COLORADO GENERAL ASSEMBLY
JOINT BUDGET COMMITTEE

SUPPLEMENTAL REQUESTS FOR FY 2015-16
(Also FY 2013-14 and FY 2014-15)

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

Department Overview

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

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

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

Summary: FY 2015-16 Appropriation and Recommendation

Department of Health Care Policy and Financing: Recommended Changes for FY 2015-16

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
FY 2015-16 Appropriation						
SB 15-234 (Long Bill)	8,873,331,056	2,506,252,972	1,024,522,841	6,110,549	5,336,444,694	413.7
Other legislation	17,123,341	827,638	7,324,383	1,695,000	7,276,320	7.5
HB 15-1367 Contingent appropriations	500,000	500,000	0	0	0	0.0
Current FY 2015-16 Appropriation	**$8,890,954,397**	**$2,507,580,610**	**$1,031,847,224**	**$7,805,549**	**$5,343,721,014**	**421.2**
Recommended Changes						
Current FY 2015-16 Appropriation	$8,890,954,397	2,507,580,610	$1,031,847,224	$7,805,549	$5,343,721,014	421.2
S1 Medical Service Premiums	207,160,125	37,869,753	115,663,744	0	53,626,628	0.0
S2 Behavioral health	(46,143,264)	(16,974,835)	(278,601)	0	(28,889,828)	0.0

Department of Health Care Policy and Financing: Recommended Changes for FY 2015-16						
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
S3 Childrens Basic Health Plan	(22,754,545)	1	(3,785,168)	0	(18,969,378)	0.0
S4 Medicare Modernization Act	(1,318,801)	(1,318,801)	0	0	0	0.0
S5 Office of Community Living caseload adjustment	(14,834,944)	(7,288,014)	0	0	(7,546,930)	0.0
S6 Fed reg for assuring access	267,859	133,930	0	0	133,929	0.0
S7 Fed reg for managed care	0	0	0	0	0	0.0
S9 Provider enrollment fee	2,000,000	0	2,000,000	0	0	0.0
S10 Medicaid-Medicare grant ture up	6,374,303	(276,303)	0	0	6,650,606	0.0
S11 Technical adjustments	7,101,996	30,317	(30,906)	(1,565)	7,104,150	1.0
S12 External quality review fed match	0	207,225	0	0	(207,225)	0.0
S13 Old Age Pension Health and Medical	5,388,407	(3,821,341)	10,081	9,199,667	0	0.0
S14 Public school health services	8,470,989	0	4,126,655	0	4,344,334	0.0
Nonprioritized Requests	3,683,299	1,367,637	479,774	0	1,835,888	0.0
Recommended FY 2015-16 Appropriation	**$9,046,349,821**	**$2,517,510,179**	**$1,150,032,803**	**$17,003,651**	**$5,361,803,188**	**422.2**
Recommended Increase/(Decrease)	$155,395,424	$9,929,569	$118,185,579	$9,198,102	$18,082,174	1.0
Percentage Change	1.7%	0.4%	11.5%	117.8%	0.3%	0.2%
FY 2015-16 Executive Request	**$9,054,435,719**	**$2,539,525,225**	**$1,145,293,916**	**$7,803,984**	**$5,361,812,594**	**422.2**
Request Above/(Below) Recommendation	$8,085,898	$22,015,046	($4,738,887)	($9,199,667)	$9,406	0.0

Prioritized Supplemental Requests

S1 MEDICAL SERVICES PREMIUMS

	Request	**Recommendation**
Total	**$207,160,125**	**$207,160,125**
General Fund	37,869,753	37,869,753
Cash Funds	115,663,744	115,663,744
Federal Funds	53,626,628	53,626,628

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of new **data that was not available** when the original appropriation was made regarding actual enrollment and expenditures.	

Department Request: The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2015-16 appropriation incorporated trend data through December 2014 while the latest forecast used for this supplemental request incorporates data through June 2015. The Department will submit a new forecast in February that uses data through December 2015. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The FY 2015-16 revised projection of expenditures is $207.2 million, or 3.1 percent, higher than the appropriation in total. This is largely due to changes in assumptions about booster payments to hospitals that are financed with the Hospital Provider Fee. The estimated costs for medical services are actually down $50.3 million, or 0.9 percent.

Looking at just the General Fund, the Department is projecting an increase of $37.9 million, or 2.1 percent, primarily due to higher than expected per capita medical services costs for children.

Because the trends are so different for medical services and for booster payments/financing are so different, the table and discussion below describe the two independent of each other.

S1 Medical Services Premiums	Total	General Fund	Cash Funds	Federal Funds
Appropriation	**$6,594,830,484**	**$1,816,359,768**	**$703,597,288**	**$4,074,873,428**
Medical Services	5,648,340,622	1,958,346,824	75,535,542	3,614,458,256
Booster Payments/Financing	946,489,862	(141,987,056)	628,061,746	460,415,172
S1 Forecast	**$6,801,990,609**	**$1,854,229,521**	**$819,261,032**	**$4,128,500,056**
Medical Services	5,598,029,703	$1,988,426,066	$66,110,711	$3,543,492,926
Booster Payments/Financing	1,203,960,906	(134,196,545)	753,150,321	585,007,130
Dollar Difference	**$207,160,125**	**$37,869,753**	**$115,663,744**	**$53,626,628**
Medical Services	(50,310,919)	30,079,242	(9,424,831)	(70,965,330)
Booster Payments/Financing	257,471,044	7,790,511	125,088,575	124,591,958
Percent Difference	**3.1%**	**2.1%**	**16.4%**	**1.3%**
Medical Services	-0.9%	1.5%	-12.5%	-2.0%
Booster Payments/Financing	27.2%	-5.5%	19.9%	27.1%

Medical Services

There are lots of little stories that compound to explain the change in the projection, but there are two big stories responsible for the lion's share of the difference:

- The Department increased projected base acute care expenditures by $79.3 million total funds, including $47.9 million General Fund. In this context, base acute care expenses are those acute care expenses without special financing. Most of the change is due to increasing assumptions about per capita costs for children. Last year, the Department assumed that a rapid increase in enrollment of children, attributable to secondary effects of outreach efforts related to the Medicaid expansion, would put downward pressure on per capita expenditures,

with new enrollees needing time to connect with providers and new enrollees generally being healthier than the base population. However, actual per capita costs for children have been higher than anticipated. For example, for acute care the Department previously projected FY 14-15 per capita expenditures for children to 106% percent of the FPL would be $1,617.93 and that would remain unchanged in FY 15-16 before policy adjustments approved by the General Assembly. The actual per capita expenditure for this population in FY 14-15 was $1,637.29 and the Department has raised the forecast for FY 15-16 before policy changes to $1,645.48. Children are one of the largest enrollment categories and the state share of financing for children comes from the General Fund, so the $27.55 difference in the base per capita assumption, or 1.7 percent difference, makes a large dollar difference in both the total funds and General Fund forecast. The Department also increased cost assumptions for policies approved by the General Assembly that affect per capita expenditures for children, most notably for the primary care rate bump, where utilization has been higher than expected. This adjustment should be interpreted as a correction of a forecast error, and not an indicator that utilization has increased. The data the Department pulled last year to make the original forecast of the primary care rate bump did not capture all the eligible codes.

- The Department decreased projected acute care expenditures for adults without dependent children by $112.2 million total funds, all from federal funds. This is again primarily due to a change in per capita cost assumptions based on actual utilization in FY 2014-15, but in this case the Department lowered the per capita estimate. This is an expansion population that the Department had very little experience serving. There are many potential causes of the lower-than-expected per capita expenditures in FY 2014-15, including potentially the population being healthier than expected, the new clients having trouble connecting with providers, the new clients being served primarily by less-costly providers, or some combination of many factors.

Booster Payments/Financing

Almost all the variance in the booster payments/financing is attributable to changes in the Hospital Provider Fee. Delays in approval from the Centers for Medicare and Medicaid Services (CMS) of the Department's Hospital Provider Fee distribution plan caused a large increase in payments the Department had expected to occur in FY 2014-15 to move to FY 2015-16.

There were two main reasons the Department had been expecting a large increase in expenditures in FY 2014-15:

- The expansion of Medicaid eligibility increased the revenue the Department could collect under federal limits on the Hospital Provider Fee. Prior to the expansion, the most restrictive federal limit on Hospital Provider Fee revenues was the Upper Payment Limit (UPL). 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. With the expansion there were more instances of an incremental difference between the Medicaid and Medicare reimbursement, so the dollar room under the UPL increased significantly. The most restrictive federal limit on Hospital Provider Fee revenue is now six percent of net patient revenues.

- Revenue collections in FY 2013-14 were artificially low due to carrying a large balance forward from the prior year, conservative forecasting after some federal disallowances in prior years, and uncertainty about Medicaid expansion populations.

Approval from CMS of the large increase was delayed so that the Department had to operate under the model year 2013-14 plan for all of FY 2014-15. When CMS finally granted approval of the increase it was too late to reconcile revenue collections and disbursements in state FY 2014-15. All of the reconciliation occurred at the beginning of FY 2015-16. As a result, the projected revenues and expenditures for FY 2015-16 spiked.

The spike in revenues and expenditures might have been larger, but the Department changed assumptions about the schedule of collections and expenditures for state FY 2015-16. Each year CMS approves a model year plan for the Hospital Provider Fee that is based on the federal fiscal year, which crosses two state fiscal years. Up until state FY 2015-16 the Department had always collected three quarters of the model year's revenues in the first state fiscal year and the remaining quarter in the second state fiscal year. For model year 2015-16 the Department changed the schedule of collections to allow more time for potential delays in CMS approval. For the first three quarters of model year 2015-16, which are the last three quarters of state FY 2015-16, the Department will collect and disburse revenues at the model year 2014-15 rate and then in the last quarter of model year 2015-16, which is the first quarter of state FY 2016-17, the Department will increase collections and disbursements to account for the differences in the model years.

Staff Recommendation: Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law. If the February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

S3 CHILDREN'S BASIC HEALTH PLAN

	Request	Recommendation
Total	**($22,754,545)**	**($22,754,545)**
General Fund	1	1
Cash Funds	(3,785,168)	(3,785,168)
Federal Funds	(18,969,378)	(18,969,378)

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of new **data that was not available** when the original appropriation was made regarding actual enrollment and expenditures.	

Department Request: The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2015-16 appropriation incorporated trend data through December 2014 while the latest forecast used for this supplemental request incorporates data through June 2015. The Department will submit a new forecast in February that uses data through December 2015. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The Department lowered projected expenditures in FY 2015-16 primarily because FY 2014-15 expenditures were lower than expected. The Department describes this as a bucketing issue where the Department overestimated Children's Basic Health Plan (CHP+) caseload and underestimated the Medicaid children caseload. The Department lowered the projected number of children on CHP+ by 924 for FY 2015-16. Some of these children contributed to the increase in the FY 2015-16 projected children on Medicaid with family income from 107 percent to 147 percent of the FPL (children eligible through S.B. 11-008) of 3,684. The federal match rate for CHP+ and for Medicaid children eligible through S.B. 11-008 is the same (an average for state FY 2015-16 of 82.8 percent). The per capita costs for children on Medicaid tend to be lower than the per capita costs for children on CHP+.

Staff Recommendation: Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. All of the expenditures contained in the supplemental are for programs authorized in current law. If the February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

As discussed at the briefing, projected revenues for the CHP+ Trust exceed projected expenditures for the time period the program is authorized at the federal level. This is primarily due to the recent dramatic increase in the federal match rate for the CHP+ program. Legislative Legal Services has reviewed the CHP+ Trust statutes and indicates no statutory change would be necessary to use the money in the CHP+ Trust in place of General Fund for the Medical Services Premiums line item for the Medicaid children eligible through S.B. 11-008. The Department is projecting it will spend $15.9 million on the S.B. 11-008 children in FY 2015-16. The JBC could consider spending down some of the projected balance in the CHP+ Trust in this way, if necessary to help balance the FY 2015-16 budget.

Children's Basic Health Plan Trust					
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Beginning Fund Balance	$13,937,178	$18,291,567	$26,104,511	$39,995,315	$52,027,384
Revenue	$31,840,037	$28,998,891	$28,992,549	$28,766,805	$28,861,088
Fees	896,127	1,205,499	1,299,858	1,376,216	1,470,499
Tobacco Settlement	27,889,272	27,600,000	27,500,000	27,200,000	27,200,000
Interest	195,419	193,392	192,691	190,589	190,589
Recoveries	2,859,220	0	0	0	0
Expenses	$27,485,649	$21,185,947	$15,101,745	$16,734,736	$17,315,691
Net Cash Flow	$4,354,389	$7,812,944	$13,890,804	$12,032,069	$11,545,397
Ending Fund Balance	$18,291,567	$26,104,511	$39,995,315	$52,027,384	$63,572,782

S4 MEDICARE MODERNIZATION ACT

	Request	Recommendation
Total	**$16,865,498**	**$1,318,801)**
General Fund	16,865,498	(1,318,801)

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of new **data that was not available** when the original appropriation was made regarding actual enrollment and expenditures.	

Department Request: The Department requests funding based on a new projection of enrollment and expenditures under current law. The forecast used for the original FY 2015-16 appropriation incorporated trend data through December 2014 while the latest forecast used for this supplemental request incorporates data through June 2015. The Department will submit a new forecast in February that uses data through December 2015. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill.

The federal Medicare Modernization Act requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula. This payment is sometimes referred to as the "clawback." Costs are driven by the number of clients who are eligible for both Medicaid and Medicare, their utilization of prescription drugs, and nuances of the federal formula that estimates the state share of costs.

Staff Recommendation: Staff recommends a reduction of $1,318,801 General Fund, rather than the request. The request contains a technical error. Rather than asking for the difference between the appropriation and the revised projection of expenditures for FY 2015-16, the Department mistakenly asked for the difference between projected expenditures for FY 2015-16 and FY 2016-17. The Department agrees this was a technical error in the request.

