COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

FY 2015-16 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

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

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.

Department Summary of Staff Recommendations

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$7,855,593,433	$2,259,525,686	$946,748,434	$7,782,578	$4,641,536,735	389.1
Other legislation	21,262,030	4,945,577	5,529,056	0	10,787,397	1.8
SB 15-147 (Supplemental)	135,848,721	89,830,809	35,353,260	(1,677,787)	12,342,439	0.0
Recommended Long Bill Supplemental	(73,490,260)	82,764	(86,754,540)	0	13,181,516	0.0
Supplemental package bill changes	(1,081,344)	(1,081,344)	0	0	0	0.0
TOTAL	**$7,938,132,580**	**$2,353,303,492**	**$900,876,210**	**$6,104,791**	**$4,677,848,087**	**390.9**

Department of Health Care Policy and Financing

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$7,938,132,580	$2,353,303,492	$900,876,210	$6,104,791	$4,677,848,087	390.9
Annualize prior year budget decisions	(32,778,259)	(4,631,662)	(3,399,267)	596	(24,747,926)	0.2
FMAP change	0	(21,294,774)	(9,311,141)	(978)	30,606,893	0.0
R1 Medical Services Premiums - services	490,270,926	92,338,953	7,971,326	0	389,960,647	0.0
R1 Medical Services Premiums - booster / financing	290,785,123	9,409,493	150,996,434	0	130,379,196	0.0
R2 Behavioral health programs	92,715,806	18,692,358	1,251,435	0	72,772,013	0.0
R3 Children's Basic Health Plan	2,390,026	11,763,217	(15,800,082)	0	6,426,891	0.0
R4 Medicare Modernization Act	8,867,899	9,297,324	0	0	(429,425)	0.0
R5 Office of Community Living	22,459,283	11,002,803	0	0	11,456,480	0.0
R6 Enrollment simplification	0	0	0	0	0	0.0
R7 Community First Choice planning	314,041	157,020	0	0	157,021	0.9
R7 Participant directed programs	1,394,581	659,344	0	0	735,237	0.0
R8 Children with autism waiver	0	0	0	0	0	0.0
R9 Personal health records	772,570	122,257	0	0	650,313	0.0
R10 Customer service center	2,042,250	661,840	359,286	0	1,021,124	20.8
R11 Public health and Medicaid alignment	0	0	0	0	0	0.0
R12 Provider rates	19,093,849	6,918,045	528,591	0	11,647,213	0.0
R13 ACC reprocurement preparation	250,000	125,000	0	0	125,000	0.0
R14 Primary Care Fund audit	0	0	0	0	0	0.0
R15 Managed care organization audits	300,000	150,000	0	0	150,000	0.0
R16 Comprehensive primary care	84,952	42,476	0	0	42,476	0.0
R17 School-based early intervention and prevention	4,365,859	2,000,000	0	0	2,365,859	0.0
R18 DDDWeb stabilization	205,260	102,629	0	0	102,631	0.0
R19 Public school health services	5,476,888	0	2,683,127	0	2,793,761	0.0
BA6 CBMS funding simplification	195,022	(1,261,022)	1,452,042	(140,143)	144,145	0.0
BA7 MMIS adjustments	18,496,593	2,669,969	934,236	0	14,892,388	0.0
BA8 Legacy systems and technology support	(201,262)	(100,632)	0	0	(100,630)	0.0
BA9 CLAG recommendations and HCBS final rule review	588,713	256,857	37,500	0	294,356	0.0
BA10 Provider fee analytics	0	0	0	0	0	0.0
BA12 Leased space	(444,117)	(284,307)	62,247	0	(222,057)	0.0
BA13 Predictive analytics FTE	78,723	7,873	0	0	70,850	0.9
BA15 PACAP contractor	(159,073)	(79,537)	0	0	(79,536)	0.0
BA14 Medical identification cards	(6,473)	(348)	(2,887)	0	(3,238)	0.0
BA16 Public school health services	633,911	0	103,393	0	530,518	0.0

Department of Health Care Policy and Financing	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Continuous eligibility financing	(80,182,997)	(33,251,745)	(6,206,308)	0	(40,724,944)	0.0
Rate setting process	517,176	258,588	0	0	258,588	3.6
Centrally appropriated line items	4,168,980	1,814,290	271,764	128,066	1,954,860	0.0
Human Services programs	1,475,255	809,223	0	0	666,032	0.0
Fund source adjustment	3,993	0	3,993	0	0	0.0
Indirect cost adjustment	(27,612)	27,612	(9,383)	20,611	(66,452)	0.0
TOTAL	**$8,792,280,466**	**$2,461,686,636**	**$1,032,802,516**	**$6,112,943**	**$5,291,678,371**	**417.3**
Increase/(Decrease)	$854,147,886	$108,383,144	$131,926,306	$8,152	$613,830,284	26.4
Percentage Change	10.8%	4.6%	14.6%	0.1%	13.1%	6.8%
FY 2015-16 Executive Request	**$8,666,656,110**	**$2,495,405,456**	**$1,018,697,121**	**$6,126,761**	**$5,146,426,772**	**414.7**
Request Above/(Below) Recommendation	($125,624,356)	$33,718,820	($14,105,395)	$13,818	($145,251,599)	(2.6)

Annualize prior year budget decisions: Annualizes prior year budget decisions

FMAP change: Adjusts appropriations for changes in the federal medical assistance percentage (FMAP).

R1 Medical Service Premiums - services: Adjusts the Medical Services Premiums appropriation for projected changes in caseload, utilization, and per capita costs based on current eligibility and benefit policies.

R1 Medical Service Premiums - services: Adjusts the Medical Services Premiums appropriation for projected changes in provider fee financing for booster payments and other changes in financing.

R2 Behavioral Health Programs: Adjusts the behavioral health appropriations for projected changes in caseload, utilization, and per capita costs based on current eligibility and benefit policies. *Recommendations covered during figure setting for Behavioral Health Community Programs.*

R3 Children's Basic Health Plan: Adjusts the Children's Basic Health Plan appropriation for projected changes in caseload, utilization, and per capita costs based on current eligibility and benefit policies.

R4 Medicare Modernization Act: Adjusts the appropriation based on the state's projected obligation pursuant to the Medicare Modernization Act to pay the federal government in lieu of covering prescription drugs for people dually eligible for Medicaid and Medicare.

R5 Office of Community Living: Adjusts the appropriations for services for people with developmental disabilities for projected changes in caseload, utilization, and per capita costs

based on current eligibility and benefit policies. *Recommendations covered during figure setting for the Office of Community Living.*

R6 Enrollment simplification: No funding is recommended for the Department's request provide a one-month grace period to pay the annual CHP+ enrollment fee, study the potential impact of implementing continuous eligibility for adults, and modify the income calculation process for Medicaid and CHP+ to use annualized income, rather than monthly income.

R7 Community First Choice planning: Provides funding and FTE to manage the Colorado First Choice (CFC) implementation process.

R7 Participant directed programs: Would allow individuals receiving services on the Supported Living Services (SLS) waiver for individuals with intellectual and developmental disabilities to utilize Consumer Directed Attendant Support Services (CDASS). *Recommendations covered during figure setting for the Office of Community Living.*

R8 Children with autism waiver: Expands and modifies the Children with Autism (CWA) waiver. No funding is recommended in the Long Bill, because this requires legislation. The JBC has introduced H.B. 15-1186 based on the Department's request.

R9 Personal health records: Creates a secure, centralized web portal through which Medicaid clients can access online health education materials and view their personal health records and communicate securely with their providers.

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

R11 Public health and Medicaid alignment: No funding is recommended for the Department's request to fund grants from Regional Care Collaborative Organizations (RCCOs) to local public health agencies (LPHAs).

R12 Provider rates: Increases provider rates by 0.5 percent for Medical Services Premiums and 2.7 percent for all other providers, based on the JBC's common policy, and does not include funding for the Department's proposed targeted rate increases.

R13 ACC reprocurement preparation: Provides funding for consulting services in preparation for the reprocurement of Regional Care Collaborative Organizations (RCCOs) responsible for administering the Accountable Care Collaborative (ACC).

R14 Primary Care Fund audit: Transfers tobacco tax dollars from the Primary Care Fund Program to pay for audits necessary to distribute the grants appropriately. Does not include funding for the Department's request to transfer money to the Personal Services line item.

R15 Managed care organization audits: Funding to audit the financial and encounter data submitted by managed care providers to ensure accuracy and consistency and to explore the use

of medical loss ratios (MLRs) for managed care contracts, based on recommendations from the Government Accountability Office (GAO)

R16 Comprehensive primary care: Funding for Medicaid's allocated share of the Comprehensive Primary Care initiative (CPCi) that connects payer information with health outcomes.

R17 School-based early intervention and prevention: Continues paying behavioral health organizations for school-based substance abuse prevention and intervention programs authorized through S.B. 14-215. Recommendations covered during figure setting for *Behavioral Health Community Programs.*

R18 DDDWeb stabilization: Addresses security and stability issues with the case management system for clients with intellectual and developmental disabilities.

R19 Public school health services: Adjusts assumptions about certified public expenditures for public school health services, based on projected increases in enrollment and school district participation.

Centrally appropriated line items: Makes adjustments to centrally appropriated line items.

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

BA6 CBMS funding simplification: Continues and annualizes changes approved during the supplemental to the format of appropriations for the Colorado Benefits Management System.

BA7 MMIS adjustments: Continues and annualizes changes approved during the supplemental for the Medicaid Management Information System.

BA8 Legacy systems and technology support: Continues and annualizes changes approved during the supplemental to address a 2-year backlog of change requests for the Business Utilization Services application that is used for case management of long term services and supports.

BA9 CLAG recommendations and HCBS final rule review: Provides funding to analyze new rules concerning Home and Community Based Services and the *Community Living Plan Colorado's Response to the Olmstead Decision*.

BA 10 Provider fee analytics: Continues the base increase in administrative expenditures from the Hospital Provider Fee approved in the supplemental.

BA12 Leased space: Annualizes supplemental changes to leased space associated with the move to 303 E. 17th Ave.

BA13 Predictive analytics FTE: Provides funding for staff to manage technology that identifies and prevents potentially fraudulent claims.

BA15 PACAP contractor: Annualizes supplemental funding to redesign the Public Assistance Cost Allocation Plan (PACAP) that attributes administrative expenses by federal program to determine the appropriate match rate.

BA14 Medical identification cards: Annualizes supplemental funding for an increase in costs for medical identification cards.

BA16 Public school health services: Adjusts assumptions about certified public expenditures for public school health services, based on projected increases in enrollment and school district participation.

Continuous eligibility financing: Changes the financing for continuous eligibility for children from General Fund to the Hospital Provider Fee to be more consistent with the statutes.

Rate setting process: Provides funding and staff for the Department to implement an annual rate review process.

Centrally appropriated line items: Makes adjustments to centrally appropriated line items.

Human Services programs: Reflects adjustments for several programs that are financed with Medicaid funds but operated by the Department of Human Services. *See the figure setting for the Department of Human Services for more information.*

➔ FMAP Change

Request: The Department requests adjustments to account for a change in the federal match rate for Medicaid, known as the Federal Medical Assistance Percentage (FMAP). These adjustments affect multiple line items, and so the request is discussed before the rest of the presentation.

The change in the federal match rate is the result of a decrease in the ratio of estimated per capita income in Colorado to the national average. The FMAP is calculated for each state annually according to a formula[1] that takes into account each state's per capita income compared to the national average. Federal law provides for a minimum match rate of 50 percent and a maximum of 83 percent. The match rate for CHP+ is then calculated as a derivative of the Medicaid FMAP[2]. A state with per capita income equal to the national average would get a 55 percent Medicaid match and states get a larger or smaller match based on having per capita income below or above the national average.

For federal fiscal year 2015-16 Colorado's FMAP will decrease, but because the federal fiscal year does not start until after the state fiscal year, the average FMAP for the state fiscal year will slightly increase.

Medicaid Federal Medical Assistance Percentage (FMAP)					
State Fiscal Year	Ave. FMAP	FMAP by Quarter (of state fiscal year)			
		Q1	Q2	Q3	Q4
FY 12-13	50.00	50.00	50.00	50.00	50.00
FY 13-14	50.00	50.00	50.00	50.00	50.00
FY 14-15	50.76	50.00	51.01	51.01	51.01
FY 15-16	50.79	51.01	50.72	50.72	50.72

Generally, the activities that qualify for this FMAP rate are health services while administrative costs are typically reimbursed with a 50 percent federal match. However, there are a myriad of special match rates for a certain populations, services, and administrative expenses. The table below summarizes special match rates currently applicable in Colorado. There are other enhanced match rates that Colorado could qualify for in the future if certain program changes are implemented, such as home health services for people with chronic disabilities for the first 8 quarters the benefit is in place.

Special Match Rates	
Activity/Population	Rate
Breast and Cervical Cancer Treatment	CHIP Rate
Clinical Preventive Services for Adults	FMAP + 1%
Family Planning Services	90%
Money Follows the Person Rebalancing Demonstration	FMAP + 25% in rebalancing fund
Services provided through Indian Health Service and Tribal Facilities	100%
Primary care physician evaluation and management and vaccinations through December 31, 2014	100%

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

[2] The enhanced FMAP (eFMAP) for CHP+ is seventy percent of the standard Medicaid FMAP + 30 percentage points, up to a maximum of 85 percent.

Special Match Rates	
Activity/Population	Rate
Newly eligible under ACA	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%

For the Children's Basic Health Plan (CHP+) the eFMAP will change in correspondence with the FMAP for Medicaid, but in addition the eFMAP for CHP+ is scheduled to increase 23 percentage points from October 1, 2015 through September 30, 2019 pursuant to the Affordable Care Act (ACA).

CHP+ Enhanced Federal Medical Assistance Percentage (eFMAP)					
State	Ave.	eFMAP by Quarter (of state fiscal year)			
Fiscal Year	FMAP	Q1	Q2	Q3	Q4
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

(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. Major funding sources for this division include the General Fund, federal funds received for the Medicaid and Children's Basic Health Plan programs, the Health Care Expansion Fund, the Children's Basic Health Plan Trust Fund, and various other cash funds.

Executive Director's Office	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$233,142,438	$52,428,793	$24,783,896	$5,271,928	$150,657,821	358.6
Other legislation	451,307	250,221	138,243	0	62,843	1.8
SB 15-147 (Supplemental)	2,480,763	1,637,208	1,140,428	(1,658,859)	1,361,986	0.0
TOTAL	**$236,074,508**	**$54,316,222**	**$26,062,567**	**$3,613,069**	**$152,082,650**	**360.4**
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$236,074,508	$54,316,222	$26,062,567	$3,613,069	$152,082,650	360.4
Annualize prior year budget decisions	(6,288,028)	(3,247,490)	630,722	596	(3,671,856)	0.2
FMAP change	0	0	0	(978)	978	0.0
R6 Enrollment simplification	0	0	0	0	0	0.0
R7 Participant directed programs	426,616	188,309	0	0	238,307	0.9
R8 Children with autism waiver	0	0	0	0	0	0.0
R9 Personal health records	772,570	122,257	0	0	650,313	0.0
R10 Customer service center	2,042,250	661,840	359,286	0	1,021,124	20.8
R13 ACC reprocurement preparation	250,000	125,000	0	0	125,000	0.0
R14 Primary Care Fund audit	50,000	0	50,000	0	0	0.0
R15 Managed care organization audits	300,000	150,000	0	0	150,000	0.0
R16 Comprehensive primary care	84,952	42,476	0	0	42,476	0.0
R18 DDDWeb stabilization	205,260	102,629	0	0	102,631	0.0
BA6 CBMS funding simplification	11,625,583	4,096,429	1,787,518	(121,215)	5,862,851	0.0
BA7 MMIS adjustments	18,496,593	2,669,969	934,236	0	14,892,388	0.0
BA8 Legacy systems and technology support	(201,262)	(100,632)	0	0	(100,630)	0.0
BA9 CLAG recommendations and HCBS final rule review	588,713	256,857	37,500	0	294,356	0.0
BA10 Provider fee analytics	0	0	0	0	0	0.0
BA12 Leased space	(444,117)	(284,307)	62,247	0	(222,057)	0.0
BA13 Predictive analytics FTE	78,723	7,873	0	0	70,850	0.9

Executive Director's Office	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
BA15 PACAP contractor	(159,073)	(79,537)	0	0	(79,536)	0.0
BA14 Medical identification cards	(6,473)	(348)	(2,887)	0	(3,238)	0.0
Rate setting process	517,176	258,588	0	0	258,588	3.6
Centrally appropriated line items	4,168,980	1,814,290	271,764	128,066	1,954,860	0.0
Indirect cost adjustment	(27,612)	27,612	(9,383)	20,611	(66,452)	0.0
TOTAL	**$268,555,359**	**$61,128,037**	**$30,183,570**	**$3,640,149**	**$173,603,603**	**386.8**
Increase/(Decrease)	$32,480,851	$6,811,815	$4,121,003	$27,080	$21,520,953	26.4
Percentage Change	13.8%	12.5%	15.8%	0.7%	14.2%	7.3%
FY 2015-16 Executive Request:	**$267,714,409**	**$60,714,248**	**$29,954,764**	**$3,635,039**	**$173,410,358**	**384.2**
Request Above/(Below) Recommendation	($840,950)	($413,789)	($228,806)	($5,110)	($193,245)	(2.6)

(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.

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 by the Department of that service. 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

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 is pending for several of the line items. The amounts included in the numbers pages are based on the request and will be updated to reflect the JBC's actions.

Health, Life, and Dental
Short-term Disability
Amortization Equalization Disbursement
Supplemental AED
Salary Survey
Merit Pay
Workers' Compensation
Legal Services
Administrative Law Judge Services
Purchase of Services from Computer Center
Multi-use Network Payments
Management and Administration of OIT
Information Technology Security
Payment to Risk Management and Property
Capitol Complex Leased Space

Personal Services

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

Request: The Department requests:

- *R7 Participant directed programs expansion*
- *R8 Children with Autism waiver expansion*
- *R10 Customer service center*
- *BA6 CBMS funding simplification*
- *BA9 CLAG recommendations and HCBS final rule review*
- *BA13 Predictive analytics FTE*
- Annualizations of prior year budget decisions

Recommendation: All of the staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. For the recommendation on *R14 Primary Care Fund audit* see the line item Primary Care Fund.

Executive Director's Office, General Administration, Personal Services						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$25,943,060	$8,747,250	$2,653,532	$1,885,519	$12,656,759	358.6
Other legislation	94,851	49,537	22,657	0	22,657	1.8
SB 15-147 (Supplemental)	0	180,371	0	(360,742)	180,371	0.0
TOTAL	**$26,037,911**	**$8,977,158**	**$2,676,189**	**$1,524,777**	**$12,859,787**	**360.4**

Executive Director's Office, General Administration, Personal Services	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$26,037,911	$8,977,158	$2,676,189	$1,524,777	$12,859,787	360.4
Annualize prior year budget decisions	870,611	326,737	69,972	34,743	439,159	0.2
R7 Participant directed programs	58,483	29,241	0	0	29,242	0.9
R8 Children with autism waiver	0	0	0	0	0	0.0
R10 Customer service center	824,970	298,144	114,341	0	412,485	20.8
R14 Primary Care Fund audit	0	0	0	0	0	0.0
BA6 CBMS funding simplification	0	15,182	0	(30,365)	15,183	0.0
BA9 CLAG recommendations and HCBS final rule review	0	0	0	0	0	0.0
BA13 Predictive analytics FTE	73,165	7,317	0	0	65,848	0.9
Rate setting process	244,944	122,472	0	0	122,472	3.6
Indirect cost adjustment	0	27,612	0	(27,612)	0	0.0
TOTAL	**$28,110,084**	**$9,803,863**	**$2,860,502**	**$1,501,543**	**$13,944,176**	**386.8**
Increase/(Decrease)	$2,072,173	$826,705	$184,313	($23,234)	$1,084,389	26.4
Percentage Change	8.0%	9.2%	6.9%	(1.5%)	8.4%	7.3%
FY 2015-16 Executive Request:	**$28,165,209**	**$9,755,159**	**$2,938,818**	**$1,529,155**	**$13,942,077**	**384.2**
Request Above/(Below) Recommendation	$55,125	($48,704)	$78,316	$27,612	($2,099)	(2.6)

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below.

Personal Services Annualizations	TOTAL	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
Prior year salary survey	$779,028	$246,246	$64,811	$24,814	$443,157	0.0
Prior year merit pay	244,615	83,695	19,453	9,929	131,538	0.0
SB 14-180 Dental health seniors	4,340	4,340	0	0	0	0.2
FY 14-15 BA12 Enroll dual eligibles in ACC	(71,620)	21,040	0	0	(92,660)	0.0
FY 14-15 R12 Administrative contract reprocurements	(57,168)	(14,292)	(14,292)	0	(28,584)	0.0
FY 14-15 BA13 Disability determinations contract reprocurement	(28,584)	(14,292)	0	0	(14,292)	0.0
TOTAL	**$870,611**	**$326,737**	**$69,972**	**$34,743**	**$439,159**	**0.2**

➔ R7 Participant directed programs expansion (Community First Choice planning)

Request: The portion of the request discussed here is related to the Community First Choice (CFC) planning. The other part of this request, to allow individuals receiving services on the Supported Living Services (SLS) waiver for individuals with intellectual and developmental disabilities to utilize Consumer Directed Attendant Support Services (CDASS), will be discussed during figure setting for the Office of Community Living.

The Department requests 1.0 FTE and contract funds to manage the CFC planning. The CFC is an option under the ACA to include participant-directed waiver services in the state plan. Adopting this option would make services available to a broader population. It would also provide a six percentage point increase in the federal match for these services. However, the costs of implementing the CFC option are potentially significant. A preliminary report estimated the General Fund cost between $46.7 million and $79.2 million.

Consultants hired by the Department to assist with the CFC planning have raised several technical issues that would need to be addressed, including whether to provide health maintenance as a distinct service, how the Nurse Practice Act would apply, how inconsistences and ambiguities in current regulations would be resolved, whether utilization would change, and whether dollar or day limits should be implemented to control costs.

To address these complex issues and coordinate stakeholder communication, the Department requests an increase of 1.0 FTE. The Department also requests a total of $500,000, including $250,000 General Fund, for contract services over two years to help with actuarial analysis, cost modeling, regulatory review, and stakeholder engagement.

Recommendation: Staff recommends approval of the request with modifications to be consistent with the JBC's common policies regarding new FTE. The Community First Choice option is a high priority for many stakeholder groups. Whether to implement the CFC, and what form the implementation might take, will be a major policy decision. The Department's request for 1.0 FTE and consulting services is a reasonable investment to ensure that the Department and the General Assembly have the analysis necessary to make good decisions.

The table below summarizes key assumptions and shows the recommended appropriations by line item.

R7 Community First Choice planning								
			FY 2015-16			**FY 2016-17**		
	Rate	Units	Months	Amount	FTE	Months	Amount	FTE
Personal Services								
General Professional IV	$4,764	1.0	11	$52,404	0.9	12	$57,168	1.0
PERA	10.15%			5,319			5,803	
Medicare	1.45%			760			829	
Personal Services				$58,483	0.9		$63,800	1.0
Operating Expenses								
Regular FTE Operating Expenses	500			450			500	
Telephone Expenses	450			405			450	
PC, One-Time	1,230	1		1,230			0	
Office Furniture, One-Time	3,473	1		3,473			0	
Operating Expenses				$5,558			$950	
General Professional Services								
Project management				31,687			31,687	
Ad hoc reports/presentations				82,320			82,320	

R7 Community First Choice planning								
			FY 2015-16			FY 2016-17		
	Rate	Units	Months	Amount	FTE	Months	Amount	FTE
Cost model				51,668			51,668	
Benefits collaborative/rule review				84,325			84,325	
				$250,000			$250,000	
TOTAL				**$314,041**	**0.9**		**$314,750**	**1.0**
General Fund				157,020			157,375	
Federal Funds				157,021			157,375	

➔ R8 Children with autism

Request: The Department requested an expansion and modification of the Children with Autism waiver program. The proposed changes require a bill. The JBC has introduced H.B. 15-1186 to implement the requested changes.

➔ R10 Customer service center

Request: The Department requests 25.0 FTE (20.8 in the first year) and associated operating costs to address an increase in call volume experienced by the customer service center. The Department reports that call volume increased from 10,471 in May 2013 to 97,775 in May 2014. The Department experienced a peak in January 2014 of 97,775 calls. The Department is able to answer only about half the calls to the Customer Service Center (CSC) within five minutes.

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

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

The request makes five arguments for using in-house staff versus outsourcing the call center: (1) the Department has trouble retaining temporary staff; 2) experience and research "confirms that agents have the greatest impact on customer satisfaction"; (3) Medicaid is complex; (4) in-house

staff can receive consistent training and a better team environment; (5) in-house staff offer flexibility to shift staff based on the type and number of calls. The Department did not estimate the cost of outsourcing, but the Department did indicate that it spends $3,750,000 for a contract to serve CHP+ clients. The CHP+ contractor is responsible for hosting, maintaining and updating the CHP+ website, CHP+ eligibility and enrollment, and customer service, which includes basic applicant and client questions, and enrollment fee processing. The CHP+ contractor's duties are not exactly equivalent to the CSC, but enrollment in CHP+ is slightly more than 62,000 versus over a million in Medicaid.

Recommendation: Staff recommends approval of the request with modifications to be consistent with the JBC's common policies regarding benefits and new FTE at the range minimum. This request is being driven by an increase in call volume. The Department's current capacity to respond to calls is below industry standards and particularly problematic given that the Department serves a vulnerable population. At the hearing the Department described the Customer Service Center as one of the Department's least effective programs due to insufficient resources.

The Department also responded to a number of JBC questions about the Customer Service Center for the hearing. One of these questions related to the use of technology to mitigate the workload. Based on the Department's response, it appears to the JBC staff that the Department is taking appropriate measures to utilize technology and still faces a significant workload that needs addressing. The Department highlighted the use of several technology tools, including: (1) interactive voice response technology that provides self-service options for clients by automating functions, such as Medicaid ID card requests, and mines data about the nature of calls to develop new customer service options; (2) the use of Customer Relationship Management software that allows agents to obtain real-time eligibility data to help respond to a caller's specific issues, as well as access a database of knowledge articles for commonly asked questions; (3) the use of on-line chat, which is more efficient than calls, because agents can handle multiple chats at once; and (4) improvements to the Department's web site customized to address the most frequently asked questions and assist in getting clients directed to the correct state agency.

The table below summarizes the JBC staff calculations for the cost of the request according to the JBC's common policies for new FTE.

R10 Customer Service Center								
			FY 2015-16			**FY 2016-17**		
	Rate	Units	Months	Amount	FTE	Months	Amount	FTE
Personal Services								
Customer Service Inbound Call Representative (Technician I)	$2,500	8.0	11	$220,000	7.3	12	$240,000	8.0
Customer Service Rep/PEAK Chat Rep (Technician II)	$2,688	10.0	11	295,680	9.2	12	322,560	10.0
Team Leader (General Professional IV)	$4,764	1.0	11	52,404	0.9	12	57,168	1.0
Manager (General Professional V)	$5,960	1.0	11	65,560	0.9	12	71,520	1.0
CRM Project Manager (General Professional II)	$3,318	1.0	6	19,908	0.5	12	39,816	1.0

R10 Customer Service Center								
			FY 2015-16			FY 2016-17		
	Rate	Units	Months	Amount	FTE	Months	Amount	FTE
PEAK Help Desk Specialists (Technician I)	$2,500	2.0	6	30,000	1.0	12	60,000	2.0
Knowledge Management (General Professional II)	$3,318	1.0	6	19,908	0.5	12	39,816	1.0
Operations Supervisor (GPV)	$5,960	1.0	6	35,760	0.5	12	71,520	1.0
Subtotal Salaries				$739,220	20.8		$902,400	25.0
PERA	10.15%			75,031			91,594	
Medicare	1.45%			10,719			13,085	
Personal Services				$824,970	20.8		$1,007,079	25.0
Benefits								
AED	4.40%			32,526			39,706	
SAED	4.25%			31,417			38,352	
STD	0.22%			1,626			1,985	
Health-Life-Dental	$7,927.20			164,886			198,180	
Benefits				$230,455			$278,223	
Operating Expenses								
Regular FTE Operating Expenses	500			10,400			12,500	
Telephone Expenses	450			9,360			11,250	
PC, One-Time	1,230	20		24,600			0	
Office Furniture, One-Time	3,473	20		69,460			0	
Call Center Headsets, One Time	200	20		4,000			0	
Operating Expenses				$117,820			$23,750	
Leased Space				$76,230			$85,801	
General Professional Services and Special Projects								
IVR and CRM additional minutes and software licenses				$792,775			$792,775	
TOTAL				**$2,042,250**	**20.8**		**$2,187,628**	**25.0**
General Fund				661,840			714,380	
Hospital Provider Fee				359,286			379,436	
Federal Funds				1,021,124			1,093,812	

➔ BA6 CBMS funding simplification

Request: The Department requests continuation and annualization of *S6 CBMS funding simplification.*

Recommendation: This request was discussed during figure setting for the Department of Human Services, Office of Information Technology Services figure setting. The figures in the table currently reflect the Department's request, but will be updated to reflect the JBC's action.

➔ BA9 CLAG recommendations and HCBS final rule review

Request: The Department requests continuation and annualization of *S9 CLAG recommendations and HCBS final rule review* to analyze and respond to recently released policy directives and reports regarding long term services and supports (LTSS), including: (1) Recommendations from the Community Living Advisory Group (CLAG); (2) New federal rules regarding Home and Community Based Services (HCBS) addressing the settings that qualify and the person-centered planning process (including conflict-free case management); and (3) *The Community Living Plan Colorado's Response to the Olmstead Decision*. The request also included FTE to manage the contracts. The table below summarizes the Department's original request.

Summary of S9/BA9 CLAG Recommendations and HCBS Final Rule	FY 14-15	FY 15-16	FY 16-17
Backfill accrued CLAG costs			
Chair/Facilitator @ 1,000 per month	$4,000	$0	$0
Facilitation contract	13,340	0	0
Final report preperation	21,784	0	0
	$39,124	$0	$0
Evaluation of CLAG recommendations			
Chair/Facilitator @ 1,000 per month	6,000	12,000	0
Facilitation contract	149,400	149,400	0
Meeting expenses	31,950	40,000	0
Financial/Feasibility Analysis	25,000	75,000	0
	$212,350	$276,400	$0
HCBS rules analysis and implementation			
HCBS settings	148,500	351,675	50,000
Person-centered planning	63,300	70,800	50,000
Conflict-free case management*	25,000	100,000	0
Meeting expenses	0	6,638	0
	$236,800	$529,113	$100,000
Community Living Plan	$30,000	$90,000	$0
State Oversight of LTSS contracts			
Personal Services	0	58,479	63,800
Benefits	0	12,575	13,512
Operating	0	5,182	950
	$0	$76,236	$78,262
TOTAL	**$518,274**	**$971,749**	**$178,262**
General Fund	246,637	435,875	89,131
Cash Funds*	12,500	50,000	0
Federal Funds	259,137	485,874	89,131

* The cash funds are for the analysis of the conflict-free case management and the source is the Intellectual and Developmental Disabilities (IDD) Services Cash Fund, which receives year-end reversions from appropriations for IDD services.

Recommendation: Staff recommends continuation and annualization of the portions of the supplemental request approved by the JBC related to the HCBS rules and the *Community Living Plan*. During the supplemental process the JBC denied the portions of the request related to the CLAG and the FTE to provide oversight of the the LTSS contracts. The portions of the request approved by the JBC through the supplemental are summarized in the table below. All of these costs are in the General Professional Services line item.

Portions of S9/BA9 Approved by JBC			
	FY 14-15	FY 15-16	FY 16-17
HCBS rules analysis and implementation			
HCBS settings	$148,500	$351,675	$50,000
Person-centered planning	63,300	70,800	50,000
Conflict-free case management	25,000	100,000	0
Meeting expenses	0	6,638	0
	$236,800	$529,113	$100,000
Community Living Plan	$30,000	$90,000	$0
TOTAL	**$266,800**	**$619,113**	**$100,000**
General Fund	120,900	259,557	50,000
Cash Funds	12,500	50,000	0
Federal Funds	133,400	309,556	50,000

➔ BA13 Predictive analytics FTE

Request: The Department requests continuation and annualization of *S13 Predictive analytics FTE* that asked for 1.0 new FTE to implement predictive analytic software designed to identify potentially fraudulent billing patterns and prevent inappropriate payments. The JBC denied the supplemental request, based on the new FTE not meeting the JBC's supplemental criteria. However, it is an appropriate time to consider adding a new FTE for this purpose in the FY 2015-16 budget cycle, and so the request is analyzed here.

Currently the Department works with contractors to conduct post-payment reviews of claims and then recover unallowable payments or overpayments. The Department characterizes this method of detecting fraud as "pay and chase." The contractors are paid on a contingency basis.

Predictive analytic software would attempt to prevent the payment of fraudulent claims in the first place, avoiding the need to recover the funds afterwards. This would reduce losses due to contingency fees, unrecoverable payments, and delays in repayment. It may also increase the amount of fraud detected and prevented. Costs for the technology are built into the budget for the MMIS reprocurement.

The proposed staff would be responsible for understanding Medicaid business rules and the capacities of the software and would develop guidelines for the design, implementation, and updating of the program as strategies of fraudulent providers change. The Department would implement the new technology beginning in FY 2017-18.

The Department was required to issue a request for information about this technology by S.B. 13-137 (Roberts/Navarro). However, S.B. 13-137 did not require implementation. The bill encouraged the Department to create a RFP if: (1) the technology was expected to generate

savings; (2) the work could be integrated in current operations; and (3) there would be no delays in payments. The bill also expressed the intent of the General Assembly that savings achieved must more than cover the cost of implementation and administration.

The Department's request indicates that no savings are expected in the short term, due to the time required to hire staff and set up the shift to the new fraud detection model, but the Department anticipates, "the potential for significant long-term savings." The request does not attempt to quantify the potential savings.

Recommendation: Staff recommends approval of the request with modifications to be consistent with the JBC's common policies regarding benefits for new FTE. The Department anticipates a 90 percent federal match rate for the new FTE during development of the technology and a 75 percent federal match rate thereafter. With these match rates the General Fund cost is relatively minimal for a potentially significant future savings. The JBC staff assumes the 90 percent federal match rate in both FY 2015-16 and FY 2016-17, which is different than the request, based on the system being in development until FY 2017-18. The table below summarizes the JBC staff calculations for the cost of the new FTE.

BA13 Predictive analytics FTE								
			FY 2015-16			**FY 2016-17**		
	Rate	Units	Months	Amount	FTE	Months	Amount	FTE
Personal Services								
General Professional V	$5,960	1.0	11	$65,560	0.9	12	$71,520	1.0
PERA	10.15%			6,654			7,259	
Medicare	1.45%			951			1,037	
Personal Services				$73,165	0.9		$79,816	1.0
Operating Expenses								
Regular FTE Operating Expenses	500			450			500	
Telephone Expenses	450			405			450	
PC, One-Time	1,230	1		1,230			0	
Office Furniture, One-Time	3,473	1		3,473			0	
Operating Expenses				$5,558			$950	
TOTAL				**$78,723**	**0.9**		**$80,766**	**1.0**
General Fund				7,872			8,077	
Federal Funds				70,851			72,689	

➔ Rate setting process (JBC staff recommendation)

Request: In the FY 2014-15 budget the JBC included $150,000 for contract services so that the Department could respond to two Legislative Requests for Information (LRFI):

1. Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects – The Department is requested to submit a plan to the Joint Budget Committee by November 1, 2014 for an ongoing annual process to address disparities in Medicaid rates that limit client access to cost-effective care. The proposed process must include opportunities for legislative input and modification. The proposed process

must provide actions that can be taken to improve or preserve client access and quality of care in years when state funding for rates is flat or declining as well as years when funding increases. The Department is also requested to report on rate setting procedures used by other public and private insurers and evaluate the applicability of those processes to addressing rate disparities in Colorado. The plan should include an estimate of administrative costs and any statutory changes that may be necessary for implementation.

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

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

1. The rate review process should complement and not conflict with forthcoming federal regulations from the Centers for Medicare and Medicaid Services (CMS) regarding rates.
2. The JBC should consider making any targeted rate increases approved through an annual rate review process effective January 1, rather than the start of the fiscal year.
3. The Department would need an additional 4.0 FTE and contract resources to provide the necessary administrative support for the annual rate review process.

The Department did not request the necessary administrative funding in FY 2015-16 to implement the process recommended by PCG. Two factors contributed to the Department's decision not to request funding: (1) the limited time between the completion of the initial PCG report and the due date for the Governor's request; and (2) a desire to wait until the new CMS regulations regarding rates were finalized. The Department anticipated that it would likely need resources to implement the new CMS regulations, if funding is not provided for a state process that synchronizes with the federal requirements, but the Department says it is premature to estimate those costs until the federal regulations are finalized.

In subsequent meetings with the JBC the Department refined the proposed rate setting process. As envisioned by the Department, the rate review process would look at subset of all rates every year on a rotating schedule. This rotating schedule would be flexible to allow rates to be reviewed out of turn, but every rate category would be reviewed at least once every five years.

The rate review process would have four phases:

1. Access, service, quality, utilization analysis – This would use quantitative tools to assess areas where rates may contribute to subpar performance. It would include comparisons of

Medicaid rates to available benchmarks. The phase would culminate in a report that would be publicly available sometime in the spring.

2. Rate review and stakeholder input – In this stage the Department would work with stakeholders to review the first phase analysis and develop strategies for responding to the findings, including potentially non-fiscal approaches or rebalancing rates.
3. Budget review – In this step the Department would work with the Office of State Planning and Budgeting to determine achievable goals and executive branch priorities within the statewide budget.
4. Legislative approval and rate change implementation – In this phase the Department would provide data to the legislature and make formal recommendations, which may or may not include a budget request.

According to the Department, the schedule would need to be "abbreviated" in the first year of implementation, but the Department has committed to providing recommendations to the JBC by November 1.

One of the JBC's chief concerns has been stakeholder engagement, and so the JBC staff asked the Department to elaborate on how stakeholders fit into the proposed process.

> *The Department envisions this process would be similar to our current rule review and benefits collaborative process. This set cycle would allow for full engagement of stakeholders, providers and clients in the process to understand current issues related to access, utilization and comparative rates. While a set cycle will ensure rates are reviewed at least once every five years, there will be flexibility in the process to allow for reviews of rates that are in need of immediate review. The Department commits to working with stakeholders fully develop the structure for stakeholder engagement and to ensuring that the rate review process is clearly defined, transparent and ensures equal opportunity for stakeholder engagement.*
>
> *The Department would publish the data analysis for rates to be reviewed that year in the spring and establish the stakeholders meetings over the summer to provide additional context or information. For example, a provider could use this opportunity to explain why they disagree with a metric used in the analysis (i.e. Medicare formula has not been changed in five years). This input would be entered into a listening log and provided along with the full rate review analysis to the JBC in an annual report due November 1st. The contractor analysis and the stakeholder input could then be used by the Department and Joint Budget Committee to inform budget requests or changes to the budget.*

Recommendation: Staff recommends funding for 4.0 FTE and consulting services for the Department to implement the proposed annual rate setting process. Since the November response to the two LRFIs, the refined estimates of the specific staff that would be needed. The JBC staff recommendation is consistent with what the Department identified.

Rate Setting Process								
			FY 2015-16			FY 2016-17		
	Rate	Units	Months	Amount	FTE	Months	Amount	FTE
Personal Services								
Access to Care Specialist (General Professional IV)	$4,764	1.0	11	$52,404	0.9	12	$57,168	1.0
Rate Analyst III	$5,063	2.0	11	111,386	1.8	12	121,512	2.0
Provider Access Specialist (Statistical Analyst III)	$5,063	1.0	11	55,693	0.9	12	60,756	1.0
Subtotal Salaries				$219,483	3.6		$239,436	4.0
PERA	10.15%			22,278			24,303	
Medicare	1.45%			3,183			3,472	
Personal Services				$244,944	3.6		$267,211	4.0
Operating Expenses								
Regular FTE Operating Expenses	500			1,800			2,000	
Telephone Expenses	450			1,620			1,800	
PC, One-Time	1,230	4		4,920			0	
Office Furniture, One-Time	3,473	4		13,892			0	
Operating Expenses				$22,232			$3,800	
General Professional Services								
Contract services				$200,000			$200,000	
Provider surveys and data sources				$50,000			$50,000	
				$250,000			$250,000	
TOTAL				**$517,176**	**3.6**		**$521,011**	**4.0**
General Fund				258,588			260,506	
Federal Funds				258,588			260,505	

The expectation is that with this funding the Department will deliver, by November 1, 2015, rate proposals that have gone through the process described above. The hope is that this will result in proposals that are prioritized and justified based on analysis, rather than the squeakiest wheel.

In addition, staff recommends a LRFI asking the Department for a comprehensive comparison of Medicaid rates with available benchmarks. The process proposed by the Department would look at only a subset of rates each year. This allows the Department to do a deeper dive into the data. It also recognizes that the adequacy of rates does not frequently change overnight, and so looking at every rate every year might be less efficient than examining rates periodically every few years. However, one of the comments that has stuck with staff through the discussions with the Department is Senator Steadman's complaint that he has yet to "see the whole elephant" and understand the magnitude of Medicaid rate disparities. To kick off a periodic rate review process, staff believes the Department also needs to produce a one-time report that attempts to describe the whole elephant.

The Department proposed such a report as an alternative to the JBC's H.B. 11-1151 that establishes a floor for Medicaid rates based on a percentage of Medicare rates or "the average fair market rate." The following JBC staff-recommended LRFI is based on the language suggested by the Department:

N 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 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.

→ **Indirect cost adjustment:** *Staff recommends a fund source adjustment to account for a change in the indirect costs assessed to the Department for statewide overhead according to the state plan.* Pursuant to JBC policy, the money collected from indirect cost assessments 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 source of reappropriated funds is a transfer from the Statewide Indirect Cost Assessment line item. See the explanation for the Statewide Indirect Cost Assessment line item for more detail.

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

- *R6 Enrollment simplification*
- *R7 Participant directed programs*
- *R10 Customer service center*
- *BA6 CBMS funding simplification*
- *BA9 CLAG recommendations and HCBS final rule review*
- *BA12 Leased space*
- *BA13 Predictive analytics FTE*
- Annualizations of prior year budget decisions

Recommendation: The staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. Most of the recommended changes for this line item are related to requests that are discussed elsewhere in this document. For the recommendations on *R6 Enrollment simplification* and *R10 Customer service center* see the line item Medical Services Premiums. For the recommendations on *R7*

Participant directed programs, BA6 CBMS funding simplification, BA9 CLAG recommendations and HCBS final rule review, BA13 Predictive analytics FTE, and *Rate setting process* see the line item Personal Services. For the recommendation on *BA12 Leased space* see the Leased Space line item.

