This document includes the following components:

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Hearing Responses from the Commission on Affordable Health Care

Colorado Commission on Affordable Health Care

1. Please provide an overview of the Commission on Affordable Health Care and the FY 2016-2017 request $424,000 General Fund.

Response: The Commission was created by the passage of SB14-187, which appropriated dollars effective July 1, 2014 in the amount of $400,000. This initial amount was increased by $25,000 by the passage of HB15-1083, which required the Commission to provide a study of the impact of copayments and coinsurance on physical rehabilitative services.

The Commission held its first meeting on September 22, 2014. The Commission's initial work included: creating by-laws and internal procedures; setting meeting locations and a regular schedule for its meetings; creating a budget and financial accounting system; electing officers; requesting proposals for staffing to the Commission, and creating a plan and scope of work.

Thus far, expenses have included: attorney's fees, fees to the Commission staff (independent contractors), establishing a web-based portal so that members of the public could join the Commission meetings via the phone and/or Internet. As of November 2015 $184,465 had been spent, leaving cash balance of $212,701.93.

The Commission is empanelled until July 1, 2017. The cash balance remaining from the initial appropriation will allow the Commission to continue until **June 30, 2016.**

Not included in these expenses is the billing for the actuarial consultant who provided the required report to fulfill the requirements of HB15-1083 (the Physical Therapy study).

The requested 2016-2017 funds would provide the Commission with the funds needed to complete its work (through June of 2017). These activities include conducting additional statewide meetings to solicit input from citizens in the seven Congressional Districts; comparing Colorado's expenditures to those of other states; assessing the primary drivers of health cost increases; and, proposing potential solutions.

Some might note that this is not an insignificant amount of funding, and yet the Commission appears to be moving slowly. We would note that the work we have been assigned is very complicated and there are many things that need to be considered. For instance:

Take Children's Hospital. Five years ago their Medicaid patients represented 38% of patients, today it is 47%.

On average, Medicaid pays 72% of hospital costs, which is the same as 26% of charges. This means that Children's has to charge commercial insurers more for the care they render to non-Medicaid patients to cover their costs. For example: an appendectomy under Medicaid is reimbursed at $5,027 for the hospital portion of the service. An appendectomy under one of the major commercial payers is charged $14,970 for the same procedure ($9944 more, or a mark-up of almost 200%).

When we place this example in context, it is even more concerning as we see the percent of the population that is covered by Medicaid growing. The Cost Commission is trying to understand that actual cost of the care provided (appendectomy in this case) and what is the appropriate charge for such services.

Another example: pharmacy cost in a typical health plan amounted to 12-14% of total costs, two years ago. Today, many claim pharmacy represents over 30% of the typical health care dollar, and by 2020 some have predicted they will represent 50%.

Pharmacy benefits are an important part of the health care system. Therapies supported by a sound pharmacy regimen lower cost and often result in better quality care. However, why is it that the cost of drugs is increasing so fast, and are these medications resulting in lower overall cost, or not?

2. Please discuss how the Commission continued their work after the June, 2015 emergency supplemental was declined. Please provide a list of the expenditures reductions/revisions made to stay within the $400,000 budget.

The Commission's earlier request was unclear and created confusion. The Commission did not act on its own authority as we are now, we worked through CDPHE. We did not have the opportunity to directly address that confusion until now. Thank you for this opportunity.

At the time of the emergency request the Commission had enough funds to continue its work through the end of April 2016. We have since raised $75,000 in community funds which will take us through the end of this current fiscal year. The emergency-funding request was to provide the funds necessary to enable the Commission to continue until the end of the Commission's initial prescribed term (July, 2017).

To enable the Commission to accomplish its goals of providing an interim report (as required by the enabling statute) along with the Therapy Study, the Commission expanded its meeting schedule so that meetings would be held twice a month, and it dissolved its committee structure so that staff time would be reduced. The result was to demand more of the Commissioners themselves, and for a portion of the research to be performed by the Commissioners, along with the staff of the Commission, rather than utilizing outside experts.

3. Please provide a list of grants and donations that the Commission has received to date.

To augment the state's appropriation the Commission has been awarded $75,000 in funds from local Foundations. The Commission has received $40,000 through November. A contract has been signed for the additional $35,000, and the Commission anticipates receiving those funds no later than the end of this calendar year.

Rose Community Foundation	$15,000
The Colorado Trust	$25,000
The Colorado Health Foundation	$35,000 (Grant contract signed, awaiting check)

4. Please discuss who has oversight of the Commission's expenditures.

The Joint Budget Committee has oversight. We are, by legislative design, not under the control of the administration due to the sensitive nature of our charge. The enabling legislation designated CDPHE as the fiscal agent for the Commission. They hold the Commission's funds, pay expenses, and provide the Commission with quarterly reports of expenditures, however have no authority over those expenditures. One of the Commission members serves

as treasurer and reviews and approves the expenses. All expenses are reimbursed based on department policies – there are department contracts with all subcontractors, and all expenses require invoices prior to payment. The enabling legislation delegated control of the expenditure of the funds to the Commission.

Colorado Commission on Affordable Health Care

Scope of Work

Mission (SB14-187 Page 7):

The Mission of the Commission is to ensure that Coloradans have access to affordable health care in Colorado. The Commission shall focus its recommendations on evidence-based cost-control, access, and quality improvement initiatives and the cost-effective expenditure of limited state moneys to improve the health of the state's population.

Powers and Duties of the Commission (SB14-187: Pages 8-10)

1. (a) Identify, examine and report on:
    a. the principle cost drivers for Colorado Businesses and their employees,
    b. individuals who purchase their own health insurance,
    c. Colorado's Medicaid Program and
    d. Uninsured based on data driven, evidence based analysis
2. (b) Evidence Based Initiatives: Data Analysis on evidence based initiatives designed to reduce health care costs while maintaining or improving access to and quality of care.
3. (c) Information Availability: Analyze the impact of increased availability of information on:
    a. Health care pricing
    b. Cost
    c. Quality of provider
    d. Payers
    e. Purchasers
    f. Consumer behavior
4. (d) State Regulations: Review, analyze and seek public input on state regulations impacting delivery and payment system innovations.
5. (e) Out of Pocket Costs: Analyze impact of out-of-pocket costs and high deductible plans have on:
    a. Patient Spending
    b. Uncompensated Care
    c. Outcomes
    d. Access to Care
6. (f) Access to Care: Examine access to care and its impact on health costs including:
    a. Network Adequacy
    b. Composition of health care workforce
    c. Distribution of Colorado's Health Care Workforce
7. (g) Existing Information Resources: Review reports and studies for potential information including:
    a. Reports
    b. Studies

c. Work
d. Colorado and out of state organizations
e. Blue Ribbon Commission for Health Care Reform
f. Accountable Care Collaborative
g. Colorado Foundation for Medical Care
h. Colorado's State Health Innovation Plan

8. (h) Report out comes of the 208 Commission as well as the impact of implementing those recommendations.
9. (i) Data: Collect and review data including:
    a. Rate Review Process Data from DOI
    b. Payment information from HCPF
10. (j) Medicaid Expansion: Review the impact of Medicaid Expansion on:
    a. Health Care Costs
    b. Access to Care
    c. Access to Commercial Insurance
11. (k) Medicaid Waivers: Evaluate the impact of a Global Medicaid Waiver on:
    a. Health Care Costs
    b. Access to Care
    c. Quality of Care
12. (l) Public information: Review publicly available information:
    a. Pricing Transparency
    b. Adequacy, Composition and distribution of physician and health care networks.
    c. Drug Formularies
    d. Co-Insurance, Copayments and deductibles
    e. Health Plan Availability
13. (m) Collaboration: To ensure existing cost containment and payment reform efforts are fully integrated, the Commission will work with other Boards, Task Forces, Commissions, or other entities that study or address:
    a. Health care costs
    b. Access
    c. Quality
14. (n) Enter into business associate agreements with HIPAA covered entities.
15. (o) To make recommendations about other public or private entities that should continue to study health cost drivers in Colorado.
16. (p) To make recommendations to the Congressional Delegation about changes in Federal law that may be needed to make health care affordable in Colorado.
17. (q) Any other authority necessary to perform its administrative duties.
18. (r) Any other duties necessary to fulfill its mission.

Colorado Commission on Affordable Health Care
Work Plan

Date	Objectives/ Deliverables	Actuals/Outcomes
October 2014	• Finalize and adopt by-laws. • Review and finalize revisions to Conflict of Interest Statement (COI). • Initial review and discussion of statutory duties and staffing needs necessary for completion of duties.	• Completed and adopted by-laws • COI statement given to members for execution. • Directive for Planning Committee to seek and interview appropriate staff necessary to fulfill the Commission's work.
November 2014	• Collect all completed COI disclosures forms from Commissioners. • Review and finalize SOW and timeline. • Commission discussion on staffing plan and necessary resources.	• Completed COI from all Commissioners. • Draft scope of work and timeline developed.
December 2014	• Finalize working budget. • Commission approval of staff recommendations. • Elect permanent Officers.	• Scope of work developed for consultants/ staff. • RFI released and responses collected.
January 2015	• Interview and select appropriate staff. • Elect permanent officers	• Interviews with consultants/ staff chosen. • Staff recommendations made by committee and scheduled to be presented at February Commission meeting. • Permanent officers selected for the Commission.
February 2015	• Transition administrative duties to staff. • Review and discuss draft working budget.	• Creation of three committees – planning, communications/liaison, and research. Chairs and membership of committees selected. • The Commission approved a draft budget, recognizing the need to make revisions as the committees identify additional needs; the Commission will also need to explore additional funding sources. o The Planning Committee was given authority to initiate grants with signatory responsibility given to the chair and

Date	Objectives/ Deliverables	Actuals/Outcomes
		vice-chair of the Commission.
March 2015	• Develop a mechanism/ framework to prioritize work of the Commission. • Create a draft schedule for statewide Congressional District meetings. • Identify gaps in data and information resources. • Identify communications and outreach needs.	• Defined filters for recommendations (actionable, measurable, impacts public systems and private markets, and drivers of absolute cost/ rates of cost). • Draft of plan for statewide meetings shared with Commissioners to ensure a quorum at meetings. • Protocols adopted for disseminating and collecting information from the public that is accessible to Commissioners and shareable with the public. • Protocols adopted for the creation of subcommittees and membership of those subcommittees.
April 2015	• Discussion on working definitions and identifying regional cost drivers. • Start to identify the right Colorado and national speakers to address cost for the Commission. o Identify presentations for the May Commission meeting. o Develop an understanding of what is being done in Colorado related to cost. • Develop key talking points for leadership on the charge and work of the Commission. • Develop a Colorado Commission for Affordable Health Care webpage. • Develop a sustainable funding plan for Commission. • Make meetings more accessible with online tools. • Develop draft itinerary and agenda for the statewide meetings.	• Developed working definitions on cost and spending related to the charge of the Commission. • Working with SIPA to develop a Colorado Commission for Affordable Health Care webpage. • Met with Colorado funders to gauge interest in funding the work of the Commission. • Broadcast the meeting publically using technology available at Regis. Will begin using ReadyTalk in May allowing people to join meeting remotely. • Developed a questionnaire for stakeholders to provide input on what they see as the drivers and efforts related to cost.
May 2015	• Develop a draft communications and outreach plan. • Identify and assess existing information resources including reports, studies, work, Blue Ribbon Commission, Accountable	• Developed a draft communications and outreach plan to key legislative leadership. • Identified and assessed existing information resources including reports,

Date	Objectives/ Deliverables	Actuals/Outcomes
	Care Collaborative. • Understand Colorado efforts related to cost containment. • Discussion of delivery and payment system innovations. • Develop draft outline for November report Communications Committee: • Prepare a specific legislative outreach plan to contact and inform the key legislative leadership of the work of the Commission (overall plan, progress to date, etc.) • Develop Committee protocols on outreach to legislators. • Define policies and procedures for managing communications for different stakeholders including the public, public officials and the media. • Review and update the Committee's Charter, if necessary. • Develop a budget narrative for the Committee's work (with a range of basic/minimum and optimal) so that the overall Commission budget can be finalized. • Draft outline for November report presented to Commission for approval. Research Committee: • Review the original Charge for the Committee to confirm it is still relevant • Build a specific, written framework for the next six months including a timeline and benchmarks for measuring progress. • Provide the Planning Committee with your financial needs (two levels; minimum and desired/optimal) so that the budget can be finalized • Identify framework for discussion topics to be held at meeting for committee learning – questions, articles, criteria • Create a record of articles – related to research (document/ evaluation form) – content, strengths, weaknesses	studies, work, Blue Ribbon Commission, Accountable Care Collaborative. • CHI and CIVHC presented on Colorado efforts related to cost containment. • Developed a draft outline for November report, reviewed by all committees and presented to the Board on June 8. • Developed protocols and key talking points on the work of the Commission. • Identified committee budget needs to further refine Commission budget. • Identified key topic areas and timeline for Research Committee analysis. • Created a Dropbox file to store articles that inform the topic conversations. • Began development of content for new website.

Date	Objectives/ Deliverables	Actuals/Outcomes
	• Research Committee to review the topic of transparency and develop recommendations for the Commission	
June 2015	• Build a media contact list and a list of talking points for the media • Create a media and legislative contact strategy Research Committee: • Review health care spending data and provide a list of revisions or additional data needed • Review and synthesize cost/ spending driver priority areas to be reported to the Commission on with related data points	• Media and legislative outreach lists, strategy, and talking points created and shared • Presented on the topic of transparency to the research committee • Discussed the document related to spending by service area with the research committee to identify direction of future data needs. Identification of the questions trying to answer
July 2015	• Send out stakeholder questionnaire with a deadline for response by September 2015 • Website for the Commission launches • Identify potential speakers for future meetings Communications Committee: • Develop key talking points to inform the media of the need for Colorado to address the cost of care in our state • Develop a strategic response plan to address issues that arise including responding to complaints, addressing incorrect information, and crisis communication. Research Committee: • Have CHI present to Research Committee spending by payer to inform the Committee • Research Committee discuss workforce topic to develop recommendations	• Legislative outreach priorities identified o Commissioner legislative point people identified (Elisabeth Arenales and Cindy Sovine Miller) • Website launched – www.colorado.gov/cocostcommission • Commission structure revised o Operate as Commission of the Whole and meet two times a month – 2nd Monday and 4th Friday of the month o Research and communication committees dissolved • Reviewed spending data by payer at the Research Committee • Reviewed spending data by service area at the Commission • Identified topic areas for discussion related to spending data to be covered by the Commission – presentation on the connection of spending to topic areas • Stakeholder questionnaire distributed and posted on the webpage

Date	Objectives/ Deliverables	Actuals/Outcomes
August 2015	• Present transparency topic to the Commission development of recommendations • Identify buckets of focus for discussion on workforce • Work with CHI, CIVHC and others to identify data sources and how it can inform the work • Discuss development of advisory committee and how could be best used by Commission in the development of recommendations • Identify items to be included in November report to the General Assembly.	• Topic of transparency reviewed by Commission and draft recommendations developed as well as identified other issues for potential review if time and resources allow a. Presentation and draft recommendations available on the website • Focus areas identified for workforce presentation in September • Draft outline for November report developed and shared with Commission
September 2015	• Present workforce topic to the Commission and development of recommendations • Follow up on transparency • Stakeholder presentations • Discussion of items to be included in November report to the General Assembly.	• Topic of workforce reviewed by Commission and draft recommendations developed as well as identified other issues for potential review if time and resources allow. a. Presentation of the Commission and CDPHE available on the website • Reviewed and revised potential recommendations and parking lot issues related to transparency and workforce • Outline for the November report approved as well as a timeline for the review schedule of the report was shared with Commissioners
October 2015	• Present payment and delivery reform topic to the Commission and development of recommendations • Follow up on past topics • Review and Finalize initial report for the General Assembly • Stakeholder presentations	• Topic of payment and delivery reform were reviewed by Commission. Presentations made at both meetings in October a. Presentations available on the website • Reviewed and revised potential recommendations and parking lot issues related to transparency and workforce • A matrix of stakeholder responses to the questionnaire was shared with Commissioners to identify and align potential stakeholder presentations with topic areas • Reviewed the Milliman report on copays and rehab • Draft November report shared with Commissioners for feedback and

Date	Objectives/ Deliverables	Actuals/Outcomes
		comments
November 2015	• Initial report submitted to the General Assembly including (but not limited to): o Commission Organization o By-Laws, COI and SOW o All deliverables o Overview of Listening Tour o Progress on definitions and timeline for 2016/17 action plan. • Present market competitiveness topic to the Commission and development of recommendations • Identify buckets of focus for discussion on social determinants of health • Follow up on past topics • Stakeholder presentations	
December 2015	• Discussion on principle cost drivers, statewide and regional, for businesses and their employees, government and individuals who purchase their own insurance. • Identify gaps in data and information resources relevant to duties assigned to the Commission. • Stakeholder presentations • Identify and examine the cost drivers each of the Congressional Districts have in common. • Identify and examine the cost drivers unique to each District.	
January 2016	• Present regulatory costs topic to the Commission and development of recommendations • Identify buckets of focus for discussion on administrative costs • Stakeholder presentations • Ongoing review of past topics • Workgroup formation on topics	

Date	Objectives/ Deliverables	Actuals/Outcomes
February 2016	• Present administrative costs topic to the Commission and development of recommendations • Identify buckets of focus for discussion on technology • Stakeholder presentations • Ongoing review of past topics	
March 2016	• Begin Statewide Meetings Round 1 – receive public input from local stakeholders and experts on cost drivers specific to regions. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2, 3, 4 and 5). • Present technology topic to the Commission and development of recommendations • Identify buckets of focus for discussion on incentive mechanism • Stakeholder presentations • Ongoing review of past topics	
April 2016	• Stakeholder presentations • Statewide meetings continued – receive public input from local stakeholders and experts on cost drivers specific to regions. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2, 3, 4 and 5). • Present incentive mechanisms topic to the Commission and development of recommendations • Ongoing review of past topics	
May 2016	• Statewide meetings continued – receive public input from local stakeholders and experts on cost drivers specific to regions. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2,	

Date	Objectives/ Deliverables	Actuals/Outcomes
	3, 4 and 5). • Launch stakeholder work groups to meet monthly on Commission's preliminary recommendations: 1. Transparency 2. Workforce 3. Social Determinants 4. Incentive Mechanisms 5. Regulatory Costs 6. Administrative Costs 7. Payment and delivery reform 8. Market Competitiveness 9. Technology	
June 2016	• Statewide meetings concluded – receive public input from local stakeholders and experts on cost drivers specific to regions. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2, 3, 4 and 5). • Guest Speaker and/or stakeholder panel on Transparency • Ongoing workgroup discussion and review of recommendations • Deep dive into recommendations on Transparency • Ongoing review of past topics	
July 2016	• Guest Speaker and/or stakeholder on Workforce • Monthly workgroup discussions and review of recommendations. • Deep Dive into recommendations on Workforce. • Ongoing review of past topics.	
August 2016	• Guest Speaker and/or stakeholder panel on Social Determinants • Monthly workgroup discussions and review of	

Date	Objectives/ Deliverables	Actuals/Outcomes
	recommendations. • Deep Dive into recommendations on Social Determinants. • Ongoing review of past topics.	
September 2016	• Guest Speaker and/or stakeholder panel on Regulatory Costs • Monthly workgroup discussions and review of recommendations. • Deep Dive into recommendations on Regulatory Costs • Ongoing review of past topics.	
October 2016	• Guest Speaker and/or stakeholder panel on Administrative Costs. • Monthly workgroup discussions and review of recommendations. • Deep Dive into recommendations on Administrative Costs • Ongoing review of past topics.	
November 2016	• Second annual report for legislature to be presented in November including statewide meetings, stakeholder and work group feedback and preliminary recommendations.	
December 2016	• Guest Speaker and/or stakeholder panel on Payment and Delivery Reform • Monthly workgroup discussions and review of recommendations. • Deep Dive into recommendations on Payment and Delivery Reform • Ongoing review of past topics.	
January 2017	• Guest Speaker and/or stakeholder panel on Market Competitiveness. • Monthly workgroup discussions and review of recommendations. • Deep Dive into recommendations on Market Competitiveness.	

Date	Objectives/ Deliverables	Actuals/Outcomes
	• Ongoing review of past topics.	
February 2017	• Guest Speaker and/or stakeholder panel on Technology. • Monthly workgroup discussions and review of recommendations. • Deep Dive into recommendations on Technology. • Ongoing review of past topics.	
March	• Discussion of any other recommendations. • Review of all recommendations • Wrap up stakeholder workgroups, present final conclusions.	
April 2017	• Begin Statewide Meetings Round 2 – Present final recommendations and solicit feedback. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2, 3, 4 and 5).	
May 2017	• Continue Statewide Meetings Round 2 – Present final recommendations and solicit feedback. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2, 3, 4 and 5).	
June 2017	• Conclude Statewide Meetings Round 2 – Present final recommendations and solicit feedback. Meetings in Colorado Springs, La Junta, Alamosa, Summit County, and Grand Junction (Congressional Districts 2, 3, 4 and 5).	
July 2017	• Review feedback from statewide meetings, deliberate on any changes. • Finalize legislative recommendations.	
August	• Review feedback from statewide meetings, deliberate on any changes.	

Date	Objectives/ Deliverables	Actuals/Outcomes
	• Finalize legislative recommendations.	
September 2017	• Final Report complete. • Recommendations delivered to the legislature	

Commission on Affordable Healthcare Budget

Fiscal Year 2016-2017 Budget Request*

Expenditure		Amount	Description
Legal - AG Office	$	11,000.00	Estimate based on 2014-15 actuals and adjusted for anticipated legal review of recommendations and commisioner requests in future periods
Contract Personnel Services	$	337,000.00	Estimate includes a $50,000 increase to the Keystone group from 2014/15 actuals for the addition of 10 public stakeholder workgroups to assemble and deliberate on legislative recommendations. Assumes continued support for bi-monthly commission meetings and all statewide outreach meetings required by statute.
Mileage/Travel	$	8,000.00	Estimate based on 2014-15 actuals for regular Commission meetings and the second round of statewide meetings to solicit feedback on legislative recommendations.
ReadyTalk Communication and Outreach Technology	$	7,000.00	Estimate includes Ready Talk technology for regular Commission meetings and the addition of work groups.
Portable Sound Amplification Technology	$	1,000.00	Estimate is for the acquisition of portable sound amplification technology. We are constantly asked if we can speak up, this is so we don't have to yell at each other around the table for the public to hear us.
Speakers/Educators on Health Care Costs	$	10,000.00	Estimate on travel expenses for identified experts in areas of health care cost containment to speak to cost commission to provide better understanding of trends
Data Purchases	$	50,000.00	Data purchase estimate based on estimated costs of purchasing data from the All Payer Claims Database through the Center for Improving Value in Health Care. We have applied for a scholarship through a program designed for non-profits and hope to achieve our data pulls through these means but do not have an answer yet as to whether we will meet their criteria so we wanted to put in a placehoder.
Total	$	424,000.00	

* Our final report is due September 2017 so we are requesting operational funding through that period as part of this request.

Commission on Affordable Healthcare
Fiscal Year 2016 Expenditures and Fiscal Year 2016 projection

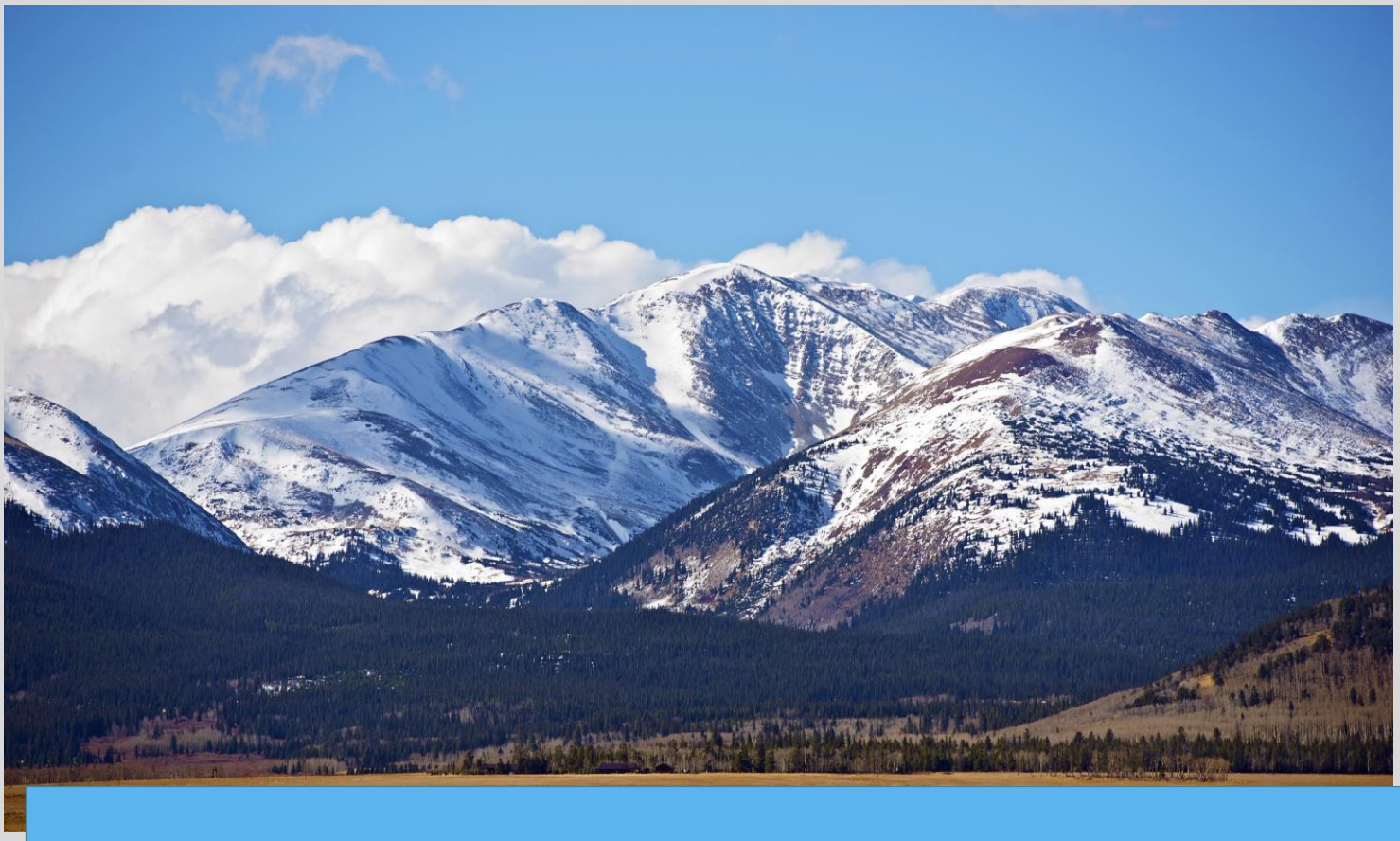
Expenditure	Balance at 6/30/15	Actual Paid Jul-15	Actual Paid Aug-15	Actual Paid Sep-15	Estimated Oct-15	Estimated Nov-15
Cash	280,156.02	$ 314,754.02	$ 280,420.69	$ 256,840.36	$ 243,367.93	$ 240,534.93
Legal - AG Office (billed 1 month behind)	$ 11,941.22		$ -		$ 1,000.00	$ 1,000.00
Pers Serv - Minutes			$ -		$ 175.00	$ 175.00
Mileage/Travel	$ 204.00		$ -	$ -	$ 250.00	$ 250.00
Encumbrance payments paid	$ 75,533.32			$ 13,333.33		
Encumbrance payments to pay		$ 34,333.33	$ 23,833.33		$ 23,833.00	$ 23,833.00
Conference call line - Ready Talk	$ 336.11		$ -	$ 360.10	$ 300.00	$ 300.00
PO in progress RE: Additional appropriation FY16					$ 2,500.00	$ 2,500.00
Total	$ 88,014.65	$ 34,333.33	$ 23,833.33	$ 13,693.43	$ 28,058.00	$ 28,058.00
Revenue						
Funds Appropriated or Carried Forward	$ 400,000.00					
Additional Approprated Funding 7/1/15					$ 25,000.00	
Interest Income	$ 2,768.67		253.00	221.00	225.00	225.00
Total	$ 402,768.67	$ -	$ 253.00	$ 221.00	$ 25,225.00	$ 225.00
Funds available to spend FY16	$ 314,754.02	$ 280,420.69	$ 256,840.36	$ 243,367.93	$ 240,534.93	$ 212,701.93

Commission on Affordable Healthcare
Fiscal Year 2016 Expenditures and Fiscal Year 2016 projec

	Fiscal Year 2016					
	Estimated	Estimated	Estimated	Estimated	Estimated	Estimated
Expenditure	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Cash	$ 212,701.93	$ 184,868.93	$ 157,035.93	$ 129,202.93	$ 101,368.93	$ 73,534.93
Legal - AG Office (billed 1 month behind)	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00	$ 1,000.00
Pers Serv - Minutes	$ 175.00	$ 175.00	$ 175.00	$ 175.00	$ 175.00	$ 175.00
Mileage/Travel	$ 250.00	$ 250.00	$ 250.00	$ 250.00	$ 250.00	$ 250.00
Encumbrance payments paid						
Encumbrance payments to pay	$ 23,833.00	$ 23,833.00	$ 23,833.00	$ 23,834.00	$ 23,834.00	$ 23,834.00
Conference call line - Ready Talk	$ 300.00	$ 300.00	$ 300.00	$ 300.00	$ 300.00	$ 300.00
PO in progress RE: Additional appropriation FY16	$ 2,500.00	$ 2,500.00	$ 2,500.00	$ 2,500.00	$ 2,500.00	$ 2,500.00
Total	$ 28,058.00	$ 28,058.00	$ 28,058.00	$ 28,059.00	$ 28,059.00	$ 28,059.00
Revenue						
Funds Appropriated or Carried Forward						
Additional Approprated Funding 7/1/15						
Interest Income	225.00	225.00	225.00	225.00	225.00	225.00
Total	$ 225.00	$ 225.00	$ 225.00	$ 225.00	$ 225.00	$ 225.00
Funds available to spend FY16	$ 184,868.93	$ 157,035.93	$ 129,202.93	$ 101,368.93	$ 73,534.93	$ 45,700.93

Commission on Affordable Healthcare
Fiscal Year 2016 Expenditures and Fiscal Year 2016 projec

Expenditure	Estimated Jun-16	Final FY16 Pymts Paid for June 30 work paid in 7/16 Estimated	TOTAL All YRS
			$ -
Cash	$ 45,700.93		
Legal - AG Office (billed 1 month behind)	$ 1,000.00	$ 1,000.00	21,941.22
Pers Serv - Minutes	$ 175.00	$ 175.00	1,750.00
Mileage/Travel	$ 250.00	$ 250.00	2,704.00
Encumbrance payments paid			88,866.65
Encumbrance payments to pay	$ 23,834.00		272,667.66
Conference call line - Ready Talk	$ 300.00	$ 300.00	3,696.21
PO in progress RE: Additional appropriation FY16	$ 2,500.00	$ 2,500.00	25,000.00
Total	$ 28,059.00		$ 416,625.74
Revenue			
Funds Appropriated or Carried Forward			400,000.00
Additional Approprated Funding 7/1/15			25,000.00
Interest Income	$ 225.00		5,267.67
			$ -
Total	$ 225.00		$ 430,267.67
Funds available to spend FY16	$ 17,866.93		$ 13,641.93



Colorado Commission on Affordable Health Care

2015 Report to the Colorado General Assembly and Colorado Governor

November 13, 2015

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Letter from the Chairman

November 13, 2015

Governor John Hickenlooper
Office of the Governor
Colorado Capitol
200 E Colfax Ave.
Denver, CO 80203

Representative Elizabeth McCann
Chairman, House Committee on Health, Insurance, and Environment
200 E Colfax Ave.
Denver, CO 80203

Senator Kevin Lundberg
Chairman, Senate Committee on Health and Human Services
200 E Colfax Ave.
Denver, CO 80203

Representative Dianne Primavera
Chairman, House Committee on Public Health Care and Human Services
200 E Colfax Ave.
Denver, CO 80203

Gov. Hickenlooper, Sen. Lundberg, and Reps. McCann and Primavera,

Health care costs have been dramatically rising for the past two decades, in Colorado and across our nation. Despite the progress made on expanding access to health care as well as improving quality, rising costs are creating challenges for families, businesses, and public agencies alike. Recognizing this problem — not only for everyday Coloradans, but also for our state's fiscal health — the Colorado General Assembly passed Senate Bill 14-187 and created the Colorado Commission on Affordable Health Care.

Our mission from Day 1 has been to study this enduring problem, explore the root causes of rising health costs in Colorado, and lay a framework for the important work we have to do in 2016. Our work complements the progress of past commissions and work, while also deliberately focusing on cost containment.

