JOINT BUDGET COMMITTEE

STAFF BUDGET BRIEFING
FY 2019-20

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

PREPARED BY:
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DECEMBER 10, 2018

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DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

DEPARTMENT OVERVIEW

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

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

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, administering grants such as the Primary Care and Preventive Care Grant Program, and housing the Commission on Family Medicine Residency Training Programs.

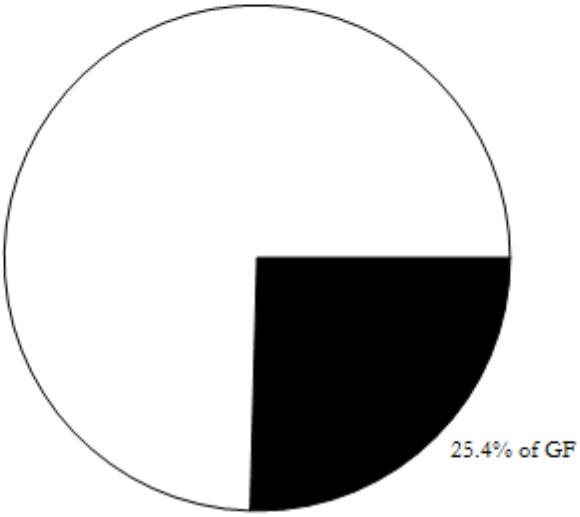
DEPARTMENT BUDGET: RECENT APPROPRIATIONS

FUNDING SOURCE	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20 *
General Fund	$2,630,255,841	$2,810,881,032	$2,904,579,002	$3,106,304,745
Cash Funds	1,030,963,941	1,212,347,879	1,292,022,699	1,413,372,064
Reappropriated Funds	15,828,008	77,491,711	84,557,891	84,612,145
Federal Funds	5,420,330,083	5,795,608,107	5,875,377,043	6,014,733,177
TOTAL FUNDS	**$9,097,377,873**	**$9,896,328,729**	**$10,156,536,635**	**$10,619,022,131**
Full Time Equiv. Staff	435.8	459.3	506.3	528.7

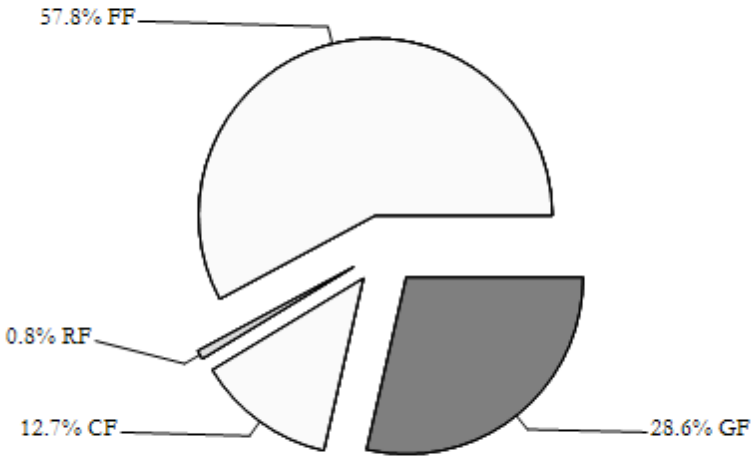
*Requested appropriation.

DEPARTMENT BUDGET: GRAPHIC OVERVIEW

Department's Share of Statewide General Fund

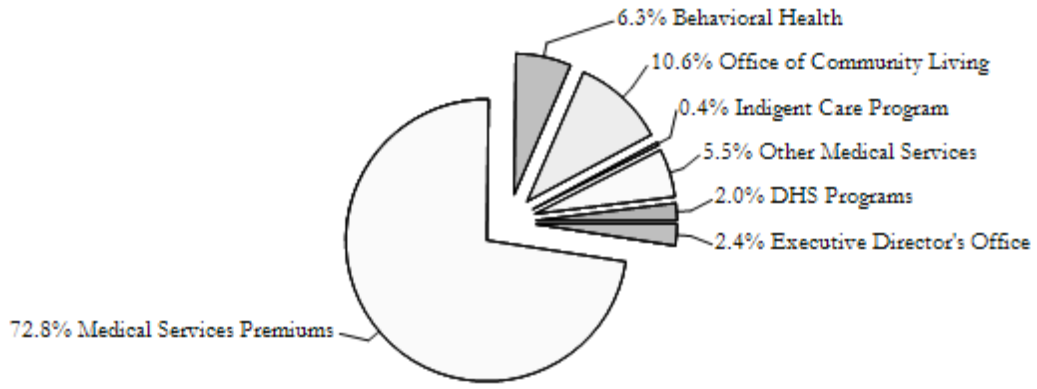


Department Funding Sources

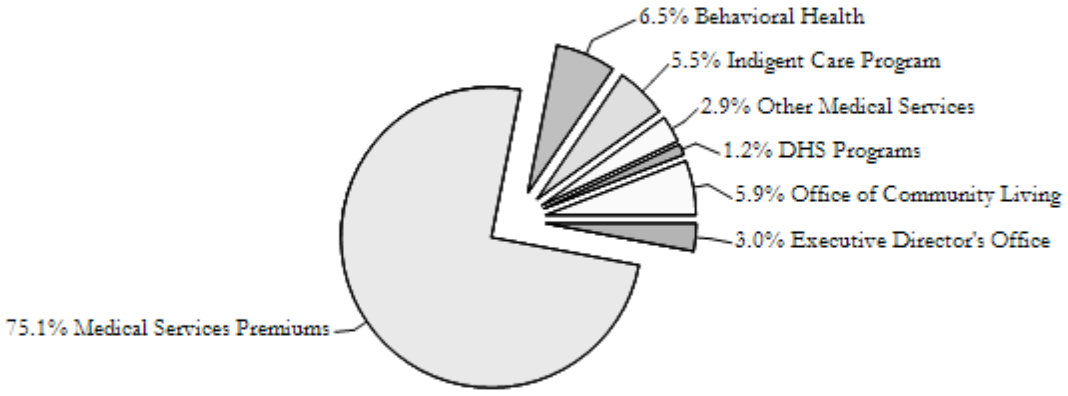


All charts are based on the FY 2018-19 appropriation.

Distribution of General Fund by Division



Distribution of Total Funds by Division



All charts are based on the FY 2018-19 appropriation.

GENERAL FACTORS DRIVING THE BUDGET

Funding for this department consists of 28.6 percent General Fund, 12.7 percent cash funds, 0.8 percent reappropriated funds, and 57.8 percent federal funds. The largest sources of cash funds include: (1) hospital and nursing facility provider fees; (2) tobacco taxes and tobacco settlement funds; (3) local government funds (certified public expenditures); (4) recoveries and recoupments; (5) money from the Unclaimed Property Trust Fund that is transferred to the Adult Dental Fund; and (6) sales taxes diverted to the Old Age Pension Health and Medical Care Fund. The federal funds include matching funds for the Medicaid program (through Title XIX of the Social Security Administration Act) and matching funds for the Children's Basic Health Plan (through Title XXI of the Social Security Administration Act). The subsections below discuss some of the most important factors driving the budget.

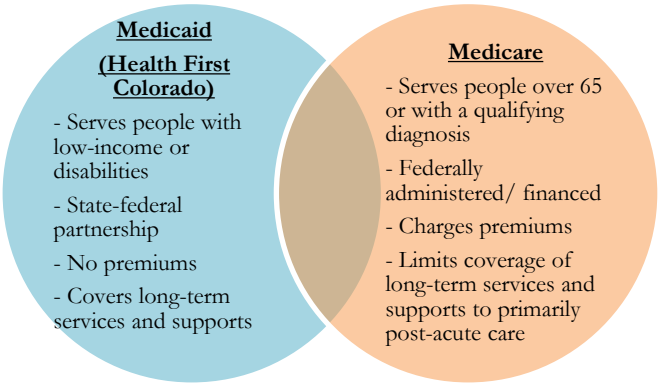
MEDICAID

Medicaid (marketed by the Department as Health First Colorado) provides health insurance to people with low income and people needing long-term care. Participants generally do not pay annual premiums[1] and copayments at the time of service are either nominal or not required. The federal government and state government share responsibility for financing, administering, and policy setting for the program.

Medi**caid** is sometimes confused with the similarly named Medi**care** that provides insurance for people who are elderly or have a specific eligible diagnosis regardless of income. The federal government administers Medicare and finances it with a combination of federal funds and annual premiums charged to participants. While the two programs are distinct, they do interact with each other, as some people are eligible for both Medicaid, due to their income, and Medicare, due to their age. For these people (called "dual eligible"), Medicaid pays the Medicare premiums and may assist with copayments, depending on the person's income. In addition, there are some differences in the coverage provided by Medicaid and Medicare. Most notably from a budgeting perspective, Medicaid covers long-term services and supports (LTSS) while Medicare coverage for LTSS is generally limited to post-acute care.

Nearly all citizens on Medicaid age 65 and older are enrolled in Medicare and a portion of people with disabilities.

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



The federal government matches state expenditures for the Medicaid program. The federal match rate, called the Federal Medical Assistance Percentage (FMAP), can vary based on economic conditions in the state, the type of services provided, and the population receiving services. For state fiscal year 2018-19 the average FMAP for the majority of Colorado Medicaid expenditures is 50.0 percent and that is not expected to change in FY 2019-20. For adults "newly eligible" pursuant to the federal Affordable Care Act, Colorado will receive an enhanced federal match of 94.0 percent in calendar year 2018, 93.0 percent in 2019, and 90 percent in 2020 and beyond.

Standard Medicaid Federal Match					
State Fiscal Year	Ave. Match	Federal Match by Quarter (of state fiscal year)			
		Q1-July	Q2-October	Q3-January	Q4-April
FY 14-15	50.76	50.00	51.01	51.01	51.01
FY 15-16	50.79	51.01	50.72	50.72	50.72
FY 16-17	50.20	50.72	50.02	50.02	50.02
FY 17-18	50.00	50.02	50.00	50.00	50.00
FY 18-19	50.00	50.00	50.00	50.00	50.00
FY 19-20	*50.00*	50.00	*50.00*	*50.00*	*50.00*

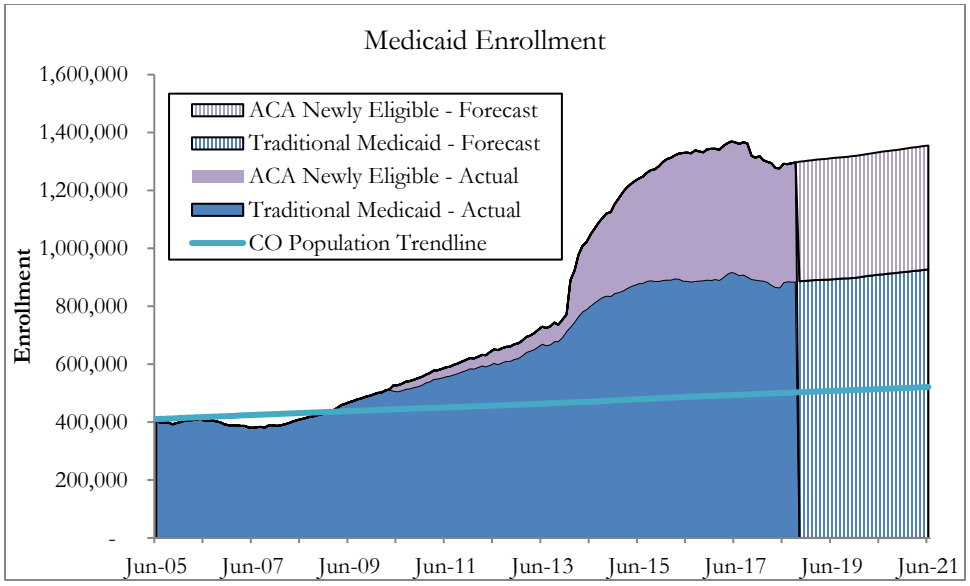
Italicized figures are projections.

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

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

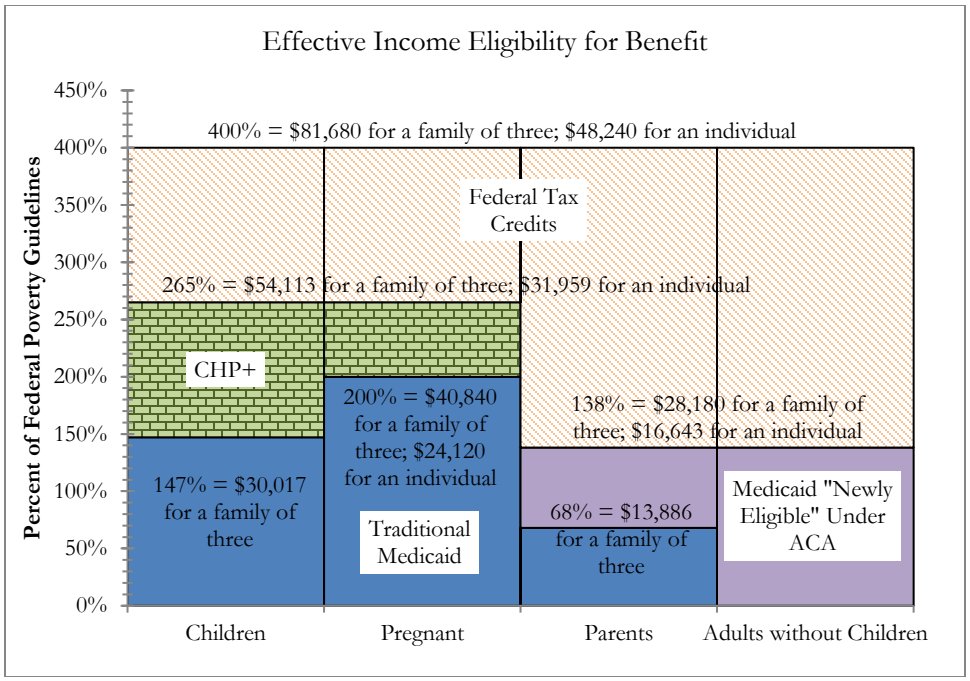
obligation is greater than anticipated, the Department has statutory authority to overexpend the Medicaid appropriation.[2]

The most significant factor affecting Medicaid expenditures is enrollment. Medicaid enrollment increased significantly for most of the years shown in the chart, due to increases in the state population, economic conditions that influence the number of people who meet the income eligibility criteria, and state and federal policy changes regarding eligibility. In FY 2017-18, enrollment decreased, mostly driven by the adult and children populations that are most sensitive to changes in economic conditions. The following chart shows the actual and forecasted Colorado Medicaid population. The chart highlights the population that is "newly eligible" pursuant to the federal Affordable Care Act and therefore qualifies for the enhanced federal match. The state match for the "newly eligible" comes from a provider fee charged to hospitals. The "CO Population Trendline" shows the projected trajectory of enrollment if Medicaid had grown at the same rate as Colorado's population since June 2005.



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

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



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

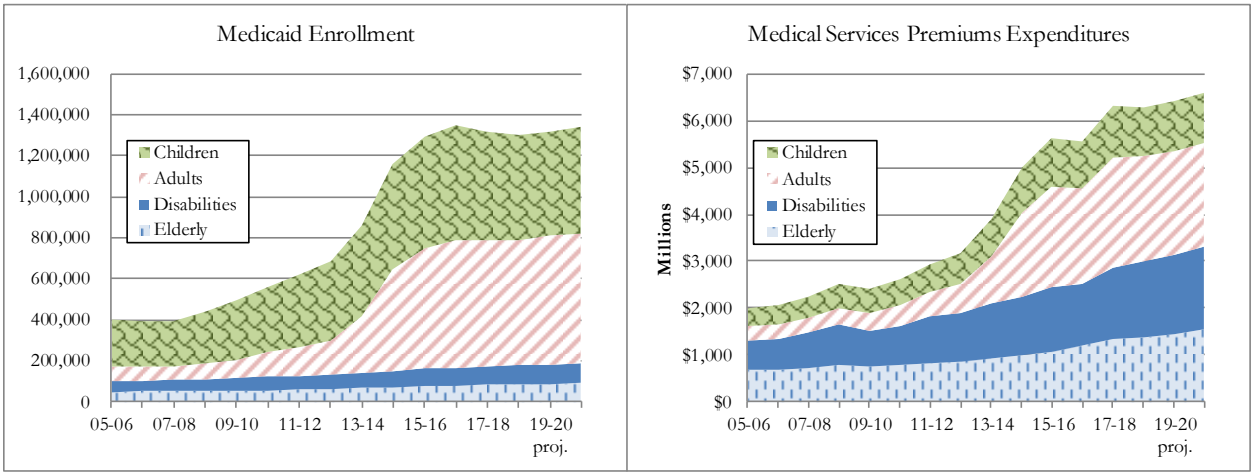
FAMILY SIZE	FEDERAL POVERTY GUIDELINE - 2018	SSI ANNUAL INCOME LIMIT
1	$12,140	$9,000
2	$16,460	$13,500
3	$20,780	
4	$25,100	
More	add $4,320 each	

Appropriations for Medicaid are divided into six main components, not including administration: (1) Medical Services Premiums; (2) Behavioral Health Community Programs; (3) the Office of Community Living; (4) the Indigent Care Program; (5) the Medicare Modernization Act State Contribution; and (6) programs administered by other departments. The subsections below discuss each in more detail.

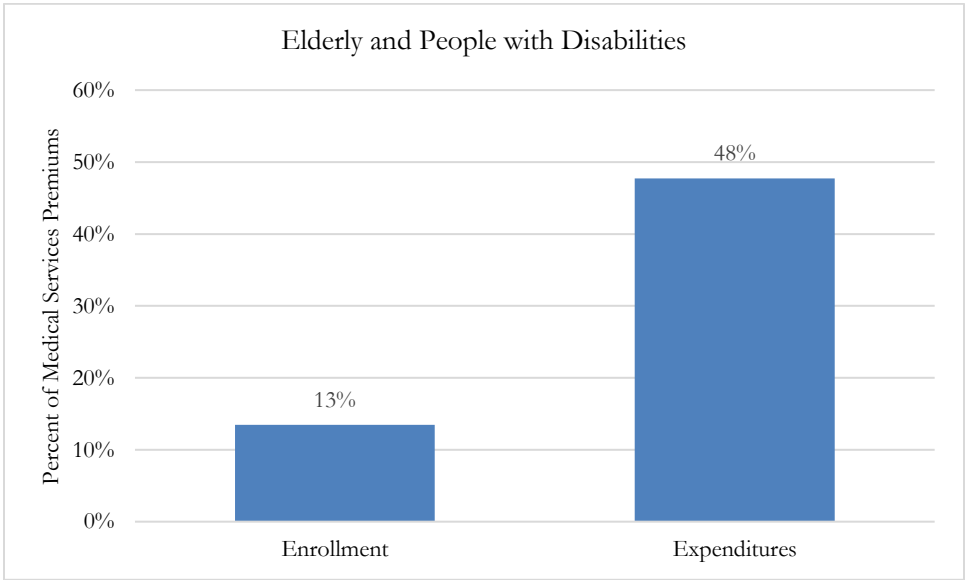
(1) Medical Services Premiums

Medical Services Premiums is a subset of Medicaid expenditures that pays for physical health care and long-term services and supports. The number of Medicaid clients, the costs of providing health care services, and the utilization of health care services drives expenditures for Medical Service Premiums.

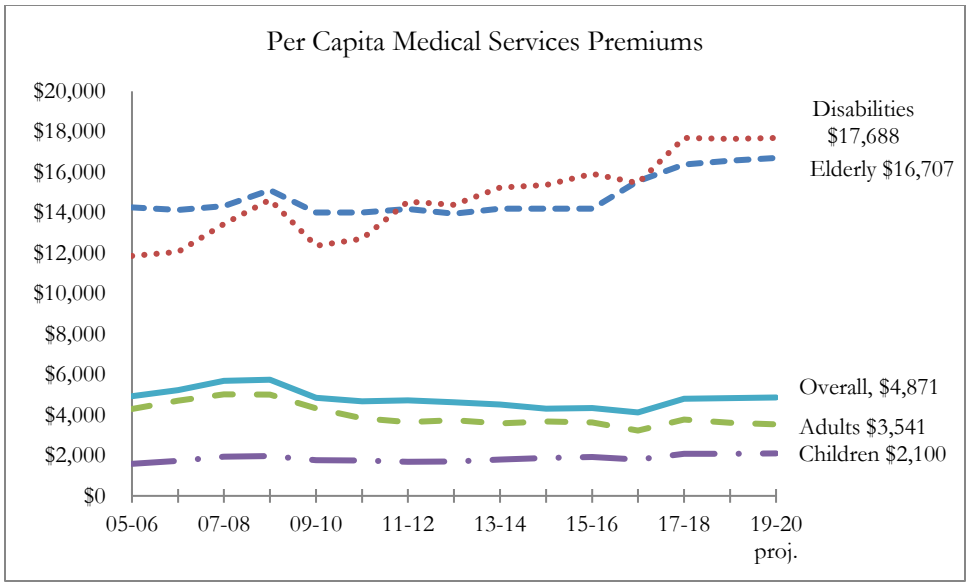
The two charts below illustrate recent changes in Medicaid enrollment and expenditures by broad eligibility category. The expenditures in these charts do not include special financing from provider fees, certified public expenditures, and interagency transfers for providers such as hospitals, nursing homes, and the physicians of the University of Colorado's School of Medicine. This special financing does not necessarily follow trends in enrollment, utilization, and the cost of care. Therefore, a separate chart that appears later illustrates the trends in special financing.



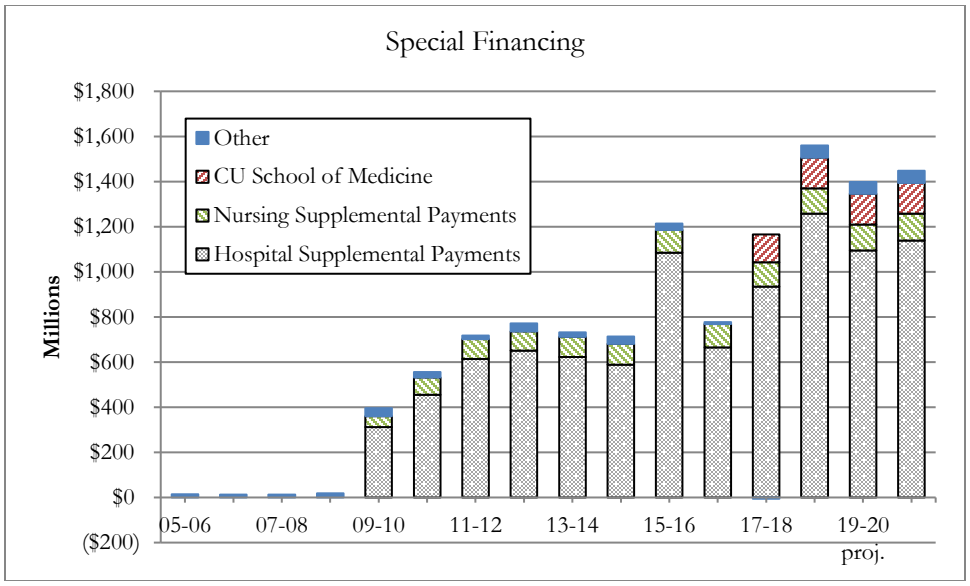
People 65 and over and people with disabilities utilize more medical services and higher cost medical services than the overall population. In addition, for qualifying clients Medicaid covers long-term services and supports, such as assistance with bathing, dressing, meals, and managing medications.



As illustrated in the following chart, per capita costs for the elderly and people with disabilities are much higher than for children and adults. For the population that is dually eligible for Medicare and Medicaid, Medicare absorbs a portion of the expenditures, which dampens the trends in Medicaid per capita costs for the elderly. Changes in the caseload mix influence per capita costs as well as changes in utilization and the cost of care. For example, recent eligibility expansions have added higher income adults and children, who tend to have lower medical costs, resulting in lower per capita trends.



The charts above track direct payments for physical health services and for long-term services and supports, but the Medical Services Premiums section also includes indirect special financing through provider fees, certified public expenditures, and interagency transfers for providers like hospitals, nursing homes, and the physicians of the University of Colorado's School of Medicine. A portion of the Healthcare Affordability and Sustainability (HAS) Fee, which replaced the Hospital Provider Fee, pays for enrollment expansion, but the majority of the fee matches federal funds in order to make supplemental payments back to hospitals based on the amount of services they provide to low-income clients. The Nursing Facility Fee works in a similar way to boost payments for nursing homes. Beginning in FY 2017-18, the General Assembly authorized interagency transfers between the Department of Higher Education and the Department of Healthcare Policy and Financing to increase payments for physicians of the University of Colorado's School of Medicine. Federal and state policies setting parameters on these types of special financing influence expenditures more than Medicaid enrollment, utilization, and cost of care patterns. The table below shows actual and projected expenditures on special financing.



(2) Behavioral Health Community Programs

Behavioral health services include both mental health and substance use-related services. With a few exceptions (e.g., non-citizens), Medicaid clients are eligible for behavioral health services. Behavioral health services are provided to Medicaid clients through a statewide managed care or "capitated" program. Under capitation, the Department contracts with regional entities to provide or arrange for behavioral health services for clients within their geographic region enrolled in the Medicaid program. Each regional entity receives a pre-determined monthly amount for each Medicaid client who is eligible for behavioral health services within its region. The "per-member-per-month" rates are unique for each Medicaid eligibility category in each geographic region. These rates are periodically adjusted based on clients' actual utilization of behavioral health services and the associated expenditures.

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

See the 12/11/18 briefing on Behavioral Health Community Programs for more information.

(3) Office of Community Living

Intellectual and developmental disability waiver services are not subject to standard Medicaid State Plan service and duration limits. Instead, these services are provided under a Medicaid waiver program. As part of the waiver, Colorado may limit the number of waiver program participants, which has resulted in a large number of individuals being unable to immediately access the services they need. Colorado has three Medicaid waivers for individuals who qualify for intellectual and developmental disability services:

- Adult Comprehensive waiver (also called the Comprehensive or Comp waiver) is for individuals over the age of eighteen who require residential and daily support services to live in the community.
- Supported Living Services waiver (SLS waiver) is for individuals over the age of eighteen who do not require residential services but require daily support services to live in the community.
- Children's Extensive Services waiver (also called the CES waiver or children's waiver) is for youth ages five to eighteen who do not require residential services but do require daily support services to be able to live in their family home.

New enrollments are funded for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and to service all individuals eligible for the Supported Living Services (SLS) and Children's Extensive Services (CES) waivers.

See the 12/11/18 briefing on the Office of Community Living for more information.

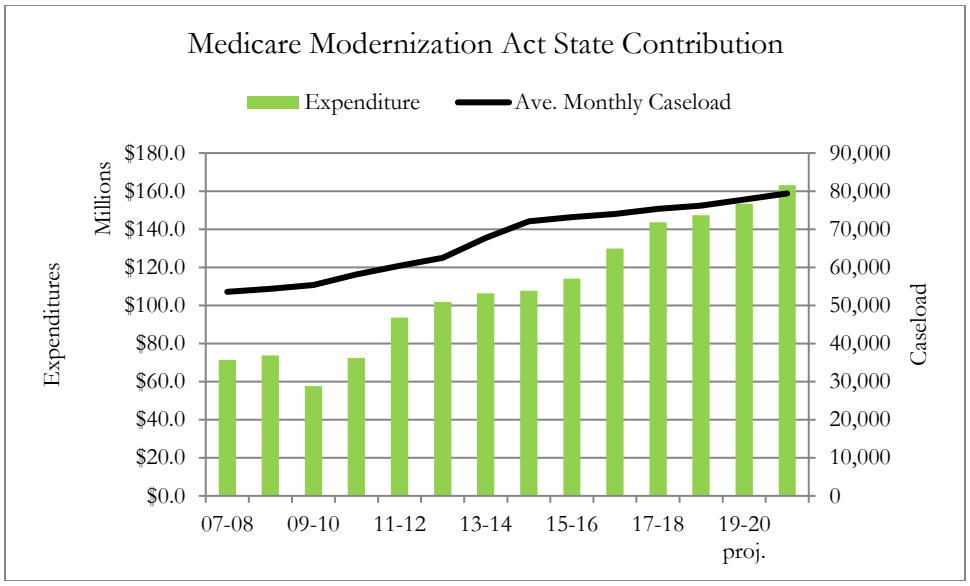
(4) INDIGENT CARE PROGRAM

The Indigent Care Program distributes Medicaid funds to hospitals and clinics that have uncompensated costs from treating uninsured or underinsured Coloradans. Unlike the rest of Medicaid, this is not an insurance program or an entitlement. Federal and state policies influence funding more than the number of individuals served, utilization, or the cost of services. The majority of the funding is from federal sources. State funds for the program come from the Healthcare Affordability and Sustainability (HAS) Fee, certifying public expenditures at hospitals, and the General Fund.

Colorado Indigent Care Program						
	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation
Safety Net Provider Payments	$309,976,756	$309,470,584	$310,125,957	$311,296,186	298,355,771	311,296,186
Clinic Based Indigent Care	6,119,760	6,119,760	6,119,760	6,119,760	6,119,760	6,090,896
Pediatric Specialty Hospital	11,799,938	13,455,012	13,455,012	13,455,012	13,455,012	13,455,012
TOTAL	**$327,896,454**	**$329,045,356**	**$329,700,729**	**$330,870,958**	**$317,930,543**	**$330,842,094**
General Fund	8,959,849	9,639,107	9,632,746	9,748,236	9,786,412	9,758,522
Cash Funds	152,391,319	153,201,150	152,556,889	155,073,238	149,107,296	155,648,093
Federal Funds	166,545,286	166,205,099	167,511,094	166,049,484	159,036,835	165,435,479
Total Funds Change		$1,148,902	$655,373	$1,170,229	($12,940,415)	$12,911,551
Percent Change		0.7%	0.4%	0.7%	-7.8%	8.1%

(5) MEDICARE MODERNIZATION ACT

The federal Medicare Modernization Act requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid in Medicaid, as estimated by a federal formula. From FY 2012-13 to FY 2014-15, in order to offset General Fund costs, Colorado applied bonus payments received from the federal government for meeting performance goals in CHP+ toward this obligation. The table below summarizes Colorado's payments to the federal government.



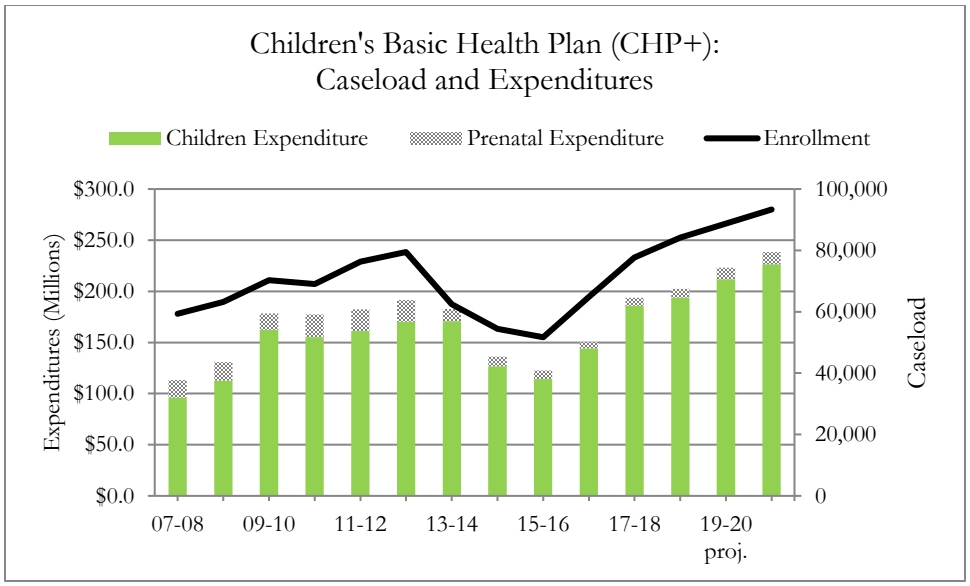
(6) Programs Administered By Other Departments

The Department of Health Care Policy and Financing (HCPF) transfers Medicaid money to several other departments. The General Assembly appropriates money to HCPF and then transfers it to the administering departments to comply with federal regulations that one state agency receives all federal Medicaid funding. The cost drivers for these programs are described in more detail in the "General Factors Driving the Budget" for the receiving departments. The Department of Human Services is the largest recipient of transfers from HCPF.

CHILDREN'S BASIC HEALTH PLAN

The Children's Basic Health Plan (marketed by the Department as the Children's Health Plan *Plus* and abbreviated as CHP+) compliments the Medicaid program, providing low-cost health insurance for children and pregnant women in families with slightly more income than Medicaid eligibility criteria allow. Annual membership premiums vary based on income, with an example being $75 to enroll one child in a family earning 205 percent of the federal poverty guidelines. Coinsurance costs are nominal. Federal funds pay approximately 88.0 percent of the program costs not covered by member contributions, and state funds pay the remaining 12.0 percent as a match. CHP+ typically receives roughly $28 million in revenue from the tobacco master settlement agreement, and any remaining state match comes from the General Fund.

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


Children's Basic Health Plan (CHP+):
Caseload and Expenditures
Children Expenditure
Prenatal Expenditure
Enrollment
Expenditures (Millions)
$300.0
$250.0
$200.0
$150.0
$100.0
$50.0
$0.0
100,000
80,000
60,000
40,000
20,000
0
Caseload
07-08
09-10
11-12
13-14
15-16
17-18
19-20 proj.

SUMMARY: FY 2018-19 APPROPRIATION & FY 2019-20 REQUEST

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 APPROPRIATION:						
HB 18-1322 (Long Bill)	10,130,526,763	2,891,689,537	1,290,827,504	84,557,891	5,863,451,831	491.4
Other legislation	26,009,872	12,889,465	1,195,195	0	11,925,212	14.9
TOTAL	**$10,156,536,635**	**$2,904,579,002**	**$1,292,022,699**	**$84,557,891**	**$5,875,377,043**	**506.3**
FY 2019-20 REQUESTED APPROPRIATION:						
FY 2018-19 Appropriation	$10,156,536,635	2,904,579,002	$1,292,022,699	$84,557,891	$5,875,377,043	506.3
R1 Medical Services Premiums	354,643,647	166,725,932	79,381,786	74,999	108,460,930	0.0
R2 Behavioral Health	26,909,077	12,743,445	6,764,296	0	7,401,336	0.0
R3 Children's Basic Health Plan	27,968,602	0	22,506,477	0	5,462,125	0.0
R4 Medicare Modernization Act	1,520,436	1,520,436	0	0	0	0.0
R5 Office of Community Living	6,298,371	2,526,890	701,023	0	3,070,458	0.0
R6 Local administration transformation	3,266,842	2,090,396	202,724	3	973,719	2.5
R7 Primary care alternative payment	2,570,871	535,928	281,908	0	1,753,035	1.8
R8 Benefits and technology advisory committee	342,248	124,897	46,227	0	171,124	1.8
R9 Long-term home health and private duty nursing acuity tool	358,583	179,292	0	0	179,291	0.0
R10 Transform customer experience	2,215,752	753,356	354,520	0	1,107,876	1.8
R11 All-Payer Claims Database	2,619,731	2,811,464	0	0	(191,733)	0.0
R12 Medicaid enterprise operations	26,407,927	654,663	1,828,468	0	23,924,796	1.8
R13 Provider rate adjustments	61,064,820	26,768,039	1,750,713	0	32,546,068	0.0
R14 Office of Community Living governance	1,561,165	422,482	250,000	0	888,683	0.9
R15 Operational compliance and oversight	(780,722)	0	5,355	0	(786,077)	5.5
R16 Employment first initiatives and state programs for IDD	3,028,666	(800,000)	3,828,666	0	0	1.8
NP CBMS PEAK	20,350,847	4,090,801	2,084,566	(93,565)	14,269,045	0.0
NP Office of Electronic Health Information	1,759,468	981,831	0	0	777,637	0.0
NP Transfer home modification child welfare program	57,800	28,900	0	0	28,900	0.0
Centrally appropriated items	2,415,944	821,588	237,882	40,982	1,315,492	0.0
Transfers to other agencies	414,600	158,090	0	30,738	225,772	0.0
Annualize prior year budget actions	(80,384,983)	(20,323,711)	1,119,583	1,097	(61,181,952)	4.5
Human Services programs	(2,080,827)	(1,045,607)	5,171	0	(1,040,391)	0.0
Tobacco forecast	(43,369)	(43,369)	0	0	0	0.0
TOTAL	**$10,619,022,131**	**$3,106,304,745**	**$1,413,372,064**	**$84,612,145**	**$6,014,733,177**	**528.7**
INCREASE/(DECREASE)	$462,485,496	$201,725,743	$121,349,365	$54,254	$139,356,134	22.4
Percentage Change	4.6%	6.9%	9.4%	0.1%	2.4%	4.4%

DESCRIPTION OF INCREMENTAL CHANGES

R1 MEDICAL SERVICES PREMIUMS: The Department requests a net increase of $354.6 million total funds, including $166.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item. *See the issue brief "Forecast Trends" for more information.*

R2 BEHAVIORAL HEALTH PROGRAMS: The Department requests a net increase of $26.9 million total funds, including an increase of $12.7 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for behavioral health services. *See the 12/11/18 briefing on Behavioral Health Community Programs for more information.*

R3 CHILDREN'S BASIC HEALTH PLAN: The Department requests a net increase of $28.0 million total funds for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan. *See the issue brief "Forecast Trends" for more information.*

R4 MEDICARE MODERNIZATION ACT: The Department requests an increase of $1.5 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare. *See the issue brief "Forecast Trends" for more information.*

R5 OFFICE OF COMMUNITY LIVING: The Department requests a net increase of $6.3 million total funds, including $2.5 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for services for people with intellectual and developmental disabilities. *See the 12/11/18 briefing on the Office of Community Living for more information.*

R6 LOCAL ADMINISTRATION TRANSFORMATION: The Department requests $3.3 million, including $2.1 million General Fund, and 2.5 FTE for three initiatives to improve county administration of public assistance:

- Consolidate returned mail processing to remove it from county responsibilities;
- Increase incentive funding for county performance; and
- Centralize administration of non-emergency medical transportation (NEMT).

