5,888</u>	 <u>5,887</u>	 <u>5,887</u>	 <u>5,887</u>
General Fund	2,943	2,944	2,944	2,944	2,944
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,943	2,944	2,943	2,943	2,943
 Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	 <u>324,041</u>	 <u>324,041</u>	 <u>324,041</u>	 <u>324,041</u>	 <u>324,041</u>
General Fund	147,369	147,368	147,369	147,369	147,369
Cash Funds	0	0	0	0	0
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652
Federal Funds	162,020	162,021	162,020	162,020	162,020
 Reviews, Transfer to the Department of Regulatory Agencies	 <u>4,160</u>	 <u>3,852</u>	 <u>10,000</u>	 <u>10,000</u>	 <u>10,000</u>
General Fund	2,080	1,926	5,000	5,000	5,000
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,080	1,926	5,000	5,000	5,000

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Public School Health Services Administration, Transfer to the Department of Education	<u>143,721</u>	<u>160,335</u>	<u>160,335</u>	<u>170,979</u>	<u>170,979</u> *
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	143,721	160,335	160,335	170,979	170,979
Federal Funds	0	0	0	0	0
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	<u>0</u>	<u>205,146</u>	<u>215,955</u>	<u>215,955</u>	<u>219,356</u>
General Fund	0	102,573	107,977	107,977	109,678
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	102,573	107,978	107,978	109,678
SUBTOTAL - (B) Transfers to Other					
Departments	5,834,115	6,504,351	9,966,228	9,866,872	9,980,273
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	1,397,895	1,731,953	2,579,062	2,579,062	2,580,763
Cash Funds	0	110,000	110,000	0	110,000
Reappropriated Funds	623,456	653,793	1,656,208	1,684,611	1,684,611
Federal Funds	3,812,764	4,008,605	5,620,958	5,603,199	5,604,899

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
(C) Information Technology Contracts and Projects					
Medicaid Management Information System					
Maintenance and Projects	<u>30,637,273</u>	<u>24,715,778</u>	<u>34,365,296</u>	<u>35,263,793</u>	<u>35,263,793</u> *
General Fund	6,594,356	5,655,519	6,823,649	7,198,178	7,198,178
Cash Funds	1,181,953	934,073	3,099,843	2,209,009	2,209,009
Reappropriated Funds	293,350	293,350	293,350	293,350	293,350
Federal Funds	22,567,614	17,832,836	24,148,454	25,563,256	25,563,256
MMIS Reprocurement Contracts	<u>9,933,790</u>	<u>26,955,910</u>	<u>41,437,857</u>	<u>26,916,597</u>	<u>26,916,597</u>
General Fund	967,847	2,657,672	4,164,679	2,615,317	2,615,317
Cash Funds	100,036	539,548	1,177,899	701,879	701,879
Reappropriated Funds	0	23,758,690	0	0	0
Federal Funds	8,865,907	0	36,095,279	23,599,401	23,599,401
MMIS Reprocurement Contracted Staff	<u>920,936</u>	<u>407,681</u>	<u>4,448,524</u>	<u>5,145,018</u>	<u>5,145,018</u>
General Fund	89,321	4,017	353,814	431,304	431,304
Cash Funds	20,954	64,139	131,360	134,757	134,757
Reappropriated Funds	0	339,525	0	0	0
Federal Funds	810,661	0	3,963,350	4,578,957	4,578,957
Fraud Detection Software Contract	<u>144,565</u>	<u>135,000</u>	<u>250,000</u>	<u>250,000</u>	<u>250,000</u>
General Fund	38,938	34,136	62,500	62,500	62,500
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	105,627	100,864	187,500	187,500	187,500

JBC Staff Staff Figure Setting - FY 2016-17
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	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Centralized Eligibility Vendor Contract Project	<u>6,875,044</u>	<u>6,824,419</u>	<u>5,133,612</u>	<u>0</u>	<u>0</u> *
General Fund	0	0	0	0	0
Cash Funds	2,816,997	2,281,751	1,785,326	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,058,047	4,542,668	3,348,286	0	0
Health Information Exchange Maintenance and Projects	<u>0</u>	<u>3,746,881</u>	<u>14,168,746</u>	<u>10,622,455</u>	<u>10,622,455</u>
General Fund	0	524,667	2,321,875	2,046,246	2,046,246
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	3,222,214	11,846,871	8,576,209	8,576,209
Colorado Benefits Management Systems, Operating and Contract Expenses	<u>0</u>	<u>0</u>	<u>13,400,522</u>	<u>23,132,658</u>	<u>25,647,919</u> *
General Fund	0	0	4,578,401	7,691,683	8,499,215
Cash Funds	0	0	2,088,462	3,405,911	3,819,089
Reappropriated Funds	0	0	51,628	0	51,628
Federal Funds	0	0	6,682,031	12,035,064	13,277,987
Colorado Benefits Management System Administration	<u>0</u>	<u>0</u>	<u>0</u>	<u>648,441</u>	<u>648,441</u> *
General Fund	0	0	0	232,139	232,139
Cash Funds	0	0	0	92,938	92,938
Federal Funds	0	0	0	323,364	323,364

JBC Staff Staff Figure Setting - FY 2016-17
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	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
CBMS Modernization Project	<u>789,500</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	789,500	0	0	0	0
Federal Funds	0	0	0	0	0

SUBTOTAL - (C) Information Technology					
Contracts and Projects	49,301,108	62,785,669	113,204,557	101,978,962	104,494,223
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	7,690,462	8,876,011	18,304,918	20,277,367	21,084,899
Cash Funds	4,119,940	3,819,511	8,282,890	6,544,494	6,957,672
Reappropriated Funds	1,082,850	24,391,565	344,978	293,350	344,978
Federal Funds	36,407,856	25,698,582	86,271,771	74,863,751	76,106,674

(D) Eligibility Determinations and Client Services

Medical Identification Cards	<u>140,257</u>	<u>247,001</u>	<u>278,974</u>	<u>278,974</u>	<u>278,974</u> *
General Fund	59,400	63,966	90,988	90,988	90,988
Cash Funds	9,932	58,738	44,587	44,587	44,587
Reappropriated Funds	1,593	1,593	28	28	28
Federal Funds	69,332	122,704	143,371	143,371	143,371
 Contracts for Special Eligibility Determinations	 <u>6,017,314</u>	 <u>6,623,800</u>	 <u>11,402,297</u>	 <u>11,402,297</u>	 <u>11,402,297</u>
General Fund	945,228	664,131	969,756	969,756	969,756
Cash Funds	1,763,845	2,290,311	4,343,468	4,343,468	4,343,468
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,308,241	3,669,358	6,089,073	6,089,073	6,089,073