In considering this matter it is important to note the complexity of the topic and the fact that obvious potential actions may in fact not address any particular topic, or even make things worse. This is also important to acknowledge that health care represents one-sixth of our economy, and this is another clarion call for diligence and appropriate care.

This report — the result of more than a year's worth of outreach, research, and expert testimony — lays out the challenges Colorado faces today on health care spending, the primary drivers of rising health costs, and several topics we will continue to grapple with in our second year. In many ways this nonpartisan, comprehensive, and evidence-based analysis of the major drivers of health care costs is a landmark resource for policymakers and others across the Centennial State. However, this is only one step toward our goal of true cost containment.

We still have work to do to study the effectiveness of strategies for controlling health care costs and propose collaborative solutions to address this problem. These challenges remain for our second year of work, and we look forward to collaborating with the Colorado General Assembly and the Governor's Office to ensure we can accomplish our legislative mandate. Your perspectives are essential to our ongoing work.

Please do not hesitate to provide us with any feedback.

Sincerely,

William N. Lindsay III
Chairman, Colorado Commission on Affordable Health Care

Commission members

Elisabeth Arenales of Denver, from an organization representing consumers and understands consumers with chronic medical conditions

Jeffrey J. Cain, M.D., FAAFP, of Denver, a health care provider who is not employed by a hospital and who is a physician recommended by a statewide society or association whose membership includes at least one-third of the doctors of medicine or osteopathy licensed in the state

Rebecca Cordes of Denver, representing large, self-insured Colorado businesses

Greg D'Argonne of Littleton, with expertise in health care payment and delivery

Steve ErkenBrack of Grand Junction, representing carriers offering health plans in the state

Ira Gorman, PT, PhD, of Evergreen, a health care provider who is not employed by a hospital and is not a physician

Linda Gorman of Greenwood Village, a health care economist

Bill Lindsay (Chair/Planning Committee Chair) of Centennial, representing licensed health insurance producers

Marcy Morrison of Manitou Springs, from an organization representing consumers

Dorothy Perry, PhD, of Pueblo, with expertise in public health and the provision of health care to populations with low incomes and significant health care needs

Cindy Sovine-Miller (Vice-Chair) of Lakewood, representing small Colorado businesses

Christopher Gordon Tholen of Centennial, representing hospitals and recommended by a statewide association of hospitals

Ex officio Commission members

Susan Birch, MBA, BSN, RN, Executive Director, Colorado Department of Health Care Policy and Financing

Julie Krow, Deputy Executive Director for Community Partnerships, Colorado Department of Human Services

Marguerite Salazar, Commissioner of Insurance, Colorado Department of Regulatory Agencies

Jay Want, M.D., representing the Colorado All Payer Claims Database

Larry Wolk, M.D., MPH, Executive Director, Colorado Department of Public Health and Environment

I. Health Care in Colorado

Health care spending has been rising as a share of household income for decades, and is projected to keep rising. This growing expense squeezes families, particularly those struggling to make ends meet.

Issues of health care costs and spending are sometimes used interchangeable by policymakers but have distinct meanings. While much of the data analysis focuses on spending, the work of the Commission will focus primarily on cost — the price of that service, or the cost or price of all of the services an individual uses annually. This focus on cost will not be to the exclusion of a focus on spending. The increased attention to health care costs likely reflects the recent trend of health insurance premiums — the most visible indicator of health care costs — growing at a much faster rate than workers' earnings.

Finding ways to stabilize health care costs — a highly visible topic of discussion for individuals and families, employers, state policymakers, providers, and the media — is essential for our state, now and for decades to come.

Improving efficiency and reducing costs in health care in Colorado will require extraordinary public leadership and a commitment from the public and private sectors. Leaders from all sectors will need to work collaboratively to advocate for systemic changes that improve the affordability of essential health services for all Coloradans.

Legislative Charge — Senate Bill 14-187

The Mission of the Commission is to ensure that Coloradans have access to affordable health care in Colorado.

The Commission shall focus its recommendations on evidence-based cost-control, access, and quality improvement initiatives and the cost-effective expenditure of limited state moneys to improve the health of the state's population.

Powers and Duties of the Commission:

- Identify, examine, and report on cost drivers for Colorado businesses, individuals, Medicaid, and the uninsured.
- Data analysis on evidence based initiatives designed to reduce health care costs while maintaining or improving access to and quality of care.
- Analyze the impact of increased availability of information.
- Review, analyze, and seek public input on state regulations impacting delivery and payment system innovations.
- Analyze impact of out-of-pocket costs and high-deductible plans.
- Examine access to care and its impact on health costs.
- Review reports and studies for potential information.
- Report outcomes of the 208 Commission

Total national spending on health care services and supplies — that is, by all people and entities in the United States, governmental and nongovernmental — increased from 4.6 percent of gross domestic product (GDP) in calendar year 1960 to 9.5 percent in 1985 and to 16.4 percent, about one-sixth of the economy, in 2013.[1]

[1] Congressional Budget Office, The 2015 Long-Term Budget Outlook. http://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250/50250-breakout-Chapter2-2.pdf

Most of the population under 65 is privately insured under an employer's plan or by themselves. federal and state health care provision and spending comes from programs such as Medicare (for those above 65 and certain people with disabilities), Medicaid and the Children's Health Insurance Program (for those below a defined income level), and the Veterans Health Administration. There are a variety of payment and delivery methodologies within these private and public systems. Without changes in the health system as a whole, achieving cost sustainability or stability will be out of reach for most Coloradans.

Legislative Charge (continued)

Collect and review data including:

- Rate Review Process Data from DOI
- Payment information from HCPF
- The impact of Medicaid expansion
- Evaluate the impact of a Global Medicaid Waiver
- Review information on pricing transparency: Adequacy, composition, and distribution of physician and health care networks; Drug Formularies; Co-Insurance, copayments, and deductibles; and Health plan availability
- Make recommendations entities that should continue to study health cost drivers
- Make recommendations to the Congressional delegation about needed changes in federal law

Work

State governments have a unique opportunity to transform the current health care system into one that provides higher-quality care at lower costs. Recognizing this, state policymakers established the Colorado Commission on Affordable Health Care (Commission). The Commission was created to identify how Colorado might use its authorities and policy levers to guide this transformation and to make recommendations for actionable reforms that will reduce the principal drivers of health spending in Colorado.

The Commission is comprised of individuals representing diverse Colorado constituencies or geographic areas as well as professionals with deep subject-matter expertise on health. These experts bring the experience, understanding, and analytic capacity to delve in to this difficult topic. They also have the ability to provide the leadership across multiple sectors and constituencies necessary to arrive at and move forward with recommendations to control health care costs.

Shared Framework and Approach

This report provides a basic overview of the drivers of health care spending growth in Colorado. It also serves as an analytical starting point for the Commission's work on health care cost containment.

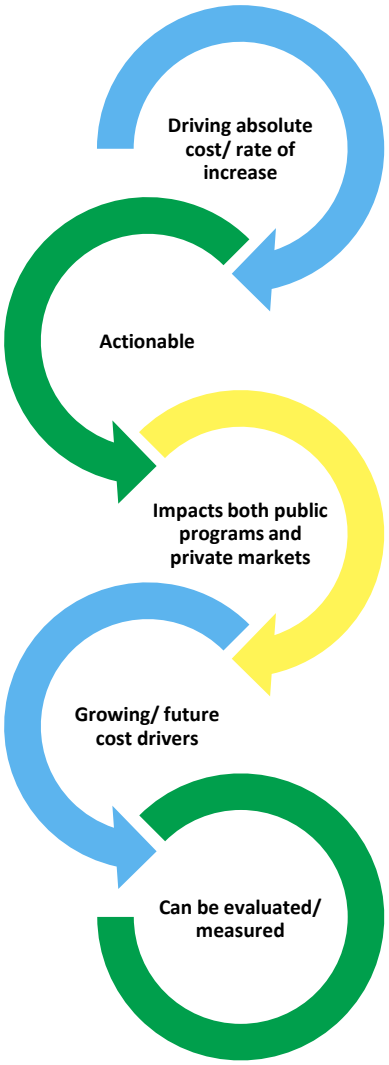
Numerous commissions, task forces, and blue ribbon panels have tackled issues surrounding health care in Colorado. Although those entities have made important progress, the Commission is focused on health care costs — for individuals, families, businesses, and public agencies. This focus not only ensures that the Commission's work is not duplicative of earlier efforts, but also focuses on this critical and enduring issue for Coloradans.

The Commission's final recommendations will encourage initiatives to control health care costs and maximize value, achieving the best outcomes at the lowest cost. The Commission also will

make recommendations that impact the total cost of care, now and in the future. The Commission's final report and recommendations, due at the end of June 2017, will address public systems as well as offer metrics to measure short and long-term success. In its analysis, the Commission is looking at health care spending and costs from the beginning of life to the end of life.

The Commission created the following framework to identify and prioritize recommendations.

Commission's Framework to Identify and Prioritize Recommendations



Though the goal of the Commission is to reduce health care costs, the Commission will work to ideally ensure that cost reductions do not come at the expense of access and quality, but at a minimum point out the possible tradeoffs.

The Commission recognizes that it must look at the health drivers that impact the total cost of care. There are not simple solutions given the interplay of public and private systems and multiple payers.

The analysis of the fundamental drivers of health care spending will help inform the Commission's selection and prioritization of recommendations. Thus far the Commission has reviewed analyses of state spending on personal health care by type of service, payer, and disease as well as reviewed work and recommendations of the 208 Commission. Additionally, the Commission has looked at Colorado compared to national data and has not found much in the way of Colorado-specific details.

From this analysis, the Commission has determined key topic areas for further discussion:

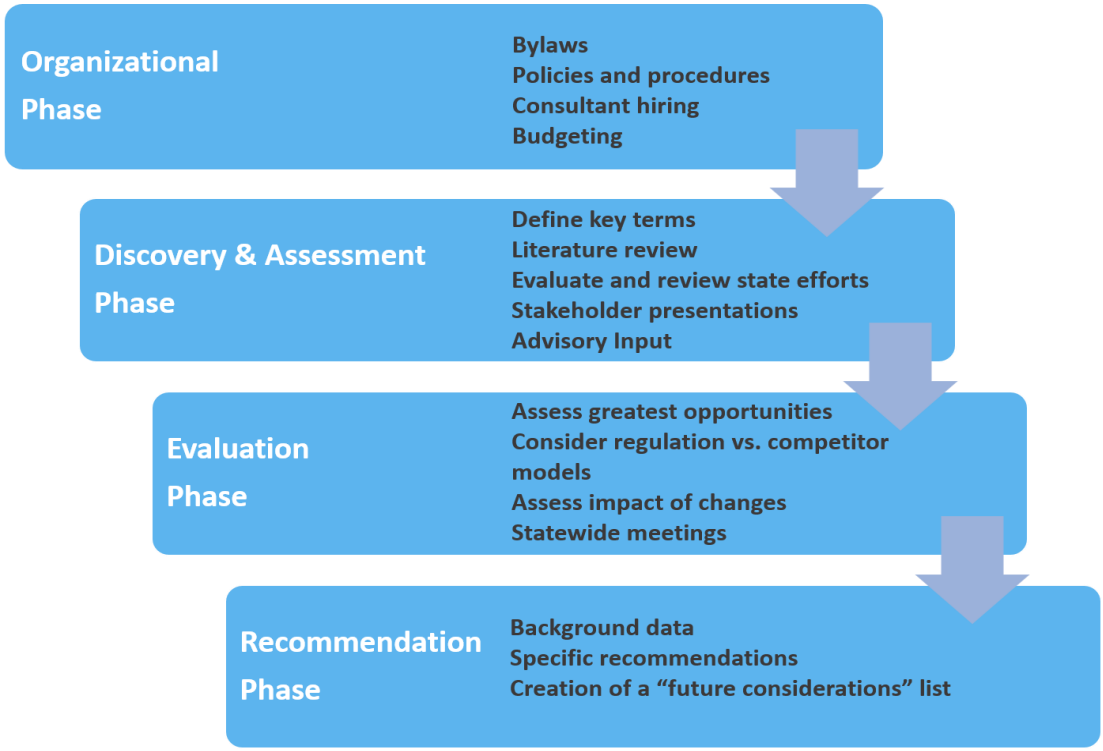
- Transparency
- Workforce
- Social Determinants
- Incentive Mechanisms
- Regulatory Costs
- Administrative Costs
- Payment & Delivery Reform
- Market Competitiveness
- Technology

The drivers of health care spending growth are complex and multi-faceted. Just as no single driver is responsible for our high and rising health care costs, no single policy solution will be adequate to meet this challenge. The Commission must take the time to carefully evaluate the data and evidence to understand the effects of any of its final policy recommendations.

Timeline of Work

There are four phases to the work of the Commission. The Commission completed the Organizational Phase which included the establishment of governing and decision-making policies, and is in the midst of the Discovery & Assessment Phase.

The remainder of the Commission's work will focus on developing recommendations for the Colorado General Assembly and Governor's Office based on further analysis of the information gathered to-date, additional research and comparative models, and input from key stakeholders and members of the public and professional community across Colorado.



IV. Stakeholder Engagement

Statewide input forms the bedrock of the Commission's work.

The Commission's meetings are broadcast via ReadyTalk, a user friendly and reliable technology, so that the public and Commissioner participation is not limited by the location of the meetings in Denver. All Commission meetings are noticed a week prior on the website and through an interested party listserv and all meetings have several opportunities for public comment.

Following its first year of work, analyzing the fundamental drivers of health care spending and hearing from experts, the Commission will create mechanisms to gather statewide feedback on multiple relevant topics. The Commission distributed a questionnaire to health care stakeholders and received a series of responses from ClinicNet, Colorado Academy of Family Physicians, Colorado Association of Health Plans and AHIP, Colorado Business Group on Health, Colorado Coalition for the Medically Underserved, Colorado Community Health Network, Colorado Foundation for Universal Health Care, Colorado Hospital Association, Colorado Medical Society, Colorado Nursing Association, Colorado Telehealth Network, COPIC, Health Care for All, LiveWell, and PhRMA.

The questionnaire and responses can be found in the appendices. The Commissioners are reviewing the submitted questionnaires and will invite stakeholders to provide additional information and perspective as the Commission moves through its deliberations.

In an effort to build on this expert input, the Commission will conduct nine statewide community meetings in early 2016 to gather reactions and feedback on its work and recommendations. These meetings will be held in in Arapahoe County, Greeley, Colorado Springs, Alamosa, La Junta, Grand Junction, Summit County, Denver, and Adams County. These meetings will not only provide vital input to Commission's work and recommendations to-date, but also build support for and community ownership of its eventual recommendations.

This buy-in is essential to the Commission's long-term success and its ability to meet its legislatively mandated goals. These mechanisms include a questionnaire to key communities and stakeholders, an electronic survey, working with key organizations and individuals that have community standing and presence to do outreach, as well as using the new Commission website to solicit feedback, www.colorado.gov/cocostcommission.

V. Health Care Spending in Colorado

Spending on health care in the United States has increased dramatically over the past two decades, and Colorado's health care spending has mirrored that trend.

At the request of the Commission, the Colorado Health Institute (CHI) drew on a number of resources to gather data and provide an analysis of spending on personal health care in Colorado over the past two decades.

CHI provided analytical reports to the Commission that delved into spending by a number of different criteria, including:

- Spending by types of service, such as hospital care, physician care, pharmaceutical and other durable medical products, home health care and many more.
- Spending by types of payer, such as commercial insurance, public insurance programs and out-of-pocket expenditures.
- Spending by age group.
- Spending on a per-capita basis over the years.

The information in this chapter is based on those analyses. The data shine a spotlight on where each health dollar is going in Colorado, providing a foundational understanding as policymakers target their efforts to rein in costs and spending in both private and public sector markets.

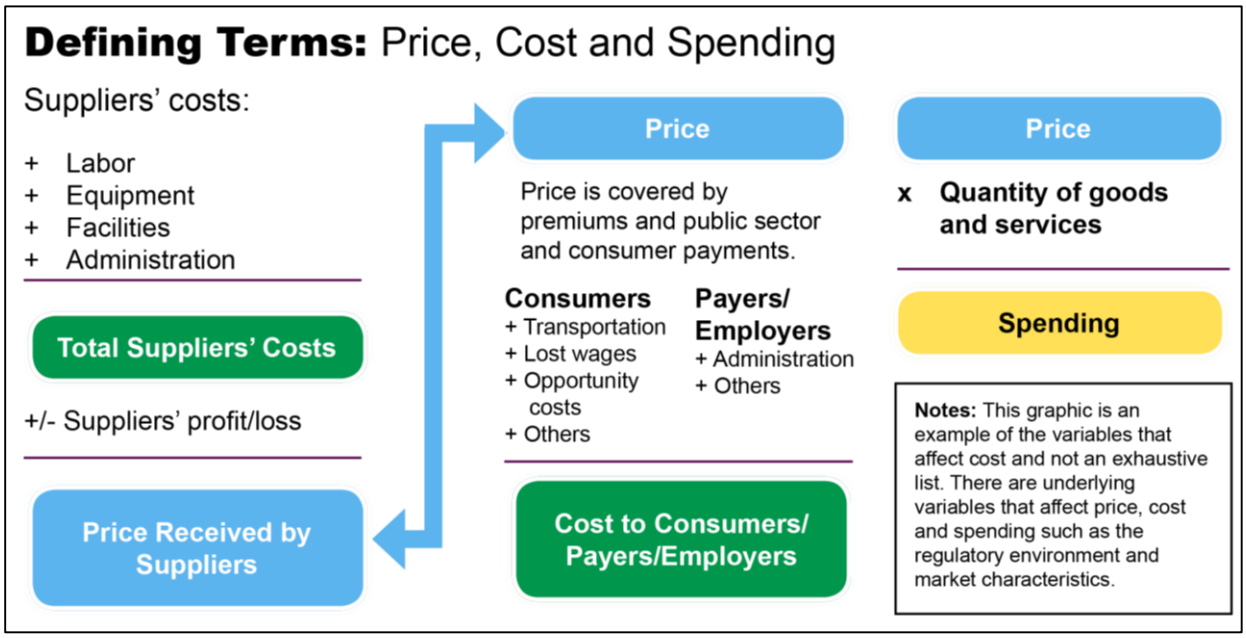
This data in partnership with literature reviews and stakeholder input will focus the work of the Commission on areas of greatest cost by service, payer, disease or condition, and age. The data that follow are based upon 2009-2013 data, which is the latest available.

Defining Cost, Price, and Spending

The Commission's Research Committee spent time to reach agreement on how to define the basic terms — price, cost, and spending — related to the work of the Commission and its mission to analyze health care costs and make policy recommendations on how to lower those costs. (See Figure 1.)

- **Cost:** The resources it takes for health care suppliers to produce goods or services, including labor, equipment, facilities, and administration.
- **Price:** Amount received by health care suppliers in exchange for their goods or services. When prices are higher than suppliers' costs, profits are generated; when prices are lower than suppliers' costs, losses occur. These prices are paid by insurance premiums, public sector programs, and consumers.
- **Spending:** The price of the goods or services multiplied by the quantity purchased. This means that both price and quantity impact total spending.

Figure 1.



Delving into these definitions reveals nuances. For instance, consumers face additional "costs" besides what they pay for premiums or their out-of-pocket share. These include, among others, transportation, lost wages, and the opportunity to spend their time and money on other goods or services. Payers and employers also face additional costs, including administration.

Because there are little data on the cost of different products and services, the Commission has focused its analysis on the spending side of the equation.

Understanding the relationship between price and quantity, meanwhile, is crucial to the policy discussion. Although the price of a specialty drug may be $10,000 a dose, if only a few Coloradans use it, cutting the price would do little to reduce health care spending here. On the other hand, the price of a doctor's office visit might be $100, but it is a service purchased millions of times a year in Colorado.

Price X Quantity = Spending

It is important to note that the price may not always cover suppliers' costs. When the price does not cover costs, suppliers will lose money. They will have to cross subsidize from other profitable service lines or take on debt to stay in business. However, when the price exceeds costs, suppliers will make a profit. Prices that are "administered," or set by payers without using the market demand to set prices may or may not cover costs.

Health Spending in Colorado: Research Analysis

Personal health care expenditures in Colorado reached an estimated $36.3 billion in 2013. That's an increase of 327 percent over the past two decades, compared to 216 percent in the United States. And spending in Colorado has more than doubled from 2000, when it stood at $16.3 billion. Since 2000, cumulative inflation in Colorado has been much lower at 33.3 percent.[2]

Personal health care expenditures, unlike total health care expenditures, do not include items such as research, structures, equipment, government public health activities, program administration, and the net cost of private health insurance. It accounts for roughly 80 percent of all health care spending.

CHI based its analyses on personal health care expenditures because the data from the U.S. Centers for Medicare and Medicaid Services are the only data that are available at the state level.

While personal health care expenditures have increased significantly in Colorado, however, residents of many other states are spending more.

Colorado's per capita personal health care spending of $5,994 in 2009 was the nation's seventh lowest. Utah was the lowest at $5,031 and most of the other states with relatively low spending were also in the Intermountain West.

The District of Columbia had the highest per capita spending of $10,349, followed by Massachusetts at $9,278.

Expenditures by Types of Services

Hospital care accounts for the greatest share of personal health care spending in Colorado. It was an estimated $13.5 billion in 2013. This means that 37 cents of each dollar spent on personal health care in Colorado went for hospital care in 2013. (See Figures 2 and 3). Physician and clinical services came in second at $9.6 billion in 2013.

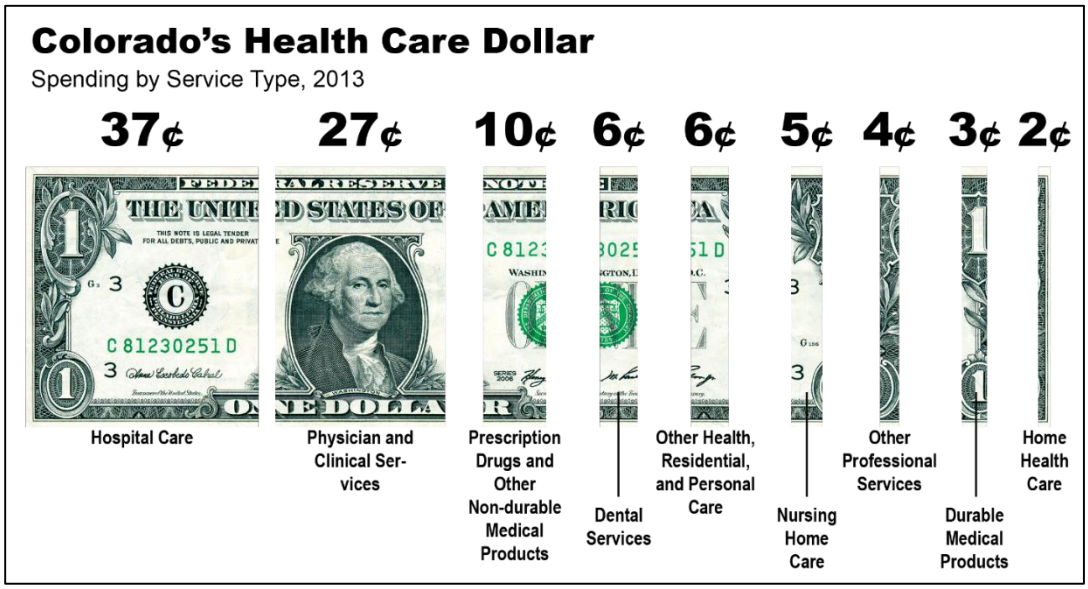
These two categories have been the top expenditures over the past two decades, and together account for nearly two-thirds of annual personal health care spending in Colorado.

The prescription drugs and other non-durable category was third at $3.8 billion.

On the other end of the spectrum, home health care expenditures were $866 million, or two cents of every dollar.

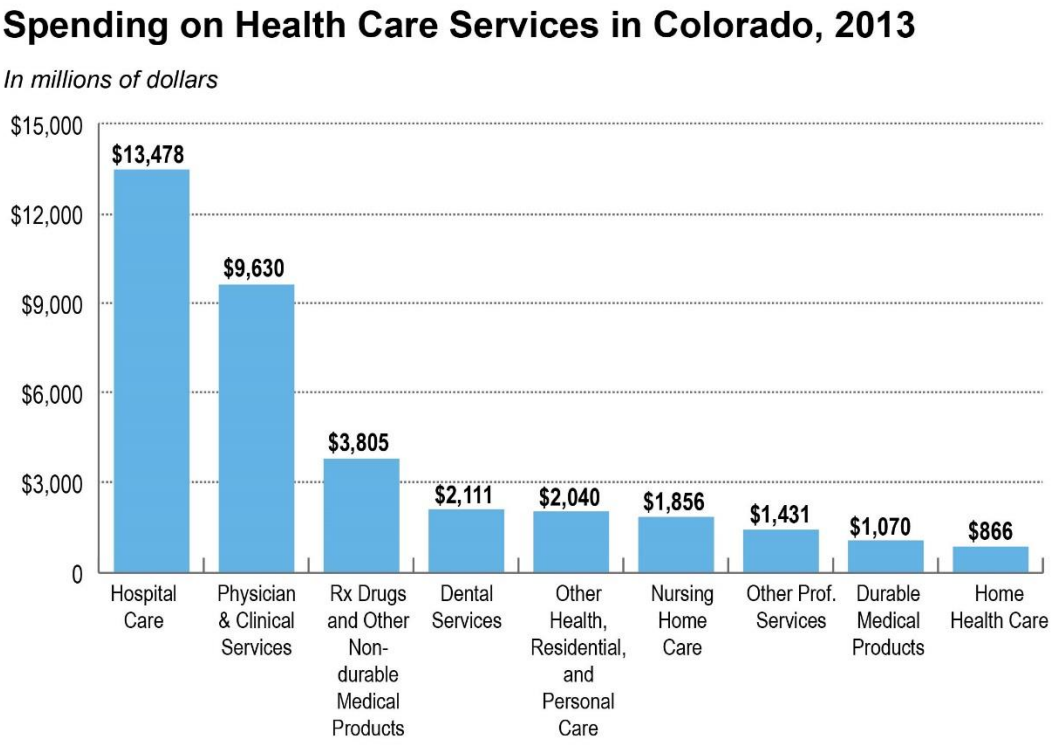
[2] U.S. Bureau of Labor Statistics

Figure 2.



Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014

Figure 3.



Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014

Growth in Expenditures by Types of Services

While spending on personal health care services increased dramatically between 1991 and 2013, the state population grew by 56 percent during this time frame. But population growth alone does not explain all of the increase in personal health care spending.

Spending per person has increased nearly 175 percent over the past two decades. In 1991, personal health spending for each Coloradan was $2,511. By 2013, per capita spending was $6,893. While the nominal increase in per capita personal health spending was 175 percent during this time frame, Colorado's per capita GDP grew in nominal terms by 132 percent. To put these numbers in context, cumulative inflation was 84 percent.

Comparing three time periods — 2000 to 2005; 2005 to 2010; and 2010 to 2013 — finds that the lowest annual growth rate occurred between 2010 and 2013, when it was 3.6 percent. The highest was between 2000 and 2005, when it was 5.7 percent. (See Figure 4.)

Figure 4.

	2000-2005	2005-2010	2010-2013
Average Annual Growth in Total Nominal Personal Health Care Services, Colorado	5.7%	4.5%	3.6%
Average Annual Inflation, Colorado	2.0%	2.2%	2.8%

Source: CHI estimates using data from the National Health Expenditure Accounts, CenCMS, 2011 and 2014.

There is not consensus on the reasons for the slowdown in growth in recent years. However, likely factors include:

- A weak economy, leading to reduced demand for services of all sorts.
- Early or preliminary payment reform efforts implemented by the federal government that changed the way in which Medicare compensated hospitals for hospital re-admissions.
- Increases in hospitals' productivity for certain conditions and movement to outpatient care.
- Changes made by health care providers' practice behavior in anticipation of the Affordable Care Act and other reforms.
- The increased prevalence of high deductible plans, which lead to higher cost sharing and put pressures on consumers to reduce their consumption of health care services.

Overall personal health care spending grew by 327 percent since 1991, but some services experienced faster growth than others. (See Figure 5).

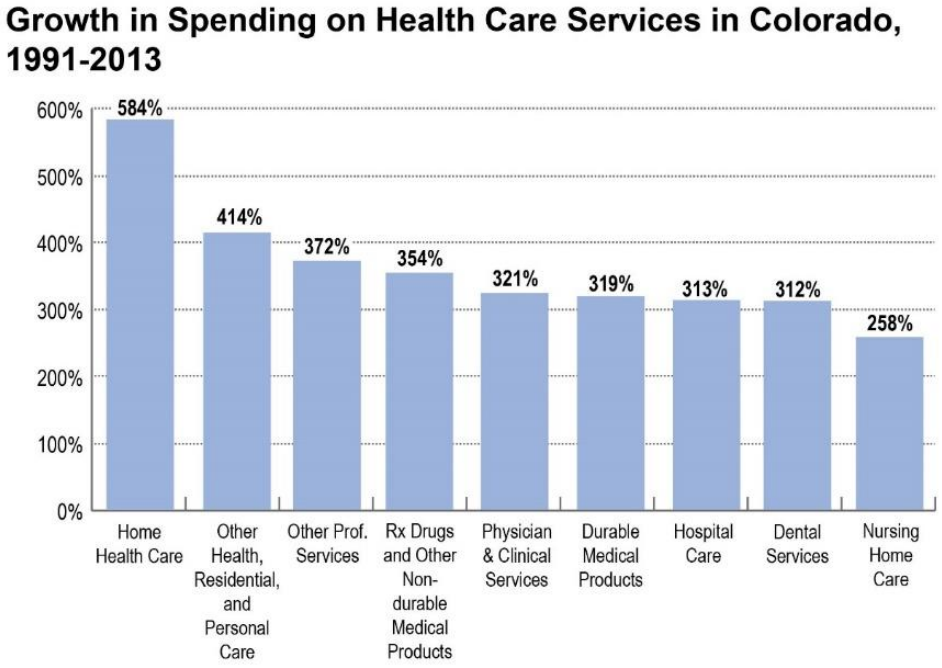
The home health category, for instance, posted the fastest growth. It increased 584 percent, from $127 million in 1991 to $866 million in 2013. However, it's important to note that home health care is still the smallest category of spending, despite this rapid growth. This growth reflects a shift away from more expensive institutional-based care.

Spending on the category called "other health, residential, and personal care" increased by 414 percent, the second-highest growth rate, reaching an estimated $2.1 billion in 2013.

The biggest expenditure categories — hospital services and physician and clinical services — grew at a slower clip, with hospital services climbing 313 percent from $3.3 billion in 1991 to an estimated $13.5 billion in 2013. The physician and clinical services category grew 321 percent from $2.3 billion in 1991 to an estimated $9.6 billion in 2013.

Meanwhile, spending on nursing home care increased by 258 percent, making it the slowest growing category. This trend reflects the U.S. Supreme Court's 1999 ruling that people with disabilities must reside in the community instead of institutions when certain conditions are met. This also explains the increase in home health and personal health services over the same timeframe. This illustrates how reducing utilization in one area of the health care economy can increase utilization in others.

Figure 5.



Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014

Expenditures by Payer

Commercial insurance is Colorado's largest type of payer, accounting for 41 cents of each expenditure dollar in 2013. (See Figure 6.) More than 60 percent of Coloradans were commercially insured in 2013, according to the Colorado Health Access Survey (CHAS), either by employer-sponsored insurance (52.6 percent) or through the individual market (8.2 percent).[3]

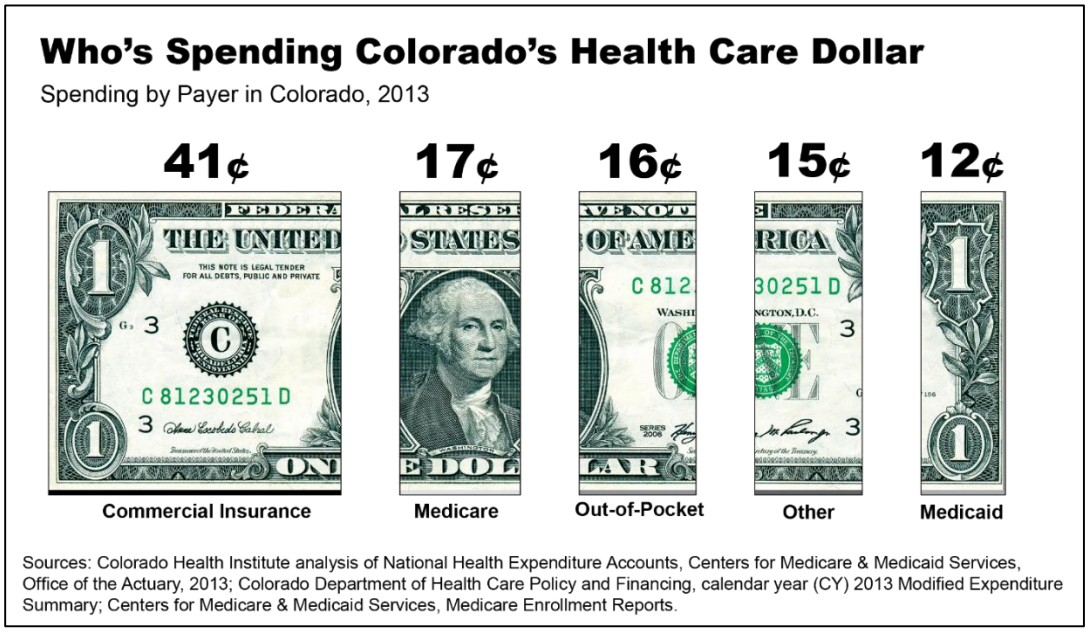
Medicare, the public insurance program for seniors and the disabled that is funded with federal dollars, was Colorado's next biggest payer. It accounted for 17 cents of each expenditure dollar in 2013, but covered 11.4 percent of the population.