The Department anticipates the consolidation of returned mail processing and the county incentive payments will help the Department identify people who have moved out of state more quickly, leading to savings in FY 2020-21 that partially offset costs. Centralizing the administration of non-emergency medical transportation is intended to improve consistency and customer service and reduce county workloads.

R6 Local Administration						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2019-20						
Consolidate returned mail	$876,996	$273,849	$74,351	$0	$528,796	0.9
Administration	*180,231*	*58,316*	*20,803*	*0*	*101,112*	*0.9*
Development	*696,765*	*215,533*	*53,548*	*0*	*427,684*	*0.0*
Cost avoidance	*0*	*0*	*0*	*0*	*0*	*0.0*
County incentive payments	1,586,624	1,529,452	13,859	0	43,313	0.9
Administration	*86,624*	*29,452*	*13,859*	*0*	*43,313*	*0.9*
Incentive payments	*1,500,000*	*1,500,000*	*0*	*0*	*0*	*0.0*
Centralize admin of NEMT	803,219	287,095	114,514	0	401,610	0.7
TOTAL- HCPF	**$3,266,839**	**$2,090,396**	**$202,724**	**$0**	**$973,719**	**2.5**
Hunan Services share of mail	27,865	4,578	13,401	0	9,886	0.0
TOTAL - All Departments	**$3,294,704**	**$2,094,974**	**$216,125**	**$0**	**$983,605**	**2.5**
FY 2020-21						
Consolidate returned mail	($5,107,840)	($1,594,822)	($212,326)	$111,942	($3,412,634)	1.0
Administration	*3,403,423*	*1,020,785*	*260,051*	*111,942*	*2,010,645*	*1.0*
Development	*0*	*0*	*0*	*0*	*0*	*0.0*
Cost avoidance	*(8,511,263)*	*(2,615,607)*	*(472,377)*	*0*	*(5,423,279)*	*0.0*
County incentive payments	1,588,294	1,530,020	14,127	0	44,147	1.0
Administration	*88,294*	*30,020*	*14,127*	*0*	*44,147*	*1.0*
Incentive payments	*1,500,000*	*1,500,000*	*0*	*0*	*0*	*0.0*
Centralize admin of NEMT	2,084,957	748,221	294,257	0	1,042,479	1.0
TOTAL- HCPF	**($1,434,589)**	**$683,419**	**$96,058**	**$111,942**	**($2,326,008)**	**3.0**
Hunan Services share of mail	112,608	18,502	54,157	0	39,949	0.0
TOTAL - All Departments	**($1,321,981)**	**$701,921**	**$150,215**	**$111,942**	**($2,286,059)**	**3.0**

R7 PRIMARY CARE ALTERNATIVE PAYMENT: The Department requests $2.6 million total funds, including $535,928 General Fund, and 1.8 FTE for three initiatives to expand and improve performance payments for primary care.

- *Risk Sharing Option* - Request federal approval to offer providers an option to split current fee-for-service payments into a portion that is paid on a capitated basis and a remainder that is paid on a fee-for-service basis
- *Clinical Quality Measures* - Collect Electronic Clinical Quality Measure (eCQM) information from providers, which can be more useful for designing effective performance payments than claims data
- *Claims data common format* - Finance Medicaid's share of work by the Multi-Payer Collaborative to aggregate claims data in a common format, so that Medicaid can use the same performance measures, definitions, and data sources as other payers and not pull providers in multiple directions

The Department expects expanding and improving performance payments will result in better health outcomes and lower costs, and the Department projects savings, beginning in FY 2021-22, at least as great as the General Fund cost.

R8 BENEFITS AND TECHNOLOGY COMMITTEE: The Department requests $342,248 total funds, including $124,897 General Fund, and 1.8 FTE to create a standing benefits and technology advisory committee to evaluate new evidence-based research to inform decisions about the amount, scope, and duration of benefits. The Department currently invites interested parties to assist with benefit reviews through the Benefits Collaborative, but the lack of a standing membership has led to criticism of the process as biased toward those who choose to participate. The requested funding would pay for staff

for the proposed committee, an annual budget of $150,000 for outside research and expert consultation, and, beginning in FY 2020-21, $250,000 for an annual external evaluation of the cost savings of each initiative implemented. The Department anticipates savings from otherwise projected expenditures of approximately $5.0 million total funds ($1.4 million General Fund) per year, beginning in FY 2020-21, from improved health outcomes when benefit policies are better aligned with evidence-based research.

R9 LONG-TERM HOME HEALTH AND PRIVATE DUTY NURSING ACUITY TOOL: The Department requests $358,583 total funds, including $179,292 General Fund, to develop a statistically-valid and clinically-based tool for assessing the needs of clients for long-term home health services and for private duty nursing services. According to the Department, current methods for assessing needs are inconsistent and/or rely on tools designed for other purposes or tools that are outdated and insufficiently validated. The Department projects improved needs assessments will result in a shift of utilization toward lower cost alternative Home- and Community-Based Services, resulting in savings beginning in FY 2020-21.

R9 Long-term Home Health and Private Duty Nursing Acuity Tool					
	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24
Stakeholder engagement	$26,580	$13,290	$13,290	$0	$0
Tool development	332,003	195,373	0	0	0
Post-implementation evaluation	0	0	0	50,000	50,000
Shift in utilization	0	(704,982)	(7,837,543)	(13,485,585)	(14,707,037)
TOTAL	**$358,583**	**($496,319)**	**($7,824,253)**	**($13,435,585)**	**($14,657,037)**
General Fund	179,292	(242,042)	(3,844,124)	(6,600,784)	(7,200,912)
Cash Funds	0	(3,573)	(39,722)	(68,347)	(74,538)
Federal Funds	179,291	(250,704)	(3,940,407)	(6,766,454)	(7,381,587)

R10 CUSTOMER EXPERIENCE: The Department requests $2.2 million total funds, including $753,356 General Fund, and 1.8 FTE for several initiatives to improve customer experience.

- Update, index, and expand the automated call center knowledge library
- Create a pool of call center temporary staff to address turnover and employee absences
- Contract for assistance ensuring that all communications to clients, including those produced by vendors, use plain language, consistent terminology, and proper translation
- Automate online chat assistance to use artificial intelligence for the most commonly asked questions
- Utilize one-time contract services and on-going in-house staff to improve and maintain training for call center staff and quality control for communications
- Provide funding to support volunteer clients who serve on the Member Experience Advisory Councils that provide recommendations on Department communications and procedures for Medicaid and the Children's Basic Health Plan

R10 Customer Experience					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2019-20					
Call center knowledge library	$300,000	$102,000	$48,000	$150,000	0.0
Call center temporary pool	499,200	169,728	79,872	249,600	0.0
Plain language contract	192,000	65,280	30,720	96,000	0.0
Automate on-line chat	920,000	312,800	147,200	460,000	0.0
Improve training and quality control	267,248	90,865	42,759	133,624	1.8
Member Experience Advisory Committees	37,304	12,683	5,969	18,652	0.0
Total	**$2,215,752**	**$753,356**	**$354,520**	**$1,107,876**	**1.8**
FY 2020-21					
Call center knowledge library	$40,000	$13,600	$6,400	$20,000	0.0
Call center temporary pool	499,200	169,728	79,872	249,600	0.0
Plain language contract	192,000	65,280	30,720	96,000	0.0
Automate on-line chat	184,000	62,560	29,440	92,000	0.0
Improve training and quality control	170,588	57,999	27,295	85,294	2.0
Member Experience Advisory Committees	37,304	12,683	5,969	18,652	0.0
Total	**$1,123,092**	**$381,850**	**$179,696**	**$561,546**	**2.0**

R11 ALL-PAYER CLAIMS DATABASE: The Department requests a net increase of $2.6 million total funds, including $2.8 million General Fund, to finance the All-Payer Claims Database (APCD). House Bill 18-1327, sponsored by the JBC, allowed General Fund to support the APCD and appropriated funding based on Medicaid's share of the costs. However, the federal government approved a different method to estimate Medicaid's share of costs than assumed in last year's bill, resulting in a funding shortfall that the Department proposes closing with General Fund. Also, the Department proposes increasing funding in FY 2019-20 and providing inflationary increases in out years to allow the APCD staff to focus on data quality, rather than fundraising, and to stabilize support for the APCD.

R11 All-Payer Claims Database			
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS
Close funding gap	$0	$191,733	($191,733)
Increase funding	2,619,731	2,619,731	0
TOTAL	**$2,619,731**	**$2,811,464**	**($191,733)**

R12 MEDICAID ENTERPRISE OPERATIONS: The Department requests $26.4 million total funds, including $654,663 General Fund, and 1.8 FTE to address operating and compliance issues with a collection of information technology systems and processes related to eligibility, benefits authorization, and claims processing. The federal government refers to these information technology systems and processes as the Medicaid Enterprise System. The request is not related to the provider fee on hospitals that is designated as an enterprise under TABOR. In addition to the request for the Department of Health Care Policy and Financing, there are components of the request that affect the Governor's Office of Information Technology.

The Legislative Requirements for System Functionality component of the request includes resources for the time-intensive federal process of certifying that recently reprocured components of the Medicaid Enterprise System are operating as intended. Federal certification is necessary to continue qualifying for an enhanced federal match. Also, it includes funds for a new care and case management tool to replace systems that are outdated and do not communicate with each other or the Department's

billing system. It makes adjustments to estimated costs for implementing S.B. 16-192 regarding a single assessment tool and S.B. 18-266, which authorized claims editing software to improve the accuracy of claims edits. Finally, it includes funds for federally required information technology architecture self-assessments and independent verification and validations.

The components for Improvements to Member/Provider Support and Planning for Future of Medicaid Enterprise are about improving and maintaining responsiveness and strategic planning.

R12 Medicaid Enterprise Operations					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2018-19					
Legislative requirements on system functionality	$5,569,423	($3,682)	$171,545	$5,401,560	0.0
Improvements to member/provider experience	3,907,866	437,106	262,168	3,208,592	0.0
Planning for future of Medicaid Enterprise	0	0	0	0	0.0
TOTAL	**$9,477,289**	**$433,424**	**$433,713**	**$8,610,152**	**0.0**
FY 2019-20					
Legislative requirements on system functionality	5,999,604	(1,510,423)	334,721	7,175,306	0.0
Improvements to member/provider experience	13,312,176	1,528,602	938,745	10,844,829	0.9
Planning for future of Medicaid Enterprise	8,096,148	910,285	605,702	6,580,161	0.9
TOTAL	**$27,407,928**	**$928,464**	**$1,879,168**	**$24,600,296**	**1.8**
FY 2020-21					
Legislative requirements on system functionality	4,912,672	(398,221)	228,423	5,082,470	0.0
Improvements to member/provider experience	12,663,985	1,493,294	891,804	10,278,887	1.0
Planning for future of Medicaid Enterprise	15,396,283	1,959,443	1,222,265	12,214,575	1.0
TOTAL	**$32,972,940**	**$3,054,516**	**$2,342,492**	**$27,575,932**	**2.0**

R13 PROVIDER RATES: The Department requests a net increase of $61.1 million total funds, including $56.8 million General Fund, for changes to provider rates.

R13 Provider Rates				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Personal care/Homemaker	$20,534,428	$10,267,214	$0	$10,267,214
Home- & Community-Based Services	10,167,918	5,083,959	0	5,083,959
Transportation	6,828,678	1,825,047	526,754	4,476,877
Dental	4,451,570	803,064	739,851	2,908,655
Maternity	4,373,298	1,966,672	0	2,406,626
Other	211,190	62,517	10,164	138,509
Primary care/Radiology/PT&OT	0	0	0	0
Laboratory/Pathology	(9,262,666)	(2,301,773)	(470,544)	(6,490,349)
Anesthesia	(8,519,153)	(2,514,854)	(412,327)	(5,591,972)
Diabetes test strips	(2,301,070)	(873,026)	(70,414)	(1,357,630)
Subtotal - Targeted Changes	**$26,484,193**	**$14,318,820**	**$323,484**	**$11,841,889**
Across-the-board 0.75 percent	34,580,627	12,449,219	1,427,229	20,704,179
Total	**$61,064,820**	**$26,768,039**	**$1,750,713**	**$32,546,068**

See the issue brief "Provider Rates" for more information.

R14 OFFICE OF COMMUNITY LIVING GOVERNANCE: The Department requests $1.6 million total funds, including $422,482 General Fund, and 0.9 FTE for five initiatives to improve the Office of Community Living:

- Contract with a case management broker to assist clients in selecting a case management agency, in order to comply with conflict-free case management requirements
- Address inadequate funding for the federally-mandated Preadmission Screening and Resident Review (PASRR) that identifies mental health or intellectual and developmental disability needs before people enter a nursing home, and separate responsibility for administering the PASRR from entities that provide services, in order to remove a potential conflict of interest
- Continue funding for staff associated with the Behavioral Health Crisis Pilot, in order to coordinate behavioral health services for people with intellectual and developmental disabilities
- Increase a statutory limit on the amount of nursing home civil penalty revenues that can be used for nursing home innovation grants, in order to spend down the fund balance and improve nursing care
- Increase oversight of Individual Residential Support Services for people with intellectual and developmental disabilities by giving the Medical Services Board rule-making authority in statute and providing funding for the Department of Local Affairs to conduct housing quality inspections

The last two initiatives would require legislation.

R15 OPERATIONAL COMPLIANCE AND OVERSIGHT: The Department requests a net decrease of $780,722 total funds and an increase of 5.5 FTE for seven compliance and oversight initiatives:

- *Eligibility system audits* – Contract for services and hire internal staff to audit eligibility determinations, which the Department projects will lead to faster corrections and savings
- *PACE oversight* – Hire staff to increase oversight of billing, quality and adequacy of care, and enrollment for the fast-growing Program for All-Inclusive Care for the Elderly (PACE), which serves elderly people who meet nursing level of care and within a flat rate tries to manage care and provide community supports to allow clients to live as independently as possible
- *Managed care financial reviews* – Increase contracts to perform financial reviews of managed care organizations and their subcontracts to ensure accurate rates
- *Hospital back-up data validation* – Contract for services to validate data used in rate setting for the hospital back-up program, which provides nursing services for high-acuity patients and allows them to discharge from a hospital setting
- *Single Entry Point oversight* - Hire staff to meet federal oversight standards for the Single Entry Points, which provide case management, care planning, and referrals for long-term services and supports
- *Audit management* – Hire staff to manage an announced increase in federal audits and ensure federal auditors receive the information needed in a timely and coordinated fashion
- *Claims review for intellectual and developmental disability services* – Hire staff to investigate and recover erroneously paid claims for services for people with intellectual and developmental disabilities in response to referrals from the Department of Public Health and Environment, internal staff, case management agencies, etc.

R15 Operational compliance and oversight					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2019-20					
Eligibility system audits	($1,528,973)	($335,896)	($27,139)	($1,165,938)	0.9
Staff	*91,744*	*26,946*	*15,962*	*48,836*	*0.9*
Contract services	*111,499*	*45,375*	*31,889*	*34,235*	*0.0*
Eligibility corrections	*(1,732,216)*	*(408,217)*	*(74,990)*	*(1,249,009)*	*0.0*
PACE oversight	231,744	115,872	0	115,872	0.9
Staff	*91,744*	*45,872*	*0*	*45,872*	*0.9*
Contract services	*140,000*	*70,000*	*0*	*70,000*	*0.0*
Managed care financial reviews	85,794	23,594	16,531	45,669	0.0
Hospital back-up data validation	64,000	32,000	0	32,000	0.0
Single Entry Point oversight	183,225	91,613	0	91,612	1.8
Audit management	91,744	26,945	15,963	48,836	0.9
Claims review for IDD	91,744	45,872	0	45,872	0.9
TOTAL	**($780,722)**	**$0**	**$5,355**	**($786,077)**	**5.4**
FY 2020-21					
Eligibility system audits	($2,670,274)	($596,279)	$10,128	($2,084,123)	1.0
Staff	*94,154*	*27,653*	*16,377*	*50,124*	*1.0*
Contract services	*700,000*	*192,500*	*143,732*	*363,768*	*0.0*
Eligibility corrections	*(3,464,428)*	*(816,432)*	*(149,981)*	*(2,498,015)*	*0.0*
PACE oversight	94,154	47,076	0	47,078	1.0
Staff	*94,154*	*47,076*	*0*	*47,078*	*1.0*
Contract services	*0*	*0*	*0*	*0*	*0.0*
Managed care financial reviews	85,794	23,594	16,531	45,669	0.0
Hospital back-up data validation	64,000	32,000	0	32,000	0.0
Single Entry Point oversight	188,076	94,039	0	94,037	2.0
Audit management	94,154	27,654	16,377	50,123	1.0
Claims review for IDD	94,154	47,077	0	47,077	1.0
TOTAL	**($2,049,942)**	**($324,839)**	**$43,036**	**($1,768,139)**	**6.0**

R16 EMPLOYMENT FIRST INITIATIVES AND STATE PROGRAMS FOR PEOPLE WITH IDD: The Department requests a net increase of $3.0 million total funds, including a decrease of $800,000 General Fund, and 1.8 FTE to: 1) conduct a supported employment pilot program for individuals with intellectual and developmental disabilities; 2) eliminate the current waitlist for the State-only Supported Living Services Program; and 3) enroll 272 waitlist members onto the Family Support Services Program.

CENTRALLY APPROPRIATED ITEMS: The request includes adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; short-term disability; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; salary survey; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; Capitol complex leased space; payments to the Governor's Office of Information Technology (OIT); and CORE operations.

TRANSFERS TO OTHER STATE AGENCIES: The Department requests $414,600 total funds, including $158,090 General Fund, for transfers to programs administered by other departments, primarily for the Facility Survey and Certification program in the Department of Public Health and Environment.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: The request includes adjustments for out-year impacts of prior year legislation and budget actions, summarized in the table below. The titles of the annualizations begin with either a bill number or the relevant fiscal year. For budget decisions made in the Long Bill, the title includes a reference to the priority number the Department used in that year for the initiative, if relevant.

The largest increase is for H.B. 18-1407, which expanded eligibility and increased provider rates for certain services for people with intellectual and developmental disabilities. The largest decrease is for H.B. 17-1353, which projected savings as a result of changes to the Accountable Care Collaborative and performance-based payments for primary care and behavioral health services. The second largest decrease is for S.B. 18-266, which (1) authorized cost and quality technology to help the Regional Accountable Entities identify the most effective providers and medications and steer clients to these resources, (2) implemented a hospital admission review program, (3) authorized billing system safeguards, and (4) created an administrative unit dedicated to resource control.

Prior Year Budget Actions						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
HB 18-1407 Access to disability services	$42,809,549	$21,512,521	$0	$0	$21,297,028	0.3
FY 18-19 BA12 Public school health	12,223,893	0	6,111,946	0	6,111,947	0.0
FY 18-19 R17 Single assessment tool	6,521,399	3,260,700	0	0	3,260,699	0.0
FY 18-19 R9 Provider rate adjustments	6,125,482	2,392,249	175,341	0	3,557,892	0.0
SB 16-192 IDD Assessment tool	2,934,860	1,467,430	0	0	1,467,430	0.0
FY 18-19 Twelve-month contraceptive supply	1,160,668	28,016	102,189	0	1,030,463	0.0
FY 07-08 S5 Revised federal rule for PERM program	588,501	147,125	102,988	0	338,388	0.0
FY 18-19 R6 Electronic visit verification	581,196	350,707	0	0	230,489	0.3
FY 18-19 NP CBMS-PEAK annual adjustment	542,909	118,673	69,443	1,743	353,050	0.0
HB 18-1328 Redesign children health waiver	339,835	169,917	0	0	169,918	0.2
SB 18-145 Employment first recommendations	303,525	303,525	0	0	0	0.1
SB 17-091 Home health services in community	148,050	69,867	4,032	0	74,151	0.0
SB 18-200 PERA	129,062	47,659	9,258	2,635	69,510	0.0
FY 17-18 R10 RCTF recommendation	13,217	6,609	0	0	6,608	0.0
FY 18-19 R18 Vendor consolidation	7,328	2,401	1,263	0	3,664	0.0
FY 18-19 CHASE admin costs	3,932	0	1,965	0	1,967	1.1
HB 18-1327 All-payer Health Claims	3,141	1,571	0	0	1,570	0.1
FY 17-18 R8 MMIS operations	0	(15,266)	32,717	22	(17,473)	0.0
FY 17-18 R16 CU School of Medicine sup payment	0	0	0	1	(1)	0.0
HB 17-1353 Medicaid delivery and payment initiatives	(104,141,668)	(35,769,688)	(3,842,355)	0	(64,529,625)	0.4
SB 18-266 Controlling Medicaid costs	(38,281,506)	(10,617,803)	(2,003,395)	0	(25,660,308)	1.2
FY 18-19 R8 Medicaid savings initiatives	(3,200,085)	(2,201,319)	2,447,255	(3,304)	(3,442,717)	1.1
HB 18-1326 Transition from institutional setting	(3,159,236)	(1,444,618)	0	0	(1,714,618)	0.0
FY 18-19 R11 Admin contracts	(1,246,191)	(1,275,237)	0	0	29,046	0.0
HB 15-1368 Cross-system Response Pilot	(916,217)	0	(916,217)	0	0	(1.0)
FY 18-19 R14 Safety net program adjustments	(611,367)	0	(611,367)	0	0	0.0
FY 18-19 R10 Drug cost containment	(505,885)	(38,124)	(13,307)	0	(454,454)	0.0
SB 17-267 Sustainability of rural CO	(436,536)	(76,809)	(15,560)	0	(344,167)	0.0
FY 17-18 R6 Delivery system and payment reform	(431,184)	2,010,359	(273,520)	0	(2,168,023)	0.0
FY 18-19 IDD Waiver consolidation	(301,500)	(150,750)	0	0	(150,750)	0.0
FY 06-07 R8 Nursing facility appraisals	(279,746)	(139,873)	0	0	(139,873)	0.0
FY 17-18 BA9 Pueblo regional center corrective action	(267,864)	(133,932)	0	0	(133,932)	0.0
FY 18-19 BA14 Business utilization system	(230,040)	(115,020)	0	0	(115,020)	0.0
HB 18-1321 Non-emergency medical transportation	(212,863)	(101,559)	9,748	0	(121,052)	0.2
HB 18-1003 Opioid misuse prevention	(175,000)	0	(175,000)	0	0	0.0
HB 17-1343 Conflict-free case management	(150,000)	0	(75,000)	0	(75,000)	0.0
SB 18-231 Transition to community services	(109,500)	(109,500)	0	0	0	0.0
FY 15-16 R9 Public health record and online health ed	(95,070)	(9,507)	0	0	(85,563)	0.0

Prior Year Budget Actions						
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
HB 18-1136 Substance use disorder treatment	(49,681)	(16,278)	(8,562)	0	(24,841)	0.5
CDPHE Prior year salary survey	(11,003)	(4,401)	0	0	(6,602)	0.0
HB 15-1368 Cross-system Response Pilot impact on cost allocation	(5,882)	8,397	(14,279)	0	0	0.0
CDPHE FY 17-18 R3 Health survey	(3,506)	(1,753)	0	0	(1,753)	0.0
TOTAL	**($80,384,983)**	**($20,323,711)**	**$1,119,583**	**$1,097**	**($61,181,952)**	**4.5**

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

TOBACCO FORECAST: The Department requests a decrease of $43,369 General Fund based on a new forecast of tobacco tax revenues available to finance the Children's Basic Health Plan.

OTHER ISSUES IN THE GOVERNOR'S REQUEST

SET ASIDE FOR SUPPLEMENTALS: The Governor's budget letter includes a set aside in FY 2018-19 of $20.1 million General Fund for potential supplementals for the Department of Health Care Policy and Financing, including $19.6 million for the most recent forecast of enrollment and expenditures and $433,424 for the FY 2018-19 impact of a discretionary request. Although the Governor's official supplemental request is not due until January 2019, the budget request for the Department includes projected FY 2018-19 impacts associated with the following requests.

FY 2018-19 Set-Aside for Supplementals					
	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
R1 Medical Services Premiums	235,732,421	39,232,431	121,025,050	106,282	75,368,658
R2 Behavioral Health	(16,862,088)	(208,296)	(1,526,548)	0	(15,127,244)
R3 Children's Basic Health Plan	7,306,529	0	513,646	0	6,792,883
R4 Medicare Modernization Act	(4,453,533)	(4,453,533)	0	0	0
R5 Office of Community Living	(29,039,991)	(14,929,804)	414,411	0	(14,524,598)
R12 Medicaid enterprise operations	9,477,289	433,424	433,713	0	8,610,152
Total	**$202,160,627**	**$20,074,222**	**$120,860,272**	**$106,282**	**$61,119,851**

POTENTIAL LEGISLATION

- In *R14 Office of Community Living governance*, the Department proposes increasing a statutory limit on annual expenditures from nursing home civil penalty revenues and giving the Medical Services Board rule-making authority for the Individual Residential Support Services, both of which would require legislation.
- In *R1 Medical Services Premiums*, the Department's forecast assumes the legislative authority for the Breast and Cervical Cancer Prevention and Treatment Program will be renewed, but this would require a bill. The Breast and Cervical Cancer Prevention and Treatment Program provides diagnostic and screening services to low-income uninsured and underinsured people who do not qualify for Medicaid, using cash funds revenue from specialty license plate fees.

ISSUE: MEDICAID'S ROLE IN COLORADO

This issue brief provides context for where Medicaid fits in the health coverage landscape in Colorado, which might be useful as background for potential proposals aimed at universal health care. Governor-elect Polis expressed support for universal health care when on the campaign trail. Medicaid currently covers 23 percent of the population statewide, but the importance of Medicaid varies by region and service type. Public insurance, including Medicare, covers 38.1 percent of the statewide population, but in 21 counties more than 50 percent of the population is on public insurance. An estimated 350,000 people remain uninsured in Colorado with 25 percent lacking documentation. In addition to the long-term goal of universal health coverage, Governor-elect Polis provided on the campaign trail a "100-Day Roadmap" that may provide clues about health proposals to expect in the legislative session.

SUMMARY

- Three major Medicaid expansions financed respectively with revenue from tobacco settlement moneys, tobacco taxes, and a provider fee on hospitals, expanded Medicaid to cover an estimated 23 percent of Colorado's population
- Medicaid enrollment as a percentage of the population can vary widely by county from 8.1 percent in Douglas to 54.3 percent in Costilla
- Medicaid's importance as an insurer varies by type of service and provider, with maternity care and long-term services and supports examples of service types where Medicaid has a disproportionate impact.
- In 21 Colorado counties more than 50 percent of the people are already on public insurance.
- Most commercial insurance is through employer-sponsored plans. The share of the market in employer-sponsored plans has decreased with increases in Medicare, due to an aging population, and Medicaid, due to eligibility expansions. The share of the population that is uninsured decreased during the same time span, likely for similar reasons, plus policy changes made by the federal Affordable Care Act.
- The Colorado Health Institute estimates there are 350,000 uninsured in Colorado and as much as 25 percent may lack documentation.
- In addition to public insurance, there are tax credits for people in the individual insurance market and an indigent care program that reduces private pay costs for low-income people to increase access to health services.
- When on the campaign trail, Governor-elect Polis provided a list of shorter-term goals than universal coverage. The JBC may want to gather background information about some of these shorter-term goals from the Department at the hearing.

DISCUSSION

This issue brief provides context for where Medicaid fits in the health coverage landscape in Colorado, which might be useful as background for potential proposals aimed at universal health care. Governor-elect Polis expressed support for universal health care when on the campaign trail.

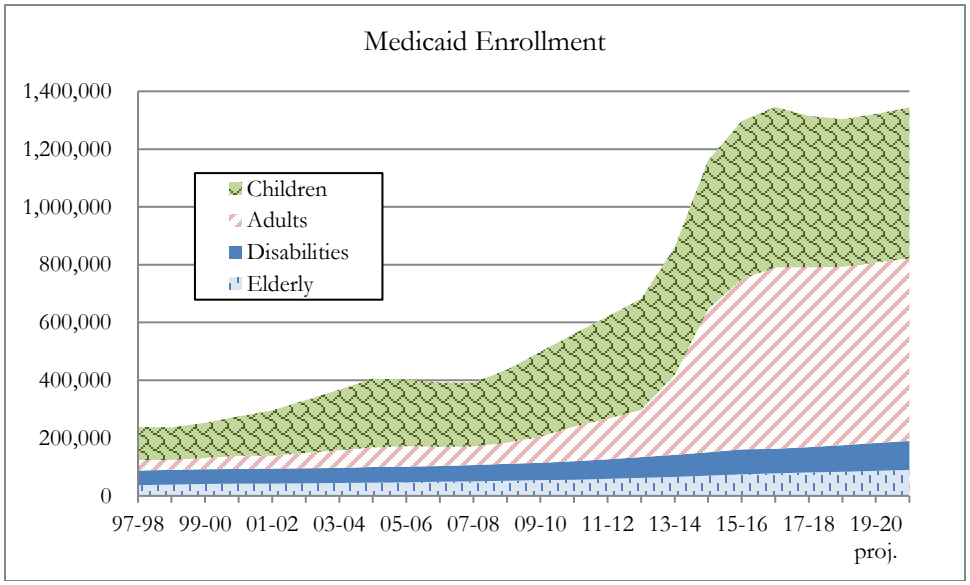
Some ideas for how to achieve universal health care, such as expanding the people who can buy in to Medicare to the entire population, would require federal legislation. However, there are other ideas

that might be achievable with federal waivers and/or state level action, such as allowing more people to buy in to Medicaid or entering a multi-state consortium to moderate healthcare costs, and thereby make coverage more affordable and accessible to people.

MEDICAID EXPANSION

Colorado implemented three major Medicaid eligibility expansions and a number of smaller expansions over the last 20 years that significantly increased the proportion of the population enrolled in Medicaid. To the extent any plan for universal coverage includes an expansion of Medicaid, understanding who is served by Medicaid, how expansions have been financed, and the proportion of the population covered by Medicaid is useful.

Prior to the expansions, Medicaid served children, people with disabilities, the elderly, very low-income parents, and pregnant adults. Now it serves the full spectrum of people with low income. Medicaid has somewhat higher income eligibility limits for children and pregnant women and eligibility criteria that allow people with severe disabilities to qualify. The first of the three major expansions was initially financed with tobacco settlement revenues and occurred toward the end of the 1990s. It primarily increased eligibility for children. The second expansion, in the mid-2000s, used revenue from a tobacco tax approved by voters to further expand eligibility for children, moderately increase income limits for parents, and remove asset tests. Over time, increases in the population and costs of services exceeded tobacco settlement and tobacco tax revenues and the General Fund filled in the difference for these expansions, as planned and expected by the legislature. In the third expansion, authorized by H.B. 09-1293 and S.B. 13-200, a provider fee on hospitals combined with a 90 percent federal match rate, provided through the federal Affordable Care Act (ACA), allowed Colorado to nearly double income eligibility limits for parents and begin covering low-income adults without dependent children, along with some smaller changes to eligibility determination procedures for children that increased enrollment. Medicaid grew from serving less than six percent of Colorado's population in 1998 to serving 23 percent in 2018.

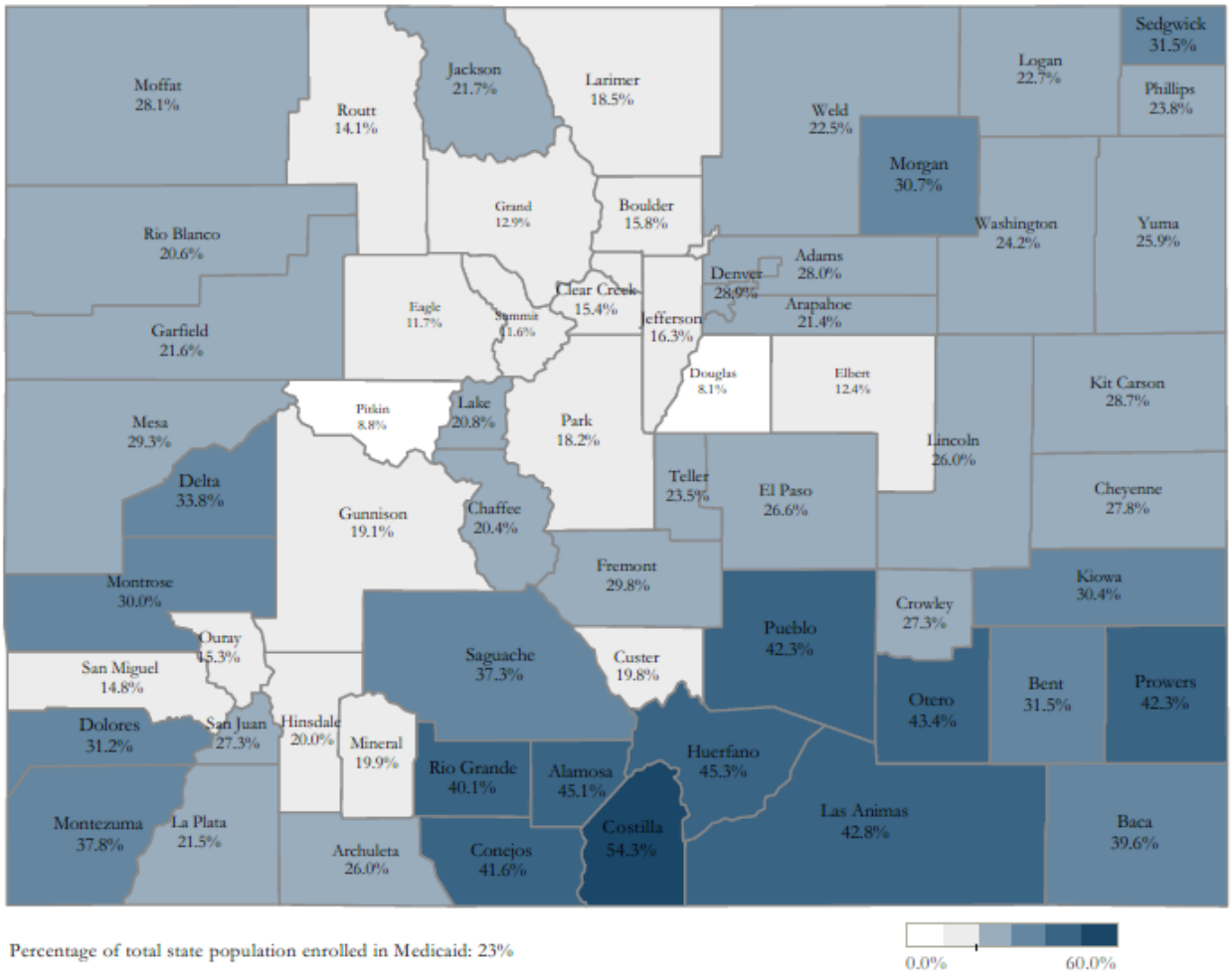


REGIONAL VARIATION

While Medicaid covers approximately 23 percent of the population statewide, there are significant variations in the importance of Medicaid as an insurer and payer by geographic region. This is potentially useful to understand when considering how any plan for universal coverage that includes an expansion of Medicaid might affect regions differently. It is also useful to understand when thinking about how changes in Medicaid policy and pricing may affect the market and non-Medicaid care.