Executive Director's Office, General Administration, Operating Expenses	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$3,344,827	$1,576,996	$62,411	$23,910	$1,681,510	0.0
Other legislation	5,795	5,463	166	0	166	0.0
SB 15-147 (Supplemental)	922,083	467,772	0	(13,461)	467,772	0.0
TOTAL	**$4,272,705**	**$2,050,231**	**$62,577**	**$10,449**	**$2,149,448**	**0.0**
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$4,272,705	$2,050,231	$62,577	$10,449	$2,149,448	0.0
Annualize prior year budget decisions	(1,399,122)	(693,585)	0	0	(705,537)	0.0
R6 Enrollment simplification	0	0	0	0	0	0.0
R7 Participant directed programs	5,558	2,779	0	0	2,779	0.0
R10 Customer service center	117,820	42,580	16,330	0	58,910	0.0
BA6 CBMS funding simplification	0	0	0	0	0	0.0
BA9 CLAG recommendations and HCBS final rule review	6,638	3,319	0	0	3,319	0.0
BA12 Leased space	(909,723)	(454,862)	0	0	(454,861)	0.0
BA13 Predictive analytics FTE	5,558	556	0	0	5,002	0.0
Rate setting process	22,232	11,116	0	0	11,116	0.0
TOTAL	**$2,121,666**	**$962,134**	**$78,907**	**$10,449**	**$1,070,176**	**0.0**
Increase/(Decrease)	($2,151,039)	($1,088,097)	$16,330	$0	($1,079,272)	0.0
Percentage Change	(50.3%)	(53.1%)	26.1%	0.0%	(50.2%)	0.0%
FY 2015-16 Executive Request:	**$2,286,578**	**$1,045,682**	**$77,778**	**$10,449**	**$1,152,669**	**0.0**
Request Above/(Below) Recommendation	$164,912	$83,548	($1,129)	$0	$82,493	0.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below.

Operating Annualizations	TOTAL	General Fund	Federal Funds
Annualize SB 14-180 Dental health seniors	$950	$950	$0
Annualize FY 14-15 S6 BA6 Leased space	(1,394,582)	(697,291)	(697,291)
Annualize FY 14-15 BA12 Enroll dual eligibles in ACC	(5,490)	2,756	(8,246)
TOTAL	**($1,399,122)**	**($693,585)**	**($705,537)**

➔ R6 Enrollment simplification (study continuous eligibility for adults)

Request: In this component of R6 the Department requests $150,000 total funds, including $75,000 General Fund, to study ways to ameliorate the negative impacts of churn, including the feasibility of implementing continuous eligibility for adults. There are two other components of the request related to annualized income for adults and a one-month grace period for CHP+ enrollment fees that are discussed with the Medical Services Premiums line item and the Children's Basic Health Plan line item respectively. Continuous eligibility means that once a person has been deemed eligible they remain eligible for a calendar year, even if they have a change in income.

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

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

Recommendation: Staff does not recommend the request. The study is likely to result in a request for a new eligibility expansion. The Department recently implemented a major expansion of Medicaid eligibility and not all of the ramifications are yet understood. The JBC staff is reluctant to recommend compounding more eligibility expansions unless there is a compelling and urgent need. Adults who experience an increase in income already have access to Transitional Medicaid and subsidized insurance options through the health exchange. The JBC staff believes it is worth waiting to see if other states implement continuous eligibility for adults to learn from their experiences before attempting to implement the policy in Colorado. Implementing continuous eligibility for adults would extend the length of time people stay on Medicaid when the economy improves, putting upward pressure on enrollment.

If the JBC decides to approve the Department's request, the JBC staff would recommend that the funding should be located in the General Professional Services and Special Projects line item, rather than following the Department's request to put it in the Operating Expenses line item.

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

- *R10 Customer service center*
- *BA12 Leased space*
- Annualizations of prior year budget decisions

Recommendation: Staff recommends the requested funding. For the recommendation on R10 Customer service center see the line Personal Services. The annualization is for FY 14-15 S6/BA6 that authorized the purchase of space at 303 E. 17th Avenue and additional funds for an expected increase in costs associated with expiring contracts at 225 E 16th Street. The recommendation on BA12 is discussed below.

Executive Director's Office, General Administration, Leased Space	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2014-15 Appropriation					
HB 14-1336 (Long Bill)	$1,472,104	$593,298	$142,754	$736,052	0.0
SB 15-147 (Supplemental)	(183,868)	(74,104)	(17,830)	(91,934)	0.0
TOTAL	**$1,288,236**	**$519,194**	**$124,924**	**$644,118**	**0.0**
FY 2015-16 Recommended Appropriation					
FY 2014-15 Appropriation	$1,288,236	$519,194	$124,924	$644,118	0.0
Annualize prior year budget decisions	239,634	100,672	19,145	119,817	0.0
R10 Customer service center	76,230	27,550	10,565	38,115	0.0
BA12 Leased space	599,693	237,599	62,247	299,847	0.0
TOTAL	**$2,203,793**	**$885,015**	**$216,881**	**$1,101,897**	**0.0**
Increase/(Decrease)	$915,557	$365,821	$91,957	$457,779	0.0
Percentage Change	71.1%	70.5%	73.6%	71.1%	0.0%
FY 2015-16 Executive Request:	**$2,203,793**	**$885,015**	**$216,881**	**$1,101,897**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	0.0

➔ BA12 Leased space

Request: The Department requests funding to continue and annualize *S12 Leased space* that provided for unexpected costs associated with the move to 303 E. 17th Avenue.

Recommendation: Staff recommends approval of the request to continue and annualize the JBC's supplemental decision.

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 last year 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, Coordinated Care for People with Disabilities Fund, Nursing Home Penalties, and gifts, grants, and donations. The federal match rate varies based on the specific contracts.

Request: The Department requests:

- *R7 Participant directed programs*
- *R10 Customer service center*
- *R13 ACC reprocurement preparation*
- *R16 Comprehensive primary care*
- *R18 DDDWeb stabilization*
- *BA8 Legacy systems and technology support*
- *BA9 CLAG recommendations and HCBS final rule review*
- *BA10 Provider fee analytics*
- *BA12 Leased space*
- *BA15 PACAP contractor*
- Annualizations of prior year budget decisions

Recommendation: The staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. For the recommendations on *R7 Participant directed programs, R10 Customer service center,* and *BA9 CLAG recommendations and HCBS final rule review* see the line item Personal Services. For the recommendation *BA 12 Lease space* see the line item Leased Space.

Executive Director's Office, General Administration, General Professional Services and Special Projects					
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**	**FTE**
FY 2014-15 Appropriation					
HB 14-1336 (Long Bill)	$5,793,120	$2,039,127	$562,500	$3,191,493	0.0
Other legislation	193,688	186,188	0	7,500	0.0
SB 15-147 (Supplemental)	1,868,091	421,547	512,500	934,044	0.0
TOTAL	**$7,854,899**	**$2,646,862**	**$1,075,000**	**$4,133,037**	**0.0**
FY 2015-16 Recommended Appropriation					
FY 2014-15 Appropriation	$7,854,899	$2,646,862	$1,075,000	$4,133,037	0.0
Annualize prior year budget decisions	(670,300)	(307,050)	0	(363,250)	0.0
R7 Participant directed programs	250,000	125,000	0	125,000	0.0
R10 Customer service center	792,775	210,279	186,109	396,387	0.0
R13 ACC reprocurement preparation	250,000	125,000	0	125,000	0.0
R16 Comprehensive primary care	84,952	42,476	0	42,476	0.0

Executive Director's Office, General Administration, General Professional Services and Special Projects	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
R18 DDDWeb stabilization	205,260	102,629	0	102,631	0.0
BA8 Legacy systems and technology support	(201,262)	(100,632)	0	(100,630)	0.0
BA9 CLAG recommendations and HCBS final rule review	582,075	253,538	37,500	291,037	0.0
BA10 Provider fee analytics	0	0	0	0	0.0
BA12 Leased space	(134,087)	(67,044)	0	(67,043)	0.0
BA15 PACAP contractor	(159,073)	(79,537)	0	(79,536)	0.0
Rate setting process	250,000	125,000	0	125,000	0.0
TOTAL	**$9,105,239**	**$3,076,521**	**$1,298,609**	**$4,730,109**	**0.0**
Increase/(Decrease)	$1,250,340	$429,659	$223,609	$597,072	0.0
Percentage Change	15.9%	16.2%	20.8%	14.4%	0.0%
FY 2015-16 Executive Request:	**$9,303,370**	**$3,093,087**	**$1,463,609**	**$4,746,674**	**0.0**
Request Above/(Below) Recommendation	$198,131	$16,566	$165,000	$16,565	0.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below.

General Professional Services and Special Projects Annualizations	TOTAL	General Fund	Federal Funds
FY 14-15 R10 Primary care specialty collaboration	($300,000)	($150,000)	($150,000)
FY 14-15 Rate setting study	(150,000)	(75,000)	(75,000)
FY 14-15 R15 LTSS for individuals with complex medical conditions	(125,000)	(62,500)	(62,500)
SB 14-215 Disposition of Legal Marijuana Related Revenue	(50,000)	(50,000)	0
FY 14-15 BA12 Enroll dual eligibles in ACC	(45,300)	30,450	(75,750)
TOTAL	**($670,300)**	**($307,050)**	**($363,250)**

➔ R13 ACC reprocurement

Request: The Department requests consulting services to prepare for the reprocurement in FY 2016-17 of contracts with Regional Care Collaborative Organizations (RCCOs) that are essential to the operation of the Accountable Care Collaborative (ACC). The RCCOs are responsible for developing a network of providers for Medicaid clients, assisting providers in navigating the Medicaid program and improving quality of care for Medicaid clients, coordinating care for Medicaid clients (e.g. ensuring smooth handoffs between providers, performing outreach to ensure clients follow home care recommendations, and helping clients address nonmedical needs with bearing on their health), and reporting. The requested consulting services would assist with stakeholder engagement, financial analysis, and program/policy assessment. Regarding stakeholder engagement, the Department highlights in particular the need to discuss the potential integration of behavioral health services with the ACC. The financial analysis would focus on payment methods for purchasing quality, rather than volume. The program/policy assessment

would evaluate the strengths and weaknesses of the current program and identify best practices from other public and private care coordination efforts nationally. In addition to the FY 2015-16 cost there would be a cost of $100,000 total funds, including $50,000 General Fund, for ongoing stakeholder engagement in FY 2016-17 up until the new contracts take effect July 1, 2017.

Recommendation: Staff recommends approval of the request. The ACC is the Department's primary initiative for improving the quality and cost-effectiveness of care. The initiative attempts to tie a component of reimbursement to health outcomes, rather than the quantity of care provided. The contracts with the RCCOs are critical to the performance of the initiative, because they establish the duties of the RCCOs and the compensation parameters. The requested consulting services are a reasonable investment to promote a successful reprocurement process.

➔ R16 Comprehensive primary care

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

Recommendation: Staff recommends approval of the request. The technology will allow for better evaluations of the cost-effectiveness of care and new ways of connecting expenditures with health outcomes. This is a collaborative project involving several different insurers. To get the benefits from the CPCi Medicaid needs to pay its allocated share. Lack of participation by Medicaid would be a significant set-back to the CPCi, as Medicaid insurers an estimated 20 percent of Colorado's population.

➔ R18 DDDWeb stabilization

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

Recommendation: Staff recommends approval of the request. The DDDWeb is mission critical software for services for people with intellectual and developmental disabilities. Stability and security risks should be minimized until the technology can be replaced with the MMIS.

➔ BA8 Legacy systems and technology support

Request: The Department requests funding to continue and annualize *S8 Legacy systems and technology support* that sought funding to address technology issues with the Department's audit database, transaction control number database, Business Utilization Support, and DDDWeb.

Recommendation: Staff recommends an annualization of $61,869 total funds, including $30,934 General Fund, which is less than the Department's request, based on the JBC's supplemental decisions to approve only portions of the request. When the annualization is combined with the amount approved in the supplemental it results in a total of $325,000, including $162,500 General Fund, all related to reducing a 2-year backlog of change requests for the Business Utilization Services application that is used for case management of long term services and supports.

➔ BA10 Provider fee analytics

Request: The Department requests funding to continue and annualize *S10 Provider fee analytics* that provided an ongoing increase in the base appropriations from the Hospital Provider Fee for administrative costs. The request was to address several issues, including ensuring that ACA-mandated changes to the way income is determined are being implemented correctly, responding to annual audit findings of the Disproportionate Share Hospital program, improving modeling and data collection related to the distribution of Hospital Provider Fee moneys to comply with CMS regulations, and researching the interaction of payment reforms with the Upper Payment Limit and the allowable payments from the Hospital Provider Fee. All of these tasks are to protect the Department's ability to continue using the Hospital Provider Fee to maximize federal funds for hospital reimbursement.

Recommendation: Staff recommends the Department's request, based on the JBC's supplemental decision. The total amount approved in the supplemental was $1.0 million, including $500,000 from the Hospital Provider Fee. Since the money is already in the base, no additional moneys are needed for FY 2015-16.

➔ BA15 PACAP contractor

Request: The Department requests funding to continue and annualize *S15 PACAP contractor* that provided funding for the Department to update the Public Assistance Cost Allocation Plan (PACAP) that apportions overhead costs to the various programs of the Department for purposes of determining the federal match rate. After the annualization, a total of $45,000 ongoing funds, including $22,500 General Fund will remain in the line item for the PACAP contractor to make updates to the plan as federal rules and business processes change.

Recommendation: Staff recommends approval of the request consistent with the JBC's supplemental decisions.

(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, pursuant to Section 25-1.5-103, C.R.S. Financing for the Medicaid-related regulation is provided as follows:

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

Request: The Department requests 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 50 percent.

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.

Request: The Department requests continuation funding.

Recommendation: The staff recommendation is based on the JBC's actions during figure setting for the Department of Regulatory Agencies and is consistent with the request. 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.

Request: For FY 2014-15 the Department requests funding for two scheduled reviews, each projected to cost $5,000.

Recommendation: Staff recommends the request based on the statutory sunset reviews required in FY 2014-15. 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 Section 25.5-5-318, C.R.S., 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.

Request: The Department requests continuation funding.

Recommendation: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Education, which were pending at the time of this publication. The amount reflected in the numbers pages is the Department's request.

Local Affairs

Home Modifications Benefit administration and Housing Assistance Payments

This appropriation pays the Department of Local Affairs to administer the existing Medicaid home modifications benefit. In addition, the Department of Local Affairs assists clients of the Colorado Choice Transitions (CCT) program in acquiring housing.

Request: The Department requests an annualization of FY 14-15 *R9 Medicaid community living initiative* that created the intergovernmental agreement with the Department of Local Affairs.

Recommendation: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Local Affairs.

(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.

Request: The Department requests:

- *R7 Participant directed programs*
- *BA7 MMIS adjustments*
- Annualizations of prior year budget decisions

Recommendation: All of the staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. The portion of *R7 Participant directed programs* that effects this line item is related to the expansion of Consumer Directed Attendant Support Services for people on the Supported Living Services waiver for individuals with intellectual and developmental disabilities. This portion of R7 will be discussed during figure setting for the Office of Community Living. The amount reflected in the table is based on the Department's request and will be updated based on the JBC's action during figure setting for the Office of Community Living.

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 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$29,887,830	$6,135,664	$1,696,376	$293,350	$21,762,440	0.0
Other legislation	25,200	6,300	0	0	18,900	0.0
SB 15-147 (Supplemental)	295,878	105,451	41,127	0	149,300	0.0
TOTAL	**$30,208,908**	**$6,247,415**	**$1,737,503**	**$293,350**	**$21,930,640**	**0.0**
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$30,208,908	$6,247,415	$1,737,503	$293,350	$21,930,640	0.0
R7 Participant directed programs	100,000	25,000	0	0	75,000	0.0
Annualize prior year budget decisions	(425,200)	(24,163)	(53,636)	0	(347,401)	0.0
BA7 MMIS adjustments	2,875,925	569,097	235,513	0	2,071,315	0.0
TOTAL	**$32,759,633**	**$6,817,349**	**$1,919,380**	**$293,350**	**$23,729,554**	**0.0**
Increase/(Decrease)	$2,550,725	$569,934	$181,877	$0	$1,798,914	0.0
Percentage Change	8.4%	9.1%	10.5%	0.0%	8.2%	0.0%
FY 2015-16 Executive Request:	**$32,759,633**	**$6,817,349**	**$1,919,380**	**$293,350**	**$23,729,554**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below.

➔ BA7 MMIS adjustments

Request: The Department requests funding to continue and annualize the supplemental *S7 MMIS adjustments*.

Recommendation: Staff recommends approval of the request based on the JBC's supplemental action. The table below summarizes the fiscal impact by year.

S7/BA7 MMIS Adjustments - JBC Action	FY 2014-15	FY 2015-16	FY 2016-17	TOTAL
Extend the current MMIS contract	$295,878	$3,171,803	$5,449,183	$8,916,864
PBMS & BIDM				
Pharmacy Benefits Management System	(1,587,273)	3,665,753	2,582,877	4,661,357
Business Intelligence Data Management	(146,667)	9,800,000	3,600,000	13,253,333
Independent verification and validation	483,000	240,000	240,000	963,000
Commercial off-the-shelf software	2,223,070	3,859,841	2,667,138	8,750,049
Roll-forward	1,204,655	(3,895,897)	0	(2,691,242)
	2,176,785	13,669,697	9,090,015	24,936,497
Temporarily backfill Department staff				
Contract services	1,424,794	2,123,806	2,147,770	5,696,370
Roll-forward	(1,402,718)	(675,717)	0	(2,078,435)
	22,076	1,448,089	2,147,770	3,617,935
Core MMIS design, development, and implementation	(2,176,785)	(1,375,042)	(3,168,043)	(6,719,870)
Health Information Exchange	(1,200,000)	1,200,000	0	0
TOTAL	**($882,046)**	**$18,114,547**	**$13,518,925**	**$30,751,426**
General Fund	(394,559)	2,775,420	1,946,728	4,327,589
Cash Funds	63,203	997,439	844,180	1,904,822
Federal Funds	(550,700)	14,341,688	10,728,018	24,519,006

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.

Request: The Department requests *BA7 MMIS adjustments* and annualization of FY 13-14 R5 Medicaid Management Information System reprocurement.

Recommendation: Staff recommends the request consistent with the JBC's supplemental action. For information about *BA7 MMIS adjustments* see the line item Information Technology 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.

Request: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding.

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.

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

Recommendation: Staff recommends the request. The annualizations are summarized in the table below.

Centralized Eligibility Vendor	Total	Hospital Fee	Federal Funds
FY 14-15 R12 Administrative contract reprocurements	($1,191,335)	($592,515)	($598,820)
FY 14-15 R6 Eligibility determination enhanced match	0	(307,282)	307,282
SB 13-200 Medicaid eligibility expansion	1,982,470	991,235	991,235
TOTAL	**$791,135**	**$91,438**	**$699,697**

CBMS Modernization Project

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

Request: The Department requests *BA6 CBMS funding simplification*.

Recommendation: The recommendation for *BA6 CBMS funding simplification* was discussed during figure setting for the Department of Human Services, Office of Information Technology Services figure setting. The figures throughout this document currently reflect the Department's request, but will be updated to reflect the JBC's action.

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:

- R9 Personal health records
- BA7 MMIS adjustments
- Annualizations of FY 14-15 R5 Medicaid health information exchange.

Recommendation: All of the staff recommended changes are summarized in the table below and selected changes are discussed in more detail in the arrowed items below the table. The recommendation for BA7 MMIS adjustments is discussed in the line item Medicaid Management Information Systems and Projects.

Executive Director's Office, Information Technology Contracts and Projects, Health Information Exchange Maintenance and Projects	**Total Funds**	**General Fund**	**Federal Funds**	**FTE**
FY 2014-15 Appropriation				
HB 14-1336 (Long Bill)	$8,228,926	$1,302,893	$6,926,033	0.0
SB 15-147 (Supplemental)	(1,200,000)	(500,000)	(700,000)	0.0
TOTAL	**$7,028,926**	**$802,893**	**$6,226,033**	**0.0**
FY 2015-16 Recommended Appropriation				
FY 2014-15 Appropriation	$7,028,926	$802,893	$6,226,033	0.0
Annualize prior year budget decisions	3,967,250	396,725	3,570,525	0.0
R9 Personal health records	772,570	122,257	650,313	0.0
BA7 MMIS adjustments	1,900,000	500,000	1,400,000	0.0
TOTAL	**$13,668,746**	**$1,821,875**	**$11,846,871**	**0.0**
Increase/(Decrease)	$6,639,820	$1,018,982	$5,620,838	0.0
Percentage Change	94.5%	126.9%	90.3%	0.0%
FY 2015-16 Executive Request:	**$14,168,746**	**$2,321,875**	**$11,846,871**	**0.0**
Request Above/(Below) Recommendation	$500,000	$500,000	$0	0.0

➔ R9 Personal health records

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

years and total $2,140,697, including $214,070 General Fund. When fully implemented the ongoing operational and maintenance costs are expected to be $950,139 per year, including $475,070 General Fund.

Recommendation: Staff recommends approval of the request. Staff views this as a relatively low priority, but the federal match is favorable and it makes sense to develop the tool in conjunction with the Health Information Exchange. This functionality is becoming more common in private insurance plans and staff anticipates that in a few years failure by Medicaid to provide it could be viewed as substandard. The table below summarizes the expected cost by fiscal year.

R9 Personal Health Records						
	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	Cumulative
90% Federal Match						
Two Contracted Project Managers	$95,070	$190,139	$190,139	$95,070	$0	$570,418
Two Contracted Technical Project Managers, Implementation	0	190,139	190,139	0	0	380,279
PHR System Implementation	150,000	150,000	0	0	0	300,000
Clinical Data Interface	15,000	15,000	0	0	0	30,000
Eligibility Data Interface	0	30,000	0	0	0	30,000
Claims Data Interface	0	0	30,000	0	0	30,000
Centralized Web Portal Implementation	400,000	400,000	0	0	0	800,000
Subtotal for 90% Match	$660,070	$975,279	$410,279	$95,070	$0	$2,140,697
50% Federal Match						
Two Contracted Technical Project Managers, Operations	0	0	0	190,139	190,139	380,279
PHR System Operations	62,500	250,000	500,000	500,000	500,000	1,812,500
Centralized Web Portal Operations	0	160,000	160,000	160,000	160,000	640,000
Shared Decision Making Tool	50,000	100,000	100,000	100,000	100,000	450,000
Subtotal for 50% Match	$112,500	$510,000	$760,000	$950,139	$950,139	$3,282,779
Total	**$772,570**	**$1,485,279**	**$1,170,279**	**$1,045,209**	**$950,139**	**$5,423,476**
General Fund	122,258	352,529	421,029	484,577	475,070	1,855,460
Federal Funds	650,312	1,132,750	749,250	560,632	475,069	3,568,016

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

Medical Identification Cards

Funding in this line item pays for production of plastic 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.

Request: The Department requests BA 14 to continue and annualization *S14 Medical identification card adjustment* and an annualization of S.B. 13-200 Medicaid eligibility expansion.

Recommendation: Staff recommends the requested funding, including the annualizations. 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.

Request: The Department requests annualization of FY14-15 *BA13 Disability determination contract reprocurement.*

Recommendation: Staff recommends the request, including the annualization.

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 so that in FY 2013-14 county funds represent 14 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.

Request: The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility and *FY 14-15 R6 Eligibility determination enhanced match* that reinvested the General Fund savings achieved as a result of the higher federal match when CMS reinterpreted the qualifying activities.

Recommendation: Staff recommends approval of the request, including the annualizations.

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. The federal participation rate is 50.0 percent.

The Department requests annualization of S.B. 13-200 that expanded Medicaid eligibility and *FY 14-15 R6 Eligibility determination enhanced match* that reinvested the General Fund savings achieved as a result of the higher federal match when CMS reinterpreted the qualifying activities.

Recommendation: Staff recommends approval of the request, including the annualizations.

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.

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.

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 is a requested new line item to begin paying Medical Assistance sites for their work in processing applications.

Request: The Department requests annualization of *FY 14-15 R6 Eligibility determination enhanced match* that reinvested the General Fund savings achieved as a result of the higher federal match when CMS reinterpreted the qualifying activities.

Recommendation: Staff recommends the request, including the annualization.

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.

Request: The Department requests annualizations of *FY 14-15 R12 Admin contract reprocurements* and *FY 14-15 BA12 Enroll dual eligibles in ACC.*

Recommendation: The staff recommends the request, including the annualizations.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

Professional Services Contracts

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

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

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

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

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

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

Request: The Department requests annualization of *FY 14-15 BA12 Enroll dual eligibles in the ACC* and HB 14-1211 Complex rehab.

Recommendation: Staff recommends the request, including the annualizations.

(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.

The sources of cash funds are the Hospital Provider Fee and Nursing Facility Fee. The federal match rate is 50.0 percent.

Request: The Department requests:
- *R14 Primary Care Fund audit*
- *R15 Managed care organization audits*

Recommendation: Staff recommends the request the request. For the discussion of *R14 Primary Care Fund audit* see the Primary Care Fund line item.

➔ R15 Managed care organization audits

Request: The Department requests $300,000, including $150,000 General Fund, to evaluate applying medical loss ratios (MLRs) to managed care contracts and to audit the financial and encounter data submitted by managed care providers to ensure accuracy and consistency. A MLR is the portion of total expenditures on client services versus other expenditures such as administration and profit. The request is based on indicators from CMS that they may require MLRs as part of managed care contracts in the future and a recent recommendation from the Government Accountability Office (GAO) that state Medicaid plans perform audits of managed care contracts. The Department is interested in exploring MLR requirements that could change based on achieving improved health outcomes.

Recommendation: Staff recommends approval of the request. The proposed audits are based on the best practice recommendations of the Government Accounting Office to avoid overpayment of managed care contracts.

(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 of 10.9 percent. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

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 six months worth of funding. The first fiscal year provided six months of funding and this request is for the second six months, after which the program will end.

Recommendation: Staff recommends the requested funding based on the JBC's decisions last year.

Dental Provider Network Adequacy

This line item financed one-time bonus payments to new and existing dentists and hygienists who took on additional Medicaid clients, using savings from the FY 2015-16 change in the FMAP rate.

Request: The Department requests an annualization to eliminate the one-time funding.

Recommendation: Staff recommends the requested amount based on the one-time nature of the 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 and *BA6 CBMS funding simplification*.

Recommendation: Staff recommends an adjustment based on the indirect cost plan approved by the JBC and the JBC's actions. The amount shown for *BA6 CBMS funding simplification* is based on the Department's request, but will be updated to reflect the JBC's actions during figure setting for the Department of Human Services.

(2) Medical Service 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 would be the same as the line item summary table.

Medical and Long-term Care Services for Medicaid Eligible Individuals

Appropriations in this section are a function of three factors:

1. Number of clients
2. Cost per client, and
3. Available financing according to federal policy and state law.

Policy initiatives expected to change the forecast are typically detailed individually for the first several years until a trend is established, and then they become part of the base forecast. Thus, the request and the staff recommendation frequently include several annualizations of budget decisions from prior years that have not yet been incorporated into the base forecast.

The way Medicaid is set up in both state and federal statutes, all people who meet the eligibility criteria are entitled to the covered services. Since the exact number of eligible people and the services they will utilize are both unknown, state statutes provide the Medicaid program with unlimited over-expenditure authority, as long as the over-expenditures are consistent with the statutory provisions of the Medicaid program (Section 24-75-109, C.R.S.).

The cost per client is impacted by both the cost per unit of service and changes in the number of units of service utilized per client.

Request: The Department requests:

- *R1 Medical Services Premiums* to make adjustments for changes in the caseload and expenditure forecast. The November request was based on data through June 2014. On February 13, 2015 the Department submitted an unofficial revised forecast incorporating data through December 2014 into the projection model.
- *R7 Participant directed programs expansion* to manage the Colorado First Choice (CFC) implementation process and to allow individuals receiving services on the Supported Living Services (SLS) waiver for individuals with intellectual and developmental disabilities to utilize Consumer Directed Attendant Support Services (CDASS).
- *R8 Children with autism waiver expansion* to expand and modify the Children with Autism (CWA) waiver. This requires legislation and the JBC has introduced HB 15-1186 to make the requested changes.
- *R11 Public health and Medicaid alignment* to connect direct health care with population-based health initiatives of local public health agencies (LPHAs). The Department would distribute an average of $200,000 to each Regional Care Collaborative Organization (RCCO) responsible for coordinating the Medicaid health delivery system within the Accountable Care Collaborative (ACC). The RCCOs would then give grants to LPHAs, which the Department estimates would total about $30,000 each, to better connect Medicaid clients with LPHA programs like diabetes management and obesity intervention.
- *R12 Provider rate increase* to increase provider funding by a total of 1.0 percent, with 0.5 percent distributed to all eligible providers across the board and 0.5 percent reserved for targeted rate increases.
- *BA17 FMAP change* to account for the change in the federal medical assistance percentage (FMAP) or the federal match rate for Medicaid and CHP+.
- Annualizations of prior year legislation and budget decisions.

Recommendation: The staff recommendation is summarized in the table below and select components of the recommendation are detailed in the arrowed items below the table.

Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$5,716,177,008	$1,608,148,500	$620,547,350	$0	$3,487,481,158	0.0
Other legislation	8,340,762	663,954	2,516,018	0	5,160,790	0.0
SB 15-147 (Supplemental)	141,891,780	83,683,422	25,167,600	0	33,040,758	0.0
Recommended Long Bill Supplemental	(60,925,199)	11,338,074	(91,903,528)	0	19,640,255	0.0
TOTAL	**$5,805,484,351**	**$1,703,833,950**	**$556,327,440**	**$0**	**$3,545,322,961**	**0.0**
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$5,805,484,351	$1,703,833,950	$556,327,440	$0	$3,545,322,961	0.0
Annualize prior year budget decisions	(4,503,261)	2,368,040	(591,258)	0	(6,280,043)	0.0
FMAP change	0	(1,058,041)	(233,262)	0	1,291,303	0.0
R1 Medical Services Premiums - services	490,270,926	92,338,953	7,971,326	0	389,960,647	0.0
R1 Medical Services Premiums - booster / financing	290,785,123	9,409,493	150,996,434	0	130,379,196	0.0
Continuous eligibility financing	(80,182,997)	(33,251,745)	(6,206,308)	0	(40,724,944)	0.0
R6 Enrollment simplification	0	0	0	0	0	0.0
R7 Participant directed programs	(1,389,674)	(680,802)	0	0	(708,872)	0.0
R8 Children with autism waiver	0	0	0	0	0	0.0
R11 Public health and Medicaid alignment	0	0	0	0	0	0.0
R12 Provider rates	13,965,105	4,521,553	189,909	0	9,253,643	0.0
TOTAL	**$6,514,429,573**	**$1,777,481,401**	**$708,454,281**	**$0**	**$4,028,493,891**	**0.0**
Increase/(Decrease)	$708,945,222	$73,647,451	$152,126,841	$0	$483,170,930	0.0
Percentage Change	12.2%	4.3%	27.3%	0.0%	13.6%	0.0%
FY 2015-16 Executive Request:	**$6,364,672,466**	**$1,802,799,387**	**$691,475,096**	**$0**	**$3,870,397,983**	**0.0**
Request Above/(Below) Recommendation	($149,757,107)	$25,317,986	($16,979,185)	$0	($158,095,908)	0.0

A significant portion of the difference between the JBC staff recommendation and the Department's request is attributable to the Department's February 2015 revised forecast of enrollment and expenditures, which informs the JBC staff recommendation, but is not included in the Department's "official" request.

→ **Recommended Long Bill Suppplemental:** The recommended supplemental add-on to the Long Bill adjusts the FY 2014-15 appropriation for the February 2015 forecast of enrollment and expenditures. The February 2015 forecast is discussed in more detail under R1 below.

The total change for FY 2014-15 is primarily attributable to a change in the Department's assumptions about booster payments from the Hospital Provider Fee. The November request

assumed the Department would operate under the FY 2014-15 Hospital Provider Fee plan, but there have been delays in CMS approval and so the Department is currently operating under the plan approved by CMS for FY 2013-14 that doesn't fully account for the Medicaid expansion authorized by SB 13-200. The February 2015 forecast lowers the projected Hospital Provider Fee booster payments for FY 2014-15 by $84.8 million, primarily due to the delays in approval of the FY 2014-15 Hospital Provider Fee plan.

The net increase in General Fund includes three important changes in assumptions about financing:

- Resource proxy for people with disabilities – Previously CMS was not allowing the ACA 100 percent federal match rate for any adults with disabilities, based on the assumption that this population would have qualified for Medicaid absent the ACA. However, HCPF believes a portion would have failed the asset test required to qualify with a disability. HCPF has developed, in cooperation with CMS, a resource proxy to estimate the number of people with disabilities who should receive the 100 percent federal match, because they would not have qualified for Medicaid without the ACA expansion. This change saves approximately $8-$10 million General Fund per year, but the impact in FY 2014-15 is roughly $12.5 million due to retroactive adjustments.
- Income disregard at breaks in eligibility – The ACA uses a standard five percent income disregard in lieu of state-specific income disregards that existed prior to the ACA. Federal guidance requires that the five percent income disregard be applied only when it change's a person's eligibility and not when it merely changes financing. The Department was previously applying the income disregard at all breaks in eligibility, resulting in less federal matching funds. In January 2015 the Department implemented a system change to comply with federal policy and it is expected to save $10-$11 million General Fund per year. For FY 2014-15 the General Fund savings is closer to $15 million due to retroactive adjustments.
- Other insurance – Previously CMS was not allowing the ACA 1000 percent federal match rate for clients with other sources of insurance. A rule clarification indicates it is okay for clients to have other insurance and receive the 100 percent federal match provided the other insurance is not Medicare. This rule clarification saves approximately $5 million General Fund, but for FY 2014-15 the impact is closer to $7.5 million due to retroactive adjustments.

The rest of the net change in General Fund is attributable to changes in projected enrollment and per capita costs. The enrollment and per capita trends are discussed in more detail under R1 Medical Services Premiums. Absent the above financing changes, the net projected change in General Fund in FY 2014-15 would be larger.

→ **FMAP change:** This is the estimated change in the appropriation attributable to the change in the FMAP rate. It was calculated by taking the FY 2014-15 projected expenditures and applying the FY 2015-16 FMAP rate.

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below. These are the amounts assumed in the fiscal note for the relevant bill or when the budget action was taken in the Long Bill. In some cases the Department has revised the estimated fiscal impact and in all cases the

applicable FMAP rate has changed. Differences in assumptions between when the budget action was taken and the February 2015 forecast are attributed to the forecast changes identified in *R1 Medical Services Premiums*. Last year's provider rate increases have an annualization to account for services billed in FY 2014-15 and paid in FY 2015-16.

Medical Service Premiums Annualizations	TOTAL	General Fund	Cash Funds	Federal Funds
FY 14-15 Provider rate increases	$8,036,405	$2,618,437	$100,521	$5,317,447
FY 14-15 Full denture benefit	2,430,715	0	546,729	1,883,986
FY 14-15 Raise cap on home modifications	253,846	125,000	0	128,846
FY 14-15 Remove 5-year bar for legal immigrants	1,304,745	632,379	0	672,366
SB 14-130 Personal care allowance nursing facility	1,588,240	778,079	0	810,161
HB 14-1357 In-home support services	893,956	437,949	0	456,007
FY 14-15 R9 Medicaid community living initiative	7,164	2,590	0	4,574
FY 14-15 BA12 Enroll dual eligibles in Accountable Care Collaborative	(10,593,190)	(7,229)	0	(10,585,961)
HB 14-1045 Breast & Cervical Cancer Prevention reauthorization	(3,556,502)	0	(1,231,801)	(2,324,701)
FY 14-15 R8 New IDD enrollments	(1,868,689)	(934,345)	0	(934,344)
FY 14-15 R12 Administrative contract reprocurements	(1,753,499)	(876,750)	0	(876,749)
HB 08-1373 Breast & Cervical Cancer Fund	(834,968)	(287,793)	0	(547,175)
FY 14-15 R10 Primary care specialty collaboration	(411,484)	(120,277)	(6,707)	(284,500)
TOTAL	**($4,503,261)**	**$2,368,040**	**($591,258)**	**($6,280,043)**

➔ R1 Medical Service Premiums

Request: The Department requests a change to the appropriation based on a new forecast of caseload and expenditures under current law and policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. Once the eligibility criteria and plan benefits are set, the state and federal government must pay the resulting costs. The budget is based on an estimate of those costs, but Section 24-75-109 (1) (a), C.R.S., allows the Department to overexpend the Medicaid appropriation should that be necessary to pay the plan benefits. R1 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 12, 2015 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. In the comparison between the Department's request and the JBC staff recommendation the Department's request has not been updated for the February 2015 forecast, and that explains a significant portion of the difference from the staff recommendation. The November request incorporated data through June 2014 while the February forecast includes data through at least December 2014.

The February forecast is significantly higher than the November request for FY 2015-16 by $255.5 million total funds and 67,628 enrollments, but most of the difference is in the forecast for the federally-financed expansion population and for booster payments to hospitals financed with the Hospital Provider Fee. In January 2015 the Governor submitted a budget amendment to account for the General Fund impact of the change in the FMAP rate. Compared to the

November request plus the January budget amendment for the change in the FMAP rate, the February forecast is approximately $13.1 million General Fund higher.

The Governor's January submission also included a set-aside for HCPF of $29.4 million General Fund. The purpose of the set-aside was originally described in November as a contingency to deal with potential costs due to the change in the FMAP, but since the January request accounted for the change in the FMAP, the purpose of the set-aside presumably morphed in January to dealing with any potential change in the forecast. The change to Medical Service Premiums in the February forecast uses $13.1 million General Fund, leaving $16.3 million from the set aside.

The table below summarizes the changes in expenditure and caseload projected in the February forecast.

Medical Service Premiums February 2015 Forecast					
	Total	General Fund	Cash Funds	Federal Funds	Caseload
FY 14-15 Appropriation	$5,866,409,550	$1,692,495,876	$648,230,968	$3,525,682,706	1,126,466
FY 14-15 February 2015 projection	5,805,484,351	1,703,833,950	556,327,440	3,545,322,961	1,161,133
Difference	**($60,925,199)**	**$11,338,074**	**($91,903,528)**	**$19,640,255**	34,667
Percent	-1.0%	0.7%	-14.2%	0.6%	3.1%
FY 14-15 February 2015 projection	$5,805,484,351	$1,703,833,950	$556,327,440	$3,545,322,961	1,161,133
Annualizations	($4,503,261)	$2,368,040	($591,258)	($6,280,043)	
FMAP	0	(1,058,041)	(233,262)	1,291,303	
FY 15-16 Base	5,800,981,090	1,705,143,949	555,502,920	3,540,334,221	
FY 15-16 February 2015 projection	6,582,037,139	1,806,892,395	714,470,680	4,060,674,064	1,289,493
Difference	**$781,056,049**	**$101,748,446**	**$158,967,760**	**$520,339,843**	128,360
Percent	13.5%	6.0%	28.6%	14.7%	11.1%

Recommendation: Staff recommends using the Department's February forecast of enrollment and expenditures to modify both the FY 2014-15 and FY 2015-16 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 projected change in expenditures for Medical Service Premiums 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

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 tables below show the projected year over year changes by detailed enrollment category. Of the projected change in expenditures for Medical Services Premiums, changes in services account for $485.8 million of the total and $93.6 million of the General Fund.

Enrollment				
Category	FY 14-15	FY 15-16	Difference	Percent
Adults 65+ to SSI	42,087	42,971	884	2.1%
Adults with Disabilities 60 to 64	10,581	11,307	726	6.9%
Individuals with Disabilities to 59	66,821	69,501	2,680	4.0%
Disabled Buy-In to 450% FPL	3,425	4,327	902	26.3%
Parents / Caretakers to 68% FPL	163,685	180,612	16,927	10.3%
Breast & Cervical Cancer to 250% FPL	379	179	(200)	-52.8%
Children to 107% FPL	448,326	480,322	31,996	7.1%
SB 11-008 Children 107% to 147% FPL	47,107	56,118	9,011	19.1%
Foster Care to 26 years	20,129	20,237	108	0.5%
Pregnant Adults to 142% FPL	14,883	14,862	(21)	-0.1%
SB 11-250 Pregnant 142% to 200% FPL	1,751	1,923	172	9.8%
Non-Citizens - Emergency Services	2,573	2,551	(22)	-0.9%
Adults 65+ SSI to 135% FPL-Medicare premiums	28,124	32,033	3,909	13.9%
Subtotal	**849,871**	**916,943**	**67,072**	**7.9%**
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	70,900	85,311	14,411	20.3%
Adults w/out Dependent Children to 138% FPL	240,362	287,239	46,877	19.5%
Subtotal	**311,262**	**372,550**	**61,288**	**19.7%**
TOTAL	**1,161,133**	**1,289,493**	**128,360**	**11.1%**

Expenditures				
Category	FY 14-15	FY 15-16	Difference	Percent
Adults 65+ to SSI	$965,072,783	$992,245,289	$27,172,506	2.8%
Adults with Disabilities 60 to 64	189,137,331	196,828,204	7,690,873	4.1%
Individuals with Disabilities to 59	1,032,439,469	1,063,910,216	31,470,747	3.0%
Disabled Buy-In to 450% FPL	33,970,150	44,058,607	10,088,457	29.7%
Parents / Caretakers to 68% FPL	483,937,147	520,995,541	37,058,394	7.7%
Breast & Cervical Cancer to 250% FPL	6,083,145	2,875,930	(3,207,215)	-52.7%
Children to 107% FPL	782,651,898	843,598,502	60,946,604	7.8%
SB 11-008 Children 107% to 147% FPL	71,341,980	85,123,040	13,781,060	19.3%
Foster Care to 26 years	82,415,074	83,653,569	1,238,495	1.5%
Pregnant Adults to 142% FPL	147,666,078	148,231,695	565,617	0.4%
SB 11-250 Pregnant 142% to 200% FPL	15,296,638	16,873,759	1,577,121	10.3%
Non-Citizens - Emergency Services	42,883,621	43,928,964	1,045,343	2.4%
Adults 65+ SSI to 135% FPL-Medicare premiums	33,942,733	39,085,411	5,142,678	15.2%
Subtotal	**$3,886,838,047**	**$4,081,408,727**	**$194,570,680**	**5.0%**
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	165,304,640	194,024,374	28,719,734	17.4%
Adults w/out Dependent Children to 138% FPL	1,026,921,227	1,289,398,478	262,477,251	25.6%

Expenditures				
Category	FY 14-15	FY 15-16	Difference	Percent
Subtotal	**$1,192,225,867**	**$1,483,422,852**	**$291,196,985**	**24.4%**
Medical Services Subtotal	**$5,079,063,914**	**$5,564,831,579**	**$485,767,665**	**9.6%**
Booster Payments / Financing	726,420,437	1,017,205,560	290,785,123	40.0%
TOTAL	**$5,805,484,351**	**$6,582,037,139**	**$776,552,788**	**13.4%**

Per Capita Expenditures				
Category	FY 14-15	FY 15-16	Difference	Percent
Adults 65+ to SSI	$22,930.42	$23,091.04	$160.62	0.7%
Adults with Disabilities 60 to 64	$17,875.18	$17,407.64	($467.54)	-2.6%
Individuals with Disabilities to 59	$15,450.82	$15,307.84	($142.98)	-0.9%
Disabled Buy-In to 450% FPL	$9,918.29	$10,182.25	$263.96	2.7%
Parents / Caretakers to 68% FPL	$2,956.51	$2,884.61	($71.90)	-2.4%
Breast & Cervical Cancer to 250% FPL	$16,050.51	$16,066.65	$16.14	0.1%
Children to 107% FPL	$1,745.72	$1,756.32	$10.60	0.6%
SB 11-008 Children 107% to 147% FPL	$1,514.47	$1,516.86	$2.39	0.2%
Foster Care to 26 years	$4,094.35	$4,133.69	$39.34	1.0%
Pregnant Adults to 142% FPL	$9,921.80	$9,973.87	$52.07	0.5%
SB 11-250 Pregnant 142% to 200% FPL	$8,735.94	$8,774.71	$38.77	0.4%
Non-Citizens - Emergency Services	$16,666.78	$17,220.29	$553.51	3.3%
Adults 65+ SSI to 135% FPL-Medicare premiums	$1,206.90	$1,220.16	$13.26	1.1%
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	$2,331.52	$2,274.32	($57.20)	-2.5%
Adults w/out Dependent Children to 138% FPL	$4,272.39	$4,488.94	$216.55	5.1%
TOTAL (without booster payments/financing)	**$4,374.23**	**$4,315.52**	**($58.71)**	**-1.3%**

Almost all of the projected increase in expenditures is attributable to caseload growth. The Department estimates that less than 10% of the total increase from FY 2014-15 to FY 2015-16 is attributable to per client cost growth. Per capita cost increases are mostly flat. Increases in cost per client (mostly associated with annual increases in nursing facility reimbursement, and utilization trends in community based long-term care) are offset by decreases in per capita costs for clients with disabilities (occurring due to management through the Accountable Care Collaborative).