The projected decrease in expenditures is the net result of a decrease in the projected caseload and an increase in the per member per month charge according to the federal formula due to an unusually large 11.76% annual percentage increase in average per capita aggregate Medicare prescription drug expenditures.

S6 FED REG FOR ASSURING ACCESS

	Request	Recommendation
Total	**$267,859**	**$267,859**
General Fund	133,930	133,930
Federal Funds	133,929	133,929

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of **data that was not available** when the original appropriation was made. The final rule is different than the proposed rule	

Department Request: The Department requests resources to implement a new federal rule regarding assuring access to providers for Medicaid clients. The request for FY 2015-16 is primarily for contract actuarial services, but includes $14,109 total funds, including $7,055 General Fund, for one-time operating costs for 3.0 new FTE that would be hired June 1, 2016. A corresponding budget amendment requests $505,986 total funds, including $252,994 General Fund, in FY 2016-17 for the cost of the new FTE and continuation of the contract actuarial services.

The new rule requires the Department to assess Medicaid client access to care and the relationship between provider rates and access to care. The Department is concerned that failure to comply with the new federal rule could affect the Department's ability to implement proposed provider rate reductions in FY 2016-17.

Some of the requirements of the new federal rule overlap with provisions of S.B. 15-228, sponsored by the JBC, which established an annual provider rate review process. The Department received 4.0 FTE and $250,000 for contract actuarial services to implement S.B. 15-228. However, the Department believes some of the provisions of the new federal rule are significantly different than the requirements of S.B. 15-228, necessitating additional resources.

The following are key differences between the new federal rule and S.B. 15-228 that were highlighted by the Department as driving the need for the new resources:

- Regional analysis of access – The new federal rule requires states to describe the characteristics of Medicaid clients by geographic area, assess local access needs, and track changes in Medicaid client utilization by region over time. It also requires procedures for collecting regional provider and beneficiary feedback. Pursuant to S.B. 15-228 the Department's rate review is required to include analysis of access, service, quality, and utilization, as well as collect public input, but the bill does not require regional analysis and regional feedback.
- Three-year review cycle – The new federal rule requires analysis of provider rates at least once every three years for primary care services, physical specialist services, behavioral health services, pre- and post-natal obstetric services, and home health services. In S.B. 15-228 the Department was required to review rates on a 5-year cycle. Also, S.B. 15-228 allowed exceptions for rates that are adjusted on a periodic basis as a result of state or federal laws or regulations. As a result, behavioral health rates that are capitated and must be adjusted annually by federal regulation to be actuarially sound were exempted from the S.B. 15-228 review. Also, rates for Federally Qualified Health Centers and hospitals that are cost-based were exempted from S.B. 15-228, but rates for services covered by the federal rule, such as pre- and post-natal obstetrics, that are performed in these settings will need to be reviewed under the federal rule.
- Services receiving access complaints – The new federal rule requires separate analysis of services with a high volume of complaints. It is not clear how many rates might require this special review, but the Department will need to demonstrate that it has a process for tracking access complaints across all communication mediums and evaluating the merits of complaints to determine what requires additional review.
- Assessment of access to care with State Plan Amendment – Pursuant to the new federal rule, for any rate reduction or restructure that requires a State Plan Amendment, the Department must submit an assessment of how access to care would be affected, collect feedback from stakeholders, and submit analysis of the feedback. The Department must also monitor the effect on access for three years after the rate reduction or restructure is implemented. The Governor's request for FY 2016-17 includes several rate reductions that the Department anticipates would be subject to this requirement, including a 1.0 percent across-the-board community provider rate reduction, the end of the primary care rate bump, and restricting hospital provider fee revenue by $100 million. If the General Assembly approves these rate reductions, it will require the Department to do rate reviews before they are scheduled to occur pursuant to S.B. 15-228.
- Remediation of rate deficiencies – If any of the procedures described above identify issues with access to care, the Department must submit a plan within 90 days with specific steps and timelines to remediate the deficiencies.

The Department estimates it needs $253,750 for roughly 1,250 hours of actuarial services to assist with comparing Colorado Medicaid rates to available benchmarks. This is based on the Department's experience responding to Legislative Request for Information #1 that asked for a

comparison of Colorado Medicaid rates to Medicare or usual and customary rates. The Department anticipates the data will need to be updated and regionalized to satisfy the new federal rule for the rates the Governor proposes reducing in FY 2016-17, and then periodically recalculated for each rate as it comes up for review in the three-year cycle.

In addition, the Department requests three FTE to be hired June 1. Due to the paydate shift, the costs in FY 2015-16 would be restricted to one-time costs for office equipment and computers of $14,109, with ongoing costs for salaries and benefits beginning in FY 2016-17 of $252,236. The FTE would include:

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

Staff Recommendation: Staff recommends the request with modifications for the JBC's common policies on new FTE. The need for funding is driven by the final rule that was issued November 2 and included several unexpected provisions that were not part of the proposed rule, including the requirement for a regional analysis of access, the three-year review cycle, and the requirement for an assessment of access to care with State Plan Amendments.

Although the JBC staff is recommending the request, the JBC staff has some concerns that the Department's cost estimates are high. In particular, the request for contract actuarial services appears to overlap with funding provided for the same purpose in S.B. 15-228 and the JBC staff wonders if the Department could eliminate this cost by aligning the review schedule in S.B. 15-228 with the three-year cycle required by the federal rule. The JBC staff decided to recommend the request based on uncertainty about how the new federal rule will be implemented by CMS. It could be costly for the state if skimping on administrative expenses resulted in CMS denying a provider rate reduction, due to insufficient analysis of the effect on access. Funding in this area could be revisited in future years after some experience with the new regulation.

Funding for this request is particularly important in light of the provider rate reductions proposed by the Governor for FY 2016-17. The proposed rate reductions include a 1.0 percent across-the-board community provider rate decrease, the end of the primary care rate bump, and restricting hospital provider fee revenue by $100 million. If the General Assembly approves all or some of these requests the Department will need to submit to CMS an analysis of the effect of the rate reductions on access. The analysis will require a significant amount of work from the Department and the results of the analysis could potentially lead CMS to deny a rate reduction, or require an access remediation plan. Providing funding for this request does not guarantee

CMS approval of provider rate decreases, but it provides the resources the Department estimates are needed to make a good faith effort to comply with the new federal regulation.

The table below summarizes the staff recommendation.

S6 Fed Reg for Assuring Access						
			FY 2015-16		FY 2016-17	
	Units	Rate	Amount	FTE	Amount	FTE
Personal Services						
Access Data Analyst - Statistical Analyst III		$5,372	$0	0.0	$64,464	1.0
Rate Benchmarking Analyst - Rate/Financial Analyst III		$5,215	$0	0.0	$62,580	1.0
Client Access Specialist - General Professional IV		$4,907	$0	0.0	$58,884	1.0
Subtotal			$0	0.0	$185,928	3.0
PERA		10.15%	$0		$18,872	
Medicare		1.45%	$0		$2,696	
Personal Services			$0	0.0	$207,496	3.0
Operating						
Regular FTE Operating Expenses	3	$500	$0		$1,500	
Telephone Expenses	3	$450	$0		$1,350	
PC, One-Time	3	$1,230	$3,690		$0	
Office Furniture, One-Time	3	$3,473	$10,419		$0	
Operating Expenses			$14,109		$2,850	
General Professional Services						
Actuarial Analysis	1,250	$203	$253,750		$253,750	
TOTAL			$267,859	0.0	$464,096	3.0
General Fund			$133,930		$232,048	
Federal Funds			$133,929		$232,048	
Not recommended, per JBC common policy:						
Health, Life, Dental					$23,781	
Short-term disability					$353	
Amortization Equalization Disbursement (AED)					$8,924	
Supplemental AED					$8,832	

S7 FED REG FOR MANAGED CARE

	Request	Recommendation
Total	**$18,812**	**$0**
General Fund	9,406	0
Federal Funds	9,406	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of **an unforeseen contingency**. The Department had expected the federal Centers for Medicaid and Medicare Services to allow postponement or waiver of a provider enrollment fee, but this did not occur.	

Department Request: The Department requests resources to implement a proposed new federal rule regarding managed care. The request for FY 2015-16 is for one-time operating costs for 4.0 new FTE that would be hired June 1, 2016. A corresponding budget amendment requests $722,809 total funds, including $361,405 General Fund, in FY 2016-17. The FY 2016-17 amount includes $321,309, including $295,655 General Fund, for the ongoing costs for the new FTE, plus $401,500, including $200,750 General Fund, to increase the scope of actuarial and quality review contracts to comply with the proposed federal rule.

The federal Centers for Medicare and Medicaid Services (CMS) issued the proposed new rule governing managed care services for clients in Medicaid and the Children's Basic Health Plan (CHP+) on June 1, 2015. The Department indicates the scope of changes is unusually large and would require significant new resources to implement. Based on the pattern for other recently announced rules, including the Methods for Assuring Access to Covered Medicaid Services, the Department anticipates that from the date the final rule is announced states will have 60 days to comply. Failure to comply could result in federal disallowances of payments to managed care entities.

In FY 2014-15 the Department spent just under $1 billion on full risk managed care contracts for behavioral health, Rocky Mountain Health Plan, Denver Health, and CHP+. In addition, the Department expects a large portion of the proposed new rule would apply to contracts through the Accountable Care Collaborative, which the Department is in the process of reprocuring. The tables below summarize the Department's managed care contracts.

FY 2014-15 Expenditure and Average Enrollment by Full-Risk Managed Care Plan		
Managed Care Plan	**Expenditure**	**Average Enrollment**
Medicaid		
Behavioral Health Organizations		
Access Behavioral Care Northeast	$64,723,895	181,205
Access Behavioral Care Denver	$89,357,350	140,902
Behavioral Healthcare Inc.	$127,572,765	273,924
Colorado Health Partnerships	$195,890,203	389,459
Foothills Behavioral Health Partners	$92,609,291	139,497
Subtotal: Behavioral Health Organizations	**$570,153,504**	**1,124,987**
Physical Health Managed Care Plans		
Rocky Mountain Health Plan (RMHP Prime)	$130,526,394	20,921
Denver Health	$162,333,678	66,453
Subtotal: Physical Health Managed Care Plans	**$292,860,072**	**87,374**
CHP+		
Colorado Choice	$2,717,662	1,913
Rocky Mountain Health Plans	$14,860,469	32,168
Denver Health	$7,491,492	1,376
Kaiser Permanente	$13,571,652	4,192
Colorado Access	$49,200,340	7,264
Colorado Access or State Managed Care Network (SMCN)	$31,024,648	7,474
Subtotal: CHP+	**$118,866,263**	**54,387**
Grand Total: Medicaid and CHP+[1]	**$981,879,839**	

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

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

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

- State Comprehensive Quality Strategy -- The proposed new rule would require a comprehensive quality strategy for all programs (not just managed care) that includes measurable goals and objectives for continuous quality improvement. The rule requires public input and tribal consultation on the quality strategy.
- Actuarially sound Capitation Rates for Medicaid Managed Care Programs -- The proposed new rule would require an actuarially sound rate for each rating cohort. Current rules allow the use of an actuarially sound rate range, rather than requiring certification of individual rates.
- Encounter Data and Health Information Systems -- The proposed new rule would require all encounter data submitted by managed care plans to be audited for accuracy, completeness, and timeliness. All the Department's managed care contracts would need to be amended to add this requirement and monitored by the Department.
- Medical Loss Ratio -- The proposed new rule would establish a standard Medical Loss Ratio (MLR) for all managed care contracts. The MLR defines the allowable premium revenue to medical costs and the remainder that can be used for administration and profit. The Department would be involved in the calculation of the standard MLR and all of the Department's managed care contracts would need to modified and monitored for compliance.

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

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

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

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

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

Staff Recommendation: Staff does not recommend approval of the supplemental. This is a proposed rule that is not yet final. Many states are raising concerns about the scope of the changes and the administrative burden they represent, including states that rely much more heavily on managed care than Colorado. It might be a long time before the final rule is issued, and the final rule may differ significantly from the proposed rule, as was the case with the rule regarding assuring access to providers for Medicaid clients discussed in S6 above. The Department notes in the request that CMS has not provided guidance on whether all changes would need to be implemented immediately, or if states will be able to adopt the rules over time. The JBC staff believes it would be unreasonable for CMS to assume that states will provide supplemental funding to begin implementing the proposed rule and that if CMS tried to impose an implementation timeline that required supplemental funding a majority of states would not comply, resulting in a national problem for CMS.

While the JBC staff believes a supplemental is not justified, some increase in administrative funding through the normal budget process for FY 2016-17 may be warranted in anticipation of the new rule. When CMS proposed a new rule regarding assuring access to providers for Medicaid clients, the JBC included provisions in S.B. 15-228 intended to match up with those provisions, to the extent that the proposed new rule overlapped with the priorities of the General

Assembly regarding provider rates. The JBC staff would like to see a similar approach with the proposed new rule regarding managed care where additional administrative funding is provided where the General Assembly agrees with the intent and purpose of the proposed new rule. For provisions of the proposed new rule that don't fit the General Assembly's priorities, staff recommends waiting to see if the provisions are included in the final rule before providing funding. For example, the Department indicates some of the most significant provisions of the new rule relate to the state comprehensive quality strategy. This seems to align with efforts the General Assembly has made to improve performance and quality systems through the SMART Act and related initiatives and might be something the JBC wants to support. On the other hand, the provisions of the new rule requiring actuarial certification of individual managed care rates instead of using an actuarially certified range for the rates seems needlessly prescriptive and takes away some of the state's authority over provider rates, and so it is hard to see this aligning with the General Assembly's policy priorities. The JBC staff intends to work with the Department to identify portions of the proposed new rule that the Department believes represent good policy changes, as opposed to just a new mandate, and may recommend additional administrative funding at figure setting for those policy changes.

S9 PROVIDER ENROLLMENT FEE

	Request	Recommendation
Total	**$1,180,463**	**$2,000,000**
Cash Funds	1,180,463	2,000,000

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of **an unforeseen contingency**. The Department had expected the federal Centers for Medicaid and Medicare Services to allow postponement or waiver of a provider enrollment fee, but this did not occur.	