There are two counties (Douglas and Pitkin) where Medicaid insures less than 10 percent of the estimated population and nine counties, mostly in the south central region, where Medicaid insures more than 40 percent of the estimated population (Alamosa, Conejos, Costilla, Huerfano, Las Animas, Otero, Prowers, Pueblo, and Rio Grande). Costilla is the only county where Medicaid is the majority insurer, but in many counties Medicaid is the plurality insurer.

Medicaid Enrollment as a Percentage of the Population

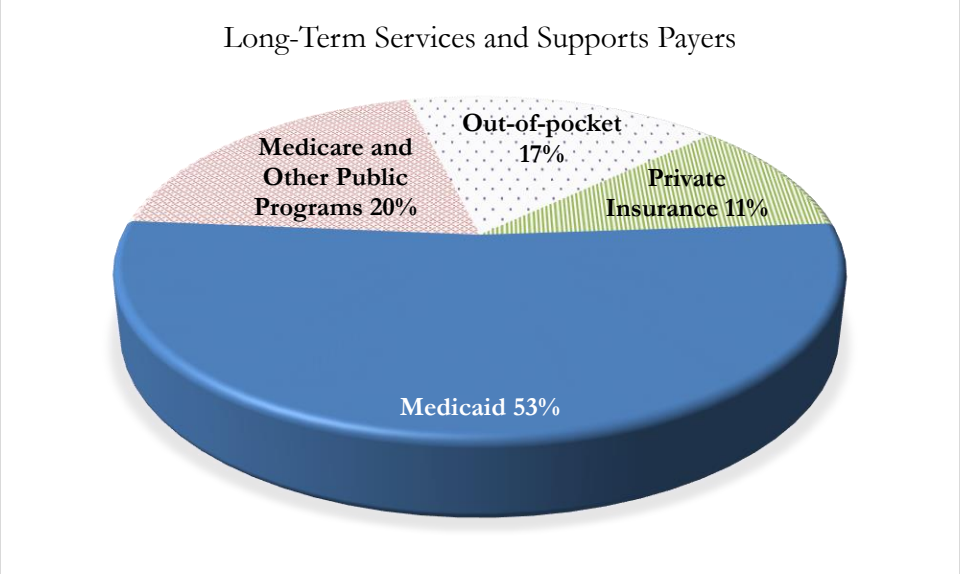


VARIATION BY TYPE OF SERVICE

There can be significant variation in the importance of Medicaid as an insurer by type of service. Similar to the variation by region, the variation by type of service informs considerations of how different Medicaid policies can affect the market.

While Medicaid covers 23 percent of Coloradoans, in calendar year 2017 Medicaid paid for 45 percent of Colorado births. This is partially attributable to Medicaid covering pregnant adults to 200 percent of the federal poverty guidelines compared to 138 percent of the federal poverty guidelines for non-pregnant adults, but demographic and economic factors also contribute.

Medicaid is the primary payer for long-term services and supports (LTSS). The next largest payer is Medicare, but Medicare coverage of LTSS is limited, generally to post-acute services such as surgery recovery and home health for qualifying beneficiaries who are home bound. Nationally, Medicaid accounted for an estimated 53 percent of payments for LTSS in 2015 (the JBC staff is not aware of any Colorado-specific estimates).

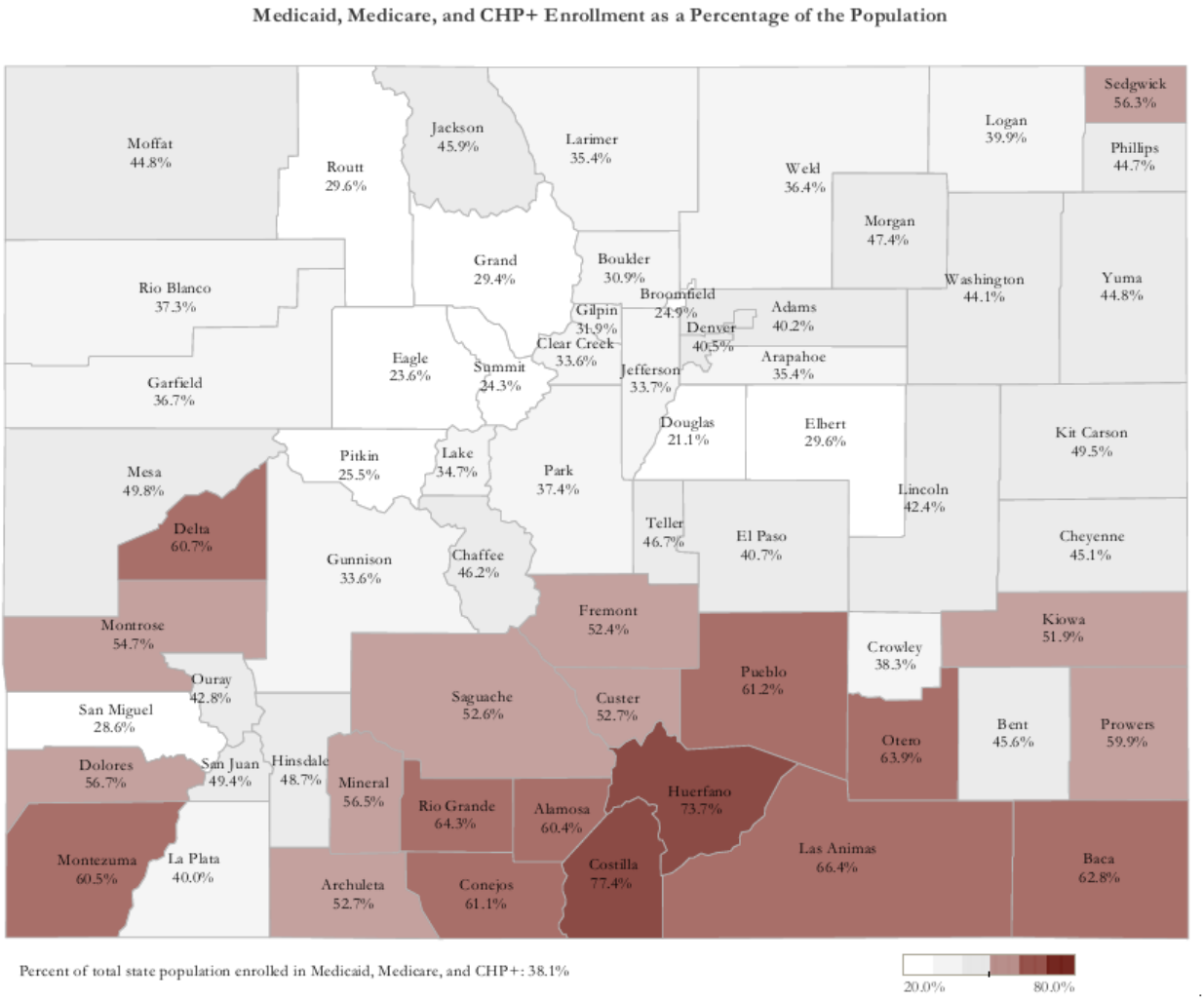


In some communities, Medicaid clients become concentrated at a few providers. This can occur because of geography, when there are a lot of Medicaid clients and only a few providers, or when there are some providers more interested in serving Medicaid clients than others, such as a mission-driven provider with outreach and expertise aimed at serving people with low income or disabilities.

OTHER PUBLIC INSURANCE

To the extent any proposal for universal coverage moves Colorado toward a public payer for healthcare, it is useful to understand that public insurance already covers 38.1 percent of the population statewide. This is the based on the unduplicated enrollment in Medicaid, the Children's Basic Health Plan (CHP+), and Medicare. Enrollment in CHP+ represents 1.5 percent of the statewide population. Medicare insures 15.6 percent of the statewide population, but of the 874,134

people enrolled in Medicare, 110,649 are also enrolled in Medicaid. After removing the double count, the Medicare-only enrollment is 13.6 percent of the statewide population. When Medicaid, CHP+, and Medicare are combined, there are 21 counties, almost all in the southern half of the state, where more than 50 percent of the people are on public insurance. There are two counties where 3 out of 4 people are on public insurance. In many other counties it would not take much of an expansion for public insurance to become the majority insurer.

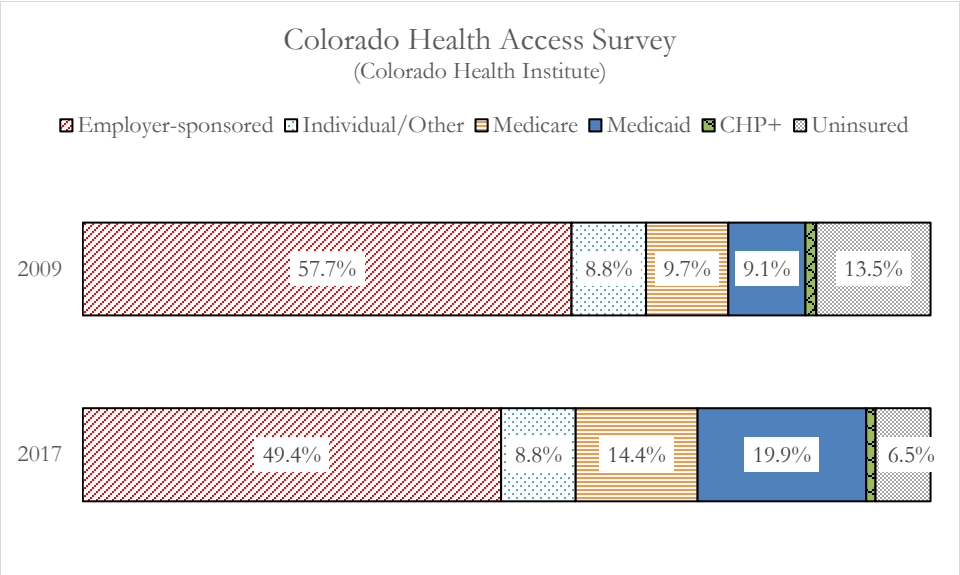


PRIVATE INSURANCE AND THE UNINSURED

People who do not qualify for public insurance primarily get insurance through employer-sponsored plans. The Colorado Health Institute, a nonprofit research organization, conducts a biennial health access survey that estimated in 2017 49.4 percent of the population enrolled in employer-sponsored health insurance, 8.1 percent in individual insurance, and 6.5 percent were uninsured.

The Colorado Health Institute's estimates of the publicly insured are somewhat lower than the JBC staff's estimates above. The JBC staff estimates are more recent, using data from June 2018 rather than calendar year 2017, and based on federal enrollment statistics rather than survey results, and so they are probably the better source for the percent on public insurance. However, the CHI survey is

the better source for estimates of employer-sponsored insurance, individual insurance, and the uninsured.



From 2009 to 2017 the proportion of the population decreased for employer-sponsored coverage and the uninsured and increased for Medicare and Medicaid. These changes correspond with an aging population and the three major increases in Medicaid eligibility described previously. Other demographic, economic, and regulatory changes may also explain the changes in coverage during this time frame.

The Colorado Health Institute estimates the remaining uninsured at 350,000. Of the uninsured, the Colorado Health Institute estimates 25 percent do not have documentation. The most common reason cited for a lack of insurance, by 78.4 percent of the participants in the Colorado Health Access Survey, was cost.

FEDERAL TAX CREDITS FOR INDIVIDUAL MARKET

For some people in the individual market, the ACA provides refundable federal tax credits to defer the cost of premiums. To qualify a family must have income between 400 percent and 100 percent of the federal poverty guidelines and purchase an approved plan through the healthcare exchange. Colorado's healthcare exchange is called Connect for Health Colorado. The tax credits may be paid prospectively to the insurance company, so families don't have to wait to file tax claims to get the credit. The value of the tax credits is calculated on a sliding scale with the largest tax credits limiting family expenditures for the cost of a benchmark health insurance plan to 2.0 percent of income and the smallest tax credits limiting family expenditures for the benchmark plan to 9.5 percent of family income. Thus, the tax credits are indexed to both family income and the cost of benchmark insurance for that family. Families who purchase insurance that is more or less expensive than the benchmark plan get the same credit. People with income below 250 percent of the federal poverty guidelines can also qualify for assistance with coinsurance by purchasing a qualifying plan. Based on enrollment in February 2018, the Kaiser Family Foundation estimated Colorado has 102,628 people receiving tax credits totaling $633.0 million, with an average monthly value per tax credit of $514.

COLORADO INDIGENT CARE PROGRAM

For people who are uninsured, or underinsured, who earn less than 250 percent of the FPL, the Colorado Indigent Care Program (CICP) can reduce costs. The CICP is not an insurance program, but participating providers agree to accept reduced payments, on a sliding scale based on income, from people enrolled in the program. In exchange, the providers receive supplemental Medicaid payments. Of the supplemental funding, 75 percent is distributed based on write-off costs and 25 percent on performance metrics. Most of the money goes to hospitals through the federal Disproportionate Share Hospital program that allows supplemental Medicaid payments to hospitals that serve a high number of indigent clients. Revenue from the provider fee on hospitals serves as the state match. A small amount of the money goes to clinics where Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds. The state match for the clinic payments comes from the General Fund. In addition, there is a special pediatric hospital supplemental payment with a state match from the General Fund. The Department's most recent annual report indicates that in FY 2016-17 a total of 49,135 people received reduced bills due to participation in the CICP. The FY 2018-19 appropriation provides $330.8 million for the CICP with $9.8 million from the General Fund.

A 100-DAY ROADMAP

Universal coverage is, obviously, an ambitious goal and it may take time for significant proposals to emerge from Governor-elect Polis' administration. However, when on the campaign trail Governor-elect Polis provided a list of shorter-term goals, with varying degrees of specificity, in a document called "A 100-Day Roadmap" that is available from his campaign website: https://polisforcolorado.com/hcroadmap/.

It is too soon to expect the Department to discuss any specifics with the JBC at the hearing, before Governor-elect Polis is even sworn in or Department leadership determined. However, many of the ideas in this list have been discussed previously in the legislature, such as establishing a reinsurance program or requiring hospital data disclosure. Some of the ideas appear to be extensions of initiatives the Department has already been working on, such as improving support of the All-Payer Claims Database and integrating physical and behavioral health. The Department may be able to talk generally and provide background information, if the JBC wants to learn more about any of the concepts.

Some of the ideas proposed in the plan include:

- Increase consumer safeguards on prices hospitals negotiate with insurance companies
    - Strengthen Division of Insurance consumer protection
    - Conduct a statewide audit
- Implement a single geographic rating system and rating bands
- Establish a reinsurance program
- Require hospital data disclosure
- Improve support for the All-Payer Claims Database
- Control pharmacy expenditures through

    - Pricing disclosure
    - Justification for increases above inflation
    - Penalties for "bad actors"
    - Importing drugs from Canada
    - Increasing oversight of pharmacy benefit managers
- Expand bundled payments, global budgets, and value-based payments
- Provide venture capital for clinics that open in rural Colorado
- Expand the scope of practice for physician assistants, nurses, and nurse practitioners
- Improve reciprocity in licensing to attract providers
- Supplement loan repayments for behavioral health professionals in rural areas
- Enforce rules requiring mental health coverage equivalent to physical health
- Integrate physical and behavioral health
- Expand rural school-based health clinics to improve mental health coverage
- Create a toolbox for local campaigns to fund clinics through targeted marijuana tax initiatives, modeled on Eagle County
- Examine public health impacts of gun violence with a focus on death by suicide
- Support community purchasing groups, modeled on Summit County, to increase local bargaining power with hospitals
- Reduce delays in Medicaid reimbursements

One of the higher cost initiatives on this list appears to be establishing a reinsurance program. If H.B. 18-1392 is the model for what the Governor-elect desires, that bill had a $270 million fiscal note, with half of the money from a fee on health insurance carriers and half from federal funds.

ISSUE: FORECAST TRENDS (R1, R3, R4)

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy and account for over 90 percent of the new funding proposed. These requests explain what drives the budget, but they are non-discretionary, as they represent the expected obligations under current law and policy. It would take a change to current law or policy to change the trends.

SUMMARY

- Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy and account for over 90 percent of the new funding proposed.
- They are non-discretionary, as they represent the expected obligations under current law and policy.
- Enrollment is the major driver of overall expenditures and the Department projects only 1.4 percent enrollment growth in FY 2019-20.
- Despite the rosy enrollment projection, the Department projects an increase in General Fund expenditures for Medical Services Premiums of $82.7 million, or 3.8 percent.
- The major driver of General Fund expenditures is enrollment of the elderly and people with disabilities and their utilization of long-term services and supports.
- The federal match rate for the Children's Basic Health Plan is scheduled to step down over federal fiscal years 2019-20 and 2020-21 by a total of 23 percentage points from the current 88 percent to 65 percent. The Department projects sufficient reserves and revenues in the Children's Basic Health Plan Trust to cover increased state costs in state FY 2019-20, but beginning in FY 2020-21 the General Fund will need to provide additional support in the range of $40 million annually under current law.

DISCUSSION

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. Combined, the forecast requests account for over 90 percent of the new funding proposed by the Department, including $417.3 million total funds and $183.5 million General Fund. It is important to understand these requests from the perspective of knowing what drives the budget and understanding how laws or policies might change the trends. However, these requests are, for the most part, non-discretionary, as they represent the expected obligations the Department will incur absent a change in law or policy. The difficult decisions the JBC will make during figure setting will be less about these forecast requests and more about changes to law or policy intended to influence the trends in these forecast requests.

The forecasts that are the basis for R1 through R5 reflect actual enrollment and expenditure data through June 2018. In mid-February the Department will submit revised forecasts incorporating enrollment and expenditure data through December 2018. The mid-February forecasts come after deadlines for the Governor to submit supplementals and budget amendments. Typically, governors

do not submit official revised requests based on the mid-February forecasts, nor official adjustments to other areas of the budget to fit the revised forecasts. Sometimes governors make their priorities known through unofficial channels. Despite the lack of an official request, the JBC typically uses the mid-February forecast for the budget, because it is the most recent available. If the mid-February forecast is higher than the November forecast, then the JBC makes adjustments elsewhere in the budget to accommodate it, and if the mid-February forecast is lower, then the JBC has more money to increase reserves or allocate for other priorities.

The amounts requested in R1 through R5 are actually the projected cumulative change over two years. Part of the requests are attributable to the Department's revised forecasts of FY 2018-19 expenditures. The requests for changes in FY 2018-19 will be officially submitted in January and until then the Governor's budget includes a placeholder for the FY 2018-19 fiscal impact of the forecasts. The amounts in R1 through R5 are also the net remaining change after annualizations. The tables below separate the changes by fiscal year and add in the annualizations. Note that the table for FY 2018-19 is the change from the appropriation and not the change from FY 2017-18.

FY 18-19					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
Appropriation					
Medical Services Premiums	$7,631,479,929	$2,114,180,322	$939,712,695	$77,385,674	$4,500,201,238
Behavioral Health	656,887,430	184,437,583	30,054,951	0	442,394,896
Children's Basic Health Plan	194,981,200	429,909	24,402,360	0	170,148,931
Medicare Modernization Act	151,835,471	151,835,471	0	0	0
Office of Community Living	591,835,984	305,848,078	356,193	0	285,631,713
TOTAL	**$9,227,020,014**	**$2,756,731,363**	**$994,526,199**	**$77,385,674**	**$5,398,376,778**
FY 18-19 Projection (Nov)					
Medical Services Premiums	7,867,212,350	2,153,412,753	1,060,737,745	77,491,956	4,575,569,896
Behavioral Health	640,025,342	184,229,287	28,528,403	0	427,267,652
Children's Basic Health Plan	202,287,729	429,909	24,916,006	0	176,941,814
Medicare Modernization Act	147,381,938	147,381,938	0	0	0
Office of Community Living	562,795,993	290,918,274	770,604	0	271,107,115
TOTAL	**$9,419,703,352**	**$2,776,372,161**	**$1,114,952,758**	**$77,491,956**	**$5,450,886,477**
Difference Proj. to Approp.					
Medical Services Premiums	235,732,421	39,232,431	121,025,050	106,282	75,368,658
Behavioral Health	(16,862,088)	(208,296)	(1,526,548)	0	(15,127,244)
Children's Basic Health Plan	7,306,529	0	513,646	0	6,792,883
Medicare Modernization Act	(4,453,533)	(4,453,533)	0	0	0
Office of Community Living	(29,039,991)	(14,929,804)	414,411	0	(14,524,598)
TOTAL	**$192,683,338**	**$19,640,798**	**$120,426,559**	**$106,282**	**$52,509,699**
Percent Change					
Medical Services Premiums	3.1%	1.9%	12.9%	0.1%	1.7%
Behavioral Health	-2.6%	-0.1%	-5.1%	n/a	-3.4%
Children's Basic Health Plan	3.7%	0.0%	2.1%	n/a	4.0%
Medicare Modernization Act	-2.9%	-2.9%	n/a	n/a	n/a
Office of Community Living	-4.9%	-4.9%	116.3%	n/a	-5.1%
TOTAL	**2.1%**	**0.7%**	**12.1%**	**0.1%**	**1.0%**

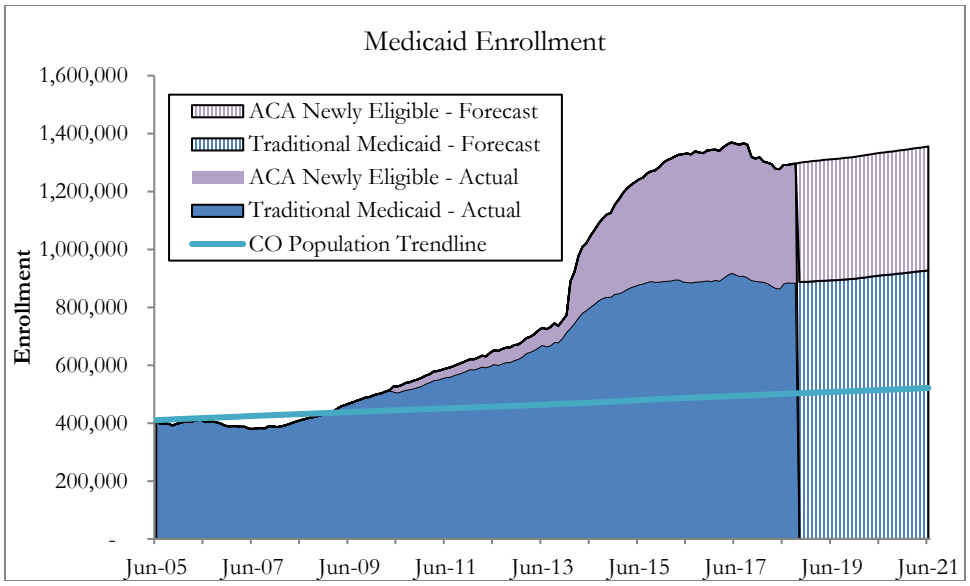
FY 19-20					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS
FY 18-19 Projection (Nov)					
Medical Services Premiums	$7,867,212,350	$2,153,412,753	$1,060,737,745	$77,491,956	$4,575,569,896
Behavioral Health	640,025,342	184,229,287	28,528,403	0	427,267,652
Children's Basic Health Plan	202,287,729	429,909	24,916,006	0	176,941,814
Medicare Modernization Act	147,381,938	147,381,938	0	0	0
Office of Community Living	562,795,993	290,918,274	770,604	0	271,107,115
TOTAL	**$9,419,703,352**	**$2,776,372,161**	**$1,114,952,758**	**$77,491,956**	**$5,450,886,477**
FY 19-20 Projection (Nov)					
Medical Services Premiums	7,844,942,169	2,236,125,390	1,015,867,256	77,385,674	4,515,563,849
Behavioral Health	684,871,404	197,393,468	36,771,772	0	450,706,164
Children's Basic Health Plan	222,949,802	390,000	46,514,878	0	176,044,924
Medicare Modernization Act	153,355,907	153,355,907	0	0	0
Office of Community Living	644,866,312	331,748,690	1,057,673	0	312,059,949
TOTAL	**$9,550,985,594**	**$2,919,013,455**	**$1,100,211,579**	**$77,385,674**	**$5,454,374,886**
Difference FY 18-19 Proj. to FY 19-20 Proj.					
Medical Services Premiums	(22,270,181)	82,712,637	(44,870,489)	(106,282)	(60,006,047)
Behavioral Health	44,846,062	13,164,181	8,243,369	0	23,438,512
Children's Basic Health Plan	20,662,073	(39,909)	21,598,872	0	(896,890)
Medicare Modernization Act	5,973,969	5,973,969	0	0	0
Office of Community Living	82,070,319	40,830,416	287,069	0	40,952,834
TOTAL	**$131,282,242**	**$142,641,294**	**($14,741,179)**	**($106,282)**	**$3,488,409**
Percent Change					
Medical Services Premiums	-0.3%	3.8%	-4.2%	-0.1%	-1.3%
Behavioral Health	7.0%	7.1%	28.9%	n/a	5.5%
Children's Basic Health Plan	10.2%	-9.3%	86.7%	n/a	-0.5%
Medicare Modernization Act	4.1%	4.1%	n/a	n/a	n/a
Office of Community Living	14.6%	14.0%	37.3%	n/a	15.1%
TOTAL	**1.4%**	**5.1%**	**-1.3%**	**-0.1%**	**0.1%**

This issue brief focuses on the forecasts for *R1 Medical Services Premiums*, *R3 Children's Basic Health Plan,* and *R4 Medicare Modernization Act*. The forecasts for *R2 Behavioral Health* and *R5 Office of Community Living* will be covered in the 12/11/18 briefings for those programs.

R1 MEDICAL SERVICES PREMIUMS

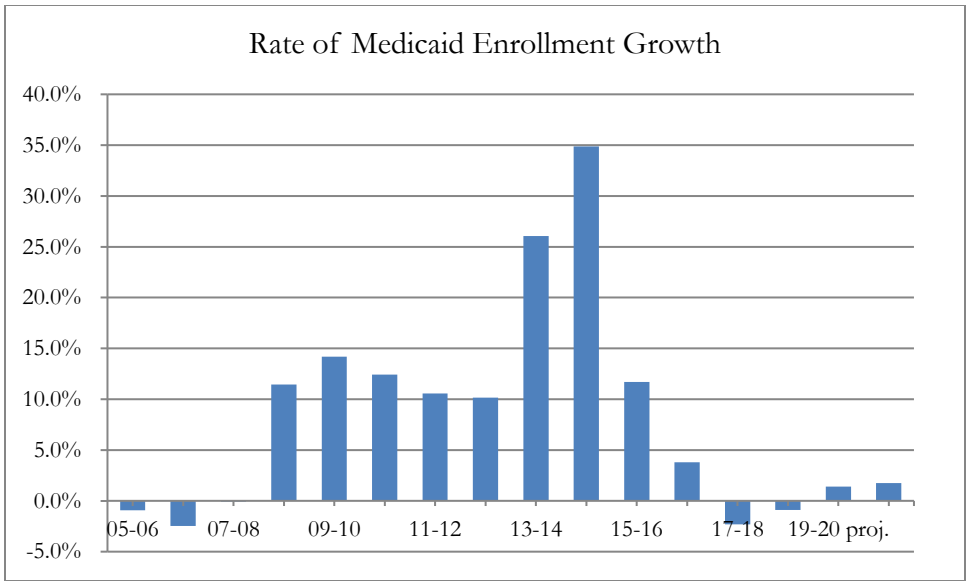
ENROLLMENT TRENDS

The biggest factor driving all of the forecast requests is enrollment. On top of economic and demographic drivers of enrollment growth, H.B. 09-1293 and S.B. 13-200 authorized a major eligibility expansion. A provider fee on hospitals and federal funds finances the expansion. In addition, the federal Affordable Care Act (ACA) changed the way Medicaid calculates income for determining eligibility in a manner that increased eligibility in Colorado. Finally, enrollment from among people previously eligible but not enrolled increased.



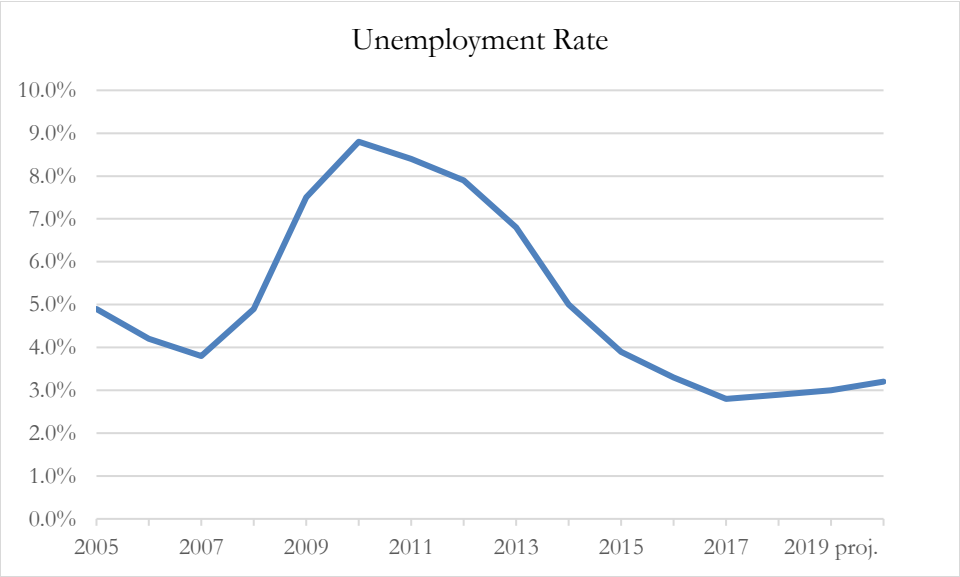
Several factors contributed to the increased Medicaid penetration rate of the previously eligible but not enrolled, including: the individual mandate of the ACA, which required people to purchase health insurance or pay a tax penalty; the requirement that a person disqualify for Medicaid to receive a tax credit that helps pay for insurance through the healthcare exchange; and increased awareness about Medicaid due to marketing and media coverage associated with the eligibility expansions and the ACA.

From FY 2008-09 through FY 2015-16 Medicaid enrollment grew more than 10 percent a year. Medicaid enrollment actually decreased in FY 2017-18, and the Department expects a decrease in FY 2018-19. For FY 2019-20 the Department projects enrollment growth of only 1.4 percent and similarly modest enrollment growth for the rest of the forecast period.



The Department assumes the recent reductions in enrollment will not continue in FY 2019-20 and FY 2020-21. Colorado's population continues to increase. Colorado is experiencing historically low

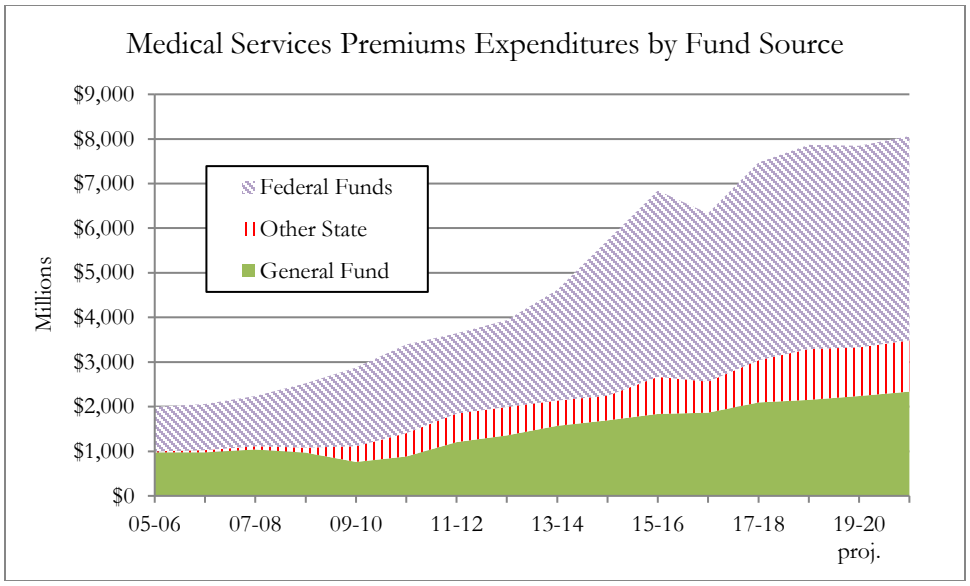
unemployment that the Department assumes will not last indefinitely. Also, a single year reduction in Medicaid enrollment is unusual and multi-year sustained reductions very uncommon.



EXPENDITURE TRENDS

The overall expenditure trend largely mirrors the enrollment trend. As noted previously, enrollment is the primary driver of expenditures. A notable exception occurred in FY 2016-17 and FY 2017-18, when the transition to new payment systems moved money between state fiscal years. There are some less prominent deviations in the expenditure trend from the enrollment trend, mostly due to historic payment delays and variations in special financing.

When looking at expenditures by fund source, the variations in General Fund are less pronounced than the variations in other fund sources. This is because a provider fee on hospitals and federal funds finances most of the expansion populations behind the large increases in enrollment and finances the supplemental payments to hospitals. The General Fund expenditures are driven by the traditional Medicaid populations of children, pregnant women, the elderly, people with disabilities, and very low income parents. Of the traditional Medicaid populations, the elderly and people with disabilities cost the most per capita by a wide margin, and so these populations are typically the most responsible for the overall level of General Fund expenditures.



The brief dip in General Fund expenditure in FY 2009-10 and FY 2010-11 is attributable to the federal American Recovery and Reinvestment Act that temporarily increased the federal match rate for Medicaid.

Despite the rosy projection that overall Medicaid enrollment will increase by only 1.4 percent in FY 2019-20, the Department is projecting an increase in General Fund expenditures of $82.7 million, or 3.8 percent. This is because General Fund expenditures are driven primarily by the elderly and people with disabilities. Enrollment for the elderly and people with disabilities is projected to grow 4.0 percent.

FY 2018-19

The table below shows key differences between the Department's November 2018 forecast for FY 2018-19 and the FY 2018-19 appropriation. The table does not show differences from FY 2017-18 expenditures. For example, the table shows that the Department lowered the forecast for private duty nursing by $12.9 million total funds from the assumptions used for the appropriation, but the Department still expects private duty nursing will increase significantly, by $10.6 million total funds or 11.7 percent, from the FY 2017-18 actual.