JBC Staff Staff Figure Setting - FY 2016-17
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	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
County Administration	<u>34,733,208</u>	<u>36,730,383</u>	<u>45,998,063</u>	<u>45,998,063</u>	<u>45,998,063</u> *
General Fund	8,558,486	10,572,620	11,114,448	11,114,448	11,114,448
Cash Funds	4,460,662	0	5,859,623	5,859,623	5,859,623
Reappropriated Funds	0	0	0	0	0
Federal Funds	21,714,060	26,157,763	29,023,992	29,023,992	29,023,992
Hospital Provider Fee County Administration	<u>4,654,643</u>	<u>10,038,778</u>	<u>15,748,868</u>	<u>15,748,868</u>	<u>15,748,868</u> *
General Fund	0	0	0	0	0
Cash Funds	1,752,329	3,208,371	4,945,446	4,945,446	4,945,446
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,902,314	6,830,407	10,803,422	10,803,422	10,803,422
Administrative Case Management	<u>1,648,048</u>	<u>1,514,868</u>	<u>869,744</u>	<u>869,744</u>	<u>869,744</u>
General Fund	824,024	757,434	434,872	434,872	434,872
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	824,024	757,434	434,872	434,872	434,872
Medical Assistance Sites	<u>0</u>	<u>78,000</u>	<u>1,452,000</u>	<u>1,531,968</u>	<u>1,531,968</u> *
General Fund	0	0	0	0	0
Cash Funds	0	39,000	363,000	402,984	402,984
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	39,000	1,089,000	1,128,984	1,128,984
Customer Outreach	<u>4,943,170</u>	<u>5,079,676</u>	<u>5,830,825</u>	<u>5,741,256</u>	<u>5,741,256</u> *
General Fund	2,384,724	2,203,298	2,543,792	2,474,880	2,474,880
Cash Funds	86,861	336,621	336,621	336,621	336,621
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,471,585	2,539,757	2,950,412	2,929,755	2,929,755

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Centralized Eligibility Vendor Contract Project	0	0	0	<u>5,053,644</u>	<u>5,053,644</u> *
General Fund	0	0	0	0	0
Cash Funds	0	0	0	1,745,342	1,745,342
Federal Funds	0	0	0	3,308,302	3,308,302
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow					
Contingency	862,471	774,366	0	0	0
General Fund	268,702	74,945	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	593,769	699,421	0	0	0
SUBTOTAL - (D) Eligibility Determinations and Client Services	52,999,111	61,086,872	81,580,771	86,624,814	86,624,814
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	13,040,564	14,336,394	15,153,856	15,084,944	15,084,944
Cash Funds	8,073,629	5,933,041	15,892,745	17,678,071	17,678,071
Reappropriated Funds	1,593	1,593	28	28	28
Federal Funds	31,883,325	40,815,844	50,534,142	53,861,771	53,861,771
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	<u>6,121,625</u>	<u>8,825,726</u>	<u>11,984,409</u>	<u>11,985,007</u>	<u>11,985,007</u> *
General Fund	1,784,427	2,514,723	3,353,473	3,452,759	3,452,759
Cash Funds	93,766	329,807	461,089	461,089	461,089
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,243,432	5,981,196	8,169,847	8,071,159	8,071,159

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
SUBTOTAL - (E) Utilization and Quality					
Review Contracts	6,121,625	8,825,726	11,984,409	11,985,007	11,985,007
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	1,784,427	2,514,723	3,353,473	3,452,759	3,452,759
Cash Funds	93,766	329,807	461,089	461,089	461,089
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,243,432	5,981,196	8,169,847	8,071,159	8,071,159

(F) Provider Audits and Services

Professional Audit Contracts	<u>2,382,760</u>	<u>2,108,454</u>	<u>2,813,406</u>	<u>3,401,907</u>	<u>3,401,907</u>
General Fund	1,066,015	947,607	1,119,283	1,266,408	1,266,408
Cash Funds	204,210	106,620	312,420	415,408	415,408
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,112,535	1,054,227	1,381,703	1,720,091	1,720,091
SUBTOTAL - (F) Provider Audits and Services	<u>2,382,760</u>	<u>2,108,454</u>	<u>2,813,406</u>	<u>3,401,907</u>	<u>3,401,907</u>
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	1,066,015	947,607	1,119,283	1,266,408	1,266,408
Cash Funds	204,210	106,620	312,420	415,408	415,408
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,112,535	1,054,227	1,381,703	1,720,091	1,720,091

(G) Recoveries and Recoupment Contract Costs

Estate Recovery	<u>564,482</u>	<u>844,170</u>	<u>700,000</u>	<u>700,000</u>	<u>700,000</u>
General Fund	0	0	0	0	0
Cash Funds	282,241	422,085	350,000	350,000	350,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	282,241	422,085	350,000	350,000	350,000

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
SUBTOTAL - (G) Recoveries and Recoupment					
Contract Costs	564,482	844,170	700,000	700,000	700,000
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	0	0	0	0	0
Cash Funds	282,241	422,085	350,000	350,000	350,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	282,241	422,085	350,000	350,000	350,000

State of Health Projects

Pain Management Capacity Program	<u>0</u>	<u>492,000</u>	<u>500,000</u>	<u>0</u>	<u>0</u>
General Fund	0	246,000	246,212	1,262	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	246,000	253,788	(1,262)	0
Transfer from General Fund to State of Health Cash					
Fund	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
State of Health Projects	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Dental Provider Network Adequacy	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
SUBTOTAL - State of Health Projects	0	492,000	500,000	0	0
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	0	246,000	246,212	1,262	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	246,000	253,788	(1,262)	0

(H) Indirect Cost Assessment

Indirect Cost Assessment	<u>452,913</u>	<u>245,511</u>	<u>635,877</u>	<u>695,366</u>	<u>695,366</u>
General Fund	0	0	0	0	0
Cash Funds	121,193	141,654	178,540	224,727	224,727
Reappropriated Funds	0	2,766	4,720	5,941	5,941
Federal Funds	331,720	101,091	452,617	464,698	464,698
SUBTOTAL - (H) Indirect Cost Assessment	452,913	245,511	635,877	695,366	695,366
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	0	0	0	0	0
Cash Funds	121,193	141,654	178,540	224,727	224,727
Reappropriated Funds	0	2,766	4,720	5,941	5,941
Federal Funds	331,720	101,091	452,617	464,698	464,698

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
TOTAL - (1) Executive Director's Office	162,855,875	193,953,648	277,807,596	272,211,393	274,698,925
<i>FTE</i>	<u>363.7</u>	<u>360.4</u>	<u>388.0</u>	<u>398.9</u>	<u>398.9</u>
General Fund	40,328,899	47,279,342	61,494,693	63,476,458	64,219,277
Cash Funds	16,995,763	15,547,469	31,343,500	31,499,165	32,015,471
Reappropriated Funds	3,451,309	26,697,442	3,668,890	3,738,386	3,789,924
Federal Funds	102,079,904	104,429,395	181,300,513	173,497,384	174,674,253