[3] Colorado Health Access Survey 2015. Colorado Health Institute website. http://coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf. Accessed Oct. 2, 2015.

Out-of-pocket spending by consumers came in third at 16 cents of every dollar.

And Medicaid, the federal-state public insurance program for those with the lowest incomes, was fourth at 12 cents of each dollar in 2013 when Medicaid covered 11.6 percent of the population.

Figure 6.



These 2013 estimates reflect spending before many insurance reforms and policy changes associated with the federal Affordable Care Act, also referred to as Obamacare, were implemented on January 1, 2014. These changes include Medicaid expansion, launch of the health insurance marketplace, availability of subsidies in the individual market and the prohibition against denying coverage based on pre-existing conditions or historical claims experience.

The addition of a Medicare prescription drug benefit in 2006 (Medicare Part D) accelerated Medicare expenditures for pharmaceutical drugs, according to national estimates. Some analysis shows that after the implementation of Medicare Part D some other health care expenditures declined for some Medicare beneficiaries who did not have prescription drug coverage previously. Nonetheless, as the Baby Boom generation ages, total Medicare spending will grow more in the coming years.

Asked to analyze changes in what the state and federal governments spend on Medicaid medical services in Colorado over the past decade, CHI found that total medical services premiums grew by 142 percent, from $1.9 billion in fiscal year (FY) 2003-04 to $4.6 billion in FY 2013-14.[4]

[4] Based on data from the Nov. 1, 2014, Executive Budget Request submitted to the General Assembly by the Colorado Department of Health Care Policy and Financing. "Medicaid medical services premiums" are those funds expended by the state and federal governments to cover Medicaid enrollees' physical health services.

Spending by Disease or Condition

While Colorado-specific data for spending by disease or condition are not available, the Commission reviewed national data. Based on other analyses conducted by CHI, it is not expected that the relative magnitude of spending by disease is substantially different in Colorado than the rest of the country.

Circulatory conditions, the largest category at $235 billion, accounted for more than 13 percent of national health care spending in 2010. (See Figure 7.) Ill-defined conditions, those not easily diagnosed by a physician, and musculoskeletal conditions made up more than 10 percent each of national health care spending.

Infectious diseases, meanwhile, were the third-smallest category of health care spending at $58 billion. Pregnancy and childbirth were the lowest at $38 billion.

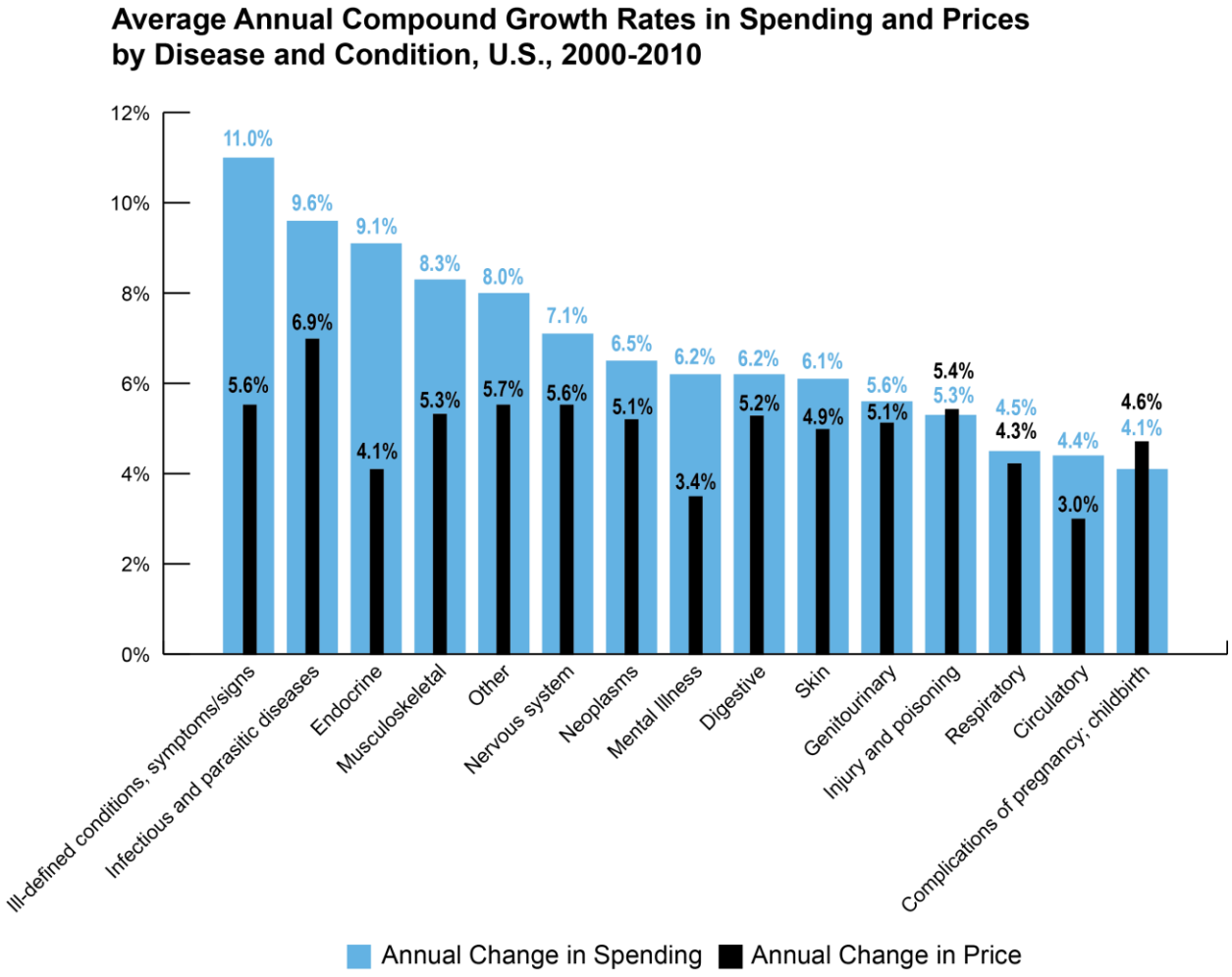
Figure 7. Medical Services Expenditures by Disease and Condition, U.S., 2010

Condition	Annual spending
Circulatory	$235 billion
Ill-defined conditions	$207 billion
Musculosketal	$170 billion
Respiratory	$144 billion
Endocrine	$126 billion
Nervous system	$120 billion
Neoplasms	$116 billion
Genitourinary	$111 billion
Injury and poisoning	$110 billion
Digestive	$102 billion
Mental illness	$79 billion
Other	$70 billion
Infectious and parasitic diseases	$58 billion
Skin	$38 billion
Pregnancy and childbirth	$38 billion

Prices and spending by condition have grown at uneven rates. (See Figure 8.) For example, spending for circulatory diseases increased by 11 percent annually, but the average prices paid, or reimbursement rates, went up by 5.6 percent annually. This most likely means that the remaining increase in spending growth for circulatory diseases has been driven by higher use or intensity of services, not by unit increases in reimbursement or price increases.

On the other hand, spending on childbirth complications increased by 4.1 percent, while the prices, or rates paid, went up 4.6 percent. This most likely means that higher prices were the major driver of increased spending in this area rather than increased demand.

Figure 8.



Spending by Age

Health care spending increases with age.

CHI estimated that spending for adults aged 85 and above was about $31,600 on a per capita basis in 2013, nine times more than children ages 18 and under. (See Figure 9).

When analyzing the rate at which per capita spending increases, essentially telling us when spending on health care really heads higher, the largest percentage increase — 107 percent — was between the group aged 65 to 84 and the 85-plus age group.

But the 85-plus age group accounts for just a small share of Colorado's population — and its overall health care spending.

Nearly one-third of all health care spending was posted by the 45- to 64-year age group in 2013. (See Figure 10). Next up was the 65- to 84-year age group at $8.7 billion.

Figure 9.

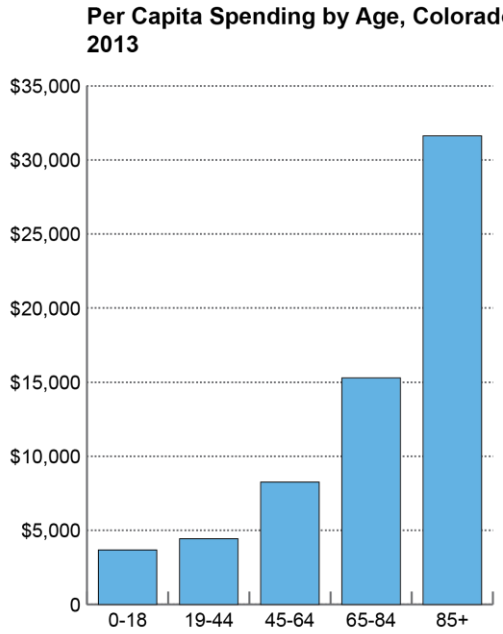
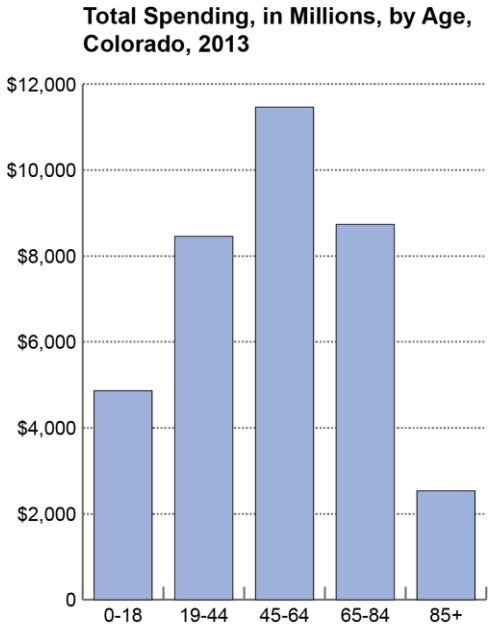


Figure 10.



Per capita expenditures illustrate average spending across a population, but do not account for the variation among populations. It is important to note that these variations can be large. For example, according to the Medical Expenditure Panel Survey, among those individuals in the United States 65 and older, the top five percent of spenders account for $65,600 in per capita spending, the lowest 50 percent of spenders account for $1,689 in per capita spending.[5]

[5] Paschchenko and Porapakkarm, "Medical Spending in the U.S.: Fact from the Medical Expenditure Panel Survey Dataset," July 15, 2015. Available at: https://mpra.ub.uni-muenchen.de/65630/1/MPRA_paper_65630.pdf

VI. The Colorado Framework

Colorado, in many ways, has been a national leader in working to rein in health care costs and spending. It has seen many efforts, some small and some sweeping, to tackle this challenge.

Although there are many programs underway in Colorado to address health care spending, this is a survey of several programs in Colorado that have shown proven savings. These programs hold lessons for policymakers moving forward.

Accountable Care Collaborative

Lead Organization: Colorado Department of Health Care Policy and Financing (HCPF)
Time Frame: It began in 2011 and is ongoing.
Funding Source: Medicaid
Big Ideas: Seven Regional Care Collaborative Organizations (RCCOs) are responsible for coordinating care, developing networks, referring patients and reporting data. Medicaid clients assigned to the RCCOs are connected with a primary care medical home where they build a relationship with a provider. Payments are made on a fee-for-service basis, with participating RCCOs and providers getting a base payment plus incentive payments if they reach the program's targets.
Intended Results: Improve member health, improve the experience of members and providers, and contain costs. Key performance indicators include reducing emergency department use, cutting hospital readmissions within 30 days of discharge, using less high-cost imaging, and increasing well-child visits.
Actual Results: There have been no savings from children. Participating adults at first used more emergency department care and imaging services and had higher hospital readmissions, but use decreased after six months of enrollment, suggesting a pent-up demand for services among newly insured clients.
Savings: Net savings totaled between $29 million and $33 million in FY 2013-14. This is between 0.5 percent and 1 percent of total spending on Medicaid medical services premiums.

21st Century Care

Lead Organization: Denver Health
Time Frame: Between 2012 and 2015
Funding Source: Federal Health Care Innovation Challenge Grant from the Centers for Medicare & Medicaid Services (CMS) Innovation Center
Big Ideas: Establish a team-based, patient-centered medical home for 130,000 patients at Denver Health. The patients were placed into four tiers of services based on need. Services ranged from simple assistance, such as text message appointment reminders, to more complicated arrangements, such as integrated behavioral health services, complex care coordination, and care transition support, and specialized, high-intensity teams.
Intended Results: Over the three-year grant period, Denver Health intended to save money by reducing in-patient and emergency department use; expanding access to care for 15,000 patients; improving overall population health for Denver Health patients.
Actual Results: Preliminary results exceeded the access goal of 15,000 people. Among adult high-risk patients, inpatient use dropped. Access to primary care services for adults increased

slightly during this time frame as reported by the Healthcare Effectiveness Data and Information Set (HEDIS).[6]
Savings: According to an actuarial analysis conducted by Milliman, from November 2012 to December 2013, the program reduced total cost of care by 2 percent and Medicaid managed care spending declined by $6.7 million.[7] These results are relative to the overall trend. The annual cost of the program moving forward is $2.8 million which does not include development or pre-existing infrastructure costs.

Bridges to Care

Lead Organization: Metro Community Provider Network
Time Frame: Between 2013 and 2015
Funding Source: Healthcare Innovation Challenge Grant from the Centers for Medicare and Medicaid Innovation (CMMI)
Big Ideas: Patients in two Aurora ZIP codes with more than three hospital visits in a six-month period were identified and enrolled in a home visit program that provided intensive care coordination, education and mental health services for eight weeks after a hospital admission or emergency room discharge.
Intended Result: Better and more cost-effective care for frail seniors and people with disabilities.
Actual Results: All users reduced the number of emergency department and hospital admissions. Mid- to high-utilizers saw the greatest decline. More than nine of 10 patients (94 percent) were successfully linked to primary care providers within 60 days after graduating from the program and 89 percent of those who lacked a primary care physician before the class had one after the class was over.
Finally, 24 percent of the uninsured participants had health insurance by graduation.
Savings: $1.1 million over a six-month period.[8]

Colorado Beacon Consortium (CBC)

Lead Organization: Rocky Mountain Health Plans (lead), Quality Health Network, Mesa County Physicians Independent Practice Association, and St. Mary's Hospital
Time Frame: Between 2010 and 2012
Funding Source: U.S. Department of Health and Human Services
Big Ideas: Use data to improve medical care in the Grand Junction area by investing in Quality Health Network's existing health information exchange, allowing it to add new data sources, develop a regional data platform, and deploy high-value applications for community-wide interoperability.
Intended Results: Improve quality of care for patients with asthma, diabetes, and heart disease. Reduce unnecessary emergency department visits and hospital admissions. Reduce

[6] Colorado Medicaid HEDIS 2014 Results, Statewide Aggregate Report, December 2014.
[7] Trend is considered the impact of inflation and policy changes absent the implementation of the initiative. To calculate savings relative to trend, Milliman assumed a 3.7 percent trend factor for Medicaid, consistent with annual rate setting practices. Denver Health's 21st Century Care project is supported by Grant Number 1C1CMS331064 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. This analysis does not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies and was conducted by the awardee. Findings may or may not be consistent with or confirmed by the findings of the independent evaluation contractor.
[8] Bridges to Care Program Evaluation Final Report. Prepared for Metro Community Providers Network by Smith and Lehman Consulting. Dec. 19, 2014.

health risks associated with obesity and depression. Strengthen a secure health information exchange at the community level.
Actual Results: Increase in tobacco counseling, decrease in patients with high cholesterol. Quality Health Network has added three hospital system interfaces and two reference laboratory system interfaces, upgraded or improved four hospital systems, and successfully linked to more than 30 electronic medical record systems used by 150 providers.
Savings: At least $3.1 million in hospital readmission spending for Medicaid adults and dual eligible patients (those eligible for both Medicare and Medicaid). Colorado Medicaid awarded $2.2 million in shared savings to CBC participants. Beacon practices, though, had mixed results, with a slight trend toward lower costs for providers 2011, but higher costs in 2012. The results were inconclusive.[9]

Colorado's Blue Ribbon Commission for Healthcare Reform

Recommendations from Colorado's Blue Ribbon Commission for Healthcare Reform laid the groundwork for health reform in Colorado.

Passed by the General Assembly in 2006, it was known as the 208 Commission because it was created by Senate Bill 06-208.[10] It was charged with identifying strategies to expand health care coverage and reduce health care costs for Coloradans. Its final report went to lawmakers in January 2008.[11]

Many of the 208 Commission's 32 recommendations have been put into practice, either through state action or federal law, notably the Affordable Care Act.

This section classifies each of the recommendations as implemented, partially implemented or not implemented. The classification is based on legislation that has been passed since the 208 Commission ended. (In some cases, sub-recommendations have different classifications, which are noted.)

The numbers on the main recommendations refer to the original sequence of the commission's final report. The final report was not supported by all of the members of 208 Commission and included two minority reports.

Implemented

1. Slow the rate of growth of employer and private health insurance premiums by covering the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing cost-shifting. ***Partially implemented.***

a. Reduce uncompensated care by covering at least 85 percent of the uninsured in Colorado. ***Partially implemented.***
b. Reduce cost-shifting by increasing Medicaid provider reimbursements. ***Partially implemented.***

2. Reduce employee health insurance premium costs. ***Not implemented.***

[9] Colorado Beacon Consortium Fact Sheet. Office of the National Coordinator for Health Information Technology. Oct. 25, 2012. http://www.healthit.gov/sites/default/files/beacon-factsheet-colorado.pdf
[10] State of Colorado website. Blue Ribbon Commission for Healthcare Reform page. http://www.colorado.gov/208commission/
[11] State of Colorado website. Final Report. http://www.colorado.gov/cs/Satellite/BlueRibbon/RIBB/1201542097631

a. Require Colorado employers to establish at least a Section 125 premium-only plan that allows employees to purchase health insurance with pre-tax dollars. ***Not implemented.***
b. Provide sliding scale subsidies for uninsured low-income workers below 400 percent of federal poverty level (FPL; i.e., annual income of about $80,000 for a family of four) to purchase their employer's plan. ***Not implemented.***

3. Reduce administrative costs. ***Partially implemented.***

a. Require health insurers and encourage all payers in Colorado to use standard claims attachment requirements, eligibility and coverage verification systems, electronic ID cards and prior authorization procedures; and uniform insurance application forms. Adopt nationally-recognized standards that have been accepted by industry groups but not yet implemented. ***Partially implemented.***
b. Combine administrative functions of public health insurance programs (such as Medicaid, CHP+, premium subsidy program, CoverColorado). ***Partially implemented.***
c. Review regulatory requirements on third-party payers and providers with the goal of reducing administrative burden. ***Not implemented.***

4. Increase use of prevention and chronic care management. ***Partially implemented.***

a. Where allowed by federal law, allow health insurance premiums to be reduced for enrollees who engage in healthy behaviors. ***Partially implemented.***
b. Eliminate patient copayments for preventive care and reduce patient copayments for chronic care management services. ***Partially implemented.***
c. Encourage employers to provide workplace wellness programs. ***Partially implemented.***
d. Encourage individual responsibility for health, wellness and preventive behavior. ***Implemented.***
e. Increase funding for local public health agencies in Colorado to perform such functions as preventing disease and injury, assessing community health and promoting healthy behavior. ***Partially implemented.***

5. Conduct a comprehensive review of current Colorado and national long-term care information to understand challenges and opportunities and identify appropriate strategies for reform. ***Implemented.***

6. Improve end-of-life care. ***Partially implemented.***

a. Develop strategies to foster clinically, ethically and culturally appropriate end-of-life care, including palliative and hospice care, based upon best scientific evidence. ***Partially implemented.***
b. Ask patients, upon entry to a nursing home, home health agency or other critical point of access, to complete an advanced directive. ***Partially implemented.***

7. Commission an independent study to explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training. ***Implemented.***

8. Provide a medical home for all Coloradans. ***Partially implemented.***

a. Enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs." ***Implemented.***
b. Reimburse providers for care coordination and case management, particularly in the

Medicaid/CHP+ and CoverColorado programs. ***Partially implemented.***

c. Provide targeted case management services for Medicaid patients. ***Partially implemented.***

9. Support the adoption of health information technology. ***Implemented.***

a) Support the creation of a statewide health information network, focusing on interoperability and building upon regional efforts already in place for sharing data among providers. ***Implemented.***
b) Support the creation of an electronic health record for every Coloradan, with interoperability across health plans and hospitals systems and protections for patient privacy. ***Implemented.***

10. Support the provision of evidence-based medicine. ***Partially implemented.***

a. Adopt population-specific care guidelines and performance measures, where they exist, based on existing national evidence-based guidelines and measures, recognizing the importance of patient safety and best care for each patient. ***Partially implemented.***
b. Develop a statewide system aggregating data from all payer plans, public and private. ***Implemented.***

11. Pay providers based on quality. ***Partially implemented.***

a. Pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care and use of health information technology. ***Partially implemented.***

12. Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g., a website). ***Partially implemented.***

a. Make information on insurer and provider price and quality available to all Coloradans and that it is easily accessible through a single entry point. ***Partially implemented.***
b. Require the Colorado Division of Insurance (DOI) to report annually to the legislature regarding financial information on licensed carriers and public programs, including medical loss ratios, administrative costs, etc., by line of business; require Medicaid, CHP+, CoverColorado and other public programs to provide DOI with this information; and require brokers to report their compensation to their clients. ***Not implemented.***

13. Promote consumer choice and direction in the health care system. ***Partially implemented.***

a. Provide a choice of Minimum Benefit Plans, including a Health Savings Account option, for all consumers purchasing in the individual insurance market. ***Implemented.***
b. Create a Connector for individuals and employees. ***Implemented.***
c. Increase price and quality transparency. ***Partially implemented.***
d. Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care. ***Partially implemented.***

14. Examine and expand the efforts of Colorado communities that have been proven over the years to enhance quality and lower cost. ***Partially implemented.***

15. Create a multi-stakeholder "Improving Value in Health Care Authority." ***Partially implemented.***

Before implementing the coverage expansions identified in Section 2, the state should establish an Improving Value in Health Care Authority to fundamentally realign incentives in the Colorado health care system to reduce costs and improve outcomes, and identify other means of containing systemic cost drivers. ***Implemented.***

a. Give the Authority rule-making authority to implement the Commission's recommendations regarding administrative simplification, health care transparency, design of the Minimum Benefit Package and the Consumer Advocacy Program. ***Partially implemented.***
b. Direct the Authority to study and make recommendations to the governor, state legislature and rule-making agencies regarding prevention, end-of-life care, medical homes, health information technology, evidence-based medicine, and provider reimbursement. ***Partially implemented.***
c. Direct the Authority to oversee development of a statewide system aggregating data from all payer plans, public and private, building upon regional systems, or efforts already taking place for sharing data among providers. ***Implemented.***
d. The Authority also should be responsible for assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers. ***Partially implemented.***
e. Establish the Authority before embarking on the improvements to coverage and access. ***Implemented.***

16. Require every legal resident of Colorado to have at least a Minimum Benefit Plan, with provisions to make the mandate enforceable. ***Implemented.***

a. Require purchase of a Minimum Benefit plan (average monthly premium of approximately $200 for an individual). ***Implemented.***
b. Design and periodically review the Minimum Benefit Plan through the "Improving Value Authority." ***Not Applicable.***
c. Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level. Assuring affordability should include consideration of both premium and out-of-pocket costs. ***Implemented.***
d. Enforce through tax penalty; automatically enroll those who are eligible into fully-subsidized public coverage programs. ***Partially implemented.***

17. Implement measures to encourage employees to participate in employer-sponsored coverage. ***Not implemented.***

a. Require Colorado employers to establish premium-only Section 125 plans that allow employees to purchase health insurance with pre-tax dollars. ***Not implemented.***
b. Provide subsidies for uninsured low-income workers below 400 percent FPL (approximately $80,000 annual income for a family of four) to purchase their employer's plan. ***Not implemented.***
c. Enforce waiting periods (minimum periods of being uninsured) for eligibility for the premium subsidy program, to discourage employers and employees from dropping employer coverage to enroll in public programs; create exceptions for involuntary loss of coverage, COBRA coverage, or qualifying events, such as marriage or birth. ***Not implemented.***

18. Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector." ***Implemented.***

19. Maximize access to/enrollment in private coverage for working lower-income Coloradans who are not offered coverage at the workplace. ***Implemented.***

a. Provide premium subsidies to workers who are not offered coverage at the workplace who earn less than 300 percent FPL (approximately $60,000 annual income for a family of four) for purchase of private health insurance equivalent to CHP+ benefit package. ***Implemented.***
b. Provide premium subsidies to individuals and families who earn between 300-400 percent FPL (between $60,000 and $80,000 annual income for a family of four) such that their premium cost of the Minimum Benefit Plan is no more than 9 percent of their income. (The same subsidy would be available to workers with access to coverage at the workplace.) ***Implemented.***
c. To facilitate enrollment and reduce fraud, use auto enrollment strategies that use existing state data to determine subsidy eligibility (e.g., tax, wage, and nutrition program information). ***Implemented.***

20. Require all health insurance carriers operating in Colorado to offer a Minimum Benefit Plan in the individual market. ***Partially implemented.***

a. Require all health carriers offering health insurance in Colorado to offer a Minimum Benefit Plan in the individual market, with an emphasis on value-based and consumer-directed benefit design. ***Partially implemented.***

21. Guarantee access to affordable coverage for Coloradans with health conditions (implement in conjunction with Recommendation 16). ***Implemented.***

a. Require health insurance companies to issue coverage (guarantee issue) to any individual or family who applies for individual health insurance and who is not eligible for the restructured CoverColorado program due to a high-cost pre-existing condition ("qualified applicant"). ***Implemented.***
b. Allow health insurance companies to set premiums for these individuals and families based on their age and geographic location; disallow the consideration of past and current health conditions. ***Implemented.***
c. Restructure CoverColorado to cover those who apply for coverage, have a specified high-cost health condition as defined by the newly expanded program, and are not eligible for Medicaid, CHP+, or a premium subsidy. ***Not applicable under the ACA.***

22. Merge Medicaid and CHP+ into one program for all parents, childless adults and children (excluding the aged, disabled and foster care eligibles). ***Partially implemented.***

a. Pay health plans at actuarially-sound rates and providers at least CHP+ rates in the new program. ***Not implemented.***
b. For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75 percent of Medicare rates. ***Partially implemented.***
c. Provide the CHP+ benefit and cost-sharing package, including dental, to enrollees in the new program. Provide access to a Medicaid supplemental package, including early and periodic screening, diagnosis and testing (EPSDT) for children, for those who need Medicaid services. ***Not Implemented.***
d. Provide dental coverage up to $1,000 per covered person per year. ***Implemented.***
e. Require enrollment in managed care, where available.

23. Improve benefits and case management for the disabled and elderly in Medicaid. ***Implemented.***

a. Encourage enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care. ***Implemented.***
b. Promote care delivery in a consumer-directed, culturally competent manner to promote cost-efficiency and consumer satisfaction. ***Implemented.***
c. Increase the number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services. ***Implemented.***
d. Explore potential for further reforms to Medicaid, particularly for those who are disabled. ***Implemented.***

24. Improve delivery of services to vulnerable populations. ***Partially implemented.***

a. Create a Medicaid buy-in program for working disabled individuals. ***Implemented.***
b. Create a Medically-Correctable fund for those who can return to work or avoid institutionalization through a one-time expense. ***Not implemented.***
c. Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services. ***Partially implemented.***
d. Provide mental health parity in the Minimum Benefit Plan. ***Implemented.***
e. Establish a Medically-Needy or other catastrophic care program for those between 300-500 percent FPL ($30,000 to $50,000 annual income for an individual) to address the issue of people who have health insurance but do not have coverage for catastrophic events (fund at $18 million in state funds). ***Not implemented.***

25. Expand eligibility in the combined Medicaid/CHP+ program to cover more uninsured low-income Coloradans. ***Partially implemented.***

a. Expand Medicaid/CHP+ to cover all uninsured legal residents of Colorado under 205 percent FPL (approximately $42,000 annual income for a family of four). ***Partially implemented.***
b. Expand CHP+ to cover children in families earning up to 250 percent FPL (approximately $51,000 annual income for a family of four). ***Implemented.***
c. Provide assistance with premiums and co-payments to low-income, elderly Medicare enrollees up to 205 percent FPL (approximately $21,000 annual income for an individual). ***Implemented.***
d. Restrict the expansion to adults with less than $100,000 in assets, excluding car, home, qualified retirement and educational accounts, and disability-related assets. ***Not implemented.***
e. Work with the federal government to ensure federal funding for low-income childless adults; do not fund expansion through reduction of services to current Medicaid and CHP+ eligible people. ***Implemented.***

26. Ease barriers to enrollment in public programs. ***Partially implemented.***

a. Use automatic enrollment strategies to increase enrollment, reduce fraud and lower administrative costs; pursue presumptive eligibility where possible. ***Partially implemented.***
b. Provide one-year continuous eligibility to childless adults, parents, and children in the newly merged Medicaid/CHP+ program. ***Partially implemented.***

27. Enhance access to needed medical care, especially in rural Colorado where provider shortages are common. ***Partially implemented.***

a. Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients. ***Partially implemented.***
b. Explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists, and others from practicing to the fullest extent of their licensure and training. ***Implemented.***
c. Promote and build upon the existing statewide nurse advice line. ***Partially implemented.***
d. Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas. ***Partially implemented.***
e. Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches. ***Implemented.***

28. Create a Consumer Advocacy Program including an Ombudsman Program. ***Partially implemented.***

a. Create a program that is independent and consumer-directed to guide people through the system, resolve problems, provide assistance with eligibility and benefit denials, help qualify people on Medicare for Medicaid, and help people qualify for SSI. ***Partially implemented.***

29. Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled. ***Not implemented.***

30. Continue to explore the feasibility of allowing employers to offer 24-hour coverage (e.g., all of an employee's health needs, including health and workers compensation claims, are covered by a single insurer). ***Not implemented.***

31. Adopt these recommendations as a comprehensive, integrated package but do so in stages, increasing efficiency and assuring access before expanding coverage. ***Partially implemented.***

Notable Spending Control Initiatives in Other States

Innovative work is going on across the nation when it comes to health care. This list is a small sample of innovations occurring nationally, with an emphasis on initiatives that have generated the most savings. It includes a diverse array of ideas for both public and private coverage.

California
Entity: California Public Employees' Retirement System (CalPERS)
Initiative: Reference pricing for hip and knee replacements. Procedures are fully covered up to the price that most providers charge, but patients pay the difference if they choose a more expensive provider.
Findings: CalPERS in 2011 saved an estimated $2.8 million, or 0.26 percent of its total health care spending, for its Anthem enrollees. The limited savings resulted from the fact that few CalPERS enrollees have hip or knee replacements each year — between 450 and 500 — and these procedures account for only about 0.75 percent of CalPERS's total spending.[12]

[12] http://www.hschange.org/CONTENT/1397/#ib2

Massachusetts
Entity: Blue Cross Blue Shield Massachusetts
Initiative: Alternative Quality Contract (AQC). The five-year AQC provides rewards to 11 participating physician groups for controlling spending and improving the quality of care delivered to a designated panel of patients. Providers receive a global budget for the entire continuum of care.
Findings: AQC patients with a primary care provider saved two percent in the first year and 10 percent by the fourth year compared with a control group. The positive results are because providers used lower cost methods of care and patients used less care.[13]

Arkansas
Entity: Arkansas Medicaid
Initiative: Bundled payments for five episodes of care: perinatal; attention deficit hyperactivity disorder; upper respiratory infection; total joint replacement for both hips and knees; and congestive heart failure. Providers share in both savings and excess costs. It is coupled with a medical home model.
Findings: 73 percent of Medicaid providers Principle Accountable Providers and 60 percent of Blue Cross Blue Shield Principle Accountable Providers either improved their costs or remained in a commendable or acceptable cost range.[14]

Maryland
Entity: State of Maryland
Initiative: Maryland operates the nation's only all-payer hospital rate regulation system. In this system, all third-party purchasers pay the same rate for hospital services. This is made possible by a Medicare waiver.
Findings: The system has limited the growth of per-admission costs, but it has also created pressure to increase the volume of services.[15]

Illinois
Entity: Illinois Department of Healthcare and Family Services
Initiative: Illinois Medicaid Redetermination Project. Independent consultants were brought in to verify income, residency, and identity eligibility for all Medicaid applicants.
Findings: Around 100,000 people were deemed ineligible, though the state will not save as much money as it had hoped because many of them were not using services.[16]

Indiana
Entity: Indiana Medicaid
Initiative: The Healthy Indiana Plan replaced traditional Medicaid in Indiana for all non-disabled adults between the ages of 19 and 64 with consumer-directed health plan options in 2008.
Findings: Since 2008, emergency room use has been seven percent less compared with traditional Medicaid,[17] preventive care use is similar to commercially-insured customers and more members choose generic drugs compared with the commercially-insured.[18]

[13] https://www.bluecrossma.com/visitor/pdf/avalere-lessons-from-aqc.pdf
[14] http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=276
[15] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10.html
[16] https://www.illinoispolicy.org/more-than-100000-medicaid-enrollees-found-ineligible-for-the-program/
[17] Further research needs to be conducted to determine the extent to which co-pays have been collected and impacted utilization.