FY 2018-19 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
FY 2018-19 Appropriation	$7,631,479,929	$2,114,180,322	$1,017,098,369	$4,500,201,238
Acute Care				
Elderly/disabilities enrollment	7,017,661	4,200,776	(691,946)	3,508,831
ACA Expansion enrollment	(102,952,162)	0	(6,691,891)	(96,260,271)
All other enrollment	12,193,713	7,465,610	261,878	4,466,225
Per capita	(2,567,891)	(1,335,922)	1,187,507	(2,419,476)
Subtotal - Acute Care	*(86,308,679)*	*10,330,464*	*(5,934,452)*	*(90,704,691)*
Long-term Services and Supports				
HCBS waivers	26,818,419	12,171,027	1,105,947	13,541,445
Long-Term Home Health	8,153,449	3,460,493	616,231	4,076,725
Private Duty Nursing	(12,922,428)	(6,825,313)	364,099	(6,461,214)
Nursing Homes	5,029,083	2,519,072	113,626	2,396,385
PACE	28,732,405	14,366,202	0	14,366,203
Hospice	1,097,604	475,094	73,708	548,802
Subtotal - LTSS	*56,908,532*	*26,166,575*	*2,273,611*	*28,468,346*
Medicare Insurance Premiums	4,118,035	5,542,217	0	(1,424,182)
Provider Fees				
Hospitals	248,761,826	0	124,380,912	124,380,914
Nursing Homes	428,549	0	214,275	214,274
Subtotal - Provider Fees	*249,190,375*	*0*	*124,595,187*	*124,595,188*
Service management	1,521,284	1,964,100	(214,869)	(227,947)
Other	10,302,874	(4,770,925)	411,855	14,661,944
TOTAL	**$7,867,212,350**	**$2,153,412,753**	**$1,138,229,701**	**$4,575,569,896**
Increase/(Decrease)	235,732,421	39,232,431	121,131,332	75,368,658
Percentage Change	3.1%	1.9%	11.9%	1.7%

ACUTE CARE

In acute care the appropriation overestimated ACA expansion enrollment. The ACA expansion includes adults without dependent children and higher income parents and the enrollment of these populations is sensitive to economic conditions, which remain better than the Department anticipated. These populations are financed with the provider fee on hospitals and federal funds, and so correcting the forecast does not change the General Fund. The Department is modestly increasing enrollment projections for other populations, including some with high per capita costs, such as the elderly, people with disabilities, and pregnant adults. The acute care category includes expenditures for hospitals, primary care, specialty care, and pharmacy, among others.

LONG-TERM SERVICES AND SUPPORTS

In long-term services and supports the increase in the forecast is primarily attributable to a combination of higher than expected costs for the home- and community-based service waivers and a reconciliation to correct FY 2017-18 payments for the Program for All-inclusive Care for the Elderly (PACE). The higher than expected costs for the HCBS waivers is partially a result of the Department correcting some data integrity issues that previously clouded the forecast and lead to an underestimate of baseline utilization and costs. Of the total increase in the projection for PACE expenditures, approximately $16 million is for the one-time reconciliation to correct FY 2017-18 payments.

FY 2019-20

The next table highlights key factors driving the projected growth in expenditures from FY 2018-19 to FY 2019-20.

FY 2018-19 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
FY 2018-19 Projection	$7,867,212,350	$2,153,412,753	$1,138,229,701	$4,575,569,896
Acute Care				
Elderly/disabilities enrollment	31,038,614	10,315,467	5,203,840	15,519,307
ACA Expansion enrollment	21,119,258	0	1,372,752	19,746,506
All other enrollment	19,054,427	8,538,910	259,721	10,255,796
Per capita	(71,116,415)	(9,607,670)	(6,311,508)	(55,197,237)
Subtotal - Acute Care	*95,884*	*9,246,707*	*524,805*	*(9,675,628)*
Long-term Services and Supports				
HCBS waivers	50,827,227	24,905,523	356,187	25,565,517
Long-Term Home Health	13,668,967	6,696,525	137,958	6,834,484
Private Duty Nursing	8,123,481	4,005,282	56,458	4,061,741
Nursing Homes	33,238,479	16,517,279	75,469	16,645,731
PACE	(6,638,388)	(3,319,194)	0	(3,319,194)
Hospice	3,827,844	1,836,774	77,148	1,913,922
Subtotal - LTSS	*103,047,610*	*50,642,189*	*703,220*	*51,702,201*
Medicare Insurance Premiums	12,908,689	7,157,431	0	5,751,258
Provider Fees				
Hospitals	(162,860,274)	0	(81,430,137)	(81,430,137)
Nursing Homes	3,191,441	0	1,595,720	1,595,721
Subtotal - Provider Fees	*(159,668,833)*	*0*	*(79,834,417)*	*(79,834,416)*
Service management	22,663,550	7,935,084	583,311	14,145,155
Federal match rate	0	10,566,334	27,950,768	(38,517,102)
Other	(1,317,081)	(2,835,108)	5,095,542	(3,577,515)
TOTAL	**$7,844,942,169**	**$2,236,125,390**	**$1,093,252,930**	**$4,515,563,849**
Increase/(Decrease)	(22,270,181)	82,712,637	(44,976,771)	(60,006,047)
Percentage Change	-0.3%	3.8%	-4.0%	-1.3%

Some highlights of the FY 2019-20 forecast include:

ACUTE CARE

- Enrollment of the elderly and people with disabilities accounts for $10.3 million of the increase in General Fund.
- Decreasing per capita costs are primarily a result of annualizing the savings from H.B. 17-1353 and S.B. 18-266. House Bill 17-1353 authorized phase II of the Accountable Care Collaborative and performance-based payments for primary care and behavioral health services. Senate Bill 18-266 authorized cost and quality technology to help the Regional Accountable Entities identify the most effective providers and medications and steer clients to these resources, implemented a hospital admission review program, authorized billing system safeguards, and created an administrative unit dedicated to resource control.

LONG-TERM SERVICES AND SUPPORTS

- For HCBS waivers the Department is projecting an increase of 5.0 percent in the number of utilizers and an increase of 3.6 percent in the cost per utilizer
- Increases for long-term home health and private duty nursing reflect projected increases in the utilizers of 11.6 percent and 12.4 percent respectively
- Nursing home utilization is expected to grow slowly and the projected increase in expenditures is primarily due to a statutory formula that adjusts nursing home rates annually based on costs and allows up to 3.0 percent growth in the rates
- The decrease for PACE is the net result of a projected 11.2 percent increase in utilization, ending a one-time reconciliation in FY 2018-19 for payments in FY 2017-18, and an assumed 6.0 percent decrease in provider rates as a result of implementing S.B. 16-199, which changed procedures for how the Department annually adjusts the PACE rates.

OTHER

- The increase in Medicare insurance premiums is a combination of assumptions about federal increases in rates and enrollment growth. A portion of the premium costs do not receive a federal match under federal rules.
- A projected large decrease in supplemental payments to hospitals is the result of artificially high expenditures in FY 2018-29, rather than a change in trend assumptions. After the provider fee was declared an enterprise with the revenues no longer subject to the TABOR limit, the Department and the hospitals made changes to the timing of the supplemental payments that shifted some of the payments forward and increased expenditures on a one-time basis in FY 2018-19.
- The increase for service management is primarily for projected higher enrollment in the Accountable Care Collaborative
- There are two scheduled changes to federal match rates affecting projected expenditures by fund source for FY 2019-20. First, the average match rate for the state fiscal year for the "newly eligible" pursuant to the ACA is decreasing from 93.5 percent to 91.5 percent. In calendar year 2020 and beyond the match will be 90.0 percent. The change in this match rate reduces federal funds and increases cash funds from the provider fee on hospitals. Second, the average match rate for the state fiscal year for CHP+ is decreasing from 88.0 percent to 79.38 percent. Some higher income children and pregnant adults on Medicaid receive the CHP+ match rate, because Colorado expanded Medicaid to absorb these populations from CHP+. The change in this match reduces federal funds and increases General Fund.

ACCURACY OF THE FORECAST

With so much of the funding for the Department based on forecasted enrollment and expenditures under current law, it begs the question of how accurate the Department is in forecasting. The accuracy of the Department's forecasts may also influence discussions of the Governor's proposal to increase the General Fund reserve.

FORECAST VERSUS ACTUALS

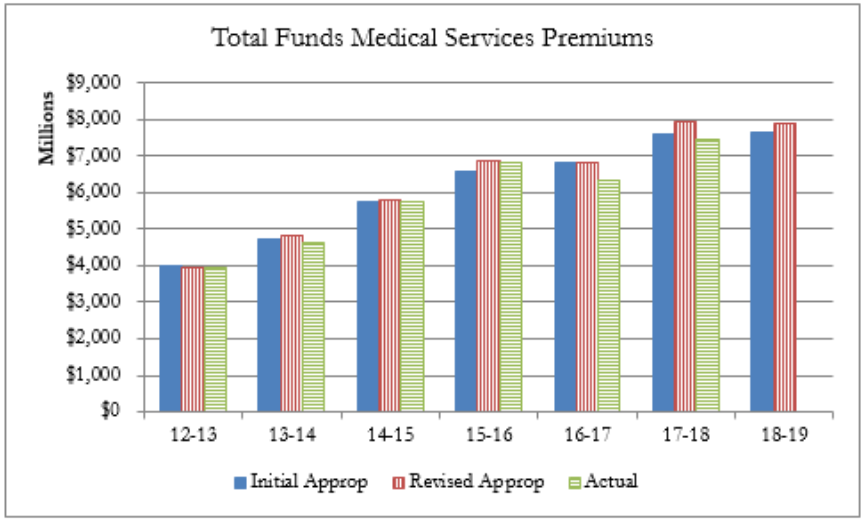
Measuring the accuracy of the forecast is surprisingly difficult, because it is challenging to disentangle the effects of policy decisions by the General Assembly from what the Department could reasonably project. Every year the Department includes with the request a comparison of prior year forecasts to actuals, but it does not account for policy changes of the General Assembly. For example, the

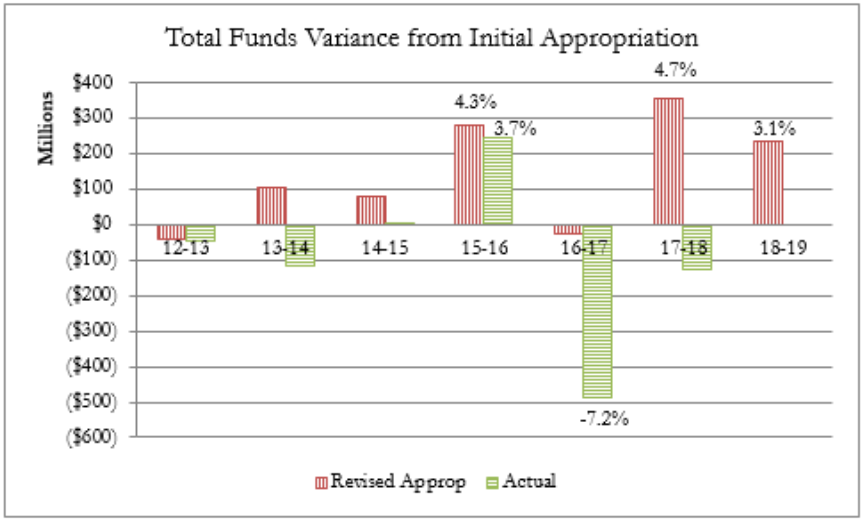
comparison shows that in FY 2013-14 the revised forecast increased $551.4 million from the initial forecast, suggesting a significant forecast error, until considering that the revised forecast took into account the Medicaid expansion authorized by S.B. 13-200. The Department's comparison also focuses on total funds, when much of the forecast errors in recent years have been due to misjudgment of the financing leading to the need for General Fund adjustments. To address these weaknesses in the Department's comparison, the JBC looked at the appropriations, which reflect a combination of the Department's base forecast and the predicted impact of policy actions of the General Assembly. This means that some of the forecast error will be attributable to assumptions of the JBC staff and Legislative Council Staff, but the Department works very closely with the JBC staff and Legislative Council Staff in estimating the impact of policy actions of the General Assembly and disagreements of a large magnitude are infrequent. To minimize the skewing by policy actions of the General Assembly, the JBC staff limited the analysis to the Medical Services Premiums line item. Finally, the JBC staff did not go back further than FY 2012-13, because prior to that year the JBC staff prepared a competing forecast of expenditures that the JBC sometimes selected for the appropriation.

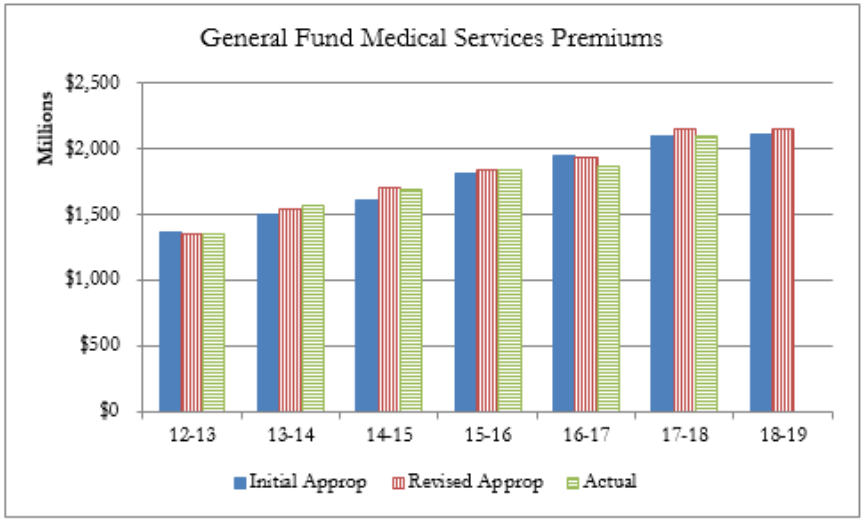
The tables on the next page compare the initial appropriation, the revised appropriation after supplementals, and the actual expenditures. Due to the scale of the graphs on the left of the page, it can be difficult to judge the magnitude of variations. The graphs on the right show just the variations from the initial appropriation. So, for example, in FY 2013-14 the revised appropriation, or supplemental, increased total funds by $105.1 million from the initial appropriation, but the actual expenditure ended up being $118.1 million below the initial appropriation. Places where the revised appropriation or actual varied by more than three percent from the initial appropriation are highlighted.

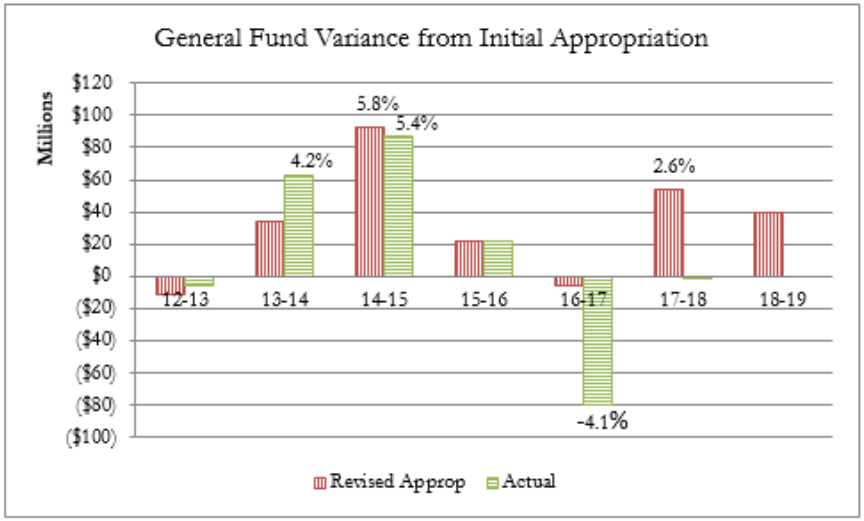
During this period, the implementation of the federal Affordable Care Act (ACA) in 2014 introduced significant uncertainty to the forecast. The Department began serving a large new population it had never served before where both the likely enrollment and expenditures per capita were unknown. The combination of outreach efforts and publicity associated with the expansion and the individual mandate caused increased enrollment from people previously eligible but not enrolled. Furthermore, the ACA changed the calculation of income for eligibility determination purposes in ways that caused restated income to switch between eligibility bands that have significantly different financing. The significant changes to Medicaid contributed to the forecast error.

The Department believes the transition to the new billing system in the last quarter of FY 2016-17 caused a shift in payments from FY 2016-17 to FY 2017-18. The resulting forecast error exceeded the magnitude of the total funds forecast error and rivaled the General Fund forecast error experienced during the ACA expansion.


Total Funds Medical Services Premiums
Millions
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
12-13
13-14
14-15
15-16
16-17
17-18
18-19
Initial Approp
Revised Approp
Actual


Total Funds Variance from Initial Appropriation
Millions
$400
$300
$200
$100
$0
($100)
($200)
($300)
($400)
($500)
($600)
4.3%
3.7%
4.7%
3.1%
-7.2%
12-13
13-14
14-15
15-16
16-17
17-18
18-19
Revised Approp
Actual


General Fund Medical Services Premiums
Millions
$2,500
$2,000
$1,500
$1,000
$500
$0
12-13
13-14
14-15
15-16
16-17
17-18
18-19
Initial Approp
Revised Approp
Actual


General Fund Variance from Initial Appropriation
Millions
$120
$100
$80
$60
$40
$20
$0
($20)
($40)
($60)
($80)
($100)
5.8%
5.4%
4.2%
2.6%
-4.1%
12-13
13-14
14-15
15-16
16-17
17-18
18-19
Revised Approp
Actual

SHOCK THE SYSTEM

As another way to look at the potential magnitude of forecast errors, the JBC staff asked the Department to estimate Medicaid expenditures assuming a shock to the system similar to the economic downturn in FY 2002-03. The Department's models predict a similar downturn would increase FY 2019-20 expenditures for Medical Services Premiums and Behavioral Health by a combined $713.1 million total funds, including $175.9 million General Fund, compared to the November 2018 forecast.

Based on prior experience, the Department assumes an economic downturn would have limited effects on the enrollment of people with disabilities and the elderly. The enrollment of children and parents with low income would drive the majority of General Fund increases in an economic downturn.

R3 CHILDREN'S BASIC HEALTH PLAN (CHP+)

The Department requests a net increase of $28.0 million total funds for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan. The total requested change is the sum of the forecasted changes in FY 2018-19 and FY 2019-20. The Department will officially submit a supplemental request for FY 2018-19 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2019.

The federal match rate for CHP+ is scheduled to decrease in federal fiscal year 2019-20. The federal Affordable Care Act had temporarily increased the reimbursement rate for Colorado to 88.0 percent, but the federal reauthorization for CHP+ steps the federal match rate down over two years to the pre-ACA match rate. As a result, the Department projects the available federal funds for CHP+ will decrease and the state obligation will increase by $19.6 million in FY 2019-20.

CHP+ Federal Match					
State	Ave.	Federal Match by Quarter (of state fiscal year)			
Fiscal Year	Match	Q1-July	Q2-October	Q3-January	Q4-April
FY 14-15	65.53	65.00	65.71	65.71	65.71
FY 15-16	82.80	65.71	88.50	88.50	88.50
FY 16-17	88.14	88.50	88.01	88.01	88.01
FY 17-18	88.00	88.01	88.00	88.00	88.00
FY 18-19	88.00	88.00	88.00	88.00	88.00
FY 19-20	*79.38*	88.00	*76.50*	*76.50*	*76.50*
FY 20-21	*67.88*	76.50	*65.00*	*65.00*	*65.00*

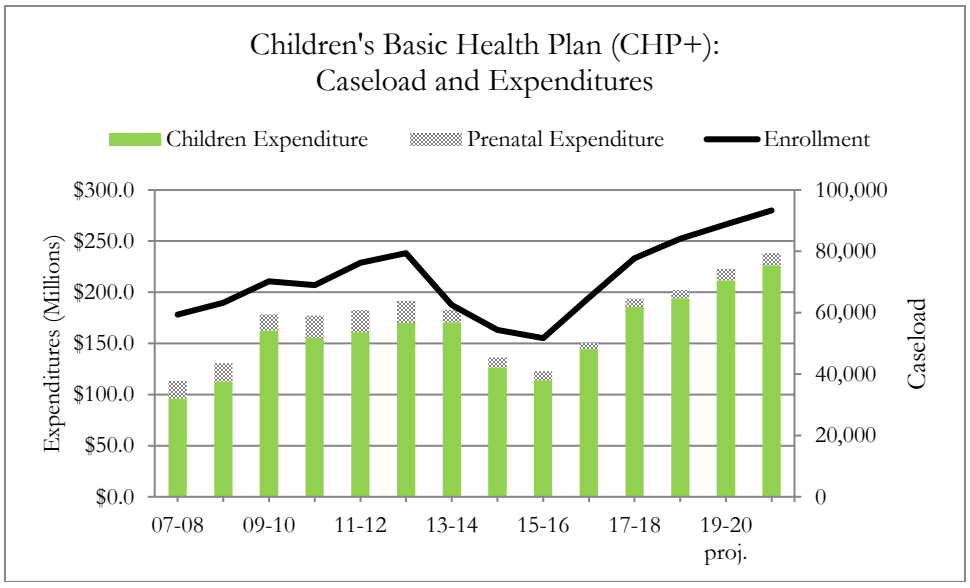
Italicized figures are projections.

The state match for CHP+ currently comes primarily from the approximately $15 million in tobacco master settlement money deposited in the Children's Basic Health Plan Trust annually. The Department projects that the fund balance plus new revenue to the Children's Basic Health Plan Trust will be sufficient to cover the expected state obligation in FY 2019-20, but it will completely spend down the fund balance. Beginning in FY 2020-21, General Fund would need to make up any difference between the state obligation for CHP+ and the annual revenue to the Children's Basic Health Plan Trust, absent a change in law.

Children's Basic Health Plan Trust				
	FY 16-17	FY 17-18	FY 18-19	FY 19-20
Beginning Fund Balance	$32,152,034	$17,755,289	$17,853,283	$16,589,458
Revenue	$18,093,685	$15,328,966	$15,657,846	$15,986,808
Fees	1,272,538	1,127,546	357,018	370,797
Tobacco Settlement	16,617,777	13,701,033	14,922,000	15,264,000
Interest	203,370	376,749	378,828	352,011
Recoveries	0	123,638	0	0
Expenses	$32,490,430	$15,230,972	$16,921,671	$32,273,392
Net Cash Flow	($14,396,745)	$97,994	($1,263,825)	($16,286,584)
Ending Fund Balance	$17,755,289	$17,853,283	$16,589,458	$302,874

The Department projects a General Fund cost for CHP+ of $37.4 million in FY 2020-21. The General Fund cost would increase again in FY 2021-22 by another roughly $4.5 million to annualize the change in the federal match rate for CHP+ before stabilizing and adjusting annually with changes in projected enrollment and per capita expenditures.

The chart below summarizes the Department's forecast of enrollment and expenditures for CHP+. The Department's projection assumes enrollment and expenditures for CHP+ will increase in an improving economy as families move from Medicaid to CHP+.

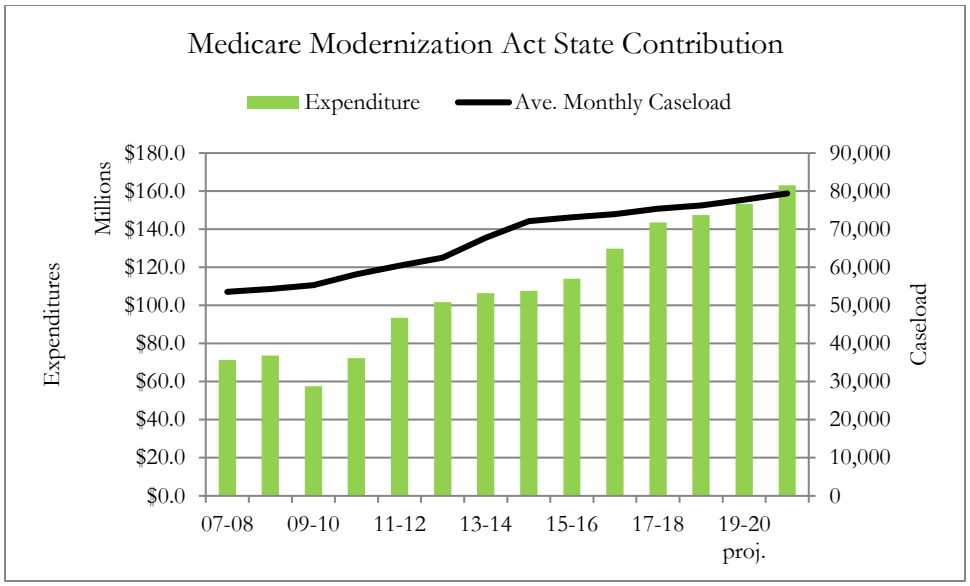


R4 Medicare Modernization Act

The Department requests an increase of $1.5 million General Fund for the projected state obligation, pursuant to the federal Medicare Modernization Act, to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare. The total requested change is the sum of the forecasted changes in FY 2018-19 and in FY 2019-20. The Department will

officially submit a supplemental request for FY 2018-19 in January. The Department will submit a new forecast of enrollment and expenditures by February 15, 2018.

In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid in Medicaid, as estimated by a federal formula. The Medicare Modernization Act is a 100 percent General Fund obligation. Growth in the enrollment of people dually eligible for Medicare and Medicaid and changes in the cost of pharmaceuticals drive expenditures.



ISSUE: HOSPITALS

Hospital care represents roughly 31 percent of the Department's expenditures for Medicaid services. However, 48 percent of the expenditures are attributable to supplemental payments financed with a provider fee on hospitals. In addition, the Medicaid client mix served by hospitals includes expansion populations financed with the provider fee on hospitals and a 90 percent federal match. As a result, hospital expenditures represent 14 percentage of the Department's General Fund budget. Hospital expenditures per adjusted discharge are higher and rising faster than national averages. Within Colorado, hospital expenditure patterns vary widely. The Department is meeting with hospitals to understand the variations and inform policies and payment methods to encourage efficient operation and reduce the cost shift from Medicaid to private insurance.

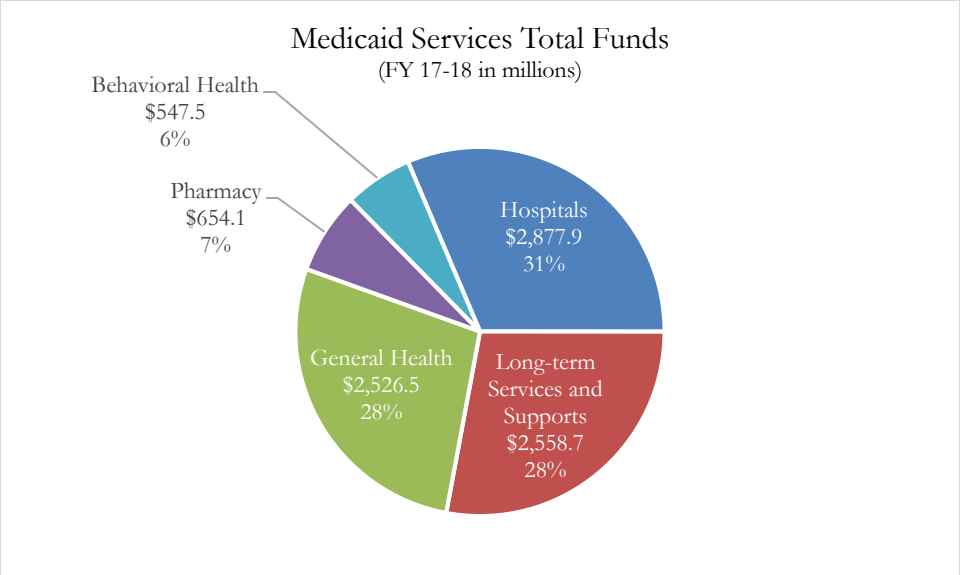
SUMMARY

- Hospital care represents roughly 31 percent of the Department's expenditures for Medicaid services.
- Forty-eight percent of the expenditures are attributable to supplemental payments financed with a provider fee on hospitals and the Medicaid client mix served by hospitals includes expansion populations financed with the provider fee on hospitals and a 90 percent federal match.
- Hospital expenditures represent 14 percentage of the Department's General Fund budget.
- The provider fee on hospitals dramatically increased hospital compensation.
- One of the goals of the provider fee was to reduce a cost shift from Medicaid to private insurance.
- Per the metrics used by the hospitals, the cost shift is not decreasing.
- Hospital expenditures per adjusted discharge are higher and rising faster than national averages.
- Within Colorado, hospital expenditure patterns vary widely, suggesting opportunities for more efficient operation.
- The Department is meeting with hospitals to understand the variations in expenditures and inform policies and payment methods to encourage efficient operation.
- The Colorado Hospital Association has concerns about the Department's analysis and premature conclusions that might be drawn from the data.

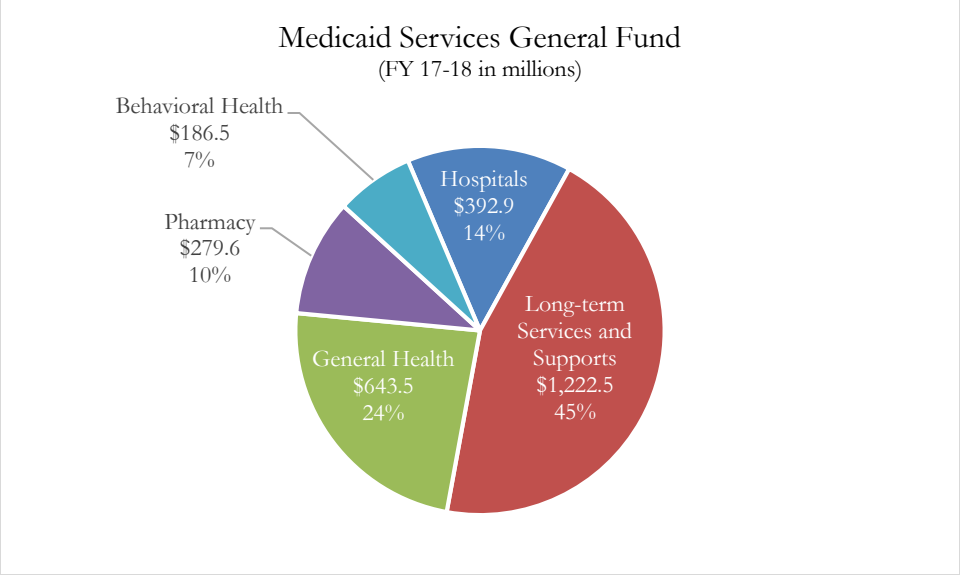
DISCUSSION

MEDICAID SPEND ON HOSPITAL CARE

In the most recent actual year (FY 2017-18), hospital care represented roughly 31 percent of the Department's expenditures for Medicaid services. The pie chart focuses on expenditures for Medicaid services and does not include the roughly 3 percent of the Department's budget spent on administration or the 2 percent on programs other than Medicaid (mostly the Children's Basic Health Plan).

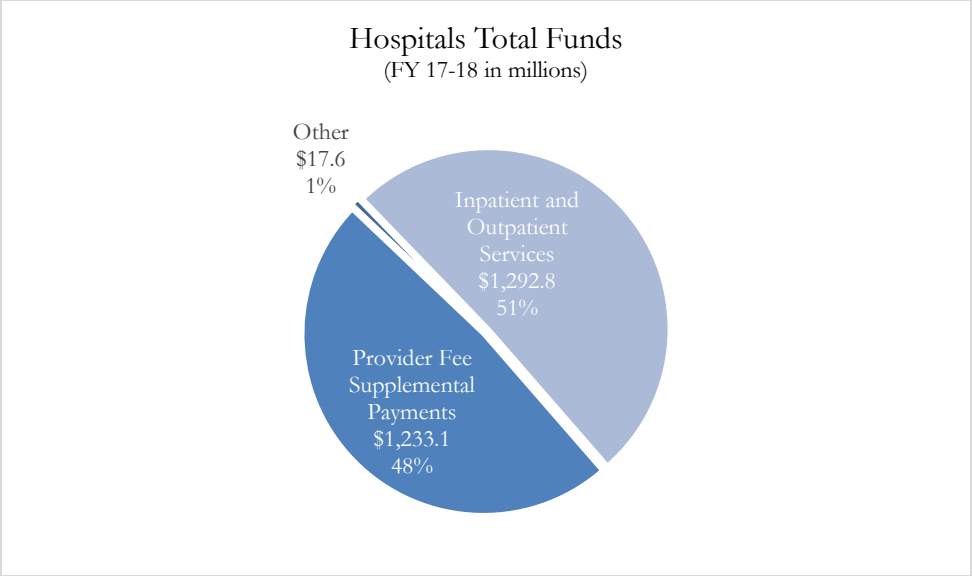


The relative importance of some of the categories of expenditures changes when focusing on just the General Fund. Most notably, hospitals decrease to roughly 14 percent of expenditures and long-term services and supports jump to approximately 45 percent of expenditures. In part this reflects differences in the types of services utilized by populations with alternative financing and/or enhanced federal match rates versus populations with a 50 percent General Fund match. For example, no General Fund is spent on adults "newly eligible" pursuant to the federal Affordable Care Act, and this population of adults without dependent children and higher income parents uses almost no long-term services and supports. The change in percentages also reflects supplemental payments to hospitals where the state match comes from the provider fee on hospitals.

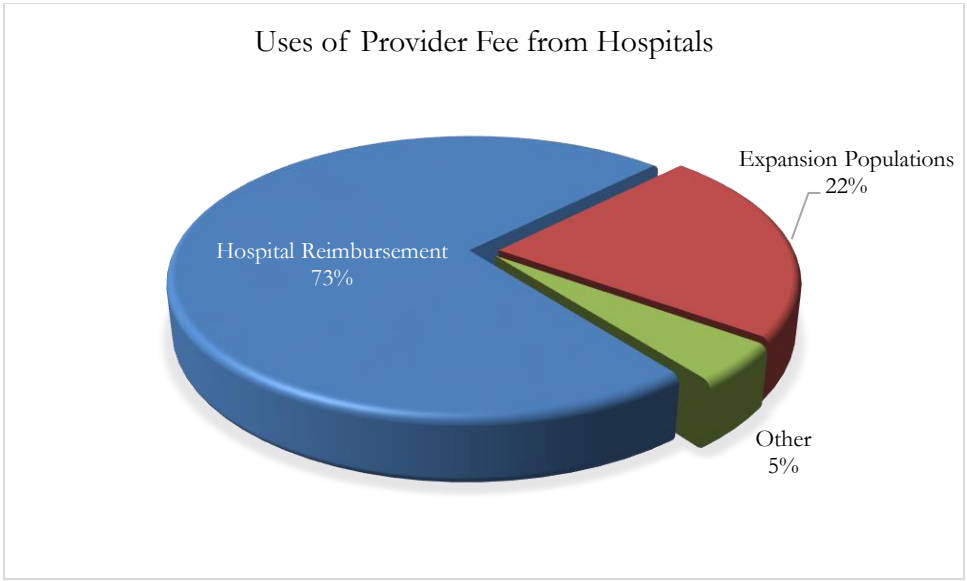


PROVIDER FEE ON HOSPITALS

Of the $2.9 billion total funds spent on hospitals, nearly half was in the form of supplemental payments where the state share was financed with revenue from a provider fee on hospitals.



The provider fee, called the Healthcare Affordability and Sustainability (HAS) fee, is collected from hospitals based on beds filled per day and a percentage of outpatient charges. A portion of the revenue is used to pay for Medicaid eligibility expansions, but the lion's share of the expansion populations are considered "newly eligible" pursuant to the federal Affordable Care Act, and therefore qualified for a 90 percent enhanced federal match rate. In FY 2017-18 the state's share of costs for these expansion populations required roughly 22 percent of the provider fee. The majority of the provider fee was used for supplemental payments that increase hospital reimbursements.



The money collected for supplemental payments is matched with federal funds and redistributed back to the hospitals. Thus, for every dollar paid in provider fees for the purpose of increasing hospital reimbursements, the hospitals receive two dollars in additional payments. Federal rules require that provider fees redistribute funding, and so some hospitals receive more than others, but in aggregate a $1 investment in the provider fee provides $2 in additional revenue to the hospitals for a nearly instantaneous 100 percent return on the investment.