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
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(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	<u>4,618,770,195</u>	<u>5,728,093,904</u>	<u>6,877,424,675</u>	<u>6,573,594,996</u>	<u>6,707,426,574</u> *
General Fund	926,160,050	882,751,482	990,553,419	1,090,355,147	1,102,452,061
General Fund Exempt	642,235,957	813,135,957	848,124,468	848,124,468	848,124,468
Cash Funds	567,267,338	549,802,496	819,317,292	669,472,084	655,621,668
Reappropriated Funds	2,936,892	0	9,145,518	0	0
Federal Funds	2,480,169,958	3,482,403,969	4,210,283,978	3,965,643,297	4,101,228,377

TOTAL - (2) Medical Services Premiums	4,618,770,195	5,728,093,904	6,877,424,675	6,573,594,996	6,707,426,574
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	926,160,050	882,751,482	990,553,419	1,090,355,147	1,102,452,061
General Fund Exempt	642,235,957	813,135,957	848,124,468	848,124,468	848,124,468
Cash Funds	567,267,338	549,802,496	819,317,292	669,472,084	655,621,668
Reappropriated Funds	2,936,892	0	9,145,518	0	0
Federal Funds	2,480,169,958	3,482,403,969	4,210,283,978	3,965,643,297	4,101,228,377

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
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(4) 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	<u>309,976,756</u>	<u>309,470,584</u>	<u>311,296,186</u>	<u>311,296,186</u>	<u>311,296,186</u> *
General Fund	0	0	0	0	0
Cash Funds	154,988,378	152,391,319	153,201,150	155,073,238	155,073,238
Reappropriated Funds	0	0	0	0	0
Federal Funds	154,988,378	157,079,265	158,095,036	156,222,948	156,222,948
 Clinic Based Indigent Care	 <u>6,119,760</u>	 <u>6,119,760</u>	 <u>6,119,760</u>	 <u>6,119,760</u>	 <u>6,119,760</u> *
General Fund	3,059,880	3,013,523	3,011,534	3,047,640	3,047,640
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,059,880	3,106,237	3,108,226	3,072,120	3,072,120
 Pediatric Specialty Hospital	 <u>11,799,938</u>	 <u>13,455,012</u>	 <u>13,455,012</u>	 <u>13,455,012</u>	 <u>13,455,012</u> *
General Fund	5,899,969	6,625,584	6,621,212	6,700,596	6,700,596
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	5,899,969	6,829,428	6,833,800	6,754,416	6,754,416
 Appropriation from Tobacco Tax Fund to the					
General Fund	<u>421,610</u>	<u>423,600</u>	<u>427,593</u>	<u>427,593</u>	<u>423,630</u>
General Fund	0	0	0	0	0
Cash Funds	421,610	423,600	427,593	427,593	423,630
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Primary Care Fund	<u>26,679,334</u>	<u>26,828,000</u>	<u>26,778,000</u>	<u>26,778,000</u>	<u>26,829,900</u>
General Fund	0	0	0	0	0
Cash Funds	26,679,334	26,828,000	26,778,000	26,778,000	26,829,900
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Children's Basic Health Plan Administration	<u>4,013,739</u>	<u>3,653,692</u>	<u>5,033,274</u>	<u>5,033,274</u>	<u>5,033,274</u>
General Fund	0	0	0	0	0
Cash Funds	1,502,836	1,214,777	2,363,824	2,363,824	2,363,824
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,510,903	2,438,915	2,669,450	2,669,450	2,669,450
Children's Basic Health Plan Medical and Dental					
Costs	<u>182,753,054</u>	<u>130,538,362</u>	<u>135,488,847</u>	<u>149,119,335</u>	<u>141,455,044</u> *
General Fund	12,114,378	6,003,180	2,098,125	2,072,848	2,076,811
General Fund Exempt	438,300	0	427,593	427,593	423,630
Cash Funds	72,640,720	48,154,315	26,697,542	18,549,228	17,533,954
Reappropriated Funds	0	0	0	0	0
Federal Funds	97,559,656	76,380,867	106,265,587	128,069,666	121,420,649
Hospice Supplemental Payment	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
TOTAL - (4) Indigent Care Program	541,764,191	490,489,010	498,598,672	512,229,160	504,612,806
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	21,074,227	15,642,287	11,730,871	11,821,084	11,825,047
General Fund Exempt	438,300	0	427,593	427,593	423,630
Cash Funds	256,232,878	229,012,011	209,468,109	203,191,883	202,224,546
Reappropriated Funds	0	0	0	0	0
Federal Funds	264,018,786	245,834,712	276,972,099	296,788,600	290,139,583

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
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(5) OTHER MEDICAL SERVICES

Primary functions: This division provides funding for the Old Age Pension Medical Program and the Medicare Modernization Act State Contribution Payment. This division also contains funding for programs that eligible for Medicaid funding but are not part of the other divisions.

Old Age Pension State Medical	<u>6,581,973</u>	<u>431,000</u>	<u>12,962,510</u>	<u>3,899,128</u>	<u>12,962,510</u> *
General Fund	0	0	2,962,510	2,962,510	2,962,510
Cash Funds	6,581,973	431,000	10,000,000	936,618	10,000,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
 Commission on Family Medicine Residency					
Training Programs	<u>3,371,077</u>	<u>5,401,843</u>	<u>7,597,298</u>	<u>7,867,298</u>	<u>7,597,298</u> *
General Fund	1,685,538	2,652,350	3,743,374	4,056,304	3,786,304
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,685,539	2,749,493	3,853,924	3,810,994	3,810,994
 State University Teaching Hospitals Denver Health and Hospital Authority	<u>1,831,714</u>	<u>2,804,714</u>	<u>2,804,714</u>	<u>2,804,714</u>	<u>2,804,714</u> *
General Fund	915,857	1,381,111	1,380,200	1,396,748	1,396,748
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	915,857	1,423,603	1,424,514	1,407,966	1,407,966