Department Request: The Department requests that the JBC sponsor legislation to create a new cash fund for a provider enrollment fee that the Department is required by federal regulation to collect, and that the JBC provide flexible spending authority from the cash fund for administrative costs associated with enrolling providers in Medicaid. The estimated expenditures from the fund in FY 2015-16 are $1,180,463.

By federal regulation the Department is required to revalidate all Medicaid providers by March 24, 2016[1] and screen them based on a calculated risk for potential waste, fraud, and abuse. For providers who have not already been screened by Medicare or by another state Medicaid program or Children's Health Insurance Program, the Department must collect an enrollment fee

[1] 42 CFR Section 455.414

to cover screening costs.[2] The amount of the fee, which is set by the federal government, is $553 for calendar year 2015 and it increases each year based on inflation.[3]

The Department submitted this as supplemental, rather than through the budget process, because the Department was hoping to avoid collecting the fee. The Department had previously received approval from the Centers for Medicaid and Medicare Services (CMS) to postpone the provider revalidation process, because the Department was procuring a new Medicaid Management Information System (MMIS) and wanted to avoid costly changes to both the new and current MMIS. Also, the Department submitted an application to waive the fee under provisions in the federal regulation that allow for accommodation when the fee presents an economic hardship. However, the Department received notice from CMS that it could not delay the provider revalidation further, and it has not yet received a reply on the application to waive the fee. In September 2015 the Department began provider revalidation and collection of the fee.

The Department has broad statutory authority to comply with federal regulations regarding Medicaid, but there are no specific statutes concerning the collection and expenditure of a provider enrollment fee. The enrollment fee is not currently accounted for in the budget.

The revenue from the enrollment fee is subject to TABOR. Neither the Legislative Council Staff nor the Office of State Planning and Budgeting projected a TABOR refund in FY 2015-16 in their December 2015 revenue forecast, but the revenue from the provider enrollment fee would increase the expected General Fund obligation for a TABOR refund in FY 2016-17.

The Department expects revenue and expenditures from the provider enrollment fee will spike in FY 2015-16 when all providers are required to revalidate, but it will be minimal in subsequent years until 2021 when providers are again required to revalidate on the five-year cycle. The Department's projection of revenue and expenditures from the provider enrollment fee for FY 2016-17 is $119,280.

Without the provider enrollment fee, the Department would have paid for screening providers from within existing appropriations for the MMIS, but the Department did not request reducing existing appropriations for the MMIS. This is primarily due to uncertainty about how much revenue will actually be collected from the provider enrollment fee. The Department does not know how many providers will be exempt from the fee because the providers have already been screened by Medicare or another state Medicaid program or the Children's Health Insurance Program. The Department's revenue projections are based on the number of in-state only providers, but the Department does not have information to determine who will and will not be subject to the fee until the providers apply. In addition, the Department notes that the application to waive the fee is still pending before CMS and could potentially be approved.

The Department admits that this request may lead to an overappropriation in the current year, but indicates that any unexpended General Fund from the MMIS appropriation would roll forward to the next fiscal year, pursuant to Section 25.5-4-211 (1), C.R.S., and could be used by the General

[2] 42 CFR Section 455.460
[3] 42 CFR Section 424.514

Assembly to offset future year obligations. In response to a JBC staff question, the Department indicated that it will be able to provide an accounting of the amount of General Fund saved in FY 2015-16 and rolled forward to FY 2016-17 as a result of collecting the enrollment fee. This would allow for a supplemental adjustment to the FY 2016-17 appropriation based on the actual revenue collected.

Staff Recommendation: Rather than the Department's request, the JBC staff recommends a $2.0 million appropriation from the Health Care Policy and Financing Cash Fund to the Medicaid Management and Information System Maintenance and Projects line item. It would be unusual to sponsor legislation to create a new cash fund through the supplemental process. The Health Care Policy and Financing Cash Fund is already set up in Section 25.5-1-109, C.R.S. as a catch-all for fees or other revenues collected by the Department that don't have a specific cash fund. The fund has not historically been used except for some specific bills that relied on gifts, grants, and donations.

In the long run, the JBC staff believes it would be better to have specific statutory authority for the Department to collect and expend the fee and have a dedicated cash fund for the fee, especially since the revenue is subject to TABOR, but as the Department notes there is still a pending application to CMS to waive the fee. If the application to waive the fee is denied by CMS, the Department could resubmit the request for a bill for the regular FY 2017-18 budget cycle.

The staff recommendation to provide more spending authority than the request is due to the statute for the Department of Health Care Policy and Financing Cash Fund requiring that the funds be subject to annual appropriation by the General Assembly. It would not be consistent with the statute to try to provide continuous spending authority through a footnote or (I) notation in the Long Bill. The Department has made a case that the amount of revenue that will be collected is uncertain, and the Department needs spending authority for the entire amount collected to comply with the federal regulation. Therefore, staff is recommending more spending authority than the request in case revenues exceed the Department's projection. If the revenues are less than the appropriation, then the appropriation will provide phantom spending authority, because the Department cannot spend more from a cash fund than it collects.

To clarify the intent of the General Assembly, staff recommends adding the following footnote with the appropriation:

N Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System and Maintenance Projects – The appropriation includes $2.0 million cash funds from the Department of Health Care Policy and Financing Cash Fund from provider enrollment fees for the purpose of screening costs associated with provider enrollment pursuant to federal regulation. It is the intent of the General Assembly that the Department reduce General Fund and federal funds expenditures for the Medicaid Management Information System in proportion to the revenue received from provider enrollment fees, thereby increasing the spending authority rolled forward to FY 2016-17 pursuant to Section 25.5-4-211 (1), C.R.S. It is further the intent of the General Assembly that any increased rollforward as a result of

collecting the provider enrollment fee will be used to reduce the General Fund required for future obligations for the Medicaid Management Information System.

S10 MEDICAID-MEDICARE GRANT TRUE UP

	Request	Recommendation
Total	**$6,374,303**	**$6,374,303**
General Fund	(276,303)	(276,303)
Cash Funds	6,650,606	6,650,606

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of **data that was not available** when the original appropriation was made regarding the timing of approval from the Centers for Medicare and Medicaid Services (CMS), the number of people eligible for the demonstration program, and the amount of federal grant funding.	

Department Request: The Department requests appropriation adjustments to reflect changes in a demonstration grant program to coordinate care for people eligible for both Medicaid and Medicare. This population has not previously been included in the state-funded Accountable Care Collaborative because some of the savings from coordinating care accrue to the federally-funded Medicare program, rather than Medicaid. The Department received a two-stage federal grant to begin coordinating care for this population and share savings with Medicare from reduced costs due to care coordination. One stage of the grant requires a 25 percent state match and the other stage is 100 percent federally funded. Because part of the grant requires a state match, all of the grant funds were included in the state budget.

The request is due to a delay in enrollment, lower-than-expected enrollment, and a higher-than-expected grant award. The Department originally anticipated enrollment in the demonstration would begin July 2014, but CMS did not approve the demonstration until June 2014 and enrollment did not begin until September 2014. Total enrollment for the program has been less than originally anticipated, because a large number of clients the Department thought would enroll are already participating in a Medicare Advantage plan that provides care coordination, making them ineligible for the demonstration. Data about the number of Medicare clients enrolled in a Medicare Advantage plan was not available to the Department when the original appropriation was made. The Department is now expecting enrollment of 32,000 compared to the original estimated enrollment of 50,000. The total federal grant award was higher than the Department anticipated and the federal Centers for Medicare and Medicaid Services (CMS) has indicated that the Department will have rollforward authority for the federal funds.

In addition to adjusting the funding to reflect these changes in the grant program, the Department requests a footnote for line items with an "(M)" headnote identifying that the grant funds are not part of the money used to calculate compliance with the "(M)" headnote. The "(M)" headnote in the Long Bill requires that the General Fund be decreased in proportion to any increase or

decrease in federal funds for the line item. The purpose of the "(M)" headnote is to ensure that if the federal match rate for a program changes the Department cannot spend General Fund to either draw more federal funds or backfill lost federal funds without consulting the General Assembly. In this case, the Department argues that the "(M)" headnote is problematic, because the timeline and allocation of expenditures is dependent on CMS approval and the Department anticipates frequent future adjustments directed by CMS.

Staff Recommendation: Staff recommends approval of the request to reflect the new information about the timing and scope of the demonstration project. With the lower General Fund investment to match the federal funds, the JBC staff is comfortable with the Department's request for a footnote to exempt the grant funds from the calculation of compliance with the "(M)" headnote.

S11 TECHNICAL ADJUSTMENTS

	Request	Recommendation
Total	**$7,101,996**	**$7,103,561**
FTE	1.0	1.0
General Fund	30,317	30,317
Cash Funds	(30,906)	(29,341)
Reappropriated Funds	(1,565)	(1,565)
Federal Funds	7,104,150	7,104,150

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available* when the original appropriation was made.	

Department Request: The Department requests a number of changes to the appropriation that the Department views as technical. The requested changes are summarized in the table below. A brief description of each requested change and the JBC staff recommendation follows the table.

S11 Technical Adjustments	TOTAL	GF	CF - HPF	CF - CHP+	RF	FF
Transfer from Centralized Eligibility Vendor to counties	$0	$0	$0	$0	$0	$0
Centralized Eligibility Vendor Contract Project	(4,000,000)	0	(1,360,000)	0	0	(2,640,000)
Hospital Provider Fee County Administration	4,000,000	0	1,360,000	0	0	2,640,000
Fund source correction						
Centralized Eligibility Vendor Contract Project	0	0	991,235	(991,235)	0	0
County Administration federal funding	7,105,769	0	0	0	0	7,105,769
County Administration	6,461,585	0	0	0	0	6,461,585
Hospital Provider Fee County Administration	644,184	0	0	0	0	644,184
County Administration remove "(M)" headnote	Not recommended					
County Administration add "(I)" headnote	Recommended					
Customer service technology						
Payments to OIT	(715,468)	(357,734)	0	0	0	(357,734)
Human Services, Executive Director's Office	713,260	356,630	0	0	0	356,630
Federal match rate for Human Services administration	0	4,399	0	0	0	(4,399)
Division of Child Welfare, Administration	0	1,112	0	0	0	(1,112)
Behavioral Health Services, Administration	0	3,287	0	0	0	(3,287)
Medical Identification Cards	0	27,022	(30,728)	1,387	(1,565)	3,884
Contractor costs in H.B. 15-1186	0	0	0	0	0	0
Personal Services	(62,000)	(31,000)	0	0	0	(31,000)
General Professional Services and Special Projects	62,000	31,000	0	0	0	31,000
FTE omitted from H.B. 15-1368	Add 1.0 FTE					
Rollforward for Health Information Exchange	Recommended					
Rollforward authority for LTSS planning	Not recommended					
State University Teaching Hospitals	0	0	0	0	0	0
University of Colorado Hospital Authority	547,890	270,000	0	0	0	277,890
Colorado Commission on Family Medicine	(547,890)	(270,000)	0	0	0	(277,890)
Transfer to DOE for Public School Health Services	Not recommended					
TOTAL	$7,103,561	$30,317	$960,507	($989,848)	($1,565)	$7,104,150

Transfer from Centralized Eligibility Vendor to counties: The Department requests transferring $4,000,000 total funds, including $1,360,000 cash funds, from the Centralized Eligibility Vendor Contract Project line item to the Hospital Provider Fee County Administration line item. The source of cash funds transferred is the Hospital Provider Fee. When the

Department reprocured the centralized eligibility vendor contract, the Department decided to transfer some of the duties previously performed by the vendor to the counties. The new vendor, Denver Health, is responsible for enrollment for CHP+ and the Medicaid buy-in program for people with disabilities, and for Medicaid clients who are also in the Department of Corrections. Counties are taking over responsibility for follow-up on applications through the on-line Program Eligibility and Application Kit (PEAK), and for ongoing case management of all Medicaid and CHP+ clients regardless of who performed the eligibility determination. The Department made this change based on counties performing better than the vendor on timeliness and customer service metrics. Also, the previous division of responsibilities meant some clients who contacted counties could not get their needs met and had to be transferred to the centralized eligibility vendor, resulting in anger and frustration.

Staff recommendation: Staff recommends approval of this component of the request. The scope and cost of the work being done is not changing, only who performs the work. A case could be made that the Department should have consulted the General Assembly before transferring the duties, since the General Assembly separated the funding in different line items. However, a case could also be made that this falls under the Department's responsibility to administer the appropriation. Furthermore, had the Department consulted the General Assembly, the JBC staff would have recommended the transfer of duties, based on the evidence provided by the Department that the transfer will improve timeliness and customer service.

Fund source correction for Centralized Eligibility Vendor: Of the remaining cash funds for the Centralized Eligibility Vendor after the transfer described above, $991,235 is identified as from the Children's Basic Health Plan Trust fund, but should be identified as from the Hospital Provider Fee. The Department made an error in how it requested annualizing some appropriations that were made in S.B. 13-200 and the JBC staff did not catch the error.

Staff recommendation: Staff recommends approval of this component of the request. Changing the fund source as requested will more accurately reflect the General Assembly's original intent in S.B. 13-200 and the fund sources for the populations driving the workload.

County Administration federal funding: The Department requests additional federal funding based on a higher-than-expected portion of county administration activities qualifying for an enhanced federal match rate of 75 percent.

Staff recommendation: Staff recommends this component of the request to reflect the higher portion of activities eligible for the enhanced General Fund match. The request is consistent with the JBC's action this summer on the emergency 1331 supplemental regarding County Administration. The JBC could consider taking a General Fund savings here to help balance the FY 2015-16 budget.

County Administration remove "(M)" headnote: The Department requests removal of the "(M)" headnote on the General Fund for the County Administration line item. The "(M)" headnote restricts the General Fund if the federal funds are higher or lower than appropriated. The purpose of the "(M)" headnote is to ensure that if the federal match rate for a program changes the Department cannot spend General Fund to either draw more federal funds or backfill

lost federal funds without consulting the General Assembly. If the "(M)" headnote were removed the Department would not need to submit a supplemental to maximize federal funds and total reimbursements for counties every time there is a change in the federal match.