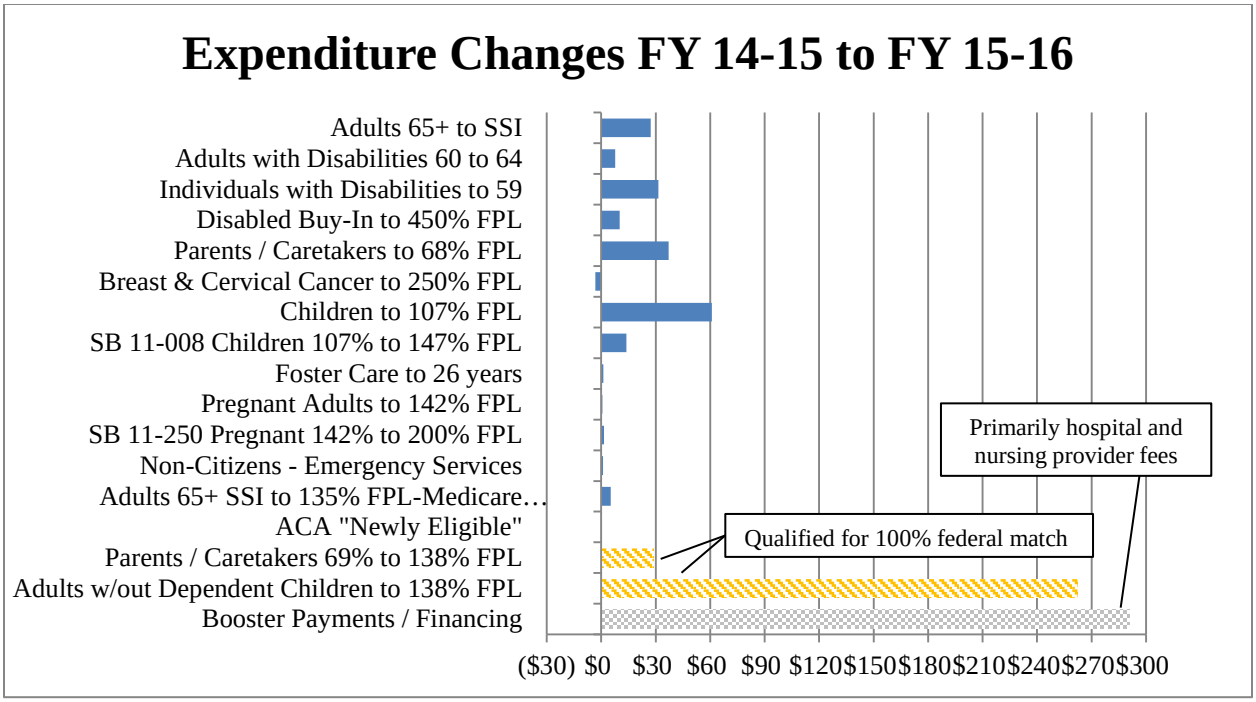
The bullets below highlight key factors contributing to the projected enrollment growth for populations with a significant effect on the expected General Fund expenditures.

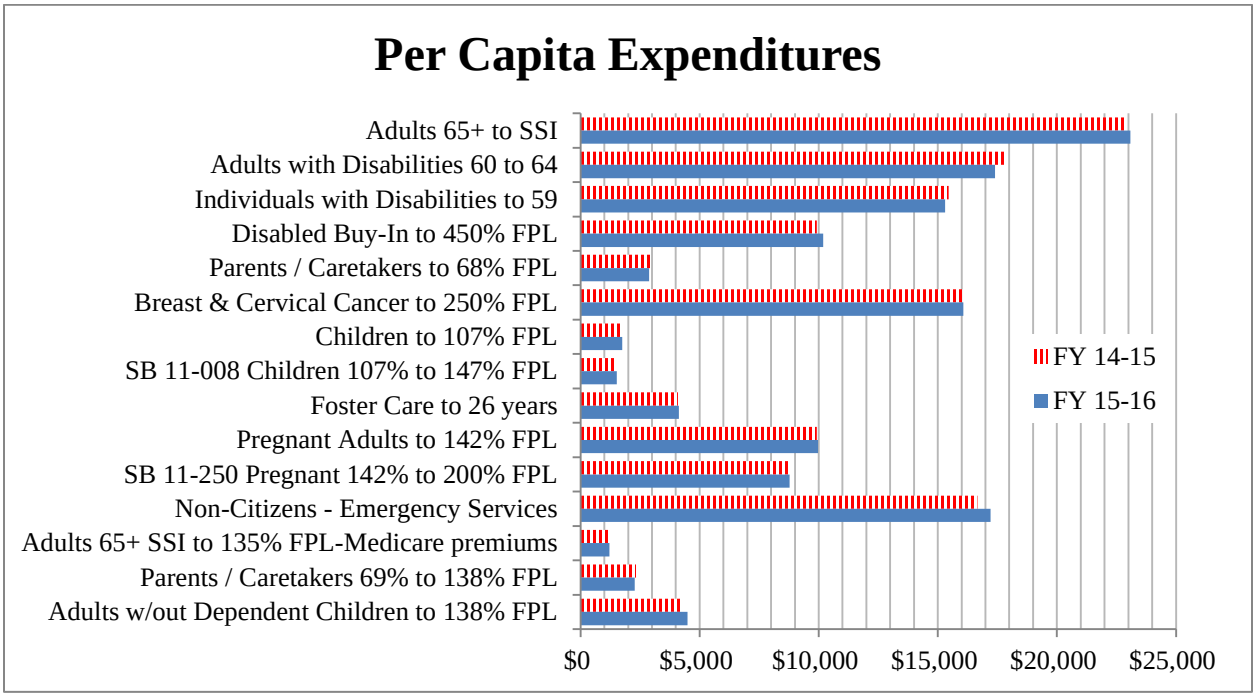
- Children – The Department attributes the strong projected enrollment growth to two factors. First, the Department believes there is increased enrollment from among people previously eligible but not enrolled (ENBE). The Department describes this as a "welcome mat" effect due to national attention on the ACA implementation and the individual mandate. Second, continuous eligibility for children locks clients into Medicaid eligibility for 12 months, even if their income changes. This was implemented March 2014 in conjunction with S.B. 13-200. Not only does Medicaid caseload have a lagged response to improvements in the economy, but as Medicaid clients experience these improvements, children will stay enrolled until they

reach 12 months. This slows the rate at which clients leave Medicaid, which puts upward pressure on caseload.

- Parents/Caretakers to 68% FPL – Similar to children, the Department believes the "welcome mat" effect associated with the ACA implementation is contributing to strong enrollment growth. While there is no continuous eligibility for adults, there is Transitional Medicaid that allows qualifying adults to stay on Medicaid for up to 12 months following an increase in income. Not only does Medicaid caseload have a lagged response to improvements in the economy, but as Medicaid clients experience these improvements, parents/caretakers who qualify for Transitional Medicaid can stay enrolled until they reach 12 months. This slows the rate at which clients leave Medicaid.
- Individuals with Disabilities to 59 – According to the American Community Survey, the proportion of Colorado's population that is reported as having a disability is growing. In 2009, 9.4% of Colorado's population reported having a disability. By 2013, 10.1% of Colorado's population reported having a disability. The enrollment trends have been fairly steady, but small changes in enrollment drive significant changes in expenditures, due to the high base per capita costs for these clients.
- Adults 65+ to SSI – Colorado's population is aging, putting upward pressure on enrollment in this category. Although the rate of growth has been fairly steady, small changes in enrollment drive significant changes in expenditures, due to the high base per capita costs for these clients.

Below is a series of graphs that present the same information that was contained in the previous tables, but in a pictorial format to highlight the year over year changes in enrollment, expenditures, and per capita expenditures.

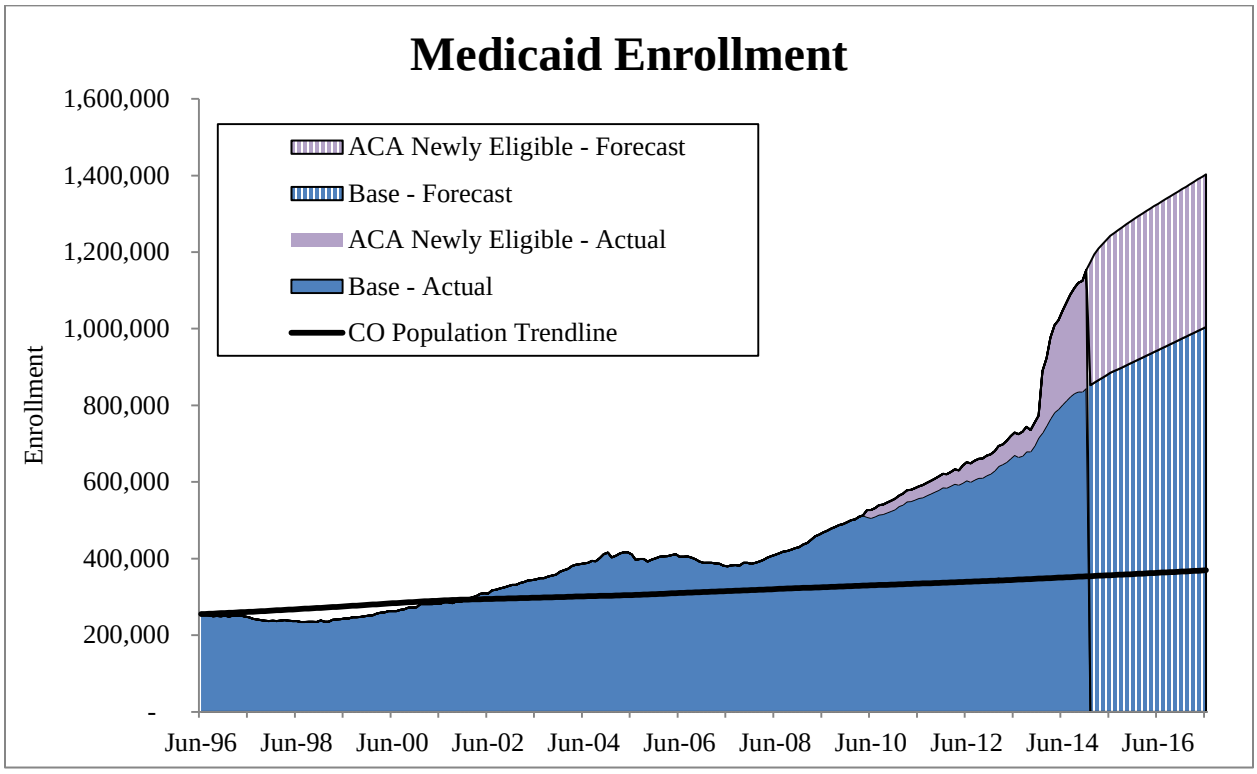




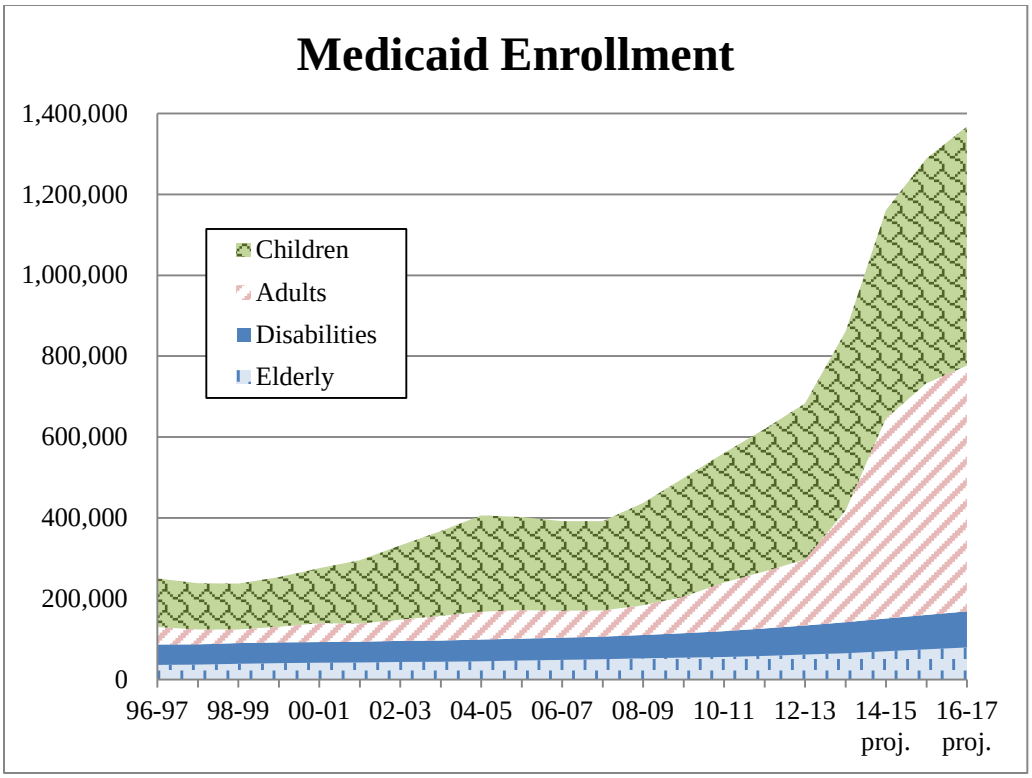
Rather than focusing on the year over year changes, the next several graphs focus on long-term trends and aggregate the data at a higher level.

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 a 100 percent 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 1996.

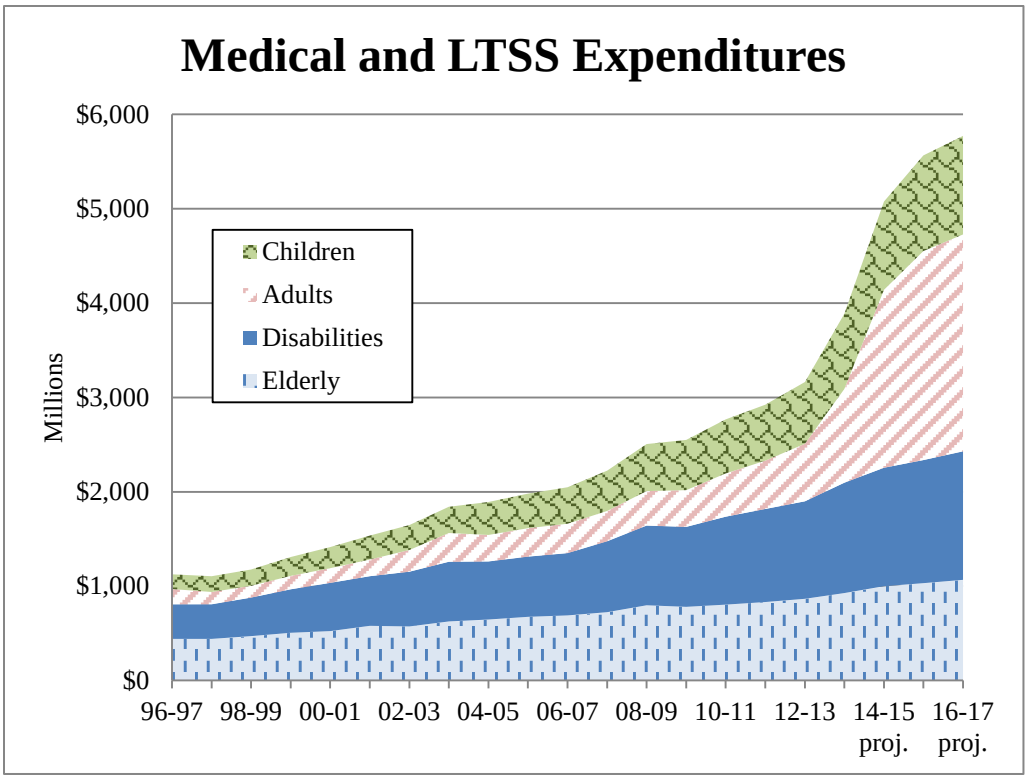
Medicaid currently covers an estimated 20 percent of Colorado's population and HCPF is projecting that it will cover almost 25 percent by the end of FY 2016-17.



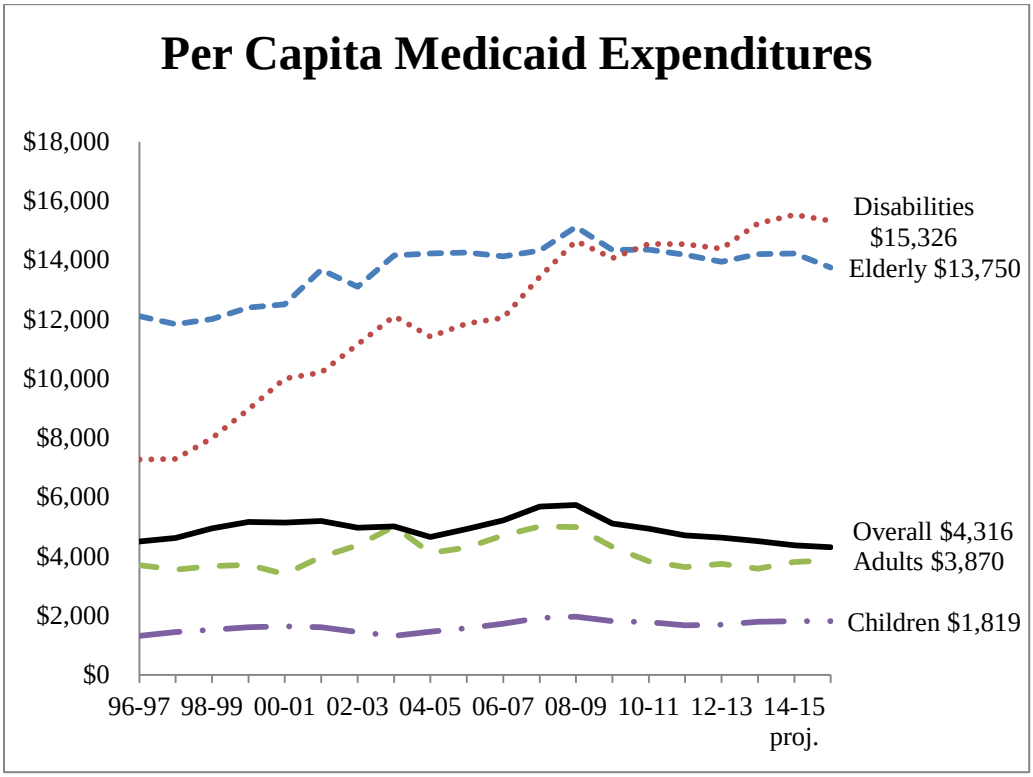
The next graph breaks the Medicaid enrollment into broad categories of children, adults, people with disabilities, and the elderly. Historically, most of the variability in enrollment trends is among children and adults. These populations are sensitive to changes in the economy. The recent growth is 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 (ENBE). 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 2015-16 the elderly and disabled represent 12 percent of the projected enrollment, but 42 percent of the projected expenditures.



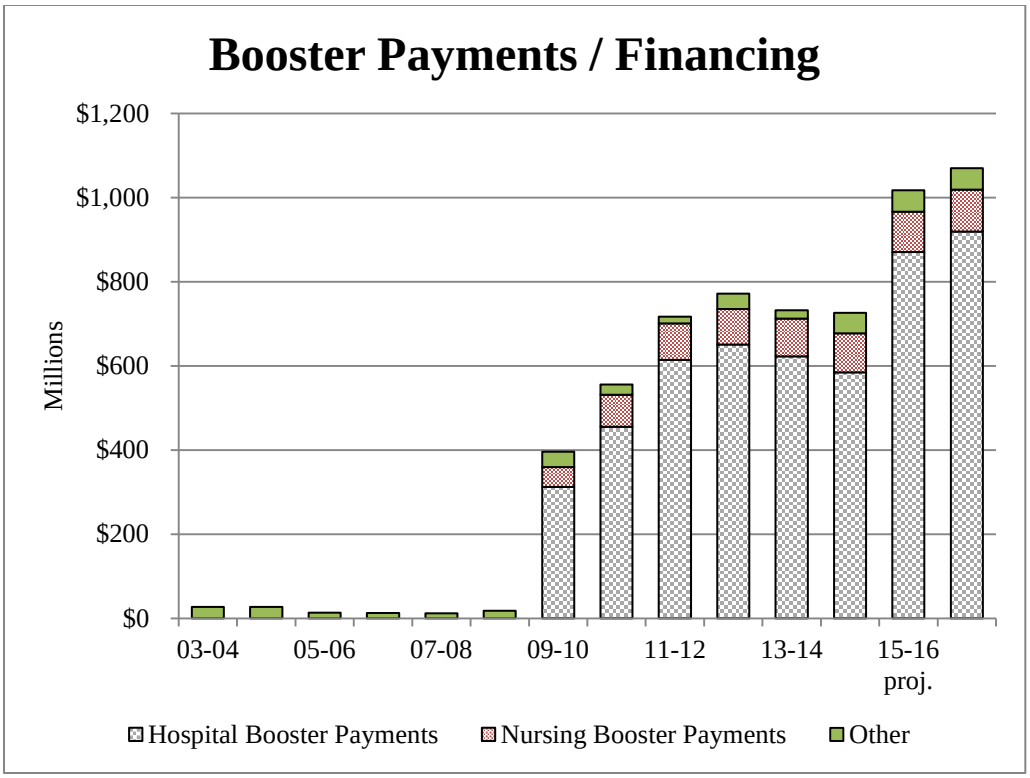
The next graph provides projected changes in per capita expenditures by enrollment category, not including booster payments / financing.



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 and hospitals and nursing facilities refer 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. Of the projected change in expenditures for Medical Services Premiums, the booster payments / financing account for $290.8 million of the total dollar change and only $9.4 million of the General Fund change, since the booster payments are financed with provider fees.

The table below summarizes the trends in booster payments / financing.



Most of the variability in this expenditure category is being driven by the Hospital Booster Payments. According to the Department, the decrease in expenditures from FY 2012-13 to FY 2013-14 and then again to FY 2014-15 is attributable to two main factors. First, the Department is making audit adjustments for prior-year over-payments relative to the federal allowable limits on booster payments. These audit adjustments reduce both expenditures and the Hospital Provider Fee revenue collected. Second, the Hospital Provider Fee plan for FY 2013-14 intentionally paid less than the maximum allowable under the federal limits. The Department and hospitals negotiated the payments to be less than the federal limits based on increased scrutiny from CMS and an attempt to prevent the need for future audit adjustments.

In FY 2015-16 expenditures are expected to increase dramatically due to the Medicaid expansion increasing the federal limits on booster payments. Some of the growth projected in FY 2015-16 should be occurring in FY 2014-15, but the Department is currently operating under an outdated Hospital Provider Fee plan that doesn't account for the Medicaid expansion, due to delays in CMS approval. The Department does not anticipate the new model taking effect until FY 2015-16.

➔ Continuous eligibility financing (JBC staff recommendation)

Request: Built into the Department's February 2015 forecast is an assumption that the state share of continuous eligibility for children will be financed with the Hospital Provider Fee. Continuous eligibility is a policy that once Medicaid eligibility is determined the person remains eligible for a period of one year. Continuous eligibility for children was authorized in H.B. 09-1293, but the Department did not implement it until S.B. 13-200 was adopted, based on a determination that there were insufficient funds from the Hospital Provider Fee. The assumption

in the February forecast is a change from the November request, when the Department assumed that the state share of costs for continuous eligibility would be financed with the General Fund. However, the JBC staff believes the Department is still not estimating the cost of continuous eligibility in a manner consistent with the statute.

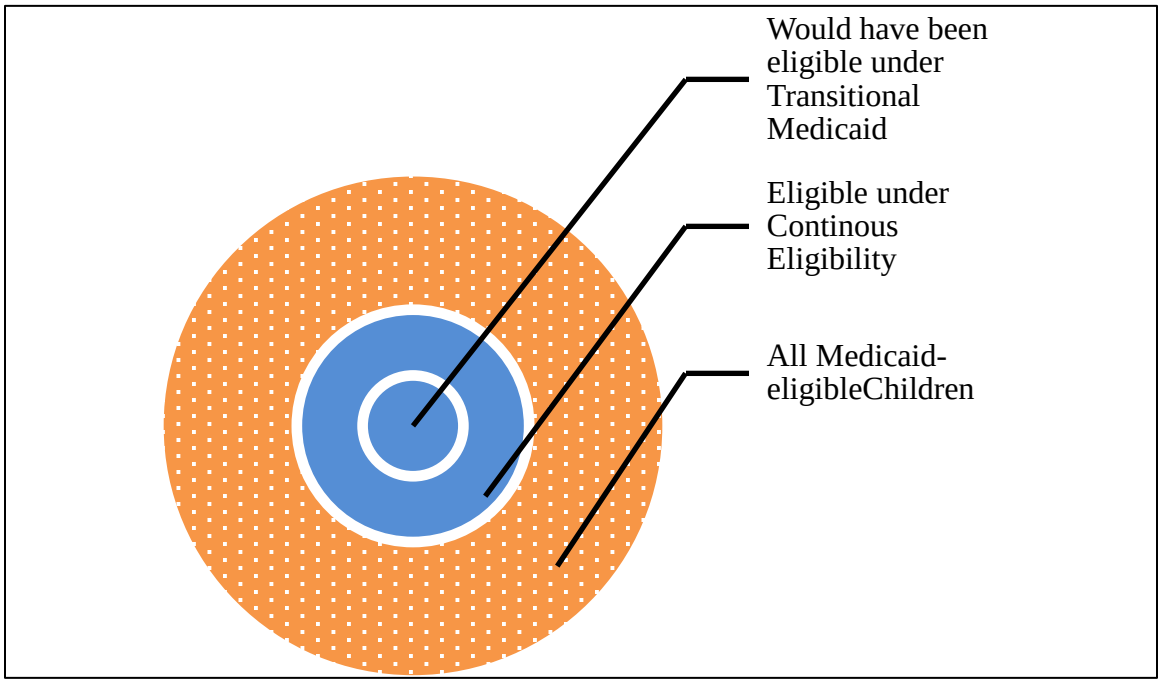
Recommendation: Staff recommends a reduction in General Fund and a corresponding increase in appropriations from the Hospital Provider Fee of $39.5 million in FY 2015-16 to more accurately reflect the state share of costs for continuous eligibility for children. This adjustment is composed of $21.0 million for continuous eligibility costs in FY 2015-16, which is roughly the on-going correction expected in future years, and $18.4 million for retroactive adjustments for FY 2014-15 and FY 2013-14.

Prior to the implementation of continuous eligibility for children, there was a population of children who experienced an increase in income and remained eligible for Medicaid as a result of Transitional Medicaid. Transitional Medicaid is a federally required program that allows people who have been eligible for Medicaid for at least three of the last six months to remain eligible for a period of up to one year, if they would otherwise lose eligibility due to an increase in income. The incremental cost of implementing continuous eligibility was estimated as the difference between the children eligible based on Transitional Medicaid and the children expected to be eligible based on continuous eligibility.

Since the implementation of continuous eligibility, the population of children eligible based on Transitional Medicaid has been diminishing. This is because the Department tests for eligibility under the continuous eligibility criteria, finds the applicants eligible, and then never needs to test for eligibility based on the Transitional Medicaid criteria. The population traditionally eligible for Transitional Medicaid is being consumed by continuous eligibility.

The Department's February 2015 forecast assumes that the cost for continuous eligibility that needs to be financed from the Hospital Provider Fee is the difference between the number of children who would have been eligible under Transitional Medicaid and the children actually eligible under continuous eligibility. Because the Department doesn't know how many children would have been eligible under Transitional Medicaid, the Department makes a projection based on the population on Transitional Medicaid prior to the implementation of continuous eligibility.

In the Venn diagram below the Department is trying to finance the donut between the children who would have been eligible under Transitional Medicaid and the children eligible under continuous eligibility.



The JBC staff does not believe the Department's interpretation of the costs of continuous eligibility to be financed with the Hospital Provider Fee is consistent with the statute. The statute does not say that the Hospital Provider Fee will pay for the difference in costs between an estimate of the Transitional Medicaid population and the continuous eligibility population. Rather, Section 25.5-4-402.3 (4) (b) (V), C.R.S., says the Hospital Provider Fee shall be used, "to provide continuous eligibility for twelve months for children enrolled in the state medical assistance program." Another statute, Section 25.5-5-204.5, C.R.S., describes who qualifies for continuous eligibility, and it does not exclude children who would otherwise have been eligible for Transitional Medicaid.

In the Venn diagram above the staff position is that the Hospital Provider Fee should fund the entire solid blue area, both the children eligible under continuous eligibility and the children who would have been eligible under Transitional Medicaid. The competing policies can be described as the donut versus the hole.

In addition to the JBC staff's concern about the Department's interpretation of the statute, the JBC staff has a practical concern about the Department's ability to accurately identify the number of children who would have been eligible for Transitional Medicaid absent continuous eligibility. The more time passes from when Transitional Medicaid for children mattered, the less accurate the forecast. Because the Department's estimate is not verifiable, the amount allocated from the Hospital Provider Fee for continuous eligibility could be subject to manipulation during annual negotiations on the Hospital Provider Fee plan.

The fiscal note for S.B. 13-200 correctly identified the incremental cost of continuous eligibility in the initial year, but it failed to account for continuous eligibility consuming Transitional Medicaid in future years. Staff views this as an error in assumptions in the fiscal note. There was a consequence of the General Assembly's policy that was not foreseen. Possibly this was an

unintended consequence, but that is not known. An error in the fiscal note assumptions about the future year costs of a policy should not govern the interpretation of the plain meaning of the statute.

If the General Assembly agrees with the JBC staff's interpretation of the statute, then the Department under-collected from the Hospital Provider Fee for the costs of continuous eligibility since the policy was implemented in March 2014. It follows that the Department should recover the underpayments at the earliest practical date, which the JBC staff assumes would be FY 2015-16, based on the time required to make changes to the Hospital Provider Fee plan. The retroactive recovery may seem punitive to people not immersed in Medicaid financing, but it is really not unusual. The Department regularly makes reconciliations with providers for under- or over-payments, often for activities from several years in the past. Similarly, the federal government will make reconciliations with Colorado for practices from several years ago.

The table below summarizes the JBC staff estimate of the cost of financing the population that would have been eligible for Transitional Medicaid with money from the Hospital Provider Fee.

Continuous Eligibility for Children				
	FY 2013-14	FY 2014-15	FY 2015-16	Cumulative
Assumptions				
Caseload	4,984	23,235	31,388	
Medical Services Premiums per capita	$1,708.01	$1,745.72	$1,756.32	
Behavioral Health per capita	$209.54	$226.92	$236.24	
Average FMAP	50.90%	52.16%	54.14%	
JBC Staff forecast of costs				
Medical Services Premiums	$8,511,868	$40,561,278	$55,127,264	
Hospital Provider Fee	4,179,682	19,402,648	25,281,977	
Federal Funds	4,332,186	21,158,630	29,845,287	
Behavioral Health	$1,044,243	$5,272,418	$7,415,087	
Hospital Provider Fee	512,767	2,522,082	3,400,642	
Federal Funds	531,476	2,750,336	4,014,445	
TOTAL	$9,556,111	$45,833,696	$62,542,351	
Hospital Provider Fee	4,692,449	21,924,730	28,682,619	
Federal Funds	4,863,662	23,908,966	33,859,732	
February 2015 HCPF projection of Hospital Provider Fee Costs				
Medical Services Premiums	1,518,521	6,431,818	7,662,224	
Behavioral Health	229,183	0	0	
TOTAL Hospital Provider Fee	$1,747,704	$6,431,818	$7,662,224	
Difference				
Medical Services Premiums				
General Fund	($2,661,162)	($12,970,831)	($17,619,753)	($33,251,745)
Hospital Provider Fee	$2,661,162	$12,970,831	$17,619,753	$33,251,745
Behavioral Health				
General Fund	($283,584)	($2,522,082)	($3,400,642)	($6,206,308)
Hospital Provider Fee	$283,584	$2,522,082	$3,400,642	$6,206,308

Continuous Eligibility for Children	FY 2013-14	FY 2014-15	FY 2015-16	Cumulative
TOTAL				
General Fund	($2,944,746)	($15,492,913)	($21,020,395)	**($39,458,053)**
Hospital Provider Fee	$2,944,746	$15,492,913	$21,020,395	**$39,458,053**

Implementing the JBC staff recommendation would save a total of $39.5 million General Fund in FY 2015-16. It would not change the projected Hospital Provider Fee revenues, because the projection is that the Hospital Provider Fee will be set to maximize revenue within the federal limits (revenues from the Hospital Provider Fee and the federal limits are discussed in more detail below, under *Limiting Hospital Provider Fee revenue – JBC staff recommendation*). It would change the allocation of the Hospital Provider Fee. More money would be needed for continuous eligibility and less money would be available for other priorities, which is financially disadvantageous to hospitals.

The JBC staff assumes the costs for continuous eligibility would come out of booster payments, but the JBC staff believes it would be acceptable if the Department took the costs out of Safety Net Provider Payments and submitted a supplemental request to true up the appropriations. The total loss to booster payments would be $80,182,997, including $39,458,053 Hospital Provider Fee and $40,724,944 federal funds. The increase in Hospital Provider Fee expenditures for continuous eligibility is completely offset by the decrease in Hospital Provider Fee expenditures for booster payments for no net change in Hospital Provider Fee appropriations.

In Section 25.5-5-204.5 (2), C.R.S., the Medical Services Board is allowed to eliminate continuous eligibility for children if the revenue from the Hospital Provider Fee is insufficient to "fully fund" all of the purposes of the Hospital Provider Fee. However, the term "fully fund" is not defined. The JBC staff does not know under what circumstances the Medical Services Board would eliminate continuous eligibility for children rather than reducing booster payments, but it seems unlikely that the Medical Services Board would adopt such a policy. In Section 25.5-4-402.3, C.R.S. there is a prioritization of the uses of the Hospital Provider Fee that indicates booster payments, among other things, should be "fully funded" before certain expansion populations, but continuous eligibility for children is not listed among those expansion populations. The statues are silent on the prioritization of continuous eligibility for children versus booster payments.

➔ Limiting Hospital Provider Fee revenue – JBC staff recommendation

Request: The Department's February 2015 forecast assumes the Hospital Provider Fee will be set in FY 2015-16 to maximize revenue within federal limits on the fee. This results in a projected 29.4 percent increase in revenue from the Hospital Provider Fee in FY 2015-16, compared to the allowable TABOR growth rate for revenue statewide of 4.4 percent. The Department's February 2015 forecast assumes the Hospital Provider Fee revenue will grow $133.0 million more than the TABOR growth rate.

Recommendation: Staff recommends that the JBC introduce legislation to reduce the growth in the Hospital Provider Fee revenue by $133.0 million in FY 2015-16. The December forecasts by both Legislative Council Staff and the Office of State Planning and Budgeting indicated a

TABOR refund would be due in FY 2015-16. Revenue collected from the Hospital Provider Fee contributes to the projected TABOR refund. All of the mechanisms for making the TABOR refund call for payments from the General Fund. So, the growth in revenue from the Hospital Provider Fee creates a General Fund obligation for the TABOR refund.

The staff recommendation would reduce the General Fund obligation for the TABOR refund by $133.0 million. It would also reduce booster payments to hospitals by a total of $270.4 million, including $133.0 million from the Hospital Provider Fee and $137.3 million from federal funds. These changes do not appear in the summary tables for the line item or the department, because the fiscal impact will be in a separate bill from the Long Bill. The reduction in the General Fund obligation for TABOR will not appear as an appropriation, but rather as a reduction to non-appropriated obligations on the General Fund overview.

Background

What is the Hospital Provider Fee?

The Hospital Provider Fee is an assessment on hospitals that includes one component based on beds filled per day and another component based on a percentage of outpatient charges. There are discounts for high volume Medicaid and Colorado Indigent Care Program providers and essential access providers. Certain hospitals are exempted from the fee, including psychiatric hospitals, Medicare certified long-term care hospitals, and Medicare certified rehabilitation hospitals.

How is the amount of the Hospital Provider Fee determined?

The Hospital Provider Fee rates are set annually by the Medical Services Board based on recommendations from the Hospital Provider Fee Advisory Board, which features five members from the hospital industry out of a total of eleven members. However, the Department's plan for the Hospital Provider Fee, including both the revenue and expenditures, must be approved by the Centers for Medicare and Medicaid Services (CMS).

There have been delays in CMS approval of the Department's FY 2014-15 Hospital Provider Fee plan, and so the Department is currently operating under the plan approved by CMS for FY 2013-14 that doesn't fully account for the Medicaid expansion authorized by SB 13-200. This helps explain why the Department's projection of FY 2014-15 revenues from the Hospital Provider Fee is so much lower than the Department's projection of FY 2015-16 revenues. The delays in CMS approval are due in part to errors in the original calculations by a contractor helping the Department develop the Hospital Provider Fee plan. Trying to correct these errors and prevent similar future mistakes was among several reasons the Department requested and the JBC approved additional funds through the supplemental process for *S10 Provider fee analytics*. The total approved for S10 was $1,000,000, including $500,000 from the Hospital Provider Fee, but dealing with the delays in CMS approval of the Hospital Provider Fee plan was only one of several parts of the request.

What are the federal limits on the Hospital Provider Fee?

Federal policies limit Hospital Provider Fee revenues to the lesser of the Upper Payment Limit and six percent of net patient revenues. Total Medicaid reimbursements to hospitals from all sources, including the Hospital Provider Fee, may not exceed the federal Upper Payment Limit.

There are nuances to the calculation of the UPL, but it can be thought of as the amount Medicare would have paid for the same services.[3] In addition, the Hospital Provider Fee may not exceed six percent of net patient revenue. Net patient revenue is the actual payments received from patients (as opposed to charges to patients) after netting out discounts to insurers and uncompensated care. The net patient revenue limit is on aggregate revenues, rather than per hospital.

Why are the federal limits on the Hospital Provider Fee increasing?
Although there are federal limits on the revenue from the Hospital Provider Fee, these limits are influenced by policy decisions about Medicaid eligibility and benefits. There are separate UPLs for different categories of service, so the UPL for hospitals is not the same as the UPL for nursing homes. The amount of room under a given UPL is dependent on the difference between Colorado's Medicaid reimbursement rates and Medicare's reimbursement rates for the category of services. If the Medicaid eligibility criteria or benefits are expanded, then there are more instances of an incremental difference between the Medicaid and Medicare reimbursement and the room beneath the UPL increases.

Similarly, the limit that Hospital Provider Fee revenue may not exceed six percent of net patient revenues is influenced by eligibility and benefit policies. If eligibility and/or benefits are expanded it can increase net patient revenues and thereby raise the limit on the amount of Hospital Provider Fee revenue that can be raised. However, there is a lag between when an increase in eligibility or benefits would occur and when the net patient revenues would increase. Also, Medicaid is only one payer, and so the trend for net patient revenues can be counter to the trend for Medicaid expenditures on hospitals

For FY 2013-14 the most restrictive federal limit was the UPL, but for FY 2014-15 and FY 2015-16 the Department is projecting that the more restricting federal limit will be six percent of net patient revenues. This is because the Department projects the Medicaid expansion will increase the room under the UPL dramatically, significantly increasing the total revenue that can be collected from the Hospital Provider Fee.

How is the Hospital Provider Fee utilized?
Based on how the Hospital Provider Fee is distributed, the primary function of the Hospital Provider Fee is to increase reimbursements to hospitals in the form of booster payments, safety net provider payments, and quality incentive payments. When the Hospital Provider Fee was created the General Fund could not support a significant increase in provider rates. The Hospital Provider Fee allowed a substantial increase for hospitals with no negative impact on the General Fund. For each dollar collected for booster payments and safety net provider payments hospitals receive in aggregate approximately two dollars in return. The distribution formulas for booster payments and safety net provider payments result in some hospitals receiving a larger net benefit

[3] Note that the UPL is estimated using aggregate data and federal formulas and the Department's ability to calculate the UPL for a class of services does not necessarily mean that the Department has detailed information about the incremental difference between individual Medicaid rates and the corresponding Medicare rate. Also, the Department has significantly more information about hospitals than other providers due to federally mandated hospital cost reports.