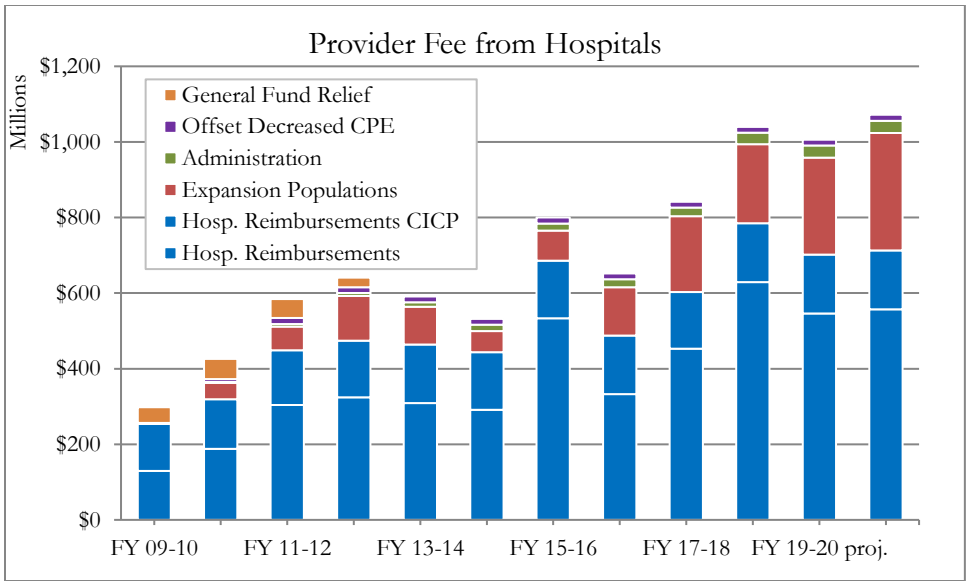
Hospitals get the money to pay the provider fee from cash on hand to pay future obligations, such as payroll or leased space. The provider fee is collected monthly and the payments are disbursed almost as quickly as the money is collected, typically in a matter of minutes or hours rather than days.[3] The transaction is complete before hospitals need the money for the other obligations. There is no need for hospitals to increase charges on patients to pay the provider fee and hospitals are explicitly prohibited in statute from putting a line item on patient bills for the provider fee.[4]

Federal policies limit the provider fee to the lesser of the Upper Payment Limit or six percent of net patient revenues. There are nuances to the calculation of the UPL, but it can be thought of as the amount Medicare would have paid for the same services, and it represents the maximum Medicaid can pay hospitals from all sources, including the provider fee. At the same time, provider fee collections may not exceed six percent of net patient revenues, which are the actual revenues received by hospitals from patients (as opposed to the amounts charged).

Several factors have contributed to some significant variations in the supplemental payments by state fiscal year, including federal approval of annual provider fee plans not aligning cleanly with the state fiscal year, reconciliations for payments in prior years that exceeded the federal limits, peculiarities in the way the UPL and net patient revenue limits are calculated, rapid Medicaid expansion, and changes in the federal match rate for expansion populations. In FY 2018-19 the Department made a change in the timing of the supplemental payments that shifted a portion of the annual payments forward by one fiscal year, resulting in a one-time increase in expenditures.

[3] Reimbursements to hospitals must occur as near to simultaneous with the collection of the fee as feasible, and no later than two days after the collection of the fee, pursuant to Section 25.5-4-402.4 (4)(e), C.R.S.

[4] Section 25.5-4-402.4 (4)(f), C.R.S.



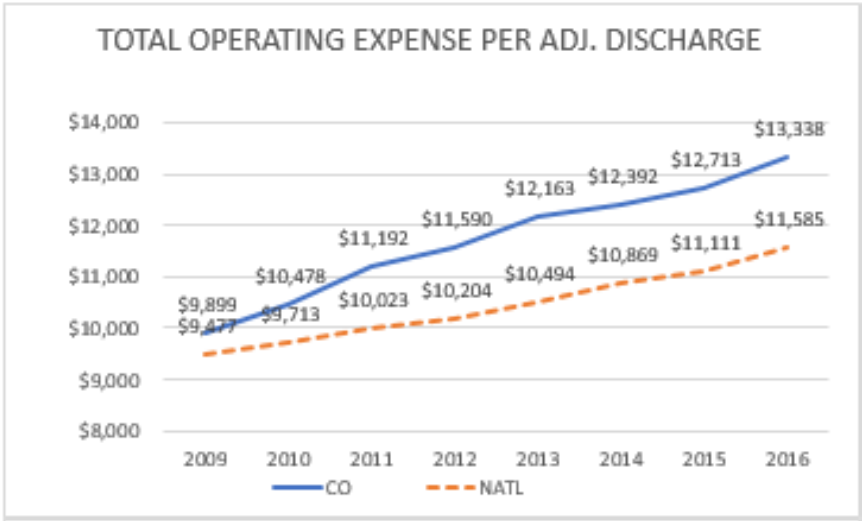
COST SHIFT FROM MEDICAID TO COMMERCIAL INSURANCE

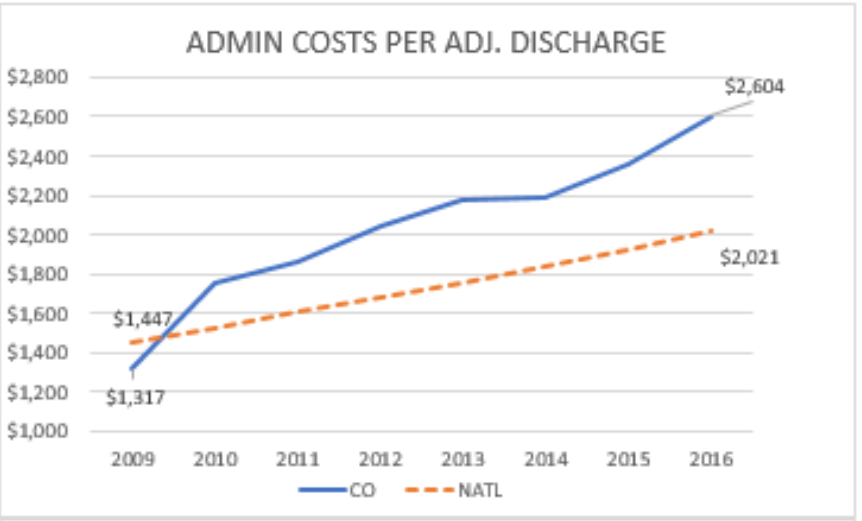
When the provider fee was created, one of the primary justifications for the fee was that it would reduce a cost shift from Medicaid to private insurance caused by low Medicaid reimbursement rates, and thereby contain private insurance costs. Shortly thereafter, the Medicaid eligibility expansion under the federal Affordable Care Act dramatically increased the amount the Department could pay hospitals through the provider fee, far and above anything contemplated in the original provider fee legislation. Also, care provided by hospitals to the uninsured decreased dramatically, likely due to the combination of the Medicaid eligibility expansion, federal tax credits for buying insurance through the healthcare exchange, and the individual mandate in the ACA to purchase health insurance or pay a tax penalty. Despite these changes, hospitals report that the payment to cost ratio for private insurance has increased, and a cost shift from Medicaid to private insurance continues.

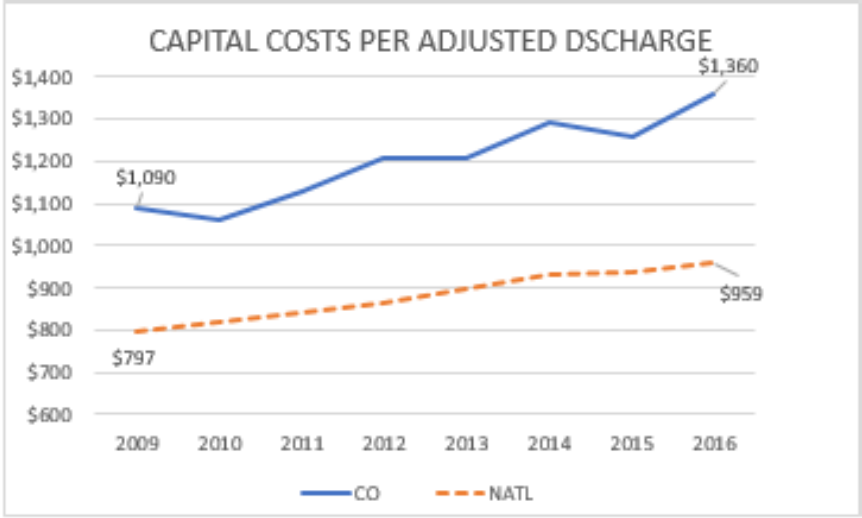
Payment to Hospital Cost Ratio								
Insurer	2009	2010	2011	2012	2013	2014	2015	2016
Medicare	0.80	0.76	0.77	0.74	0.64	0.71	0.72	0.71
Medicaid	0.54	0.74	0.76	0.79	0.80	0.72	0.75	0.71
Commercial Insurance	1.55	1.49	1.54	1.54	1.52	1.59	1.58	1.64
CICP/Self/Other	0.52	0.72	0.65	0.67	0.84	0.93	1.11	1.07
Overall	1.05	1.06	1.07	1.07	1.05	1.07	1.08	1.09

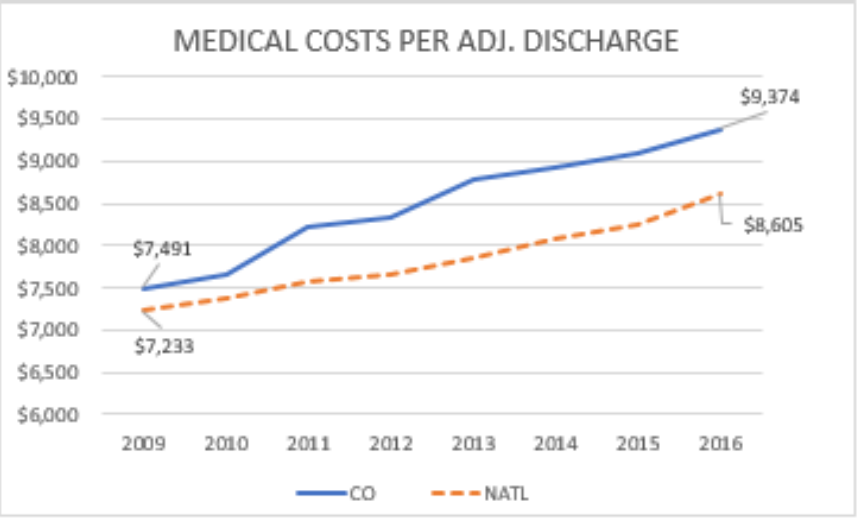
HOSPITAL COST PER ADJUSTED DISCHARGE

To better understand factors driving hospital expenditures, the Department has been analyzing federal cost reports submitted by hospitals. These cost reports are audited and used by Medicare for rate setting and other purposes. Initial results show average Colorado expenditures per adjusted discharge exceeding national averages. The Department's analysis categorizes the hospital expenditures into administrative costs, capital construction costs, and medical costs.


TOTAL OPERATING EXPENSE PER ADJ. DISCHARGE
$14,000
$13,000
$12,000
$11,000
$10,000
$9,000
$8,000
$9,899
$9,477
$10,478
$9,713
$11,192
$10,023
$11,590
$10,204
$12,163
$10,494
$12,392
$10,869
$12,713
$11,111
$13,338
$11,585
2009
2010
2011
2012
2013
2014
2015
2016
CO
NATL


ADMIN COSTS PER ADJ. DISCHARGE
$2,800
$2,600
$2,400
$2,200
$2,000
$1,800
$1,600
$1,400
$1,200
$1,000
$1,447
$1,317
$2,604
$2,021
2009
2010
2011
2012
2013
2014
2015
2016
CO
NATL


CAPITAL COSTS PER ADJUSTED DSCHARGE
$1,400
$1,300
$1,200
$1,100
$1,000
$900
$800
$700
$600
$1,090
$797
$1,360
$959
2009
2010
2011
2012
2013
2014
2015
2016
CO
NATL


MEDICAL COSTS PER ADJ. DISCHARGE
$10,000
$9,500
$9,000
$8,500
$8,000
$7,500
$7,000
$6,500
$6,000
$7,491
$7,233
$9,374
$8,605
2009
2010
2011
2012
2013
2014
2015
2016
CO
NATL

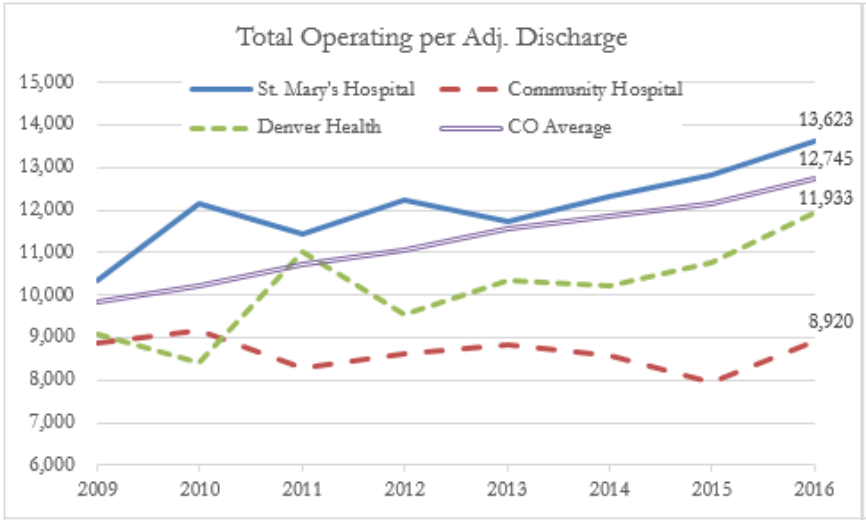
The Colorado Hospital Association has raised concerns that this comparison includes expenditures for the provider fee, implying that the inclusion of the provider fee distorts the data. However, nearly every state has implemented a variation of the provider fee, and so for a national comparison including the provider fee makes sense. Not every state uses a provider fee in a similar way or in a similar magnitude to Colorado. Also, the Department has identified some variation in the accounting of provider fees in the cost reports, with some hospitals reporting net expenditures versus gross expenditures. Taking the provider fee out of the national data would be a heavy lift, but it is possible to remove the provider fee from the Colorado data. This results in an apples to oranges comparison that is less illustrative than including the provider fee, but if there is concern that inclusion of the provider fee distorts the data, then it is worth noting the result. Removing the provider fee from the Colorado data changes the magnitude of the difference from the national data, but Colorado's costs are still higher and still growing faster. For comparisons of hospitals within the state, rather than against the national average, it might be appropriate to remove the provider fee. The in-state comparisons in the tables on the next page show the data without the provider fee.

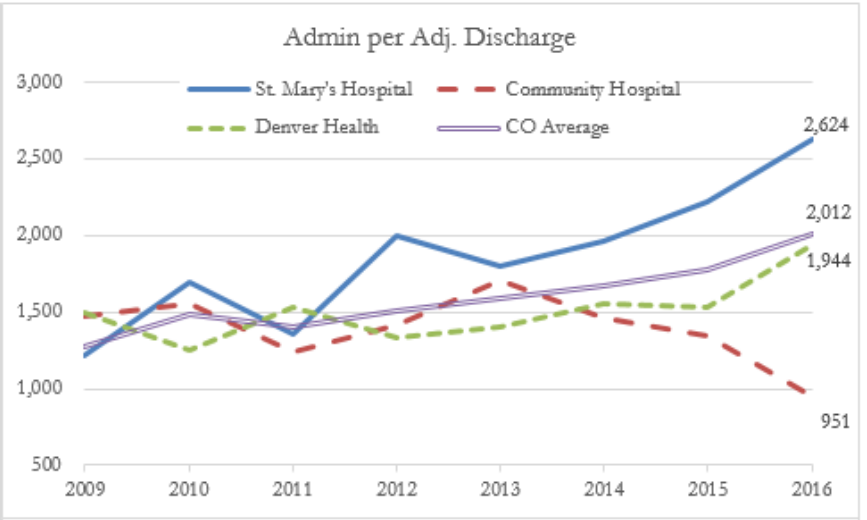
The tables on the next page compare expenditures per adjusted discharge for three different hospitals with the provider fee removed from the analysis. St. Mary's Hospital and Community Hospital are both in Grand Junction, but St. Mary's is a Level 1 trauma hospital. Denver Health is a Level 1 trauma hospital, like St. Mary's, but in a different part of the state. These hospitals were selected for comparison not because they are necessarily similar to each other, but because the Department has met with St. Mary's and Community Hospital, and Denver Health has worked closely with the Department in sharing information for this analysis. Therefore, the Department's data and methodology should not be a surprise to any of these hospitals.[5]

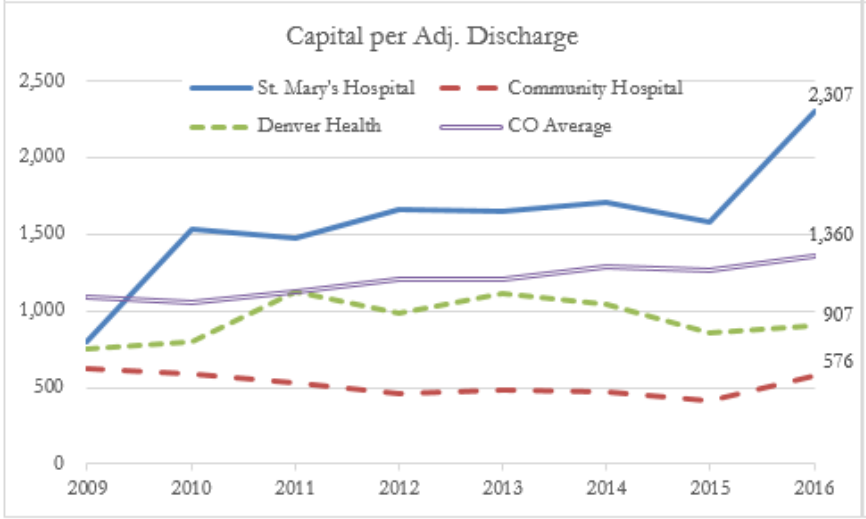
The point of the comparison is to show differing experiences of the hospitals, particularly around administrative and capital expenditures, within the same state. Community Hospital and Denver Health are below both the national and Colorado average and St. Mary's is above the average for all of the expenditure groupings, except medical per adjusted discharge, where St. Mary's is just below the Colorado average.

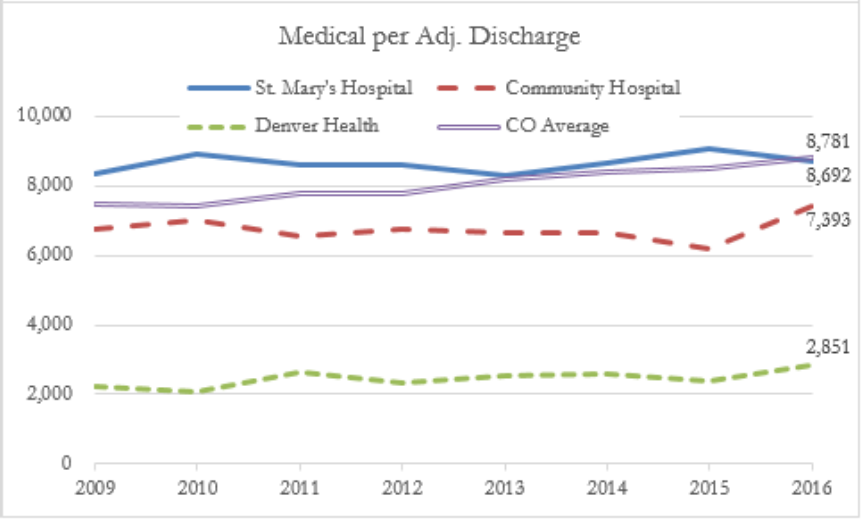
In the next steps of this project, the Department is meeting with individual hospitals and hospital systems to explain the data and methodology, validate the data, and tease apart why some hospitals spend more or less than the national and Colorado averages. The Department wants to look at whether there are correlations between hospitals with high costs relative to the state and national averages and geographic areas with high cost commercial insurance. The Department hopes understanding the differences in hospital expenditure patterns may suggest new policies or payment methods that facilitate the most efficient operation for the greatest public good, and reduce the cost shift from Medicaid to private insurance.

[5] This should not be interpreted to mean that the hospitals have validated the data or endorsed any conclusions drawn from it. That work is ongoing. But, the hospitals have had an opportunity to review the data and methodology with Department staff.


Total Operating per Adj. Discharge
St. Mary's Hospital
Community Hospital
Denver Health
CO Average
15,000
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
2009
2010
2011
2012
2013
2014
2015
2016
13,623
12,745
11,933
8,920


Admin per Adj. Discharge
St. Mary's Hospital
Community Hospital
Denver Health
CO Average
3,000
2,500
2,000
1,500
1,000
500
2009
2010
2011
2012
2013
2014
2015
2016
2,624
2,012
1,944
951


Capital per Adj. Discharge
St. Mary's Hospital
Community Hospital
Denver Health
CO Average
2,500
2,000
1,500
1,000
500
0
2009
2010
2011
2012
2013
2014
2015
2016
2,307
1,360
907
576


Medical per Adj. Discharge
St. Mary's Hospital
Community Hospital
Denver Health
CO Average
10,000
8,000
6,000
4,000
2,000
0
2009
2010
2011
2012
2013
2014
2015
2016
8,781
8,692
7,393
2,851

COLORADO HOSPITAL ASSOCIATION CONCERNS

The Colorado Hospital Association (CHA) has raised several concerns about the Department's analysis. The following highlights a few of CHA's concerns that have been shared with the JBC staff:

- CHA notes that the time period studied by the Department spans the creation of Colorado's provider fee and the Medicaid expansion financed with that fee and argues that the provider fee and the expansion account for most of the increase in administrative costs. The Department's recent effort to remove the provider fee from in-state comparisons appears to the JBC staff to partially address CHA's concern. It is not clear to the JBC staff why CHA believes the expansion increased administrative costs.
- CHA argues that a higher cost of living in Colorado likely explains much of the difference in expenditures, particularly around capital costs. The Department started the analysis by trying to make comparisons to states similar to Colorado on a variety of variables, including cost of living, but received criticism that the particular states selected biased the data, and so the Department switched to using a national average.
- CHA argues that Colorado's percentage of total expenditures on hospital care compared to other states ranks in the middle of the pack, suggesting that hospitals are not an unusually large driver of overall medical expenditures that would account for higher insurance premiums in Colorado versus other states. CHA does note that Colorado's proportion of hospital expenditures to total expenditures has increased faster than the nation's in recent years.
- Citing data from the Kaiser Family Foundation, CHA says Colorado's expenditure per capita from all payers on hospital care ranks 42nd. If Colorado's expenditure per adjusted discharge is high and the hospital expenditure per capita is low, maybe it is because Colorado is doing a good job of keeping low-acuity patients out of the hospital, CHA suggests.
- CHA cautions against assuming that administrative costs higher than the national average are unnecessarily high. Maybe high hospital administrative expenditures correlate to high quality care and case management that results in better health outcomes and lower utilization.
- Citing data from the Commonwealth Fund, CHA notes that both Colorado's average total premium for a single person plan and Colorado's percent of total household income spent on family health insurance premiums are not outliers compared to other states. CHA views this as evidence that higher than average hospital costs per discharge are not related to higher than average premiums.
- CHA argues that there is a strong relationship between total health care expenditures in a state and premiums, but for some reason Colorado has relatively high premiums compared to total health care expenditures, suggesting that the disconnect in Colorado between total health care expenditures and premiums needs to be analyzed further before any potential future reduction in expenditures will be successful in reducing premiums.

ISSUE: LONG-TERM SERVICES AND SUPPORTS

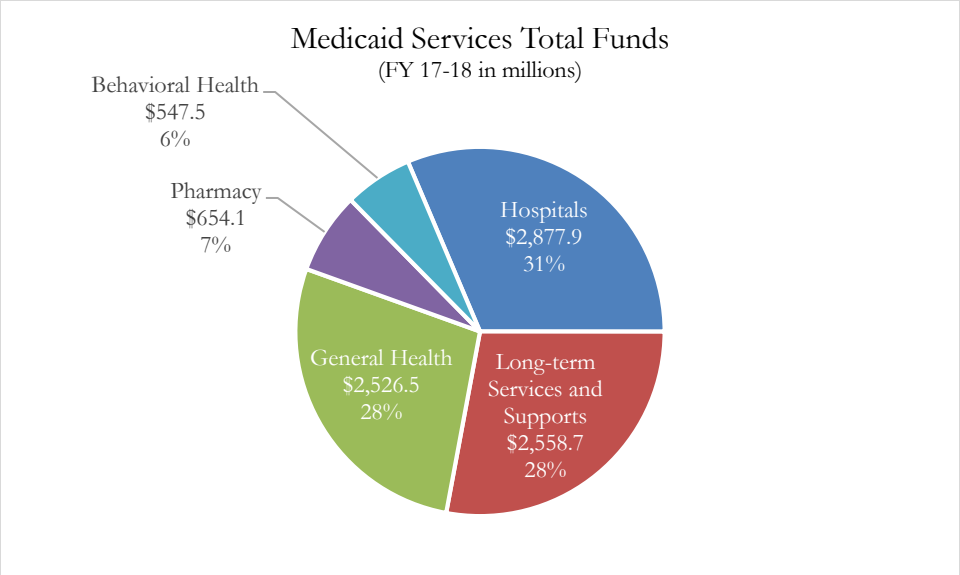
Long-term services and supports represent 28 percent of Medicaid total funds expenditures, but 45 percent of General Fund expenditures. Expenditures for home health, private duty nursing, the Home- and Community-Based Services waivers, and the Program for All-Inclusive Care for the Elderly are growing more rapidly than enrollment of the elderly and people with disabilities. For Home- and Community-Based Services waivers this is a function of provider rate increases, especially for personal care and homemaker services, and an increase in units per utilizer. For the other services, it is largely a function of increases in the number of utilizers.

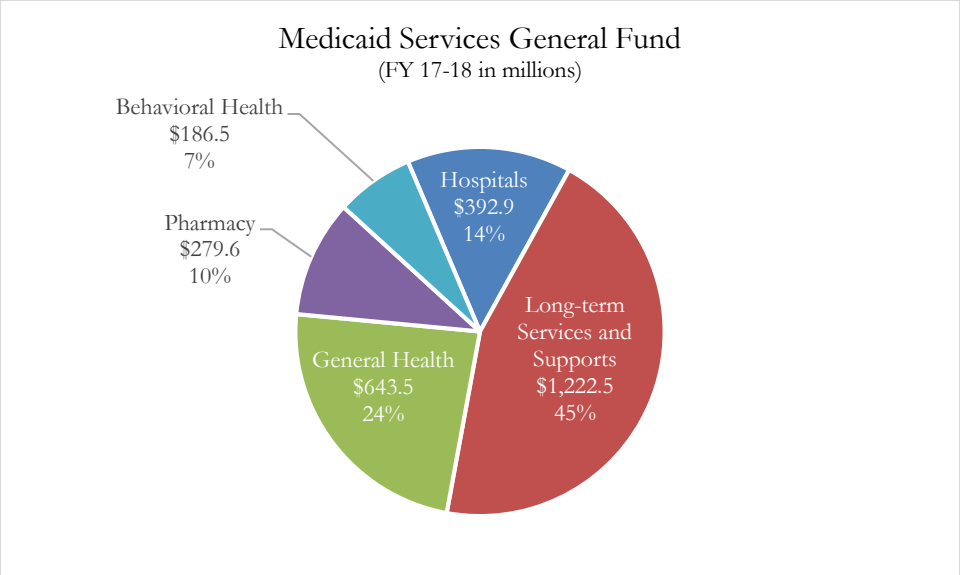
SUMMARY

- Long-term services and supports represent 28 percent of Medicaid total funds expenditures, but 45 percent of General Fund expenditures.
- Enrollment of the elderly and people with disabilities has grown at a steady pace and is relatively insensitive to changes in the economy.
- Major expenditure categories within long-term services and supports include nursing homes, services for people with intellectual and developmental disabilities, Home- and Community-Based Services waivers, and home health and private duty nursing
- Expenditures for all these categories except nursing homes are growing faster than enrollment of the elderly and people with disabilities.
- For home health, private duty nursing, and the Program for All-Inclusive Care for the Elderly (PACE), the number of utilizers is growing significantly faster than enrollment, resulting in the disproportionate increases in expenditures.
- For the Home- and Community-Based Services waivers the growth in the number of utilizers is on par with enrollment, but the General Assembly has significantly increased rates, especially for personal care and homemaker services. Also, the units per utilizer have increased.

DISCUSSION

In the most recent actual year (FY 2017-18), long-term services and supports represent roughly 28 percent of total funds and 45 percent of General Fund expenditures for Medicaid services. The pie charts below focus on expenditures for Medicaid services and do not include the roughly 3 percent of the Department's budget spent on administration or the 2 percent on programs other than Medicaid (mostly the Children's Basic Health Plan).



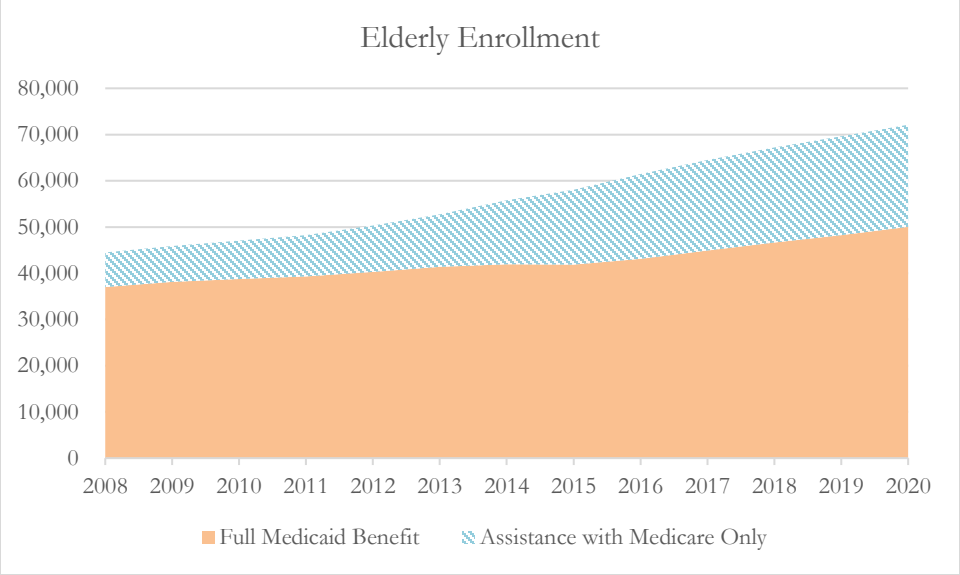


The elderly and people with disabilities are the primary users of long-term services and supports and enrollment trends for these populations have significant bearing on the expenditures.

ELDERLY ENROLLMENT TRENDS

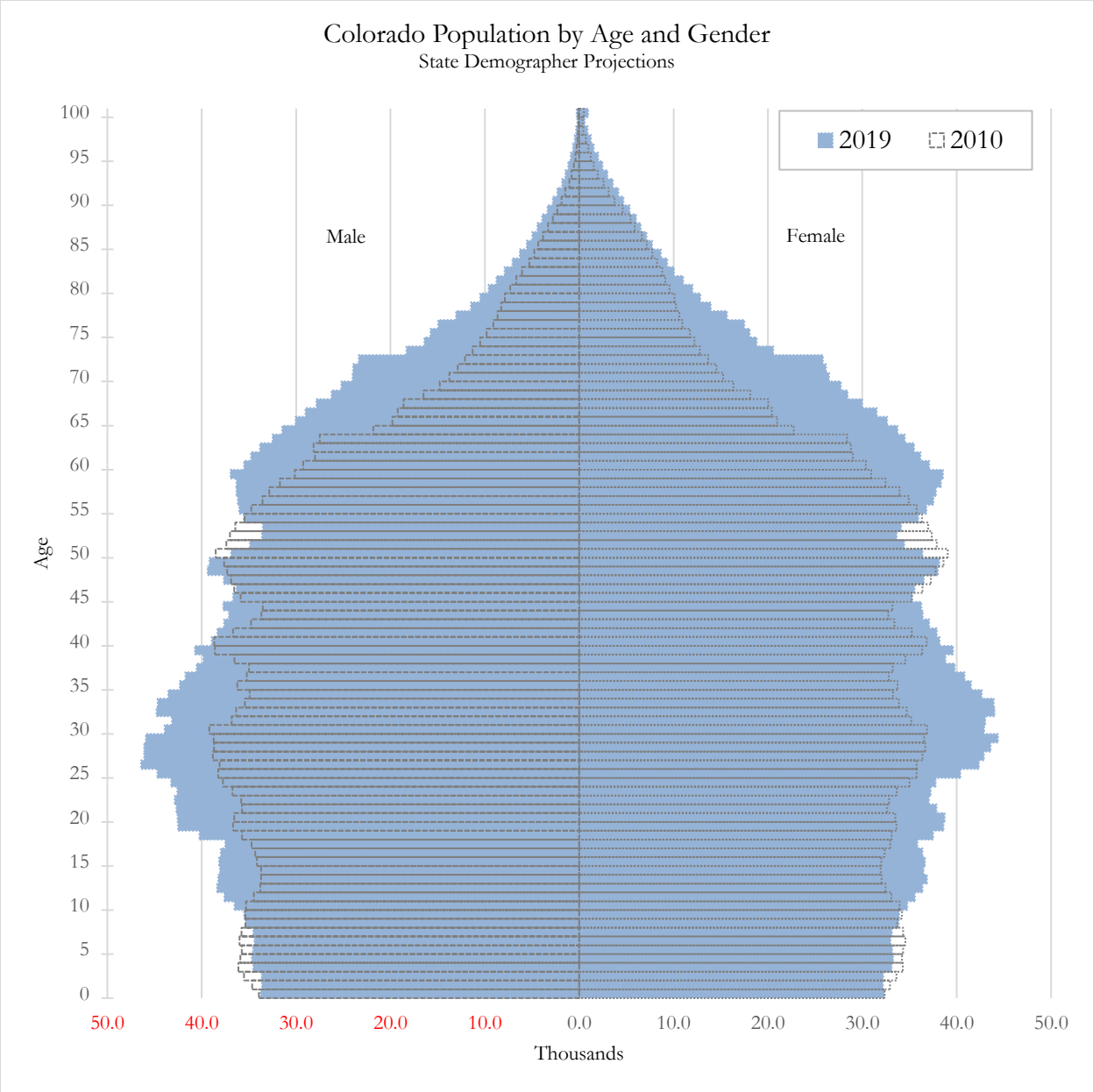
Enrollment growth in Medicaid of people 65 years and older has been relatively stable and insensitive to economic changes, growing at a compound average annual growth rate (CAAGR) of 4.2 percent from calendar year 2008 to 2017. The elderly enrollment slightly lags the estimated CAAGR of 4.7 percent for the Colorado population 65 years and older. From calendar year 2008 to 2017 elderly enrollment in Medicaid increased a cumulative 44.9 percent compared to 50.7 percent for the estimated Colorado population 65 years and older.

A disproportionate share of recent elderly enrollment growth is attributable to relatively higher income people who qualify for assistance with their Medicare premiums, but not full Medicaid benefits. Most people 65 years or older who qualify for full Medicaid benefits do so because they qualify for federal Supplemental Security Income (SSI)[6]. The annual income limits to qualify for SSI are $9,000 for an individual and $13,500 for a family of two. People can qualify for partial Medicaid benefits that pay for Medicare costs only, including Medicare premiums and in some cases (depending on income) Medicare copays, with income up to 135 percent of the federal poverty guidelines, or $13,389 for an individual and $22,221 for a family of two. The skewing of elderly enrollment growth toward relatively higher income people mitigates the cost of elderly enrollment growth, as Colorado spends an average of $1,254 per capita for elderly people who qualify for only partial Medicaid benefits versus $27,863 per capita for elderly people who qualify for full Medicaid benefits.