Staff recommendation: Staff does not recommend approval of the request. The "(M)" headnote maximizes the General Assembly's control over the appropriation by requiring the Department to submit a supplemental if it wants to spend additional money made available by a change in the federal match rate. The Department's proposed changes to County Administration funding can be accomplished through a supplemental adjustment to the appropriation without requiring removal of the "(M)" headnote. Also, the JBC staff does not view this as a "technical" change. The Department previously submitted a request to remove the "(M)" headnote from the County Administration line item and the JBC rejected the request.

County Administration "(I)" notation: The Department requests putting an "(I)" notation on the cash funds appropriation for County Administration. The "(I)" notation indicates that an appropriation is for informational purposes only and is not restricting. The Department argues that adding the "(I)" notation to the cash funds would allow counties to use local funds to draw more federal funds when state funding is exhausted. The Department did not submit an estimate of how much county and federal funds might increase if the "(I)" notation were added.

Staff recommendation: Staff recommends approval of this component of the request. This would allow counties to draw more federal funds if expenditures of county funds allow it. An increase in county spending would not increase the state's TABOR revenue.

Customer service technology: The Department requests a reduction of $715,468 total funds, including $357,734 General Fund, from the Payments to OIT line item to remove a double count. The Department requested and received funding last year in the General Professional Services and Special Projects line item for customer service technology costs. Some of this money was intended for transfer to the Governor's Office of Information Technology (OIT) and OIT received spending authority from reappropriated funds for the transfer. However, OIT then included the additional work for the Department in the OIT common policy request. As a result, the Department was appropriated money in the Payments to OIT line item that duplicated money already appropriated in the General Professional Services and Special Projects line item.

Staff recommendation: Staff recommends approval of this component of the request. It corrects an error and a double count in the appropriation.

Human Services, Executive Director's Office: The Department requests $713,260 total funds, including $356,630 General Fund, for the Department of Human Services Medicaid-funded Programs, Executive Director's Office – Medicaid Funding line item to match the reappropriated funds from Medicaid provided in the Department of Human Services to the Employment and Regulatory Affairs line item and Health Insurance Portability and Accountability Act of 1996 – Security Remediation line item. These line items support federally mandated monitoring of assistance programs and compliance with the federal Health Insurance Portability and Accountability Act (HIPPA).

Staff recommendation: Staff recommends approval of this component of the request to correct an error where the appropriation for the Department of Health Care Policy and Financing does not match the appropriation for the Department of Human Services.

Federal match rate for Human Services administration: The Department requests an increase of $4,399 General Fund and a corresponding decrease in federal funds to correct a technical error in the federal match rate for two administrative line items. In the Department of Human Services, Medicaid-funded Programs division, the federal match rate for medical services of 50.79 percent was applied to the Division of Child Welfare, Administration line item and the Behavioral Health Services, Community Behavioral Health Administration line item, but because these line items support administrative functions they are only eligible for a 50 percent federal match.

Staff recommendation: Staff recommends approval of this component of the request to correct an error in the federal match rate used for the appropriation.

Medical Identification Cards: The Department requests a $0 total funds change, but a $27,022 General Fund increase, to correct the fund splits for the Medical Identification Cards line item. As a result of a math error and oversights the Department overestimated the portion of expenditures attributable to the Hospital Provider Fee and the Old Age Pension Health and Medical Care Fund and underestimated the portion attributable to the Children's Basic Health Plan Trust. The Department also requests a corresponding reduction to the Old Age Pension State Medical Program line item.

Staff recommendation: Staff recommends partial approval of this component of the request to make the fund sources for the Medical identification cards more accurately match the funds sources for the populations driving the expenditures. Staff does not recommend the change to the Old Age Pension State Medical Program line item, because staff is recommending a restructure of the appropriations for that program (see S13 Old Age Pension Health and Medical).

Contractor costs in H.B. 15-1186 (Children with Autisim): The Department proposes moving $62,000 total funds, including $31,000 General Fund, from the Personal Services line item to the General Professional Services and Special Projects line item. The money was appropriated in H.B. 15-1186 (Children with Autism) for a waiver effectiveness study and better fits in the General Professional Services and Special Projects line item.

Staff recommendation: Staff recommends approval of this component of the request. The appropriation in H.B. 15-1186 did not conform with the format of the rest of the Department's budget. Moving the appropriation does not change the purpose of the funding. Although the expansion of the waiver was not approved by the federal Centers for Medicare and Medicaid Services (CMS) the preexisting waiver remains and there is still a statutory requirement for an evaluation in Section 25.5-6-806, C.R.S.

The Committee may want to consider a bill to either remove the statutory evaluation, or change the scope of the evaluation to include the autism services CMS is mandating that Colorado provide through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

FTE omitted from H.B. 15-1368 (Cross-system Response Pilot IDD): The Department requests an increase of 1.0 FTE that was omitted from the appropriation for H.B. 15-1368. The Fiscal Note for the bill clearly identified the need for the additional FTE and the appropriation in the bill included $75,000 total funds for the Department to hire the staff, but the appropriation failed to include an increase in the authorized FTE.

Staff recommendation: Staff recommends approval of this component of the request. There was no discussion during legislative debate on the bill about using contract staff instead of state FTE and the omission of the FTE from the appropriation appears to be an error.

Roll forward authority for Health Information Exchange Maintenance and Projects: The Department requests roll forward authority for the Health Information Exchange Maintenance and Projects line item. A number of components of the project need to be competitively bid and so the timing of expenditures for these components is uncertain. Also, the Governor's decision in Executive Order B 2015-008 to change the State Designated Entity for Health Information Technology from the Colorado Regional Health Information Organization (CORHIO) to a newly created Office of eHealth Innovation in the Governor's Office has caused delays in the project.

Staff recommendation: Staff recommends approval of this portion of the request. It is not uncommon for the General Assembly to provide roll forward authority on large, multi-year information technology projects. The total for the project is not changing.

Roll forward authority for Long-term Services and Supports planning: The Department requests roll forward authority for the General Professional Services and Special Projects line item to allow the Department to use unspent funds for additional planning related to the Community Living Advisory Group (CLAG) and Olmstead recommendations. The Department received $496,575 in FY 2014-15 with rollforward authority to FY 2015-16 to help with planning efforts and submitted an initial plan in November 2015, but has identified additional gaps in planning that need to be addressed. As an example, the Department identified a need to evaluate the information technology infrastructure to support the CLAG recommendations.

Staff recommendation: Staff does not recommend this component of the request. The Department is requesting rollforward authority on a $9.4 million line item. The Department indicates it is not able to identify how much might revert from the line item without the rollforward authority. In response to Question 63 at the hearing for the Office of Community Living the Department identified only $169,095 in additional planning costs for the CLAG and Olmstead recommendations. The Department has not provided an explanation for why it needs so much rollforward authority, or how the rollforward would be spent.

State University Teaching Hospitals: The Department requests transferring $547,890 total funds, including $270,000 General Fund, from the Commission on Family Medicine line item to the State University Teaching Hospital – University of Colorado Hospital Authority line item to

reflect where new family medicine residency positions are located. In FY 2015-16 the Department received funding for five additional family medicine residency positions. The Commission on Family Medicine awarded one of the positions to the University of Colorado and the proposed transfer of funds is intended to reflect this allocation.

Staff recommendation: Staff recommends this component of the request to reflect where one of the new family residency positions will be located.

Transfer to Department of Education for Public School Health Services Administration: The Department requests transferring $6,064 reappropriated funds from the Public School Health Services Contract Administration line item to the Transfer to Department of Education for Public School Health Services line item. The transfer would allow greater reimbursement for the Department of Education's technical assistance related to the development, review, and approval of districts' local service plans as well as technical training to districts and assistance with completing reporting requirements. According to the request, salary, travel, and rent are increasing for the Department of Education.

Staff recommendation: Staff does not recommend this component of the request. The two departments routinely have trouble coordinating their requests for this program and the JBC staff has to compare and reconcile the requests. The amount appropriated in FY 2015-16 was consistent with the request and not in error. For this supplemental, the Department of Health Care Policy and Financing has submitted a request, but the Department of Education did not request a corresponding increase. According to the Department of Education, the State Controller considers these federal funds that are not subject to appropriation. However, the General Assembly has provided spending authority to the Department of Education that should be increased with any increase in the appropriation to the Department Health Care Policy and Financing. The JBC staff recommends that the Department of Education live within the existing appropriation and use the normal budget process, rather than a supplemental, to request increases in future years, and that the Department of Education and the Department of Health Care Policy and Financing improve their coordination of the requests for this program.

S12 EXTERNAL QUALITY REVIEW

	Request	Recommendation
Total	**$0**	**$0**
General Fund	207,225	207,225
Federal Funds	(207,225)	(207,225)

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available* when the original appropriation was made. The Department received communication from the federal Centers for Medicaid and Medicare Services (CMS) that certain external quality review activities qualify for a 50 percent federal match, rather than the assumed 75 percent federal match.	

Department Request: The Department requests an increase in General Fund and decrease in federal funds after receiving notification from the federal Centers for Medicare and Medicaid Services (CMS) that certain activities of the External Quality Review vendor are eligible for a 50 percent federal match, rather than the 75 percent federal match rate assumed in the appropriation. The External Quality Review vendor evaluates quality, timeliness, and access for managed care contracts and prepaid inpatient health plans. Among the duties of the External Quality Review vendor is analysis of the Accountable Care Collaborative (ACC), including Healthcare Effectiveness Data and Information Set compliance audits and reports, site reviews of Regional Care Collaborative Organizations (RCCOs), RCCO performance improvement projects, and Colorado Health Assessment and Planning System (CHAPS) surveys to evaluate members' experience of care. The federal CMS determined that the ACC does not fit the federal definition of a managed care organization or prepaid inpatient health plan, and so the evaluation activities are eligible for a 50 percent match instead of a 75 percent match. The evaluation activities External Quality Review vendor are essential to the function of the ACC, but are not required by the federal government.

Staff Recommendation: Staff recommends approval of the request to reflect the correct federal match rate for the activities.

S13 OLD AGE PENSION HEALTH AND MEDICAL

	Request	Recommendation
Total	**($3,909,269)**	**$5,388,407**
General Fund	0	(3,821,341)
Cash Funds	(3,909,269)	10,081
Reappropriated Funds	0	9,199,667

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available* when the original appropriation was made. A new projection of the population needing services through the Old Age Pension Health and Medical Program is lower than assumed for the appropriation.	

Department Request: The Department requests a decrease in cash funds appropriations from the Old Age Pension Health and Medical Care Fund to reflect a more recent projection of expenditures for the people requiring services. Pursuant to Article XXIV, Section 7, of the Colorado Constitution, up to $10 million is transferred into the Old Age Pension Health and Medical Care Fund annually to provide health and medical care to persons who qualify to receive an old age pension and are not in an institution for tuberculosis or mental disease. The source of revenue for the transfer is a portion of excise and liquor taxes that is set aside for old age pensions and is a remainder after basic minimum old age pensions and a stabilization fund are financed. The Old Age Pension State Medical Program was set up with this money to serve old age pensioners who did not qualify for Medicaid. However, with the expansion of Medicaid the number of old age pensioners who do not qualify for Medicaid has decreased dramatically.

Staff Recommendation: Staff recommends using the excess money in the Old Age Pension Health and Medical Care Fund to offset the need for General Fund in the Medical Services Premiums line item. Also, staff recommends a restructuring of the way appropriations are made from the Old Age Pension Health and Medical Care Fund. Currently, most appropriations are directly from the Old Age Pension Health and Medical Care Fund, but appropriations for the Medicaid Management Information System and for Medical Identification Cards are identified as reappropriated funds from the appropriation for the Old Age Pension State Medical Program line item. This has resulted in some tracking errors and total spending authority in FY 2015-16 from the Old Age Pension Health and Medical Care Fund that is $10,081 less than the $10 million available in the fund. In the proposed restructured format, $10 million cash funds would go to the Old Age Pension State Medical Program and all other appropriations would appear as reappropriated funds transferred from that line item. This format would ensure that the Department has access to the full $10 million for medical services for old age pensioners consistent with the constitution. The JBC staff believes the first priority of the funds should be to serve old age pensioners who are not eligible for Medicaid, but expenditures for this population have proven difficult to project to the dollar. The proposed appropriation format would ensure that the Department could spend up to the full $10 million allocation for this purpose. If there are leftover funds, these could be used by the Department in the proposed appropriations format for administrative overhead expenses up to the reapproriated funds spending authority provided by the General Assembly. Then, an estimate would be made of the remainder in the Old Age Pension Health and Medical Care Fund and this would be applied to offset the need for General Fund in the Medical Services Premiums line item, up to the estimated expenditures for people who are eligible for an old age pension and also eligible for Medicaid. This way, mid-year adjustments to the estimated expenditures for the Old Age Pension State Medical Program could be taken care of at the same time as mid-year adjustments for the Medical Services Premiums line item without the need for a separate supplemental. Also, if the

estimated offset to General Fund in the Medical Services Premiums line item from the Old Age Pension Health and Medical Care Fund proved too high or too low after mid-year adjustments, the Department has separate statutory authority to overexpend the Medical Services Premiums line item, so there would be no need for an emergency interim supplemental through the 1331 process.

The table below summarizes the current uses of the Old Age Pension Health and Medical Care Fund and compares it to how the JBC staff proposes using the fund.