VII. Next Steps

The Commission has covered a great deal of ground since its inception. From assessing the progress Colorado has made to looking ahead at the most promising avenues for reform, 2015 has been a watershed year for the Commission. That said, the Commission still has a great deal of work to do to meet its legislative mandate.

The health care arena continues to change at a very rapid pace across the nation and statewide that the need for recommendations related to cost reduction are timelier now than ever.

In many ways, 2016 is the year the Commission moves beyond studies and seeks direct input of all Coloradans. The Commission will build off the information received in the questionnaire and plans to engage more constituents by conducting nine statewide community meetings in the spring of 2016. The Commission's statewide outreach meetings and listening sessions will provide valuable and irreplaceable guidance as its work enters the homestretch. The values and priorities of everyday Coloradans and health care professionals working on the front lines of these issues will guide the Commission's work and final report.

Alongside these outreach efforts, the Commission will continue its work on the identified topic areas. The Commission and its staff will continue to research not only the challenges facing Colorado families, businesses, and agencies, but also solutions identified through public feedback and the Commission's work.

The Commission's ability to realize these plans and meet the promise of Senate Bill 14-187 will depend on additional funding. The Commission's work, as outlined in this report, is already bearing fruit. The General Assembly's commitment to Senate Bill 14-187 and the Commission, will determine the scope and depth of its final recommendations.

[18] https://myshare.in.gov/ISDH/LHDResource/Conference%20Materials/2015%20Public%20Health%20Nurse%20Conference%20Materials/2015%20PHN%20Conference%20Presentations/HIP%202.0.pdf

Appendix A: Methods for Colorado Spending Analysis 2009 – 2013

Colorado-specific data for spending on personal health care by type of service are available only through 2009, while national data are available through 2013.

In order to estimate Colorado spending between 2010 and 2013, CHI compared the extent to which Colorado per capita spending for each type of service exceeded or was below national per capita spending for the same service lines between 2007 and 2009. CHI then applied that difference to the national growth rate for each year between 2010 and 2013 to arrive at a Colorado growth rate.

For example, between 2007 and 2009, per capita spending in Colorado for physician and clinical services was 90.9 percent relative to the growth in national per capita spending. In estimating 2010 Colorado expenditures we applied 90.9 percent to the national growth rate of 2.5 percent to arrive at a Colorado growth rate of 2.2 percent.

After estimating per capita growth rates for each service line for each year, CHI multiplied by the Colorado population to arrive at total state spending.

Cost of Rehabilitation Services

Prepared for:
Colorado Department of Public Health and the Environment (CDPHE)

Prepared by:
Milliman, Inc.

Steve Melek, FSA, MAAA
Principal and Consulting Actuary

1400 Wewatta Street
Suite 300
Denver, CO 80202-5549
USA

Tel +1 303 299 9400
Fax +1 303 299 9018

milliman.com

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BACKGROUND

On May 6, 2015, the Colorado General Assembly passed HB 15-1083, requiring the Commission on Affordable Health Care to conduct a study concerning the costs, including patient cost-sharing, for physical rehabilitation services. The study must analyze costs to the health care system, including the distribution of cost between payers and individual patients, as well as whether patient cost-sharing creates barriers to the effective use of physical rehabilitation services.

"Physical rehabilitation services" are defined as physical therapy, occupational therapy, or chiropractic services for the treatment of a person who has sustained an illness, medical condition, or injury with the goal of returning this person to his or her prior skill and function level or maintaining the person's current skill and function level.

In conjunction with our analysis, we also reviewed and comment on the analysis of rehabilitation services in Iowa performed by OptumInsight.

With this analysis, we were able to address the following topics:

- The importance of rehabilitation services as a portion of total per member per month (PMPM) costs
- Typical costs and ranges of costs for these services on a per visit basis
- Typical cost sharing levels and ranges for these services on a per visit basis
- Typical copay levels for these services and what percent of the total cost of service these copays represent
- Review of the prevalence of plans today with no copays (e.g., high deductible health plans)
- The effect of annual limits on such service utilization

Milliman's role in this study is to analyze historical claim data from Colorado to provide a snapshot of the marketplace. We are not making any public policy recommendations.

This report does not address any impact of benefit changes on healthcare premiums. This report also does not address the delivery of rehabilitation services by place of service of by type of professional, such as physical therapists vs. medical doctors.

SAMPLE SELECTION

We used Truven Health Analytics MarketScan® commercial claims and membership databases from 2013 to identify persons in Colorado with continuous enrollment during 2013. Once we identified all of these members, we pulled all of their medical claims during the same period and flagged which claims were related to any rehabilitation service using the Milliman Health Cost Guidelines (HCGs) Grouper. We then split such services in Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Chiropractor (Ch) using the same tool. These claims include both fully-insured and self-insured products. These claims do not include any Medicare or Medicaid claims.

This process identified 398,504 total members in Colorado. Of these, 54,608 were users of any of these rehabilitation services.

We used this final sample to produce all the tables of results and highlights included in this report.

RESULTS

REHABILITATION SERVICES AND CARE

Our data reveal that the allowed PMPM cost per visit (the total cost allowed by commercial insurance payers) for rehabilitation services is approximately $9.02 as shown in Table 1, accounting for about 2.8% of total healthcare costs PMPM.

TABLE 1 – COSTS PER VISIT FOR ALL REHABILITATIVE SERVICES

Number of Visits	All Rehabilitative Services					
	Visits	Utilizers	Allowed per Visit	Paid per Visit	Cost Sharing per Visit	Cost Sharing % Allowed
1	5,556	5,556	$86.85	$51.54	$35.31	40.7%
2	9,792	4,896	$66.39	$37.46	$28.93	43.6%
3	11,640	3,880	$62.02	$35.46	$26.56	42.8%
4	13,044	3,261	$59.26	$32.56	$26.70	45.1%
5	12,825	2,565	$62.78	$36.38	$26.40	42.0%
6	15,750	2,625	$57.28	$31.77	$25.50	44.5%
7	14,938	2,134	$59.45	$34.58	$24.87	41.8%
8	16,064	2,008	$56.96	$33.69	$23.27	40.9%
9	16,713	1,857	$56.28	$33.60	$22.68	40.3%
10	16,320	1,632	$55.29	$33.11	$22.18	40.1%
11	15,851	1,441	$56.84	$34.46	$22.38	39.4%
12	19,272	1,606	$50.83	$28.87	$21.96	43.2%
13	15,652	1,204	$54.38	$33.32	$21.06	38.7%
14	15,960	1,140	$54.79	$34.37	$20.42	37.3%
15	15,450	1,030	$50.03	$29.82	$20.21	40.4%
16	16,464	1,029	$53.48	$33.36	$20.12	37.6%
17	14,926	878	$51.65	$32.64	$19.01	36.8%
18	15,858	881	$51.62	$32.55	$19.07	36.9%
19	14,554	766	$50.72	$31.70	$19.02	37.5%
20	20,300	1,015	$51.99	$31.28	$20.71	39.8%
21	14,973	713	$49.46	$31.75	$17.71	35.8%
22	14,256	648	$51.84	$33.59	$18.25	35.2%
23	12,949	563	$51.05	$33.92	$17.13	33.6%
24	16,200	675	$47.95	$32.07	$15.88	33.1%
25	12,225	489	$51.83	$34.53	$17.30	33.4%
26	11,700	450	$49.21	$32.30	$16.91	34.4%
27	11,664	432	$48.33	$32.00	$16.33	33.8%
28	12,460	445	$45.39	$30.53	$14.86	32.7%
29	11,919	411	$47.64	$31.79	$15.85	33.3%
30+	456,094	7,100	$45.36	$32.19	$13.17	29.0%
Overall	871,369	53,330	$49.50	$32.62	$16.88	34.1%
Avg Visits for 30+	64.24					
PMPM			$9.02	$5.94	$3.08	
% Total PMPM			2.8%			

We observed the following allowed PMPM costs by category of rehabilitation services, in descending order of cost:

- Physical Therapy: $6.68
- Chiropractor: $1.55
- Occupational Therapy: $0.42
- Speech Therapy: $0.37

Physical Therapy contributes the largest amount of costs of any rehabilitation service to total PMPM cost. In contrast to our analysis, OptumInsight's calculated Physical Therapy allowed costs at $1.24 PMPM.

The OptumInsight study reported Physical Therapy costs as 0.43% of total PMPM, whereas we found Physical Therapy costs comprising about 2.11% of total PMPM.

As can be seen in Table 1, member cost-sharing per visit generally decreases as the number of visits used increases; this is true both for cost sharing per visit and the cost sharing as a percent of the allowed cost. This is consistent with the general pattern in outpatient or office-based healthcare services where patients tend to use more services, especially those that may be considered discretionary, when their cost sharing is lower or reduced. This pattern can certainly occur for benefits subject to a deductible, where once the deductible is satisfied, member cost sharing is reduced. Higher levels of copays or cost-sharing often leads to lower utilization of services, as can be seen in Table 1.

This analysis also needs to address whether patient cost-sharing "creates barriers to the effective use of physical rehabilitation services." This statement cannot be made conclusively based on a review of claim data alone, which is the basis of this study. It is clear, however, that insured members use more rehabilitation services as cost-sharing is reduced, and use less rehabilitation services as cost-sharing is increased. This principle also applies to healthcare services in general. Reductions to member cost-sharing for rehabilitation services in insured products will increase premiums somewhat, depending on the level of cost-sharing reduction. Such premium increases will likely be modest in size.

Please refer to Tables 1a – 1d in the appendix to see these results in detail by type of rehabilitation service.

TYPICAL COSTS

ALLOWED COST PER VISIT

According to our analysis, the average allowed cost per visit for all rehabilitation services is about $49.50.

We observed the following allowed cost per visit by category, in descending order:

- Occupational Therapy: $141.14
- Speech Therapy: $128.00
- Physical Therapy: $48.99
- Chiropractor: $38.79

The average allowed cost for all rehabilitation services is driven by the fact that the vast majority of visits are for Chiropractor and Physical Therapy services. Speech Therapy and Occupational Therapy each account for approximately 1.6% of total rehabilitation services, whereas Chiropractor composes about 21.9% and Physical Therapy about 74.9%.

RANGES OF ALLOWED COST PER VISIT

We observed the following distributions of allowed cost per visit by category, reported for the 10th and the 90th percentiles (from lowest to highest allowed cost per visit):

- Speech Therapy: $60 - $250
- Occupational Therapy: $50 - $260
- Physical Therapy: $10 - $80
- Chiropractor: $20 - $60

There is a wide range of allowed cost per visit for Speech Therapy, Occupational Therapy, and Physical Therapy services depending on the specific type of service and care setting, such as office vs. facility. The observed range is less extreme for chiropractic services.

The OptumInsight study estimated an average cost of $64 per Physical Therapy visit, which falls within the range we have identified, although it is 30% higher than the average allowed cost per visit that we observed.

COST SHARING

CLAIM DISTRIBUTION BY COST SHARING TYPE

Deductible/coinsurance represents the majority of cost sharing for all types of rehabilitation services. Occupational Therapy has the highest prevalence of copay as the type of cost sharing, while the other rehabilitation services fall closer to a split of 30% copay use versus 70% deductible/coinsurance. These results can be seen in Table 2 below.

TABLE 2 – DISTRIBUTION BY COST SHARING TYPE

Cost Sharing Type	Physical Therapy	Speech Therapy	Occupational Therapy	Chiropractor	Total
Copay	27.9%	34.3%	42.0%	27.2%	28.1%
Deduct/Coins	72.1%	65.7%	58.0%	72.8%	72.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

COST SHARING PER VISIT

Our analysis indicated that the average cost sharing amount per visit for all rehabilitation services is $16.88.

We observed the following allowed cost sharing per visit by category, in descending order:

- Speech Therapy: $32.52
- Occupational Therapy: $27.51
- Chiropractor: $20.99
- Physical Therapy: $15.11

Again, the average cost sharing per visit for all such services is skewed due to the fact that Physical Therapy constitutes the majority of total rehabilitation visits.

Please refer to Table 1a - 1d in the appendix to see these results by type of rehabilitation service.

RANGES OF COST SHARING PER VISIT

We observed the following distributions of cost sharing per visit by category, reported for the 10th and the 90th percentiles:

- Speech Therapy: $0 - $70
- Occupational Therapy: $0 - $60
- Physical Therapy: $0 - $40
- Chiropractor: $0 - $40

For each service, cost sharing decreases as number of visits used by an insured member increases. This follows the logic that lower copays result in higher utilization of rehabilitation services.

CLAIM DISTRIBUTION BY COPAY LEVEL

When analyzing the claim distribution within $5 copay ranges, we observed the following:

- Most rehabilitation services cluster around copays ranging from about $20 to $40.
- Occupational Therapy shows a higher proportion of claims in the $5 to $15 range than the other rehabilitation categories.
- Services with copays greater than $60 show much lower utilization.
- For Physical, Speech, and Occupational Therapy, no $5 copay range has more than a 25% claim distribution; however, 38% of claims for Chiropractor services fall within a copay range of $25 to $30.

These results can be seen in Table 3 below. As noted above in Table 2, not all physical rehabilitation services are subject to copays; in fact, most are not. This table only reflects the portion of services that are subject to copays (as opposed to deductible/coinsurance arrangements). Values in this table represent percentages of total visits subject to copays.

TABLE 3 – DISTRIBUTION BY COPAY LEVEL

Copay	Physical Therapy	Speech Therapy	Occupational Therapy	Chiropractor	Total
$0-$4.99	5.4%	1.4%	6.5%	2.1%	4.5%
$5-$9.99	12.2%	2.7%	17.0%	2.9%	9.8%
$10-$14.99	11.8%	9.1%	15.3%	7.3%	10.7%
$15-$19.99	9.3%	2.6%	8.4%	6.6%	8.5%
$20-$24.99	12.4%	10.4%	10.0%	14.1%	12.7%
$25-$29.99	18.9%	19.2%	12.1%	38.0%	23.5%
$30-$34.99	11.2%	24.8%	14.2%	14.8%	12.5%
$35-$39.99	6.9%	10.7%	5.3%	9.5%	7.6%
$40-$44.99	4.9%	9.2%	4.2%	4.5%	4.9%
$45-$49.99	4.3%	3.8%	4.5%	0.1%	3.2%
$50-$59.99	2.3%	4.5%	1.8%	0.1%	1.8%
$60-$69.99	0.4%	1.3%	0.4%	0.0%	0.3%
$70-$79.99	0.1%	0.1%	0.1%	0.0%	0.1%
$80-$89.99	0.0%	0.0%	0.1%	0.0%	0.0%
$90-$99.99	0.0%	0.0%	0.0%	0.0%	0.0%
$100+	0.0%	0.2%	0.2%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

COPAY AS PERCENTAGE OF ALLOWED COST

When analyzing copays as a percentage of allowed cost within $5 copay ranges, we observed the following:

- Higher copays tend to represent a higher percentage of allowed cost. This differs from a coinsurance arrangement, where members would (assuming deductibles are met) pay a fixed percentage of allowed costs.
- By a wide margin, copays represent the highest portion of allowed cost for Chiropractor services, despite having a relatively low average copay. This is indicative of the fact that the overall allowed costs per visit for Chiropractor services tend to be much lower than for the other rehabilitation service categories.
- Copays of $25-$35 are fairly common for physical therapy and chiropractic services (about 30% of all physical therapy visits, and more than 50% of all chiropractor visits, as seen in Table 3), and the percent of allowed costs at these levels are close to 40% for physical therapy and 70% for chiropractic visits.

These results can be seen in Table 4 below. This table should be viewed in conjunction with Table 3. As with that table, Table 4 only represents visits that were subject to copays. Also, some of the cells in Table 4 are based on only a small number of encounters. For example, Table 3 shows that there are very few Physical Therapy visits with a copay over $70, so the percentages in the corresponding cells in Table 4 are not based on a credible sample size.

TABLE 4 – COPAY PERCENT OF ALLOWED COST

Copay	Physical Therapy	Speech Therapy	Occupational Therapy	Chiropractor	Total
$0-$4.99	9.7%	2.0%	4.1%	12.0%	9.3%
$5-$9.99	18.2%	5.4%	9.7%	29.6%	17.8%
$10-$14.99	22.2%	10.0%	10.8%	33.8%	22.2%
$15-$19.99	25.8%	10.9%	11.3%	49.3%	27.3%
$20-$24.99	29.1%	17.0%	12.1%	62.9%	32.8%
$25-$29.99	40.0%	19.7%	15.2%	69.7%	46.4%
$30-$34.99	37.3%	20.2%	17.1%	70.1%	40.3%
$35-$39.99	51.1%	39.0%	22.6%	80.1%	55.8%
$40-$44.99	54.6%	32.4%	24.6%	93.0%	57.2%
$45-$49.99	63.9%	43.2%	35.0%	56.5%	61.6%
$50-$59.99	62.2%	43.8%	30.7%	94.8%	59.9%
$60-$69.99	62.9%	28.8%	54.7%	59.0%	57.5%
$70-$79.99	37.4%	40.4%	42.1%	58.9%	40.3%
$80-$89.99	34.8%	N/A	22.7%	N/A	31.7%
$90-$99.99	22.3%	N/A	40.0%	100.0%	27.8%
$100+	20.2%	61.7%	30.0%	64.9%	24.4%
Overall	35.9%	22.7%	15.6%	66.3%	39.0%

PLAN PREVALENCE BY COST SHARING

When analyzing paid to allowed ratios by category, we observed the following:

- Approximately 9% of all rehabilitation services have no cost sharing (or a paid to allowed ratio of 100%).
- Occupational Therapy services have the highest prevalence of no cost sharing.
- For Physical, Speech, and Occupational Therapy, paid to allowed ratios between 80% and 90% are most prevalent.
- The highest portion of claims for Chiropractor services are claims with 100% cost sharing (or a paid to allowed ratio of 0%).

These results can be seen in Table 5 below.

TABLE 5 – DISTRIBUTION BY PAID TO ALLOWED RATIO

Paid-to-Allowed Ratio	Physical Therapy	Speech Therapy	Occupational Therapy	Chiropractor	Total
0%	7.5%	3.3%	4.7%	16.6%	9.4%
0.01%-9.99%	1.2%	3.0%	1.0%	3.2%	1.7%
10-19.99%	1.5%	1.4%	0.9%	6.4%	2.6%
20-29.99%	2.9%	3.3%	1.8%	7.7%	4.0%
30-39.99%	3.9%	2.9%	1.1%	10.2%	5.2%
40-49.99%	6.6%	5.7%	2.7%	9.2%	7.1%
50-59.99%	9.4%	8.5%	3.7%	10.4%	9.6%
60-69.99%	12.5%	13.4%	5.6%	9.6%	11.8%
70-79.99%	14.2%	10.7%	11.6%	8.3%	12.8%
80-89.99%	19.0%	22.7%	28.8%	9.2%	17.1%
90-99.99%	11.1%	16.0%	20.5%	4.4%	9.9%
100%	10.1%	9.2%	17.5%	4.9%	9.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

ANNUAL LIMITS

MEMBER UTILIZATION

When analyzing member utilization, we observed the following:

- Between 12 and 13 visits and 20 and 21 visits, there is a noticeable decrease in utilizers for all rehabilitation services. This may suggest the presence of an annual limit on visits, although it could also represent a common average of rehabilitation utilization duration.
- Plan design parameters (such as visit limits) were not available in the data we relied upon for this study, so we recommend using caution in inferring contractual service limits from these data.

Please refer to Table 1 above and the tables 1a – 1d in the appendix for details.

VISIT DISTRIBUTION

We analyzed the distribution of visit counts both by the total number of visits a member had, as well as the number of utilizers at each visit count. We observed the following:

- The highest percentage of total visits per member for all rehabilitation services is 30+, averaging about 64 visits. However, only 13% of utilizers used 30 or more visits.
- Through 30 visits, each successive visit generally has fewer utilizers. There are some exceptions, such as the "bump" at 20 visits noted earlier in this report.
- For each type of therapy, the single most common number of visits is 1 visit.
- For Occupational Therapy, about 56% of all utilizers had 1 encounter.

These results can be seen in Table 6 below.

TABLE 6 – DISTRIBUTION OF VISITS BY NUMBER OF UTILIZERS

Visits per Member	Physical Therapy	Speech Therapy	Occupational Therapy	Chiropractor	Total
1	11.0%	32.0%	56.1%	16.8%	10.4%
2	9.3%	10.6%	13.8%	13.9%	9.2%
3	7.3%	5.4%	5.2%	9.5%	7.3%
4	6.2%	3.8%	3.0%	8.2%	6.1%
5	5.0%	4.2%	2.6%	5.4%	4.8%
6	5.0%	3.4%	2.0%	5.4%	4.9%
7	4.2%	3.4%	1.4%	4.2%	4.0%
8	3.9%	2.8%	1.2%	3.9%	3.8%
9	3.6%	1.7%	1.5%	3.2%	3.5%
10	3.1%	1.5%	1.2%	3.4%	3.1%
11	2.7%	1.6%	1.0%	2.8%	2.7%
12	2.8%	1.4%	1.1%	3.4%	3.0%
13	2.3%	1.3%	1.0%	1.9%	2.3%
14	2.2%	1.3%	0.6%	2.0%	2.1%
15	2.0%	1.2%	0.8%	1.6%	1.9%
16	1.9%	1.3%	0.8%	1.4%	1.9%
17	1.8%	1.6%	0.4%	1.0%	1.6%
18	1.6%	1.4%	0.6%	1.2%	1.7%
19	1.4%	1.7%	0.4%	1.0%	1.4%
20	1.6%	2.5%	0.4%	1.8%	1.9%
21	1.3%	1.3%	0.2%	0.7%	1.3%
22	1.2%	1.1%	0.5%	0.8%	1.2%
23	1.2%	1.1%	0.4%	0.4%	1.1%
24	1.2%	0.5%	0.4%	0.8%	1.3%
25	1.0%	0.9%	0.4%	0.4%	0.9%
26	0.9%	0.5%	0.3%	0.6%	0.8%
27	0.9%	1.0%	0.3%	0.3%	0.8%
28	0.8%	0.7%	0.2%	0.5%	0.8%
29	0.8%	0.4%	0.2%	0.3%	0.8%
30+	11.6%	7.9%	2.1%	3.4%	13.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

CAVEATS

These tables were prepared by Milliman for the Colorado Department of Public Health and the Environment (CDPHE) in its study concerning the costs, including patient cost-sharing, for physical rehabilitation services, funded by the Commission on Affordable Health Care and subject to a purchase order with Milliman dated October 15, 2015. These represent preliminary results that will be reviewed by the Commission, and they may be revised or supplemented as you review this document. Other uses may be inappropriate. Future claims experience may vary from the values contained in these tables. We relied on the Truven Health Analytics MarketScan® commercial databases for 2013 in developing these exhibits without audit, although reasonability checks have been conducted. We understand that this information may be shared with the Colorado legislature. Milliman does not intend to create a legal duty to any third party recipient of its work. Any inclusion of data from our analysis should be materially complete.

The OptumInsight report cited above was not prepared by Milliman. We have provided some observations about how our results compare to the results in that study. However, we do not have access to the full data, assumptions, and methodologies in the other report and cannot provide an explanation for differences in the results.

The data source underlying this analysis is from 2013, which is the most recent calendar year currently available. These data represent a commercially insured population (predominantly with employer-sponsored coverage) from that year and are not necessarily representative of other populations, such as:

- Individuals covered by Medicare
- Individuals covered by Medicaid
- Individuals covered by CHP
- Individuals covered by insurance policies compliant with the market reform rules of the Patient Protection and Affordable Care Act (including its essential health benefit requirements)
- Uninsured patients

Guidelines issued by the American Academy of Actuaries require actuaries to disclose their professional qualifications in actuarial communications. I am a member of the American Academy of Actuaries and meet the qualification standards for performing this analysis.

Please review, and feel free to contact me with any questions or other thoughts. We look forward to your review of this work in anticipation of a final report.

Best regards,

Stephen P. Melek, FSA, MAAA
Principal and Consulting Actuary

APPENDIX

These tables show numbers of visits, utilizers, and costs for each type of rehabilitative service. Allowed and paid costs are calculated on a per visit basis, and cost sharing per visit calculates the difference between the two. Costs for each service were also calculated on a PMPM basis in order to observe the portion of total PMPM these services comprise.

TABLE 1a – COSTS PER VISIT FOR PHYSICAL THERAPY SERVICES

Number of Visits	Physical Therapy					
	Visits	Utilizers	Allowed per Visit	Paid per Visit	Cost Sharing per Visit	Cost Sharing % Allowed
1	4,597	4,597	$71.00	$43.72	$27.28	38.4%
2	7,736	3,868	$63.08	$37.64	$25.44	40.3%
3	9,183	3,061	$61.55	$37.88	$23.67	38.5%
4	10,344	2,586	$58.44	$34.60	$23.85	40.8%
5	10,490	2,098	$62.89	$38.46	$24.43	38.8%
6	12,444	2,074	$58.04	$34.89	$23.15	39.9%
7	12,264	1,752	$58.62	$35.90	$22.72	38.8%
8	13,000	1,625	$55.44	$34.46	$20.97	37.8%
9	13,680	1,520	$56.31	$35.61	$20.71	36.8%
10	12,960	1,296	$55.50	$35.69	$19.81	35.7%
11	12,397	1,127	$55.42	$34.91	$20.51	37.0%
12	14,184	1,182	$50.03	$31.41	$18.62	37.2%
13	12,584	968	$54.75	$35.47	$19.28	35.2%
14	12,964	926	$53.43	$35.23	$18.20	34.1%
15	12,540	836	$50.61	$33.05	$17.56	34.7%
16	12,624	789	$53.77	$34.98	$18.78	34.9%
17	12,512	736	$50.81	$33.51	$17.30	34.0%
18	12,222	679	$52.07	$34.80	$17.27	33.2%
19	11,495	605	$52.52	$35.48	$17.03	32.4%
20	13,560	678	$52.55	$33.55	$19.00	36.2%
21	11,781	561	$50.71	$34.59	$16.11	31.8%
22	10,692	486	$51.75	$35.87	$15.88	30.7%
23	11,569	503	$49.72	$33.34	$16.38	32.9%
24	12,384	516	$48.96	$34.19	$14.77	30.2%
25	10,025	401	$51.65	$36.40	$15.25	29.5%
26	9,906	381	$47.78	$33.50	$14.28	29.9%
27	9,909	367	$49.42	$35.30	$14.12	28.6%
28	9,828	351	$46.83	$32.25	$14.58	31.1%
29	9,918	342	$46.96	$33.21	$13.75	29.3%
30+	322,575	4,844	$44.15	$32.81	$11.34	25.7%
Overall	652,367	41,755	$48.99	$33.87	$15.11	30.9%
Avg Visits for 30+	66.59					
PMPM			$6.68	$4.62	$2.06	
% Total PMPM			2.1%			

TABLE 1b – COSTS PER VISIT FOR SPEECH THERAPY SERVICES

Number of Visits	Speech Therapy					
	Visits	Utilizers	Allowed per Visit	Paid per Visit	Cost Sharing per Visit	Cost Sharing % Allowed
1	427	427	$300.06	$225.45	$74.61	24.9%
2	284	142	$178.09	$134.11	$43.99	24.7%
3	216	72	$172.76	$128.28	$44.48	25.7%
4	204	51	$157.39	$116.42	$40.96	26.0%
5	280	56	$137.81	$110.06	$27.75	20.1%
6	276	46	$145.43	$100.06	$45.38	31.2%
7	322	46	$155.31	$115.07	$40.24	25.9%
8	304	38	$128.71	$99.52	$29.20	22.7%
9	207	23	$139.99	$106.28	$33.71	24.1%
10	200	20	$120.53	$95.78	$24.75	20.5%
11	242	22	$145.16	$118.02	$27.14	18.7%
12	228	19	$152.38	$113.19	$39.20	25.7%
13	221	17	$155.59	$126.30	$29.28	18.8%
14	252	18	$152.37	$115.27	$37.10	24.3%
15	240	16	$102.21	$73.69	$28.52	27.9%
16	272	17	$119.35	$97.60	$21.74	18.2%
17	374	22	$139.71	$105.24	$34.47	24.7%
18	342	19	$131.22	$94.61	$36.61	27.9%
19	437	23	$134.87	$106.86	$28.02	20.8%
20	680	34	$114.35	$80.59	$33.76	29.5%
21	378	18	$146.24	$124.39	$21.84	14.9%
22	330	15	$139.26	$114.72	$24.53	17.6%
23	345	15	$138.40	$108.03	$30.37	21.9%
24	168	7	$118.33	$97.72	$20.61	17.4%
25	300	12	$154.50	$116.89	$37.61	24.3%
26	182	7	$117.20	$95.25	$21.95	18.7%
27	351	13	$116.67	$71.36	$45.32	38.8%
28	252	9	$133.15	$107.40	$25.75	19.3%
29	145	5	$96.65	$51.07	$45.58	47.2%
30+	5,234	105	$100.32	$71.71	$28.60	28.5%
Overall	13,693	1,334	$128.00	$95.47	$32.52	25.4%
Avg Visits for 30+	49.66					
PMPM			$0.37	$0.27	$0.09	
% Total PMPM			0.1%			

TABLE 1c – COSTS PER VISIT FOR OCCUPATIONAL THERAPY SERVICES

Number of Visits	Occupational Therapy					
	Visits	Utilizers	Allowed per Visit	Paid per Visit	Cost Sharing per Visit	Cost Sharing % Allowed
1	1,705	1,705	$128.78	$91.07	$37.71	29.3%
2	838	419	$123.48	$89.21	$34.27	27.8%
3	477	159	$141.95	$113.85	$28.11	19.8%
4	364	91	$141.86	$110.81	$31.05	21.9%
5	400	80	$154.68	$121.58	$33.10	21.4%
6	360	60	$162.51	$117.53	$44.98	27.7%
7	308	44	$173.98	$140.31	$33.68	19.4%
8	288	36	$196.04	$159.05	$36.99	18.9%
9	423	47	$146.40	$121.94	$24.46	16.7%
10	350	35	$165.15	$129.96	$35.19	21.3%
11	341	31	$167.67	$137.28	$30.39	18.1%
12	408	34	$123.61	$89.50	$34.11	27.6%
13	390	30	$144.62	$103.03	$41.59	28.8%
14	238	17	$167.46	$140.35	$27.11	16.2%
15	360	24	$149.45	$117.65	$31.80	21.3%
16	400	25	$163.59	$135.35	$28.23	17.3%
17	187	11	$143.61	$100.64	$42.97	29.9%
18	324	18	$161.33	$135.95	$25.38	15.7%
19	228	12	$167.24	$136.07	$31.17	18.6%
20	260	13	$184.10	$144.95	$39.16	21.3%
21	126	6	$138.78	$126.93	$11.85	8.5%
22	352	16	$155.68	$137.10	$18.58	11.9%
23	276	12	$128.89	$111.93	$16.96	13.2%
24	264	11	$160.11	$140.81	$19.30	12.1%
25	275	11	$132.61	$103.23	$29.39	22.2%
26	208	8	$135.71	$103.05	$32.66	24.1%
27	243	9	$129.23	$117.66	$11.57	9.0%
28	168	6	$126.09	$114.42	$11.67	9.3%
29	203	7	$132.03	$120.07	$11.96	9.1%
30+	3,509	63	$125.24	$108.50	$16.74	13.4%
Overall	14,273	3,040	$141.14	$113.62	$27.51	19.5%
Avg Visits for 30+	55.49					
PMPM			$0.42	$0.34	$0.08	
% Total PMPM			0.1%			

TABLE 1d – COSTS PER VISIT FOR CHIROPRACTOR SERVICES

Number of Visits	Chiropractor					
	Visits	Utilizers	Allowed per Visit	Paid per Visit	Cost Sharing per Visit	Cost Sharing % Allowed
1	3,891	3,891	$39.60	$14.45	$25.15	63.5%
2	6,434	3,217	$36.88	$12.80	$24.07	65.3%
3	6,630	2,210	$37.97	$14.29	$23.68	62.4%
4	7,612	1,903	$36.92	$14.35	$22.57	61.1%
5	6,275	1,255	$38.24	$14.95	$23.28	60.9%
6	7,464	1,244	$37.16	$14.43	$22.73	61.2%
7	6,762	966	$38.03	$15.07	$22.96	60.4%
8	7,272	909	$36.69	$15.80	$20.89	56.9%
9	6,597	733	$38.40	$15.93	$22.48	58.5%
10	7,830	783	$37.02	$14.68	$22.34	60.4%
11	7,029	639	$37.57	$16.63	$20.95	55.8%
12	9,480	790	$37.27	$15.17	$22.10	59.3%
13	5,668	436	$40.01	$16.30	$23.71	59.3%
14	6,524	466	$37.42	$16.27	$21.15	56.5%
15	5,430	362	$38.74	$18.01	$20.73	53.5%
16	5,248	328	$38.14	$17.15	$20.99	55.0%
17	4,046	238	$39.07	$18.30	$20.77	53.2%
18	5,022	279	$37.46	$18.94	$18.52	49.4%
19	4,408	232	$37.64	$18.01	$19.63	52.2%
20	8,380	419	$38.78	$18.32	$20.46	52.8%
21	3,213	153	$38.99	$19.41	$19.57	50.2%
22	3,850	175	$37.68	$19.23	$18.45	49.0%
23	2,392	104	$42.38	$22.34	$20.04	47.3%
24	4,584	191	$39.33	$19.53	$19.79	50.3%
25	2,250	90	$46.40	$21.79	$24.61	53.0%
26	3,744	144	$37.31	$16.29	$21.02	56.3%
27	1,998	74	$41.56	$22.13	$19.43	46.7%
28	3,024	108	$41.23	$20.93	$20.31	49.2%
29	1,885	65	$42.53	$21.47	$21.07	49.5%
30+	36,094	781	$41.07	$23.10	$17.96	43.7%
Overall	191,036	23,185	$38.79	$17.80	$20.99	54.1%
Avg Visits for 30+	46.24					
PMPM			$1.55	$0.71	$0.84	
% Total PMPM			0.5%			

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 1, 2015
9:00 am – 12:00 pm

COMMISSION ON AFFORDABLE HEALTH CARE

9:00-9:30 COMMISSION ON AFFORDABLE HEALTH CARE

1. Please provide an overview of the Commission on Affordable Health Care and the FY 2016-17 request $424,000 General Fund.