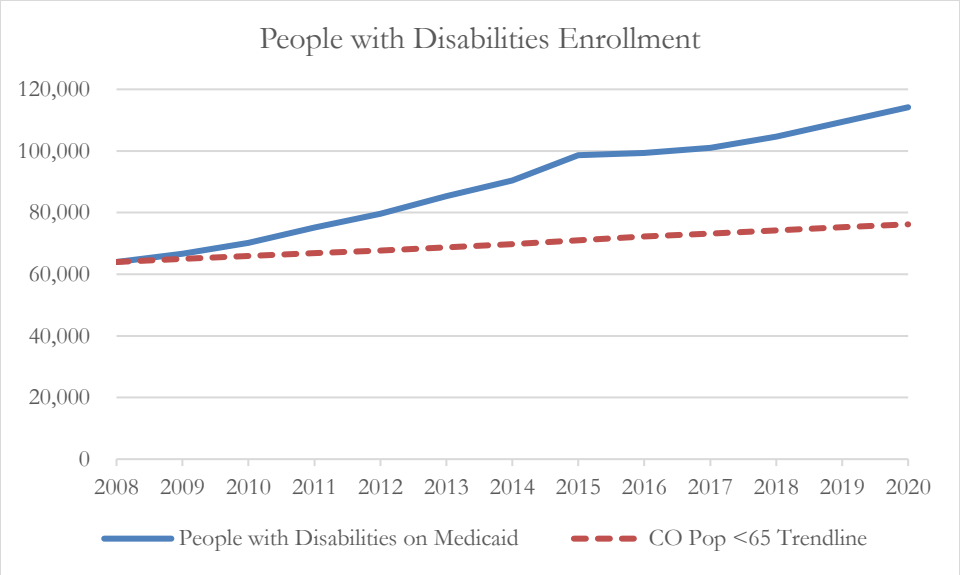
Estimates from the State Demographer, based on U.S. Census Bureau data, show a population bubble ages 71 to 53. This newly elderly and approaching elderly group might be richer than the previous average, which would explain Medicaid elderly enrollment lagging the elderly population growth and Medicaid elderly income skewing higher. If this is the case, it is possible that over time the newly elderly will spend down assets, causing overall elderly enrollment and enrollment of people eligible for full Medicaid benefits to increase.

[6] People 65 and older can also qualify for full Medicaid benefits if they require a nursing home level of care and have income up to 300 percent of the SSI limits, or $27,000 for an individual and $40,500 for a family of two.



PEOPLE WITH DISABILITIES ENROLLMENT TRENDS

Similar to the elderly, the enrollment of people with disabilities has been relatively stable and insensitive to economic changes, growing at a 5.2 percent CAAGR from calendar year 2008 to 2017. Unlike the elderly, the enrollment growth of people with disabilities far exceeds the estimated 1.5 percent CAAGR for the Colorado population under 65. From calendar year 2008 to 2017, enrollment of people with disabilities increased a cumulative 57.9 percent compared to 14.4 percent for the estimated Colorado population under 65. The chart below shows enrollment for people with disabilities and the trendline if enrollment had grown at the same rate as the Colorado population under 65.



During this period, the General Assembly expanded Medicaid eligibility to allow people with disabilities and income up to 450 percent of the federal poverty guidelines to "buy in" to Medicaid by paying a premium on a sliding scale. This expansion has increased enrollment by about 8,000 people to date.

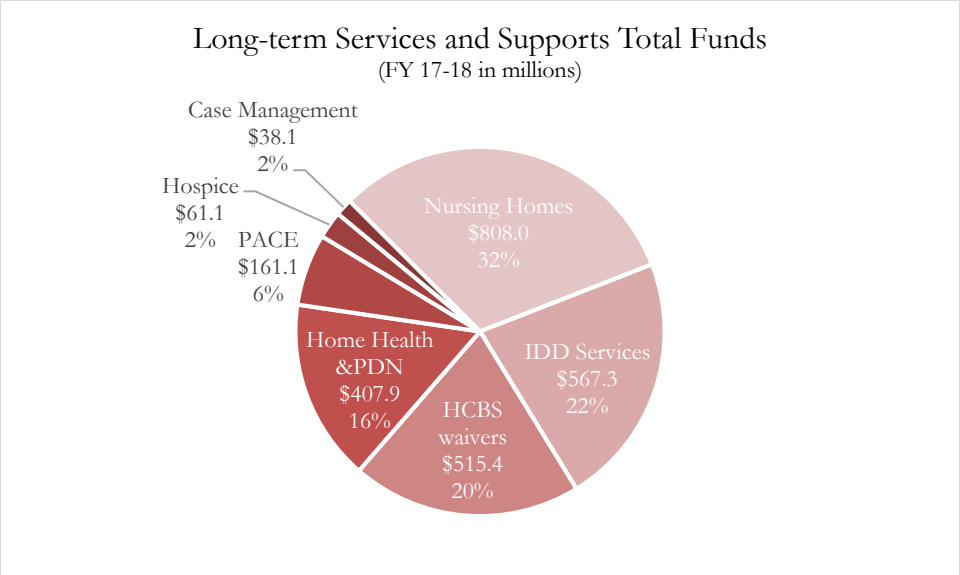
According to the Department, the relationship in Colorado between the enrollment of people with disabilities and the population under 65 is consistent with national trends for programs that serve people with disabilities, including disabled worker benefits and Supplemental Security Income. The federal Social Security Administration identifies several factors that influence the proportion of the population receiving disability benefits, including changes in the age distribution due to the baby boomers, improvements in medical treatments and the health of people with disabilities, economic circumstances, and disability policy.

It is important to note that despite the relatively faster enrollment growth for people with disabilities compared to the population under 65, the enrollment of people with disabilities is still a tiny fraction of the total population. In 2017, the enrollment of people with disabilities represented 1.8 percent of the Colorado population under 65, compared to 1.3 percent in 2008.

Long-Term Services and Supports Expenditure Trends

The elderly and people with disabilities utilize more medical services and higher cost medical services than the overall population, but an even more important distinguishing characteristic from a Medicaid cost perspective is the utilization by these populations of long-term services and supports.

Long-Term Services and Supports (LTSS) can be broken down into major categories as depicted in the pie chart below. The General Fund percentages for each subcategory of LTSS are the same as the total funds percentages, because, apart from a few nuances that are not large enough to change the picture, the federal match rate for LTSS is 50 percent and the fund source for the state match is by and large the General Fund.



NURSING HOMES

While nursing homes are expensive per utilizer, the utilization has been growing very slowly, at a 0.9 percent CAAGR from FY 2009-10 to FY 2017-18. A bigger driver of nursing home expenditures is rates. Nursing home rates are adjusted annually according to a statutory formula based on the lesser of actual costs or a 3.0 percent increase in the General Fund. Changing the nursing home rates would require a statutory change.

In addition to standard payments, the total expenditure for nursing homes includes a little more than $100 million in supplemental payments where the state match comes from a provider fee that operates similarly to the provider fee on hospitals, except on a much smaller scale. Statutes allow the nursing provider fee supplemental payments to fill in the difference when actual allowable costs exceed the statutory 3.0 percent cap on growth in the General Fund.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDD)

This category includes both community-based services and costs for the state-operated Regional Centers. These services will be discussed in more detail during the 12/11/18 briefing for the Office of Community Living. Both utilization and rates are based on annual funding appropriated by the General Assembly, as the waivers that authorize community-based services allow for caps on enrollment.

HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

These services assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning a feeding tube. These particular examples fit in categories of services called personal care, homemaker, and health maintenance respectively, which are the most used and frequently referenced categories of services within HCBS. Other examples of the services that might be available through HCBS waivers include adult day services, non-medical transportation, assisted living services (not room and board), and respite care.

In order to use Medicaid to pay for these services, Colorado received waivers from federal Medicaid rules. The federal government allows these waivers in part because the services are expected to reduce costs for nursing homes, which would otherwise be covered for these clients by Medicaid. While the HCBS waivers share many common characteristics, each waiver is reviewed and approved individually and can include unique services or special parameters, such as enrollment or expenditure caps, that do not apply anywhere else within Medicaid.

The vast majority of expenditures are for consumer directed services where the Medicaid client is given a budget based on assessed needs and can select, train, and manage attendants. Clients eligible for consumer directed services can choose Consumer Directed Attendant Support Services (CDASS) that offers full control, or In-Home Support Services (IHSS) where an organization provides assistance with payroll and human resource functions. In CDASS and IHSS the Nurse Practice Act is waived so clients can hire staff without certifications or licensure for routine and repetitive health maintenance that does not require clinical judgement or assessment.

The amount in the JBC staff's pie chart for HCBS waivers excludes services for people with intellectual and developmental disabilities. There are HCBS waivers specifically targeted for people with intellectual and developmental disabilities (IDD) that are included in the pie chart under IDD services. In different contexts the term HCBS waivers sometimes includes services for people with IDD, but not in the JBC staff pie chart.

The number of utilizers has been growing only slightly faster than enrollment of the elderly and people with disabilities, but expenditures have been growing more rapidly. From FY 2009-10 to FY 2017-18 the cumulative increase in utilizers was 50.7 percent (5.3 percent CAAGR) compared to a 121.6 percent cumulative increase in expenditures (10.5 percent CAAGR). The faster growth in expenditures is partly a result of significant provider rate increases approved by the General Assembly for personal care and homemaker services, but also reflects increases in the units of service authorized per utilizer. For the non-IDD HCBS waivers, utilization is controlled by the Single Entry Point (SEP) agencies that perform needs assessments and provide case management. Rates are set within the annual funding appropriated by the General Assembly.

HOME HEALTH AND PRIVATE DUTY NURSING (PDN)

These are skilled nursing and therapy services provided in a home setting. People can potentially receive both HCBS waiver services and Home Health and Private Duty Nursing services. The difference between Home Health and Private Duty Nursing is a matter of degree, with Private Duty Nursing the more intensive service and generally limited to people who are machine-dependent and/or require round-the-clock care. In addition to traditional nursing services, Home Health includes physical therapy, occupational therapy, and speech therapy.

From FY 2009-10 to FY 2017-18 the number of utilizers increased a cumulative 126.6 percent (10.8 percent CAAGR) and expenditures increased a cumulative 152.9 percent (12.3 percent CAAGR). Utilization is currently authorized based on needs assessments by the SEPs, although the Department proposes changing to an assessment performed by nurses and physicians in *R9 Long-term home health and private duty nursing acuity tool*. Rates are set within annual appropriations by the General Assembly. Average units per utilizer has been relatively constant, but in recent years the General Assembly provided funding to increase rates, resulting in expenditure growth that exceeds growth in the number of utilizers.

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a managed care program with a capitated rate for providers. The PACE providers accept the risk and keep the reward if actual costs are higher or lower than expected in the rate calculation. The JBC staff included all PACE expenditures in the long-term services and supports wedge of the pie, but in addition to LTSS the capitated rate covers hospital, general health, pharmacy, and behavioral health care. Medicaid clients must be 55 years old or older, live in a PACE facility catchment area, and be assessed by a SEP as needing a nursing facility level of care to qualify. The Medicaid client may then choose to enroll in a PACE program or receive services à la carte.

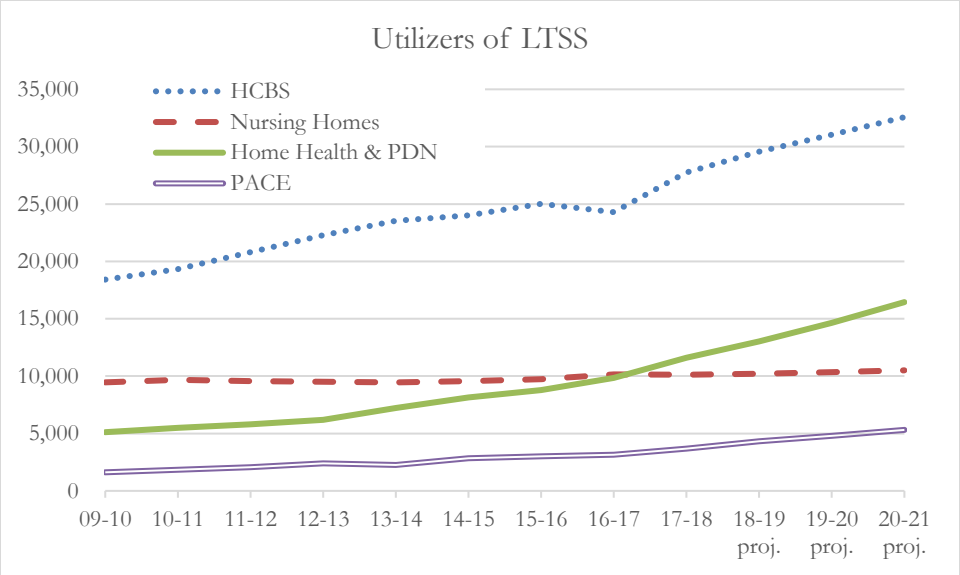
Utilization of PACE increased a cumulative 127.7 percent (10.8 percent CAAGR) from FY 2009-10 to FY 2017-18 and PACE expenditures increased correspondingly by 132.6 percent (11.1 percent CAAGR) during the same time frame. PACE rates are updated every year to meet federal standards as actuarially sound. The rates relate to assumptions about what the clients would have cost Medicaid outside of the PACE program. Thus, annual budget decisions by the General Assembly about non-PACE rates indirectly influence the PACE rates. A portion of the PACE rates are based on the costs of nursing home care, which adjust annually according to a statutory formula. The primary driver of the increased expenditures for PACE has been the increased utilization.

HOSPICE

The number of hospice utilizers has grown very slowly, by a cumulative 3.1 percent (0.4 percent CAAGR) from FY 2009-10 to FY 2017-18. Expenditures have increased by a cumulative 39.9 percent (4.3 percent CAAGR). Eligibility for hospice is based on physician certification that a client is terminally ill and election for hospice by the client or client representative. Rates are adjusted annually based on a combination of a federal formula and nursing rates, and can potentially go higher with discretionary funds from the General Assembly.

CASE MANAGEMENT

This expenditure is primarily for the SEPs that assess needs and provide case management, but also includes some other very small miscellaneous case management-related services. Expenditures have increased 46.8 percent (4.9 percent CAAGR) in step with increases in enrollment of the elderly and people with disabilities.


Utilizers of LTSS
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
HCBS
Nursing Homes
Home Health & PDN
PACE
09-10
10-11
11-12
12-13
13-14
14-15
15-16
16-17
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18-19 proj.
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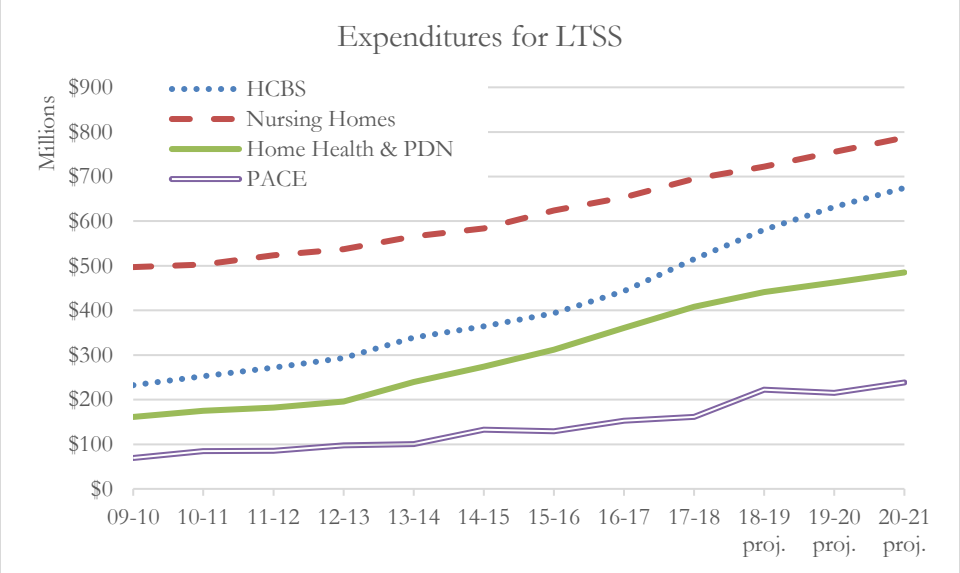
Expenditures for LTSS
Millions
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
HCBS
Nursing Homes
Home Health & PDN
PACE
09-10
10-11
11-12
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18-19 proj.
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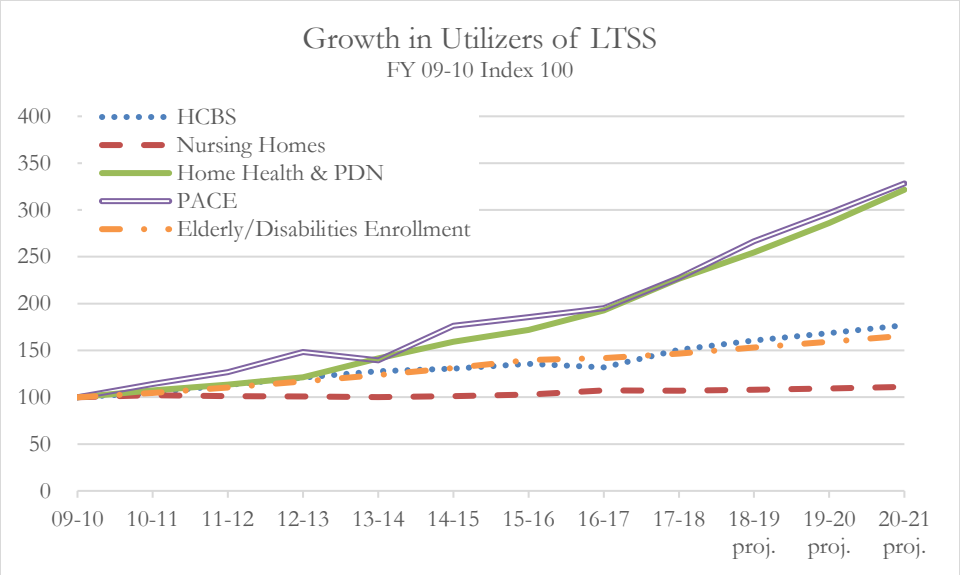
Growth in Utilizers of LTSS
FY 09-10 Index 100
HCBS
Nursing Homes
Home Health & PDN
PACE
Elderly/Disabilities Enrollment
400
350
300
250
200
150
100
50
0
09-10
10-11
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14-15
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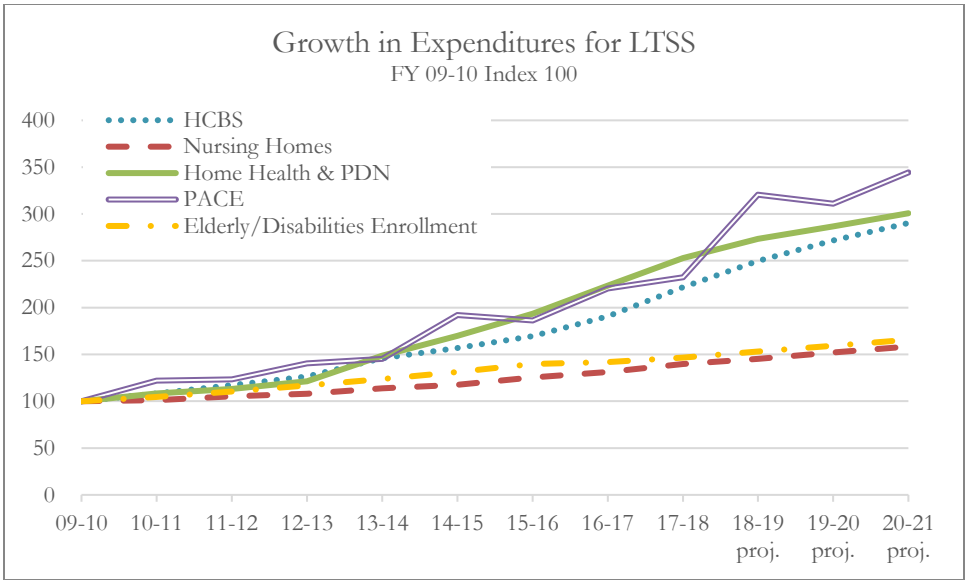
18-19 proj.
19-20 proj.
20-21 proj.


Growth in Expenditures for LTSS
FY 09-10 Index 100
HCBS
Nursing Homes
Home Health & PDN
PACE
Elderly/Disabilities Enrollment
400
350
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200
150
100
50
0
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18-19 proj.
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ISSUE: PROVIDER RATES (R13)

Through *R13 Provider rates* the Department requests a net increase of $61.1 million total funds, including $26.8 million General Fund, for both positive and negative changes to provider rates. Of the increase, $26.5 million total funds, including $14.3 million General Fund, is for targeted rate increases, primarily for rates identified by the Medicaid Provider Rate Review Advisory Committee as needing adjustment. The remaining $34.6 million total funds, including $12.4 million General Fund, is for an across-the-board 0.75 percent increase.

SUMMARY

- *R13 Provider rates* requests a net increase of $61.1 million total funds, including $26.8 million General Fund, for both positive and negative changes to provider rates.
- The General Assembly established a process in S.B. 15-228 for the Department to review rates on a five-year cycle.
- The review includes benchmark comparisons and analysis of whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services
- Of the requested increase, $26.5 million total funds, including $14.3 million General Fund, is for targeted rate increases, primarily for rates identified by the Medicaid Provider Rate Review Advisory Committee as needing adjustment
    - The Department requests increases for personal care, homemaker, Home- and Community-Based Services, transportation dental, maternity, and miscellaneous other rates.
    - The Department proposes a budget neutral rebalancing of rates below 80 percent or above 100 percent of the benchmark for primary care, radiology, and physical and occupational therapy.
    - The Department requests decreases for laboratory and pathology, anesthesia, and diabetes test strips.
- The remaining $34.6 million total funds, including $12.4 million General Fund, is for an across-the-board 0.75 percent increase.
- In addition to the discretionary changes requested in *R13 Provider rates*, the Department expects to significantly reduce rates for the Program for All-Inclusive Care for the Elderly (PACE) to implement the requirements of S.B. 16-199. The corresponding change in funding is reflected in the Department's *R1 Medical Services Premiums* forecast request.

DISCUSSION

Through *R13 Provider rates* the Department requests a net increase of $61.1 million total funds, including $26.8 million General Fund, for both positive and negative changes to provider rates. In addition, the Department's forecast in *R1 Medical Services Premiums* makes an assumption about a decrease in provider rates for the Program for All-Inclusive Care for the Elderly (PACE) that is discussed in this issue brief.

PROVIDER RATE REVIEW PROCESS UNDER S.B. 15-228

In developing the request, the Department leaned on recommendations from the Medicaid Provider Rate Review Advisory Committee (MPPRAC), created by S.B. 15-228. The JBC sponsored S.B. 15-228 to assist the legislature in evaluating rate change proposals. Medicaid is becoming an increasingly important payer for medical services with nearly 25 percent of Colorado's population now covered by Medicaid. JBC members frequently hear complaints from providers about the insufficiency of Medicaid reimbursement rates. The Department has brought forth several proposals in recent years to target certain rates for increases, but not others. The process established by S.B. 15-228 was intended to address these issues by providing data to support rate setting decisions, and by establishing formal procedures for the Department to engage with providers regarding rate setting priorities.

Some of the key features of S.B. 15-228 include:

- Five-year review cycle – The requirement that rates be reviewed at least once every five years ensures that all rates covered by S.B. 15-228 get a day in the sun, while spreading the workload out for the Department, the advisory committee, and the General Assembly.
- Analysis report – The bill requires an analysis report by May 1 each year that provides information for the rates under review on the level of access, service, quality, and utilization provided, as well as comparisons of the rates with available benchmarks, including Medicare and usual and customary rates paid by private payers. The report must assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. If a rate is identified as needing adjustment, but the budget does not support a change, the annual reports ensure the data and analysis remain available to inform decision making in future years.
- Recommendation report - A second report, due by November 1 each year, explains the Department's recommendations on the rates.
- Medicaid Provider Rate Review Advisory Committee (MPRRAC) – This 24 member advisory committee, appointed by the House and Senate leadership and composed of providers and stakeholders, reviews the Department's May 1 report and helps the Department devise strategies for responding to the findings, including non-fiscal approaches or rebalancing of rates. The Advisory Committee also holds meetings with the Department to solicit public comment on the rates under review. The MPRRAC also may direct the Department to change the rate review schedule and may make recommendations to the General Assembly for how to improve the rate review process.

Concurrent with the passage of S.B. 15-228, the federal government issued new rules requiring states to conduct periodic rate reviews. The federal rules require states to review certain rates at least once every three years. There is some overlap, but also variation, between the rate reviews required by federal regulation and those required by S.B. 15-228. The federal rules emphasize analysis of regional variations in access, and so the Department has incorporated a discussion of regional access in the S.B. 15-228 process. Significantly, the federal rules require an analysis of the expected effect on member access to services prior to any reduction in Medicaid rates.

EVALUATING RATE SUFFICIENCY

Statutes direct the Department and the MPRRAC to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. To do this the Department makes comparisons to benchmark rates, analyzes claims data for access issues, and solicits stakeholder feedback.

The Department's reports emphasize that there are a number of limitations to claims-based analysis of access to consider before drawing conclusions. First, factors other than rates may influence observed access issues, such as the administrative burden of participation in Medicaid, client characteristics and behaviors, provider outreach efforts, and provider scheduling practices. Second, rates may not be optimal when there are no observed access issues. For example, rates can drive over utilization or underutilization of services in a manner inconsistent with best practices. Third, claims data alone does not reveal potentially important information such as the number of providers accepting new clients, the supply of providers not participating in Medicaid, appointment wait times, the level of care provided compared to the level of need, or the portion of payments passed on to employee wages. For these reasons, the Department encourages looking at the claims-based analysis of access in context of the other information available, including the benchmark comparisons and stakeholder input.

The Department's May 1 analysis report includes for each rate reviewed a description of the service, a benchmark comparison, an access to care index, and a conclusion. The Department streamlined the report this year, moving the supporting documentation to appendices and removing some items, like a description of the usual place of service or an estimate of the cost to pay at the benchmark rate, that come out in the stakeholder engagement and budget process when relevant. The description includes information on expenditures for the service, the number of clients utilizing the service, the change in clients over time, and the change in providers over time. The benchmark comparison frequently uses Medicare rates, which Medicare develops using national average costs with regional modifiers, but may reference other state Medicaid rates or private pay or cost-based analysis when Medicare services are not equivalent. The benchmark comparison includes the number of procedure codes compared to different benchmarks and the range of rate ratios. The access to care index is a score by region based on the percent of clients who used the service compared to other regions, the member to provider ratio, the travel distance to service, the number of months providers billed Medicaid, and the average number of clients seen per provider. For some service groups the report identifies areas for additional research.

The November 1 recommendation report provides a high-level summary of the analysis findings, the Department's recommendations and their relationship to the Governor's request, information and data that informed the Department's recommendation, and a discussion of how the Department's recommendations align or differ from the MPRRAC recommendations and why.

The service categories that were reviewed in 2018, which is year 3 of the review cycle, include:

- Primary care and evaluation and management
- Radiology
- Physical and occupational therapy
- Maternity

- A subset of physician services that includes:
  - Allergy services
  - Neurology services
  - Infusion and similar products
  - Sleep studies
  - Skin procedures
  - Genetic counseling
  - Miscellaneous services
- A subset of surgeries that includes
  - Genital system surgeries
  - Nervous system surgeries
  - Urinary system surgeries
  - Endocrine system surgeries
- Dental

The Department's provider rate request includes components that touch all of these service categories. It also includes several changes based on rates reviewed in prior years. All of the MPRRAC reports are available from the Department's web site at: https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

R13 Provider Rates

The table below summarizes the dollar changes requested in the Department's *R13 Provider rates.*

R13 Provider Rates				
	Total Funds	General Fund	Cash Funds	Federal Funds
Personal care/Homemaker	$20,534,428	$10,267,214	$0	$10,267,214
Home- & Community-Based Services	10,167,918	5,083,959	0	5,083,959
Transportation	6,828,678	1,825,047	526,754	4,476,877
Dental	4,451,570	803,064	739,851	2,908,655
Maternity	4,373,298	1,966,672	0	2,406,626
Other	211,190	62,517	10,164	138,509
Primary care/Radiology/PT&OT	0	0	0	0
Laboratory/Pathology	(9,262,666)	(2,301,773)	(470,544)	(6,490,349)
Anesthesia	(8,519,153)	(2,514,854)	(412,327)	(5,591,972)
Diabetes test strips	(2,301,070)	(873,026)	(70,414)	(1,357,630)
Subtotal - Targeted Changes	**$26,484,193**	**$14,318,820**	**$323,484**	**$11,841,889**
Across-the-board 0.75 percent	34,580,627	12,449,219	1,427,229	20,704,179
Total	**$61,064,820**	**$26,768,039**	**$1,750,713**	**$32,546,068**

Personal care/Homemaker

The Department request $20.5 million total funds, including $10.3 million General Fund, to increase rates for personal care and homemaker services and equivalent consumer directed services by 8.1 percent in FY 2019-20. The Department proposes additional rate changes in future years for these providers based on inflation. The Department indicates it would promulgate rules ensuring the rate increases are passed through to employees by providers, similar to the requirements of H.B. 18-1407 that provided rate increases for disability services. The Department believes it can implement rules requiring the pass through within existing statutory authority.

Personal care and homemaker rates were reviewed by the MPRRAC in 2017. For personal care, rates were identified as ranging from 80.9 percent to 140.9 percent of the five benchmark comparison states. For homemaker services, rates were identified as ranging from 81.0 percent to 133.7 percent of the five benchmark comparison states. The General Assembly approved increases for personal care and homemaker rates of 3.1 percent in FY 2017-18 before the MPRRAC review and 5.3 percent in FY 2018-19 after the MPRRAC review.

In support of the request, the Department describes personal care and homemaker services as vital in allowing the elderly and people with disabilities to stay in their homes, rather than nursing facilities or assisted living facilities. Also, the Department notes than in 2016 Colorado voters passed Amendment 70 to increase the minimum wage in increments to $12 an hour by 2020, and then by inflation each year thereafter. Providers have testified to the JBC that personal care and homemaker attendants work near minimum wage and when there are other available minimum wage opportunities that pay similarly or marginally less it can be difficult to recruit and retain staff.

HOME- AND COMMUNITY-BASED SERVICES

The Department requests $10.2 million total funds, including $5.1 million General Fund, to increase select HCBS waiver services with large gaps between current rates and expected costs. The Department has a new rate setting methodology, approved by the federal Centers for Medicare and Medicaid Services, for the HCBS waivers that identifies expected costs for salaries, facilities, administration, capital, and potentially other inputs identified through the stakeholder process. The Department then applies a budget neutrality factor to prevent adjustments from current rates to the expected costs. The Department proposes eliminating the budget neutrality factor for respite care, transition services, and behavioral health counseling, and reducing the budget neutrality factor by 24 percent for adult day programs. Completely closing the gap for adult day programs would require a significant increase in the budget due to the cost per unit.

Home- and Community-Based Services were reviewed by the MPRRAC in 2017. Rates were identified as ranging from 36.7 percent to 184.6 percent of the relevant benchmark comparison states. As part of the review, the MPRRAC recommended migrating toward using the values from the Department's new rate setting methodology before the budget neutrality factor as the benchmark for HCBS services, rather than other state Medicaid rates.

The Department indicates the targeted HCBS waiver rates are among the lowest relative to the Department's new rate setting methodology and were identified by stakeholders as most in need of adjustment.

TRANSPORTATION

The Department requests $6.8 million total funds, including $1.8 million General Fund, to increase a subset of emergency medical transportation and non-emergency medical transportation rates.

Transportation services were reviewed by the MPRRAC in 2016. Rates for EMT were identified at 28.2 percent of the benchmark and rates for NEMT at 30.7 percent of the benchmark. The analysis of NEMT identified problems with inconsistent and incomplete utilization data from providers, compounded by fragmented administration, which contributed to the Department's *R6 Local administration transformation* this year to centralize the administration of NEMT. Since the MPRRAC review, the General Assembly approved funding for transportation rates that resulted in a 7.0 percent

increase in FY 2017-18 and a 6.6 percent increase in FY 2018-19. In addition, public EMT providers can now get a federal match for eligible local government expenditures to increase reimburse.

The Department's request does not explain why the particular subset of transportation rates is targeted, rather than an across-the-board increase for transportation. The request highlights that some of the targeted rates include air travel mileage and bariatric transport.

DENTAL

The Department requests $4.5 million total funds, including $803,064 General Fund, to increase rates for a subset of preventive dental services the Department identifies as high value services.

Dental services were reviewed by the MPRRAC in 2018. Rates were identified as within 98.1 percent and 153.5 percent of the benchmark comparison states. While the rates look high relative to the benchmarks, the MPRRAC recommended no changes, and the Department reports that testimony to the MPRRAC identified several considerations:

- Colorado recently completed rate setting to establish the adult dental benefit and more time should pass before evaluating trend data.
- The benchmarks are other state Medicaid rates that may not reimburse adequately. Not all state Medicaid plans cover adult dental services.
- The General Assembly has increased rates for prevention, basic fillings, and extractions and these increases have increased access.
- Utilization is low, but this is a national trend across all payers and Colorado Medicaid client and provider participation are among the highest nationally.

In support of the request, the Department argues that regular dental care and prevention are the most cost-effective methods to prevent minor oral conditions from developing into more complex oral and physical health conditions that require emergency or palliative care.

MATERNITY SERVICES

The Department requests $4.4 million total funds, including $2.0 million General Fund, to increase maternity rates to 80 percent of the benchmark.

Maternity rates were reviewed by the MPRRAC in 2018. Rates were identified as 69.5 percent of the benchmark. Medicaid is the largest payer of maternity services in Colorado and covers roughly 45 percent of births. The MPRRAC recommended increasing rates to 90 percent of the benchmark, arguing that access may appear sufficient because Medicaid is the largest payer and so providers have limited alternatives. Also, individual rates appear uniformly lower than the relevant benchmark comparison.

The Department proposes a more limited increase than recommended by the MPRRAC to 80 percent of the benchmark, rather than 90 percent. In addition, the Department indicates it will work to incorporate maternity services into performance based payments. House Bill 17-1353 authorized the Department to make performance-based payments. Prior to implementing a new performance-based payment, the Department must submit to the JBC either evidence that the payments are designed to achieve budget savings or a budget request for costs associated with the performance-based payments, an estimate of the performance-based payments compared to total reimbursements for the affected

service, and a description of the stakeholder engagement process and the Department's response to stakeholder feedback.

OTHER

The Department requests $211,190 total funds, including $62,517 General Fund, for miscellaneous rates the Department indicates are outdated and have been identified by stakeholders as creating access-to-care issues. Specifically, the Department proposes increasing rates for tracheae prosthesis, aquatic therapy, and polysomnography.

PRIMARY CARE/RADIOLOGY/PT & OT

The Department proposes a budget neutral rebalancing of rates that are below 80 percent or above 100 percent of the benchmark for primary care, evaluation and management, radiology, physical therapy, and occupational therapy. In addition, the subset of physician services and surgeries reviewed by the MPRRAC in 2018 will be rebalanced based on place of service and payments below 80 percent or above 100 percent consistent with the subset of these services that were reviewed by the MPRRAC in 2017. To preserve budget neutrality, prevent disproportionate negative impacts on providers, and ensure investments in high value services, the Department may not rebalance all rates that otherwise meet the criteria.

These services were reviewed by the MPRRAC in 2018. The Department believes overall payments for these services appear reasonable relative to the benchmarks, but rates for individual services varied wildly relative to the benchmarks. The MPRRAC recommended rebalancing the rates to bring logic and consistency to the rates and prevent potentially perverse incentives to provide certain services over others. For primary care and evaluation and management the MPRRAC recommend a slightly tighter band for rates of between 85 percent and 100 percent of the benchmark. For physician services and surgeries the MPRRAC recommended an overall increase in funding, as overall payments were 67 percent and 68.1 percent of the benchmark respectively.

Budget neutral rebalancing is within the Department's existing statutory authority. Any rate changes through this component of the request would require noticing, public comment, and approval from the Medical Services Board before implementation, and may require federal approval from the Centers for Medicare and Medicaid Services (CMS).