Old Age Pension Health and Medical Care Fund	Current Use	Proposed Use	Difference
Old Age Pension Health and Medical Program	$4,611,593	$10,000,000	$5,388,407
Cash Funds for non-Medicaid eligible pensioners	4,611,565	702,324	(3,909,241)
Cash Funds for Medicaid eligible pensioners and overhead	28	9,297,676	9,297,648
Administrative Overhead			
Medicaid Management Information System	$97,981	$97,981	$0
Cash Funds	0	0	0
Reappropriated Funds	97,981	97,981	0
Colorado Benefits Management Systems	$8,390	$8,390	$0
Cash Funds	8,390	0	(8,390)
Reappropriated Funds	0	8,390	8,390
Medical Identification Cards*	$28	$28	$0
Cash Funds	0	0	0
Reappropriated Funds	28	28	0
DHS - Office of Information Technology Services	$457	$457	$0
Cash Funds	457	0	(457)
Reappropriated Funds	0	457	457
Medical Services Premiums GF Offset	$0	$0	$0
General Fund	(5,369,479)	(9,190,820)	(3,821,341)
Cash Funds	5,369,479	0	(5,369,479)
Reappropriated Funds	0	9,190,820	9,190,820
TOTAL	$4,718,449	$10,106,856	$5,388,407
General Fund	(5,369,479)	(9,190,820)	(3,821,341)
Cash Funds	9,989,919	10,000,000	10,081
Reappropriated Funds	98,009	9,297,676	9,199,667

**The Current Use amount listed is after the technical correction recommended in S11.*

S14 PUBLIC SCHOOL HEALTH SERVICES

	Request	Recommendation
Total	**$8,470,989**	**$8,470,989**
Cash Funds	4,126,655	4,126,655
Federal Funds	4,344,334	4,344,334

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of *data that was not available* when the original appropriation was made. A new projection of certified public expenditures by schools for school health services is higher than assumed for the appropriation.	

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

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

S15 RELEASE OVER-EXPENDITURE RESTRICTION

	FY 2014-15 Request	FY 2013-14 Recommendation	FY 2014-15 Recommendation
Total	**($15,006,316)**	**$30,211,136**	**$2,787,826**
General Fund	23,553,073	30,211,136	489,536
Cash Funds	(3,266,365)	0	2,298,290
Federal Funds	(35,293,024)	0	0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? [An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.]	**YES**
JBC staff and the Department agree that this request is the result of **data that was not available** when the original appropriation was made regarding actual expenditures for Medicaid.	

Department Request: The Department requests the release of restrictions on the FY 2015-16 appropriations imposed by the State Controller due to over-expenditures in prior years. Because of the entitlement nature of the Medicaid program, the Medicaid line items are provided 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.). However, the State Controller restricts the current fiscal year's appropriation until the General Assembly approves a supplemental for the prior year over-expenditure. This restriction allows the JBC an opportunity to review the reasons for over expenditures and to decide if the over-expenditures could have been avoided with better management of the appropriation or if the over-expenditures occurred as a result of an unforeseen event or forecast error.

In FY 2014-15 the overexpenditures were almost entirely due to the General Assembly not releasing restrictions on the appropriation from overexpenditures that occurred in FY 2013-14. In the past the JBC staff has brought any Medicaid overexpenditure restriction to the attention of the JBC for a vote on releasing the restriction, but last year this did not happen due to an oversight by the JBC staff. The JBC staff received information about the overexpenditure restriction from the State Controller's Office, but this documentation did not provide sufficient detail to draft a bill to release the restriction, and it did not reconcile with information the JBC staff received from the Department. As a result, the JBC staff temporarily set the information aside to focus on other policy issues, but then forgot to return to sorting out the overexpenditure restriction. This summer the JBC staff and the Department discussed ways to avoid this problem in the future and the Department agreed to submit a formal request each year with the supplemental process that would include the necessary detail to draft a bill.

The overexpenditures that occurred in FY 2013-14 were due to an underforecast of parents and caregivers eligible for Medicaid, an unanticipated increase in utilization of behavioral health services, and an increase in the state's obligation pursuant to the federal Medicare Modernization Act for prescription drugs for clients dually eligible for Medicaid and Medicare.

Staff Recommendation: Staff recommends releasing the overexpenditures, as requested by the Department, but the JBC staff recommends adjusting the FY 2013-14 appropriation in some cases, instead of the FY 2014-15 appropriation. This is because the FY 2014-15 appropriation restriction is due to the unreleased restriction carried forward from FY 2013-14. The staff-proposed method of releasing the overexpenditure restriction has the same effect as the Department's request, but will keep the appropriation history more consistent with prior years. The table below summarizes the General Fund changes to appropriations that will be made to release the overexpenditure restrictions.

Recommended GF Appropriations to Release Medicaid Overexpenditure Restrictions		
	FY 2013-14	FY 2014-15
Medical Services Premiums	$27,130,236	
Behavioral Health Capitation Payments	1,791,913	
Behavioral Health Fee-for-service Payments		489,536
Adult Supported Living Services	3,296	
Medicare Modernization Act State Contribution Payment	1,285,691	
TOTAL	$30,211,136	$489,536

These overexpenditures have already been accounted for in the revenue forecasts by the Legislative Council Staff and the Office of State Planning and Budgeting and so making appropriations to release the overexpenditure restrictions will not change the projected available General Fund for FY 2015-16 and FY 2016-17. There might be a slight shift in presentation on the General Fund overview where money moves from one line to another, but no change in the bottom line.

In addition to releasing the General Fund restrictions due to overexpenditures, staff recommends the requested release of cash funds restrictions on Behavioral Health Capitation Payments of $2,275,956 from the Hospital Provider Fee and $22,334 from the Breast and Cervical Cancer Program.

The Department also requested some decreases in spending authority to match actual expenditures, but these decreases are not necessary to release overexpenditure restrictions, and so staff is not recommending the requested decreases.

This change does not appear in the numbers pages or the Summary: FY 2015-16 Appropriation and Recommendation table, because it affects FY 2014-15.

PREVIOUSLY APPROVED INTERIM SUPPLEMENTAL REQUEST COUNTY ADMINISTRATION

	FY 2014-15 Request	FY 2014-15 JBC Action
Federal Funds	$2,224,426	$2,224,426

Department Request: The Department requested $2.2 million additional federal funds spending authority in FY 2014-15 for County Administration, based on a revised estimate of activities eligible for an enhanced federal match. The County Administration line item reimburses counties for their work in determining Medicaid eligibility. Prior to the Affordable Care Act, eligibility determination activities received a 50 percent match. After the Affordable Care Act the federal government began reimbursing states for certain Medicaid eligibility determination activities at a 75 percent match rate. However, because the Department had not previously tracked the specific activities eligible for the enhanced match, there was some uncertainty about how much of the work by counties would qualify for the enhanced match. The Department originally estimated that 56 percent of county activities would qualify for the enhanced match, but the actual experience has been 65 percent. With additional spending authority from the JBC, the Department could draw more federal funds to reimburse counties with no increased General Fund cost.

The Department also requested removal of the "(M)" headnote from the appropriation to allow flexibility if the portion of activities eligible for the enhanced federal match changes in the future.

Committee Action: The JBC approved the requested change in the appropriation, but not removal of the "(M)" headnote. This change does not appear in the numbers pages or the Summary: FY 2015-16 Appropriation and Recommendation table, because it affects FY 2014-15. This previously approved request will be included in the supplemental bill.

Appendix A: Number Pages

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
Sue Birch, Executive Director					
S1 Medical Services Premiums					
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	5,728,093,904	6,594,830,484	207,160,125	207,160,125	6,801,990,609
General Fund	882,751,482	968,235,300	37,869,753	37,869,753	1,006,105,053
General Fund Exempt	813,135,957	848,124,468	0	0	848,124,468
Cash Funds	549,802,496	703,597,288	115,663,744	115,663,744	819,261,032
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,482,403,969	4,074,873,428	53,626,628	53,626,628	4,128,500,056
Total for S1 Medical Services Premiums	5,728,093,904	6,594,830,484	207,160,125	207,160,125	6,801,990,609
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	882,751,482	968,235,300	37,869,753	37,869,753	1,006,105,053
General Fund Exempt	813,135,957	848,124,468	0	0	848,124,468
Cash Funds	549,802,496	703,597,288	115,663,744	115,663,744	819,261,032
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,482,403,969	4,074,873,428	53,626,628	53,626,628	4,128,500,056

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S2 Behavioral Health					
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
Behavioral Health Capitation Payments	565,420,239	646,025,263	(46,091,828)	(46,091,828)	599,933,435
General Fund	173,415,971	188,346,101	(16,053,804)	(16,053,804)	172,292,297
Cash Funds	5,333,335	8,967,481	(242,677)	(242,677)	8,724,804
Federal Funds	386,670,933	448,711,681	(29,795,347)	(29,795,347)	418,916,334
Behavioral Health Fee-for-service Payments	7,525,423	8,410,359	(51,436)	(51,436)	8,358,923
General Fund	2,946,662	2,685,684	(921,031)	(921,031)	1,764,653
Cash Funds	20,963	143,951	(35,924)	(35,924)	108,027
Federal Funds	4,557,798	5,580,724	905,519	905,519	6,486,243
Total for S2 Behavioral Health	572,945,662	654,435,622	(46,143,264)	(46,143,264)	608,292,358
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	176,362,633	191,031,785	(16,974,835)	(16,974,835)	174,056,950
Cash Funds	5,354,298	9,111,432	(278,601)	(278,601)	8,832,831
Federal Funds	391,228,731	454,292,405	(28,889,828)	(28,889,828)	425,402,577

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S3 Children's Basic Health Plan					
(4) INDIGENT CARE PROGRAM					
Children's Basic Health Plan Medical and Dental Costs	130,538,362	166,723,024	(22,754,545)	(22,754,545)	143,968,479
General Fund	6,003,180	2,098,125	1	1	2,098,126
General Fund Exempt	0	427,593	0	0	427,593
Cash Funds	48,154,315	29,111,476	(3,785,168)	(3,785,168)	25,326,308
Reappropriated Funds	0	0	0	0	0
Federal Funds	76,380,867	135,085,830	(18,969,378)	(18,969,378)	116,116,452
Total for S3 Children's Basic Health Plan	130,538,362	166,723,024	(22,754,545)	(22,754,545)	143,968,479
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	6,003,180	2,098,125	1	1	2,098,126
General Fund Exempt	0	427,593	0	0	427,593
Cash Funds	48,154,315	29,111,476	(3,785,168)	(3,785,168)	25,326,308
Reappropriated Funds	0	0	0	0	0
Federal Funds	76,380,867	135,085,830	(18,969,378)	(18,969,378)	116,116,452

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S4 Medicare Modernization Act					
(5) OTHER MEDICAL SERVICES					
Medicare Modernization Act State Contribution Payment	107,776,447	116,816,749	16,865,498	(1,318,801)	115,497,948
General Fund	107,360,512	116,816,749	16,865,498	(1,318,801)	115,497,948
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	415,935	0	0	0	0
Total for S4 Medicare Modernization Act	107,776,447	116,816,749	16,865,498	(1,318,801)	115,497,948
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	107,360,512	116,816,749	16,865,498	(1,318,801)	115,497,948
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	415,935	0	0	0	0

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S5 Office of Community Living					
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(ii) Program Costs					
Adult Comprehensive Services	316,670,767	368,974,132	1,094,982	1,094,982	370,069,114
General Fund	156,848,877	166,178,488	538,854	538,854	166,717,342
Cash Funds	1	31,281,613	0	0	31,281,613
Federal Funds	159,821,889	171,514,031	556,128	556,128	172,070,159
Adult Supported Living Services	56,136,806	78,378,376	(8,745,162)	(8,745,162)	69,633,214
General Fund	33,457,241	42,592,426	(4,303,494)	(4,303,494)	38,288,932
Federal Funds	22,679,565	35,785,950	(4,441,668)	(4,441,668)	31,344,282
Children's Extensive Support Services	15,985,596	22,574,419	(2,776,005)	(2,776,005)	19,798,414
General Fund	8,389,564	11,108,871	(1,366,071)	(1,366,071)	9,742,800
Federal Funds	7,596,032	11,465,548	(1,409,934)	(1,409,934)	10,055,614
Case Management	26,970,379	34,577,785	(4,408,759)	(4,408,759)	30,169,026
General Fund	14,302,452	18,194,562	(2,157,303)	(2,157,303)	16,037,259
Federal Funds	12,667,927	16,383,223	(2,251,456)	(2,251,456)	14,131,767
Total for S5 Office of Community Living	415,763,548	504,504,712	(14,834,944)	(14,834,944)	489,669,768
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	212,998,134	238,074,347	(7,288,014)	(7,288,014)	230,786,333
Cash Funds	1	31,281,613	0	0	31,281,613
Federal Funds	202,765,413	235,148,752	(7,546,930)	(7,546,930)	227,601,822

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S6 Fed reg for assuring access					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Operating Expenses	2,967,212	2,128,109	14,109	14,109	2,142,218
General Fund	1,426,580	965,356	7,055	7,055	972,411
Cash Funds	37,759	78,907	0	0	78,907
Reappropriated Funds	0	10,449	0	0	10,449
Federal Funds	1,502,873	1,073,397	7,054	7,054	1,080,451
General Professional Services and Special Projects	5,584,179	9,351,970	253,750	253,750	9,605,720
General Fund	2,037,349	3,117,387	126,875	126,875	3,244,262
Cash Funds	511,089	1,463,609	0	0	1,463,609
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,035,741	4,770,974	126,875	126,875	4,897,849
Total for S6 Fed reg for assuring access	8,551,391	11,480,079	267,859	267,859	11,747,938
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	3,463,929	4,082,743	133,930	133,930	4,216,673
Cash Funds	548,848	1,542,516	0	0	1,542,516
Reappropriated Funds	0	10,449	0	0	10,449
Federal Funds	4,538,614	5,844,371	133,929	133,929	5,978,300

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S7 Fed reg for managed care					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Operating Expenses	2,967,212	2,128,109	18,812	0	2,128,109
General Fund	1,426,580	965,356	9,406	0	965,356
Cash Funds	37,759	78,907	0	0	78,907
Reappropriated Funds	0	10,449	0	0	10,449
Federal Funds	1,502,873	1,073,397	9,406	0	1,073,397
Total for S7 Fed reg for managed care	2,967,212	2,128,109	18,812	0	2,128,109
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	1,426,580	965,356	9,406	0	965,356
Cash Funds	37,759	78,907	0	0	78,907
Reappropriated Funds	0	10,449	0	0	10,449
Federal Funds	1,502,873	1,073,397	9,406	0	1,073,397