2. Please discussion how the Commission continued their work after the June 2015 emergency supplemental was declined. Please provide a list of the expenditure reductions/revisions made to stay within the $400,000 budget.

3. Please provide a list of grants and donations the Commission has received to date.

4. Please discuss who has oversight of Commission's expenditures.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

9:30-9:50 INTRODUCTIONS AND OPENING COMMENTS

9:50-10:30 Questions Related to FY 2016-17 Budget Priorities

R1 Family Planning Purchase of Services Increase

5. What are all the ways an individual can access family planning services in Colorado?

Response: Men and women can access family planning services (counseling, education and direct clinical services) in a variety of settings: OBGYN and general practitioner clinics and offices, and family planning clinics, including the clinics in the Title X network. Most clinics take cash and for-profit insurance as payment and a smaller percentage also accept Medicaid as payment. Title X funded clinics take all forms of payment, offer a full menu of services and are experts in family planning methods, education and counseling.

6. Please discuss what services are funded through the Family Planning Purchase of Services line item and how these services are different than services provided through other programs.

Response: CDPHE contracts with 29 providers throughout the state for Title X services through the Purchase of Services line. Services provided by Title X funded clinics include, but are not limited to, contraceptive services, preventive health counseling and education services, reproductive health related testing and, screening and referrals. Pregnancy termination is not a family planning service. All services are provided on a sliding fee scale for clients with incomes that are at or below 250% of poverty level.

CDPHE's family planning contractors provide similar services as other family planning clinics around the State, the primary difference is that CDPHE's contractors are required to serve low-income individuals, who may not otherwise have access to health care services. Other clinics, such as Federally Qualified Health Centers also serve low-income and other individuals in need of health care services.

7. **According to the JBC documents, most of the money that goes to Planned Parenthood is sent through county health departments. What oversight does the CDPHE exercise over the expenditures once the counties get the money? What records do the counties or CDPHE maintain of how that money is expended?**

Response: The CDPHE Family Planning Program does not contract with Planned Parenthood. The CDPHE Family Planning Program contracts with 29 organizations. Each organization is given a budget and must adhere to the terms of the contract, itemizing their expenses. Contractors invoice monthly for reimbursement and are monitored on a monthly basis to ensure funds are being spent according to contract and scope of work. Every three years, contractors are given an administrative program review whereby fiscal processes are reviewed, as well. Contractors are expected to comply with State and Federal law, following best fiscal practices in terms of monitoring and maintaining fiscal records onsite.

In addition to specific program monitoring, CDPHE has two other fiscal oversight systems in place:

1. **Financial Risk Management System (FRMS) for Local Public Health Agencies:** CDPHE FPP contractors are subject to CDPHE's Financial Risk Management System (FRMS). FRMS is a standardized process to assess a contractor's risk of noncompliance with contractual fiscal requirements. Additionally, the system improves fiscal monitoring throughout the department by establishing standardized practices at the department and program level and utilizes a standardized invoice form. Contractors are monitored through random samplings of paid invoices and supporting documentation. Monitoring is conducted by FRMS expert staff based on risk level. Contractors rated as "high risk" are monitored more frequently than "low risk" rated contractors.

2. **Prevention Services Compliance Unit:** Annually, CDPHE's fiscal compliance unit works with non-local public health agencies in performing a robust fiscal

review on each site. These reviews help to ensure the agencies are in good fiscal standing and provide technical assistance to those agencies that need additional fiscal training.

8. **Since contraceptives are one of the ten essential services under ACA, hence everyone has access, why do Planned Parenthood and other providers need more funding for what appear to be the same services?**

   Response: Clinics funded through CDPHE's family planning program primarily serve low-income women who may not have health insurance or are not eligible for Medicaid. CDPHE Title X funded clinics bridge the gap between pre and post ACA medical practices. CDPHE FPP is optimistic that through the on-going implementation of the Affordable Care Act and Colorado Medicaid Expansion, fewer women will be in need of subsidized family planning services. However, it will take time for the eligible, but not enrolled, population to become covered.

   Although the ACA mandate dictates that all citizens have access to family planning health coverage, many issues make it challenging for all women to access contraceptive health care. Safety net providers need more funding to continue working on family planning gains because patients continue to grapple with the following:

   - Cost of insurance for low-income citizens: While there may be access to insurance coverage for all citizens, not all can afford the premiums – even with the subsidies. The health care law does allow for an exemption from the individual mandate for those who cannot find affordable coverage.
   - Religious Exemption: Allows certain employers to "opt-out" of including/paying for the contraceptive benefit in their employer-sponsored plans.
   - "Churn": Churn is typically caused by a change in the insured eligibility status, such as fluctuations in income, loss of a job, or changes in family circumstance, lack of funding for premium, etc. which results in episodic health care coverage.
   - Medical Management: Federal regulations implementing the preventive services coverage requirements permit health insurers to use "reasonable medical management techniques" to determine the frequency, method, treatment or setting for any of the required services to the extent not already specified in the guidelines. In some cases, medical management may include requiring that patients try a different (e.g., less expensive) contraceptive method before a LARC method is approved. If insurers require a medical justification for a woman to gain access to LARC, preferences based on factors other than medical contraindications may not be reimbursed. In these cases women may turn to a family planning clinic for assistance.
   - Women's Preventive Health Benefit: Federal regulation states that plans may not limit coverage to one type of contraceptive, such as oral

contraceptives, but must provide at least one version of each FDA-approved contraceptive method. This means that insurance companies are only required to support one of the three available IUDs on the market. If that one version is not the LARC method that the clinical provider prescribes, the client may turn to a Title X funded clinic for contraceptive assistance.

- Wait Times: Because of the Affordable Care Act, many health clinics have long wait periods for patients to get their healthcare needs met. Research shows that wait times for contraceptive coverage oftentimes leads to unintended pregnancy. Due to these wait times, many "overflow" clients turn to the FPP for their services.
- Confidentiality: Billing and claims processing procedures widely used in private health insurance routinely, albeit inadvertently, make it impossible for anyone insured as a dependent on someone else's policy to obtain sensitive services confidentially. Many women require confidential contraceptive services due to intimate partner violence issues, unsupportive family members, cultural nuances and much more. . Because they feel unable to use their coverage, insured individuals, seeking contraceptive services, often turn to publicly funded family planning centers to obtain affordable, confidential care.
- Community education and provider training: Providers play a key role in the success or failure of contraceptive method uptake and continuation. In some health centers, providers have limited confidence to insert or remove LARC methods and have low capacity for side effect counseling and follow-up care. These providers may have dated information on best practices or have not been trained in recent LARC insertion techniques. These facts impact LARC provision and continuation rates for all women.
- Inventory Management: Because of the high cost of LARC devices, some health centers do not have LARC stock on hand. This means the patient has to wait to obtain the device from the pharmacy and make a return appointment for insertion. Research shows that wait times for contraceptive coverage oftentimes leads to unintended pregnancy.

9. Regarding the budget requests for LARCs, what has been the source (and amount) of private grant money that has previously funded this program. What have been the measurable results, if any, and how do those results differ from trends in the same population not served with LARCs?

Response: The CDPHE Family Planning Program does not have a LARC-specific budget request for FY2016-17. The request is for $2,511,135 expansion of the full suite of family planning services.

The following data is in support of the Family Planning Program, CFPI, which will end on June 30, 2016. Source of the grants money: Private Donor Amount:

- FY 2008-09 = $3,585,188

- FY 2009-10 = $5,400,000
- FY 2010-11 = $4,837,707
- FY 2011-12 = $4,828,852
- FY 2012-13 = $4,916,859
- FY 2013-14 = $1,601,640
- FY 2014-15 = $2,200,000
- FY 2015-16 = $2,600,000

Family Planning Program Facts at a Glance:

- Since the start of the CDPHE enhanced FPP program, the birth rate for young Colorado women ages 15 to19 has been cut nearly in half, falling 48 percent between 2009 and 2014, while nationally the birth rate for women ages 15-19 decreased 30% between 2009 and 2014 (note 2014 national birth data is still preliminary)
- A similar downward trend can be seen among Colorado women ages 20 to 24, with birth rates dropping 20 percent between 2009 and 2014, while nationally the birth rate for women ages 20-24 decreased 18% between 2009 and 2014 (note that 2014 national birth data is still preliminary)
- The number of Colorado repeat teen births (teens giving birth for the second or third time, etc.) dropped 58 percent between 2009 and 2014, while nationally the number of repeat teen births dropped 45% between 2009 and 2014 (note that 2014 national birth data is still preliminary)
- The abortion rate among Colorado women 15 to 19 fell by 48 percent while nationally the abortion rate among women 15-19 fell by 43% between 2009-2012 (most recent national data available)
- The abortion rate among Colorado women 20 to 24 fell by 18 percent while nationally the abortion rate among women 20-24 fell by 15% between 2009-2012 (most recent national data available)
- In 2008, in the counties with Title X clinics, one in 170 low-income women ages 15 to 24 received an IUD or implant – by 2011, one in 15 had received one of these long-acting reversible methods.
- Between 2009 and June 2015 more than 36,000 LARC methods have been provided to women across Colorado who could not have otherwise afforded them.
- IUD and implant use among family planning clients using contraception grew from 4.5 percent before the initiative began to 29.6 percent in 2014. Nationally, only 7.2 percent of women use these more effective forms of birth control.

The CDPHE FPP continues to prove its effectiveness, empowering thousands of low-income Colorado women to pursue their education and careers while they are free to choose when to start a family.

10. **Are the same LARC contraceptives available under Medicaid and ACA-mandated health plans? If not, what are the differences?**

    Response: Yes, the same LARCs are available under Medicaid and ACA-mandated health plans. Some insurance companies, however, can claim religious exemption from providing contraceptive services.
    In addition, Federal regulations implementing the preventive services coverage requirements permit health insurers to use "reasonable medical management techniques" to determine the frequency, method, treatment or setting for any of the required services to the extent not already specified in the guidelines. In some cases, medical management may include requiring that patients try a different (e.g., less expensive) contraceptive method before a LARC method is approved.

11. **Regarding Governor Ritter's 2007 announcement that he was restoring funds to Planned Parenthood after the Owens-Norton 2001-02 decision to defund Planned Parenthood, what guidance did Governor Ritter or CDPHE receive from the Attorney General that supported this decision?**

    Response: The Department did not receive any guidance from the Attorney General's Office specific to the restoration of funds to Planned Parenthood of the Rocky Mountains. Although Governor Ritter would have allowed the restoration of family planning funds to Planned Parenthood, Planned Parenthood decided not to participate in the federal Title X program administered by the Department; thus, Planned Parenthood has not received money for family planning services from the Department since 2002. The Department has continuously contracted with Planned Parenthood for breast and cervical cancer screening services from the Owens administration up to the present day. Two separate lawsuits have been filed against the Department concerning the payment of contract funds to Planned Parenthood, and the Attorney General's Office has represented the Department in both actions. The first case was dismissed by the court and the appeals have been exhausted; the second case was also dismissed by the district court and is now pending in the Colorado Court of Appeals.

12. **Regarding C.R.S. 25-2-111.5 (fetal tissue trafficking):**
    a. **describe any investigations CDPHE has conducted of potential violations of this statute;**

    Response: Based upon requests received from some members of the Colorado General Assembly and a private citizen to investigate allegations of a potential violation of Section 25-2-111.5, C.R.S. pertaining to Planned Parenthood of the Rocky Mountains, the Department reviewed video footage provided with the request to ascertain whether the conduct complained of was attributed to activities occurring specifically in Colorado. As nowhere in the footage provided was there a reference to fetal tissue transfers in Colorado, the Department concluded its investigation.

b. If there have been no investigations, what tools does CDPHE need to investigate potential violations of this statute; and

See Response to (a) above

c. How this statute should be amended by the Legislature to be made effective.

Neither the Department nor any other agency is provided sufficient investigative authority pursuant to the existing statute. As currently written, the Department cannot subpoena any entity to obtain records pertaining to allegations of potential statutory violations.

13. Regarding Planned Parenthood's participation in the Colorado Medicaid program and during the last 3 fiscal years please answer the following questions for the following four items: (1) oral contraceptives, (2) emergency contraceptives, (3) LARCs, and (4) LARCs paid for by the Department's Family Planning Program:

a. How many patients have been prescribed the item by Planned Parenthood;
b. What Planned Parenthood's actual acquisition cost of such item;
c. What the State's reimbursement rate for each item; and
d. What the State's dispensing fee for such each item.

Response:

This response was provided by the Department of Health Care Policy and Financing (HCPF.) The response is limited by the following factors:

- The Department's data does not identify whether any item has been prescribed by Planned Parenthood.
- The Department's data does not contain Planned Parenthood's actual acquisition cost of any item;
- Because Planned Parenthood is not a pharmacy, the Department does not pay a dispensing fee for services provided.

The reimbursement rate for each item is provided in the table below.

Procedure Code	Procedure Cost Description	FY 2012-13	FY 2013-14	FY 2014-15
11981	Insert drug implant device	$84.43	$86.11	$86.55
57170	Diaphragm or cervi cap fit w/instruction	$23.18	$23.64	$23.76
58300	Insertion of intra-uterine device (iud)	$49.67	$50.66	$50.91
A4266	Diaphragm	$30.05	$30.64	$30.80
J1050	Injection,medroxprogesterone acetate 1mg	N/A	$0.43	$0.43
J7300	Intrauterine copper contraceptive (t38a)	$617.54	$629.65	$742.70
J7302	Levonorgestrel iu 52 mg	$717.32	$731.38	$892.99
J7303	Contraceptive vaginal ring	$34.88	$35.57	$40.31
J7304	Contraceptive hormone patch	$16.44	$16.76	$19.00

J7307	Etonogestrel implant system	$672.61	$685.80	$777.37
S4993	Contraceptive pills for bc	$13.68	$13.95	$35.19

A fee schedule for HCPF can be found here:
https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule

It is not possible for CDPHE to report on the cost of LARCs purchased by FPP contractors. Funding is provided to contractors for general operating support. CDPHE does not track spesific clinical expenses.

R3 Emergency Medical and Trauma Services Grant Program

14. Please discuss the history of the funding for the Emergency Medical and Trauma Grants Program.

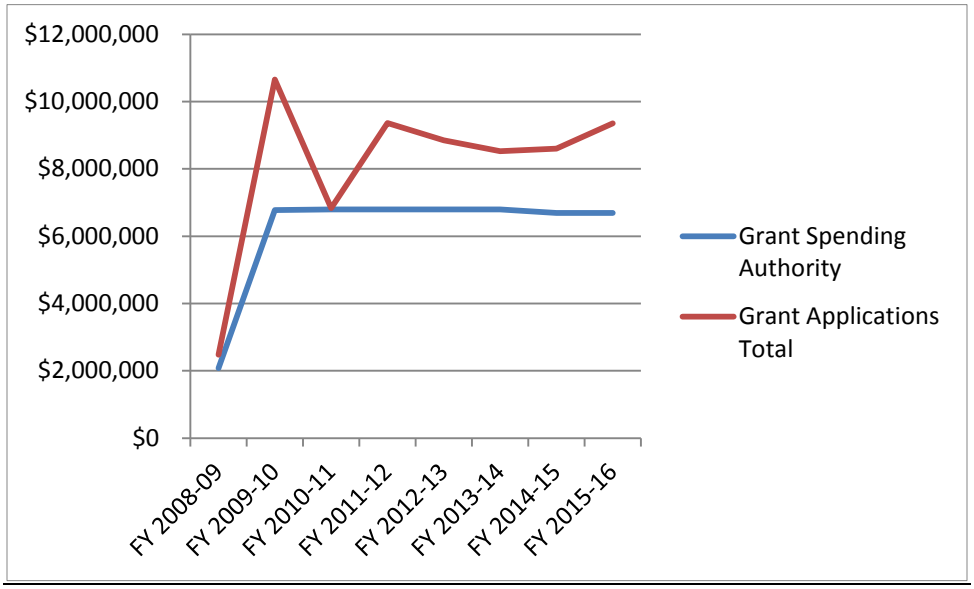
Response: Prior to FY 2008-09, a $1.00 fee on all vehicle registrations in the state funded the majority of the statutory duties performed by CDPHE in its oversight of the emergency medical and trauma services system. This fee was implemented in the late 1980's. In 2009-10 the fee increased to $2.00 (SB 09-002). The increased money from the fee change was almost entirely applied to the EMTS grants program. The spending authority for the grant program was increased by $4,698,189 for FY 2009-10. The spending authority was adjusted slightly for an annualization of that bill for FY 2010-11 where it stayed until FY 2014-15. At that time, the appropriation was reduced by $100,000 that was transferred to the EMS Coordination line to cover a contract to maintain the computer system used by the program to house data submitted by EMS transporting agencies across the state. Given the increase iin the number of vehicles in the State, Program revenue has grown. Without additional spending authority, the Program is unable to use the additional revenue. Authorizing additional spending authority will increase funding to first responders across the state and help to bring the fund balance into compliance.

The chart below shows the history of the grant program from FY 2008-09 through the current fiscal year.

	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Grant Spending Authority	$2,078,793	$6,776,982	$6,793,896	$6,793,896	$6,793,896	$6,793,896	$6,693,896	$6,693,896
Difference between Applications and Spending Authority	**($400,849)**	**($3,880,788)**	**($42,231)**	**($2,563,376)**	**($2,057,657)**	**($1,734,037)**	**($1,903,655)**	**($2,662,064)**
Grant Applications Total	**$2,479,642**	**$10,657,770**	**$6,836,127**	**$9,357,272**	**$8,851,553**	**$8,527,933**	**$8,597,551**	**$9,355,960**
Ambulance and Vehicle	$1,249,208	$3,688,710	$1,456,967	$2,676,883	$2,593,205	$2,514,631	$2,504,098	$3,272,412
Communication	$76,382	$444,850	$35,083	$184,469	$950,337	$417,665	$57,741	$674,572
Conferences/Education	$455,488	$781,446	$556,500	$632,550	$782,433	$617,171	$667,797	$655,600
Data	$93,243	$530,261	$168,101	$118,673	$121,273	$149,483	$334,246	$27,411

Emergency			$415,112	$165,629		$315,706	$286,954	$53,222
EMTS Equipment	$238,067	$2,213,943	$1,916,359	$2,672,031	$3,131,774	$2,447,438	$3,307,195	$3,589,973
Injury Prevention	$19,370	$240,856	$155,586	$203,185	$148,120	$170,545	$107,373	$3,127
Other	$164,807	$2,413,252	$861,002	$216,846	$37,546	$616,380	$15,600	$53,143
Personnel	$0	$0	$413,146	$1,475,939	$307,313	$531,909	$594,067	$385,583
Recruitment and Retention	$43,078	$73,069	$149,947	$51,048	$41,332	$39,949	$27,498	$0
Regional Medical Direction	$0	$0	$0	$306,950	$320,054	$370,793	$362,666	$362,008
RETAC Operations	$0	$0	$0	$0	$34,054	$41,860	$43,394	$51,095
Special projects/base funding	$0	$0	$0	$430,573	$0	$0	$0	$0
Systems Improvement	$140,000	$271,383	$687,590	$175,915	$300,229	$248,038	$170,301	$178,431
Technical Assistance	$0	$0	$20,735	$46,580	$83,883	$46,366	$118,623	$49,384

The chart below represents the difference between grant applications and the available spending authority for the grant program.



R4 Cervical Cancer Eligibility Expansion

15. Please provide an overview of the Breast and Cervical Cancer Screening Program including:

Response: The Breast and Cervical Cancer **Screening** Program is known as Women's Wellness Connection. The screening program is housed and administered by the Colorado Department of Public Health and Environment.

This program should not be confused with the Breast and Cervical Cancer **Treatment** Program, which is housed and administered by the Colorado Department of Health Care Policy and Financing (HCPF.)

a. Who provides the screenings;

Response: Screenings paid for by the Women's Wellness Connection (WWC) are provided by 45 WWC Clinical Services contractors at approximately 140 clinic sites across Colorado. Contractors sub-contract for clinical services they cannot provide on-site. For example, some providers do not have the equipment or training to perform biopsies. Contractors include federally qualified health centers, local public health adencies, rural hospitals, safety net clinics, private physicians and nonprofit organizations. A map of WWC clinic locations can be found here: https://www.colorado.gov/cdphe/wwc-clinic-locations

b. The role of the Women's Wellness Connection,

Response: The role of Women's Wellness Connection is to determine eligibility and provide funding for screening and diagnostic services to uninsured and underinsured women through contractual agreements with clinical services agencies; reimburse contractors for services provided; provide and monitor adherence to program requirements; provide technical assistance and training to contractors; monitor performance and quality of contractor services through site visits, progress reports, email, and phone calls; approve WWC clients with an eligible diagnosis for proceeding with an application to the Medicaid Breast and Cervical Cancer Treatment Program (BCCP Medicaid); organize two no cost referral lines; provide outreach materials; collect data from agencies about clients served and submit to the Centers for Disease Control and Prevention (CDC); match program data to BCCP Medicaid data and cancer registry data; implement evaluation activities; and write grant applications for receipt of CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funding.

c. How the Department determines who is a qualified screener,

Response: The Women's Wellness Connection uses a Request for Applications (RFA) process to solicit potential contractors to provide breast and cervical cancer screening and diagnostic services. A review team convenes to evaluate and score applications against the criteria outlined in the RFA.

d. Eligibility criteria for women to be screen through the Breast and Cervical Cancer Program.

Response: Current eligibility criteria for women to be screened through the Breast and Cervical Cancer Program (Women's Wellness Connection) include women who

are 40-64 years of age, have a family income at or below 250 percent of the Federal Poverty Level, are lawfully present in the United States (per CRS 24-76.5-101), and have no health insurance or are underinsured.

16. **Please provide an overview of the Breast and Cervical Cancer Treatment Program including who provides the treatment services.**

Response: The following response was provided from HCPF. The Breast and Cervical Cancer Program (BCCP) at the Department of Health Care Policy and Financing is a Medicaid program for women diagnosed with breast or cervical cancer, or breast and cervical conditions that may lead to cancer if not treated. Participants must meet the following criteria for entry into the program:

- Between 40 and 64 years old;
- Have an income between 134% and 250% of the federal poverty level ;
- Have not had a mammogram or pap smear test in the last year;
- Do not have health insurance or the insurance does not cover breast or cervical cancer treatment;
- Are not currently enrolled in Medicaid and are not eligible for Medicare; and,
- Are U.S. citizens or have been legal permanent residents for at least five years.

Breast and Cervical Cancer Program participants receive all Medicaid services, including reconstruction after breast cancer surgery. Services are covered throughout the duration of the client's course of treatment. Should the client have a recurrence after completing treatment and leaving the program, she can be reenrolled in the program.

17. **Why was this decision item not part of the Department of Health Care Policy and Financing caseload adjustment?**

Response: The following is a joint response from HCPF and CDPHE: The departments felt that a stand-alone decision item would be the most transparent way to bring this issue to the attention of the General Assembly. Historically, the purpose of the Department of Health Care Policy and Financing's decision items for Medical Services Premiums (R-1) and Behavioral Health Community Programs (R-2) is to make adjustments for the most recent estimates of cost and caseload for previously approved legislative and budget items.

In this instance, CDPHE is requesting a change in policy that would have the effect of increasing Medicaid caseload. While recommended by multiple external organizations, this is an optional change which would require new appropriations; the General Assembly does not have to extend Medicaid coverage to this group of young

women with cervical cancer. Therefore, the departments believed that it was most appropriate to call specific attention to this budget item via a stand-alone decision item.

18. Please provide a summary of projected cost savings if additional women ages 21 to 39 years old are screened, and the benefits of additional screenings.

Response: In Colorado, for every cervical cancer that is identified at the earliest pre-cancerous stage (CIN II) instead of at the late stage (invasive cervical cancer) there is an average BCCP Medicaid treatment cost savings of $14,081 per year [cost for treatment of Invasive Cervical Cancer ($17,471) minus cost for treatment of CIN II ($3,390)]. In addition, there is an unknown cost savings for women where disease is prevented before it gets to a precancerous condition.

According to the Centers for Disease Control and Prevention (CDC):

- "Pap tests can detect precancerous lesions so they can be treated before cervical cancer develops. Researchers in many countries found that rates of cervical cancer death dropped by 20%–60% after screening programs began."
- "Health economists generally agree that an intervention is cost effective if it can save 1 year of life for less than $50,000. Pap screening every 3 years extends life at a cost of about $5,392 per year of life saved."

In the absence of screening, modeling predicts a lifetime risk of cervical cancer in the United States of approximately 31 to 33 incident cancers per 1,000 women. In addition, these studies predict a lifetime risk of cancer associated with screening every 3 years of approximately 5 to 8 incident cancers per 1,000 women.

19. What is the source of cash funds for the treatment costs in the Department of Health Care Policy and Financing?

Response: The following response was provided by HCPF. Pursuant to Section 25.5-5-308(9)(g), C.R.S., the source of cash funds for treatment costs is the Breast and Cervical Cancer Prevention and Treatment fund. Revenue into the fund comes from two sources. Primarily, revenue is collected from a $25 surcharge on breast cancer awareness special license plates, pursuant to Section 42.3-217.5(3)(c), C.R.S. Additionally, the fund receives interest accrued by the Tobacco Litigation Settlement Trust Fund, pursuant to Section 24-22-115(1)(a), C.R.S.

R7 Lab Building Maintenance and Repair and R9 Cubical Replacement

20. Why are these requests in the operating budget and not a controlled maintenance request?

Response:

Lab Building Maintenance – At the time the State lab building was acquired in 1996, the department was appropriated a "building maintenance and repair" operating line in the amount of $271,858 to cover the costs of routine maintenance and repairs, janitorial costs, etc. As the building ages, the need for general maintenance and repairs has increased. Additionally, the cost for maintenance and repairs has increased. However the appropriation has not been increased in 17 years.

The Standard operating procedures for State owned buildings include conducting a building/facility audit every 5-7 years. In May 2015, the department contracted with RMH Group for the audit which details the condition of the building and necessary repairs. The report details numerous general maintenance and repairs required to keep the State Laboratory Building and equipment running properly. Many of these repairs cannot be made without an increase in the building maintenance and repair operating line spending authority. The requested increase is based on the findings in the audit report.

The Department does not believe that this request meets the criteria for a controlled maintenance request. Based on the following criteria the Department believes it should be an operating budget request.

A) The Office of the State Architect State Buildings Programs annual report and controlled maintenance instructions which state: Pursuant to C.R.S. 24-30-1301-Definitions :

   (4) "Controlled maintenance" means: (a) Corrective repairs or replacement, including improvements for health, life safety, and code requirements, used for existing real property; and (b) Corrective repairs or replacement, including improvements for health, life safety, and code requirements, of the fixed equipment necessary for the operation of real property, when such work is not funded in a state agency's or state institution of higher education's operating budget.

   (7) (a) Controlled maintenance funds may not be used for: (b) Minor maintenance items shall not be accumulated to create a controlled maintenance project, nor shall minor maintenance work be accomplished as a part of a controlled maintenance project unless the work is directly related to the project and:

B) Senate Joint Resolution 14-039 which states:
   45. Classification of a Budget Request (a) COMMENCING WITH BUDGET REQUESTS FOR THE 2015-16 STATE FISCAL YEAR AND EACH STATE FISCAL YEAR THEREAFTER, IN ORDER TO FACILITATE THE INITIAL REVIEW OF BUDGET REQUESTS, THE FOLLOWING RULES APPLY: (1) Operating budget requests reviewed by the joint budget committee. THE

OPERATING BUDGET GENERALLY INCLUDES ROUTINE EXPENSES RELATED TO DAY-TO-DAY OPERATIONS, INCLUDING ITEMS THAT REQUIRE ONGOING FUNDING LEVELS FROM YEAR TO YEAR SUCH AS PERSONNEL, UTILITIES, AND PROGRAM EXPENSES. OPERATING BUDGET REQUESTS ARE REVIEWED AND PRIORITIZED BY THE JOINT BUDGET COMMITTEE AND INCLUDE THE FOLLOWING: (A) THE OPERATING BUDGET INCLUDES BUILDING AND EQUIPMENT REPAIR AND RENOVATION ASSOCIATED WITH ROUTINE MAINTENANCE OF EXISTING ASSETS AND FOR CONSTRUCTION PROJECTS OF LIMITED SCOPE, IF SUCH REPAIR, RENOVATION, OR CONSTRUCTION FALLS WITHIN THE DEFINITION OF CAPITAL OUTLAY AS DEFINED IN SECTION 24-75-112 (1), COLORADO REVISED STATUTES.

The requested funding will be used for “routine repairs, which are excluded from the definition of controlled maintenance as sighted above.

The building audit also outlined that the lab building is in need of a new roof. The Department submitted a controlled maintenance request for the new roof since it fits the criteria for a controlled maintenance request.

Cubical Replacement – The Department’s request is to replace 665 outdated cubes. The replacement is requested to be staggered over an eight year period at a cost of $371,818 per year. Staggering the replacements is necessary due to the level of effort in planning and execution necessary to complete the project. The department is requesting to increase the existing operating budget to cover this expense.

This request does not meet the criteria for a controlled maintenance request and should be an operating request based upon:

A) The Office of the State Architect State Buildings Programs annual report and controlled maintenance instructions which state: Pursuant to C.R.S. 24-30-1301-Definitions :

(4) “Controlled maintenance” means: (a) Corrective repairs or replacement, including improvements for health, life safety, and code requirements, used for existing real property; and (b) Corrective repairs or replacement, including improvements for health, life safety, and code requirements, of the fixed equipment necessary for the operation of real property, when such work is not funded in a state agency's or state institution of higher education's operating budget.

21. Are the repairs to the State Lab building and the cubicle replacements on the State Architect's list? If so, at what level? If not, why not?

Response: The department did not include these requests as part of its controlled maintenance request because the items were "routine" in nature. See previous response for more detail.

R8 Leave Payouts Increase

22. Why does the Department have a line item specific to Leave Payouts and how is this different from how other departments fund leave payouts?

Response: Under State Personnel Rules, the Department is required to pay retiring and terminating employees for unused accrued leave. However, federal regulations do not allow leave payouts to be paid directly out of federal grants. CFR-200, Cost Principles of State, Local, and Indian Tribal Governments, establishes principles and standards for determining costs for federal awards carried out through grants, cost reimbursement contracts, and other agreements with governmental units including state governments. The regulation states that, "Payments for unused leave when an employee retires or terminates employment are allowable in the years of payment provided they are allocated as a general administrative expense to all activities of the governmental unit or component (i.e., indirect)".