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
State University Teaching Hospitals University of Colorado Hospital	<u>633,314</u>	<u>633,314</u>	<u>1,181,204</u>	<u>911,204</u>	<u>1,181,204</u> *
General Fund	316,657	311,860	581,654	315,390	585,390
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	316,657	321,454	599,550	595,814	595,814
Medicare Modernization Act State Contribution Payment	<u>106,376,992</u>	<u>107,776,447</u>	<u>113,860,126</u>	<u>134,216,441</u>	<u>130,667,733</u> *
General Fund	68,306,130	107,360,512	113,860,126	134,216,441	130,667,733
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	38,070,862	415,935	0	0	0
Public School Health Services Contract Administration	<u>812,550</u>	<u>854,207</u>	<u>2,491,722</u>	<u>2,481,078</u>	<u>2,491,722</u> *
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	812,550	854,207	2,491,722	2,481,078	2,491,722
Federal Funds	0	0	0	0	0
Public School Health Services	<u>43,494,624</u>	<u>62,716,218</u>	<u>80,673,638</u>	<u>82,604,632</u>	<u>82,604,632</u> *
General Fund	0	0	0	0	0
Cash Funds	21,747,312	31,449,659	39,767,175	41,001,948	41,001,948
Reappropriated Funds	0	0	0	0	0
Federal Funds	21,747,312	31,266,559	40,906,463	41,602,684	41,602,684

JBC Staff Staff Figure Setting - FY 2016-17
Staff Working Document - Does Not Represent Committee Decision

	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2016-17 Request	FY 2016-17 Recommendation
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	<u>0</u>	<u>0</u>	<u>500,000</u>	<u>500,000</u>	<u>500,000</u>
General Fund	0	0	500,000	500,000	0
Cash Funds	0	0	0	0	500,000
TOTAL - (5) Other Medical Services	163,102,244	180,617,743	222,071,212	235,284,495	240,809,813
<i>FTE</i>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
General Fund	71,224,182	111,705,833	123,027,864	143,447,393	139,398,685
Cash Funds	28,329,285	31,880,659	49,767,175	41,938,566	51,501,948
Reappropriated Funds	812,550	854,207	2,491,722	2,481,078	2,491,722
Federal Funds	62,736,227	36,177,044	46,784,451	47,417,458	47,417,458
TOTAL - Department of Health Care Policy and Financing	5,486,492,505	6,593,154,305	7,875,902,155	7,593,320,044	7,727,548,118
<i>FTE</i>	<u>363.7</u>	<u>360.4</u>	<u>388.0</u>	<u>398.9</u>	<u>398.9</u>
General Fund	1,058,787,358	1,057,378,944	1,186,806,847	1,309,100,082	1,317,895,070
General Fund Exempt	642,674,257	813,135,957	848,552,061	848,552,061	848,548,098
Cash Funds	868,825,264	826,242,635	1,109,896,076	946,101,698	941,363,633
Reappropriated Funds	7,200,751	27,551,649	15,306,130	6,219,464	6,281,646
Federal Funds	2,909,004,875	3,868,845,120	4,715,341,041	4,483,346,739	4,613,459,671

Appendix B: Department responses to JBC questions regarding BA6 Fed reg for assuring access

DATE: March 11, 2016

TO: Joint Budget Committee
Senator Kent Lambert
Representative Bob Rankin

FROM: Department of Health Care Policy & Financing

RE: Supplemental Resources: Federal Access Regulation Compliance

Per your request, please find supplemental information outlining the overlap and differences between the work being conducted (and anticipated work to be conducted) to comply with SB 15-228 and the new federal regulations under access to care.

While many of the rates being reviewed are the same between the two processes, the scope of work between the two has significant differences. The new federal regulations under access to care has two components. The first is a plan due to CMS by July 1, 2016 that gives an overview of access to five core services categories. The second is a detailed evaluation at the code level (similar to the SB15-228 process) if the State intends to reduce rates or change the methodology.

Per the requests of Senator Lambert and Representative Rankin, please find enclosed:

1. A chart describing the overlap and concurrence of work
2. A chart/table outlining the department's rates, how they are impacted by the two processes, and who has the authority to change rates
3. Opinion by the Assistant Attorney General on CMS' authority to review and approve rates

Should you require any additional information, please do not hesitate to ask.

Sincerely,



Gretchen M. Hammer
Medicaid Director
Health Programs Office

SCOPE OF WORK

TASK/SCOPE OF WORK	RATE REVIEW COMMITTEE SB 15-228	FEDERAL ACCESS TO CARE REGULATIONS	
		ACCESS TO CARE PLAN 447.203	STATE PLAN AMENDMENTS ON RATE CHANGES 447.204
Services Impacted	22 Provider Services; Over 5 Years	5 CORE Services + Access Monitoring Review Plan (AMRP)	29 Provider Services (only if rate reductions occur/methodology changes)*
Frequency of Work	Continuous	Every 3 Years	Continuous, For 3 years Following a Rate Cut
Update/Maintain Access Plan	-	Every 3 Years	-
Quality Review	Include	Include	-
Manage Stakeholder Feedback	Log/Share Committee Member Feedback with JBC	Include Department-Wide & Stakeholder Feedback	Include Department-Wide & Stakeholder Feedback
Utilization Review	Included in Access Review	Analyze utilization	Analyze Utilization
Rate Comparison	Compare to Other State Medicaid, Medicare, Usual/Customary Charges	Compare to Medicare and commercial, split by HSR (if able)	Compare to Medicare and commercial, split by HSR (if able)
Demographic Breakdown	Children, Adults, Expansion, Elderly, Disabled Individuals	Children, Adults, Disabled Individuals	Children, Adults, Disabled Individuals
Access Analysis	Access Analysis	Access Analysis & Recommendation	Access Analysis & Recommendation
Access Remediation	-	If Access Problem, Remediate Within 12 Months	If Access Problem, Remediate Within 12 Months
Recommendation Report	Recommendation Due to JBC	-	-
Investigate Access Issues	-	If Access problem, Investigate	If Access problem, Investigate

*Exclusive of Physician Services, which falls under the 1202 Rate Bump and will need to have an access review report regardless of the 1% across the board decreases. These services include: Office Visits & Vaccine Administration for both Physician and Non-Physician Services, and the Administration of Vaccines under the Pediatric Immunization Program.

JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

PROGRAM/SERVICE	RATE REVIEW COMMITTEE SB 15-228	FEDERAL ACCESS TO CARE REGULATIONS		RATE CAN BE CHANGED THROUGH LONG BILL	RATE SET BY STATUTE OR REGULATION
		ACCESS MONITORING REVIEW PLAN 447.203	STATE PLAN AMENDMENTS ON RATE CHANGES 447.204		
Ambulatory Surgical Centers	✓		✓	✓	
Anesthesia	✓		✓	✓	
Behavioral Health Services (CORE SERVICE)		✓			✓
Clinic Services		✓	✓	✓	
County Brokered Non-Emergent Transportation	✓		✓	✓	
Dental Services	✓	✓	✓	✓	
Dental, Surgical and Medical		✓	✓	✓	
Dialysis Centers	✓		✓	✓	
Disposable Supplies	✓		✓	✓	
Durable Medical Equipment: Home Health	✓	✓	✓	✓	
Early Periodic Screening, Diagnosis and Treatment			✓	✓	
Emergency Transportation	✓		✓	✓	
Eyeglasses	✓		✓	✓	
Family Planning Services	✓	✓	✓	✓	



JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

PROGRAM/SERVICE	RATE REVIEW COMMITTEE SB 15-228	FEDERAL ACCESS TO CARE REGULATIONS		RATE CAN BE CHANGED THROUGH LONG BILL	RATE SET BY STATUTE OR REGULATION
		ACCESS MONITORING REVIEW PLAN 447.203	STATE PLAN AMENDMENTS ON RATE CHANGES 447.204		
Federally Qualified Health Centers		✓		✓	✓
Home and Community Based Service Waivers	✓			✓	
Home Health (CORE SERVICE)	✓	✓	✓	✓	
Hospice Services			✓	✓	✓
Inpatient Hospital Services			✓	✓	
Intermediate Care Facilities					✓
Laboratory and Pathology	✓	✓	✓	✓	
Mental Health Fee-For-Service		✓	✓	✓	
Non-Practitioner Services		✓	✓	✓	
Nursing Facilities					✓
Obstetrics (CORE SERVICE)		✓	✓	✓	
Office Visits & Vaccines: Physician Services; Non-Physician Services; Pediatric Vaccines (1202)		✓	✓	✓	
Outpatient Hospital Services			✓	✓	
Physician Administered Drugs	✓		✓	✓	



JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

PROGRAM/SERVICE	RATE REVIEW COMMITTEE SB 15-228	FEDERAL ACCESS TO CARE REGULATIONS		RATE CAN BE CHANGED THROUGH LONG BILL	RATE SET BY STATUTE OR REGULATION
		ACCESS MONITORING REVIEW PLAN 447.203	STATE PLAN AMENDMENTS ON RATE CHANGES 447.204		
Physician Services	✓	✓	✓	✓	
Prescribed Drugs					✓
Prenatal Plus		✓	✓	✓	
Primary Care (CORE SERVICE)		✓	✓	✓	
Private Duty Nursing	✓		✓	✓	
Prosthetic Services	✓		✓	✓	
Psychiatric Residential Treatment Facilities	✓		✓	✓	
Physical, Occupational, Speech Therapy and Audiology Services		✓	✓	✓	
Rehabilitation Services: Outpatient Substance Use Disorder Treatment			✓	✓	
Rehabilitation Services: Mental Health & Substance Abuse Rehabilitation Services for Children			✓	✓	
Residential Child Care Facilities; Therapeutic	✓		✓	✓	



JBC Staff Figure Setting: FY 2016-17
Staff Working Document – Does Not Represent Committee Decision

PROGRAM/SERVICE	RATE REVIEW COMMITTEE SB 15-228	FEDERAL ACCESS TO CARE REGULATIONS		RATE CAN BE CHANGED THROUGH LONG BILL	RATE SET BY STATUTE OR REGULATION
		ACCESS MONITORING REVIEW PLAN 447.203	STATE PLAN AMENDMENTS ON RATE CHANGES 447.204		
Residential Child Care Facilities;	✓		✓	✓	
Rural Health Centers		✓			✓
Screening, Brief Intervention, Referral to Treatment			✓	✓	
School Based Clinic Services					✓
School Based Clinic Care Mgmt.			✓	✓	
Specialty Care (CORE SERVICE) ³		✓	✓	✓	
Substance Use Disorder-Targeted Case Management			✓	✓	
Surgery	✓		✓	✓	
Targeted Case Management-Developmentally Disabled	✓		✓	✓	
Targeted Case Management-Individuals with Intellectual Disabilities Class II and Class IV			✓	✓	
Tobacco Cessation: Pregnant Women		✓	✓	✓	

³ Please note, that the services denoted as CORE SERVICES, this means that they umbrella multiple services and encompass a larger scope of work opposed to an individual service or program.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
Chief of Staff

FREDERICK R. YARGER
Solicitor General



STATE OF COLORADO
DEPARTMENT OF LAW

RALPH L. CARR
COLORADO JUDICIAL CENTER
1300 Broadway, 6th Floor
Denver, Colorado 80203
Phone (720) 508-6000

State Services Section

February 22, 2016

PRIVILEGED ATTORNEY-CLIENT CORRESPONDENCE

Gretchen M. Hammer
Medicaid Director
Colorado Department of Health Care Policy and Financing

RE: *Armstrong v. Exceptional Child Center, Inc.* and its effect on Colorado's
authority to establish Medicaid rates.

Dear Gretchen:

You have asked this office to research the Joint Budget Committee's inquiry as to whether the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), provides clarification of state authority to set provider reimbursement rates. This question relates to recent federal Medicaid regulations that impose new requirements on State Medicaid agencies in setting provider fee-for-service reimbursement rates. For example, the new regulations, found at 42 C.F.R. Part 447, require the Department to engage in significant data collection and analysis, review access metrics, review current rates, and monitor ongoing access to services and care. The goal of the new regulations is to ensure that rates are sufficient to enlist providers so as to assure beneficiary access to covered care and services. The JBC's inquiry appears to question whether the federal Centers for Medicare and Medicaid Services (CMS) has the authority to impose these new requirements on states.

In *Armstrong*, Medicaid habilitation providers sued Idaho state officials, claiming that Idaho established rates lower than permitted by the Medicaid Act at 42 U.S.C. § 1396a(30)(A). The United States Supreme Court determined that the Medicaid providers could not sue to enforce section (30)(A) of the Medicaid Act. The Court reasoned that the Supremacy Clause did not create a private right of action, nor could the suit proceed in equity.

CMS is citing this decision as the motivation behind its new regulations stating that because providers and Medicaid clients are unable to bring a claim in court to challenge the sufficiency of state Medicaid rates, CMS must take action to ensure adequacy of rates and beneficiary access to covered services.

42 U.S.C. § 1396a(a)(30)(A) requires states to "...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..." As noted in *Armstrong*, this broad statute grants sole authority to CMS to regulate the adequacy of state reimbursement rates. *Armstrong*, 135 S. Ct. at 1385, *citing Gonzaga Univ. v. Doe*, 536 U.S. 273, 292 (2002) ("Explicitly conferring enforcement of this judgment-laden standard upon the Secretary alone establishes, we think, that Congress 'wanted to make the agency remedy that it provided exclusive,' thereby achieving the 'expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking' and avoiding the 'comparative risk of inconsistent interpretation and misincentives that can arise out of an occasional inappropriate application of the statute in a private action'").