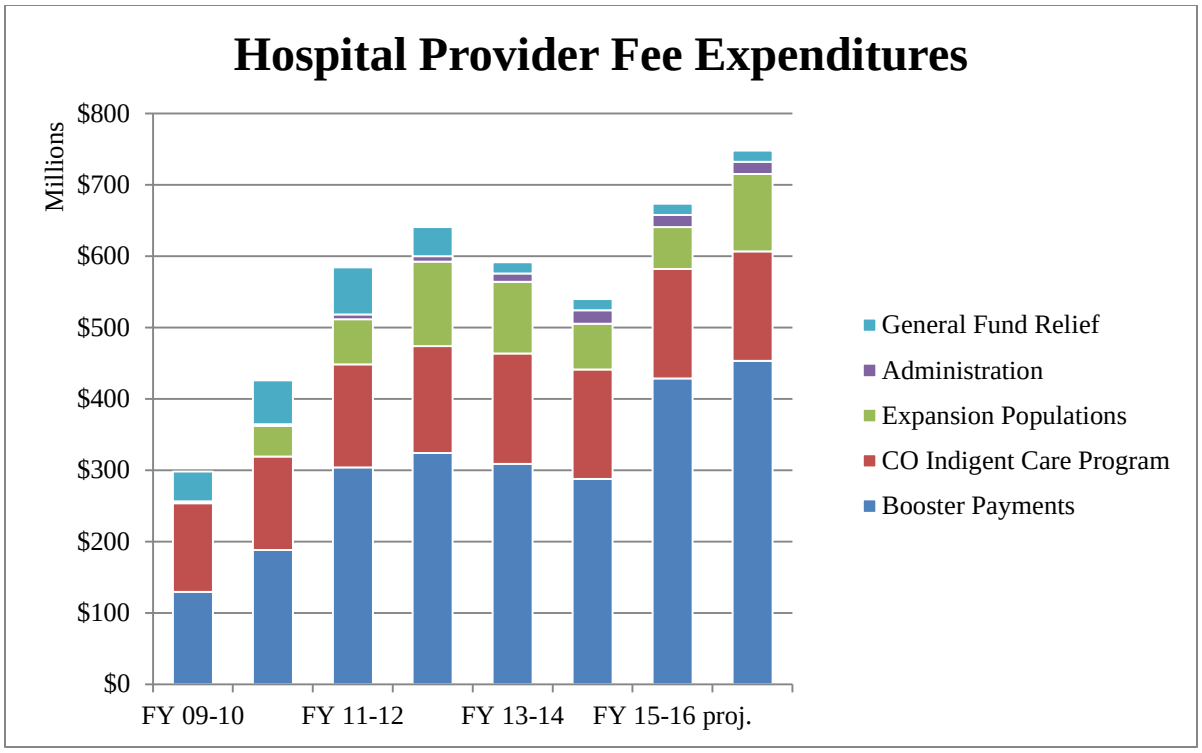
and some actually losing money on the exchange, but in aggregate hospitals come out significantly ahead financially by paying the Hospital Provider Fee. The financial incentive for hospitals is to maximize this portion of the Hospital Provider Fee. Even better than paying $1 and getting $2 in return is paying $2 and getting $4 in return.

In addition to increasing hospital reimbursement the Hospital Provider Fee also finances Medicaid and CHP+ eligibility expansions. The financial benefit to hospitals from subsidizing the expansion populations is a mixed bag. The eligibility expansions reduce uncompensated care for hospitals, potentially bring in new business for hospitals, and the match rates under the ACA are very favorable. However, some of the money from the Hospital Provider Fee that is used for expansion populations goes to providers other than hospitals. Also, expanding Medicaid and CHP+ eligibility may increase utilization of hospital services and to the extent that Medicaid and CHP+ reimburse below costs this could have a negative effect on hospital budgets compared to if the population did not utilize the services due to a lack of insurance. To varying degrees, depending on the institution, an increased utilization of hospital services may offset more or less of the value to hospitals of reducing uncompensated care. Trying to quantify the net benefit to hospitals from the portion of the Hospital Provider Fee devoted to financing expansion populations is a complicated and controversial analysis.

A third use of the Hospital Provider Fee is to offset the need for General Fund. Prior to the adoption of the Hospital Provider Fee the General Assembly documented expenditures by local governments to support public hospitals and used these as certified public expenditures to match federal funds for Medicaid reimbursement in lieu of using the General Fund. The Hospital Provider Fee took over the cost off offsetting the General Fund pursuant to Section 25.5-4-402.3 (4)(b)(VII), C.R.S., and continues to pay it at the historic level of $14.5 million per year. In addition to this historic amount, in order to balance the budget the General Assembly has temporarily used significant amounts from the Hospital Provider Fee to offset the need for General Fund for Medical Services Premiums. The temporary use of the Hospital Provider Fee for General Fund relief was essentially in place of a provider rate decrease for hospitals in those years.

The final use of the Hospital Provider Fee is for administrative expenses. These expenses relate to the collection and disbursement of the Hospital Provider Fee and to the management of the expansion populations.

The table below summarizes actual and projected expenditures for each category over time. These are just the expenditures from the Hospital Provider Fee and do not include the matching federal funds.



Where do hospitals get the money to pay for the Hospital Provider Fee? Do they increase charges to patients?
Hospitals get the money for the Hospital Provider Fee from cash on hand to pay future obligations, such as payroll or leased space. The Hospital Provider Fee is collected monthly and the booster payments are disbursed almost as quickly as the money is collected. The Hospital Provider Fee transaction is complete before hospitals need the money for other obligations. There is no need for hospitals to increase charges on patients to pay the Hospital Provider Fee.

Do hospitals like paying the Hospital Provider Fee?
The JBC staff can't speak for the opinions of hospitals, but there is a strong financial incentive for hospitals to support the portion of the Hospital Provider Fee that pays for booster payments and safety net provider payments. General Fund to support these payments would be better for the hospitals, but in the absence of General Fund the JBC staff suspects most hospitals welcome the opportunity to double their money by paying the Hospital Provider Fee. Staff suspects there would be significant opposition from hospitals to reigning in the amount of the Hospital Provider Fee collected for these purposes.

There may be differing opinions on the portion of the Hospital Provider Fee that supports expansion populations. Some of the money for expansion populations goes to providers other than hospitals. Also, as noted previously, expanding eligibility or benefits can result in greater utilization of hospital services that are compensated below cost.

What effect does the Hospital Provider Fee have on the TABOR refund?
If the state owes a TABOR refund, as projected by both Legislative Council Staff and OSPB in both FY 2014-15 and FY 2015-16, an increase in revenue from the Hospital Provider Fee will

increase the TABOR refund. Revenue from the Hospital Provider Fee is subject to the TABOR limit, but the federal matching funds are exempt. The current TABOR refund mechanisms make all of the payments from the General Fund. So, an increase in Hospital Provider Fee revenue increases the General Fund obligation for the TABOR refund.

The contributions of cash funds to the TABOR refund are often measured based on the growth rate of the cash fund relative to the growth of the TABOR limit. If a cash revenue source is growing faster than the TABOR limit allows, then the difference increases the General Fund obligation compared to if the cash revenue source did not exist. Conversely, if the cash revenue is growing slower than the TABOR limit allows, then the cash revenue source results in a lower General Fund refund obligation than if the cash revenue source did not exist.

For FY 2015-16 the Department is projecting a significant increase in Hospital Provider Fee revenue compared to the growth in the TABOR limit.

Hospital Provider Fee Revenue	
FY 14-15 Revenue	$532,708,137
FY 15-16 Revenue	$689,195,211
Dollar change from FY 14-15	$156,487,074
Percent	29.4%
TABOR allowable growth	4.4%
FY 15-16 Revenue at TABOR rate	$556,147,295
Dollar change from FY 14-15	$23,439,158
FY 15-16 Revenue above TABOR	$133,047,916

What happens to the Hospital Provider Fee revenue if the General Assembly approves a new expenditure from the Hospital Provider Fee?
The Hospital Provider Fee model is built to maximize revenue within the federal limits, and so a policy change that increases expenditures will not directly change the revenue projection. However, there could be an indirect effect on the revenue projection if the policy change results in an increase in the federal limits. This could happen if the policy change increases the available room under the Upper Payment Limit or increases hospital net patient revenues, such as a policy change that expands eligibility or benefits.

Rationale for the recommendation
With a projected TABOR refund due in FY 2015-16, growth in revenue from the Hospital Provider Fee creates a General Fund obligation. This means that increasing compensation for hospitals with financing from the Hospital Provider Fee is just as expensive for the General Fund as a provider rate increase, or an increase in K-12 per pupil funding, or an increase in higher education stipends. However, under the current statutory framework for the Hospital Provider Fee, increased compensation for hospitals will just happen without competing with other potential General Fund expenditure priorities through the budget process.

When the Hospital Provider Fee was created a TABOR refund was not due, and so the General Assembly was able to increase compensation for hospitals with no negative impact on the General Fund. Now that the overall budget outlook has changed, the JBC staff believes it is

appropriate and necessary to reexamine the Hospital Provider Fee and put some limits on the growth in revenue.

In order to limit the Hospital Provider Fee revenue, the JBC staff believes a statutory change is necessary. Section 25.5-4-402.3 (3) (b) (III), C.R.S. requires the Medical Services Board to establish the Hospital Provider Fee so that revenues are approximately equal to or less than the appropriation. The General Assembly could just lower the appropriation in the Long Bill to reduce revenues from the Hospital Provider Fee. However, doing so could result in a decrease in eligibility or benefits, due to the prioritized uses of the Hospital Provider Fee in Section 25.5-4-402.3 (5) (b) (II), C.R.S., which requires full funding of booster payments (among other things) before financing expansion populations. Reducing eligibility or benefits would likely result in noncompliance with the minimum federal standards for receiving an enhanced federal match for populations that are "newly eligible" pursuant to the ACA, which would dramatically increase the state's General Fund costs. If the JBC wants to reduce Hospital Provider Fee revenues, but does not want to reduce eligibility or benefits, then the safest course of action is legislation. Otherwise, the Medical Services Board will need to determine what "fully funded" booster payments mean, and the JBC may not like the results, and/or there could be a legal challenge from hospitals.

Even if the JBC decides not to restrict Hospital Provider Fee revenues in FY 2015-16, staff believes the prioritized uses of the Hospital Provider Fee in Section 25.5-4-402.3 (5) (b) (II), C.R.S., are problematic. The JBC staff believes the current prioritization is the exact opposite of what would serve the General Assembly best. Staff believes the Hospital Provider Fee should first ensure coverage of the expansion populations and only then increase reimbursements to hospitals with available remaining revenue. Staff would recommend a change to the prioritization whether the JBC decides to restrict revenue or not, but this is likely to be controversial legislation and there is less urgency in FY 2015-16 to change the prioritization if the JBC does not want to pursue the staff recommendation to restrict revenue.

The JBC staff is recommending a reduction in the Hospital Provider Fee revenue of $133.0 million based on the difference between the TABOR allowable growth and HCPF's February 2015 projection of growth for the Hospital Provider Fee. The JBC could allow the hospitals to generate more revenue from the Hospital Provider Fee, but the cost to the state budget would be the same as if the JBC appropriated General Fund to the hospitals. From the perspective of the hospitals, it would be much better to have a dollar of General Fund than a dollar of Hospital Provider Fee. When a hospital pays $1 of Hospital Provider Fee they get $2 in return for a net benefit of $1, but when the state pays $1 in General Fund the hospital gets $2 and doesn't have to give up anything (except state taxes, which would be a liability in either scenario).

If the JBC feels that a $133.0 million dollar reduction in revenue from the Hospital Provider Fee creates a burden on hospitals, the JBC could choose to backfill all or some of the loss with an increase in hospital rates. The JBC staff recommendation is to simply limit Hospital Provider Fee revenue by $133.0 million, but the table below illustrates an option where General Fund for provider rate increases is substituted for Hospital Provider Fee for booster payments.

Limiting Hospital Provider Fee Revenue

	Expenditures	Inpatient	Outpatient	Safety Net	Booster	HPF Obligation for Safety Net/ Booster	Net Effect
FY 14-15 Estimate	$2,153,044,483	$685,188,429	$571,763,766	$311,296,186	$584,796,102	($440,967,015)	$1,712,077,468
Enrollment/utilization trend 10.5%	193,950,628	72,155,748	60,211,236	0	61,583,644	(30,305,311)	163,645,317
Subtotal FY 15-16 base	$2,346,995,111	$757,344,177	$631,975,002	$311,296,186	$646,379,746	($471,272,326)	$1,875,722,785
Policy Changes							
Provider rate increases	230,736,311	3,495,435	2,916,808	0	224,324,068	(110,389,874)	120,346,437
Continuous eligibility - FY 15-16	(42,715,698)	0	0	0	(42,715,698)	0	(42,715,698)
Continuous eligibility - retroactive	(37,467,299)	0	0	0	(37,467,299)	0	(37,467,299)
Limit HPF revenue by $133.0 M	(270,367,641)	0	0	0	(270,367,641)	133,047,916	(137,319,725)
Subtotal policy changes	($119,814,327)	$3,495,435	$2,916,808	$0	($126,226,570)	$22,658,042	($97,156,285)
Percent change	-5.1%	0.5%	0.5%	0.0%	-19.5%	-4.8%	-5.2%
Optional increase hospital rates							
General Fund	31,718,925	17,290,587	14,428,338	0	0	0	31,718,925
Cash Funds	1,221,666	665,953	555,713	0	0	0	1,221,666
Federal Funds	73,594,308	40,117,650	33,476,658	0	0	0	73,594,308
TOTAL	$106,534,899	$58,074,190	$48,460,709	$0	$0	$0	$106,534,899
Policy changes w/ optional rate inc.	($13,279,428)	$61,569,625	$51,377,517	$0	($126,226,570)	$22,658,042	$9,378,614
Percent change	-0.6%	8.1%	8.1%	0.0%	-19.5%	-4.8%	0.5%

Following is an explanation of the column headings. The Expenditures column sums expenditures for inpatient and outpatient services that are paid on the Department's fee schedule with safety net provider payments and booster payments. All of these figures are total funds, including the matching federal funds. The HPF Obligation for Safety Net/Booster column shows the amount hospitals have to pay for safety net and booster payments. To simplify the analysis this table does not include the Hospital Provider Fee obligations for expansion populations, although some of the payments for inpatient and outpatient services are related to expansion populations. The Net Effect column is the value of the expenditures less the hospital provider fee obligation.

Key assumptions for the rows are explained in this paragraph. The "Enrollment/utilization trend 10.5%" row is based on the Department's February 2015 forecasted increase in acute care expenditures. For the Booster column the JBC attributed a portion of the overall projected $285.9 million increase in booster payments to the enrollment and utilization trend. The remainder appears in the "Provider rate increases" row. The "Provider rate increases" for inpatient and outpatient services are based on the JBC's common policy 0.5 percent increase and do not include any portion of the targeted rate increases, although some of the targeted rate increases may effect hospitals. The two "Continuous eligibility" rows show the effect of the JBC's staff recommendation on the hospitals. The totals here include the matching federal funds, and so are slightly more than twice the cut in Hospital Provider Fee associated with the staff recommendation regarding continuous eligibility financing. The "Limit HPF revenue by $133.0 M" row shows the staff assumption about the reduction in booster payments that would occur. The combined impact of all the recommended policy changes is a 5.2 percent reduction in hospital compensation, including safety net and booster payments.

The "Optional increase hospital rates" presents a scenario where the JBC would backfill a portion of the lost revenue to hospitals from booster payments with an increase in hospital rates. Because of the favorable FMAP rates for expansion populations, the General Fund required to fully backfill the loss in booster payments would be less than the decrease in the Hospital Provider Fee. This scenario does not fully backfill the loss in booster payments, but rather provides an increase in hospital rates so that the Net Effect for hospitals is a 0.5 percent increase, consistent with the JBC's common policy.

The previous table showed the combined effect of both the staff recommendation for continuous eligibility financing and the staff recommendation for limiting hospital provider fee revenue, along with an optional increase in hospital rates. The next table isolates the ramifications for the General Fund and for the hospitals of just the recommendation to limit hospital provider fee revenue and the optional increase in hospital rates.

Net General Fund benefit from limiting HPF revenue	
TABOR Refund	($133,047,916)
Optional increase in hospital rates	31,718,925
TOTAL	($101,328,991)
Net hospital loss from limiting HPF revenue	
Reduced HPF obligation	$133,047,916
Booster payments	(270,367,641)
Optional increase hospital rates	106,534,899
TOTAL	($30,784,826)

Depending on the March revenue forecasts, the decrease in the General Fund obligation for the TABOR refund may benefit the capital construction and highway budgets more than the operating budget. Based on the Legislative Council Staff's December forecast, a decrease in the TABOR refund of $133.0 million would drop the TABOR refund to below 1.0 percent, triggering an increase in required transfers to the Capital Construction Fund and Highway Users Tax Fund of $25.6 million and $102.5 million respectively. However, the March revenue forecasts may change assumptions about the size of the TABOR refund. Also, the General Assembly could modify the transfers to the Capital Construction Fund and the Highway Users Tax Fund. The JBC staff cannot evaluate this potential secondary ramification of the recommendation until the March revenue forecasts are available.

If the JBC decided to do the optional increase in hospital rates, it could change the distribution of funds to hospitals compared to if the money was allocated through booster payments. The Department would need to analyze the extent to which the rate increases and/or remaining booster payments could be customized to result in a similar distribution to the status quo, if that is a goal of the JBC.

➔ R6 Enrollment simplification (Annualized income)

Request: In this portion of the request, the Department proposes allowing the use of annualized income, rather than monthly income, to determine Medicaid and CHP+ eligibility. There are two other components of the request related to a study of continuous eligibility for adults and a one-

month grace period for CHP+ enrollment fees that are discussed with the Operating Expenses line item and the Children's Basic Health Plan line item respectively.

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

There are no costs projected for FY 2015-16. Implementing the annualized income option will require changes to CBMS that the Department indicates can be accomplished within existing resources, but not soon enough to implement the policy before FY 2016-17. The Department says that they requested the option to use annualized income as part of the package of requests in R6 that also includes a one-month grace period to pay the annual CHP+ enrollment fee and a study of the feasibility of implementing continuous eligibility for adults. If R6 is approved, the Department would treat the cost of creating an option to use annualized income as an annualization in the FY 2016-17 budget process.

The purpose of the request is to reduce churn, where clients gain or lose Medicaid eligibility based on fluctuating income, and in particular the request highlights seasonal workers, such as migrant farmers and hospitality workers, as vulnerable to churn. The Department also notes that using annualized income would be more similar to the way eligibility is determined for health insurance tax credits available through the Health Exchange.

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

If the annualized income option is approved, a Medicaid client who is already enrolled (not a new applicant) could request the use of annualized income. They would need to provide a clear indicator, such as a signed contract or history of fluctuating income. The eligibility system would then make a projection of their income for the rest of the year. Clients who disagree with the projection could appeal. Federal regulations allow annualizing income for the remainder of the year, which is not quite the same as annualizing income for the entire year. Clients are responsible for reporting variances between their actual and estimated income. For employment income the Department receives monthly reports that verify income. A variance that doesn't meet rules for reasonable compatibility and reasonable explanation would require a redetermination and could result in a loss of benefits.

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

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

The JBC staff is not recommending legislation at this time. The Department recently implemented a major expansion of Medicaid eligibility and not all of the ramifications are yet understood. The JBC staff is reluctant to recommend compounding more eligibility expansions unless there is a compelling and urgent need. In this case, the JBC staff is not convinced that there are a large number of people with an urgent need who would not be served by Transitional Medicaid or the subsidized insurance options available through the health exchange.

➔ R7 Participant directed programs (CDASS for SLS)

Request: This portion of the request is to allow individuals receiving services on the Supported Living Services (SLS) waiver for individuals with intellectual and developmental disabilities to utilize Consumer Directed Attendant Support Services (CDASS). The recommendation will be discussed during figure setting for the Office of Community Living. There is another portion of the request related to the Community First Choice (CFC) planning that is discussed with the Personal Services line item. The amounts included in the table are based on the Department's request and will be updated to reflect the JBC's action during figure setting for the Office of Community Living.

➔ R8 Children with autism

Request: The Department requested an expansion and modification of the Children with Autism waiver program. The proposed changes require a bill. The JBC has introduced H.B. 15-1186 to implement the requested changes.

➔ R11 Public health and Medicaid alignment

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

Recommendation: Staff does not recommend approval of the request. The Department's description of the work to be done and the urgency for the request is vague. Collaboration between the LPHAs and the RCCOs would be consistent with the core missions of both entities. The JBC staff does not understand why this wouldn't be done within existing resources and why additional money is necessary to promote coordination.

➔ R12 Provider rate increase

Request: The Department requests funding for provider rate increases in an amount equal to 1.0 percent of estimated eligible expenditures. This is a total of $32.9 million, including $11.4 million General Fund. The Department would use half the money to increase all discretionary rates by 0.5 percent across-the-board and the remaining funds would be used for targeted rate increases. In a February 13, 2015 letter to the JBC the Department detailed specific targeted rate increases totaling $16.3 million, including $7.3 million General Fund.

The total cost of the February targeted rate increases is within the original amount set aside in the November request, but the estimated General Fund cost is $1.6 million higher. This is partly due to a timing issue where the fund splits for the February targeted rate increases are estimated based on a more recent forecast of the caseload mix and associated funding sources than the November request used. In addition, the November estimated General Fund cost was based on aggregate fund splits for Medical Services Premiums while the fund splits for the February 2015 targeted rate increases are estimated based on the specific populations effected by each proposal. The Department did not identify where the Governor's request should be modified to get the additional $1.6 million General Fund required for the February targeted rate increases.

R 12 Provider rate increase request, as modified by February 13, 2015 letter

	TOTAL Increase		0.5% Across-the-board		Targeted	
Line Item	TOTAL	General Fund	TOTAL	General Fund	TOTAL	General Fund
Medical Services Premiums	$30,267,642	$11,779,160	$13,965,102	$4,521,551	$16,302,540	$7,257,609
Behavioral Health Community Programs	37,546	11,302	37,546	11,302	0	0
Office of Community Living						
Adult Comprehensive Services	1,760,151	771,355	1,760,151	771,355	0	0
Adult Supported Living Services	373,890	203,138	373,890	203,138	0	0
Children's Extensive Support Services	123,328	60,300	123,328	60,300	0	0
Case Management	145,478	77,150	145,478	77,150	0	0
Family Support Services	34,220	34,220	34,220	34,220	0	0
Preventive Dental Hygiene	321	303	321	303	0	0

R 12 Provider rate increase request, as modified by February 13, 2015 letter						
	TOTAL Increase		0.5% Across-the-board		Targeted	
Line Item	TOTAL	General Fund	TOTAL	General Fund	TOTAL	General Fund
Eligibility Determination and Waiting List Management	15,345	15,243	15,345	15,243	0	0
Total February 13, 2015	$32,757,921	$12,952,171	$16,455,381	$5,694,562	$16,302,540	$7,257,609
Original Request	$32,910,761	$11,389,124	$16,455,381	$5,694,562	$16,455,380	$5,694,562
February 13, 2015 higher/(lower) than Original Request	($152,840)	$1,563,047	$0	$0	($152,840)	$1,563,047

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

- A portion of physician and EPSDT rates that have already been increased to 100 percent of Medicare rates pursuant to Section 1202 of the Affordable Care Act
- A portion of expenditures related to non-medical emergency transportation services that are rendered under a fixed price contract.
- Class I and Class II nursing facility rates that are determined in accordance with statutory guidelines
- Hospice rates that are set in part as a function of nursing facility rates and in part as a result of federal requirements
- Physical health managed care programs, including risk-based health maintenance organizations such as the Program of All-Inclusive Care for the Elderly (PACE), that receive rate adjustments based on the rates for the services covered under their contracts.
- Behavioral health organization (BHO) rates that are set in accordance with federal regulation and actuarial standards
- Pharmaceutical rates that have transitioned to a methodology that reflects the actual costs of purchasing and dispensing medications
- Services under the home and community based services waiver for children with autism because of the cap on client expenses. An increase in rates would reduce the amount of services that clients are able to receive.
- Rates for rural health clinics (RHCs) that are based on actual cost or the Medicare upper payment limit

The Department argues that targeted rate increases are necessary because there are dramatic variations in the adequacy of current rates. According to the Department, some rates are so low that Medicaid clients have trouble accessing services. In these cases, an across-the-board increase would not be sufficient to change provider behavior to increase access. Targeted rate increases allow for larger changes for select providers that are sufficient to address access issues and therefore more cost-effective than an across-the-board increase.

The dramatic variations in the adequacy of rates occur when provider costs change more quickly than Medicaid rates. The Department goes through a detailed analysis to establish the initial Colorado Medicaid rate for each service, including a review of suggested guidance from the federal Centers for Medicare and Medicaid Services (CMS). According to the Department, current practice usually results in new rates set at approximately 75 percent of the benchmark guidance from CMS. Once the Colorado Medicaid rate is set, it generally does not change without action by the General Assembly, unless federal or state laws and regulations require adjustments.

The Department has statutory authority to set rates, but the General Assembly has authority to set funding, and so the Department does not typically act on rates without General Assembly approval. Occasionally the Department will change rates in a manner designed to be expenditure neutral. In unusual circumstances the Department may make a change to a rate without first receiving an appropriation for that purpose. Under state statute the Department is authorized to take actions necessary to comply with federal Medicaid laws and regulations, and pursuant to 42 CFR 447.204:

> *The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.*

In recent years most of the emergency rate changes to preserve access have been for physician-administered pharmaceuticals.

Historically, most rate adjustments both requested by the Department and approved by the General Assembly have been allocated across-the-board. Provider costs, however, may not change equally for all procedures due to new treatment standards, new technologies, new service delivery methods, or other factors. As a result, some Colorado Medicaid rates come closer to covering provider costs than others.

To develop a list of targeted rate increases for recommendation to the JBC the Department solicited feedback from stakeholders. The Department received 41 responses, including 30 that the Department considered formal proposals. The Department asked that formal proposals include the following:

- A focus on ensuring or improving access to cost-effective care
- Specific services or units of service recommended for increase
- The requested percentage and dollar increase
- Known challenges and barriers to implementation
- An explanation of how the increase would incent more providers to deliver the services

According to the Department, the formal proposals were evaluated against the following criteria:

- Improves access
- Increases value for dollars spent
- Improves health outcomes

- Proposal is operationally and programmatically feasible and sustainable
- Proposal can be implemented by July 1, 2015

The table on the next page summarizes the specific targeted rate increases proposed by the Department in the February 13, 2015 letter. After the table are bullets provided by the Department summarizing the recommended targeted rate increases. In the context of the bullets, the "Recommendation" is the Department's recommendation, rather than the JBC staff recommendation.

Targeted Rate Increases Recommended by Health Care Policy and Financing									
		COST				RATES			
	Recommended	TOTAL	General Fund	Cash Funds	Federal Funds	Units	Current Rate	Proposed Rate	Difference
1	Special Connections Outpatient Group Rate	$23,835	$11,696	$0	$12,139	1,705	$15.32	$29.30	$13.98
2	Special Connections Per Diem Rate	227,604	111,683	0	115,921	7,281	$156.31	$187.57	$31.26
3	Prostate Biopsy	5,485	1,206	18	4,261	136	$67.54	$107.87	$40.33
4	Diabetic Self-Management Education Group Visits	485,433	162,280	874	322,279	27,000			
	G0109: Diabetic Management - Group	268,272				24,300	$0.00	$11.04	$11.04
	G0108: Diabetic Management - Individual	217,161				2,700	$0.00	$80.43	$80.43
5	Dental X-Rays	365,089	99,278	32,736	233,075	14,459	$53.11	$78.36	$25.25
6	Dental Flouride Varnish	2,711,409	1,246,791	0	1,464,618	340,290	$15.94	$23.91	$7.97
7	Dental Sealants for Children	3,545,183	1,630,187	0	1,914,996	168,007	$23.90	$45.00	$21.10
8	Vision Retinal Services	407,583	136,255	734	270,594	Not provided	Varies	75% Medicare	Varies
9	Eye Materials	3,995,056	1,837,053	0	2,158,003	592,753	Varies	Varies	49.5% inc.
10	Physical and Occupational Therapy Services	3,000,000	1,401,267	79,653	1,519,080	Not provided	Varies	50% Medicare	Varies
11	Prenatal and Postpartum Care Services	624,511	306,442	0	318,069	5,320			
	Postpartum Care (59430)	89,346				1,688	$81.12	$134.05	$52.93
	Antepartum Care, 4-6 Visits (59425)	175,172				1,768	$232.43	$331.51	$99.08
	Antepartum Care, 7+ Visits (59426)	359,993				1,864	$399.97	$593.10	$193.13
12	Selected Office Injectable Drugs	845,032	282,494	1,521	561,017	Not provided	Varies	Ave. Sale $	Varies
13	In-Home Respite	66,320	30,977	1,761	33,582	40,687	$3.24	$4.87	$1.63
	TOTAL	**$16,302,540**	**$7,257,609**	**$117,297**	**$8,927,634**				

1. Special Connections Outpatient Group Rate (Substance Use Disorder treatment for pregnant women)
   Submitted by: Arapahoe House
   Description/Rationale: Low rates limit the number of clients that can be accepted to the program as operating costs exceed revenues from Medicaid payment. Recently, the Joint Budget Committee asked the Department why the program has so few providers, citing that providers had expressed inadequate reimbursement as a barrier to becoming Special Connections providers. An increase in the rates is a necessary component in helping Special Connections grow and reach this vulnerable population of pregnant women and their unborn children.Proposal: Increase payment for Special Connections services to $210 per diem; increase group and individual outpatient therapy rates by 10%
   Recommendation: Partially recommend. Increased outpatient therapy rates from 50% to 100% of Medicaid Fee-For-Service rate
   Federal Authority: No State Plan amendment required
   Fiscal Impact: $23,835

2. Special Connections Per Diem Rate Submitted by: Department proposal
   Descriptions/Rationale: Substance use during pregnancy has long- and short-term effects on two large segments of the Medicaid population - women and children. Potential future expenses for children are greatest, due to lifelong effects resulting from exposure to drugs or alcohol in the womb. By treating Substance Use Disorder during pregnancy, current and future physical medicine costs for both mother and infant are greatly reduced or alleviated.
   Proposal: Increase per diem reimbursement rates by 20%
   Recommendation: Fully recommend
   Federal Authority: No State Plan Amendment required
   Fiscal Impact: $227,604

3. Prostate Biopsy
   Submitted by: Urology Center of Colorado
   Description/Rationale: The current rate covers only six core biopsies during a standard visit; however, best practices recommend 12 biopsies to appropriately detect and provide early diagnosis of cancer. Effective early diagnosis is essential to reduce metastasis, alleviate cost of additional treatment, and improve health outcomes.
   Proposal: Increase rate for prostate biopsies from 47% to 100% of Medicare
   Recommendation: Partially recommend. Increase to 75% of Medicare
   Federal Authority: No State Plan Amendment required
   Fiscal Impact: $5,485

4. Diabetic Self-Management Education Group Visits Submitted by: UPI/Colorado School of Medicine
   Description/Rationale: Curriculum for diabetic self-management includes one individual visit followed by nine group visits. Both services were opened to cover the full program. Diabetic self-management is an important, high-value service that prevents the need for higher-cost treatments.
   Proposal: Increase group visit rate for diabetic self-management to 100% of Medicare rate.

Recommendation: Partially recommend. Two service codes opened, priced at 75% of Medicare
Federal Authority: No State Plan Amendment required
Fiscal Impact: $485,433

5. Dental X-Rays
Submitted by: Colorado Dental Association
Description/Rationale: Evaluated and recommended by Medicaid Dental Clinical team. This x-ray series is foundational to any dental services and can only be billed once every five years. Supported by DentaQuest, Oral Health Colorado.
Proposal: Increase to 65% of American Dental Association (ADA) average fee survey
Recommendation: Fully recommend
Federal Authority: No State Plan amendment required
Fiscal Impact: $365,089

6. Dental Fluoride Varnish
Submitted by: Delta Dental of Colorado
Description/Rationale: Evaluated and recommended by Medicaid Dental Clinical team. Fluoride varnish is an evidence-based preventative service that reduces decayed, missing, and filled tooth surfaces. Supported by CDPHE, Delta Dental, and Oral Health Colorado; also recommended by CDC and the American Dental Association (ADA).
Proposal: Increase rate for fluoride varnish by 50%, from $15.94 to $23.91 per application
Recommendation: Fully recommend
Federal Authority: No State Plan amendment required
Fiscal Impact: $2,711,409

7. Dental Sealants for Children Submitted by: Department Proposal
Description/Rationale: Increasing the rate for this preventive dental procedure will increase access for more children. When children have increased access to this preventive service, data shows that their need for more expensive, painful, and severe dental interventions decreases.
Proposal: Increase payment for application of dental sealant from 10% to 50% of American Dental Association (ADA) average fee survey
Recommendation: Fully recommend
Federal Authority: No State Plan amendment required
Fiscal Impact: $3,535,183

8. Vision Retinal Services
Submitted by: Colorado Retina Associates
Description/Rationale: Retinal services are key to recovering vision and preventing visual disability and blindness. Improved rates allow providers to accept more Medicaid patients, avoiding delays in diagnosis and treatment. Early intervention allows clients to remain at work, able to drive and to recover lost productivity.
Proposal: Increase 20 targeted retinal service codes to 100% of Medicare rate
Recommendation: Partially recommend. Five lowest-paid codes increased to 75% of Medicare

Federal Authority: No State Plan Amendment required
Fiscal Impact: $407,583

9. Eye Materials
Submitted by: Colorado Optometric Association
Description/Rationale: Reimbursement rates for eye glasses materials is so low that it hinders providers' ability to provide quality options for clients. The Colorado Optometric Association has been unable to increase the number of providers offering eyeglasses at these rates. Improved reimbursement will allow higher quality products with fewer replacements needed. It will allow clients to receive full service for exam/glasses at a single location and will alleviate expending time and money to travel to several locations for a pair of glasses.
Proposal: Increase reimbursement on materials for prioritized services for children's eyeglasses by 70%
Recommendation: Partially recommend. Increase in rates for children's lens and frames by 49.5%
Federal Authority: No State Plan Amendment required
Fiscal Impact: $3,995,056

10. Physical and Occupational Therapy Services
Submitted by: Department Proposal
Description/Rationale: Increasing reimbursement for these services will help ensure client access to quality treatment by allowing providers to increase their Medicaid patient panels, by attracting more high quality providers to Medicaid, and by retaining existing Medicaid providers. PT/OT services are also used as alternative or complementary chronic pain treatment options.
Proposal: Increase for codes of seven lowest PT/OT services to 50% of Medicare rate.
Recommendation: Fully recommend
Federal Authority: State Plan amendment required
Fiscal Impact: $3,000,000

11. Prenatal and Postpartum Care Services
Submitted by: Department Proposal
Description/Rationale: An increase in payment for prenatal and postpartum care services will encourage high quality care, improved access and better health outcomes for both Medicaid mothers and infants. This proposal will increase for CPT codes 59425, 59436, and 59430 (prenatal and postpartum care) to 70% of Medicare rate.
Proposal: Increase rate for prenatal and postpartum care services to 70% of Medicare
Recommendation: Fully recommend
Federal Authority: A State Plan amendment may be required
Fiscal Impact: $624,511

12. Selected Office Injectable Drugs (Oncology and Antipsychotic)
Submitted by: Department Proposal
Description/Rationale: Low pricing for office-injected drugs leads to clients not receiving services or being sent to hospitals to receive the medication, creating a higher cost service.

This increase addresses two subsets of office-administered drugs, oncology, and injectable antipsychotic medications. A list of codes is included in the Addendum below.
Proposal: Increase rates for office-administered drugs for oncology and antipsychotic medications to average sale price
Recommendation: Fully recommend
Federal Authority: State Plan Amendment is not required
Fiscal Impact: $845,032

13. In-Home Respite
Submitted by: Department Proposal
Description/Rationale: Increasing this rate will positively impact clients by allowing options for respite other than transitioning in and out of a nursing facility.
Proposal: Increase rate for in-home respite services by 33.4%
Recommendation: Fully recommend
Federal Authority: The Department would likely need to change rule and submit an amendment for the Home and Community Based Service waivers that would be impacted
Fiscal Impact: $66,320

In addition to information about the approved rate proposals, the Department provided information about the rejected rated proposals. This information is included in an appendix at the end of this document.

Recommendation: Staff recommends a 0.5 percent increase for discretionary rates, consistent with the JBC's common policy, and nothing for the Department's proposed targeted rate increases.

Staff has concerns that the Department's stakeholder feedback process was not designed effectively to encourage a sufficient response that would be representative of the rate concerns in the stakeholder community. As a result, the Department evaluated only a narrow subset of rate proposals by parties with sufficient resources and knowledge of the process to respond within the Department's time frame. The Department indicates it solicited feedback for 1,000 stakeholders and received responses from 30. This 3 percent response rate could be interpreted to mean that there only 30 problems with rates. However, staff believes it is more likely the result of a flawed stakeholder feedback process. The JBC staff is not sure what factors prevented a higher response rate, but some potential barriers include the short response time, the level of detail and technical information requested, the ad hoc nature of the process (as opposed to an institutionalized annual process planned well in advance), and the format of the notification. Whatever the barriers, the JBC staff is not convinced that these are the highest priority rate issues.

The Department's justification for the amounts recommended is very limited. In many cases the Department recommended only a portion of the stakeholder proposal, but provided no explanation for why this was the case. The Department provided no evidence that the proposed rate changes are sized appropriately to achieve the desired outcomes. Also, the Department's explanation of why some proposals were rejected is very limited.

Staff is concerned that the people making decisions about which proposals to forward to the JBC may have lacked key information. The JBC staff does not know what information the Department staff had available, and so this may be an unjust criticism, but when the JBC staff asked for details about the proposals such as the General Fund share of costs, the number of people served, or the number of units effected by the proposed rate changes, the Department was not able to provide this information readily. In several cases the Department staff had to back into the assumptions based on the total dollar amount being recommended. Apparently there was no summary of this type of data available when the Department evaluated the proposals against each other for prioritization.

In estimating the costs for the proposed rate increases, the Department did not project any increase in utilization, but one of the expected results of the rate increases (in many cases the primary goal of the rate increase) is an increase in utilization. This suggests to the JBC staff that the Department is underestimating the actual costs of the targeted rate increases. For some of the proposed rate increases that target preventive care, it might be reasonable to expect an offsetting decrease in utilization of more expensive services. However, any offsetting decrease is likely to lag the initial increase in cost. Also, not all care that improves health outcomes decreases costs. Sometimes the care improves quality of life with no effect on service utilization, or the care makes people live longer so they actually incur more health expenses in future years. The Department did not attempt to estimate potential offsetting decreases in utilization of more expensive services.

The specific proposed rate increases were submitted well after the November 1 deadline for budget submissions, the January 2 deadline for budget amendments, or even the deadline exceptions for caseload-driven budgets. The late submission left inadequate time for the question and answer and refinement process typical of other budget requests. The JBC staff raised a similar concern with the Department's request last year, but the Department repeated the process this year. The JBC staff is concerned that approving the Department's request could result in the Department ignoring the statutory deadlines for budget submissions again next year. These deadlines are important for ensuring an effective, open, and transparent legislative budget process.

(3) Medicaid Mental Health Community Programs

Funding recommendations for the line items in this division are addressed in the figure setting presentation for mental health programs.

(4) 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.

Indigent Care Program	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2014-15 Appropriation					
HB 14-1336 (Long Bill)	$562,952,715	$31,893,589	$231,189,651	$299,869,475	0.0
Other legislation	129,831	44,519	0	85,312	0.0
SB 15-147 (Supplemental)	(15,923,038)	(4,761,426)	237,914	(11,399,526)	0.0
Recommended Long Bill Supplemental	(22,766,851)	(6,961,976)	4,855,234	(20,660,109)	0.0
TOTAL	**$524,392,657**	**$20,214,706**	**$236,282,799**	**$267,895,152**	**0.0**
FY 2015-16 Recommended Appropriation					
FY 2014-15 Appropriation	$524,392,657	$20,214,706	$236,282,799	$267,895,152	0.0
Annualize prior year budget decisions	3,094,984	(1,554,219)	558,960	4,090,243	0.0
FMAP change	0	(18,265,240)	(9,113,770)	27,379,010	0.0
R3 Children's Basic Health Plan	2,390,026	11,763,217	(15,800,082)	6,426,891	0.0
R6 Enrollment simplification	0	0	0	0	0.0
R14 Primary Care Fund audit	(50,000)	0	(50,000)	0	0.0
Fund source adjustment	3,993	0	3,993	0	0.0
TOTAL	**$529,831,660**	**$12,158,464**	**$211,881,900**	**$305,791,296**	**0.0**
Increase/(Decrease)	$5,439,003	($8,056,242)	($24,400,899)	$37,896,144	0.0
Percentage Change	1.0%	(39.9%)	(10.3%)	14.1%	0.0%
FY 2015-16 Executive Request:	**$568,386,230**	**$9,710,336**	**$218,984,728**	**$339,691,166**	**0.0**
Request Above/(Below) Recommendation	$38,554,570	($2,448,128)	$7,102,828	$33,899,870	0.0

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. In addition to financing hospitals that participate in the CICP, approximately $13 million of the appropriation is used for hospitals that do not participate in the CICP but serve a high proportion of Medicaid clients and have costs for treating people without insurance.

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. Although there are nuances to the calculation of the UPL, the additional federal funds the state can draw under the UPL are approximately equal to the difference between Colorado's Medicaid reimbursement rates and what Medicare would have paid for the same services. 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 CICP. Many people eligible for the CICP would also qualify for federal tax credits to purchase insurance through Connect for Health Colorado, but may not be able to meet out-of-pocket expenses.

Request: The Department requests adjustments to account for the change in the federal match rate. The Department estimates that 99.5 percent of the appropriation is eligible for the standard Medicaid FMAP, but the remainder must be reimbursed at the 50 percent rate for administration.

Recommendation: Staff recommends the requested total funds, but the recommended fund split is slightly different than the Department's request based on the JBC staff calculation of the adjustment needed for the change in the FMAP.

Clinic Based Indigent Care

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

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

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

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

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

Recommendation: Staff recommends the requested total funds, but the recommended fund split is slightly different than the Department's request based on the JBC staff calculation of the adjustment needed for the change in the FMAP. This program is discretionary, rather than a required component of Medicaid.

Health Care Services Fund Programs

The appropriation for this program in FY 2011-12 was part of a financing mechanism the JBC used to reduce the need for General Fund for Medical Service Premiums with minimal impact on providers. Senate Bill 11-219, sponsored by the JBC, used half of the tobacco tax money deposited in the Primary Care Fund to finance supplemental payments to clinics, rather than primary care grants. The supplemental payments to clinics were eligible for federal financial participation, and so providers received approximately the same total funds. Then the remaining money in the Primary Care Fund was appropriated to offset the need for General Fund in the Medical Service Premiums line item. This financing was only possible under the constitutional provisions governing the tobacco tax because the General Assembly passed SJR 11-009 declaring a fiscal emergency. The Department did not request funding for FY 2015-16 and staff does not recommend funding.

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.

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

Recommendation: Staff recommends the requested total funds, but the recommended fund split is slightly different than the Department's request based on the JBC staff calculation of the adjustment needed for the change in the FMAP. This program is discretionary, rather than a required component of Medicaid.

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.

Request: The Department requests continuation funding.

Recommendation: Staff recommends an update based on the December forecast of tobacco tax revenues approved by the JBC. The staff recommendation is $3,993 higher than the Department's request.

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.

In FY 2011-12 S.B. 11-219, sponsored by the JBC, used half of the tobacco tax money deposited in the Primary Care Fund to finance supplemental payments to clinics, rather than primary care grants. The supplemental payments to clinics were eligible for federal financial participation, and so providers received approximately the same total funds. Then the remaining money in the

Primary Care Fund was appropriated to offset the need for General Fund in the Medical Service Premiums line item. This financing was only possible under the constitutional provisions governing the tobacco tax because the General Assembly passed SJR 11-009 declaring a fiscal emergency.

Request: The Department requests *R14 Primary Care Fund audit* to move some of the tobacco tax money from this line item to the Executive Director's Office to finance auditing of the program and better reflect the administrative staff time devoted to the program.