Because the indirect cost assessment methodology is the allowable methodology for federal participation regarding leave payouts, the Department includes the full Leave Payouts line item appropriation of $481,145 in the Department's indirect cost recovery rate plan. The indirect cost pool is then used to cover all sick and annual leave payouts from all fund sources: General Fund, Cash Funds, Reappropriated Funds and Federal funds. In this way, leave payout obligations are treated consistently and equitably across all fund sources without the need for one fund source such as General fund or Cash Funds to subsidize another I.E. Federal Funds. If leave payouts are not funded through indirect cost recoveries, then General fund and Cash funds pay for leave payouts of federally funded employees.

RM1 Health survey Data Collection

23. Please provide a link and/or a copy of reports produced pursuant to the requirements of S.B. 13-283 (Amendment 64 Consensus Recommendations).

Response: Findings and Recommendations: Monitoring Health Concerns Related to Marijuana 2014:

https://drive.google.com/a/state.co.us/folderview?id=0BxqXhstk92DbfnNfSURHd0VFZjEtRFpsVEg3bjM5QUJXOEd0VWZDOUNjSnpWWEFvTVdiUFU&usp=sharing#

https://www.colorado.gov/pacific/cdphe/retail-marijuana-public-health-advisory-committee.

Marijuana Infographic:
http://www.chd.dphe.state.co.us/MJ/2014-Adult-Marijuana-Use-In-Colorado.html

24. Please discuss, if there is not statutory change to collect data on a regional level, how the Department's request for funds will change.

Response: In order to examine patterns of marijuana use broken down by county and race/ethnicity as currently required by Senate Bill 13-283, CDPHE must employ sampling strategies and weighting techniques that will produce a large enough sample size to support the statistical analysis of marijuana use patterns at the county level.

The minimum sample size to receive weighted, representative county-level data is 500 people per county. CDPHE estimates that it would cost approximately $1.6 million to obtain county level estimates. This cost estimate is based on the cost of each completed survey ($50) x 500 x 64 counties.

Not only is it cost-prohibitive to recruit a large, representative sample from every county in the state, it is also not likely that a sample of 500 people could be recruited from rural and frontier Colorado counties.

CDPHE would like to propose a technical amendment to C.R.S. 25-1.5-111 to change the requirement of collecting “county level” data to “region level” to align with best practice and the department’s collection of data by health statistics regions.

10:30-10:45 General Department and Program Specific Questions

25. Please provide an update on the Air Pollution Control Division's work to reduce the backlog of permit and renewal applications. Please include a five year history of the number of applications, permits, renewals, and the size of the backlog.

Response:

Title V Permits Update

The division received new FTE during the 2015 legislative session through a decision item to address the backlog and staffing constraints in Title V permitting. Since approval of the decision item, the division has hired the new permitting staff. The 6 permit engineers whose main task will be to draft and issue Title V permits in order to reduce the backlog started in November 2015. The 2 new technicians who review applications for completeness when they are received started in October and November 2015.

Given the complexity of Title V permitting, the new staff will require a significant amount of training to fully understand and perform their job functions. The training process for the new staff has already begun with a focus on simpler tasks. The new staff will continue to develop over the remainder of the fiscal year and will start taking on more complex work, including the backlogged Title V permit applications with the focus on the most overdue applications.

Additionally, the Title V program is implementing process improvement projects to increase the efficiency of Title V permitting to further reduce the permit backlog.

Five-year history of the number of applications, permits, renewals and the backlog:

Year	Total Title V Permits[1]	Applications Received			Permits Issued			Backlog[3]		
		Initial	Renewal	All Mods[2]	Initial	Renewal	All Mods[2]	Initial	Renewal	All Mods[2]
2010	237	13	16	49	1	16	28	31	41	N/A
2011	238	4	20	50	2	11	23	41	45	N/A
2012	248	15	23	41	6	16	60	45	59	N/A
2013	238	3	16	43	4	21	22	42	56	N/A
2014	239	7	19	48	1	14	24	58	71	140
2015 (as of 11/18)	240	5	4	41	0	8	22	62	75	164

[1] Data reflects issued permits plus permits applied for (as a point of reference, there were 200 total Title V permits in 2007).
[2] All Modifications include Administrative, Significant, and Minor modifications plus Reopened permits.
[3] Number of pending applications that are overdue (have not been issued within the required time period). Data for backlog of modifications is not available prior to 2014.

Oil and Gas Permitting Update

Oil and gas permitting has also been a continuing area of interest and the Division is providing the latest figures demonstrating progress on permitting of the industry.

Metric	Initial Data (circa 2011)	Current Data (as of Oct. 2015)
Total oil and gas permitting workload (e.g., permit applications in process)	1,991	750
Permit applications waiting to be assigned and processed by an engineer	1,396	15
Permits awaiting supervisor review	282	8
Median No. of Days To Process Applications (rolling twelve month figure)	381	159

Furthermore, the Division continues to identify and implement process improvement strategies to further expedite high quality permits for the oil and gas industry.

26. Please discuss the following questions related to the Emission Technical Center located in Aurora:

a. The FY 2015-16, and projected FY 2016-17, cost of operating the Emission Technical Center, the fund source used to pay for the Center, and what line item funds the Emission Technical Center;

Response: The total annualized costs of running all of the state mobile source program operations in the Aurora facility are about $950,000. The costs are expected to remain the same in FY 2016-17. The activities are funded out of the Personal Service, Operating and the Diesel Inspection/Maintenance lines in the Mobile Sources section of the Air Pollution Control Division in the Long Bill.

b. The cost of the equipment purchased for the Center, the fund source used to pay for the equipment, and how that expenditure was authorized;

Response: No major (over $5,000) equipment purchases have been made for the Aurora Tech Center in recent years. All state purchases for the Center have been made out of the existing Long Bill operating appropriation for the Mobile Sources program. The contractor for the state's vehicle inspection and maintenance program has agreed to replace emissions equipment at the Lab at no cost to the State.

c. The Department's plan for the long-term operation of the Center and how the ongoing maintenance and support costs of the Center will be paid for.

Response: All planned ongoing expenditures will be paid for by the existing Long Bill appropriation to the Mobile Sources program. The Department has no plans to request an increase in funding for the Aurora Tech Center.

27. Please provide an update on the Infrared Camera Program.

Response: The Colorado Air Pollution Control Division is successfully implementing its Infrared Camera Program (Program). The Program has hired all of its inspectors and the inspectors have completed their training. Furthermore, the Program is aiming to complete up to 2,000 infrared camera inspections this year. Inspections are conducted throughout Colorado with a focus on areas where oil and gas development is concentrated, particularly the North Front Range ozone non-attainment area. Lastly, in February 2014 Colorado became the first state to directly regulate methane emissions (including leaks) from oil and gas operations. The regulation requires oil and gas companies to use instruments (including infrared cameras) to detect and fix leaks. The Program has the permanent resources needed to ensure the effective oversight of these new emission reduction requirements.

28. Please provide an update of the data analysis of data collected through the Front Range Air Pollution and Photochemistry Experiment (FRAPPE).

Response: An RFP has been developed and is currently under final review. The goal is to get the RFP out to bid in the next few weeks, with a contractor being selected by the end of December.

29. Please provide an update on the Necessary Document Assistance Program, and the expenditure of the $300,000 General Fund appropriated for this purpose

Response: The department explored a variety of options to award the $300,000 while meeting State Procurement Rules. The department issued a Request for Proposal (RFP.) Subsequent to the evaluation process the contract was awarded to Metro Caring. It is estimated the contract will be executed and effective December 4, 2015. Based upon the vendor's scope of work, the department estimates the fiscal year expense to be $290,000.

30. Please discuss the jurisdictional issues the Department must navigate when engaging in public health issues. Please explain why additional statutory authority is needed for the Department to intervene on certain public health issues, specifically the reported side effects of the sounds emitted by wind turbines.

Response: The Department and local public health agencies share many concurrent powers and duties in performing their public health responsibilities. For example, both state and local public health agencies are statutorily tasked with investigating and controlling the causes of epidemic and communicable disease affecting the public health. The Department works collaboratively with local health agency partners in performing this work. See Sections 25-1-506(3)(b)(V) and 25-1.5-102(1)(a)(I), C.R.S. With respect to potential issues related to wind turbines, preliminary analysis of the scientific literature on potential wind turbine health effects suggests the primary concern is noise annoyance leading to sleep disturbances and headaches in some individuals. Other potential health effects, such as nausea, are less supported in the literature.

With a lack of scientific evidence demonstrating that turbines are causing anything more than noise annoyance, the authority that could potentially be used to remedy such concerns is nuisance law. The Department's authority regarding nuisance law is limited to "to abate nuisances when necessary for the purpose of eliminating sources of epidemic and communicable diseases affecting the public health…." See Section 25-1.5-102(1)(d), C.R.S. As the Department's authority in the nuisance realm is limited to eliminating sources of epidemic and communicable diseases, and there is a lack of scientific evidence demonstrating epidemic or communicable diseases associated with the use of wind turbines, the Department does not have jurisdiction to regulate or take action regarding this issue.

10:45-11:00 BREAK

11:00-11:20 Electronic Cigarettes

31. Please discuss where nicotine comes from.

Response: Nicotine is a nitrogen-containing chemical - an alkaloid, found in tobacco plant leaves, occurring in a range of 0.5 to 7.5% of the plant, depending on variety. It is also found in lesser amounts in other plants in the nightshade family, and serves as an anti-herbivore. Two plants in particular are the source for most nicotine on the market - the Nicotinia tobacum and Nicotina rustica plants.[1]

Nicotine is the major chemical component responsible for addiction in tobacco products (USDHHS 1988). On its own, separated from tobacco, it is highly toxic. According to the American Academy of Pediatrics (AAP), as little as half a teaspoon of liquid nicotine can be fatal if ingested by an average sized toddler. In 2014, there were more than 3,000 calls to U.S. poison control centers for liquid nicotine exposure, and one toddler died.[2]
Nicotine in e-cigarettes comes from tobacco plants. There are synthetic nicotines but their health impacts are unknown and are primarily used in insecticides. One related compound, neonicotinoids, has been linked to the decline of honey bee populations across the world.

Nicotine is highly addictive and has adverse effects on health across the full life course - extending from gestation through adulthood.[3] There is sufficient evidence to infer that:

- Nicotine adversely affects maternal and fetal health during pregnancy, contributing to multiple adverse outcomes such as preterm delivery and stillbirth, and having lasting adverse consequences for fetal brain development;
- Nicotine activates multiple biological pathways which increases the risk for smoking related diseases and at high-enough doses nicotine can lead to acute toxicity; and
- The evidence is suggestive that nicotine exposure during adolescence, a critical window for brain development, may have lasting adverse consequences for brain development.

Although nicotine only accounts for about 5% of the tobacco leaves by weight, it is this portion that is used by the electronic smoking industry to make e-liquids for

[1] Richtel, Matt. "Selling a Poison by the Barrel: Liquid Nicotine for E-Cigarettes" in New York Times, March 23, 2014. accessed from: http://www.nytimes.com/2014/03/24/business/selling-a-poison-by-the-barrel-liquid-nicotine-for-e-cigarettes.html?_r=0 on November 20, 2015.
[2] For more information - see here: https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Tobacco-and-E-Cigarettes.aspx#sthash.UMIHqb22.dpuf
[3] From: http://www.surgeongeneral.gov/library/reports/50-years-of-progress/ sgr50-chap-5.pdf

vaporisers and e-cigs.4 Electronic cigarettes, also referred to as electronic nicotine delivery systems (ENDS), or e-cigarettes, are an emerging challenge for public health. They turn chemicals, including nicotine, into an aerosol that is inhaled by the user in order to deliver nicotine to the user. There is no evidence to date that ENDS are a safe and proven way to quit smoking or a safe alternative to smoking tobacco leaves. Because the nicotine and other ingredients are vaporised and inhaled, their impacts on the body are still unknown. The evidence is strong and consistent that nicotine replacement therapies (NRT) such as patches and gum, are proven as safer, pharmacologically regulated treatments for smoking cessation that can help people quit smoking and are significantly safer as compared with tobacco products. (USDHHS 2000). The US Preventive Services Task Force recommends pharmacotherapy interventions, including NRT, based on substantial evidence that the use of these therapies—with or without behavioral counseling interventions—substantially improves achievement of tobacco cessation in non-pregnant adults who smoke.[5]

32. Please explain the history of nicotine regulation. Has nicotine ever been classified as a controlled substance? If so, when? If not, why not?

Response: The Controlled Substances Act of 1970 specifically excludes distilled spirits, wine, malt beverages, or tobacco, from the definition of "controlled substance".

Regulating tobacco and nicotine separately is part of a relatively recent development. Until the arrival of e-cigarettes, refined nicotine was available only as a pesticide or as a pharmaceutical grade product marketed for smoking cessation. In 2012, the Minnesota Department of Revenue issued a notice that the nicotine in electronic cigarettes is presumed to be derived from tobacco and therefore subject to the state's tobacco excise tax, unless documentation, at the taxpayers' expense, can be provided otherwise. To date, no documentation has been provided.[6]

The U.S. Food and Drug Administration (FDA) classifies and regulates smoking cessation products and cigarettes differently. Under the current FDA regulatory framework, a product containing nicotine may be regulated as either a drug or a tobacco product, depending on the product's intended use. This is because a product's intended use, rather than its formulation, determines whether it is a drug, even when the product is introduced into, or has some chemical effect upon, the body. The intended use of a product typically is determined by its labeling and any

[4] E-Cigs: Blessing for the Tobacco Industry?" from Vaporizing Times. Accessed: Nov 20, 2015 from https://vaporizingtimes.com/tag/where-does-nicotine-come-from/

[5] *Final Recommendation Statement: Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions*. U.S. Preventive Services Task Force. October 2015.

[6] Minnesota Department of Revenue, 2015.

other promotional claims. Because nicotine replacement therapies such as gums and nicotine replacement therapy patches are promoted as smoking cessation aids and are intended to treat nicotine dependence, they are regulated as drugs. Cigarettes are marketed without such therapeutic claims and thus are regulated as a recreational product.

In 1996, the FDA attempted to regulate tobacco products under its existing drug and device authorities; however, this action was successfully challenged in the courts by the tobacco industry in 2000. When the FDA attempted to regulate e-cigarettes under this same drug and device authority, the courts found that unless marketed for a therapeutic purpose, refined nicotine is to be regulated as a tobacco product.
The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) was signed into law June 22, 2009, and gives FDA broad authority to regulate the manufacture, distribution, and marketing of tobacco products. On April 25, 2014, the FDA issued a Notice of Proposed Rulemaking outlining the agency's plans to begin regulating all tobacco products. More than 81,000 public comments were submitted to the docket. On October 19, 2015, FDA submitted to the Office of Budget and Management for final approval a rule to make electronic cigarettes, dissolvables and other products containing nicotine within the regulations of the Tobacco Control Act. A public announcement of the rule is expected between January 17 and February 18, 2016.

The American Academy of Pediatrics (AAP) has released a policy statement recommending raising the legal age to purchase tobacco to 21 across the United States. Currently only one state—Hawaii—and about 90 cities in several other states have increased the minimum age to purchase tobacco products to 21. The statement is one of several recommendations aimed at tightening regulations on cigarettes, e-cigarettes, tobacco and nicotine products to reduce youth smoking and nicotine addiction.
In another statement AAP calls for the U.S. Food and Drug Administration to regulate e-cigarettes the same way it regulates other tobacco products. This includes age restrictions, taxes, bans on advertising to youth, and bans on flavored products that are particularly attractive to youth. The AAP also recommends smoke-free laws that already govern secondhand smoke be expanded to include e-cigarettes. AAP has included evidence in the statement to show that use of e-cigarettes among teens is associated with a higher likelihood of using regular tobacco products and lower rates of cessation

11:20-11:40 Clean Water Treatment

33. Please provide the expenditure and revenue data for each Sector. How are the Sectors defined and is there consensus on these definitions? If not, where is there disagreement?

Response: Please see the attached document for expenditure and revenue data for each sector.

Definitions of each sector per the statute:

- The commerce and industry sector includes annual fee schedules for regulated activities associated with mining, hydrocarbon refining, sugar processing, industrial storm water, utilities not included in the private and public utilities sector, manufacturing activities, commercial activities, and all other industrial activities. There is general consensus by stakeholders regarding this definition.
- The construction sector includes annual fee schedules for regulated activities associated with construction activities. There is general consensus by stakeholders regarding this definition.
- The pesticide sector includes annual fee schedules for regulated activities associated with pesticide applications that are regulated under the federal act as follows: For a general permit, decision makers with pesticide application on or over waters of the state that are subject to annual reporting requirements under the pesticide general permit, an annual fee of two hundred seventy-five dollars. There is general consensus by stakeholders regarding this definition.
- The public and private utilities sector includes annual fee schedules for regulated activities associated with the operation of domestic wastewater treatment works, water treatment facilities, reclaimed water systems, municipal separate storm sewer systems (MS4), and industrial operations that discharge to a domestic wastewater treatment works. There is consensus by stakeholders regarding this definition; however, stakeholders disagree whether MS4 should be defined within the public and private utility sector or tracked as a separate category specific to MS4.
- The water quality (401) certifications includes the following:
    - Tier 1 projects are projects that incur minimal costs and minimal water quality impacts. Tier 1 includes certifications of channel stabilization projects and single drainage improvement projects. There is general consensus by stakeholders regarding this definition.
    - Tier 2 projects are projects that incur moderate costs and potential water quality impacts. Tier 2 includes certifications of projects that affect multiple drainages. There is general consensus by stakeholders regarding this definition.
    - Tier 3 projects are projects that involve a large watershed area, a high degree of complexity, or high potential for water quality impacts. Tier 3 includes certification of federal energy regulatory commission relicensing projects or projects involving more long-term water quality impacts. There is general consensus by stakeholders regarding this definition.
    - Tier 4 projects are projects that involve multiple or large watershed areas, a very high degree of complexity, very high potential for water quality impacts, or a high level of public participation. Tier 4 includes trans-mountain water supply projects. There is general consensus by stakeholders regarding this definition.

34. Does CORE allow for the collection and reporting of data the request for information asked for? If not, why not?

Response: Yes, CORE does allow for the collection and reporting of this data; however, there is a significant delay (currently a three month delay) for the state closing the books for period 1 (July) for the current fiscal year. Once the books are closed and this information becomes available, CDPHE will provide the information as requested.

35. Why does the fine revenue from water quality violations go into the Water Quality Improvement Fund? Does this create an incentive for the regulators to fine permittees? How does this practice compare with how other state programs handle fine revenue?

Response: Fine revenue collected under the Water Quality Control Act (C.R.S. §25-8-101 et seq.) goes directly into the water quality improvement fund because it is required by statute in C.R.S. §25-8-608. Except for the 5% allowed for administering the grants, the Department is statutorily prohibited from using the money collected in the fund for any direct benefit (i.e. for operations and maintenance expenses); therefore, there is no financial incentive for regulators to impose fines. The water quality improvement fund statute establishes the following purposes for which grants from the fund can be awarded:

- Storm water Management and Best Practices Training,
- Projects that improve water quality in the community or water body which has been impacted by a water quality violation,
- Projects that plan, design, construct or repair storm water projects and wastewater facilities identified on the current fiscal year Water Pollution Control Revolving Fund Intended Use Plan, and
- The non-federal match funding for the current fiscal year's nonpoint source projects as approved by the Water Quality Control Commission.

In terms of fines imposed by other CDPHE controlled programs, the fines collected by the Air Pollution Control Division and Hazardous Material and Waste Management Division for violations of their program requirements are credited to the General Fund.

11:40-12:00 CASH FUNDS

36. Are the waste tire funds building up excess reserves because there is no longer an issue with waste tires? If so, should the fee be lowered? If not, please discuss the Department's plan for how to spend down the reserves.

Response: Waste tires are still an issue in Colorado. Approximately 60 million waste tires exist throughout the state with approximately 6 million additional waste tires being disposed of each year. The Division increased the rebate offered to waste tire

processors and end users from $40/ton to $80/ton effective January 1, 2016 in an effort to increase the processing of waste tires while spending down the fund balance. This is the maximum allowed by statute. The Division will assess the balance of the waste tire funds in early 2016 to determine if the $1.50 fee per tire should be reduced.

37. Please discuss the Recycling Resources Economic Opportunity Program including:

Response: Colorado's recycling rate has consistently lagged behind the national average. To advance opportunities for recycling, the Recycling Resources Economic Opportunity Act (RREO) of 2007 established a grant program within the department to help create and expand existing recycling programs. The Act also established a recycling rebate program to reward those Colorado businesses and organizations who are actively collecting materials for recycling. These funds promote economic development through the productive management of recyclable materials that would otherwise be treated as discards.

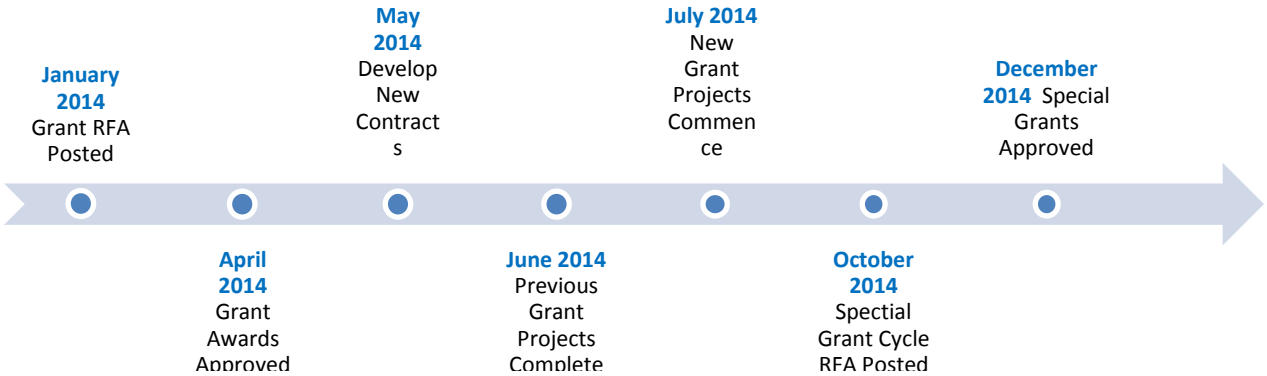
Funding for the RREO program comes from a tipping fee at state landfills. For every cubic yard of waste disposed at landfills within Colorado, the Fund received a portion of the tipping fee. With the passage of SB13-50, this fee was increased incrementally over a three-year period from $0.07 to $0.14 per cubic yard.

TABLE 1: RREO Sources of Funding

	Rate Per Cubic Yard of Solid Waste Disposed
July 2011 – Dec 2013	$0.07
Jan 2014 – Dec 2014	$0.09
Jan 2015 – Dec 2015	$0.11
Jan 2016 – Dec 2016	$0.14

a. The calendar year timeline for grant application and grant awards;

Response: The chart below depicts the timeline for the grant application and grant awards in CY2014. Note that the grant cycle crosses over calendar years.



b. The number of grant applications and dollar amount received in FY 2014-15;
c. The number of grants issued and the dollar amount in FY 2014-15; and

Recurring Grant Cycle:

For the FY 2014-15 recurring grant cycle, 32 eligible applications requesting a total of $4.5 million were received. The department's revenue projection for the FY15 cycle was made in April 2014. The projection indicated lower revenues than spending authority. Therefore, only ten projects were approved for a total of $1.34 million. Two of the awarded projects were not completed and approximately $230,000 remained unspent.

TABLE 2: FY15 Approved Grants

#	Name of Applicant	Project Title	Geographic Location	Amount Awarded	Amount Expended	Amount Remaining
1	Discover Goodwill of Southern and Western Colorado	Retail Support Center Recycling Expansion	Southern half of Colorado, Utah to Kansas	$279,000	$275,542	$3,458
2	City of Fort Collins	Integrated Recycling Facility (IRF)	Fort Collins	$68,000	$0	$68,000
3	City of Pueblo	Pueblo Waste and Recycling Ordinance	City of Pueblo	$162,586	$0	$162,586
4	Clear Intentions	Clear Intentions Hub-and-Spoke Glass Recycling	Wheat Ridge, Front Range	$250,000	$250,000	$0
5	Twin Enviro Services	Twin Enviro Recycling Expansion in Fremont County	Fremont County	$231,006	$231,006	$0
6	Lake County	Lake County Recycling Initiative	Lake County	$165,498	$165,498	$0
7	Clean Valley Recycling	Clean Valley Recycling Expansion Project	Otero, Bent, Kiowa, Prowers Counties	$29,790	$29,749	$41
8	Terra Firma Recycling	Recycling and Waste Diversion in Las Animas County	Las Animas County	$99,333	$99,333	$0
9	Southwest Colorado Council of Governments	Southwest Colorado Waste Study	Cities and Counties in the Four Corners Region	$46,245	$46,199	$46
10	**Yuma County**	**Storage for Electronic Recycling**	**Yuma County**	**$5,640**	**$5,491**	**$149**
			Total:	$1,337,098	$1,102,818	$234,280

Special Grant Opportunities:

A one-time grant opportunity was created to allocate the $1.5 million in revenue awarded to the RREO Fund by the Joint Budget Committee. This solicitation funded projects that would create or expand an end-use manufacturing process that used recycled materials as a feedstock. A Request for Applications was released in

October 2014 and the department received six applications requesting over $2.3 million. The department awarded funding to three projects in the amount of $1.3 million in December 2014. One of the grantees was able to fulfill the intent of their project at a considerably lower cost and approximately $73,000 was left unspent.

In addition to these projects, in response to an identified need for additional regional planning and collaboration, the department prepared a second special grant opportunity specifically to fund the development of regional waste diversion studies in late CY 2014. This opportunity would have spent down the remainder of the $1.5 million. Unfortunately, delays in the procurement process forced the solicitation into FY16. The process is now nearly complete and an additional three projects will be funded through this process in FY 2015-16.

TABLE 3: FY15 Material End-Use Development Grants

#	Name of Applicant	Project Title	Geographic Location	Award Amount	Amount Expended	Amount Remaining
1	Earth Enterprises Inc. (DBA Waste-Not Recycling)	Disruptive Innovative Technology: Waste to Product in Colorado	Larimer County	$933,209	$933,209	$0
2	Recycle Projects	Food-Grade Plastics Sorting Facility	Denver	$209,000	$209,000	$0
3	Spring Back Colorado	Building Capacity to Recycle Mattress Byproducts	Denver	$192,495	$119,258	$73,237
			Total:	$1,334,704	$1,264,467	$73,237

d. An explanation for the Recycling Resources Economic Opportunity Fund's projected excess uncommitted reserve.

Response: There were several independent factors that collectively resulted in a high excess uncommitted reserve figure. These factors included:

- Actual revenue collected from tipping fees in FY 15 greatly exceeded revenue projections;
- Actual grant expenditures were lower than the amount awarded; and
- The regional recycling study grant awards were delayed until FY16.

The need for improving Colorado's recycling and waste diversion infrastructure remains high as demonstrated through the large number of funding requests for grant opportunities. The last several fiscal years have shown there is an average unmet need of more than $4 million per year. In January 2016, the solid waste tipping fee will increase to the maximum $0.14 per cubic yard, as directed in statute by SB13-50.

38. Please discuss what has occurred to cause the projected shift in the Newborn Screening and Genetics Counseling Cash Fund balance. Was a capital outlay expenditure made from the Fund? If so, when was the expenditure, how much was the expenditure for, and how does this recent expenditure compare to prior capital outlay expenditures?

Response: The Newborn Screening and Genetics Counseling Cash Fund (NBSF) fund balance has shifted from an excess fund balance to a projected negative fund balance primarily because of the loss of the toxicology function and the revenue it generated. In 2014, when the toxicology lab was eliminated, cash fund revenue at the Laboratory was reduced by approximately $1 million. As a result, the NBSF has assumed a larger portion of the administrative and overhead costs at the Laboratory resulting in a larger than anticipated negative cash position. Additionally, increases in contract services, an additional day of specimen collection and testing, laboratory supplies resulted in expenditure increases in FY 2014-15 and not a capital outlay expenditure.

A full review of Laboratory expenditures as well as fees charged by the lab will be conducted in FY 2015-16. This review will determine what expenditure changes and/or fee increases will be necessary for both the Newborn Screening Fund and Laboratory Fund to ensure the viability of both funds.

39. Please provide the number of medical marijuana registry card holders over the past three years.

Response:

- September 2012 - 107,666 patients
- September 2013 - 112,862 patients
- September 2014 - 116,287 patients
- September 2015 - 114,767 patients

40. What is the balance of the Health Research Subaccount of the Medical Marijuana Program Cash Fund?

Response: The $9 million in grant funding authorized by the state legislature was approved by the Board of Health in February 2015 to be awarded to nine grantees over a period of three years. Contracts for six of the nine projects have been executed as of October 1, 2015. These six contracts are all written as one-year contracts with one-year budgets; they will need to be renewed for years two and three. The six contracts have different start dates, ranging from April 10, 2015 to October 1, 2015.

- The total amount of the year 1 budgets for these six contracts is: $1,645,149.
- The total amount of the 3 year budgets for these six contracts is: $4,935,447.

The remaining three studies are clinical trials, which require review and approval by several federal agencies (FDA, NIDA, DEA), which was not required of the six observational studies that currently have contracts in place. Once approved, these studies will fully utilize the remaining budget amount of $4,064,553. At this time,

CDPHE anticipates that the full $10 million ($9 million in grant funding and $1 million in administration) will be spent at the end of the 5-year research project period.

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. **Provide a list of any legislation that the Department has: (a) not implemented or (b) partially implemented. Explain why the Department has not implemented or has only partially implemented the legislation on this list.**

   Response: Section 25-1.5-111, C.R.S – CDPHE is currently collecting region level data, not county level data.

   HB 15-1015 - REPLICA: Not implemented. Implementation of this bill will occur after 10 states have agreed to join the compact. As of 11/17/2015 there are two states that have joined, Colorado and Texas. There are potentially ten more states proposing the passage of REPLICA bills in their upcoming sessions.

   HB 15-1242 - Designated Caregiver: This bill requires hospitals to have patients/families designate a caregiver for the patient upon discharge. The bill specifically states that the bill does not affect a license issued to a hospital, essentially eliminating any enforcement opportunities of the division. Therefore, the Health Facilities and Emergency Medical Services Division opted not to request that the Board of Health implement rules. The division will continue to monitor complaints received from consumers, to date none have been received. Consumer guidance regarding the hospital's requirements as defined in this legislation has been drafted and will be posted on the website by the end of November 2015.

   HB 15-1283 - Marijuana Reference Library: This bill requires CDPHE to be responsible for proficiency testing and to establish a reference library of marijuana testing methodologies by December 31, 2015. The Program is working to implement this legislation, but will not be able to fulfill the requirements by December 2015. The program is working diligently to meet with the statutory mandate and will comply as soon as possible.

2. **Please provide a detailed description of all program hotlines administered by the Department, including:**
   a. **The purpose of the hotline;**
   b. **Number of FTE allocated to the hotline;**
   c. **The line item through which the hotline is funded; and**
   d. **All outcome data used to determine the effectiveness of the hotline.**

   Response:

   Air Pollution Control Division

Smoking Vehicle Hotline

The Smoking Vehicle Hotline exists to receive reports about smoking vehicles from citizens. A recorded message is transcribed and the response process is automated from that point. In response to complaints, the department mails out 250 to 500 advisory letters to the owners of smoking vehicles each month. The letters advise the motorist of the applicable laws, possible vehicle repair issues and the availability of Department-run Emissions Technical Centers that can assist with free diagnostics.

There are approximately 0.2 FTE spread over several positions. The line item name is (4) air Pollution Control Division, Mobile Sources, Personal Services. The Department's Emissions Technical Centers track vehicle evaluations performed, as well as phone inquiries made in response to the receipt of smoking vehicle hotline letters. Typically, the Tech centers evaluate 15-20 smoking vehicles and field 25-45 phone inquiries on smoking vehicle letters each month. Additionally, the contractor-run emission test centers will conduct a heightened level of review of any vehicle that was previously reported as a smoking vehicle.

Hazardous Materials and Waste Management division

Customer Technical Assistance

The purpose of the Customer Technical Assistance (CTA) phone line is to provide callers comprehensive technical, regulatory, and compliance assistance help on any question they may have about any of the Division's programs. The number of FTE assigned to the CTA phone line is 0.35 FTE. Each program within the Division supports the cost of the phone line. The Division tracks the total number of calls, the subject matter of the calls, the disposition of the calls (referral to another division, referral to a local government, or answer within the Division and the response time for each call.