In conclusion, it is my opinion that 42 U.S.C. § 1396a(a)(30)(A) grants CMS the authority to place restrictions and requirements on how states set provider reimbursement rates and to enact and enforce the regulations at 42 C.F.R. Part 447. I am unaware of any state initiating a challenge to CMS's authority.

This letter expresses the opinion of the authoring First Assistant Attorney General and should not be construed as the opinion of the Attorney General.

Sincerely,

FOR THE ATTORNEY GENERAL



JENNIFER L. WEAVER

First Assistant Attorney General

Health Care Unit

State Services Section

(720) 508-6145

Email: Jennifer.Weaver@coag.gov

Hospital Provider Fee by Hospital
SFY 2016-17 Budget Limit Comparison (estimated)

Hospital	County	CICP Payments prior to Hospital Provider Fee A	\$656.250M Budget Limit			\$729.4M Budget Limit			Net Reimbursement Change H (D-G)
			SFY 2016-17 Total			SFY 2016-17 Total			
			Fees B	Payments C	Net Reimbursement D (C-B-A)	Fees E	Payments F	Net Reimbursement G (F-E-A)	
Fee Exempt Hospitals (Psychiatric, Long Term Acute Care, and Rehabilitation)									
Haven Behavioral Health at North Denver	Adams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
HealthOne Spalding Rehabilitation Hospital	Adams	\$0	\$0	\$112,324	\$112,324	\$0	\$129,019	\$129,019	(\$16,695)
Kindred Hospital Aurora	Adams	\$0	\$0	\$15,787	\$15,787	\$0	\$18,133	\$18,133	(\$2,346)
Vibra Long Term Acute Care Hospital	Adams	\$0	\$0	\$44,340	\$44,340	\$0	\$50,931	\$50,931	(\$6,590)
Craig Hospital	Arapahoe	\$0	\$0	\$420,329	\$420,329	\$0	\$482,804	\$482,804	(\$62,475)
HealthSouth Rehabilitation Hospital - Denver	Arapahoe	\$0	\$0	\$136,301	\$136,301	\$0	\$156,559	\$156,559	(\$20,259)
Centennial Peaks Hospital	Boulder	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Colorado Acute Long Term Hospital	Denver	\$0	\$0	\$46,186	\$46,186	\$0	\$53,050	\$53,050	(\$6,865)
Colorado Mental Health Institute-Ft Logan	Denver	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Eating Recovery Center	Denver	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Kindred Hospital	Denver	\$0	\$0	\$15,232	\$15,232	\$0	\$17,496	\$17,496	(\$2,264)
Select Specialty Hospital - Denver	Denver	\$0	\$0	\$64,803	\$64,803	\$0	\$74,435	\$74,435	(\$9,632)
Highlands Behavioral Health System	Douglas	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Cedar Springs Behavior Health System	El Paso	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HealthSouth Rehabilitation Hospital - Colorado Springs	El Paso	\$0	\$0	\$191,581	\$191,581	\$0	\$220,056	\$220,056	(\$28,475)
Peak View Behavioral Health	El Paso	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Select Long Term Care Hospital	El Paso	\$0	\$0	\$2,585	\$2,585	\$0	\$2,969	\$2,969	(\$384)
Northern Colorado Long Term Acute Care Hospital	Larimer	\$0	\$0	\$912	\$912	\$0	\$1,048	\$1,048	(\$136)
Colorado West Psychiatric Hospital Inc	Mesa	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Colorado Mental Health Institute-Pueblo	Pueblo	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Haven Behavioral Senior Care at St. Mary-Corwin	Pueblo	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Northern Colorado Rehabilitation Hospital	Weld	\$0	\$0	\$80,271	\$80,271	\$0	\$92,202	\$92,202	(\$11,931)
Fee Paying Hospitals (Critical Access and General Hospitals)									
Children's Hospital Colorado	Adams	\$2,854,794	\$19,131,682	\$45,898,472	\$23,911,996	\$21,264,227	\$52,720,541	\$28,601,520	(\$4,689,524)
HealthOne North Suburban Medical Center	Adams	\$0	\$13,202,885	\$14,801,555	\$1,598,670	\$14,674,567	\$17,001,568	\$2,327,001	(\$728,331)
Platte Valley Medical Center	Adams	\$1,499,298	\$4,574,179	\$7,901,133	\$1,827,656	\$5,084,048	\$9,075,510	\$2,492,164	(\$664,508)
University of Colorado Hospital	Adams	\$36,264,181	\$43,007,796	\$61,788,083	(\$17,483,894)	\$47,801,732	\$70,971,887	(\$13,094,026)	(\$4,389,869)
San Luis Valley Regional Medical Center	Alamosa	\$962,324	\$2,781,835	\$9,644,055	\$5,899,896	\$3,091,917	\$11,077,488	\$7,023,247	(\$1,123,352)
Centura Health - Littleton Adventist Hospital	Arapahoe	\$0	\$15,687,612	\$16,116,084	\$428,472	\$17,436,258	\$18,511,481	\$1,075,222	(\$646,751)
HealthOne Medical Center of Aurora	Arapahoe	\$0	\$33,604,686	\$18,424,358	(\$15,180,328)	\$37,350,488	\$21,162,842	(\$16,187,646)	\$1,007,318
HealthOne Swedish Medical Center	Arapahoe	\$0	\$33,520,373	\$39,080,762	\$5,560,389	\$37,256,777	\$44,889,488	\$7,632,711	(\$2,072,322)
Pagosa Mountain Hospital	Archuleta	\$0	\$328,040	\$1,265,274	\$937,234	\$364,606	\$1,453,337	\$1,088,731	(\$151,497)
Southeast Colorado Hospital	Baca	\$34,179	\$177,575	\$1,269,154	\$1,057,400	\$197,369	\$1,457,793	\$1,226,245	(\$168,846)
Boulder Community Hospital	Boulder	\$1,063,630	\$16,842,848	\$15,123,319	(\$2,783,159)	\$18,720,264	\$17,371,157	(\$2,412,737)	(\$370,422)
Centura Health - Avista Adventist Hospital	Boulder	\$0	\$6,107,738	\$12,205,816	\$6,098,078	\$6,788,547	\$14,020,014	\$7,231,467	(\$1,133,389)
Good Samaritan Medical Center	Boulder	\$0	\$13,276,089	\$7,055,622	(\$6,220,467)	\$14,755,931	\$8,104,327	(\$6,651,604)	\$431,137
Longmont United Hospital	Boulder	\$1,633,746	\$10,490,284	\$16,234,516	\$4,110,486	\$11,659,601	\$18,647,515	\$5,354,168	(\$1,243,683)

Hospital Provider Fee by Hospital
SFY 2016-17 Budget Limit Comparison (estimated)