Recommendation: Staff recommends: (1) an increase of $252,890 based on the Legislative Council Staff's December forecast of tobacco tax revenue; (2) a portion of *R14 Primary Care Fund audit*, discussed in more detail below.

➔ R14 Primary Care Fund audit

Request: The Department requests transferring a total of **$**126,056 tobacco tax cash funds out of the Primary Care Fund Program line item with $50,000 going to the Professional Audit Contract line item and $76,056 to the Personal Services line item. The audit funds would ensure applicants are reporting data consistently for use in the formula allocation of the grant funds. The Department explains that the reallocation of funding to personal services would more accurately reflect the portion of administrative costs devoted to this program.

Recommendation: Staff recommends the portion of the request related to auditing, but not the reallocation to personal services. The Department does not currently audit the data submitted by providers that is used to determine eligibility for grants and the formula allocation of funds to eligible providers. The providers must use a third party to verify their data, but the Department does not have procedures to ensure consistent sampling methodologies and certification practices. The proposed auditing is a reasonable precaution to ensure the availability and quality of services funded through the program.

The request to transfer funds to the personal services line item does not make sense to the JBC staff. The Department indicates that the General Fund and Hospital Provider Fee have been absorbing administrative costs related to the Primary Care Fund grant program, but the Department is proposing an increase in total funds for personal services, rather than a rebalancing of fund sources that includes a corresponding reduction in resources from the General Fund and Hospital Provider Fee. This implies that the Department believes the Primary Care Fund is generating additional work, but the Department is not requesting additional FTE. Nor has the Department provided any evidence that the workload created by the Primary Care Grant program has changed in recent years. The Department says the money would be used to, "alleviate existing needs including costs of centralized department functions, such as budget, data analysis, accounting, management and supervision." This suggests to the JBC staff that the Department plans to use the money to support existing salaries for budget, data analysis, accounting, management and supervision, which would be inappropriate without a corresponding reduction in money from another fund source. In addition, the Department says, "Funds also may be used for short-term temporary staff for workload associated with the proposed compliance audit." This sounds to the JBC staff like a more reasonable use of the funds, but it is the secondary purpose, the Department suggests it may not happen, and the Department did not

submit any evidence to support this specific workload level. Overall, the JBC staff has too many concerns about how the money will be used to recommend approval of the request.

The JBC staff does believe some rebalancing between the sources of funds may need to occur in the Executive Director's Office, but this rebalancing should be cost neutral in total funds. Also, it should be done with consideration for all fund sources, rather than piecemeal with just the Primary Care Fund. This is why the JBC staff recommended during the supplemental process, and the JBC approved, a request to the Department to develop an improved plan that can be updated annually for allocating administrative costs by state cash fund.

Primary Care Grant Program Special Distributions

This line item was funded in FY 2011-12 as part of the financing that occurred in S.B. 11-219 to minimize the adverse impacts on some providers. No funding is requested or recommended for FY 2015-16.

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. The federal match rate for CHP+ is 65 percent, but 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. The portion of the line item related to Medicaid is funded at the 50 percent Medicaid administrative match rate and is based on a time allocation model approved by the federal government.

Request: The Department requests a negative annualization for FY 14-15 R12 Administrative contract reprocurement that provided one-time funding related to obtaining a new vendor and a positive annualization for the implementation of S.B. 13-200 that expanded Medicaid eligibility and was expected to result in more people enrolling in CHP+ from among the eligible but not enrolled due to increased awareness.

Recommendation: Staff recommends the requested funding based on the expected administrative costs associated with 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+ is scheduled to increase by 23 percentage points.

CHP+ Enhanced Federal Medical Assistance Percentage (eFMAP)					
State Fiscal Year	Ave. FMAP	eFMAP by Quarter (of state fiscal year)			
		Q1	Q2	Q3	Q4
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

Request: The Department requests

- *R3 Children's Basic Health Plan*
- *R6 Medicaid and CHP+ enrollment simplification*
- Adjustments to account for the change in the FMAP rate
- Annualizations of prior year budget decisions

Recommendation: The staff recommendation is summarized in the table below and select components of the recommendation are detailed in the arrowed items below the table.

Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs					
	Total Funds	**General Fund**	**Cash Funds**	**Federal Funds**	**FTE**
FY 2014-15 Appropriation					
HB 14-1336 (Long Bill)	$199,702,385	$22,254,482	$48,226,542	$129,221,361	0.0
Other legislation	129,831	44,519	0	85,312	0.0
SB 15-147 (Supplemental)	(15,923,038)	(4,761,426)	237,914	(11,399,526)	0.0
Recommended Long Bill Supplemental	(22,766,851)	(6,961,976)	4,855,234	(20,660,109)	0.0
TOTAL	**$161,142,327**	**$10,575,599**	**$53,319,690**	**$97,247,038**	**0.0**

Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2015-16 Recommended Appropriation					
FY 2014-15 Appropriation	$161,142,327	$10,575,599	$53,319,690	$97,247,038	0.0
Annualize prior year budget decisions	3,189,482	(1,554,219)	599,171	4,144,530	0.0
FMAP change	0	(18,258,879)	(9,007,446)	27,266,325	0.0
R3 Children's Basic Health Plan	2,390,026	11,763,217	(15,800,082)	6,426,891	0.0
R6 Enrollment simplification	0	0	0	0	0.0
TOTAL	**$166,721,835**	**$2,525,718**	**$29,111,333**	**$135,084,784**	**0.0**
Increase/(Decrease)	$5,579,508	($8,049,881)	($24,208,357)	$37,837,746	0.0
Percentage Change	3.5%	(76.1%)	(45.4%)	38.9%	0.0%
FY 2015-16 Executive Request:	**$205,356,454**	**$73,412**	**$36,622,225**	**$168,660,817**	**0.0**
Request Above/(Below) Recommendation	$38,634,619	($2,452,306)	$7,510,892	$33,576,033	0.0

→ **Annualize prior year budget decisions:** The staff recommendation includes annualizing the prior year legislation and budget decisions detailed in the table below.

Children's Basic Health Plan (CHP+) Medical and Dental Costs	TOTAL	General Fund	Cash Funds	Federal Funds
FY 14-15 Removal of five-year bar	$1,822,218	($229,710)	$0	$2,051,928
FY 14-15 BA11 Alignment of CHP+ oral health benefits to CHIPRA	1,178,100	(1,334,347)	599,171	1,913,276
HB 14-1213 Pharmacy benefit manager	189,164	9,838	0	179,326
TOTAL	**$3,189,482**	**($1,554,219)**	**$599,171**	**$4,144,530**

➔ R3 Children's Basic Health Plan

Request: The Department requests a change to the appropriation based on a new forecast of caseload and expenditures under current law and policy. R3 represents the Department's forecast of expenditures based on the eligibility criteria and plan benefits in current law and policy and proposed changes to the eligibility criteria or plan benefits are contained in other requests.

On February 12, 2015 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. In the comparison between the Department's request and the JBC staff recommendation the Department's request has not been updated for the February 2015 forecast, and that explains most of the difference from the staff recommendation. The November request incorporated data through June 2014 while the February forecast includes data through at least December 2014.

The February forecast is lower than the FY 2014-15 appropriations by $22.8 million total funds and $7.0 million General Fund, primarily due to a reduction in the caseload forecast of 15,048.

The reduced caseload assumptions carry forward into FY 2015-16 and result in the February 2015 expenditure forecast being $37.7 million total funds lower than the November request. However, where the November request included no General Fund for CHP+ due to the increase in the eFMAP, the February forecast assumes $2.1 million General Fund to account for some federal disallowances of prior year payments.

The table below summarizes the changes in expenditure projected in the February 2015 forecast compared to the appropriation.

CHP+ February 2015 Forecast				
	Total	General Fund	Cash Funds	Federal Funds
FY 14-15 Appropriation	$183,909,178	$17,537,575	$48,464,456	$117,907,147
FY 14-15 February 2015 projection	161,142,327	10,575,599	53,319,690	97,247,038
Difference	**($22,766,851)**	**($6,961,976)**	**$4,855,234**	**($20,660,109)**
Percent	-12.4%	-39.7%	10.0%	-17.5%
FY 14-15 February 2015 projection	$161,142,327	$10,575,599	$53,319,690	$97,247,038
Annualizations	3,189,482	(1,554,219)	599,171	4,144,530
FMAP	0	(18,258,879)	(9,007,446)	27,266,325
FY 15-16 Base	164,331,809	(9,237,499)	44,911,415	128,657,893
FY 15-16 February 2015 projection	166,721,835	2,525,718	29,111,333	135,084,784
Difference	**$2,390,026**	**$11,763,217**	**($15,800,082)**	**$6,426,891**
Percent	1.5%	-127.3%	-35.2%	5.0%

In total funds the Department is projecting little change. Most of the difference from FY 2014-15 is financing adjustments to account for the large increase in the FMAP rate and the General Fund cost of disallowances from prior years.

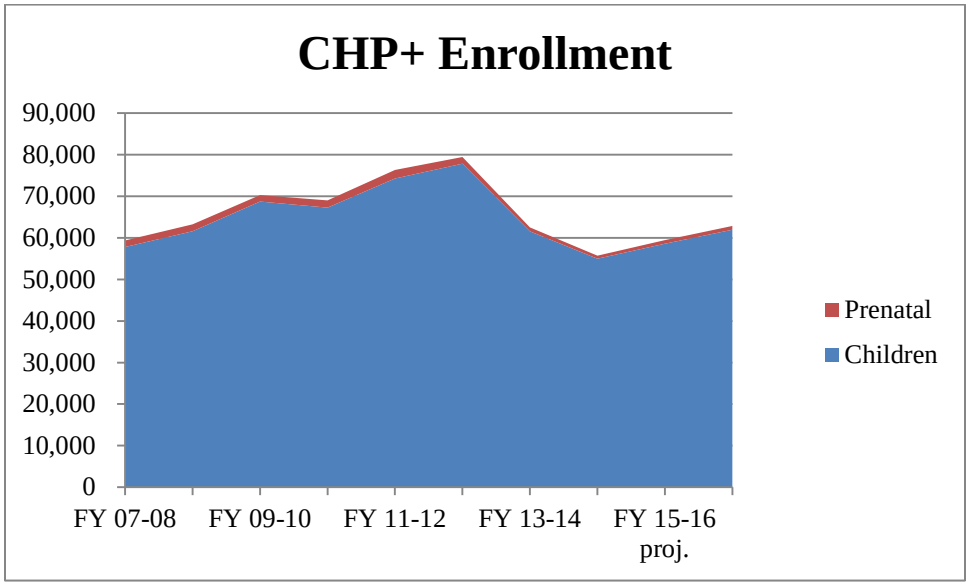
Recommendation: Staff recommends using the Department's February 2015 forecast of enrollment and expenditures to modify both the FY 2014-15 and FY 2015-16 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

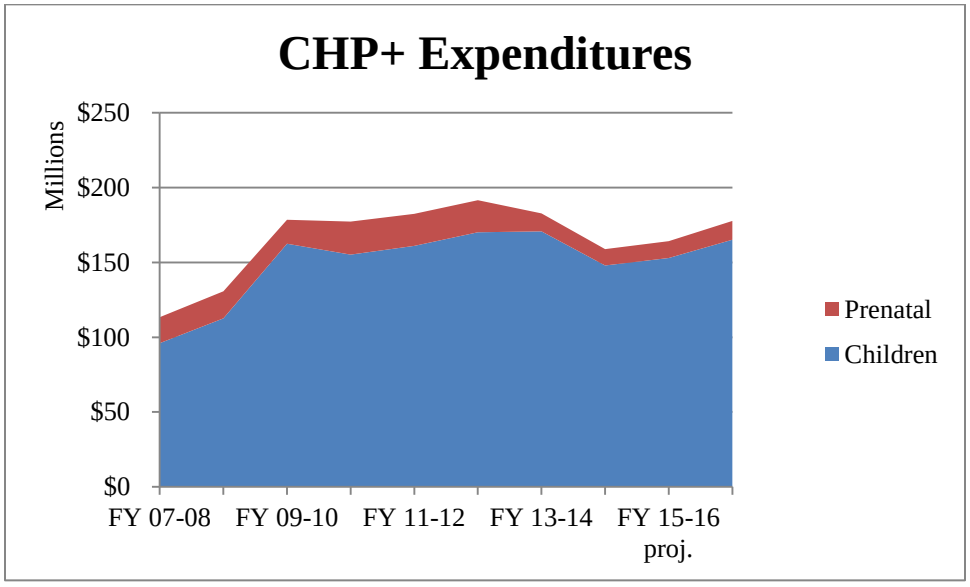
For FY 2015-16 there are two significant stories that explain the difference in the projection. First, for FY 2015-16 enrollment growth is expected to be relatively modest. The Department believes the "welcome mat" effect for CHP+ is smaller than originally anticipated in the fiscal note for S.B. 13-200. The "welcome mat" effect on enrollment occurred more quickly in FY 2014-15 than originally anticipated, resulting in a higher enrollment estimate for that fiscal year, but the overall population is less than expected, resulting in a lower enrollment estimate for FY 2015-16. Second, the enhanced federal medical assistance percentage is scheduled to grow by 23 percentage points beginning in October 2015, dramatically reducing the state share of costs for CHP+.

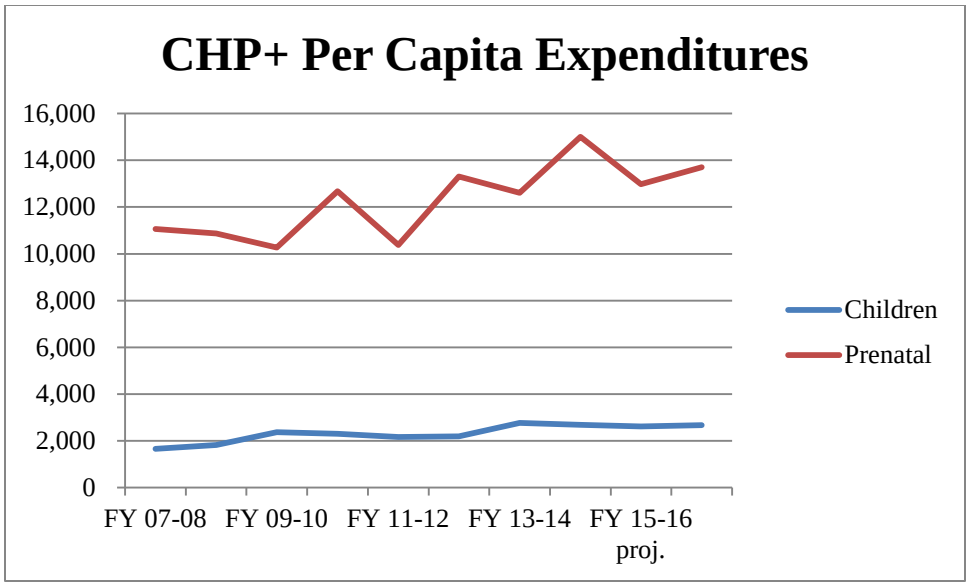
Although the enhanced FMAP rate for CHP+ is scheduled to increase in October 2015, the reauthorization of federal funding for CHP+ has not yet occurred. There is some risk that federal

funding might not be reauthorized, but the Department believes this is unlikely based on the level of support the program has received at the national level in prior years.

If federal funding for CHP+ is not reauthorized, Colorado would have a few months before enhanced federal funding ran out. This is because federal funding for CHP+ is provided in block grants. If Colorado doesn't use the entire block grant in a fiscal year, then the spending authority rolls forward to the next year. For several years the federal formula for determining Colorado's block grant has resulted in an over allocation compared to Colorado's need. Based on the revised CHP+ forecast, the Department anticipates that roll over block grant funding would allow continued operation of CHP+ until the 2015 legislative session when the General Assembly could take action.







➔ R6 Enrollment simplification (CHP+ fee grace period)

Request: In this portion of R6 the Department requests funding to allow CHP+ applicants a one-month grace period to pay the annual enrollment fee. The other portion of R6 related to Medicaid is discussed under the Medical Services Premiums line item.

Providing the one-month grace period would allow applicants to receive a real-time eligibility determination when they apply on-line and immediately begin receiving services. In calendar year 2013 there were 5,383 clients in Colorado who applied and met the income qualifications for CHP+ but were deemed ineligible for failure to pay the enrollment fee. The Department assumes that if provided a one-month grace period to pay the annual enrollment fee that 90 percent of this population would follow through. This is based on a large portion of clients who reapply within a short period of time and pay the annual enrollment fee. The remaining 10 percent would be eligible for services for one month and then be denied services.

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

Recommendation: Staff does not recommend approval of the request. One of the criteria for participation in the CHP+ program is to pay the annual enrollment fee. The JBC staff does not believe the Department has made a compelling case for providing services before people pay the enrollment fee. One issue the Department has raised is that people applying on-line cannot receive an instant determination of eligibility. However, staff does not see why the Department could not indicate to applicants that they meet the eligibility criteria provided they pay the enrollment fee. Another issue the Department raised is that the courts view the delay between when an applicant applies and when they pay the enrollment fee as a delay in processing the application. This is a problem with the judicial performance measure and not a problem with the processing of the application, as the Department has done everything it can until the client pays.

Changing the Department's enrollment procedures based on a flawed judicial performance measure does not make sound policy.

If the JBC wants to implement the policy, the JBC staff believes the Department made a technical error in estimating the cost. The table below summarizes the JBC staff estimate of the cost of the policy change.

R6 CHP+ fee grace period		
	FY 15-16	FY 15-16
TOTAL	$977,730	$1,266,591
General Fund	87,204	74,574
Hospital Provider Fee	80,968	71,086
CHP+ Fees	0	0
Federal Funds	$809,558	$1,120,931

(5) OTHER MEDICAL SERVICES

Other Medical Services	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
FY 2014-15 Appropriation						
HB 14-1336 (Long Bill)	$174,198,027	$103,657,959	$31,424,455	$2,491,722	$36,623,891	0.0
Other legislation	75,000	0	0	0	75,000	0.0
SB 15-147 (Supplemental)	17,484,548	10,038,677	5,876,968	0	1,568,903	0.0
Recommended Long Bill Supplemental	(1,824,237)	(1,824,237)	0	0	0	0.0
TOTAL	**$189,933,338**	**$111,872,399**	**$37,301,423**	**$2,491,722**	**$38,267,794**	**0.0**
FY 2015-16 Recommended Appropriation						
FY 2014-15 Appropriation	$189,933,338	$111,872,399	$37,301,423	$2,491,722	$38,267,794	0.0
Annualize prior year budget decisions	3,013,058	2,962,510	125,548	0	(75,000)	0.0
FMAP change	0	2,254	38,622	0	(40,876)	0.0
R4 Medicare Modernization Act	8,867,899	9,297,324	0	0	(429,425)	0.0
R19 Public school health services	5,476,888	0	2,683,127	0	2,793,761	0.0
BA6 CBMS funding simplification	0	0	0	0	0	0.0
BA16 Public school health services	633,911	0	103,393	0	530,518	0.0
TOTAL	**$207,925,094**	**$124,134,487**	**$40,252,113**	**$2,491,722**	**$41,046,772**	**0.0**
Increase/(Decrease)	$17,991,756	$12,262,088	$2,950,690	$0	$2,778,978	0.0
Percentage Change	9.5%	11.0%	7.9%	0.0%	7.3%	0.0%
FY 2015-16 Executive Request:	**$210,729,286**	**$126,941,136**	**$40,252,113**	**$2,491,722**	**$41,044,315**	**0.0**
Request Above/(Below) Recommendation	$2,804,192	$2,806,649	$0	$0	($2,457)	0.0

Old Age Pension State Medical Program

Article XXIV, Section 7 of the Colorado Constitution and Section 25.5-2-101, C.R.S., require a program to provide 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. The program costs may not exceed $10.0 million per fiscal year. The source of cash funds is a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund.

With the expansion of Medicaid authorized in S.B. 13-200 a large portion of the people eligible for the Old Age Pension are also eligible for Medicaid, and so a portion of the funds are being used 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.

Request: The Department requests annualization of S.B. 11-180 Dental health seniors and S.B. 13-200 Medicaid eligibility expansion. The Department also requests *BA6 CBMS funding simplification*.

Recommendation: Staff recommends the request with the annualizations. The amount for *BA6 CBMS funding simplification* is based on the Department's request, but will be updated to reflect the JBC's decisions during figure setting for the Department of Human Services.

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.

Request: The Department requests annualization of S.B. 14-144 that expanded the Commission's duties related to rural family medicine programs and required a one-time report on family medicine residency programs and the primary care workforce. The Department also requests adjustments to account for the change in the FMAP rate.

Recommendation: Staff recommends the requested funding. Traditionally this line item has received periodic rate adjustments rather than the community provider rate increase. In FY 2013-14 the JBC added $630,000 total funds to improve care coordination and stabilize the recruitment program (a 3.6 percent increase). In addition, S.B. 13-264 added $1.0 million total funds to develop residency training programs.

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.

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

Recommendation: Staff recommends the total requested funding, but slightly less General Fund than the Department's request based on the JBC staff calculation of the FMAP adjustment. Traditionally these line item have received periodic rate adjustments rather than the community provider rate increase. For example, in FY 2014-15 the Denver Health and Hospital Authority line item received an increase of $973,000, or a 53 percent increase. A 2.7 percent increase on both line items, consistent with the JBC's common policy community provider rate increase, would cost $92,827 total funds including $45,681 General Fund.

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. In addition, the required state contribution started at 90 percent and phases down each year by 1.67 percent until 2015, where it remains at 75 percent.

This is a 100 percent state obligation and there is no federal match. However, for the past several years the General Assembly has 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.

Request: The Department requests *R4 Medicare Modernization Act* to update the appropriation to match the forecasted state obligation.

Recommendation: Staff recommends adjusting both the FY 2014-15 and FY 2015-16 appropriations based on an updated February 2015 forecast discussed in more detail below.

➔ R4 Medicare Modernization Act

Request: The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation. 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 12, 2015 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. In the comparison between the Department's request and the JBC staff recommendation the

Department's request has not been updated for the February 2015 forecast, and that explains most of the difference from the staff recommendation. The November request incorporated data through June 2014 while the February forecast includes data through at least December 2014.

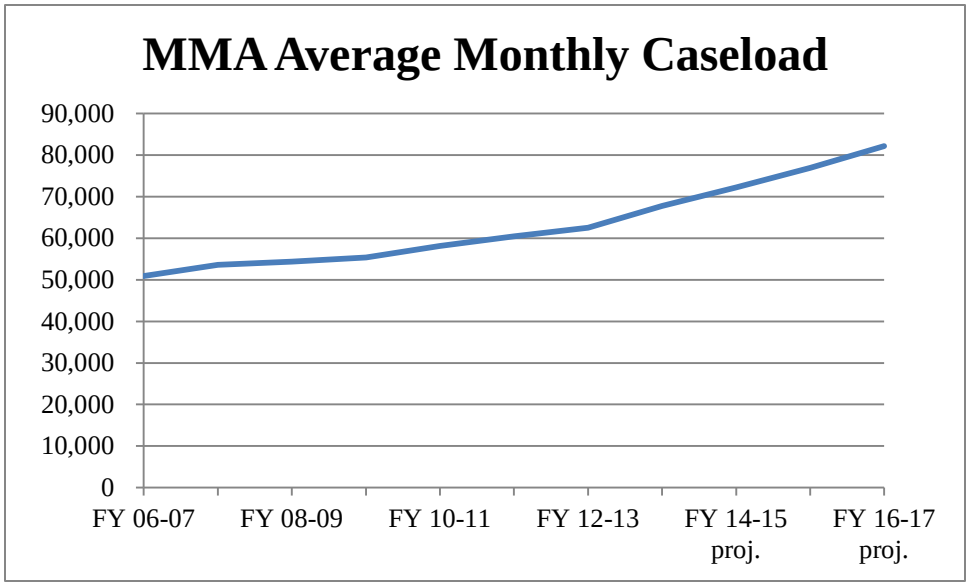
Compared to the November request the February forecast is $1.8 million lower in FY 2014-15 and $2.8 million lower in FY 2015-16.

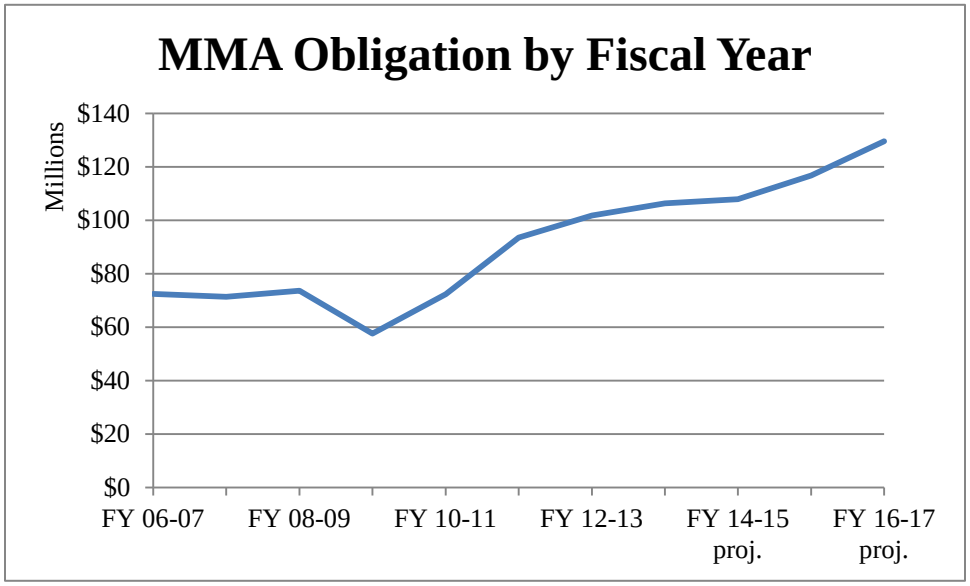
The table below summarizes the February 2015 estimate of the state obligation.

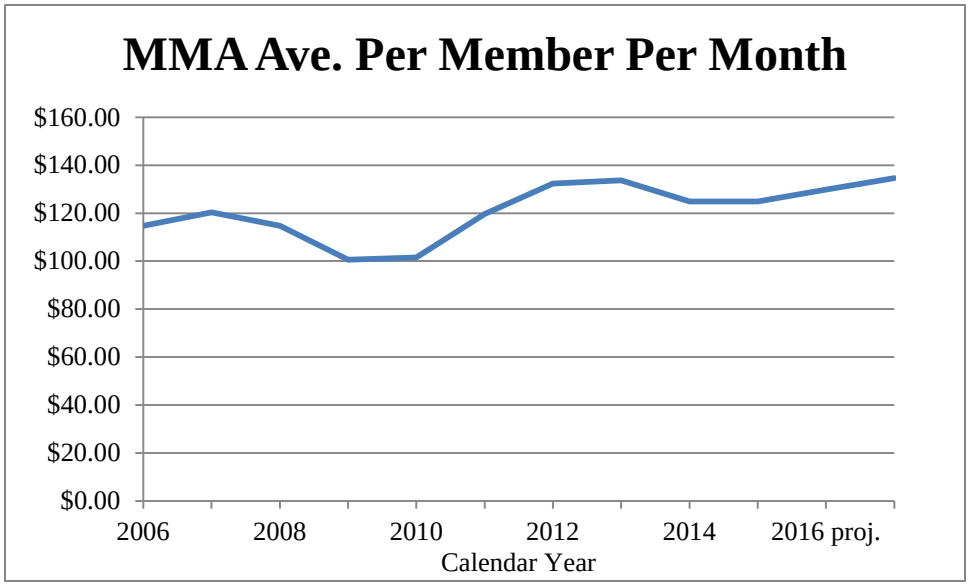
Medicare Modernization Act February 2015 Forecast			
	Total	General Fund	Federal Funds
FY 14-15 Appropriation	$109,773,087	$109,343,662	$429,425
FY 14-15 February 2015 projection	107,948,850	107,519,425	429,425
Difference	**($1,824,237)**	**($1,824,237)**	**$0**
Percent	-1.7%	-1.7%	0.0%
FY 14-15 February 2015 projection	$107,948,850	$107,519,425	$429,425
FY 15-16 February 2015 projection	116,816,749	116,816,749	0
Difference	**$8,867,899**	**$9,297,324**	**($429,425)**
Percent	8.2%	8.6%	-100.0%

Recommendation: Staff recommends using the Department's February 2015 forecast of enrollment and expenditures to modify both the FY 2014-15 and FY 2015-16 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. Part of the projected increase for FY 2015-16 is attributable to the elimination of the phase down percentage in the federal formula beginning in calendar year 2015. 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.


MMA Average Monthly Caseload
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
FY 06-07
FY 08-09
FY 10-11
FY 12-13
FY 14-15 proj.
FY 16-17 proj.


MMA Obligation by Fiscal Year
Millions
$140
$120
$100
$80
$60
$40
$20
$0
FY 06-07
FY 08-09
FY 10-11
FY 12-13
FY 14-15 proj.
FY 16-17 proj.



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.

Request: The Department requests *R19/BA16 Public school health services* to make adjustments based on a projected increase in certified public expenditures by schools. The Department also requests adjustments to account for the change in the FMAP rate. These reimbursements are based on actual allowable costs and certified public expenditures, and so no additional community provider rate increase was requested.

Recommendation: Staff recommends the requested funds. 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 (see the discussion of Medicaid enrollment under the Medical Services Premiums line item). 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. The staff recommendation for continuation funding is with the understanding that the actual certified public expenditures are not in the direct control of the Department and that the available data to forecast these certified public expenditures is limited, and so there may need to be a true-up at a later date.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID FUNDED PROGRAMS

Funding recommendations for the line items in this division are addressed in figure setting presentations for the Department of Human Services.

Long Bill Footnotes and Requests for Information

LONG BILL FOOTNOTES

Staff recommends **continuing** the following footnotes:

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

Comment: The footnote explains the purpose of the appropriation.

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

Comment: The footnote explains the purpose of the appropriation.

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

Comment: This footnote authorizes transfers between line items in the division Department of Human Services Medicaid-Funded Programs.

Staff recommends **discontinuing** the following footnotes:

10 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects – This appropriation includes $150,000 for the purpose of consulting services and stakeholder outreach to

assist the Department in developing a plan for addressing disparities in Medicaid rates that limit client access to cost-effective care.

Comment: The Department completed the requested study and no ongoing funding is recommended. See the JBC staff recommendation regarding a rate setting process under the Personal Services line item.

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

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

Comment: The JBC staff believes this sort of caseload and per capita information is better provided in the Long Bill Narrative and Appropriations Report. When the table is included in the Long Bill it creates confusion about whether the table needs to be adjusted for every amendment or supplemental. Generally, the table has not been updated, resulting in a footnote in the Long Bill that does not reflect the General Assembly's final action.

13 Department of Health Care Policy and Financing, Medical Service Premiums -- This appropriation includes $1,015,383 total funds, including $500,000 General Fund and $515,383 federal funds for the purpose of increasing the current $10,000 lifetime cap on home modifications by an amount projected to be feasible within this level of funding, up to a maximum lifetime cap of $20,000.

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

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

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

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

Comment: The Department is paying primary care providers for oral health risk assessments and fluoride varnishes as described in the footnote.

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

Comment: The JBC staff believes this sort of caseload and per capita information is better provided in the Long Bill Narrative and Appropriations Report. When the table is included in the Long Bill it creates confusion about whether the table needs to be adjusted for every amendment or supplemental. Generally, the table has not been updated, resulting in a footnote in the Long Bill that does not reflect the General Assembly's final action.

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

Comment: The JBC staff believes this sort of caseload and per capita information is better provided in the Long Bill Narrative and Appropriations Report. When the table is included in the Long Bill it creates confusion about whether the table needs to be adjusted for every amendment or supplemental. Generally, the table has not been updated, resulting in a footnote in the Long Bill that does not reflect the General Assembly's final action.

REQUESTS FOR INFORMATION

Staff recommends CONTINUATION of the following requests for information:

3. Department of Health Care Policy and Financing, Executive Director's Office -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, ~~mental~~ 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 a long-standing report that provides useful information.

4. Department of Health Care Policy and Financing, Medical Services Premiums -- The Department is requested to submit a report by ~~November 1, 2014~~ November 1, 2015, 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: This is the Department's primary initiative to improve the quality and cost-effectiveness of care and on-going report would be useful.

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

   Comment: This is a long-standing report that provides useful information.

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

   Comment: This is a long-standing report that provides useful information.

Staff recommends **DISCONTINUING** the following footnotes:

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

Comment: The Department submitted the report as requested.

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

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

Appendix A: Number Pages

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Sue Birch, Executive Director**						
(1) EXECUTIVE DIRECTOR'S OFFICE						
(A) General Administration						
Personal Services	22,338,943	25,782,006	26,037,911	28,165,209	28,110,084	*
FTE	315.9	363.7	360.4	384.2	386.8	
General Fund	8,062,731	8,477,796	8,977,158	9,755,159	9,803,863	
Cash Funds	1,922,374	2,564,595	2,676,189	2,938,818	2,860,502	
Reappropriated Funds	1,176,645	1,613,082	1,524,777	1,529,155	1,501,543	
Federal Funds	11,177,193	13,126,533	12,859,787	13,942,077	13,944,176	
Health, Life, and Dental	2,216,793	2,322,449	2,476,612	3,340,185	3,314,823	*
General Fund	796,479	748,152	928,931	1,238,282	1,229,116	
Cash Funds	174,652	227,867	166,066	279,426	275,911	
Reappropriated Funds	111,821	72,376	64,887	76,733	76,733	
Federal Funds	1,133,841	1,274,054	1,316,728	1,745,744	1,733,063	
Short-term Disability	33,497	42,151	64,185	61,393	61,361	*
General Fund	12,334	13,671	21,358	22,805	22,794	
Cash Funds	2,503	3,764	4,955	4,751	4,746	
Reappropriated Funds	1,309	802	1,363	1,457	1,457	
Federal Funds	17,351	23,914	36,509	32,380	32,364	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
S.B. 04-257 Amortization Equalization Disbursement	730,633	850,598	1,235,106	1,317,068	1,316,425	*
General Fund	283,141	273,870	409,819	489,740	489,507	
Cash Funds	53,468	76,148	96,428	101,903	101,814	
Reappropriated Funds	37,574	16,232	27,452	30,035	30,035	
Federal Funds	356,450	484,348	701,407	695,390	695,069	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	627,713	767,027	1,157,972	1,272,168	1,271,547	*
General Fund	242,160	246,370	384,601	473,765	473,540	
Cash Funds	45,949	68,744	90,431	98,429	98,344	
Reappropriated Funds	33,280	14,654	24,943	27,570	27,570	
Federal Funds	306,324	437,259	657,997	672,404	672,093	
Salary Survey	0	669,740	831,265	321,383	321,383	*
General Fund	0	199,437	283,209	121,695	121,695	
Cash Funds	0	53,484	64,811	24,853	24,853	
Reappropriated Funds	0	10,800	3,127	1,794	1,794	
Federal Funds	0	406,019	480,118	173,041	173,041	
Merit Pay	0	372,361	265,923	317,662	317,662	*
General Fund	0	119,442	98,565	118,042	118,042	
Cash Funds	0	28,027	19,363	26,760	26,760	
Reappropriated Funds	0	9,889	1,176	1,975	1,975	
Federal Funds	0	215,003	146,819	170,885	170,885	
Worker's Compensation	30,844	47,286	52,712	43,207	43,207	
General Fund	15,422	23,643	26,356	21,604	21,604	
Federal Funds	15,422	23,643	26,356	21,603	21,603	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
Operating Expenses	1,503,436	2,497,422	4,272,705	2,286,578	2,121,666 *
General Fund	663,213	1,141,931	2,050,231	1,045,682	962,134
Cash Funds	43,601	121,029	62,577	77,778	78,907
Reappropriated Funds	64,796	1,382	10,449	10,449	10,449
Federal Funds	731,826	1,233,080	2,149,448	1,152,669	1,070,176
Legal and Third Party Recovery Legal Services	896,802	979,454	1,426,338	1,361,512	1,361,512
General Fund	284,349	346,973	461,512	440,536	440,536
Cash Funds	162,313	153,671	251,658	240,220	240,220
Reappropriated Funds	0	0	0	0	0
Federal Funds	450,140	478,810	713,168	680,756	680,756
Administrative Law Judge Services	510,597	538,016	376,861	570,872	582,726
General Fund	211,949	219,941	146,434	221,820	226,426
Cash Funds	43,350	49,067	41,996	63,616	64,937
Federal Funds	255,298	269,008	188,431	285,436	291,363
Purchase of Services from Computer Center	1,001,906	882,219	0	0	0
General Fund	496,907	436,917	0	0	0
Reappropriated Funds	4,046	4,193	0	0	0
Federal Funds	500,953	441,109	0	0	0
Multiuse Network Payments	245,162	139,002	0	0	0
General Fund	122,581	69,501	0	0	0
Federal Funds	122,581	69,501	0	0	0

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
CORE Operations	569,048	504,637	2,717,568	1,601,045	3,367,953	*
General Fund	329,397	331,447	1,297,165	544,698	1,511,440	
Cash Funds	173,190	173,190	679,257	285,501	791,568	
Reappropriated Funds	2,052	0	0	0	0	
Federal Funds	64,409	0	741,146	770,846	1,064,945	
Information Technology Security	0	11,374	0	0	0	
General Fund	0	5,687	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	5,687	0	0	0	
Management and Administration of OIT	0	72,130	0	0	0	
General Fund	0	36,065	0	0	0	
Federal Funds	0	36,065	0	0	0	
Payment to Risk Management and Property Funds	123,841	131,604	166,889	112,673	112,673	
General Fund	61,921	65,802	83,445	56,337	56,337	
Federal Funds	61,920	65,802	83,444	56,336	56,336	
Vehicle Lease Payments	0	0	0	0	0	
General Fund	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Leased Space	659,770	747,035	1,288,236	2,203,793	2,203,793	*
General Fund	216,966	195,437	519,194	885,015	885,015	
Cash Funds	99,625	138,874	124,924	216,881	216,881	
Federal Funds	343,179	412,724	644,118	1,101,897	1,101,897	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
Capitol Complex Leased Space	394,599	496,658	386,909	599,833	599,833	
General Fund	197,300	248,329	193,455	299,917	299,917	
Federal Funds	197,299	248,329	193,454	299,916	299,916	
Payments to OIT	0	201,448	1,578,757	3,319,062	3,326,076	
General Fund	0	100,724	780,676	1,649,384	1,652,870	
Cash Funds	0	0	4,826	10,147	10,168	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	100,724	793,255	1,659,531	1,663,038	
Scholarships for research using the All-Payer Claims Database	0	0	500,000	500,000	500,000	
General Fund	0	0	500,000	500,000	500,000	
General Professional Services and Special Projects	3,350,149	7,145,144	7,854,899	9,303,370	9,105,239	*
General Fund	1,353,401	2,048,401	2,646,862	3,093,087	3,076,521	
Cash Funds	354,610	442,324	1,075,000	1,463,609	1,298,609	
Federal Funds	1,642,138	4,654,419	4,133,037	4,746,674	4,730,109	
SUBTOTAL - (A) General Administration	35,233,733	45,199,761	52,690,848	56,697,013	58,037,963	
FTE	315.9	363.7	360.4	384.2	386.8	
General Fund	13,350,251	15,349,536	19,808,971	20,977,568	21,891,357	
Cash Funds	3,075,635	4,100,784	5,358,481	5,832,692	6,094,220	
Reappropriated Funds	1,431,523	1,743,410	1,658,174	1,679,168	1,651,556	
Federal Funds	17,376,324	24,006,031	25,865,222	28,207,585	28,400,830	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	4,672,189	4,426,141	6,105,822	6,105,822	6,105,822
General Fund	1,383,261	1,257,350	1,895,914	1,895,914	1,895,914
Cash Funds	0	0	110,000	110,000	110,000
Federal Funds	3,288,928	3,168,791	4,099,908	4,099,908	4,099,908
Life Safety Code Inspections for Health Facilities, Transfer to Department of Public Safety	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
Nurse Home Visitor Program, Transfer from the Department of Human Services	964,536	930,166	3,010,000	3,010,000	3,010,000
General Fund	0	(11,847)	0	0	0
Reappropriated Funds	481,337	465,083	1,482,199	1,481,221	1,481,221
Federal Funds	483,199	476,930	1,527,801	1,528,779	1,528,779
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	5,887	5,886	5,887	5,887	5,887
General Fund	2,943	2,943	2,944	2,944	2,944
Federal Funds	2,944	2,943	2,943	2,943	2,943
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,041	324,041	324,041	324,041	324,041
General Fund	147,369	147,369	147,369	147,369	147,369
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652
Federal Funds	162,020	162,020	162,020	162,020	162,020

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
Reviews, Transfer to the Department of Regulatory Agencies	4,818	4,160	10,000	10,000	10,000
General Fund	2,409	2,080	5,000	5,000	5,000
Federal Funds	2,409	2,080	5,000	5,000	5,000
Public School Health Services Administration, Transfer to the Department of Education	145,640	143,721	160,335	160,335	160,335
Reappropriated Funds	0	143,721	160,335	160,335	160,335
Federal Funds	145,640	0	0	0	0
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	0	0	205,146	206,185	206,185
General Fund	0	0	102,573	103,092	103,092
Federal Funds	0	0	102,573	103,093	103,093
Enhanced Prenatal Care Training, Transfer to the Department of Public Health and Environment	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
SUBTOTAL - (B) Transfers to Other Departments	6,117,111	5,834,115	9,821,231	9,822,270	9,822,270
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,535,982	1,397,895	2,153,800	2,154,319	2,154,319
Cash Funds	0	0	110,000	110,000	110,000
Reappropriated Funds	495,989	623,456	1,657,186	1,656,208	1,656,208
Federal Funds	4,085,140	3,812,764	5,900,245	5,901,743	5,901,743

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(C) Information Technology Contracts and Projects					
Medicaid Management Information System					
Maintenance and Projects	28,115,228	30,637,273	30,208,908	32,759,633	32,759,633 *
General Fund	6,273,361	6,594,356	6,247,415	6,817,349	6,817,349
Cash Funds	1,254,472	1,181,953	1,737,503	1,919,380	1,919,380
Reappropriated Funds	100,328	293,350	293,350	293,350	293,350
Federal Funds	20,487,067	22,567,614	21,930,640	23,729,554	23,729,554
MMIS Reprocurement Contracts	0	9,933,790	30,177,141	41,437,857	41,437,857
General Fund	0	967,847	2,736,240	4,164,679	4,164,679
Cash Funds	0	100,036	552,209	1,177,899	1,177,899
Federal Funds	0	8,865,907	26,888,692	36,095,279	36,095,279
MMIS Reprocurement Contracted Staff	0	920,936	3,022,511	4,448,524	4,448,524
General Fund	0	89,321	273,730	353,814	353,814
Cash Funds	0	20,954	77,125	131,360	131,360
Federal Funds	0	810,661	2,671,656	3,963,350	3,963,350
Fraud Detection Software Contract	144,054	144,565	250,000	250,000	250,000
General Fund	36,419	38,938	62,500	62,500	62,500
Federal Funds	107,635	105,627	187,500	187,500	187,500
Centralized Eligibility Vendor Contract Project	4,695,409	6,875,044	8,342,477	9,133,612	9,133,612
Cash Funds	2,335,093	2,816,997	3,053,888	3,145,326	3,145,326
Federal Funds	2,360,316	4,058,047	5,288,589	5,988,286	5,988,286