LABORATORY/PATHOLOGY

The Department requests a net reduction of $9.3 million total funds, including $3.5 million General Fund, to rebalance laboratory and pathology rates below 80 percent and above 100 percent of the benchmark. The Department indicates there are 54 rates above or below the 80-100 percent band and rebalancing all of them to fit in the band would result in a net reduction to expenditures.

Laboratory and pathology services were reviewed by the MPRRAC in 2017. Providers analyze bodily fluids and specimens to assist in the screening and treatment of diseases and disorders. Many of the providers work across regions and even across states. The MPRRAC raised concerns that rates might be too high, but at the time the Department recommended no changes, in part because Medicare was in the process of revising rates and Medicare is the benchmark for these rates.

The Medicare rate revisions are now complete and the Department recommends rebalancing rates based on the revised Medicare rates.

ANESTHESIA

The Department proposes a reduction of $8.5 million total funds, including $2.5 million General Fund, to reduce anesthesia rates to 100 percent of Medicare rates.

Anesthesia rates were reviewed by the MPRRAC in 2017. Aggregate payments were identified as 131.6 percent of the benchmark and no individual service rate was below 100 percent of the benchmark. The MPRRAC recommended reducing anesthesia rates to 100 percent of the benchmark.

The Department submitted a similar request last year that was not approved by the JBC. As further background, in FY 2015-16 the JBC added money to the budget to increase rates for anesthesia services. This was just prior to the creation of the MPRRAC and the rate review process established in S.B. 15-228.

DIABETES TEST STRIPS

The Department proposes a reduction of $2.3 million total funds, including $873,026 General Fund, to decrease rates for diabetes test strips, based on analysis of other state payments and the average reimbursement retailers receive per box of test strips.

Rates for diabetes test strips are scheduled for review by the MPRRAC in 2019. However, last year the Department and JBC were approached by an out-of-state provider arguing that these test strips are commonly available for significantly less than the Department is paying. This provider wanted a sole source contract, which would require a statutory change, but the Departmen's analysis of the proposal confirmed that Colorado rates appear high. Rather than waiting for completion of the MPRRAC review, the Department proposes the reduction to begin savings in FY 2019-20.

ACROSS-THE-BOARD INCREASE

For providers in other departments, the Governor's request includes a 1.0 percent across-the-board increase, but for providers paid by the Department of Health Care Policy and Financing, the request is for a 0.75 percent across-the-board increase. The reduced amount is to make room in the budget for the targeted rate increases described above. Rates receiving a targeted increase described above would not be eligible for the across-the-board increase.

As an across-the-board increase, the request does not relate to any single specific recommendations of the MPRRAC.

PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Senate Bill 16-199 made modifications to the way contracts with PACE providers are structured, created a state PACE ombudsman, and required the Department to develop an actuarially sound method for calculating the upper payment limit for PACE providers. The expectation of PACE organizations that promoted the bill was that the detailed method for calculating the upper payment limit prescribed in the bill, called a Grade of Membership (GoM) model, would lead to higher reimbursement. However, the opposite occurred.

Following the procedures detailed in the bill, from which the Department may not deviate without a statutory change, the Department concluded that previous assumptions about the needs of clients served by PACE were too high, and that rates should therefore be reduced. Prior to the GoM, the rate setting method assumed 56 percent of the PACE population would have received community-

based services outside of PACE and 44 percent would have been in a nursing home. The GoM model estimates 66 percent of the PACE population would have received community-based services outside of PACE and 34 percent nursing home care. Based on the lower acuity assumptions, an initial analysis showed PACE rates should decrease by between 8.8 percent and 17.4 percent, varying by region.

For purposes of the forecast in *R1 Medical Services Premiums*, the Department assumed PACE per capita expenditures would decrease 6.0 percent. This lowered the forecast by $13.8 million total funds, including $6.9 million General Fund. This was an intentionally conservative estimate by the Department's forecasters. It is lower than the lowest estimate of how much PACE rates will decrease as a result of implementing the GoM. The Department is in the process of validating the data and methodology with the PACE providers and did not want to assume General Fund savings in the forecast that would need to be added back in the February forecast because an error was discovered in the data or calculation procedures.

Ultimately, the PACE rates will not be determined by any amount included in the Long Bill, but by the rates adopted by the Medical Services Board, following the procedures required by S.B. 16-199, and approved by the federal Centers for Medicare and Medicaid Services (CMS). The General Assembly could potentially change the rates through a bill to eliminate or modify the procedures required by S.B. 16-199. However, the rates will still need to be approved by CMS. Now that the GoM analysis is public, the Department might need to convince CMS to approve an alternative rate setting method, rather than taking the savings indicated by the GoM model.

PACE providers have expressed several concerns about the GoM analysis and whether it accurately reflects the acuity of PACE clients.

One of the primary concerns of the PACE providers is that the analysis limited the clients included to those with at least one Medicaid claim prior to entering PACE. The Department explains this was necessary so that standardized Medicaid acuity metrics were available for the GoM. As a result, only 30 percent of the clients enrolled from 2010 to 2016 were included in the analysis. PACE providers say most PACE clients start on Medicare and only use Medicaid when they need extra supports. The PACE organizations argue that the limited sample size skews the data. As evidence, they note that in the limited sample analyzed in the GoM 16.8 percent of the PACE clients had a diagnosis of dementia, but the PACE organizations report 51 percent of PACE clients have a diagnosis of dementia. Also, the GoM calculated that 27.2 percent of PACE clients are 55-64, but the PACE organizations report a range of 16 to 23 percent of clients in this age range.

Another major concern of the PACE providers is that the analysis included data from the Instrumental Activities of Daily Living assessment for comparing acuity. The assessment attempts to measure a client's ability to perform activities related to independent living, such as preparing meals, managing money, and performing housework. The PACE providers question the validity of the assessment based on several counterintuitive results. As an illustration, the PACE providers note that 23.7 percent of clients in nursing homes scored as independent in transportation, meaning they can drive or access

public transportation. Also, 26 percent were independent in hygiene, but only 3.5 percent were independent in bathing.

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**					
(1) EXECUTIVE DIRECTOR'S OFFICE					
(A) General Administration					
Personal Services	29,364,616	35,581,470	34,785,923	38,193,706	*
FTE	418.4	467.3	465.8	488.3	
General Fund	10,232,108	10,518,571	11,935,474	13,173,997	
Cash Funds	2,985,617	2,985,184	3,129,300	3,614,639	
Reappropriated Funds	1,407,908	1,253,594	2,242,657	2,274,826	
Federal Funds	14,738,983	20,824,121	17,478,492	19,130,244	
Health, Life, and Dental	3,434,070	3,637,126	4,647,883	4,814,253	*
General Fund	1,230,952	1,305,776	1,575,324	1,704,948	
Cash Funds	337,577	344,132	399,501	441,787	
Reappropriated Funds	104,755	103,855	135,355	123,276	
Federal Funds	1,760,786	1,883,363	2,537,703	2,544,242	
Short-term Disability	55,072	58,060	60,727	68,323	*
General Fund	20,569	21,586	21,043	24,838	
Cash Funds	4,588	4,802	5,213	5,748	
Reappropriated Funds	1,393	1,364	1,484	1,522	
Federal Funds	28,522	30,308	32,987	36,215	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
S.B. 04-257 Amortization Equalization Disbursement	1,434,489	1,615,047	1,855,596	2,045,593	*
General Fund	535,695	600,398	642,806	743,807	
Cash Funds	119,586	133,634	159,439	171,181	
Reappropriated Funds	36,269	37,970	45,371	45,699	
Federal Funds	742,939	843,045	1,007,980	1,084,906	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	1,419,546	1,615,047	1,855,596	2,045,593	*
General Fund	530,115	600,398	642,806	743,807	
Cash Funds	118,340	133,634	159,439	171,181	
Reappropriated Funds	35,891	37,970	45,371	45,699	
Federal Funds	735,200	843,045	1,007,980	1,084,906	
PERA Direct Distribution	0	0	0	1,010,190	
General Fund	0	0	0	367,753	
Cash Funds	0	0	0	81,755	
Reappropriated Funds	0	0	0	23,266	
Federal Funds	0	0	0	537,416	
Salary Survey	56,903	614,974	1,203,861	69,159	
General Fund	19,245	228,651	416,661	26,225	
Cash Funds	6,898	50,834	103,653	8,025	
Reappropriated Funds	898	14,443	29,534	0	
Federal Funds	29,862	321,046	654,013	34,909	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Merit Pay	0	291,490	0	1,250,503	
General Fund	0	106,662	0	454,640	
Cash Funds	0	25,682	0	99,323	
Reappropriated Funds	0	7,235	0	29,101	
Federal Funds	0	151,911	0	667,439	
Worker's Compensation	54,318	65,937	98,914	110,194	
General Fund	27,159	32,969	40,940	45,686	
Cash Funds	0	0	8,517	9,410	
Reappropriated Funds	0	0	0	0	
Federal Funds	27,159	32,968	49,457	55,098	
Operating Expenses	2,024,191	2,010,100	2,450,635	2,425,643	*
General Fund	947,590	903,223	961,623	954,138	
Cash Funds	71,522	74,170	239,823	240,357	
Reappropriated Funds	10,449	26,219	13,297	13,297	
Federal Funds	994,630	1,006,488	1,235,892	1,217,851	
Legal Services	941,634	1,114,404	1,287,013	1,465,034	
General Fund	338,179	360,582	415,701	474,128	
Cash Funds	241,591	196,620	227,806	258,390	
Reappropriated Funds	0	0	0	0	
Federal Funds	361,864	557,202	643,506	732,516	
Administrative Law Judge Services	697,852	647,622	589,791	664,253	
General Fund	271,159	251,642	244,114	275,399	
Cash Funds	77,767	72,169	50,782	56,728	
Reappropriated Funds	0	0	0	0	
Federal Funds	348,926	323,811	294,895	332,126	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Payment to Risk Management and Property Funds	176,936	128,274	93,002	122,267	
General Fund	88,468	64,137	38,495	50,694	
Cash Funds	0	0	8,006	10,440	
Reappropriated Funds	0	0	0	0	
Federal Funds	88,468	64,137	46,501	61,133	
Leased Space	2,026,721	2,303,824	2,514,035	2,514,035	
General Fund	854,879	904,547	1,040,559	1,042,319	
Cash Funds	247,365	247,365	216,459	214,699	
Reappropriated Funds	0	0	0	0	
Federal Funds	924,477	1,151,912	1,257,017	1,257,017	
Capitol Complex Leased Space	572,466	666,217	612,044	535,954	
General Fund	286,233	333,109	253,325	222,206	
Cash Funds	0	0	52,697	45,771	
Reappropriated Funds	0	0	0	0	
Federal Funds	286,233	333,108	306,022	267,977	
Payments to OIT	4,703,675	5,314,055	5,548,321	8,113,367	*
General Fund	1,974,295	2,226,587	2,296,450	3,163,548	
Cash Funds	377,545	430,440	477,711	861,227	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,351,835	2,657,028	2,774,160	4,088,592	
CORE Operations	1,417,701	1,583,166	1,376,873	148,413	
General Fund	465,080	577,669	607,623	65,600	
Cash Funds	243,770	257,301	118,548	12,675	
Reappropriated Funds	0	0	0	0	
Federal Funds	708,851	748,196	650,702	70,138	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
General Professional Services and Special Projects	5,041,327	6,518,315	15,242,917	19,917,529 *	
General Fund	1,455,022	2,380,873	5,270,423	7,024,800	
Cash Funds	936,811	1,350,247	2,303,928	2,491,007	
Reappropriated Funds	0	150,000	150,000	150,000	
Federal Funds	2,649,494	2,637,195	7,518,566	10,251,722	
Scholarships for research using the All-Payer Claims Database	499,950	524,656	0	0	
General Fund	499,950	524,656	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (A) General Administration	53,921,467	64,289,784	74,223,131	85,514,009	15.2%
FTE	418.4	467.3	465.8	488.3	4.8%
General Fund	19,776,698	21,942,036	26,403,367	30,558,533	15.7%
Cash Funds	5,768,977	6,306,214	7,660,822	8,794,343	14.8%
Reappropriated Funds	1,597,563	1,632,650	2,663,069	2,706,686	1.6%
Federal Funds	26,778,229	34,408,884	37,495,873	43,454,447	15.9%
(B) Transfers to Other Departments					
Public School Health Services Administration, Education	170,979	179,365	185,688	216,426	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	170,979	179,365	185,688	216,426	
Federal Funds	0	0	0	0	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
OeHI Operating, Governor's Office	0	0	0	2,008,154	*
General Fund	0	0	0	1,011,017	
Federal Funds	0	0	0	997,137	
Nurse Home Visitor Program, Human Services	195,049	47,012	3,010,000	3,010,000	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	87,892	23,128	1,505,000	1,505,000	
Federal Funds	107,157	23,884	1,505,000	1,505,000	
Host Home Regulation, Local Affairs	0	0	0	124,248	*
General Fund	0	0	0	62,124	
Federal Funds	0	0	0	62,124	
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	219,356	219,356	219,356	277,156	*
General Fund	109,678	109,678	109,678	138,578	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	109,678	109,678	109,678	138,578	
Facility Survey and Certification, Public Health and Environment	6,061,065	6,773,203	7,931,831	8,308,569	*
General Fund	2,060,929	2,343,497	2,976,556	3,130,865	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,000,136	4,429,706	4,955,275	5,177,704	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Local Public Health Agencies, Public Health and Environment	0	360,484	728,177	735,459	*
General Fund	0	360,484	364,089	367,730	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	364,088	367,729	
Prenatal Statistical Information, Public Health and Environment	5,887	5,887	5,887	5,887	
General Fund	2,943	2,943	2,944	2,944	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,944	2,944	2,943	2,943	
Nurse Aide Certification, Regulatory Agencies	324,041	324,041	324,041	324,041	
General Fund	147,369	147,368	147,369	147,369	
Cash Funds	0	0	0	0	
Reappropriated Funds	14,652	14,652	14,652	14,652	
Federal Funds	162,020	162,021	162,020	162,020	
Regulation of Medicaid Transportation Providers, Regulatory Agencies	68,257	93,027	103,503	103,503	
General Fund	54,507	55,528	66,003	66,003	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	13,750	37,499	37,500	37,500	

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation	
Reviews, Regulatory Agencies	10,000	5,120	3,750	3,750		
General Fund	5,000	2,560	1,875	1,875		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	5,000	2,560	1,875	1,875		
SUBTOTAL - (B) Transfers to Other Departments	7,054,634	8,007,495	12,512,233	15,117,193	20.8%	
FTE	0.0	0.0	0.0	0.0	0.0%	
General Fund	2,380,426	3,022,058	3,668,514	4,928,505	34.3%	
Cash Funds	0	0	0	0	0.0%	
Reappropriated Funds	273,523	217,145	1,705,340	1,736,078	1.8%	
Federal Funds	4,400,685	4,768,292	7,138,379	8,452,610	18.4%	
(C) Information Technology Contracts and Projects						
Medicaid Management Information System Maintenance and Projects	31,555,877	33,149,521	48,224,470	73,926,260	*	
General Fund	8,031,732	4,951,401	6,862,226	9,786,637		
Cash Funds	1,800,106	3,584,734	4,521,956	6,363,279		
Reappropriated Funds	13,366	11,808	12,182	12,204		
Federal Funds	21,710,673	24,601,578	36,828,106	57,764,140		
Fraud Detection Software Contract	150,019	115,000	115,000	0	*	
General Fund	62,500	28,345	28,345	0		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	87,519	86,655	86,655	0		

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Colorado Benefits Management Systems, Operating and Contract Expenses	20,412,988	25,851,203	30,068,612	49,655,410	*
General Fund	4,138,421	4,914,547	6,587,252	10,522,859	
Cash Funds	2,486,414	2,721,479	3,754,018	5,726,395	
Reappropriated Funds	53,221	8,740	94,608	2,601	
Federal Funds	13,734,932	18,206,437	19,632,734	33,403,555	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	681,776	861,539	1,005,415	2,077,511	*
General Fund	244,624	312,261	315,815	670,624	
Cash Funds	95,126	149,609	184,764	339,973	
Reappropriated Funds	1,711	260	3,227	111	
Federal Funds	340,315	399,409	501,609	1,066,803	
Health Information Exchange Maintenance and Projects	6,112,053	7,481,177	7,947,385	7,603,629	*
General Fund	2,046,246	821,423	1,954,794	1,916,101	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,065,807	6,659,754	5,992,591	5,687,528	
Connect for Health Colorado Systems	669,328	669,757	669,757	669,757	
General Fund	0	0	0	0	
Cash Funds	122,690	122,690	122,690	122,690	
Reappropriated Funds	0	0	0	0	
Federal Funds	546,638	547,067	547,067	547,067	

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
All-Payer Claims Database	0	0	2,550,000	5,169,731	*
General Fund	0	0	1,525,000	4,336,464	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	1,025,000	833,267	
MMIS Reprocurement Contracts	16,482,901	11,338,757	0	0	
General Fund	478,314	500,311	0	0	
Cash Funds	507,984	748,910	0	0	
Reappropriated Funds	9,675	0	0	0	
Federal Funds	15,486,928	10,089,536	0	0	
MMIS Reprocurement Contracted Staff	469,690	0	0	0	
General Fund	371,082	0	0	0	
Cash Funds	97,693	0	0	0	
Reappropriated Funds	915	0	0	0	
Federal Funds	0	0	0	0	
SUBTOTAL - (C) Information Technology Contracts and Projects	76,534,632	79,466,954	90,580,639	139,102,298	53.6%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	15,372,919	11,528,288	17,273,432	27,232,685	57.7%
Cash Funds	5,110,013	7,327,422	8,583,428	12,552,337	46.2%
Reappropriated Funds	78,888	20,808	110,017	14,916	(86.4%)
Federal Funds	55,972,812	60,590,436	64,613,762	99,302,360	53.7%

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(D) Eligibility Determinations and Client Services					
Medical Identification Cards	135,912	127,993	278,974	278,974	
General Fund	44,330	40,299	90,988	90,988	
Cash Funds	21,664	20,749	44,587	44,587	
Reappropriated Funds	14	13	28	28	
Federal Funds	69,904	66,932	143,371	143,371	
Contracts for Special Eligibility Determinations	7,905,176	8,650,653	11,402,297	11,402,297	
General Fund	876,881	969,756	969,756	969,756	
Cash Funds	2,659,396	2,968,513	4,343,468	4,343,468	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,368,899	4,712,384	6,089,073	6,089,073	
County Administration	45,534,281	62,286,444	68,516,841	70,542,701	*
General Fund	11,114,448	12,003,877	11,114,448	12,709,189	
Cash Funds	5,859,623	4,945,446	14,892,419	15,004,268	
Reappropriated Funds	0	0	0	0	
Federal Funds	28,560,210	45,337,121	42,509,974	42,829,244	
Medical Assistance Sites	1,435,692	1,517,448	1,531,968	1,531,968	
General Fund	0	0	0	0	
Cash Funds	372,429	402,984	402,984	402,984	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,063,263	1,114,464	1,128,984	1,128,984	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Administrative Case Management	2,155,964	2,344,964	869,744	869,744	
General Fund	1,077,982	1,172,482	434,872	434,872	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,077,982	1,172,482	434,872	434,872	
Customer Outreach	5,379,810	5,634,464	5,948,561	6,117,542	*
General Fund	2,353,284	2,477,718	2,637,660	2,722,151	
Cash Funds	336,620	336,621	336,621	336,621	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,689,906	2,820,125	2,974,280	3,058,770	
Centralized Eligibility Vendor Contract Project	3,985,752	3,475,879	5,053,644	5,053,644	
General Fund	0	0	0	0	
Cash Funds	1,251,751	1,189,823	1,745,342	1,745,342	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,734,001	2,286,056	3,308,302	3,308,302	
Connect for Health Colorado Eligibility Determination	4,470,877	4,474,451	4,474,451	4,474,451	
General Fund	0	0	0	0	
Cash Funds	1,667,766	1,667,767	1,667,767	1,667,767	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,803,111	2,806,684	2,806,684	2,806,684	
Hospital Provider Fee County Administration	17,184,924	0	0	0	
General Fund	0	0	0	0	
Cash Funds	4,945,446	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	12,239,478	0	0	0	

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
SUBTOTAL - (D) Eligibility Determinations and Client Services	88,188,388	88,512,296	98,076,480	100,271,321	2.2%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	15,466,925	16,664,132	15,247,724	16,926,956	11.0%
Cash Funds	17,114,695	11,531,903	23,433,188	23,545,037	0.5%
Reappropriated Funds	14	13	28	28	0.0%
Federal Funds	55,606,754	60,316,248	59,395,540	59,799,300	0.7%
(E) Utilization and Quality Review Contracts					
Professional Service Contracts	9,374,992	10,001,762	20,291,689	22,864,305 *	
General Fund	3,092,674	3,331,922	6,246,451	3,724,802	
Cash Funds	311,539	386,847	1,449,885	1,587,101	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,970,779	6,282,993	12,595,353	17,552,402	
SUBTOTAL - (E) Utilization and Quality Review Contracts	9,374,992	10,001,762	20,291,689	22,864,305	12.7%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	3,092,674	3,331,922	6,246,451	3,724,802	(40.4%)
Cash Funds	311,539	386,847	1,449,885	1,587,101	9.5%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	5,970,779	6,282,993	12,595,353	17,552,402	39.4%

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(F) Provider Audits and Services					
Professional Audit Contracts	3,033,408	3,096,366	4,182,232	4,891,358 *	
General Fund	1,222,791	1,244,805	1,598,154	1,758,484	
Cash Funds	299,950	312,420	423,472	629,262	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,510,667	1,539,141	2,160,606	2,503,612	
SUBTOTAL - (F) Provider Audits and Services	3,033,408	3,096,366	4,182,232	4,891,358	17.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,222,791	1,244,805	1,598,154	1,758,484	10.0%
Cash Funds	299,950	312,420	423,472	629,262	48.6%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	1,510,667	1,539,141	2,160,606	2,503,612	15.9%
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	833,726	657,215	700,000	700,000	
General Fund	0	0	0	0	
Cash Funds	416,863	328,880	350,000	350,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	416,863	328,335	350,000	350,000	
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	833,726	657,215	700,000	700,000	0.0%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	416,863	328,880	350,000	350,000	0.0%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	416,863	328,335	350,000	350,000	0.0%

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(H) Indirect Cost Assessment					
Indirect Cost Assessment	635,268	695,563	1,138,205	1,465,996	
General Fund	0	0	0	0	
Cash Funds	224,727	257,456	305,445	365,239	
Reappropriated Funds	0	0	52,041	52,041	
Federal Funds	410,541	438,107	780,719	1,048,716	
SUBTOTAL - (H) Indirect Cost Assessment	635,268	695,563	1,138,205	1,465,996	28.8%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	0	0	0	0	0.0%
Cash Funds	224,727	257,456	305,445	365,239	19.6%
Reappropriated Funds	0	0	52,041	52,041	0.0%
Federal Funds	410,541	438,107	780,719	1,048,716	34.3%
TOTAL - (1) Executive Director's Office	239,576,515	254,727,435	301,704,609	369,926,480	22.6%
FTE	418.4	467.3	465.8	488.3	4.8%
General Fund	57,312,433	57,733,241	70,437,642	85,129,965	20.9%
Cash Funds	29,246,764	26,451,142	42,206,240	47,823,319	13.3%
Reappropriated Funds	1,949,988	1,870,616	4,530,495	4,509,749	(0.5%)
Federal Funds	151,067,330	168,672,436	184,530,232	232,463,447	26.0%

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	6,330,278,759	7,479,971,210	7,631,479,929	7,893,359,901 *	
General Fund	1,032,811,311	1,273,703,036	1,321,080,322	1,464,178,352	
General Fund Exempt	830,201,667	820,701,666	793,100,000	793,100,000	
Cash Funds	687,831,607	879,977,682	939,712,695	1,017,468,580	
Reappropriated Funds	9,504,132	71,040,487	77,385,674	77,385,674	
Federal Funds	3,769,930,042	4,434,548,339	4,500,201,238	4,541,227,295	
TOTAL - (2) Medical Services Premiums	6,330,278,759	7,479,971,210	7,631,479,929	7,893,359,901	3.4%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	1,032,811,311	1,273,703,036	1,321,080,322	1,464,178,352	10.8%
General Fund Exempt	830,201,667	820,701,666	793,100,000	793,100,000	0.0%
Cash Funds	687,831,607	879,977,682	939,712,695	1,017,468,580	8.3%
Reappropriated Funds	9,504,132	71,040,487	77,385,674	77,385,674	0.0%
Federal Funds	3,769,930,042	4,434,548,339	4,500,201,238	4,541,227,295	0.9%

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(3) BEHAVIORAL HEALTH COMMUNITY PROGRAMS					
TOTAL - (3) Behavioral Health Community Programs	611,682,288	522,184,728	656,887,430	684,938,350	4.3%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	159,218,234	173,810,931	184,437,583	197,407,474	7.0%
Cash Funds	17,482,275	21,992,399	30,054,951	36,775,589	22.4%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	434,981,779	326,381,398	442,394,896	450,755,287	1.9%
(4) OFFICE OF COMMUNITY LIVING					
TOTAL - (4) Office of Community Living	493,774,051	535,569,520	596,683,089	662,131,814	11.0%
FTE	40.1	40.1	40.5	40.4	(0.2%)
General Fund	254,659,319	271,545,879	307,692,087	338,237,449	9.9%
Cash Funds	7,216,276	7,516,096	1,564,074	5,039,647	222.2%
Reappropriated Funds	308,229	0	0	0	0.0%
Federal Funds	231,590,227	256,507,545	287,426,928	318,854,718	10.9%

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(4) INDIGENT CARE PROGRAM					
Safety Net Provider Payments	311,152,663	298,355,771	311,296,186	311,296,186	
General Fund	0	0	0	0	
Cash Funds	155,017,426	149,107,296	155,648,093	155,648,093	
Reappropriated Funds	0	0	0	0	
Federal Funds	156,135,237	149,248,475	155,648,093	155,648,093	
Clinic Based Indigent Care	6,119,145	6,119,760	6,090,896	6,079,573	
General Fund	3,047,639	3,059,579	3,031,016	3,019,693	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,071,506	3,060,181	3,059,880	3,059,880	
Pediatric Specialty Hospital	13,453,666	13,455,012	13,455,012	13,455,012	
General Fund	6,700,596	6,726,833	6,727,506	6,727,506	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,753,070	6,728,179	6,727,506	6,727,506	
Appropriation from Tobacco Tax Fund to the General Fund	429,444	413,092	429,909	386,540	
General Fund	0	0	0	0	
Cash Funds	429,444	413,092	429,909	386,540	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Primary Care Fund	27,276,358	26,709,204	28,382,436	27,714,032	
General Fund	0	0	0	0	
Cash Funds	27,276,358	26,709,204	28,382,436	27,714,032	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Children's Basic Health Plan Administration	2,251,214	1,664,454	5,033,274	5,033,274	*
General Fund	0	0	0	0	
Cash Funds	270,725	205,206	603,993	1,037,861	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,980,489	1,459,248	4,429,281	3,995,413	
Children's Basic Health Plan Medical and Dental Costs	153,062,926	194,266,268	194,981,200	222,949,802	*
General Fund	2,069,366	181,276	0	0	
General Fund Exempt	432,590	440,340	429,909	386,540	
Cash Funds	22,551,321	24,790,795	24,402,360	46,518,338	
Reappropriated Funds	0	0	0	0	
Federal Funds	128,009,649	168,853,857	170,148,931	176,044,924	
TOTAL - (4) Indigent Care Program	513,745,416	540,983,561	559,668,913	586,914,419	4.9%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	11,817,601	9,967,688	9,758,522	9,747,199	(0.1%)
General Fund Exempt	432,590	440,340	429,909	386,540	(10.1%)
Cash Funds	205,545,274	201,225,593	209,466,791	231,304,864	10.4%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	295,949,951	329,349,940	340,013,691	345,475,816	1.6%

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(5) OTHER MEDICAL SERVICES					
Old Age Pension State Medical	3,379,476	3,400,279	10,000,000	10,000,000	
General Fund	2,962,510	2,940,155	0	0	
Cash Funds	416,966	460,124	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Senior Dental Program	0	0	2,990,358	2,990,358	
General Fund	0	0	2,962,510	2,962,510	
Cash Funds	0	0	27,848	27,848	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Commission on Family Medicine Residency Training Programs	7,597,298	7,596,518	8,196,518	8,196,518	
General Fund	3,784,182	3,797,879	4,098,259	4,098,259	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,813,116	3,798,639	4,098,259	4,098,259	
State University Teaching Hospitals Denver Health and Hospital Authority	2,804,434	2,804,714	2,804,714	2,804,714	
General Fund	1,396,748	1,402,217	1,402,357	1,402,357	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,407,686	1,402,497	1,402,357	1,402,357	

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
State University Teaching Hospitals University of Colorado Hospital	1,175,387	1,331,984	1,481,984	1,631,984	
General Fund	585,390	590,926	590,992	590,992	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	75,000	150,000	225,000	
Federal Funds	589,997	666,058	740,992	815,992	
Medicare Modernization Act State Contribution Payment	129,807,096	143,579,022	151,835,471	153,355,907	*
General Fund	129,807,096	143,579,022	151,835,471	153,355,907	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Public School Health Services Contract Administration	979,431	1,055,162	2,491,722	2,491,722	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	979,431	1,055,162	2,491,722	2,491,722	
Federal Funds	0	0	0	0	
Public School Health Services	93,151,205	104,194,094	110,852,394	123,076,287	
General Fund	0	0	0	0	
Cash Funds	46,241,334	52,039,318	55,426,197	61,538,143	
Reappropriated Funds	0	0	0	0	
Federal Funds	46,909,871	52,154,776	55,426,197	61,538,144	

	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	721,699	750,000	1,675,000	1,500,000	
General Fund	0	0	0	0	
Cash Funds	721,699	750,000	1,675,000	1,500,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Office Administered Drugs Supplemental Payment	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
Durable Medical Equipment Supplemental Payment	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	
TOTAL - (5) Other Medical Services	239,616,026	264,711,773	292,328,161	306,047,490	4.7%
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	138,535,926	152,310,199	160,889,589	162,410,025	0.9%
Cash Funds	47,379,999	53,249,442	67,129,045	73,065,991	8.8%
Reappropriated Funds	979,431	1,130,162	2,641,722	2,716,722	2.8%
Federal Funds	52,720,670	58,021,970	61,667,805	67,854,752	10.0%

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	FY 2016-17 Actual	FY 2017-18 Actual	FY 2018-19 Appropriation	FY 2019-20 Request	Request vs. Appropriation
(7) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS					
TOTAL - (7) Department of Human Services Medicaid-Funded Programs	108,276,698	113,161,211	117,784,504	115,703,677	(1.8%)
FTE	0.0	0.0	0.0	0.0	0.0%
General Fund	51,574,829	54,428,737	56,753,348	55,707,741	(1.8%)
Cash Funds	1,866,142	1,888,903	1,888,903	1,894,074	0.3%
Reappropriated Funds	0	0	0	0	0.0%
Federal Funds	54,835,727	56,843,571	59,142,253	58,101,862	(1.8%)
TOTAL - Department of Health Care Policy and Financing	8,536,949,753	9,711,309,438	10,156,536,635	10,619,022,131	4.6%
FTE	458.5	507.4	506.3	528.7	4.4%
General Fund	1,705,929,653	1,993,499,711	2,111,049,093	2,312,818,205	9.6%
General Fund Exempt	830,634,257	821,142,006	793,529,909	793,486,540	0.0%
Cash Funds	996,568,337	1,192,301,257	1,292,022,699	1,413,372,064	9.4%
Reappropriated Funds	12,741,780	74,041,265	84,557,891	84,612,145	0.1%
Federal Funds	4,991,075,726	5,630,325,199	5,875,377,043	6,014,733,177	2.4%

APPENDIX B
RECENT LEGISLATION AFFECTING DEPARTMENT BUDGET

2017 SESSION BILLS

S.B. 17-091 (ALLOW MEDICAID HOME HEALTH SERVICES IN COMMUNITY): Removes the requirement in state statute that home health services under Medicaid be provided in a client's place of residence in order to comply with new federal regulations. Provides $2,211,530 total funds to the Department of Health Care Policy and Financing in FY 2017-18, including $1,025,567 General Fund, $18,216 cash funds, and an anticipated $1,167,747 federal funds for increased utilization.

S.B. 17-121 (IMPROVE MEDICAID CLIENT CORRESPONDENCE): Requires the Department of Health Care Policy and Financing to implement an ongoing process to improve communications with Medicaid clients. Provides $283,781 total funds to the Department, including $95,662 General Fund, $46,228 cash funds, and an anticipated $141,891 federal funds, and 0.7 FTE for the communication improvements. Appropriates $8,100 General Fund to the Department of Personnel in FY 2017-18 for administrative courts.

S.B. 17-162 (SUPPLEMENTAL BILL): Modifies FY 2016-17 appropriations to the Department. Includes provisions modifying FY 2015-16 appropriations to the Department.

S.B. 17-256 (HOSPITAL REIMBURSEMENT RATES): Reduces appropriations for the Department of Health Care Policy and Financing in FY 2017-18 from the Hospital Provider Fee by $264,100,000 cash funds and requires that the reduction come from supplemental payments to the hospitals, resulting in an anticipated reduction in federal funds of $264,100,000.

S.B. 17-267 (SUSTAINABILITY OF RURAL COLORADO): The bill:

- Repeals the Hospital Provider Fee and creates the Healthcare Affordability and Sustainability (HAS) Fee as part of an enterprise for purposes of the Taxpayer's Bill of Rights (TABOR) such that the revenue from the HAS Fee does not count against the state fiscal year spending limit (Referendum C cap)
- Permanently reduces the Referendum C cap by reducing the FY 2017-18 cap by $200 million and specifying that the base amount for calculating the cap for all future state fiscal years is the reduced FY 2017-18 cap
- Specifies that reimbursements to local governments from the state for property tax exemptions for qualifying seniors and disabled veterans are a TABOR refund mechanism in years when a refund is required
- Requires the state to execute lease-purchase agreements for state buildings in increments of up to $500 million per year in FYs 2018-19 through 2021-22 (up to $2 billion in total) to generate funding for transportation and capital construction projects
    - The first $120 million in proceeds must be used for controlled maintenance and capital construction projects and the remaining proceeds for tier 1 transportation projects
    - Of the transportation money, 25 percent must be expended for projects in rural counties and 10 percent must be expended for transit

- The maximum term of the lease-purchase agreements is 20 years and the maximum total annual payment is $150 million
- Of the annual payment the first $9 million is from the General Fund (or other legal sources designated by the General Assembly), the next $50 million is from funds under the control of the Transportation Commission, and the remaining $91 million is from the General Fund (or other legal sources designated by the General Assembly)
- Eliminates current law transfers from the General Fund to the Highway Users Tax Fund of $160 million that are scheduled to occur on June 30, 2019 and June 30, 2020

- Increases the rate of retail marijuana sales tax (currently 10 percent and scheduled to decrease under current law to 8 percent) to 15 percent effective July 1, 2017
  - Offsets a portion of the state retail marijuana sales tax rate increase by exempting retail sales of marijuana upon which the state retail marijuana sales tax is imposed from the 2.9 percent general state sales tax, but provides that local governments can continue to impose their local general sales taxes on retail sales of marijuana
  - Holds local governments that currently receive an allocation of 15 percent of state retail marijuana sales tax revenue based on the current tax rate of 10 percent harmless by specifying that on and after July 1, 2017, they receive an allocation of 10 percent of state retail marijuana sales tax revenue based on the new rate of 15 percent
  - Of the 90 percent of the state retail marijuana sales tax revenue that the state retains for FY 2017-18:
    - 28.15 percent less $30 million stays in the general fund
    - 71.85 percent is credited to the marijuana tax cash fund
    - $30 million is credited to the state public school fund and distributed to rural school districts
  - Of the 90 percent of the state retail marijuana sales tax revenue that the state retains for FY 2018-19:
    - 15.56 percent stays in the general fund
    - 71.85 percent is credited to the marijuana tax cash fund
    - 12.59 percent is credited to the state public school fund for the state share of total program
- Requires state departments, other than the departments of Education and Transportation, to submit budget requests to the Office of State Planning and Budgeting (OSPB) that are at least 2.0 percent lower than the FY 2017-18 budget, and requires OSPB to seek to ensure that the budget submitted to the legislature for FY 2018-19 is at least 2.0 percent lower than FY 2017-18
- Requires copayments for Medicaid for pharmacy and hospital outpatient services to double from January 1, 2017 rates, except that copayments may not exceed federal maximums
- Requires the Department of Health Care Policy and Financing to seek any federal approval necessary for an enhanced pediatric health home for children with complex medical conditions consistent with the federal Advancing Care for Exceptional Kids Act within 120 days of federal enactment
- Replaces an existing temporary income tax credit for business personal property taxes with a more generous permanent income tax credit for business personal property taxes paid on up to $18,000 of the total actual value of a taxpayer's business personal property

For FY 2016-17 the bill appropriates $3,750 General Fund to the Department of Revenue for implementation of the tax policy changes.