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S9 Provider enrollment fee					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(C) Information Technology Contracts and Projects					
Medicaid Management Information System					
Maintenance and Projects	24,715,778	32,784,833	1,180,463	2,000,000	34,784,833
General Fund	5,655,519	6,823,649	0	0	6,823,649
Cash Funds	934,073	1,919,380	1,180,463	2,000,000	3,919,380
Reappropriated Funds	293,350	293,350	0	0	293,350
Federal Funds	17,832,836	23,748,454	0	0	23,748,454
Total for S9 Provider enrollment fee	24,715,778	32,784,833	1,180,463	2,000,000	34,784,833
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	5,655,519	6,823,649	0	0	6,823,649
Cash Funds	934,073	1,919,380	1,180,463	2,000,000	3,919,380
Reappropriated Funds	293,350	293,350	0	0	293,350
Federal Funds	17,832,836	23,748,454	0	0	23,748,454

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S10 Medicaid-Medicare grant true up					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Personal Services	28,066,886	28,299,126	307,446	307,446	28,606,572
FTE	360.4	388.0	0.0	0.0	388.0
General Fund	8,982,621	9,898,385	(39,060)	(39,060)	9,859,325
Cash Funds	2,676,189	2,860,502	0	0	2,860,502
Reappropriated Funds	1,524,777	1,501,543	0	0	1,501,543
Federal Funds	14,883,299	14,038,696	346,506	346,506	14,385,202
Operating Expenses	2,967,212	2,128,109	500	500	2,128,609
General Fund	1,426,580	965,356	(5,163)	(5,163)	960,193
Cash Funds	37,759	78,907	0	0	78,907
Reappropriated Funds	0	10,449	0	0	10,449
Federal Funds	1,502,873	1,073,397	5,663	5,663	1,079,060
General Professional Services and Special Projects	5,584,179	9,351,970	(146,800)	(146,800)	9,205,170
General Fund	2,037,349	3,117,387	(51,925)	(51,925)	3,065,462
Cash Funds	511,089	1,463,609	0	0	1,463,609
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,035,741	4,770,974	(94,875)	(94,875)	4,676,099
(1) EXECUTIVE DIRECTOR'S OFFICE					

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
(C) Information Technology Contracts and Projects					
Medicaid Management Information System Maintenance and Projects	24,715,778	32,784,833	400,000	400,000	33,184,833
General Fund	5,655,519	6,823,649	0	0	6,823,649
Cash Funds	934,073	1,919,380	0	0	1,919,380
Reappropriated Funds	293,350	293,350	0	0	293,350
Federal Funds	17,832,836	23,748,454	400,000	400,000	24,148,454
(1) EXECUTIVE DIRECTOR'S OFFICE **(D) Eligibility Determinations and Client Services**					
Customer Outreach	5,079,676	6,194,093	(363,268)	(363,268)	5,830,825
General Fund	2,203,298	2,686,447	(142,655)	(142,655)	2,543,792
Cash Funds	336,621	336,621	0	0	336,621
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,539,757	3,171,025	(220,613)	(220,613)	2,950,412
(1) EXECUTIVE DIRECTOR'S OFFICE **(E) Utilization and Quality Review Contracts**					
Professional Service Contracts	8,825,726	11,881,984	102,425	102,425	11,984,409
General Fund	2,514,723	3,183,748	(37,500)	(37,500)	3,146,248
Cash Funds	329,807	461,089	0	0	461,089
Reappropriated Funds	0	0	0	0	0
Federal Funds	5,981,196	8,237,147	139,925	139,925	8,377,072

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	5,728,093,904	6,594,830,484	6,074,000	6,074,000	6,600,904,484
General Fund	882,751,482	968,235,300	0	0	968,235,300
General Fund Exempt	813,135,957	848,124,468	0	0	848,124,468
Cash Funds	549,802,496	703,597,288	0	0	703,597,288
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,482,403,969	4,074,873,428	6,074,000	6,074,000	4,080,947,428
Total for S10 Medicaid-Medicare grant true up	5,803,333,361	6,685,470,599	6,374,303	6,374,303	6,691,844,902
FTE	360.4	388 .0	0 .0	0 .0	388 .0
General Fund	905,571,572	994,910,272	(276,303)	(276,303)	994,633,969
General Fund Exempt	813,135,957	848,124,468	0	0	848,124,468
Cash Funds	554,628,034	710,717,396	0	0	710,717,396
Reappropriated Funds	1,818,127	1,805,342	0	0	1,805,342
Federal Funds	3,528,179,671	4,129,913,121	6,650,606	6,650,606	4,136,563,727

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
HUM S11 Technical adjustments					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Personal Services	28,066,886	28,299,126	(62,000)	(62,000)	28,237,126
FTE	360.4	388.0	0.0	0.0	388.0
General Fund	8,982,621	9,898,385	(31,000)	(31,000)	9,867,385
Cash Funds	2,676,189	2,860,502	0	0	2,860,502
Reappropriated Funds	1,524,777	1,501,543	0	0	1,501,543
Federal Funds	14,883,299	14,038,696	(31,000)	(31,000)	14,007,696
Payments to OIT	1,578,757	3,775,292	(715,468)	(715,468)	3,059,824
General Fund	784,642	1,876,284	(357,734)	(357,734)	1,518,550
Cash Funds	4,736	11,360	0	0	11,360
Reappropriated Funds	0	0	0	0	0
Federal Funds	789,379	1,887,648	(357,734)	(357,734)	1,529,914
General Professional Services and Special Projects	5,584,179	9,351,970	62,000	62,000	9,413,970
General Fund	2,037,349	3,117,387	31,000	31,000	3,148,387
Cash Funds	511,089	1,463,609	0	0	1,463,609
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,035,741	4,770,974	31,000	31,000	4,801,974
(1) EXECUTIVE DIRECTOR'S OFFICE					

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
(B) Transfers to Other Departments					
Public School Health Services Administration, Transfer to the Department of Education	160,335	160,335	6,064	0	160,335
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	160,335	160,335	6,064	0	160,335
Federal Funds	0	0	0	0	0
(1) EXECUTIVE DIRECTOR'S OFFICE					
(C) Information Technology Contracts and Projects					
Centralized Eligibility Vendor Contract Project	6,824,419	9,133,612	(4,000,000)	(4,000,000)	5,133,612
General Fund	0	0	0	0	0
Cash Funds	2,281,751	3,145,326	(1,360,000)	(1,360,000)	1,785,326
Reappropriated Funds	0	0	0	0	0
Federal Funds	4,542,668	5,988,286	(2,640,000)	(2,640,000)	3,348,286
(1) EXECUTIVE DIRECTOR'S OFFICE					
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	247,001	278,974	0	0	278,974
General Fund	63,966	63,966	27,022	27,022	90,988
Cash Funds	58,738	73,928	(29,341)	(29,341)	44,587
Reappropriated Funds	1,593	1,593	(1,565)	(1,565)	28
Federal Funds	122,704	139,487	3,884	3,884	143,371

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
County Administration	36,730,383	39,536,478	6,461,585	6,461,585	45,998,063
General Fund	10,572,620	11,114,448	0	0	11,114,448
Cash Funds	0	5,859,623	0	0	5,859,623
Reappropriated Funds	0	0	0	0	0
Federal Funds	26,157,763	22,562,407	6,461,585	6,461,585	29,023,992
Hospital Provider Fee County Administration	10,038,778	11,104,684	4,644,184	4,644,184	15,748,868
General Fund	0	0	0	0	0
Cash Funds	3,208,371	3,585,446	1,360,000	1,360,000	4,945,446
Reappropriated Funds	0	0	0	0	0
Federal Funds	6,830,407	7,519,238	3,284,184	3,284,184	10,803,422
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	2,598,056	3,090,607	0	0	3,090,607
FTE	30.5	33.2	1.0	1.0	34.2
General Fund	1,241,132	1,405,951	0	0	1,405,951
Cash Funds	0	259,564	0	0	259,564
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,356,924	1,425,092	0	0	1,425,092

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	431,000	7,574,103	(1,565)	0	7,574,103
General Fund	0	2,962,510	0	0	2,962,510
Cash Funds	431,000	4,611,593	(1,565)	0	4,611,593
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Commission on Family Medicine Residency Training Programs	5,401,843	8,145,188	(547,890)	(547,890)	7,597,298
General Fund	2,652,350	4,013,374	(270,000)	(270,000)	3,743,374
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,749,493	4,131,814	(277,890)	(277,890)	3,853,924
State University Teaching Hospitals University of Colorado Hospital	633,314	633,314	547,890	547,890	1,181,204
General Fund	311,860	311,654	270,000	270,000	581,654
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	321,454	321,660	277,890	277,890	599,550
Public School Health Services Contract Administration	854,207	2,491,722	(6,064)	0	2,491,722
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	854,207	2,491,722	(6,064)	0	2,491,722
Federal Funds	0	0	0	0	0
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
(A) Executive Director's Office - Medicaid Funding					
Executive Director's Office - Medicaid Funding	13,036,103	16,709,224	713,260	713,260	17,422,484
General Fund	6,436,271	8,223,190	356,630	356,630	8,579,820
Federal Funds	6,599,832	8,486,034	356,630	356,630	8,842,664
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
(D) Division of Child Welfare - Medicaid Funding					
Administration	128,550	140,806	0	0	140,806
General Fund	64,274	69,291	1,112	1,112	70,403
Federal Funds	64,276	71,515	(1,112)	(1,112)	70,403
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
(F) Behavioral Health Services - Medicaid Funding					
Community Behavioral Health Administration	323,369	416,056	0	0	416,056
General Fund	161,684	204,741	3,287	3,287	208,028
Federal Funds	161,685	211,315	(3,287)	(3,287)	208,028
Total for HUM S11 Technical adjustments	112,637,180	140,841,491	7,101,996	7,103,561	147,945,052
FTE	390.9	421.2	1 .0	1 .0	422.2
General Fund	33,308,769	43,261,181	30,317	30,317	43,291,498
Cash Funds	9,171,874	21,870,951	(30,906)	(29,341)	21,841,610
Reappropriated Funds	2,540,912	4,155,193	(1,565)	(1,565)	4,153,628
Federal Funds	67,615,625	71,554,166	7,104,150	7,104,150	78,658,316

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S12 External quality review federal match					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	8,825,726	11,881,984	0	0	11,881,984
General Fund	2,514,723	3,183,748	207,225	207,225	3,390,973
Cash Funds	329,807	461,089	0	0	461,089
Reappropriated Funds	0	0	0	0	0
Federal Funds	5,981,196	8,237,147	(207,225)	(207,225)	8,029,922
Total for S12 External quality review federal match	8,825,726	11,881,984	0	0	11,881,984
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	2,514,723	3,183,748	207,225	207,225	3,390,973
Cash Funds	329,807	461,089	0	0	461,089
Reappropriated Funds	0	0	0	0	0
Federal Funds	5,981,196	8,237,147	(207,225)	(207,225)	8,029,922

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S13 Old Age Pension medical					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(C) Information Technology Contracts and Projects					
Colorado Benefits Management Systems, Operating and Contract Expenses	0	10,885,261	0	0	10,885,261
General Fund	0	3,770,869	0	0	3,770,869
Cash Funds	0	1,675,284	0	(8,390)	1,666,894
Reappropriated Funds	0	0	0	8,390	8,390
Federal Funds	0	5,439,108	0	0	5,439,108
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	5,728,093,904	6,594,830,484	0	0	6,594,830,484
General Fund	882,751,482	968,235,300	0	(3,821,341)	964,413,959
General Fund Exempt	813,135,957	848,124,468	0	0	848,124,468
Cash Funds	549,802,496	703,597,288	0	(5,369,479)	698,227,809
Reappropriated Funds	0	0	0	9,190,820	9,190,820
Federal Funds	3,482,403,969	4,074,873,428	0	0	4,074,873,428
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	431,000	7,574,103	(3,909,269)	5,388,407	12,962,510
General Fund	0	2,962,510	0	0	2,962,510
Cash Funds	431,000	4,611,593	(3,909,269)	5,388,407	10,000,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
(B) Office of Information Technology Services - Medicaid Funding					
Colorado Benefits Management System	11,146,358	559,814	0	0	559,814
General Fund	4,192,880	205,473	0	0	205,473
Cash Funds	1,393,789	74,625	0	(457)	74,168
Reappropriated Funds	0	0	0	457	457
Federal Funds	5,559,689	279,716	0	0	279,716
Total for S13 Old Age Pension medical	5,739,671,262	6,613,849,662	(3,909,269)	5,388,407	6,619,238,069
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	886,944,362	975,174,152	0	(3,821,341)	971,352,811
General Fund Exempt	813,135,957	848,124,468	0	0	848,124,468
Cash Funds	551,627,285	709,958,790	(3,909,269)	10,081	709,968,871
Reappropriated Funds	0	0	0	9,199,667	9,199,667
Federal Funds	3,487,963,658	4,080,592,252	0	0	4,080,592,252