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
CBMS Modernization Project	0	789,500	0	0	0	*
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	789,500	0	0	0	
Federal Funds	0	0	0	0	0	
Health Information Exchange Maintenance and Projects	0	0	7,028,926	14,168,746	13,668,746	
General Fund	0	0	802,893	2,321,875	1,821,875	
Federal Funds	0	0	6,226,033	11,846,871	11,846,871	
CBMS Temporary Line Item	0	0	0	11,627,217	11,627,217	*
General Fund	0	0	0	4,043,412	4,043,412	
Cash Funds	0	0	0	1,773,972	1,773,972	
Federal Funds	0	0	0	5,809,833	5,809,833	
SUBTOTAL - (C) Information Technology Contracts and Projects	32,954,691	49,301,108	79,029,963	113,825,589	113,325,589	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	6,309,780	7,690,462	10,122,778	17,763,629	17,263,629	
Cash Funds	3,589,565	4,119,940	5,420,725	8,147,937	8,147,937	
Reappropriated Funds	100,328	1,082,850	293,350	293,350	293,350	
Federal Funds	22,955,018	36,407,856	63,193,110	87,620,673	87,620,673	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	117,011	140,257	278,974	278,974	278,974
General Fund	53,532	59,400	63,966	63,966	63,966
Cash Funds	4,177	9,932	73,928	73,928	73,928
Reappropriated Funds	1,593	1,593	1,593	1,593	1,593
Federal Funds	57,709	69,332	139,487	139,487	139,487
Contracts for Special Eligibility Determinations	3,800,160	6,017,314	11,695,703	11,402,297	11,402,297
General Fund	826,993	945,228	1,116,459	969,756	969,756
Cash Funds	827,925	1,763,845	4,343,468	4,343,468	4,343,468
Federal Funds	2,145,242	3,308,241	6,235,776	6,089,073	6,089,073
County Administration	25,338,161	34,733,208	41,718,342	39,536,478	39,536,478
General Fund	9,894,404	8,558,486	10,572,620	11,114,448	11,114,448
Cash Funds	0	4,460,662	5,707,810	5,859,623	5,859,623
Federal Funds	15,443,757	21,714,060	25,437,912	22,562,407	22,562,407
Hospital Provider Fee County Administration	2,029,164	4,654,643	9,723,802	11,104,684	11,104,684
Cash Funds	1,014,582	1,752,329	3,208,371	3,585,446	3,585,446
Federal Funds	1,014,582	2,902,314	6,515,431	7,519,238	7,519,238
Administrative Case Management	1,866,788	1,648,048	869,744	869,744	869,744
General Fund	933,394	824,024	434,872	434,872	434,872
Federal Funds	933,394	824,024	434,872	434,872	434,872

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
Affordable Care Act Implementation and Technical Support and Eligibility Determination Overflow Contingency	0	862,471	986,436	0	0
General Fund	0	268,702	314,109	0	0
Federal Funds	0	593,769	672,327	0	0
Medical Assistance Sites	0	0	1,152,000	1,452,000	1,452,000
General Fund	0	0	0	0	0
Cash Funds	0	0	288,000	363,000	363,000
Federal Funds	0	0	864,000	1,089,000	1,089,000
Customer Outreach	4,917,340	4,943,170	6,924,550	6,194,093	6,194,093
General Fund	2,371,809	2,384,724	2,860,895	2,686,447	2,686,447
Cash Funds	86,861	86,861	336,621	336,621	336,621
Federal Funds	2,458,670	2,471,585	3,727,034	3,171,025	3,171,025
SUBTOTAL - (D) Eligibility Determinations and Client Services	38,068,624	52,999,111	73,349,551	70,838,270	70,838,270
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	14,080,132	13,040,564	15,362,921	15,269,489	15,269,489
Cash Funds	1,933,545	8,073,629	13,958,198	14,562,086	14,562,086
Reappropriated Funds	1,593	1,593	1,593	1,593	1,593
Federal Funds	22,053,354	31,883,325	44,026,839	41,005,102	41,005,102

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
(E) Utilization and Quality Review Contracts						
Professional Service Contracts	6,435,636	6,121,625	11,856,020	11,881,984	11,881,984	
General Fund	1,799,872	1,784,427	3,152,257	3,183,748	3,183,748	
Cash Funds	103,638	93,766	461,089	461,089	461,089	
Federal Funds	4,532,126	4,243,432	8,242,674	8,237,147	8,237,147	
SUBTOTAL - (E) Utilization and Quality Review Contracts	6,435,636	6,121,625	11,856,020	11,881,984	11,881,984	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	1,799,872	1,784,427	3,152,257	3,183,748	3,183,748	
Cash Funds	103,638	93,766	461,089	461,089	461,089	
Federal Funds	4,532,126	4,243,432	8,242,674	8,237,147	8,237,147	
(F) Provider Audits and Services						
Professional Audit Contracts	2,207,726	2,382,760	2,463,406	2,813,406	2,813,406	*
General Fund	891,703	1,066,015	969,283	1,119,283	1,119,283	
Cash Funds	0	204,210	262,420	312,420	312,420	
Reappropriated Funds	212,160	0	0	0	0	
Federal Funds	1,103,863	1,112,535	1,231,703	1,381,703	1,381,703	
SUBTOTAL - (F) Provider Audits and Services	2,207,726	2,382,760	2,463,406	2,813,406	2,813,406	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	891,703	1,066,015	969,283	1,119,283	1,119,283	
Cash Funds	0	204,210	262,420	312,420	312,420	
Reappropriated Funds	212,160	0	0	0	0	
Federal Funds	1,103,863	1,112,535	1,231,703	1,381,703	1,381,703	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	531,346	564,482	700,000	700,000	700,000
Cash Funds	265,673	282,241	350,000	350,000	350,000
Federal Funds	265,673	282,241	350,000	350,000	350,000
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	531,346	564,482	700,000	700,000	700,000
FTE	0.0	0.0	0.0	0.0	0.0
Cash Funds	265,673	282,241	350,000	350,000	350,000
Federal Funds	265,673	282,241	350,000	350,000	350,000
State of Health Projects					
Transfer from General Fund to State of Health Cash Fund	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
State of Health Projects	0	0	0	0	0
Cash Funds	0	0	0	0	0
Pain Management Capacity Program	0	0	500,000	500,000	500,000
General Fund	0	0	246,212	246,212	246,212
Federal Funds	0	0	253,788	253,788	253,788
Dental Provider Network Adequacy	0	0	5,000,000	0	0
General Fund	0	0	2,500,000	0	0
Federal Funds	0	0	2,500,000	0	0

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
SUBTOTAL - State of Health Projects	0	0	5,500,000	500,000	500,000	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	2,746,212	246,212	246,212	
Cash Funds	0	0	0	0	0	
Federal Funds	0	0	2,753,788	253,788	253,788	
(H) Indirect Cost Assessment						
Indirect Cost Assessment	0	452,913	663,489	635,877	635,877	*
Cash Funds	0	121,193	141,654	178,540	145,818	
Reappropriated Funds	0	0	2,766	4,720	37,442	
Federal Funds	0	331,720	519,069	452,617	452,617	
SUBTOTAL - (H) Indirect Cost Assessment	0	452,913	663,489	635,877	635,877	
FTE	0.0	0.0	0.0	0.0	0.0	
Cash Funds	0	121,193	141,654	178,540	145,818	
Reappropriated Funds	0	0	2,766	4,720	37,442	
Federal Funds	0	331,720	519,069	452,617	452,617	
TOTAL - (1) Executive Director's Office	121,548,867	162,855,875	236,074,508	267,714,409	268,555,359	
FTE	315.9	363.7	360.4	384.2	386.8	
General Fund	37,967,720	40,328,899	54,316,222	60,714,248	61,128,037	
Cash Funds	8,968,056	16,995,763	26,062,567	29,954,764	30,183,570	
Reappropriated Funds	2,241,593	3,451,309	3,613,069	3,635,039	3,640,149	
Federal Funds	72,371,498	102,079,904	152,082,650	173,410,358	173,603,603	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	3,937,400,734	4,618,770,195	5,805,484,351	6,364,672,466	6,514,429,573 *
General Fund	847,647,042	926,160,050	992,997,993	1,091,963,430	1,066,645,444
General Fund Exempt	507,235,957	642,235,957	710,835,957	710,835,957	710,835,957
Cash Funds	639,607,454	567,267,338	556,327,440	691,475,096	708,454,281
Reappropriated Funds	2,936,892	2,936,892	0	0	0
Federal Funds	1,939,973,389	2,480,169,958	3,545,322,961	3,870,397,983	4,028,493,891
TOTAL - (2) Medical Services Premiums	3,937,400,734	4,618,770,195	5,805,484,351	6,364,672,466	6,514,429,573
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	847,647,042	926,160,050	992,997,993	1,091,963,430	1,066,645,444
General Fund Exempt	507,235,957	642,235,957	710,835,957	710,835,957	710,835,957
Cash Funds	639,607,454	567,267,338	556,327,440	691,475,096	708,454,281
Reappropriated Funds	2,936,892	2,936,892	0	0	0
Federal Funds	1,939,973,389	2,480,169,958	3,545,322,961	3,870,397,983	4,028,493,891

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS						
This section provides for behavioral health services through the purchase of services from five regional behavioral health organizations (BHOs), which manage mental health and substance use disorder services for eligible Medicaid recipients in a capitated, risk-based model. This section also contains funding for Medicaid behavioral health fee-for-service programs for those services not covered within the capitation contracts and rates. The funding for this section is primarily from the General Fund and federal Medicaid funds. Cash fund sources include the Hospital Provider Fee Cash Fund and the Breast and Cervical Cancer Prevention and Treatment Fund.						
Behavioral Health Capitation Payments	301,303,046	415,933,333	553,659,183	620,621,342	645,729,591	*
General Fund	136,833,502	151,532,141	174,885,950	191,641,708	191,547,143	
Cash Funds	13,513,748	12,402,378	4,403,548	4,902,675	5,621,589	
Federal Funds	150,955,796	251,998,814	374,369,685	424,076,959	448,560,859	
School-based Prevention and Intervention Substance Use Disorder Services	0	0	4,363,807	4,216,324	4,365,859	*
General Fund	0	0	2,000,000	1,931,346	2,000,000	
Federal Funds	0	0	2,363,807	2,284,978	2,365,859	
Behavioral Health Fee-for-service Payments	4,569,198	5,295,835	7,449,504	7,917,221	8,493,056	*
General Fund	2,253,518	2,475,020	2,457,126	2,576,708	2,779,611	
Cash Funds	0	6,385	79,515	84,197	89,888	
Federal Funds	2,315,680	2,814,430	4,912,863	5,256,316	5,623,557	
School-based Substance Abuse Prevention and Intervention Grant Program	0	0	868,656	0	0	
General Fund	0	0	868,656	0	0	
Contract Reprocurement	0	0	203,752	0	0	
General Fund	0	0	101,876	0	0	
Federal Funds	0	0	101,876	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
TOTAL - (3) Behavioral Health Community Programs	305,872,244	421,229,168	566,544,902	632,754,887	658,588,506
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	139,087,020	154,007,161	180,313,608	196,149,762	196,326,754
Cash Funds	13,513,748	12,408,763	4,483,063	4,986,872	5,711,477
Federal Funds	153,271,476	254,813,244	381,748,231	431,618,253	456,550,275

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	0	517,386	2,575,884	2,648,939	2,648,939
FTE	0.0	0.0	30.5	30.5	30.5
General Fund	0	250,167	1,369,423	1,405,951	1,405,951
Cash Funds	0	0	38,730	38,730	38,730
Federal Funds	0	267,219	1,167,731	1,204,258	1,204,258
Operating Expenses	0	57,981	967,036	292,036	967,036
General Fund	0	28,991	144,899	144,899	144,899
Cash Funds	0	0	675,000	0	675,000
Federal Funds	0	28,990	147,137	147,137	147,137
Community and Contract Management System	0	54,700	137,480	137,480	137,480
General Fund	0	36,851	89,362	89,362	89,362
Federal Funds	0	17,849	48,118	48,118	48,118
Support Level Administration	0	32,490	57,368	57,368	57,368
General Fund	0	16,245	28,684	28,684	28,684
Federal Funds	0	16,245	28,684	28,684	28,684
System Capacity	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
Appropriation from General Fund to Disabilities Services Cash Fund	0	0	0	0	0	
General Fund	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
SUBTOTAL - (i) Administrative Costs	0	662,557	3,737,768	3,135,823	3,810,823	
FTE	0.0	0.0	30.5	30.5	30.5	
General Fund	0	332,254	1,632,368	1,668,896	1,668,896	
Cash Funds	0	0	713,730	38,730	713,730	
Federal Funds	0	330,303	1,391,670	1,428,197	1,428,197	
(ii) Program Costs						
Adult Comprehensive Services	0	0	343,130,295	360,790,069	356,813,850	
General Fund	0	0	150,674,965	161,858,505	159,900,615	
Cash Funds	0	0	33,628,301	31,134,998	31,134,998	
Federal Funds	0	0	158,827,029	167,796,566	165,778,237	
Adult Supported Living Services	0	1,976,615	68,326,297	89,818,758	87,496,622	*
General Fund	0	1,976,615	37,566,528	48,213,933	47,070,513	
Federal Funds	0	0	30,759,769	41,604,825	40,426,109	
Children's Extensive Support Services	0	0	21,088,329	22,411,675	18,889,112	*
General Fund	0	0	10,345,903	11,003,191	9,268,681	
Federal Funds	0	0	10,742,426	11,408,484	9,620,431	
Case Management	0	734,516	28,764,218	31,738,956	31,202,441	*
General Fund	0	734,516	15,330,416	16,804,604	16,540,424	
Federal Funds	0	0	13,433,802	14,934,352	14,662,017	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
Family Support Services	0	838,100	7,828,718	6,912,298	7,912,298	*
General Fund	0	838,100	6,828,718	6,912,298	6,912,298	
Cash Funds	0	0	1,000,000	0	1,000,000	
Federal Funds	0	0	0	0	0	
Preventive Dental Hygiene	0	30,892	65,754	66,534	66,534	*
General Fund	0	30,892	62,112	62,856	62,856	
Cash Funds	0	0	3,642	3,678	3,678	
Federal Funds	0	0	0	0	0	
Eligibility Determination and Waiting List Management	0	81,661	3,062,117	3,099,596	3,099,596	*
General Fund	0	81,661	3,041,968	3,079,101	3,079,101	
Cash Funds	0	0	0	0	0	
Federal Funds	0	0	20,149	20,495	20,495	
Regional Center Adult Comprehensive Services	0	0	0	21,525,353	21,525,353	*
General Fund	0	0	0	10,592,626	10,592,626	
Federal Funds	0	0	0	10,932,727	10,932,727	
SUBTOTAL - (ii) Program Costs	0	3,661,784	472,265,728	536,363,239	527,005,806	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	3,661,784	223,850,610	258,527,114	253,427,114	
Cash Funds	0	0	34,631,943	31,138,676	32,138,676	
Federal Funds	0	0	213,783,175	246,697,449	241,440,016	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
TOTAL - (4) Office of Community Living	0	4,324,341	476,003,496	539,499,062	530,816,629
FTE	0.0	0.0	30.5	30.5	30.5
General Fund	0	3,994,038	225,482,978	260,196,010	255,096,010
Cash Funds	0	0	35,345,673	31,177,406	32,852,406
Federal Funds	0	330,303	215,174,845	248,125,646	242,868,213

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(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	299,175,424	309,976,756	311,296,186	311,296,186	311,296,186
Cash Funds	149,587,712	154,988,378	153,307,474	152,873,135	153,201,150
Federal Funds	149,587,712	154,988,378	157,988,712	158,423,051	158,095,036
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760
General Fund	3,059,880	3,059,880	3,013,523	3,011,534	3,011,534
Federal Funds	3,059,880	3,059,880	3,106,237	3,108,226	3,108,226
Health Care Services Fund Programs	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Pediatric Specialty Hospital	11,799,938	11,799,938	13,455,012	13,455,012	13,455,012
General Fund	5,899,969	5,899,969	6,625,584	6,625,390	6,621,212
Federal Funds	5,899,969	5,899,969	6,829,428	6,829,622	6,833,800
General Fund Appropriation to Pediatric Specialty Hospital	0	0	0	0	0
General Fund	0	0	0	0	0
General Fund Exempt	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
Appropriation from Tobacco Tax Fund to the General Fund	429,812	421,610	423,600	423,600	427,593	
Cash Funds	429,812	421,610	423,600	423,600	427,593	
Primary Care Fund	27,258,545	26,679,334	26,828,000	26,701,944	26,778,000	*
Cash Funds	27,258,545	26,679,334	26,828,000	26,701,944	26,778,000	
Primary Care Grant Program Special Distribution	0	0	0	0	0	
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Children's Basic Health Plan Administration	4,245,129	4,013,739	5,127,772	5,033,274	5,033,274	
General Fund	0	0	0	0	0	
Cash Funds	1,883,715	1,502,836	2,404,035	2,363,824	2,363,824	
Federal Funds	2,361,414	2,510,903	2,723,737	2,669,450	2,669,450	
Children's Basic Health Plan Medical and Dental Costs	191,570,458	182,753,054	161,142,327	205,356,454	166,721,835	*
General Fund	29,398,182	12,114,378	10,151,999	73,412	2,102,118	
General Fund Exempt	441,600	438,300	423,600	0	423,600	
Cash Funds	37,761,085	72,640,720	53,319,690	36,622,225	29,111,333	
Federal Funds	123,969,591	97,559,656	97,247,038	168,660,817	135,084,784	
Comprehensive Primary and Preventive Care Grants	0	0	0	0	0	
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
Hospice Supplemental Payment	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
Children's Basic Health Plan Trust	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
Children's Basic Health Plan Premium Costs (Children & Pregnant Adults)	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
Children's Basic Health Plan Dental Costs	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
HB 09-1293 Childless Adult	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0
TOTAL - (4) Indigent Care Program	540,599,066	541,764,191	524,392,657	568,386,230	529,831,660
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	38,358,031	21,074,227	19,791,106	9,710,336	11,734,864
General Fund Exempt	441,600	438,300	423,600	0	423,600
Cash Funds	216,920,869	256,232,878	236,282,799	218,984,728	211,881,900
Federal Funds	284,878,566	264,018,786	267,895,152	339,691,166	305,791,296

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(5) OTHER MEDICAL SERVICES					
Primary functions: This division provides funding for the following three state-only Medical programs: (1) Old Age Pension Medical Program, (2) the Medicare Modernization Act State Contribution Payment, and (3) the Colorado Cares RX Program. This division also contains funding for programs that eligible for Medicaid funding but are not part of the Medical Services Premiums or Mental Health Programs.					
Old Age Pension State Medical	9,675,508	6,581,973	4,486,045	7,574,103	7,574,103 *
General Fund	0	0	0	2,962,510	2,962,510
Cash Funds	9,675,508	6,581,973	4,486,045	4,611,593	4,611,593
Tobacco Tax Transfer from General Fund to the Old Age Pension State Medical	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Commission on Family Medicine Residency Training Programs	1,741,077	3,371,077	5,476,843	5,401,843	5,401,843
General Fund	870,538	1,685,538	2,660,002	2,663,374	2,663,374
Federal Funds	870,539	1,685,539	2,816,841	2,738,469	2,738,469
State University Teaching Hospitals Denver Health and Hospital Authority	1,831,714	1,831,714	2,804,714	2,804,714	2,804,714
General Fund	915,857	915,857	1,381,112	1,382,657	1,380,200
Federal Funds	915,857	915,857	1,423,602	1,422,057	1,424,514
State University Teaching Hospitals University of Colorado Hospital	633,314	633,314	633,314	633,314	633,314
General Fund	316,657	316,657	311,860	311,654	311,654
Federal Funds	316,657	316,657	321,454	321,660	321,660

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
Medicare Modernization Act State Contribution Payment	101,817,855	106,376,992	107,948,850	119,620,941	116,816,749
General Fund	52,136,848	68,306,130	107,519,425	119,620,941	116,816,749
Reappropriated Funds	0	0	0	0	0
Federal Funds	49,681,007	38,070,862	429,425	0	0
Public School Health Services Contract Administration	811,941	812,550	2,491,722	2,491,722	2,491,722
Reappropriated Funds	0	812,550	2,491,722	2,491,722	2,491,722
Federal Funds	811,941	0	0	0	0
Public School Health Services	49,784,091	43,494,624	66,091,850	72,202,649	72,202,649
Cash Funds	24,887,311	21,747,312	32,815,378	35,640,520	35,640,520
Federal Funds	24,896,780	21,747,312	33,276,472	36,562,129	36,562,129
TOTAL - (5) Other Medical Services	166,295,500	163,102,244	189,933,338	210,729,286	207,925,094
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	54,239,900	71,224,182	111,872,399	126,941,136	124,134,487
Cash Funds	34,562,819	28,329,285	37,301,423	40,252,113	40,252,113
Reappropriated Funds	0	812,550	2,491,722	2,491,722	2,491,722
Federal Funds	77,492,781	62,736,227	38,267,794	41,044,315	41,046,772

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS						
This section reflects the Medicaid funding used by the Department of Human Services. The Medicaid dollars appropriated to that Department are first appropriated in this section and then transferred to the Department of Human Services. See the Department of Human Services for additional details about the line items contained in this division.						
(A) Executive Director's Office - Medicaid Funding						
Executive Director's Office - Medicaid Funding	14,543,801	16,549,747	18,085,504	16,622,493	16,622,493	*
General Fund	7,271,901	8,274,874	9,042,753	8,431,413	8,431,413	
Federal Funds	7,271,900	8,274,873	9,042,751	8,191,080	8,191,080	
SUBTOTAL - (A) Executive Director's Office - Medicaid Funding	14,543,801	16,549,747	18,085,504	16,622,493	16,622,493	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	7,271,901	8,274,874	9,042,753	8,431,413	8,431,413	
Federal Funds	7,271,900	8,274,873	9,042,751	8,191,080	8,191,080	
(B) Office of Information Technology Services - Medicaid Funding						
Colorado Benefits Management System	10,006,971	19,045,031	10,455,768	0	1,941,778	*
General Fund	4,249,653	5,454,849	3,837,679	0	(389,031)	
Cash Funds	8,092	23,928	1,393,789	0	1,379,194	
Reappropriated Funds	37,834	13,499	0	0	(18,809)	
Federal Funds	5,711,392	13,552,755	5,224,300	0	970,424	
CBMS SAS-70 Audit	46,554	24,859	53,792	0	(1,412)	*
General Fund	23,164	12,393	19,745	0	(7,671)	
Cash Funds	25	15	7,170	0	7,081	
Reappropriated Funds	155	31	0	0	(119)	
Federal Funds	23,210	12,420	26,877	0	(703)	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
Colorado Benefits Management System, HCPF Only	0	578,146	611,520	0	0	*
Cash Funds	0	289,073	305,760	0	0	
Federal Funds	0	289,073	305,760	0	0	
CBMS Modernization Project Personal Services, Operating Expenses, and Centrally Appropriated Expenses	0	9,388,569	551,832	0	(12,281)	*
General Fund	0	1,896,821	202,543	0	(79,515)	
Cash Funds	0	43,902	73,562	0	73,562	
Reappropriated Funds	0	18,003	0	0	0	
Federal Funds	0	7,429,843	275,727	0	(6,328)	
CBMS Modernization Project, Phase II	0	0	23,751,186	0	(3,019,620)	*
General Fund	0	0	3,893,553	0	(3,208,991)	
Cash Funds	0	0	1,426,822	0	140,790	
Federal Funds	0	0	18,430,811	0	48,581	
Other Office of Information Technology Services line items	500,820	572,373	615,989	583,932	583,932	
General Fund	250,410	286,187	303,328	287,215	287,215	
Federal Funds	250,410	286,186	312,661	296,717	296,717	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
SUBTOTAL - (B) Office of Information Technology Services - Medicaid Funding	10,554,345	29,608,978	36,040,087	583,932	(507,603)
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	4,523,227	7,650,250	8,256,848	287,215	(3,397,993)
Cash Funds	8,117	356,918	3,207,103	0	1,600,627
Reappropriated Funds	37,989	31,533	0	0	(18,928)
Federal Funds	5,985,012	21,570,277	24,576,136	296,717	1,308,691
(C) Office of Operations - Medicaid Funding					
Office of Operations - Medicaid Funding	4,069,739	3,941,460	4,979,011	4,945,311	4,945,311
General Fund	2,034,870	1,970,730	2,451,789	2,433,641	2,433,641
Federal Funds	2,034,869	1,970,730	2,527,222	2,511,670	2,511,670
SUBTOTAL - (C) Office of Operations - Medicaid Funding	4,069,739	3,941,460	4,979,011	4,945,311	4,945,311
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	2,034,870	1,970,730	2,451,789	2,433,641	2,433,641
Federal Funds	2,034,869	1,970,730	2,527,222	2,511,670	2,511,670
(D) Division of Child Welfare - Medicaid Funding					
Administration	132,899	133,069	137,306	140,806	140,806
General Fund	66,449	66,535	68,653	70,403	69,291
Federal Funds	66,450	66,534	68,653	70,403	71,515
Child Welfare Services	8,428,490	7,935,965	14,943,615	15,093,051	15,372,042
General Fund	4,214,245	3,960,443	7,358,611	7,429,393	7,564,582
Federal Funds	4,214,245	3,975,522	7,585,004	7,663,658	7,807,460

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
SUBTOTAL - (D) Division of Child Welfare - Medicaid Funding	8,561,389	8,069,034	15,080,921	15,233,857	15,512,848	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	4,280,694	4,026,978	7,427,264	7,499,796	7,633,873	
Federal Funds	4,280,695	4,042,056	7,653,657	7,734,061	7,878,975	
(D.5) Office of Early Childhood - Medicaid Funding						
Division of Community and Family Support, Early Intervention Services	0	3,407,528	5,550,855	5,612,324	5,695,874	*
General Fund	0	1,703,764	2,733,374	2,763,559	2,802,940	
Federal Funds	0	1,703,764	2,817,481	2,848,765	2,892,934	
SUBTOTAL - (D.5) Office of Early Childhood - Medicaid Funding	0	3,407,528	5,550,855	5,612,324	5,695,874	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	1,703,764	2,733,374	2,763,559	2,802,940	
Federal Funds	0	1,703,764	2,817,481	2,848,765	2,892,934	
(E) Office of Self Sufficiency - Medicaid Funding						
Systematic Alien Verification for Eligibility	26,338	33,951	33,951	34,505	34,505	
General Fund	0	0	0	0	0	
Federal Funds	26,338	33,951	33,951	34,505	34,505	
SUBTOTAL - (E) Office of Self Sufficiency - Medicaid Funding	26,338	33,951	33,951	34,505	34,505	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	0	0	0	0	0	
Federal Funds	26,338	33,951	33,951	34,505	34,505	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
(F) Behavioral Health Services - Medicaid Funding						
Community Behavioral Health Administration	293,274	318,262	404,350	416,056	416,056	
General Fund	146,637	159,131	199,112	203,944	203,944	
Federal Funds	146,637	159,131	205,238	212,112	212,112	
Mental Health Treatment Services for Youth (H.B. 99-1116)	44,226	20,624	121,558	122,774	122,774	*
General Fund	22,113	10,312	59,858	60,416	60,416	
Federal Funds	22,113	10,312	61,700	62,358	62,358	
High Risk Pregnant Women Program	1,052,270	1,138,015	1,464,861	1,479,510	1,479,510	*
General Fund	526,135	569,008	721,334	728,067	728,067	
Federal Funds	526,135	569,007	743,527	751,443	751,443	
Mental Health Institutes	1,899,838	1,050,942	6,000,000	5,971,876	5,971,876	
General Fund	947,761	516,910	2,952,020	2,937,637	2,937,637	
Federal Funds	952,077	534,032	3,047,980	3,034,239	3,034,239	
SUBTOTAL - (F) Behavioral Health Services - Medicaid Funding	3,289,608	2,527,843	7,990,769	7,990,216	7,990,216	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	1,642,646	1,255,361	3,932,324	3,930,064	3,930,064	
Federal Funds	1,646,962	1,272,482	4,058,445	4,060,152	4,060,152	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
(G) Services for People with Disabilities - Medicaid Funding					
Regional Centers	48,571,244	47,397,999	48,974,477	28,794,652	28,794,652 *
General Fund	20,499,769	21,805,812	22,215,109	12,277,697	12,277,697
Cash Funds	3,785,853	1,866,142	1,866,142	1,866,142	1,866,142
Reappropriated Funds	0	0	0	0	0
Federal Funds	24,285,622	23,726,045	24,893,226	14,650,813	14,650,813
Regional Center Depreciation and Annual Adjustments	1,187,826	1,187,825	943,063	932,429	932,429
General Fund	593,913	593,913	464,388	458,849	458,849
Federal Funds	593,913	593,912	478,675	473,580	473,580
Community Services for People with Developmental Disabilities, Administration	2,356,594	2,017,844	0	0	0
General Fund	1,178,297	1,008,922	0	0	0
Federal Funds	1,178,297	1,008,922	0	0	0
Community Services for People with Developmental Disabilities, Program Costs	327,987,037	351,796,642	0	0	0
General Fund	163,993,519	175,890,710	0	0	0
Cash Funds	0	0	0	0	0
Federal Funds	163,993,518	175,905,932	0	0	0
Community Services for People with Developmental Disabilities, Early Intervention Services	0	0	0	0	0
General Fund	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation	
SUBTOTAL - (G) Services for People with Disabilities - Medicaid Funding	380,102,701	402,400,310	49,917,540	29,727,081	29,727,081	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	186,265,498	199,299,357	22,679,497	12,736,546	12,736,546	
Cash Funds	3,785,853	1,866,142	1,866,142	1,866,142	1,866,142	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	190,051,350	201,234,811	25,371,901	15,124,393	15,124,393	
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding						
Community Services for the Elderly	1,800	1,800	1,800	1,800	1,800	
General Fund	900	900	900	900	900	
Federal Funds	900	900	900	900	900	
SUBTOTAL - (H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding	1,800	1,800	1,800	1,800	1,800	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	900	900	900	900	900	
Federal Funds	900	900	900	900	900	
(I) Division of Youth Corrections - Medicaid Funding						
Division of Youth Corrections - Medicaid Funding	1,503,985	1,682,431	1,518,890	1,648,251	1,611,120	*
General Fund	751,992	841,216	744,880	811,443	790,099	
Federal Funds	751,993	841,215	774,010	836,808	821,021	

	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
SUBTOTAL - (I) Division of Youth Corrections - Medicaid Funding	1,503,985	1,682,431	1,518,890	1,648,251	1,611,120
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	751,992	841,216	744,880	811,443	790,099
Federal Funds	751,993	841,215	774,010	836,808	821,021
(J) Other					
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs	0	500,000	500,000	500,000	500,000
General Fund	0	0	0	0	0
Federal Funds	0	500,000	500,000	500,000	500,000
SUBTOTAL - (J) Other	0	500,000	500,000	500,000	500,000
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Federal Funds	0	500,000	500,000	500,000	500,000
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	422,653,706	468,723,082	139,699,328	82,899,770	82,133,645
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	206,771,728	225,023,430	57,269,629	38,894,577	35,361,483
Cash Funds	3,793,970	2,223,060	5,073,245	1,866,142	3,466,769
Reappropriated Funds	37,989	31,533	0	0	(18,928)
Federal Funds	212,050,019	241,445,059	77,356,454	42,139,051	43,324,321

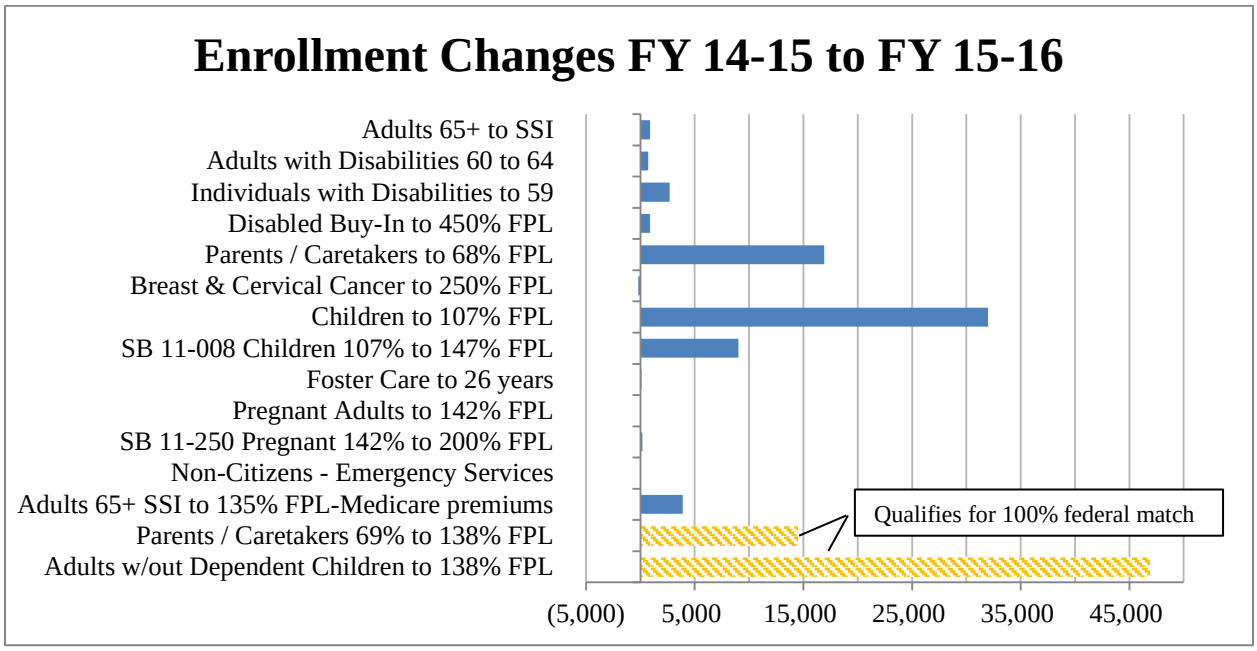
	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Appropriation	FY 2015-16 Request	FY 2015-16 Recommendation
TOTAL - Department of Health Care Policy and Financing	5,494,370,117	6,380,769,096	7,938,132,580	8,666,656,110	8,792,280,466
FTE	315.9	363.7	390.9	414.7	417.3
General Fund	1,324,071,441	1,441,811,987	1,642,043,935	1,784,569,499	1,750,427,079
General Fund Exempt	507,677,557	642,674,257	711,259,557	710,835,957	711,259,557
Cash Funds	917,366,916	883,457,087	900,876,210	1,018,697,121	1,032,802,516
Reappropriated Funds	5,216,474	7,232,284	6,104,791	6,126,761	6,112,943
Federal Funds	2,740,037,729	3,405,593,481	4,677,848,087	5,146,426,772	5,291,678,371

Appendix B Medical Services Premiums Forecast

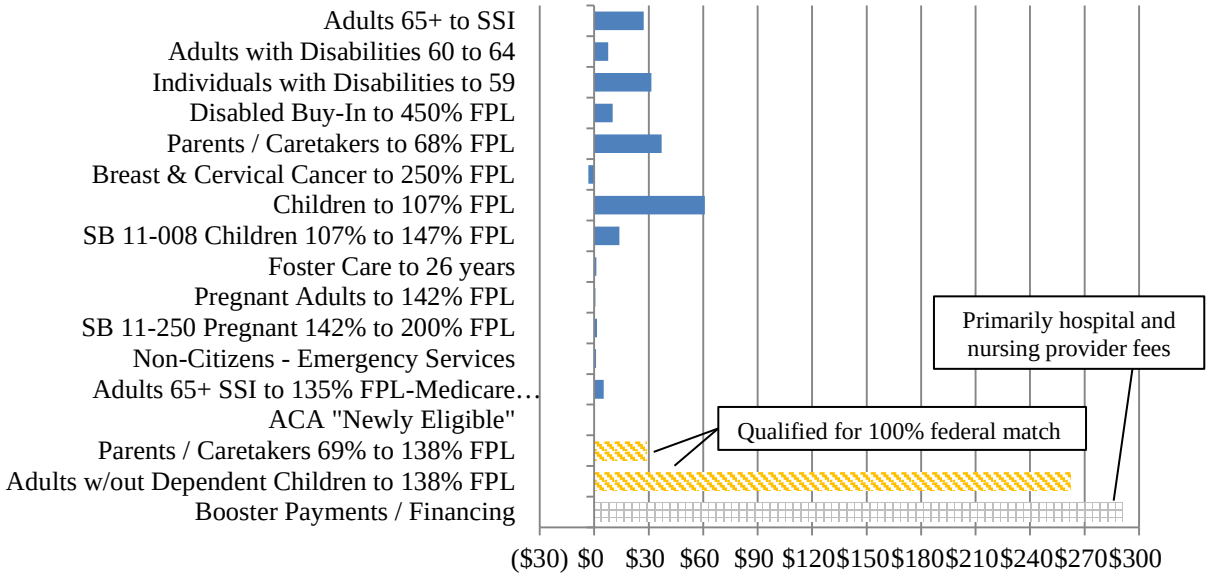
Enrollment				
Category	FY 14-15	FY 15-16	Difference	Percent
Adults 65+ to SSI	42,087	42,971	884	2.1%
Adults with Disabilities 60 to 64	10,581	11,307	726	6.9%
Individuals with Disabilities to 59	66,821	69,501	2,680	4.0%
Disabled Buy-In to 450% FPL	3,425	4,327	902	26.3%
Parents / Caretakers to 68% FPL	163,685	180,612	16,927	10.3%
Breast & Cervical Cancer to 250% FPL	379	179	(200)	-52.8%
Children to 107% FPL	448,326	480,322	31,996	7.1%
SB 11-008 Children 107% to 147% FPL	47,107	56,118	9,011	19.1%
Foster Care to 26 years	20,129	20,237	108	0.5%
Pregnant Adults to 142% FPL	14,883	14,862	(21)	-0.1%
SB 11-250 Pregnant 142% to 200% FPL	1,751	1,923	172	9.8%
Non-Citizens - Emergency Services	2,573	2,551	(22)	-0.9%
Adults 65+ SSI to 135% FPL-Medicare premiums	28,124	32,033	3,909	13.9%
Subtotal	**849,871**	**916,943**	**67,072**	**7.9%**
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	70,900	85,311	14,411	20.3%
Adults w/out Dependent Children to 138% FPL	240,362	287,239	46,877	19.5%
Subtotal	**311,262**	**372,550**	**61,288**	**19.7%**
TOTAL	**1,161,133**	**1,289,493**	**128,360**	**11.1%**

Expenditures				
Category	FY 14-15	FY 15-16	Difference	Percent
Adults 65+ to SSI	$965,072,783	$992,245,289	$27,172,506	2.8%
Adults with Disabilities 60 to 64	189,137,331	196,828,204	7,690,873	4.1%
Individuals with Disabilities to 59	1,032,439,469	1,063,910,216	31,470,747	3.0%
Disabled Buy-In to 450% FPL	33,970,150	44,058,607	10,088,457	29.7%
Parents / Caretakers to 68% FPL	483,937,147	520,995,541	37,058,394	7.7%
Breast & Cervical Cancer to 250% FPL	6,083,145	2,875,930	(3,207,215)	-52.7%
Children to 107% FPL	782,651,898	843,598,502	60,946,604	7.8%
SB 11-008 Children 107% to 147% FPL	71,341,980	85,123,040	13,781,060	19.3%
Foster Care to 26 years	82,415,074	83,653,569	1,238,495	1.5%
Pregnant Adults to 142% FPL	147,666,078	148,231,695	565,617	0.4%
SB 11-250 Pregnant 142% to 200% FPL	15,296,638	16,873,759	1,577,121	10.3%
Non-Citizens - Emergency Services	42,883,621	43,928,964	1,045,343	2.4%
Adults 65+ SSI to 135% FPL-Medicare premiums	33,942,733	39,085,411	5,142,678	15.2%
Subtotal	**$3,886,838,047**	**$4,081,408,727**	**$194,570,680**	**5.0%**
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	165,304,640	194,024,374	28,719,734	17.4%
Adults w/out Dependent Children to 138% FPL	1,026,921,227	1,289,398,478	262,477,251	25.6%
Subtotal	**$1,192,225,867**	**$1,483,422,852**	**$291,196,985**	**24.4%**
Booster Payments / Financing	726,420,437	1,017,205,560	290,785,123	40.0%
TOTAL	**$3,886,838,047**	**$4,081,408,727**	**$194,570,680**	**5.0%**

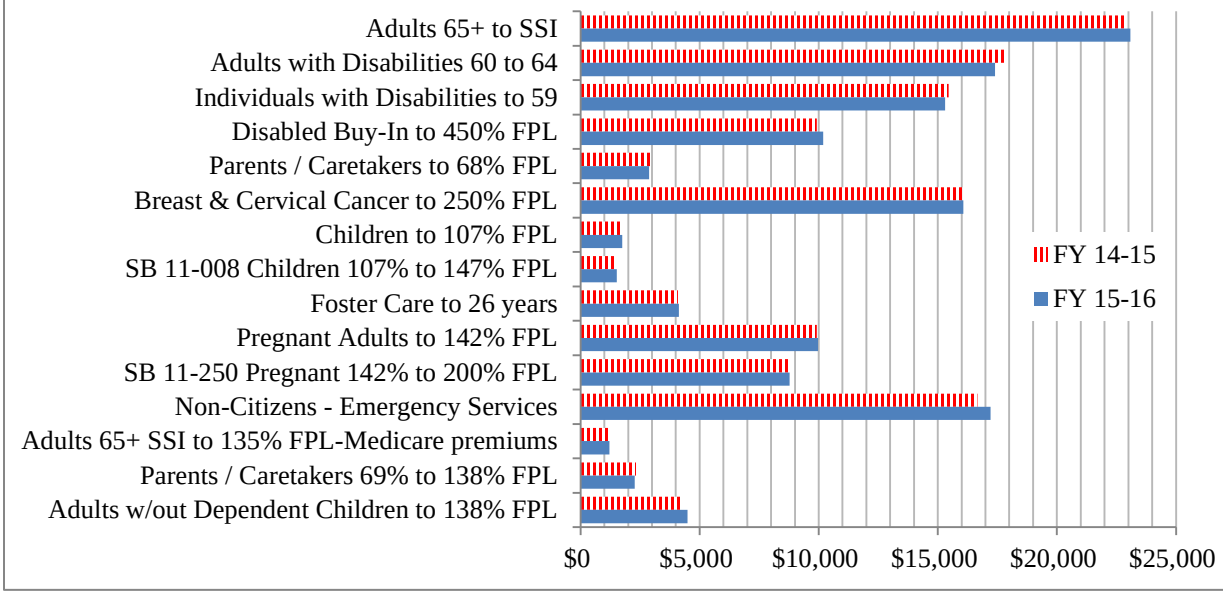
Per Capita Expenditures				
Category	FY 14-15	FY 15-16	Difference	Percent
Adults 65+ to SSI	$22,930.42	$23,091.04	$160.62	0.7%
Adults with Disabilities 60 to 64	$17,875.18	$17,407.64	($467.54)	-2.6%
Individuals with Disabilities to 59	$15,450.82	$15,307.84	($142.98)	-0.9%
Disabled Buy-In to 450% FPL	$9,918.29	$10,182.25	$263.96	2.7%
Parents / Caretakers to 68% FPL	$2,956.51	$2,884.61	($71.90)	-2.4%
Breast & Cervical Cancer to 250% FPL	$16,050.51	$16,066.65	$16.14	0.1%
Children to 107% FPL	$1,745.72	$1,756.32	$10.60	0.6%
SB 11-008 Children 107% to 147% FPL	$1,514.47	$1,516.86	$2.39	0.2%
Foster Care to 26 years	$4,094.35	$4,133.69	$39.34	1.0%
Pregnant Adults to 142% FPL	$9,921.80	$9,973.87	$52.07	0.5%
SB 11-250 Pregnant 142% to 200% FPL	$8,735.94	$8,774.71	$38.77	0.4%
Non-Citizens - Emergency Services	$16,666.78	$17,220.29	$553.51	3.3%
Adults 65+ SSI to 135% FPL-Medicare premiums	$1,206.90	$1,220.16	$13.26	1.1%
ACA "Newly Eligible"				
Parents / Caretakers 69% to 138% FPL	$2,331.52	$2,274.32	($57.20)	-2.5%
Adults w/out Dependent Children to 138% FPL	$4,272.39	$4,488.94	$216.55	5.1%
TOTAL (without booster payments/financing)	**$4,374.23**	**$4,315.52**	**($58.71)**	**-1.3%**



Expenditure Changes FY 14-15 to FY 15-16



Per Capita Expenditures



Appendix C Targeted Provider Rate Increase Proposals Rejected by the Department

FY 2015-16 Targeted Rate Increase Proposals Not Recommended

Several submitted proposals did not contain all of the information the Department requested and needed to complete evaluation. Staff attempted to research and fill in missing information where possible – if the proposal met other critical criteria (such as needed improved access to care, incentivizing more health care providers to deliver a needed service, improving health outcomes for clients), and in some cases were able to move forward with a full review. These are discussed in more detail below.