Disease Control and environmental Epidemiology Division

Oil and Gas Health Information and Response Line

The purpose of this program is to centralize the response for all citizen health concerns related to oil and gas development and production activities in Colorado. Callers to the hotline are able to speak directly to a health professional knowledgeable about oil and gas related exposures and potential health concerns. Program staff coordinate a response for the caller including working with other state agencies, oil and gas operators, and community health professionals to evaluate the concern and determine appropriate steps to help resolve the issue. The hotline does not provide individual medical recommendations. Only a healthcare provider can make individual health recommendations. The centralized response allows CDPHE to collect standardized health and location information to facilitate aggregate analysis of health concerns and exposures related to oil and gas activities. 3.0 FTE are allocated to the program. The line item name is (8) Disease Control and Environmental Epidemiology Division, Environmental Epidemiology, Oil and Gas Health Activities. The program tracks the total number of health concerns reported, number of concerns resolved, average length of time to close concerns, and

customer/stakeholder surveys to determine satisfaction with responsiveness, process, and outcome.

Health Facilities and Emergency Medical Services Division

Poison Control Center

This hotline is provided through a Contract with the Rocky Mountain Poison and Drug Center (RMPDC). The RMPDC agrees to provide 24/7 hotline response to poisoning incidents.

The contract is $1,535,140 in General Fund. There are no FTE. Based on the RMPDC quarterly report dated 11/15/2015 the state funding via this contract covers approximately 33% of the overall costs of the service. This contract is funded through the (10) Health Facilities and Emergency Medical Services, (C) Emergency Medical Services, Poison Control line.

Health Facility Complaints

The division operates a hotline where consumers, families, advocates, etc can call to file a complaint regarding a health facility and the care received at those facilities. The hotline is staffed by two FTE that perform the intake on the complaints and assign the complaint to the appropriate staff for investigation and resolution. The hotline is funded from three lines – All lines are in the (10) Health Facilities and Emergency Medical Services Division, (B) Health Facilities Programs, Nursing Facility Survey, Home and Community Survey, and Medicaid/Medicare Certification Program. The program tracks the number of calls and the number of complaint surveys generated from the complaints received.

Office of Emergency Preparedness and Response

Emergency Hotline

The purpose of this hotline is to answer questions pertaining to large scale emergencies.

There are three staff associated with this line, but less than 1.0 FTE. This hotline is funded through the (11) Office of Emergency Preparedness and Response, Emergency Preparedness and Response Program. The Program tracks the number of calls it receives.

Spill Line

The purpose of this hotline is to report environmental and public health incidents. There is 1.0 FTE associated with this line. This hotline is funded through the (11) Office of Emergency Preparedness and The Response, Emergency Preparedness and Response Program. The program tracks the number of incidents reported and the number of calls received.

CO-Help Line (Contracted)

The purpose of this hotline is to provide a Help Line to:

- Develop a standardized and prepared response to public health events,

- Provide consistent, accurate, up-to-date information,
- Collect and maintain structured data to better characterize events and responses, and
- Develop capability and capacity to adapt to other public health emergencies.
- The Medical Marijuana Registry (MMR) also uses the services of COHELP to provide basic registry information to patients, applicants, physicians, caregivers and other stakeholders who are seeking information about the registry.

This is a contract with Denver Health and Hospital Authority: Rocky Mountain Poison and Drug Center in the amount of $246,633. $80,000 of this funding comes from the Medical Marijuana Cash Fund. There are no state FTE associated with this hotline. The program monitors expenditures and the number of calls received.

3. Describe the Department's experience with the implementation of the new CORE accounting system.

a. How has the implementation improved business processes in the Department?

Response: The Department is continuing to work on completing full implementation of the CORE modules. In this first year of the statewide transition to CORE, there has been a steep learning curve for all agencies. Now that the second annual cycle in CORE is beginning, there will be more opportunities to identify and implement business process improvements.

b. What challenges has the Department experienced since implementation and how have they been resolved (i.e. training, processes, reports, payroll)?

Response: In the first year of implementation, two of the main challenges have been posting payroll and gathering proper financial data to submit Federal Financial Reports (FFRs). The State has been working closely with the Department of Personnel and Administration (DPA), the Office of Information Technology (OIT) and the contract vender to resolve issues with payroll. It is our belief the FY2015-16 payrolls will process more smoothly. In general FFRs are required to be submitted to federal agencies on a quarterly basis but the Department has experienced delays in reconciling grant expenditures; in large part due to delays in processing payroll. As appropriate, the Department has notified federal partners about the delays and they have granted extensions related to the reporting deadlines.

c. What impact have these challenges had on the Department's access to funding streams?

Response: Since the Department relies so heavily on federal grants, we have been in contact with our federal funding partners about the on-going transition to

CORE. Thus far, the federal partners have been accomidating and federal funding has not been impacted.

d. How has the implementation of CORE affected staff workload?

Response: During this first year of the implementation of CORE, fiscal and accounting staff in the Department has had to devote extra time and effort to ensure the transition occurs as seamlessly as possible. The Department does expect this pattern to change during this next fiscal year as staff becomes more familiar with the new system and statewide process improvements are implemented.

e. Do you anticipate that CORE implementation will result in the need for a permanent increase in staff? If so, indicate whether the Department is requesting additional funding for FY 2016-17 to address it.

Response: At this early phase of CORE implementation it is not possible to determine what impacts the system will have on staffing.

4. If the Department receives federal funds of any type, please provide a detailed description of any federal sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2015-16.

Response: The Department is not aware of any pending federal sanctions.

5. Does the Department have any outstanding high priority recommendations as identified in the "Annual Report of Audit Recommendations Not Fully Implemented" that was published by the State Auditor's Office and dated October 2015 (link below)? What is the department doing to resolve the outstanding high priority recommendations?

http://www.leg.state.co.us/OSA/coauditor1.nsf/All/4735187E6B48EDF087257ED0007FE8CA/$FILE/1542S%20Annual%20Report.%20Status%20of%20Outstanding%20Audit%20Recommendations,%20As%20of%20June%2030,%202015.%20Informational%20Report.%20October%202015.pdf

Response:
Medical Marijuana Regulatory System Part II Performance Audit, June 2013, Findings 7A, 7B, 7C, 7E - Information System Controls

These recommendations cannot be fully implemented until the new Medical Marijuana Registry system is implemented. The system is currently under development and will be implemented in late summer 2016.

6. Is the department spending money on public awareness campaigns related to

marijuana? How is the department working with other state departments to coordinate the campaigns?

Response: Pursuant to Colorado Revised Statutes § 25-3.5-1001 through 1007, the Colorado Department of Public Health and Environment (CDPHE) is tasked with educating Colorado residents and visitors on the parameters of safe, legal and responsible use of marijuana through the following:

- an 18-month public awareness and education campaign directed at educating the public on legal use and the health effects of marijuana and legal use.
- ongoing targeted education and prevention sub-campaigns that reach:
  - retailers on the importance of preventing youth access,
  - high-risk populations, which CDPHE has so far identified as parents on safe storage and reducing secondhand marijuana smoke exposure and the prevention of use by youth or pregnant/breastfeeding women, and
  - the overconsumption of edibles.
- maintenance of the colorado.gov/marijuana web portal,
- alignment of messaging across state agencies, and
- evaluation of the campaigns' effectiveness and impact.

On Jan. 5, 2015, CDPHE launched the Good to Know campaign to educate the public on the laws pertaining to legal marijuana use and included messages to prevent high-risk behaviors, such as the risks to youth brain development, over-consuming edibles and safe storage to prevent unintentional ingestions. The Good to Know campaign has been seen nearly 170 million times across Colorado.

CDPHE contracted with the Colorado School of Public Health (CSPH) to evaluate the effectiveness of these public awareness efforts. CSPH administered a survey with a sample of Colorado residents to gather a baseline of knowledge, awareness, perceptions and behaviors. CSPH re-administered this survey to monitor changes over time in the Spring 2015 following the height of Good to Know campaign activity and analyzed whether exposure to CDPHE campaigns and materials contributed to changes. The results found that Colorado adults surveyed who reported they were aware of the Good to Know campaign were more than twice as likely as other adults to correctly identify key retail marijuana laws. Additionally, accurate awareness of all four of these components increased from 62.0 percent of survey respondents at baseline to 73.1 percent at follow-up. There also were statistically significant increases in the knowledge of health effects and perceptions of risk of use. These results are included in the legislative report sent to the General Assembly on November 1, 2015.

Beginning Spring 2015, CDPHE provided point-of-sale materials to marijuana retailers using the Good to Know platform. Over the summer, CDPHE launched an educational campaign for parents, teachers and other "askable adults" found at GoodtoKnowColorado.com/talk. CDPHE also released two new campaigns: a

culturally relevant Spanish-language campaign (Marihuana en Colorado) and a youth prevention campaign (What's Next). Evaluation of on-going public awareness campaigns, including the Spanish language campaign, youth prevention campaign and outreach to retailers, is ongoing. A campaign focused on marijuana use during pregnancy or while breastfeeding is slated for launch late this fiscal year, paid for with funding from Proposition BB.

How is the department working with other state departments to coordinate the campaigns?
Colorado Revised Statutes § 25-3.5-1006 requires CDPHE to work with other state departments to coordinate the campaigns. Examples of collaboration are included below:

- Align Statements on Health Effects: CDPHE staff collaborate regularly across state agencies to align messaging on retail marijuana with the statements of the health effects from the Retail Marijuana Public Health Advisory Committee and each of the campaigns.
- Informing Campaign Messaging: CPDHE collaborated across state agencies to use existing assessments on substance abuse knowledge, attitudes and behaviors to inform public education efforts. The departments of Transportation, Education and Human Services, and the Governor's Office of Community Partnerships shared results from past surveys to inform CDPHE's education efforts. Additionally, these agencies helped to disseminate surveys about priority campaign messages.
- Web Portal: CDPHE incorporates information from all state agencies into the Colorado.gov/marijuana web portal, and reviews the content at least twice annually with each contact.
- Technical Assistance: CDPHE staff are available to provide technical assistance and materials to other state agencies and their local grantees regarding the health effects of marijuana, data, effective prevention strategies, or campaign messaging/materials.
- Align DUI Messaging: As part of CDPHE's coordination efforts with other state agencies, CDPHE Retail Marijuana Education Program staff meet regularly with the CO Department of Transportation's staff that are leading the "Drive High, Get a DUI" Campaign.
- Cross-agency Campaign Oversight: CDPHE meets monthly with the Marijuana Education Oversight Committee, a diverse group of statewide stakeholders convened pursuant to Executive Order 2013-007, to guide education efforts, including the development of campaign messages. This group has representation from the Governor's Office of Marijuana Coordination; Colorado General Assembly; Colorado departments of Revenue (DOR), Education (CDE), Human Services (CDHS), Public Health and Environment (CDPHE) and Transportation (CDOT); the marijuana industry; medical marijuana patient advocacy groups; substance abuse prevention; higher education; health care providers; local and state prevention groups; grantees from CDHS Tony

Grampsas Youth Services (TGYS) program or the Office of Behavioral Health (OBH); and local government.

- Trainings: CDPHE recruits training participants from CDPHE, CDE, CDHS TGYS, CDHS OBH, CDPS, and HCPF grantees addressing marijuana and substance abuse prevention. At these regional trainings, CDPHE disseminates campaign materials, resources, and builds local contact skills to incorporate campaign resources into local prevention/education work.

7. Based on the Department's most recent available record, what is the FTE vacancy rate by department and by division? What is the date of the report?

Response: The Governor's Office of State Planning and Budgeting will provide a consolidated statewide response to this question.

8. For FY 2014-15, do any line items in your Department have reversions? If so, which line items, which programs within each line item, and for what amounts (by fund source)? What are the reasons for each reversion? Do you anticipate any reversions in FY 2015-16? If yes, in which programs and line items do you anticipate this reversions occurring? How much and in which fund sources do you anticipate the reversion being?

Response: Year-end spending authority reversions are common. It is difficult to project exact spending needs to the dollar and programs are generally conservative to ensure that they do not overspend line item appropriations. With the advent of a new accounting system, this natural caution was heightened and managers were more conservative with expenditures due to the lag in the availability of expenditure data; thus reversions for FY 2014-15 may be higher than is typical.

Appendix B, attached, provides explanations for reversions greater than 1 percent. The Department believes that most reversions less than 1 percent are not material and did not provide explanations.

9. Are you expecting an increase in federal funding with the passage of the FFY 2015-16 federal budget? If yes, in which programs and what is the match requirement for each of the programs?

Response: The Governor's Office of State Planning and Budgeting will provide a consolidated statewide response to this question.

10. For FY 2014-15, did your department exercise a transfer between lines that is allowable under state statute? If yes, between which line items and programs did this transfer occur? What is the amount of each transfer by fund source between programs and/or line items? Do you anticipate transfers between line items and programs for FY 2015-16? If yes, between which line items/programs and for how much (by fund source)?

Response: The Governor's Office of State Planning and Budgeting will provide a consolidated statewide response to this question.

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Appendix A: Clean Water

WATER QUALITY CONTROL DIVISION

Cash Revenues by Sector

Clean Water Sectors	July	August	September	October	November	December	January	February	March	April	May	June	Total
Commerce and Industry	$937,175	$1,610	$20,931	$4,764	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$14,804	**$1,014,284**
Construction	$1,161,637	$18,691	$30,941	$38,902	$31,714	$30,000	$30,000	$30,000	$30,000	$30,000	$30,000	$44,561	**$1,506,446**
MS4	$139,040	$0	$5,425	$0	$0	$0	$0	$0	$0	$0	$0	$1,410	**$145,875**
Pesticide	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,600	$0	$172	**$17,772**
Public/Private Utilities	$1,621,287	$14,332	$42,627	$18,789	$25,553	$25,553	$25,553	$25,553	$25,553	$25,553	$25,553	$44,088	**$1,919,994**
WQ Certification	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Total	**$3,859,139**	**$34,633**	**$99,924**	**$62,455**	**$62,267**	**$60,553**	**$60,553**	**$60,553**	**$60,553**	**$78,153**	**$60,553**	**$105,035**	**$4,604,371**

Administrative Costs By Sector (CW portion of Admin)

Clean Water Sectors	July	August	September	October	November	December	January	February	March	April	May	June	Total
Commerce and Industry	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$7,292**	**$87,507**
CF	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$7,292	$87,507
Construction	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$10,831**	**$129,968**
CF	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$10,831	$129,968
MS4	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$1,049**	**$12,585**
CF	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$1,049	$12,585
Pesticide	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$128**	**$1,533**
CF	$128	$128	$128	$128	$128	$128	$128	$128	$128	$128	$128	$128	$1,533
Public/Private Utilities	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$13,804**	**$165,647**
CF	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$13,804	$165,647
WQ Certification	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
CF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$33,103**	**$397,240**

Indirect Costs By Sector

Clean Water Sectors	July	August	September	October	November	December	January	February	March	April	May	June	Total
Commerce and Industry	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$18,231**	**$218,767**
CF	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$18,231	$218,767
Construction	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$27,077**	**$324,920**
CF	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$27,077	$324,920
MS4	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$2,622**	**$31,463**
CF	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$2,622	$31,463
Pesticide	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$319**	**$3,833**
CF	$319	$319	$319	$319	$319	$319	$319	$319	$319	$319	$319	$319	$3,833
Public/Private Utilities	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$34,510**	**$414,116**
CF	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$34,510	$414,116
WQ Certification	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
CF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$82,758**	**$993,100**

Program Expenses By Sector

Clean Water Sectors	July	August	September	October	November	December	January	February	March	April	May	June	Total
Commerce and Industry	**$129,297**	**$129,297**	**$129,297**	**$152,176**	**$152,176**	**$152,176**	**$152,176**	**$152,176**	**$152,176**	**$152,176**	**$152,176**	**$152,176**	**$1,757,476**
GF	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$52,908	$634,901
CF	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$59,001	$708,010
FF	$17,388.18	$17,388	$17,388	$40,267	$40,267	$40,267	$40,267	$40,267	$40,267	$40,267	$40,267	$40,267	$414,565
Construction	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$113,392**	**$1,360,700**
GF	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$25,762	$309,142
CF	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$87,630	$1,051,558
FF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
MS4	**$18,420**	**$18,420**	**$18,420**	**$21,710**	**$21,710**	**$21,710**	**$21,710**	**$21,710**	**$21,710**	**$21,710**	**$21,710**	**$21,710**	**$250,653**
GF	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$7,434	$89,204
CF	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$8,486	$101,826
FF	$2,501	$2,501	$2,501	$5,791	$5,791	$5,791	$5,791	$5,791	$5,791	$5,791	$5,791	$5,791	$59,623
Pesticide	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$14,262**	**$171,141**
GF	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$13,228	$158,735
CF	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$1,034	$12,406
FF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Public/Private Utilities	**$242,068**	**$242,068**	**$242,068**	**$285,376**	**$285,376**	**$285,376**	**$285,376**	**$285,376**	**$285,376**	**$285,376**	**$285,376**	**$285,376**	**$3,294,588**
GF	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$97,467	$1,169,604
CF	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$111,686	$1,340,231
FF	$32,915	$32,915	$32,915	$76,223	$76,223	$76,223	$76,223	$76,223	$76,223	$76,223	$76,223	$76,223	$784,753
WQ Certification	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$19,083**	**$229,001**
GF	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$19,083	$229,001
CF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
General Fund Subsidy	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$20,455**	**$245,457**
GF	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$20,455	$245,457
CF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	**$536,522**	**$536,522**	**$536,522**	**$605,999**	**$605,999**	**$605,999**	**$605,999**	**$605,999**	**$605,999**	**$605,999**	**$605,999**	**$605,999**	**$7,309,016**
GF	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	$236,337	**$2,836,043**
CF	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	$267,836	**$3,214,032**
FF	$52,804	$52,804	$52,804	$122,281	$122,281	$122,281	$122,281	$122,281	$122,281	$122,281	$122,281	$122,281	**$1,258,941**

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — **FY 2016-17**

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
01. Administration and Support						
(A) Administration						
(1) Administration						
Health, Life, and Dental						
FY 2014-15 Reversion	**$885,200**	**$0**	**$835,200**	**$50,000**		Reversion of personal services common policy POTS spending authority.
Legal Services						
FY 2014-15 Reversion	**$72,654**	**$0**	**$27,518**	**$45,137**		Continuously Appropriated Cash Fund spending authority associated with settlement funding. Reduced litigation resulted in Reappropriated Fund reversion.
Toxicology Unit Legal Services						
FY 2014-15 Reversion	**$219,947**	**$219,947**	**$0**	**$0**		Reduced litigation resulted in General Fund reversions - FY 2016 spending authority was reduced to $25K.
Vehicle Lease Payments						
FY 2014-15 Reversion	**$50,574**	**$0**	**$30,748**	**$19,826**		Reversion of operating common policy POTS spending authority
Utilities						
FY 2014-15 Reversion	**$30,386**	**$0**	**$29,850**	**$536**		Rates\consumptions lower than anticipated - new sites opening in FY 2016
Indirect Costs Assessment						
FY 2014-15 Reversion	**$60,003**	**$0**	**$23,072**	**$36,932**		Reversion in indirect cost assessment spending authority is based solely on the reversions in direct cost lines.
(B) Office of Health Disparities						
(1) Office of Health Disparities						
Operating Expenses						
FY 2014-15 Reversion	**$23,573**	**$0**	**$23,573**	**$0**		Project did not come to fruition.
Health Disparities Grants						
FY 2014-15 Reversion	**$842,094**	**$0**	**$842,094**	**$0**		End of a 2 year grant cycle - spending authority and funding needed to support the new year grants in FY16-FY18
(C) Local Public Health Planning and Support						
(1) Local Public Health Planning and Support						
Distributions To Local Public Health Agencies						
FY 2014-15 Reversion	**$162,478**	**$0**	**$162,478**	**$0**		Insufficient MSA cash revenue for full utilization of appropriation.

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — FY 2016-17

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
02. Center for Health and Environmental Information						
(B) Health Statistics and Vital Records						
(1) Health Statistics and Vital Records						
Operating Expenses						
FY 2014-15 Reversion	**$149,512**	**$0**	**$149,512**	**$0**		Response pending.
(C) Medical Marijuana Registry						
(1) Medical Marijuana Registry						
Personal Services						
FY 2014-15 Reversion	**$162,585**	**$0**	**$162,585**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
Operating Expenses						
FY 2014-15 Reversion	**$8,195**	**$0**	**$8,195**	**$0**		Response pending.
(D) Health Data Programs and Information						
(1) Health Data Programs and Information						
Cancer Registry						
FY 2014-15 Reversion	**$131,008**	**$131,008**	**$0**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
Birth Defects Monitoring and Prevention Program						
FY 2014-15 Reversion	**$43,814**	**$2,967**	**$40,847**	**$0**		Response pending.
Health Information Exchange						
FY 2014-15 Reversion	**$449,378**	**$449,378**	**$0**	**$0**		The project took loger than anticipated to initiate.
Electronic Health Records for Local Public Health Agencies						
FY 2014-15 Reversion	**$3,273,930**	**$3,273,930**	**$0**	**$0**		Appropriation has roll-forward authority. Not a true reversion.
03. Laboratory Services						
(A) Laboratory Services						
(1) Laboratory Services						
Director's Office						
FY 2014-15 Reversion	**$39,215**	**$0**	**$39,215**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc). Insufficient Revenues for Cash and RAF spending

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — **FY 2016-17**

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
Chemistry and Microbiology Personal Services						
FY 2014-15 Reversion	**$476,465**	**$28**	**$355,508**	**$120,928**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc). Insufficient Revenues for Cash and RAF spending
Chemistry and Microbiology Operating Expenses						
FY 2014-15 Reversion	**$639,334**	**$0**	**$405,213**	**$234,121**		Insufficient revenues for Cash and RAF spending.
Certification						
FY 2014-15 Reversion	**$96,047**	**$0**	**$96,047**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc). Insufficient Revenues for Cash and RAF spending
04. Air Pollution Control Division						
(A) Administration						
(1) Administration						
Program Costs						
FY 2014-15 Reversion	**$17,448**	**$0**	**$17,448**	**$0**		Reversion of POTS Allocation due to vacancy savings. Reversion is less than 5%.
(B) Technical Services						
(1) Technical Services						
Personal Services						
FY 2014-15 Reversion	**$340,867**	**$0**	**$340,867**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
Operating Expenses						
FY 2014-15 Reversion	**$25,401**	**$0**	**$25,401**	**$0**		Reversion is less than 10%. Reversion of spending authority due to projects not completed in the previous FY. Projects are continued in the current FY.
Local Contracts						
FY 2014-15 Reversion	**$43,776**	**$0**	**$43,776**	**$0**		Work did not get completed and will continue in the current FY.
(C) Mobile Sources						
(1) Mobile Sources						
Personal Services						
FY 2014-15 Reversion	**$134,333**	**$0**	**$134,333**	**$0**		Reversion of POTS Allocation due to vacancy savings. Reversion is less than 5%.

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — **FY 2016-17**

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
Operating Expenses						
FY 2014-15 Reversion	**$72,769**	**$0**	**$72,769**	**$0**		Work did not get completed and will continue in the current FY.
Diesel Inspection / Maintenance Program						
FY 2014-15 Reversion	**$138,173**	**$0**	**$138,173**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
Mechanic Certification Program						
FY 2014-15 Reversion	**$1,957**	**$0**	**$1,957**	**$0**		Insufficient cash revenue to support full utilization of spending authority.
Local Grants						
FY 2014-15 Reversion	**$2,088**	**$0**	**$2,088**	**$0**		Reversion is less than 3% due to variance in contractual costs.
(D) Stationary Sources						
(1) Stationary Sources						
Local Contracts						
FY 2014-15 Reversion	**$99,002**	**$0**	**$99,002**	**$0**		Projects did not get completed and will continue in the current FY.
05. Water Quality Control Division						
Operating Expenses						
FY 2014-15 Reversion	**$69,824**	**$0**	**$69,824**	**$0**		Insufficient cash revenue to support full utilization of spending authority.
Nutrients Grant Fund						
FY 2014-15 Reversion	**$7,328,881**	**$0**	**$7,328,881**	**$0**		Continuously appropriated cash fund spending authority. Nutrients Grant Fund.
(C) Clean Water Program						
(1) Clean Water Program						
Local Grants and Contracts						
FY 2014-15 Reversion	**$9,177,875**	**$0**	**$9,177,875**	**$0**		Continuously appropriated cash fund spending authority. Small Communities Water and Wastewater Grant Fund.
Water Quality Improvement						
FY 2014-15 Actual						
FY 2014-15 Reversion	**$85,505**	**$0**	**$85,505**	**$0**		An RFA was not completed for FY 2014-15 and therefore the monies were not obligated and expended.
(D) Drinking Water Program						
(1) Drinking Water Program						

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — FY 2016-17

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
(E) Indirect Cost Assessment						
(1) Indirect Cost Assessment						
Indirect Cost Assessment						
FY 2014-15 Reversion	**$149,582**	**$0**	**$149,582**	**$0**		Reversion in indirect cost assessment spending authority is based solely on the reversions in direct cost lines.
06. Hazardous Materials and Waste Management Division						
(A) Administration						
(1) Administration						
Program Costs						
FY 2014-15 Reversion	**$142,416**	**$0**	**$103,016**	**$39,400**		Reversion of POTS Allocation, Vacancies, Personal Services distributed to various program lines.
Legal Services						
FY 2014-15 Reversion	**$341,599**	**$0**	**$341,144**	**$455**		Reduced litigation resulted in reversion of budget authority. Based on hours billed by DOL
(B) Hazardous Waste Control Program						
(1) Hazardous Waste Control Program						
Personal Services						
FY 2014-15 Reversion	**$606,547**	**$0**	**$606,547**	**$0**		Staff attrition and vacancy savings.
(C) Solid Waste Control						
(1) Solid Waste Control						
Program Costs						
FY 2014-15 Reversion	**$76,227**	**$0**	**$76,227**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
(D) Contaminated Site Cleanups and Remediation Programs						
(1) Contaminated Site Cleanups and Remediation Programs						
Personal Services						
FY 2014-15 Reversion	**$746,269**	**$0**	**$746,269**	**$0**		State component of the 5-year Superfund Block Grant
Operating Expenses						
FY 2014-15 Reversion	**$61,176**	**$0**	**$61,176**	**$0**		State component of the 5-year Superfund Block Grant
Contaminated Sites Operation And Maintenance						
FY 2014-15 Reversion	**$650,025**	**$0**	**$650,025**	**$0**		CERCLA sites still under the 90/10 split with EPA

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — **FY 2016-17**

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
Transfer To The Department Of Law For CERCLA-Related Costs						
FY 2014-15 Reversion	**$274,932**	**$0**	**$274,932**	**$0**		Based on hours billed by DOL
Natural Resource Claims at Rocky Mountain Arsenal, Law						
FY 2014-15 Reversion	**$50,000**	**$0**	**$50,000**	**$0**		Damage claims have slowly declined
(E) Radiation Management						
(1) Radiation Management						
Personal Services						
FY 2014-15 Reversion	**$230,597**	**$0**	**$230,597**	**$0**		Reversion of POTS Allocation, Vacancies. Reduced expenditures due to an insufficient fund balance
Operating Expenses						
FY 2014-15 Reversion	**$102,852**	**$0**	**$102,852**	**$0**		Reduced expenditures due to an insufficient fund balance
(F) Waste Tire Program						
(1) Waste Tire Program						
Waste Tire Administration, and Cleanup Program Enforcement						
FY 2014-15 Reversion	**$1,957,224**	**$0**	**$1,957,224**	**$0**		Lower than anticipated cleanup projects in FY 2015
Waste Tire Market Development						
FY 2014-15 Reversion	**$220,065**	**$0**	**$220,065**	**$0**		This program is still developing; it's expected that more producers will take advantage of this program in FY 16
Waste Tire Rebates						
FY 2014-15 Reversion	**$2,697,645**	**$0**	**$2,697,645**	**$0**		Higher than anticipated revenues and rebate was set too low. Rebate rate is corrected for 2016.
07. Division of Environmental Health and Sustainability						
(A) Division of Environmental Health and Sustainability						
(1) Division of Environmental Health and Sustainability						
Environmental Health Programs						
FY 2014-15 Reversion	**$100,547**	**$1,727**	**$92,776**	**$6,044**		Reversions of POTS allocations and one cash fund with insufficient revenue.
Sustainability Programs						
FY 2014-15 Reversion	**$69,198**	**$0**	**$69,198**	**$0**		Insufficient revenue to support full utilization of spending authority.
Recycling Resources Economic Opportunity Program						
FY 2014-15 Reversion	**$1,182,886**	**$0**	**$1,182,886**	**$0**		Actual grant expenditures were lower than the amount awarded; and the regional recycling study grant awards were delayed until FY 2016.

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — FY 2016-17

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
Household Medication Take-back Program						
FY 2014-15 Reversion	**$15,124**	**$911**	**$14,212**	**$0**		Insufficient cash fund revenue from donations to support full utilization of spending authority.
Indirect Cost Assessment						
FY 2014-15 Reversion	**$45,241**	**$0**	**$45,241**	**$0**		Reversion due to lower expenditures as a result of reasons explained above.
08. Disease Control and Environmental Epidemiology Di						
(A) Administration, General Disease Control, Surveillance						
(1) Administration, General Disease Control and Surveillance						
Immunization Operating Expenses						
FY 2014-15 Reversion	**$469,424**	**$423,600**	**$45,824**	**$0**		Post closing entry reduced the General Fund reversion to $17,749, CF: Revenue came in less than projected.
Approp. from the Tobacco Tax Cash Fund to the General Fund						
FY 2014-15 Reversion	**$423,600**	**$0**	**$423,600**	**$0**		Post closing entry fixed this
Indirect Costs Assessment						
FY 2014-15 Reversion	**$7,553**	**$0**	**$7,553**	**$0**		Reversion in indirect cost assessment spending authority is based solely on the reversions in direct cost lines.
(B) Special Purpose Disease Control Programs						
(1) Special Purpose Disease Control Programs						
Sexually Transmitted Infections, HIV and AIDS, Operating Exp						
FY 2014-15 Reversion	**$332,523**	**$0**	**$332,523**	**$0**		Contractors underspent awarded amount.
Ryan White Act, Personal Services						
FY 2014-15 Reversion	**$3,327**	**$3,327**	**$0**	**$0**		Vacancy savings, position has since been filled.
(C) Environmental Epidemiology						
(1) Environmental Epidemiology						
Cannabis Health Environmental and Epidemiological Training						
FY 2014-15 Reversion	**$29,977**	**$0**	**$29,977**	**$0**		Vacancy savings, position has since been filled.
09. Prevention Services Division						
(A) Administration						
Indirect Cost Assessment						
FY 2014-15 Reversion	**$143,823**	**$0**	**$24,680**	**$119,142**		Reversion in indirect cost assessment spending authority is based solely on the reversions in direct cost lines.

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — FY 2016-17

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
(B) Chronic Disease Prevention Programs						
(1) Chronic Disease Prevention Programs						
Transfer to the Health Disparities Grant Program Fund						
FY 2014-15 Reversion	**$3,388,800**	**$0**	**$3,388,800**	**$0**		CORE functionality no longer requires revenue transfers to incur an expenditure against budgets. Transfer was fully executed.
Chronic Disease and Cancer Prevention Grants						
FY 2014-15 Reversion	**$305,656**	**$0**	**$305,656**	**$0**		Insufficient gifts/grants/donations received to utilize cash spending authority. Typical year end reversion, essentially fully spent.
Breast and Cervical Cancer Screening						
FY 2014-15 Reversion	**$2,236,730**	**$0**	**$2,236,730**	**$0**		Due to additional medical coverage from ACA and limited age range for screeninig eligibility, funding was not fully utilized.
Cancer, Cardiovascular, and Chronic Pulmonary Disease Grants						
FY 2014-15 Reversion	**$4,334,215**	**$0**	**$4,334,215**	**$0**		Due to additional medical coverage from the ACA, grants associated with cancer screenings experienced an unusual level of reversions. Adjustments for future years are being made and similar reversions are not expected in future years.
Tobacco Education, Prevention, and Cessation Program Grants						
FY 2014-15 Reversion	**$3,880,392**	**$0**	**$2,701,774**	**$1,178,618**		Less than 10% reversion based on available cash fund balance as there was insufficient cash to support all of the allocated spending authority.
Oral Health Programs						
FY 2014-15 Reversion	**$1,439,715**	**$1,439,715**	**$0**	**$0**		Old Age Pension program GF reversions. Additional reversions are not expected in future years as this program has been transferred to HCPF.
(C) Primary Care Office						
(1) Primary Care Office						
Primary Care Office						
FY 2014-15 Reversion	**$1,701,264**	**$0**	**$1,701,264**	**$0**		Reversion of Continuously Appropriated Cash Funds. Cash funds are associated with private grants received near the end of the fiscal year. The private grants are expected to be fully spent during their performance period.