	FY 2014-15 Actual	FY 2015-16 Appropriation	FY 2015-16 Requested Change	FY 2015-16 Rec'd Change	FY 2015-16 Total w/Rec'd Change
S14 Public school health services					
(5) OTHER MEDICAL SERVICES					
Public School Health Services	62,716,218	72,202,649	8,470,989	8,470,989	80,673,638
General Fund	0	0	0	0	0
Cash Funds	31,449,659	35,640,520	4,126,655	4,126,655	39,767,175
Reappropriated Funds	0	0	0	0	0
Federal Funds	31,266,559	36,562,129	4,344,334	4,344,334	40,906,463
Total for S14 Public school health services	62,716,218	72,202,649	8,470,989	8,470,989	80,673,638
FTE	0 .0	0 .0	0 .0	0 .0	0 .0
General Fund	0	0	0	0	0
Cash Funds	31,449,659	35,640,520	4,126,655	4,126,655	39,767,175
Reappropriated Funds	0	0	0	0	0
Federal Funds	31,266,559	36,562,129	4,344,334	4,344,334	40,906,463
Totals Excluding Pending Items HEALTH CARE POLICY AND FINANCING					
TOTALS for ALL Departmental line items	7,705,853,939	8,890,954,397	159,798,023	151,713,690	9,042,668,087
FTE	390.9	421.2	1 .0	1 .0	422.2
General Fund	1,502,756,056	1,659,028,549	30,576,978	8,561,932	1,667,590,481
General Fund Exempt	813,135,957	848,552,061	0	0	848,552,061
Cash Funds	838,837,333	1,031,847,224	112,966,918	117,707,370	1,149,554,594
Reappropriated Funds	27,551,649	7,805,549	(1,565)	9,198,102	17,003,651
Federal Funds	4,523,572,944	5,343,721,014	16,255,692	16,246,286	5,359,967,300

JBC Staff Supplemental Recommendations Department of Health Care Policy and Financing

Presented by:

Eric Kurtz, JBC Staff
January 28, 2016

Summary Table

Staff recommendation is $22.0 M GF lower than the request, primarily due to:

- $18.1 M for S4 Medicare Modernization Act
- $3.8 M for S13 Old Age Pension
- <$1.0 M for S7 Fed reg for managed care

Technical Note on Summary Table

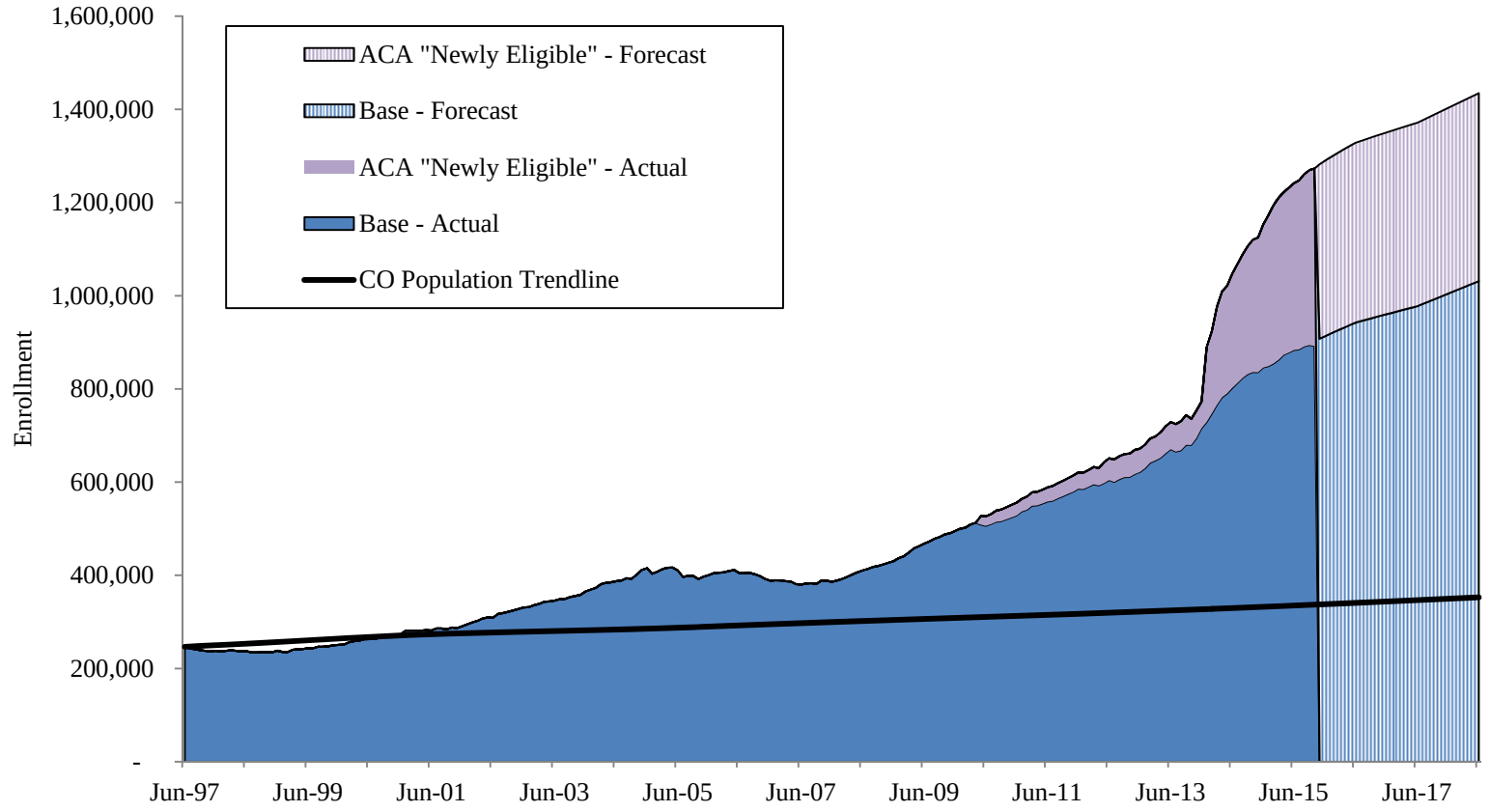
- Includes S2 Behavioral Health, S5 Office of Community Living, and Nonprioritized requests that the JBC has already acted on
- Does not include S15 Release Overexpenditure Restriction or an interim action on County Administration that relate to prior years
- Skips S8, because there was no S8

S1 Medical Services Premiums
RECOMMEND

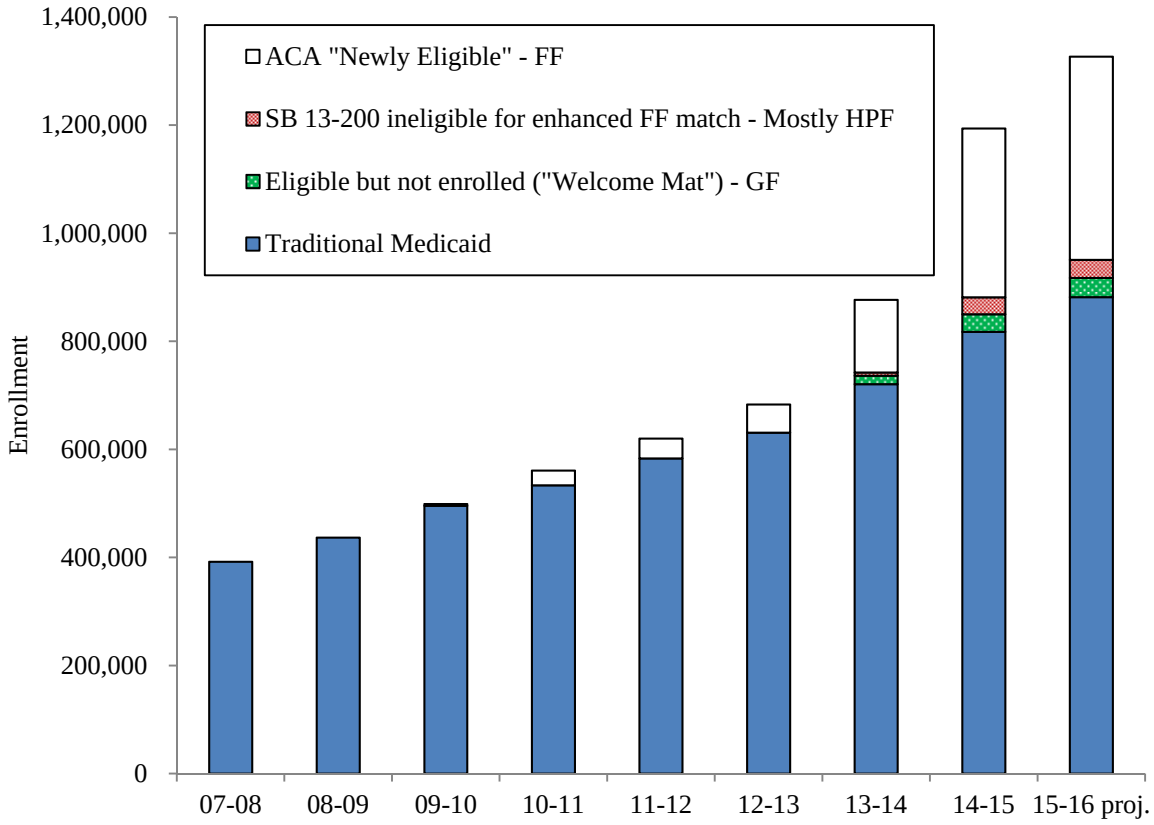
	Request	Recommendation
Total	$207,160,125	$207,160,125
General Fund	37,869,753	37,869,753
Cash Funds	115,663,744	115,663,744
Federal Funds	53,626,628	53,626,628

- Forecast adjustment
- GF change is primarily driven by higher than expected per capita costs for kids
- CF and FF change is primarily due to a delay in CMS approval of the Department's Hospital Provider Fee distribution plan moving costs from FY 2014-15 into FY 2015-16.

Medicaid Enrollment



Medicaid Enrollment



S3 Children's Basic Health Plan (CHP+)
RECOMMEND

	Request	Recommendation
Total	($22,754,545)	($22,754,545)
General Fund	1	1
Cash Funds	(3,785,168)	(3,785,168)
Federal Funds	(18,969,378)	(18,969,378)

- Forecast adjustment
- FY 14-15 expenditures were lower than expected
- Overestimated CHP+ children and underestimated Medicaid children

S4 Medicare Modernization Act
RECOMMEND $18.1 M LESS THAN REQUEST

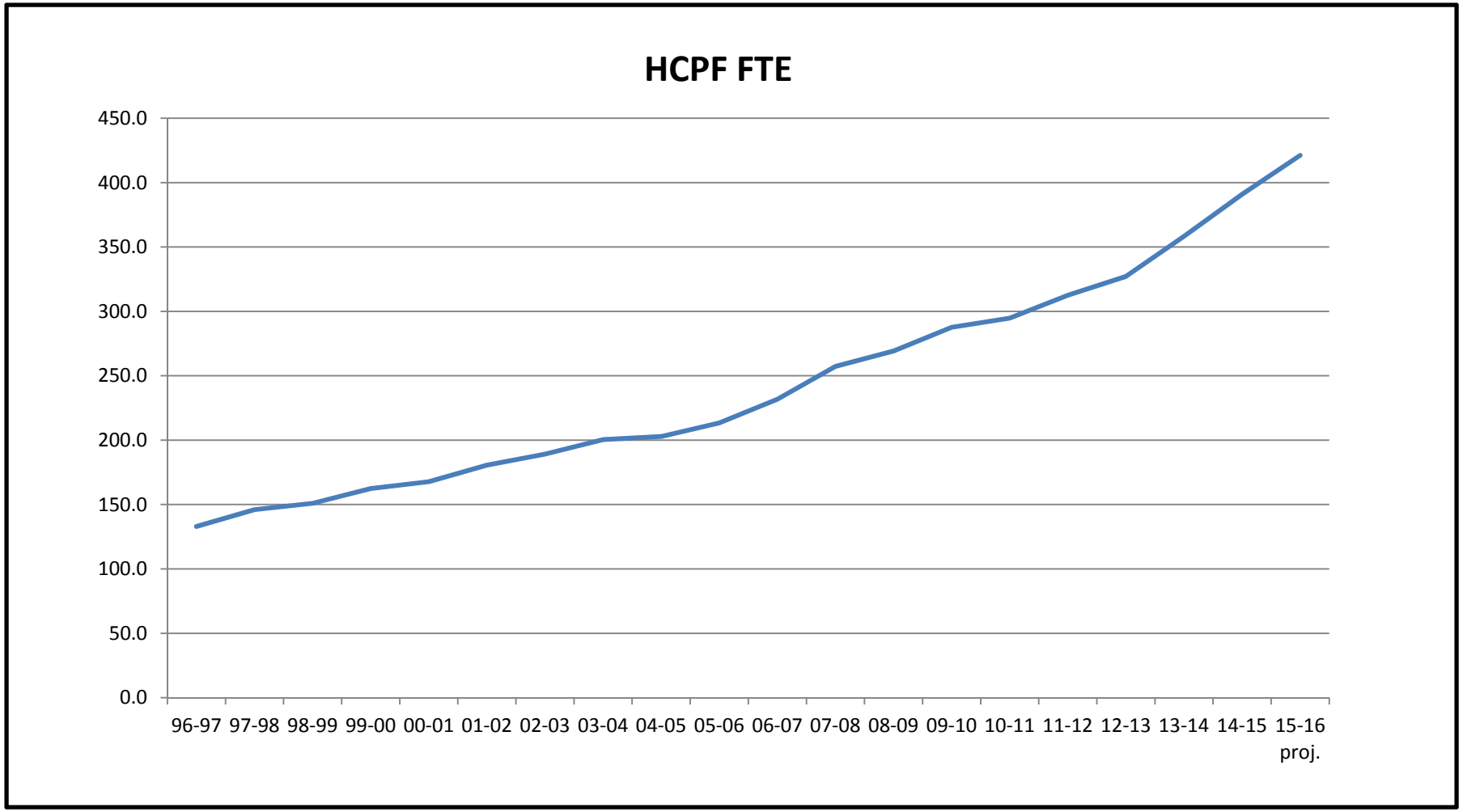
	Request	Recommendation
Total	$16,865,498	($1,318,801)
General Fund	16,865,498	(1,318,801)