A. Adult Day, Alternative Care Facilities rates increase

Submitted by: Leading Age Colorado

Stakeholder Description/Rationale: Increasing rates will improve client access to cost-effective long term services and supports by allowing providers to continue to service Medicaid clients (many of whom are at risk of not being able to continue to serve Medicaid clients).

Proposal: Proposing a 2.2% rate increase for Elderly Blind and Disabled Waiver Adult Day and Alternative Care Facility services.

Recommendation: Not recommended

Explanation of Recommendation: The Department's budget request for across the board rate increases would fund a large majority of the rate increases requested in this proposal.

Federal Authority: CMS approval required

Fiscal Impact: $1,081,730

B. Rate increases for all anesthesia services or in rural and critical access facilities

Submitted by: Colorado Society of Anesthesiologists

Stakeholder Descriptions/Rationale: Providing a rate increase to all anesthesia service codes would promote utilization of high quality anesthesia services that would improve client outcomes and reduce expenditures. It would also address an inadequate provider reimbursement rate to improve client access to cost-effective care.

Proposal: 1. Request that HCPF increase Medicaid rate to Workman's Comp level, $55.73 **Proposal 2.** Alternate proposal for same rate increases but for rural practices and critical access facilities only.

Recommendation: Not recommended

Explanation of Recommendation: The cost estimate exceeds the entire TRI budget request. The second proposal was not a state-wide recommendation; implementation may not be possible under current system constraints. For those reasons, other requests for funding received higher priority.

Federal Authority: State Plan Amendment required

Fiscal Impact: 1. $56,255,360 **2**. Fiscal impact not estimated due to incomplete information and implementation obstacles.

C. CES Respite rate increase

Submitted by: Community Residential & Respite, LLC

Stakeholder Description/Rationale: Requested rate increase for respite care for children in the CES waiver to induce additional agencies to provide this service, enhance the level of care, ensuring more families will have higher comfort level leaving their children with a provider with the skills and abilities to provide for their health and safety.

Proposal: Increase rate for CES waver rate by one percent, or $0.48 per 15 minute unit.

Recommendation: Not recommended

Explanation of Recommendation: A request for a one percent increase in rates is less than the Department's budget request for community provider rate increases. The Department did not consider this request in the TRI process as the Department has requested to fund this provider rate increase outside of the TRI process. Respite utilization of CES participants is 68.14%. There is no evidence of widespread access to care barriers. Increases in funding would plausibly provide for increases in the intensity of service delivery, with probable client benefits. However, other requests that were funded provided evidence of more urgent or immediate access to care problems.

Federal Authority: Waiver amendment required

Fiscal Impact: One percent increase including respite camp: $572,590; one percent increase not including respite camp: $11,920; $0.48 increase including respite camp: $146,484; $0.48 increase not including respite camp: $105,459

D. Residential Child Care Facility rate increase and request for payment of trauma assessment

Submitted by: Mount Saint Vincent

Stakeholder Description/Rationale: Increase daily Residential Children's Care Facility (RCCF) rate to allow for a 1:3 ratio for RCCF (Colorado rules and regulations require 1:6 or 1:8, depending on the age of the children), allowing for optimum care, safety, and supervision. Request Medicaid create a new payment to reimburse for a specific, best-practice comprehensive trauma assessment model used by Mount Saint Vincent.

Proposal: 1. Increase daily RCCF rate by five percent (from $186.18 to $195.50). **2.** Create payment for Neurosequential Model of Therapeutics (NMT) comprehensive trauma assessment model and price it at $1,300 per assessment (provider-reported cost is between $1,500 - $2,000).

Recommendation: Not recommended

Explanation for Recommendation: Proposal 1: The Department does pay for behavioral treatment outside of the BHO managed care program for children residing in RCCFs as a result of a county child welfare placement; it is not a per diem payment. RCCF services are only paid at a daily rate when they are provided through a BHO. This request for an increase in a daily rate would impact the BHO contract and is outside the scope of this Targeted Rate Increase project. Additionally, there was no evidence provided of access to care issues, nor are any known to the Department. **Proposal 2**: Requested funding appears to be opening up a new benefit and is not a targeted rate increase. For those reasons, other requests for funding received higher priority.

Federal Authority: State Plan Amendment required

Fiscal Impact: Indeterminate fiscal impact due to reimbursement methodology.

E. Increase to a number of dental codes

Submitted by: DentaQuest

Description/Rationale: No description or rationale was provided.

Stakeholder Proposal: Increase to a number of dental service codes.

Recommendation: Not recommended

Explanation for Recommendation: The proposal was a spreadsheet with a number of codes priced out and a column for recommended increases. There was no information provided on how the proposed increases would improve quality health outcomes for clients, incentivize more providers to deliver services, or ensure improved client access to care. There was no discussion of challenges or barriers to implementation.

Federal Authority: State Plan Amendment may be required

Fiscal Impact: $2,510,313

F. Request to raise all home health rates except home health aides rates

Submitted by: Home Care Association of Colorado

Stakeholder Description/Rationale: Raising home care rates to Medicare rate will incentivize home care agencies to deliver the services to Medicaid beneficiaries, improve client access to care, and save the state money by increasing access to home care versus hospitalization and other institutional care.

Proposal: Increase all home care rates (including skilled nursing, therapies, telehealth, private duty nursing, personal care, and homemaker services) to 100% of Medicare rates.

Recommendation: Not recommended

Explanation for Recommendation: Proposal cost of $73.1 million quoted by submitter exceeds the entire budget for the TRI proposal. Current Medicaid rates for these services are at 78% of Medicare.

Federal Authority: State Plan Amendment required

Fiscal Impact: $73,163,053

G. Option: Home Health rate increase for two counties

Submitted by: Hospice of Montezuma and Home Care Services

Description/Rationale: An increase in rates in these two medically underserved areas would improve client outcomes and reduce health care expenditures by providing an alternative to an assisted living facility or nursing home, particularly in rural communities where there are limited beds and long wait lists for housing options.

Proposal: Increase rates by 30% for home health services provided by Hospice of Montezuma Home Care Services.

Recommendation: Not recommended

Explanation for Recommendation: Proposal is not state-wide in scope. Proposal feedback regarding "non-reimbursable mileage and employee training," is outside the scope of the TRI project, particularly because overtime and "drive time" issues are pending before a district court judge in an appeal regarding the Department of Labor's rule making authority and the scope of the Fair Labor Standards Act.

Federal Authority: State Plan Amendment required, waiver amendment may be required

Fiscal Impact: Fiscal impact not estimated; additional legal and policy evaluation needed

H. Individual, family, and group therapy

Submitted by: Ryon Medical & Associates, LLC

Stakeholder Description/Rationale: An increase in outpatient Medicaid provider rates can attract private providers, driving and supporting the local economies and communities. It offers clients a choice of providers to meet their individual needs.

Proposal: Increase Individual, Family, and Group therapy rates, and diagnostic and assessment rates (and "other") by 20%.

Recommendation: Not recommended

Explanation for Recommendation: The proposal did not provide sufficient detail (specific units of services/procedures) to allow for a fiscal impact determination. It also did not address any challenges or barriers to implementation.

Federal Authority: State Plan Amendment required

Fiscal Impact: Unable to determine due to insufficient proposal detail

I. Inpatient rehabilitation

Submitted by: Denver Health (two proposals)

Stakeholder Description/Rationale: 1. Denver Health (DH) has implemented a major practice transformation that employs a "population health" approach to services and achieved the "triple aim" of improved health, care, and costs. DH would like to replicate the model. **2.** DH received 51% of the Medicare rate on inpatient rehabilitation costs, which represents 41% of actual costs.

Proposal: 1. Provide incentive payments for "shared savings" proportionate to documented cost-avoidance. **2.** Increase rates for hospitals with Medicare-certified inpatient rehabilitation unit via an add-on to the base rate.

Recommendation: Not recommended

Explanation for Recommendation: 1. This was not a TRI request, but rather a shared-savings proposal. **2.** The proposal was limited to Denver Health, and was not a state-wide proposal.

Federal Authority: State Plan Amendment required

Fiscal Impact: Fiscal impact not estimated

J. Adolescent depression screening reimbursement increase

Submitted by: Colorado Association for School-based Health Care

Stakeholder Description/Rationale: School-based Health Care (SBHC) are dependent upon grants to keep their doors open. A targeted rate increase would help SBHCs provide crucial health care services in a sustainable way. The service is underpaid and currently rely on other funds to cover the gaps.

Proposal: Increase code 99420 (patients aged 11 to 20) from $10.28 to $30.05 to make it comparable to CPT code 99408 (substance use screening).

Recommendation: Not recommended

Explanation for Recommendation: Adolescent depression screening rate was reviewed and determined utilization continues to increase, and no barrier to access is evident. Other states' rate averages $8.55 for this service; Colorado's rate is $10.28

Federal Authority: State Plan Amendment not required.

Fiscal Impact: $207,613

K. Requests addition of facility reimbursements for five specialty clinical areas

Submitted by: University of Colorado Hospital

Stakeholder Description/Rationale: Five specialty areas (Dermatology, Ophthalmology, Gastroenterology, Orthopedics, and Urology) are clinical services currently in high demand by Medicaid patients. A rate increase could help improve patient access to care and could incentivize more providers to deliver these services in their private practices.

Proposal: 1. Adding facility reimbursements for the above-listed specialty areas. **2.** Examine potential funding for new (and some existing) programs or services such as grant funding for supporting patient access and care models that encourage and provide greater access to primary care.

Recommendation: Not recommended

Explanation for Recommendation: Proposal 1 requires creation of a new type of payment (facility reimbursements), and would not be implementable by July 1, 2015. There is not enough information to allow for a fiscal impact determination (no specific units of service recommended, no percentage or dollar amount represented by the recommended rate increase, and no discussion of known challenges and barriers to implementation. **2.** This is not a TRI request, but rather a suggestion of new ways of providing funding.

Federal Authority: Would require State Plan Amendment and CMS approval.

Fiscal Impact: Unable to determine

L. Funding to RCCO 6 for grants to fund studies on alternative payment methodologies for orthopedic care

Submitted by: Panorama Orthopedics & Spine Center

Stakeholder Description/Rationale: Through population health analytics and management, Panorama seeks to build a cost-neutral system to the state, eliminating unnecessary cost shifting, and directing financing to the right sites of care.

Proposal: Provide $2.3 million to RCCO 6 structured as a draw down grant, to fund actuarial study for alternative payment methodologies, and to cover the startup expenses of building an orthopedic delivery network of RCCO 6 patients.

Recommendation: Not recommended

Explanation for Recommendation: This is not a TRI request, but a request for a grant. This is not a state-wide proposal. No specifics were provided.

Federal Authority: Would require State Plan Amendment and CMS approval

Fiscal Impact: Unable to determine due to insufficient proposal detail

M. Rate increase request for independent outpatient physical therapist providers

Submitted by: American Physical Therapy Association

Stakeholder Description/Rationale: Raising the state's Medicaid rates to the Medicare level will incentivize more physical therapy providers to deliver the services to clients, improve client access to care, and will save the state money by increase access to physical therapy services.

Proposal: Increase codes for manual therapy (97140), Neuromuscular re-education (97112), PT evaluation (97001), PT re-evaluation (97002), Therapeutic activities (97530), and Therapeutic services (97110) to equal Medicare rates.

Recommendation: Partially recommended

Explanation for Recommendation: Department proposal to increase the lowest PT rates to 50% of Medicare was already submitted and recommended (including three of the above six codes). Two codes recommended for increase were already at 78% and 79% of Medicare.

Federal Authority: State Plan Amendment may be required

Fiscal Impact: $4,306,423

N. Increase rates for ultrasounds

Submitted by: Radiology Imaging Associates

Stakeholder Description/Rationale: Increased access to quality prenatal and well-woman diagnostic imaging will support national and state initiatives to provide women with access to quality prenatal and pre-pregnancy care.

Proposal: Increase reimbursement for prenatal and related women's diagnostic ultrasound imaging to at least 80% of Medicare rates (codes 76801, 76805, 76815, 76816, 76817, and 76830).

Recommendation: Not recommended

Explanation for Recommendation: Most codes are currently paid at 70% of Medicare or higher. Increases for prenatal/delivery/postpartum physician visits were determined to be likely to have greater implications on access to quality and timely maternity care.

Federal Authority: State Plan amendment may be required

Fiscal Impact: $3,572,513 (one code excluded as the reimbursement is above the requested rate).

O. Supported Living Services (day habilitation) rate increase

Submitted by: Continuum of Colorado

Stakeholder Description/Rationale: Increasing the unit rate will encourage providers to provide one-on-one services to clients who need it, while being more equitable to covering the costs associated with providing the service.

Proposal: Increase unit rate for Supported Community Connection services for individuals with SIS levels 1 – 3 (20% for SIS Level 1 to $3.38, 13% for SIS Level 2 to $3.49, and eight percent increase for SIS Level 3 to $3.76).

Recommendation: Not recommended

Explanation for Recommendation: There is not an identified provider shortage in the I/DD system that would be addressed through an across the board rate increase. Adjusting the rate is not prioritized at this time because rebasing the rates, a process for on-going re-basing, and benefits restructuring are planned for system redesign. The JBC has identified funds and FTE for waiver redesign that allows the Department to complete this work over the next 18-24 months.

Federal Authority: Wavier amendment required

Fiscal Impact: $1,242,089

P. Modification of above previously submitted proposal: Supported Living Services (day habilitation) rate increase

Submitted by: Continuum of Colorado

Stakeholder Description/Rationale: There is a shortage of providers because of the low hourly rate. With increases as recommended, more providers would offer the services, and clients would have more access to services.

Proposal: Increase Day Habilitation SIS levels 2 – 6 (Level 2 from $2.55 to $2.85; Level 3 from $2.84 to $3.75; Level 4 from $3.34 to $4.14; Level 5 from $4.14 to $5.95; and Level 6 from $5.95 to $6.33). Increase Community Connections SIS levels 1 – 6 (Level 1 from $2.82 to $4.00; Level 2 from $3.09 to $4.82; Level 3 from $3.48 to $6.33; Levels 4 – 6 "no less than $7.00").

Recommendation: Not recommended

Explanation for Recommendation: There is not an identified provider shortage in the I/DD system that would be addressed through an across the board rate increase. Adjusting the rate is not prioritized at this time because rebasing the rates, a process for on-going re-basing, and benefits restructuring are planned for system redesign. The JBC has identified funds and FTE for waiver redesign that allows us to complete this work over the next 18-24 months.

Federal Authority: Waiver amendment required

Fiscal Impact: $8,393,725

Q. Increase five rates for wheelchairs and wheelchair accessories

Submitted by: NuMotion

Stakeholder Description/Rationale: Ensure clients have the opportunity to receive the best mobility solution for their unique needs by offering products that are both functional and highly reliable. Current reimbursement could limit access to particular products that might be the most clinically appropriate selection based on the reimbursement rate.

Proposal: Increase unit rate for five wheelchair and wheelchair accessory HCPCS rates: E1028 to $223; E0960 to $102.63, E2622 to $317.10, E2624 to $319.71, and K0005 to $2,200.

Recommendation: Not recommended

Explanation for Recommendation: Last year DME providers came together collaboratively and requested to repurpose the 2% across-the-board increases to instead increase or decrease targeted codes. Three of the requested codes have seen significant increases as a result. The Department is not aware of any member access issues related to reimbursement. The requestor did not provide any documentation on their acquisition costs for these items.

- E1028: Current rate is now about three percent higher than last fiscal year, and is at 97% of the Medicare rate.
- E0960: Wheelchair providers (including Numotion) requested a decrease to the current rate to shift those savings to other wheelchair procedure codes.
- K0005: Current rate is approximately 34% higher than last fiscal year and is at 99% of the Medicare rate. (The requested amount would put the rate $147.96 above the Medicare rate.)

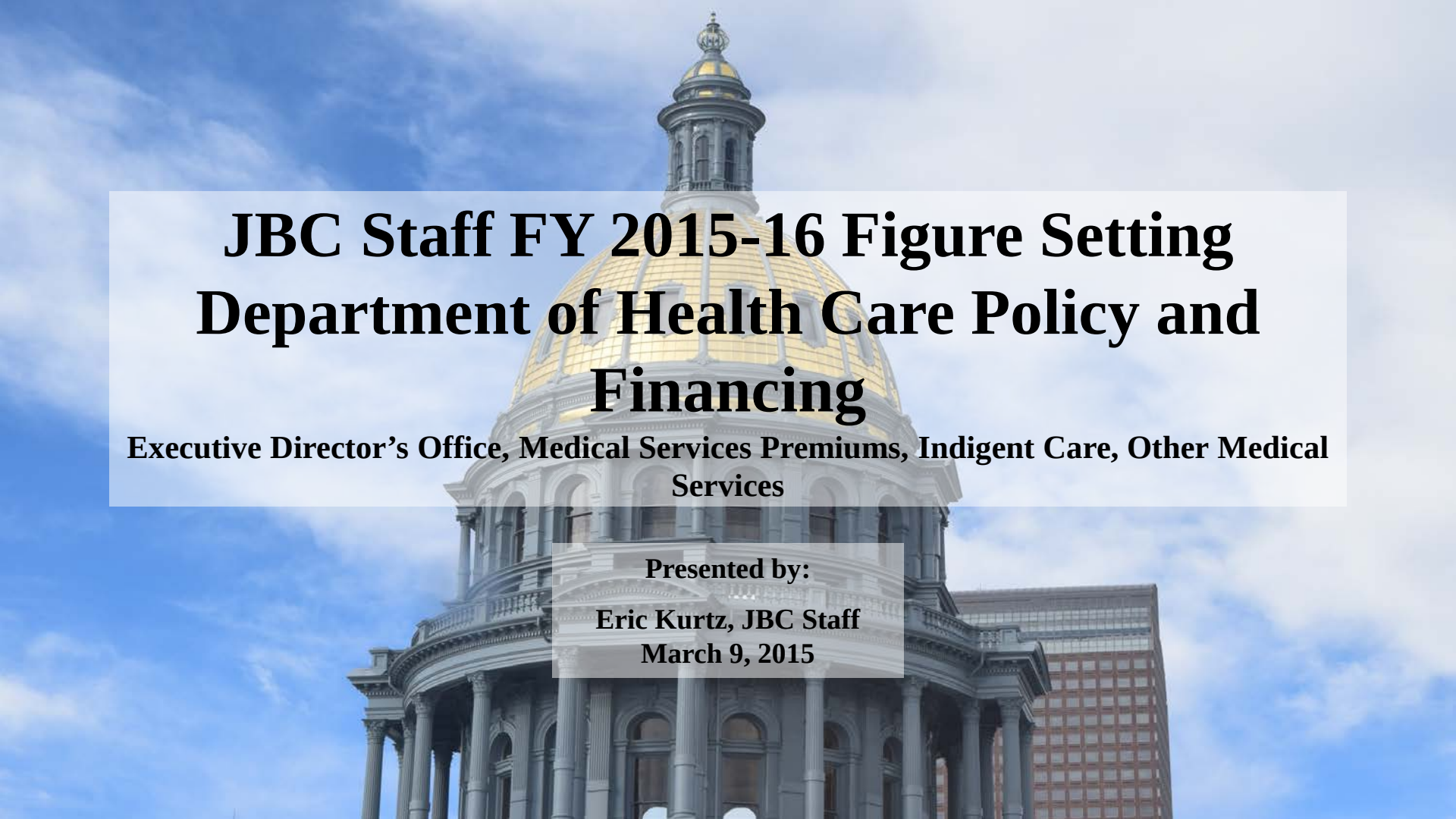
- E2622: Current rate is about 56% higher than last fiscal year, and is at 98% of the Medicare rate.
- E2624: Current rate is about 63% higher than last fiscal year, and exceeds the Medicare rate by about 1%.

Federal Authority: State Plan Amendment may be required

Fiscal Impact: $73,555 (E1028, E2622, and E2624 not included in calculation as the current rate exceeds the proposed rate.)

Other Submissions:

Submitter	**Organization**	**Type of Submission**
Gretchen McGinnis	Access Management Services	Comments/support for TRI process
Joshua Rael	Alliance	Feedback/does not support TRI process but recommends any TRI increases should go to various ID/D services
Greg Hill	Colorado Dental Association	Comments/support for dental increases
Lisa Tarr	First Steps Pediatric Therapy	Support for TRI process
Deborah Foote	Oral Health Colorado	Comments/support for dental increases
Katie Pachan Jacobson	CCHN	Comments/support for non-specific rate increases in five areas
Julie Reiskin	CCDC	Feedback on proposed areas of increase and non-specific suggestions for other areas of focus
Linda Ross Reiner	Caring for Colorado Fund	Support for dental increases
Annie Mannering	Unknown	Comment on independent providers
Carol Bruce-Fitz	Community Health Partnership	Feedback and support for four Department proposals
Julie Dreyfuss	CCI Colorado	Comment on lack of overall funding
Karen Mooney	Women's SUD Programs	Feedback/support for Special Connections proposal



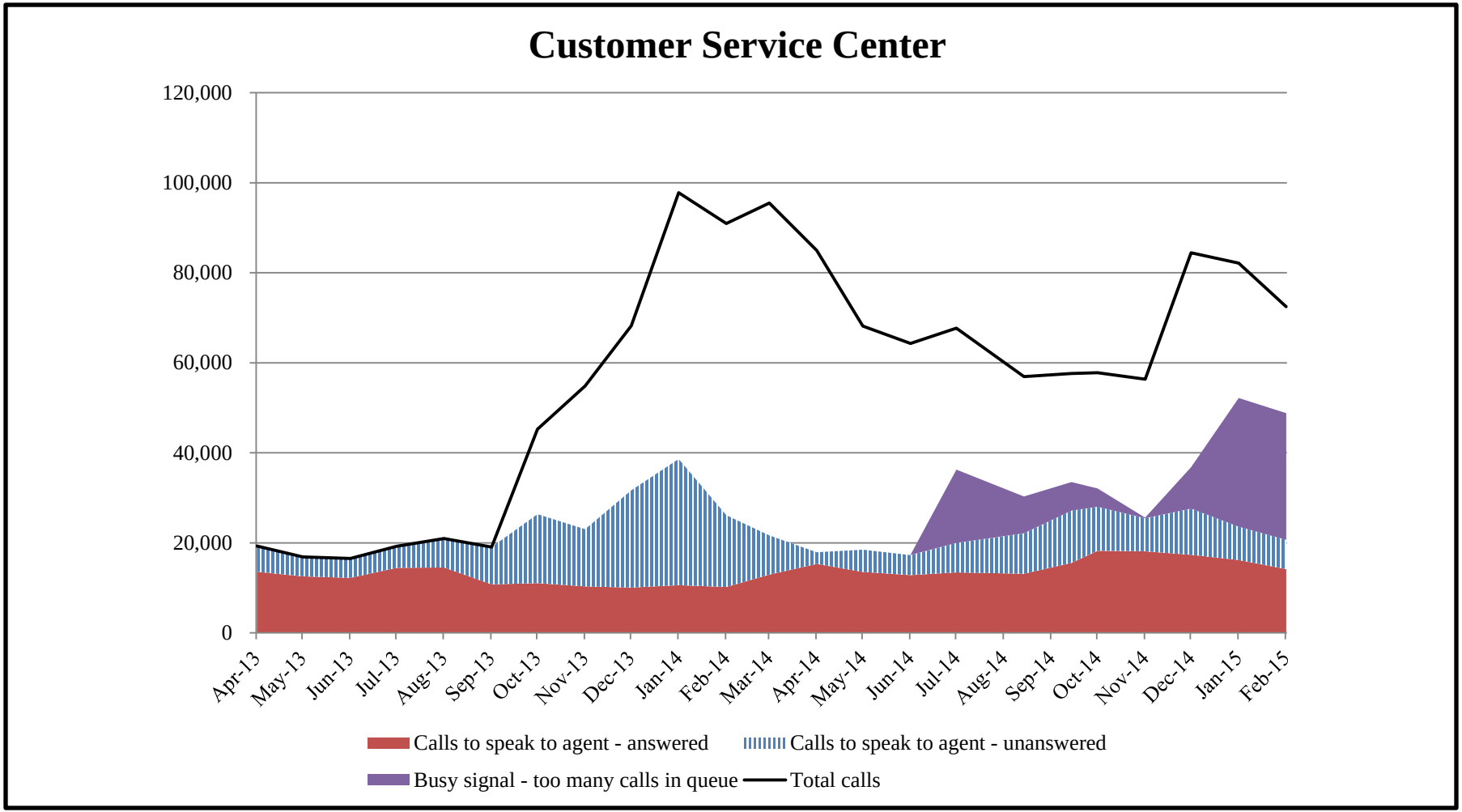
JBC Staff FY 2015-16 Figure Setting Department of Health Care Policy and Financing

Executive Director's Office, Medical Services Premiums, Indigent Care, Other Medical Services

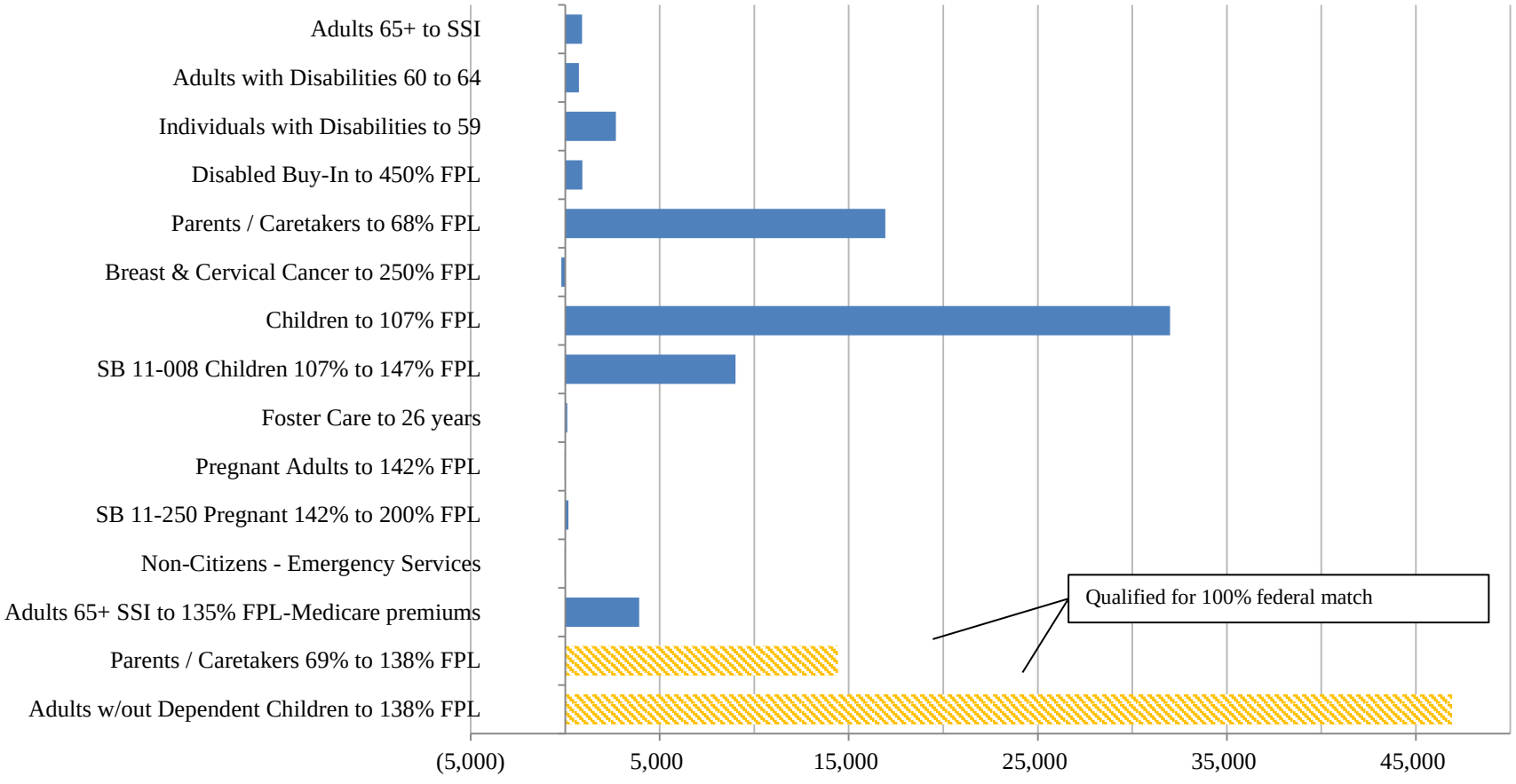
Presented by:

Eric Kurtz, JBC Staff

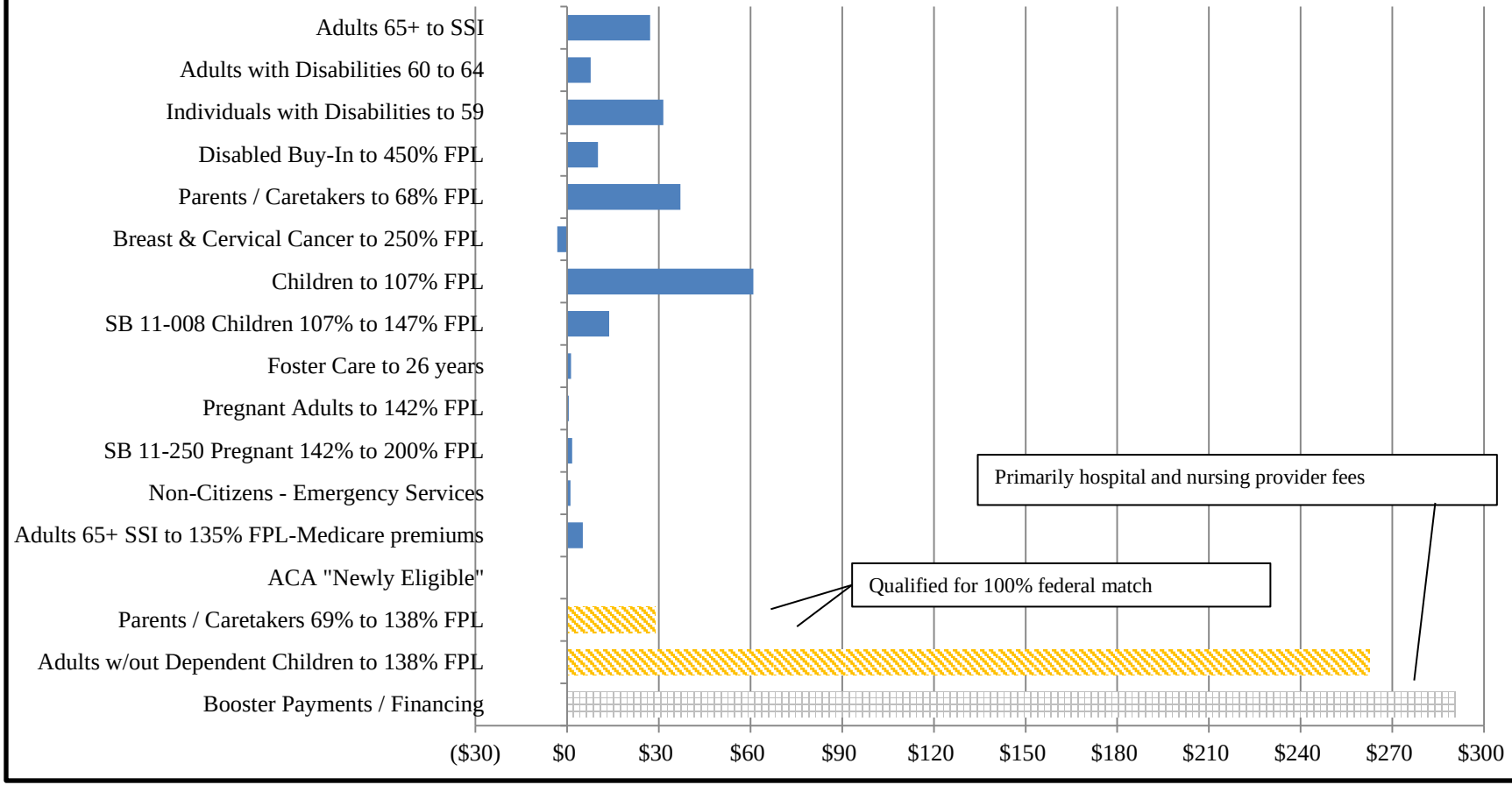
March 9, 2015


Customer Service Center
120,000
100,000
80,000
60,000
40,000
20,000
0
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Calls to speak to agent - answered
Calls to speak to agent - unanswered
Busy signal - too many calls in queue
Total calls

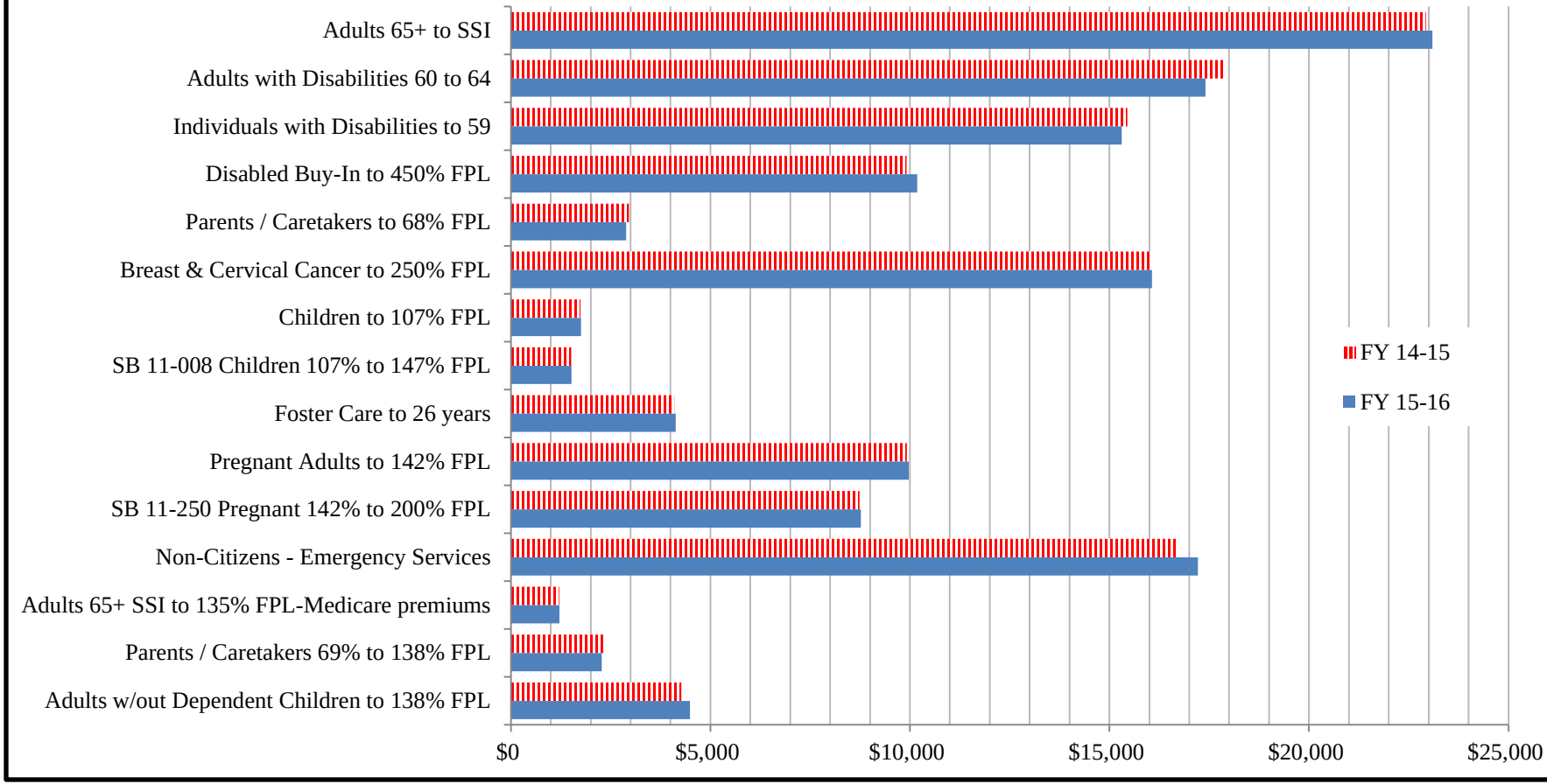
Enrollment Changes FY 14-15 to FY 15-16



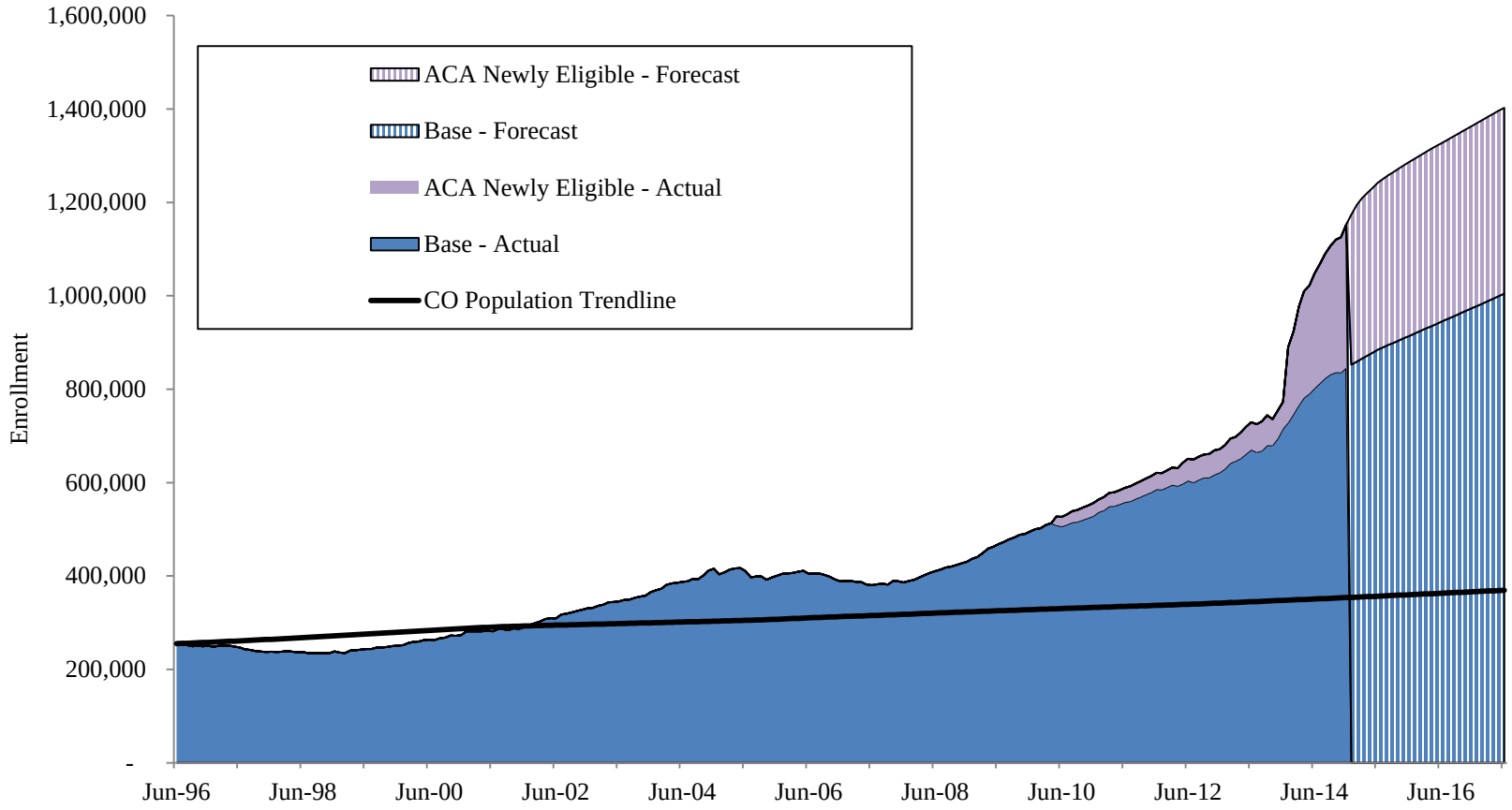
Expenditure Changes FY 14-15 to FY 15-16