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — FY 2016-17

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
(D) Family and Community Health						
Adult Stem Cells Cure Fund						
FY 2014-15 Reversion	**$139,979**	**$0**	**$139,979**	**$0**		Insufficient cash revenue to support full utilization of spending authority.
Maternal and Child Health						
FY 2014-15 Reversion	**$0**	**$0**	**$0**	**$0**	**$2,158,935**	Reversion of Federal Fund spending authority. No reversion, federal funds carry forward, not yet expired
Genetics Counseling Program Costs						
FY 2014-15 Reversion	**$66,296**	**$0**	**$66,296**	**$0**		Lower utilization and contracts were renegotiated at lower rates.
School-based Health Centers						
FY 2014-15 Reversion	**$585,588**	**$585,588**	**$0**	**$0**		This is a typical reversion based on underspending by grantees.
Healthy Kids Survey						
FY 2014-15 Reversion	**$220,947**	**$0**	**$220,947**	**$0**		due to first year infrastructure creation, under spent their grant and resulted in current reversion.
(3) Injury, Suicide, and Violence Prevention						
Suicide Prevention						
FY 2014-15 Reversion	**$24,594**	**$24,594**	**$0**	**$0**		Post-closing entry resolved this, no reversion
10. Health Facilities and Emergency Medical Services						
(A) Operations Management						
(1) Operations Management						
Administration and Operations						
FY 2014-15 Reversion	**$275,704**	**$1**	**$275,703**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
(B) Health Facilities Program						
(1) Health Facilities Program						
Home and Community Survey						
FY 2014-15 Reversion	**$38,116**	**$0**	**$33,481**	**$4,635**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
Nursing Facility Survey						
FY 2014-15 Reversion	**$27,053**	**$1**	**$27,052**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
Medicaid / Medicare Certification Program						
FY 2014-15 Reversion	**$320,803**	**$0**	**$0**	**$320,803**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).

APPENDIX B: Line Item Reversions

Department of Public Health and Environment — FY 2016-17

Long Bill Line Item	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Appropriated Federal Funds	Comments
Transfer to Department of Public Safety						
FY 2014-15 Reversion	**$135,189**	**$0**	**$0**	**$135,189**		Reversions in this line occur due to lower than anticipated inspections.
(C) Emergency Medical Services						
(1) Emergency Medical Services						
Emergency Medical Services Provider Grants						
FY 2014-15 Reversion	**$564,533**	**$0**	**$564,533**	**$0**		Reversion in grant funds occurs, not because the funds are not needed, but because the actual costs of the final purchases for the myriad of equipment, vehicles, etc. are sometimes lower than originally anticipated. In some cases large reversions may occur if there are difficulties with timely delivery (i.e. before June 30 of the fiscal year) of large purchases, such as ambulances
Trauma Facility Designation Program						
FY 2014-15 Reversion	**$54,813**	**$0**	**$54,813**	**$0**		Reversion of POTS Allocation. Reversion in cash funds based on an overestimation of POTS needs from early in the year. This can include issues such as changing insurance plans, vacancy savings, etc).
(D) Indirect Cost Assessment						
(1) Indirect Cost Assessment						
Indirect Cost Assessment						
FY 2014-15 Reversion	**$43,109**	**$0**	**$43,109**	**$0**		Reversion in indirect cost assessment spending authority is based solely on the reversions in direct cost lines above.

Joint Budget Committee Hearing

December 1, 2015

Larry Wolk, MD, MSPH
Executive Director, Chief Medical Officer

COLORADO
Department of Public Health & Environment

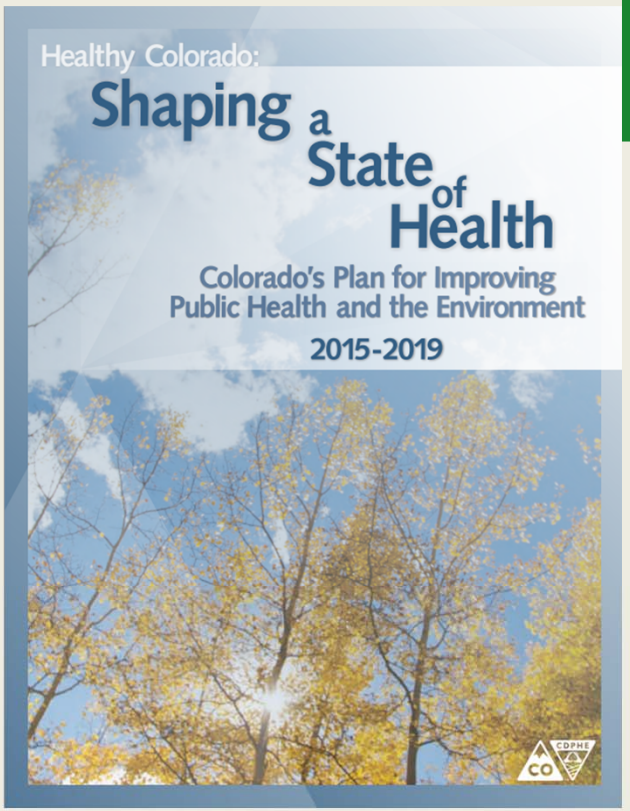
Mission

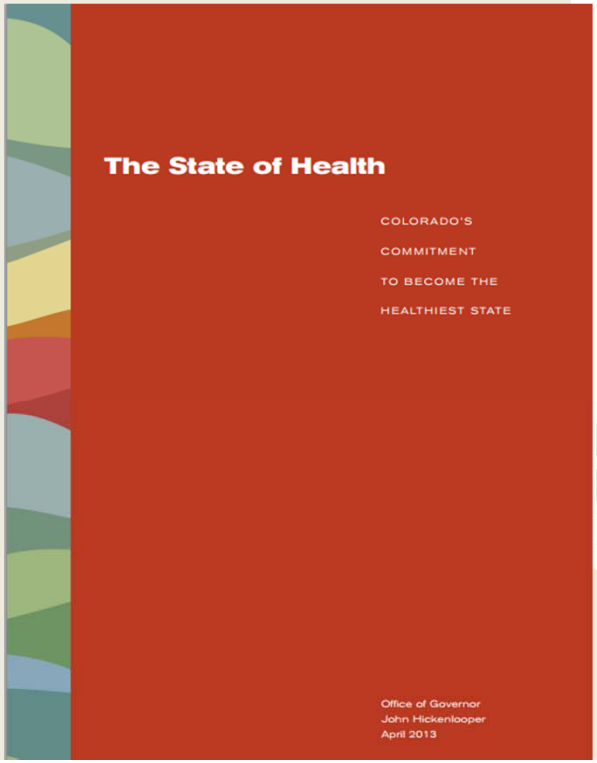
- The mission of the Colorado Department of Public Health and Environment is to protect and improve the health of Colorado's people and the quality of its environment.

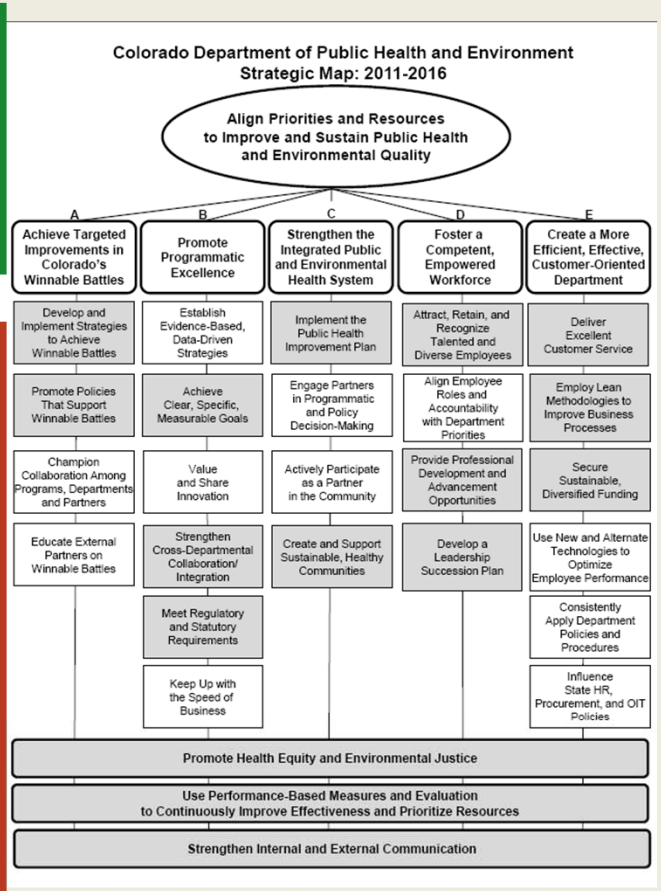
Vision

- Colorado will be the healthiest state with the highest quality environment.

Development of 2015-16 Priorities

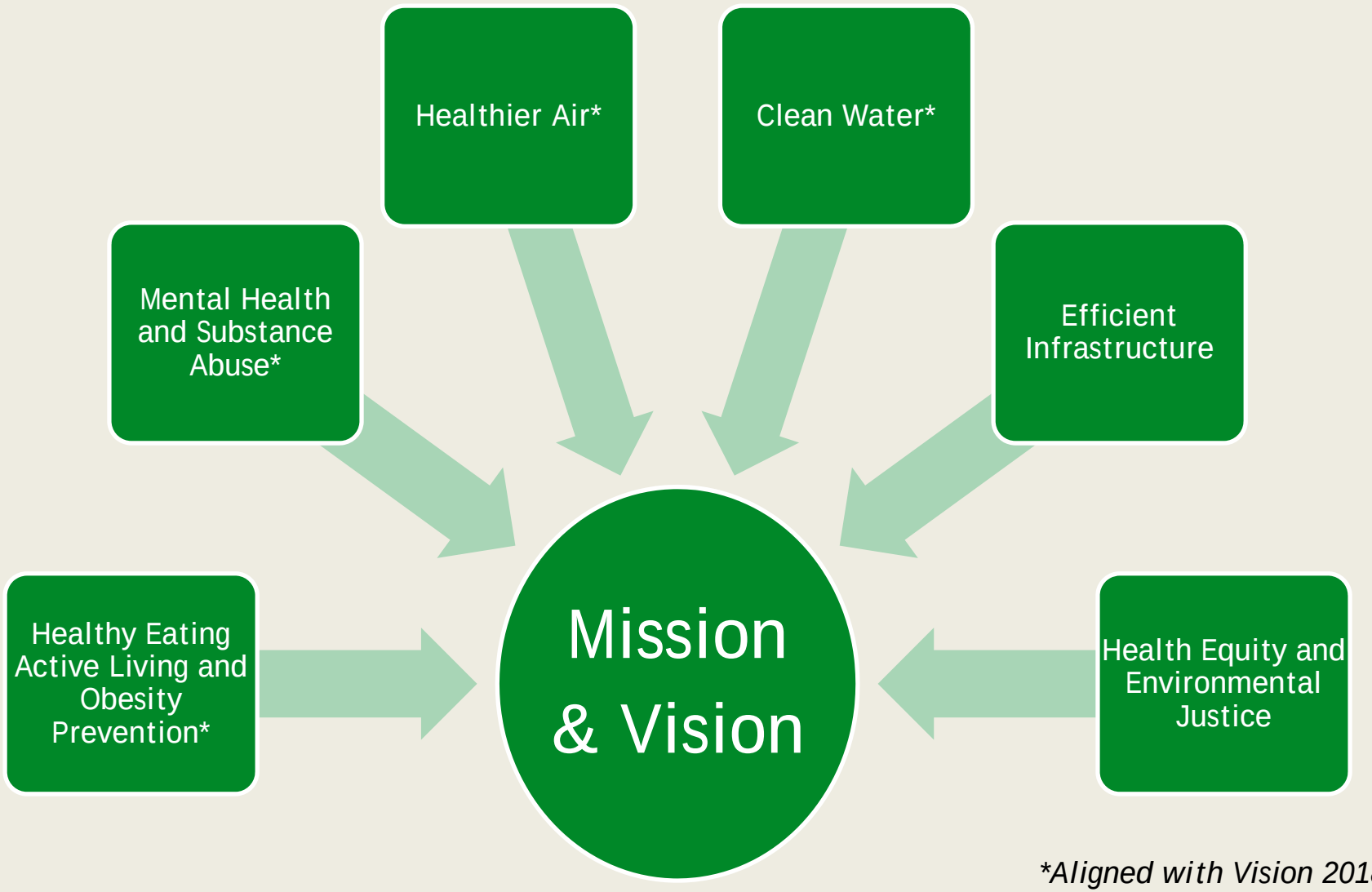






COLORADO
Department of Public Health & Environment

Department Priorities



**Aligned with Vision 2018*

Healthy Eating Active Living

Strategies:

- Breastfeeding-friendly environments
- Nutrition and physical activity environments for children
- Access to worksite wellness programs
- Diabetes Prevention Program
- Advance ‘health in all policies’
- Coordinated obesity surveillance

Mental Health and Substance Abuse

Strategies:

- Access to high quality mental and behavioral health care
- Screening and referral practices for depression
- Continuing education about safe prescribing practices
- Safe prescribing practices and permanent drug disposal sites

Healthier Air

Strategies:

- Decreasing emissions through regulatory mechanisms and emission standards
- Reduce annual emissions of carbon dioxide from electric generation units consistent with the Clean Air Clean Jobs Act and the federal Clean Power Plan

Clean Water

Strategies:

- Expand water body characterization
- Restore impaired water bodies
- Maintain water quality status with continued population growth

Sustainable, efficient programs and infrastructure

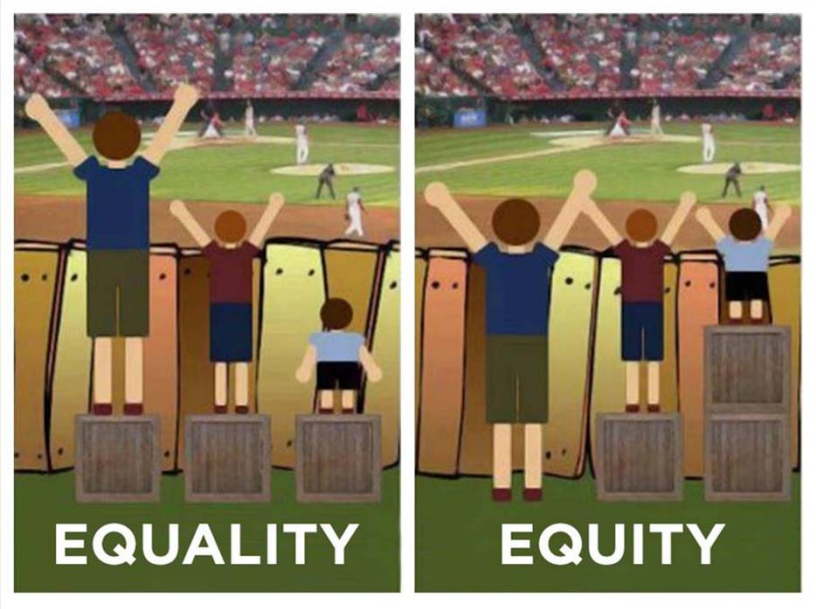
Strategies:

- Developing a quality improvement (QI) culture
- Improving workforce engagement
- Utilizing health information, data and technology
- Developing funding and resources

Promote Health Equity and Environmental Justice

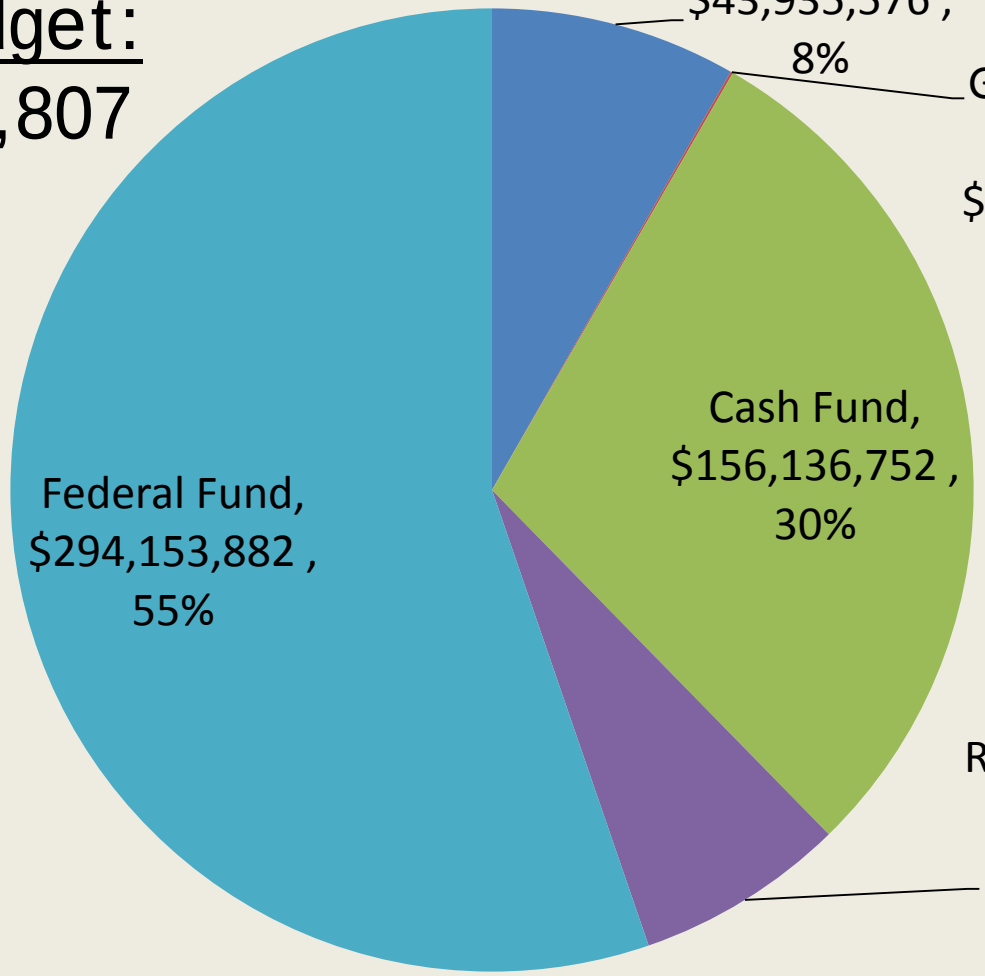
Strategies:

- Language services
- Increase engagement with disadvantaged populations to promote healthy people and healthy places
- Increase internal knowledge and use of HE&EJ principles



CDPHE Budget by Funding Sources

FY2015-16
Total budget:
$532,213,807



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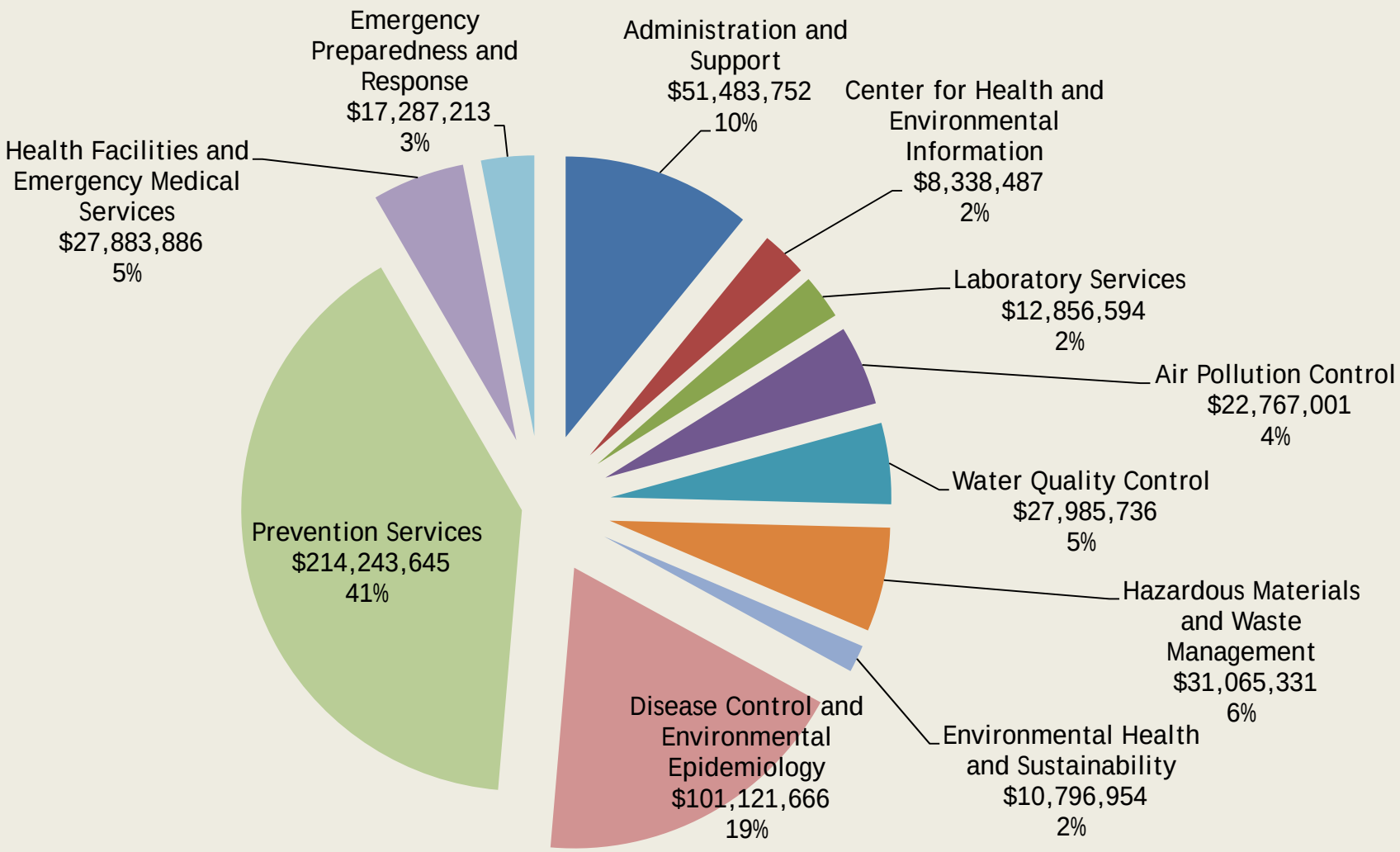
CDPHE Budget by Division



COLORADO
Department of Public Health & Environment

FY 2016-17 Decision Items: Health Programs

- $2.5M to reduce unintended pregnancy rates (general fund).
- $1.75M spending authority for EMS and Trauma Service grants (cash fund).
- $238K to examine regional impacts from marijuana use (MJ Tax cash fund).
- $346K for a marijuana poison control hotline (MJ Tax cash fund).

FY 2016-17 Decision Items: Environmental Programs

- $1.2M to continue current clean water program operations (general fund).

FY 2016-17 Decision Items: General Administrative

- Net $0 Long Bill adjustments to match current organizational structure.
- $85k and 1.1 FTE for a grant accountant to address Federal Funding Accountability and Transparency Act reporting (reappropriated funds).
- $340K for maintenance and repair at the State Laboratory Building (reappropriated funds).
- $257K to increase funding for leave payouts (reappropriated funds).
- $372K to replace cubicles for better utilization of current space (reappropriated funds).

Legislative Priorities

- Healthy Homes
- EBAT
- Marijuana Edibles

Technical bills:

- Air Ambulances
- Immunizations

Questions?

COLORADO
Department of Public
Health & Environment

COLORADO
Department of Public
Health & Environment

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
FY 2016-17 JOINT BUDGET COMMITTEE HEARING AGENDA

Tuesday, December 1, 2015
9:00 am – 12:00 pm

COMMISSION ON AFFORDABLE HEALTH CARE

9:00-9:30 COMMISSION ON AFFORDABLE HEALTH CARE

1. Please provide an overview of the Commission on Affordable Health Care and the FY 2016-17 request $424,000 General Fund.

2. Please discussion how the Commission continued their work after the June 2015 emergency supplemental was declined. Please provide a list of the expenditure reductions/revisions made to stay within the $400,000 budget.

3. Please provide a list of grants and donations the Commission has received to date.

4. Please discuss who has oversight of Commission's expenditures.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

9:30-9:50 INTRODUCTIONS AND OPENING COMMENTS

9:50-10:30 Questions Related to FY 2016-17 Budget Priorities

R1 Family Planning Purchase of Services Increase

5. What are all the ways an individual can access family planning services in Colorado?

6. Please discuss what services are funded through the Family Planning Purchase of Services line item and how these services are different than services provided through other programs.

7. According to the JBC documents, most of the money that goes to Planned Parenthood is sent through county health departments. What oversight does the CDPHE exercise over the expenditures once the counties get the money? What records do the counties or CDPHE maintain of how that money is expended?

8. Since contraceptives are one of the ten essential services under ACA, hence everyone has access, why do Planned Parenthood and other providers need more funding for what appear to be the same services?

9. Regarding the budget requests for LARCs, what has been the source (and amount) of private grant money that has previously funded this program. What have been the measurable results, if any, and how do those results differ from trends in the same population not served with LARCs?

10. Are the same LARC contraceptives available under Medicaid and ACA-mandated health plans? If not, what are the differences?

11. Regarding Governor Ritter's 2007 announcement that he was restoring funds to Planned Parenthood after the Owens-Norton 2001-02 decision to defund Planned Parenthood, what guidance did Governor Ritter or CDPHE receive from the Attorney General that supported this decision?

12. Regarding C.R.S. 25-2-111.5 (fetal tissue trafficking):
    a. describe any investigations CDPHE has conducted of potential violations of this statute;
    b. if there have been no investigations, what tools does CDPHE need to investigate potential violations of this statute; and
    c. how this statute should be amended by the Legislature to be made effective.

13. Regarding Planned Parenthood's participation in the Colorado Medicaid program and during the last 3 fiscal years please answer the following questions for the following four items: (1) oral contraceptives, (2) emergency contraceptives, (3) LARCs, and (4) LARCs paid for by the Department's Family Planning Program:
    a. How many patients have been prescribed the item by Planned Parenthood;
    b. What Planned Parenthood's actual acquisition cost of such item;
    c. What the State's reimbursement rate for each item; and
    d. What the State's dispensing fee for such each item.

<u>R3 Emergency Medical and Trauma Services Grant Program</u>

14. Please discuss the history of the funding for the Emergency Medical and Trauma Grants Program.

<u>R4 Cervical Cancer Eligibility Expansion</u>

15. Please provide an overview of the Breast and Cervical Cancer Screening Program including:
    a. Who provides the screenings;
    b. The role of the Women's Wellness Connection,
    c. How the Department determines who is a qualified screener,
    d. Eligibility criteria for women to be screen through the Breast and Cervical Cancer Program.

16. Please provide an overview of the Breast and Cervical Cancer Treatment Program including who provides the treatment services.

17. Why was this decision item not part of the Department of Health Care Policy and Financing caseload adjustment?

18. Please provide a summary of projected cost savings if additional women ages 21 to 39 years old are screened, and the benefits of additional screenings.

19. What is the source of cash funds for the treatment costs in the Department of Health Care Policy and Financing?

R7 Lab Building Maintenance and Repair and R9 Cubical Replacement

20. Why are these requests in the operating budget and not a controlled maintenance request?

21. Are the repairs to the State Lab building and the cubicle replacements on the State Architect's list? If so, at what level? If not, why not?

R8 Leave Payouts Increase

22. Why does the Department have a line item specific to Leave Payouts and how is this different from how other departments fund leave payouts?

RM1 Health survey Data Collection

23. Please provide a link and/or a copy of reports produced pursuant to the requirements of S.B. 13-283 (Amendment 64 Consensus Recommendations).

24. Please discuss, if there is not statutory change to collect data on a regional level, how the Department's request for funds will change.

10:30-10:45 General Department and Program Specific Questions

25. Please provide an update on the Air Pollution Control Division's work to reduce the backlog of permit and renewal applications. Please include a five year history of the number of applications, permits, renewals, and the size of the backlog.

26. Please discuss the following questions related to the Emission Technical Center located in Aurora:
    a. The FY 2015-16, and projected FY 2016-17, cost of operating the Emission Technical Center, the fund source used to pay for the Center, and what line item funds the Emission Technical Center;
    b. The cost of the equipment purchased for the Center, the fund source used to pay for the equipment, and how that expenditure was authorized;
    c. The Department's plan for the long-term operation of the Center and how the ongoing maintenance and support costs of the Center will be paid for.

27. Please provide an update on the Infrared Camera Program.

28. Please provide an update of the data analysis of data collected through the Front Range Air Pollution and Photochemistry Experiment (FRAPPE).

29. Please provide an update on the Necessary Document Assistance Program, and the expenditure of the $300,000 General Fund appropriated for this purpose

30. Please discuss the jurisdictional issues the Department must navigate when engaging in public health issues. Please explain why additional statutory authority is needed for the Department to intervene on certain public health issues, specifically the reported side effects of the sounds emitted by wind turbines.

10:45-11:00 BREAK

11:00-11:20 Electronic Cigarettes

31. Please discuss where nicotine comes from.

32. Please explain the history of nicotine regulation. Has nicotine ever been classified as a controlled substance? If so, when? If not, why not?

11:20-11:40 Clean Water Treatment

33. Please provide the expenditure and revenue data for each Sector. How are the Sectors defined and is there consensus on these definitions? If not, where is there disagreement?

34. Does CORE allow for the collection and reporting of data the request for information asked for? If not, why not?

35. Why does the fine revenue from water quality violations go into the Water Quality Improvement Fund? Does this create an incentive for the regulators to fine permittees? How does this practice compare with how other state programs handle fine revenue?

11:40-12:00 CASH FUNDS

36. Are the waste tire funds building up excess reserves because there is no longer an issue with waste tires? If so, should the fee be lowered? If not, please discuss the Department's plan for how to spend down the reserves.

37. Please discuss the Recycling Resources Economic Opportunity Program including:
    a. The calendar year timeline for grant application and grant awards;
    b. The number of grant applications and dollar amount received in FY 2014-15;
    c. The number of grants issued and the dollar amount in FY 2014-15; and

d. An explanation for the Recycling Resources Economic Opportunity Fund's projected excess uncommitted reserve.

38. Please discuss what has occurred to cause the projected shift in the Newborn Screening and Genetics Counseling Cash Fund balance. Was a capital outlay expenditure made from the Fund? If so, when was the expenditure, how much was the expenditure for, and how does this recent expenditure compare to prior capital outlay expenditures?

39. Please provide the number of medical marijuana registry card holders over the past three years.

40. What is the balance of the Health Research Subaccount of the Medical Marijuana Program Cash Fund?

ADDENDUM: OTHER QUESTIONS FOR WHICH SOLELY WRITTEN RESPONSES ARE REQUESTED

1. Provide a list of any legislation that the Department has: (a) not implemented or (b) partially implemented. Explain why the Department has not implemented or has only partially implemented the legislation on this list.

2. Please provide a detailed description of all program hotlines administered by the Department, including:
   a. The purpose of the hotline;
   b. Number of FTE allocated to the hotline;
   c. The line item through which the hotline is funded; and
   d. All outcome data used to determine the effectiveness of the hotline.

3. Describe the Department's experience with the implementation of the new CORE accounting system.
   a. How has the implementation improved business processes in the Department?
   b. What challenges has the Department experienced since implementation and how have they been resolved (i.e. training, processes, reports, payroll)?
   c. What impact have these challenges had on the Department's access to funding streams?
   d. How has the implementation of CORE affected staff workload?
   e. Do you anticipate that CORE implementation will result in the need for a permanent increase in staff? If so, indicate whether the Department is requesting additional funding for FY 2016-17 to address it.

4. If the Department receives federal funds of any type, please provide a detailed description of any federal sanctions for state activities of which the Department is already aware. In addition, please provide a detailed description of any sanctions that MAY be issued against the Department by the federal government during FFY 2015-16.

5. Does the Department have any outstanding high priority recommendations as identified in the "Annual Report of Audit Recommendations Not Fully Implemented" that was published by

the State Auditor's Office and dated October 2015 (link below)? What is the department doing to resolve the outstanding high priority recommendations?

http://www.leg.state.co.us/OSA/coauditor1.nsf/All/4735187E6B48EDF087257ED0007FE8CA/$FILE/1542S%20Annual%20Report.%20Status%20of%20Outstanding%20Audit%20Recommendations,%20As%20of%20June%2030,%202015.%20Informational%20Report.%20October%202015.pdf

6. Is the department spending money on public awareness campaigns related to marijuana? How is the department working with other state departments to coordinate the campaigns?

7. Based on the Department's most recent available record, what is the FTE vacancy rate by department and by division? What is the date of the report?

8. For FY 2014-15, do any line items in your Department have reversions? If so, which line items, which programs within each line item, and for what amounts (by fund source)? What are the reasons for each reversion? Do you anticipate any reversions in FY 2015-16? If yes, in which programs and line items do you anticipate this reversions occurring? How much and in which fund sources do you anticipate the reversion being?

9. Are you expecting an increase in federal funding with the passage of the FFY 2015-16 federal budget? If yes, in which programs and what is the match requirement for each of the programs?

10. For FY 2014-15, did your department exercise a transfer between lines that is allowable under state statute? If yes, between which line items and programs did this transfer occur? What is the amount of each transfer by fund source between programs and/or line items? Do you anticipate transfers between line items and programs for FY 2015-16? If yes, between which line items/programs and for how much (by fund source)?