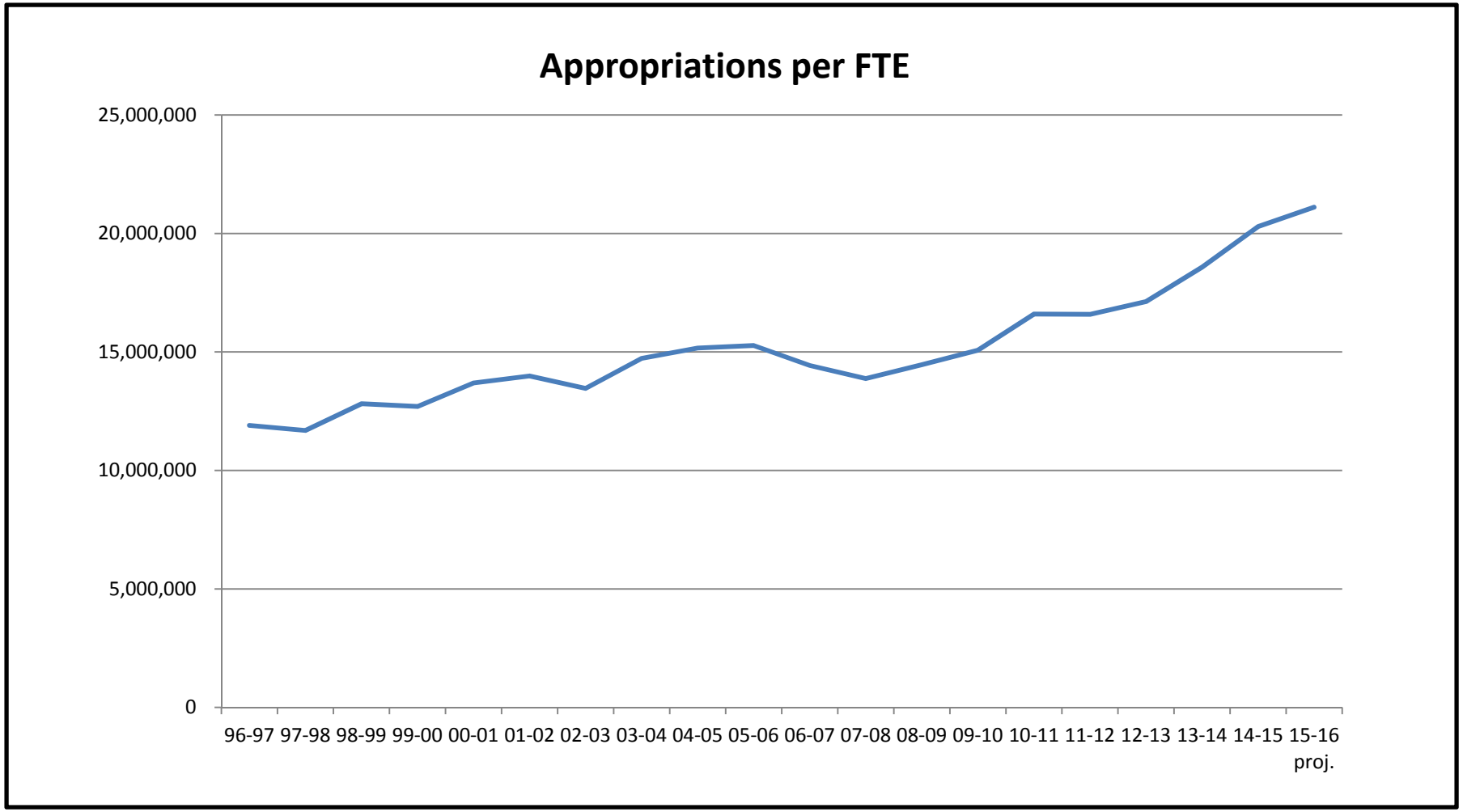
- Forecast adjustment
- Reimburses feds for prescription drugs for people dually eligible for Medicaid and Medicare
- Department made a technical error and requested more than their forecast
- Decrease is net result of lower caseload and higher Medicare prescription drug costs

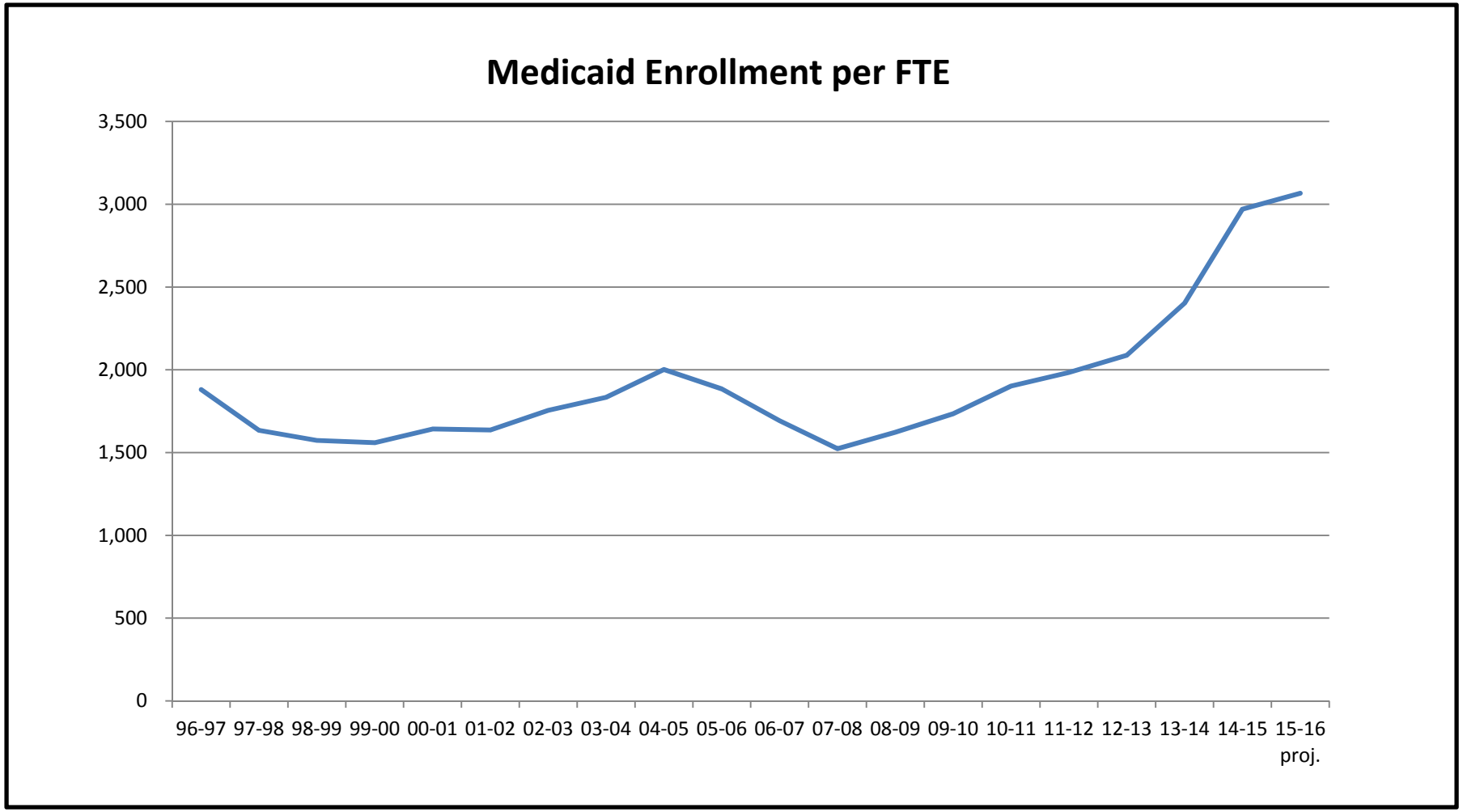
S6 Fed Reg for Assuring Access
RECOMMEND WITH MODIFICATIONS FOR JBC COMMON POLICY

	Request	Recommendation
Total	$267,859	$267,859
General Fund	133,930	133,930
Federal Funds	133,929	133,929

- Add 3.0 FTE and actuary services to implement new federal regulation
- Ongoing costs of $464,096, including $232,048 GF and 3.0 FTE, in FY 2016-17
- Fed reg requires analysis of the affect of provider rates on access to services
- Compliance with the reg needed to implement requested rate reductions of:
  - 1% across-the-board
  - End of primary care rate bump
  - $100 M restriction on the Hospital Provider Fee


HCPF FTE
450.0
400.0
350.0
300.0
250.0
200.0
150.0
100.0
50.0
0.0
96-97
97-98
98-99
99-00
00-01
01-02
02-03
03-04
04-05
05-06
06-07
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
15-16 proj.


Appropriations per FTE
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
0
96-97 97-98 98-99 99-00 00-01 01-02 02-03 03-04 04-05 05-06 06-07 07-08 08-09 09-10 10-11 11-12 12-13 13-14 14-15 15-16 proj.


Medicaid Enrollment per FTE
3,500
3,000
2,500
2,000
1,500
1,000
500
0
96-97 97-98 98-99 99-00 00-01 01-02 02-03 03-04 04-05 05-06 06-07 07-08 08-09 09-10 10-11 11-12 12-13 13-14 14-15 15-16 proj.

S7 Fed Reg for Managed Care
NOT RECOMMEND

	Request	Recommendation
Total	$18,812	$0
General Fund	9,406	0
Federal Funds	9,406	0

- Add 4.0 FTE plus external quality review and actuary services
- Ongoing costs of $722,809, including $361,405 GF and 4.0 FTE, in FY 2016-17
- Fed reg requires expanded quality strategy and overhaul of managed care admin
- This is a proposed rule, rather than final
- Final rule could be different and might take years
- Might make sense to add resources at figure setting, but not in supplemental
- Will explore changes Department views as good policy, not just a mandate

S9 Provider Enrollment Fee
RECOMMEND WITH MODIFICATION

	Request	Recommendation
Total	$1,180,463	$2,000,000
Cash Funds	1,180,463	2,000,000

- Feds require revalidation of providers and collection of an enrollment fee
- The fee will be used to screen for fraud, waste, and abuse
- Dept. asked for a bill to create a new cash fund, but the JBC staff recommends using an existing fund
- Staff rec is higher than the request to create a margin for error in the forecast
- Footnote that the Dept is to decrease GF and FF expenditures as revenue comes in to save money that can be used for future obligations

S10 Medicaid-Medicare Grant True Up
RECOMMEND

	Request	Recommendation
Total	$6,374,303	$6,374,303
General Fund	(276,303)	(276,303)
Cash Funds	6,650,606	6,650,606

- Changes in funding needs for a demonstration grant to coordinate care for people eligible for both Medicaid and Medicare as a result of:
  - Delay in CMS approval
  - Lower enrollment due to people participating in Medicare Advantage plan
  - Larger federal grant
- Lower GF investment over the life of the grant
- Footnote to exempt grant funds from calculation of compliance with “(M)” note

S11 Technical Adjustments
RECOMMEND IN PART

	Request	Recommendation
Total	$7,101,996	$7,103,561
FTE	1.0	1.0
General Fund	30,317	30,317
Cash Funds	(30,906)	(29,341)
Reappropriated Funds	(1,565)	(1,565)
Federal Funds	7,104,150	7,104,150

- Several changes the Dept views as technical corrections

Staff does not recommend:

- Removing the "(M)" note from County Admin (JBC previously voted to keep it)
- Reducing Old Age Pension State Medical Program (restructure instead)
- Rollforward for LTSS planning (lack of specifics on the amount and use of funds)
- Transfer to K-12 for Public School Health Services Admin (not an error)

S12 External Quality Review
RECOMMEND

	Request	Recommendation
Total	$0	$0
General Fund	207,225	207,225
Federal Funds	(207,225)	(207,225)

- Notified by CMS that certain activities of the External Quality Review vendor related to the ACC are eligible for 50% match, rather than 75%
- External Quality Review vendor evaluates quality, timeliness, and access for managed care contracts and prepaid inpatient health plans
- ACC manages care, but is not a capitated, risk-based contract, and so not subject to certain fed requirements for which a 75% match is provided

S13 Old Age Pension Health and Medical
RECOMMEND RESTRUCTURE APPROPS TO SAVE GF

	Request	Recommendation
Total	($3,909,269)	$5,388,407
General Fund	0	(3,821,341)
Cash Funds	(3,909,269)	10,081
Reappropriated Funds	0	9,199,667

- Forecast adjustment
- With Medicaid expansion enrollment has shifted from OAP State Medical Program to Medicaid
- Department proposed cut to OAP State Medical Program, which would result in a reversion to the GF at the end of the year
- JBC staff recommends reappropriating funds to offset GF in Medical Services Premiums so the GF savings can be counted in the budget
- Also, other restructuring to provide flexibility and reduce future supplementals

S14 Public School Health Services
RECOMMEND

	Request	Recommendation
Total	$8,470,989	$8,470,989
Cash Funds	4,126,655	4,126,655
Federal Funds	4,344,334	4,344,334

- Forecast adjustment
- Increase in Certified Public Expenditures by school districts and BOCES
- No increase in GF expenditures or TABOR revenue
- Increase in utilization corresponds with increase in children enrolled in Medicaid

S15 Release Over-expenditure Restriction
RECOMMEND WITH MODIFICATION

	FY 2014-15 Request	FY 2013-14 Recommendation	FY 2014-15 Recommendation
Total	($15,006,316)	$30,211,136	$2,787,826
General Fund	23,553,073	30,211,136	489,536
Cash Funds	(3,266,365)	0	2,298,290
Federal Funds	(35,293,024)	0	0

- Medicaid is allowed to overexpend, but the Controller restricts the next year
- FY 14-15 overexpenditures mostly due to unreleased restrictions from FY 13-14
- FY 13-14 overexpenditure due to underforecast of parents and caregivers, unanticipated increase in utilization of behavioral health, and increased obligation for prescription drugs under the Medicare Modernization Act
- Staff recommendation differences
  - Modify only overexpenditures and not underexpenditures
  - Go back to FY 13-14 where root problem occurred

Previously Approved Interim Supplemental – County Adminstration RECOMMEND

	FY 2014-15 Request	FY 2014-15 JBC Action
Federal Funds	$2,224,426	$2,224,426

- More activities are related to the ACA expansion than originally thought and eligible for a 75% match, rather than 50% match
- Rather than keeping the total funds the same and reducing the GF, the Dept proposed, and the JBC approved, increasing the total funds
- Affects FY 2014-15
- Will be included in the supplemental bill