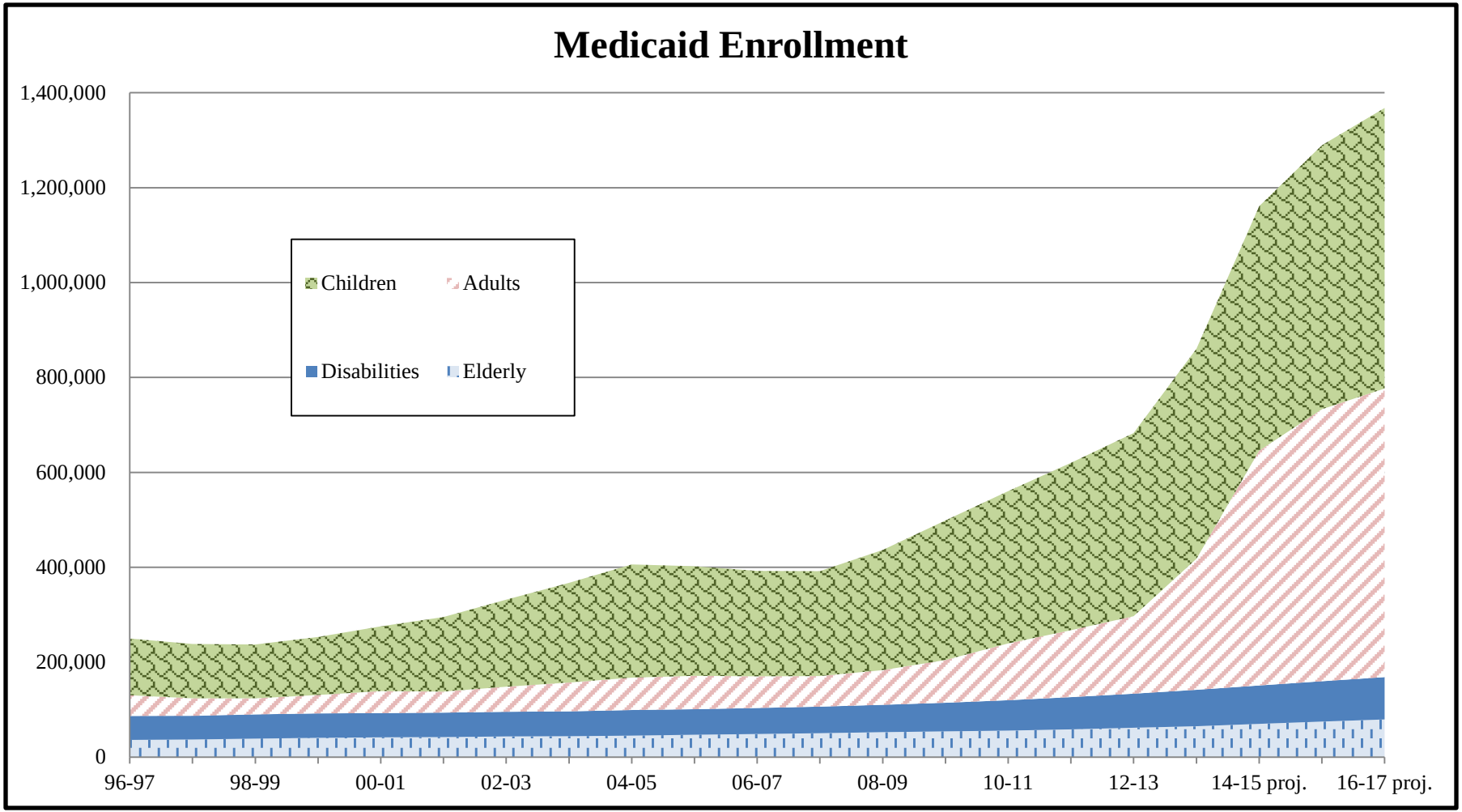


Per Capita Expenditures

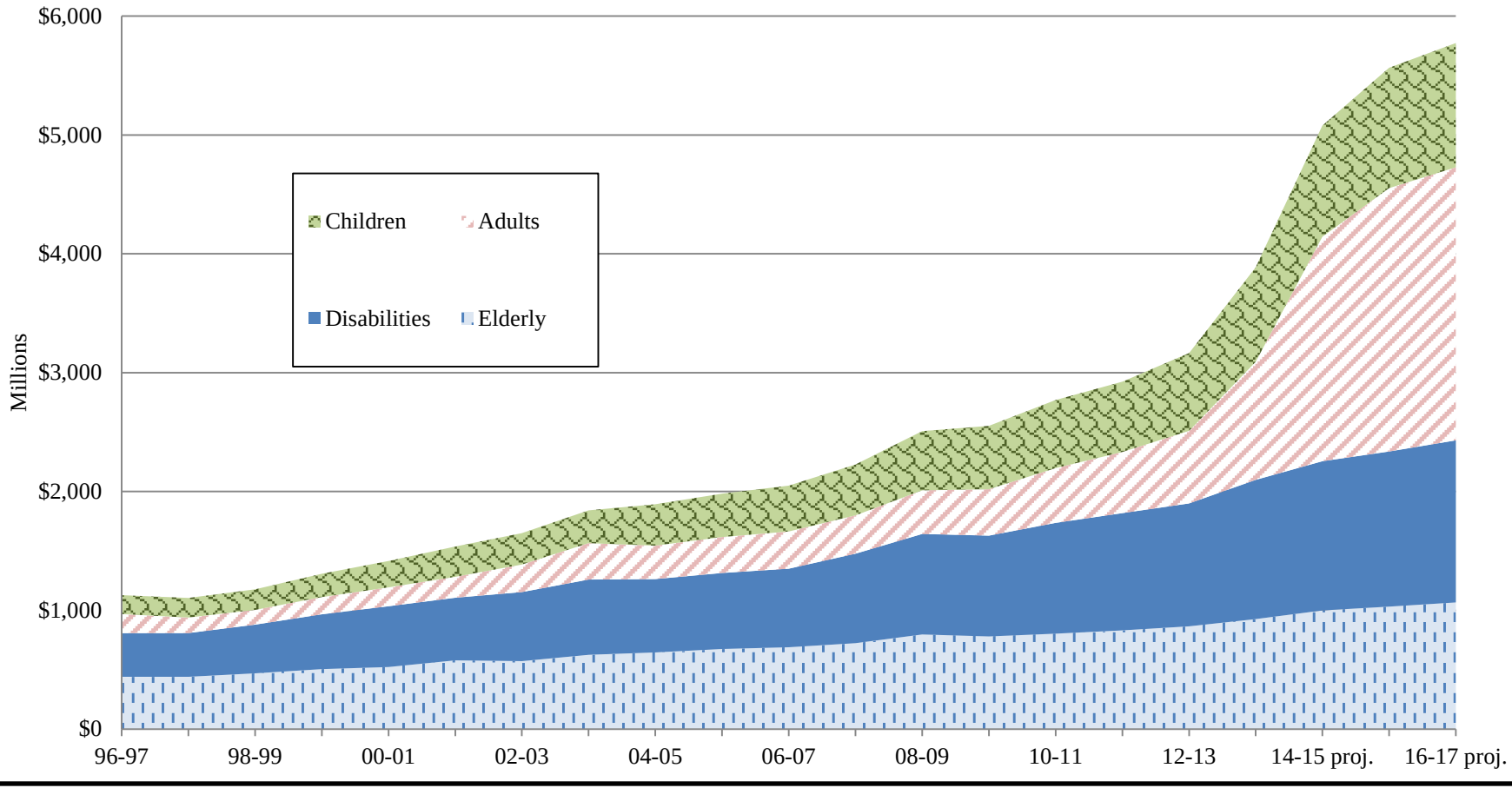


Medicaid Enrollment

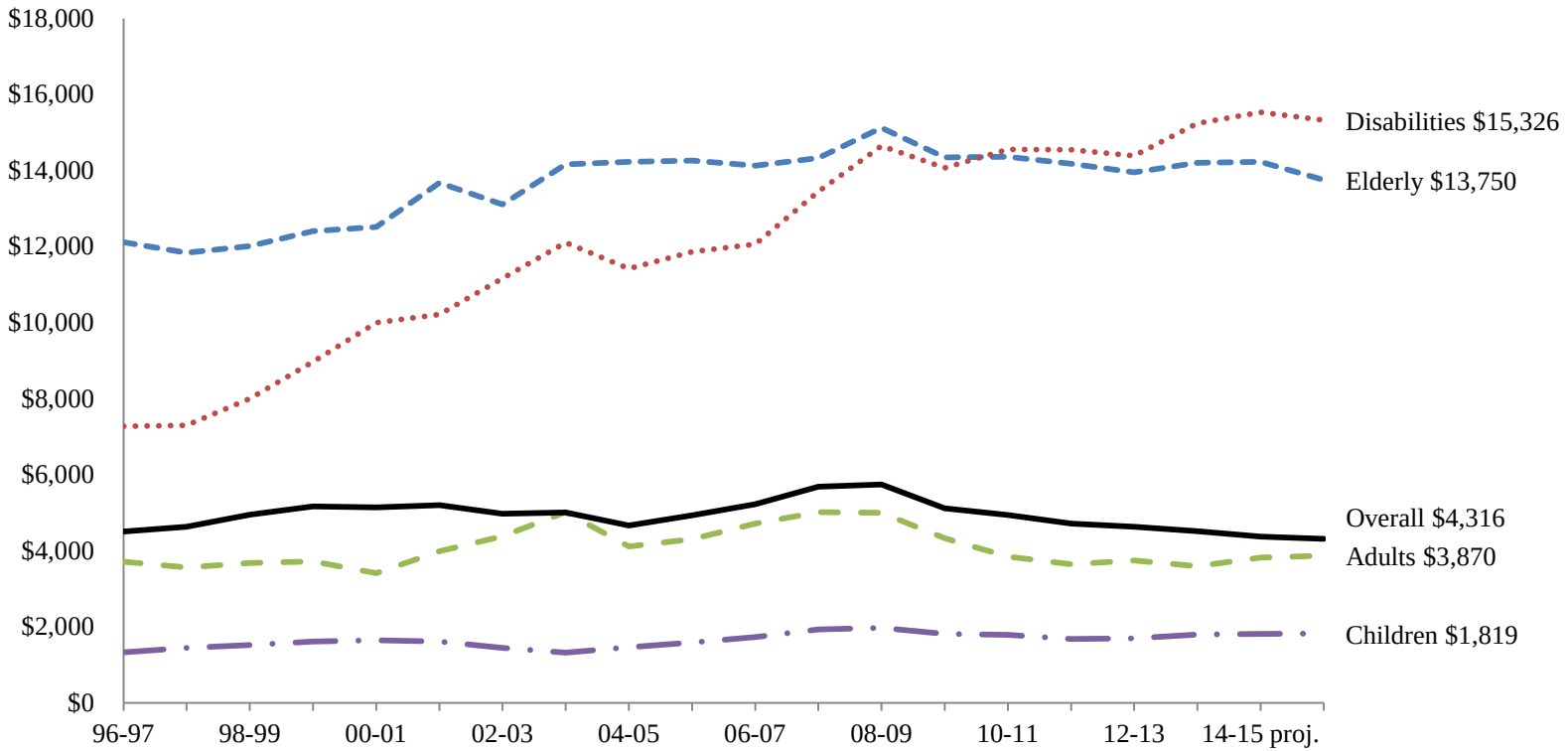



Medicaid Enrollment
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Children
Adults
Disabilities
Elderly
96-97
98-99
00-01
02-03
04-05
06-07
08-09
10-11
12-13
14-15 proj.
16-17 proj.

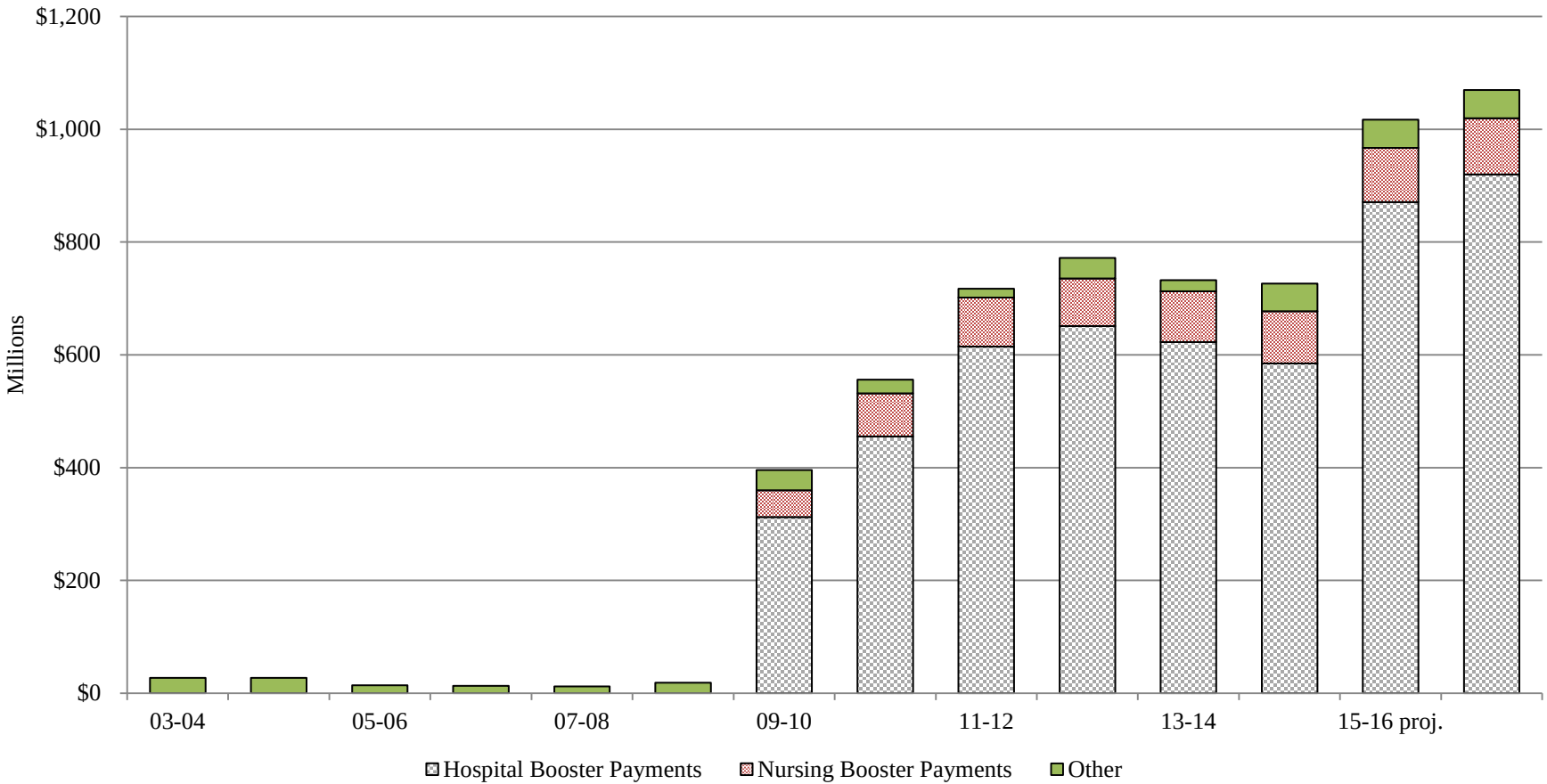
Medical and LTSS Expenditures

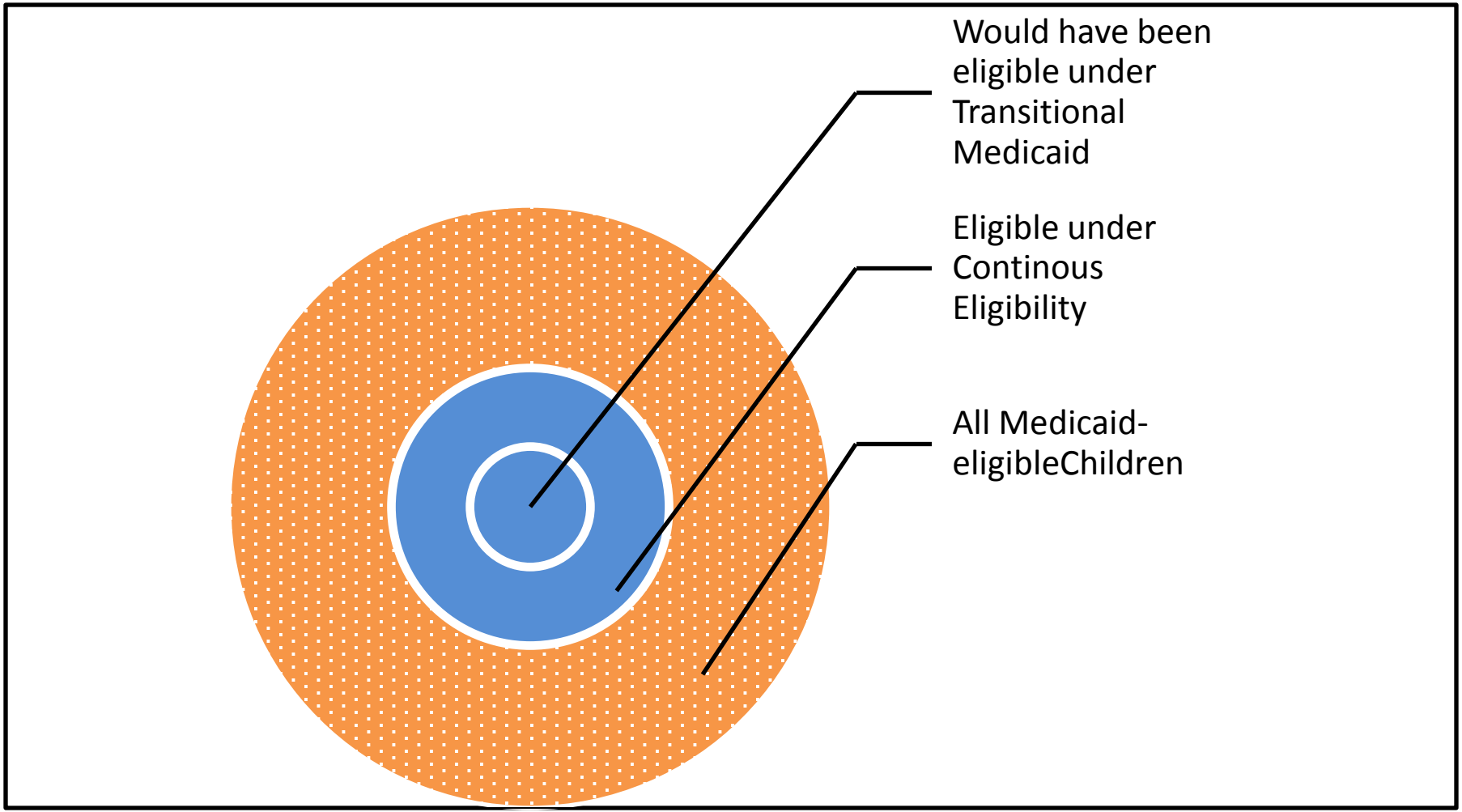


Per Capita Medicaid Expenditures



Booster Payments / Financing

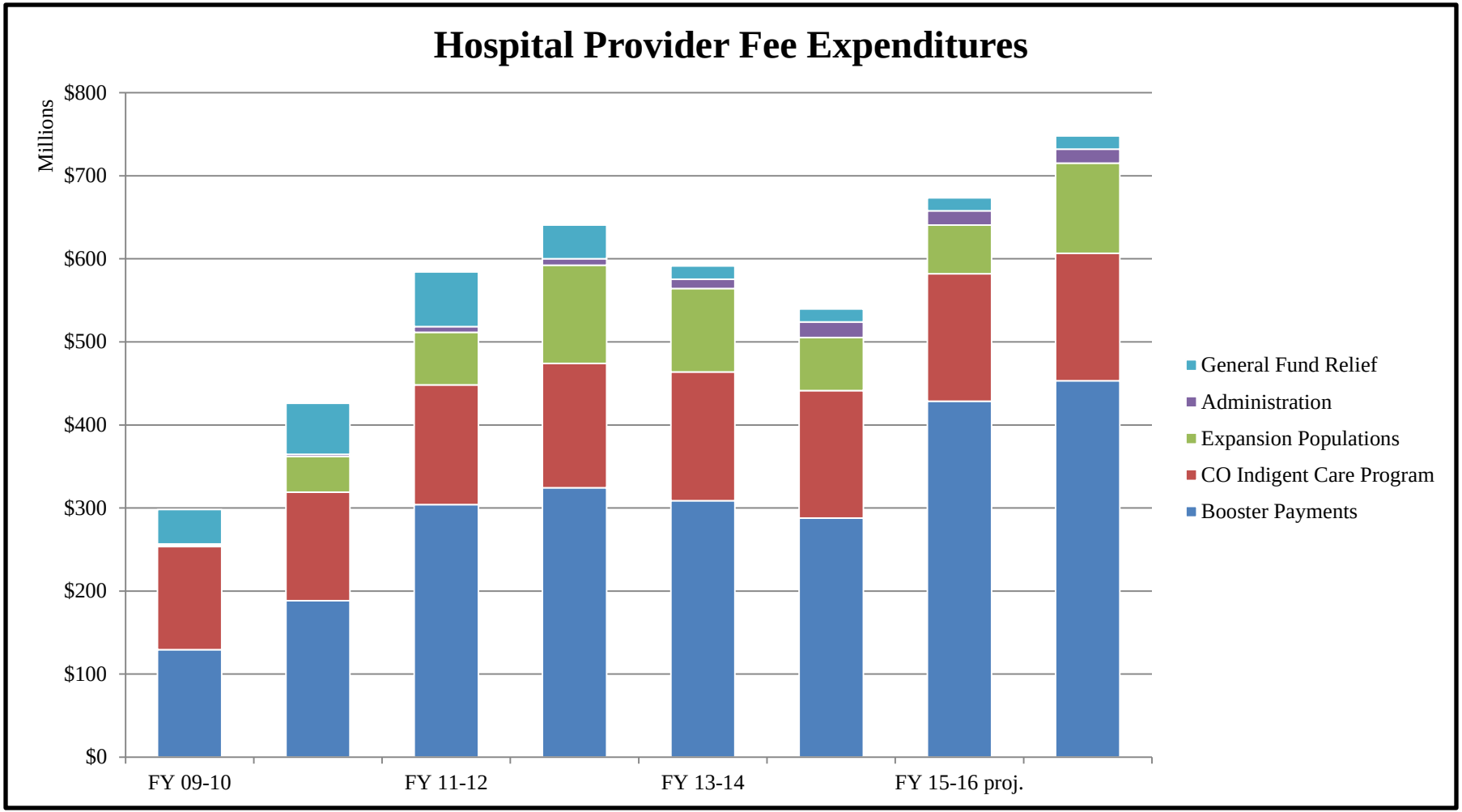



Would have been eligible under Transitional Medicaid
Eligible under Continous Eligibility
All Medicaid-eligibleChildren

Health Care Policy & Financing

Hospitals

Hospitals

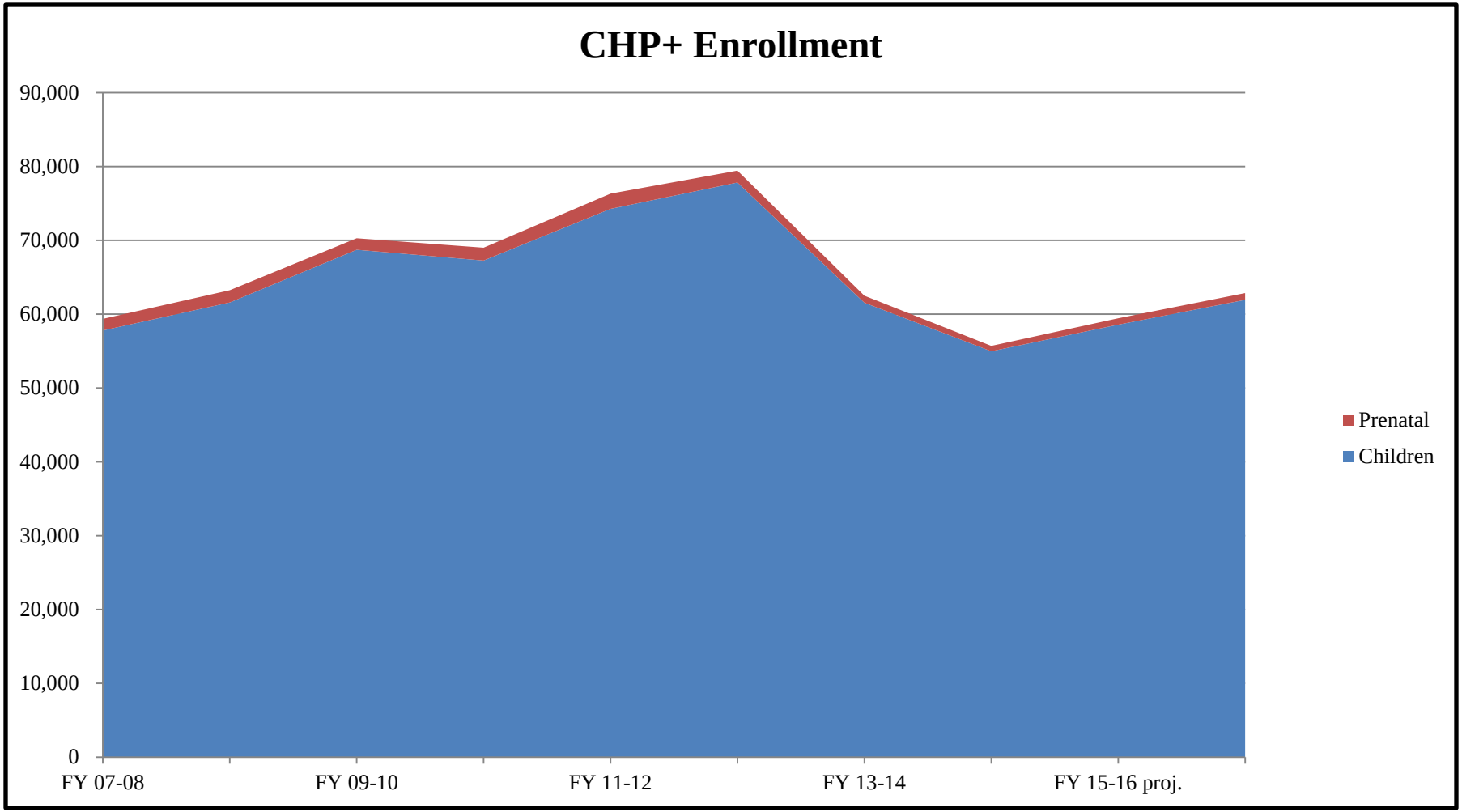

Hospital Provider Fee Expenditures
Millions
$800
$700
$600
$500
$400
$300
$200
$100
$0
FY 09-10
FY 11-12
FY 13-14
FY 15-16 proj.
General Fund Relief
Administration
Expansion Populations
CO Indigent Care Program
Booster Payments

Staff Recommendation	
Net General Fund benefit from limiting HPF revenue	
TABOR Refund	(133,047,916)
Optional increase in hospital rates	31,718,925
TOTAL	(101,328,991)
Net hospital loss from limiting HPF revenue	
Reduced HPF obligation	133,047,916
Booster payments	(270,367,641)
Optional increase hospital rates	0
TOTAL	(137,319,725)

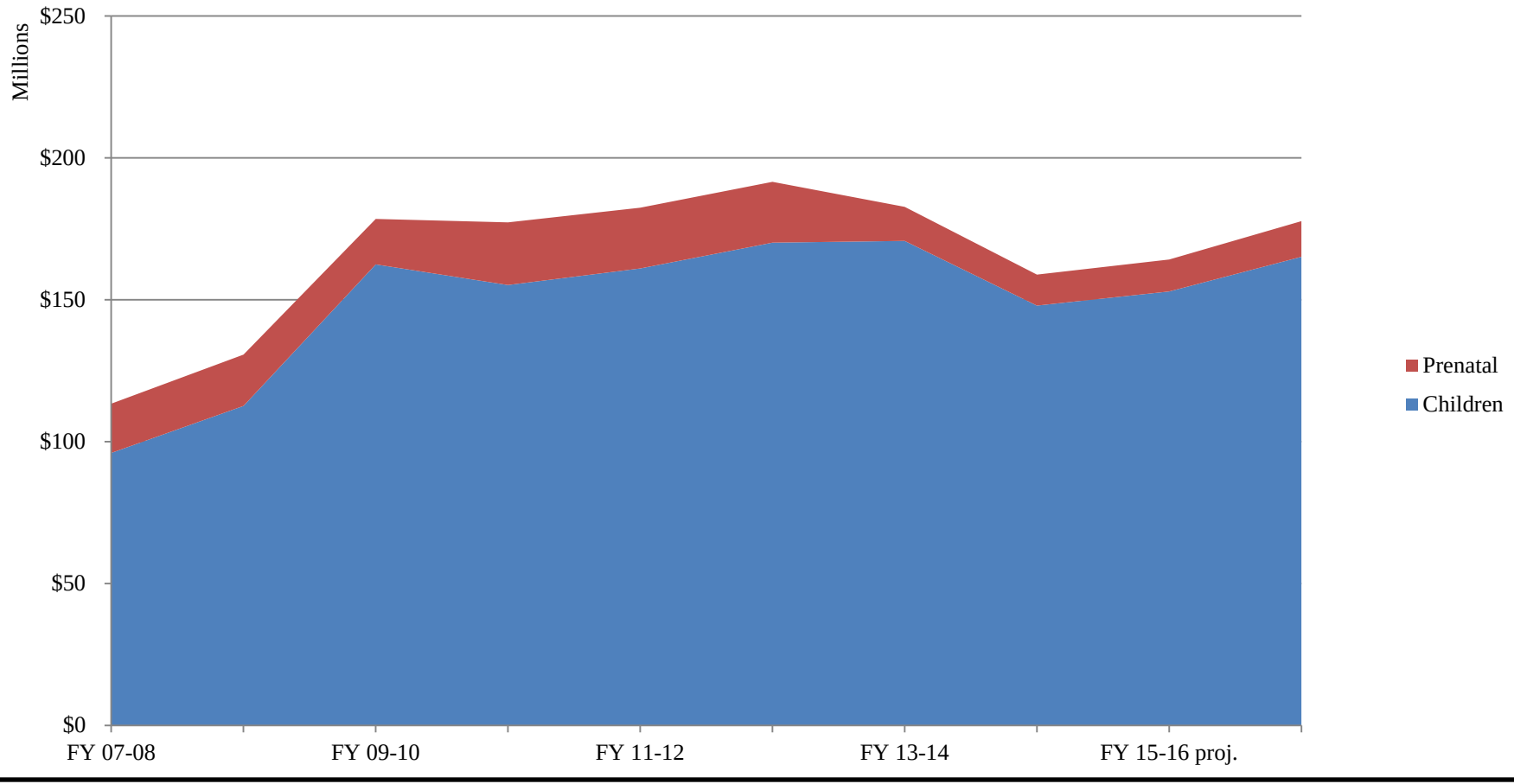
Option 1	
Net General Fund benefit from limiting HPF revenue	
TABOR Refund	(133,047,916)
Optional increase in hospital rates	31,718,925
TOTAL	(101,328,991)
Net hospital loss from limiting HPF revenue	
Reduced HPF obligation	133,047,916
Booster payments	(270,367,641)
Optional increase hospital rates	106,534,899
TOTAL	(30,784,826)

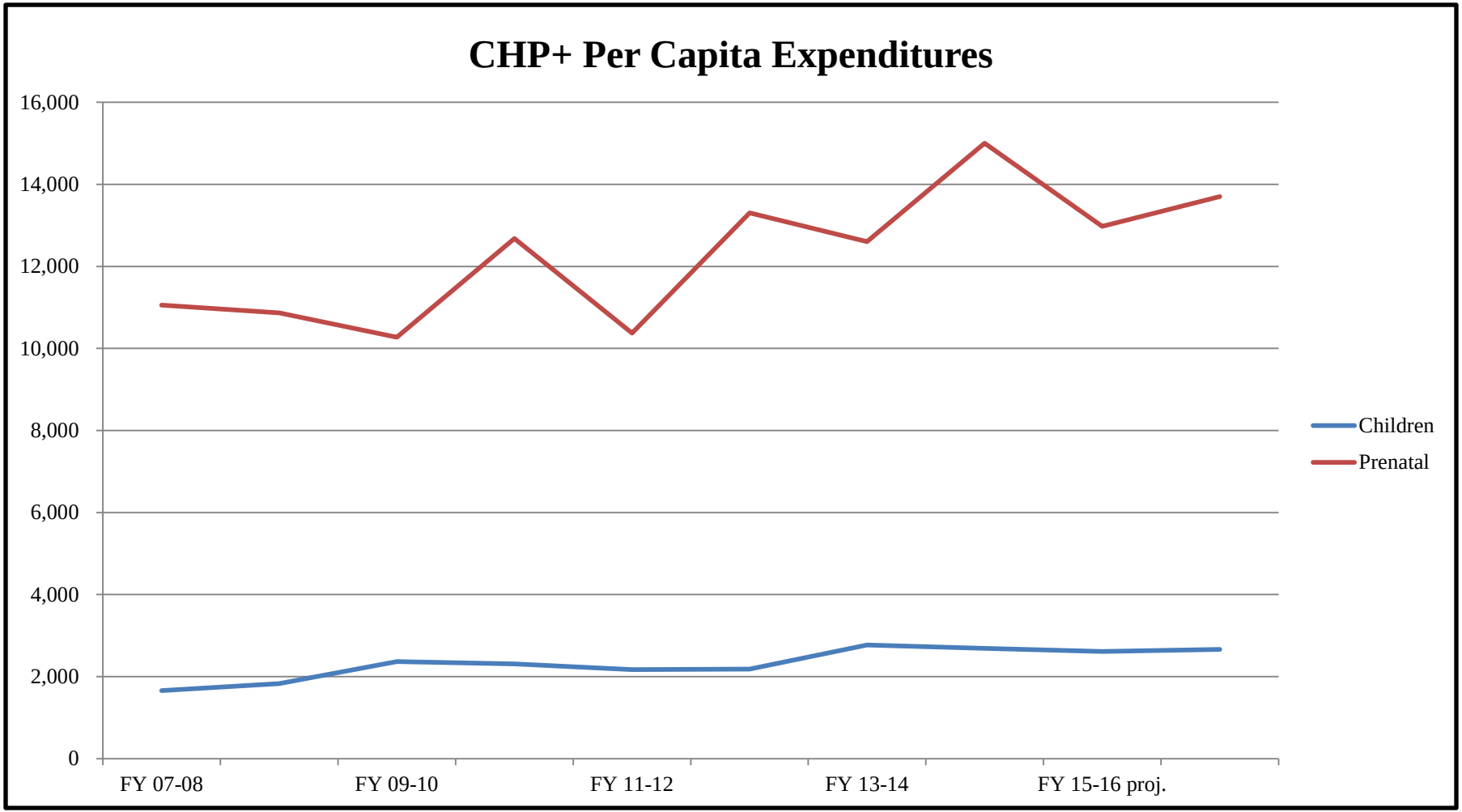
Option 2	
Net General Fund benefit from limiting HPF revenue	
TABOR refund	($133,047,916)
General Fund for rate increase	$42,459,259
General Fund savings	($90,588,657)
Net hospital loss from limiting HPF revenue	
Reduced HPF obligation	$133,047,916
Booster payments	($270,367,641)
Rate increase	$137,319,725
TOTAL	$0

Option 3	
Net General Fund benefit from limiting HPF revenue	
TABOR Refund	(133,047,916)
Optional increase in hospital rates	50,036,546
TOTAL	(83,011,370)
Net hospital loss from limiting HPF revenue	
Reduced HPF obligation	133,047,916
Booster payments	(270,367,641)
Optional increase hospital rates	168,058,606
TOTAL	30,738,881

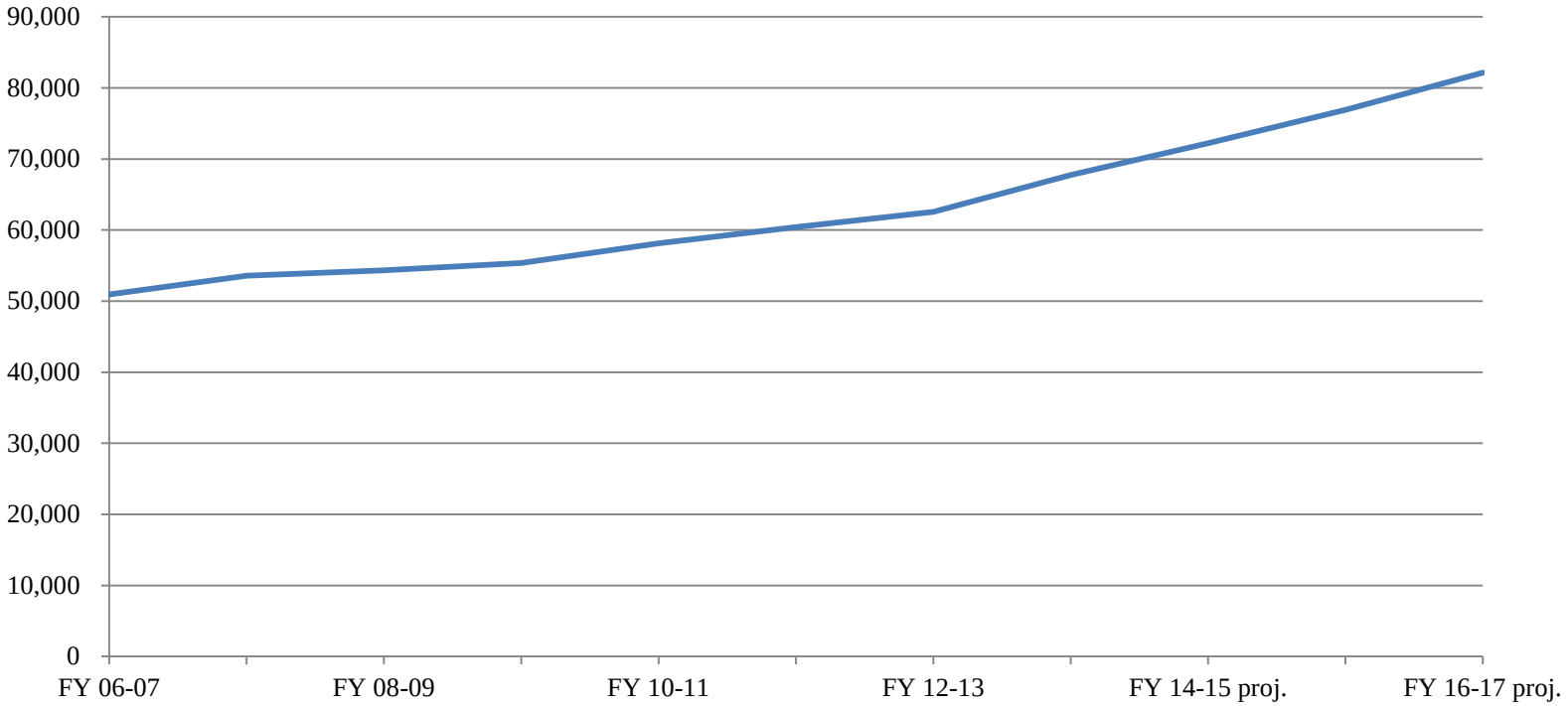

CHP+ Enrollment
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
FY 07-08
FY 09-10
FY 11-12
FY 13-14
FY 15-16 proj.
Prenatal
Children

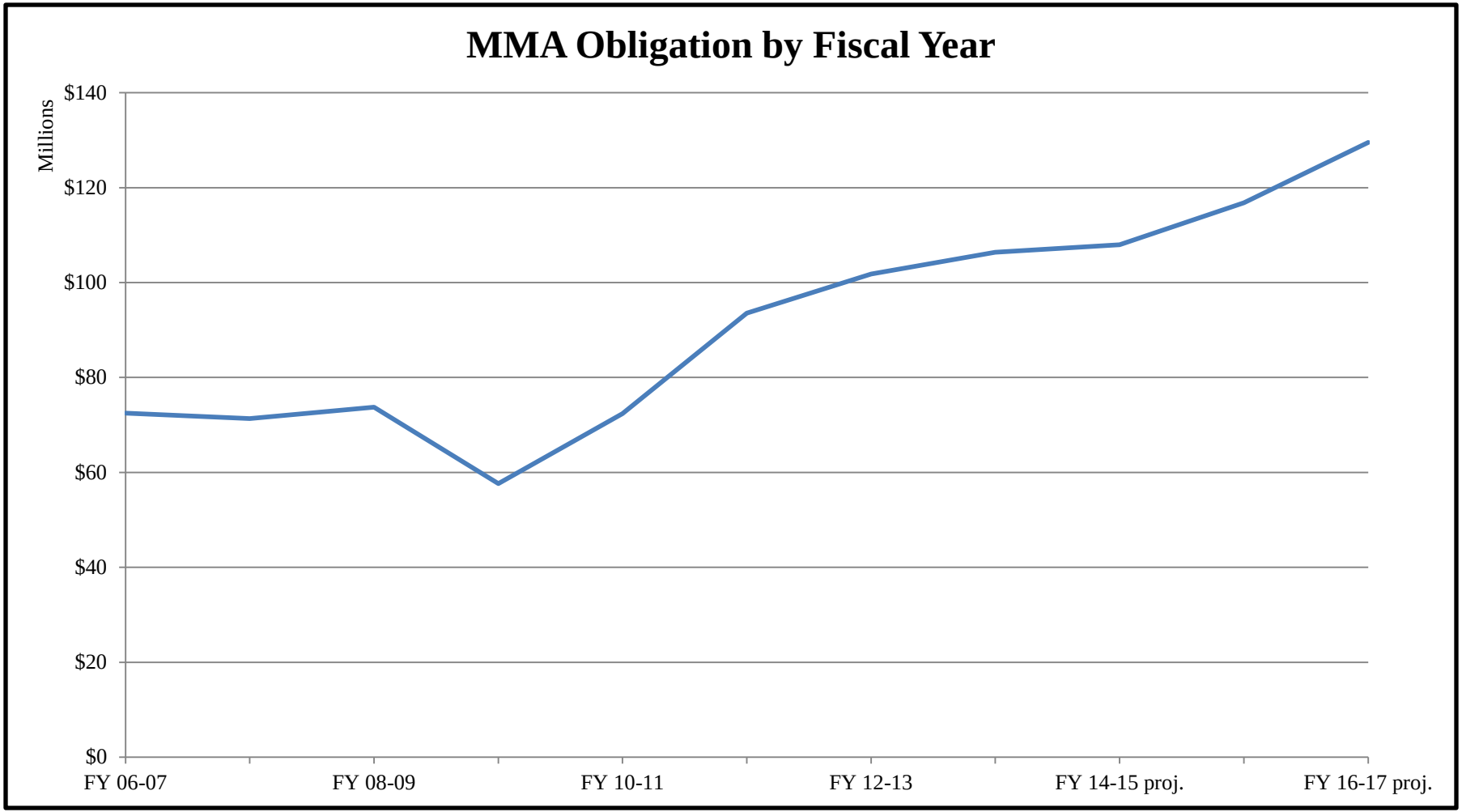
CHP+ Expenditures




CHP+ Per Capita Expenditures
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
FY 07-08
FY 09-10
FY 11-12
FY 13-14
FY 15-16 proj.
Children
Prenatal

MMA Average Monthly Caseload




MMA Obligation by Fiscal Year
Millions
$140
$120
$100
$80
$60
$40
$20
$0
FY 06-07
FY 08-09
FY 10-11
FY 12-13
FY 14-15 proj.
FY 16-17 proj.

MMA Ave. Per Member Per Month