Hospital	County	CICP Payments prior to Hospital Provider Fee A	\$656.250M Budget Limit			\$729.4M Budget Limit			Net Reimbursement Change H (D-G)
			SFY 2016-17 Total			SFY 2016-17 Total			
			Fees B	Payments C	Net Reimbursement D (C-B-A)	Fees E	Payments F	Net Reimbursement G (F-E-A)	
Heart of the Rockies Regional Medical Center	Chaffee	\$247,500	\$1,147,316	\$3,536,447	\$2,141,632	\$1,275,203	\$4,062,083	\$2,539,380	(\$397,749)
Keefe Memorial Hospital	Cheyenne	\$0	\$70,502	\$920,524	\$850,022	\$78,360	\$1,057,345	\$978,984	(\$128,962)
Conejos County Hospital	Conejos	\$99,884	\$173,383	\$1,796,551	\$1,523,284	\$192,709	\$2,063,579	\$1,770,986	(\$247,702)
Delta County Memorial Hospital	Delta	\$912,623	\$2,906,052	\$4,136,513	\$317,837	\$3,229,980	\$4,751,339	\$608,735	(\$290,898)
Centura Health - Porter Adventist Hospital	Denver	\$0	\$17,473,814	\$9,504,286	(\$7,969,528)	\$19,421,561	\$10,916,945	(\$8,504,617)	\$535,089
Denver Health Medical Center	Denver	\$64,455,024	\$22,490,137	\$105,061,238	\$18,116,077	\$24,997,038	\$120,676,901	\$31,224,839	(\$13,108,762)
HealthOne Presbyterian/St. Luke's Medical Center	Denver	\$0	\$24,749,359	\$43,282,000	\$18,532,640	\$27,508,088	\$49,715,173	\$22,207,085	(\$3,674,444)
HealthOne Rose Medical Center	Denver	\$0	\$19,977,668	\$24,512,904	\$4,535,236	\$22,204,512	\$28,156,352	\$5,951,840	(\$1,416,605)
National Jewish Health	Denver	\$1,682,780	\$2,189,757	\$7,700,642	\$3,828,105	\$2,433,842	\$8,845,218	\$4,728,596	(\$900,492)
Saint Joseph Hospital	Denver	\$0	\$23,139,240	\$40,857,069	\$17,717,828	\$25,718,494	\$46,929,815	\$21,211,320	(\$3,493,492)
Castle Rock Adventist Hospital	Douglas	\$0	\$4,470,521	\$4,161,901	(\$308,619)	\$4,968,835	\$4,780,501	(\$188,334)	(\$120,286)
Centura Health - Parker Adventist Hospital	Douglas	\$0	\$10,884,643	\$6,324,181	(\$4,560,462)	\$12,097,917	\$7,264,169	(\$4,833,749)	\$273,287
HealthOne Sky Ridge Medical Center	Douglas	\$0	\$17,457,824	\$5,025,902	(\$12,431,922)	\$19,403,789	\$5,772,922	(\$13,630,867)	\$1,198,946
Vail Valley Medical Center	Eagle	\$0	\$3,391,596	\$6,094,540	\$2,702,944	\$3,769,646	\$7,000,396	\$3,230,750	(\$527,805)
Centura Health - Penrose -St. Francis Health Services	El Paso	\$2,195,836	\$32,259,964	\$34,524,093	\$68,293	\$35,855,875	\$39,655,544	\$1,603,833	(\$1,535,540)
Memorial Hospital	El Paso	\$16,142,511	\$33,219,925	\$57,895,986	\$8,533,550	\$36,922,839	\$66,501,293	\$13,435,943	(\$4,902,393)
Centura Health - St. Thomas More Hospital	Fremont	\$779,972	\$1,832,853	\$8,235,458	\$5,622,633	\$2,037,155	\$9,459,526	\$6,642,400	(\$1,019,766)
Grand River Medical Center	Garfield	\$190,609	\$826,108	\$3,863,269	\$2,846,551	\$918,192	\$4,437,481	\$3,328,681	(\$482,129)
Valley View Hospital	Garfield	\$444,750	\$4,754,808	\$15,463,806	\$10,264,248	\$5,284,810	\$17,762,252	\$12,032,691	(\$1,768,443)
Kremmling Memorial Hospital	Grand	\$117,393	\$323,152	\$1,810,615	\$1,370,070	\$359,173	\$2,079,734	\$1,603,168	(\$233,098)
Gunnison Valley Hospital	Gunnison	\$42,048	\$605,102	\$2,140,217	\$1,493,067	\$672,551	\$2,458,326	\$1,743,727	(\$250,660)
Spanish Peaks Regional Health Center	Huerfano	\$135,879	\$309,531	\$1,863,027	\$1,417,617	\$344,034	\$2,139,936	\$1,660,023	(\$242,407)
Centura Health - Ortho Colorado	Jefferson	\$0	\$1,176,111	\$0	(\$1,176,111)	\$1,307,208	\$0	(\$1,307,208)	\$131,097
Centura Health - Saint Anthony Central Hospital	Jefferson	\$0	\$20,425,500	\$17,375,438	(\$3,050,062)	\$22,702,263	\$19,958,017	(\$2,744,245)	(\$305,817)
Centura Health - Saint Anthony North Hospital	Jefferson	\$0	\$9,993,446	\$13,305,136	\$3,311,691	\$11,107,382	\$15,282,731	\$4,175,349	(\$863,658)
Lutheran Medical Center	Jefferson	\$0	\$27,543,760	\$19,733,324	(\$7,810,435)	\$30,613,971	\$22,666,366	(\$7,947,605)	\$137,170
Weisbrod Memorial County Hospital	Kiowa	\$0	\$39,268	\$848,775	\$809,506	\$43,645	\$974,931	\$931,286	(\$121,780)
Kit Carson County Memorial Hospital	Kit Carson	\$0	\$310,720	\$1,745,465	\$1,434,746	\$345,354	\$2,004,901	\$1,659,546	(\$224,800)
Animas Surgical Hospital	La Plata	\$0	\$666,083	\$1,523,195	\$857,112	\$740,329	\$1,749,593	\$1,009,264	(\$152,152)
Mercy Medical Center	La Plata	\$534,968	\$5,999,963	\$11,756,322	\$5,221,391	\$6,668,759	\$13,503,711	\$6,299,984	(\$1,078,592)
St. Vincent General Hospital District	Lake	\$118,153	\$173,476	\$1,391,993	\$1,100,364	\$192,813	\$1,598,891	\$1,287,925	(\$187,561)
Banner Health Fort Collins	Larimer	\$0	\$2,338,201	\$5,190,652	\$2,852,451	\$2,598,832	\$5,962,159	\$3,363,327	(\$510,875)
Estes Park Medical Center	Larimer	\$435,234	\$704,831	\$1,445,591	\$305,526	\$783,397	\$1,660,455	\$441,825	(\$136,299)
McKee Medical Center	Larimer	\$2,131,572	\$6,418,222	\$12,055,426	\$3,505,632	\$7,133,639	\$13,847,271	\$4,582,060	(\$1,076,427)
Medical Center of the Rockies	Larimer	\$1,584,786	\$13,725,520	\$18,589,994	\$3,279,689	\$15,255,457	\$21,353,098	\$4,512,854	(\$1,233,166)
Poudre Valley Hospital	Larimer	\$5,935,254	\$21,686,921	\$30,615,710	\$2,993,535	\$24,104,290	\$35,166,243	\$5,126,699	(\$2,133,164)
Mount San Rafael Hospital	Las Animas	\$134,622	\$834,276	\$3,309,670	\$2,340,772	\$927,270	\$3,801,599	\$2,739,708	(\$398,935)
Lincoln Community Hospital and Nursing Home	Lincoln	\$0	\$199,831	\$848,173	\$648,342	\$222,106	\$974,241	\$752,135	(\$103,793)