For FY 2017-18 the bill replaces $597,380,996 in cash fund appropriations to the Department of Health Care Policy and Financing from the Hospital Provider Fee with cash fund appropriations from the Healthcare Affordability and Sustainability Fee Cash Fund (HAS Fee CF). In addition, the appropriation includes for the Department of Health Care Policy and Financing $264,100,000 from the HAS Fee CF and an anticipated like amount of federal funds, which is the amount of provider fees from hospitals that was restricted in S.B. 17-256. The appropriation also reduces the Department of Health Care Policy and Financing by $1,818,901 total funds, including $320,035 General Fund, $64,835 cash funds, and $1,434,031 federal funds based on the projected fiscal impact of the increase in Medicaid copayments. Finally, the bill includes a statutory appropriation to the Department of Education from marijuana sales tax proceeds transferred to the State Public School Fund.

S.B. 17-254 (LONG BILL): General appropriations act for FY 2017-18. Includes provisions modifying FY 2015-16 and FY 2016-17 appropriations to the Department.

H.B. 17-1343 (IMPLEMENT CONFLICT-FREE CASE MANAGEMENT): Implements changes to the system of services for individuals with intellectual and developmental disabilities provided through one of the three intellectual and developmental disability waivers to ensure there is not a conflict of interest in the provision of case management services. Requires Community-Centered Boards to implement business changes to ensure the same entity is not providing case management services and direct services to the same individual by June 30, 2020. Requires all individuals receiving services through one of the three Medicaid waivers for intellectual and developmental disabilities is not receiving case management and direct services from the same entity by June 30, 2022. Adds a definition for case management agency and conflict-free case management. Prioritizes the funds in the Intellectual and Developmental Disability Services Cash Fund for the system changes required for conflict-free case management, and repeals the fund on July 1, 2022. Establishes a definition for "case management agency" and how a case management agency will be certified and decertified and the duties of a case management agency. Defines a rural Community-Centered Board. Establishes the following timeline for system changes and how the State can seek a rural exemption for interested rural Community-Centered Boards:

- Timeline of system changes:
    - July 1, 2017 – Department of Health Care Policy and Financing must determine business options for Community-Centered Boards;
    - January 1, 2018 – Department must publish guidance on the components of the business continuity plan;
    - July 1, 2018 – Community-Centered Boards must submit their business continuity plan to the Department;
    - June 30, 2019 – Department must complete an analysis of the continuity plans, unreimbursed transition costs, and community impacts;
    - June 30, 2020 – Community-Centered Boards must complete the business operation changes;
    - June 30, 2021 – At least 25.0 percent of individuals must be served through a conflict-free system; and
    - June 30, 2022 – All individuals must be served through a conflict-free system.

- Rural exemption requirements and timeline:
    - July 1, 2017 – A rural Community-Centered Board must notify the Department in writing they would like the Department to seek a federal rural exemption;
    - The Department must evaluate capacity, and where appropriate, seek a federal exemption;
    - The Community-Centered Board upon notification of a federal decision must submit a business continuity plan and make any necessary business operation changes by June 30, 2022;
    - If, by July 1, 2019, the Department has not received federal notification of requests, the State Board must promulgate rules for the provision of services and supports; and
    - The State Board is required to promulgate rules to ensure there is choice and access to services for individuals served by rural Community-Centered Boards.

Appropriates $222,794 total funds, of which $111,398 is cash funds from the Intellectual and Developmental Disabilities Services Cash Fund and states that this appropriation is based on the assumption that the Department will receive $111,396 federal funds and 1.0 FTE to implement the act.

H.B. 17-1351 (STUDY INPATIENT SUBSTANCE USE DISORDER TREATMENT): Requires the Department of Health Care Policy and Financing (HCPF), with assistance from the Department of Human Services' Office of Behavioral Health, to prepare a written report concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program or as a state-funded benefit. Requires HCPF to submit the report to several legislative committees by November 1, 2017. Requires the State Treasurer to transfer $37,500 cash funds from the Marijuana Tax Cash Fund to the General Fund on June 30, 2018. Appropriates $37,500 General Fund to HCPF for FY 2017-18, and states that this appropriation is based on the assumption that HCPF will receive $37,500 federal funds to implement the act.

H.B. 17-1353 (IMPLEMENT MEDICAID DELIVERY & PAYMENT INITIATIVES): Provides a statutory framework for the existing Accountable Care Collaborative (ACC), authorizes elements that will be featured in phase II of the ACC, authorizes performance-based payments to providers, and places guidelines and reporting requirements on these initiatives. With regard to the Accountable Care Collaborative, the bill:

1. Lists elements that must be included in the ACC, such as providing a primary care medical home for all Medicaid clients and integrating the delivery of behavioral health and physical health services
2. Requires the creation of stakeholder advisory committees
3. Requires an annual report on the ACC. The statutory annual report combines elements of an existing statutory report and an annual request for information submitted by the JBC.
4. Requires a report outlining changes required to align state statute with a new federal rule regarding managed care
5. Clarifies that the Medical Services Board has oversight and must promulgate rules to implement the ACC

Regarding performance-based payments, the bill:

1. Authorizes the Department to implement performance-based payments and specifically authorizes performance payments for:

a. Primary care providers
b. Federally qualified health centers
c. Providers of long-term services and supports
d. Behavioral health providers

2 Requires that prior to implementing performance payments the Department must submit to the JBC:
   a. Either:
      i. Evidence that the payments are designed to achieve budget savings, or
      ii. A budget request for costs associated with the performance-based payments
   b. The estimated performance-based payments compared to total reimbursements for the affected service
   c. A description of the stakeholder engagement process and the Department's response to stakeholder feedback

3 Requires an annual report on performance payments including factors such as the evidence for the performance payments, the expected outcomes, the stakeholder engagement process, and evaluation results

The bill is not expected to have any fiscal impact on FY 2017-18 expenditures, but there are projected costs and savings associated with different elements beginning in FY 2018-19 as summarized in the table below.

ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2018-19					
Accountable Care Collaborative (ACC)					
Administrative staff	$268,092	$134,046	$0	$134,046	3.7
Mandatory enrollment	29,183,877	11,177,425	1,138,171	16,868,281	
Increase PMPM by $1	15,086,585	5,778,162	588,377	8,720,046	
Savings - Mandatory enrollment	(50,830,650)	(21,621,473)	(1,882,759)	(27,326,418)	
Savings - Physical-behavioral health	(57,785,147)	(15,364,614)	(1,897,370)	(40,523,163)	
Subtotal - ACC	*($64,077,243)*	*($19,896,454)*	*($2,053,581)*	*($42,127,208)*	*3.7*
Performance payments					
Rate analyst	$66,999	$33,499	$0	$33,500	0.9
Primary care	58,062,151	20,231,923	1,159,202	36,671,026	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	26,717,069	7,215,319	1,090,836	18,410,914	
Subtotal - Performance payments	*$84,846,219*	*$27,480,741*	*$2,250,038*	*$55,115,440*	*0.9*
TOTAL FY 2018-19	**$20,768,976**	**$7,584,287**	**$196,457**	**$12,988,232**	**4.6**

ACCOUNTABLE CARE COLLABORATIVE/PERFORMANCE-BASED PAYMENTS LEGISLATION	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2019-20					
Accountable Care Collaborative (ACC)					
Administrative staff	$271,907	$135,953	$0	$135,954	4.0
Mandatory enrollment	26,169,379	10,022,872	1,020,606	15,125,901	
Increase PMPM by $1	15,379,665	5,890,412	599,807	8,889,446	
Savings - Mandatory enrollment	(95,391,901)	(41,260,953)	(3,155,463)	(50,975,485)	
Savings - Physical-behavioral health	(117,205,890)	(31,164,084)	(4,909,831)	(81,131,975)	
Subtotal - ACC	*($170,776,841)*	*($56,375,801)*	*($6,444,881)*	*($107,956,159)*	**4.0**
Performance payments					
Contract performance evaluator	$150,000	$75,000	$0	$75,000	
Rate analyst	67,977	33,988	0	33,989	1.0
Primary care	59,055,014	20,577,889	1,492,346	36,984,779	
Federally Qualified Health Centers	0	0	0	0	
Behavioral Health	28,131,120	7,503,004	1,306,187	19,321,929	
Subtotal - Behavioral health	*$87,404,111*	*$28,189,881*	*$2,798,533*	*$56,415,697*	*1.0*
TOTAL FY 2018-19	**($83,372,730)**	**($28,185,920)**	**($3,646,348)**	**($51,540,462)**	**5.0**

2018 SESSION BILLS

SB 18-145 (IMPLEMENT EMPLOYMENT FIRST RECOMMENDATIONS): Requires the Department of Labor and Employment (CDLE) and the Medical Services Board in the Department of Health Care Policy and Financing (HCPF) to promulgate rules by July 1, 2019 requiring training or certification for certain providers of supported employment services for persons with disabilities. These requirements are contingent upon appropriations to HCPF to reimburse vendors of supported employment services for the cost of training and certification. Also expands HCPF reporting requirements. Provides the following appropriations for FY 2018-19:

- $27,675 General Fund and 0.4 FTE to HCPF;
- $2,131 General Fund to CDLE for legal services; and
- $2,131 reappropriated funds to the Department of law for legal services to CDLE.

Appropriations to HCPF are expected to increase to $331,200 General Fund and 0.5 FTE in FY 2019-20.

S.B. 18-195 (HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE CASH FUND APPROPRIATIONS): Makes money in the Healthcare Affordability and Sustainability Fee (HAS Fee) Cash Fund subject to annual appropriation by the General Assembly, rather than continuously appropriated to the Colorado Healthcare Affordability and Sustainability Enterprise. The bill does not change the statutory allowable uses of the HAS Fee and any appropriations by the General Assembly would need to comply with those allowable uses.

S.B. 18-231 (TRANSITION TO COMMUNITY-BASED SERVICES TASK FORCE): Establishes a task force for transition planning to make recommendations on improvements for the transition of individuals with disabilities who are receiving services and supports in an educational setting to receiving services and supports through home- and community-based services. It specifies membership on the task force and duties including making a report to specified committees of the general assembly. Appropriates $109,500 General Fund to the Department of Health Care Policy and Financing in FY 2018-19.

SB 18-266 (CONTROLLING MEDICAID COSTS): Authorizes four new initiatives intended to control Medicaid expenditures:

- Create a resource control unit of six people (5.4 FTE in the first year) dedicated to controlling costs
- Deploy cost and quality technology for the Regional Accountable Entities and providers that identifies the most effective providers and medications to help steer clients to the best health outcomes and reduce expenditures
- Implement a comprehensive hospital admission review program, including pre-admission certification, continued stay reviews, discharge planning, and retrospective claims reviews
- Purchase commercial technology that would periodically update billing system safeguards that identify and reject inappropriate claims

The bill includes requirements for stakeholder engagement, technology testing, and reporting to the General Assembly, and parameters around coverage determinations for hospital stays. For FY 2018-19 the bill includes appropriations and assumptions about federal funds and FTE with a net result for the Department of Health Care Policy and Financing of a decrease of $2,061,973 total funds, including a decrease of $730,316 General Fund, an increase of $222,613 cash funds, a decrease of $1,554,270 federal funds, and an increase of 6.8 FTE.

HB 18-1003 (OPIOID MISUSE PREVENTION): Implements several policies related to the prevention of opioid and substance misuse. Makes appropriations to several departments, including an appropriation of $925,000 cash funds from the Marijuana Tax Cash Fund to the Department of Health Care Policy and Financing for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) training program for the development of a training module on substance-exposed pregnancies and additional funding for SBIRT grants. For additional information, see the "Recent Legislation" section at the end of Part III for the Department of Public Health and Environment.

H.B. 18-1136 (EXPAND MEDICAID BENEFIT FOR SUBSTANCE USE DISORDER): Adds residential and inpatient substance use disorder treatment and medical detoxification services as a benefit under the Colorado Medicaid Program, conditional upon federal approval. If the new benefit is enacted, requires Managed Service Organizations (MSOs) to determine to what extent money allocated from the MTCF may be used to assist in providing substance use disorder services if those services are not otherwise covered by private or public insurance. Appropriates a total of $236,827 in state funds to the Department of Health Care Policy and Financing (HCPF) for FY 2018-19 (including $155,193 General Fund and $81,634 cash funds from the Healthcare Affordability and Sustainability Fee Cash Fund), and states the assumption that HCPF will receive $236,828 federal funds for FY 2018-19.

HB 18-1161 (SUPPLEMENTAL BILL): Modifies FY 2017-18 appropriations to the Department.

HB 18-1321 (EFFICIENT ADMINISTRATION MEDICAID TRANSPORTATION): Requires that the Department of Health Care Policy and Financing (HCPF) create and implement an efficient and cost-effective method to meet urgent transportation needs within the existing Medicaid non-medical transportation benefit. This method must include medical service provider and facility access to approved transportation providers and an efficient method for obtaining and paying for transportation services. For FY 2018-19 the bill includes appropriations and assumptions about federal funds and

FTE with a net result for the Department of Health Care Policy and Financing of a decrease of $104,303 total funds, including a decrease of $34,052 cash funds, a decrease of $70,251 federal funds, and an increase of 0.8 FTE.

H.B. 18-1322 (LONG BILL): General appropriations act for FY 2018-19. Includes provisions modifying FY 2016-17 and FY 2017-18 appropriations to the Department.

HB 18-1326 (SUPPORT FOR TRANSITION FROM INSTITUTIONAL SETTINGS): Allows Medicaid clients moving from an institutional setting to a community setting to access the following transition services:

- Intensive case management
- Household set-up
- Home delivered meals
- Peer mentorship
- Independent living skills training

For FY 2018-19 the bill includes appropriations and assumptions about federal funds with a net result for the Department of Health Care Policy and Financing of a decrease of $684,116 total funds, including a decrease of $477,058 General Fund and a decrease of $207,058 federal funds. Appropriates $306,000 General Fund to the Department of Local Affairs' Division of Housing for FY 2018-19 to provide housing vouchers for HCPF transition clients.

HB 18-1327 (ALL-PAYER HEALTH CLAIMS DATABASE): Allows the General Assembly to appropriate General Fund for the operations of the All-Payer Claims Database (APCD) and establishes a scholarship grant program to support research using the APCD. The Department of Health Care Policy and Financing distributes the scholarship grants to nonprofits and governmental entities to defray the cost of research using the APCD, except that the Department may not make grants back to itself. For FY 2018-19 the bill includes appropriations and assumptions about federal funds and FTE with a net result for the Department of Health Care Policy and Financing of $2,640,790 total funds, including $1,570,395 General Fund, $1,070,395 federal funds, and 0.9 FTE.

H.B. 18-1328 (REDESIGN RESIDENTIAL CHILD HEALTH CARE WAIVER): Directs the Department of Health Care Policy and Financing (HCPF) to initiate a stakeholder process for purposes of preparing and submitting a redesigned Children's Habilitation Residential Program (CHRP) waiver for federal approval that allows for home- and community-based services for children with intellectual and developmental disabilities who have complex behavioral support needs. HCPF may also request federal authorization to change the agency designated to administer and operate the program from the Department of Human Services to HCPF. Includes language creating the redesigned program, relocates the program in statute, and makes conforming changes in statute to reflect the new location of the program. The new program will become effective once federal approval has been granted for the redesigned CHRP waiver. Appropriates $97,263 total funds, including $48,633 General Fund, to the Department of Health Care Policy and Financing in FY 2018-19 and states the assumption that the Department will require an additional 1.8 FTE.

HB 18-1329 (SUPPLEMENTAL PAYMENT DURABLE MEDICAL EQUIPMENT): Authorizes the Department of Health Care Policy and Financing to make General Fund payments, with no matching federal funds, in FY 2017-18 to providers who were negatively affected by a federal law that requires

Medicaid rates for durable medical equipment not exceed comparable Medicare rates. Appropriates $7,591,815 General Fund to the Department of Health Care Policy and Financing in FY 2017-18.

HB 18-1330 (SUPPLEMENTAL PAYMENT OFFICE-ADMINISTERED DRUGS MEDICAID): Authorizes the Department of Health Care Policy and Financing to make General Fund payments, with no matching federal funds, in FY 2017-18 to providers who were negatively affected by implementation of a federal rule that required a planned change to physician-administered drug rates to be implemented six months sooner than authorized by the General Assembly. Appropriates $754,000 General Fund to the Department of Health Care Policy and Financing in FY 2017-18.

H.B. 18-1407 (ACCESS TO DISABILITY SERVICES AND STABLE WORKFORCE): Requires the Department of Health Care Policy and Financing (HCPF) to seek federal approval for a 6.5 percent increase in the reimbursement rate for certain services specified in the bill that are delivered through the home- and community-based services intellectual and developmental disabilities, supported living services, and children's extensive supports waivers. Service agencies are required to use 100 percent of the increased funding for compensation for direct support professionals as defined in the bill. Requires service agencies to document the use of the increased funding for compensation using a reporting tool developed by the Department and the service agencies. Allows the Department to recoup from the service agency the amount of funding resulting from the reimbursement rate increase that is not used for compensation for direct support professionals. Requires the Department to assess the impact and outcomes of the reimbursement rate increase on persons with intellectual and developmental disabilities and to include the impact and outcome data, including staff stability survey data, in its annual report to the general assembly concerning the waiting list for intellectual and developmental disability services. Requires the Department to initiate 300 nonemergency enrollments from the waiting list for the home- and community-based services developmental disabilities waiver in the 2018-19 state fiscal year. Appropriates $24,586,381 total funds, including $12,185,446 General Fund, to the Department of Health Care Policy and Financing in FY 2018-19 and states the assumption that the Department will receive $12,400,935 federal funds and will require an additional 2.7 FTE.

APPENDIX C
FOOTNOTES AND INFORMATION REQUESTS

UPDATE ON LONG BILL FOOTNOTES

10 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, General Professional Services and Special Projects -- This line item includes $62,000 total funds, including $31,000 General Fund, the purpose of which is the autism waiver program evaluation required by Section 25.5-6-806 (2)(c)(I), C.R.S. It is the General Assembly's intent that the Department also use the $62,000 total funds to evaluate the new behavioral therapy benefit through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Comment: This footnote explains the purpose of the appropriation. An evaluation of the new behavioral therapy benefit was included in the statutory report. The statutory report, under the title "Behavioral Therapies for Children Annual Report – June 2018", is available from the Department's legislator resource center web site: https://www.colorado.gov/hcpf/legislator-resource-center

As of June 30, 2018, the Department ended the Children with Autism waiver, since the pediatric behavioral therapies benefit offered through the waiver is now available through EPSDT. A cleanup bill would be appropriate, especially if the General Assembly wants to continue the annual report on behavioral therapies.

The Children with Autism waiver was authorized in Section 25.5-6-801 et seq., C.R.S. Part of the statute authorizes the Colorado Autism Treatment Fund that receives two percent of the tobacco master settlement agreement revenues every year (approximately $1.6 million annually), which used to support the Children with Autism waiver and now supports the behavioral therapy benefit through EPSDT.

11 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects; Colorado Benefits Management Systems, Operating and Contract Expenses -- These line items include a total of $206,570 ($33,919 General Fund) for administrative costs related to collecting a monthly premium, on a sliding scale based on family income, for the Children's Home and Community Based Services waiver. It is the intent of the General Assembly that the Department of Health Care Policy and Financing submit the planned fees by income tier to the health committees and the Joint Budget Committee in the 2019 legislative session prior to implementing the fees in FY 2019-20.

Comment: A response to this footnote is not due until the 2019 legislative session and prior to implementing the planned fees in FY 2019-20. As background, the Department submitted a proposal last year (part of *R8 Medicaid Savings Initiatives*) for administrative costs, mostly for system changes, to begin implementing the parental fee. The Department identified an inequity with the Children's Home- and Community-Based Services (CHCBS) waiver. If a child is deemed at risk of placement in a nursing home, then the family can access Medicaid services for the child at no cost. If a child has a disability that is slightly less severe, then the family would need to pay to buy

in to Medicaid. A buy in family could potentially have less income than a CHCBS family receiving services for free.

The Department projected General Fund savings of approximately $1.4 million annually when the parental fee was fully implemented. The Department targeted beginning the fee in October 2019 and this year's request assumes savings of $1.0 million General Fund in FY 2019-20. The JBC approved last year's request, but added the footnote to ensure that the General Assembly (especially the health committees) would be able to see the actual fees, rather than projections, before the fees were implemented. Reversing or decreasing the fees would require an increase in General Fund for the Department from the current projection in R1.

The JBC and the Department have received letters objecting to the fees. The Department is engaged in outreach and stakeholder meetings about the proposed fees.

12 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses and Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department is authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote. The Department is also authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote to line item appropriations within the Department of Human Services, Office of Information Technology Services, Colorado Benefits Management System subsection.

Comment: This footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is complying with the footnote.

13 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses -- Of this appropriation, $2,500,000 remains available through June 30, 2020.

Comment: This footnote provides roll-forward authority for a limited portion of the appropriations for the Colorado Benefits Management System. The Department is complying with the footnote.

14 Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- Of the appropriation, $1,802,293 total funds, which includes $43,504 from the General Fund, is to allow Medicaid clients to receive a one-year supply of contraceptives.

Comment: This footnote explains that the purpose of a portion of the appropriation is to allow Medicaid clients to receive a one-year supply of contraceptives. The Department is on track to implement the benefit change by January 1, 2019, as assumed when the funding was added.

14a Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals -- Of the appropriation, $6,425,971 total funds, which includes $3,176,358 General Fund, is to increase rates for homemaker, personal care,

and equivalent consumer directed services, in addition to any other rate adjustments for these services.

Comment: This footnote explains that the purpose of a portion of the appropriation is to increase rates for homemaker, personal care, and equivalent consumer directed services. The Department is on track to implement the rate increases January 1, 2019, as assumed when the funding was provided.

15 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs -- It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for Program Costs.

Comment: This footnote provides flexibility for the Department to move money between line items within the Office of Community Living. The Department is complying with the footnote.

16 Department of Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs, Preventive Dental Hygiene -- It is the General Assembly's intent that this appropriation be used to provide special dental services for persons with intellectual and developmental disabilities.

Comment: This footnote explains the purpose of the appropriation to provide special dental services for persons with intellectual and developmental disabilities. The Department is complying with the footnote.

17 Department of Health Care Policy and Financing, Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program -- It is the General Assembly's intent that this appropriation be used to sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse that is authorized in Section 25.5-5-208, C.R.S., through:

- Training for health professionals statewide that is evidence-based and that may be either in person or web based;
- Consultation and technical assistance to providers, healthcare organizations, and stakeholders;
- Outreach, communication, and education of providers and patients;
- Coordination with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; and
- Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce the stigma of treatment.

Comment: This footnote explains the purpose of the appropriation to provide a grant program for substance abuse screening services. The Department is complying with the footnote.

18 Department of Health Care Policy and Financing, Department of Human Services Medicaid-Funded Programs, Executive Director's Office - Medicaid Funding -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the

Department of Human Services. Consistent with the definition of "centralized appropriation" that applies, pursuant to section 24-75-112 (1)(b), C.R.S., to the headnotes to the Long Bill, the Department of Human Services is authorized to transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing is authorized by section 24-75-105 (1), C.R.S., to make line item transfers out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This footnote authorizes transfers between line items in the Department of Human Services Medicaid-funded Programs section of the Long Bill for centralized appropriations, such as Health, Life, and Dental expenses. The Department is complying with the footnote.

19 Department of Health Care Policy and Financing, Grand Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; and Governing Boards, Regents of the University of Colorado -- The Department of Higher Education shall transfer $515,288 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continue to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $68,281,957, to the Department of Health Care Policy and Financing FY 2018-19 pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $68,281,957 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

Comment: This footnote explains the General Assembly's assumptions about supplemental payments to the University of Colorado School of Medicine. The Department is complying with the footnote.

UPDATE ON REQUESTS FOR INFORMATION

REQUESTS AFFECTING MULTIPLE DEPARTMENTS

4 Department of Health Care Policy and Financing, Executive Director's Office; and Department of Military Affairs, Executive Director and Army National Guard -- The Departments are requested to explore the potential for comparing Medicaid, veterans services, and other data sources to identify individuals who might benefit from enrolling in or expanding their use of federal Veterans Administration (VA) benefits. The Departments are requested to submit a report by November 1, 2018, addressing the following questions.

- Based on Public Assistance Reporting Information System (PARIS) data matching, how many veterans are dually enrolled in Medicaid and VA benefits in Colorado? What are the Medicaid expenditures for such dually enrolled individuals, and what share of this is supported with state funds? Provide a comparison of the most significant Medicaid service expenditures being made on behalf of these individuals and the services available through the VA. Based on this review, do the Departments believe that a significant number of dually enrolled individuals could make better use of VA services than they do presently? Based on available Colorado data and the experience of other states, do the Departments believe that assisting or encouraging a targeted group of individuals to access specific additional VA services is likely to yield service benefits to the individuals and/or financial benefits to the State? Provide an analysis of the costs and financial and other benefits the State might achieve from such an initiative. If the data indicate that benefits would outweigh the costs, include recommendations for next steps for achieving these savings. For example, should the State implement a pilot program? If so, in which department?

- How can the State identify veterans who are accessing state supported benefits such as Medicaid but who are **not** enrolled for federal veterans benefits? Can the State cross-check its enrollees with federal databases that identify former service members/ former service members known to reside in Colorado? Is relevant information about veteran status currently collected in the Colorado Benefits Management System (CBMS) or could such information be collected? What do the Departments see as the benefits versus risks associated with adding a question to CBMS about whether an applicant formerly served in the U.S. Military? Have any other states successfully launched initiatives to mine federal data or use their own benefits enrollment systems to identify veterans who may be eligible for federal benefits but who have not enrolled? If so, how have they used this data and what has been the impact?

Comment: The Departments submitted the report as requested. *See the 11/16/18 briefing for the Department of Military Affairs for more information.*

5 Department of Health Care Policy and Financing, Executive Director's Office and Department of Higher Education, Governing Boards, Regents of the University of Colorado -- Based on agreements between the University of Colorado and the Department of Health Care Policy and Financing regarding the use of Anschutz Medical Campus Funds as the State contribution to the Upper Payment Limit, the General Assembly anticipates various public benefits. The General Assembly further anticipates that any increases to funding available for this program will lead to commensurate increases in public benefits. The University of Colorado and the Department of Health Care Policy and Financing are requested to submit a report to the Joint Budget Committee about the program and these benefits by October 1, 2018.

Comment: The departments submitted the report as requested.

Beginning in FY 2017-18, the General Assembly authorized General Fund appropriated for the University of Colorado for the School of Medicine to be transferred to the Department of Health Care Policy and Financing, so that it could be matched with federal funds for a supplemental payment to University of Colorado Medicine (CU Medicine), which is the organization that

handles clinical billing for the faculty of the School of Medicine. CU Medicine then makes a payment back to the University of Colorado equal to the original appropriation for the School of Medicine. The net result is that the University of Colorado's School of Medicine receives the same funding, but the faculty receives significant additional funds for their clinical work for Medicaid clients. In FY 2017-18, the additional funds for the faculty totaled $62.0 million.

The request for information expresses the General Assembly's expectations that the funding will result in public benefits and that any increase in funding will lead to commensurate increases in public benefits. From FY 2017-18 to FY 2018-19 the General Fund available to match federal funds increased $6.8 million, or nearly 11.0 percent. The report does not address how the public benefit expectations for FY 2018-19 compared to FY 2017-18 have increase commensurately.

The report describes FY 2017-18 as a "building year" dedicated to infrastructure, increasing staffing, and completing initial assessments and planning activities. It describes how the money was allocated by initiative, which aligns with testimony the JBC received when the General Assembly initially approved the financing, and it mentions a plan for 10 percent of the funding to be tied to performance. However, there is almost no quantifiable information in the report on the actual public benefits achieved in FY 2017-18.

Instead of providing metrics, the report indicates in a narrative format that the funding accomplished:

- A family medicine residency position
- Six department personnel
- Extension for Community Health Outcomes (ECHO), which is a telemedicine program
- Rural track program support
- Rural track and diversity scholarships
- Sickle Cell Center support
- Supplemental payments to providers for direct clinical care
- Collaborative analytics projects with the CU School of Medicine Health Data Compass program
- Filling positions required for the successful performance of programmatic deliverables

The report discusses a Community Needs Assessment that informs the project plan and identifies the following areas of focus for future expenditures:

- Mental and behavioral health access for adults and children, including substance use disorder treatment
- Adult specialty access
- Pediatric specialty access, with an emphasis on developmental pediatrics and services for children and youth with special health care needs
- Comprehensive integrated primary care teams for adults and children
- Transitions of care programs for high risk and/or high utilizing Medicaid patients

Near the end, the report indicates that over a two-year period from July 2017 through June 2019 the aim is to care for an additional 15,000 unique Medicaid clients. One of the primary promises of the departments when the JBC agreed to support the request was that the CU physicians would see 15,000 additional Medicaid clients. The report does not indicate how many additional clients were seen in FY 2017-18 or why a two-year ramp up is required.

6 Department of Health Care Policy and Financing, Medical Services Premiums; Indigent Care Program, Children's Basic Health Plan Medical and Dental Costs; Department of Higher Education, Colorado Commission on Higher Education, Special Purpose, University of Colorado, Lease Purchase of Academic Facilities at Fitzsimons; Governing Boards, Regents of the University of Colorado; Department of Human Services, Division of Child Welfare, Tony Grampsas Youth Services Program; Office of Early Childhood, Division of Community and Family Support, Nurse Home Visitor Program; Department of Military and Veterans Affairs, Division of Veterans Affairs, Colorado State Veterans Trust Fund Expenditures; Department of Personnel, Division of Human Resources, Employee Benefits Services, H.B. 07-1335 Supplemental State Contribution Fund; Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division, Administration, General Disease Control, and Surveillance, Immunization Operating Expenses; Special Purpose Disease Control Programs, Sexually Transmitted Infections, HIV and AIDS Operating Expenses, and Ryan White Act Operating Expenses; Prevention Services Division, Chronic Disease Prevention Programs, Oral Health Programs; Primary Care Office -- Each Department is requested to provide the following information to the Joint Budget Committee by November 1, 2018, for each program funded with Tobacco Master Settlement Agreement money: the name of the program; the amount of Tobacco Master Settlement Agreement money received and expended by the program for the preceding fiscal year; a description of the program including the actual number of persons served and the services provided through the program; information evaluating the operation of the program, including the effectiveness of the program in achieving its stated goals.

Comment: *See the 11/27/18 briefing for tobacco-related programs for a discussion of this request for information.*

DEPARTMENT OF HEALTHCARE POLICY AND FINANCING

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

Comment: The Department continues to submit the monthly expenditure and caseload reports as requested. *See the issue brief "Forecast Trends" for more information.*

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

Comment: The requested report is not due until February.

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

Comment: The Department submitted the report as requested.

When schools provide health services to public school children with disabilities, as required by federal and state law[7], and the children are eligible for Medicaid, then federal funds can reimburse a portion of the expenses. Qualifying services include those provided as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). In addition, administrative expenses that directly support efforts to identify and enroll potentially eligible children may qualify for reimbursement.

Schools pay for the services and then complete documentation to get the costs certified as public expenditures by the Department of Health Care Policy and Financing in order to claim the matching federal funds. Under state law, schools must use the additional federal funds to expand or enhance health services for all students through a Local Services Plan developed with community input.

Examples of qualifying services include rehabilitative therapies, services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, personal care, and specialized non-emergency transportation services. Primary care and behavioral health services that are not part of an IEP or IFSP do not qualify through this program.

Services must be "medically necessary" as determined by a referral and authorization process. A qualified practitioner of the healing arts refers a client for services and the services become authorized when included in the IEP or IFSP. The Public School Health Services program defines "medically necessary" in Colorado regulation[8] as a service expected to:

. . . prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

[7] Individuals with Disabilities Education Act, Section 504 of the Rehabilitation act of 1973, and Title 22, C.R.S.
[8] 10 CCR 2505-10, Section 8.290.1.

For services provided in FY 2016-17, school districts and Boards of Cooperative Education Services received $43.4 million in federal funds through the Public School Health Services program. The service areas most frequently targeted for additional support by the Local Service Plans include $7.8 million for nursing services, $7.8 million for mental health services, $2.9 million for technician/clinic aid hours, and $1.3 million for outreach to the uninsured. Due to the timing of payments, data is only available for three quarters of interim payments for services provided in FY 2017-18.

Detailed information on the distributions by school and the number of children served is available in the report, which is available from the Department's legislator resource center:

https://www.colorado.gov/hcpf/legislator-resource-center

The Public School Health Services program related to expenditures for children with disabilities is sometimes confused with the School-Based Health Center program operated by the Department of Public Health and Environment. The School-Based Health Center program provides $5.0 million in General Fund grants for primary care clinics within public schools. If these clinics enroll as Medicaid providers and submit claims for covered services supplied to Medicaid clients, they can receive Medicaid payments, just like any other provider. Those primary care services offered by School-Based Health Centers would not be part of the services for children with disabilities that the Public School Health Services program certifies as public expenditures to receive matching federal funds.

4 Department of Health Care Policy and Financing, Office of Community Living; Department of Human Services, Services for People with Disabilities, Regional Centers; and Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, Health Facilities Division -- The Departments are requested to provide by November 1, 2018 the status of the implementation of Regional Center Task Force recommendations.

Comment: The Department submitted the report as requested. *See the 12/11/18 briefing on the Office of Community Living for an analysis of the report.*

5 Department of Health Care Policy and Financing, Office of Community Living – The Department is requested to provide to the Joint Budget Committee, by November 1, 2018, information concerning the intellectual and developmental disabilities home and community based services waiver search function on the Department's website, including the process through which the Department will: publicize the search functionality of the website, determine the degree to which individuals are utilizing the website to find the services and providers they need; and the degree to which individuals utilize the information obtained through the website. In addition, the Department is requested to provide data for each of the above metrics.

Comment: The Department submitted the report as requested. *See the 12/11/18 briefing on the Office of Community Living for an analysis of the report.*

APPENDIX D
DEPARTMENT ANNUAL PERFORMANCE REPORT

Pursuant to Section 2-7-205 (1)(a)(I), C.R.S., by November 1 of each year, the Office of State Planning and Budgeting is required to publish an **Annual Performance Report** for the *previous fiscal year* for the Department of Health Care Policy and Financing. This report is to include a summary of the Department's performance plan and most recent performance evaluation for the designated fiscal year. In addition, pursuant to Section 2-7-204 (3)(a)(I), C.R.S., the Department of Health Care Policy and Financing is required to develop a **Performance Plan** and submit the plan for the *current fiscal year* to the Joint Budget Committee and appropriate Joint Committee of Reference by July 1 of each year.

For consideration by the Joint Budget Committee in prioritizing the Department's FY 2019-20 budget request, the FY 2017-18 Annual Performance Report dated October 2018 and the FY 2018-19 Performance Plan dated November 2018 can be found at the following link:

https://www.colorado.gov/pacific/performancemanagement/department-performance-plans