Hospital Provider Fee by Hospital
SFY 2016-17 Budget Limit Comparison (estimated)

Hospital	County	CICP Payments prior to Hospital Provider Fee A	\$656.250M Budget Limit			\$729.4M Budget Limit			Net Reimbursement Change H (D-G)
			SFY 2016-17 Total			SFY 2016-17 Total			
			Fees B	Payments C	Net Reimbursement D (C-B-A)	Fees E	Payments F	Net Reimbursement G (F-E-A)	
Sterling Regional Medical Center	Logan	\$794,952	\$1,284,825	\$4,655,539	\$2,575,762	\$1,428,041	\$5,347,510	\$3,124,517	(\$548,756)
Community Hospital	Mesa	\$170,542	\$3,153,862	\$3,587,905	\$263,501	\$3,505,412	\$4,121,189	\$445,235	(\$181,734)
Family Health West Hospital	Mesa	\$0	\$491,393	\$1,646,034	\$1,154,641	\$546,167	\$1,890,690	\$1,344,523	(\$189,882)
St. Mary's Hospital and Medical Center	Mesa	\$1,747,192	\$20,959,456	\$27,591,814	\$4,885,166	\$23,295,737	\$31,692,893	\$6,649,964	(\$1,764,798)
The Memorial Hospital	Moffat	\$167,785	\$730,627	\$3,712,693	\$2,814,280	\$812,068	\$4,264,525	\$3,284,672	(\$470,391)
Southwest Memorial Hospital	Montezuma	\$383,352	\$1,201,909	\$5,730,780	\$4,145,520	\$1,335,881	\$6,582,569	\$4,863,335	(\$717,816)
Montrose Memorial Hospital	Montrose	\$1,054,452	\$4,337,743	\$6,979,976	\$1,587,781	\$4,821,257	\$8,017,437	\$2,141,728	(\$553,947)
Colorado Plains Medical Center	Morgan	\$162,836	\$3,074,887	\$6,050,532	\$2,812,810	\$3,417,634	\$6,949,847	\$3,369,377	(\$556,567)
East Morgan County Hospital	Morgan	\$175,025	\$542,940	\$2,454,472	\$1,736,507	\$603,460	\$2,819,290	\$2,040,805	(\$304,298)
Arkansas Valley Regional Medical Center	Otero	\$1,374,965	\$2,270,194	\$5,768,105	\$2,122,946	\$2,523,245	\$6,625,441	\$2,727,231	(\$604,285)
Haxtun Hospital	Phillips	\$0	\$71,164	\$1,016,562	\$945,398	\$79,096	\$1,167,658	\$1,088,561	(\$143,163)
Melissa Memorial Hospital	Phillips	\$40,279	\$168,734	\$862,402	\$653,389	\$187,543	\$990,584	\$762,763	(\$109,374)
Aspen Valley Hospital	Pitkin	\$490,839	\$1,060,069	\$3,194,783	\$1,643,875	\$1,178,231	\$3,669,636	\$2,000,566	(\$356,691)
Prowers Medical Center	Prowers	\$407,322	\$636,445	\$4,515,953	\$3,472,185	\$707,388	\$5,187,176	\$4,072,466	(\$600,281)
Centura Health - St. Mary-Corwin Medical Center	Pueblo	\$2,978,448	\$12,574,528	\$23,428,103	\$7,875,128	\$13,976,168	\$26,910,314	\$9,955,697	(\$2,080,570)
Parkview Medical Center	Pueblo	\$3,603,807	\$29,223,821	\$43,821,921	\$10,994,293	\$32,481,303	\$50,335,345	\$14,250,235	(\$3,255,942)
Pioneers Hospital	Rio Blanco	\$0	\$153,221	\$665,420	\$512,199	\$170,300	\$764,324	\$594,024	(\$81,825)
Rangely District Hospital	Rio Blanco	\$0	\$84,028	\$1,084,023	\$999,995	\$93,394	\$1,245,146	\$1,151,751	(\$151,756)
Rio Grande Hospital	Rio Grande	\$51,020	\$338,832	\$1,529,896	\$1,140,044	\$376,600	\$1,757,290	\$1,329,670	(\$189,626)
Yampa Valley Medical Center	Routt	\$168,950	\$1,935,321	\$5,358,256	\$3,253,984	\$2,151,045	\$6,154,674	\$3,834,679	(\$580,695)
Sedgwick County Memorial Hospital	Sedgwick	\$27,239	\$157,659	\$850,094	\$665,197	\$175,233	\$976,447	\$773,976	(\$108,779)
Centura Health - Saint Anthony Summit Hospital	Summit	\$0	\$1,728,303	\$3,435,791	\$1,707,488	\$1,920,951	\$3,946,466	\$2,025,515	(\$318,027)
Pikes Peak Regional Hospital	Teller	\$55,614	\$564,611	\$1,977,142	\$1,356,916	\$627,547	\$2,271,012	\$1,587,851	(\$230,935)
North Colorado Medical Center	Weld	\$6,182,516	\$19,209,184	\$28,191,616	\$2,799,917	\$21,350,367	\$32,381,846	\$4,848,963	(\$2,049,046)
Wray Community District Hospital	Yuma	\$107,405	\$274,424	\$1,790,002	\$1,408,173	\$305,013	\$2,056,057	\$1,643,639	(\$235,466)
Yuma District Hospital	Yuma	\$98,017	\$398,813	\$1,809,180	\$1,312,349	\$443,268	\$2,078,085	\$1,536,800	(\$224,451)
Total		\$162,876,107	\$656,250,000	\$988,093,880	\$168,967,773	\$729,400,000	\$1,134,958,137	\$242,682,030	(\$73,714,257)